



Cambridgeshire and Peterborough Annual Health Protection Report 2019

Produced by partner organisations of the Cambridgeshire and Peterborough Health Protection Steering Group on behalf of the Director of Public Health (February 2020)

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1. Introduction

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

The services that fall within Health Protection include:

- The prevention and management of communicable (infectious) diseases;
- routine antenatal, new born, young person and adult screening;
- routine immunisation and vaccination;
- infection control;
- environmental hazards;
- sexual health; and
- health emergency planning.

It is important that there is publicly available information that demonstrates the 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.

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, 2016 – 2019 (Source: Public Health England, East of England Health Protection Team HP Zone)								
	Cambridgeshire				Peterborough			
Notifiable Disease[†]	2016	2017	2018	2019*	2016	2017	2018	2019*
Acute infectious hepatitis	20	39	36	35	14	13	9	11
Acute meningitis	12	10	8	7	<5	<5	<5	<5
Food poisoning (including the organisms below)	226	195	183	181	86	59	67	58
E coli O157 VTEC	<5	<5	<5	6	<5	<5	<5	5
Cryptosporidium	85	90	68	65	19	15	11	9
Giardia	22	23	22	19	20	6	16	18
Salmonella	101	77	88	93	38	35	37	32
Infectious bloody diarrhoea	11	12	12	11	6	<5	<5	<5
Invasive group A streptococcal disease	20	34	25	29	7	14	11	6
Legionnaires' disease	6	<5	9	12	<5	<5	<5	0
Malaria	13	7	7	8	<5	0	<5	<5
Measles**	17 (6)	18 (0)	7 (0)	10 (<5)	<5 (0)	<5 (0)	<5 (0)	<5 (<5)
Meningococcal septicaemia	11	8	8	<5	<5	<5	<5	0
Mumps**	39 (<5)	55 (10)	51 (10)	116 (41)	11 (<5)	10 (<5)	11 (0)	7 (<5)
Rubella**	5 (0)	5 (0)	<5 (0)	<5 (0)	0	<5	0	<5 (0)
Scarlet fever	239	161	252	206	56	92	105	32
Whooping cough	203	157	88	119	49	33	10	14

NB. Figures for 2019 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 in Cambridgeshire and Peterborough, 2019 (Source: Public Health England, East of England Health Protection Team, HP Zone)		
Type of incident	Cambridgeshire	Peterborough
Gastroenteritis in residential settings	27	8
Influenza / influenza-like illness in residential settings	33	<5
Likely foodborne	<5	<5
Other	9	<5

There were a number of outbreaks notified to the Public Health England Health Protection Team which were investigated. In **Cambridgeshire** this included 27 outbreaks of gastroenteritis and 33 outbreaks of Influenza/Influenza-like-illness in residential care home settings. Other outbreaks reported in 2019 include:

- Three outbreaks of scabies in residential care homes
- One outbreak of mumps at an educational institution
- A cluster of MRSA cases in a hospital setting
- Gastroenteritis outbreaks in different settings, including a hospital setting and a custodial institution

Additionally there were a number of health protection incidents in Cambridgeshire;

- Mycobacterium (tuberculosis and non-tuberculosis mycobacterium)
 - Four exposure incidents in healthcare settings
 - Four incidents of people exposed to cats with TB
- Six chemical incidents/environmental exposure incidents
- A cluster of legionella cases
- A cluster of salmonella cases

In **Peterborough** there were 8 outbreaks of gastroenteritis and 2 outbreaks of Influenza/Influenza-like-illness in residential care home settings. Other outbreaks reported in 2019 include:

- An outbreak of confirmed norovirus in the community
- One outbreak of gastroenteritis in a custodial institution
- One outbreak of MRSA in a hospital
- One outbreak of scabies in a care home

Additionally there were a number of health protection incidents in Peterborough;

- Several exposures to mycobacterium (tuberculosis and non-tuberculosis mycobacterium), Hepatitis A and Hepatitis B
- A community cluster of E.coli O157 cases

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. This will be achieved by focusing on and implementing the ten evidence-based areas for action detailed in the strategy. These are:

1. Improve access to services and ensure early diagnosis
2. Provide universal access to high quality diagnostics
3. Improve treatment and care services
4. Ensure comprehensive contact tracing
5. Improve BCG vaccination uptake
6. Reduce drug-resistant TB
7. Tackle TB in under-served populations
8. Systematically implement new entrant latent TB screening
9. Strengthen surveillance and monitoring
10. Ensure an appropriate workforce to deliver TB control

A detailed Tuberculosis Health Needs Assessment is currently being conducted through a multi-agency partnership led by the local Public Health team and including TB services, PHE, and representatives from Council Housing and Adult Social Services. Further data analysis and specific recommendations for TB services will be included in the work which is scheduled for completion in the summer of 2020.

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 2018, (2019 is provisional).

From 2016 - 2019 the incidence rate of TB Cambridgeshire & Peterborough has exceeded the England rate, the provisional data for 2019 indicates a total of 92 cases with a crude rate of 10.8 per 100,000 (95% CI 8.7-13.2), higher than the East of England rate of 6.5 per 100,000. In 2019 the Cambridgeshire the provisional count of 52 cases gives a crude rate of 8.0 per 100,000 (95% CI 6.0-10.5), whilst in Peterborough there were provisionally 40 cases with a crude rate of 20.0 per 100,000 (95% CI 14.2-27.1).

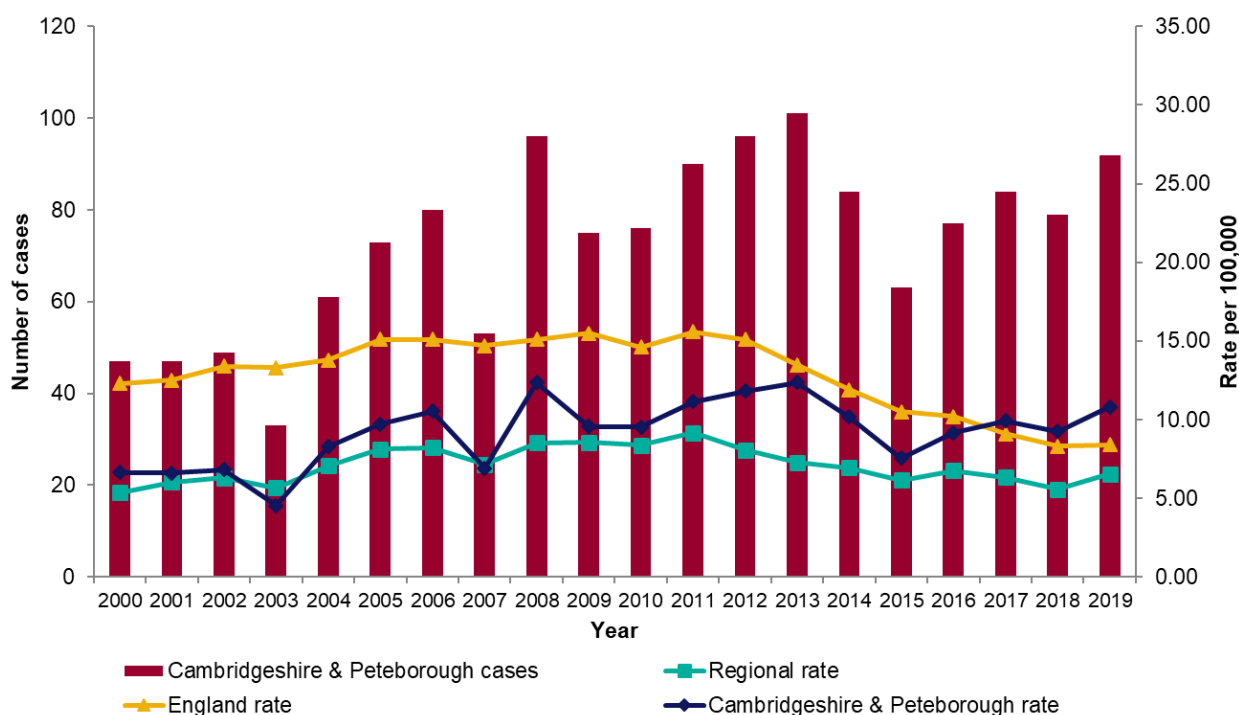


Figure 1: Annual incidence of TB per 100,000 population – provisional data (Source: PHE Field Epidemiology Service)

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

- 2018 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.

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

Several 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 (phlebotomy).

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 is continuing to run across Cambridgeshire and Peterborough. from 1 April 2018, 18 practices have signed up to deliver (17 Greater Peterborough Practices and one practice 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's TB Project Manager supports the delivery of the action plan and to carry out the face to face work with the public and community organisations. The focus of the action plan is to identify and target eligible people through community groups, educational settings, and workplace settings.

3.3.2.4 Activity

Result	Number of screens
Negative	494
Positives	93
Borderline negative	13
Borderline positive	11
Indeterminate	6
Non reportable insufficient cells	4
Technical error	3
Assay not run	5
Total screened	629

Oxford Immunotec continue to report the activity on a monthly basis and we also have confirmation of numbers via the LES reporting and NWAFT.

3.3.2.5 Next Steps

The total number of people screened for TB to date (December 2019) is 629, however, there are potentially many more eligible people that are entitled to be screened. The CCG acknowledges that there continues to be a reduction of activity due to exhaustion of eligible patient lists. This will be addressed by targeting those specific practices with higher numbers of registered eligible patients through Flag4 data. The CCG 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.

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 immunisation 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 an infection to spread because there are so few susceptible people left to infect. This can effectively stop the spread of infection 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 quarterly as a collaboration between Public Health, Child Health, the NHS England Screening and Immunisations team and the CCG working with GP practices.

In 2019 the forum has considered the school aged immunisation service offering to check and offering to vaccinate children in Reception year that have an incomplete record. The service will now also offer MMR vaccination to those school age adolescents who are partially or wholly unvaccinated.

Due to lower uptake rates of the shingles vaccination in Peterborough, a Shingles project was launched in October 2018, and ran until September 2019. Engagement of GP practices was not as good as hoped but learning from other areas reinforces that a combination of training and active call in the shape of a Birthday card, was found to have a positive effect on uptake. Further work is planned on shingles from January 2020.

Childhood Primary Vaccinations

4.1.1 6-in-1 Vaccine (12 months)

TABLE 3: Uptake rates for 6-in-1 vaccine at 12 months (diphtheria, tetanus, pertussis, polio, haemophilus influenza B, hepatitis B – target 95%), Cambridgeshire and Peterborough, 2017/18 to 2018/19, <i>Source: Cover, Public Health England</i>				
12 months DTaP/IPV/Hib/Hep B [target 95%]	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 of England	94.6	95.3	94.6	94.5
	Q1 2018/19 %	Q2 2018/19 %	Q3 2018/19 %	Q4 2018/19 %
Cambridgeshire	94.2	93.2	93.1	94.2
Peterborough	92.1	91.3	91.0	92.0
East of England	93.2	92.4	92.1	92.2

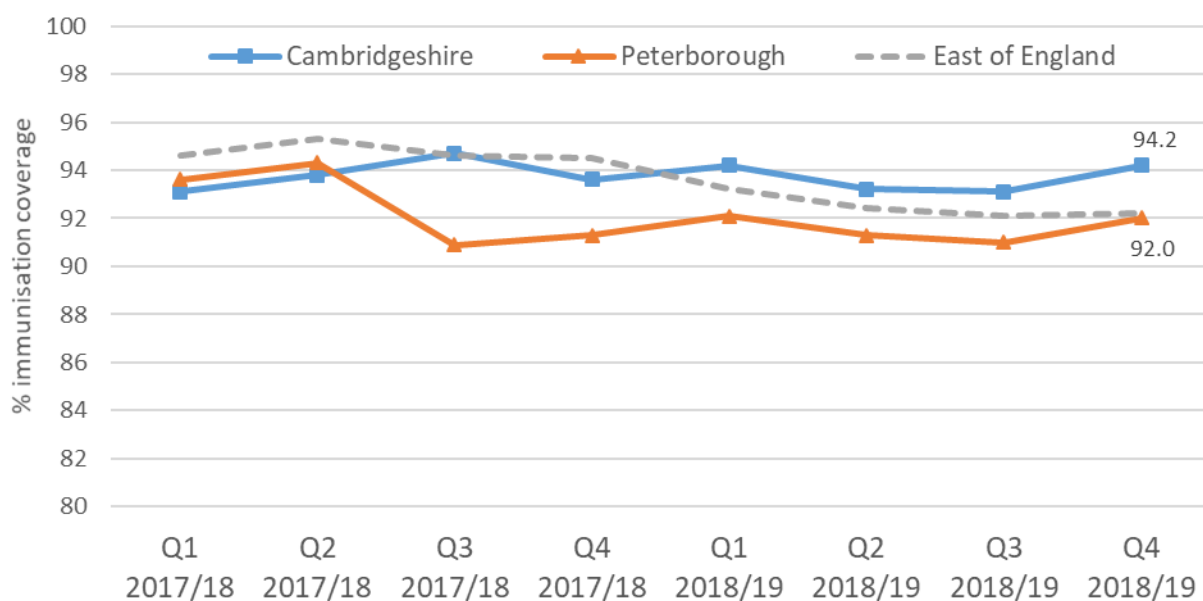


Figure 2: Uptake rates for 6-in-1 vaccine at 12 months (diphtheria, tetanus, pertussis, polio, haemophilus influenza B, hepatitis B – target 95%), Cambridgeshire, Peterborough and East of England, 2017/18 to 2018/19, *Source: Cover, Public Health England*

4.1.2 Pneumococcal Vaccine (12 months)

TABLE 4: Uptake rates for pneumococcal (PCV) vaccine at 12 months (target 95%), Cambridgeshire and Peterborough, 2017/18 to 2018/19, <i>Source: Cover, Public Health England</i>				
12 months PCV%	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 of England	94.9	95.5	94.9	95.0
	Q1 2018/19 %	Q2 2018/19 %	Q3 2018/19 %	Q4 2018/19 %
Cambridgeshire	94.7	93.9	94.3	95.0
Peterborough	92.1	91.5	91.3	92.4
East of England	93.8	93.3	93.2	93.2

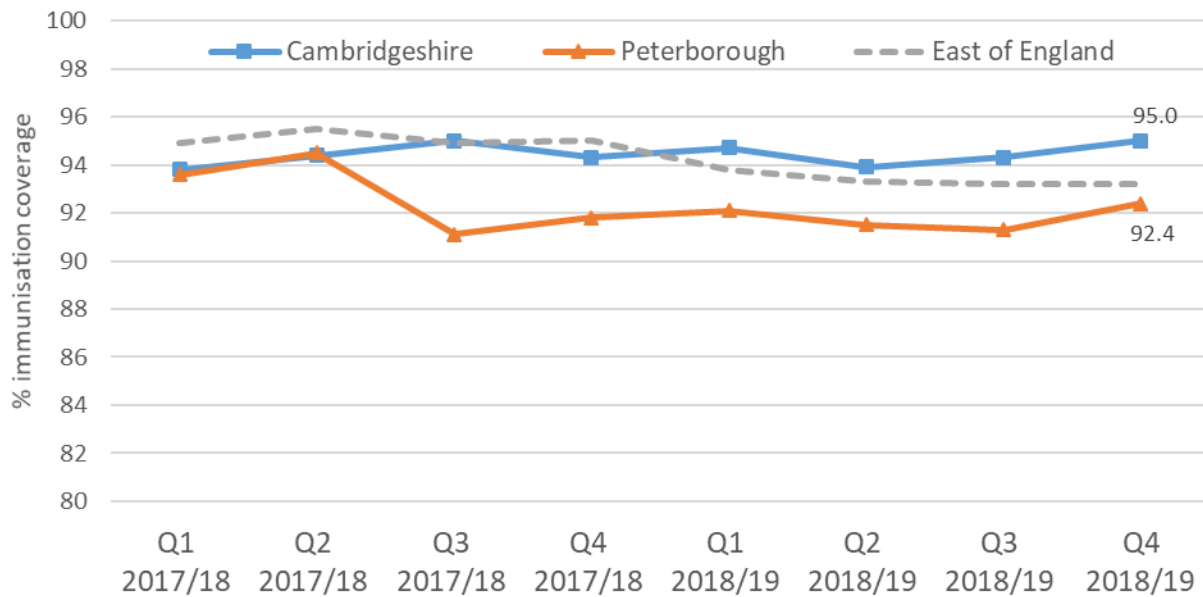


Figure 3: Uptake rates for pneumococcal vaccine at 12 months (target 95%), Cambridgeshire, Peterborough and East of England, 2017/18 to 2018/19, *Source: Cover, Public Health England*

