

PETERBOROUGH CITY COUNCIL
ANNUAL HEALTH PROTECTION REPORT 2017-2018

Contents

1.	INTRODUCTION	4
2.	PETERBOROUGH HEALTH PROTECTION COMMITTEE	4
3.	SURVEILLANCE	5
4.	PREVENTION	7
4.1.	Immunisation programmes	7
4.1.1	Childhood Primary Vaccinations	8
4.1.3	Meningitis B.....	15
4.1.4	Men ACWY	15
4.1.5	Seasonal Flu Vaccination.....	16
4.1.6	Prenatal Pertussis Vaccination	17
4.1.7	Rotavirus Vaccination	18
4.1.8	School Immunisation Service.....	18
4.1.9	Shingles	19
4.1.10	Cambridgeshire and Peterborough Immunisations network	19
5	SCREENING PROGRAMMES.....	20
5.1	Antenatal and Newborn Screening.....	20
5.2	Programme Updates.....	22
5.2.1	Foetal Anomaly Screening Programme	22
5.2.2	Infectious Diseases	22
5.2.3	Newborn hearing.....	22
5.2.4	Non Invasive Prenatal Testing	22
5.3	Cancer Screening programmes.....	23
5.3.1	Breast Screening.....	23
5.3.2	Cervical Cancer Screening.....	24
5.3.3	Improving uptake in Cancer screening programmes	24
5.3.4	Bowel Cancer Screening.....	24
6	Adult and Young People Screening	25
6.1	Diabetic Eye Screening Programme.....	25
6.2	Abdominal Aortic Aneurysm (AAA) Screening Annual Data.....	26

7	Healthcare Associated Infection (HCAI) and Antimicrobial Resistance (AMR).....	27
7.4	Antimicrobial Resistance	29
8	Environmental Health	30
9	Air Quality	32
10	NATIONAL TUBERCULOSIS STRATEGY	33
10.1	Latent TB Identification Project.....	33
11.	SEXUAL HEALTH	36
12	Health Emergency Planning	41
13	Summary	42
	Annex1: UK Vaccination Programme	44

Annual Health Protection Report for Peterborough 2017-2018

1. INTRODUCTION

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

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.

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.

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.

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

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.

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 were drawn up for the Joint Cambridgeshire and Peterborough Health Protection Steering Group. To ensure that the shared membership fully protected the confidentiality of any sensitive items discussed the Terms of Reference include a Confidentiality/Non-disclosure Agreement.

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.

Table 0.1: Notifiable Diseases in Peterborough

Notifiable Disease*	2014	2015	2016	2017***
Acute infectious hepatitis	7	17	14	13
Acute meningitis	<5	<5	<5	<5
Food poisoning (excluding campylobacter**, but including the organisms below)	71	63	86	59
E coli O157 VTEC	<5	<5	<5	<5
Cryptosporidium	13	18	19	15
Giardia	15	12	20	6
Salmonella	34	23	38	35
Infectious bloody diarrhoea	8	<5	6	<2
Invasive group A streptococcal disease	9	<5	7	14
Legionnaires' disease	0	<5	<5	<5
Malaria	<5	<5	<5	0
Measles*	5 (0)	<5 (0)	<5 (0)	<5 (0)
Meningococcal septicaemia	5	<5	<5	<5
Mumps*	8 (<5)	8 (<5)	11 (<5)	10 (<5)
Rubella*	<5	<5	0	<5
Scarlet fever	20	98	56	92
Whooping cough	18	15	49	33

***** Please note that 2017 numbers are provisional**

SOURCE: East of England HPT HPZone

* *These are notifications of infectious disease and are not necessarily laboratory confirmed. Numbers in brackets indicate confirmed cases. There have been no confirmed cases of 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 There was a marked increase in Invasive Group A streptococcal (iGAS) disease cases in 2017, double the number of cases for 2016. The iGAS cases were not linked and no pattern to the cases has been identified. There has also been a big rise in iGAS cases nationally in January 2018, [reasons for the rise in iGAS infection are not known, with preliminary analysis suggesting a rise in influenza co-infection](#). Group A Streptococcus (GAS) is a bacterium that can cause diverse range of skin, soft tissue and respiratory tract infections, but occasionally can cause infections that are very severe. Invasive GAS is an infection where the bacteria is isolated from a normally sterile body site such as the blood.

3.3 Outbreaks and Incidents

There have been 7 outbreaks of gastroenteritis. Of these 6 were in care homes and 1 was a day centre. None were laboratory confirmed.

34 Tuberculosis surveillance

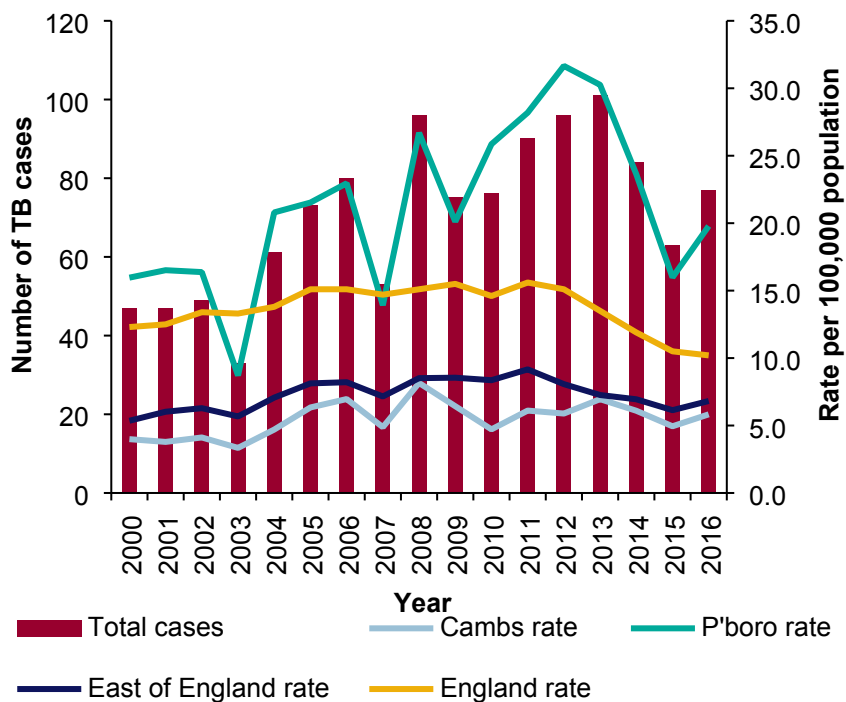
The minimal dataset collected through the NOIDs system affords no possibility to monitor trends within subgroups in the population. The increasing incidence of TB in E&W, particularly affecting subgroups within the population, led to the introduction, on 1 January 1999, of continuous Enhanced Tuberculosis Surveillance (ETS). This aims to provide detailed and comparable information on the epidemiology of TB by collecting a minimum dataset on all cases of TB reported by clinicians.

Official TB statistics are based on data extracted from ETS in April each year. The time to process and analyse this data takes a further six months, therefore the latest official statistics are for data to the end of 2016.

- In 2016, 77 cases of TB were notified among residents of Cambridgeshire and Peterborough local authorities (Fig. 0.1). The TB rate in Cambridgeshire (5.8 per 100,000) remains below the East of England average (6.8 per 100,000), whereas the rate in Peterborough (19.8 per 100,000) has declined since 2012 (31.7 per 100,000) but remains substantially higher than average. TB cases increased in both areas in 2016 compared to 2015.
- The majority of cases were aged 15-44 years, with a mean age of 41.7 years.

- 77.6% of cases were non-UK born, with India, Pakistan, Timor-Leste and Lithuania being the most common non-UK countries of birth. In 2016, substantially more cases were UK born than in 2015.
- A larger proportion of patients in Peterborough had social risk factors (34.4%) compared to the national average (15.4%), whereas Cambridgeshire cases showed no notable difference (15.6%).

Figure 0.1: Annual TB notifications 2000-2016



4. 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 1: Diphtheria, Tetanus, Pertussis, Polio and Haemophilus Influenza B

12 months DTaP/IPV/Hib [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Peterborough	94.8	96.3	96.1	93.8
East Anglia	95.6	95.6	95.4	95.5
	Q1 2016/17 %	Q2 2016/17 %	Q3 2016/17 %	Q4 2016/17 %
Peterborough	93.5	93.8	93.9	94.3
East Anglia	95.0	95.2	95.2	95.0

Source: Cover, Public Health England

Figure 1.0 - 12m DTaP/IPV/Hib Percentage Uptake in Peterborough by Similar Local Authorities

