

## **ANNUAL HEALTH PROTECTION REPORT FOR PETERBOROUGH 2016/7**

### **1. INTRODUCTION**

- 1.1 This report provides an annual summary on activities in Peterborough to ensure health protection for the local population and includes areas that are covered by the Peterborough Health and Well-being Strategy
- 1.2 The services that fall within Health Protection include:
  - i. communicable (infectious) diseases – their prevention and management
  - ii. infection control
  - iii. routine antenatal, new born, young person and adult screening
  - iv. routine immunisation and vaccination
  - v. sexual health
  - vi. environmental hazards.
- 1.3 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.
- 1.4 The Director of Public Health (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.
- 1.5 Details of the legislative background to the role of DPH and the role of the City Council in relation to health protection has been included in previous annual health protection reports and will not be reproduced here.

### **2. PETERBOROUGH HEALTH PROTECTION COMMITTEE**

- 2.1 To enable the DPH to fulfil the statutory responsibilities in relation to health protection, the Peterborough Health Protection Committee (PHPC) was established in October 2013 and is chaired by the DPH or nominated deputy. The PHPC enabled 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 facilitated information sharing and planning across agencies.
- 2.2 With the greater sharing of public health roles across the two local authorities – Peterborough City Council and Cambridgeshire County Council - and in recognition that the role of many of the organisations that contribute to the PHPC also cover the wider geography, it was agreed to bring the committees for both areas together from October 2015. Initially the agendas consisted of three sections – Peterborough only items; Joint Peterborough and Cambridgeshire items; and Cambridgeshire only items.

However it became clear that most items of concern to the committee were shared across the two areas and from October 2016 the agendas were merged and revised Terms of Reference drawn up for the Joint Cambridgeshire and Peterborough Health Protection Steering Group. To ensure that the shared membership fully protected confidentiality of any sensitive items discussed, a Confidentiality / Non-disclosure Agreement was included with the terms of Reference.

### 3. SURVEILLANCE

#### 3.1 Notifications of Infectious Diseases

Doctors in England and Wales have a statutory duty to notify suspected cases of certain infectious diseases. These notifications along with laboratory and other data are an important source of surveillance data. The table below shows the main notifiable diseases reported to the HPT from 2013 - 2016.

**Table 1: Notifiable Diseases in Peterborough 2013-2016**

Notifiable Disease*	2013 <sup>†</sup>	2014 <sup>†</sup>	2015 <sup>†</sup>	2016 <sup>†</sup>
<b>Acute infectious hepatitis</b>	9	7	17	14
<b>Acute meningitis</b>	<5	<5	<5	<5
<b>Food poisoning</b> (excluding campylobacter**, but including the organisms below)	72	71	64	86
E coli O157 VTEC	<5	<5	<5	<5
Cryptosporidium	17	13	18	19
Giardia	11	15	12	20
Salmonella	39	34	23	38
<b>Infectious bloody diarrhoea</b>	8	8	<5	6
<b>Invasive group A streptococcal disease</b>	<5	9	<5	7
<b>Legionnaires' disease</b>	<5	0	<5	<5
<b>Malaria</b>	0	<5	<5	<5
<b>Measles*</b>	7	5	<5	<5
<b>Meningococcal septicaemia</b>	<5	5	<5	<5
<b>Mumps*</b>	7 (1)	8 (3)	8 (4)	11 (4)
<b>Rubella*</b>	<5	<5	<5	0
<b>Scarlet fever</b>	15	20	98	56
<b>Whooping cough</b>	17	18	15	49

SOURCE: East of England HPT HPZone

\* These are notifications of infectious disease and are not necessarily laboratory confirmed. Numbers in brackets indicate confirmed cases of mumps. There were no confirmed cases of measles or rubella.

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

\*\* During 2016, the HPT stopped importing laboratory reports of campylobacter into its HPZone database as public health follow up is not undertaken for individual cases and there is a national system for laboratory surveillance.

### 3.2 Pertussis (whooping cough)

There were 4535 cases of whooping cough notified in England and Wales in 2016, up from 3033 in 2015. Peterborough had a higher rate of notifications than the East of England with 23.20 per 100 000 population compared to 15.56 for the East of England. The median age of cases in Peterborough was 43.5 (range: 0 – 85). 90% of cases were laboratory confirmed pertussis. Pertussis cases usually increase in the third quarter of each year and follow a recognised epidemiological pattern of 3 – 4 yearly cyclical peaks. Following the declaration of a national outbreak of pertussis in 2012, immunisation for pregnant women was introduced in September 2012.

### 3.3 Scarlet fever

Similar to the rest of the country, scarlet fever activity has remained elevated across Peterborough. In 2016, there were 19,155 notifications of scarlet fever in England and Wales, an increase from 17,577 in 2015. This increase has also been seen in the East of England, although in Peterborough there was a drop in cases in 2016 compared to 2015. In Peterborough there were 25.78 cases per 100 000 population in 2016, slightly less than the rate for the East of England which was 29.44. The median age of scarlet fever cases in Peterborough is 4 years (range 1 to 34 years); most cases are reported in children under 10. Reporting of scarlet fever cases peaked in March but has remained at higher than normal levels throughout 2016.

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

### 3.4 Outbreaks and Incidents

In 2016, there were 9 outbreaks of gastroenteritis in Peterborough. Eight of these were in care homes (3 confirmed and 5 suspected norovirus) and one in an educational establishment (suspected norovirus).

There were also 2 pseudomonas incidents. One related to environmental contamination in a healthcare setting, where there was an intermittent problem with pseudomonas spp contamination of endoscope washers and dental chair spittoons. The other was a national incident with cases of severe *Pseudomonas aeruginosa* infection following cosmetic piercing procedures using potentially contaminated cleaning solution. A piercing studio in Peterborough was involved

## 4.0 PREVENTION

### 4.1 Immunisation programmes

The tables below detail uptake of the various vaccination programmes over time and compared to the regional level of uptake. Overall uptake is steady or has increased for most of the childhood programmes and for the seasonal influenza vaccination programme, which appears to indicate some success from the work we have undertaken with partner organisations to improve uptake. The aim for all childhood programmes is to achieve at least 95% uptake, the level which ensures Herd Immunity. However the target uptake as outlined in the Public Health Outcomes Framework is 90%

Herd immunity occurs when the vaccination of a significant portion of a population provides a measure of protection for individuals who have not developed immunity. It arises when a high percentage of the population is protected through vaccination, making it difficult for a disease to spread because there are so few susceptible people left to infect.

This can effectively stop the spread of disease in the community. It is particularly crucial for protecting people who cannot be vaccinated. These include children who are too young to be vaccinated, people with immune system problems, and those who are too ill to receive vaccines (such as some cancer patients).

Details of the UK vaccination programme and what each vaccine protects against are included at Annex 1 at the end of this report.

#### 4.1.1 Childhood Primary Vaccinations

**Table 2 - Diphtheria, Tetanus, Pertussis, Polio and Haemophilus Influenza B**

<b>12 months DTaP/IPV/Hib [target 95%]</b>				
	<b>Q1 2013/14 %</b>	<b>Q2 2013/14 %</b>	<b>Q3 2013/14 %</b>	<b>Q4 2013/14 %</b>
Peterborough	94.8	93.6	94.5	93.9
East Anglia	95.7	95.8	95.8	95.2
	<b>Q1 2014/15</b>	<b>Q2 2014/15</b>	<b>Q3 2014/15</b>	<b>Q4 2014/15</b>
Peterborough	94.2	<b>94.2</b>	<b>96.3</b>	<b>95.2</b>
East Anglia	95.6	95.0	96.0	95.6
	<b>Q1 2015/16</b>	<b>Q2 2015/16</b>	<b>Q3 2015/16</b>	<b>Q4 2015/16</b>
Peterborough	<b>94.8</b>	<b>96.3</b>	<b>96.1</b>	<b>93.8</b>
East Anglia	95.6	95.6	95.4	95.5
	<b>Q1 2016/17</b>	<b>Q2 2016/17</b>	<b>Q3 2016/17</b>	<b>Q4 2016/17</b>
Peterborough	<b>93.5</b>	<b>93.8</b>		
East Anglia	95.0	95.2		

Source: COVER

**Table 3 – Pneumococcal Vaccine**

<b>12 months PCV [target 95%]</b>				
	<b>Q1 2013/14 %</b>	<b>Q2 2013/14 %</b>	<b>Q3 2013/14 %</b>	<b>Q4 2013/14 %</b>
Peterborough	93.9	93.3	93.9	93.6
East Anglia	95.3	95.4	95.3	95.6
	<b>Q1 2014/15 %</b>	<b>Q2 2014/15 %</b>	<b>Q3 2014/15 %</b>	<b>Q4 2014/15 %</b>
Peterborough	93.1	<b>93.4</b>	<b>95.6</b>	<b>94.8</b>
East Anglia	95.3	94.6	95.8	95.3
	<b>Q1 2015/16 %</b>	<b>Q2 2015/16 %</b>	<b>Q3 2015/16 %</b>	<b>Q4 2015/16 %</b>
Peterborough	<b>94.5</b>	<b>95.8</b>	<b>96.6</b>	<b>93.0</b>
East Anglia	95.4	95.4	95.5	95.6
	<b>Q1 2016/17</b>	<b>Q2 2016/17</b>	<b>Q3 2016/17</b>	<b>Q4 2016/17</b>
Peterborough	<b>93.6</b>	<b>93.6</b>		
East Anglia	95.4	95.3		

