



# Coventry and Warwickshire Health Protection Strategy 2017 - 2021



Protecting and improving the nation's health



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## Health Protection Strategy 2017-2021 Plan on a Page

Priority Area	Vision	Measures of success	What the Strategy will Deliver
<b>Air Quality</b>	To reduce the concentrations of air pollutants which have a negative impact on health, with a focus on areas of poorest air quality	<ul style="list-style-type: none"> <li>↓Concentrations of NO2 and PM 2.5</li> <li>↓Use of cars for short journeys</li> <li>↑Development of Cycleways and use of cycle ways</li> </ul>	<ul style="list-style-type: none"> <li>•Practical solutions to promote behaviour shifts and initiatives that reduce car journeys and promote physical activity, including in school and workplace environments</li> <li>•More 'active' travel infrastructure solutions with increased cycle ways, and improved public transport infrastructure</li> <li>•Evidence of designing in health through planning processes</li> <li>•Exploration of wider opportunities for improving fleet vehicles, and green procurement. opportunities</li> </ul>
<b>TB</b>	To improve prompt diagnosis of suspected TB, maintain high treatment completion rates, and establish a latent TB case finding programme	<ul style="list-style-type: none"> <li>↓Time between onset of symptoms and diagnosis</li> <li>↑Treatment completion rates</li> <li>↑Diagnosis and treatment of latent TB in new entrants from high incidence countries</li> </ul>	<ul style="list-style-type: none"> <li>•Raise TB awareness among professionals and high-risk communities to improve knowledge and early diagnosis in underserved groups.</li> <li>• Increase prompt diagnosis and treatment: All patients to commence treatment within 2 days of suspected diagnosis, with suspected infectious cases seen in clinic within 2 weeks</li> <li>•Screening of New Entrants: a nurse led Latent TB Screening programme is being established and will target people within Coventry and Rugby CCG catchment area who are new entrants from high incidence countries.</li> <li>•Effective management of both hospital and community incidents with outcomes and learning shared appropriately.</li> </ul>
<b>Hepatitis B/C</b>	To develop clear and agreed pathways for testing of those at risk, high quality treatment for those diagnosed, and the public health management of contacts	<p>Agreed commissioning policy re Hepatitis B/C testing in community</p> <p>NICE recommendations re Hepatitis B/C treatment in Acute contracts</p> <p>Agreed commissioning policy for screening of contacts</p>	<ul style="list-style-type: none"> <li>•Reduce the spread of Hepatitis B/C through appropriate targeted testing and screening and engagement with treatment</li> <li>•Increase uptake of appropriate Hepatitis B vaccinations for individuals in high risk groups and contacts of cases.</li> <li>•Support commissioned Sexual Health and Drug and Alcohol service providers in Coventry and Warwickshire to increase appropriate identification, treatment and vaccination within their service area.</li> <li>•Embed NICE Guidance into future commissioning planning and service specifications for treatment and care of individuals with Hepatitis B/C</li> </ul>
<b>Screening and Immunisations</b>	To maintain/increase uptake in all screening/immunisation programmes, with a focus on groups with low uptake, and service-related disparities in uptake	Maintain or increase uptake in all screening and immunisation programmes, with a focus on groups with low uptake	<ul style="list-style-type: none"> <li>•Maintain or increase (as appropriate) uptake across all screening and vaccination programmes</li> <li>•Effectively targeting underserved/'harder to reach' groups or those programmes with lower levels to increase specific engagement and uptake.</li> <li>•Work with commissioners and services supporting Looked After Children to increase uptake of routine immunisations</li> </ul>
<b>Infection Control</b>	To reduce the incidence and duration of outbreaks in health and care settings, and develop and deliver a system-wide Antimicrobial resistance strategy	<ul style="list-style-type: none"> <li>↓incidence of outbreaks in health and care settings</li> <li>↓duration of outbreaks in health and care settings</li> </ul>	<ul style="list-style-type: none"> <li>•Work to reduce both the incidence and duration of outbreaks in health and care settings, and ensure when these do occur, reflective learning drives service change and good practice is shared.</li> <li>•Embed a 'Champions' model in all care homes so all staff are trained and confident in preventing infections</li> <li>•Develop and embed an Antimicrobial Strategy to sit alongside this overarching strategy</li> <li>•Standardise the Root Cause Analysis approach for all C. difficile infection cases (caused by a number of things including inappropriate antibiotic prescribing).</li> </ul>
<b>Emergency Planning</b>	To develop a comprehensive system-wide pandemic flu plan, and focus on continuous improvement in outbreak planning arrangements	NHS and LA/LRF pandemic flu plans in place and tested	<ul style="list-style-type: none"> <li>•Development of comprehensive system-wide pandemic flu plan(s) that focus on continuous improvement in outbreak planning arrangements, at both strategic and operational levels, including NHS, Local Authority and Local Resilience Forum Plans.</li> </ul>
<b>Excess Winter Deaths and Health Effects of Cold Weather</b>	To minimise excess winter deaths and morbidity through collective preventative action on key drivers of cold-related ill-health	<ul style="list-style-type: none"> <li>↓Number of households in fuel poverty</li> <li>↓Flu-related hospital admissions and deaths</li> <li>↑Seasonal Flu vaccination uptake among risk groups</li> </ul>	<ul style="list-style-type: none"> <li>•Reduce the number of homes experiencing fuel poverty through increasing referrals to commissioned services that offer advice/support and physical interventions, including 'affordable warmth on prescription' services to vulnerable, eligible households.</li> <li>•Increase uptake of Flu vaccinations in eligible groups through annual campaigns, and engaging with frontline staff to recommend flu vaccinations</li> <li>•Explore multi agency commissioning opportunities to look at widening out affordable warmth initiatives</li> <li>•Ensure an ongoing collaborative approach to planning for cold weather across health and care services</li> </ul>

Health Protection Strategy 2017 - 2021 – Local Focus		
Priority	Focus in Coventry	Focus in Warwickshire
Air Quality	City-wide Air Quality management required	Urban Areas
TB	Establishing Latent TB Case-finding programme and strengthening partnerships for managing patients with complex medical and social needs	Focus on education of health professionals regarding epidemiology of TB in Warwickshire, when to “think TB”, as well as maintaining excellent treatment completion rates
Hepatitis B/C	Understanding and tackling reasons for high incidence of Hepatitis B/C in Coventry	Ensuring whole pathway of care – from screening/testing to treatment is evidence-based and working well.
Screening and Immunisations	Focus on adult screening programmes (lower uptake than national), and immunisation uptake in Looked after Children	Focus on maintaining overall good immunisation and screening uptake, identifying geographical areas/particular groups where uptake is lower
Infection Control	Establishing Root Cause Analysis for healthcare acquired infections in the Community, and development of an Antimicrobial Resistance Strategy for the sub-region	Particular focus on infection control and outbreaks in health and care settings, and an Antimicrobial Resistance Strategy for the sub-region
Emergency Planning	Ensuring multi-agency pandemic flu plans are in place and tested.	Focus on access to treatment/prevention services (e.g. antivirals, vaccinations) during a pandemic, especially in rural areas
Excess Winter Deaths	Reducing numbers and proportions of households in fuel poverty, and increasing uptake of seasonal flu vaccinations across all risk groups	Reducing numbers and proportions of households in fuel poverty, with a focus on ensuring support services are accessible to rural populations. Increasing seasonal flu vaccination uptake across all risk groups, particularly in North of the County

## **Introduction**

### ***Background***

This strategy sets out the partnership approach and specific aims and priorities for Health Protection across Coventry and Warwickshire for 2017-2021.

Health Protection is concerned with ensuring the health and wellbeing of the Coventry and Warwickshire populations. It uses population-wide surveillance and interventions to prevent disease and provide protection from a range of potential hazards and harms. To achieve this, a multi-agency approach is required.

### ***Purpose and Priorities***

The purpose of developing this strategy, which builds on work outlined in the previous 2013 - 2015 strategy document, is to produce a shared and integrated 5-year vision for Health Protection for the population of Coventry and Warwickshire. A summary of progress made since the 2013-15 strategy was implemented is outlined in Appendix 1.

The Health and Social Care Act 2012 proposed new duties and responsibilities for both the NHS and Local Authorities, creating a range of new organisations, each with a number of health protection responsibilities. It placed the responsibility for system-wide health protection assurance with Directors of Public Health, to ensure appropriate oversight and challenge in the system for the effective planning and delivery of health protection programmes.

Coventry and Warwickshire have well-established and effective relationships and a long history of collaborative working to deliver health protection functions. However, we are confronted with new and evolving challenges to population health; emerging epidemics and drug resistance; changing environments and demographics, and the ongoing risk of chemical and biological incidents. This clearly demands an ongoing robust health protection response.

This strategy is structured around the shared priorities and aims of the multi-agency membership of the Coventry and Warwickshire Health Protection Committee.

The collective role of the Health Protection Committee is to provide assurance on behalf of the population of Coventry and Warwickshire that there are safe and effective plans in place to protect local population health. This includes communicable disease control, infection prevention and control, emergency planning, environmental health, and screening and immunisation programmes. The Committee therefore takes a strategic lead for Health Protection, provides a professional forum for discussion/collaboration, ensures plans are tested, reviews risks and outbreaks as appropriate, and seeks assurance that quality improvements and incident 'lessons learnt' are embedded in practice.

The identified priorities, as set out below, have been agreed by the Committee, as well as being aligned to regional/national health protection priorities. It is the responsibility of Health



Protection Committee members to monitor progress against the strategy and underpinning action plans delegated to specialist working groups/teams.

The overarching aims of the Committee with regard to supporting the strategy are to guide the collective work of partners on the priorities, monitor progress against actions and be a vehicle to discharge statutory Public Health obligations required through the Health and Social Care Act 2012.

The Priorities identified for 2017 – 2021 are:

- Air Quality
- Tuberculosis
- Viral Hepatitis
- Population Screening and Immunisation Programmes
- Infection Control
- Emergency Planning
- Excess Winter Deaths

### ***Who is the strategy for?***

Coventry and Warwickshire residents, Local Health and Wellbeing Boards, Executive Teams of City, County, District and Borough Councils, local NHS organisations, Clinical Commissioning Groups, voluntary sector partner organisations and Public Health England in the West Midlands.

This strategy has links with other key local strategies such as the Joint Strategic Needs Assessments (JSNA), and Health and Wellbeing Strategies. It also links to and compliments a range of specific strategies underpinning the work of local partners and members of the Committee.

### ***Implementation***

The implementation of this strategy will be carried out jointly by partner organisations, and implementation groups and Boards which already exist (or will be convened in the future), e.g. the Coventry & Warwickshire TB Programme Board, Coventry and Warwickshire Hepatitis Strategic Group, Coventry and Warwickshire Air Quality Alliance, Warm and Well in Warwickshire and Keeping Coventry Warm Programme boards/operational groups.

## Air Quality

### ***Why is this important?***

Poor air quality, both indoor (such as second hand smoke) and outdoor, can lead to significant adverse health effects. Our focus in this strategy is on outdoor air pollution, which has been linked to cancer, asthma/respiratory disease, strokes, and heart disease. Older people, those with existing long term conditions and children are more vulnerable to the effects of living or working in areas of high pollution.<sup>1</sup> There is also emerging evidence of effects in pregnancy and childhood.<sup>1</sup>

It is estimated that the equivalent of 40,000 deaths per year in the UK are directly attributable to outdoor air pollution.

Air quality across the UK has been impacted by the modern pollutants associated with the rapid increase in transport infrastructures, increased freight journeys and personal vehicle use/ownership. Nitrogen Dioxide (NO<sub>2</sub>) and particulate matter PM<sub>10</sub> and PM<sub>2.5</sub> are specific areas for concern.<sup>2</sup>

### ***What does the data tell us?***

Figure 1 shows that in Warwickshire, there has been a reduction in measured NO<sub>2</sub> concentrations from 2009-11 to 2012-14 across 15 of 17 monitoring sites (selected on the basis of showing the worst measured pollutant levels across the county), with half of the monitoring stations reporting levels below the annual mean objective. Please note the monitoring sites presented in Figure 1 are 17 (9%) of a total of 180 monitoring sites across the County. The remaining sites show lower measured levels of pollutants. It should be noted that the increasing trend shown for one of the roadside<sup>3</sup> monitoring sites in Nuneaton and Bedworth (34, Old Hinckley Rd, Nuneaton) is likely due to a high reading in 2012 attributed to the presence of roadworks. NO<sub>2</sub> concentrations have declined since 2012.