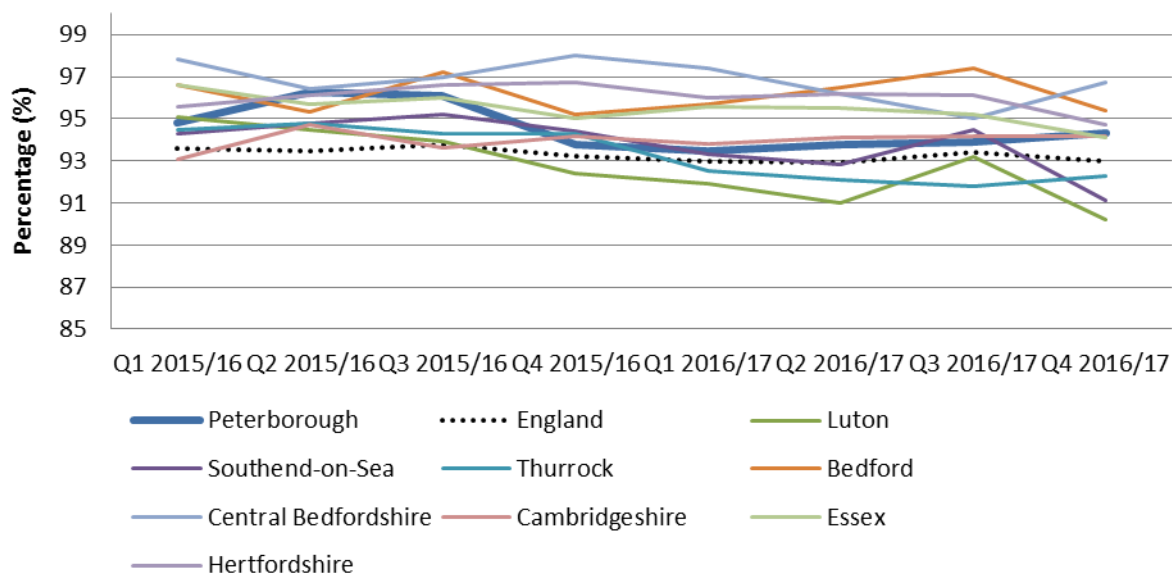


Table 2: Pneumococcal Vaccine

12 months PCV [target 95%] [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Peterborough	94.5	95.8	96.6	93.0
East Anglia	95.4	95.4	95.5	95.6
Q1 2016/17 %	Q2 2016/17 %	Q3 2016/17 %	Q4 2016/17 %	
Peterborough	93.6	93.6	93.5	94.2
East Anglia	95.4	95.3	95.3	95.1

Source: Cover, Public Health England

Figure 2.0 - 12m PCV Percentage Uptake in Peterborough and Surrounding Geographical Area

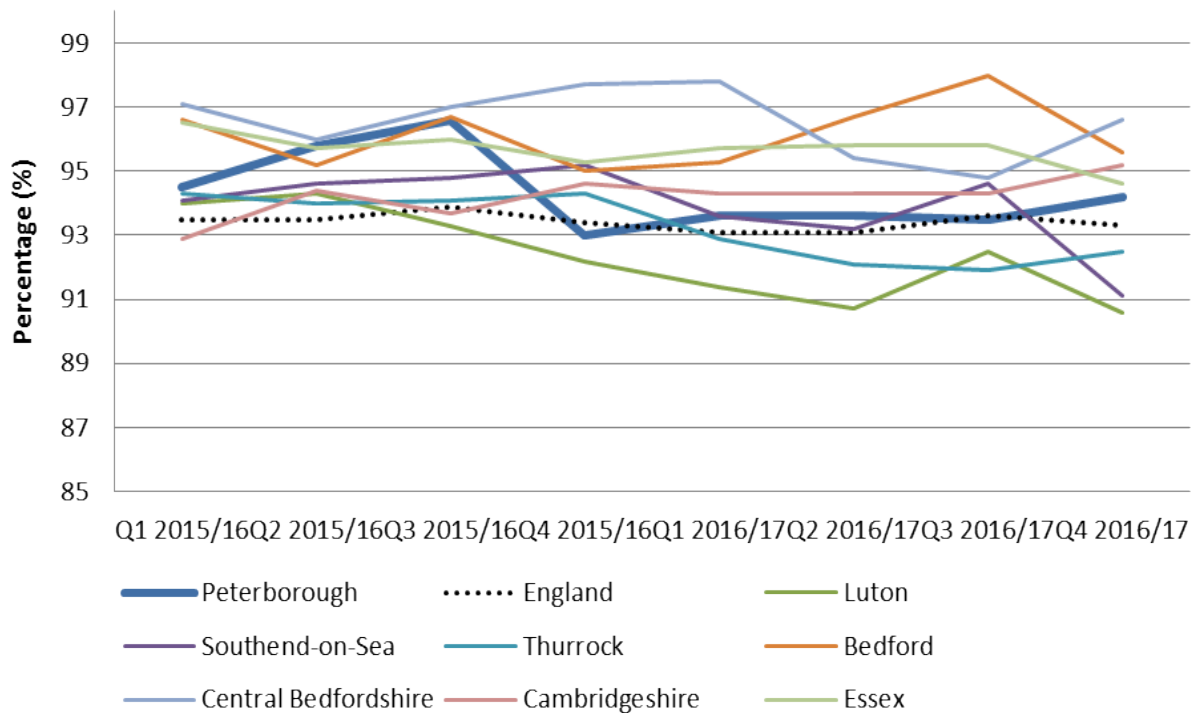


Table 3: Diphtheria, Tetanus, Pertussis, Polio and Haemophilus Influenza B

24 months DTaP/IPV/Hib [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Peterborough	95.5	96.2	96.0	97.2
East Anglia	96.5	95.7	96.2	96.0
	Q1 2016/17 %	Q2 2016/17 %	Q3 2016/17 %	Q4 2016/17 %
Peterborough	95.6	96.9	96.4	96.4
East Anglia	96.1	96.2	96.4	96.3

Source: Cover, Public Health England

Table 4: Pneumococcal vaccine

24 months PCV Booster [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Peterborough	92.8	92.8	93.7	92.6
East Anglia	93.6	93.0	93.5	93.3
	Q1 2016/17 %	Q2 2016/17 %	Q3 2016/17 %	Q4 2016/17 %
Peterborough	91.2	91.9	89.9	90.8
East Anglia	92.9	94.3	94.1	94.0

Source: Cover, Public Health England

Figure 3.0 - 24m PCV Booster Percentage Uptake in Peterborough and Surrounding Geographical Area

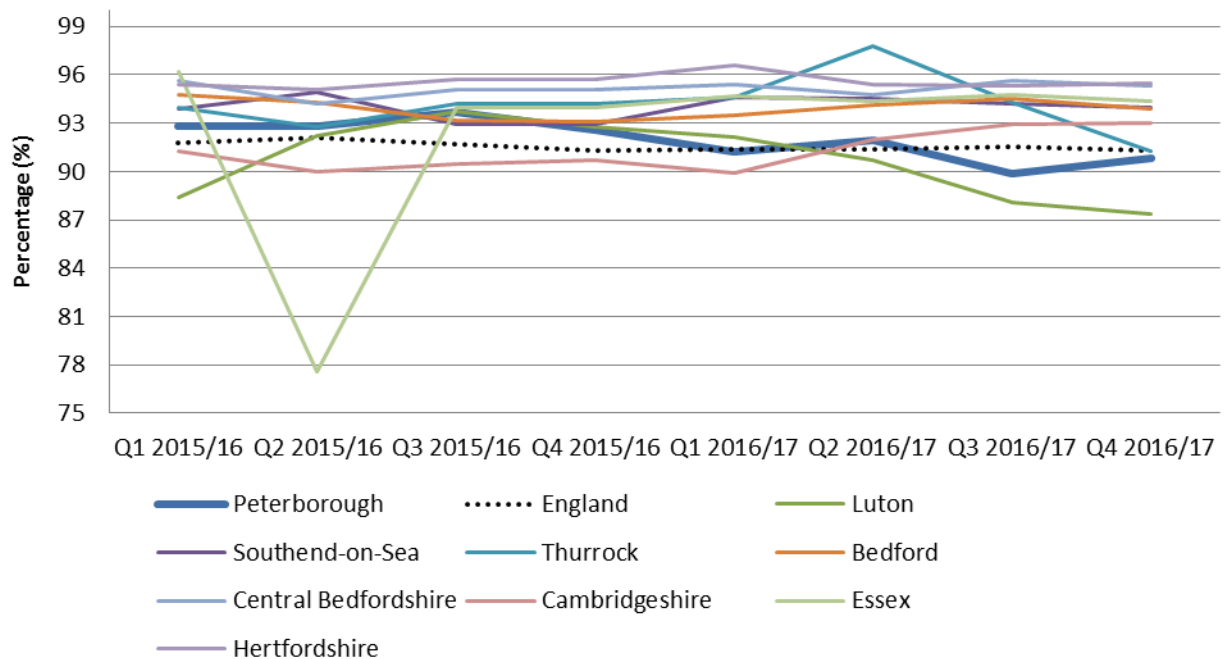


Table 5: Haemophilus Influenza B and Meningococcus C

24 months Hib/Men C [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Peterborough	92.6	91.5	93.3	91.9
East Anglia	93.8	92.5	93.4	93.3
	Q1 2016/17 %	Q2 2016/17 %	Q3 2016/17 %	Q4 2016/17 %
Peterborough	90.8	92.6	89.5	90.7
East Anglia	92.8	94.3	94.1	94.0

Source: Cover, Public Health England

Table 6: Measles, Mumps and Rubella

24 months MMR 1 [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Peterborough	92.6	92.6	92.1	92.1
East Anglia	93.4	92.3	93.1	93.4
	Q1 2016/17 %	Q2 2016/17 %	Q3 2016/17 %	Q4 2016/17 %
Peterborough	91.8	92.2	89.2	91.6
East Anglia	92.7	93.8	93.9	94.0