4.1.3 5-in-1 Vaccine (24 months)

TABLE 5: Uptake rates for 5-in-1 vaccine at 24 months (diphtheria, tetanus, pertussis, polio, haemophilus influenza B – target 95%), Cambridgeshire and Peterborough, 2017/18 to 2018/19, <i>Source: Cover, Public Health England</i>				
24 months DTaP/IPV/Hib %	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 of England	96.3	96.3	95.9	96.3
	Q1 2018/19 %	Q2 2018/19 %	Q3 2018/19 %	Q4 2018/19 %
Cambridgeshire	96.2	94.9	94.7	94.7
Peterborough	94.0	93.6	92.4	92.6
East of England	95.3	95.0	94.8	94.6

4.1.4 Pneumococcal Vaccine (24 months)

TABLE 6: Uptake rates for pneumococcal vaccine at 24 months (target 95%), Cambridgeshire and Peterborough, 2017/18 to 2018/19, Source: Cover, Public Health England

24 months PCV%	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 of England	94.0	94.0	92.8	92.9
	Q1 2018/19 %	Q2 2018/19 %	Q3 2018/19 %	Q4 2018/19 %
Cambridgeshire	92.3	91.7	91.3	92.4
Peterborough	88.5	88.8	86.6	87.5
East of England	92.1	92.0	91.0	91.4

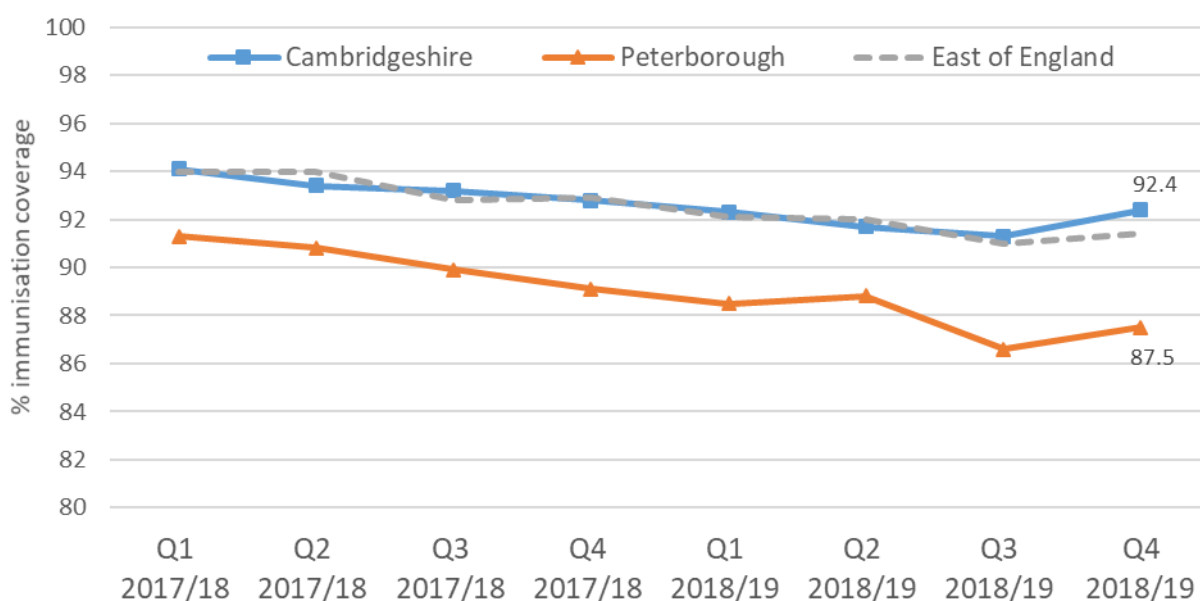


Figure 4: Uptake rates for pneumococcal vaccine at 24 months (target 95%), Cambridgeshire, Peterborough and East of England, 2017/18 to 2018/19, Source: Cover, Public Health England

4.1.5 Haemophilus influenza B and meningococcus C (24 months)

TABLE 7: Uptake rates for haemophilus influenza B and meningococcus C vaccine at 24 months (target 95%), Cambridgeshire and Peterborough, 2017/18 to 2018/19, Source: Cover, Public Health England

24m Hib/MenC%	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 of England	94.0	93.9	92.5	92.8
	Q1 2018/19 %	Q2 2018/19 %	Q3 2018/19 %	Q4 2018/19 %
Cambridgeshire	92.3	91.6	91.4	92.5
Peterborough	88.5	88.4	86.8	87.4
East of England	92.3	92.2	91.3	91.7

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

TABLE 8: Uptake rates for measles, mumps and rubella (MMR) vaccine at 24 months (target 95%), Cambridgeshire and Peterborough, 2017/18 to 2018/19, *Source: Cover, Public Health England*

24 months MMR1%	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 of England	93.7	93.7	92.6	92.5
	Q1 2018/19 %	Q2 2018/19 %	Q3 2018/19 %	Q4 2018/19 %
Cambridgeshire	91.8	91.1	90.9	92.5
Peterborough	88.7	88.0	85.9	86.9
East of England	91.7	91.5	90.6	91.3

4.1.7 5-in-1 Vaccine (24 months)

TABLE 9: Uptake rates for 5-in-1 vaccine at 24 months (diphtheria, tetanus, pertussis, polio, haemophilus influenza B – target 95%), Cambridgeshire and Peterborough, 2017/18 to 2018/19, *Source: Cover, Public Health England 24m*

24 months DTaP/IPV/Hib3 %	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 of England	96.1	96.1	96.6	96.8
	Q1 2018/19 %	Q2 2018/19 %	Q3 2018/19 %	Q4 2018/19 %
Cambridgeshire	96.2	94.9	94.7	94.7
Peterborough	94.0	93.6	92.4	92.6
East of England	95.3	95.0	94.8	94.6

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

TABLE 10: Uptake rates for measles, mumps and rubella (MMR) vaccine – first dose at 5 years (target 95%), Cambridgeshire and Peterborough, 2017/18 to 2018/19, *Source: Cover, Public Health England*

5 years MMR1%	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 of England	95.6	95.6	95.8	96.4
	Q1 2018/19 %	Q2 2018/19 %	Q3 2018/19 %	Q4 2018/19 %
Cambridgeshire	95.9	94.0	96.1	95.8
Peterborough	95.9	94.6	93.1	93.3
East of England	95.9	95.4	95.8	95.8

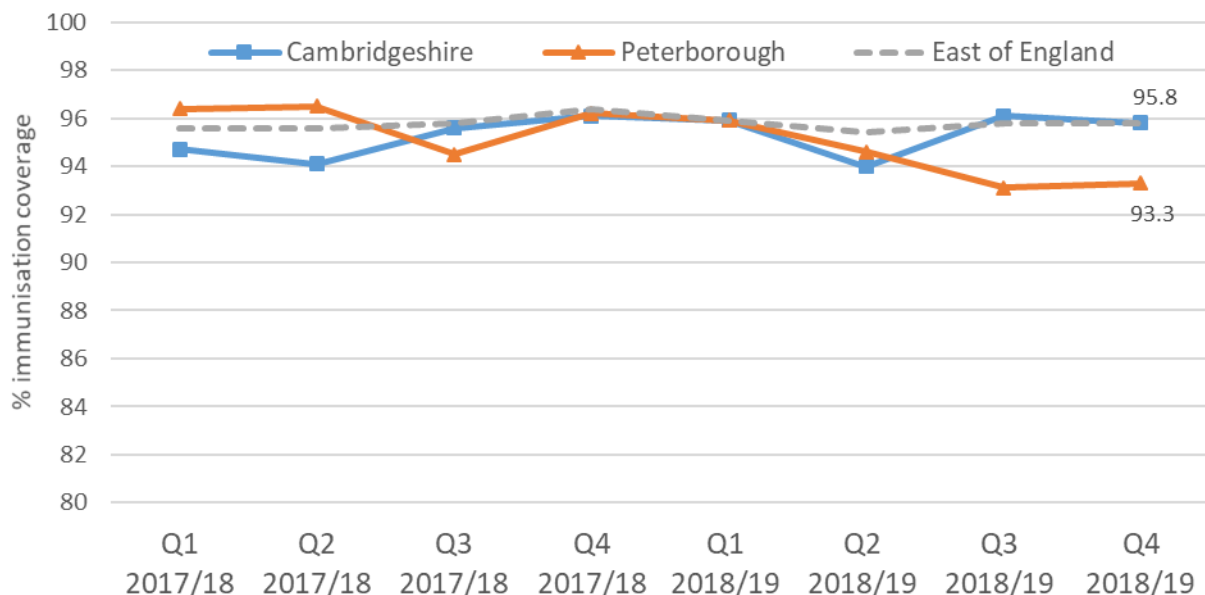


Figure 5: Uptake rates for MMR vaccine – first dose at 5 years (target 95%), Cambridgeshire, Peterborough and East of England, 2017/18 to 2018/19, Source: Cover, Public Health England

TABLE 11: Uptake rates for measles, mumps and rubella (MMR) vaccine – second dose at 5 years (target 95%), Cambridgeshire and Peterborough, 2017/18 to 2018/19, Source: Cover, Public Health England

5 years MMR2%	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 of England	89.3	90.0	89.9	90.7
	Q1 2018/19 %	Q2 2018/19 %	Q3 2018/19 %	Q4 2018/19 %
Cambridgeshire	89.7	87.2	88.2	88.0
Peterborough	86.3	85.0	83.4	84.1
East of England	88.6	88.0	88.7	89.1

Source: Cover, Public Health England

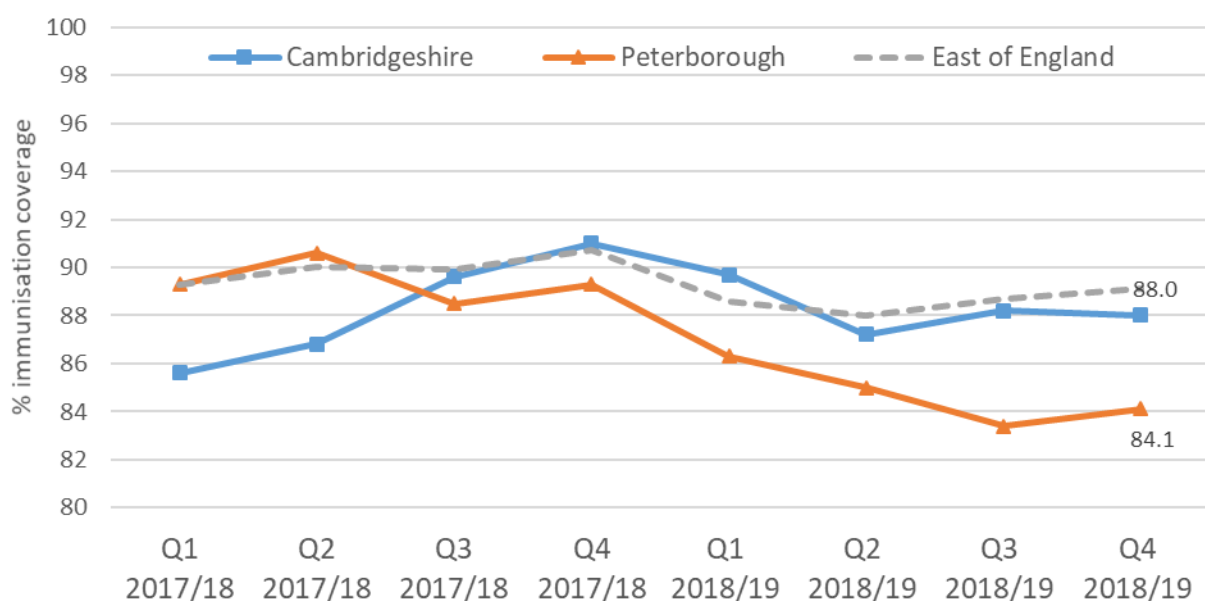


Figure 6: Uptake rates for MMR vaccine – second dose at 5 years (target 95%), Cambridgeshire, Peterborough and East of England, 2017/18 to 2018/19, Source: Cover, Public Health England

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

TABLE 12: Uptake rates for 4-in-1 preschool booster at 5 years (diphtheria, tetanus, pertussis, polio - target 95%), Cambridgeshire and Peterborough, 2017/18 to 2018/19, Source: Cover, Public Health England

5 years DTaPIPv%	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 of England	88.3	88.7	88.7	89.2
	Q1 2018/19 %	Q2 2018/19 %	Q3 2018/19 %	Q4 2018/19 %
Cambridgeshire	86.5	86.1	86.3	86.8
Peterborough	82.1	82.9	81.6	82.2
East of England	86.9	86.9	87.6	88.2

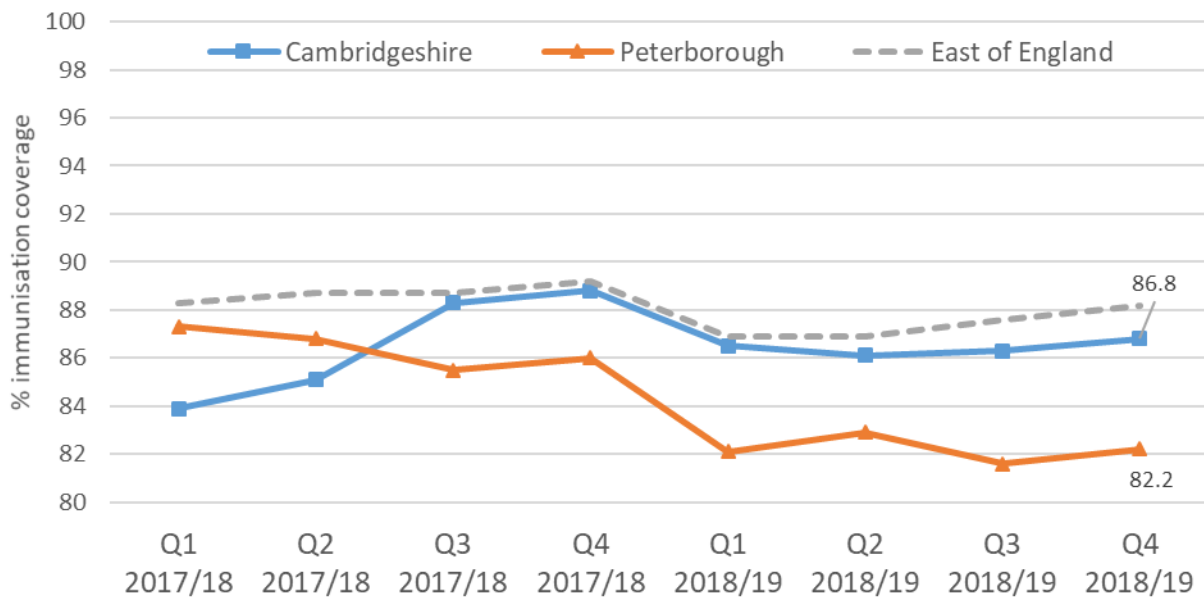


Figure 7: Uptake rates for 4-in-1 pre-school booster at 5 years (target 95%), Cambridgeshire, Peterborough and East of England, 2017/18 to 2018/19, Source: Cover, Public Health England

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

TABLE 13: Uptake rates for haemophilus influenza B and meningococcus C vaccine at 5 years (target 95%), Cambridgeshire and Peterborough, 2017/18 to 2018/19, Source: Cover, Public Health England

5 years Hib/MenC%	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 of England	92.5	92.8	92.7	93.3
	Q1 2018/19 %	Q2 2018/19 %	Q3 2018/19 %	Q4 2018/19 %
Cambridgeshire	91.6	89.8	92.1	92.3
Peterborough	92.1	90.0	88.8	90.0
East of England	93.9	93.5	93.7	94.0

