

APPENDIX A

ANNUAL HEALTH PROTECTION REPORT FOR PETERBOROUGH CITY COUNCIL FOR 2016

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..
- 1.2 The Health and Well Being Board (HWB) has statutory responsibilities and is currently consulting on a draft health and wellbeing strategy 2016-19. Whilst much of this relates to health improvement, health protection is interwoven into the strategy's aims, including protecting health from communicable diseases.
- 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 The DPH produces an annual health protection report to the Health & Wellbeing Board (HWB) which provides a summary of relevant activity. This report covers multi-agency health protection plans in place which establish how the various responsibilities are discharged. 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 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 DPH is co-chair of the LHRP;
- 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 Peterborough 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. In addition, a memorandum of understanding (MOU) has been agreed with partner organisations. The PHPC facilitates information sharing and planning across agencies.

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 member organisations of the Local Health Resilience Partnership (LHRP), which is co-chaired by the NHS England Cambridgeshire and Peterborough Director and the Cambridgeshire and Peterborough DPH. 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: CCDC
 - Cambridgeshire and Peterborough CCG (rep for HCAI)
 - NHS England Anglia and Essex 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 is chaired by the Director of Public Health or the Consultant in Public Health Medicine.

3.9 The PHPC meets quarterly in January, April, July and October. Starting in October 2015, the PHPC has been meeting jointly with the Cambridgeshire Health Protection Steering Group in recognition of the fact that many health protection issues cross geographic boundaries and are often reported by CCG geography (Cambridgeshire and Peterborough). The meetings are run in three sections – an initial section for Peterborough only issues, a middle section to discuss issues relevant to both local authorities and a final section for Cambridgeshire only issues. The joint middle section receives reports on work across both areas on issues such as immunisation, screening, emergency planning, implementation of the national TB strategy and communicable diseases common to both areas.

4 Memorandum of Understanding

4.1 The 2014, Memorandum of Understanding (MOU) for health protection, developed to ensure agreement from all relevant organisations to provide reports and assurance to the PHPC and to collaborate with other partners in the response to any incident that affects public health in the area, is due to be reviewed and revised and re-issued to partner organisations for sign-off.

4.2 In practice this MOU proved to be very helpful over the past two years during the response to public health incidents, as it clarified responsibilities, including financial responsibilities, in an incident and meant that there were no delays while this clarification was sought.

5 Joint Communicable Disease Outbreak Management Plan

5.1 Development of this plan was led by Public Health England with support from the public health teams in local authorities, it was initially ratified in 2014 by the LHRP and LRF, and has been in use since then. It was revised in 2015, and organisations are working to the consultation draft of the 2015 revision. However, due to changes in organisational structure in PHE, with the PHE Centre now covering, Peterborough, Cambridgeshire, Norfolk, Suffolk, Essex, Hertfordshire, Bedfordshire and Milton Keynes, final ratification has been delayed. The revised plan will need to be approved by all relevant LHRPs and Local Resilience Forums (LRFs) in the PHE East area.

5.2 It constitutes a joint plan to manage an outbreak or significant incident of communicable disease/infection. It covers a range of scenarios from a minor outbreak that will be managed within the PHE Health Protection Team (HPT) to an outbreak which could lead to a major incident being declared that requires a full multi-agency response.

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

5.4 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.

5.5 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 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

6.3 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 2013 – 31 March 2015.

Table 1: Notifications of Infectious Diseases in Peterborough by year 2013 - 2015

Notifiable Disease*	2013†	2014†	2015†
Acute infectious hepatitis	9	7	17
Acute meningitis	<5	<5	<5
Cholera	0	0	<5
Food poisoning	300	318	253
Infectious bloody diarrhoea	8	8	<5
Invasive Group A streptococcal disease	<5	9	<5
Legionnaires' Disease	<5	0	<5
Malaria	0	<5	<5
Measles	7	5	<5**
Meningococcal septicaemia	<5	5	<5
Mumps	7	8	8**
Rubella	<5	<5	<5**
Scarlet fever	15	20	98
Whooping cough	17	18	15

SOURCE: East of England HPT (Thetford) HPZone

* Notifiable diseases with no reported cases during the three years are not listed here. These are notifications of infectious disease and are not necessarily laboratory confirmed.

† Because of the confidentiality risk associated with reporting very small numbers, where there are fewer than 5 cases they are reported as <5

** There were no laboratory confirmed cases of measles or rubella in 2015. There were 4 laboratory confirmed cases of mumps.

6.4 It is particularly important to note the number of cases notified that are of illness which could have been prevented by immunisation, in particular mumps, measles, whooping cough, rubella (German measles), each of which can have serious long term health consequences, especially when also considering the childhood immunisation uptake data later in this report..

6.5 Scarlet fever

Scarlet fever is a common childhood infection caused by *Streptococcus pyogenes*, also known as group A streptococcus (GAS). It is most common between the ages of 2 and 8 years, although children and adults of all ages can develop it.

