# Cambridgeshire and Peterborough Annual Health Protection Report 2018

Produced by partner organisations of the Cambridgeshire and Peterborough Health Protection Steering Group on behalf of the Director of Public Health (February 2019)

## Contents

# 1. Introduction

This report provides an annual summary of activities in Cambridgeshire and Peterborough to ensure health protection for the local population.

The services that fall within Health Protection include:

- The prevention and management of communicable (infectious) diseases;
- infection control;
- routine antenatal, new born, young person and adult screening;
- routine immunisation and vaccination;
- sexual health; and
- 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 and Wellbeing Boards or Health Committee as appropriate, which provides a summary of relevant activity. This report covers multi-agency health protection plans that are in place to 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 has arisen. Details of the legislative background to the role of DPH and the role of the County Council in relation to health protection have been included in previous annual health protection reports and will not be reproduced here.

# 2. Cambridgeshire and Peterborough Health Protection Steering Group

To enable the DPH to fulfil the statutory responsibilities in relation to health protection, the Cambridgeshire and Peterborough Health Protection Steering Groups were established in October 2013. These committees were replaced in October 2016 by a joint committee for Cambridgeshire and Peterborough that recognised the wider geography covered by many of the member organisations and the closer working on Public Health between the two local authorities. The Cambridgeshire and Peterborough Health Protection Steering Group (CP HPSG) enables all agencies involved to demonstrate that statutory responsibilities for health protection are being 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. 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 of Infectious Diseases

## 3.1 Notifications of Infectious Diseases

Registered medical practitioners in England and Wales have a statutory duty to notify their local authority or local Public Health England Health Protection Team of suspected cases of certain infectious diseases. These notifications along with laboratory confirmed data enable surveillance of the diseases and for the Health Protection Team to take any required public health action to minimize risk to others.

| **TABLE 1:** Numbers of cases of notifiable diseases, Cambridgeshire and Peterborough, 2015 – 2018 (Source: Public Health England, East of England Health Protection Team HP Zone) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Cambridgeshire** | | | | **Peterborough** | | | |
| **Notifiable Disease†** | **2015** | **2016** | **2017** | **2018*** | **2015** | **2016** | **2017** | **2018** |
| **Acute infectious hepatitis** | 25 | 20 | 39 | 36 | 17 | 14 | 13 | 9 |
| **Acute meningitis** | 8 | 12 | 10 | 8 | <5 | <5 | <5 | <5 |
| **Food poisoning** (including the organisms below) | 205 | 226 | 195 | 183 | 63 | 86 | 59 | 67 |
| E coli O157 VTEC | 5 | <5 | <5 | <5 | <5 | <5 | <5 | <5 |
| Cryptosporidium | 90 | 85 | 90 | 68 | 18 | 19 | 15 | 11 |
| Giardia | 16 | 22 | 23 | 22 | 12 | 20 | 6 | 16 |
| Salmonella | 80 | 101 | 77 | 88 | 23 | 38 | 35 | 37 |
| **Infectious bloody diarrhoea** | 5 | 11 | 12 | 12 | <5 | 6 | <5 | <5 |
| **Invasive group A streptococcal disease** | 18 | 20 | 34 | 25 | <5 | 7 | 14 | 11 |
| **Legionnaires' disease** | <5 | 6 | <5 | 9 | <5 | <5 | <5 | <5 |
| **Malaria** | 9 | 13 | 7 | 7 | <5 | <5 | 0 | <5 |
| **Measles**** | 13 (<5) | 17 (6) | 18 (0) | 7 (0) | <5 (0) | <5 (0) | <5 (0) | <5 (0) |
| **Meningococcal septicaemia** | 9 | 11 | 8 | 8 | <5 | <5 | <5 | <5 |
| **Mumps**** | 24 (<5) | 39 (<5) | 55 (10) | 51 (10) | 8 (<5) | 11 (<5) | 10 (<5) | 11 (0) |
| **Rubella**** | 5 (0) | 5 (0) | 5 (0) | <5 (0) | <5 | 0 | <5 | 0 |
| **Scarlet fever** | 159 | 239 | 161 | 252 | 98 | 56 | 92 | 105 |
| **Whooping cough** | 80 | 203 | 157 | 88 | 15 | 49 | 33 | 10 |

*NB. Figures for 2018 are provisional.*

*** These are notifications of infectious disease and are not necessarily laboratory confirmed. Numbers in brackets indicate confirmed cases.*

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

## 3.2 Outbreaks and Incidents

| **TABLE 2:** Number of outbreaks and incidents in Cambridgeshire and Peterborough, 2018 (Source: Public Health England, East of England Health Protection Team, HP Zone) | | |
|---|---|---|
| **Type of incident** | **Cambridgeshire** | **Peterborough** |
| Gastroenteritis in residential settings | 29 | 7 |
| Influenza / influenza-like illness in residential settings | 24 | 2 |
| Likely foodborne | 4 | 1 |
| Other | 1 | 1 |

There were a number of outbreaks notified to the Public Health England Health Protection Team which were investigated. In **Cambridgeshire** this included:

- 29 gastrointestinal (GI) outbreaks in residential settings, which included care homes, a custodial institution and a youth hostel.
- 24 influenza or influenza-like illness outbreaks which were all in care homes. Seven of these were confirmed outbreaks of influenza A, three influenza B and one each of metapneumovirus, parainfluenza, and rhinovirus.
- There were four outbreaks of gastrointestinal infection that were likely to be foodborne illness. This included a cluster of salmonella cases linked by whole genome sequencing. There were two separate outbreaks of gastrointestinal illness possibly associated with restaurants and an outbreak of GI illness following a self-catered party. The causal organism was not identified for either of these outbreaks.
- There was also notification of an outbreak of scarlet fever at a nursery.

In **Peterborough**, this included:

- There were seven outbreaks of gastrointestinal (GI) infection in care homes, and one outbreak of GI infection linked to a catered wedding event.
- Peterborough also saw two outbreaks of Influenza-like illness in care homes, along with an outbreak of scabies in a care home.
- Two separate tuberculosis (TB) screening events were held in in Peterborough following identification of significant TB exposure with employees screened at a factory and a distribution centre. All active TB cases were treated for TB and are no longer infectious and people who screen positive for TB are clinically assessed by the local NHS respiratory clinicians and offered appropriate treatment.

## 3.3 Tuberculosis

TB is a bacterial infection spread through inhaling tiny droplets from the coughs or sneezes of an infected person. It mainly affects the lungs, but it can affect any part of the body, including the abdomen glands, bones and nervous system. TB is a serious condition but it can be cured if it's treated with the right antibiotics. The Collaborative Tuberculosis Strategy for England (2015 to 2020) brings together best practice in clinical care, social support and public health to strengthen TB control, with the aim of achieving a year-on-year decrease in incidence, a reduction in health inequalities and, ultimately, the elimination of TB as a public health problem in England. The strategy aims to make improvements in a number of key areas including strengthening surveillance and monitoring, and systematically implementing new entrant latent TB screening.

### 3.3.1 Tuberculosis Surveillance

The minimal dataset collected through the Notification of Infectious Diseases (NOIDs) system affords no possibility to monitor trends within subgroups in the population. The increasing incidence of TB in England and Wales, 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 2017.

In 2017, 84 cases of TB were notified among residents of Cambridgeshire and Peterborough local authorities (figure 1). The TB rate in Cambridgeshire (6.2 per 100,000) remains below the East of England average (6.4 per 100,000). The rate in Peterborough (22.1 per 100,000) remains substantially higher than average, and increased between 2015 and 2017 following a decline from the peak in 2012 (31.6 per 100,000). The number of TB cases increased in both areas in 2017 compared to 2016.

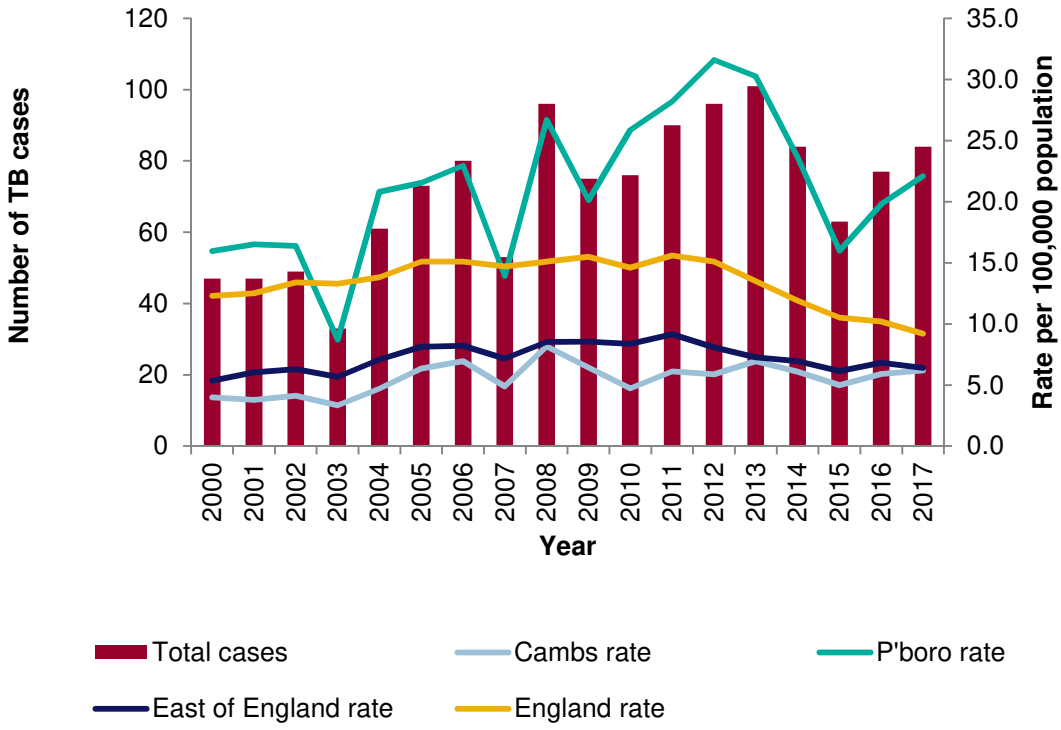


**Figure 1:** Annual TB notifications by area, 2000-2017 (Source: Public Health England ETS)

- Across Cambridgeshire and Peterborough, the majority of cases were aged 15-44 years, with a mean age of 39.8 years (figure 2).
- 77.1% of cases were non-UK born, with India, Lithuania, Pakistan and Timor-Leste being the most common non-UK countries of birth. In 2017, a similar number of cases were UK born as in 2016.
- In Cambridgeshire, a smaller proportion (8.8%) of patients had a social risk factor compared to the East of England region as a whole (11.3%), whereas a larger proportion of patients in Peterborough had social risk factors (22.9%).
- 4.5% of TB patients in Cambridgeshire, and 3.7% in Peterborough had multi-drug resistant TB. Across the East of England region as a whole, the percentage was 3.4%.
- In Cambridgeshire, 18.4% of TB patients received Directly Observed Treatment (DOT), compared to 4.9% in Peterborough. Across the East of England region as a whole 7.1% of TB patients received DOT.

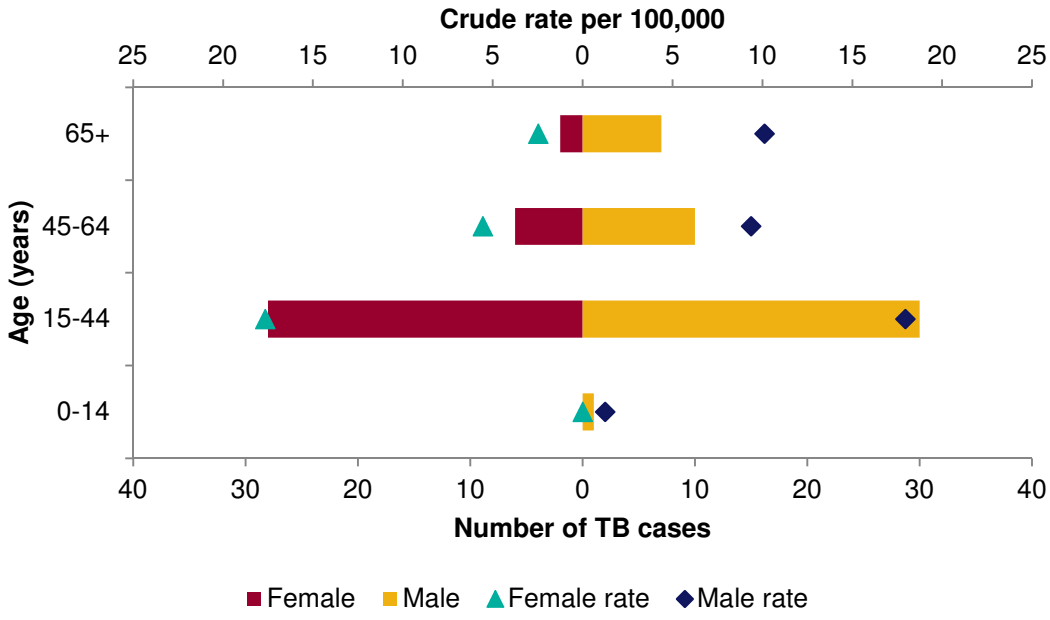


**Figure 2:** TB notifications by age and sex, Cambridgeshire and Peterborough, 2017 (Source: Public Health England ETS)

Further information on TB in Cambridgeshire and Peterborough can be found in the following resources:

- 2017 data on TB monitoring indicators for local authorities can be found on Fingertips: https://fingertips.phe.org.uk/profile/tb-monitoring.
- Tuberculosis East of England Annual Review 2018 (including data to the end of 2017): https://www.gov.uk/government/publications/tuberculosis-tb-regional-reports

### 3.3.2 Latent Tuberculosis Infection Screening Programme

#### *3.3.2.1 Background*

Latent TB infection (LTBI) is where a person has been infected with the TB bacteria but doesn't have any symptoms of active infection. In cases of LTBI, there is a risk that the infection may become active. The aim of the LTBI screening programme is to support the early diagnosis of latent TB and offer treatment of active disease.

Following the publication of the National Collaborative Tuberculosis Strategy, NHS England has committed £10 million for the establishment of testing for, and treatment of, LTBI 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 LTBI, an asymptomatic phase of TB which can last for years. There is a 5% risk of a patient with LTBI becoming TB. LTBI can be diagnosed by a single, validated blood test and treated effectively with antibiotics, preventing TB disease in the future.

Following the publication of the national strategy, a review of TB services was undertaken in Cambridgeshire and Peterborough. The key epidemiology findings are summarised below which provide an overview of the impact of TB on the resident population of the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG).

- There were 999 cases of TB reported in Cambridgeshire and Peterborough residents between 2004 and 2014. Cambridgeshire had an average of 44 cases/year, and Peterborough had an average of 47 cases/year despite its smaller population.
- 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. Public Health England recommend screening patients born or spent >6 months in high TB incidence country (150 cases per 100,000 or more/Sub- Saharan Africa).

#### *3.3.2.2 Method*

The eligibility criteria for the LTBI Screening Programme is any new patient registering with a practice or retrospectively identified by the practice as being:

- Born or spent > 6 month in 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

A number of stakeholders from across the local system are involved in the programme. These include the CCG, a number of local GP practices, North West Anglia Foundation Trust (NWAFT), Cambridgeshire and Peterborough Foundation Trust (CPFT), Peterborough City Council, Public Health England, Oxford Immunotec and Novice.

GP practices with a high crude rate of TB cases were identified by Public Health England (PHE). Of these, practices with a crude annual rate of active TB ≥ 20 cases/100,000 have been prioritised for the LTBI screening programme. High active TB rates are used as a proxy for an anticipated high incidence of latent TB. Engagement of the designated practices is on-going and all have agreed to deliver the project. The CCG offers a Local Enhanced Service (LES) to all participating practices.

The project initially commenced in March 2016 and from 1 April 2018, 18 practices have signed up to deliver (17 Greater Peterborough Practices and Cornford House based in Cambridgeshire).
We are now conducting outreach and face to face work with community organisations, leaders and members of the public to inform them of TB and the Latent TB programme.