4.1.10 Meningococcus B (12 and 24 months)

TABLE 14: Uptake rates for meningococcus B vaccine at 12 months (target 95%), Cambridgeshire and Peterborough, 2017/18 to 2018/19, *Source: Cover, Public Health England*

12 months MenB%	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 of England	94.3	95.1	94.4	94.6
	Q1 2018/19 %	Q2 2018/19 %	Q3 2018/19 %	Q4 2018/19 %
Cambridgeshire	94.3	93.6	93.7	94.5
Peterborough	91.8	91.2	91.5	91.7
East of England	93.4	93.1	92.9	92.9

TABLE 15: Uptake rates for meningococcus B booster at 24 months (target 95%), by local authority, 2018/19

	Cambridgeshire	Peterborough	East of England
24 months Men B%	90.1	85.5	89.4

Source: NHS Digital

4.1.11 Rotavirus Vaccination

TABLE 16: Rotavirus vaccination – 2 doses at 12 months (target 95%), Cambridgeshire & Peterborough, monthly uptake January 2018 to December 2019, *Source: ImmForm*

	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	92.6
Peterborough	84.7	92.2	85.7	86.5	90.2	89.2	89.4	86.6	83.9	89.3	89.5	85.2
East Anglia	90.4	89.8	90.5	91.3	92.0	91.0	91.8	92.7	90.4	91.3	91.5	92.5
	Jan 2019	Feb 2019	March 2019	April 2019	May 2019	June 2019	July 2019	Aug 2019	Sept 2019	Oct 2019	Nov 2019	Dec 2019
Cambridgeshire	89.6	92.6	90.6	92.9	90.4	92.2	93.7	93.5	95.1	93.3	92.3	NA
Peterborough	92.0	85.9	89.5	89.0	89.8	87.7	88.6	87.8	87.1	87.1	87.9	NA
East Anglia	90.9	91.7	91.3	91.5	92.1	92.8	92.7	92.5	92.2	92.4	91.8	NA

TABLE 17: Rotavirus vaccination – 2 doses at 12 months (target 95%), Cambridgeshire & Peterborough by local authority, 2018/19

	Cambridgeshire	Peterborough	East of England
Men B at 24 months (%)	91.7	88.6	89.7

4.1.13 Meningococcus ACWY (14 years)

TABLE 18: Uptake rates for meningococcus ACWY vaccine 2018-19, Cambridgeshire and Peterborough, <i>Source: ImmForm</i>	
Area	Vaccine uptake %
Cambridgeshire and Peterborough CCG	77.5
East Anglia Total	78.3

4.1.14 HPV Vaccine (Year 8 & Year 9)

TABLE 19: Uptake rates for HPV vaccine, by local authority and cohort, September 2018/19, <i>Source: Public Health England</i>				
Local Authority		Cambridgeshire	Peterborough	England
Cohort 16: 12-13 Year Olds	Number of females in Cohort 16 (Year 9)	3,239	1,345	313,942
	No. vaccinated with HPV Vaccine at least one dose by 31/08/2018	2,890	1,126	276,296
	% Coverage	89.2	83.7	88.0
Cohort 15: 13-14 Year Olds (Year 9 Birth Cohort: 1 September 2004 - 31 August 2005)	Number of females in Cohort 15 (Year 9)	3,301	1,293	308,378
	No. vaccinated with HPV Vaccine at least one dose by 31/08/2018	3,050	1,142	274,087
	% Coverage	92.4	88.3	88.9
	No. vaccinated with two doses by 31/08/2018	2,876	1,079	258,785
	% Coverage	87.1	83.4	83.9

4.1.15 School Immunisation Service

TABLE 20: School immunization service vaccinations, Cambridgeshire & Peterborough, end of school year 2018/19, <i>Source: CCS</i>			
	Target	Cambridgeshire %	Peterborough %
Girls HPV vaccination by end of school year nine dose 2	90%	85%	85%
Cohort 6 (13-14) Sept 2004 -August 2005 Td/IPV by end of school year 9	80%	88%	92%
Cohort 5(14-15) Sept 2004–August 2005 Td/IPV by end of school year 10	80%	86%	80%
Cohort 6 (13-14) Sept 2004 -August 2005 Men ACWY by end of school year 9.	80%	87%	81%
Childhood Flu vaccination school years R 1 2 3 4 & 5	60%	60%	38%
Schools participating in the programme		341	90

4.2 Seasonal Flu Vaccination

TABLE 21: Flu vaccination uptake by key groups - adults, Cambridgeshire and Peterborough, 2017/18 to 2018/19

Source: ImmForm

Area	Summary of flu vaccine uptake %					
	65 and over		Under 65 (at risk)		Pregnant women	
	2017/18	2018/19	2017/18	2018/19	2017/18	2018/19
Cambridgeshire	74.4	73.8	49.8	47.6	49.1	45.8
Peterborough	71.3	69.8	47.3	44.3	38.4	35.4
Cambridgeshire & Peterborough CCG	73.9	73.0	49.3	46.8	46.7	43.7
East Anglia	72.6	71.1	48.9	46.2	47.2	44.1

TABLE 22: Flu vaccination uptake – pre-school children, Cambridgeshire and Peterborough, 2017/18 to 2018/19,

Source: ImmForm

Area	Summary of flu vaccine uptake %			
	All aged 2		All aged 3	
	2017/18	2018/19	2017/18	2018/19
Cambridgeshire LA	45.5	55.4	47.1	57.3
Peterborough LA	25.5	40.3	30.0	42.6
Cambridgeshire & Peterborough CCG	40.5	51.6	42.7	53.2
East Anglia	42.8	51.4	44.2	52.3

TABLE 23: Flu vaccination uptake – healthcare workers, by NHS trust, 2017/18 to 2018/19, Source: ImmForm

Area	No of HCW's with Direct Patient Care	Seasonal Flu doses since 1 September 2018-Feb 2019		% Seasonal Flu doses given since 1 September 2017-Feb 2018
		No	%	%
Papworth Hospital NHS Foundation Trust	1469	1225	83.4	78.1
Cambridge University Hospitals NHS Foundation Trust	7908	5992	75.8	84.3
North West Anglia Foundation Trust	6082	4345	71.4	68.4
Cambridgeshire and Peterborough NHS Foundation Trust	2982	2296	77.0	66.5
Cambridgeshire Community Services NHS Trust	1677	1102	65.7	62.4
East Anglia Total	77229	50721	65.7	65.6

4.3 Prenatal Pertussis Vaccination

TABLE 24: Prenatal pertussis vaccination, Cambridgeshire & Peterborough, monthly uptake April 2017 to November 2019
Source: ImmForm

	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
	Apr 2018 %	May 2018 %	Jun 2018 %	Jul 2018 %
Cambridgeshire & Peterborough CCG	74.5	71.5	67.9	69.4
East Anglia Total	72.5	69.6	68.5	69.6
	Aug 2018 %	Sept 2018 %	Oct 2018 %	Nov 2018 %
Cambridgeshire & Peterborough CCG	65.4	68.1	71.4	69.2
East Anglia Total	66.9	68.8	70.1	71.3
	Dec 2018 %	Jan 2019 %	Feb 2019 %	March 2019 %
Cambridgeshire & Peterborough CCG	75.1	72.4	73.2	68.8
East Anglia Total	73.4	71.7	72.7	70.2
	Apr 2019 %	May 2019 %	Jun 2019 %	Jul 2019 %
Cambridgeshire & Peterborough CCG	68.0	67.2	65.2	65.0
East Anglia Total	69.8	69.7	68.9	68.5
	Aug 2019 %	Sept 2019 %	Oct 2019 %	Nov 2019 %
Cambridgeshire & Peterborough CCG	70.8	72.4	69.6	
East Anglia Total	68.7	69.8	70.3	

TABLE 25: Prenatal pertussis vaccination, Cambridgeshire & Peterborough, Annual Data 1.4.2018 to 31.3.2019 %
Source: ImmForm

Cambridgeshire & Peterborough CCG	68.1
East Anglia	70.6

4.4 Shingles Vaccination

TABLE 26: Shingles vaccination – aged 70 & 78, Cambridgeshire & Peterborough, Quarter 2 Uptake (Jul-Sep 2019)
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	8642	1403	16.2	5456	929	17.0
East Anglia Total	68412	13463	19.7	43269	8460	19.6

4.5 Immunisation Summary

Some childhood vaccinations are lower than the recommended 95% target, specifically, Rotavirus: NHS England Screening and Immunisation Team (SIT) are working with stakeholders to investigate the reasons for lower uptake. There is evidence both locally, regionally and nationally, that Rotavirus vaccinations are falling with no regions achieving the 95% target. There is only limited opportunity for vaccination catch up on this programme as it cannot be given beyond 6 months of age.

The 12 month vaccinations of Hib/Men C, Men B, MMR and PCV are lower in Peterborough than Cambridgeshire, and the recommended 95%. One possible explanation is that children attend late for their appointments, as the uptakes have improved by the age of 5 years. The SIT will continue to work with poor performing practices to encourage parents to attend their appointments on time.

The 5 year pre-school booster, DT/aP/IPV and MMR dose 2, remains low in Peterborough and Cambridgeshire. The NHS England Regional SIT continue to work with the Local authority and key stakeholders and GP practices to increase awareness and improve uptakes. Waiting lists have continued to improve. The school immunisations team will check vaccination history in reception and offer catch up of missing vaccines.

The universal programme for HPV has been introduced from September 2019 to all eligible children in school year 8.

Flu vaccination uptake overall are slightly lower than last year, for under 65yrs at risk, over 65 yrs and pregnant women. One specific issue this year was the supply of the Fluad and QIV vaccine, and the phased delivery of Fluad vaccine. This led to practices having to re arrange clinics and having to wait for supplies to be delivered, this seemed to have an impact on all their clinics for the 2018/19 season. School age children's flu vaccine in Peterborough is lower than last year; one issue is the families who decline Fluenz nasal spray due to the porcine gelatine in the vaccine. Pre-school children uptakes of flu vaccine improved this year, one additional strategy this year included sending a reminder letter from Child Health Departments to parents of eligible pre-school age children.

The UK lost its measles free status in 2019. The measles elimination strategy explains the UK's strategy towards measles and rubella elimination:

<https://www.gov.uk/government/publications/measles-and-rubella-elimination-uk-strategy>

The strategy focuses on 4 core components required to maintain elimination of measles and rubella:

1. Achieve and sustain $\geq 95\%$ coverage in the routine childhood programme.
2. Achieve $\geq 95\%$ coverage with 2 doses of MMR vaccine in older age cohorts through opportunistic and targeted catch-up.
3. Strengthen measles and rubella surveillance.
4. Ensure easy access to high-quality, evidence-based information

In Cambridge and Peterborough, the Screening and Immunisation team are working in collaboration with the local authority, CCGs and Healthy child programme to improve vaccination uptake by:

- Increasing vaccination opportunity with school immunisation teams offering catch up to Reception year children and children in Year 10.
- By improving the data flow and collection between GP practices and child health departments.
- There is a national project investigating the accuracy of reporting of the MMR vaccination in primary care.

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 (ANNB)

Q1 sees the introduction of some new Key Performance Indicators for the ANNB screening programmes. A coverage KPI is added for the fetal anomaly programme FA3 and the sickle cell and thalassaemia programme has the addition of ST4 monitoring offer of prenatal diagnosis to those at risk.

FA3 was introduced as a coverage KPI for Downs, Edwards and Patau's from Q1 2018. There is no intention to publish this KPI by individual maternity service and thus it is not included in this report. Thresholds are not set for this KPI; performance between providers should not be compared. FASP supports informed choice for women.

5.1.2 Antenatal and Newborn Screening Key Performance Indicators

TABLE 27: Percentage Uptake, Antenatal infectious disease screening KPIs, by provider, 2017/18 – 2018/19											
<i>Source: maternity services</i>											
2017-2018								2018-2019			
Indicator	Accpt.	Ach.	Provider	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ID1 Antenatal HIV test coverage	≥95%	≥ 99%	CUH	97.4	99.0	98.2	99.0	99.6	99.4	99.1	99.9
	≥95%	≥ 99%	HHT	99.7	99.6	99.1	99.0	99.0	99.0	99.8	99.8
	≥95%	≥ 99%	PCH	99.4	98.9	99.0	99.6	99.8	99.4	99.9	99.9
ID2 Hep B timely referral for women found to be Hepatitis B	≥70%	≥ 90%	CUH	No Cases	100	100	100	100	100	100	83.3
	≥70%	≥ 90%	HHT	No Cases	100	100	No Cases	No Cases	No Cases	No Cases	No Cases
	≥70%	≥ 90%	PCH	No Data	100	0.0	80.0	No Cases	100	33.3	100
ID3 Hep B Coverage	≥95%	≥ 99%	CUH	n/a	n/a	n/a	n/a	99.6	99.4	99.1	99.9
	≥95%	≥ 99%	HHT	n/a	n/a	n/a	n/a	99.0	99.0	100	99.8
	≥95%	≥ 99%	PCH	n/a	n/a	n/a	n/a	99.8	99.4	99.8	99.9
ID4 Syphilis Coverage	≥95%	≥ 99%	CUH	n/a	n/a	n/a	n/a	99.6	99.4	99.1	99.9
	≥95%	≥ 99%	HHT	n/a	n/a	n/a	n/a	99.8	99.4	99.9	99.9
	≥95%	≥ 99%	PCH	n/a	n/a	n/a	n/a	99.0	99.0	100	99.8

TABLE 28: Percentage Uptake Fetal anomaly screening KPIs, by provider, 2018/19, Source: maternity services							
				2018-2019			
FA1: Completion of laboratory request forms	Accpt.	Ach.	Provider	Q1	Q2	Q3	Q4
	≥97%	≥100%	CUH	99.8	99.1	99.7	97.8
	≥97%	≥100%	HHT	99.4	99.8	100	99.5
	≥97%	≥100%	PCT	99.3	99.2	99.6	99.6
FA2: Fetal anomaly screening fetal anomaly ultrasound) – coverage *	Accpt.	Ach.	Provider	Q1	Q2	Q3	Q4
	≥90%	≥95%	CUH	99.8	99.9	99.8	99.8
	≥90%	≥95%	HHT	99.8	99.6	99.4	99.4
	≥90%	≥95%	PCT	99.0	98.3	99.4	99.7

TABLE 29: Antenatal sickle cell and thalassaemia KPIs, by provider, 2017/18 - 2018/19, Source: maternity services											
				2017-2018				2018-2019			
Indicator	Standard	Achievable	Provider	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ST1 Antenatal sickle cell and thalassaemia screening – coverage	≥95%	≥99%	CUH	96.4	97.6	96.3	98.2	99.2	98.9	98.9	99.5
	≥95%	≥99%	HHT	100	98.8	98.4	98.7	98.8	99.0	100	99.3
	≥95%	≥99%	PCT	97.1	97.4	99.6	98.9	99.4	98.5	99.5	99.6
ST2 Antenatal sickle cell and thalassaemia screening Timeliness of Test	≥50%	≥75%	CUH	57.9	55.7	54.9	54.6	56.0	54.5	57.0	56.4
	≥50%	≥75%	HHT	48.5	50.8	53.1	54.0	60.2	58.2	57.4	60.5
	≥50%	≥75%	PCT	63.8	59.5	58.2	56.9	64.0	67.9	67.6	67.8
ST3 Antenatal sickle cell and thalassaemia completion of FOQ	≥95%	≥99%	CUH	99.2	98.3	97.4	98.0	97.2	97.9	95.6	98.1
	≥95%	≥99%	HHT	98.3	96.4	96.1	97.5	98.1	98.8	98.2	98.5
	≥95%	≥99%	PCT	99.4	98.1	98.0	97.7	96.0	97.6	95.8	97.6
ST4a Antenatal sickle cell and thalassaemia screening - timely offer of prenatal diagnosis (PND) to women at risk of having an affected infant	To be set	To be set	CUH	n/a	n/a	n/a	n/a	50.0	0.0	100	100
	To be set	To be set	HHT	n/a	n/a	n/a	n/a	No cases	No cases	0.0	0.0
	To be set	To be set	PCT	n/a	n/a	n/a	n/a	No cases	100	0.0	0.0
ST4b Antenatal sickle cell and thalassaemia screening - timely offer of prenatal diagnosis (PND) to couples at risk of having an affected infant	To be set	To be set	CUH	n/a	n/a	n/a	n/a	No cases	No cases	No cases	100
	To be set	To be set	HHT	n/a	n/a	n/a	n/a	No cases	No cases	No cases	0.0
	To be set	To be set	PCT	n/a	n/a	n/a	n/a	50.0	0.0	100	No cases