Similar to the rest of the country, scarlet fever seasonal activity has remained elevated across Peterborough, following the increase in notifications seen last year. Since the start of 2015 there has been a rapid and higher than expected increase in notifications compared to the previous year.

Although scarlet fever is usually a mild illness, patients can develop complications such as an ear infection, throat abscess, pneumonia, sinusitis or meningitis. Clinicians should also

be mindful of a potential increase in invasive GAS (iGAS) infection which tends to follow trends in scarlet fever. Early recognition and prompt initiation of specific and supportive therapy for patients with iGAS infection can be lifesaving.

Table 2. Outbreaks and Incidents - Peterborough, January - December 2015

Gastroenteritis	Bloodborne virus	Environmental / Chemical	Other	Total
6	1	1	3	11

SOURCE: East of England HPT (Thetford) HPZone

6.5.1 Food poisoning remains the most commonly notified infectious disease, with campylobacter accounting for the vast majority.

6.5.2 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, the number of whooping cough cases has been fairly steady over the past three years

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

6.6.1 HCAI

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

There is now a zero tolerance of preventable MRSA bacteraemia with our own hospital in Peterborough having just one case in 2015/16 after a period with no cases for more than two and half years.

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

Following significant reductions in the number of C diff cases nationally since 2007, the number continues to fall at a slower rate. Peterborough has had a variable year and has just exceeded its trajectory due to a cluster of cases in December. For the rest of the year its rate of infection has been mainly in line with national and regional averages. 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. A process whereby cases identified to meet specific criteria can be removed from the local trajectory is managed locally at CCG level by the Lead Nurse for Infection Prevention and Control.

In addition to C Diff and MRSA, two other bacterial infections are also monitored – E Coli and Methicillin Sensitive Staphylococcus Aureus (MSSA) – for both of

which the level of infection in Peterborough is low and is below the regional and national average

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; a strategy has been developed 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. PHPC is awaiting a report on the outcome of the strategy.

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.

This is an area that will continue to be tackled by the CCG in collaboration with local prescribers in acute, community and primary care.

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 Anglia and Essex Public Health Commissioning Team guided by a specialist advice from a PHE public health screening and immunisation team, embedded in NHS England, 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. As a result of the success 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.

7.1.2 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. Where uptake is below 90%, a breakdown in herd immunity can result in cases and outbreaks occurring, most notably in Measles, Mumps or Rubella in recent years associated with low uptake of the MMR vaccine.

7.1.3 The annual coverage data for the universal childhood immunisation programmes is provided at tables 3, 4 and 5. 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 of 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 developed by CCG staff for Cambridgeshire and Peterborough GP practices to improve recording has not yet been implemented due to some technical problems;
- 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 missing children are likely to have moved overseas not knowing that they should advise their GP to de-register them.

7.1.4 A multi-agency Task and Finish group convened to try to find solutions to these issues and address the inequalities in uptake of childhood immunisations in inner city practices and deprived populations reported in 2015 and an implementation group is now working to develop the recommendations and implement them.

Table 3: Annual Childhood Vaccination Uptake for Age 12 months Peterborough, 2014/15

12 months					
	Number	DTaP/IPV/Hib % [number]	PCV % [number]		
P'boro LA	3.0	95.2	94.2		
England	663.1	95.7	92.2		

Source: Cover

Table 4: Annual Childhood Vaccination Uptake for Age 24 months for Peterborough, 2014/15

24 months					
	Number	DTaP/IPV/Hib % [number]	MMR 1 % [number]	Hib/men C % [number]	PCV B % Number]
P'boro LA	3.2	96.7	92.6	92.6	
England	691.8	95.7	92.3	92.1	

Source: Cover

Table 5: Annual Childhood Vaccination Uptake for Age 5 years for Peterborough, 2014/15

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	3.2	95.9	88.9	94.6	87.5	90.8
England	693.9	95.6	88.5	94.4	88.6	92.4

Source: Cover

7.1.5 Targeted Vaccination programmes

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

7.1.6 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 - most recent data is 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.

7.1.7 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 6: Hepatitis B vaccination

	Q1 2015	Q2 2015	Q3 2015	Q4 2015
	Peterborough %			
Hep B 12 months	100	100	NA	NA
Hep B 24 months	66.7	100	NA	NA

Source Cover NA not available yet

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

7.1.8 School based programmes

There are some immunisation programmes delivered in schools, for the school age population; others are provided via primary care. Human Papilloma Virus vaccine (HPV) is offered to girls in school. This 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. It is reported annually by school year hence the latest full year data is for school year 2014/15.

Table 7: Annual HPV vaccination uptake all 3 doses by local authority

School year 2014/15	Peterborough	England
HPV uptake	92.1	89.4

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
- all two, three and four-year-olds on 31 August 2015
- all children of school years 1 and 2 age

7.1.10 Plans were developed by the ¹Cambridge and Peterborough Immunisation and Vaccination Committee for the 2015/6 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.