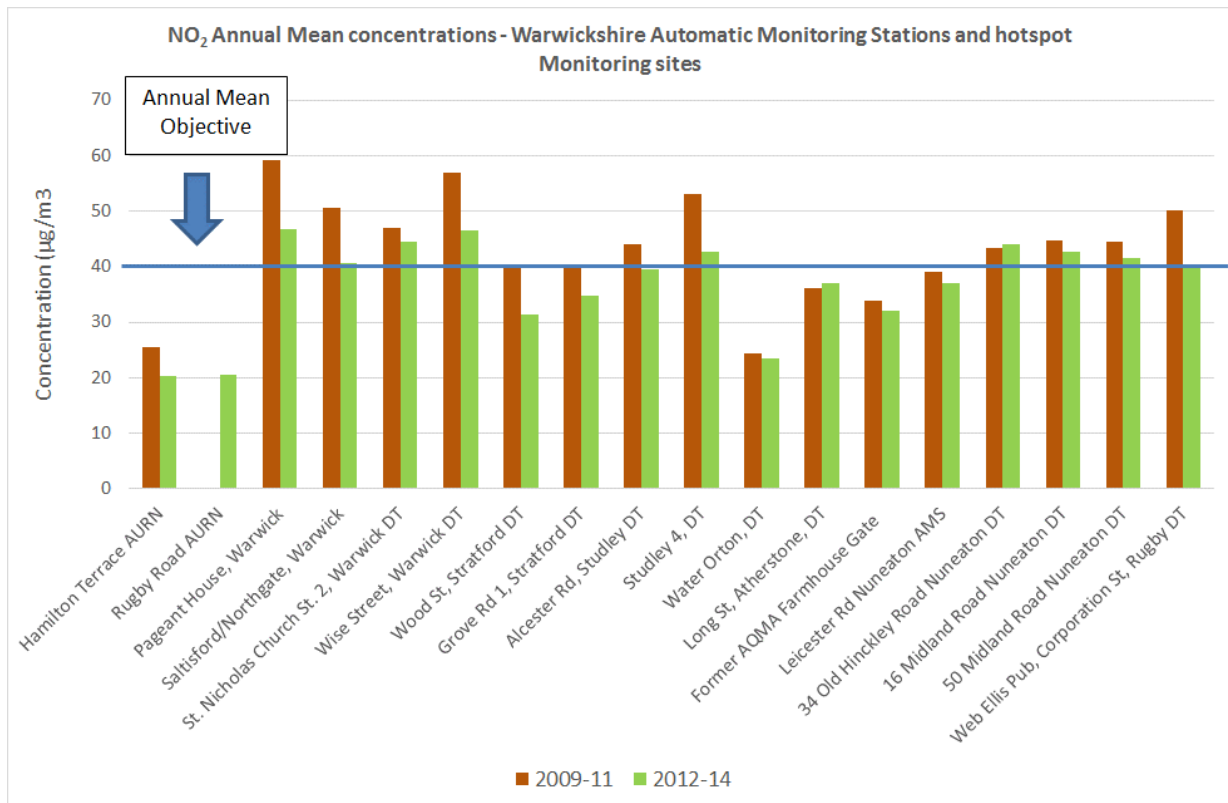
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<sup>1</sup> <https://www.rcplondon.ac.uk/projects/outputs/every-breath-we-take-lifelong-impact-air-pollution>

<sup>2</sup> <https://www.gov.uk/government/collections/comeap-reports>

<sup>3</sup> NB This is not a receptor location.

**Figure 1. NO<sub>2</sub> annual mean concentrations Warwickshire 2009-11 and 2012-14\***

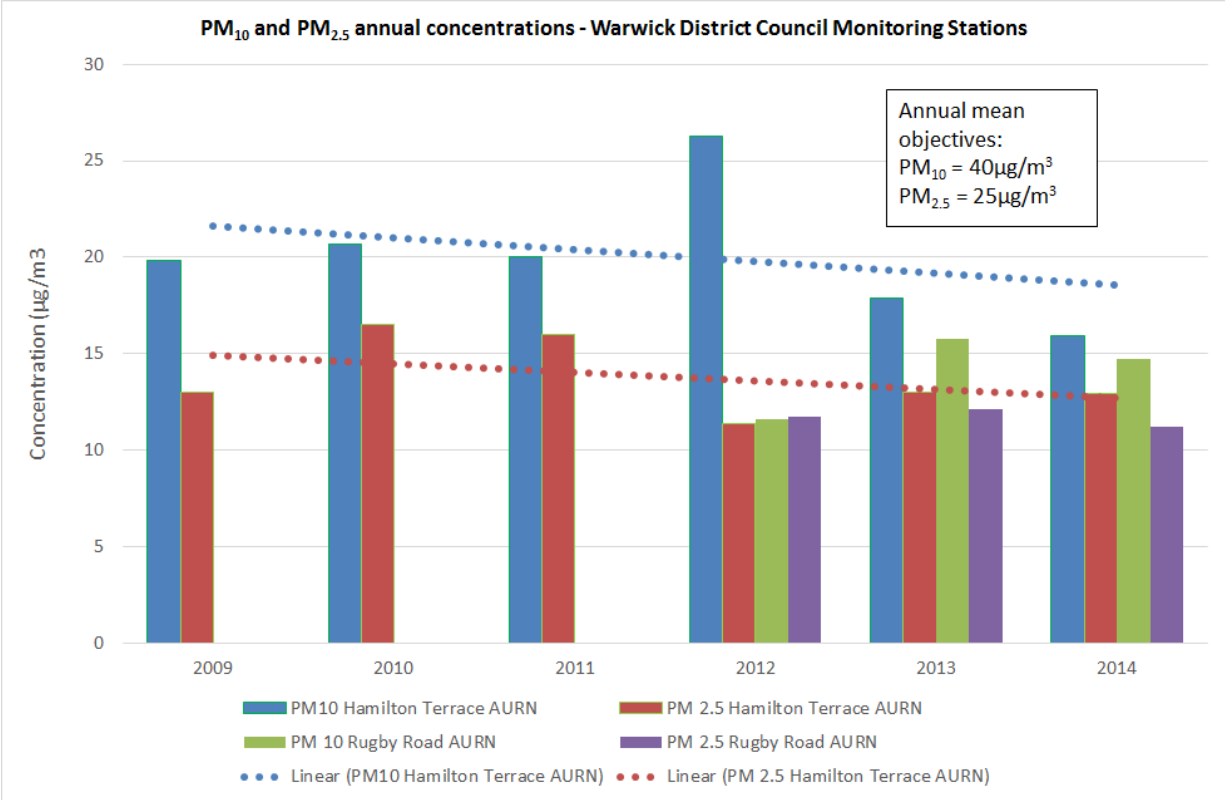


Source: Updating and Screening Assessment Reports, 2015

\*All sites are roadside locations with the exception of Hamilton Terrace (urban background) and Long St. Atherstone (kerbside location).

In Warwick district, there has emerged an overall trend towards a reduction in both PM<sub>10</sub> and PM<sub>2.5</sub> at Hamilton Terrace automatic monitoring station between 2009 and 2014 (Figure 2).

Figure 2. PM<sub>10</sub> and PM<sub>2.5</sub> annual concentrations Warwick\*

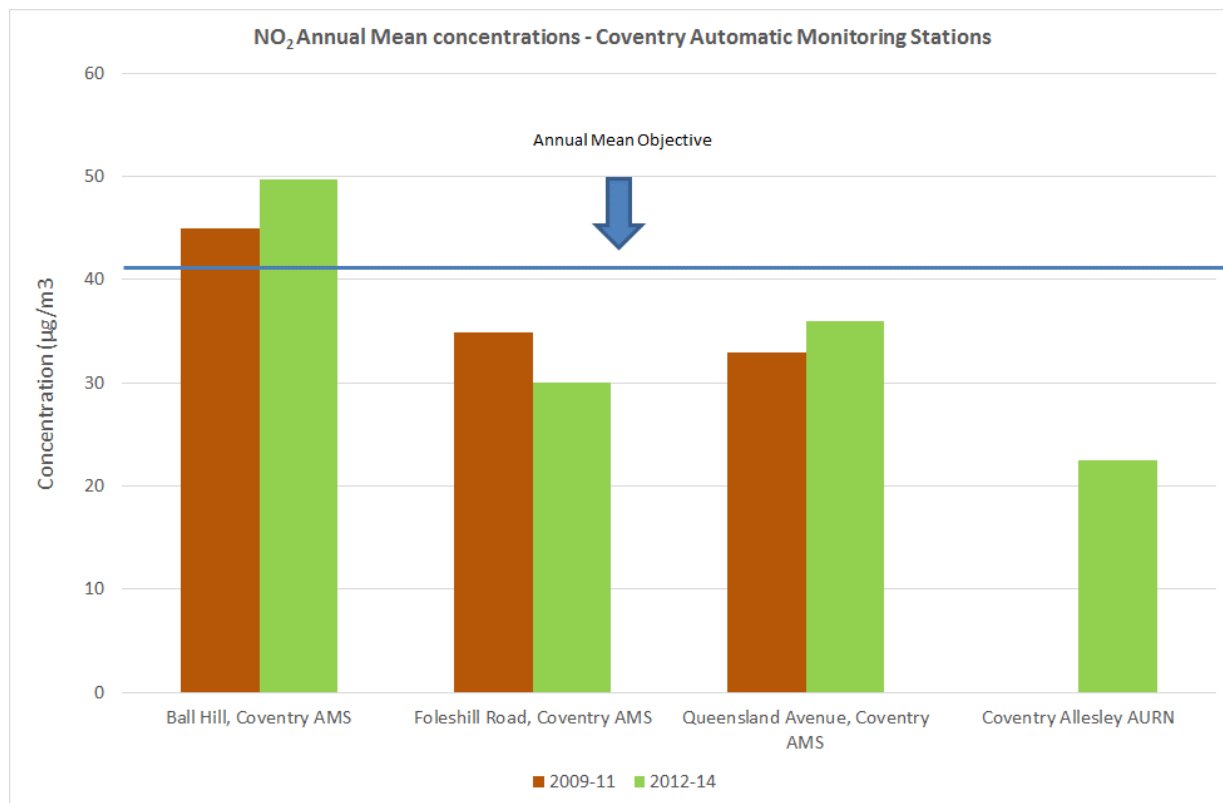


Source: Updating and Screening Assessment Reports, 2015

\*All sites are roadside locations with the exception of Hamilton Terrace (urban background)

Figure 3 shows that in Coventry, 3 out of 4 automatic monitoring stations have shown NO<sub>2</sub> levels below the annual mean objective concentration, although in 2 of the 3 stations where data is available from both 2009-11 and 2012-14, an increase is seen between these time periods.