TABLE 30: Newborn blood spot screening KPIs, by provider, 2017/18 – 2018/19, Source: maternity services

Indicator	Standard	Achievable	Provider	2017-18				2018-19			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
NB1 Newborn blood spot screening coverage	≥95%	≥99.9%	Cambs.	95.5	98.5	99.3	94.5	99.3	99.4	99.2	99.4
	≥95%	≥99.9%	Hunts.	n/a	n/a	98.1	92.6	98.3	99.4	98.1	95.9
	≥95%	≥99.9%	Peterborough	98.8	99.5	99.7	93.9	99.2	99.4	99.8	99.5
NB2 Newborn blood spot screening avoidable repeats	≥2%	≥0.5%	CUH	2.5	1.1	2.3	1.7	1.6	1.2	1.9	1.6
	≥2%	≥0.5%	HHT	3.1	3.0	1.4	2.5	1.9	2.8	2.3	3.0
	≥2%	≥0.5%	PCT	1.9	1.8	0.9	1.8	1.6	0.4	1.1	1.1
NB4 Newborn blood spot screening coverage- movers in	≥95%	≥99.9%	Cambs.	90.2	91.2	76.1	76.3	95.2	82.1	90.7	94.4
	≥95%	≥99.9%	Hunts.	n/a	n/a	91.8	95.6	95.7	94.9	100	95.7
	≥95%	≥99.9%	Peterborough	85.4	92.6	91.5	89.3	89.1	91.4	100	98.0

				2017-18				2018-19			
Indicator	Accpt.	Ach.	Provider	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
NH1 Newborn hearing screening coverage	≥97%	≥99.5%	CUH	98.7	99.8	99.2	99.2	99.2	99.4	99.0	99.7
	≥97%	≥99.5%	HHT	99.6	99.7	99.6	99.7	99.7	99.7	99.4	99.8
	≥97%	≥99.5%	PCT	99.9	99.8	99.9	99.9	99.8	99.9	100	100
NH2 Newborn hearing screening timely referral for assessment	≥90%	≥95%	CUH	90.0	93.8	100	89.5	100	84.2	87.5	77.3
	≥90%	≥95%	HHT	100	50.0	44.4	100	77.8	66.7	100	100
	≥90%	≥95%	PCT	100.	76.9	85.7	100	100	100	100	100

				2017-18				2018-19			
Indicator	Accpt.	Ach.	Provider	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
NP1 Newborn and Infant Physical Examination-coverage newborn	≥95%	≥99.5%	CUH	95.3	94.0	95.5	93.9	96.2	95.4	96.4	96.1
	≥95%	≥99.5%	HHT	97.2	94.8	94.5	94.1	95.0	97.3	96.4	96.0
	≥95%	≥99.5%	PCT	96.8	97.2	96.1	97.1	97.2	96.7	98.3	97.3
NP2 Newborn and Infant Physical Examination timely assessment	≥95%	≥100%	CUH	75.0	100	0.0	77.8	100	100	100	100
	≥95%	≥100%	HHT	100	100	75	0.0	33.3	No cases	100	100
	>95%	100%	PCT	100.	100	80.	No cases	50	100	100	No cases

5.1.3 Antenatal and Newborn Screening Programme Updates

The Cambridge programme board and the North West Anglia Programme board meet quarterly to review Key Performance Indicators (KPIs), standards and performance. The boards are well attended with representatives from each of the 6 ANNB programmes present, including laboratory and radiology staff and senior management attendance.

- **Infectious diseases:** KPIs and standards are generally met by all maternity units for this programme and the achievable level is regularly attained in terms of coverage. The explanatory commentary is always taken into account, when reviewing the KPI's as failure to meet KPIs is usually because of patient choice and small numbers.
- **Haemoglobinopathies:** The maternity units are performing to a good standard, meeting the coverage KPI at an achievable level. All maternity units now meet the acceptable level at ST2 which offers insight into the accessibility of the first booking appointment and the screening and immunisations team continue to work

with Trusts to move closer to the achievable level for this KPI. The acceptable level for ST3 is met by all providers.

The introduction of ST4a and ST4b came into effect from Quarter 1, and targets have not been nationally defined;

- ST4a: Antenatal sickle cell and thalassaemia screening - timely offer of prenatal diagnosis (PND) to women at risk of having an affected infant: 'at risk women offered PND by 12 weeks and 0 days gestation' (numerator) is the total number of at risk women that are offered PND testing by 12 weeks and 0 days gestation.
- ST4b: Antenatal sickle cell and thalassaemia screening - timely offer of prenatal diagnosis (PND) to couples at risk of having an affected infant at risk couples offered PND by 12 weeks and 0 days gestation' (numerator) is the total number of at risk couples that are offered PND testing by 12 weeks and 0 days gestation. No thresholds currently set.

The KPI is impacted by low denominators and no achievable standard has been set; so the KPI must be interpreted in context provided in the commentary by the maternity units.

- **Fetal anomaly:** The KPIs and standards associated with this programme are met by all providers. FA1 all maternity units meet the acceptable standard and the achievable standard is met for FA2. The coverage KPI for Patau's, Edwards and Downs (FA3) introduced from quarter 1 2018 continues to be discussed at programme boards; the vast majority of women opt for screening of all 3 conditions. 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.
- **Non-invasive prenatal testing (NIPT):** The original evidence review by the University of Warwick was recently re-considered by the UK NSC. An updated review was necessary as genomics is a fast-moving area and consideration of the new technologies now available which were not when the evidence was first considered.

The UK NSC agreed that: another type of technology (microarray) could be used as well as next generation sequencing (NGS) in the laboratory procurement for the offer of NIPT as an additional option on the FASP screening pathway. NIPT could be offered in twin pregnancies as part of the evaluative roll out. Given the above developments, NHS England, following discussion with Public Health England Screening, has decided to cancel the existing procurement and will put in place new plans to procure laboratory services for NIPT in line with the latest evidence considered by the UK NSC.

- **Newborn hearing:** Coverage rates for the newborn hearing programme are met at the achievable level for all maternity units. There continues to be occasions where there is some slippage in the referral KPI, but all of these cases are discussed and it is established that the appointments were offered in timely fashion.
- **Newborn bloodspot:** Coverage rates are good. There is ongoing work with Hinchingsbrooke site to reduce the avoidable repeat rate on this programme and to meet the acceptable KPI threshold. Hinchingsbrooke have an action plan in place and this is closely monitored at the programme boards. Health visiting teams attend the programme board and are active in discussions on NB4 which reflects the movers in who are eligible for bloodspot screening.
- **Newborn and infant physical examination:** All Trusts meet the acceptable level for newborn infant examination. Referral for hip ultrasound within two weeks sometimes is not met, but this is monitored closely. Denominators are very small, and this can adversely impact the KPI, hence why the KPI is always interpreted with the explanatory commentary. The screening and immunisation team have no concerns on this pathway.

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, 2017/18 – 2018/19, Source: Oracle Business Intelligence Enterprise Edition (OBIEE)

Cambridgeshire and Huntingdon Screening Centre		2017-2018				2018-2019			
Acceptable	Achievable	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
≥ 70.0%	≤ 80.0%	70.6	70.4	68.5	69.8	72.3	68.0	68.1	74.0
Peterborough Screening Centre		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
≥ 70.0%	≤ 80.0%	74.5	72.5	71.0	71.0	72.8	73.0	67.6	72.4

The Uptake of Breast screening for both units has met or has come close to achieving the 70% acceptable standard over the last two years. NHS England is working with both these services to improve attendance to screening and maintain levels above 70% coverage. This includes exploring the use of text messaging reminders and social media to promote the services.

TABLE 34: Breast screening round length - % of women first offered an appointment within 36 months, by screening centre, 2017/18 – 2018/19, Source: OBIEE

BS2 - Percentage of women first offered an appointment within 36 months

Cambridgeshire and Huntingdon Screening Centre		2017-2018				2018-2019			
Acceptable	Achievable	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
≥ 90.0%	≤ 100.0%	70.5	70.4	68.5	69.0	72.3	67.0	94.6	95.3
Peterborough Screening Centre		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
≥ 90.0%	≤ 100.0%	92.3	81.0	74.7	56.2	96.5	96.0	99.7	63.5

There has been considerable variability in the round length over the last two years, some of this can be attributed by readjustments to the service and changes to staffing. The Peterborough service has had a particularly difficult time recruiting Radiology staff due to the national shortage of Radiographers and Radiologists. Both screening centres are looking at different aspects of round length planning to improve on this KPI.

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, 2017/18 – 2018/19, Source: OBIEE

Cambridgeshire and Huntingdon Screening Centre		2017-2018				2018-2019			
Acceptable	Achievable	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
≥ 98.0%	≤ 100.0%	99.6	91.6	100.0	99.3	98.7	99.6	98.5	99.4
Peterborough Screening Centre		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
≥ 98.0%	≤ 100.0%	90.2	96.4	65.7	92.8	61.8	61.7	78.4	74.8

The Cambridge and Huntingdon breast screening service has routinely met the target for waiting time for assessment and continues to do so. The Peterborough service has continued to have problems attaining the standard over the last two years. This is largely associated with the difficulties this small unit has had with recruitment and pressures from the symptomatic service. The service is working hard to address some of the specific issues which have impacted on the services KPI's. NHS England and the CCG are monitoring this whole process closely and expect the trust to improve in by the end of 2020. Current monthly data returns indicate that this is likely to happen.

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, 2018/19, Source: Screening Quality Assurance Service (SQAS) and Open Exeter

Acceptable	Achievable	Provider	Q1 2018-19	Q2 2018-19	Q3 2018-19	Q4 2018-19
CS2 - Coverage of eligible population (all women) every 5 years						
≥ 75%	≥ 80%	Cambridgeshire Upper Tier LA	71.0	70.5	70.2	71.2
≥ 75%	≥ 80%	Peterborough Upper Tier LA	69.0	68.6	74.1	68.9
CS2a - Coverage of eligible population, all women aged 25-49 every 3 years						
≥ 75%	≥ 80%	Cambridgeshire Upper Tier LA	68.2	67.5	67.2	68.2
≥ 75%	≥ 80%	Peterborough Upper Tier LA	66.8	66.3	66.4	66.8
CS2b - Coverage of eligible population, all women aged 50-64 every 5 years						
≥ 75%	≥ 80%	Cambridgeshire Upper Tier LA	77.1	76.8	76.5	76.7
≥ 75%	≥ 80%	Peterborough Upper Tier LA	74.8	74.4	74.1	74.3

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, 2017/18 – 2018/19, Source: OBIEE

CUHFT Screening Centre			2017-2018				2018-2019			
	Acc.	Ach.	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
BCS2 – Uptake	≥52%	≥60%	No Data	60.4	57.4	57.9	62.1	61.3	59.3	64.0
Screening Positivity	≤ 2.0%	≤ 1.0%	2.4	2.1	1.5	2.1	1.6	1.8	1.5	1.5
BCS7– Diagnostic Test Waiting Times	≥90%	≥95%	75.5	45.3	26.3	49.4	37.3	100	100	99.4
BCS8 - Diagnostic test attendance	Not set		n/a	n/a	n/a	n/a	26.7	73.8	68.9	73.5
BS11a – Colonoscopy Uptake	≤ 81%	≤ 90%	88.4	85.7	77.4	81.3	90.2	89.2	83.8	91.9

NWAFT Screening Centre			2017-2018				2018-2019			
	Acc.	Ach.	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
BCS2– Uptake	≥52%	≥60%	59.7	57.3	56.8	59.1	61.0	60.2	57.5	62.2
Screening Positivity	≤ 2.0%	≤1.0%	2.4	2.6	2.2	2.1	1.8	2.1	1.7	1.4
BCS7 - Diagnostic test waiting times	≥90%	≥95%	5.2	30.1	10.2	20.6	No data	No data	16.2	71.3
BCS8 - Diagnostic test attendance	Not set		n/a	n/a	n/a	n/a	13.1	5.4	10.6	46.6
BS11a – Colonoscopy Uptake	≤ 81%	≤ 90%	69.0	75.3	64.8	68.4	73.1	71.6	80.3	88.1

5.3 Adult and Young People Screening

5.3.1 Diabetic Eye Screening Programme

The KPI data for the diabetic eye screening programme provided through In 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. Referral into hospital eye services has steadily improved throughout the year at Cambridge; low denominators adversely impact on the achievement of the KPI.

TABLE 38: Diabetic eye screening KPIs for Cambridgeshire & Peterborough CCG through East Anglia DESP, by 2017/18 – 2018/19, *Source: Health Intelligence*

Indicator & Target	2017-2018				2018-2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Acceptable 70% Achievable 80%								
DE1-Uptake of routine digital screening event	84.3	84.8	85.4	90.8	91.1	91.1	91.0	90.8
Acceptable 70% Achievable 80%								
DE2-Results issued within 3 weeks of screening	98.5	99.8	100	100	99.9	99.9	100	99.9
DE3 - Timely assessment for R3A screen positive					Acceptable 80% Achievable 95%			
CUHFT	55.6	62.5	70.0	55.5	36.4	33.0	46.0	75.0
NWAFT Peterborough	100	85.7	78.6	80.0	75.0	100	80.0	100
NWAFT Hinchingsbrooke	66.7	83.3	80.0	100	100	67.0	83.0	75.0

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	2016-17	2017-18	2018-19
AA1 Completeness of Offer	≥ 52%	≥ 70%	99.9	retired	retired

TABLE 40: AAA screening KPIs, Cambridgeshire screening cohort, 2018/19							
AAA Data - Cambridgeshire Screening Cohort							
Indicator		Accpt.	Ach.	18-19 Q1	18-19 Q2	18-19 Q3	18-19 Q4
Coverage of Initial Screen	AA2	≥ 75%	≥85%	17.4	36.3	54.1	73.5
Coverage of Annual Surveillance screen	AA3	≥ 85%	≥95%	92.7	88.9	89.6	88.2
Coverage of Quarterly Surveillance screen	AA4	≥ 85%	≥95%	81.1	91.7	94.9	90.5

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*). HCAs 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 remain 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). Mandatory reporting remains in place with formal reviews undertaken with provider trusts.

Cases are assigned according to the time of onset of infection with more than 2 days (48 hours) after admission assigned as hospital onset and all pre 48-hour cases community onset. The epidemiology of MRSA has changed with the greatest proportion of cases now being community-onset and multi-factual.

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. 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. Swabbing and decolonisation remain key initiatives to maintaining good practice and reducing further cases of MRSA bacteraemia infection.

TABLE 41: Number of MRSA bacteraemia cases			
	2017/18	2018/19	April – December 2019
National	846	805	612
Cambridgeshire and Peterborough CCG	11	23	14

The MRSA bacteraemia rate continues to fall with a further decrease of 5.2% during 2018/19 and a total decrease of 81.9% from 2007/08 (n= 4,451). The national rate per 100,000 is 1.4%. 271 were hospital onset (5 fewer than 2017/18).

The geographical distribution across England does not show any obvious pattern for community onset cases and are largely evenly distributed across the country.

Of the 14 cases reported to December 2019, only one is assigned as a hospital onset, the remaining are community onset. No themes or trends were identified with nine of these, however people who inject drugs (PWID), have been of significant relevance to Cambridgeshire and Peterborough in 2019.

People who inject drugs (PWID)

Five cases have been identified in PWID and all are known to one specific practice in Cambridge serving a largely homeless or hostel living community. A common link identified is the association with specific local hostels, a day centre and night shelter. Working alongside Public Health England, support visits were undertaken to the night shelter and day centre as well as support provided to the practice. The practice has screened several patients when presenting with wounds for MRSA with a further 12 found to have colonisation. A pilot programme (completed end of November 2019) at Addenbrookes Hospital Laboratory of Whole Genome Sequencing (WGS), has identified all strains as being of the same type and statistically person to person transmission has taken place. A total of 28 patients have been linked to the same strain from several practices within short distances of each other.