#### *3.3.2.3 Communication and Engagement*

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;
- To register with a practice if not already; and
- To dispel myths and beliefs about TB.

The CCG has appointed a Project Support Officer to deliver the action plan and to carry out the face to face work with the public and community organisations. This will support the Latent TB programme and the identification of eligible people for screening. The main focus of the action plan is to target eligible people through community groups, educational settings, work place setting and the prison service.

#### *3.3.2.4 Activity*

**TABLE 3:** LTBI Screening Programme Activity to Date (until end of November 2018), Source: Cambridgeshire and Peterborough Clinical Commissioning Group

| **Activity** | **Data** |
|---|---|
| Negative | 475 |
| Positives | 90 |
| Borderline negative | 12 |
| Borderline positive | 11 |
| Indeterminate | 5 |
| Non reportable insufficient cells | 4 |
| Technical error | 3 |
| Assay not run | 5 |
| **Total screened** | **605** |

Oxford Immunotec continue to report the activity on a monthly basis and we also have confirmation of numbers via LES reporting and NWAFT. The CCG has acknowledged that there has been a reduction of activity due to exhaustion of eligible patient lists. However, numbers are continued to being picked up by the GP practices through new registrations and prospective searches. The CCG also anticipates that the uptake of screening will increase as a result of the targeted outreach and face to face work, alongside promotion of the screening programme.

#### *3.3.2.5 Next Steps*

There has been a positive response by the participating practices to the screening programme and the CCG is receiving positive feedback regarding the activity that is being seen and treated. The CCG has recruited a new Project Support Officer to conduct the outreach work. We will work closely with Public Health England to ensure that there is a coordinated approach to the outreach, which will ensure eligible people are targeted for the uptake of screening. The Project Support Officer will continue to work closely with representatives from community connectors, local Youth Support Team, colleges, employers, drug & alcohol service and rough sleepers in order to maintain the promotion and raising awareness of the screening programme.

# 4. Immunisation Programmes

The tables and figures in this section detail uptake of the various vaccination programmes over time and compared to the regional level of uptake. NHS England commissions various providers to deliver the vaccination programmes including GPs, pharmacies and school nursing teams. The full UK vaccination schedule can be found here: https://www.nhs.uk/Conditions/vaccinations/.

The Cambridgeshire and Peterborough Health Protection Steering Group receives regular reports on vaccination uptake and work that is happening to increase uptake for certain vaccines with lower uptake rates, which has recently included the pre-school booster, MMR and the flu vaccination. The aim for all childhood programmes is to achieve at least 95% uptake, the level which ensures herd immunity, although for many vaccinations, the target rate set by 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 can be found on the NHS choices website.

The Cambridgeshire and Peterborough Immunisation Forum 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. The Task and Finish 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 and high waiting lists to reduce the number of children waiting for their routine immunisations, including the pre-school booster; waiting lists have reduced by 65.7% [period Feb 2018 to Nov 2018].
- Immunisations targeted in a local campaign in March / April 2018 with specific focus on the pre-school booster, MMR2 and HPV vaccines.
- NHS England has commissioned Cambridgeshire Community Services to offer MMR vaccination to those school age adolescents who are partially or unimmunised, commencing in 2018-2019.
- Due to lower uptake rates of the shingles vaccination in Peterborough, a Shingles project was launched in October 2018, and will run until March 2019. GP practices voluntarily sign up to the project that involves reimbursement for sending 70 year old birthday cards with shingles vaccination reminders, additional training for their staff, and a resource pack for practices.

## 4.1 Childhood Primary Vaccinations

### 4.1.1 6-in-1 Vaccine (12 months)

**TABLE 4:** Uptake rates for 6-in-1 vaccine at 12 months (diphtheria, tetanus, pertussis, polio, haemophilus influenza B, hepatitis B – target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

| **12 months DTaP/IPV/Hib/Hep B [target 95%]** | **Q1 2016/17 %** | **Q2 2016/17 %** | **Q3 2016/17 %** | **Q4 2016/17 %** |
|---|---|---|---|---|
| Cambridgeshire | 93.8 | 94.1 | 94.2 | 94.2 |
| Peterborough | 93.5 | 93.8 | 93.9 | 94.3 |
| East Anglia | 95.0 | 95.2 | 95.2 | 95.0 |

| | Q1 2017/18 % | Q2 2017/18 % | Q3 2017/18 % | Q4 2017/18 % |
|---|---|---|---|---|
| Cambridgeshire | 93.1 | 93.8 | 94.7 | 93.6 |
| Peterborough | 93.6 | 94.3 | 90.9 | 91.3 |
| East Anglia | 94.6 | 95.3 | 94.6 | 94.5 |

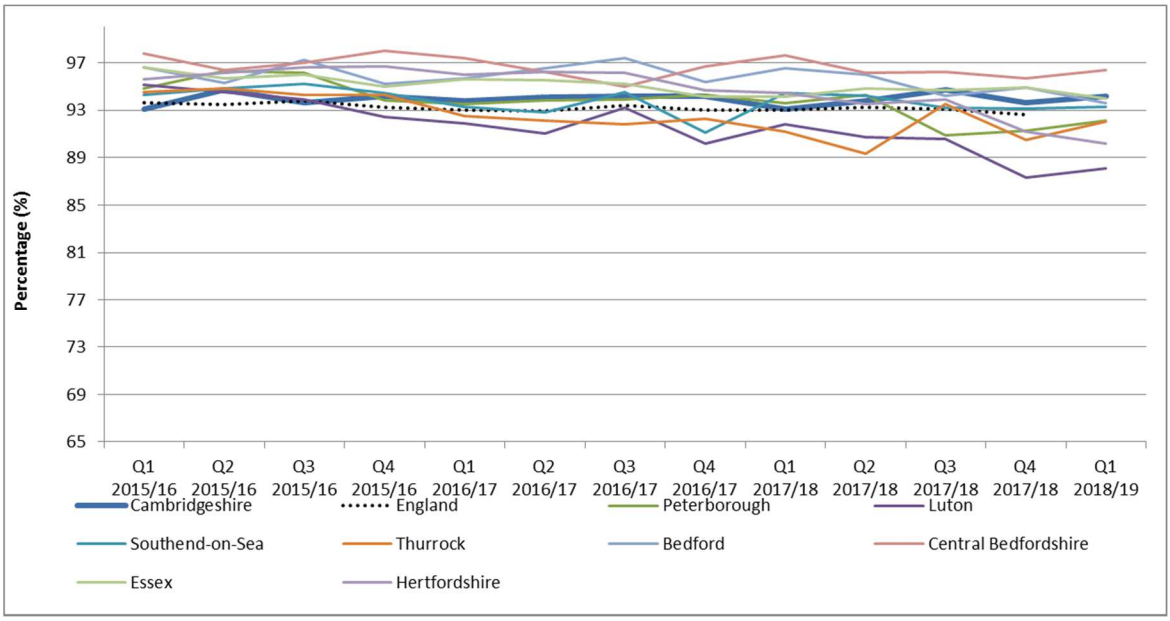


**Figure 3:** Uptake rates for 6-in-1 vaccine at 12 months (diphtheria, tetanus, pertussis, polio, haemophilus influenza B, hepatitis B – target 95%), Cambridgeshire, Peterborough and geographical neighbours, 2016/17 to 2017/18, *Source: Cover, Public Health England*

### 4.1.2 Pneumococcal Vaccine (12 months)

**TABLE 5:** Uptake rates for pneumococcal (PCV) vaccine at 12 months (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

| | Q1 2016/17 % | Q2 2016/17 % | Q3 2016/17 % | Q4 2016/17 % |
|---|---|---|---|---|
| Cambridgeshire | 94.3 | 94.3 | 94.3 | 95.2 |
| Peterborough | 93.6 | 93.6 | 93.5 | 94.2 |
| East Anglia | 95.4 | 95.3 | 95.3 | 95.1 |
| | **Q1 2017/18 %** | **Q2 2017/18 %** | **Q3 2017/18 %** | **Q4 2017/18 %** |
| Cambridgeshire | 93.8 | 94.4 | 95.0 | 94.3 |
| Peterborough | 93.6 | 94.5 | 91.1 | 91.8 |
| East Anglia | 94.9 | 95.5 | 94.9 | 95.0 |

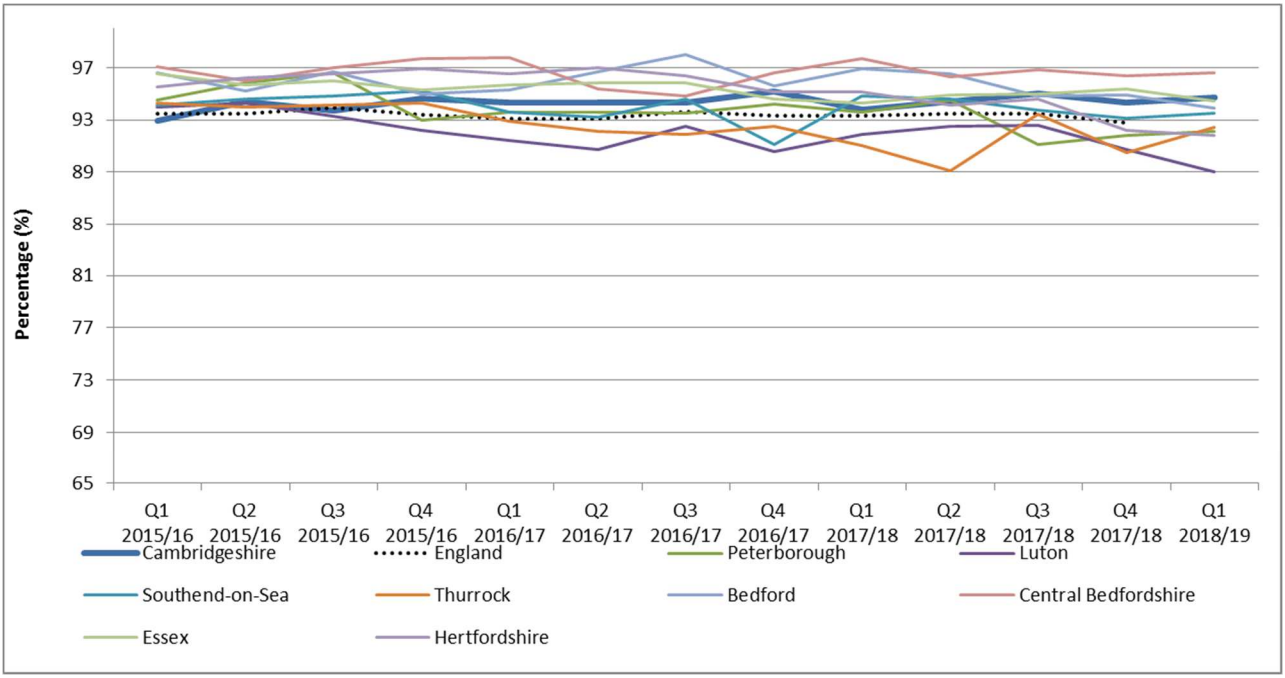


**Figure 4:** Uptake rates for pneumococcal vaccine at 12 months (target 95%), Cambridgeshire, Peterborough and geographical neighbours, 2016/17 to 2017/18, *Source: Cover, Public Health England*

### 4.1.3 5-in-1 Vaccine (24 months)

**TABLE 6:** Uptake rates for 5-in-1 vaccine at 24 months (diphtheria, tetanus, pertussis, polio, haemophilus influenza B – target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

| | **Q1 2016/17 %** | **Q2 2016/17 %** | **Q3 2016/17 %** | **Q4 2016/17 %** |
|---|---|---|---|---|
| Cambridgeshire | 93.7 | 95.4 | 94.8 | 95.6 |
| Peterborough | 95.6 | 96.9 | 96.4 | 96.4 |
| East Anglia | 96.1 | 96.2 | 96.4 | 96.3 |
| | **Q1 2017/18 %** | **Q2 2017/18 %** | **Q3 2017/18 %** | **Q4 2017/18 %** |
| Cambridgeshire | 95.3 | 95.6 | 96.2 | 96.1 |
| Peterborough | 96.1 | 95.1 | 93.8 | 95.7 |
| East Anglia | 96.3 | 96.3 | 95.9 | 96.3 |

### 4.1.4 Pneumococcal Vaccine (24 months)

**TABLE 7:** Uptake rates for pneumococcal vaccine at 24 months (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

| | **Q1 2016/17 %** | **Q2 2016/17 %** | **Q3 2016/17 %** | **Q4 2016/17 %** |
|---|---|---|---|---|
| Cambridgeshire | 89.9 | 92.0 | 92.9 | 93.0 |
| Peterborough | 92.8 | 92.8 | 93.7 | 92.6 |
| East Anglia | 92.9 | 94.3 | 94.1 | 94.0 |
| | **Q1 2017/18 %** | **Q2 2017/18 %** | **Q3 2017/18 %** | **Q4 2017/18 %** |
| Cambridgeshire | 94.1 | 93.4 | 93.2 | 92.8 |
| Peterborough | 91.3 | 90.8 | 89.9 | 89.1 |
| East Anglia | 94.0 | 94.0 | 92.8 | 92.9 |

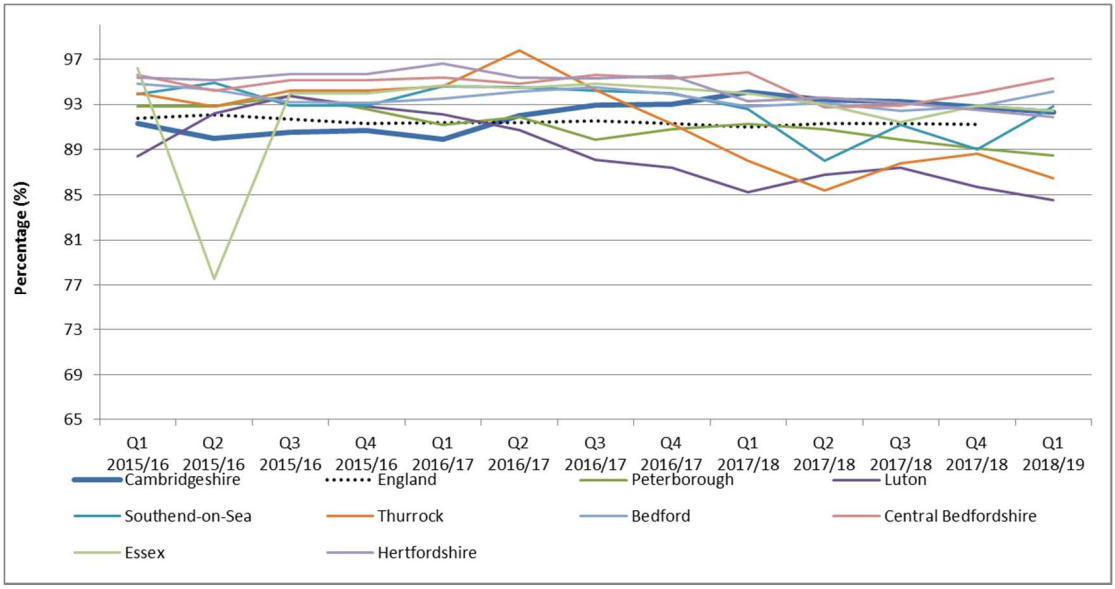


**Figure 5:** Uptake rates for pneumococcal vaccine at 24 months (target 95%), Cambridgeshire, Peterborough and geographical neighbours, 2016/17 to 2017/18, *Source: Cover, Public Health England*

### 4.1.5 Haemophilus influenza B and meningococcus C (24 months)

**TABLE 8:** Uptake rates for haemophilus influenza B and meningococcus C vaccine at 24 months (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

| | **Q1 2016/17 %** | **Q2 2016/17 %** | **Q3 2016/17 %** | **Q4 2016/17 %** |
|---|---|---|---|---|
| Cambridgeshire | 89.6 | 92.0 | 92.7 | 93.0 |
| Peterborough | 90.8 | 92.6 | 89.5 | 90.7 |
| East Anglia | 92.8 | 94.3 | 94.1 | 94.0 |
| | **Q1 2017/18 %** | **Q2 2017/18 %** | **Q3 2017/18 %** | **Q4 2017/18 %** |
| Cambridgeshire | 94.2 | 93.3 | 92.6 | 93.1 |
| Peterborough | 91.0 | 91.4 | 90.1 | 88.9 |
| East Anglia | 94.0 | 93.9 | 92.5 | 92.8 |