**Figure 3. NO<sub>2</sub> annual mean concentrations Coventry 2009-11 and 2012-14\***

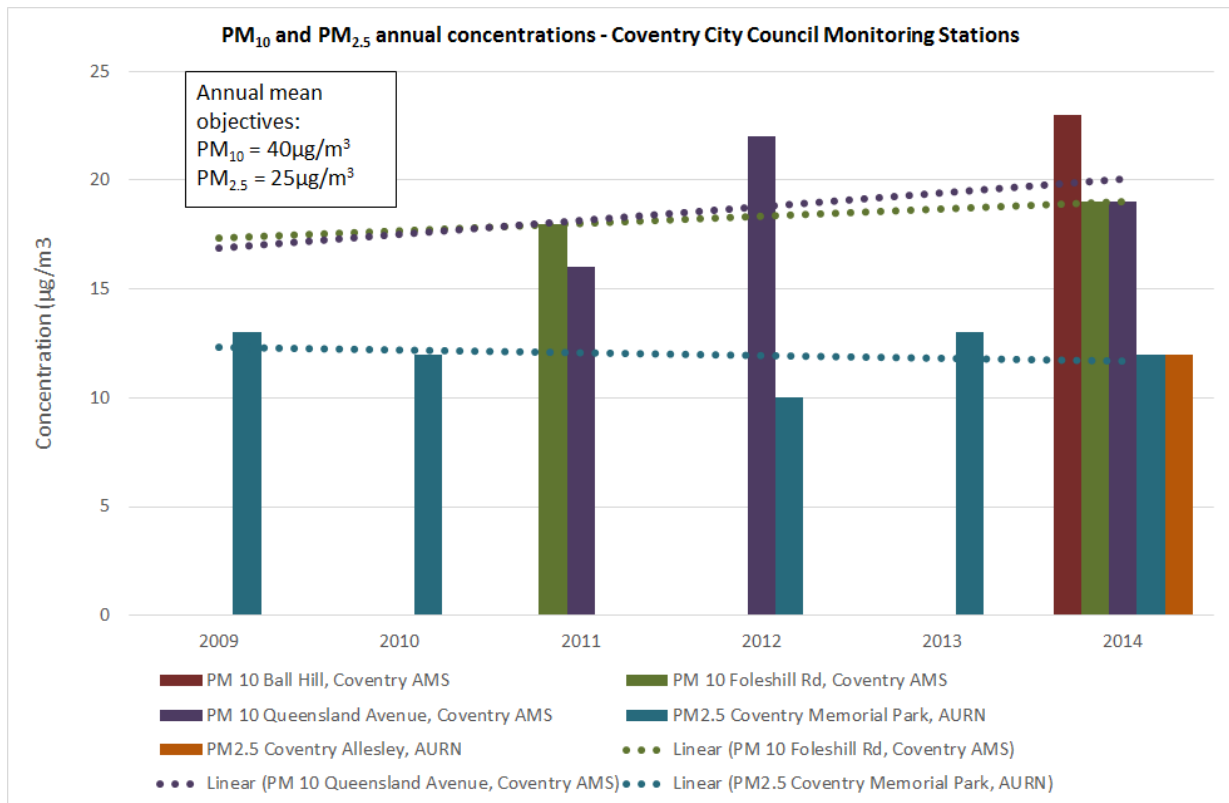


Source: *Updating and Screening Assessment Reports, 2015*

\*All sites are roadside locations with the exception of the Allesley AURN (urban background)

In Coventry, there has been a small reduction in PM<sub>2.5</sub> annual concentrations at Memorial Park from 2009 to 2014, although there has been an increase in PM<sub>10</sub> annual concentrations at Queensland Avenue and Foleshill Road between 2011 and 2014 (Figure 4). Please note that the only remaining monitoring station presented below is at Allesley. There is a further automatic monitoring station which will soon also be operational at Gosford Green. Non-automatic monitoring (with diffusion tubes) also continues across the City.

**Figure 4. PM<sub>10</sub> and PM<sub>2.5</sub> annual concentrations Coventry**



Source: Updating and Screening Assessment Reports, 2015

\*All sites are roadside locations with the exception of the Allesley and Memorial Park AURNs (urban background)

**What will the strategy deliver?**

- **Practical solutions to promote behaviour shifts** and initiatives that reduce car journeys and promote physical activity, including in school and workplace environments.
- **More ‘active’ travel infrastructure solutions** with increased cycle ways, and improved public transport infrastructure.
- **Evidence of designing in health through planning** processes.
- **Exploration of wider opportunities** for improving fleet vehicles, and green procurement opportunities.

## **Tuberculosis**

### ***Why is this important?***

Tuberculosis (TB) is an infectious disease commonly affecting the lungs, but which can involve any part of the body. It is usually spread by the cough of an infected person. Prolonged close contact with a person with active TB, for example living in the same household, is usually necessary for infection to be passed on. However, it may take many years before someone infected with TB develops the disease, this is known as latent TB.

Active TB requires a minimum of 6 months treatment, with drug resistant TB costing much more in terms of treatment, hospitalisation and complex social care needs.

Nationally, the rates of active TB have shown increases since the mid-1980s, but since 2010 the incidence has decreased, partly due to reduced migration into the UK from high incidence countries. This trend has been mirrored locally across Coventry and Warwickshire. However, the complexity of cases and incidents has increased locally.

The National Collaborative Tuberculosis Strategy for England 2015 - 2020<sup>4</sup> was launched in 2015 proposing key areas for action. One of these relates to establishing Latent TB case finding programmes, which is one of the four areas for action locally identified by the Coventry and Warwickshire TB programme board, and mirrored in the strategy priorities for TB highlighted below.

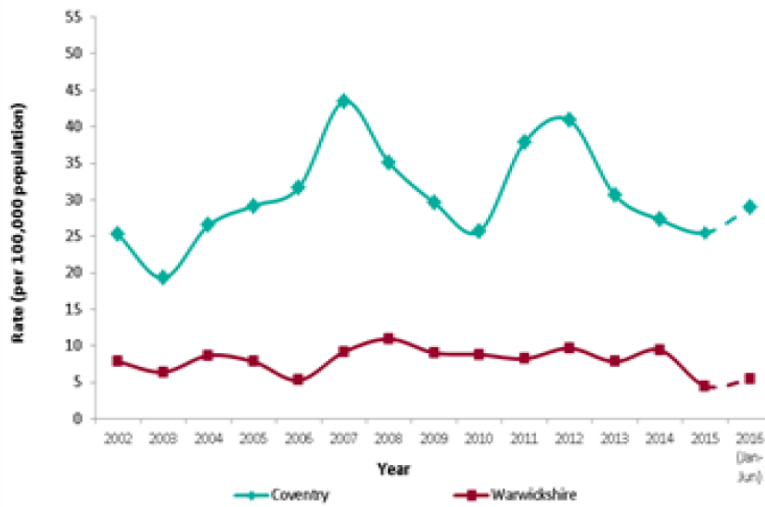
### ***What does the data tell us?***

Figure 5 shows that rates of TB in Warwickshire have remained fairly steady over time with around 5-10 per 100,000 population since 2002. Rates in Coventry have been higher, although there has been a reduction in rates from 2012 to 2015.

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<sup>4</sup> <https://www.gov.uk/government/publications/collaborative-tuberculosis-strategy-for-england>

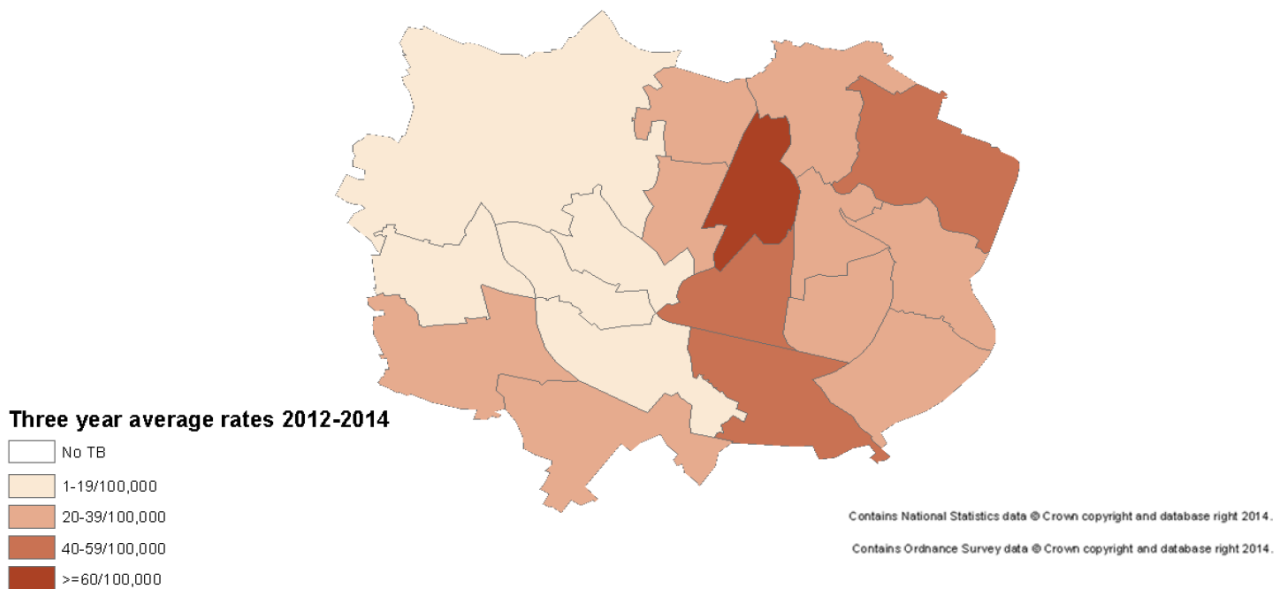
**Figure 5. TB rates per 100,000 population in Coventry and Warwickshire 2002-2016**



Source: PHE, Tuberculosis (TB) Quarterly Report West Midlands, Quarter 2, 2016

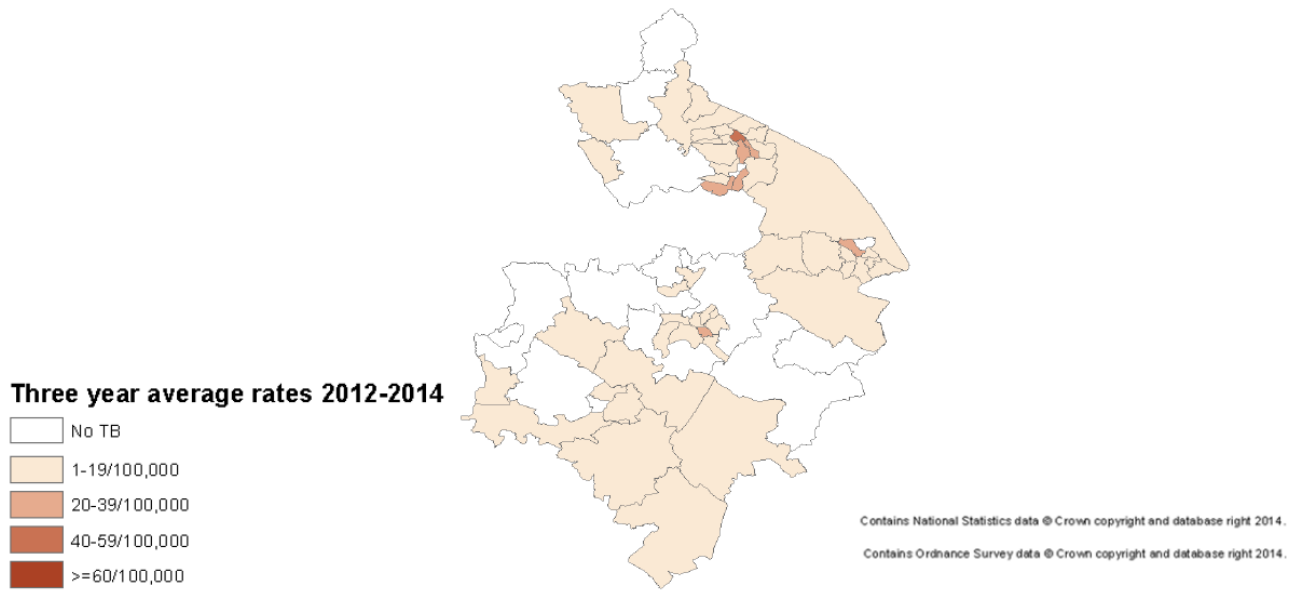
There is variation in the rates of TB across Coventry and Warwickshire, as can be seen in Figures 6 and 7. In Coventry, the North and East of the city see more cases of TB, with Foleshill and St Michael's wards having the highest rates in the city. Across Warwickshire, the highest rates can be seen in areas of Rugby, Nuneaton and Bedworth and Leamington. Coventry and Rugby CCG has the third highest rate of TB amongst all CCGs across the West Midlands