A series of harm reduction measures were agreed through collaborative multi-agency teleconferencing through which leaflets and posters were circulated across the homeless community centres and hostels as well as primary care, to heighten awareness across this group of patients and to encourage clean and safe injection technique. Additional information was added to needle exchange packs as well as chlorhexidine wipes. Those identified with colonisation are provided with decolonisation treatment and encouraged to use, though accepted as challenging for those not accessing regular showering facilities or choosing not to conform to the request.

Four nursing staff within the Cambridge practice managing wounds of these patients have been swabbed for MRSA and all returned negative.

A published paper in Bristol (2018) was identified and discusses the issues identified when faced with an unexplainable rise of MRSA colonisation and infection in this group of patients between 2012-17. Clinical presentation was from a range of skin and soft tissue infections, like those seen in Cambridge. The Government maintains its zero tolerance to avoidable blood stream infections, however, is controversial when organisms can be introduced through multiple independent sources (Packer et al, 2018).

A number of themes were identified in Bristol which reflect similarities to those found in Cambridge; injecting in public places, hospital contact, injecting in groups of three or more, soft skin tissue infections, homelessness in the previous year and injecting into the groin. The suggestion is of ongoing circulation and transmission within this group over several years.

The situation continues to be monitored by PHE and multi-agency partners. Monthly telephone conferences continue for monitoring and action planning purposes. The case definition of PWID, homeless and/or have been in prison and have a confirmed infection, has been agreed to for sending specimens to Colindale for WGS.

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 2018/19, 12,275 cases of C. difficile were reported nationally which demonstrates a small decrease of 7.7%. Recent research has shown over time, elderly individuals are getting frailer and experiencing polypharmacy, however, patients more often have multiple co-morbidities, sicker on admission and receiving greater levels of healthcare interactions. The age range of patients affected is frequently 85 years or older and little difference between the sexes.

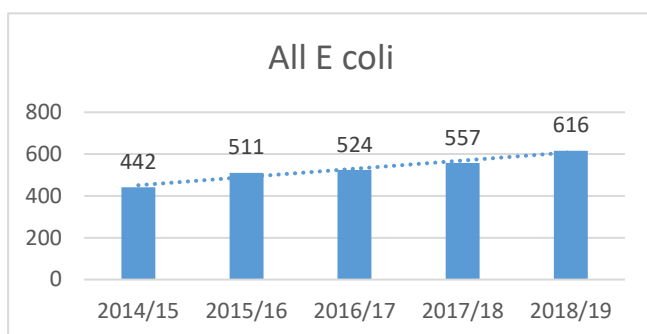
The reporting process from April 2019 has been broken down into four categories. The objectives for each organisation were adjusted (increased) to allow for the second category (discharge within the previous 28 days) now also assigned to hospital providers.

In Cambridgeshire and Peterborough:

- There were 196 cases of *C. difficile* reported between April and December 2019. This compares to 135 at the same point in 2018 and places the CCG above the annual objective of 187.
- One trust exceeded their annual trajectory in October 2019 and continues to be monitored closely through an exceptional action plan.
- Outcomes from Scrutiny panels identifies that overall nursing management is good, the focus now on antimicrobial prescribing across the healthcare economy with primary care prescribing not currently reviewed.

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 the reduction of cases by 10% during the period of 2017/18 and by half at the end of March 2019. Nationally this has not been achieved and a revised plan from April 2020 is for a 10% reduction in the first year, as 25% reduction by the end of the second year and 50% reduction achieved by March 2024. Publication of the full requirements will be provided prior to March 2020. Attempts to address this early on were unsuccessful and the approach now being reviewed. Cases have continued to show a rise as demonstrated in the graph below.



The majority of 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. A Regional event was held in November 2019 to share approaches and provide draft tools to consider as a way forward. A project plan is under development with STP Leadership/support in place.

6.4 Outbreaks

Seasonal gastroenteritis and respiratory-like symptoms are reported to the local Health Protection team of Public Health England. These are shared using Iolog, a database used widely and uniquely across the East of England. Quick reference to notification alerts the region to where cases of infection are occurring, confirming if gastroenteritis is testing positive for Norovirus or swabbing confirming Influenza or other common types of respiratory-like infections. Care homes are advised by the Health Protection Team (HPT) on infection control measures and possible closure which helps with information sharing to providers wanting to discharge patients. Hospitals also use this system to report their own closures, either bays or wards. There is a good response by care homes to report concerns and symptomatic patients. Homes identified through other routes are contacted either by HPT or the CCG to clarify and offer advice, however this is rare and suggests the system works well.

The CCG has commissioned the services of Commisceo, also commissioned by more than a dozen other areas in the region, to swab residents in care homes where respiratory-like symptoms are reported and tested for Influenza. Where positive they are also provided with treatment and contact residents with prophylaxis. The primary focus is to stop residents being unnecessarily admitted to hospital when they can be treated at home, unless there are other circumstances requiring admission. Homes can then inform hospitals for isolation purposes of residents on arrival.

The flip side of the process is the point of care testing provided by one hospital trust who identify influenza on admission screening and inform the home who would otherwise not be aware.

During the period of April to December 2019, care homes reported the following number of outbreaks:

Gastroenteritis	22
Norovirus	1
Respiratory-like symptoms	13
Rhinovirus	3
Parainfluenza	2
Influenza A	3

6.5 References

- Annual epidemiological commentary: Gram-negative bacteraemia, MSSA bacteraemia and *C difficile* infections, up to and including financial year April 2018 to March 2019. Public Health England. 11 July 2019.

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 GP prescribed antibiotic items from 126,275 in Q3 2017/18 to 119,328 in Q3 2019/20. 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. 22.3% of urine community *E. coli* (or coliform) samples tested in quarter 3 2019-2020 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 2018-2019. 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 2020-2021.

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 in 2018-2019 was above 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. During 2019-2020, a significant reduction in the prescribing of broad spectrum antibiotics in Primary Care has been seen, with the CCG almost achieving the national target of 10% of overall antibacterial prescribing. There will be a continued focus on both overall antibacterial and broad spectrum prescribing during 2020-2021, to further reduce inappropriate prescribing where clinically appropriate.

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 27.1.20.
4. Public Health England. English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR) 2018 and accessed 27.1.20.

8. Environmental Health and Regulatory Services

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. As an example the Environmental Health team worked in partnership with Public Health England (PHE) to address a non-compliant TB patient who ceased taking medication and visiting the TB clinic. The patient was thought to be infectious and a potential risk to the public's health. The case required an Environmental Health Officer (EHO) to apply to the Magistrates Court for a Part 2A Order under the Health Protection Regulations 2010 to take the patient to Peterborough City Hospital (PCH) and offer treatment for this condition. The Part 2A Order was successfully administered and the patient was taken to PCH. The patient was later transferred to Leicester Royal Infirmary to receive more targeted treatment. This transfer required close liaison and working with Leicester City Council and PHE East Midlands and re-applying to the Magistrates Court to vary the Part 2A Order. Upon the patient's return to PCH and in preparation for the patient's discharge the EHO worked collaboratively with PHE and Peterborough City Council's Housing Needs Team to secure suitable accommodation for this patient to aid continued and sustainable TB treatment.

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 2018/19, the proportion of food establishments across the country achieving broad compliance was 93.19% illustrated in Table 43, (broadly compliant is equivalent to a hygiene rating of 3, generally satisfactory, or above).

Table 43: Proportion of food establishments achieving broad compliance, by local authority, 2018/19, *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	1485	94.68%
East Cambridgeshire	807	94.65%
Fenland	808	95.79%
Huntingdonshire	1430	91.45%
Peterborough City	1835	89.37%
South Cambridgeshire	1194	90.64%

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

- A suspected food poisoning outbreak in November 2019 was linked to a local restaurant involving 10 people from 4 families. The illness was attributed to norovirus and the Food Safety team provided the appropriate advice to the restaurant.
- Officers dealt with an issue of open and ready to eat meats being displayed beyond the use by date. The Food Business Operator had been informed of this issue previously and had been instructed to implement controls to prevent this. Officers seized and disposed of approximately £1K of meat.
- **Peterborough Healthier Options.** The Healthier Options scheme was launched to promote healthier choices when eating out. Local takeaways and food outlets with a food hygiene rating of three or above are awarded for providing and promoting Healthier Options. In 2019, 3 local businesses met this criteria and have joined the scheme and can now include the logo on their promotional material, and allowed to promote through the council's media channels.



Cllr Walsh awarding Healthier Option certificates to Netherton Fisheries and Pizza Parlour in Peterborough

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.

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 left the land 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. Peterborough City Council reports to DEFRA on the air quality findings on an annual basis. The 2019 Air Quality report can be found on the Council's website under Environmental Health.

The Pollution Team has a significant input into the development control process, acting as a statutory consultee for planning applications and for the discharge of conditions. The Pollution Team recommend conditions and agree mitigation measures where noise, contamination, air quality or other environmental issues may be of concern.

Examples of developments considered in the previous 12 months include:

- Comments relating to impact of noise on residential development at Cranmore House, Eye. The initial noise assessment had not included early morning works. Input from officers resulted in industrial noise being determined as having a significant adverse impact. Planning permission was refused on the grounds of noise.
- The upgrade of Werrington Gas Compressor continues with the Control of Pollution Act 1974 Section 61 Notice prescribing working hours and measures to control dust, light and noise remaining in force until July 2020. Over the last 12 months there has been overnight works to test the imperviousness of the pipe work. The Council have not received any noise complaints in relation to this work.
- Werrington Grade Separation "Dive-Under". The railway at Werrington Junction is undergoing major redevelopment which is scheduled to be completed by mid-2021. Upon assessment of previous noise reports it was anticipated that the noise resulting from this significant construction scheme would adversely impact local residents. As a result of measures taken by Network Rail and their contractor Morgan Sindall there have been very few complaints relating to noise from works, this has included overnight works. Officers continue to work with Network Rail to ensure the impacts of construction noise of the civil engineering project will be controlled so far as reasonably practicable.
- Former District Hospital – assessment of noise and contaminated land reports for the development of the site to residential status. This has included consideration of noise impacts from a school playground.
- Consideration and comments in relation to dust and noise management plans for the demolition of Market Street Car Park and Gas Holder at Wellington Street.

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.

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 continued the work from 2018 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. This has provided a media platform allowing the service to raise awareness, educate the public and disrupt the importers.
- **Allergens:** the trading standards service has responsibility for food labelling including the correct labelling of allergens in food. Trading Standards have been conducting a sampling project in takeaways and caterers following on from work in the previous year. Test purchases have been made from a range of premises where the meal was purchased as being free from a certain allergen. These meals were then analysed for the presence of the allergen and unfortunately, we're finding a failure rate of currently around 1 in 5. Where businesses have previously failed test purchases formal action is being considered. This work is on-going and being coordinated with the Environmental Health Team.
- **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.
 - In April a warrant was executed at a self-storage yard which resulted in a large seizure. The investigation has been ongoing throughout the year and is now pending prosecution.
 - A multi-agency day of action in June resulted in seizures from three shops, one of these was a licensed premises so we requested a licence review.
- **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, made worse by the fact many of the cigarettes were also illicit, and further work is planned.

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 interventions (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. 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 NO₂ and particulate matter (PM) at locations close to busy, congested roads where people may live, work or shop.

Cambridge City

- Air quality has been improving, slowly, in most parts of Cambridge in recent years
- Levels of nitrogen dioxide (NO₂) continue to be higher than the legal limits in parts of the city, including the busy central streets,

- The main source of nitrogen dioxide in Cambridge is from vehicle emissions
- The levels of PM10 in Cambridge are below the legal limits.
- Cambridge monitor for the following pollutants:
 - non-automatic (passive) monitoring of NO2 at 63 sites
 - automatic (continuous) monitoring at 5 sites of which PM10 is monitored at three sites in Cambridge; Gonville Place, Montague Road and Parker Street all of which are roadside sites, PM2.5 is monitored at two sites; Gonville Place and Newmarket Road
- Cambridge has declared an Air Quality Management Area (AQMA) for the city centre

Case Study – Cambridge City Clean Air Zone

At present there is a proposed Clean Air Zone for Cambridge City in the “Cambridge City Air Quality Action Plan 2018-2023” it is one of a series of measures proposed to tackle poor air quality in the city. It is important to distinguish between a Clean Air Zone (CAZ) and a Congestion Charging Zone.

The Action Plan states:

“... In recognition of the strong public support for addressing air quality, the Greater Cambridge Partnership (GCP) has undertaken a feasibility study for a Clean Air Zone in Cambridge. The results of this study were included as part of the ‘Choices for Better Journeys engagement activity undertaken in March 2019. The results of the engagement activity have been put to the GCP Executive Board with options to take forward for further work and consideration. This may include a type of Clean Air Zone...”

“A “Clean Air Zone” is anticipated to be implemented from Year Three (2020) of this Plan. Responsibility – These projects will be undertaken by the GCP, with input from all partners.”

Feasibility study

Cambridge City Council together with Cambridgeshire County Council (funded by the Greater Cambridge Partnership) ran a feasibility study to investigate whether introducing one or more clean air zones in Cambridge would help reduce air pollution.

The key points from the study were:

- The main source of emissions in Cambridge is from road traffic. Buses account for 49% of the nitrogen oxide emissions in the city centre, and diesel cars contribute a further 32%.
- The predicted growth in traffic levels between 2021 and 2031 means further action will be required to maintain annual mean NO2 concentrations below the current limit.
- Without any interventions, exceedances of the current air quality limit value for annual average NO2 concentrations are predicted at locations in the city centre in 2021 and 2031.

Study recommendations

- The most effective intervention to improve air quality and protect public health is a charging ‘Class D’ Clean Air Zone which includes all vehicles. Improvement in the bus fleet should be a priority due to their large contribution to emissions. It is recommended that focus is given to improvement in the vehicle fleet within the city centre area by 2021.
- By 2031, reductions in concentrations across the whole of Cambridge will bring further public health benefits. Introducing a more ambitious charging CAZ (including Light Goods Vehicles, buses and coaches to be Zero Emission Vehicle or Ultra Low Emission Vehicle) is predicted to reduce NO2 levels to below 80% of the AQO across Cambridge; it is recommended that this option is pursued. Vehicles that conform to more recent euro standards should emit less pollution and are allowed free entry into the zone.

South Cambridgeshire

- Air quality issues within South Cambridgeshire are linked directly to the volume of traffic that runs through it, The A14 is congested on a regular basis between Bar Hill and Milton
- South Cambridgeshire operate Automatic Monitoring Stations at three sites, Orchard Park, Girton and Impington. They measure PM10 and NO2. Girton site also measures PM2.5.
- The data indicates a general improvement of air quality since 2016.
- South Cambridgeshire has declared an Air Quality Management Area (AQMA) for the A14 between the Milton Junction and Bar Hill

Huntingdonshire

In Huntingdonshire air pollution is concentrated around the A14 and the ringroad, some central sections of St Neots are also affected e.g. the High Street, which is both canyon-like and congested.

