

ANNUAL HEALTH PROTECTION REPORT FOR PETERBOROUGH CITY COUNCIL FOR 2014

1. Introduction

- 1.1. Upon implementation of the Health and Social Care Act 2012, on 1 April 2013, the Peterborough City Council, through the Director of Public Health (DPH), took on statutory responsibilities to advise on and promote local health protection plans across agencies, which complements the statutory responsibilities of Public Health England, NHS England, the Clinical Commissioning Group (CCG) and the City Council. Prior to that date, Peterborough Primary Care Trust (PCT) had arrangements in place through various groups (both strategic and operational) to ensure these responsibilities were discharged and to allow for professional dialogue about new initiatives, local pressure points etc. and to have a clear escalation plan in place, should it be needed.
- 1.2 The Health and Well Being Board (HWB) has statutory responsibilities and has developed a health and wellbeing strategy 2012-15. Whilst much of this relates to health improvement, health protection is interwoven into the strategy's aims, particularly in relation to priority two- 'preventing and treating avoidable illness'.
- 1.3 The services that fall within Health Protection include:
 - communicable diseases
 - infection control
 - routine antenatal/new born, young person and adult screening
 - routine immunisation and vaccination
 - sexual health
 - environmental hazards.
- 1.4 It is important that there is publicly available information that demonstrates that statutory responsibilities for health protection have been fulfilled; to have the means to seek assurance of this; and to have processes in place to address and escalate any issues that may arise.
- 1.5 To facilitate information sharing and planning across agencies, the DPH has established the Peterborough Health Protection Committee (PHPC). In addition to this Committee, "Task and Finish" groups may be convened to address specific issues, taking into account the reduced staff resources overall in the system, the need to work in partnership to ensure that maximum efficiency is achieved.
- 1.6 The DPH will produce an annual health protection report to the Health & Wellbeing Board (HWB) which would provide a summary of relevant activity. This report will cover the multi-agency health protection plans in place which establish how the various responsibilities are discharged and identify their relationship to the Joint Strategic Needs Assessment and

Health and Wellbeing Strategy priorities. Any other reports will be provided on an ad hoc or exceptional basis where a significant incident, outbreak or concern had arisen.

2. Background

2.1 In order to have the oversight that is necessary to meet their statutory responsibilities the DPH needs:

- To be able to, on behalf of the City Council, advise on and promote local health protection plans across agencies. This role complements the statutory responsibilities of Public Health England (PHE), NHS England, and the CCG;
- To be assured, on behalf of the City Council, of Health Protection arrangements by relevant organisations in the Local Authority area;
- To be provided with information, including surveillance and other data from PHE and other partners, in order to be able to scrutinise and as necessary challenge performance;

- On the basis of this scrutiny to be able to provide strategic challenge to health protection plans/arrangements produced by partner organisations;
- To have a clear escalation plan in place agreed with the Local Authorities, PHE, NHS England, CCG, and Department of Health (DH) to enable any concerns to be escalated as appropriate, including to the Local Health Resilience Partnership (LHRP);
- To have clear agreement that information on all local health protection incidents and outbreaks, including screening incidents, are reported to the DPH such that the DPH can take any necessary action, working in concert with PHE and the NHS. This may include, for example, chairing an outbreak control committee, or chairing a look back exercise in response to an untoward incident;
- To be a member of, and to contribute to, the work of the Cambridgeshire and Peterborough LHRP. The lead DPH for the area and co-chair of the LHRP is currently provided by Cambridgeshire;
- To provide the public health input into the city council emergency management plan;
- To be able to provide a comprehensive annual report to the HWB on all aspects of health protection to include performance, issues and incidents.

2.2 While the DPH is accountable to the Secretary of State for Health as well as to Peterborough City Council, Peterborough Health and Well-being Board and the Peterborough population for providing advice on health protection in the local authority, the DPH has no managerial responsibility for other organisations that provide the services that deliver health protection.

2.3 To enable the DPH to fulfil these statutory responsibilities, the Health Protection Committee (PHPC) was established in October 2013 and is chaired by the DPH or nominated deputy. The PHPC enables all agencies involved to demonstrate that statutory responsibilities for health protection have been fulfilled; to have the means to seek assurance of this; and to have processes in place to address and escalate any issues that may arise. The PHPC reports to the Health and Wellbeing Programme Board. In addition, a memorandum of understanding (MOU) has been developed and agreed with partner organisations.

3 Peterborough Health Protection Committee

- 3.1 The aim of the Health Protection Committee is to provide assurance to the Director of Public Health and Peterborough Health & Wellbeing Board that there are safe and effective mechanisms in place to protect the health of the population of Peterborough.
- 3.2 To provide a forum for information sharing and planning between public agencies that have responsibilities in Peterborough for health protection as defined in 1.3.
- 3.3 To receive reports from member agencies that enable monitoring of these arrangements and reporting of any issues or incidents.
- 3.4 To provide a mechanism to consider the implications of national guidance/changes for local implementation and be assured that there are mechanisms in place for their delivery.
- 3.5 To identify:
 - Gaps and issues which need resolution by one or more of the member agencies
 - Procedures/processes which need to be developed or improved
 - The actions that need to be taken jointly by member agencies
 - Gaps and resources needed by the Committee to function effectively, e.g. missing data or information.
- 3.6 To support the production of an annual health protection report for submission to the HWB.
- 3.7 Public health emergency planning responsibility is shared between the Local Health Resilience Partnership (LHRP), which is co-chaired by the NHS England Area Team Director of Operations and the Cambridgeshire DPH and the Local Health Resilience Forum. The DPH will report health protection emergency planning issues to the LHRP on a regular basis.
- 3.8 The membership of the PHPC includes:
 - Director of Public Health (Peterborough City Council)
 - Consultant in Public Health Medicine (Peterborough City Council)
 - Public Health England Anglia & Essex Centre: CCDC
 - Cambridgeshire and Peterborough CCG (rep for HCAI)
 - NHS England Area Team (Screening & Immunisation)
 - Acute Trust (Infection Prevention & Control/Microbiology)
 - Environmental Health Officer (Peterborough City Council)
 - Sexual Health Commissioner (Peterborough City Council)
 - Adult Social Care Representative (Peterborough City Council)
 - Children's Services Representative (Peterborough City Council)
 - Resilience Representative (Peterborough City Council)

The Committee will be chaired by the Director of Public Health or the Consultant in Public Health Medicine.

4 Memorandum of Understanding

4.1 A Memorandum of Understanding (MOU) for Health Protection was signed in July 2014, following discussion in the PHPC and consultation with partner organisations. Signatory organisations include:

- NHS England : East Anglia Area Team
- Public Health England : Anglia & Essex Centre
- Cambridgeshire & Peterborough Clinical Commissioning Group
- Peterborough City Council

4.2 The purpose of the MOU is to ensure that new agreements and protocols are in place that meet the needs of the organisations that are responsible for discharging health protection responsibilities after implementation of the Health and Social Care Act, 2012.

4.3 The scope of the MOU includes:

- Organisational roles and responsibilities for health protection in Peterborough
- The role of Peterborough Health Protection Committee
- Arrangements for 24/7 on call for public health
- Information sharing arrangements to ensure sharing of routine and ad hoc (outbreaks and incidents) data with the Director of Public Health, Peterborough City Council and between partner organisations
- Escalation and management arrangements for public health incidents
- Arrangements for the management of cross-border incidents and outbreaks
- Escalation and information sharing arrangements for public health incidents
- Arrangements for exercising and testing plans for Peterborough
- Arrangements for the review of the MOU.