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

Risk Group	2013/14	2014/15	2015/16
Over 65yrs	72.2	71.2	72.4
Under 65yrs at risk	50.7	48.7	42.7
Pregnant and in another clinical risk group	64.8	63.5	55.6
Pregnant but not in any other clinical risk group	41.9	41.5	29.9
All pregnant	43.6	43.3	32.2
Age 2 not in a risk group	30.9	31.4	36.6
Age 2 (in a clinical risk group)	40.4	36.8	49.9
Age 3 not in a risk group	40.6 31.3	34.0	38.7
Age 3 (in a clinical risk group)	53.8 46.8	45.5	54.1
Age 4 yrs not in clinical group	n/a	22.7	33.5
Age 4 yrs in clinical group	n/a	39.7	51.6
Age 5 yrs not in clinical group	n/a	NA	57.2
Age 5 yrs in clinical group	n/a	NA	67.1
Age 6 yrs not in clinical group	n/a	NA	54.4
Age 6 yrs in clinical group	n/a	NA	64.6

Table 9: Flu vaccination uptake (%) – Peterborough NHS frontline staff

Uptake to Jan 2014 Health Care workers	2012/13	2013/14 %	2014/15	2015/16
PSHFT	71.5	75.3	69.5	62.9
CPFT	23.7	54.2	51.2	61.9
Cambridgeshire Community Services CCS)	37.0	51.5	52.6	59.2

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 for Cambridgeshire & Peterborough CCG but not for Peterborough residents alone.

Table 10: Pertussis vaccination uptake (%) by pregnant women

	April 2014	May 2014	June 2014	July 2014	August 2014
East Anglia	60.6%	60.5%	57.2%	55.8%	55.5%
	April 2015	May 2015	June 2015	July 2015	August 2015
Cambs & P'boro CCG	49.8	45.9	52.7	50.5	51.2
East Anglia	56.8	53.8	58.9	56.3	54.1
	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016
Cambs & P'boro CCG	50.5	54.1	52.5	50.7	NA
East Anglia	67.2	60.3	61.4	60.3	NA

7.2 New Vaccination Programmes

A number of changes have been made to the vaccination programmes over the past two years, most 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.

7.2.1 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 was introduced for teenagers aged 13-14 years. However in 2015, this was replaced by Meningococcus ACWY vaccine, covering four strains of Meningococcus following an increase in cases of meningitis and septicaemia (blood poisoning) by Meningococcus W. The group most affected were those in their first year at university, so the programme aims to vaccinate all children in year 9 (age 13 – 14) at school with a catch up offer by GPs of the vaccine to those in year 13 and university freshers. This latter programme has been poorly taken up and may need to be publicised again.

It is important to note the second dose for infants at 4 months was removed last year. Uptake of Men C vaccination, administered by GPs aimed at students in school year 13 and by University freshers is worryingly low nationally.

7.2.2 Meningitis B (MenB) –this vaccination was introduced into the national immunisation schedule from July 2015 and has been offered to all babies born since May 2015. The UK is the first country to introduce this programme and vaccine manufacturers report that, while there is sufficient supply for those in the national programme, it is in relatively short supply.

7.2.3 Seasonal flu vaccine – In 2015-16 the childhood programme has been extended to children in school years 1 and 2 with plans to extend eventually to all those up to age 16.

7.2.4 HPV vaccination – following a change in the schedule from September 2014, when the number of doses was reduced from three to two, most schools in the area have agreed to the two doses being given 12 months apart:

1st dose given in Year 8 (12-13 years)

2nd dose can be in Year 9..

7.2.5 The shingles vaccination programme is being gradually introduced – it will eventually be given to all aged 70 years with a catch up programme to ensure vaccination of all who were between the ages of 70 and 80 at the time this programme was introduced.

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 11: initial Shingles vaccination uptake reported by NHS England

Shingles Sentinel	August 2015 %		
	70 yrs	78 yrs	79 yrs
CCG	63.0	59.6	61.1
East Anglia	61.9	59.5	60.7

7.2.6 Rotavirus vaccine – rotavirus is a highly infectious gastrointestinal infection that mainly affects infants and leads to a high number of hospital admissions each year due to complications such as dehydration. The vaccination was introduced in 2013 with two doses at 2 months and 3 months as part of the routine programme. This has been a highly successful programme with cases of rotavirus reduced dramatically since its introduction.

Table 12: Rotavirus vaccination uptake reported by NHS England

Rotavirus Sentinel [dose 2]			
	April 2014 %	May 2014 %	June 2014 %
CCG	90.9	90.5	90.6
East Anglia	92.5	90.1	90.7
	July 2014 %	August 2014 %	Sept 2014 %
CCG	91.2	92.3	92.5
East Anglia	91.8	91.9	92.5
	Oct 2014 %	Nov 2014 %	Dec 2014 %
CCG	90.4	88.5	91.2
East Anglia	92.5	89.3	90.6
	Jan 2015 %	Feb 2015 %	March 2015 %
CCG	91.3	90.3	90.3
East Anglia	91.0	91.3	91.5
	April 2015 %	May 2015 %	June 2015 %
CCG	91.0	92.0	NA
East Anglia	90.4	92.2	NA
	July 2015 %	August 2015 %	Sept 2015 %
CCG	92.1	91.8	91.0
East Anglia	91.6	91.7	91.8
	Oct 2015 %	Nov 2015 %	Dec 2015 %
CCG	91.3	88.5	NA
East Anglia	92.2	90.7	NA