Source: Cover, Public Health England

Figure 4.0 - 24m MMR1 Percentage Uptake in Peterborough and Surrounding Area

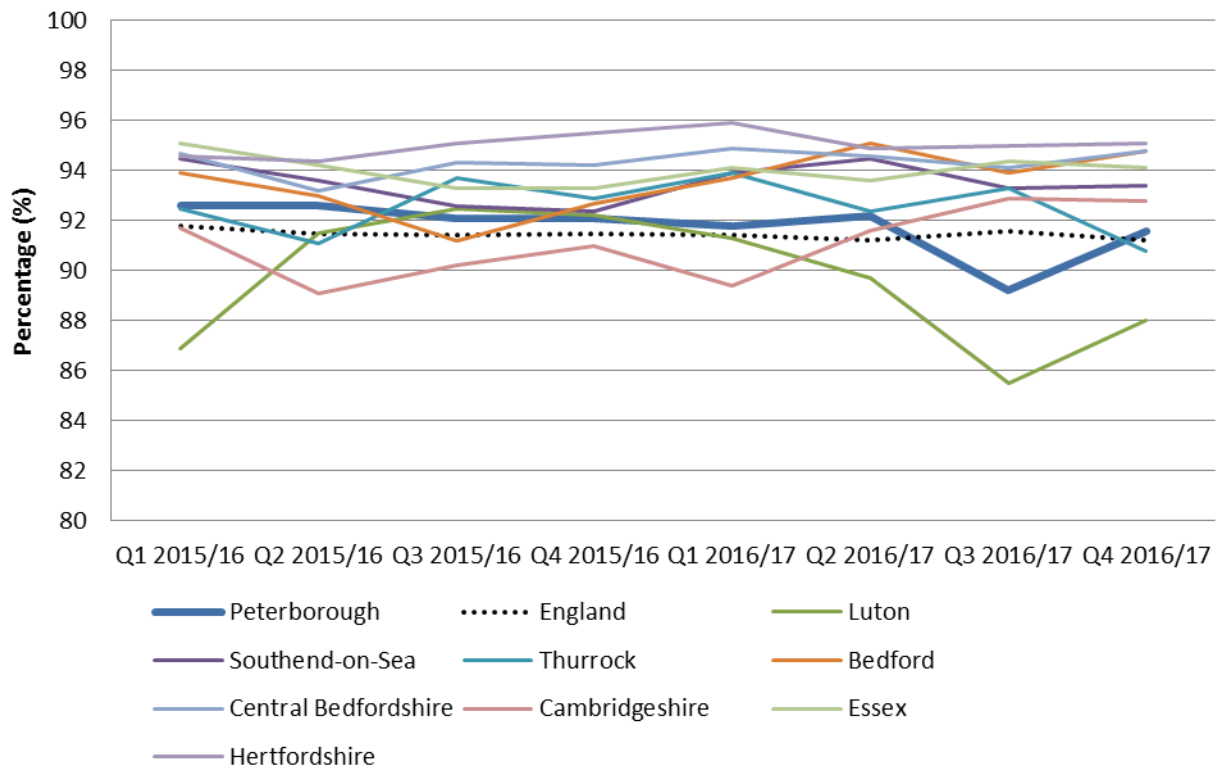


Table 7: Diphtheria, Tetanus, Pertussis, Polio and Haemophilus Influenza B

5 years DTaP IPV Hib [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Peterborough	97.6	92.5	96.4	95.2
East Anglia	96.2	95.3	95.6	96.2
	Q1 2016/17 %	Q2 2016/17 %	Q3 2016/17 %	Q4 2016/17 %
Peterborough	95.7	96.4	97.5	97.1
East Anglia	96.0	96.9	96.2	96.2

Source: Cover, Public Health England

Table 8: Measles, Mumps and Rubella (first dose)

5 years MMR 1 [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Peterborough	95.5	89.0	94.6	93.9
East Anglia	94.2	93.1	93.8	95.2
	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17
Peterborough	95.3	95.7	96.6	96.7
East Anglia	95.4	96.0	95.5	95.6

Source: Cover, Public Health England

Figure 5.0 - 5y MMR1 Percentage Up in Peterborough and Surrounding Geographical Area

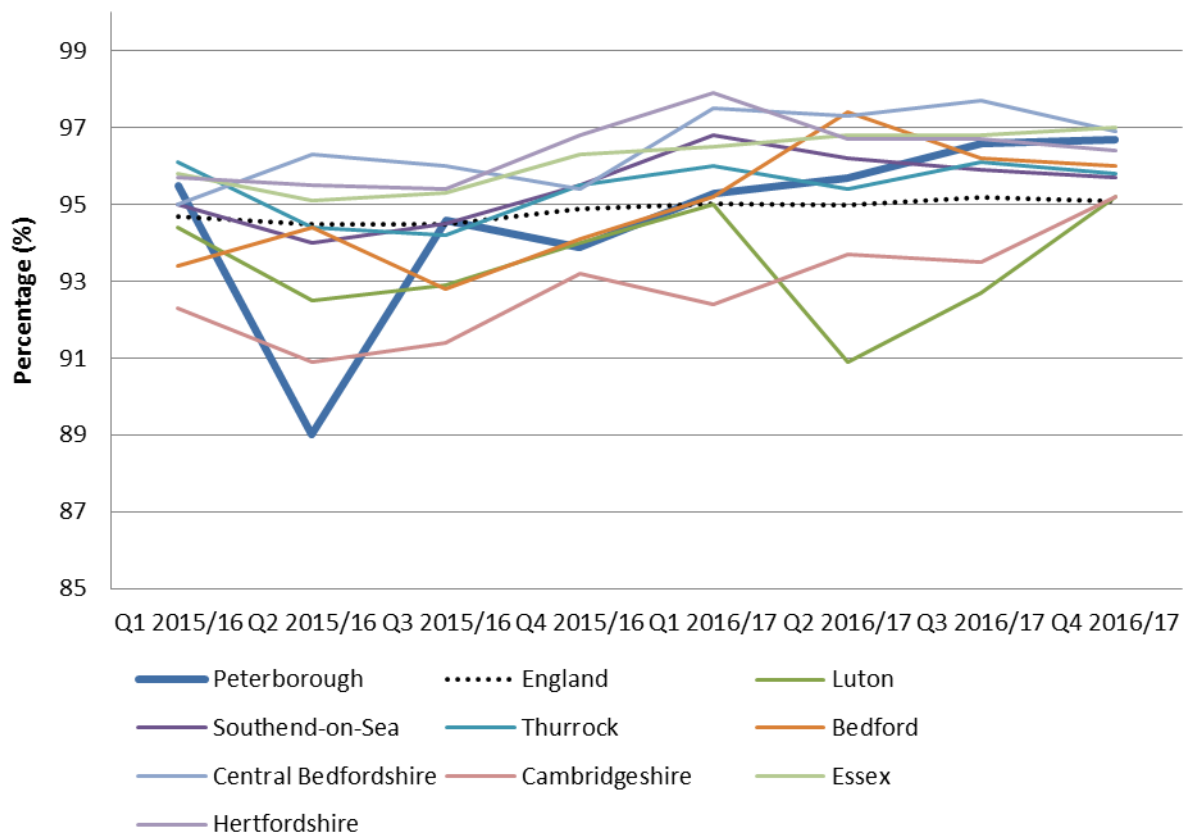


Table 9: Measles, Mumps and Rubella (second dose)

5 years MMR 2 [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Peterborough	90.0	89.0	88.9	89.9
East Anglia	91.4	88.8	89.4	90.8
	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17
Peterborough	89.8	91.6	92.6	88.6
East Anglia	88.2	89.8	90.1	90.1

Source: Cover, Public Health England

Figure 6.0 - 5y MMR2 Percentage Uptake in Peterborough and Surrounding Geographical Area

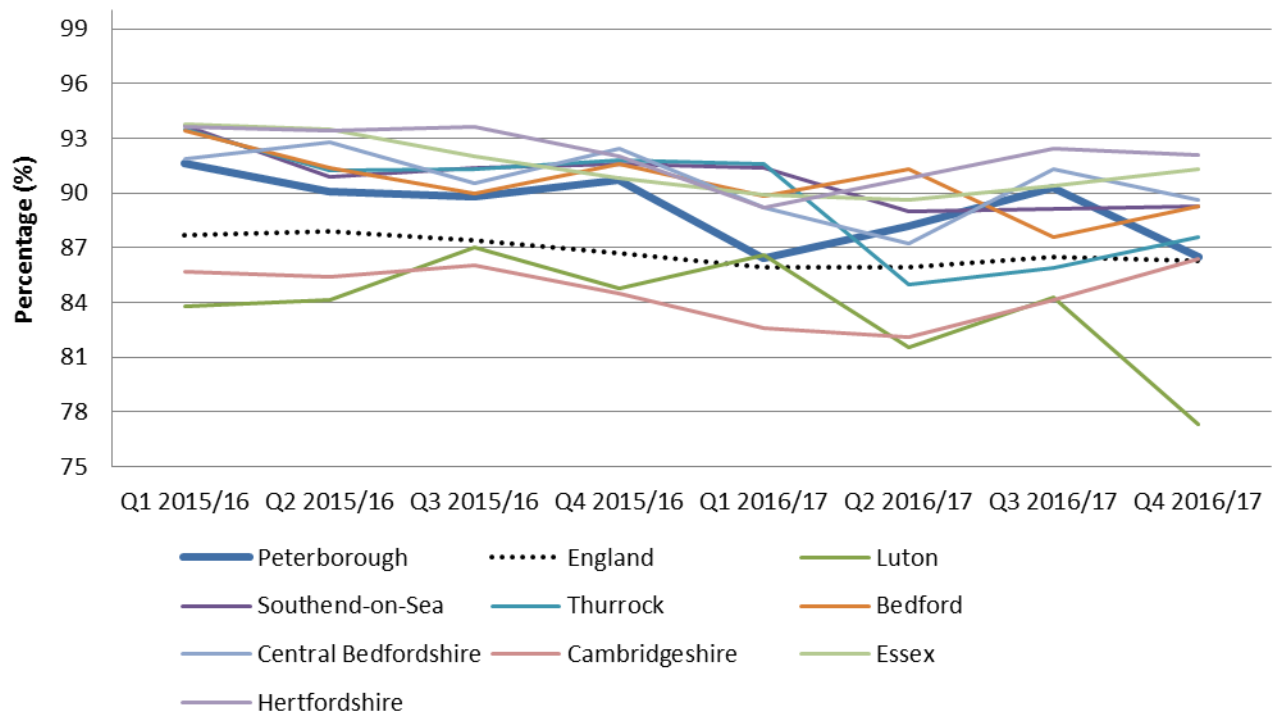


Table 10: Diphtheria, Tetanus, Pertussis, Polio

5 years DTaP/IPV Booster [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Peterborough	91.6	90.1	89.8	90.7
East Anglia	90.7	89.5	90.4	89.0
	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17
Peterborough	86.4	88.2	90.3	86.5
East Anglia	87.6	88.7	88.8	89.1

Source: Cover, Public Health England

4.1.2 The very low uptake of the MMR2 and DTaP/IPV boosters by age 5 years are subject to specific communications using the Healthy Peterborough programme.