5 Joint Communicable Disease Outbreak Management Plan

5.1 This Plan, which was led by Public Health England with input from local public health teams in its development, provides a framework for partnership working across the new public health structures including the Public Health England Centre (PHEC) local health protection team (HPT), local authority public health directorates and local authority (LA) environmental health departments, Clinical Commissioning Groups (CCGs), NHS England (NHSE) and other relevant bodies.

5.2 The plan was adopted as a working draft for use by public health teams across Cambridgeshire, Peterborough, Norfolk and Suffolk prior to the final draft being circulated and signed-off by all partner organisations in summer 2014.

5.3 It constitutes a joint plan to manage an outbreak or significant incident of communicable disease/infection in Norfolk, Suffolk, Cambridgeshire and Peterborough. It covers a range of scenarios from a minor outbreak that will be managed within the PHE HPT to an outbreak which could lead to a major incident being declared that requires a full multi-agency response.

5.4 For this plan, the term 'outbreak', refers both to outbreaks and significant incidents of communicable disease and infection.

- 5.5 The plan gives clarity on roles and responsibilities in managing an outbreak -essential to providing a coordinated approach to management- including communication, investigation and control procedures.
- 5.6 In addition to PHE, NHS organisations (providers and commissioners) and Peterborough Public Health team, the varied nature of outbreaks will lead to the involvement of a number of partners in their investigation and management. These may include:
- Local Authority (LA) Environmental Health (EH) Services;
 - School or care home representatives where the outbreak affects specific groups;
 - Health and Safety Executive (HSE) where HSE enforced premises are involved;
 - The Animal Health and Veterinary Laboratories Agency (AHVLA) will be involved in the event of an outbreak of a zoonotic disease;
 - Water Company representatives if water supplies are affected e.g. cryptosporidiosis.

This plan has been tested and judged to be effective in both exercises and actual incidents.

6 Surveillance

6.1 In order to understand and monitor the incidence of communicable diseases, the effectiveness of prevention activities such as immunisation, and the threats posed by new and emerging infections, the UK has an active communicable disease surveillance service provided by PHE both through national centres and through their Field Epidemiology Teams. These teams provide a wide range of reports on a frequent basis ranging from weekly through to annual reports.

6.2 Notifications of Infectious Diseases

Doctors in England and Wales have a statutory duty to notify a Proper Officer of the local authority, usually the Consultant in Communicable Disease Control in the local Health Protection Team (HPT), of suspected cases of certain infectious diseases. These notifications, along with laboratory and other data, are an important source of surveillance information. The table below shows the notifiable diseases reported to the HPT from 1 April 2011 – 31 March 2014.

Table 1: Notifications of Infectious Diseases in Peterborough by year 2011-2014

Notifiable Disease*	1 Apr 2011 - 3 Mar 2012	1 Apr 2012 - 31 Mar 2013	1 Apr 2013 - 31 Mar 2014
Acute encephalitis	0	0	0
Acute infectious hepatitis ¹	8	10	12
Acute meningitis	7	1	2
Enteric fever	1	2	0
Food poisoning ²	222	328	304
Infectious bloody diarrhea	0	13	15
Invasive group A streptococcal disease	11	6	6
Legionnaires' disease	1	3	1
Malaria	3	5	0
Measles ³	3	11	16
Meningococcal septicaemia	4	5	2
Mumps	14	16	9
Rubella ⁴	4	6	1
Scarlet fever	7	26	12
Whooping cough ⁵	1	39	20

SOURCE: Anglia HPT HPZone

Notes:

1. In recent years Hepatitis E has become a more frequent cause of acute viral hepatitis. It used to be associated with travel to endemic areas (especially the Indian sub-continent) but an increasing proportion of cases are now acquired in the UK. There is a growing awareness that undercooked pork products can be associated with the infection. In most cases the illness is self-limiting and the person makes a full recovery. It can be severe if it affects someone who is immunocompromised.
 2. Campylobacter is the most frequent organism identified as causing food poisoning. The Food Standards Agency is encouraging the big supermarkets to look at ways of reducing the risk of infection from poultry products.
 3. These reports are made on the basis of a clinical diagnosis. The Health Protection Team sends out a sampling kit to collect oral fluid to confirm the clinical diagnosis. The last case of measles confirmed by this method was reported in 2012.
 4. None of these cases was confirmed by oral fluid testing.
 5. In 2012 there was a big outbreak of pertussis (whooping cough) nationally affecting people of all ages. As the effects of infection are most severe in young babies a national programme offering vaccination to pregnant women was introduced which remains in place.
- 6.2.1 Food poisoning remains the most commonly notified infectious disease, with campylobacter accounting for the vast majority.
- 6.2.2 Measles activity rose in 2012-13 but showed a drop in 2013-14. The confirmed cases in 2013 were mainly in school-age children. Experts believe the rise in measles cases can be mostly attributed to the proportion of unprotected 10-16 year olds who missed out on vaccination in the late 1990s and early 2000s when concern around the now discredited opinion about a link between autism and the vaccine was widespread. A national catch-up programme to increase MMR immunisation uptake in children and teenagers was launched in April 2013.
- 6.2.3 Whooping cough (Pertussis) is a cyclical disease with increases occurring every 3-4 years. The third quarter (running from July to September) is usually the period of highest pertussis activity annually. In Peterborough, similar to the national picture, whooping cough cases rose sharply in 2012-13; but fell during 2013-14.

6.3 Healthcare Associated Infection (HCAI) and Antimicrobial Resistance (AMR)

6.3.1 HCAI

National mandatory reporting has remained in place for multi-resistance Staphylococcus Aureus (MRSA) bacteraemia and Clostridium difficile since 2009.

There is now a zero tolerance of preventable MRSA bacteraemia with our own hospital in Peterborough not having had a case for more than two and half years.

National processes have highlighted that some cases are not attributable to either a hospital or the CCG, which had been the only options, and in April 2014 an assignment category of 'third party' was introduced in recognition that there are often many other providers involved in patient care within the community.

Two cases identified in Peterborough Hospital (September and October 2014) have been assigned as 'third party' following an arbitration process which is managed by the Regional Nursing Director.

The number of Clostridium difficile cases nationally continues to fall but at a slower rate, significant reductions having already been made. There are still challenges for some Trusts to achieve this; however, Peterborough have had a better year by maintaining the trajectory line. The most important factor is to review every single case through the root cause analysis process and scrutiny panel meetings which are held for each new case. There has been further change this year at a national level where cases identified to meet assessment criteria can be removed from the local trajectory. This is managed locally at CCG level by the Lead Nurse for Infection Prevention Control.

6.3.2 **Antimicrobial Resistance**

The prescribing of antibiotics continues to be monitored by the Medicines Management Team within the CCG for primary care and by hospital pharmacists for in-patient prescriptions. Prescribing is also noted and discussed at each scrutiny panel for Clostridium difficile and following completion of the root cause analysis. Any concerns identified with primary care are either discussed with the GP directly or with the medicines management team. The medicines management team have identified high prescribing levels of two particular groups of drugs over recent months which is being looked into to better understand the reasons for this change; a strategy is being prepared to address the associated issues, one of which is the increased risk of developing Clostridium difficile. It should also be noted that although these groups of drugs should be limited in general use, the condition of individual patients may specifically require their prescription. The outcome from the strategy will be known in the early part of 2015/16.