**Figure 6. Three year annual average TB incidence rate per 100,000 population Coventry 2012-2014**



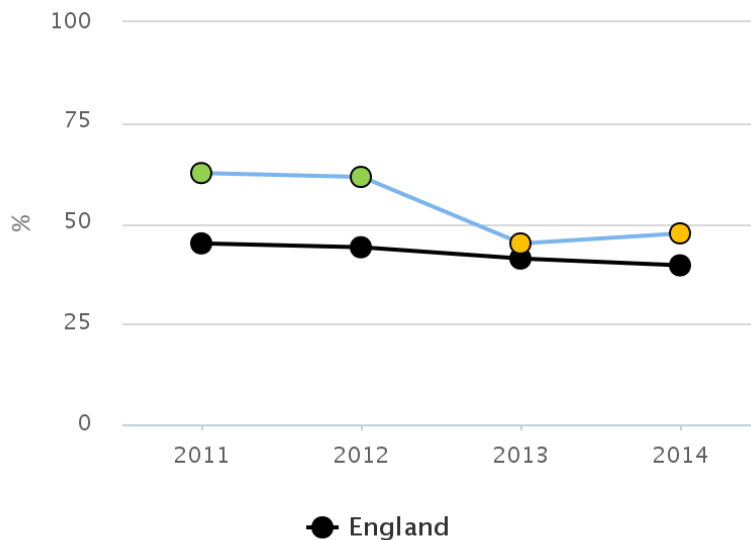


**Figure 7. Three year annual average TB incidence rate per 100,000 population Warwickshire 2012-2014**



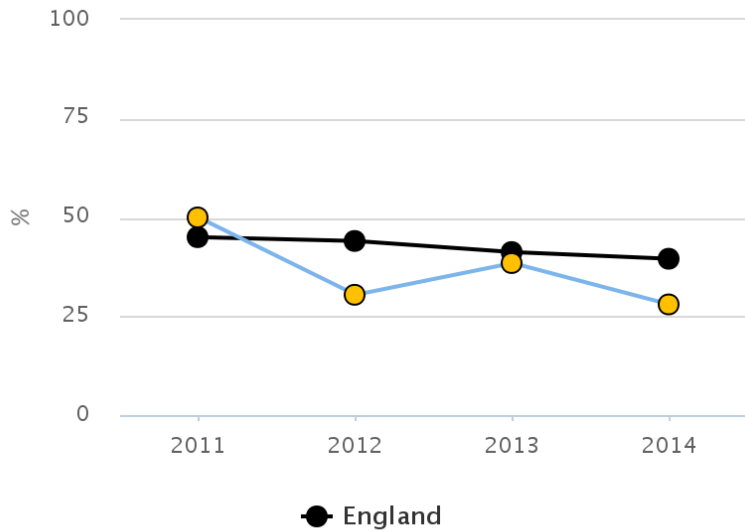
In Coventry, there is a higher proportion of pulmonary TB cases starting treatment within two months of symptom onset compared with the national average. The proportion in Warwickshire has been similar to the national average. Figures 8 and 9 below show that in the latest figures for 2014, both areas show no significant difference compared to the national average.

**Figure 8. Proportion of pulmonary TB cases starting treatment within two months of symptom onset Coventry 2011-2014**



Source: Enhanced Tuberculosis Surveillance system (ETS)

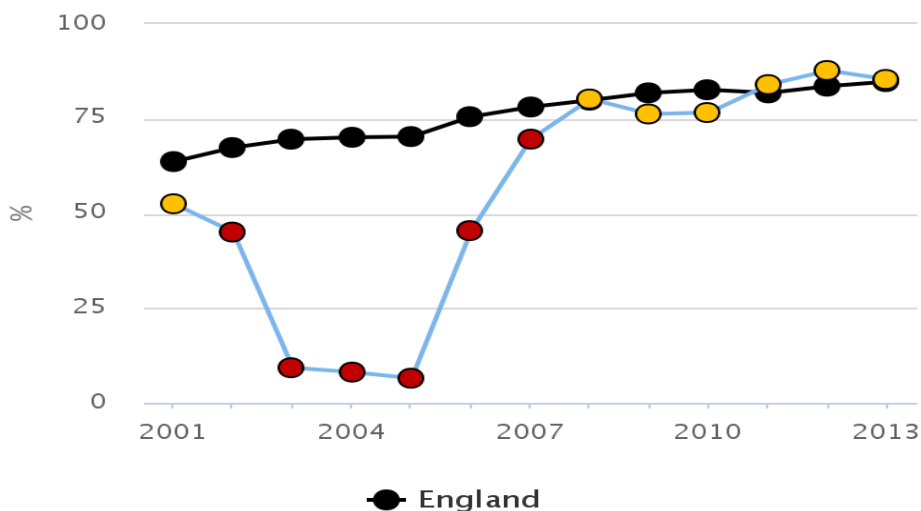
**Figure 9. Proportion of pulmonary TB cases starting treatment within two months of symptom onset Warwickshire 2011-2014**



Source: Enhanced Tuberculosis Surveillance system (ETS)

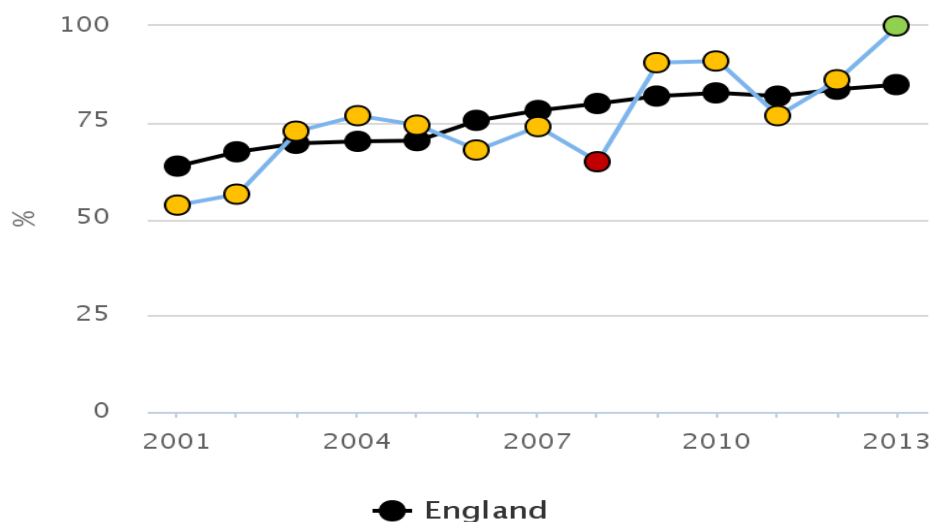
Figures 10 and 11 below show that since 2008, both Coventry and Warwickshire have seen similar rates of treatment completion for drug sensitive TB within 12 months compared to the national average, with an overall increase in treatment completion over time.

**Figure 10. Proportion of drug sensitive TB cases who had completed a full course of treatment by 12 months Coventry 2001-2013**



Source: Enhanced Tuberculosis Surveillance system (ETS)

**Figure 11. Proportion of drug sensitive TB cases who had completed a full course of treatment by 12 months Warwickshire 2001-2013**



Source: Enhanced Tuberculosis Surveillance system (ETS)

### **What will the strategy deliver?**

- **Raise TB awareness** among professionals and high-risk communities to improve knowledge and early diagnosis in under-served groups.
- **Increase prompt diagnosis and treatment:** All patients to commence treatment within 2 days of suspected diagnosis, with suspected infectious cases seen in clinic within 2 weeks.
- **Screening of new entrants:** a nurse led Latent TB Screening programme is being established and will target people within Coventry and Rugby CCG catchment area who are new entrants from high incidence countries.
- **Effective management of both hospital and community incidents** with outcomes and learning shared appropriately.

## Viral Hepatitis (Hepatitis B and Hepatitis C)

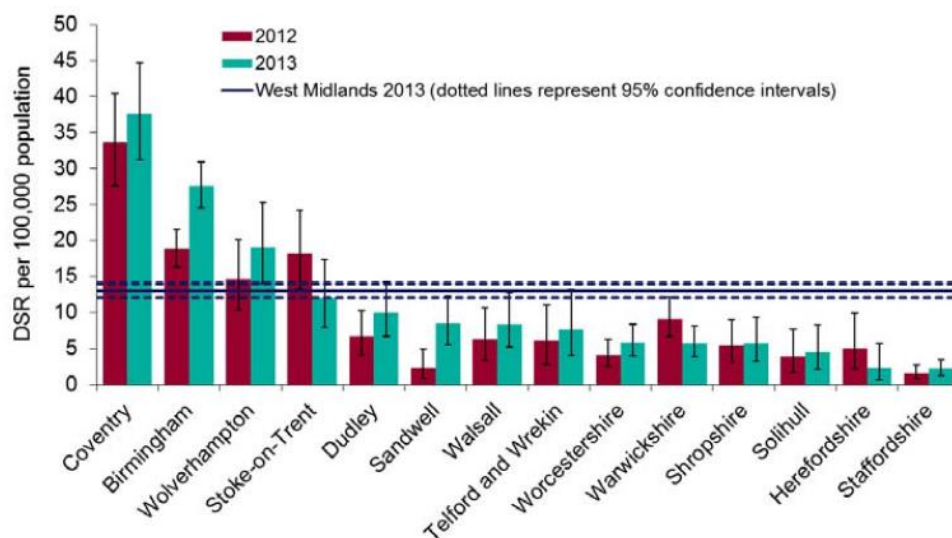
### Why is this important?

Hepatitis B virus (HBV) and Hepatitis C virus (HCV) are both blood borne viruses which cause liver infection. Both viruses are spread by contact with blood or body fluids from an infected person, with HBV being more infectious than HCV. Many people who carry the viruses are unaware of this and can therefore spread the infection without knowing. Untreated Hepatitis infection can lead to cirrhosis and liver cancer. In the UK, the commonest risk factor for acute cases of HBV is transmission via unprotected sex, followed by injected drug use (IDU). In contrast, more than 90% of all newly diagnosed HCV infections for which the source of infection is reported, are acquired via IDU. Other groups at increased risk of infection include individuals originating from countries where the prevalence of Hepatitis B and C is high (such as South Asia and Africa). It should be noted that Hepatitis B is preventable by vaccination and both Hepatitis B and C are notifiable diseases.

### What does the data tell us?

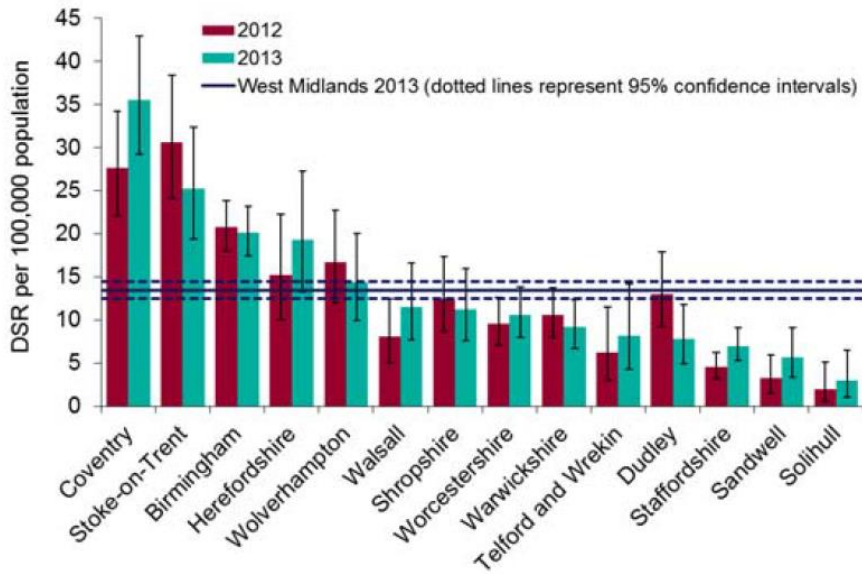
Standardised rates of Hepatitis B and C are shown in Figures 12 and 13 below. Rates in Coventry in 2012 and 2013 were both well above the West Midlands average, whilst rates in Warwickshire fall below the West Midlands average.