### 4.1.6 Measles, mumps & rubella (MMR) Vaccine (24 months)

**TABLE 9:** Uptake rates for measles, mumps and rubella (MMR) vaccine at 24 months (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

| | **Q1 2016/17 %** | **Q2 2016/17 %** | **Q3 2016/17 %** | **Q4 2016/17 %** |
|---|---|---|---|---|
| Cambridgeshire | 89.4 | 91.6 | 92.9 | 92.8 |
| Peterborough | 91.8 | 92.2 | 89.2 | 91.6 |
| East Anglia | 92.7 | 93.8 | 93.9 | 94.0 |
| | **Q1 2017/18 %** | **Q2 2017/18 %** | **Q3 2017/18 %** | **Q4 2017/18 %** |
| Cambridgeshire | 93.8 | 93.1 | 92.8 | 92.6 |
| Peterborough | 90.7 | 90.9 | 90.3 | 88.7 |
| East Anglia | 93.7 | 93.7 | 92.6 | 92.5 |

### 4.1.7 5-in-1 Vaccine (5 years)

**TABLE 10:** Uptake rates for 5-in-1 vaccine at 24 months (diphtheria, tetanus, pertussis, polio, haemophilus influenza B – target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

| | **Q1 2016/17 %** | **Q2 2016/17 %** | **Q3 2016/17 %** | **Q4 2016/17 %** |
|---|---|---|---|---|
| Cambridgeshire | 93.1 | 93.7 | 93.9 | 95.0 |
| Peterborough | 95.7 | 96.4 | 97.5 | 97.1 |

| | | | | |
|---|---|---|---|---|
| East Anglia | 96.0 | 96.9 | 96.2 | 96.2 |
| | **Q1 2017/18 %** | **Q2 2017/18 %** | **Q3 2017/18 %** | **Q4 2017/18 %** |
| Cambridgeshire | 94.6 | 94.0 | 96.1 | 96.4 |
| Peterborough | 97.0 | 96.6 | 95.1 | 96.3 |
| East Anglia | 96.1 | 96.1 | 96.6 | 96.8 |

### 4.1.7 Measles, mumps & rubella (MMR) Vaccine (5 years)

| **TABLE 11:** Uptake rates for measles, mumps and rubella (MMR) vaccine – first dose at 5 years (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England* | | | | |
|---|---|---|---|---|
| | **Q1 2016/17** | **Q2 2016/17** | **Q3 2016/17** | **Q4 2016/17** |
| Cambridgeshire | 92.4 | 93.7 | 93.5 | 95.2 |
| Peterborough | 95.3 | 95.7 | 96.6 | 96.7 |
| East Anglia | 95.4 | 96.0 | 95.5 | 95.6 |
| | **Q1 2017/18 %** | **Q2 2017/18 %** | **Q3 2017/18 %** | **Q4 2017/18 %** |
| Cambridgeshire | 94.7 | 94.1 | 95.6 | 96.1 |
| Peterborough | 96.4 | 96.5 | 94.5 | 96.2 |
| East Anglia | 95.6 | 95.6 | 95.8 | 96.4 |

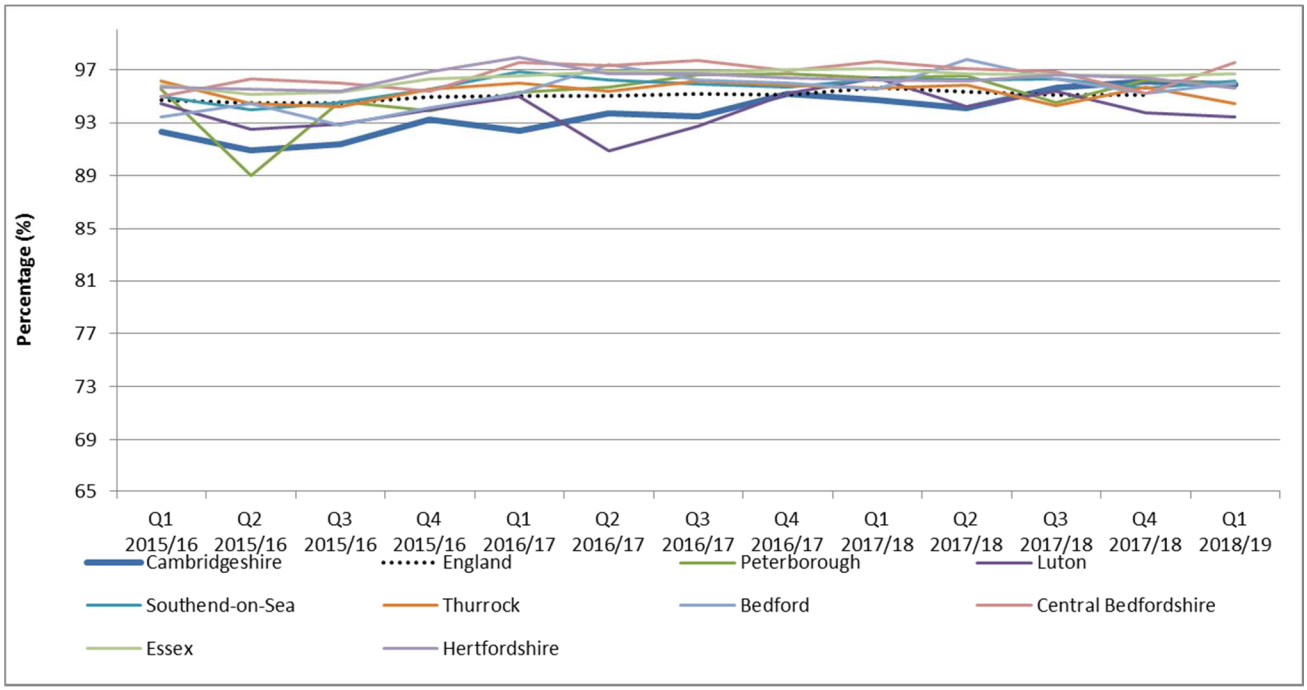


**Figure 6:** Uptake rates for MMR vaccine – **first dose** at 5 years (target 95%), Cambridgeshire, Peterborough and geographical neighbours, 2016/17 to 2017/18, *Source: Cover, Public Health England*

| **TABLE 12:** Uptake rates for measles, mumps and rubella (MMR) vaccine – second dose at 5 years (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England* | | | | |
|---|---|---|---|---|
| | **Q1 2016/17** | **Q2 2016/17** | **Q3 2016/17** | **Q4 2016/17** |
| Cambridgeshire | 82.7 | 83.8 | 85.1 | 88.8 |
| Peterborough | 89.8 | 91.6 | 92.6 | 88.6 |
| East Anglia | 88.2 | 89.8 | 90.1 | 90.1 |
| | **Q1 2017/18 %** | **Q2 2017/18 %** | **Q3 2017/18 %** | **Q4 2017/18 %** |
| Cambridgeshire | 85.6 | 86.8 | 89.6 | 91.0 |
| Peterborough | 89.3 | 90.6 | 88.5 | 89.3 |
| East Anglia | 89.3 | 90.0 | 89.9 | 90.7 |

Source: Cover, Public Health England

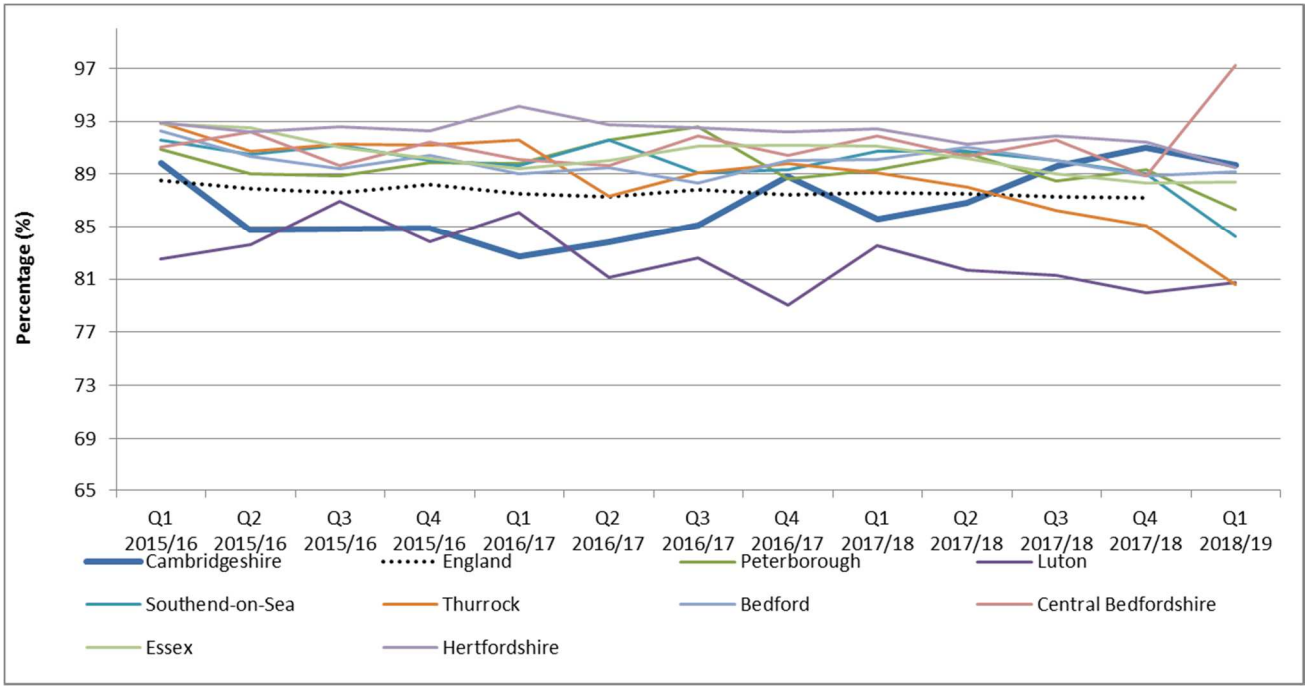


**Figure 7:** Uptake rates for MMR vaccine – **second dose** at 5 years (target 95%), Cambridgeshire, Peterborough and geographical neighbours, 2016/17 to 2017/18, *Source: Cover, Public Health England*

### 4.1.8 4-in-1 Pre-School Booster Vaccine (5 years)

**TABLE 13:** Uptake rates for 4-in-1 preschool booster at 5 years (diphtheria, tetanus, pertussis, polio - target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

| | **Q1 2016/17** | **Q2 2016/17** | **Q3 2016/17** | **Q4 2016/17** |
|---|---|---|---|---|
| Cambridgeshire | 82.6 | 82.1 | 84.1 | 86.4 |
| Peterborough | 86.4 | 88.2 | 90.3 | 86.5 |
| East Anglia | 87.6 | 88.7 | 88.8 | 89.1 |
| | **Q1 2017/18 %** | **Q2 2017/18 %** | **Q3 2017/18 %** | **Q4 2017/18 %** |
| Cambridgeshire | 83.9 | 85.1 | 88.3 | 88.8 |
| Peterborough | 87.3 | 86.8 | 85.5 | 86.0 |
| East Anglia | 88.3 | 88.7 | 88.7 | 89.2 |

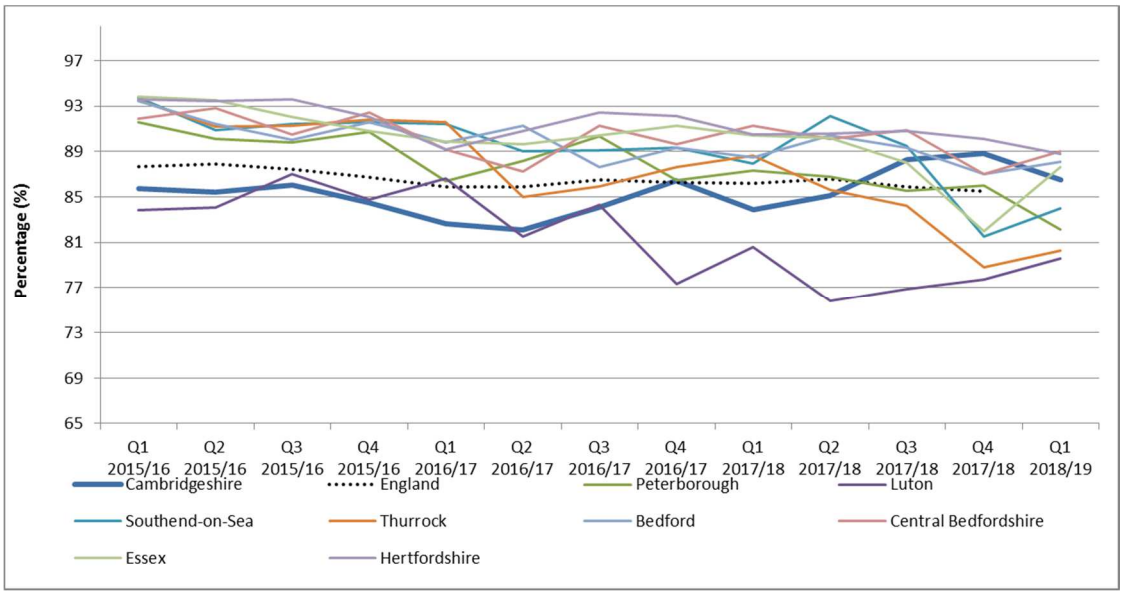

**Figure 8:** Uptake rates for 4-in-1 pre-school booster at 5 years (target 95%), Cambridgeshire, Peterborough and geographical neighbours, 2016/17 to 2017/18, *Source: Cover, Public Health England*

### 4.1.9 Haemophilus influenza B and meningococcus C Vaccine (5 years)

**TABLE 14:** Uptake rates for haemophilus influenza B and meningococcus C vaccine at 5 years (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

| | **Q1 2016/17 %** | **Q2 2016/17 %** | **Q3 2016/17 %** | **Q4 2016/17 %** |
|---|---|---|---|---|
| Cambridgeshire | 87.6 | 88.6 | 90.2 | 92.1 |
| Peterborough | 88.9 | 88.5 | 91.3 | 92.9 |
| East Anglia | 91.2 | 93.4 | 93.0 | 93.2 |
| | **Q1 2017/18 %** | **Q2 2017/18 %** | **Q3 2017/18 %** | **Q4 2017/18 %** |
| Cambridgeshire | 90.4 | 90.4 | 91.1 | 92.5 |
| Peterborough | 91.7 | 92.9 | 89.0 | 92.1 |
| East Anglia | 92.5 | 92.8 | 92.7 | 93.3 |

### 4.1.10 Meningococcus B (12 and 24 months)

**TABLE 15:** Uptake rates for meningococcus B vaccine at 12 months (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

| | **Q1 2016/17 %** | **Q2 2016/17 %** | **Q3 2016/17 %** | **Q4 2016/17 %** |
|---|---|---|---|---|
| Cambridgeshire | **Data not collected** | **93.4** | **93.0** | **94.6** |
| Peterborough | **Data not collected** | **91.6** | **92.9** | **93.7** |
| East Anglia | **Data not collected** | 93.7 | 94.4 | 94.6 |
| | **Q1 2017/18 %** | **Q2 2017/18 %** | **Q3 2017/18 %** | **Q4 2017/18 %** |
| Cambridgeshire | 93.0 | 93.7 | 94.2 | 93.9 |
| Peterborough | 92.9 | 93.7 | 90.8 | 91.0 |
| East Anglia | 94.3 | 95.1 | 94.4 | 94.6 |

**TABLE 16:** Uptake rates for meningococcus B booster at 24 months (target 95%), by local authority, 2017/18, *Source: NHS Digital*

| | **Cambridgeshire** | **Peterborough** | **East of England** |
|---|---|---|---|
| Men B at 24 months (%) | 77.3 | 72.6 | 75.1 |