Antimicrobial resistance has been identified as a national and international risk to human health by the Chief Medical Officer, WHO and the government as a whole. Antibiotics are widely used in animal health and farming; are available over the counter without a prescription in many countries; and far too many people fail to complete the prescribed course or demand antibiotics for viral or self-limiting conditions here in the UK. All these factors contribute to the development of antimicrobial resistance. In addition, no new class of antibiotics has been developed by the pharmaceutical industry in recent years.

6.4 Eastern Field Epidemiology Unit (EFEU)

The EFEU, which is part of PHE, provides regular updates with electronic links to relevant data for a wide range of communicable diseases. As this data is available on line from PHE, it is not reproduced here. The monthly reports include data on:

- Sexual and reproductive health
- Tuberculosis
- Influenza and flu-like illnesses
- Legionnaires disease
- Healthcare associated infection
- Vaccine preventable diseases
- Anti-microbial resistance
- Sexually transmitted diseases
- HIV
- Hepatitis
- Ante-natal screening
- Notifiable infectious diseases
- Gastro-intestinal infections

7 Prevention

The focus of this section is the delivery of the Immunisation and Screening programmes. From April 2013, Screening and Immunisation programmes have been commissioned by NHS England as per a Public Health agreement under section 7A of the 2006 NHS Act as inserted into the Health and Social Care Act 2012.

NHS England East Anglia Area Team leads on commissioning the following programmes for the population of Peterborough:

- Immunisation programmes: neonatal and childhood, school age and adult immunisations
- Cancer Screening: Breast, Cervical and Bowel cancer programmes
- Adult and Young People Screening: Abdominal Aortic Aneurysm (AAA) and Diabetic Eye Screening (DES)
- Antenatal and Newborn Screening programmes

7.1 Immunisation Programmes

7.1.1 A number of immunisation programmes are provided in the UK to protect our population against infectious diseases that, when they were common, caused considerable morbidity and mortality. With the advent of these immunisation programmes many of these conditions are virtually unknown today in this country. However this success can lead to complacency, in turn leading to a drop in immunisation rates. The aim of our universal immunisation programmes is to provide 'herd immunity' which can be defined as the form of immunity that occurs when a sufficient proportion of a population is vaccinated to break transmission of infection and so provide protection for individuals who have not developed immunity. Some people may have weakened immune systems for a variety of reasons and do not acquire full immunity to the illness as a result of immunisation. Others, who choose not to be vaccinated, may also be protected by 'herd immunity' if sufficient people are immunised. For the majority of universal immunisation programmes, 'herd immunity' depends on 90 to 95% of the population being immunised.

7.1.2 The annual coverage data for the universal childhood immunisation programmes has recently been published (see table2). Targets for some of the childhood immunisations are included in the Public Health Outcomes Framework. For most of the childhood vaccination programmes, Peterborough is below the 95% level for herd immunity. There are a number of factors which cause this:

- Some families choose not to have their child immunised
- Some families may have difficulty accessing services for immunisation;
- Some children have been immunised but not according to the schedule in England, resulting in their immunisation not being recorded on the national system. This is a particular problem in Peterborough , where there is a high, relatively transient population related migrant workers and new immigrants whose children may have been fully immunised in their home country, but not recorded by the UK system;
- Some children have been immunised according to the schedule but the data has not been recorded or properly reported. A new electronic template is in development by CCG staff for Cambridgeshire and Peterborough GP practices to use to improve recording;
- Some of the children, reported as not attending for immunisation when invited, may no longer live in Peterborough. If they had moved within the UK, their registration with a new UK GP would lead to them being removed from the register in Peterborough , so, in most of these cases, the children are likely to have moved overseas not knowing that they should advise their GP to de-register them.

- 7.1.3 A multi-agency Task and Finish group has been convened to try to find solutions to these issues and addresses the inequalities in uptake of childhood immunisations in inner city practices and deprived populations. It is planned to report initial findings and recommendations to the HPC in March 2015 and to the HWB in the summer.

Table 2: Annual Childhood Vaccination Uptake for Age 12 months Peterborough, 2013/14

12 months					
	Number	DTaP/IPV/Hib % [number]	PCV % [number]		
P'boro LA	3,228	94.4 [3,048]	94.4 [3,047]		
England	686,157	94.3	94.1		

Source: Cover

Table 3: Annual Childhood Vaccination Uptake for Age 24 months for Peterborough, 2013/14

24 months					
	Number	DTaP/IPV/Hib % [number]	MMR 1 % [number]	Hib/men C % [number]	PCV B % Number
P'boro LA	3,065	96.4 [2,955]	92.2 [2,825]	92.2 [2,826]	91.9 [2,816]
England	697,246	96.1	92.5	92.5	92.4

Source: Cover

Table 4: Annual Childhood Vaccination Uptake for Age 5 years for Peterborough, 2013/14

5 years						
	Number	DTaP/IPV/Hib % [number]	DTaP/IPB B % [number]	MMR 1 % [number]	MMR 1&2 % [number]	Hib Men C B % [number]
P'boro LA	3,201	94.1 [3,011]	84.9 [2,717]	91.4 [2,927]	83.6 [2,675]	85.9 [2,749]
England	681,925	95.6	88.8	94.1	88.3	91.9

Source: Cover

7.1.4 Targeted Vaccination programmes

Other childhood immunisation programmes include BCG (Bacillus Calmette–Guérin) vaccination and Hepatitis B vaccination as targeted programme for those identified as being at specific risk.

- 7.1.5 BCG vaccine, for prevention of TB (Tuberculosis) is not a very effective vaccine and the universal programme was stopped many years ago, however, because it confers some immunity, it continues to be recommended for newborn babies who:

- Are born in an area with a high incidence of TB – high incidence is defined by the World Health Organisation as 40 or more new cases per 100,000 population per year (the Peterborough rate is 28.7/100,000 for 2014)
- Have one or more parents or grandparents who were born in countries with a high incidence of TB

In Peterborough we have had a very successful programme for BCG vaccination of newborn in maternity services and via Community TB nurses to babies who fit the criteria and have moved in to the area resulting in high uptake. However we do not have clear denominator data about the number of babies born in Peterborough that meet the second criterion.

- 7.1.6 Hepatitis B vaccination is given at birth with 3 further boosters up to 12 months for babies born to Hepatitis B positive mothers. PHE is working with GPs to improve the provision of the final blood test, using a dried blood spot, to confirm sero-conversion after immunisation.

Table 5: Hepatitis B vaccination

	Q1	Q2	Q3	Q4
	Peterborough %			
Hep B 12 months			66.7	*NA
Hep B 24 months			100	100

*The numbers of babies requiring Hepatitis B vaccination is small; therefore the percentage uptakes are affected by ‘small cohort number effect’ on rates and ratios.

- 7.1.7 School based programmes

There are some immunisation programmes delivered in schools, for the school age population; others are provide via primary care. Human Papilloma Virus vaccine (HPV) is offered to girls and a teenage Meningitis C vaccine to all in a specific school year group. Other programmes are in the process of introduction and are discussed under the section on new immunisation programmes section, below.

- 7.1.8 The relatively recent programme of vaccination of girls aged 12 – 13 against Human Papilloma Virus (HPV) which is a causative factor in Cervical Cancer has been very successful.