Figure 7.0 - 5yDTaP/IPV Booster Percentage Uptake in Peterborough and Surrounding Geographical Area

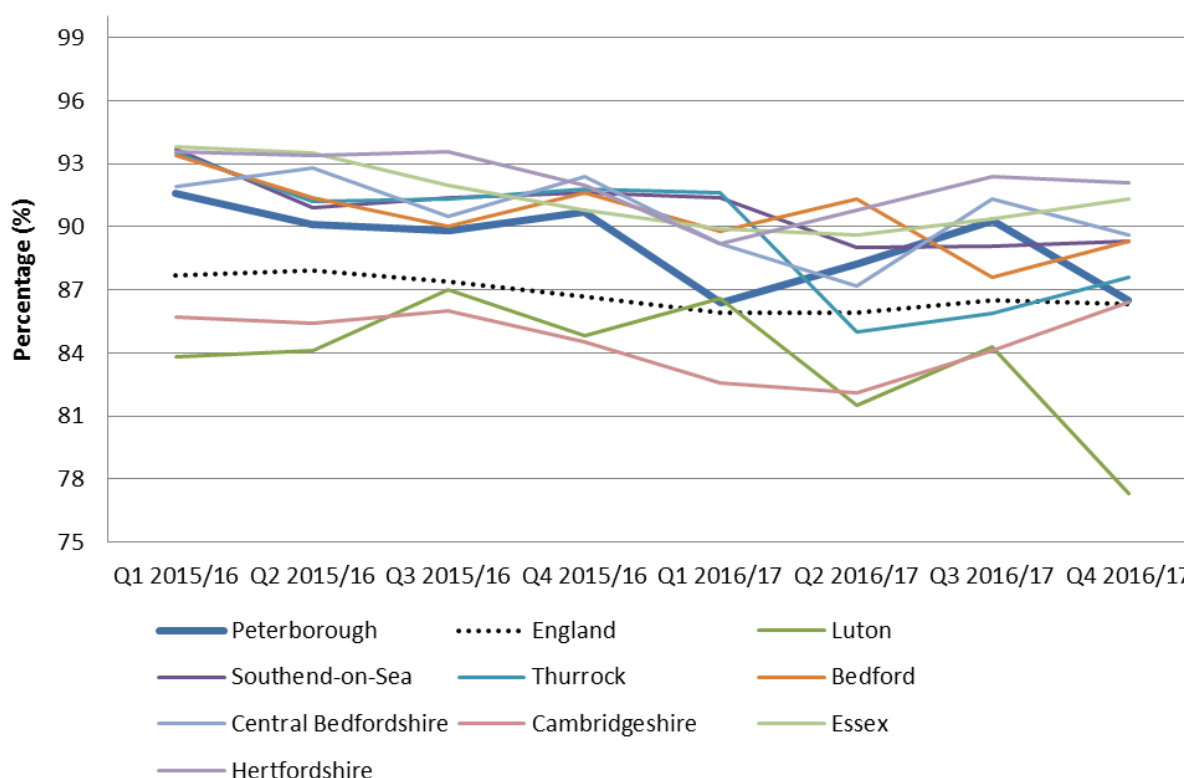


Table 11: Haemophilus Influenza B and Meningococcus C

5 years Hib/Men C [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Peterborough	92.0	91.8	91.4	89.4
East Anglia	93.1	93.0	92.9	92.2
	Q1 2016/17 %	Q2 2016/17 %	Q3 2016/17 %	Q4 2016/17 %
Peterborough	88.9	88.5	91.3	92.9
East Anglia	91.2	93.4	93.0	93.2

Source: Cover, Public Health England

<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>

4.1.3 Meningitis B

New vaccines introduced include **Meningitis B** vaccine as part of the primary vaccination for infants. This commenced **1st 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 12: Meningitis B

12 months Men B [target 95%]	Q1 2016/17 %	Q2 2016/17 %	Q3 2016/17 %	Q4 2016/17 %
Peterborough	Data not collected	91.6	92.9	93.7
East Anglia	Data not collected	93.7	94.4	94.6

Source: Cover, Public Health England

4.1.4 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 13: Men ACWY

Org Name	Vaccine uptake – December 2017					
	Becoming 18 (born 1 st Sep 1997 to 31 st Aug)	No. of patients that have received the MenACWY	% Uptake	Becoming 19 (born 1 st Sep 1996 to 31 st Aug 1997 inclusive)	No. of patients that have received the MenACWY	% Uptake
Cambridgeshire & Peterborough CCG	11839	3799	32.0%	12099	4686	38.7
East Anglia Total	29607	8880	30.0	30253	11710	38.7

Source: ImmForm December 2017

Table 14: Annual HPV Vaccine Coverage Data September 2016-17

Local Authority		Peterborough City Council	England
Cohort 13: 13-14 Year Olds (Year 9) Birth Cohort: 1 September 2002 - 31 August 2003	Number of females in Cohort 13 (Year 9)	1180	289499
	No. vaccinated with HPV Vaccine at least one dose by 31/08/2017	1062	257201
	% Coverage	90.0%	88.8%
	No. vaccinated with two doses by 31/08/2017	1005	240590
	% Coverage	85.2%	83.1%
Cohort 12: 13-14 Year Olds (Year 10) Birth Cohort: 1 September 2001 - 31 August 2002	Number of females in Cohort 12 (Year 10)	1124	281685
	No. vaccinated with HPV Vaccine at least one dose by 31/08/2017	1078	254554
	% Coverage	95.9	90.4
	No. vaccinated with two doses by 31/08/2017	1102	240929
	% Coverage	98.0%	85.5%

Source: Public Health England

4.1.5 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 15: Flu vaccination uptake by key groups

Area	Summary of flu vaccine uptake %					
	65 and over		Under 65 (at risk)		Pregnant women	
	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17
Cambridgeshire & Peterborough CCG	72.4	72.1	42.7	47.2	32.2	46.7
East Anglia	71.3	71	42.8	47.1	36.7	47.9

Source: ImmForm

Table 16: Seasonal flu vaccination uptake by age 2, 3 and 4 year olds

Area	Summary of flu vaccine uptake %					
	All aged 2		All aged 3		All aged 4	
	2015/6	2016/7	2015/6	2016/7	2015/6	2016/7
Cambridgeshire & Peterborough CCG	37	39.7	39.3	42.0	29.7	33.3
East Anglia	39.1	42.1	40.8	43.9	32.0	35.4

Source: ImmForm

Table 17: Front line healthcare workers in Trusts

Org Name	No. of HCWs with Direct Patient Care	Seasonal Flu doses given since 1 st September 2016		% Seasonal flu doses given since 1 st 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
Hinchingbrooke Health Care NHS trust	1215	920	75.7	63.6
Cambridgeshire and Peterborough NHS Foundation Trust	3375	1358	40.2	35.8
East Anglia Total	50249	29012	57.7	43.1

Source: ImmForm

We have been advised by Public Health England that flu vaccination uptake is higher in the 2017/8 season than in the 2016/7 season, but have not been provided with the validated data yet.

4.1.6 Prenatal Pertussis Vaccination

Following increased pertussis activity in all age groups, including infants under three months of age, and the declaration of a national pertussis outbreak in April 2012, pertussis vaccine has been offered to pregnant women since 1 October 2012. The prenatal pertussis vaccination programme aims to minimise disease, hospitalisation and deaths in young infants, through intra-uterine transfer of maternal antibodies, until they can be actively protected by the routine infant programme with the first dose of pertussis vaccine scheduled at eight weeks of age.

Reported pertussis activity was higher in 2016 than in any year between 2013 and 2015 but did not reach the overall peak levels recorded in 2012. The increase in 2016 was consistent with pre-existing cyclical trends with peaks in disease every 3 or 4 years.

(Source: Public Health England, Health Protection Report Volume 12 Number 1 5 January 2018)

Table 18: Prenatal Pertussis Vaccination Uptake

Pertussis	Apr 2015 %	May 2015 %	Jun 2015 %	Jul 2015 %
Cambridgeshire & Peterborough CCG	49.8	45.9	52.7	50.5
East Anglia	56.8	53.8	58.9	56.3
Pertussis	Aug 2015 %	Sept 2015 %	Oct 2015 %	Nov 2015 %
Cambridgeshire & Peterborough CCG	51.2	50.5	54.1	52.5
East Anglia	58.5	67.2	60.3	61.4
Pertussis	Dec 2015 %	Jan 2016 %	Feb 2016 %	Mar 2016 %
Cambridgeshire & Peterborough CCG	50.7	50.3	NA	NA
East Anglia	60.3	59.3	NA	NA
Pertussis	Apr 2016 %	May 2016 %	Jun 2016 %	Jul 2016 %
Cambridgeshire & Peterborough CCG	52.7	73.8	73.3	71.9
East Anglia	60.2	73.6	74.4	74.7
Pertussis	Aug 2016%	Sept 2016 %	Oct 2016 %	Nov 2016%
Cambridgeshire & Peterborough CCG	70.6	72.8	71.4	72.3
East Anglia Total	74.1	76.4	78.7	78.0
Pertussis	Dec 2016 %	Jan 2017 %	Feb 2017%	Mar 2017 %
Cambridgeshire & Peterborough CCG	76.2	78.9	76.2	75.5
East Anglia Total	79.8	82.3	79.8	77.0

Source: ImmForm

4.1.7 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 19: Rotavirus vaccination