- Nitrogen Dioxide (NO2) continues to be the only pollutant that currently exceeds the objective level within the district.
- The primary source of NO2 in Huntingdonshire is due to vehicle emissions, mostly originating from the A14 and to a lesser extent the A1 that runs through the district. However, local traffic within the market towns is also causing some elevated levels.
- Huntingdonshire currently has four Air Quality Management Areas (AQMA's):
 - Huntingdon
 - St Neots
 - Brampton
 - A14 Hemingford to Fenstanton.
- As a whole, the level of NO2 continues to fall as it has done so over the last five years, and is mostly below the annual limit.
- Huntingdon continues to experience a small hotspot, which shows readings above the annual limit and this is predominantly linked with the A14.
- Huntingdonshire undertook automatic (continuous) monitoring at one site
- Huntingdonshire undertook non- automatic (passive) monitoring of NO2 at 55 sites

East Cambridgeshire

- East Cambridgeshire is predominantly rural in character and air quality is relatively good.
- Statutory objectives are being met at all monitoring locations and the council has not designated any areas as Air Quality Management Areas.
- Road traffic emissions are the principal source of poor air quality.
- Nitrogen dioxide (NO2) and particulates are the main contaminants of concern
- East Cambridgeshire District Council currently monitors NO2 levels at 21 sites across the district.
- Overall, there has been a gradual downward trend in annual mean NO2 concentrations in recent years.
- East Cambridgeshire do not have any AQMAs
- East Cambridgeshire do not monitor for particulates and do not have an continuous monitors

Fenland

In Fenland (Wisbech) average annual PM10 in Wisbech do not exceed current European Directive annual limits, however the centre of town may have 15-30 days a year with PM10 exceedances. An assessment of source apportionment showed that HGVs and single occupancy car trips make up a large proportion of the total pollution concentrations. This could be reduced by changing short car trips to walking and cycling, as both walking and cycling levels in Wisbech have been shown to be low.

There are higher levels of nitrogen dioxide in the winter months and peaks of larger particulate matter in the spring, which may lead to seasonal health impact. Small particulates from traffic also contribute to indoor air pollution, where people spend most of their time and receive most of their exposure to air pollutants. Fenland have declared four AQMAs, 3 in Wisbech and 1 in Whittlesey

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.

Peterborough

The main pollutants of concern in the Peterborough district, as in most areas of the UK, are associated with road traffic, in particular NO₂ and particulate matter (PM) at locations close to busy, congested roads where people may live, work or shop. There is currently one Air Quality Management Area (AQMA) in Peterborough, for emissions of SO₂ resulting in a modelled exceedance of the relevant 15-minute mean values. The source of these emissions is a brickworks located in the area administered by Fenland District Council (a neighbouring local authority). It was proposed in the 2015 Updating and Screening Assessment (USA) to revoke the AQMA, subject to the agreement of DEFRA. However the AQMA is still in force and Peterborough City Council remain in consultation with Fenland District Council about this. Further details of this AQMA can be found at

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

- The Annual Status Report determines that there have been no exceedances of the 40µg/m³ limit. One tube located at a Taverners Road monitoring location registered an annual mean of 40µg/m³.
- There has been a general increase in NO₂ levels at all but one of the Taverners Road monitoring locations. This is not a trend that was reflected at other monitoring sites.
- Data indicates that at all other monitoring sites the levels of NO₂ appear to be similar to those recorded in previous years.
- The objectives for SO₂ were met for the AQMA at the monitoring locations AM1 and AM2

Specifically with regards to 2017 monitoring data at Taverners Road. Although there is no exceedance at this location, and the previous two years showing a reduction in NO₂ levels throughout this location, further studies in this location are warranted. It is proposed that this will include further monitoring, a scoping study to understand the problem, and exploration of initiatives to address NO₂ levels as required.

A Councillor led Scrutiny Task and Finish Group has reviewed air quality in Peterborough and developed an Air Quality Ambition Statement and Action Plan which was endorsed by Peterborough City Council Cabinet on 13th January 2020. The report is available on [PCC Scrutiny Task Group Air Quality Report](#)

Cambridgeshire County Council

Current school based interventions

The road safety team (funded by Public Health) at Cambridgeshire County Council run a series of activities to support schools.

- School time parking and congestion and the related safety and air quality issues are regularly raised with Council officers for investigation and action, as such the Council offers a wide range of advice and resources to support schools in tackling these issues and this support focuses on the development of a school travel plan, which helps the school, and Council officers to understand the scope of the problem and identify appropriate mitigation measures.
- These measures range from longer-term programmes such as setting up 5-minute walking zones or the Junior Travel Ambassador scheme to shorter term interventions such as banners, posters or events. Approximately 100 schools across Cambridgeshire (1/3 of all schools) are engaged in developing their school travel plan, with 55 of these having gained national accreditation through Modeshift STARS and 3 Cambridgeshire schools having won national awards for their travel plan activity over the last 3 years.

The schools engaged in the travel planning process saw an increase of 2.5% in the % of children who reported “usually” travelling to school in an active way between 2016/17 and 2017/18.

- The team also provide internal advice to the school travel team on road safety and active travel for new school builds

Planning Application for Schools (Regulation 3 applications)

Public Health are now an internal consultee for all planning applications for schools, as part of the consultation response public health consider the implications of air quality and support colleagues requesting active travel interventions.

Motion to full Council

In December 2019 the Leader of the County Council proposed a motion to Full Council on air quality. The motion, which was approved, proposed that the introduction of charging solutions would not be supported, and that alternative approaches would be taken for Cambridgeshire County Council to improve air quality throughout by:

Increasing green canopy by:

- Working with partners to locate, seek funding and plant at suitable locations, new hedges and trees, as well as technologically advanced “City Trees”, prioritising areas around schools, as well as green walls in appropriate County locations.

Promoting the uptake of low emission vehicles by:

- Consulting on the use of bus lanes for electric vehicles and motorcycles and scooters.
- Accelerate public transport to be early adopters of electric vehicles, by drawing up plans and consulting with stakeholders to deny access to Bus Lanes, with an aspiration to implement from the end of 2021.
- Lobby Cambridge City and other district partners to make available premium green licenses for taxis, and lobby the Traffic Commissioner to refuse nongreen bus licenses for those that access Cambridge City centre
- Lobby Cambridge City Council to provide free parking for electric vehicles, in their car parks.

Improving the alternative to the private motor car:

- Working with the Mayor and the Greater Cambridge Partnership to deliver the CAM metro.
- Continuing to expand the transport hub network, where you can leave your car and get on public transport.
- Continuing to improve the cycle way experience, throughout Cambridgeshire.
- Working with partners to sizeably increase the access to railways offer currently available.

Reducing air pollution at source by:

- Lobbying government for improved initiatives and for grants to help us pilot imaginative projects, such as Swaffham Prior heating and St. Ives solar park.
- Making improvements to our own fleet, and encouraging change in those we contract with
- Working with partners to develop plans for last mile delivery and will incorporate these decisions into the environmental strategy consultation.

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 has now been considered in the LTP. Public Health played a role in bringing together stakeholders on air quality to provide a more comprehensive joined up response. The development of the LTP has provided 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 Air Quality – Further Information

District Councils and Unitary 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 indicators for Sexual and Reproductive Health (SRH) found in the Public Health Outcomes Framework (PHOF) overall compare favourably to the national averages. However, there are some key areas of concern .

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

The rates of new diagnoses of sexually transmitted infections (excluding <25 chlamydia) nationally has seen an upward turn with increases in the rates of syphilis and gonorrhoea. The Cambridgeshire rate is statistically significantly better than the England average; however, there has been an upward trend in syphilis and gonorrhoea rates. For Peterborough the rate has seen small fluctuations in recent years with the trend being the same or worse than the England average. In 2018, it was statistically significantly worse than the England average, again with an increase in rates of syphilis and gonorrhoea.

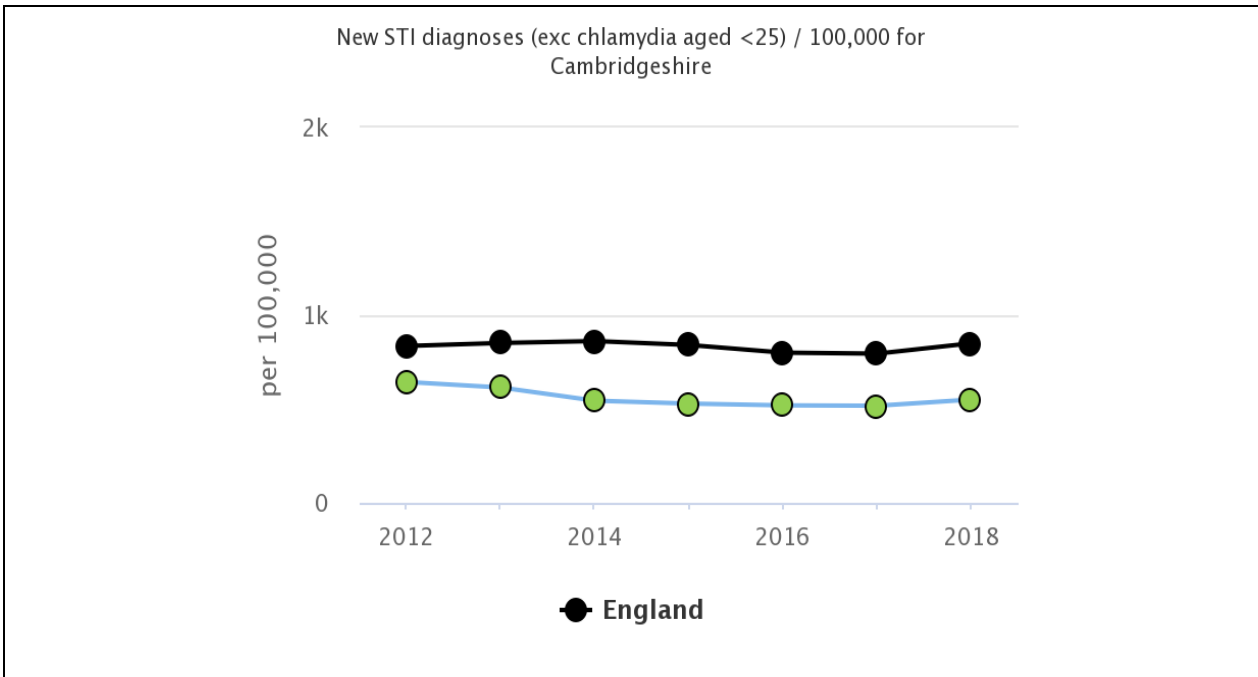


Figure 8: New STI diagnoses (excluding <25 chlamydia), Cambridgeshire, (2012-18), Source: Sexual Health Profiles Public Health England

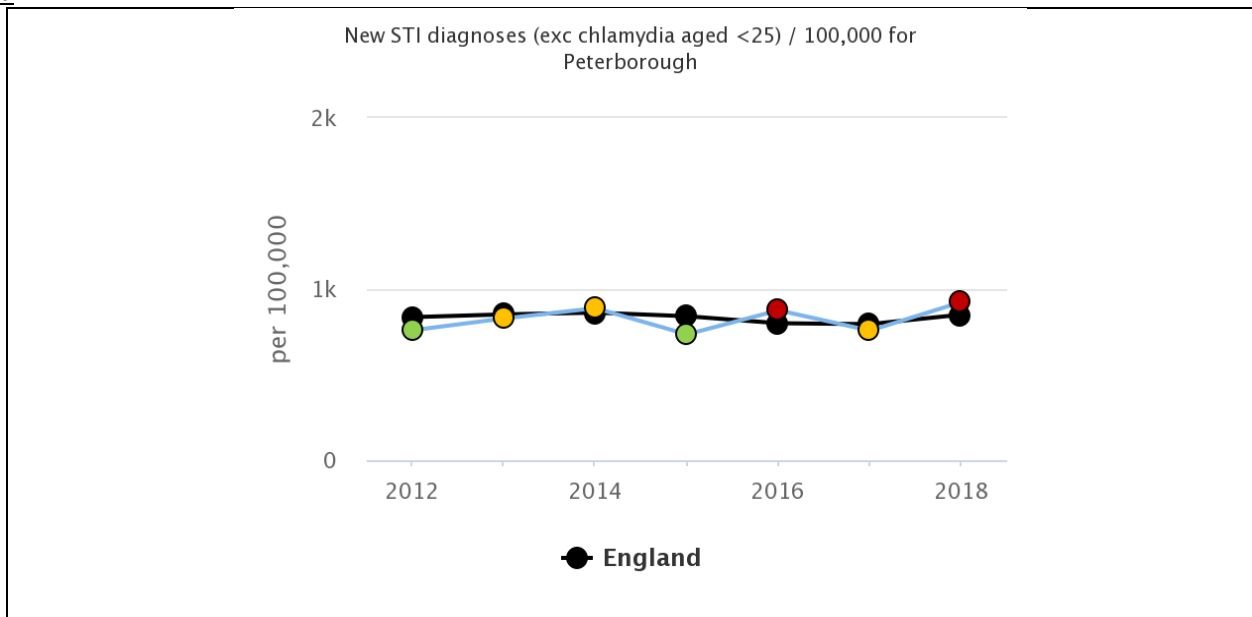


Figure 9: New STI diagnoses (excluding <25 chlamydia), Peterborough, (2012-18), Source: Sexual Health Profiles Public Health England

10.2 New HIV Diagnosis Rate

Nationally, there has been a downward trend in rates of new HIV diagnoses. This trend is also mirrored in both Cambridgeshire and Peterborough. Between 2017 and 2018, rates of new HIV diagnoses in Cambridgeshire rose from being statistically significantly better than the England average to being similar. In Peterborough, the rates of new HIV diagnoses have remained similar to the England average. Although in both areas overall numbers are small.

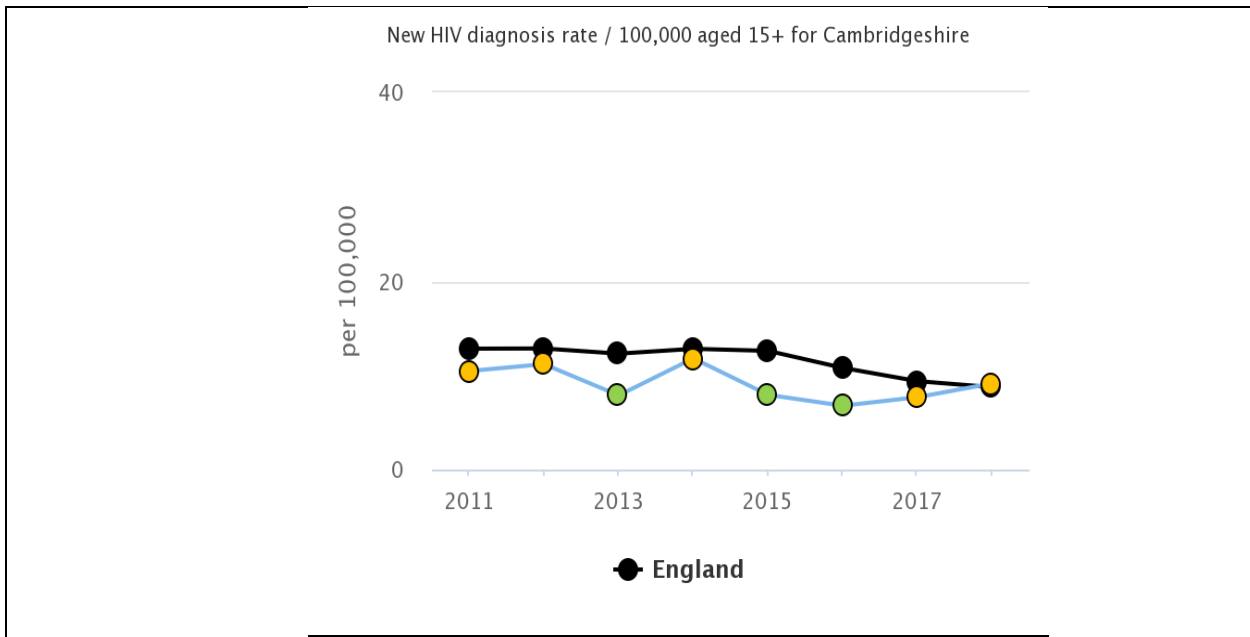


Figure 10: New HIV Diagnosis Rate, Cambridgeshire (2011-18), *Source: Sexual Health Profiles Public Health England*