Source: COVER

**Table 4 - Diphtheria, Tetanus, Pertussis, Polio and Haemophilus Influenza B**

<b>24 months DTaP/IPV/Hib [target 95%]</b>				
	<b>Q1 2013/14 %</b>	<b>Q2 2013/14 %</b>	<b>Q3 2013/14 %</b>	<b>Q4 2013/14 %</b>
Peterborough	94.8	96.8	96.4	97.3
East Anglia	97.1	96.8	96.3	96.6
	<b>Q1 2014/15 %</b>	<b>Q2 2014/15 %</b>	<b>Q3 2014/15 %</b>	<b>Q4 2014/15 %</b>
Peterborough	<b>96.5</b>	<b>96.0</b>	<b>95.5</b>	<b>96.9</b>
East Anglia	96.4	96.6	96.9	96.4
	<b>Q1 2015/16 %</b>	<b>Q2 2015/16 %</b>	<b>Q3 2015/16 %</b>	<b>Q4 2015/16 %</b>
Peterborough	<b>95.5</b>	<b>96.2</b>	<b>96.0</b>	<b>97.2</b>
East Anglia	96.5	95.7	96.2	96.0
	<b>Q1 2016/17</b>	<b>Q2 2016/17</b>	<b>Q3 2016/17</b>	<b>Q4 2016/17</b>
Peterborough	<b>95.6</b>	<b>96.9</b>		
East Anglia	96.1	96.2		

Source: COVER

**Table 5- Pneumococcal vaccine**

<b>24 months PCV Booster [target 95%]</b>				
	<b>Q1 2013/14 %</b>	<b>Q2 2013/14 %</b>	<b>Q3 2013/14 %</b>	<b>Q4 2013/14 %</b>
Peterborough	91.4	91.9	92.0	93.5
East Anglia	94.2	94.0	93.6	94.0
	<b>Q1 2014/15 %</b>	<b>Q2 2014/15 %</b>	<b>Q3 2014/15 %</b>	<b>Q4 2014/15 %</b>
Peterborough	92.8	<b>91.3</b>	<b>91.9</b>	<b>93.7</b>
East Anglia	93.6	93.7	94.0	93.9
	<b>Q1 2015/16 %</b>	<b>Q2 2015/16 %</b>	<b>Q3 2015/16 %</b>	<b>Q4 2015/16 %</b>
Peterborough	<b>92.8</b>	<b>92.8</b>	<b>93.7</b>	<b>92.6</b>
East Anglia	93.6	93.0	93.5	93.3
	<b>Q1 2016/17</b>	<b>Q2 2016/17</b>	<b>Q3 2016/17</b>	<b>Q4 2016/17</b>
Peterborough	<b>91.2</b>	<b>91.9</b>		
East Anglia	92.9	94.3		

Source: COVER

**Table 6 – Haemophilus Influenza B and Meningococcus C**

<b>24 months Hib/Men C [target 95%]</b>				
	<b>Q1 2013/14 %</b>	<b>Q2 2013/14 %</b>	<b>Q3 2013/14 %</b>	<b>Q4 2013/14 %</b>
Peterborough	91.0	92.1	92.0	93.1
East Anglia	94.2	94.6	94.1	94.2
	<b>Q1 2014/15 %</b>	<b>Q2 2014/15 %</b>	<b>Q3 2014/15 %</b>	<b>Q4 2014/15 %</b>
Peterborough	93.1	<b>91.4</b>	<b>91.4</b>	<b>93.4</b>
East Anglia	93.9	93.7	94.0	91.5
	<b>Q1 2015/16 %</b>	<b>Q2 2015/16 %</b>	<b>Q3 2015/16 %</b>	<b>Q4 2015/16 %</b>
Peterborough	<b>92.6</b>	<b>91.5</b>	<b>93.3</b>	<b>91.9</b>
East Anglia	93.8	92.5	93.4	93.3
	<b>Q1 2016/17</b>	<b>Q2 2016/17</b>	<b>Q3 2016/17</b>	<b>Q4 2016/17</b>
Peterborough	<b>90.8</b>	<b>92.6</b>		
East Anglia	92.8	94.3		

Source: COVER

**Table 7 – Measles, Mumps and Rubella**

<b>24 months MMR 1 [target 95%]</b>				
	<b>Q1 2013/14 %</b>	<b>Q2 2013/14 %</b>	<b>Q3 2013/14 %</b>	<b>Q4 2013/14 %</b>
Peterborough	91.2	92.1	91.1	93.1
East Anglia	92.6	92.9	93.0	93.5
	<b>Q1 2014/15 %</b>	<b>Q2 2014/15 %</b>	<b>Q3 2014/15 %</b>	<b>Q4 2014/15 %</b>
Peterborough	92.7	<b>91.6</b>	<b>90.9</b>	<b>93.0</b>
East Anglia	93.1	93.2	93.3	93.5
	<b>Q1 2015/16 %</b>	<b>Q2 2015/16 %</b>	<b>Q3 2015/16 %</b>	<b>Q4 2015/16 %</b>
Peterborough	<b>92.6</b>	<b>92.6</b>	<b>92.1</b>	<b>92.1</b>
East Anglia	93.4	92.3	93.1	93.4
	<b>Q1 2016/17</b>	<b>Q2 2016/17</b>	<b>Q3 2016/17</b>	<b>Q4 2016/17</b>
Peterborough	<b>91.8</b>	<b>92.2</b>		
East Anglia	92.7	93.8		

Source: COVER

**Table 8 - Diphtheria, Tetanus, Pertussis, Polio and Haemophilus Influenza B**

<b>5 years DTaP IPV Hib [target 95%]</b>				
	<b>Q1 2013/14 %</b>	<b>Q2 2013/14 %</b>	<b>Q3 2013/14 %</b>	<b>Q4 2013/14 %</b>
Peterborough	92.5	94.2	94.8	95.3
East Anglia	95.8	96.5	95.8	95.7
	<b>Q1 2014/15 %</b>	<b>Q2 2014/15 %</b>	<b>Q3 2014/15 %</b>	<b>Q4 2014/15 %</b>
Peterborough	95.0	<b>95.6</b>	<b>96.7</b>	<b>97.0</b>
East Anglia	96.0	95.7	96.3	95.8
	<b>Q1 2015/16 %</b>	<b>Q2 2015/16 %</b>	<b>Q3 2015/16 %</b>	<b>Q4 2015/16 %</b>
Peterborough	<b>97.6</b>	<b>92.5</b>	<b>96.4</b>	<b>95.2</b>
East Anglia	96.2	95.3	95.6	96.2
	<b>Q1 2016/17</b>	<b>Q2 2016/17</b>	<b>Q3 2016/17</b>	<b>Q4 2016/17</b>
Peterborough	<b>95.7</b>	<b>96.4</b>		
East Anglia	96.0	96.9		

Source: COVER

**Table 9 - Measles, Mumps and Rubella (first dose)**

<b>5 years MMR 1 [target 95%]</b>				
	<b>Q1 2013/14 %</b>	<b>Q2 2013/14 %</b>	<b>Q3 2013/14 %</b>	<b>Q4 2013/14 %</b>
Peterborough	90.8	91.0	93.1	92.8
East Anglia	93.6	94.4	93.9	93.8
	<b>Q1 2014/15 %</b>	<b>Q2 2014/15 %</b>	<b>Q3 2014/15 %</b>	<b>Q4 2014/15 %</b>
Peterborough	<b>93.6</b>	<b>94.6</b>	<b>95.0</b>	<b>95.8</b>
East Anglia	94.1	93.5	94.2	94.1
	<b>Q1 2015/16 %</b>	<b>Q2 2015/16 %</b>	<b>Q3 2015/16 %</b>	<b>Q4 2015/16 %</b>
Peterborough	<b>95.5</b>	<b>89.0</b>	<b>94.6</b>	<b>93.9</b>
East Anglia	94.2	93.1	93.8	95.2
	<b>Q1 2016/17</b>	<b>Q2 2016/17</b>	<b>Q3 2016/17</b>	<b>Q4 2016/17</b>
Peterborough	<b>95.3</b>	<b>95.7</b>		
East Anglia	95.4	96.0		