12 months Rotavirus 2 doses [target 95%]				
	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17
Peterborough	90.3	89.1	90.0	90.4
East Anglia	92.5	92.6	91.6	92.1

Source: ImmForm

4.1.8 School Immunisation Service

Table 20: Data for end of school year 2016-17

	Target	Peterborough
HPV vaccination by end of school year nine dose 2	90%	85%
School leaver booster (Td/IPV) by end of school year 9 and 10.	80%	79%
Men ACWY by end of school year 10.	80%	80%
Childhood Flu vaccination school years 1 and 2 and 3	60%	42%
Schools participating in the programme	100%	100%

Source: CCS

4.1.9 Shingles

The data for the Shingles vaccination programme is shown in the table below. The data is cumulative and is up to end August 2017. This is the fourth year of the shingles vaccination programme in England and data from September 2016 to August 2017 shows a continued decline in coverage in the routine (70 year old) and catch up (78 years old) cohorts (from 57.6% in 2015/16 to 46.8% in 2016/17 and from 51.8% in 2015/16 to 47.4% in 2016/17, 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 21: Shingles vaccination uptake August 2017

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	8284	4389	53.0	5110	2842	55.6
East Anglia Total	29332	14947	51.0	18338	9753	53.2

Source: ImmForm

4.1.10 Cambridgeshire and Peterborough Immunisations network

This groups meets 3 – 4 times per year to discuss all issues relating to immunisations and to take forward the recommendations of a previous Immunisation 'Task and Finish' group that reported two years ago. That group had been set up to identify the reasons for lower immunisation uptake for childhood immunisation. Ongoing work includes close working with GP practices in some areas with particularly low uptake.

Immunisations have been targeted in the Healthy Peterborough campaign in February / March 2018 with specific focus on the pre-school booster, MMR2 and HPV vaccines.

5 SCREENING PROGRAMMES

5.1 Antenatal and Newborn Screening

Peterborough City Hospital generally meets the Key Performance Indicator (KPI) target to an acceptable level and in some areas attains the achievable level. Explanations for red KPIs are given and are monitored through the Programme board.

Table 22: ID1 -Antenatal infectious disease screening – HIV Coverage + ID2 -Hep B timely referral for women found to be Hepatitis B

Indicator	2015-2016							2016-2017			
	Accpt.	Ach.	Provider	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ID1 Antenatal HIV test coverage	>95%	99%	PSHFT	98.7	98.9	99.0	99.8	99.5	99.4	99.4	99.3
ID2 Hep B timely referral for women found to be Hepatitis B	>70%	99%	PSHFT	66.7	85.7	100	75.0	50	No cases	100	80.0

Source: Maternity Unit

Table 23: Fetal anomaly screening – Coverage

FA2: Fetal anomaly screening fetal anomaly ultrasound) – coverage *	Accpt.	Ach.	Provider	2016-2017			
				Q1	Q2	Q3	Q4
	>90%	>95%	PSHFT	98.6	97.5	99.1	98.0

Source: Maternity Unit

Table 24: ST1 Coverage, ST2 Timeliness of Test, ST3 Completion of FOQ

				2015/-2016				2016/-2017			
Indicator	Accpt.	Ach.	Provider	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ST1 Antenatal sickle cell and thalassaemia screening – coverage	>95%	99%	PSHFT	96.4	95.6	96.3	99.5	96.6	97.8	97.8	97.5
ST2 Antenatal sickle cell and thalassaemia screening Timeliness of Test	>50%	75%	PSHFT	67.2	70.2	67.9	68.0	69.1	65.5	68.0	61.4
ST3 Antenatal sickle cell and thalassaemia completion of FOQ	>95%	99%	PSHFT	98.3	98.1	97.9	98.9	98.3	98.7	98.1	98.6

Source: Maternity Unit

Table 25: Newborn Blood Spot Screening – Coverage, Avoidable Repeats, Coverage (movers in)

				2015-16				2016-17			
Indicator	Accpt	Ach	Provider	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
NB1 Newborn blood spot screening coverage	>95%	99.9%	CPFT	98.5	98.5	99.7	99.7	99.6	97.5	98.8	98.8
NB2 Newborn blood spot screening avoidable repeats	<2%	0.5%	PSHFT	No data	1.3	2.5	3.0	1.8	1.4	1.4	1.6
NB4 Newborn blood spot screening coverage- movers in	>95%	99.9%	CPFT	100	90.9	93.3	93.3	82.4	84.5	78.0	79.7

Source: Maternity Unit

NB4: This KPI is impacted by the small denominator and refers to children who move into the area being seen and offered the NBBS within 3 weeks of being notified to the Child Health Information System (CHIS) which records all routine child health data and operates the call / recall system for routine child immunisation and screening. The numerator is impacted by declines of babies who have received screening in their own country, those transferring in very near to the cut off for screening and those experiencing slight delays whilst appropriate interpreter arrangements are made to facilitate the appointment.

Table 26: Newborn Hearing – Coverage, Referral to Assessment

Indicator	Accpt.	Ach.	Provider	2015-16				2016-17			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
NH1 Newborn hearing screening coverage	>97%	99.5%	PSHFT	99.7	99.7	100	99.9	99.8	99.9	99.5	100
NH2 Newborn hearing screening timely referral for assessment	>90%	95%	PSHFT	100	92	100	80	100	100	100	92.9

Source: Maternity Unit

Table 27: Newborn and Infant Physical Examination – Coverage and Timely Assessment

Indicator	Accpt.	Ach.	Provider	2015-2016				2016-17			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
NP1 Newborn and Infant Physical Examination-coverage newborn	>95%	99.5%	PSHFT	100	99.6	99.8	99.9	96.9	97.4	97.3	97.6
NP2 Newborn and Infant Physical Examination timely assessment	>95%	100%	PSHFT	100	40.0	100	100	33.3	**50.0	No cases	No cases

Source: Maternity Unit

**Low denominators impact on this KPI; numbers for referrals are small and there are issues with securing scans within the timeframe. On-going work is taking place to address this. For 2, 2 cases were referred and only one seen on time and for quarter3 and 4 only one referral was made.

5.2 Programme Updates

5.2.1 Foetal Anomaly Screening Programme

A new KPI (FA3) is being piloted to monitor coverage of trisomies 13 and 18.

All maternity units are required to report fetal & congenital anomalies to the National congenital anomaly and rare disease registration service. (NCARDRS).

5.2.2 Infectious Diseases

Coverage KPIs for Hepatitis B and Syphilis have been collected from April 2017.

The use of NIPE SMART became mandatory; the Trust is compliant.

5.2.3 Newborn hearing

A new screener qualification was launched and is a mandatory requirement for all new unregistered staff from April 2017.

5.2.4 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 is still awaited from the national team.

5.3 Cancer Screening programmes

5.3.1 Breast Screening

While uptake of breast screening is satisfactory and has reached a much improved level in quarter 4 of 2016/17, we will continue to closely monitor uptake.

Table 28: Peterborough Breast screening Uptake

BS1 - Percentage of eligible women who attend for screening (aged 50-70)									
Peterborough Breast Screening Centre		2015-2016				2016-2017			
Acceptable	Achievable	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
≥ 70.0%	≤ 80.0%	77.3	77.8	70.5	72.7	75.8	71.3	69.87	74.1

Source: OBIEE (Oracle Business Intelligence Enterprise Edition)

Table 29: Breast Screening Round Length

BS2 - Percentage of women first offered an appointment within 36 months									
Peterborough Breast Screening Centre		2015-2016				2016-2017			
Acceptable	Achievable	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
≥ 90.0%	≤ 100.0%	98.87	99.05	99.1	98.7	98.1	98.3	98.9	98.2

Source: OBIEE (Oracle Business Intelligence Enterprise Edition)

Table 30: Waiting Time for Assessment

BS11 – Percentage of women who attend for assessment within 3 weeks of attending for screening									
Peterborough Breast Screening Centre		2015-2016				2016-2017			
Acceptable	Achievable	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
≥ 90.0%	≤ 100.0%	95.24	94.3	99.2	94.7	98.4	96.3	96.3	94.1

Source: OBIEE (Oracle Business Intelligence Enterprise Edition)

5.3.2 Cervical Cancer Screening

We have been advised by NHSE that verified 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 62.6% of women aged 25 – 49 have taken up their invitation to be screened.

Table 31: CS2, CS2a and CS2b - Coverage of eligible population

Acceptable	Achievable	Provider	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17
CS2 - Coverage of eligible population (all women)						
≥ 80%	≥ 95.0%	Peterborough Upper Tier LA	63.3	66.1	65.9	65.6
CS2a - Coverage of eligible population, all women aged 25-49 every 3 years						
≥ 80%	≥ 95.0%	Peterborough Upper Tier LA	63.3	63.1	62.9	62.6
CS2b - Coverage of eligible population, all women aged 50-64 every 5 years						
≥ 80%	≥ 95.0%	Peterborough Upper Tier LA	74.1	73.8	73.9	73.4

Source: Screening Quality Assurance Service (SQAS) and Open Exeter

5.3.3 Improving uptake in Cancer screening programmes

We are currently working on a project to improve Cervical Screening uptake in the Cambridgeshire and Peterborough area for 25 to 49 year olds. Nationally, the uptake for cervical screening is decreasing and we are working with GP Practices, McMillian GPs, Cancer research UK and the local CCG to try and improve uptake in this area. We will be focusing on two separate areas, how to improve knowledge of cervical screening in 25 to 49 year olds and how to develop and improve GP surgeries' procedures.