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 3 and 4 of 2015/16 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; congenital hypothyroidism; and medium chain acetyl-CoA dehydrogenase deficiency; maple syrup urine disease, isovaleric acidaemia ; glutaric aciduria and homocystinuria(see <http://www.newbornbloodspot.screening.nhs.uk/> for explanations of each of these conditions)
- Newborn infant physical examination
- Newborn Hearing screening

Table 13: Ante-natal screening coverage

	Q1 2014/15 April-June	Q2 2014/15 July-Sept	Q3 2014/15 Oct-Dec	Q4 2014/15 Jan-March	Q1 2015/16 April- June	Q2 2015/16 July-Sept
KPI ID1 >90% Infectious Disease HIV coverage						
P'boro	97.8	98.7	98.3	99.4	98.7	98.9
KPI ID2 >70-90% Infectious Disease timely referral of Hep B+ women for specialist tr.						
P'boro	75.0	50.0	100	66.7	66.7	85.7
KPI FA1 >97-100 Down's syndrome completion of lab request form						
P'boro	96.5	98.8	99.0	98.4	98.0	97.6
KPI ST1 >95-99% Sickle Cell and Thalassaemia coverage						
P'boro	95.9	95.5	95.0	95.7	96.4	95.6
KPI ST2 50-75% Sickle Cell and Thalassaemia avoidable repeat						
P'boro	65.7	65.1	67.0	66.4	67.2	70.2
KPI ST3 90-95% Sickle Cell and Thalassaemia timeliness of result						
P'boro	98.1	99.0	98.2	98.5	98.3	98.1
KPI NB1 95-99% Newborn blood spot coverage						
CPFT	99.7	100	99.9	100	98.5	98.5
KPI NB2 2-0.5% Newborn blood spot avoidable repeat tests						
P'boro	1.1	0.8	0.4	0.9	Not available	1.3
KPI NB3 95-98% Newborn blood spot timeliness of result						
CPFT	100	100	100	100	KPI ceased	
KPI NB4 Newborn blood spot coverage Movers in						
CPFT	NA	NA	NA	NA	100	90.9
KPI NP1 95-100% Newborn and Infant physical examination coverage						
P'boro	99.9	99.4	98.9	99.8	100	99.6(↑0.2)
KPI NP2 95-100% Newborn and Infant physical examination timely assessment for hip referral						
P'boro	100	0 no cases	0 no cases	100	100	40
KPI NH1 100% Newborn hearing coverage						
P'boro	100	99.8	99.9	100	Not available	99.8(↔)
KPI NH2 100% Newborn hearing timely referral						
P'boro	86.6	92.3	100	100	Not available	100(↑7.7)

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 36 month screening round length (which is the metric which seeks to ensure that the programme offers a first screening appointment to 90% or more eligible women within 36 months of their previous screen); and the time from screening to clinical assessment for those women whose mammograms show some type of abnormality. This ensures early diagnosis and early access to definitive treatment which could improve the outcomes for those affected by breast cancer.

The Peterborough Programme’s performances against these standards have remained exceptionally good. The uptake data is reported annually and has not yet been reported for 2015/16, so the most recent annual data is given in Table 12 below, with the other data for the breast screening programme depicted in the charts below.

Table 14: Breast screening uptake in Peterborough 2014/15

Age group	Uptake	Coverage
All ages	<i>Data awaited</i>	73.6%

More recent but unverified data shows a further increase to 77.8% in quarter 2 of 2015/16