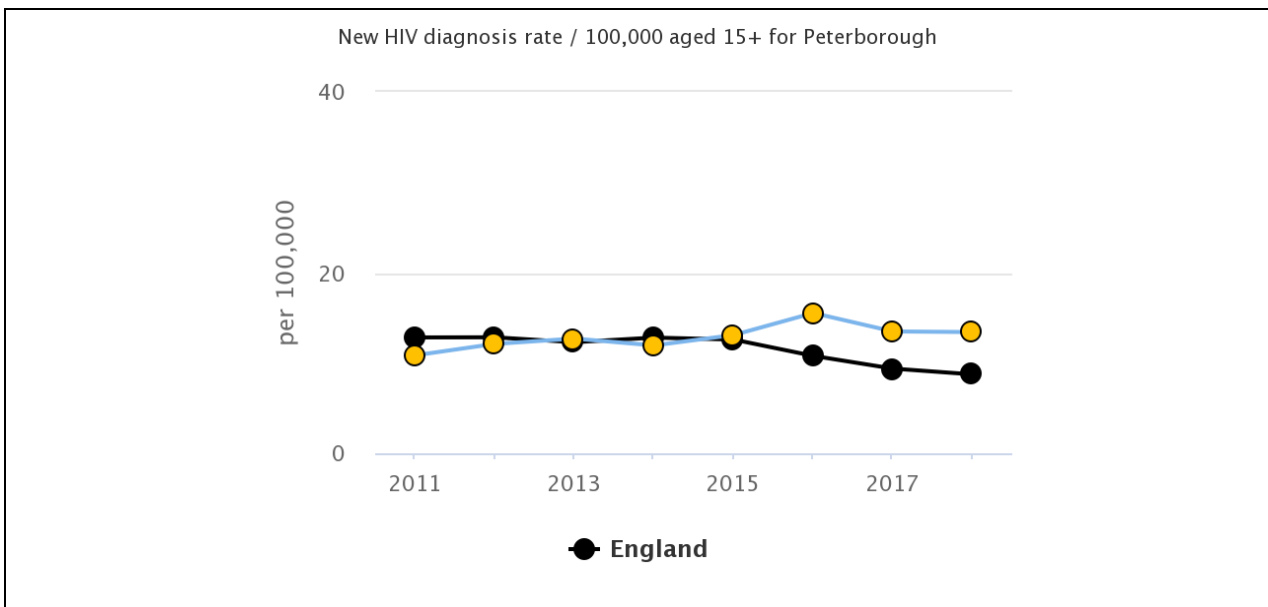


Figure 11: New HIV Diagnosis Rate, Peterborough (2011-18), *Source: Sexual Health Profiles Public Health England*

10.3 HIV diagnosed prevalence

Life expectancy for those living with HIV has increased considerably. With prompt diagnosis and treatment a person can anticipate having a life expectancy similar to the England average. For Cambridgeshire the HIV diagnosed prevalence rate has remained significantly below the England rate since 2011. The rate for Peterborough was below

the England rate from 2011 to 2015 but since 2016, it has increased to being statistically similar to the England rate. In addition the HIV diagnosed prevalence since 2016 has exceeded the 2 per 1,000 (aged 15- 59) therefore defining the authority as a high HIV prevalence local authority according to 2017 NICE and PHE guidelines. For Peterborough, the increased rate is associated in part to improved testing, diagnosis, and treatment.

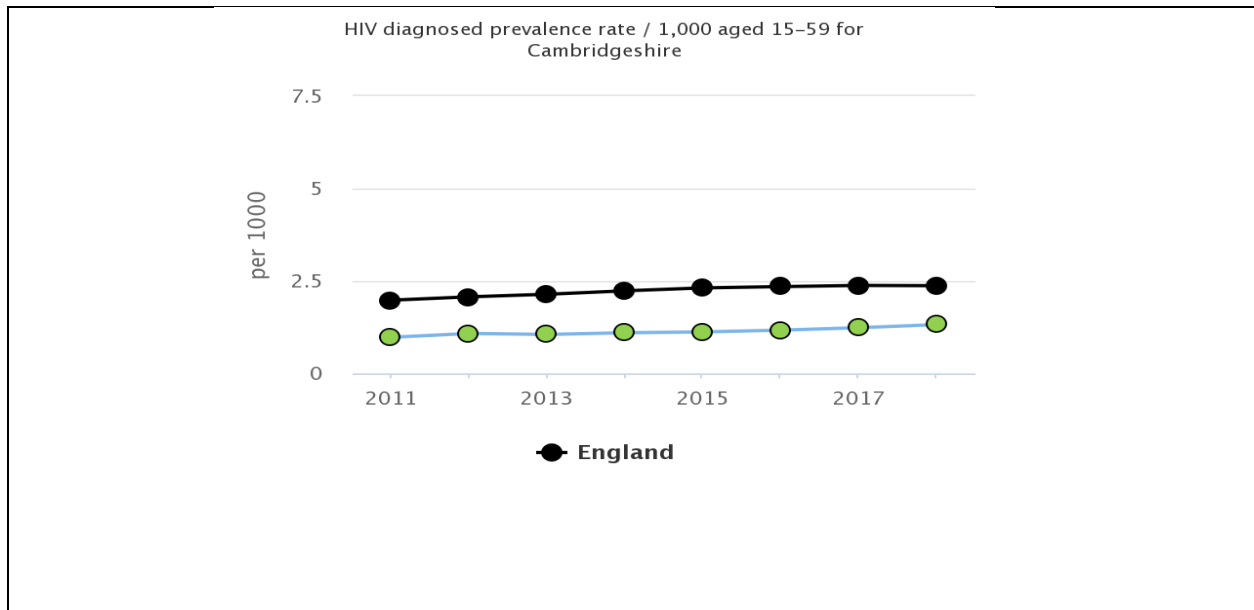


Figure 12: HIV diagnosed prevalence rate per 1000 (people aged 15 – 19 yrs), Cambridgeshire, (2011 – 18), Source: *Sexual Health Profiles Public Health England*

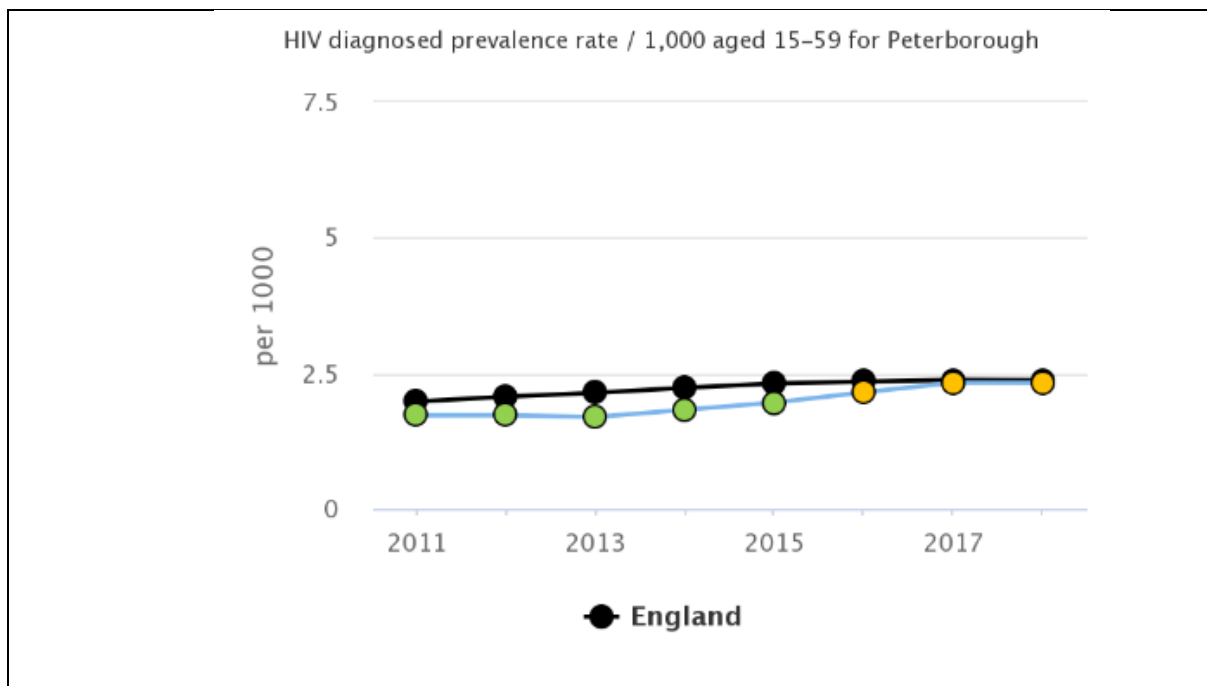


Figure 13: HIV diagnosed prevalence rate per 1000 (people aged 15 – 19 yrs), Peterborough, (2011 – 18), Source: *Sexual Health Profiles Public Health England*

10.4 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 generally statistically significantly worse than the benchmarking goal (defined as $\geq 50\%$) in the period 2015-17. However during the period 2016-18 it was once again similar to the England average. The rate of late HIV diagnosis for Peterborough was generally worse than the benchmarking goal (defined as $\geq 50\%$). However in 2016-18 the percentage of late diagnoses was similar to the benchmarking figure.

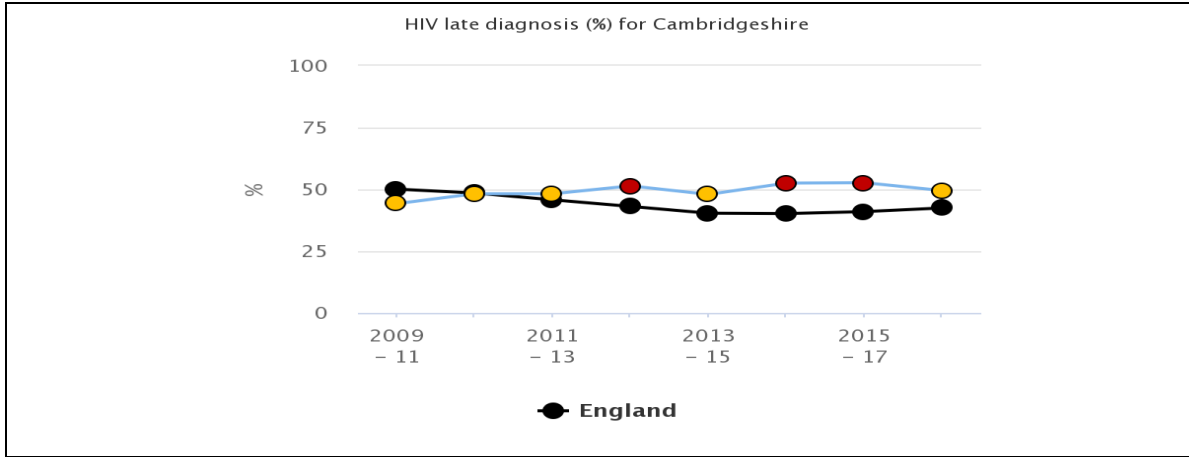


Figure 14: HIV Late Diagnosis (%)¹, (% of adults aged 15 years or over as a proportion of those diagnosed with HIV) , Cambridgeshire, (2009-18), Source: Sexual Health Profiles Public Health England

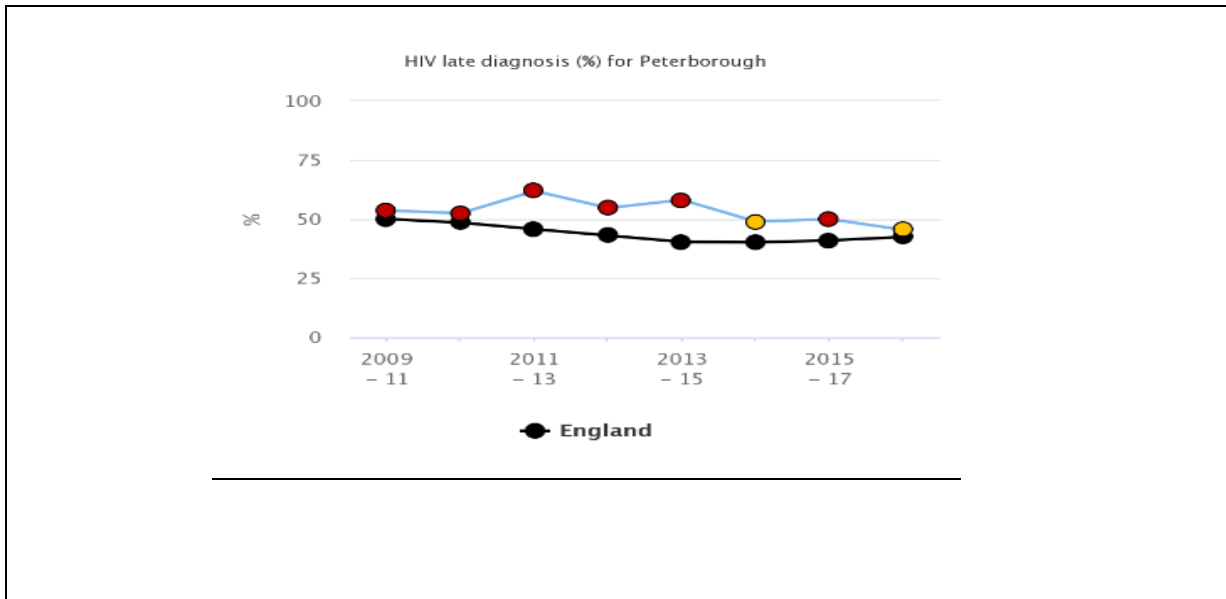


Figure 15: HIV Late Diagnosis (%)² (% of adults aged 15 years or over as a proportion of those diagnosed with HIV), Peterborough, (2009-18), Source: Sexual Health Profiles Public Health England

¹ *The graph shows the Cambridgeshire rate RAG-rated compared to the benchmark for this indicator, not England.

² *The graphs show the Cambridgeshire rate RAG-rated compared to the benchmark for this indicator, not England.

10.5 Chlamydia Diagnosis

Nationally, there has been a continued decline in Chlamydia detection rates amongst 15-24 year olds since 2012. For Cambridgeshire, the rate of chlamydia detection has remained statistically significantly lower than the national average, and lower 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.

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.

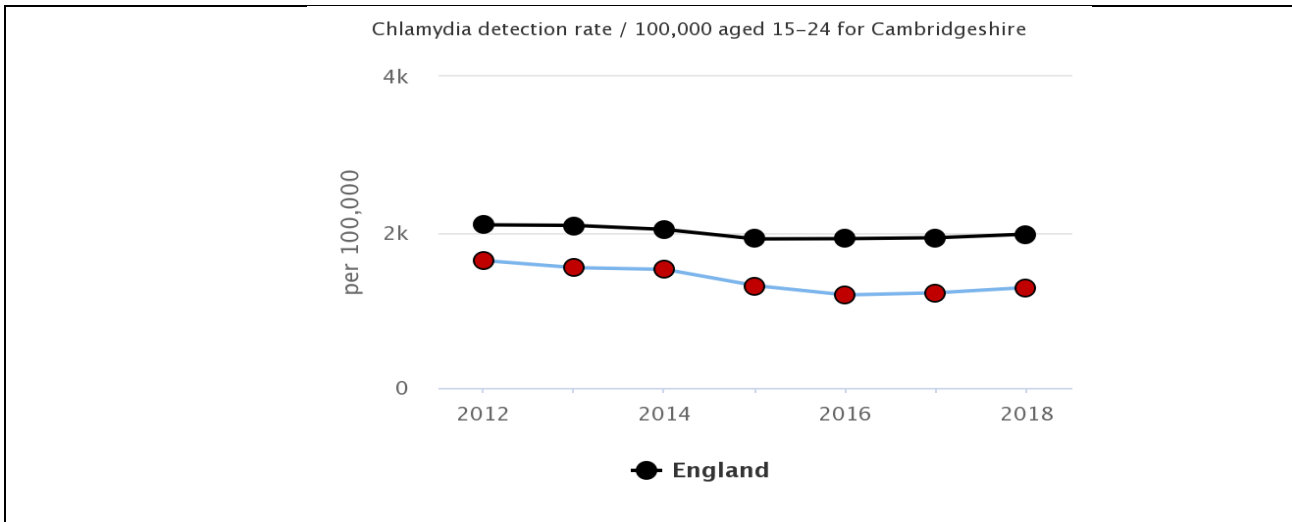


Figure 16: Chlamydia detection rate 15-24 yrs, Cambridgeshire, (2012 – 17), Source: Sexual Health Profiles Public Health England