5.3.4 Bowel Cancer Screening

Table 32: Bowel screening data

HHT/PSHFT Screening Centre			2015-2016				2016-2017			
	Acc.	Ach.	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
BCS4 – Uptake	≥52%	≥70%	58.3	57.8	55.1	58.6	59.9	58.4	55.4	58.1
BCS7– SSP Waiting Times	100% within 14 days ≤1.0%		100	100	100	94.4	100	100	100	100
BCS8 - Diagnostic test waiting times	100% within 14 days		96.7	94.3	94.8	76.3	89.9	89.6	65.9	20.0

Work is ongoing to improve endoscopy capacity to maintain the Diagnostic waiting times within the bowel cancer screening programme in Peterborough. While the uptake of the screening test is within the acceptable range we are in discussion with partners to find means to encourage greater uptake of this test. Recent work with a small number of GPs gave promising results.

6 Adult and Young People Screening

6.1 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 33: Diabetic Eye Screening

Cambridgeshire & Peterborough CCG through East Anglia DESP								
Indicator & Target	2015-2016				2016-2017			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Acceptable 70% Achievable 80%								
DE1-Uptake of routine digital screening event	91.0	90.5	78.3	77.1	85.7	87.6	85.6	83.8
Acceptable 70% Achievable 80%								
DE2-Results issued within 3 weeks of screening	99.9	100	99.0	99.0	99.8	99.7	99.8	99.8
Acceptable 80% Achievable 95%								
DE3 - Timely assessment for R3A screen positive	50.0	77.8			80.0	75.0	58.3	70.0

Source: Health Intelligence

Achievement of the KPI DE3 is affected by the capacity issues in Hospital eye services within the acute Trusts in the region and is also affected by low numbers. For example Q4 data represents 3 patients not meeting the target.

6.2 Abdominal Aortic Aneurysm (AAA) Screening Annual Data

Table 34: Annual Data AA1 Completeness of Offer

AAA Annual Data - Cambridgeshire and Peterborough population					
Indicator	Acceptable	Achievable	2014-15	2015-16	2016-17
AA1 Completeness of Offer*	≥ 52%	≥ 70%	100	99.9	99.9

* AAA1 = The proportion of men eligible for abdominal aortic aneurysm screening to whom an initial offer of screening is made.

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

7.1 MRSA

Nationally the rate of MRSA bacteraemia for 2017/18 remained steady at 1.5 cases per 100,000 population and in the two years prior. Reductions have been seen in the time to onset for admitted patients, with a greater proportion of cases having a time to onset that would be considered community onset. This is likely to reflect improved clinical awareness by NHS staff but could also be an artefact of declining durations of hospital stay (PHE, 2017).

The introduction of third party cases in April 2014 recognised the complexity of some MRSA cases and where no breach in key policy was evident as part of that patient's care. These cases are not reflected against an acute Trust or CCG on the data capture system but recorded separately within the system as part of the ongoing surveillance and identification of themes and trends of causes.

Table 35: MRSA bacteraemia

Assigned	National No. 2016/17	Local No. 2016/17	National No. 2017 (Apr 17 to Nov 17)	Local No. 2017/18 (to 31/12/17)
	823	11	547	10
CCG		1		0
Trust		4		4
Third Party		6		6

7.2 Clostridium difficile

During 2016/17, 12,840 cases were reported nationally, a decrease of 9.2% on the previous year. Of these 36% were trust-apportioned and mirrors the trend of incidence of all cases declining, though overall the decline in rate has slowed. The separation of cases into trust-apportioned and non-trust apportioned is recognized to ignore relevant information on prior health exposure. For example, some cases classed as community onset are likely to be among patients who were recently discharged from hospital. The current algorithms do not take into account complex healthcare pathways patients may have.

Locally each individual case is discussed at Scrutiny panel meetings held by the Trusts. The recognition of the fact that some cases occur even if best practice is followed and the patient receives flawless care, these are non-sanctioned cases, i.e. not counted against the annual Trust objective.

In line with the national findings, the rate of local cases has slowed down however at the same time we have seen an increase. Between April and December 2016 there were a total of 104 cases reported. In the period April to December 2017 this has risen to 142. Of these cases only 21 from our Trusts have been identified to have breached some element of key policy and sanctioned against the annual objective.

The annual objectives have not been changed by the Department of Health for the past three years but we do expect this to be reviewed prior to the 2018/19 guidance being released around February/March 2018.

7.3 *Escherichia coli* bacteraemia

Between 2012/13 and 2016/17 the national rate of e coli cases has risen from 22% to 73.9% with a total of 40,580 cases reported in 2016/17. The highest rates were among patients over the age of 85 years and greater in men than among women. The most likely primary focus over time continues to be urinary tract infections accounting for 47% in 2016/17.

April 2017 saw the introduction of a Quality Premium for CCGs to reduce the number of E coli cases by 10% during the period of 2017/18 which equates to 53 cases for Cambridgeshire and Peterborough CCG.

All CCGs have been faced with a number of challenges due to resource limitations, patient identifiable data access and engagement from primary care to collect core data for the national data capture system.

The CCG is to lead on a project from January 2018 working across the whole health economy to develop and implement a bladder bundle toolkit alongside the specialist continence and urology nurses, community and primary care services and to engage with patients, in order to address the local population needs. Removing unwarranted variations of care will identify where patient risks of infection are reduced.

Between April and December 2017 we have 403 cases reported against 407 in the same period of 2016. To reach the Quality Premium we would need to have a maximum of 481 cases by the end of March 2018. Measures put in place by in-patient settings for all types of healthcare associated infections are able to have a more significant impact than when patients are in the community setting, hence the work to be undertaken will be to identify all patients with urinary catheters and frequent non-catheter related infections across our local health economy.

References:

1. Annual Epidemiological Commentary Mandatory MRSA, MSSA, *E coli* bacteraemia and *C difficile* infection data 2016/17. Public Health England. 6 July 2017
2. Technical guidance for NHS planning 2017/18 and 2018/19 – Annex B, Reducing Gram Negative Bloodstream Infections (GNBSIs) and inappropriate antibiotic prescribing in at risk groups

7.4 Antimicrobial Resistance

- 7.4.1 Antimicrobial resistance has been described as one of the greatest threats to human kind. The overuse and incorrect use of antibiotics are major drivers of the development of antimicrobial resistance. The continued threat from the development of antimicrobial resistance and a drastic reduction in the number of new antibiotics being developed, make the need to preserve the antimicrobials we currently have a local, national and global priority. Local targets, set nationally, for reducing the amount and certain types of antimicrobial drugs prescribed across all health care sectors are in place and achieving these requires co-operation from prescribers, patients and the public.
- 7.4.2 Research has shown that antibiotic stewardship programmes could halve the number of infections due to antibiotic-resistant bacteria compared with unguided prescribing. Locally, there has been a reduction in the number of antibiotics prescribed by GPs which will contribute to conserving the antibiotics we currently use. This has been achieved through the introduction of antibiotic stewardship programmes across all health sectors, use of educational materials for GPs and patients, provision of comparative antibiotic prescribing data to GP practices, peer group review, and public education programmes.
- 7.4.3 Trimethoprim, an antibiotic used to treat infections such as urinary tract infections, is an effective treatment where infections have been shown to be susceptible and in situations where alternatives would be less suitable. However, the inappropriate use of trimethoprim, has been associated with the development of serious, life-threatening gram-negative bloodstream infections, particularly in vulnerable patients where their urine infection has been resistant to trimethoprim. 33.2% of community urine samples tested for E. coli (or coliform) between October and December 2017 in the Cambridgeshire and Peterborough CCG area were found to be resistant to trimethoprim. This figure was higher than other Clinical Commissioning Groups (CCGs) in the East region. Local and national targets have been introduced aimed at reducing the inappropriate use of trimethoprim compared to alternatives and specifically for use in patients over 70 years old who are the most vulnerable. Local targets for reducing the use of trimethoprim have been met through effective antibiotic stewardship initiatives and the addition of new antibiotic formulary choices which offer prescribers more alternatives to trimethoprim. Focusing on reducing inappropriate use of trimethoprim in urinary tract infections continues into 2018-19.
- 7.4.4 Broad spectrum antibiotics include the groups of antibiotics the quinolones, cephalosporins, and co-amoxiclav. They should normally only be used when narrow-spectrum antibiotics have not worked or the infection being treated is resistant. Inappropriate use increases the risk of producing a resistant type of bacteria known as MRSA, other resistant urinary tract infections and may cause an unpleasant life-threatening infection, Clostridium difficile, to develop. Local and national targets have been set aimed at reducing the amount of broad spectrum antibiotics prescribed compared to all types of antibiotics. Locally, use of broad spectrum antibiotics has been higher than the local target. A system wide approach using antibiotic stewardship

programmes has addressed this along with provision of prescribing data, peer group review and support to GPs in reducing their use of unwarranted broad spectrum antibiotics. Some success has been seen, but this still needs to be improved during 2018-19 and will require the co-operation of prescribers, patients and the public.

References:

The UK AMR Strategy High Level Steering Group. UK 5 Year Antimicrobial Resistance (AMR) Strategy 2013-2018. Third Annual progress report, 2016.

Available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/662189/UK_AMR_3rd_annual_report.pdf and accessed 25/2/18,

National Institute for Healthcare and Clinical Excellence (NICE). Key therapeutic topic [KTT9] Antimicrobial stewardship: prescribing antibiotics. Published date: January 2015. Last updated: January 2017. Available at:

<https://www.nice.org.uk/advice/ktt9/chapter/evidence-context> and accessed 25/2/18.

Public Health England. East Region. AMR Local Indicators. Available at:

<http://fingertips.phe.org.uk/> and accessed 25/2/18.

8 Environmental Health

- 8.1 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.
- 8.2 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.
- 8.3 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.
- 8.4 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.
- 8.5 Trading Standards deal with product safety, animal health and fair trading and credit. Product safety can include toys, cosmetics, electrical equipment and chemicals. A project into the safety and labelling of e-cigarette liquids is taking place across the East of England Trading Standards region due to the increasing prevalence of these products and recent specific legislation. 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. The team work 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.