Source: COVER

**Table 10 - Measles, Mumps and Rubella (second dose)**

<b>5 years MMR 2 [target 95%]</b>				
	<b>Q1 2013/14 %</b>	<b>Q2 2013/14 %</b>	<b>Q3 2013/14 %</b>	<b>Q4 2013/14 %</b>
Peterborough	83.3	85.5	84.5	83.1
East Anglia	87.5	90.4	88.3	88.6
	<b>Q1 2014/15 %</b>	<b>Q2 2014/15 %</b>	<b>Q3 2014/15 %</b>	<b>Q4 2014/15 %</b>
Peterborough	86.5	<b>86.5</b>	<b>87.9</b>	<b>89.8</b>
East Anglia	89.5	89.4	89.8	89.7
	<b>Q1 2015/16 %</b>	<b>Q2 2015/16 %</b>	<b>Q3 2015/16 %</b>	<b>Q4 2015/16 %</b>
Peterborough	<b>90.0</b>	<b>89.0</b>	<b>88.9</b>	<b>89.9</b>
East Anglia	91.4	88.8	89.4	90.8
	<b>Q1 2016/17</b>	<b>Q2 2016/17</b>	<b>Q3 2016/17</b>	<b>Q4 2016/17</b>
Peterborough	<b>89.8</b>	<b>91.6</b>		
East Anglia	88.2	89.8		

Source: COVER

**Table 11 - Diphtheria, Tetanus, Pertussis, Polio**

<b>5 years DTaP/IPV Booster [target 95%]</b>				
	<b>Q1 2013/14 %</b>	<b>Q2 2013/14 %</b>	<b>Q3 2013/14 %</b>	<b>Q4 2013/14 %</b>
Peterborough	84.4	87.1	85.5	84.1
East Anglia	89.3	91.7	89.7	90.1
	<b>Q1 2014/15 %</b>	<b>Q2 2014/15 %</b>	<b>Q3 2014/15 %</b>	<b>Q4 2014/15 %</b>
Peterborough	87.7	<b>86.9</b>	<b>88.9</b>	<b>90.8</b>
East Anglia	91.1	90.1	90.8	90.7
	<b>Q1 2015/16 %</b>	<b>Q2 2015/16 %</b>	<b>Q3 2015/16 %</b>	<b>Q4 2015/16 %</b>
Peterborough	<b>91.6</b>	<b>90.1</b>	<b>89.8</b>	<b>90.7</b>
East Anglia	90.7	89.5	90.4	89.0
	<b>Q1 2016/17</b>	<b>Q2 2016/17</b>	<b>Q3 2016/17</b>	<b>Q4 2016/17</b>
Peterborough	<b>86.4</b>	<b>88.2</b>		
East Anglia	87.6	88.7		

Source: COVER

**Table 12 - Haemophilus Influenza B and Meningococcus C**

<b>5 years Hib/Men C [target 95%]</b>				
	<b>Q1 2013/14 %</b>	<b>Q2 2013/14 %</b>	<b>Q3 2013/14 %</b>	<b>Q4 2013/14 %</b>
Peterborough	83.5	88.1	89.1	87.3
East Anglia	91.5	94.3	92.8	92.6
	<b>Q1 2014/15 %</b>	<b>Q2 2014/15 %</b>	<b>Q3 2014/15 %</b>	<b>Q4 2014/15 %</b>
Peterborough	91.1	<b>90.5</b>	<b>91.2</b>	<b>92.9</b>
East Anglia	93.4	92.7	93.1	91.2
	<b>Q1 2015/16 %</b>	<b>Q2 2015/16 %</b>	<b>Q3 2015/16 %</b>	<b>Q4 2015/16 %</b>
Peterborough	<b>92.0</b>	<b>91.8</b>	<b>91.4</b>	<b>89.4</b>
East Anglia	93.1	93.0	92.9	92.2
	<b>Q1 2016/17 %</b>	<b>Q2 2016/17 %</b>	<b>Q3 2016/17 %</b>	<b>Q4 2016/17 %</b>
Peterborough	<b>88.9</b>	<b>88.5</b>		
East Anglia	91.2	93.4		

Source: COVER

<https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly-cover-programme-2013-to-2014-quarterly-figures>

<https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly-cover-programme-2014-to-2015-quarterly-data>

<https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly-cover-programme-2015-to-2016-quarterly-data>

#### 4.1.2 Meningitis B

New vaccines introduced include **Meningitis B** vaccine as part of the primary vaccination for infants. This commenced **1<sup>st</sup> September 2015**. It is offered to all babies

when they attend for their first and third routine vaccinations, at 2 months and again at 4 months. A booster is offered at 12/13 months.

**Table 13**

12 months Men B [target 95%]				
	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17
Peterborough	Data not collected	91.6		
East Anglia	Data not collected	93.7		

#### 4.1.3 Men ACWY

**Men ACWY** was introduced following an increase in Men W infections. This is being delivered to adolescents by school immunisation providers. The 17-18 year old catch up offered through primary care started in August 2015.

**Table 14**

Org Name	Vaccine uptake – December 2016					
	Becoming 18 (born 1 <sup>st</sup> Sep 1997 to 31 <sup>st</sup> Aug 1998 inclusive)	No. of patients that have received the MenACWY vaccine	% Uptake	Becoming 19 (born 1 <sup>st</sup> Sep 1996 to 31 <sup>st</sup> Aug 1997 inclusive)	No. of patients that have received the MenACWY vaccine	% Uptake
Cambridgeshire & Peterborough CCG	9926	3138	31.6%	10250	3915	38.2%
East Anglia Total	21731	6508	29.9%	21852	8079	37%

Source ImmForm 05/01/17

**Table 15 - School Immunisation Service – Men ACWY**

Local Authority		Peterborough City Council	England
Catch-up Cohort 1 – School Year 11 – MenACWY 15-16 year olds born between 1 September 1999 – 31 August 2000	Number of adolescents	2,497	540,312
	Number vaccinated with MenACWY up to 31 August 2016	2,024	387,787
	% vaccinated with MenACWY up to 31 August 2016	81.1	71.8
Routine Cohort 2 – School Year 10 – Men ACWY 14-15 year olds born between 1 September 2000 – 31 August 2001	Number of adolescents	2,446	270,383
	Number vaccinated with MenACWY up to 31 August 2016	2,085	208,759
	% vaccinated with MenACWY up to 31 August 2016	85.2	77.2
Routine Cohort 3 – School Year 9 – Men ACWY 13-14 year olds born between 1 September 2001 – 31 August 2002	Number of adolescents		303,740
	Number vaccinated with MenACWY up to 31 August 2016		255,302
	% vaccinated with MenACWY up to 31 August 2016		84.1

#### 4.1.4 Seasonal Flu Vaccination

Flu vaccination uptake improved this year for most groups but especially for the younger at risk groups and for NHS staff

**Table 16: Flu vaccination uptake by key groups**

Area	Summary of flu vaccine uptake %					
	65 and over		Under 65 (at risk)		Pregnant women	
	2015/6	2016/7	2015/6	2016/7	2015/6	2016/7
<b>Cambridgeshire &amp; Peterborough CCG</b>	72.4	72.1	42.7	47.2	32.2	46.7
<b>East Anglia</b>	71.3	71	42.8	47.1	36.7	47.9

**Table 17: Seasonal flu vaccination uptake by age 2, 3 and 4 year olds**

Area	All aged 2 % uptake		All aged 3 % uptake		All aged 4 % uptake	
	2015/6	2016/7	2015/6	2016/7	2015/6	2016/7
<b>Cambridgeshire &amp; Peterborough CCG</b>	37	39.7	39.3	42.0	29.7	33.3
<b>East Anglia</b>	39.1	42.1	40.8	43.9	32.0	35.4

Source ImmForm 06/01/17

**Table 18: Front line healthcare workers in Trusts**

Org Name	No. of HCWs with Direct Patient Care	Seasonal Flu doses given since 1 <sup>st</sup> September 2016		% Seasonal flu doses given since 1 <sup>st</sup> September 2015
		No.	%	%
Papworth Hospital NHS Foundation Trust	1510	1114	73.8	64.9
Peterborough and Stamford Hospitals NHS Foundation Trust	3865	2067	53.5	62.1
Cambridge University Hospitals NHS Foundation Trust	7833	5400	68.9	41.8
Hinchingbrooke Health Care NHS trust	1215	920	75.7	63.6
Cambridgeshire and Peterborough NHS Foundation Trust	3375	1358	40.2	35.8
Cambridgeshire Community Services NHS Trust	1041	568	54.6	54.8
<b>East Anglia Total</b>	<b>50249</b>	<b>29012</b>	<b>57.7</b>	<b>43.1</b>

#### 4.1.5 Prenatal Pertussis Vaccination

In England, from April to September 2016, Pertussis vaccine coverage in pregnant women averaged 70%, 14% higher than the same period in 2015 (Figure 1). This increase is thought to be in part attributable to changes to the data extraction criteria from April 2016 and suggests coverage estimates prior to this may have been under-estimated. In addition, the extended eligibility criteria for the vaccine, available to women from 16 weeks of pregnancy since April 2016 (previously available from 28 weeks), would have started to impact coverage from September 2016, and may have contributed to the increase. Whilst the increase in uptake is great news, pertussis activity continues to be high in all age groups other than infants and therefore it remains really important that women get vaccinated at the recommended time, ideally between 20 and 32 weeks of pregnancy, as this is a safe and highly effective way to protect their baby from birth.

Please note that prior to April 2015 and again from April 2016, we have only received joint data for the Cambridgeshire and Peterborough CCG area from NHSE.