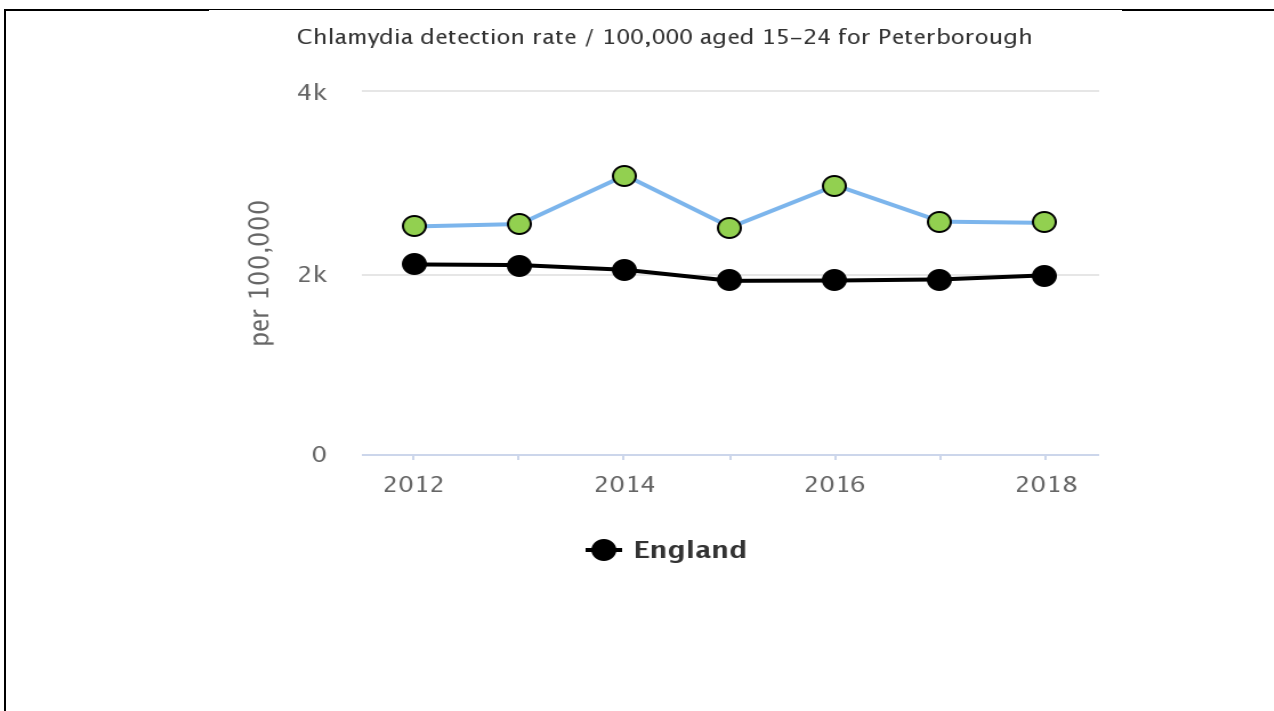


Figure 17: Chlamydia detection rate 15-24 yrs, Peterborough, (2012 – 17), Source: Sexual Health Profiles Public Health England

10.6 Teenage Pregnancy (conceptions)

The under 18 conception rate per 100,000 has improved dramatically between 1998 and 2017 in Cambridgeshire and in Peterborough. In Cambridgeshire as whole, it has remained statistically significantly better than the national average. Within Cambridgeshire, the Fenland district rate follows a downward trend but overall has remained consistently similar to England average. Peterborough also has had a downward trend in the under 18-conception rate but it has been generally statistically significantly worse than the national figure. However, in 2017 it was for the first time in six years statistically significantly similar to the national average.

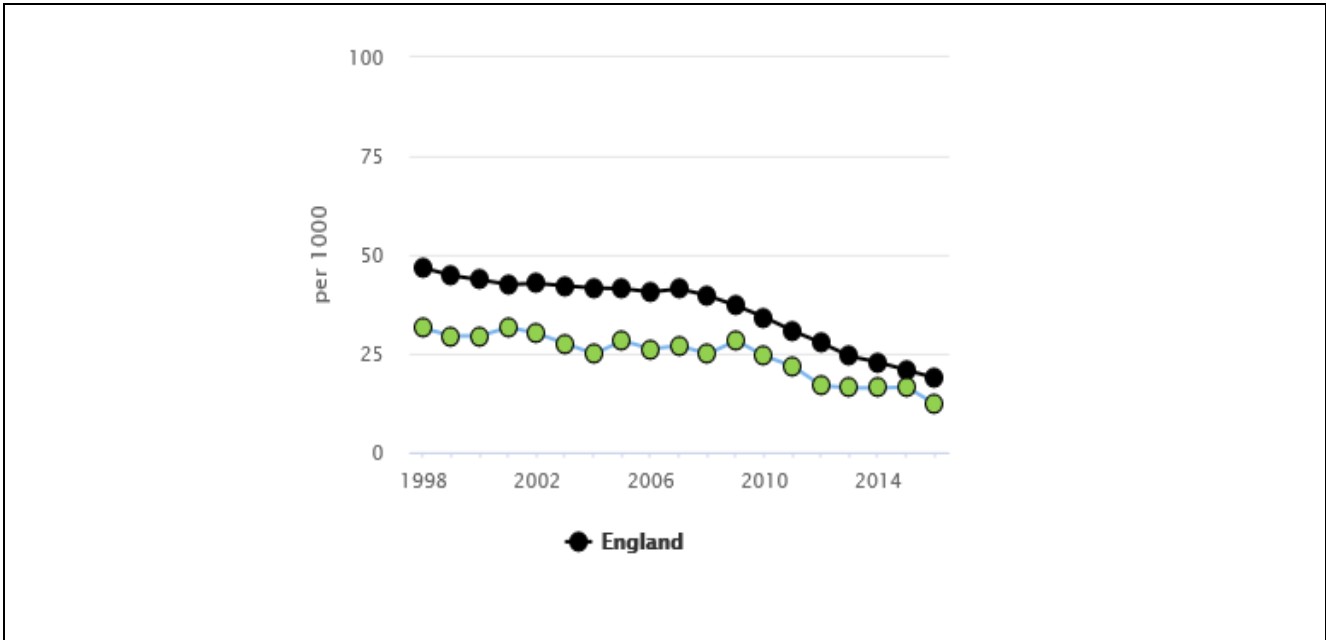


Figure 18: Under 18s Conception Rate, Cambridgeshire, (1998 - 17), Source: Sexual Health Profiles Public Health England

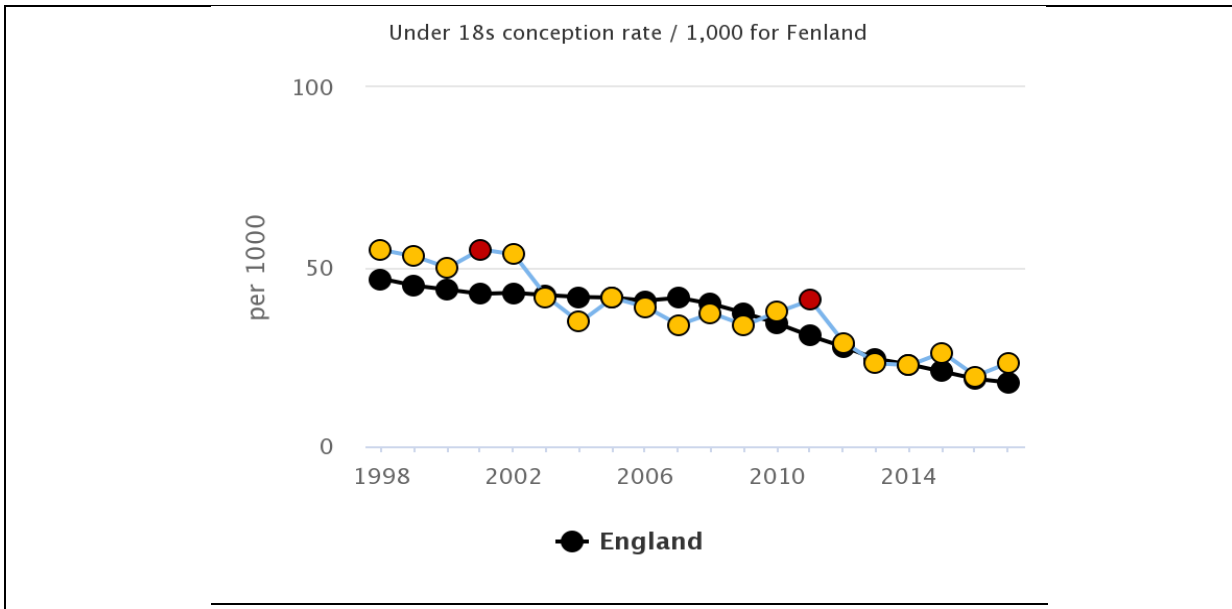


Figure 19: Under 18s Conception Rate, Fenland, (1998 - 17), Source: Sexual Health Profiles Public Health England

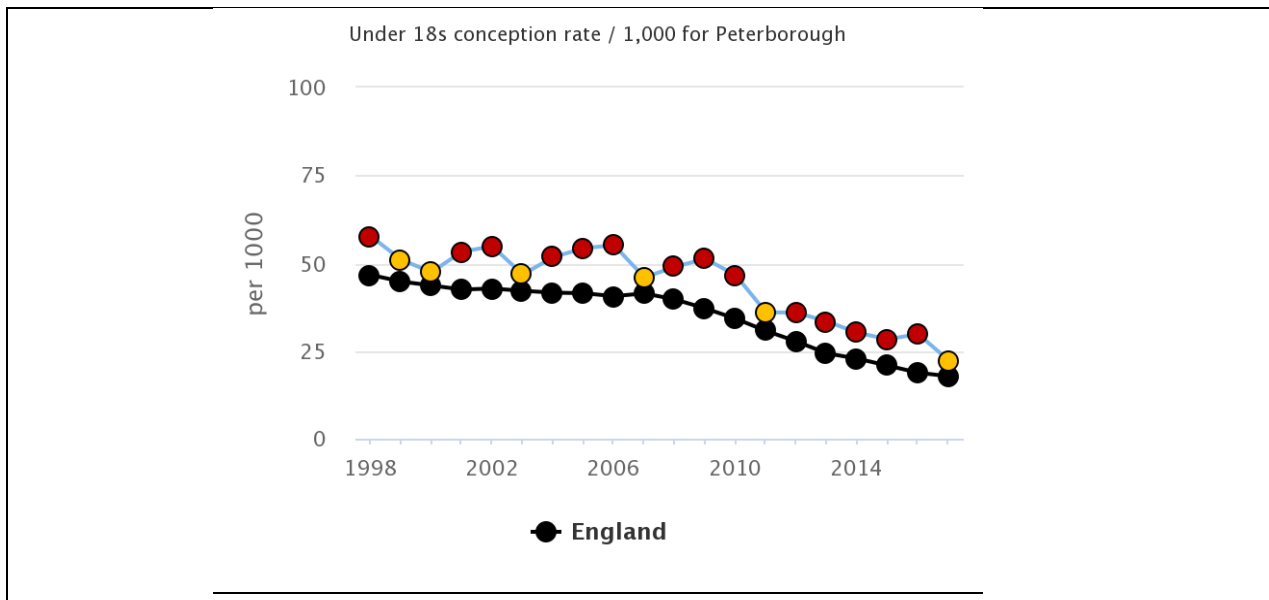


Figure 20: Under 18s Conception Rate, Peterborough, (1998 - 2017), *Source: Sexual Health Profiles Public Health England*

10.7 Prevention

As indicated above there are ongoing and emerging challenges for the Sexual and Reproductive Health (SRH) of the populations of Cambridgeshire and Peterborough.

In both Cambridgeshire and Peterborough, voluntary organisations and the SRH treatment services continue to provide a range of outreach services which also includes work with the more hard to reach/high risk groups. Outreach initiatives also highlight that many clients have other health conditions such as mental ill-health, and underlying social and financial needs such as poor housing/homelessness and exploitation. Often clients do not access services because of a lack the confidence and trust in organisations, however, outreach services can respond sensitively, and act as a conduit to other health and wellbeing resources,

Throughout the year, a number of campaigns are also undertaken in line with the national programmes. In 2019, there was focus upon late HIV diagnosis. During November and December, a number of sexual health promotion events took place in both areas to complement the National HIV Testing programme and World Aids Day.

Public Health has also commissioned the Personal, Social, Health and Economic (PSHE) Education Service to support schools to introduce the new statutory Relationships' and Sex Education (RSE) requirements for secondary and primary schools. This will contribute to the tools that are in development to support school staff to deliver this element of the curriculum.

The procurement of a new Prevention of Sexual Ill Health Service is currently underway. This service will commence on April 1 2020. Its focus is upon both supporting high-risk groups and building collaboration across the voluntary sector.

10.8 Sexual and Reproductive Health Services (SRH)

Cambridgeshire Community Services (CCS) is the main provider for the SRH Services in both Cambridgeshire and Peterborough. CCS is known locally as the Integrated Sexual Health Service (iCaSH). Both areas have since 2014 seen a continuous increase in demand for its services above the level of activity that is commissioned, which reflects the national trend in activity levels.

In response to the necessity of releasing savings to meet the cash cuts in the Public Health grant, both services have introduced service developments to accommodate this requirement but also to manage demand. Online screening for asymptomatic patients has been introduced in Cambridgeshire. This has increased overall demand but this service also has a positivity rate similar to the clinic service, suggesting unmet need.

Additional funding has been secured for both services in acknowledgment that an inability to treat infections promptly can have an impact on the sexual health of the population. Both Services still aim to meet the old Department of health 48 hour offered and seen access to services target, but find it challenging.

A new service is currently being commissioned that will commence on the 1 October 2020. This is a collaborative commissioning initiative with NHS England and Improvement and the Cambridgeshire and Peterborough Clinical Commissioning Group. Through a Hub and Spoke model, it will provide a range of services alongside the local authority mandated SRH services. There is a focus upon Women's Services but it will also include HIV treatment, HPV vaccination for men who have sex with men and community vasectomy. This commissioning initiative arose from being one of two pilot sites nationally invited by Public Health England to explore opportunities for collaborative commissioning between local authorities and the NHS.

In Cambridgeshire, chlamydia screening is commissioned from GPs for 15-25 year olds. Although numbers are low, they have a high positivity rate, which is associated with targeted opportunistic screening. Peterborough does not have a 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 has generally performed well but activity has seen a small decrease. The Peterborough community pharmacy EHC Service was re-commissioned in 2017/2018 and a significant amount of work was undertaken to ensure pharmacies received the relevant training. The initiative was very slow to establish itself and only a very small number of pharmacies participated initially. This has slowly improved but more are required to provide the Service in areas of greater need.

A priority for 2020 is to review the EHC provision in both areas and work with pharmacies and the Local Pharmacy Committee to identify and address the barriers to provision.

The newly commissioned SRH services both prevention and treatment will afford the opportunity to review partnership working to ensure that the impact of the new services is maximised through an integrated approach throughout the system.

11. 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:

- Actions from Health Protection audit;
- Cambridgeshire and Peterborough Hospital Evacuation Plan;
- CPLRF Vulnerable People Protocol; and
- Health and care system's capacity to respond to a major incident whilst experiencing severe pressures.

The actions from the Health Protection audit are completed and closed. The LRF Vulnerable People Protocol has been exercised and validated by the CPLRF Executive Board.

The period from 1 January 2019 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. Cambridgeshire Acute Hospitals Evacuation exercise: The discussion based table top exercise took place on the 10 June 2019 to test the multiagency and acute hospitals' response to an evacuation event taking place in one of the county's three main hospital sites. Forty three attendees across the CPLRF took part in the exercise.
2. Exercise Horus: This was a discussion based workshop exercise that took place on 16 October 2019. Through a series of EPRR scenarios, the exercise looked at the impact of migration into STPs, including recovery from a mass casualty incident.
3. Exercise Confluence: This was a table top exercise that took place on the 9th September 2019. The overarching aim of the exercise was to test the Cambridgeshire and Peterborough health and care system's response to a major incident whilst experiencing severe winter pressures.

The priorities for the year ahead have been agreed as:

- Planning for EU Exit;
- Operation Bridges; and
- CPLRF Mass Casualty Plan.

12. 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	Diphtheria, 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