### 4.1.11 Rotavirus Vaccination

**TABLE 17**: Rotavirus vaccination – 2 doses at 12 months (target 95%), Cambridgeshire & Peterborough, monthly uptake January 2016 to December 2018, *Source: Immform*

| | **Jan 2016** | **Feb 2016** | **March 2016** | **April 2016** | **May 2016** | **June 2016** | **July 2016** | **Aug 2016** | **Sept 2016** | **Oct 2016** | **Nov 2016** | **Dec 2016** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cambridgeshire | 92.8 | 91.1 | 89.4 | 90.4 | 91.7 | 92.1 | 94.4 | 92.1 | 91.7 | 92.4 | 90.9 | 91.9 |
| Peterborough | 86.8 | 88.1 | 87.4 | 92.1 | 90.9 | 90.0 | 90.3 | 92.2 | 86.8 | 89.8 | 90.7 | 89.1 |
| East Anglia | 91.7 | 91.5 | 91.2 | 91.6 | 92.1 | 93.2 | 92.5 | 93.3 | 92.3 | 93.5 | 932.3 | 92.9 |
| | **Jan 2017** | **Feb 2017** | **March 2017** | **April 2017** | **May 2017** | **June 2017** | **July 2017** | **Aug 2017** | **Sept 2017** | **Oct 2017** | **Nov 2017** | **Dec 2017** |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cambridgeshire | 93.2 | 91.5 | 93.6 | 93.5 | 90.6 | 93.0 | 92.1 | 92.5 | 91.0 | 90.1 | 91.6 | 89.5 |
| Peterborough | 90.2 | 88.0 | 88.4 | 87.9 | 89.9 | 89.3 | 86.6 | 87.9 | 87.3 | 90.1 | 89.3 | 86.6 |
| East Anglia | 92.5 | 92.1 | 92.3 | 93.0 | 92.3 | 92.7 | 92.8 | 92.3 | 91.4 | 91.9 | 91.5 | 90.4 |
| | **Jan 2018** | **Feb 2018** | **March 2018** | **April 2018** | **May 2018** | **June 2018** | **July 2018** | **Aug 2018** | **Sept 2018** | **Oct 2018** | **Nov 2018** | **Dec 2018** |
| Cambridgeshire | 88.7 | 89.2 | 91.8 | 93.7 | 91.9 | 91.0 | 91.4 | 93.3 | 91.3 | 90.8 | 91.7 | NA |
| Peterborough | 84.7 | 92.2 | 85.7 | 86.5 | 90.2 | 89.2 | 89.4 | 86.6 | 83.9 | 89.3 | 89.5 | NA |
| East Anglia | 90.4 | 89.8 | 90.5 | 91.3 | 92.0 | 91.0 | 91.8 | 92.7 | 90.4 | 91.3 | 91.5 | NA |

### 4.1.13 Meningococcus ACWY (14 years)

**TABLE 18:** Uptake rates for meningococcus ACWY vaccine, Cambridgeshire and Peterborough, *Source: Immform*

| **Org Name** | **Vaccine uptake %** |
|---|---|
| Cambridgeshire and Peterborough CCG | 39.7 |
| East Anglia Total | 42.0 |

### 4.1.14 HPV Vaccine (Year 8 & Year 9)

**TABLE 19:** Uptake rates for HPV vaccine, by local authority and cohort, September 2017/18, *Source: Public Health England*

| **Local Authority** | | **Cambridgeshire** | **Peterborough** | **England** |
|---|---|---|---|---|
| Cohort 15: 12-13 Year Olds (Year 8) Birth Cohort: 1 September 2004 - 31 August 2005 | Number of females in Cohort 15 (Year 8) | 3,264 | 1,289 | 306,940 |
| | No. vaccinated with HPV Vaccine at least one dose by **31/08/2018** | 2,981 | 1,115 | 266,785 |
| | **% Coverage** | 91.3% | 86.5% | 86.9% |
| Cohort 14: 13-14 Year Olds (Year 9 Birth Cohort: 1 1 September 2003 - 31 August 2004 | Number of females in Cohort 14 (Year 9) | 3,205 | 1,310 | 300,464 |
| | No. vaccinated with HPV Vaccine at least one dose by **31/08/2018** | 2,954 | 1,188 | 267,689 |
| | % Coverage | 92.2% | 90.7% | 89.1% |
| | No. vaccinated with two doses by **31/08/2018** | 2,728 | 1,118 | 251,919 |
| | **% Coverage** | 85.1% | 85.3% | 83.8% |

### 4.1.15 School Immunisation Service

**TABLE 20**: School immunization service vaccinations, Cambridgeshire & Peterborough, end of school year 2017/18, *Source: CCS Immform*

| | Cambridgeshire % | Peterborough % |
|---|---|---|

| | | |
|---|---|---|
| Girls HPV vaccination by end of school year nine dose 2 | 85.1 | 85.3 |
| Cohort 5 (13-14) Sept 2003 -August 2004 Td/IPV by end of school year 9 | 88.4 | 92.0 |
| Cohort 4 (14-15) Sept 2002 –August 2003 Td/IPV by end of school year 10 | 88.2 | 85.4 |
| Cohort 5 (13-14) Sept 2003 -August 2004 Men ACWY by end of school year 9. | 88.4 | 91.5 |
| Cohort 4 (14-15) Sept 2002 –August 2003 Men ACWY by end of school year 9. | 88.4 | 85.9 |
| Childhood Flu vaccination school years 1 and 2 and 3 | 67.0 | 48.0 |
| Schools participating in the programme | 259/260 | 70/70 |

## 4.2 Seasonal Flu Vaccination

**TABLE 21:** Flu vaccination uptake by key groups - adults, Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Immform*

| **Area** | **Summary of flu vaccine uptake %** | | | | | |
|---|---|---|---|---|---|---|
| | **65 and over** | | **Under 65 (at risk)** | | **Pregnant women** | |
| | **2016/17** | **2017/18** | **2016/17** | **2017/18** | **2016/17** | **2017/18** |
| **Cambridgeshire LA** | 72.6 | 74.4 | 47.4 | 49.8 | 48.5 | 49.1 |
| **Peterborough LA** | 69.2 | 71.3 | 46.3 | 47.3 | 39.9 | 38.4 |
| **Cambridgeshire & Peterborough CCG** | 72.1 | 73.9 | 47.2 | 49.3 | 46.7 | 46.7 |
| **East Anglia** | 71.0 | 72.6 | 47.1 | 48.9 | 47.9 | 47.2 |

**TABLE 22:** Flu vaccination uptake – pre-school children, Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Immform*

| **Area** | **Summary of flu vaccine uptake %** | | | |
|---|---|---|---|---|
| | **All aged 2** | | **All aged 3** | |
| | **2016/17** | **2017/18** | **2016/17** | **2017/18** |
| **Cambridgeshire LA** | 42.6 | 45.5 | 44.7 | 47.1 |
| **Peterborough LA** | 30.3 | 25.5 | 32.9 | 30.0 |
| **Cambridgeshire & Peterborough CCG** | 39.7 | 40.5 | 42.0 | 42.7 |
| East Anglia | 42.1 | 42.8 | 43.9 | 44.2 |

| **TABLE 23:** Flu vaccination uptake – healthcare workers, by NHS trust, 2016/17 to 2017/18, *Source: Immform* | | | | |
|---|---|---|---|---|
| Org Name | No of HCW's with Direct Patient Care | Seasonal Flu doses since 1 September **2017-Jan 2018** | | % Seasonal Flu doses given since 1 September **2016-Jan 2017** |
| | | No | % | % |
| Papworth Hospital NHS Foundation Trust | 1,510 | 1,143 | 75.7 | 75.4 |
| Cambridge University Hospitals NHS Foundation Trust | 7,755 | 6,696 | 86.3 | 72.6 |
| North West Anglia Foundation Trust | 4,612 | 3,156 | 68.4 | NA |
| Cambridgeshire and Peterborough NHS Foundation Trust | 3,036 | 1,983 | 65.3 | 52.4 |
| Cambridgeshire Community Services NHS Trust | 1,455 | 851 | 58.5 | 60.3 |
| **East of England Total** | NA | NA | 65.7 | 66.2 |

## 4.3 Prenatal Pertussis Vaccination

| **TABLE 24**: Prenatal pertussis vaccination, Cambridgeshire & Peterborough, monthly uptake April 2015 to March 2018, *Source: Immform* | | | | |
|---|---|---|---|---|
| | 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** |
| | 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** |
| | 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** |
| | 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** |
| | 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** |
| | 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** |
| | Apr 2017 % | May 2017 % | Jun 2017 % | Jul 2017 % |
| Cambridgeshire & Peterborough CCG | **77.0** | **70.2** | **72.1** | **73.8** |
| **East Anglia Total** | **78.8** | **75.4** | **77.3** | **75.8** |
| | Aug 2017 % | Sept 2017 % | Oct 2017 % | Nov 2017 % |
| Cambridgeshire & Peterborough CCG | **69.9** | **69.4** | **72.1** | **69.5** |
| **East Anglia Total** | **75.1** | **75.8** | **78.1** | **76.5** |
| | Dec 2017 % | Jan 2018 % | Feb 2018 % | Mar 2018 % |
| Cambridgeshire & Peterborough CCG | **75.3** | **73.1** | **70.3** | **68.6** |
| **East Anglia Total** | **79.8** | **76.9** | **75.6** | **73.2** |

| **TABLE 25**: Prenatal pertussis vaccination, Cambridgeshire & Peterborough, monthly uptake April 2015 to March 2018, *Source: Immform* | |
|---|---|
| **Annual Data 1.4.2017 to 31.3.2018 %** | |
| Cambridgeshire & Peterborough CCG | 68.1 |
| **East Anglia** | 73.7 |

## 4.4 Shingles Vaccination

**TABLE 26**: Shingles vaccination – aged 70 & 78, Cambridgeshire & Peterborough, uptake July 2018, *Source: Immform*

| 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 | 10158 | 4707 | 46.3 | 5246 | 2568 | 49.0 |
| **East Anglia Total** | 37108 | 17037 | 45.9 | 18615 | 9107 | 48.9 |

# 5. Screening Programmes

Screening is a way of identifying apparently healthy people who may have an increased risk of a particular condition. The NHS offers a range of screening tests to different sections of the population. The aim is to offer screening to the people who are most likely to benefit from it. For example, some screening tests are only offered to newborn babies, while others such as breast screening and abdominal aortic aneurysm screening are only offered to older people.

NHS England commission a number of screening programmes which are delivered by a range of NHS providers within Cambridgeshire and Peterborough. Current screening programmes include:

- Antenatal and newborn screening;
- Breast cancer screening;
- Bowel cancer screening;
- Cervical cancer screening;
- Abdominal Aortic Aneurysm screening; and
- Diabetic eye screening.

Key performance information for each screening programme is provided in the sections below.

## 5.1 Antenatal and Newborn Screening

### 5.1.2 Antenatal and Newborn Screening Key Performance Indicators

**TABLE 27:** Antenatal infectious disease screening KPIs, by provider, 2016/17 – 2017/18, *Source: maternity services*

| | | | | 2016-2017 | | | | 2017-2018 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Indicator** | **Accpt.** | **Ach.** | **Provider** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| ID1 Antenatal HIV test coverage | >95% | 99% | CUH | 97.3 | 99.5 | 99.4 | 98.9 | 97.4 % | 99.0 % | 98.2% | 99.0 % |
| | >95% | 99% | HHT | 99.8 | 98.9 | 99.6 | 99.7 | 99.7 | 99.6 | 99.1 | 99.0 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | >95% | 99% | PCH | 99.5 | 99.4 | 99.4 | 99.3 | 99.4 | 98.9 | 99. | 99.6 |
| ID2 Hep B timely referral for women found to be Hepatitis B | >70% | 99% | CUH | No cases | 100 | 100 | No cases | No Cases | 100% | 100% | 100 |
| | >70% | 99% | HHT | 0 | 100 | 100 | 100 | No Cases | 100 | 100 | No Cases |
| | >70% | 99% | PCH | 50 | No cases | 100 | 80.0 | No Data | 100 | 0.0 | 80.0 |

**TABLE 28:** Fetal anomaly screening KPIs, by provider, 2017/18, *Source: maternity services*

| | | | | 2017-2018 | | | |
|---|---|---|---|---|---|---|---|
| FA1: Completion of laboratory request forms | **Accpt.** | **Ach.** | **Provider** | **Q1** | **Q2** | **Q3** | **Q4** |
| | >97% | >100% | CUH | 99.4 | 99.5 | 98.2 | 99.4 |
| | >97% | >100% | HHT | 95.7 | 97.3 | 97.7 | 99.0 |
| | >97% | >100% | PCT | 98.2 | 98.5 | 99.1 | 99.4 |
| FA2: Fetal anomaly screening fetal anomaly ultrasound) – coverage * | **Accpt.** | **Ach.** | **Provider** | **Q1** | **Q2** | **Q3** | **Q4** |
| | >90% | >95% | CUH | 99.5 | 98.5 | 99.9 | 99.9 |
| | >90% | >95% | HHT | 99.3 | 100.0 | 99.1 | 99.6 |
| | >90% | >95% | PCT | 99.6 | 99.3 | No Data | 99.6 |

**TABLE 29:** Antenatal sickle cell and thalassaemia KPIs, by provider, 2016/17 - 2017/18, *Source: maternity services*

| | | | | 2016/-2017 | | | | 2017-2018 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Indicator** | **Standard** | **Achievable** | **Provider** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| ST1 Antenatal sickle cell and thalassaemia screening – coverage | >95% | 99% | CUH | 91.4 | 98.5 | 98.8 | 96.1 | 96.4 | 97.6 | 96.3 | 98.2 |
| | >95% | 99% | HHT | 98.9 | 99.0 | 97.7 | 97.1 | 100.0 | 98.8 | 98.4 | 98.7 |
| | >95% | 99% | PCT | 96.6 | 97.8 | 97.8 | 97.5 | 97.1 | 97.4 | 99.6 | 98.9 |
| ST2 Antenatal sickle cell and thalassaemia screening Timeliness of Test | >50% | 75% | CUH | 31.7 | 43.3 | 43.5 | 30.1 | 57.9 | 55.7 | 54.9 | 54.6 |
| | >50% | 75% | HHT | 49.4 | 52.0 | 55.2 | 29.9 | 48.5 | 50.8 | 53.1 | 54.0 |
| | >50% | 75% | PCT | 69.1 | 65.5 | 68.0 | 61.4 | 63.8% | 59.5 % | 58.2 % | 56.9 % |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ST3 Antenatal sickle cell and thalassaemia completion of FOQ | 99% | 99% | CUH | 76.6 | 90.9 | 97.8 | 98.2 | 99.2 | 98.3 | 97.4 | 98.0 |
| | >95% | 99% | HHT | 98.6 | 97.5 | 97.7 | 100 | 98.3 | 96.4 | 96.1 | 97.5 |
| | >95% | 99% | PCT | 98.3 | 98.7 | 98.1 | 98.6 | 99.4 | 98.1 | 98.0 | 97.7 |

**TABLE 30:** Newborn blood spot screening KPIs, by provider, 2016/17 – 2017/18, *Source: maternity services*

| | | | | 2016-17 | | | | 201718 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Indicator** | **Standard** | **Achievable** | **Provider** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| NB1 Newborn blood spot screening coverage | >95% | 99.9% | CCS | 98.1 | 98.2 | 98.9 | 91.39 | 95.5 | 98.5 | 99.3 | 94.5 |
| | >95% | 99.9% | CPFT | 99.6 | 97.5 | 98.8 | 98.8 | 98.8 | 99.5 | 99.7 | 93.9 |
| NB2 Newborn blood spot screening avoidable repeats | <2% | 0.5% | CUH | 2.4 | *3.1 | 3.1 | 2.4 | 2.5 | 1.1 | 2.3 | 1.7 |
| | <2% | 0.5% | HHT | 3.4 | **2.1 | 3.4 | 2.8 | 3.1 | 3.0 | 1.4 | 2.5 |
| | <2% | 0.5% | PCT | 1.8 | 1.4 | 1.4 | 1.6 | 1.9 | 1.8 | 0.9 | 1.8 |
| NB4 Newborn blood spot screening coverage-movers in | >95% | 99.9% | CCS | 88.2 | *80.1 | 84.1 | 85.0 | 90.2 | 91.2 | 76.1 | 76.3 |
| | >95% | 99.9% | CPFT | 82.4 | 84.5 | 78.0 | 79.7 | 85.4 | 92.6 | 91.5 | 89.3 |