**Table 19**

<b>Pertussis</b>	<b>April 2014 %</b>	<b>May 2014 %</b>	<b>June 2014 %</b>	<b>July 2014 %</b>
CCG	59.6	53.0	53.1	49.0
East Anglia	60.6	60.5	57.2	55.8
<b>Pertussis</b>	<b>August 2014 %</b>	<b>Sept 2014 %</b>	<b>Oct 2014 %</b>	<b>Nov 2014 %</b>
CCG	48.1	51.3	52.0	50.8
East Anglia	55.5	58.3	60.3	60.6
<b>Pertussis</b>	<b>Dec 2014 %</b>	<b>Jan 2015 %</b>	<b>Feb 2015 %</b>	<b>March 2015 %</b>
CCG	59.6	53.1	54.1	51.6
East Anglia	65.7	61.6	60.9	58.1
<b>Pertussis</b>	<b>April 2015 %</b>	<b>May 2015 %</b>	<b>June 2015 %</b>	<b>July 2015 %</b>
CCG	49.8	45.9	52.7	50.5
P'boro	NA	NA	NA	40.0
East Anglia	56.8	53.8	58.9	56.3
<b>Pertussis</b>	<b>August 2015 %</b>	<b>Sept 2015 %</b>	<b>Oct 2015 %</b>	<b>Nov 2015 %</b>
CCG	51.2	50.5	54.1	52.5
P'boro	42.0	42.9	NA	NA
East Anglia	58.5	67.2	60.3	61.4
<b>Pertussis</b>	<b>Dec 2015 %</b>	<b>Jan 2016 %</b>	<b>Feb 2016 %</b>	<b>March 2016 %</b>
CCG	50.7	50.3	NA	NA
East Anglia	60.3	59.3	NA	NA
<b>Pertussis</b>	<b>April 2016 %</b>	<b>May 2016 %</b>	<b>June 2016 %</b>	<b>July 2016 %</b>
Cambridgeshire & Peterborough CCG	52.7	73.8	73.3	71.9
East Anglia Total	<b>60.2</b>	<b>73.6</b>	<b>74.4</b>	<b>74.7</b>
<b>Pertussis</b>	<b>August 2016 %</b>	<b>Sept 2016 %</b>	<b>Oct 2016 %</b>	<b>Nov 2016 %</b>
Cambridgeshire & Peterborough CCG	70.6	72.8	71.4	72.3
East Anglia Total	<b>74.1</b>	<b>76.4</b>	<b>78.7</b>	<b>78.0</b>

Source: ImmForm Sentinel Survey accessed 05/01/17

#### 4.1.6 Rotavirus Vaccination

Rotavirus is a highly infectious stomach bug that affects babies and young children. Infections are routinely reported in surveillance data provided by PHE which demonstrates the effectiveness of this programme as cases have dropped to tiny numbers since the vaccine was introduced.

**Table 20: Rotavirus vaccination**

<b>12 months Rotavirus 2 doses [target 95%]</b>				
	<b>Q1 2016/17</b>	<b>Q2 2016/17</b>	<b>Q3 2016/17</b>	<b>Q4 2016/17</b>
Peterborough	<b>90.3</b>	<b>89.1</b>		
East Anglia	92.5	92.6		

#### 4.1.7 School Immunisation Service

**Table 21: Data for end of school year 2015-16**

	Target	Peterborough
HPV vaccination by end of school year nine dose 1	90%	88%
HPV vaccination by end of school year nine dose 2	90%	91%
School leaver booster (Td/IPV) by end of school year 10.	80%	78%
Men ACWY by end of school year 10.	80%	85%
Men ACWY by end of school year 11.	80%	81%
Childhood Flu vaccination school years 1 and 2	60%	51%
Schools participating in the programme	100%	100%
Vaccine administration Training	100%	100%
Patient/ service user satisfaction.	85%	100%

#### 4.1.8 Shingles

The data for the Shingles vaccination programme is shown in the table below. The data is cumulative and is up to end December 2016. This is the third year of the shingles vaccination programme in England and data from September 2015 to August 2016 shows a continued decline in coverage in the routine (70 year old) and catch up (78 years old) cohorts (from 61.8% in 2013/14 to 54.9% in 2015/16 and from 57.8% in 2014/15 to 55.5% in 2015/16, respectively). PHE note several factors may have contributed to the decline, including:

- difficulties in practices identifying the eligible patients – during busy influenza immunisation clinics
- lack of call/re-call in the service specification to allow mop up of those who missed immunisation during the flu season
- possible lowering of patients' awareness of the vaccine since its introduction in 2013.

PHE are promoting the need for shingles vaccine through professional channels and considering a range of possible approaches to simplify the programme and associated eligibility criteria.

**Table 22: Shingles vaccination uptake**

Area	Vaccine coverage for the Routine Cohort since 2013			Vaccine coverage for the Catch-up Cohort since 2013		
	Registered Patients aged 70	Received Shingles vaccine		Registered Patients aged 78	Received Shingles vaccine	
		No of patients	% of patients		No of patients	% of patients
Cambridgeshire & Peterborough CCG	6774	2895	42.7	4296	1904	44.3
<b>East Anglia Total</b>	<b>21618</b>	<b>8382</b>	<b>38.8</b>	<b>13837</b>	<b>5353</b>	<b>38.7</b>

#### 4.1.9 BCG

All Trusts are now able to order the new BCG vaccine- Intervax and have reinstated clinics within Maternity to ensure maximum usage of each vial of vaccine. A summary of the number

of BCG vaccinations given to eligible babies under the age of 1 year is provided below. There is no national collection of BCG data in the absence of a reliable source for the denominator.

**Table 23 – BCG vaccination uptake**

	2015-16
Peterborough and Stamford Hospital Foundation trust	794
Primary care – across Cambridgeshire and Peterborough	341

#### **4.1.10 Immunisation Task and Finish Group**

An Immunisation ‘Task and Finish’ group that was set up to identify the reasons for lower immunisation uptake for childhood immunisation reported 12 month ago and the group has continued to work to implement the recommendations. This has involved close working with GP practices in some areas with particularly low uptake.

Progress, includes, training local health connectors on immunisations; dispelling the myths; targeting practices with child immunisation waiting lists.; developing a pilot flag system for practices to identify children missing immunisations; and encouraging practices to run more open access immunisation clinics which have been demonstrated to improve access and increase uptake.

## 4.2 SCREENING PROGRAMMES

### 4.2.1

#### Antenatal and Newborn Screening

NHS England report to us for the Cambridgeshire and Peterborough areas jointly and data for both areas are included here for this programme.

From Q1 there have been some changes to the Key Performance Indicators (KPIs). The parameters for acceptable/achievable levels have been revised for some KPIs, resulting in some KPIs that may have been previously achieved, now moving to acceptable.

A new KPI FA2 has been introduced; Foetal Anomaly Screening coverage (at 18 to 20 weeks of pregnancy a Foetal Anomaly ultrasound examination is carried out) and is reported on for the first time with all Trusts able to report and achieving the achievable standard.

#### Key for following tables:

Cambridge University Hospital Foundation Trust	CUHFT
Peterborough and Stamford Hospital Foundation Trust	PSHFT
Hinchingbrooke Hospital Trust	HHT
Cambridgeshire Community Services	CCS
Cambridgeshire and Peterborough Partnership Foundation Trust	CPFT

**Table 24: Ante-natal screening**

Indicator	Standard	Achievable	Provider	2015-16				16/177	
				Q1	Q2	Q3	Q4	Q1	Q2
ID1 Antenatal HIV test coverage	>95%	99%	CUHFT	97.0	97.8	96.7	98.0	97.3	99.5
	>95%	99%	PSHFT	98.7	98.9	99.0	99.8	99.5	99.4
	>95%	99%	HHT	99.5	99.3	99.0	99.2	99.8	98.9
ID2 Hep B timely referral for women found to be Hepatitis B positive)	>70%	99%	CUHFT	100	100	83.3	33.3	No case	100
	>70%	99%	PSHFT	66.7	85.7	100	75.0	50	No case
	>70%	99%	HHT	No case	100	100	No case	No case	100

Indicator	Standard	Achievable	Provider	2015-16				16/17	
				Q1	Q2	Q3	Q4	Q1	Q2
FA1 completion of lab request form	>97%	100%	CUHFT	99.8	99.5	99.5	98.9	99.2	98.8
	>97%	100%	PSHFT	98.0	97.6	98.4	98.7	99.6	97.3
	>97%	100%	HHT	98.9	97.6	98.6	98.7	99.1	97.7
New				16/17					

Indicator	Standard	Achievable	Provider	Q1	Q2
FA2: Fetal anomaly screening (18+0 to 20+6 fetal anomaly ultrasound) – coverage *	>90%	>95%	CUHFT	No data*	100
	>90%	>95%	PSHFT	No data*	98.6
	>90%	>95%	HHT	No data*	99.5

\*New standard

Indicator	Standard	Achievable	Provider	2015-16				2016/17	
				Q1	Q2	Q3	Q4	Q1	Q2
ST1 Antenatal sickle cell and thalassaemia screening – coverage	>95%	99%	CUHFT	97.3	98.0	97.6	96.9	91.4	98.5
	>95%	99%	PSHFT	96.4	95.6	96.3	99.5	99.7	97.8
	>95%	99%	HHT	98.5	98.5	98.4	99	98.9	99.0
ST2 Antenatal sickle cell and thalassaemia timeliness of test	>50%	75%	CUHFT	29.6	31.6	32.1	30.1	31.7	*43.3
	>50%	75%	PSHFT	67.2	70.2	67.9	68	69.1	65.5
	>50%	75%	HHT	No data	No data	No data	29.9	49.4	52.0

\*ST2: women having a haemoglobinopathy screen within the optimum timeframe; remains an issue for Addenbrookes. The screening and immunisation team will continue to closely monitor and a remedial action plan is in place to address. Some improvement is noted.