Figure 1: Proportion of eligible women screened within 36 months

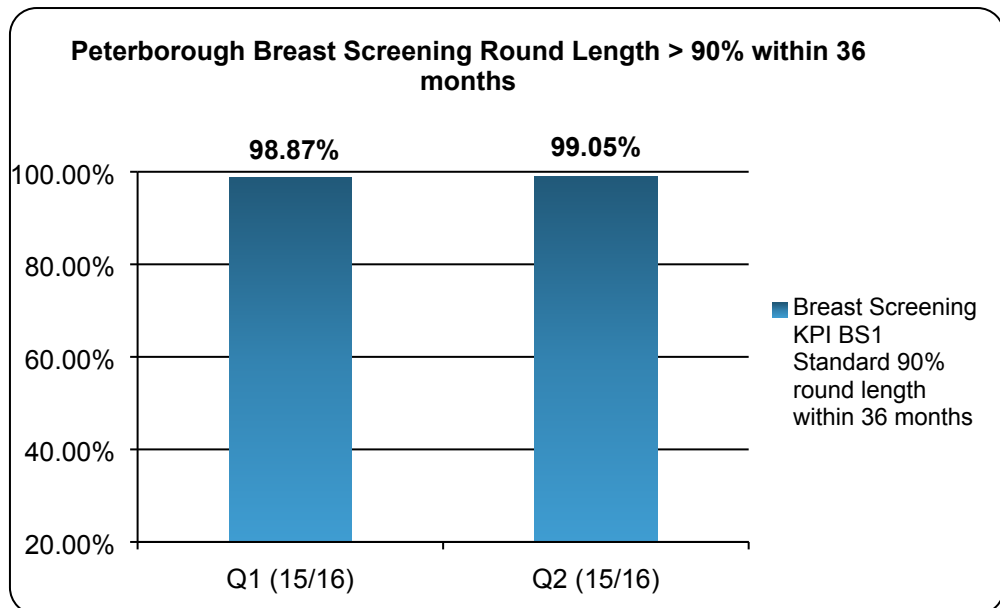
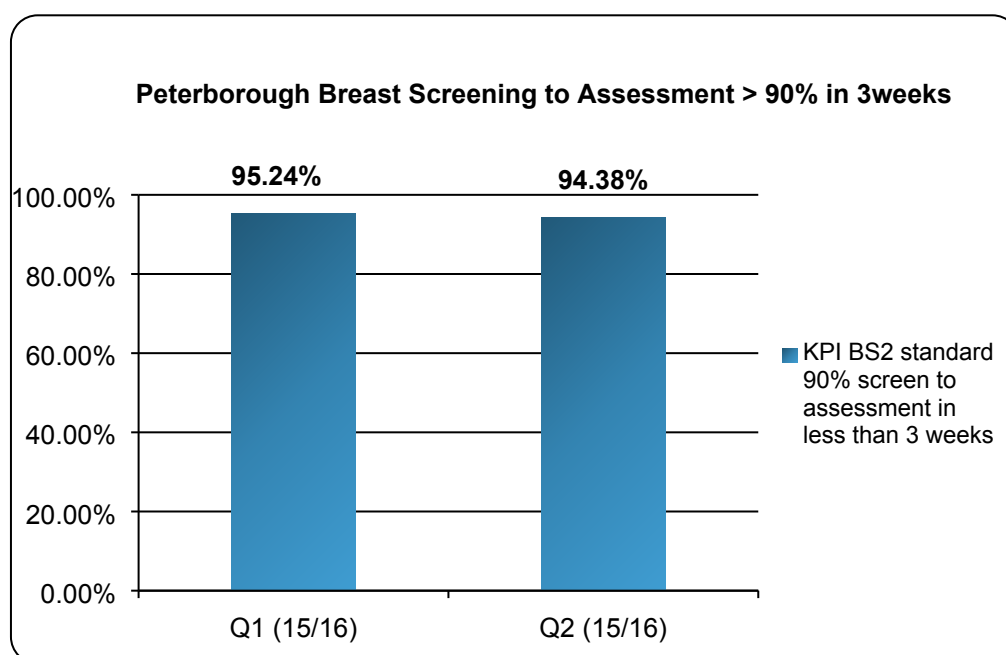


Figure 2: Proportion of women requiring assessment who are seen

within 3 weeks of the screening test



8.2.2 Bowel cancer screening

The screening programme aims to detect bowel cancer at an early stage when treatment is more likely to be effective. The screening programme offers screening every 2 years to all men and women aged 60 to 74. All eligible men and women are sent a testing kit by post, which they are asked to complete and return the completed kit to one of a number of approved laboratories when completed. The test looks for hidden (occult) blood which can indicate some problem in the bowels that is causing bleeding. The presence of Faecal Occult Blood (FOB) is not diagnostic of cancer but gives an indication that further testing is needed. The further tests are by endoscopy (examination of the bowel with a specialised scope and camera apparatus). A number of measures are reported to evaluate the success of the screening programme and these are reported in the table below.

Table 15: Bowel Cancer screening

	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16
Bowel Screening (standard 52% completion of FOBT kit)	58.6%	57.6%	Data awaited	Data awaited
Assessment by specialist screening practitioner (SSP) (standard 100% seen by SSP in 2 weeks)	100%	100%	100%	Data awaited
SSP assessment to endoscopy time (standard 100% endoscopy within 2 weeks of seeing SSP)	95.6%	94.3%	94.8%	Data awaited

8.2.3 Cervical Screening

Cervical screening is offered to all women aged 25 to 49 years every three years and those aged 50 to 64 every five years. Screening takes place in GP practices and the samples are sent to the laboratories for testing. Upon testing, women are informed of the outcome of their screening episode and those 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, coverage, the speed of getting results to service users who have been tested, as well as the timeliness of getting service users in for assessment and treatment.

From the most recent comparative data analysis available, the trend data below show a steady decline in coverage for the Cambridgeshire and Peterborough CCG area. (Coverage is a measure of the proportion of women aged 25 to 49 having an adequate sample taken in last 3 years, or in the last 5 years for those aged 50-64). The target for coverage is 80% and these trend data show that performance is now below the national (England) level. Coverage has fallen in all areas as shown in Figure 1 below; (England (national), Midlands and East Commissioning region, East Anglia Area Team (Norfolk, Suffolk, Cambridgeshire and Peterborough) and Cambridgeshire and Peterborough Clinical Commissioning Group (CCG). Also of note, is the fact that coverage remains considerably lower in the younger cohort (25 – 49) than in the 50 – 64 age group, where coverage too is now below the target of 80%. Table 14.