Table 6: Annual HPV vaccination uptake all 3 doses by local authority

School year 2013-14	Peterborough	England
HPV uptake	84.7%	86.7%

Source: www.gov.uk

7.1.9 Influenza Vaccination

Influenza (Flu) vaccination is recommended for specific population groups and is given from October to January each year to protect those most vulnerable to flu infection. For the 2013/4 season the recommended groups were:

- All those aged 65 or over
- Those aged 6 months to 65 years with long term medical conditions who are in the high risk groups for flu vaccination
- Pregnant women
- Those in long stay residential or nursing homes
- Carers of elderly or disabled people
- Health and social care staff who are in direct contact with patients/clients
- All children aged two and three

7.1.10 Plans were developed by the ¹Cambridge and Peterborough Immunisation and Vaccination Committee for the 2014/5 programme and included commissioning community pharmacies to vaccinate the at risk groups in the community. This has complemented the existing services provided by GPs and maternity units. This year pharmacies will also be permitted to provide an “outreach” service in suitable locations to these groups.

7.1.11 For the City Council the most important groups are those who are in front line roles caring for vulnerable groups in the community. Immunising these staff protects them from getting flu, thus reducing the risk of them being off sick, and in turn protects both their clients and their own families. Employers of front line staff are expected to organise and fund immunisation of their front line staff. Peterborough City Council offered to provide vouchers for immunisation to front line staff in adult social care; 29 were taken up by staff. For those not directly employed, it will be helpful if commissioning contracts are explicit about an expectation that every effort will be made to ensure that care staff are offered immunisation.

¹ A multi agency forum with key stakeholders, chaired by Public Health England/NHS England

Table 7: Flu vaccination uptake (%) in Peterborough by risk groups

Risk Group	2013/14 (%)	2014/15 Validated data not yet available
Over 65yrs	72.2	
Under 65yrs at risk	50.7	
Pregnant and in another clinical risk group	64.8	
Pregnant but not in any other clinical risk group	41.9	
All pregnant	43.6	
Carers	n/a	
Age 2 not in a risk group (new programme)	30.9	
Age 2 (in a clinical risk group)	40.4	
Age 3 not in a risk group (new programme)	40.6 31.3	
Age 3 (in a clinical risk group)	53.8 46.8	

School Pilot of influenza immunisation – years 7 and 8

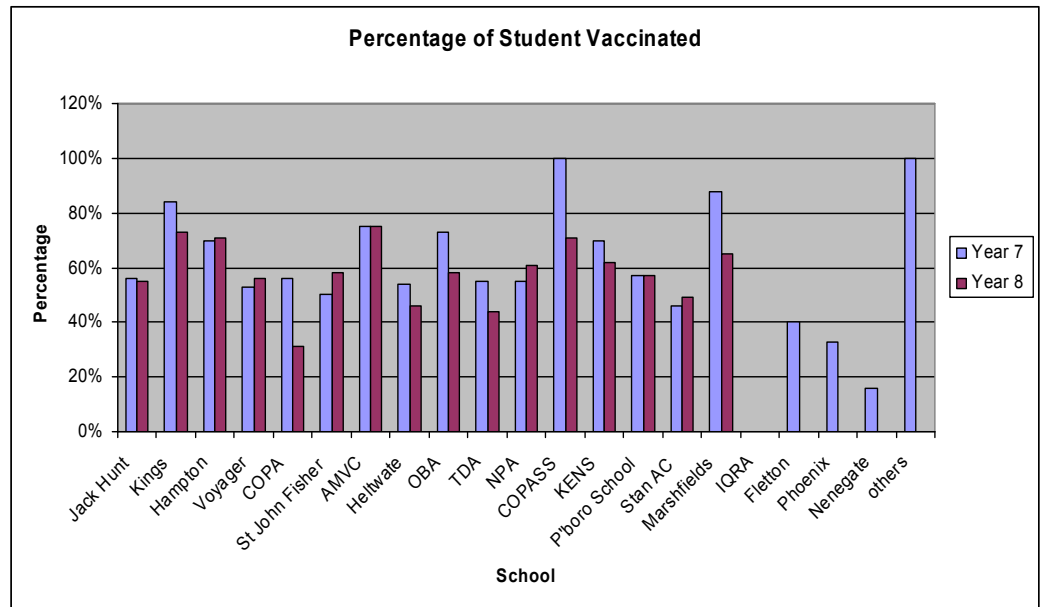


Table 8: Flu vaccination uptake (%) – Peterborough hospitals frontline staff

Uptake to Jan 2014 Health Care workers	2012/3	2013/4 %
PSHFT	71.5	75.3
CPFT	23.7	54.2
Cambridgeshire Community Services (CCS)	37.0	51.5

Source www.gov.uk

7.1.12 Pertussis vaccination in pregnancy

In the first seven months of 2012, nationally, 235 babies under 12 weeks old had whooping cough and 13 babies died from it. This led to the introduction of a programme to vaccinate pregnant women between 28 and 38 weeks of pregnancy to protect them and their babies who were too young to be immunised themselves. Following the introduction of this programme, there was a 79% drop in cases to 85 in 2013.

Uptake rates are available for the East Anglia Area and not for Peterborough residents alone.

Table 9: Pertussis vaccination uptake (%) by pregnant women

	April	May	June	July	August
East Anglia Area	60.6%	60.5%	57.2%	55.8%	55.5%

8 Screening Programmes

NHS England, which is the commissioner of these services, reported that all the screening programmes are delivering as planned for the population of Peterborough.

8.1. Antenatal and newborn screening

The following data have been provided by NHS England Screening and Immunisation Team. Screening data for Quarter 4 of 2013/14 will not be available until later this year. For the Antenatal and Newborn Screening programme, some units have not returned data for some of the programmes. The provider trusts have put in place measures to improve reporting of their data.

8.1.1 Ante-natal screening includes routine testing for a number of conditions that can adversely affect the health of the baby as well as the mother including:

- HIV
- Hepatitis B
- Syphilis
- Rubella susceptibility
- Sickle Cell and Thalassemia
- Down's syndrome

8.1.2 Newborn screening includes testing for a number of conditions that are not obvious at birth but would have serious consequences for the baby if not detected and treated early, including:

- Newborn blood spot test which detects conditions such as congenital hypothyroidism; phenylketonuria; sickle cell disease; cystic fibrosis; and medium chain acetyl-CoA dehydrogenase deficiency (see <http://www.newbornbloodspot.screening.nhs.uk/> for explanations of each of these conditions)
- Newborn infant physical examination
- Newborn Hearing screening

And, from January 2015, new screening tests (as part of the newborn blood spot test) for

- Maple syrup urine disease
- Homocystinuria
- Glutaric acidaemia type 1
- Isovaleric acidaemia.

Table 10: Ante-natal screening coverage

	Q1 April-June 2013	Q2 July-Sept 2013	Q3 Oct-Dec 2013	Q4 Jan–April 2014
HIV screening (standard is to achieve >90%)				
Peterborough & Stamford Hospital Foundation Trust	98.2	99.1	98.6	98.6
Down's Screening (standard >97%)				
Peterborough	98.3	98.4	98.9	98.8
Sickle Cell and Thalassaemia screening (standard >95%)				
Peterborough	93.5	93.6	93.7	96.0

	Q1 April –June 2014	Q2 July –Sept 2014	n/a
HIV screening (standard is to achieve >90%)			
Peterborough & Stamford Hospital Foundation Trust	97.9	98.7	
Down's Screening (standard >97%)			
Peterborough & Stamford Hospital Foundation Trust	96.5	98.8	
Sickle Cell and Thalassaemia screening (standard >95%)			
Peterborough & Stamford Hospital Foundation Trust	96.0	95.5	

Table 11: Newborn Bloodspot test (standard 95-99%)

	Q1 April-June 2013	Q2 July-Sept 2013	Q3 Oct-Dec 2013	Q4 Jan-April 2014
Peterborough & Stamford Hospital Foundation Trust	100	99.5	99.7	99.9
Newborn Bloodspot – avoidable repeat tests (standard <2%)				
Peterborough & Stamford Hospital Foundation Trust	2.4	1.0	0.9	1.9

	Q1 April-June 2014	Q2 July-Sept 2014	
Peterborough & Stamford Hospital Foundation Trust	99.7	100	
Newborn Bloodspot – avoidable repeat tests (standard <2%)			
Peterborough & Stamford Hospital Foundation Trust	1.1	0.8	

8.1.3 Newborn physical examination – Peterborough hospital achieved 99.4% coverage in Q2 2014-15 against a target of 95%.