ST3 Antenatal sickle cell and thalassaemia completion of FOQ	>95%	99%	CUHFT	89.8	80.2	96.9	77.3	76.6	*90.9
	>95%	99%	PSHFT	98.3	98.1	97.9	98.9	98.3	98.7
	>95%	99%	HHT	No data	No data	No data	96.8	98.6	97.5

\*Issues around the reliability of the data for ST3 continue as the Trust has not had a robust mechanism in place to identify Addenbrookes patients from Hinchingbrooke patients. This has been addressed and it is hoped with the circulation of the new single blood form that the laboratory will be able to provide robust data.

**Table 25: Newborn screening**

Indicator	Standard	Achievable	Provider	2015-16				16/17	
				Q1	Q2	Q1	Q4	Q1	Q2
NB1 Newborn blood spot screening coverage	>95%	99.9%	CCS	98.0	98.0	98.1	99.4	98.1	98.2
			CPFT	98.5	98.5	99.7	99.7	99.6	*No data
*Data has been requested from Child Health Record Department, Peterborough but has not been made available by the provider at the time of writing this report.									
NB2 Newborn blood spot screening avoidable repeats	<2%	0.5%	CUHFT	No data	2.7	2.7	4.9	2.4	*3.1
	<2%	0.5%	PSHFT	No data	1.3	2.5	3.0	1.8	1.4
	<2%	0.5%	HHT	No data	9.0	3.6	4.5	3.6	**2.1
<p>*NB2- unnecessary repeat bloodspots remain red. Training has taken place to address issues around technique and individual performance. Although some improvement was evident for Q1; Q2 sees a rise to 3.1. The Trust has action plans in place and are reviewing their automated lancets and SIT continue to monitor through the ANNB Programme board and also via contracting routes to drive quality and improvement</p> <p>**Hinchingsbrooke has an action plan in place to address performance on NB2. Excellent progress has been made in the past year and the data for Q2 is just 0.1% above the acceptable level.</p>									
NB4 Newborn blood spot screening coverage- movers in	>95%	99.9%	CCS	80	78.6	89.5	72.7	88.2	*80.1
			CPFT	100	90.9	93.3	93.3	82.4	**No data

\*145/181 movers in were tested within the timeframe. Explanatory commentary has been requested for the 36 babies not tested within the timeframe.

\*\*Data has been requested from Child Health Record Department, Peterborough but has not been made available by the provider at the time of writing this report.

Indicator	Standard	Achievable	Provider	2015-16				16/17	
				Q1	Q2	Q1	Q4	Q1	Q2
NH1 Newborn hearing screening coverage	>97%	99.5%	CUHFT		98.0	98.7	99.4	99.2	98.6
	>97%	99.5%	PSHFT		99.8	100		99.8	99.9
	>97%	99.5%	HHT	100	100	99.8	99.5	99.7	99.2

NH2 Newborn hearing screening timely referral for assessment	>90%	95%	CUHFT		78.9	72.7	94.1	77.8	*93.8
	>90%	95%	PSHFT		100	100		100	100
	>90%	95%	HHT	100	100	100	60	100	No case

\*15/16 babies were seen within the timeframe and all were offered an appointment within the timeframe.

Indicator	Standard	Achievable	Provider	2015-2016				16/17	16/17
				Q1	Q2	Q3	Q4	Q1	Q2
NP1 Newborn and Infant Physical Examination-coverage newborn	>95%	99.5%	CUHFT	93.2	94.0	96.4	94.6	97.3	94.5
	>95%	99.5%	PSHFT	100	99.6	99.8	99.9	96.9	97.4
	>95%	99.5%	HHT	95.9	95.4	93.3	92.8	99.7	96.5
NP2 Newborn and Infant Physical Examination timely assessment	>95%	100%	CUHFT	57.1	0.0	50	75	100	*66.7
	>95%	100%	PSHFT	100	40.0	100	100	33.3	**50.0
	>95%	100%	HHT	No Cases	100	0	20	25	No Cases

\*3 babies were referred for hip scan and 2 were scanned within the 2 week timeframe.

\*\*2 out of 4 babies referred were seen within the 2 week timeframe and two were seen on day 16.

## Programme Updates

### Newborn hearing

A new national system has been launched and went live on 1<sup>st</sup> December without any significant issues. A new screener qualification has been launched and this will be a mandatory requirement for all new unregistered staff from April 2017.

### Non Invasive Prenatal Testing

It is likely that the new non- invasive screening test for Downs, Edwards and Patau's syndrome will be commissioned in 2018/19. The highly sensitive screening test will be offered to all women who have a high risk result following the combined test. It is expected that the rates of diagnostic procedures will fall as a result. Further information will be made available as it is released.

#### 4.2.2 Cancer Screening programmes - Breast Screening

While uptake of breast screening is satisfactory and had reached a much improved level in quarter 1 of 2016/7, it has now dipped again and no explanation for this dip has been given. We will continue to closely monitor uptake.

**Table 26: Breast screening data**

% of eligible women who attend for screening (age 50-70)	Minimum standard	Achievable standard	Q1 2015-16	Q2	Q3	Q4	Q1 2016-17	Q2 2016-17
Peterborough	≥70%	>80%			70.5	72.7	75.8	71.3

% of women first offered appt. within 36 months	Minimum standard	Achievable standard	Q1 2015-16	Q2	Q3	Q4	Q1 2016-17	Q2 2016-17
Peterborough and Stamford Hospital Foundation Trust	≥90%	100%	98.87	99.05	99.17	98.7	98.1	98.3

% of women who attend for assessment within 3 weeks of attending for screening mammogram	Minimum standard	Achievable standard	Q1 2015-16	Q2	Q3	Q4	Q1 2016-17	Q2 2016-17
Peterborough and Stamford Hospital Foundation Trust	90%	100%	95.24	94.38	99.26	94.74	98.4	96.3

#### 4.2.3 Cancer Screening programmes - Cervical Screening

We have been advised by NHSE that actual uptake data for the cervical screening programme is only available annually although process data for the programme are available quarterly – see below. The most recent uptake data for Peterborough shows that 70.7% of women aged 25 – 64 have taken up their invitation to be screened.

**Table 27: Cervical screening data**

Indicator	Achievable 100%		2015-16				2016-17	2016-17
	Standard	provider	Q1	Q2	Q1	Q4	Q1	Q2
CS4 14 day TAT. From date of test to anticipated receipt of result letter	98%	The Pathology Partnership(Newmarket)	90.4	99.47	99.79	59	70.3	*82
	98%	Peterborough and Stamford Hospital Foundation Trust	90.4	99.47	99.79	59	85.7	100

\*The Pathology Partnership is working tirelessly to address the 14 day Turn Around Time (TAT) from test to result. The problem is linked to workload and limited workforce to support cytology services. Contractual measures are being used to resolve this issue.

#### 4.2.4 Cancer Screening programmes - Bowel Screening

**Table 28: Bowel screening data**

Peterborough and Hinchingsbrook Screening centre	standard	Q2 15-16	Q3 15-16	Q4 15-16	Q1 16-17	Q2 16-17
Uptake	52%	57.8%	55.1%	58.6%	59.6%	
SSP waiting times	100% within 14 days	100%	100%	94.4%	100%	100%
Diagnostic test waiting times	100% within 14 days	94.3%	94.8%	76.3%	89.7%	87.6%

An additional programme for bowel screening involving a one-off endoscopic examination at age 55 is now up and running.

#### 4.2.5 Adult and Young People Screening - Diabetic Eye Screening Programme

Diabetic retinopathy is one of the most common causes of sight loss among people of working age. It occurs when diabetes affects small blood vessels, damaging the part of the eye called the retina. Diabetic retinopathy doesn't usually cause any noticeable symptoms in the early stages. If retinopathy is detected early enough, treatment can stop it getting worse. Otherwise, by the time symptoms become noticeable, it can be much more difficult to treat. This is why the NHS Diabetic Eye Screening Programme was introduced.