Figure 3: Cambridgeshire and Peterborough CCG Cervical Screening

Coverage Trend 25 – 64 years

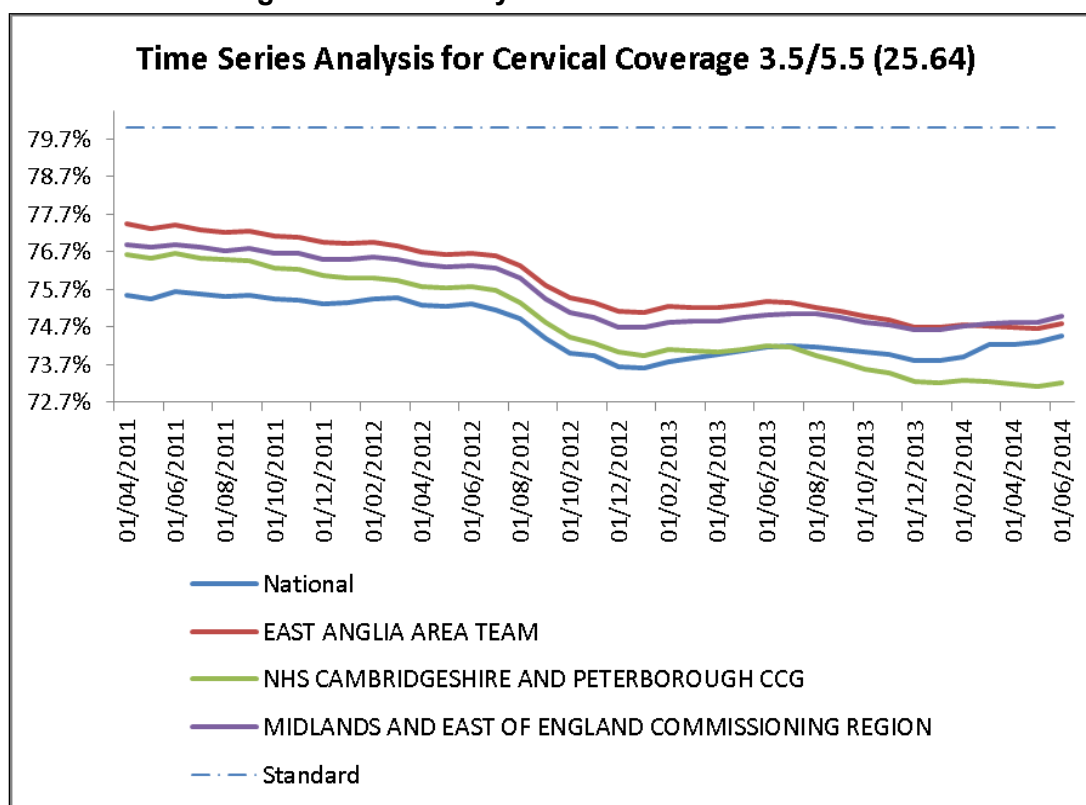


Table 16: Cervical screening measures

	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
25-49 yrs (standard 80% coverage)	63.6%	63.5%	Data awaited	Data awaited
50-64 yrs (standard 80% coverage)	74.0%	74.1%	Data awaited	Data awaited
Turnaround time (TAT) (standard 98% 14 day date of test to receipt of result letter)	99.97%	100%	Data awaited	Data awaited
Colposcopy waiting time (standard 100% women seen within 8 weeks)	100%	100%	Data awaited	Data awaited

8.2.4 Task and finish group on bowel and cervical cancer screening

In response to concerns about the poor uptake of bowel cancer and cervical cancer screening programmes in the inner city areas of Peterborough, a multi-agency task and finish group was convened in November 2014. The group commissioned and reviewed a detailed analysis of the data for bowel and cervical screening, gathered and considered national and local evidence and subsequently developed a set of recommendations to

address the pockets of poor uptake. The group reported back its findings to the PHPC and has since morphed into an Implementation Group with responsibility for overseeing the delivery of the agreed recommendations. Some of the agreed recommendations include; collaborative work with Cancer Research UK, Jo's Trust and Bowel Cancer UK to deliver training to front line public health staff and primary care staff to ensure staff are confident and knowledgeable about discussing and promoting cancer screening As well as being able to appropriately signpost service users. Awareness campaigns on cancer screening and prevention have also been planned and agreed, with plans underway to work with specific practices in areas of poorer uptake to better understand the reasons for lack of engagement and high DNA rates.

8.3 Non-cancer Screening Programmes

There are two national screening programmes for non-cancer 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. 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. As with other screening programmes, the speed of providing results and referring for further assessment and treatment is very important. As the data in Table 15 below indicates, the Diabetes Eye Screening programme is performing well. However, recent capacity issues have resulted in delays for referred patients being seen and treated within specified timescales at some Trusts. This issue is being addressed contractually and with the support of the Clinical Commissioning Group.