**TABLE 31:** Newborn hearing screening KPIs, by provider, 2016/17 – 2017/18, *Source: maternity services*

| | | | | 2016-17 | | | | 2017-18 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Indicator** | **Accpt.** | **Ach.** | **Provider** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| NH1 Newborn hearing screening coverage | >97% | 99.5% | CUH | 99.2 | 98.6 | 98.3 | 99.0 | 98.7 | 99.8 | 99.2 % | 99.2 |
| | >97% | 99.5% | HHT | 99.7 | 99.2 | 99.9 | 99.8 | 99.6 | 99.7 | 99.6 % | 99.7 |
| | >97% | 99.5% | PCT | 99.8 | 99.9 | 99.5 | 100 | 99.9 | 99.8 | 99.9 % | 99.9 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NH2 Newborn hearing screening timely referral for assessment | >90% | 95% | CUH | 77.8 | *93.8 | 88.0 | 94.4 | 90.0 | 93.8 | 100% | 89.5 |
| | >90% | 95% | HHT | 100 | No cases | 83.3 | 100 | 100 | 50.0 | 44.4 | 100 |
| | >90% | 95% | PCT | 100 | 100 | 100 | 92.9 | 100. | 76.9 | 85.7 | 100 |

**TABLE 32:** Newborn and infant physical examination KPIs, by provider, 2016/17 – 2017/18, *Source: maternity services*

| | | | | 2016-17 | | | | 2017-18 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Indicator | Accpt. | Ach. | Provider | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| NP1 Newborn and Infant Physical Examination- coverage newborn | >95% | 99.5% | CUH | 97.3 | 94.5 | 94.5 | 95.2 | 95.3 | 94. | 95.5% | 93.9 |
| | >95% | 99.5% | HHT | 99.7 | 96.5 | 95.8 | 95.2 | 97.2 | 94.8 | 94.5 | 94.1% |
| | >95% | 99.5% | PCT | 96.9 | 97.4 | 97.3 | 97.6 | 96.8 | 97.2 | 96.1 | 97.1 |
| | | | | | | | | | | | |
| NP2 Newborn and Infant Physical Examination timely assessment | >95% | 100% | CUH | 100 | *66.7 | 28.6 | 66.7 | 75.0 % | 100 | 0.0% | 77.8 % |
| | >95% | 100% | HHT | 25 | No cases | No cases | 100 | 100 | 100 | 75 | 0.0 |
| | >95% | 100% | PCT | 33.3 | **50. 0 | No cases | No cases | 100. | 100 | 80. | No cases |

### 5.1.3 Antenatal and Newborn Screening Programme Updates

The Cambridge and Peterborough Programme board meet quarterly to review key performance indicators (KPIs) and performance. With the merger of Hinchingbrooke and Peterborough hospitals to form North West Anglia Foundation Trust, a programme board will be introduced for Cambridge and another programme board will be formed for North West Anglia foundation Trust.

- **Fetal anomaly:** KPIs and standards met. Introduction of coverage KPI for Patau's, Edwards and Downs (FA3) introduced from quarter 1 2018. There is no intention to publish this KPI by individual maternity service. Thresholds are not set for this KPI, performance between providers should not be compared. FASP supports informed choice for women.
- **Infectious diseases:** KPIs and standards met. Introduction of coverage KPIs for hepatitis B and syphilis introduced from quarter 1 2018.
- **Newborn hearing:** Smart for hearing IT system introduced successfully. Coverage KPIs met, with some slippage in the referral KPI, but appointments were offered in timely fashion.
- **Non-invasive prenatal testing:** the roll out of non-invasive prenatal testing has been delayed nationally due to unforeseen circumstances.
- **Newborn bloodspot:** there have been continued efforts to reduce the avoidable repeat rate on this programme.
- **Newborn and infant physical examination**: all trusts are compliant and using the Smart IT system. There have been some on-going issues with meeting the referral pathway KPI and this is currently under review nationally.

## 5.2 Cancer Screening programmes

### 5.2.1 Breast Screening

The two breast screening centres have regularly achieved the acceptable target for their KPIs in the last year. Both screening centres have plans in place to ensure more women get screened within the required 36 months including more advanced ways of booking appointments for women.

**TABLE 33:** Breast screening - % of women who attend for screening (aged 50 – 70), by screening centre, 2016/17 – 2017/18, *Source: Oracle Business Intelligence Enterprise Edition (OBIEE)*

| **Cambs. & Hunts. Screening Centre** | | **2016-2017** | | | | **2017-2018** | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Acceptable** | **Achievable** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| ≥ 70.0% | ≤ 80.0% | 73.3 | 75.1 | 72.8 | 74.0 | 70.6 | 70.4 % | 68.5 | 69.8 % |
| **Peterborough Screening Centre** | | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| ≥ 70.0% | ≤ 80.0% | 75.8 | 71.31 | 69.87 | 74.1 | 74.5 % | 72.5 % | 71.0 | 71.0 |

**TABLE 34:** Breast screening round length - % of women first offered an appointment within 36 months, by screening centre, 2016/17 – 2017/18, *Source: OBIEE*
**BS2 - Percentage of women first offered an appointment within 36 months**

| **Cambs. & Hunts. Screening Centre** | | **2016-2017** | | | | **2017-2018** | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Acceptable** | **Achievable** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| ≥ 90.0% | ≤ 100.0% | 99.5 | 98.9 | 98.6 | 95.6 | 70.5 % | 70.4 % | 68.5 | 69.6 % |
| **Peterborough Screening Centre** | | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| ≥ 90.0% | ≤ 100.0% | 98.1 | 98.3 | 98.9 | 98.2 | 92.3 % | 81.0 | 74.7 % | 56.2 % |

**TABLE 35:** Breast screening waiting time for assessment - % of women who attend for assessment within 3 weeks of attending for screening mammogram, by screening centre, 2016/17 – 2017/18, *Source: OBIEE*

| **Cambs. & Hunts. Screening Centre** | | **2016-2017** | | | | **2017-2018** | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Acceptable** | **Achievable** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| ≥ 90.0% | ≤ 100.0% | 93.6 | 93.0 | 97.2 | 94.0 | 99.6 | 91.6 | 100.00 | 99.3 |
| **Peterborough Screening Centre** | | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| ≥ 90.0% | ≤ 100.0% | 97.6 | 99.4 | 99.6 | 95.3 | 90.2 | 96.4 | 65.7 | 92.8 |

### 5.2.2 Cervical Cancer Screening

There has been a decline in the in the coverage in cervical screening which corresponds with the pattern which is seen nationally. The NHS England Screening and Immunisation team is working with a number of stakeholders on a project to improve access to screening for women and improve the quality of different aspects of the screening pathway. It is hoped that this project, along with national initiatives will help promote cervical screening for women in Cambridgeshire and Peterborough.

**TABLE 36:** Cervical cancer screening coverage of eligible population, by local authority and age group, 2017/18, *Source: Screening Quality Assurance Service (SQAS) and Open Exeter*

| Acceptable | Achievable | Provider | Q1 2017-18 | Q2 2017-18 | Q3 2017-18 | Q4 2017-18 |
|---|---|---|---|---|---|---|
| **CS2 - Coverage of eligible population (all women) every 5 years** | | | | | | |
| ≥ 80% | ≥ 95.0% | Cambridgeshire Upper Tier LA | 68.2 | 66.6 | 68.2 | 70.9 |
| ≥ 80% | ≥ 95.0% | Peterborough Upper Tier LA | 66.3 | 65.3 | 66.3 | 72.0 |
| **CS2a - Coverage of eligible population, all women aged 25-49 every 3 years** | | | | | | |
| ≥ 80% | ≥ 95.0% | Cambridgeshire Upper Tier LA | 64.5 | 62.9 | 64.5 | 68.0 |
| ≥ 80% | ≥ 95.0% | Peterborough Upper Tier LA | 63.4 | 62.4 | 63.4 | 70.0 |
| **CS2b - Coverage of eligible population, all women aged 50-64 every 5 years** | | | | | | |
| ≥ 80% | ≥ 95.0% | Cambridgeshire Upper Tier LA | 76.1 | 74.7 | 76.1 | 77.0 |
| ≥ 80% | ≥ 95.0% | Peterborough Upper Tier LA | 74.1 | 72.9 | 74.1 | 76.0 |

### 5.2.3 Bowel Cancer Screening

Although the uptake for bowel screening has remained consistently good in Cambridgeshire and Peterborough, the screening units have not been achieving the diagnostic waiting times KPIs. The NWAFT Screening Centre is working to address Specialist Screening Practitioner (SSP) and diagnostic waiting times. CUHFT has put in plans to address the diagnostic waiting times and both trusts are showing improvements in the waiting times for patients.

**TABLE 37:** Bowel cancer screening KPIs, by screening centre, 2016/17 – 2017/18, *Source: OBIEE*

| **CUHFT Screening Centre** | | | **2016-2017** | | | | **2017-2018** | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **Acc.** | **Ach.** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| **BCS4 – Uptake** | ≥52% | ≥70% | 61.7 | 59.9 | 59.1 | 60.0 | No Data | 60.4 | 57.4 | 57.9 |
| **BCS7– SSP Waiting Times** | 100% within 14 days ≤1.0% | | 100 | 100 | 100 | 100 | 100 | 99.7 | 100 | 100 |
| **BCS8 - Diagnostic test waiting times** | 100% within 14 days | | 100 | 94.8 | 87.8 | 70.1 | 75.5 | 45.3 | 26.3 | 49.4 |

| **NWAFT Screening Centre** | | | **2016-2017** | | | | **2017-2018** | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **Acc.** | **Ach.** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| **BCS4 – Uptake** | ≥52% | ≥70% | 59.9 | 58.4 | 55.4 | 58.1 | 59.7 | 57.3 | 56.8 | 59.1 |
| **BCS7– SSP Waiting Times** | 100% within 14 days ≤1.0% | | 100 | 100 | 100 | 100 | 88.4 | 60.9 | 52.1 | 50.7 |
| **BCS8 - Diagnostic test waiting times** | 100% within 14 days | | 89.9 | 89.6 | 65.9 | 20.0 | 5.2 | 30.1 | 10.2 | 20.6 |

## 5.3 Adult and Young People Screening

### 5.3.1 Diabetic Eye Screening Programme

The KPI data for the diabetic eye screening programme carried out through Health Intelligence shows that for DE1 (uptake) and DE2 (results issued within 3 weeks) the achievable targets are regularly met for the population of Cambridgeshire and Peterborough, with good uptake of the screening programme. There are ongoing issues which are being addressed at hospital eye clinics affecting DE3 (timely assessment for R3A screen positive). This is for patients who are referred with a screen positive result to hospital eye services, who should be seen within the eye clinic within 13 weeks of referral. CUHFT has ongoing issues with capacity within eye clinics which has seen them regularly not meet this target for the whole of 2017-18. The Trust is trying to address this. NWAFT has met the target for 3 of the 4 quarters.

| **TABLE 38:** Diabetic eye screening KPIs for Cambridgeshire & Peterborough CCG through East Anglia DESP, by 2016/17 – 2017/18, *Source: Health Intelligence* | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Indicator & Target** | **2016-2017** | | | | **2017-2018** | | | |
| | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| **Acceptable 70% Achievable 80%** | | | | | | | | |
| DE1-Uptake of routine digital screening event | 85.7 | 87.6 | 85.6 | 83.8 | 84.3 | 84.8 | 85.4 | 90.8 |
| **Acceptable 70% Achievable 80%** | | | | | | | | |
| DE2-Results issued within 3 weeks of screening | 99.8 | 99.7 | 99.8 | 99.8 | 98.5 | 99.8 | 100 | 100 |
| **Acceptable 80% Achievable 95%** | | | | | | | | |
| DE3 - Timely assessment for R3A screen positive | 80.0 | 75.0 | 58.3 | 70.0 | 70.8 | 75.0 | 75.0 | 80.0 |

### 5.3.2 Abdominal Aortic Aneurysm (AAA) Screening

The Cambridgeshire, Peterborough and West Suffolk AAA screening service has an eligible population of approximately 5,583. The service offers screening to all eligible men in the year they turn 65 years of age in line with national guidance. This is delivered by screening technicians in community settings such as GP practices and community hospitals. The service performs well against AA2 (coverage of initial screen) and AA3 (coverage of annual surveillance screen). AA4 (coverage of quarterly surveillance screen) is slightly under the acceptable level and this is monitored at the programme board with breaches discussed on an individual basis. Patients breach if they move their appointment forward as well as backwards, which affects this KPI, so patients breaching AA4 may be being seen earlier rather than later. The service also screened 176 self-referrals during 2017 to 2018. Self-referrals can be received via telephone or completion of a self-referral form.

| **TABLE 39:** AAA screening completeness of offer, Cambridgeshire population, 2015/16 – 2017/18 | | | | | |
|---|---|---|---|---|---|
| **Indicator** | **Acceptable** | **Achievable** | **2015-16** | **2016-17** | **2017-18** |
| AA1 Completeness of Offer | ≥ 52% | ≥ 70% | 99.9 | 99.9 | retired |

| **TABLE 40:** AAA screening KPIs, Cambridgeshire screening cohort, 2017/18 | | | | |
|---|---|---|---|---|
| **AAA Data - Cambridgeshire Screening Cohort** | | | | **2017-2018** |
| **Indicator** | | **Accpt.** | **Ach.** | |
| Coverage of Initial Screen | **AA2** | ≥ 75% | ≥85% | 80.6% |
| Coverage of Annual Surveillance screen | **AA3** | ≥ 85% | ≥95% | 89.7% |
| Coverage of Quarterly Surveillance screen | **AA4** | ≥ 85% | ≥95% | 83.6% |

## 6. Healthcare Associated Infections

Healthcare associated infections (HCAI) can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. The term HCAI covers a wide range of infections, including methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C. difficile).

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

## 6.1 MRSA bacteraemia

MRSA is a type of bacteria that is resistant to several widely used antibiotics and mainly affects people who are staying in hospital. The term MRSA bacteraemia refers to an MRSA blood stream infection.

The government considers it unacceptable for a patient to acquire an MRSA blood stream infection while receiving care in a healthcare setting and therefore has a zero tolerance approach (NHS Improvement March 2018). From April 2018, the requirements for reporting and monitoring through a post infection review (PIR) changed. Mandatory reporting remains in place, however only those organisations with the highest rates of infection are required to hold formal reviews, with the remainder of trusts adopting a local process, though still required to be a robust clinical review. The threshold for formal reviews was the top 15% of CCGs and non-specialist trusts with a rate of 1.6 or more community onset MRSA bacteraemia per 100,000 population and trusts with a rate of 1.7 per 100,000 bed-days or more. The rate in 2016/17 was 1.5. NHS England will maintain oversight of CCG performance and NHS Improvement the acute providers' performance. These are to be reviewed on a rolling 12-month basis. Cases have previously been assigned according to the outcome of the PIR, however since April, an onset of infection >2 days after admission is considered hospital onset and all other cases community onset.

**Neither Cambridgeshire and Peterborough CCG or its local acute hospital providers were in the top 15% requiring formal reviews, but have continued to conduct the PIR process as before, to ensure any timely learning is actioned or problem areas quickly identified.**

Locally, numerous interventions aimed at reducing the incidence of MRSA bacteraemia have been introduced and targeted to the acute care setting. However, with shorter hospital stays which should reduce the risk of acquiring a hospital onset infection, patients may have acquired infections within the hospital but not manifested the symptoms at the point of discharge. An admission to hospital would then be less than 2 days and according to the definition, community onset. Early detection of MRSA bacteraemia is improving with advanced diagnostics and increased clinical awareness of sepsis; this could possibly result in an increase of isolates found to be community onset.