**Table 29 : Diabetic Eye Screening**

Diabetic Eye Screening- Cambridgeshire and Peterborough CCG through EA DESP								
KPI DE1 standard	Q3 (14/15)*	Q4 (14/15)	Q1 (15/16)	Q2 (15/16)	Q3 (15/16)	Q4 (15/16)	Q1 (16/17)	Q2 (16/17)
70% uptake (% screened out of the total offered)	79.6%	79.4%	78.5%	77.6%	78.3%	77.1%	85.7%	*No Data
KPI DE2 standard	Q3 (14/15)	Q4 (14/15)	Q1 (15/16)	Q2 (15/16)	Q3 (15/16)	Q4 (15/16)	Q2 (15/17)	Q2 (16/17)
70% results received issued within 3 weeks of screening	99.2%	98.9%	99.1%	99.4%	99.0%	99.0%	99.8%	*No data
KPI DE3 standard	2wks: 94%	2wks: 86%	2wks: 66.7%	2wks: 40%	2wks: 57.1%	2wks: 60.3%	2wks: 80%	*No data
80% treatment within 4 weeks and 60% within 2 weeks of a R3 screen positive	4wks: 94%	4wks: 86%	4wks: 83.3%	4wks: 80%	4wks: 85.7%		4wks: 80%	

\*Q2 yet to be released

#### 4.2.6 Adult and Young People Screening - Abdominal Aortic Aneurysm (AAA) Screening annual data

**Table 30**

AAA			
KPI AA1 standard 90% (acceptable level) and 100% (achievable level) Annual data	14/15	15/16	16/17
	100%	99.9%	*No data

\*Yet to be reported

Note: The data are for the combined Peterborough and Cambridgeshire population

### 5. Healthcare Associated Infection (HCAI) and Antimicrobial Resistance (AMR)

#### 5.1 HCAI

During this period national mandatory reporting has remained in place for the organisms identified as MRSA bacteraemia (blood cultures) and Clostridium difficile (faecal samples).

- 5.1.1 There continues to be a zero tolerance to preventable infections with each individual case being reviewed, firstly using a root cause analysis (RCA) process followed by a scrutiny panel using a post infection review tool. Scrutiny panels bring together a wide range of professionals at each meeting and include Chief Nurses, Consultants, Microbiologists, Senior and junior ward staff, infection control nurses (both from the hospital and the Clinical Commissioning Group (CCG)).
- 5.1.2 Following national guidance and embedding it into local policies and practice provides evidence that the recognition, management and treatment of patients keeps them safe and prevents transmission to others. It is widely recognised that there are many risk factors which may lead to acquisition of such infections, however the time of this occurring is not able to be identified, but sometimes appropriate treatment for other illness predisposes the onset of symptoms.
- 5.1.3 Rates of infections have steadied over the past 2 years and are no longer maintaining a downward trend.
- 5.1.4 Nationally MRSA bacteraemia saw an increase of 2.4% in the number of cases between 2014/15 and 2015/16 but has fallen 81.6% since 2007/8. 2015/16 was the first increase since 2007/8. Assignment of cases is demonstrated in the table below:

**Table 31**

Assigned	National No. 2015/16	Local No. 2015/16	Local No. 2016/17
CCG	294	1	1
Trust	302	1	3
Third Party	223	8	4

- 5.1.5 At the time of writing there are 2 cases outstanding. Early findings suggest these may both be attributable to Trusts and brings the total number reported in 2016/17 to 11 cases.
- 5.1.6 NHS Midlands and East (of which we are part) has a notably low rate nationally of cases at 1.1 per 100,000 population.

- 5.1.7 Performance for 2016/17 would suggest that there has been some deterioration in practice. The main cause for this has been contamination of blood culture samples used to diagnose potential blood stream infection. This is generally a technique error at the time of taking the blood culture sample.
- 5.1.8 Nationally the incidence of Clostridium difficile has reduced by 0.4% overall but since 2007/8 a reduction of 74.5%. Again the decline is not maintained and is being closely monitored. The number of cases reported by the local Trusts remains at the same level, however scrutiny panels have been able to identify between cases that have been well managed and those where learning needs to be applied. Removing cases from the local trajectory has seen the number removed increase and demonstrates embedding of practice that these could not have been prevented.
- 5.1.9 Data for 2016/17 is currently not available.
- 5.1.10 There is an anticipated change for 2017/18 for mandatory reporting of further organisms but it is unclear what that will entail at this time.
- 5.1.11 In addition to these infections there have been challenges with e.g. respiratory illnesses which have led to some bay and ward closures. Situations were managed well and as always outbreak wash up meetings are held. Norovirus (diarrhoea and vomiting) did find its way into hospitals and community settings but again, through embedding of expectations into practice, have been well managed.

## 5.2 Antimicrobial Resistance

Antimicrobial resistance has been identified as a national and international risk to human health by the Chief Medical Officer, World Health Organisation and the Government as a whole. Antibiotics are widely used with many patients in the UK failing to complete the prescribed course or demanding antibiotics for viral or self-limiting conditions. 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. Each year on European Antibiotic Awareness day in November these problems are highlighted in the media, social media and posters.

- 5.2.1 Managed by the Medicines Optimisation team, the focus has been on the national process of encouraging self care choices and options in preference to visiting the GP. The CCG is working to the national quality premium, however not meeting the requirements for two specific antibiotics. Prescribing data is provided for GPs each month and all practices see where these are and not just their own data. Some practices are using ScriptSwitch which takes into account the patient's clinical history. There is a countywide stewardship group working with Trusts which follows patients through. The team is hoping to help clinicians by a culture change to avoid prescribing unnecessarily. Social Media is helping to bring about this change.

## 6. Environmental Health

- 6.1.1 Environmental health consists of Food Safety, Health and Safety and Pollution Control and along with Licensing and Trading Standards is part of Regulatory Services. The purpose of the service is to carry out interventions to check compliance with legal requirements and where appropriate take enforcement action. The service also has a role supporting businesses to help them comply with the law. The work of Regulatory Services helps to keep people healthy and safe, reduces health inequalities and contributes to the national and local economy.

- 6.1.2 The food safety team carry out food inspections, investigate food complaints and infectious diseases and are responsible for regulating private water supplies. The team also operates the National Food Hygiene Rating scheme which helps consumers choose where to eat or shop for food by providing information about hygiene standards. Currently 84% of food businesses in Peterborough have a rating of 3 or above.
- 6.1.3 Health and Safety work in recent years has focussed on the implementation of a project to tackle illegal tattooists and the development of a toolkit to address carbon monoxide in food premises due to the indoor use of charcoal cooking equipment without adequate ventilation.
- 6.1.4 Licensing staff regulate the carrying on of all licensable activities by the appropriate control of licensed premises, temporary events and personal licence holders. Areas of licensing include alcohol, gambling, taxi, animal boarding establishments, riding establishments, pet shops, petroleum sites, tattooists and skin piercing, dangerous animals and adult entertainments.
- 6.1.5 Trading Standards deal with product safety, animal health and fair trading and credit. Fair trading and credit is extremely wide ranging and covers areas such as estate agency, hallmarking, credit arrangements, pricing, video recordings, trademarks, unfair contract terms, aggressive trade practices, scams and trade descriptions. Issues investigated by the team include rogue doorstep conmen, car clocking, counterfeit goods and illicit alcohol and tobacco sales. Recently the team secured 50K funding in partnership with Public Health England and three other local authorities to tackle illicit tobacco. The Joint Eastern Region Illicit Tobacco Control Project aims to increase the understanding of and raise awareness of illicit tobacco. Roadshows have been carried out with detection dogs to show the public how they find concealments and with experts on hand to offer help to those who wish to quit smoking. The project will provide support visits to businesses, intelligence led surveillance and follow up investigations and will result in seizure operations and prosecutions where necessary.
- 6.1.6 Pollution control staff are responsible for investigation of a wide range of statutory nuisances, air quality assessments, hoarding and infestations of vermin in domestic and commercial premises and the issuing of permits for industrial processes. The team also consider environmental impacts of building developments and deal with contaminated land through the planning process.
- 6.1.7 The Pollution Team has a significant input into the development control process, acting as a statutory consultee for planning applications and for the discharge of conditions. The Pollution Team are consulted on approximately 500 development sites each year, recommending conditions and agreeing mitigation measures where noise, contaminated land, air quality and other such environmental issues may be of concern.
- 6.1.8 Typical applications that are considered and advised upon in the development process are:
- New transport routes and Industrial/Commercial activities proposed in/near residential locations
  - Applications for residential development adjacent to noise sources such as industry or road/rail traffic
  - Proposed developments on brownfield sites when previous uses may have contaminated soils or produce ground gases with potential health impacts.

- Major developments that may have air quality impacts upon the locality, for example by emissions from associated transport or particulates.

6.1.9 Examples of developments considered in the previous 12 months include:

- The redevelopment of the South Bank and Fletton Quays, considering the impacts of historical land use; road/rail/concert noise implications for residential development; air quality impacts; and relationship between commercial activities and residential premises.
- Developments in Hampton considering road and rail traffic impacts for proposed and existing development, the impact of new traffic routes or increased traffic flows on existing development in terms of noise and air quality; mitigation measures that may be required to protect residential and other developments from any soil contamination or ground gases that may be present; considering any potential impacts upon new schools proposed on brownfield sites adjacent to major traffic routes.
- Residential development proposed adjacent to closed landfill in Stanground, considering potential for migrating ground gases and traffic noise from the Stanground by-pass.
- Johnson Press (Printworks) site, Oundle Road, considering any mitigation required for ground conditions, and noise from adjacent industrial activities that may impact upon the proposed residential development.
- Proposed quarrying activities between Eye and Thorney and potential noise and particulate impacts upon residential premises.
- Consideration of potential noise, odour and air quality impacts associated with a proposed anaerobic digester near Stanground.