8.2 Cancer Screening Programmes

There are three cancer screening programmes in the UK for Breast, Cervical and Bowel cancer and the data for these programmes was provided by NHS England

8.2.1 Breast Cancer screening

For breast cancer screening, measurements include uptake of screening among the targeted population; the round length (this should be 36 months for breast screening so that every woman in the age range is invited to attend for screening once every three years); and the time from screening to clinical assessment for those women whose mammogram appears to be abnormal. This ensures early diagnosis and early access to definitive treatment which improves the outcomes for those affected by breast cancer.

The breast screening data for Peterborough has been excellent. A snap shot of the recent Peterborough data can be seen below:

Table 12: Peterborough Breast Unit KPIs Oct 2014- Dec 2014

Monthly screening round length report for the Peterborough Screening Service

Time period	Total No. invited	No. ≤36 months	% within 36 months	No. ≤38 months	% within 38 months
Oct 14	1440	1411	98.0	1433	99.5
Nov 14	1199	1194	99.6	1196	99.7
Dec 14	927	921	99.4	925	99.8

Monthly screen to normal report for the Peterborough Screening Service

Time period	Total No.	No. ≤2 weeks	% within 2 weeks	No. ≤4 weeks	% within 4 weeks
Oct 14	1594	1584	99.4	1594	100.0
Nov 14	1304	1301	99.8	1304	100.0
Dec 14	925	921	99.6	925	100.0

Monthly technical recall/repeat rate for the Peterborough Screening Service

Time period	Total No. screened	Total No. examinations recalled	Total No. examinations repeated	Overall % rate
Oct 14	1666	5	35	2.40
Nov 14	1353	2	23	1.85
Dec 14	957	1	14	1.57

Source: Cambridgeshire and Peterborough Programme Board KPI submission

Monthly screen to assessment report for the Peterborough Screening Services

Time period	Total No.	No.≤3 weeks	% within 3 weeks	No.≤6 weeks	% within 6 weeks
Oct 14	53	51	96.2	53	100.0
Nov 14	65	65	100.0	65	100.0
Dec 14	37	37	100.0	37	100.0

Monthly DOFOA to assessment report for the Peterborough Screening Service

Time period	Total No.	No.≤3 weeks	% within 3 weeks	No.≤6 weeks	% within 6 weeks
Oct 14	53	53	100.0	53	100.0
Nov 14	65	65	100.0	65	100.0
Dec 14	37	37	100.0	37	100.0

Table 13: Breast screening uptake in Peterborough 2013/14

Percentage of eligible women screened adequately within the previous 3 years on the 31st March 2014

Peterborough	Value: 13,381	Percentage:74.7%	CI=74.1-75.3%
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Source: <http://www.phoutcomes.info/public-health-outcomes-framework#gjd/1000042/pat/43/ati/102/page/3/par/X25002AD/are/E06000031>

Table 14: Breast screening programme measures

	Q1 April-June 2013	Q2 July-Sept 2013	Q3 Oct-Dec 2013	Q4 Jan – Mar 2014
Breast Screening round length Standard 90% within 36 months	96.20%	99.20%	98.50%	97.3%
Screen to assessment (standard 90% in <3 weeks)	92.50%	91.30%	97.80%	100%

8.2.2 Bowel cancer screening

This screening programme was introduced in 2011/2 in the UK. Bowel cancer is the third most common cancer in the UK with up to 5% developing it during their lifetime. The screening programme aims to detect bowel cancer at an early stage when treatment is more likely to be effective. The screening programme is open to all those aged 60 – 69, with testing offered at 60 and every two years after that to age 69, but due to be extended to age 74. All those screened receive an introductory letter followed by a testing kit, the faecal occult blood test (FOBT) that they can complete at home, posting the completed kit to one of a number of approved laboratories when completed. The test looks for hidden blood in the bowel that may indicate an abnormality such as polyps or cancer which can bleed, but not sufficiently to be visible to the naked eye at this early stage of the disease. For negative tests (approximately 98% of those tested) a letter confirming this is sent some weeks later. Unclear results of this test will lead to a second test kit being issued to repeat the screening. For positive tests, an invitation is issued for an examination of the bowel by colonoscopy, when the bowel is viewed to ascertain the source of the blood, If abnormalities are seen, biopsy samples can be taken for histological testing. Approximately 10% of those having colonoscopy will be found to have cancer.

Table 15: Bowel Cancer screening

	Q1 April- June 2013	Q2 July-Sept 2013	Q3 Oct-Dec 2013	Q4 Jan-March 2014
Bowel Screening (standard 52% completion of FOBT kit)	54.34%	54.34%	57.33%	59.60%
Assessment by specialist screening practitioner (SSP) (standard 100% seen by SSP in 2 weeks)	100%	100%	100%	100%
SSP assessment to endoscopy time (standard 100% endoscopy within 2 weeks of seeing SSP)	90.91%	97.96%	97.17%	96.43%

Table 16: Outcome of bowel screening - Eastern Bowel Screening Hub

It is important to note that this hub covers a much larger area than Peterborough and the denominator for the population covered is not given, so an estimate of the proportion of screens with abnormality is not possible from the data provided.

CUHT Definitive Abnormal results					
Hub Name	Fiscal year	Local Area Team	Screening Centre Name	Clinical Commissioning Group	Definitive abnormal count
Eastern Bowel Cancer Screening Programme Hub	2013 - 2014	East Anglia Area Team	Cambridge Bowel Cancer Screening Centre	NHS Cambridgeshire And Peterborough CCG	230
			Kettering and Northamptonshire Bowel Cancer Screening Centre	NHS Cambridgeshire And Peterborough CCG	18
			Peterborough And Hinchingsbrooke Bowel Cancer Screening Centre	NHS Cambridgeshire And Peterborough CCG	361

8.2.3 Cervical Screening

This is the oldest of the cancer screening programmes. The test is not a test for cancer, but aims to detect pre-cancerous changes that, with early treatment, should prevent progression to cancer. The test, mainly undertaken in general practice involves taking a sample of cells from the neck of the womb every 3 years for women aged 20 to 49 and every 5 years for women aged 50 to 64. Women aged 65+ are invited only if they have not been screened since age 50 or have had recent abnormal results. This programme has led to significant reductions in deaths from cervical cancer. The introduction of the HPV vaccination programme is also aimed at reducing the risk of cervical cancer by reducing human papilloma virus infection.

Women with abnormal cervical screening tests are referred for colposcopy- a specialist test to further assess and treat the abnormalities detected. As with the other screening programmes aimed at early detection, the programme is monitored on uptake, the speed of getting results to the women tested and the speed of getting women in for assessment and treatment.