**Figure 12. Laboratory reports of Hepatitis B (acute and chronic), directly standardised rate per 100,000 population, 2012 and 2013**



Source: PHE LabBase

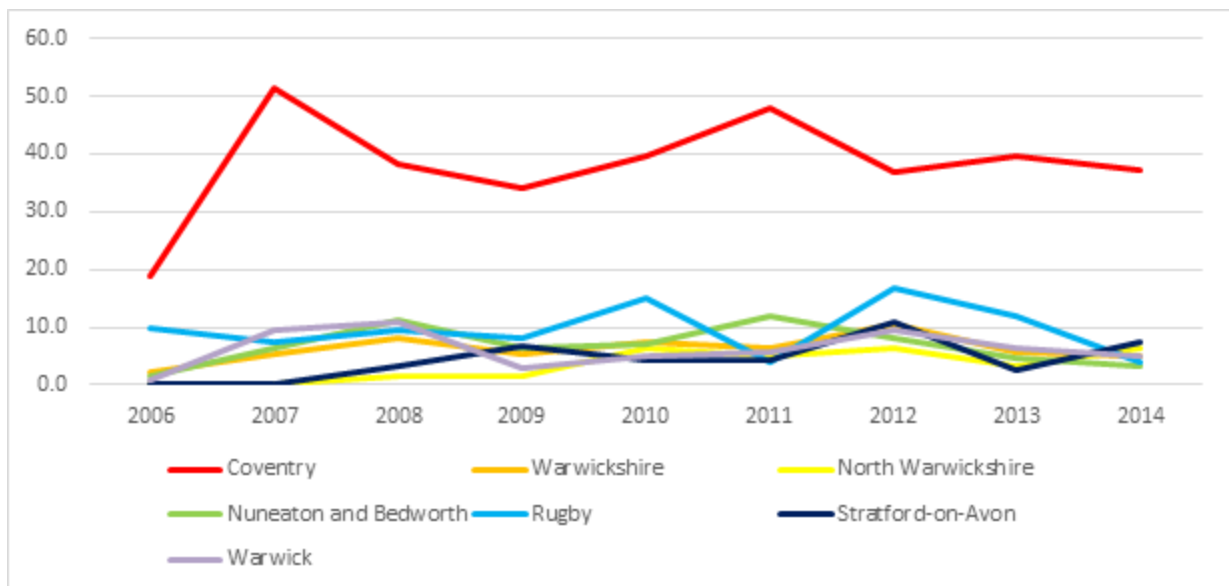
**Figure 13. Directly standardised rate of laboratory reports of Hepatitis C per 100,000 population 2012 and 2013**



Source: PHE, LabBase

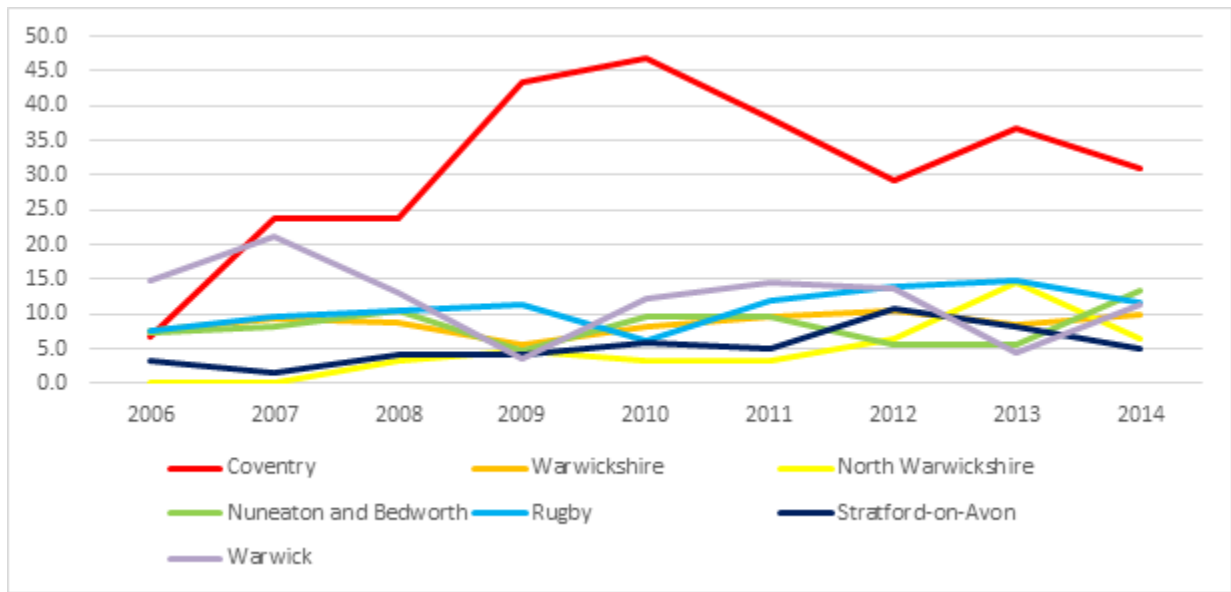
Figures 14 and 15 demonstrate the relatively stable rates of both Hepatitis B and C across the sub-region, with higher rates in Coventry compared with areas of Warwickshire. There has been a reduction in rates of Hepatitis C in Coventry since 2010.

**Figure 14. Laboratory reports of Hepatitis B (acute and chronic) per 100,000 population by local authority of residence, Coventry and Warwickshire, 2006-2014**



Source: Public Health England

**Figure 15. Laboratory reports of Hepatitis C per 100,000 population by local authority of residence, Coventry and Warwickshire, 2006-2014**



Source: Public Health England

In sexual health services in Warwickshire in 2015/16, 1332 individuals were screened for Hepatitis B/C, with 3 testing positive for Hepatitis B, and 3 for Hepatitis C. 119 individuals had their first dose of Hepatitis B vaccination in 2015/16. In Coventry sexual health services, 3298 individuals were screened for Hepatitis B and C in 2015/16, with 11 testing positive for Hepatitis B and/or C. 693 individuals were given a full course of Hep B vaccination and 498 a partial course during the year.

Figures 16 and 17 show testing, positivity and vaccination rates in Drug and Alcohol Services.

**Figure 16. Uptake of Hepatitis B vaccination and positivity rates among Drug and Alcohol Priority Service Users (i.e. those with previous or current intravenous needle usage in structured support) (April 2015 - March 2016)**

	Coventry Number (%)	Warwickshire Number (%)
<b>No. of Priority Service Users</b>	201	243
<b>Offered Hep B vaccination</b>	118 (59%)	125 (51%)
<b>Completed full course</b>	7 (6% of those offered)	9 (7% of those offered)
<b>Tested positive for Hepatitis B</b>	2 (1% of priority service users)	0 (0% of priority service users)

Source: The Recovery Partnership, Coventry and Warwickshire

In Coventry, the number of priority service users offered Hepatitis B vaccination has been steadily increasing over the past 3 years, with 59% of service users offered vaccination in 2015/16. For Warwickshire, this figure was slightly lower at 51%. Of those not offered vaccination, the majority are already immunised, or the vaccination was deemed inappropriate

due to compliance concerns. There are, however, low rates of completion of the vaccination course - 6% in Coventry and 7% in Warwickshire. Only 1% (2) of all priority service users in Coventry, and none of the priority service users in Warwickshire tested positive for Hepatitis B in 2015/16.

**Figure 17. Uptake of Hepatitis C testing and positivity rates among Drug and Alcohol Priority Service Users (i.e. those with previous or current intravenous needle usage in structured support) (April 2015 -March 2016)**

	Coventry Number (%)	Warwickshire Number (%)
<b>No. of Priority Service Users</b>	201	243
<b>Offered Hep C testing</b>	154 (77%)	175 (72%)
<b>Tested</b>	37 (24% of those offered)	69 (39% of those offered)
<b>Tested positive for Hepatitis C</b>	37 (18% of priority service users)	25 (10% of priority services users)

Source: The Recovery Partnership

The number of priority service users offered Hepatitis C testing has remained steady in Coventry over the last 3 years, with some reduction in Warwickshire. 77% of priority services users were offered testing in Coventry and 72% in Warwickshire in 2015/16. The remaining were not offered testing due to concerns regarding compliance with treatment should they test positive. A higher proportion of priority service users who had been offered testing were tested in Warwickshire (40%) than in Coventry (24%). Of all priority service users, 18% were Hepatitis C positive in Coventry, and 10% were Hepatitis C positive in Warwickshire in 2015/16.

**What will the strategy deliver?**

- **Reduce the spread of Hepatitis B/C through appropriate targeted testing and screening and engagement with treatment.**
- **Increase uptake of appropriate Hepatitis B vaccinations** for individuals in high risk groups and contacts of cases.
- **Support commissioned Sexual Health and Drug and Alcohol service providers** in Coventry and Warwickshire to increase appropriate identification, treatment and vaccination within their service area.
- **Embed NICE guidance into future commissioning planning** and service specifications for treatment and care of individuals with Hepatitis B/C.

## **Population Screening and Immunisation Programmes**

### ***Why is this important?***

Screening is the process of identifying health people who may be at increased risk of a disease or condition. The current UK population screening programmes include antenatal and newborn, as well as adult, screening programmes. They have an important role to play in population health by using a preventative model to identify individuals at higher risk of a health problem, offer them a diagnostic test which can lead to earlier diagnosis of disease, at a stage when treatment is more likely to be successful. This reduces costs to the NHS, and improves long term patient outcomes.

Robust quality assurance and initiatives to ensure good coverage are essential to ensure the effectiveness and safe operation of local screening programmes.

Worldwide vaccination and immunisation programmes have saved many lives and are the second most effective public health intervention after provision of clean water. It is important to emphasise the need to continue to achieve high uptake of vaccination in order to prevent the re-emergence of vaccine preventable diseases in our local communities. National evidence shows that inequalities in immunisation uptake persist.

Screening and immunisation programmes are currently commissioned by NHS England, with Public Health England providing oversight of the programmes. However, local authorities, and Directors of Public Health on their behalf, maintain the responsibility for health protection assurance, which includes that these programmes are working well.

Please note that Seasonal Flu vaccination programme is covered in the Excess Winter Deaths section.

### ***What does the data tell us?***

#### ***Adult Screening Programmes***

Since 2010, breast cancer screening coverage has remained below the national average (75.4%) in Coventry (71.7%), and above the national average in Warwickshire (77.9%), although Warwickshire has shown a decline in rates since 2010 (from 79.3%). Rates in Stratford on Avon District are significantly higher than those in three of the four other Boroughs in Warwickshire, which are all above the England average.