## **6.2 Air Quality**

6.2.1 Standards, as the benchmarks for setting objectives, are set purely with regard to scientific and medical evidence on the effects of the particular pollutant on health, or, in the appropriate context, on the wider environment, as minimum or zero risk levels. The EU Directive and the National Air Quality Strategy set air quality objectives for pollutants on the basis of scientific and medical evidence on the health effects of each pollutant, and according to practicability of meeting the standards.

6.2.2 For Nitrogen Dioxide (NO<sub>2</sub>), the principal pollutant when considering combustion engines, the UK Governments set two air quality objectives that reflected standards published by the World Health Organisation and by the Expert Panel on Air Quality Standards (EPAQS) in the UK who last reported on pollutants of national importance in 2002.

- annual mean concentration levels of NO<sub>2</sub> do not exceed 40µg/m<sup>3</sup> ; and
- hourly mean concentration levels of NO<sub>2</sub> do not exceed 200µg/m<sup>3</sup> more than 18 times a calendar year.

6.2.3 The Regulations make clear that likely exceedences of the objectives should be assessed in relation to those locations where members of the public are likely to be regularly present, and are likely to be exposed for a period of time appropriate to the averaging period of the objective. Technical Guidance is issued to Local Authorities for them to follow to identify and assess the locations most at risk of exceeding the objective laid down in the air quality strategy.

6.2.4 Peterborough City Council reports to DEFRA on the air quality findings on an annual basis. The most recent air quality report can be found on the Council's website.

<https://www.peterborough.gov.uk/upload/www.peterborough.gov.uk/business/environmental-health/AirQualityProgressReport-August2014.pdf?inline=true>

No exceedences of the air quality objectives have been measured in 2014, either within or outside the existing Air Quality Management Area (AQMA), although concerns remain regarding roadside locations which are identified in the report.

- 6.2.5 As is detailed in this report, assessment of new local developments relating to matters such as transportation, industrial installations and fugitive emissions have not identified any potential exceedences outside existing AQMAs. Additionally, no sources are identified as being significantly changed so as to result in such an exceedence.
- 6.2.6 The existing AQMA relates to a potential exceedence of the 15 minute air quality standard for sulphur dioxide (SO<sub>2</sub>) identified by modelling of emissions from brickworks near Whittlesey.
- 6.2.7 The 2015 Updating and Screening Assessment for Peterborough City Council reported that the AQMA in relation to SO<sub>2</sub> can be revoked for the following reasons:
- 6.2.8 There has never been a measured exceedence of the objective;
- The area was declared following modelling without physical monitoring being undertaken;
  - Since the modelling was undertaken, one of the two sites operated by Hanson which were the focus of the modelling has closed down.
- 6.2.9 It was therefore the opinion of Peterborough City Council, following consultation with Fenland District Council, that there is no need to undertake a detailed assessment and that the area can be revoked.
- 6.2.10 The Updating and Screening Assessment Appraisal Report issued by Defra confirmed this approach in the following statement:
- 6.2.11 “On the basis of the evidence provided by the local authority, the conclusions reached are considered acceptable for all sources and pollutants. The plan to revoke the AQMA for SO<sub>2</sub> is considered acceptable, given the closure of a plant, and the presentation of real monitoring results for the first time, which shows concentrations to be well below the limit values”.
- 6.2.12 Since the source of the pollution that related to the declaration of an Air Quality Management Area arises in Fenland District Council. Peterborough City Council have approached that Authority with a view to commencing the revocation.

## **7. NATIONAL TUBERCULOSIS STRATEGY**

### **7.1 Latent TB Identification Project**

The aim of this project is to support the early diagnosis of Latent TB and offer treatment of active disease.

- 7.2 NHS England and Public Health England jointly published the collaborative tuberculosis strategy on 19 January 2015. NHS England has committed £10 million for the establishment of testing for, and treatment of, latent tuberculosis (TB) in new

entrants from countries of high TB incidence. Public Health England has committed £1.5 million for the establishment of the national TB office and support teams to the nine TB control boards. It is likely that the majority of TB cases in the UK are the result of 'reactivation' of latent TB infection (LTBI), an asymptomatic phase of TB which can last for years. There is a 5% risk of a patient with LTBI developing active TB infection. LTBI can be diagnosed by a single, validated blood test and treated effectively with antibiotics, preventing TB disease in the future.

- 7.3 Following the publication of the national strategy a review of TB services was undertaken in Cambridgeshire and Peterborough. The key Epidemiological findings are summarised below and provide an overview of the impact of TB on the resident population of the CCG.
- There were 999 cases of TB reported in Cambridgeshire and Peterborough residents between 2004 and 2014. Peterborough had an average of 47 cases/year.
  - Almost three quarters (73%) of TB cases between 2004 and 2014 were in non-UK born individuals.
  - The most common countries of origin of TB cases in Cambridgeshire & Peterborough in the last three years were UK, India, Pakistan, Lithuania, East Timor and Kenya. PHE recommend screening patients born or who had spent >6 months in high TB incidence country (150 cases per 100,000 or more/Sub-Saharan Africa)
- 7.4 The eligibility criteria for the service are any new patient registering with a practice or retrospectively identified by the practice as being:
- Born or spent > 6 month in a country of high TB incidence
  - Entered the UK within the last 5 years
  - Aged 16-35 years
  - No history of TB either treated or untreated
  - Never screened for TB in the UK
- 7.5 Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) led this work supported by representatives from
- Peterborough and Stamford Foundation Hospitals (PSHFT)
  - 12 Greater Peterborough GP Practices
  - 2 Cambridgeshire GP Practices
  - Public Health England (PHE)
  - Cambridgeshire and Peterborough Foundation Trust
  - Peterborough City Council – Public Health and Housing departments
- 7.6 GP Practices with a high crude rate of TB cases were identified by PHE. Of these, practices with a crude annual rate of active TB  $\geq 20$  cases/100,000 have been prioritised for the LTBI screening programme.
- 7.7 The project commenced in March 2016 and to date, 14 practices have signed up to deliver. Using a Local Enhanced Service (LES) and two other practices have also signed up for phase 2 of the project. Training was provided by Oxford Immunotec, the provider for blood sample analysis as part of the screening.

- 7.8 Practices are expected to identify new patients on registration. PHE have provided the CCG with materials and letters to support the project.
- 7.9 There is a comprehensive action plan to cover the communication and engagement elements of this project. This aims to:
- Raise awareness of Latent TB and the need for screening
  - Get people to visit their GP practice for screening
  - Get people to register with a practice if not already
  - To dispel myths and beliefs about TB
- 7.10 Communications work so far has included an article and social media posts targeted at encouraging prospective patients to come forward. These were sent to specific community contacts obtained through partnership working with Peterborough City Council Connectors, as well as posted from the CCG's social media channels.
- 7.11 News of the project and its progress has also been shared with stakeholders on the CCG Newsletter distribution list, as well as with GP members of the organisation. Press releases were issued in September and December 2016. King's Lynn FM provided radio coverage in October, and the December release was picked up by BBC Radio Cambridgeshire and BBC Look East. Look East's coverage was particularly in depth, focusing on TB as well as Latent TB, and aired in January 2017. Future engagement with prospective patients and the public is planned for later in 2017.
- 7.12 Practices identify patients and invite them for blood screening. Bloods are taken and sent off for testing. All those with positive results are seen and treated by Secondary Care Services

**Table 32: ACTIVITY TO DATE**

<b>Activity</b>	<b>Data</b>
Negative	264
Positives	38
Borderline negative	7
Borderline positive	9
Indeterminate	5
Non reportable insufficient cells	1
Assay not run	1
<b>Total screened</b>	<b>325</b>

Table 1: Activity to end of January 2017

- 7.13 This activity is higher than other pilot areas in the region. There has been a positive response by the Practices to the screening programme and the CCG is receiving positive feedback regarding the activity that is being seen and treated.
- 7.14 The CCG is intending to roll out to other practices and will continue to work closely with the existing practices to ensure they will identify and screen eligible people.
- 7.15 The CCG also has an event planned around World TB Day to raise the profile of the project further, at which material will be provided to encourage non registered patients to come forward. In addition Task and Finish group members from Peterborough City council (Housing, Social Care and Public Health) are supporting the CCG to take a targeted approach to underserved populations to ensure they are encouraged to come forward for screening.
- 7.16 For 2017/18 the CCG will continue to support all the Greater Peterborough Practices, to continue with the Programme due to a higher than average turnover in the

catchment population.

- 7.17 The CCG will also offer screening to the remaining CCG wide practices to ensure we capture eligible people who also reside in smaller rural areas due to the nature of local employment opportunities.

## 8. **SEXUAL HEALTH**

According to the Public Health Sexual and Reproductive Health Profiles 2015, Peterborough has a rate of diagnosis of new sexually transmitted infections (STIs) at 745 diagnoses of STIs per 100,000 residents (compared to 815 per 100,000 in England, and 620 in the East of England). There is likely to be an association between the level of socio-economic deprivation in some areas and links to STI rates.