Table 17: Diabetic Eye Screening measures 2015/16

Diabetic Eye Screening				
	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
standard 70% uptake (% screened out of the total offered)	78.5%	77.6%	Data awaited	Data awaited
standard 70% results received issued within 3 weeks of screening	99.1%	99.4%	Data awaited	Data awaited
standard 80% treatment within 4 weeks and 60% within 2 weeks of significant positive screen	2wks: 66.7% 4wks: 83.3%	2wks: 40% 4wks: 80%	Data awaited	Data awaited

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%.

The AAA screening programme reported it achieved a 100% coverage in 2014/15 fiscal year. The coverage is an annually reported metrics and the 2014/15 data is the most up to date data available.

Table 18: Abdominal Aortic Aneurysm data

KPI AA1 standard 90% (acceptable level) and 100% (achievable level)		
	14/15	15/16
	100%	Data awaited

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
 - 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 Cambridgeshire & Peterborough Director and the Cambridgeshire and Peterborough 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 provides a brief update report on the activities of the LHRP to the PHPC to ensure sharing of cross cutting health sector resilience issues.
- 9.4 The DPH has been supported in this work by an interim consultant in public health who co-chairs the Health and Social Care Emergency Planning Group (HSCEPG) with the Head of EPRR from the NHS England Area Team and has oversight of all health protection issues. The function is supported by the shared Health Emergency Planning and a Resilience Officer (HEPRO) based within Public Health. The HEPRO reports into the LHRP and the LRF through the DPH.
- 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. This year's deep dive for the EPRR core standards was planning for Pandemic Influenza. The working group delivered Exercise Corvus, a local adaptation of the PHE off-shelf exercise to test the arrangements for pandemic influenza. Follow up of the seven recommendations from this exercise forms part of the work plan for the working group this year. The other priorities for this group are to revise the local Mass Casualty Plan and put in place a plan for identifying vulnerable people in an emergency, both to be presented at the LHRP and CPLRF shortly.
- 9.6 Exercise Nimbus, a two day multiagency exercise to test eight CPLRF plans, was delivered on the 5th and 6th of November 2015. A total of 60 people from 27 agencies participated and a collated list of actions is being progressed by the CPLRF.

11 Sexual Health

- 11.1 Peterborough has a high rate of diagnosis of new sexually transmitted infections (STIs) at 887 diagnoses of STIs per 100,000 residents (compared to 810.9 per 100,000 in England, and the highest rate in the east of England). This likely to be associated with the level of socio-economic deprivation in some areas and its link to STI rates.

Areas prioritised for improvement include:

Rates of HIV late diagnosis

Between 2012-2014, 56.8% of HIV diagnoses were made at a late stage of infection, compared to 42.2% in England. This is an improvement on 62% late HIV diagnoses between 2011 and 2013, compared to 45% in England. Earlier diagnosis leads to an improved outcome of treatment and reduced risk of onward transmission.

Rates of teenage pregnancy

Rates remain above the national average, although the downward trend of recent years has continued. In 2013 the under 18 conception rate was 33.4 per 1,000, compared to 36 in the previous year. The England rate has also been falling and was 24.3 per 1,000 in 2013.

Chlamydia diagnoses

In 2014, the rate of chlamydia diagnoses per 100,000 young people aged 15-24 years in Peterborough was 3404, which compares favourably with 2012 for England. This exceeds the Public Health Outcomes Framework (PHOF) target, which is considered positive (as we are reaching and treating a high proportion of young people with the infection). This positivity rate resulted from screening 27.1% of the eligible 15 – 24 year old population. (2nd highest in east of England). It is possible that our positivity rate could be even higher if screening activity increased further still.

11.2 In July 2014, following a retender 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. Close monitoring of the new service shows it has been effective against these aims.

11.3 Going forward, we have established a new Contraceptive and Sexual Health Strategic Group to act as a multi-agency network responsible for overseeing and implementing our Sexual Health Strategy. The strategy identifies four key overall themes for Peterborough:

- Increase sexual and contraceptive health awareness amongst local population;
- Increase detection of STIs amongst local population;
- Reduce the number of unplanned pregnancies; and
- Improve early HIV detection within the city to reduce high rate of late diagnosis.

All partners are actively engaged in this work, which will report via the PHPC to the Peterborough Health and Wellbeing Board.

12 Environmental Health Issues - Proactive Interventions carried out by the Food and Safety Team

12.1 Illegal Tattooist

In October 2014 the team were made aware of an unregistered tattooist operating from a residential address. Any tattooist operating from any premises is required to register their business with Peterborough City Council under the Local Government (Miscellaneous Provisions) Act 1982. Registration allows the Local authority to inspect the premises and practitioner and, subject to meeting the required standard and infection controls, permit the practitioner to continue with this activity. There were concerns that this tattooist did not have the appropriate level of cleanliness and infection controls and as such was potentially exposing his clients and himself to blood borne viruses (BBVs).