**Figure 18. Breast cancer screening coverage (previous 3 years) for eligible women aged 53-70 years, West Midlands 2015**

Area	Recent Trend	Count	Value
<b>England</b>	↓	4,327,589	75.4
West Midlands region	↓	458,009	76.0
Shropshire	↑	31,800	81.5
Worcestershire	↓	55,885	79.6
Telford and Wrekin	↑	14,364	78.6
Staffordshire	↓	80,180	78.5
Herefordshire	↓	18,424	78.2
Warwickshire	↓	49,697	77.9
Solihull	↓	18,729	76.8
Stoke-on-Trent	↑	19,471	76.5
Dudley	↓	25,877	76.0
Walsall	↑	20,542	75.7
Wolverhampton	↓	17,549	71.9
Coventry	→	20,773	71.7
Sandwell	↓	20,780	71.5
Birmingham	↓	63,938	69.6

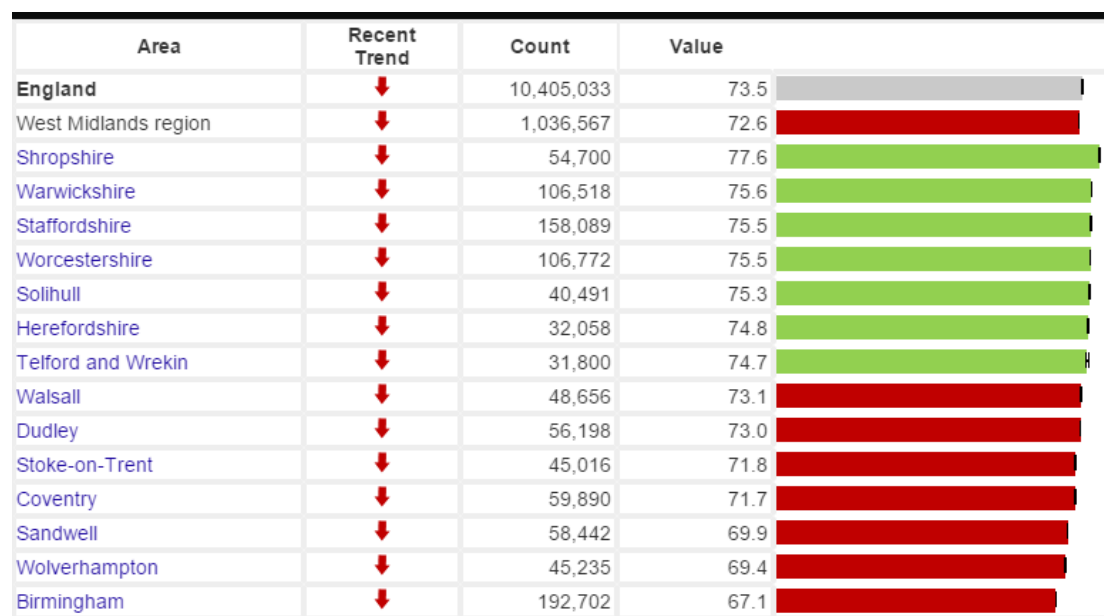
Source: Health and Social Care Information Centre (Open Exeter)/Public Health England

Area	Count	Value
<b>England</b>	4,327,589	75.4
Warwickshire	49,697	77.9
Stratford-on-Avon	12,965	79.6
North Warwickshire	6,072	78.4
Nuneaton and Bedworth	11,030	77.7
Rugby	8,459	77.2
Warwick	11,171	76.6

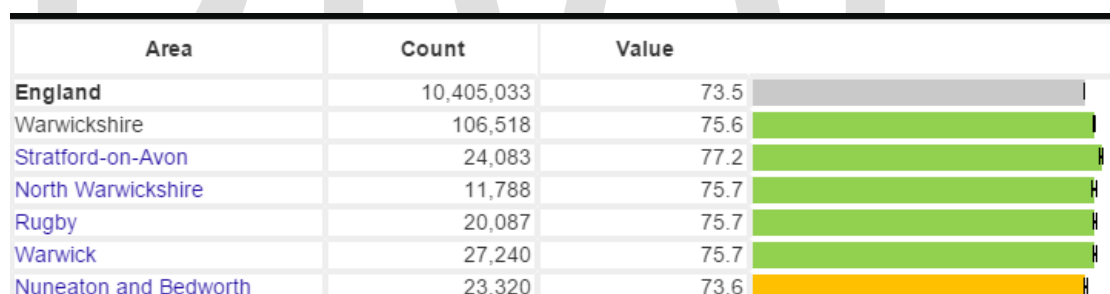
Source: Health and Social Care Information Centre (Open Exeter)/Public Health England

Cervical screening coverage has declined from 72.7% to 71.7% in Coventry between 2010 and 2015, remaining below the national average (73.5%) in 2015. Warwickshire has remained above the national average since 2011, with coverage of 75.6% in 2015. Within Warwickshire, Nuneaton and Bedworth Borough have the lowest rates of 73.6% in 2015, significantly lower than other Districts and Boroughs, although just above the England average.

**Figure 19. Cervical screening coverage West Midlands 2015<sup>5</sup>**



Source: Health and Social Care Information Centre (Open Exeter)/Public Health England



Source: Health and Social Care Information Centre (Open Exeter)/Public Health England

<sup>5</sup> The percentage of women in the resident population eligible for cervical screening who were screened adequately within the previous 3.5 years or 5.5 years, according to age (3.5 years for women aged 25-49 and 5.5 years for women aged 50-64) on 31 March.

Bowel cancer screening coverage in Coventry (57.9%) and Warwickshire (63.1%) are higher than the national average (57.1%). Figure 18 (below) shows coverage in Warwickshire as the highest in the region. North Warwickshire and Nuneaton and Bedworth have significantly lower uptake rates than the other Districts and Boroughs, although they are above the England average

**Figure 20. Bowel cancer screening coverage in 60-74 year olds (previous 2.5 yrs) West Midlands 2015**

Area	Recent Trend	Count	Value
England	–	4,406,923	57.1
West Midlands region	–	479,641	57.3
Warwickshire	–	55,708	63.1
Herefordshire	–	21,446	62.8
Worcestershire	–	61,987	62.4
Solihull	–	20,662	61.2
Staffordshire	–	86,028	60.0
Dudley	–	29,512	59.1
Shropshire	–	33,189	58.4
Coventry	–	23,019	57.9
Walsall	–	20,515	54.4
Telford and Wrekin	–	13,526	53.9
Wolverhampton	–	17,498	52.9
Stoke-on-Trent	–	18,182	51.0
Sandwell	–	19,656	49.6
Birmingham	–	58,713	48.7

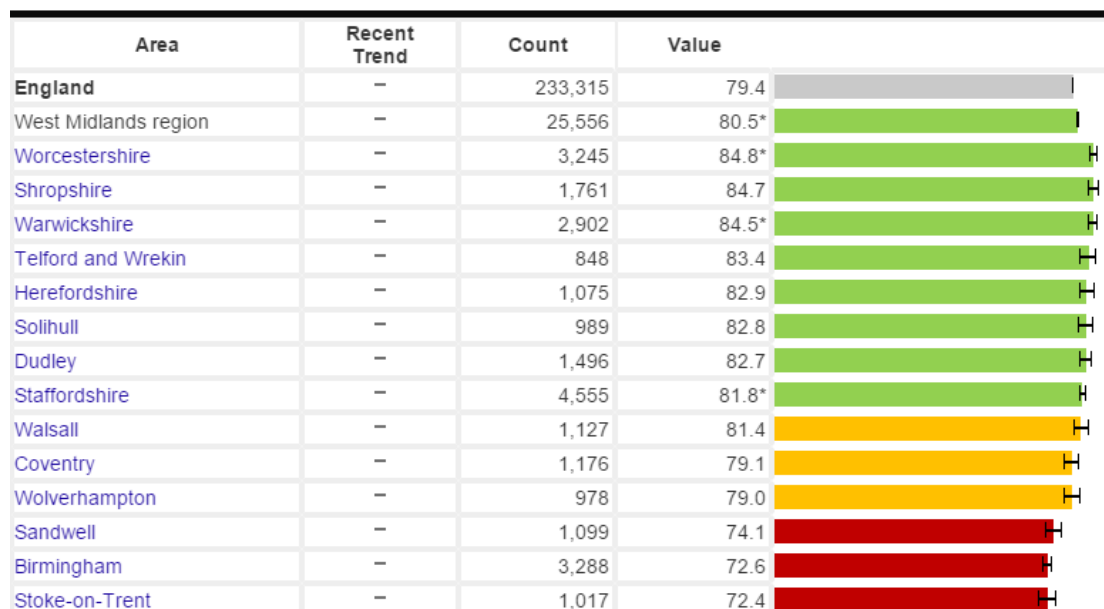
Source: Health and Social Care Information Centre (Open Exeter)/Public Health England

Area	Count	Value
England	4,406,923	57.1
Warwickshire	55,708	63.1
Stratford-on-Avon	14,975	64.9
Rugby	9,740	64.4
Warwick	12,716	63.6
North Warwickshire	6,795	62.0
Nuneaton and Bedworth	11,482	59.8

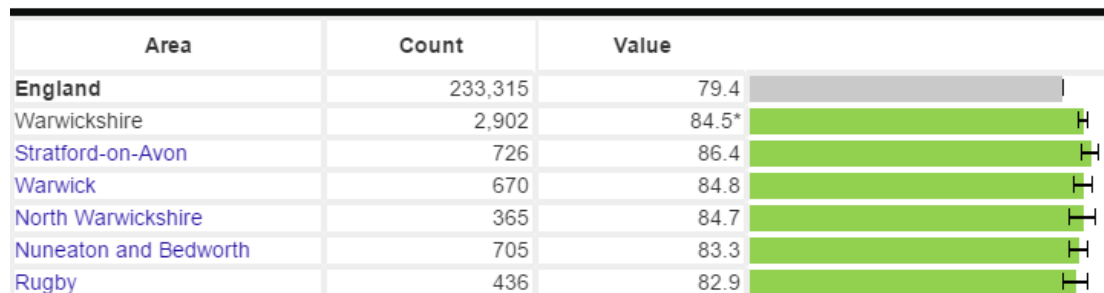
Source: Health and Social Care Information Centre (Open Exeter)/Public Health England

Figure 21 shows screening for abdominal aortic aneurism in Warwickshire is above the national average (84.5% compared with 79.4%). Coverage in Coventry is similar to the national average.

**Figure 21. Abdominal aortic aneurism screening coverage (males aged 65 years) West Midlands 2014/15**



Source: Screening Management and Referral Tracking (SMaRT) database



Source: Screening Management and Referral Tracking (SMaRT) database

The latest local screening coverage for diabetic eye disease, as shown in Figure 22, is below the national average for Warwickshire North and Coventry and Rugby CCGs, but above the national average in South Warwickshire CCG. Figures for 2015/16, provided at a Coventry and Warwickshire-wide level show an uptake of approximately 85% across the sub-region for the first three quarters of the year.

**Figure 22. Diabetic eye screening 2013/14**

	England	Coventry and Rugby CCG	South Warwickshire CCG	Warwickshire North CCG
<b>Diabetic eye screening 2013-14</b>	82.6	78.5	84.2	78.4

### **Antenatal and Newborn Screening Programmes**

Local data for Syphilis and Hepatitis B screening in pregnancy in Coventry and Warwickshire are not available through national Public Health England sources.

Figure 23 shows newborn bloodspot coverage is higher than the national average in South Warwickshire and Warwickshire North CCGs, and lower than the national average in Coventry and Rugby CCG.

**Figure 23. Newborn bloodspot coverage Q4 2015-16**

	England	Coventry and Rugby CCG	South Warwickshire CCG	Warwickshire North CCG
<b>Newborn bloodspot screening coverage</b>	96.2	95.1	98.0	96.9

*PHE Q4 2015-16 KPI data submissions (01/01/2016 - 31/03/2016)*

Local coverage of the newborn physical examination is higher than the national average. UHCW and GEH show similar coverage of antenatal testing for HIV, Sickle cell and Thalassaemia to the national average, with SWFT showing slightly lower levels.