**TABLE 41:** Numbers of MRSA bacteraemia cases, by area, 2017-18

| | 2017/18 | 2018/19 up to December 2018 |
|---|---|---|
| **National** | 846 | n/a |
| **Cambridgeshire and Peterborough CCG** | 11 | 16 |

Of the 16 cases reported to date this year, 5 were classed as hospital onset (one of which was a contaminant) and 11 community onset for the CCG (2 cases were for the same patient).

## 6.2 Clostridium difficile

C. difficile is a bacterial infection that affects the bowel and most commonly occurs in people who have recently been treated with antibiotics, especially broad-spectrum antibiotics.

During 2017/18, 13,286 cases of C. difficile were reported nationally which demonstrates a slight increase of 3.4%. The division of cases between community and hospital onset does not capture a recent admission/discharge of a patient or take into account complex healthcare pathways. The result of this is leading to a further change in the reporting process from April 2019 when the algorithm will be broken down into four categories. The objectives for each organisation were reduced by one case with plans for 2019/20 remaining unknown at this time.

Locally, scrutiny panel meetings continue to be held in each provider organisation for each individual case reported. At this meeting there is an agreement with the CCG Infection Control Lead as to whether there were any lapses in care to be addressed. Where lapses have been identified, this then becomes a sanctioned case. Lapses may include delay in sending a specimen, lack of isolation facility and no escalation, and poor documentation.

In Cambridgeshire and Peterborough:

- There were 135 cases of C. difficile reported between April to December 2018. This compares to 142 at the same point in 2017.
- The number of sanctioned cases for all hospital trusts cases is 26.
- The number of sanctioned cases for Cambridgeshire and Peterborough CCG registered patients is 17.
- Where trusts have seen more than 10 cases in a given month, support has been requested from NHS Improvement in conjunction with the CCG.

### 6.3 Escherichia coli bacteraemia

The term E. coli bacteraemia refers to a blood stream infection by E. coli bacteria. 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 equated to 53 cases for Cambridgeshire and Peterborough CCG. Our total number for this period was 557 cases which was an increase of 6%. Overall a 5% increase between July to Sept 2017 and July to Sept 2018 has been reported.

Data published for the full year of 2017/18 identified that the rates are still high, in particular with the over 85-year old age group and greater in men than women. The source of these infections has changed little over time with urinary tract infection (UTI) the most frequent with 45-49% reported as the source.

Unlike MRSA bacteraemia and C. difficile, this infection is more challenging to reduce the incidence in number. The majority of these cases develop in the community in patients who may or may not have been receiving healthcare and therefore difficult to identify until the infection develops.

NHS Improvement developed a UTI collaborative and have been working with a number of hospital trusts over the past 9 months to make an impact where the reported number of cases is considered high. This has included CUHFT. To support the work and learning, we have brought together a wide multi-professional group from our health economy that includes infection control nurses, community continence service leads, acute hospital continence leads, consultant urologists, care home team and other senior practitioners along with the CCG contract leads for Urgent and Emergency Care to examine the service pathways for urinary catheters. This work remains in progress, with the main focus ensuring that urinary catheters are only used when absolutely required and removed as soon as possible. A positive impact from this work is anticipated during the year of 2019/20. A gap in team resources is being addressed by trusts to enhance the patient experience and reduce unwanted variation in practice across the health economy.

Between April and December 2018, 426 cases of E. coli bacteraemia have been reported, which is a rise of 5 cases for the same period last year.

### 6.4 HCAI further information and references

- Annual epidemiological commentary: Gram-negative bacteraemia, MSSA bacteraemia and *C difficile* infections, up to and including financial year April 2017 to March 2018. Public Health England. 12 July 2018
- Quarterly epidemiological commentary. Mandatory MRSA, MSSA, Gram-negative bacteraemia and *C. difficile* infections data (up to July to September 2018). Public Health England. December 2018
- 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. Antimicrobial Resistance

Antimicrobial resistance has been described as one 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.

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. 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 resistance to trimethoprim. 25.8% of urine community E. coli (or coliform) samples tested in quarter 3 2018 in the Cambridgeshire and Peterborough CCG area were found to be non-susceptible to trimethoprim. This figure has reduced compared to the same quarter in 2017-2018. Local and national targets have been introduced aimed at reducing the inappropriate use of this trimethoprim compared to alternatives and specifically for use in 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 2019-20.

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 are resistant to the infection being treated. 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 continues to be higher than the National target. A system wide approach using antibiotic stewardship programmes with provision of prescribing data, audit, provision of education, peer group review and support to GPs in reducing their use of unwarranted broad spectrum antibiotics has been implemented to address this. Very limited success has been seen in the reduction of broad spectrum prescribing in 2018-2019 and further improvement is needed during 2019-2020 and will require the co-operation of prescribers, patients and the public.

## 7.1 AMR references and further information


1. 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 17.1.2019.
2. 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 17.1.19.
3. Public Health England. East Region. AMR Local Indicators. Available at: http://fingertips.phe.org.uk/ and accessed 17.1.19.

4. Public Health England. English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR) 2018 and accessed 17.1.19.

# 8. Environmental Health

Environmental Health teams and Regulatory Services play an important role in protecting the health of the Cambridgeshire and Peterborough population. Principal Environmental Health Officers sit on the Cambridgeshire and Peterborough Health Protection Steering Group reporting key environmental health issues by exception.

Environmental health is the responsibility of district and unitary councils and is delivered by the following councils within Cambridgeshire and Peterborough: Cambridge City Council, East Cambridgeshire District Council, Fenland District Council, Huntingdonshire District Council, Peterborough City Council and South Cambridgeshire District Council.

Although the role of environmental health staff vary between each council, the following regulatory services are usually delivered by environmental health teams or equivalent:

- Food safety
- Health and safety
- Pollution control – including noise pollution and contaminated land
- Private sector housing and houses of multiple occupation (HMOs)
- Licensing
- Trading standards

The work of regulatory services and environmental health teams helps to keep people healthy and safe, reduce health inequalities and contributes to the local economy.

## 8.1 Food safety

This includes carrying out hygiene inspections of food establishments, investigating complaints, regulating private water supplies, and working closely with Public Health England to manage infectious diseases. Food safety teams aim to protect consumers through the assessment or investigation of business compliance with relevant food legislation and centrally issued guidance, and/or to offer advice and guidance to businesses. These activities help to protect the community from ill health associated with poor food hygiene and safety practices.

Food Safety teams within Environmental health operate the national Food Hygiene Rating Scheme which helps consumers choose where to eat or shop for food by providing information about hygiene standards. In 2017/18, the proportion of food establishments across the country achieving broad compliance was 90.2% (broadly compliant is equivalent to a hygiene rating of 3, generally satisfactory, or above). Table 42 below shows the proportion of broadly compliant establishments locally:

**Table 42:** Proportion of food establishments achieving broad compliance, by local authority, 2017/18, *Source: Food Standards Agency LAEMS*

| | **Total number of establishments** | **Proportion of food establishments achieving broad compliance (equivalent to a hygiene rating of 3 or above), including those not yet rated** |
|---|---|---|
| Cambridge City | 1523 | 90.5% |
| East Cambridgeshire | 786 | 92.9% |
| Fenland | 842 | 95.3% |

| | | |
|---|---|---|
| Huntingdonshire | 1386 | 90.2% |
| Peterborough City | 1932 | 87.5% |
| South Cambridgeshire | 1306 | 90.8% |

Recent examples of work carried out by local food safety teams include:

- **Improving hygiene ratings at East Cambridgeshire District Council:** in order to improve hygiene ratings of food premises and public confidence within the district, the environmental health team set up a new scheme. Poorly performing businesses were identified and signed up to the scheme via a 'contract'. These businesses were offered a package of support including: an advisory visit, a good safety management system – Safer Food Better Business pack and diary sheets, an allergen pack and verbal advice on training, cleaning, labelling, structural advice and how to comply with and maintain management systems. Premises were then given three months to rectify identified issues during which time they were able to access the further support from the environmental health team. Businesses then received a further advisory visit before being inspected unannounced. The environmental health team then provide support to the businesses to help them maintain their improved ratings.

- **Investigating food fraud at Fenland District Council (FDC):** the environmental health team have been working closely with the Food Standards Agency (FSA) to investigate a significant amount (> 100 tonnes) of frozen meat detained by FDC environmental health officers. This meat did not meet hygiene standards due to suspected labelling issues. FDC officers have been working with the FSA to identify the origins of the meat product, its date of processing and whether it was fit to release back into the market place. The complex investigation has revealed common practices within the meat product industry which has helped both the council and FSA understand the risks associated with the onward sale products which may change hands many times over a period of months. The investigation confirmed breaches of hygiene standards and the company has agreed to dispose of the meat.

- **Pest infestations at Cambridge City Council and Peterborough City Council:** the food safety teams in these teams have been dealing with cockroach and rodent infestations at various premises including food businesses and a school. The teams have been taking necessary action to deal with the infestation including inspection and in some instances closure, to ensure there is no risk to public health.

- **Managing cases and outbreaks of infectious diseases:** environmental health officers throughout Cambridgeshire and Peterborough continue to work closely with Public Health England to provide an essential role in the management of complex cases of infectious diseases. Cambridge City Council have worked closely with Public Health England to assist with a case of TB which required the issuing of a warrant and a Part 2A order to prevent the patient from seconding into the community. Peterborough City Council (PCC) worked with Public Health England to investigate a gastroenteritis outbreak, providing support to the business in terms of infection prevention and control advice, providing advice to the public and working to identify the source of infection. South Cambridgeshire District Council worked closely with Public Health England to investigate a cluster of salmonella cases which had potential links to a local nursery. E coli gastrointestinal infections can be very serious and require a number of public health actions to minimise the risk to the public. PCC have dealt with a small number of cases of E. coli this year which has involved working with involved businesses, supporting the cases and their families, and liaising with Public Health England.

## 8.2 Health and safety

Health and safety teams within the district councils and Peterborough City Council are responsible for enforcing health and safety regulations in businesses which including catering and hospitality, hairdressing and beauty, motor vehicles, working in an office, retail and warehousing to make sure they are safe for employees and visitors. The health and safety teams carry out investigations into complaints, reportable accidents and ill health in relation to the workplace.

This year, the PCC health and safety team conducted a routine visit to a Shisha Bar in the City Centre, where officers observed that the smoking shelter was no longer compliant in that it had been altered to become an enclosed space.

Since 2006 smoking is not permitted inside workplaces. Smoking can take place in a smoking shelter as long as the shelter is more than 50% open. Shisha smoking is dealt with in the same manner as tobacco smoking and must also take place in a compliant shelter. At the time of the visit a number of customers were observed to be smoking in the now enclosed space. Officers worked with the business and the business returned the shelter to a compliant shelter by being more than 50% open. The business received a written warning to prevent making the shelter enclosed again.

## 8.3 Pollution control

Pollution control includes investigation of a wide range of statutory nuisances, air quality assessment, hoarding and infestations of vermin in domestic and commercial premises, and the issuing of permits for industrial processes. It also includes the inspection of potentially contaminated land where current or previous industrial activity may have had an impact on the condition of the land and left it contaminated with chemicals or other substances. All of these environmental hazards can have significant harmful effects on health; the pollution control teams therefore play a vital role in protecting the public's health from such hazards.

Recent examples of work carried out by pollution control teams include Cambridge City Council environmental health officers who have been working closely with Marshalls Airport to provide advice on noise, air quality, odour and contaminated land issues in relation to the new engine testing. The council have also been working on a challenging contaminated land case in the city, supporting planning colleagues to ensure the development is fit for purpose and does not pose a risk to human health.

**Case Study – Pollution Control at Peterborough City Council**

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

Examples of developments considered in the previous 12 months include:

- 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.
- Site for 104 affordable houses Former Perkins Engines Site Newark Road Fengate. Advice on measures to mitigate potential impact from noise sources from industrial premises, and to mitigate ground contamination and gas emissions associated with previous landfilling of the site.
- Upgrade of Werrington Gas Compressor assessed for air quality and noise impacts. Notices served to control noise levels and hours of work for the construction phase of the project which are programmed for completion in 2020.
- Werrington Grade Separation "Dive-Under" proposals. The railway at Werrington Junction is to undergo major redevelopment which is scheduled to be completed by mid-2021. The noise resulting from this significant construction scheme will impact on local residents. Officers worked with Network Rail for the agreement of work procedures and service of notices primarily to ensure the impacts of construction noise of the civil engineering project will be controlled so far as reasonably practicable.
- Energy from Waste and Biomass Generating Station, Storeys Bar Road, Fengate - Advice and recommendations have been provided in relation to emissions of pollutants to air from the plant, odour potential, operational noise, construction noise and dust, impacts of transport upon air quality and noise, and controls to mitigate lighting impacts.
- Consideration of potential noise and air quality impacts associated with proposed duelling of A47 Wansford-Sutton
- Assessment of impacts from Alwalton Hill commercial developments and their potential cumulative impacts upon future residential developments in Hampton and for Haddon.
- Consideration of proposals for industrial and commercial use on 166440 square metres of land at Red Brick Farm Fengate, advising upon controls for day and night time noise that may impact upon residents, additional traffic noise, air quality impacts, development on potentially contaminated land and lighting control
- Discharge of planning condition in relation to remediation requirements for ground contamination and required levels of ground gas protection for Sand Martin House, Fletton Quays
- Review of development proposals for housing that may be affected by the nearby Stanground Landfill and Fletton Parkway. The site has been assessed for potential impacts of landfill gas migration, contaminated land, air quality and noise.
- Stanground South: Tranches for housing development adjacent to the Stanground bypass have come forward and been assessed for noise impacts associated with traffic. Recommendations for the protection of indoor and outdoor amenities have been made as part of the planning consultation process.

**Contaminated Land at Burton Street:** the PCC Pollution Team identified significant levels of carcinogenic chlorinated solvents in the ground, potentially affecting some residential properties in the area. The presence of the contaminant was most likely associated with the historic industrial land use of a casting works in the locality. It was therefore necessary to establish if the chlorinated solvent levels in the soil amounted to unacceptable risk to human health. Following initial investigations by officers, environmental consultants were appointed who carried out investigations at locations agreed with affected residents. This identified that the measured concentrations were all below the vapour screening values that had been previously determined by risk modelling. Therefore the risk to occupants in the identified area, from vapour intrusion associated with subsurface contamination, is acceptable and does not constitute significant possibility of significant harm and land is not deemed to be 'contaminated'.

## 8.4 Private Sector Housing

Private sector housing teams within environmental health departments of district and unitary authorities undertake statutory housing and public health functions. They work with owner occupiers, private landlords and social housing providers to protect the health, wellbeing and safety of residents and visitors. This may involve taking action to deal with issues such as disrepair, fire safety, overcrowding inadequate facilities and issues relating to damp, mould or condensation. Many private sector housing teams also work to improve the health and safety of houses in multiple occupation (HMOs) including issuing HMO licenses. Some housing officers also provide advice to homeowners and landlords about energy efficiency issues such as insulation and availability of grants.

This year, for example, the Cambridge City Private Sector Housing Team worked with a number of different agencies to deal with a complex case of hoarding. The team identified a number of category 1 hazards under the Housing Health and Safety Rating System (HHSRS) which affected the safety and suitability of the housing and worked in partnership to resolve these issues.

## 8.5 Licensing Service

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 including alcohol, gambling, pet shops, petroleum sites, tattooists and skin piercing, dangerous animals and adult entertainments.

This year, a number of local councils have reviewed their Statement of Licensing Policy in relation to the Licensing Act 2003. A Cumulative Impact Policy is a local policy which introduce a presumption against new licences to sell alcohol from bars, shops, pubs or clubs in a designated area. They can be adopted where there is evidence that the number or concentration of premises give rise to a harmful impact on the promotion of the licensing objectives and where a licensing authority has consulted local people and businesses. Cumulative impact policies are in place in Cambridge City, Fenland and Peterborough City. In 2018, both Cambridge City Council and PCC reviewed the use of cumulative impact policies in their districts and it was agreed to continue with them.

A further example of local work in this area is the revocation of an alcohol licence of a convenience store in Peterborough following the seizure by trading standards of illicit cigarettes and tobacco. Cambridge City Council have also heightened enforcement in this area to ensure the licence holders, including taxi licensing, are adhering to the requirements of their licenses.