Table 17: Cervical screening measures

	Q1 April- June 2013	Q2 July- Sept 2013	Q3 Oct-Dec 2013	Q4 Jan – Mar 2014
50-64 yrs (standard 80% coverage)	75.80%	75.10%	75.00%	74.70%
25-49 yrs (standard 80% coverage)	69.10%	68.80%	68.60%	74.00%
Turnaround time (TAT) (standard 98% 14 day date of test to receipt of result letter)	99.9	100	99.6	99.70%
Colposcopy waiting time (standard 100% women seen within 8 weeks)	100%	100%	100%	100%

8.2.4 Task and finish group on bowel and cervical cancer screening

In response to concerns with the poor uptake of bowel cancer and cervical cancer screening programmes in the inner city areas in Peterborough, a multi-agency task and finish group was convened in November 2014. The group plans to report findings and recommendations to the Peterborough Health Protection Committee in March 2015 and to the Health and Wellbeing board in the summer.

8.3 Non-cancer Screening Programmes

There are two national screening programme for non-cancerous conditions, Retinal (eye) screening for people with diabetes, and screening for abdominal aortic aneurysm in men aged 65.

8.3.1 Diabetic eye screening

People who suffer with diabetes are at high risk of a number of serious complications and are routinely offered appointments in general practice, or, in some cases in hospital clinics, to assess their condition. One of these complications, diabetic retinopathy, is one of the commonest causes of sight loss in working age people, which may cause no symptoms until it is quite advanced, which is why screening is important. It occurs as a result of damage, caused by diabetes, to the small blood vessels at the back of the eye. Screening is effective, but requires specialist equipment to take images of the retina (back of the eye) which enables the blood vessels to be assessed. It is an annual programme. As with other screening programmes, the speed of providing results and referring for further assessment and treatment is very important.

Table 18: Diabetic eye screening measures

	Q1 April-June 2013	Q2 July-Sept 2013	Q3 Oct-Dec 2013
Uptake (standard 70%)	84.90	81.0	77.97
Time to receipt of results (standard 70% within 3 weeks)	99.9	100	95.50
Time results to treatment (standard 80% within 4 weeks)	65.0	73.7	76.47

8.3.2 Abdominal Aortic Aneurysm Screening

An abdominal aortic aneurysm (AAA) is a weakening and expansion of the aorta, the main blood vessel in the body. This weakening can lead to serious consequences due to leakage from, or rupture of, the aorta and an estimated 6000 people in England and Wales die each year from ruptured abdominal aortic aneurysms. This screening is aimed at men aged 65 and over, and involves a single ultrasound scan that takes approximately 10 minutes. It has been shown that this single screening can reduce the number of deaths from ruptured AAAs among men by 50%.

With regards to data on this screening programme, no data were available for uptake of this screening programme. However NHS England reported that, in quarter 3 of 2013/4, 100% of those who required either quarterly or annual surveillance of their AAA, had been tested within 4 weeks of their screening due date

9 Emergency Planning

9.1 The City Council has always been a Category 1 responder under the terms of the Civil Contingencies Act 2004, as a result there is an emergency planning/Resilience team that is working in partnership with other organisations to lead emergency planning and response for the council. Some additional responsibility for health emergency preparedness passed with the move of Public Health into local authorities. In their role within local authorities the DPH is expected to:

- Provide leadership to the public health system for health Emergency Preparedness, Resilience and Response (EPRR)
- Ensure that plans are in place to protect the health of their population and escalate concerns to the Local Health Resilience Partnership (LHRP) as appropriate
- Identify and agree a lead DPH within the Cambridgeshire and Peterborough Local Resilience Forum (CPLRF) area to co-Chair the LHRP (for Cambridgeshire and Peterborough LRF and LHRP, the lead DPH is the Cambridgeshire DPH)
- Provide initial leadership with PHE for the response to public health incidents and emergencies. The DPH will maintain oversight of population health and ensure effective communication with local communities.

- 9.2 Local Health Resilience Partnerships (LHRPs) provide strategic leadership for the health organisations of the LRF area and are expected to:
- Assess local health risks and priorities to ensure preparedness arrangements reflect current and emerging need
 - Set an annual EPRR work plan using local and national risk assessments and planning assumptions and learning from previous incidents
 - Facilitate the production and authorisation of local sector-wide health plans to respond to emergencies and contribute to multi-agency emergency planning
 - Provide a forum to raise and address issues relating to health EPRR
 - Provide strategic leadership to planning of responses to incidents likely to involve wider health economies e.g. winter capacity issues
 - Ensure that health is represented on the LRF and similar EPRR planning groups
 - Delegate tasks to operational representatives of member organisations in line with agreed terms of reference.
- 9.3 The Cambridgeshire and Peterborough Local Health Resilience Partnership (CP LHRP) is co-chaired by the NHS England Area Team Director of Operations and the Cambridgeshire DPH. Member agencies share responsibility for oversight of health emergency planning in this forum. It is for the CPLRF and/or the LHRP to decide whether LHRP plans should be tested through a multi-agency exercise as a main or contributory factor. The DPH reports health protection emergency resilience issues to the LHRP on a regular basis. The DPH provide a brief update report on the activities of the LHRP to the HPSG to ensure sharing of cross cutting health sector resilience issues.
- 9.4 The interim DPH has been supported in this work (for part of the year) by an interim consultant in public health with oversight of all health protection issues, and, from September 2014 by the Health Emergency Planning and a Resilience Officer (HEPRO) based within Public Health (a shared post with Cambridgeshire). The HEPRO reports into the LHRP and the LRF through the Health and Social Care Emergency Planning Group (HSCEPG) which she co-chairs with the Head of EPRR from the NHS England Area Team. This group acts as a supporting working group for the LHRP, to which the LHRP can delegate tasks.
- 9.5 The HSCEPG has membership from local acute hospitals, East of England ambulance service (EEAmb), community services, mental health services, social care services, other NHS funded providers, Public Health England and NHS England. Having completed a recent assurance of EPRR in all health organisations, this group is now focused on Pandemic Influenza and ensuring that all health sector organisations have robust plans in place. The group is also working on revising the Mass Casualty Plan for the area which will be presented to both the LHRP and LRF shortly. The group has organized two 'strategic leadership in crisis' workshops for directors in the health system and also completed Exercise Pooley – a joint Norfolk/ Suffolk/Cambridgeshire exercise for assurance of preparedness specific to Ebola.

10 Communicable disease incidents and outbreaks

One of the main functions of the PHE Health Protection Team (HPT) is responding to cases, enquiries, incidents and outbreaks, providing evidence-based and expert health protection advice and support. To facilitate timely response, the acute service is delivered by a single clinical response team, staffed by a medical consultant, two nurses and an administrator during office hours. For any case, enquiry or incident, the duty team undertakes a risk assessment, decides on appropriate management and follow-up, and provides specialist advice and further support where needed. The Environmental Health Department is often an essential partner in this role.

All queries are entered onto a national database called HPZone. A total of 248 incidents/outbreaks were logged for Norfolk, Suffolk and Cambridgeshire between 1 April 2013 and 31 March 2014 with 13 of these relating to Peterborough. The majority comprised gastroenteritis outbreaks in care homes due to suspected or confirmed norovirus.

10.1 E. coli O157 linked to a local petting farm

Between 20th and 28th March 2014, Anglia Health Protection Team (HPT) was notified of four presumptive cases of Ecoli O157 from two different families. All gave a history of visiting the same petting farm. There were no other links between the two families.

An Outbreak Control Team meeting (OCT) was called to co-ordinate multi-disciplinary action to investigate the farm as a potential source of this cluster of cases and to enable suitable control measures to be put in place to prevent further cases.