- 8.6 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.
- 8.7 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.
- 8.8 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.
- 8.9 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.
 - Assessment of landfill gas monitoring results for proposed additional development adjacent to closed landfill at Potters Way Fengate.
 - School and housing development Newark Road Fengate, considering any mitigation required for ground conditions – including unexpected unauthorised historic landfill; and noise from adjacent industrial activities that may impact upon the proposed development.
 - Extension of Pode Hole Quarry and proposed quarrying activities at Willow Hall Farm, and Bar Pasture Farm Thorney assessed for potential noise and particulate impacts upon residential premises.

- Consideration of potential noise and air quality impacts associated with proposed dualling of A47 Wansford-Sutton
- Upgrade of Werrington Gas Compressor assessed for air quality and noise impacts. Notice served to control noise levels and hours of work for the construction phase of the project which are programmed for completion in 2020.
- Assessment of impacts from Alwalton Hill commercial developments and their potential impacts upon future residential developments in Hampton and for Haddon.
- Recommending noise and air quality impact assessments to enable the appropriate consideration of proposed Junction 18 A47/A15 development proposals.
- Werrington Grade Separation “Dive-Under” proposals, primarily to ensure the impacts of construction noise of the civil engineering project will be controlled so far as reasonably practicable.
- Consideration of air quality and noise impacts associated with the development of a gas fired reserve facility at Peterborough Power Station, Fengate.

9. Air Quality

- 9.1 Peterborough City Council are required to assess the air quality in Peterborough as part of the Air Quality Standards Regulations 2010 legislation. Air pollutants such as benzene, carbon monoxide, nitrogen dioxide, industry emissions and sulphur dioxide are investigated.
- 9.2 The investigation process is undertaken in a series of stages by using an updating and screening assessment of air quality which are produced every three years. An updating and screening assessment of air quality identifies the pollution levels within Peterborough. In between these publications, progress reports are produced which highlight any changes which might have occurred over the previous year.
- 9.3 Should any pollutants be suspected or shown to be above the objective level, Peterborough City Council undertake a detailed assessment. If the detailed assessment shows that there is an area which exceeds the relevant air quality objective, the Council shall declare an air quality management area.
- 9.4 Currently, the main pollutants of concern in the Peterborough district, as in most areas of the UK, are associated with road traffic, in particular NO₂ and particulate matter (PM) at locations close to busy, congested roads where people may live, work or shop. There is currently one Air Quality Management Area (AQMA) in Peterborough, for emissions of SO₂ resulting in exceedance of the relevant 15-minute mean values. The source of these emissions is a brickworks located in the area administered by Fenland District Council (a neighbouring local authority). It was proposed in the 2015 Updating and Screening Assessment (USA) to revoke the AQMA, subject to the agreement of DEFRA. However the AQMA is still in force and Peterborough City Council remain in consultation with Fenland District Council about this. Further details of this AQMA can be found on our website at

<https://www.peterborough.gov.uk/business/environmental-health/pollution/>.

- 9.5 The previous round of review and assessment (beginning with the 2012 Updating and Screening Assessment and continuing through the 2013 & 2014 Progress Reports and most recently 2015 USA) did not identify that any further detailed assessments were necessary beyond that already undertaken for the existing AQMA. However as reported in the 2015 USA changes have been made to the monitoring programme in Peterborough with the identification of an area within the city namely Taverners Road that requires closer attention due to concerns regarding potential exceedance of the NO2 annual mean objective
- 9.5 This Annual Status Report determines that no exceedances have been noted in any of the locations monitored. According to the latest monitoring results, the levels appear to be similar to those recorded last year. However, due to the potential for exceedance, Taverners Road will continue to be closely monitored.
- 9.7 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/AirQualityAnnualStatusReport2016.pdf?inline=true>

10 NATIONAL TUBERCULOSIS STRATEGY

10.1 Latent TB Identification Project

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

- 10.2 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.
- 10.3 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)
- 10.4 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
- 10.5 Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) led this work supported by representatives from
- North West Anglia Foundation Trust (NWAFT)
 - 18 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
- 10.6 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 ≥ 20 cases/100,000 have been prioritised for the LTBI screening programme.
- 10.7 The project commenced in March 2016 and in 2017/18 9 additional Peterborough Practices signed up, with 3 from Phase 1 not renewing their LES. In total 18 Greater Peterborough 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.
- 10.8 Practices are expected to identify new patients on registration. PHE have provided the CCG with materials and letters to support the project.
- 10.9 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
- 10.10 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.

- 10.11 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 was scheduled for later in 2017.
- 10.12 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 36: ACTIVITY TO DATE (Cumulative May 2016 – end January 2018)

Activity	Data
Negative	397
Positives	65
Borderline negative	8
Borderline positive	11
Indeterminate	5
Non reportable insufficient cells	4
Assay not run	2
Technical error	2
Total screened	494

Table 1: Activity to end of January 2018

- 10.13 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.
- 10.14 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.
- 10.15 The Communication and Engagement Plan is also being refreshed to ensure the CCG is engaging with communities and stakeholders effectively.
- 10.16 For 2018/19 the CCG will continue to support all the Greater Peterborough Practices and the 2 Cambridgeshire Practices, to continue with the Programme due to a higher than average turnover in the catchment population.

10.17 The CCG will look to extend screening to the other populations such as student populations that meet the eligibility criteria, employees in work environments and the prison population. There will also be closer links to the Greater Peterborough Network to ensure additional screening is offered for initial invitations and those who have not responded or did not attend.

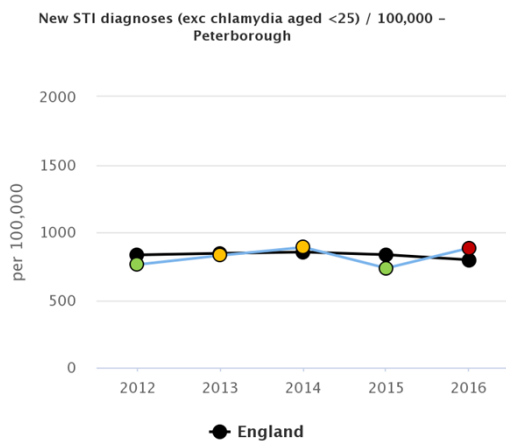
11. SEXUAL HEALTH

The following key indicators for sexual health in Peterborough raise concerns about the trends in population level sexual health.

11.2. New Sexually Transmitted Infections Diagnoses (STIs) (excluding <25 chlamydia)

The new STI diagnoses rate (excluding <25 chlamydia) per 100,000 between 2012 and 2015 was around or below the national figure. In 2016 it was significantly higher than the national figure at 882 per 100,000 compared to 795 per 100,000.

Figure 8.0: New STI diagnoses (excluding <25 chlamydia)

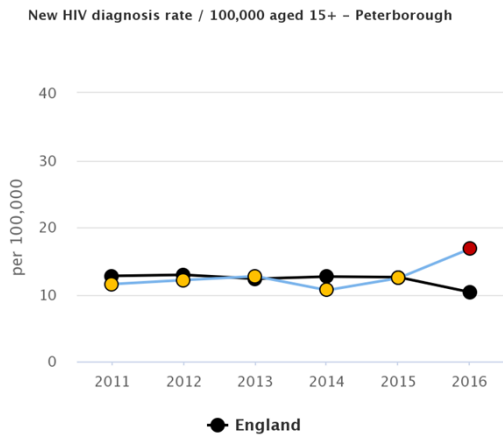


Source: Sexual Health Profiles Public Health England (2017)

11.3 New HIV Diagnosis

The rate of new HIV diagnosis per 100,000 between 2012 and 2015 was around the figure for England. In 2016 it was significantly worse at 16.8 per 100,000 compared to 10.3 per 100,000

Figure 9.0: New HIV Diagnosis Rate

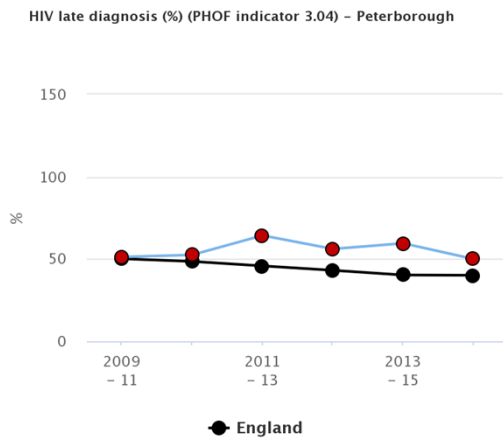


Source: Sexual Health Profiles Public Health England (2017)

11.4 Late HIV Diagnoses

Between 2009 until 2016 the rate of late HIV diagnoses per 100,000 has remained significantly higher than the English figure. During 2014/16 the rate was 50 per 100,000 compared to 40.1 per 100,000. There has been a downward trend in the national figure which is less apparent in the Peterborough figure. Earlier diagnosis leads to an improved outcome of treatment and reduced risk of onward transmission.

Figure 10: HIV Late Diagnosis (%)



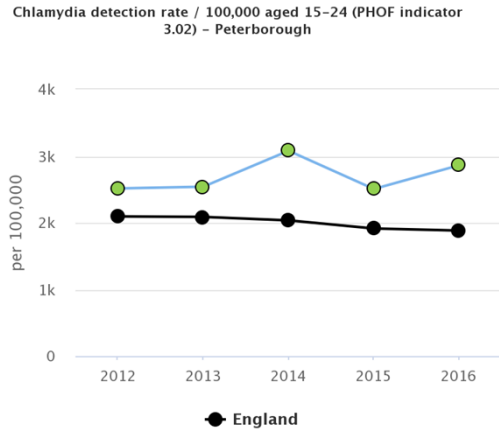
Source: Sexual Health Profiles Public Health England (2017)

11.5 Chlamydia Diagnosis

The rate of chlamydia detection amongst 15-24 year per 100,000 has remained significantly higher than the national figure and has seen an upward trend. In 2016 the rate was 2863 per 100,000 compared to 1882 per 100,000. This exceeds the Public Health Outcomes Framework (PHOF) target of 2,300 per 100,000, which is considered positive in term of

identifying and treating the infection in the population. However it indicates clearly that there is high level of infection in the population despite the high detection and treatment rate.