## 8.6 Trading standards:

On 1st April 2017 Cambridgeshire County Council's Trading Standards Service merged with Peterborough City Council's Trading Standards Service, becoming 'Cambridgeshire and Peterborough Trading Standards'. The service plays a vital role in enhancing and safeguarding the local economy, as well as protecting its residents. Through the effective delivery of its statutory duties it helps to ensure businesses based and operating in Cambridgeshire and Peterborough are aware of and comply with their legal obligations.

Trading Standards has a critical role in ensuring consumer safety, through its enforcement and advisory activities in the areas of product safety, food safety, upholding the integrity of the food chain, protecting the most vulnerable from rogue trading activity, and effective explosives and petroleum licensing. The service plays a crucial role in protecting the rural economy from animal disease outbreaks and continues to be a primary responder in the case of such an outbreak, as well as upholding animal health and welfare standards.

A key area of work is tackling illicit tobacco which can cause significant harm to the public's health due to unregulated sales of cheap cigarettes to children and high levels of contaminants in fake tobacco products. Trading Standards plays a role locally by detecting and seizing illegal tobacco products.

Cambridgeshire and Peterborough Trading Standards Service have been working on the following important issues which can pose a risk to the public's health:

- **Rabies:** the trading standards service have been working hard to disrupt the illegal importation of animals for onward sale which can present a risk of rabies when these animals come from countries with a high risk of rabies. A number of successful prosecutions have been undertaken against illegal importers (with one defendant receiving a 34 month prison sentence). This has provided a media platform allowing the service to raise awareness, educate the public and disrupt the importers resulting in a substantial drop in complaints in 2018.

- **Allergens:** the trading standards service has responsibility for food labelling including the correct labelling of allergens in food. Previous work has included sampling and analysis from takeaways but more recently the service has been focusing on caterers and hotels. Following a serious incident where a customer received food which contained nuts and had a severe allergic response, a series of inspections have taken place where controls were checked and advice given to ensure adequate controls were in place. Officers from across the councils have also provided training to caterers on allergens.

- **Illicit tobacco:** the service continues to work with partners across Cambridgeshire and Peterborough to disrupt the sale of illicit cigarettes, tobacco and alcohol. This is resource intensive work as often these products are concealed in shops or nearby vehicles so sniffer dogs are needed to find hiding places. These products are sold cheaply (£3 for packet of 20 cigarettes) thereby counteracting the Government initiatives of discouraging smoking through taxation and harming legitimate business. From four visits in Peterborough 32,000 cigarettes and 3.2kg hand rolling tobacco were seized. Licence reviews are underway against all these premises, with one premise having their licence revoked. Investigations are currently being carried out for possible court action. The trading standards service has also recently invested in new equipment to improve testing of seized cigarettes for 'reduced ignition propensity' requirements – an important safety feature on regulated cigarettes.

- **Vaping safety project:** As part of a Department of Health funded project, trading standards officers have been assessing compliance with the Tobacco and Related Products Regulations 2016. A range of premises were inspected and at each one approximately ten products (e-liquids and vaping merchandise) were inspected for compliance. Numerous non-compliances were seen around labelling and officers advised businesses on what they needed to do to comply with legal requirements. Issues found were referred to the Trading Standards departments where the suppliers were based. In addition to the funded work, 16 samples of e-liquids were taken and analysed in the laboratory of a Primary Authority Partner business for the presence of undesirable substances and nicotine strength. Of the 16 samples taken, one had high levels of acetyl propionyl and acetoin, which are both flavour ingredients that the Medicines and Healthcare Regulatory Agency (MHRA) have advised against. All nicotine strengths were within tolerance of that declared. This project has identified a range of issues facing consumers and businesses on how to comply with the law, and has fed into a larger national project.

- **Underage sales:** the trading standards service are responsible for age restricted products such as tobacco, alcohol, fireworks, knives and petrol. We, like many other authorities, do not receive many complaints about this, but recognise that it is a problem. In order to generate intelligence to target our action we have conducted a set of Challenge 25 test purchases, where a 20 year old was sent into shops claiming to operate a 21 or 25 age check policy and asked to buy cigarettes. From 46 premises visited 21 (45%) sold without asking for ID and of these 17 (80%) were illicit tobacco. This provides evidence for the perception that underage sales are still a problem, made worse by the fact many of the cigarettes were also illicit, and further work is planned.

- **Counterfeit alcohol:** Following a complaint from a consumer, trading standards officers examined a bottle of vodka purchased from a local off license. The labelling and smell of the vodka raised concerns that it may not be genuine. As a result inspections were conducted at 2 linked premises and further bottles seized. These were sent for analysis to determine whether the products are genuine or unsafe. In the past, counterfeit vodka has been found to contain industrial alcohol, such as isopropanol and ethanol, both of which can be very harmful.

## 9. Air Quality

## 9.1 Responsibility for improving air quality

The air quality agenda in Cambridgeshire and Peterborough is not owned by a single organisation or department. Cambridge City, Peterborough City Council and the four district councils have statutory requirements to assess and monitor air quality, and where required develop action plans; they also have plan making powers which can effect air quality. The Cambridgeshire County Council, Peterborough City Council and the combined authority and Greater Cambridgeshire Partnership are responsible for actions and intervention's (mainly relating to transport) which can mitigate or reduce air pollution.

The role of the public health directorate is to provide the evidenced based health implications of air quality at a population level. The public health directorate facilitate this by bringing together key stakeholders who may not normally meet for air quality issues or may only be considering the environmental aspects, for example Public Health have contributed to the Transport needs review of the Cambridge Biomedical Campus (one of the Greater Cambridge Partnership Projects) following concerns raised by members of the Cambridgeshire County Council Health Committee and officers at the Cambridge City Council, the Combined Authority's Strategic Bus Review, the Local Transport Plan and district/city level Local Plans.

There are number of challenges which need to be considered when developing a joined up county wide approach to air quality. As stated above the ownership of the air quality agenda rests with many organisations with responsibility for monitoring and mitigation held by different organisations, this makes a system wide response more challenging.

Last year the public health directorate identified a gap in the knowledge of air quality and its impact among transport and planning officers as transport planners and local planners are not experts in air quality, and in two tier areas do not have access to air quality expertise in their organisations, therefore Public Health commissioned a training programme for these officers to raise awareness of air quality and to foster closer working relationships.

There is a lack of specialist air quality capacity in many of the district and city councils, which means the majority of their focus is on their statutory duties, with little capacity for broader advocacy work or influencing planning and transport decisions.

There are co-benefits from wider interventions, as air quality should not be seen in isolation as health modelling shows that interventions to increase active travel can result in significantly greater benefits from increased physical activity, compared to direct interventions targeting air quality overall – so greater health benefits will be achieved by people switching to walking and cycling than by switching to electric cars.

The approach therefore is to focus on those areas of the county most effected by poor air quality whilst at the same time directly influencing broader strategic plans and programmes, such as transport plans and local plans, which have considerable impact on air quality across the whole of the county.

## 9.2 Monitoring air quality

Cambridge City Council, Peterborough City Council and the four district councils are required to assess the air quality in their area as part of the Air Quality Standards Regulations 2010 legislation. Levels of air pollutants such as benzene, carbon monoxide, nitrogen dioxide, industrial emissions and sulphur dioxide are assessed.

The assessment process is undertaken in a series of stages by using an updating and screening assessment of air quality which are produced every three years. The updating and screening assessment of air quality identifies the pollution levels within the local authority area. In between these publications, annual status reports (ASR) are produced which highlight any changes which might have occurred over the previous year. The guidance from DEFRA requires these ASRs to be signed off by the Director of Public Health.

Should any pollutants be suspected or shown to be above the objective level, the responsible local authority is required 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.

The burden of poorer air quality varies across Cambridgeshire and Peterborough. Currently, the main pollutants of concern in Cambridgeshire and Peterborough, as in most areas of the UK, are associated with road traffic, in particular $NO_2$ and particulate matter (PM) at locations close to busy, congested roads where people may live, work or shop. Air Quality Management Areas (AQMAs) have been declared in Cambridge City, Fenland, Huntingdonshire, Peterborough City and South Cambridgeshire; East Cambridgeshire currently do not have an AQMA. By nature this means that air quality does not have the same level of focus for all local authorities.

In areas with declared Air Quality Management Areas (AQMAs) the focus continues to be to support the authorities to bring forward measures to improve air quality and ensure that the most vulnerable are protected e.g. children and those with health conditions.

In addition to responsibility for monitoring air quality, the district and city councils also have plan making powers which can affect air quality. Recent examples of work by district and city councils to improve air quality include the introduction of a zero/ultra-low taxi vehicle policy and the introduction of electric vehicle charge points for taxis in Cambridge City Council.

## 9.3 Cambridgeshire and Peterborough Combined Authority

At a strategic level the Combined Authority is developing a new Cambridgeshire and Peterborough Local Transport Plan (LTP). As transport is one of the main contributors to air quality this will be considered in the LTP. Public Health will play a role in bringing together stakeholders on air quality to provide a more comprehensive joined up response. The development of the LTP would also provide an opportunity to champion and influence opportunities for more active travel within the plan.

The combined authority has also produced a Non Statutory Spatial Plan which focuses on providing a county perspective on infrastructure, linking up local plans and the LTP. Air quality has been considered as part of this process. The Combined Authority are reviewing and refreshing the Quality Charter for Growth which will take air quality into account. These plans will enable Public Health to indirectly influence air quality in those localities where air quality is not deemed to be a priority.

## 9.4 Cambridgeshire and Peterborough Air Quality Action Plan

The public health directorate are coordinating a Cambridgeshire and Peterborough Air Quality Action plan to address key concerns on air quality raised locally. The draft headline actions are:

- Review what resources have already been developed locally and nationally – develop / localise specific resources for planners and councillors on planning committee, councillors more broadly, children and young people, and make resources available on local authority air quality pages and Cambridgeshire Insight to address communication/key messages on air quality. There is a lack of local resources and key messages on air quality which can leave a vacuum and creates potential for inappropriate narrative.
- Examine current content on Cambridgeshire insight on Air Quality as there is a lack of links between districts air quality pages and Cambridgeshire insight and vice versa
- Identify resources from elsewhere and localise/develop resources for citizen scientists locally
- Apply for NHS sustainability fellow to work locally to better understand impact of the NHS (health service) on air quality and identify opportunities to change ways of working.
- Feed into the Combined Authority's Local Transport Plan and Quality Charter for Growth.

## 9.5 Air Quality – Further Information

Local authorities are required to publish regular air quality reports which can be found on their local websites and the Cambridgeshire Insight website.

# 10 Sexual Health

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

## 10.1 New Sexually Transmitted Infections Diagnoses (STIs) (excluding <25 chlamydia)

The rate of new diagnoses of sexually transmitted infections (excluding <25 chlamydia) is below the England average for Cambridgeshire, with a downward trend. The rate of new diagnoses of sexually transmitted infections (excluding <25 chlamydia) for Peterborough has fluctuated in recent years. The Peterborough rate in 2017 declined from 2016 to a level statistically similar to the national average (876 to 761 per 100,000).

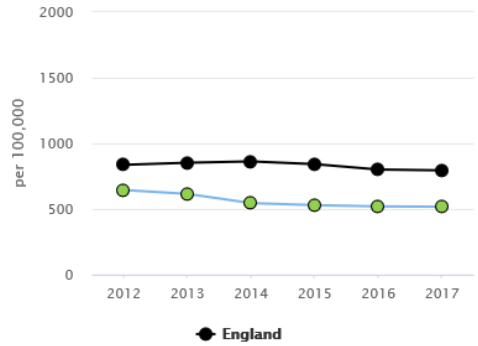


**Figure 9:** New STI diagnoses (excluding <25 chlaymdia), Cambridgeshire, 2012-2017, *Source: Sexual Health Profiles Public Health England (2018)*

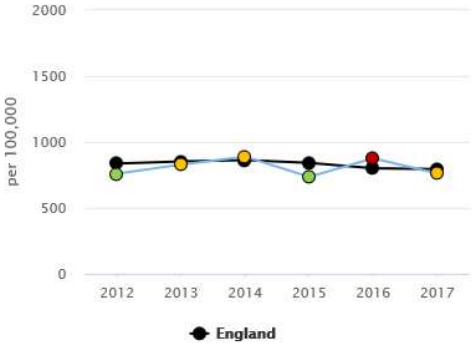


**Figure 10:** New STI diagnoses (excluding <25 chlaymdia), Peterborough, 2012-2017, *Source: Sexual Health Profiles Public Health England (2018)*

## 10.2 New HIV Diagnosis Rate

There has been an overall downward trend in the rate of new HIV diagnosis in England and Cambridgeshire. However, the rate for Cambridgeshire in 2017 increased from 2016 (6.8 to 7.3 per 100,000) to a level statistically similar to the England average.

Peterborough has remained statistically significantly similar to England since 2011, although the Peterborough rate for this indicator declined between 2016 and 2017 (from 14.9 to 13.5 per 100,000) line with the England trend.

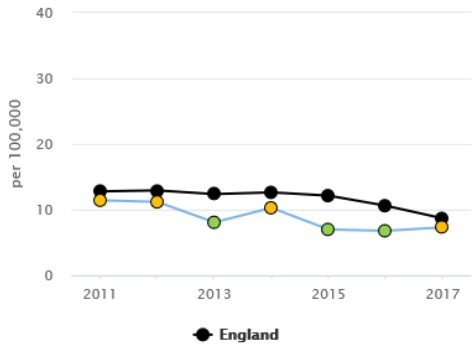


**Figure 11:** New HIV Diagnosis Rate, Cambridgeshire, 2011-2017, *Source: Sexual Health Profiles Public Health England 2018)*

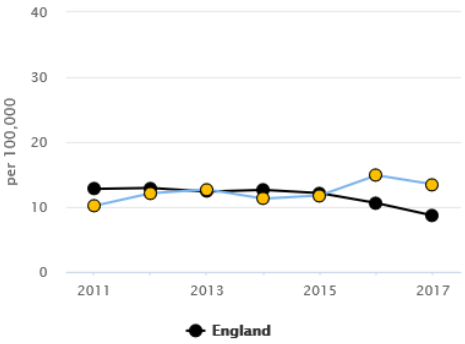


**Figure 12:** New HIV Diagnosis Rate, Peterborough, 2011-2017, *Source: Sexual Health Profiles Public Health England (2018)*

## 10.3 Late HIV Diagnosis

England has a downward trend of HIV late diagnosis. Earlier diagnosis leads to an improved outcome of treatment and reduced risk of onward transmission.

The rate of HIV late diagnosis for Cambridgeshire was worse than the benchmarking goal (defined as ≥ 50%) at 51.1% in the period 2015-17 (shown below) and statistically significantly similar to England. Since 2009 it has been statistically significantly similar or above both the benchmarking goal and England.

The rate of late HIV diagnosis for Peterborough has been worse than the benchmarking goal (defined as ≥ 50%) at 51.2% during 2015-17 (shown below). Since 2013 the Peterborough rate for late diagnosis has been statistically worse than the England figure.

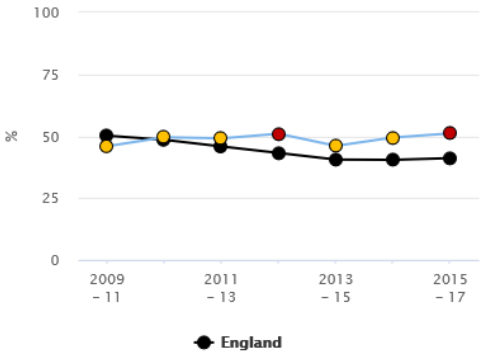


**Figure 13:** HIV Late Diagnosis (%)[1], Cambridgeshire, 2009/11-2015/17, *Source: Sexual Health Profiles Public Health England (2018)*

[1] *These graphs show the Cambridgeshire/Peterborough rate RAG-rated compared to the **benchmark** for this indicator, not England.