Under the Health Protection Regulations 2010 Officers applied to the Magistrates Court for a Part 2A Order, which was granted on 30th March 2015 allowing officers entry to the property to seize and detain equipment, items or articles associated with the practice of tattooing, to prevent the potential spread of BBVs. The Order was executed on 31st March 2015 and five tattoo guns were seized as well as numerous disposable needles, pots of ink and a tattoo couch. The Order prohibited the activity of tattooing but only for a period of 28 days.

In May 2015 the Team received further information that two 17 year olds had been recently tattooed at this address. Officers applied for a second Part 2A Order and in June 2015 entered the property while the tattooist was tattooing a client. Again equipment and articles were seized and the activity was prohibited for a period of 28 days.

It was evident that the action we were so far taking was not effective. Consequently a formal application was made to the Health and Safety Executive to transfer the enforcement responsibility for health and safety to Peterborough City Council. This was agreed and we subsequently prohibited the activity of tattooing indefinitely at this property.

As a result of these raids and the evidence that has been collected, officers prosecuted the illegal tattooist. Offences included failing to comply with a Part 2a Order, failing to register himself and his premises for tattooing and placing his clients at risk of infectious diseases due to poor standards and infection control. The case was heard at Magistrates Court on 25th November 2015 and the tattooist. pleaded guilty to all offences, he received a 16 week custodial sentence and was ordered to pay criminal court charges and a victim surcharge to be paid on his release.

This was a successful outcome to a difficult case. Whilst dealing with the unlawful activity officers have also been liaising with other agencies and departments i.e. Public Health England, Child Protection and Cambridgeshire Police, Safer Schools, to educate individuals and highlight the health concerns associated with getting a tattoo from an unregistered tattoo practitioner. The team have also been signposting individuals to seek medical advice and health screening once it has become known that they have had a tattoo at this premises.

12.2 Shisha smoking prosecution

Shisha smoking is a middle-eastern custom. It is a form of smoking both tobacco and non-tobacco containing products using a water pipe. The water pipe may be referred to as a 'shisha pipe' or a 'hookah'. The container at the base of the pipe is partially filled with water. The pipe is then placed into the container so that it submerges into the water. The substance smoked is called 'shisha' and may be a tobacco-based or herbal-based substance flavoured usually with molasses and/or fruit. The substance is placed into a clay bowl on top of the pipe and covered with foil. Holes are made in the foil with a toothpick and charcoal is burned on top of the clay bowl which burns the shisha in the bowl. The smoke created by the burning is sucked through the hose attached to the pipe to bring the smoke down into the container. The smoke is inhaled through the pipe.

Shisha smoking is a serious potential health hazard to smokers and others exposed to the smoke emitted. The World Health Organisation (WHO 2005) state that a typical 1 hour water pipe smoking session involves inhaling 100-200 times the volume of smoke inhaled with a single cigarette. Smoke from shisha and the fuel source contain high levels of toxic compounds including carbon monoxide, heavy metals and cancer-causing chemicals.

Smoking is not permitted inside a premises if it is open to the public or if it is used as a place of work by more than one person or where members of the public might attend.

Outdoor smoking shelters or areas must not be enclosed or substantially enclosed. The walls must have openings, which are at least half of the total area of the walls including other structures, which serve the purpose of walls. No account can be taken of doors, windows or other fittings that can be open or shut.

On 12 March 2013 a man was prosecuted for 'Failing to prevent smoking in a smoke free place (a restaurant in Peterborough) on 30 November 2012' under the Health Act 2006 – an offence under Section 8. The restaurateur pleaded guilty and was fined.

Despite further advice given, more complaints were received and a warning letter was issued.

On 13 January 2016 the restaurateur was prosecuted a second time for 'Failing to prevent smoking in a smoke free place at (the restaurant) on 7 August 2015, was found guilty in his absence and was fined.

13 Looking Forward

13.1 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 line with the strategy a Local TB Control Board has been established for the East of England with CCG leadership on the Board provided by Cambridgeshire and Peterborough CCG. One of its earliest actions has been to approve plans for the introduction of Latent TB Infection (LTBI) screening for new entrants to the country. In the first phase a number of GP practices in Peterborough will be undertaking this screening. The Health Protection Committee receives regular reports on implementation of this strategy.

Dr Linda Sheridan, FFPH

Consultant in Public Health

February 2016

GLOSSARY

AAA	Abdominal Aortic Aneurysm
AHVLA	Animal Health and Veterinary Laboratories Agency
AT	Area Team (part of NHS England)
BBV(s)	Blood Borne Virus(es) (Hepatitis B & C and HIV)
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
DTaP	Diphtheria, Tetanus and Pertussis (Whooping Cough) vaccine
EH	Environmental Health
EHO	Environmental Health Officer
EPRR	Emergency Preparedness, Resilience and Response
GP	General Practitioner
HiB	Haemophilus Influenza B vaccine
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
IPV	Inactivated Polio Vaccine

JHWS	Joint Health and Well-being Strategy
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
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
PCV	Pneumococcal Vaccine
PHE	Public Health England
Q 1,2,3,4	Reporting quarters for each year
TB	Tuberculosis