Figure 11 Chlamydia Detection Rate 15-24 years

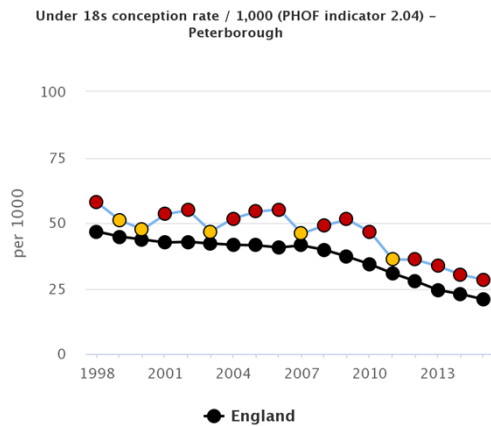


Source: Sexual Health Profiles Public Health England (2017)

11.6 Teenage Pregnancy (conceptions)

The under 18 conception rate per 100,000 has improved dramatically since 1998 in Peterborough. Although it has reached the national rate in a number of years this has not been sustained and it remains persistently above the national rate. In 2015 the rate was 28.3 per 100,000 compared to 20.8 per 100,000.

Figure 12: Under 18s Conception Rate



Source: Sexual Health Profiles Public Health England (2017)

11.7 Sexual Health Services

The Integrated Sexual Health Service (ICaSH) provided by Cambridgeshire Community Services has seen a continuous increase in demand for its services. Currently this stands at

around a 25% increase above the activity level commissioned in 2014. This increase in activity is found in both contraception and sexual health service activity. This increase suggests that it reflects the current trends across the key indicators described above for sexual health in Peterborough.

The increase in demand appears to have had an impact on the Service meeting some key targets associated with improvements in sexual and contraceptive health. Securing access to sexual health treatment within 48 hours or two working days is the recommended target for decreasing the onward transmission of infection by the Department of Health and professional bodies.

The desired percentage of people with STI needs offered an appointment within two working days is 90%. In the Peterborough Service during 2017/18 the percentage has decreased to around 70% when there are any demand surges, staff holidays and sickness absences. Similarly in the same period the percentage of people with STI needs seen within 48 hours, which has a target of 90% has decreased to around 70%. There is a similar pattern found in access to contraceptive services within two working days where the target is 90% but the Peterborough figure is around 65%. However the Service generally meets the recommended target percentage 95% of chlamydia patients being treated within six weeks of their diagnosis.

The ICaSH continues to be responsive along with its outreach team and voluntary sector in putting services in place to address the needs of population groups at higher risk.

The challenges confronting the ICaSH services are being reviewed by the Public Health Team.

11.8 Emergency Hormonal Contraception (EHC)

In 2017 a new community pharmacy EHC contract was introduced. This was a response to the number of under 18 conceptions. EHC is provided by the ICaSH services at a limited number of locations in the City. Community pharmacies provide easy access to EHC in a range of locations. It is provided free of charge and in addition it affords an opportunity for the pharmacy staff to raise the issue of chlamydia and offer a test.

The Scheme was introduced in mid 2017 and initially because of training requirements took several months to develop. However by the end of 2017 sixteen pharmacies were offering the Service, which is just over 50% of pharmacies issued with contracts. The majority are located in areas of higher need.

11.9 Prevention Needs Assessment

In 2017 a Sexual and Reproductive Health Prevention Needs Assessment was undertaken in Peterborough. The needs assessment was undertaken to inform the development of preventative services for sexual and reproductive health in Peterborough, in order to reduce inequalities and improve outcomes. It reviewed trend data, evidence for interventions including extensive consultation with the different communities, providers, service users and stakeholders in Peterborough. Its main recommendations were as follows.

1. Develop a local strategy for the reduction of late HIV diagnoses in Peterborough

2. Provide a comprehensive and timely offer of contraception to all women who give birth or have an abortion, as well as additional tailored support to those who are under 18 or vulnerable
3. Review and improve the provision of sexual and reproductive health services in schools
4. Ensure that the commissioned arrangements for condom availability are in line with the 2017 NICE Guidance*
5. Engage all sectors of the community through targeted and tailored health promotion and outreach
6. Contributing to reducing inequalities by improving sexual and reproductive health for vulnerable young people

11.10 Sexual Health Delivery Board

The Cambridgeshire and Peterborough Sexual Health Delivery Board was established in 2017. This followed the formation of the Cambridgeshire and Peterborough Public Health Joint Commissioning Unit (JCU). The JCU is responsible for commissioning Public Health services across the two local authorities. The Sexual Health Delivery Board brings together commissioners and providers from across the two areas to set the strategic direction for sexual health and to implement collaborative partnership interventions to address issues. A Delivery Action Plan has been developed and the two following priorities have been adopted by the Board to address initially.

- Under 18 conceptions in Peterborough and Fenland (has a trend similar to Peterborough).
- Improving pathways across different services (both clinical and non-clinical). This includes pathway design and closer alignment of commissioning across the three different commissioners of sexual health services i.e. the Local Authorities, the Cambridgeshire and Peterborough Clinical Commissioning Group and NHS England.

To complement this Public Health England has invited the Cambridgeshire and Peterborough local authorities and NHS commissioners to be one of two national pilot sites for a sexual health commissioning feasibility study. The aim is that the local sexual health commissioning organisations will explore opportunities for future alignment and collaborative commissioning opportunities for sexual health services in the area, which would future proof, quality assure and optimise sexual health service pathways, better address needs and potentially realising system efficiencies where appropriate.

12. HEALTH EMERGENCY PLANNING

- 12.1 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 works 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.
- 12.2 Local Health Resilience Partnerships (LHRPs) provide strategic leadership for health organisations in the LRF area and are expected to assess local health risks and priorities to ensure preparedness arrangements reflect current and emerging need.
- 12.3 The Cambridgeshire and Peterborough Local Health Resilience Partnership (CP LHRP) is co-chaired by the NHS England Locality 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 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.
- 12.4 The LHRP leads on the annual EPRR assurance process. The aim is to assess the preparedness of the NHS commissioners and providers, against common NHS EPRR Core Standards. All NHS funded organisations have completed their self-assessment against the EPRR Core Standards for 2017-2018. In respect of the deep dive into EPRR Organisational Governance, the Cambridgeshire and Peterborough system completed the assurance checklists and rated themselves against the standards. All organisations were either Full or Substantially Compliant.
- The Cambridgeshire and Peterborough health system is, at this point in time, well prepared to deliver the EPRR core standards including planning for and responding to a wide range of emergencies and business continuity incidents that could affect health or patient safety. There is strong engagement across health partners and a common aim to contribute and share best practice across the LHRP, LRF and East EPRR leads forum within the East

Locality. There are also links into the Cambridgeshire & Peterborough Health & Wellbeing and A & E Delivery Boards through the Co-Chairs of the LHRP.

12.5 The LRF and LHRP priorities for the past year were validation of:

- CPLRF Pandemic influenza Plan;
- CPLRF Vulnerable People Protocol; and
- CPLRF Mass Casualty Plan

All the three plans have been validated by the CPLRF Executive Board.

12.6 The priorities for the year ahead is validation of:

- CPLRF CBRN Plan;
- C&P Hospital Evacuation Plan; and
- CPLRF Excess Deaths Plan.

12.7 The period from 1st January 2017 to the date of this report has seen a very wide and varied training and exercise programme delivered by the CPLRF. Of significance were four exercises:-

1. Exercise Falmouth: This tabletop and live exercise took place on the 22nd Feb and 19th May respectively, to test the arrangements for Marauding Terrorist Firearms Attack (MTFA). Sixty attendees from nineteen organisations took part in the exercise.
2. JESIP exercises: Joint Emergency Services Interoperability Protocol (JESIP) awareness and table top exercises for the strategic members took place between June and October.
3. Mass Casualty plan validation: A table top exercise took place on 20th October, 2017 to validate the CPLRF Mass Casualty Plan. Thirty attendees from eight organisations took part.
4. CPLRF Tactical Emergency Management course(s): The CPLRF in collaboration with the Cabinet Office Emergency Planning College delivered three, one and a half day, bespoke Tactical Emergency Management courses between the 6th and 10th November, 2017. Forty attendees took part in the courses.

13 Summary

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

- Communicable disease surveillance including information on an increase in infections caused by Group A Streptococcus, including scarlet fever and more invasive infection.
- Immunisations which show a steady state for some and a gradual increase in uptake of many childhood immunisations and of seasonal flu vaccination. The uptake of the pre-school booster and MMR2 cause considerable concern and are subject of activity in the Healthy Peterborough programme for February / March 2018
- Screening in which there is continued below average uptake of breast, cervical and bowel cancer screening in Peterborough.
- 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 the recommendations of a prevention needs assessment and the work of the Sexual Health Delivery Board. Key priorities for action include the reducing the rate of new sexually transmitted infections including HIV, reducing late diagnosis of HIV and continued reduction in teenage pregnancy rates.
- Health emergency planning and the priorities for the coming year.

Annex 1

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 influenza 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 - administered as a single jab containing meningococcus C (another cause of meningitis) and Hib (fourth dose)

Measles, Mumps and Rubella (MMR) vaccine - administered 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 8 years including school years Reception, 1, 2, 3 and 4

Seasonal influenza (Flu) vaccine - administered 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 - administered 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 - administered 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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