### 8.1 **Areas prioritised for improvement include:**

- **Rates of HIV late diagnosis**

Between 2013-2015, 60.5% of HIV diagnoses were made at a late stage of infection, compared to 40.3% in England. This is an increase from 56.8% late HIV diagnoses between 2012 and 2014, compared to 42.2% 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 in 2014, at 30.2 per 1,000 females aged between 15-17 years, 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 from 24.3 per 1,000 in 2013 to 22.8 per 1,000 in 2014.

- **Chlamydia diagnoses**

In 2015, the rate of chlamydia diagnoses per 100,000 young people aged 15-24 years in Peterborough was 2,499, which is above the England average at 1,887 and the East of England at 1,472. This exceeds the Public Health Outcomes Framework (PHOF) higher target of 2,300 per 100,000, which is considered positive (as we are reaching and treating a high proportion of young people with the infection).

- 8.2 The integrated contraception and sexual health service (iCaSH) is now in its third year and has demonstrated to date its effectiveness in seeing patients with a 25% increase in activity since 2014/15 with a projected activity increase to 24,000 attendances per year. Further analysis around additional activity is being investigated, however clinicians suggest that this is an equal split for both GUM and contraceptive needs. It continues to meet the majority of the BASHH (British Association for Sexual Health and HIV) standards set and patient feedback is evidence that the service is working well with patient care at the forefront of the service.

- 8.3 iCaSH have also been responsive with the outreach team and voluntary sector, in dealing with need and trends within Peterborough and putting services in place to address the needs of population groups at higher risk. The current sexual health needs assessment for Peterborough (see para 8.7) will provide further information to ensure that more vulnerable groups are identified and reached appropriately.

8.4 Commissioners, iCaSH and Public Health England attended a local Chlamydia Care Pathway workshop specifically for Peterborough and identified key findings;

- Chlamydia coverage rate for 15-24 year olds 18.5% which is worse than the England Average (2015 data). The percentage of this from the core sexual health services is 65.4% which is below the 70% England Average.
- Percentage of positive chlamydia tests is significantly higher than expected (expected range 5%-12%) at 23.3% for 15-19 years and 18.5% 20-24 years suggesting that Peterborough has a higher than average rate of positivity.
- Detection rate is better than the national recommendation of 2,300 per 100,000 population aged 15-24 at 2,500. England Average 1,887 per 100,000.
- 100% of patients received their results within 10 working days. The BASHH indicator level is 95%.
- Proportion of positive patients that receive treatment within 6 weeks 98%. The BASHH standard is 95%.
- Proportion with agreed PN outcome documented 94% BASHH standard is 97%. Therefore an action for this is for iCaSH to complete a PN audit.
- Proportion of patients that came back for a re-test between 10 weeks and less than 14 weeks (NCSP indicator) 13% National audit data 8%.

8.5 The local Contraceptive and Sexual Health Strategic Group has met on a few occasions, with good attendance from all relevant agencies that are responsible for overseeing and implementing the local Sexual Health Strategy. The strategy continues to focus on 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.

8.6 Peterborough and Cambridgeshire multi agency strategic groups will align in the future and we are waiting for the finalisation of this. This group is currently reported to the PHPC which then reports into the Peterborough Health and Wellbeing Board.

8.7 There is currently a Sexual Health Needs Assessment being produced for Peterborough and therefore there may be further recommendations which come from this.

## **9. HEALTH EMERGENCY PLANNING**

9.1 The City Council is 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 Locality Director and the DPH for Cambridgeshire and Peterborough. 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 to validate the plans. 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 HPSG to ensure sharing of cross cutting health sector resilience issues.

- The DPH has been supported in this work by a 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 Midlands and East (East) and has oversight of all health protection issues. The function is supported by the shared Health Emergency Planning and Resilience Officer (HEPRO) based within Public Health. The HEPRO reports into the LHRP and the LRF through the DPH.
- 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.
- The LHRP leads on the annual EPRR assurance process for NHS funded organisations. The aim is to assess the preparedness of the NHS, both commissioners and providers, against common NHS EPRR Core Standards.
- All NHS funded organisations have completed their self-assessment against the EPRR Core Standards for 2016/7. In addition to the general standards, this self-assessment included a deep dive on Business/Service Continuity with an emphasis on fuel. Papworth Hospital NHS FT and Cambridge & Peterborough FT

attained full compliance. Cambridge University Hospitals NHS FT, Hinchingsbrooke Healthcare NHS Trust, Peterborough & Stamford Hospitals NHS FT, Cambridge Community Services NHS Trust, Cambridgeshire & Peterborough CCG, 111-Herts UK and NHS England East Locality attained substantial compliance. Work plans where required, are in place and are signed off at board level.

9.4 The LRF and LHRP priorities for this year are planning for pandemic influenza; excess deaths; mass casualty incidents; CBRN incidents; and adverse weather including flooding.

9.5 The LRF held exercises to validate all planning for all upper tier COMAH sites in Cambridgeshire.

## 10. Summary

This report has provided an update on all key areas of health protection for Peterborough including

- Communicable disease surveillance including information on the increased levels of pertussis (whooping cough) and scarlet fever cases in the past two years.
- Immunisations which show a steady state for some and a gradual increase in uptake of many childhood immunisations and of seasonal flu vaccination
- Screening in which there is continued below average uptake of breast, cervical and bowel cancer screening in Peterborough with a recent unexplained dip in breast screening uptake
- Healthcare associated infections and the work to reduce anti-microbial resistance
- The City Council Environmental Health role in protecting health including pollution control and air quality monitoring and advice
- The national TB strategy and successful local implementation of some key areas of the strategy notably Latent TB Infection Screening (LTBI)
- Sexual health including prevention and treatment of sexually transmitted infection and prevention of teenage pregnancy, the key priorities for action and the work to develop a sexual health strategy for Peterborough
- Health emergency planning and the priorities for the coming year.

## UK Vaccination programme

### Age 2 months

**5-in-1 (DTaP/IPV/Hib) vaccine** – this single jab contains vaccines to protect against five separate diseases: diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib, a bacterial infection that can cause severe pneumonia or meningitis in young children)

**Pneumococcal (PCV) vaccine** – pneumococcus can cause various infections including pneumonia

**Rotavirus vaccine** - Rotavirus is a highly infectious stomach bug that typically strikes babies and young children. This is an oral vaccine

**Men B vaccine** – Meningococcus B is responsible for approximately 90% of meningitis in young children

### Age 3 months

**5-in-1 (DTaP/IPV/Hib) vaccine** - second dose

**Rotavirus vaccine** - second dose

### Age 4 months

**5-in-1 (DTaP/IPV/Hib) vaccine** - third dose

**Pneumococcal (PCV) vaccine** - second dose

**Men B vaccine** – second dose

### **Between 12 and 13 months**

**Hib/Men C booster** - given as a single jab containing meningococcus C ( another cause of meningitis) and Hib (fourth dose)

**Measles, mumps and rubella (MMR) vaccine** - given as a single jab. Measles, mumps and rubella are highly infectious conditions that can have serious, and potentially fatal, complications, including meningitis, swelling of the brain (encephalitis) and deafness. They can also lead to complications in pregnancy that affect the unborn baby, and can lead to miscarriage

**Pneumococcal (PCV) vaccine** - third dose

**Men B vaccine** – third dose

### Age 2 to 7 years including school years 1, 2 and 3

**Seasonal influenza (Flu) vaccine - given as a nasal spray and needs to be given** annually – this programme is being gradually extended to include all children up to age 16 years.

### **3 years and 4 months, or soon after**

**Measles, mumps and rubella (MMR) vaccine, second dose**

**4-in-1 (DTaP/IPV) pre-school booster** - given as a single jab containing vaccines against diphtheria, tetanus, whooping cough (pertussis) and polio

### **Around 12-13 years**

**HPV vaccine**, which protects against the Human Papilloma Virus which causes cervical cancer, it is given to girls only – two jabs are given 6 – 12 months apart

### **Age 14 years**

**3-in-1 (Td/IPV) teenage booster** - given as a single jab which contains vaccines against diphtheria, tetanus and polio

**Men ACWY** – School children aged 14 (year 9) are now offered this vaccination routinely and students going to university or college for the first time, including overseas and mature students up to the age of 25, are advised to contact their GP to have the Men ACWY vaccine, ideally before the start of or in the first few weeks of the academic year. Cases of meningitis and septicaemia (blood poisoning) caused by Men W bacteria are rising, due to a particularly deadly strain. The highest risk of meningitis is in the first year of university, particularly the first few months.

### **65 and over**

**Flu** (every year)

Pneumococcal (PPV) vaccine

### **70 years**

**Shingles vaccine** (from September 2013)

### **Vaccines for special groups**

There are some vaccines that aren't routinely available to everyone on the NHS but which are available for people who fall into certain risk groups, such as pregnant women, people with long term health conditions and healthcare workers. These extra vaccines include **hepatitis B vaccination, TB vaccination and chickenpox vaccination.**

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