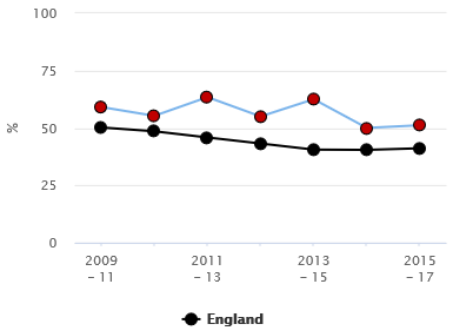


**Figure 14:** HIV Late Diagnosis (%)[2], Peterborough, 2009/11-2015/17, *Source: Sexual Health Profiles Public Health England (2018)*

## 10.4 HIV diagnosed prevalence

The HIV diagnosed prevalence rate for Cambridgeshire has remained statistically significantly better than England since 2011. The HIV diagnosed prevalence rate for Peterborough was statistically significantly better than England from 2011 to 2015. For the periods 2016 and 2017 the HIV diagnosed prevalence rate for Peterborough has increased to a level statistically similar to England. The HIV diagnosed prevalence rate has exceeded 2 per 1,000, therefore defining the authority as a high HIV prevalence local authority according to 2017 NICE and PHE guidelines. For Peterborough, the increased rate is expected to be in part due to improved testing, diagnosis, and treatment.

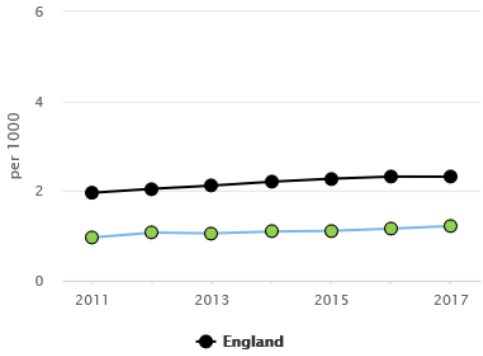


**Figure 15:** HIV diagnosed prevalence rate per 1000 (people aged 15 – 19 yrs), Cambridgeshire, 2011 - 2017, *Source: Sexual Health Profiles Public Health England (2018)*

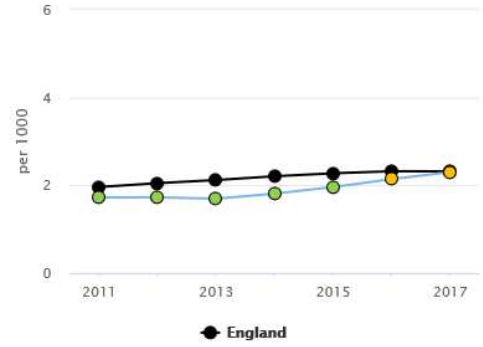


**Figure 15:** HIV diagnosed prevalence rate per 1000 (people aged 15 – 19 yrs), Peterborough, 2011 - 2017, *Source: Sexual Health Profiles Public Health England (2018)*

## 10.5 Chlamydia Diagnosis

Nationally, there has been a continued decline in Chlamydia detection amongst 15-24 year olds since 2012. For Cambridgeshire, the rate of chlamydia detection has remained significantly worse than the national average, and worse than the PHE recommended benchmarking goal of 2,300 per 100,000, since 2012. However it is difficult to interpret this as generally the rate of STIs in the Cambridgeshire population is below the national average.

[2] *These graphs show the Cambridgeshire/Peterborough rate RAG-rated compared to the **benchmark** for this indicator, not England.

The rate of chlamydia detection in Peterborough has remained significantly better than the national average, and better than the PHE recommended benchmarking goal of 2,300 per 100,000, since 2012. Continuing to exceed the national benchmarking goal is considered positive in terms 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.

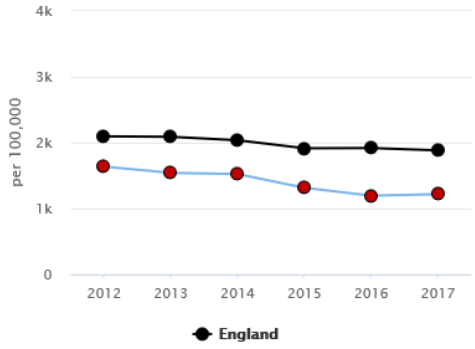


**Figure 17:** Chlamydia detection rate 15-24 yrs, Cambridgeshire, 2012 - 2017, *Source: Sexual Health Profiles Public Health England (2018)*

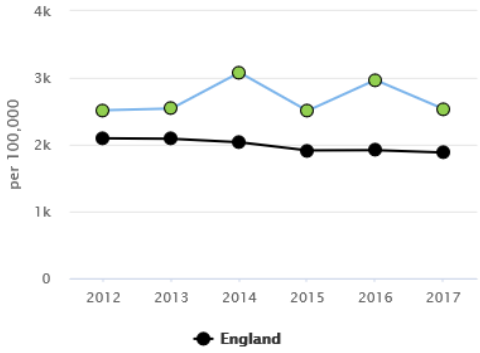


**Figure 18:** Chlamydia detection rate 15-24 yrs, Peterborough, 2012 - 2017, *Source: Sexual Health Profiles Public Health England (2018)*

## 10.6 Teenage Pregnancy (conceptions)

The under 18 conception rate per 100,000 has improved dramatically between 1998 and 2016 in Cambridgeshire and in Peterborough. The under 18 conception rate in Cambridgeshire continues to have a downward trend and it remains below the national average. The Fenland district, within Cambridgeshire, has a downward trend but remains statistically similar to England. Peterborough also has a downward trend in the under 18 conception rate, however it remains statistically significantly worse than the national average for the sixth consecutive year.

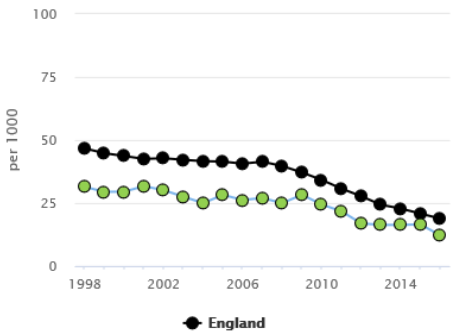


**Figure 17:** Under 18s Conception Rate, Cambridgeshire, 1998 - 2016, *Source: Sexual Health Profiles Public Health England (2018)*

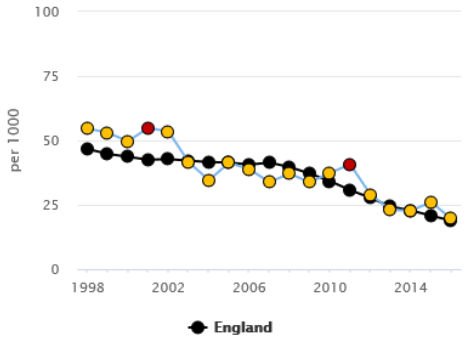


**Figure 18:** Under 18s Conception Rate, Fenland, 1998 - 2016, *Source: Sexual Health Profiles Public Health England (2018)*

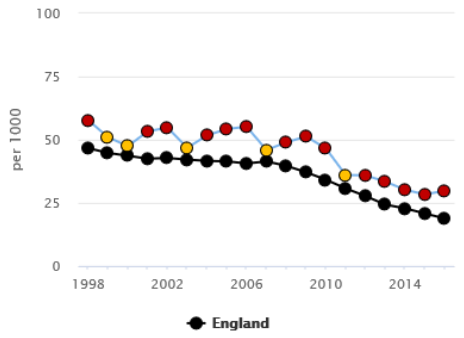


**Figure 19:** Under 18s Conception Rate, Peterborough, 1998 - 2016, *Source: Sexual Health Profiles Public Health England (2018)*

## 10.7 Sexual Health Services

The Integrated Sexual Health Service (ICaSH) in both Cambridgeshire and Peterborough is provided by Cambridgeshire Community Services. Both areas have since 2014 has seen a continuous increase in demand for its services. In Cambridgeshire during the last year this increase has been around 5% above the activity level commissioned in 2014. In Peterborough this increase has been substantially greater at around 25% above the 2014 commissioned levels. These increases in activity are found in both contraception and sexual health services.

In Cambridgeshire the Service is generally meeting its key targets. The historical Department of Health access target for GUM services was for securing access to sexual health treatment within 48 hours or two working days to reduce the risk of onward transmission of infection has consistently been met.

However the activity increase in Peterborough has contributed to a decrease in the percentage of patients being offered and accessing the sexual health services within 48 hours to around 70% on average for both measures. Measures have been taken to address the increase in activity. From October 2018 there were six clinic closures but also additional ongoing funding was secured from Peterborough City Council to address the increase in demand that had created substantial funding issues for the provider. In addition the contractual key performance indicators for the access targets were changed from being a contractual mandatory requirement to a reporting requirement. This will be reviewed regularly.

In Cambridgeshire chlamydia screening is commissioned from GPs for 15-25 year olds. And although numbers are low they have a high positivity rate which is associated with targeted opportunistic screening. Peterborough does not have comparable GP contract and the majority of screening is undertaken by the iCaSH clinic.

Community pharmacies provide Emergency Hormonal Contraception (EHC) and demand for this remains unchanged. Pharmacies who provide EHC are also required to offer access or provide advice on chlamydia screening Pharmacies are located in areas where access to other services is limited and where there are high risk groups are targeted for providing the service. In Cambridgeshire the service performs well and meeting its targets.

The Peterborough EHC Service was re-commissioned in 2017/2018 and a significant amount of work was undertaken to ensure pharmacies received the relevant training. There has been a doubling in six months in the number of pharmacies, with sixteen now providing the service in the high need areas.

### 10.8 Prevention

In both Cambridgeshire and Peterborough the voluntary organisations continue to provide a range of prevention services that range from outreach work with hard to reach/high risk groups, chlamydia screening to working in schools. The iCaSH service in Peterborough also provides an outreach service. Throughout the year a number of campaigns are also undertaken in line with the national programmes.

### 10.9 Cambridgeshire and Peterborough 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 following priorities have been adopted by the Board to address initially.

- Under 18 conceptions in Peterborough and Fenland (has a trend similar to Peterborough).
- Late HIV diagnosis
- 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.

The Public Health England (PHE) lead for Teenage pregnancy led a multi-agency Workshop in 2018 that lead to the identification of priorities for organisations to take forward to address teenage pregnancy in Peterborough and Fenland.

There is a group working to address late HIV diagnosis which includes exploring the demographic characteristics associated with late diagnosis to ensure that interventions are appropriately targeted.

PHE invited sexual and reproductive health commissioners from the Cambridgeshire and Peterborough local authorities, Clinical Commissioning Group and NHS England to be one of two national pilot sites for a sexual health commissioning feasibility study. The aim is for local sexual heath commissioning organisations 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. This has been taken forward during 2018 with work including a multi-agency workshop that identified five priorities for development that are being taken forward. The progress has been reported to PHE Advisory Board.

There have been concerns in Peterborough about the prevention and support for people living with HIV from vulnerable groups. Sex workers and those misusing drugs have raised particular concerns. This has brought together a wide range of agencies to successfully address the particular acute health and social needs of an individual and this group is now working to look at the issues more widely to develop a more strategic approach across organisations.

## 9. Health Emergency Planning

Cambridgeshire County Council and Peterborough City Council are Category 1 responders 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 councils, along with some additional

responsibilities for health emergency preparedness passed with the move of Public Health into local authorities. In the 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.
- Co-chair the Cambridgeshire and Peterborough LHRP with NHS England Locality and represent at Cambridgeshire and Peterborough Local Resilience Forum Strategic Board.
- 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.

LHRPs provide strategic leadership for health organisations in the Local Resilience Forum (LRF) area and are expected to assess local health risks and priorities to ensure preparedness arrangements reflect current and emerging needs. Member agencies share responsibility for oversight of health emergency planning in this forum. It is for the LRF 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, 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. 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 2018-2019. All organisations were either full or partially 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.

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

- PHE Health Protection audit;
- Cyber security;
- CPLRF Pandemic influenza Plan; and
- CPLRF CBRN Plan.

The LRF Pandemic Influenza Plan has been exercised and validated by the CPLRF Executive Board. The CBRN plan has been exercised and is going through the process of validation.

The period from 1 January 2018 to the date of this report has seen a very wide and varied training and exercise programme delivered by the CPLRF. Of significance were three exercises:-

1. Exercise Gallus: The discussion based table top exercise took place on the 24 July 2018 to test the arrangements within Cambridgeshire and Peterborough for Pandemic Influenza. Thirty six attendees from sixteen organisations took part in the exercise.
2. Exercise North Sea: This was a 'walk and talk' followed by 'question and answer' exercise that took place on 26 June 2018. The aim of the exercise was to assess, test and validate the procedures stated in the East Coast Flood plan for the tidal River Nene.
3. Exercise Green Cloud: This was a table top exercise that took place on the 18 and 19 September 2018. The overarching aim of the exercise was to rehearse working in a Tactical Coordinating Group (TCG) and Strategic Coordinating Group (SCG) environment and conduct a review of the recovery phase. The exercise was designed and facilitated by the Cabinet Office Emergency Planning College

The priorities for the year ahead have been agreed as:

- Actions from Health Protection audit;
- Winter Resilience; and
- Cambridgeshire and Peterborough Hospital Evacuation Plan.

# 10. Glossary

| | |
|---|---|
| AAA | Abdominal Aortic Aneurysm |
| AMR | Antimicrobial Resistance |
| AQMAs | Air Quality Management Areas |
| ASR | annual status reports |
| CBRN | Chemical, biological, radiological & nuclear |
| C. difficile | Clostridium difficile |
| CCG | Clinical Commissioning Group |
| CCS | Cambridgeshire Community Services NHS Trust |
| CP HPSG | Cambridgeshire and Peterborough Health Protection Steering Group |
| CPFT | Cambridgeshire and Peterborough NHS Foundation Trust |
| CUHFT | Cambridge University Hospitals NHS Foundation Trust |
| DEFRA | Department for Environment, Food & Rural Affairs |
| DOT | Directly Observed Treatment |
| DPH | Director of Public Health |
| DTaP | Diptheria, tetanus and pertussis (vaccine) |
| EHC | Emergency Hormonal Contraception |
| EPRR | Emergency Preparedness, Resilience and Response |
| ESPAUR | English Surveillance Programme for Antimicrobial Utilisation and Resistance |
| ETS | Enhanced Tuberculosis Surveillance |
| FDC | Fenland District Council |
| FSA | Food Standards Agency |
| GI | gastrointestinal |
| GNBSIs | Gram Negative Bloodstream Infections |
| GP | General Practice |
| HCAI | Healthcare Associated Infections |
| Hep B | Hepatitis B virus |
| HEPRO | Health Emergency Planning and Resilience Officer |
| HHSRS | Housing Health and Safety Rating System |
| Hib | Haemophilus influenzae type B |
| HIV | human immunodeficiency virus |
| HMOs | Houses of Multiple Occupation |
| HPV | Human papillomavirus |
| HSCEPG | Health and Social Care Emergency Planning Group |
| ICaSH | The Integrated Sexual Health Service |
| IPV | Polio (vaccine) |
| JCU | Cambridgeshire and Peterborough Public Health Joint Commissioning Unit |
| KPIs | key performance indicators |
| KTT9 | Key therapeutic topic |
| LA | Local authority |
| LES | Local Enhanced Service |
| LHRP | Local Health Resilience Partnership |
| LRF | Local Resilience Forum |
| LTBI | Latent TB infection |
| LTP | Local Transport Plan |
| MHRA | Medicines and Healthcare Regulatory Agency |
| MMR | Measles, Mumps & Rubella vaccine |
| MOU | Memorandum of Understanding |
| MRSA | methicillin-resistant Staphylococcus aureus |
| NICE | National Institute for Healthcare and Clinical Excellence |
| NOIDs | Notification of Infectious Diseases |
| NWAFT | North West Anglia NHS Foundation Trust |
| PCC | Peterborough City Council |

| | |
|---|---|
| PCV | Pneumococcal vaccine |
| PHE | Public Health England |
| PIR | post infection review |
| PM | particulate matter |
| SCG | Strategic Coordinating Group |
| SSP | Specialist Screening Practitioner |
| STIs | Sexually Transmitted Infections Diagnoses |
| TB | Tuberculosis |
| TCG | Tactical Coordinating Group |
| UTI | urinary tract infection |
| VTEC | Vero cytotoxin-producing |