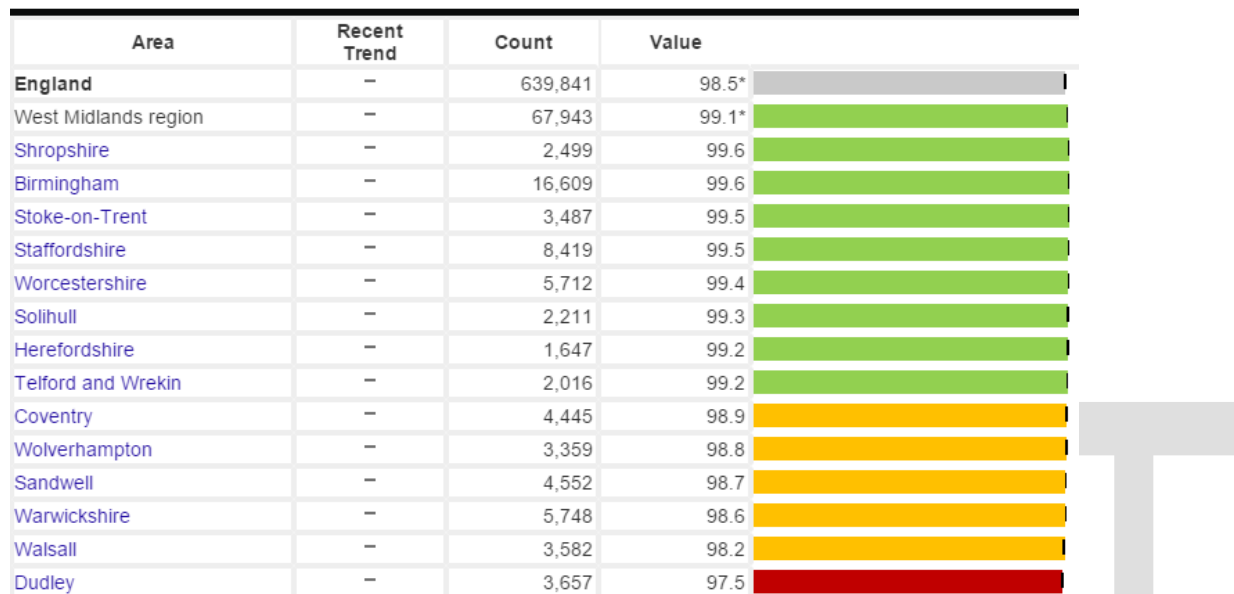
**Figure 24. Newborn physical examination, antenatal HIV screening and antenatal Sickle Cell and Thalassaemia screening by Trust Q4 2015-16**

Trust	Newborn physical examination	Antenatal HIV screening coverage	Antenatal sickle cell and thalassaemia screening coverage
<b>England</b>	94.4	99.1	98.7
<b>SWFT</b>	97.5	98.5	96.8
<b>GEH</b>	97.1	99.8	99.8
<b>UHCW</b>	98.2	99.2	98.8

*PHE Q4 2015-16 KPI data submissions (01/01/2016 - 31/03/2016)*

Coverage for newborn hearing screening nationwide is very high (98.5%), with similarly high rates in Coventry (98.9%) and Warwickshire (98.6%).

**Figure 25. Newborn hearing screening coverage West Midlands 2014/15**



Source: National hearing screening IT system

### **Childhood Immunisations**

DTaP/IPV/Hib<sup>6</sup> vaccination rates at 2 years, MMR<sup>7</sup> coverage at 5 years, and Hib/MenC<sup>8</sup> booster at 5 years in Coventry and Warwickshire are high and above the national coverage. DTaP/IPV/Hib vaccination rates have remained stable across Coventry and Warwickshire since 2010/11, MMR rates have increased year on year for Warwickshire over the same time period, with overall increases also seen in Coventry. Hib/Men C vaccination has seen a small decline in rates in Warwickshire. Figures 26 - 28 show how Coventry and Warwickshire compare to other areas in the West Midlands.

<sup>6</sup> Diphtheria, Tetanus, Pertussis (Whooping Cough), Polio and Haemophilus Influenzae B

<sup>7</sup> Measles, Mumps and Rubella

<sup>8</sup> Haemophilus Influenzae B and Meningitis C

**Figure 26. DTaP/IPV/Hib vaccination coverage at 2 years West Midlands 2014/15**

Area	Recent Trend	Count	Value
England	↓	662,348	95.7
West Midlands region	↓	71,049	96.5
Walsall	→	3,435	98.9*
Warwickshire	→	5,949	98.9*
Dudley	↑	3,755	98.6*
Coventry	→	4,531	98.4*
Staffordshire	→	9,105	98.1*
Stoke-on-Trent	→	3,550	98.1*
Worcestershire	↑	6,437	97.9*
Shropshire	→	2,904	97.7*
Telford and Wrekin	→	2,179	97.2*
Herefordshire	↑	1,884	97.0*
Solihull	↓	2,575	96.8*
Sandwell	↓	4,693	94.2*
Wolverhampton	→	3,433	93.9*
Birmingham	↓	16,619	93.4*

Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE). Available from The Health and Social Care Information Centre (HSCIC)

**Figure 27. Hib/MenC booster vaccination coverage at 5 years West Midlands 2014/15**

Area	Recent Trend	Count	Value
England	–	641,075	92.4
West Midlands region	–	65,712	93.0
Stoke-on-Trent	–	3,543	97.3*
Walsall	–	3,290	96.9*
Shropshire	–	2,900	95.5*
Telford and Wrekin	–	2,203	95.3*
Solihull	–	2,489	95.3*
Staffordshire	–	8,780	95.1*
Dudley	–	3,517	95.0*
Warwickshire	–	5,436	93.5*
Sandwell	–	4,192	93.1*
Coventry	–	4,153	92.5*
Worcestershire	–	5,713	91.2*
Birmingham	–	14,706	90.8*
Herefordshire	–	1,738	90.1*
Wolverhampton	–	3,052	86.2*

Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE). Available from The Health and Social Care Information Centre (HSCIC)

**Figure 28. MMR vaccination 2 doses coverage at 5 years West Midlands 2014/15**

Area	Recent Trend	Count	Value
England	↑	614,892	88.6
West Midlands region	↑	63,988	90.6
Walsall	↑	3,255	95.8*
Warwickshire	↑	5,544	95.3*
Coventry	↑	4,262	94.9*
Telford and Wrekin	↑	2,173	94.0*
Stoke-on-Trent	↑	3,416	93.8*
Dudley	↑	3,464	93.6*
Shropshire	↑	2,835	93.4*
Worcestershire	↑	5,760	91.9*
Staffordshire	↑	8,453	91.6*
Solihull	↑	2,392	91.5*
Herefordshire	↑	1,690	87.6*
Sandwell	↑	3,919	87.0*
Wolverhampton	↑	3,065	86.6*
Birmingham	↓	13,760	85.0*

Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE). Available from The Health and Social Care Information Centre (HSCIC)

Whilst uptake of childhood immunisations is good locally, it must be noted that uptake is much lower in certain groups. For example, in 2015 only 85% of Looked after Children in both Coventry and Warwickshire were up to date with their immunisations.<sup>9</sup>

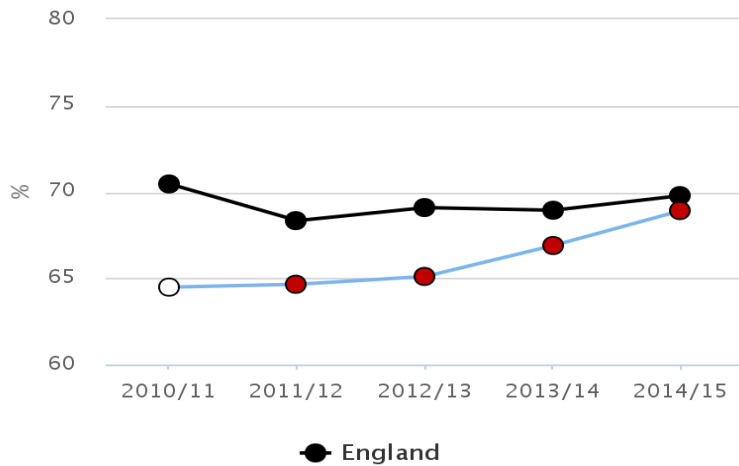
### Older adult immunisations

Pneumococcal vaccination rates have been increasing in Coventry since 2010/11 although remain slightly below the national average. Rates in Warwickshire have been slightly above the national average for the past 3 years.

<sup>9</sup> <https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2014-to-2015>

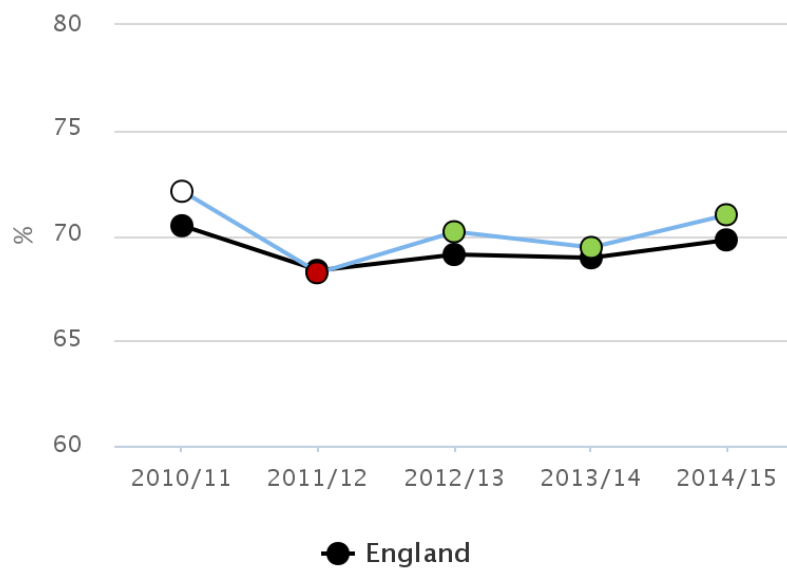


**Figure 29. Pneumococcal vaccination uptake, Coventry**



Source: Public Health England

**Figure 30. Pneumococcal vaccination uptake, Warwickshire**



Source: Public Health England

**What will the strategy deliver?**

- **Maintain or increase (as appropriate) uptake across all screening and vaccination programmes**
- **Effectively target under-served/‘harder to reach’ groups** for those screening and immunisation programmes with lower levels of uptake to increase specific engagement and uptake.

- **Work with commissioners and services supporting Looked after Children to increase uptake of routine immunisations**

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## Infection Control

### *Why is this important?*

Infection Prevention and Control is concerned with preventing the spread of infection in health and care settings. Healthcare-associated infections can affect patients of all ages. Healthcare workers, family members and carers are also at risk of acquiring infections when supporting patients. All providers of healthcare services are expected to have appropriate provision for infection prevention and control.

Outbreaks like norovirus within a health or social care setting can impact on the ability to deliver effective services. This can add to severe demands and pressures on resources/systems, especially in the winter season. However, there is also a significant need for effective infection prevention alongside the healthcare sector, for example within social care settings, schools and nurseries. Significant progress has been made over the last 10 years, both nationally and locally, in reducing rates of health-care associated infections such as MRSA<sup>10</sup> (which lives on the skin, and in the nose and throat, but can get into the body and cause life-threatening infections) and *C. difficile* (which causes infectious diarrhoea). Continuing this progress is essential.

Furthermore, in 2014, the WHO raised concerns that globally we are entering a 'post antibiotic' era; organisms and bacteria are developing multiple resistances to available antibiotic and antimicrobial treatments, meaning common infectious diseases will no longer be able to be treated effectively.<sup>11</sup> This means we need to take urgent local action to embed antimicrobial stewardship policies that respond to and reduce over-prescription of antimicrobial treatments.

An independent Infection Control Review was undertaken in Coventry and Warwickshire in 2015, focusing on the full range of health and care setting, and its key recommendations underpin the strategic focus and delivery of this strategy.