Members of the Environmental Health Team visited the farm at the start of the incident and implemented a number of control measures including restriction of contact with some animals. They also recommended that more hand wash stations be provided, that staff provide closer supervision of visitors, and that there should be better signage encouraging visitors to wash their hands. All these recommendations were fully implemented by the farm.

The OCT considered whether contact with all animals should be restricted, but it was felt that this was not necessary due to the small number of cases and the full co-operation of the farm to implement the increased control measures. Regular visits by members of the Environmental Health Team allowed the OCT to have confidence that the farm could safely remain open. Infection with E. coli O157 can be fatal, and members of the OCT were very aware of the need for a proportionate response to the potential risk.

A veterinary inspection was also carried out by an officer from the Animal Health and Veterinary Laboratories Agency (AHVLA). The aim of this investigation was to assist the OCT in identifying putative animal sources of human infection and to advise on control measures within the veterinary remit. E.coli O157 was not recovered from any of the animal faecal samples collected.

Although there was no microbiological evidence linking the human cases to the animals on the farm there was microbiological evidence strongly suggesting that the four human cases were infected by the same source. The only epidemiological link between the four cases was that they had all visited the petting farm, suggesting that this was the most likely source. There was also an increased number of Cryptosporidium cases reported to the HPT around this time, some of whom had also visited the farm during their incubation period.

The farm co-operated fully with all recommended control measures and there were no further cases of E.coli O157 or Cryptosporidium with links to the farm notified to the HPT after the control measures were implemented.

10.2 TB screening at a packing factory and a produce factory

TB is an infectious disease which develops very slowly. It is easy to treat and difficult to catch. You need a lot of close contact over a long time with an infectious TB case to catch it. Most often the TB germs are killed in the body and do not cause any problems.

In a small number of people the germs are not killed and the person can either develop active TB disease or have latent (hidden) TB infection (LTBI). With LTBI, the TB germs can survive in the body in an inactive state for many months or years. These people are not ill and are not infectious to others. A TB skin test or blood test is required to diagnose the infection.

About one in ten people with LTBI will develop active TB at some point. Having active TB means that they develop symptoms of TB and may be infectious. Screening of contacts of TB cases is designed to identify people with LTBI, which may have been acquired through contact with TB at any point in their lives, as well as to identify whether any contacts have active TB infection. Individuals identified with LTBI are assessed and offered treatment with antibiotics to reduce the risk that they might develop active TB in the future. Any individuals identified with active TB are treated with antibiotics and their close contacts are screened.

Screening for TB at the packing factory was carried out in April 2014 after 17 people working at packing factories in Fenland were diagnosed with active TB over a two year period. Many people working on the site are from countries with high rates of tuberculosis infection, and the long and highly variable incubation period for TB means that many of those diagnosed had acquired their infection in their home country. However there was clear evidence of infection being transmitted in the work place, so a screening programme was implemented. The screening process was designed to identify factory staff who required further tests because they might be at risk of developing the infection. The screening was led by Public Health England, working closely with the respiratory medicine teams at Peterborough and Addenbrooke's hospitals, who routinely manage local cases of TB and follow up of contacts, and with the public health teams in Cambridgeshire County Council and Peterborough City Council.

A second group of mainly household contacts has been identified and treated for latent TB following a case from a high prevalence country. Public Health England staff are liaising with colleagues in an adjacent area to undertake a risk assessment of the case's workplace and, following a risk assessment, screening of workplace contacts has been carried out.

10.3 Ebola

The Ebola situation in West Africa is improving. There are fewer new cases being diagnosed and fewer deaths than at the height of the outbreak. Local health care provision is being strengthened and funeral practices made safer, so if the disease should reappear the circumstances that allowed it to become so widespread this time have been controlled. There are workers travelling between the UK and West Africa to support the international control efforts whose work could put them at risk of infection. When they return home they are followed by PHE for 21 days during which they record their temperature twice each day to make sure that any signs of infection are picked up and acted on promptly. Between the start of October 2014 and February 2015 the national Imported Fever Service tested 179 people as a precautionary measure (approximately one person every day). Only one person has tested positive in that time and there has been no transmission of infection in the UK. Health care workers are not allowed to do clinical work for the 21 day surveillance period, and all returning workers are encouraged to avoid situations where they would be unable to remove themselves if they felt unwell, but no other restrictions are placed on them. This surveillance is supported by screening and infection control information provided for all travellers arriving at UK ports from affected areas. NHS and City Council services in Peterborough have plans in place to deal with a returned traveller who needs to be assessed, and there is a joint outbreak control plan that has been in existence for many years that would be used to co-ordinate the response if a case should be diagnosed locally.

The Cambridgeshire and Peterborough Local Health Resilience Partnership (LHRP) took part in a table top exercise, developed by Public Health England (PHE), to test planning and preparedness should there be an imported case of Ebola. About 20 representatives from organisations in Peterborough took part on 27th October, including representatives from PCC Public Health and Resilience teams together with hospital and Clinical Commissioning Group staff. Learning was shared with colleagues from Norfolk and Suffolk LHRPs, NHS England and PHE who also attended the exercise.

On Wednesday 29th October, a briefing session was held for members of the West African community in Peterborough to listen to their concerns and provide information on the risks and management of Ebola in England. The meeting was attended by Cllrs Diane Lamb (Cabinet member for health) and Nigel North (Cabinet member for environment and communities) who welcomed the attendees. Facilitated by the Community Cohesion Manager, the meeting covered the public health aspects of screening at ports, surveillance, and risk of infection as well as discussing the opportunities for local support for those anxious or bereaved from Cambridge and Peterborough Foundation Trust and the voluntary sector (Cruise and MIND).

11 Sexual Health

11.1 Peterborough is ranked 80 (out of 326 local authorities in England; first in the rank has highest rates) for rates of new sexually transmitted infections (STIs). This equates to 1578 new STI diagnosis, a rate of 846.7 per 100,000 residents (compared to 810.9 per 100,000 in England). This is somewhat expected given the level of deprivation in the system and its link to STI rates.

Areas to be prioritised for improvement include:

- **Rates of HIV late diagnosis**

Between 2011 and 2013, 62% of HIV diagnoses were made at a late stage of infection (CD4 count <350 cells/mm³ within 3 months of diagnosis) compared to 45% in England.

- **Rates of teenage pregnancy**

Rates remain above regional and national averages, despite reducing in recent years. In 2012, the under 18 conception rate per 1,000 females aged 15 to 17 years in Peterborough was 36.0, while in England the rate was 27.7.

- **Chlamydia diagnoses**

In 2013, the rate of chlamydia diagnoses per 100,000 young people aged 15-24 years in Peterborough was 2488.6 (compared to 2015.6 per 100,000 in England). This exceeds the positivity rate target of 2,300 set by the PHOF which is considered positive (as we are reaching and treating a high proportion of young people with the infection). However local data shows a reduction in the number of screens in the past year. This suggests our positivity rate could be even higher if screening activity increased further still.

11.2 In July 2014, following a tender exercise a new integrated contraceptive and sexual health service was launched. The service integrated hospital based GUM services into community based contraceptive services to provide 'a one stop shop' for all contraceptive and sexual health needs. The aim of integration was to improve accessibility and patient experience with a view to normalising STI testing and treatment as part of managing one's sexual and reproductive health.

11.3 Going forward, there is a recognised need to implement a strategic approach to improving sexual and reproductive health in the city involving all partners within the local sexual health economy. The iCASH service will be developing a sexual health network for the city as part of its contract during early 2015. There are discussions about how this can link into strategic governance provided by public health and the Health and Wellbeing Board.

12 Environmental health issues

12.1 Proactive interventions carried out by The Food and Health and Safety Team:

Carbon Monoxide in commercial food premises

In 2012 the team received a call from a letting agent who was almost overcome by fumes after visiting an empty flat above a local food takeaway. He reported that he had to stop his car on the way back to the office when he nearly passed out. Investigation into the incident revealed very high levels of carbon monoxide in the flat originating from the takeaway below. A charcoal grill was being used indoors and the extraction system was poorly maintained. The premises was closed and legal notices were served.

The team then found this situation in other food premises so we began developing a toolkit to tackle the issue which was finalised in 2014. The toolkit contains all the resources that a local authority would need in order to investigate and resolve high levels of carbon monoxide in a business. It explains how to measure levels using a data logger and how to interpret results. It details types of equipment and potential control measures and provides an assessment questionnaire, example notices and letters and example press release and member's briefings.

The toolkit has been rolled out to the Local Authorities in the county group via a training session and is due to be rolled out to other authorities in the near future. To date the team have worked with 16 businesses in the city.

Food Information Regulations 2014

The Food Information Regulations came into force in December 2014. All business will need to ensure allergen information is provided with food which is for sale. This includes pre-packed and non-pre-packed foods such as those sold loose and food from restaurants and takeaways. There are 14 allergenic ingredients which must be declared.

A mailshot was sent out to all Peterborough businesses to tell them about the new law with information on how to comply. We also invited all businesses to attend a free training session.

The food Safety team in conjunction with Trading Standards provided five training seminars to 140 people from 113 food businesses. Officers have also been talking to businesses about the new rules during routine food hygiene inspections in recent months.

13 Looking Forward

13.1 New Vaccination Programmes

A number of changes have been made to the vaccination programmes over the past year, some of which have already started. These changes are made as a result of the advice from the Joint Committee on Vaccination and Immunisation (JCVI). JCVI is an expert committee that reviews the evidence of effectiveness of vaccines and makes recommendation to Government.

- 13.1.1 Meningitis C (MenC) – evidence has shown that in those born after 1995, who were vaccinated in early childhood, there is declining immunity, making them more susceptible to infection. A MenC booster is being introduced for teenagers aged 13-14 years. For the same reason MenC is now being offered to freshers who enter university until 2018. Men C is currently being offered to children in year 10 (14-15 years). It is important to note the second dose for infants at 4 months was removed last year.
- 13.1.2 Meningitis B (MenB) – it is planned that this vaccination will be introduced into the national immunisation schedule subject to vaccine being procured at a cost-effective price.
- 13.1.3 Seasonal flu vaccine – In 2014-15 the new childhood programme is being extended to 4 year olds (2 and 3 year olds introduced in 2013/4). Also in several pilot programmes around the country, including one in Peterborough, vaccination has been offered to 11-13 year olds (school years 7 & 8).
- 13.1.4 HPV vaccination – a change in the schedule has started from September 2014. The number of doses is reduced from three to two;
- 1st dose given in Year 8 (12-13 years)
- 2nd dose can be given 12 months after the first.
- 13.1.5 Shingles vaccine – a new programme to protect elderly people who are at greatest risk Shingles and its adverse consequences:
- 2013/14 – Shingles vaccine (Zostavax) was routinely offered to those aged 70 with catch-up to those 79 years on 1st September 2013 until 31st August 2014
- 2014/15 – Zostavax is routinely offered to those aged 70 and catch-up to 78 and 79 years on 1st September 2014 until 31st August 2015.

Table 19: initial Shingles vaccination uptake reported by NHS England

	Feb 2104		March 2014		April 2014	
	Aged 70	Aged 79	Aged 70	Aged 79	Aged 70	Aged 79
CCG % uptake	56.2	54.0	59.8	57.0	61.8	58.5
CCG % coverage	99.1		99.1		97.2	

- 13.1.6 Rotavirus vaccine – rotavirus is a highly infectious gastrointestinal infection that manly affects infants and leads to a high number of hospital admissions each year due to complication such as dehydration. The vaccination was introduced in 2013 with two doses at 2 months and 3 months as part of the routine programme. The table below gives data provided by NHS England for the early stages of this programme.

Table 20: initial Rotavirus vaccination uptake reported by NHS England

	Jan 2014		Feb 2014		March 2014	
	Dose 1	Dose 2	Dose 1	Dose 2	Dose 1	Dose 2
CCG % uptake	32.7	25.7	93.6	90.3	93.5	90.6
CCG % coverage	87.9		88.8		73.8	

	April 2014		May 2014		June 2014	
	Dose 1	Dose 2				
CCG % uptake	94.7	90.9				
CCG % coverage	83.2		Not available		Not available	

13.2 Collaborative Tuberculosis strategy

In January 2015, PHE published a Collaborative Tuberculosis (TB) Strategy for England 2015 – 2019. This strategy recognises that TB rates have increased in England in recent years and also takes on board evidence from other countries that a systematic approach to tackling TB is effective in reducing the incidence. The Strategy focuses on ten evidence based areas for action:

- Improving access to services and early diagnosis
- High-quality diagnostics
- High-quality treatment and care services
- Contact tracing
- Vaccination
- Tackling drug resistance
- Tackling TB in underserved populations
- New entrant screening for LTBI
- Effective surveillance and monitoring
- Workforce strategy

In addition to the above, it recommends the establishment of Local TB Control Boards to develop a local TB control plan and to monitor and support its implementation. These boards will have a designated clinical lead and cover a wide geographical patch to enable sharing between high and low incidence areas.

The Health Protection Committee is to consider the implications for Peterborough now that the recommendations have been published.

Dr Anne McConville, FFPH

Interim Consultant in Public Health

February 2015

GLOSSARY

AAA	Abdominal Aortic Aneurysm
AHVLA	Animal Health and Veterinary Laboratories Agency
AT	Area Team (part of NHS England)
BCG	Bacillus Camille Guerin (vaccine fro TB)
CCC	Cambridgeshire County Council
CCA	Civil Contingencies Act 2004
CCDC	Consultant in Communicable Disease Control
CCG(s)	Clinical Commissioning Group(s)
CCS	Cambridgeshire Community Services
CPLHRP	Cambridgeshire and Peterborough Local Health Resilience Partnership
CPLRF	Cambridgeshire and Peterborough Local Resilience Forum
CUHPT	Cambridge University Hospital Foundation Trust
DH	Department of Health
DPH	Director of Public Health
DsPH	Directors of Public Health
EH	Environmental Health
EHO	Environmental Health Officer
EPRR	Emergency Preparedness, Resilience and Response
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HHT	Hinchingbrooke Hospital Trust
HPN	Health Protection Nurse
HPSG	Health Protection Steering Group
HPT	Health Protection Team (part of Public Health England)
HPV	Human Papilloma Virus
HSE	Health and Safety Executive
HWB	Health and Well-being Board
IMT	Incident Management Team
JHWS	Joint Health and Well-being Strategy
JSNA	Joint Strategic Needs Assessment
LA	Local Authority

LGA	Local Government Association
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
MMR	Measles, Mumps and Rubella (vaccine)
MOU	Memorandum of Understanding
NHS	National Health Service
NHSE	NHS England
OIMT	Outbreak Incident Management Team
OOH	Out of Hours
NHS	National Health Service
NHSE	NHS England
PCT	Primary Care Trust
PHE	Public Health England
Q 1,2,3,4	Reporting quarters for each year
TB	Tuberculosis

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