### *What does the data tell us?*

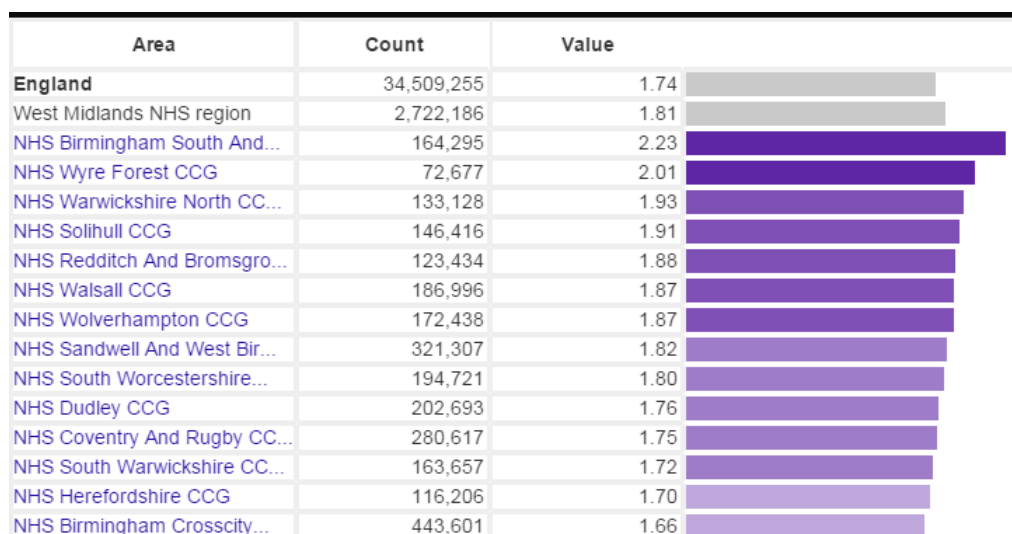
Figure 31 shows a comparison of local CCG antibiotic prescribing rates. Warwickshire North and Coventry and Rugby CCGs have slightly higher antibiotic prescription rates than the national rate, whilst South Warwickshire CCG has a slightly lower rate. Figure 32 shows that South Warwickshire CCG also has proportionally lower prescribing rates for those antibiotics considered to predispose individuals to developing *C. difficile*, an infectious diarrhoea. Despite this, Figure 33 shows that *C. difficile* rates were above the national and regional average in South Warwickshire CCG, and below these averages in Coventry and Warwickshire CCG and Warwickshire North CCG.

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<sup>10</sup> Methicillin Resistant Staph Aureus (resistant to a number of widely used antibiotics)

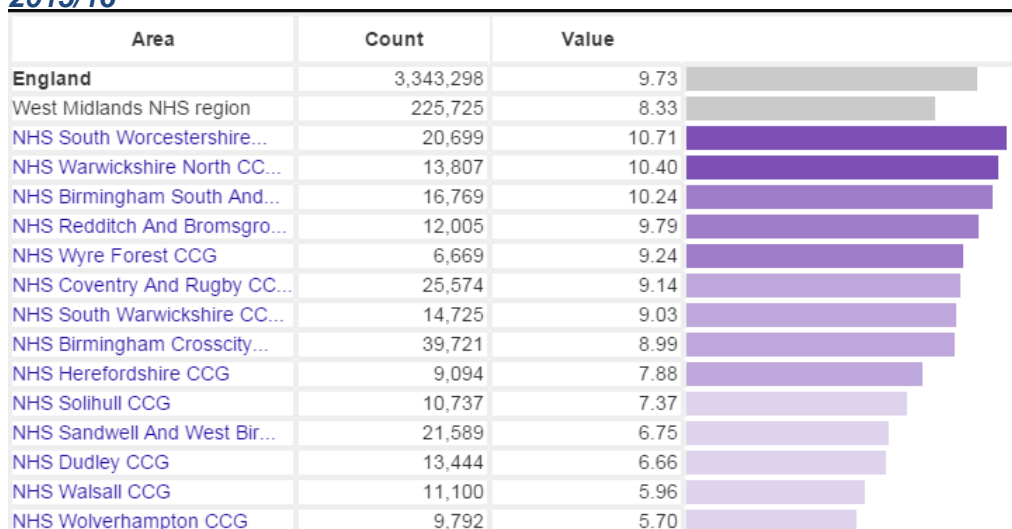
<sup>11</sup> <http://www.who.int/mediacentre/factsheets/fs194/en/>

**Figure 31. 12 month rolling total number of prescribed antibiotic items per 1000 individuals per day (crude rate) West Midlands 2015/16**



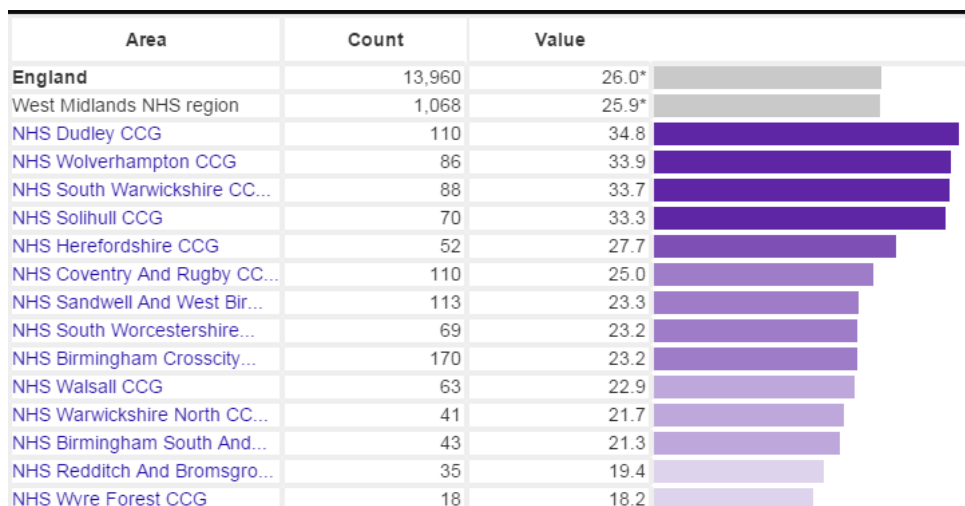
Prescribing data is sourced from HSCIC and supplied as monthly downloads that are aggregated into annual and quarterly datasets. Population data is produced by the Office of National Statistics.

**Figure 32. 12 month rolling percentage of prescribed antibiotic items from cephalosporins, quinolone and co-amoxiclav class West Midlands 2015/16**



Prescribing data is sourced from HSCIC and supplied as monthly downloads that are aggregated into annual and quarterly datasets. Population data is produced by the Office of National Statistics.

**Figure 33. C. difficile rates per 100,000 by CCG West Midlands 2015/16 financial year**



Source: HCAI Mandatory Surveillance Data

From these Figures, it can be seen that there is no clear relationship between antibiotic prescribing and C. difficile rates. This is likely to be due to these indicators not taking into account age structures of populations (e.g. older people are more vulnerable), alongside other factors. Reducing inappropriate antibiotic prescribing remains an important public health intervention.

**What will the strategy deliver?**

- **Work to reduce both the incidence and duration of outbreaks in health and care settings**, and ensure when these do occur that reflective learning drives service change and good practice is shared.
- **Embed a ‘Champions’ model in all care homes** so all staff are trained and confident in preventing infections.
- **Develop and embed an Antimicrobial Strategy** to sit alongside this overarching strategy.
- **Standardise the Root Cause Analysis** approach for all C. difficile infection cases including, but not limited to, those involving inappropriate antibiotic prescribing.

## Emergency Planning - Pandemic Flu

### *Why is this important?*

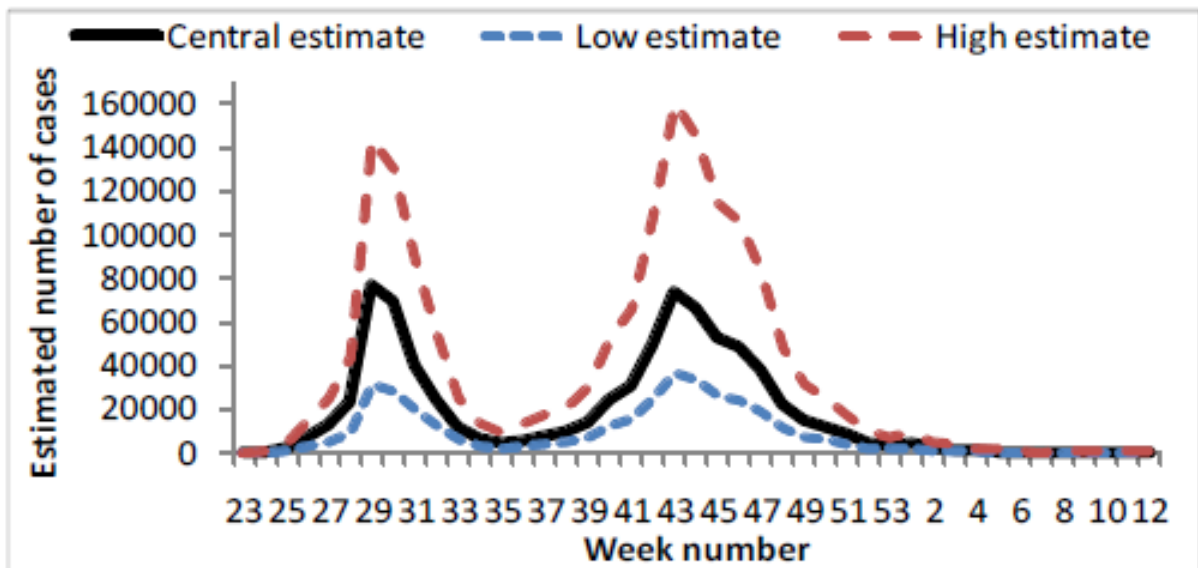
Planning for outbreaks, incidents, and environmental threats is crucial to support and protect the population, alongside protecting the provision of health and care, as well as wider services. Healthcare-related emergency planning is governed by the Local Health Resilience Partnership, which brings together health emergency planners, as well as those from local authorities.

This strategy will have a specific focus on Pandemic Flu. Following the learning from the pandemic in 2009, there needs to be assurance that all relevant agencies have plans in place, that procedures have been tested, that all partners are clear of roles and responsibilities, and that the care and support of people across the health and social care economy will continue to be effective during the next pandemic. This requires a multi-agency co-ordinated approach to testing and planning.

### *What does the data tell us?*

Figure 34 shows the estimated number of cases and deaths due to the 2009 H1N1 pandemic.<sup>12</sup>

**Figure 34. Estimated number of clinical cases in England June 2009- March 2010**



The symptomatic case-fatality ratio for this pandemic was estimated to be 0.04%. This compared favourably with previous pandemics. However, it should be noted that the

<sup>12</sup> [http://www.qresearch.org/Public\\_Documents/Pan%20flu%20report\\_final\\_8October2010%20covered\[2\].pdf](http://www.qresearch.org/Public_Documents/Pan%20flu%20report_final_8October2010%20covered[2].pdf)

pandemic in 2009 still had a significant impact on health services. Estimates suggest we should be planning for a pandemic that: could emerge anywhere in the world at any time, may cause up to 50% of the population to present with symptoms (from mild to severe), of which 30% will require primary care services, and 1-4% critical care.<sup>13,14</sup> Employers need to plan for at least 50% of staff being off work at some stage, with between 15% and 20% of staff off at any one time.

***What will the strategy deliver?***

- **Development of comprehensive system-wide pandemic flu plan(s)** that focus on continuous improvement in outbreak planning arrangements, at both strategic and operational levels, including NHS, Local Authority and Local Resilience Forum Plans.

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<sup>13</sup> <https://www.gov.uk/government/publications/responding-to-a-uk-flu-pandemic>

<sup>14</sup> <https://www.gov.uk/government/publications/health-and-social-care-response-to-flu-pandemics>

## Excess Winter Deaths and Health Effects of Cold Weather

### *Why is this important?*

Living in a cold home and experiencing fuel poverty increase the risks of cold related illness, and account for between 10 and 30% of all excess winter deaths.<sup>15</sup>

Fuel poverty is measured in England using the low income-high cost definition, which states that a household is in fuel poverty if:

- Their required energy costs are above average and
- Were they to spend this amount, they would be left with a residual income below the official poverty line.

Alongside winter deaths, cold-related illnesses in Warwickshire and Coventry place significant strain on local health and care services. People living with long term conditions and /or disabilities, those over 75 years old or under 5 years old are particularly vulnerable to the effects of cold related illness/fuel poverty.

Seasonal Flu is also one of the main drivers of excess winter deaths. One in three people are entitled to a free flu vaccination in Coventry and Warwickshire and we need to strive to improve uptake year on year in eligible groups: those aged 65 and over, adults and children with a chronic health condition, carers, care home residents, pregnant women, with the programme being rolled out to all 2 – 16 year olds over the next few years. Health and care workers who provide direct personal care are also eligible for vaccination through their employers.

### *What does the data tell us?*

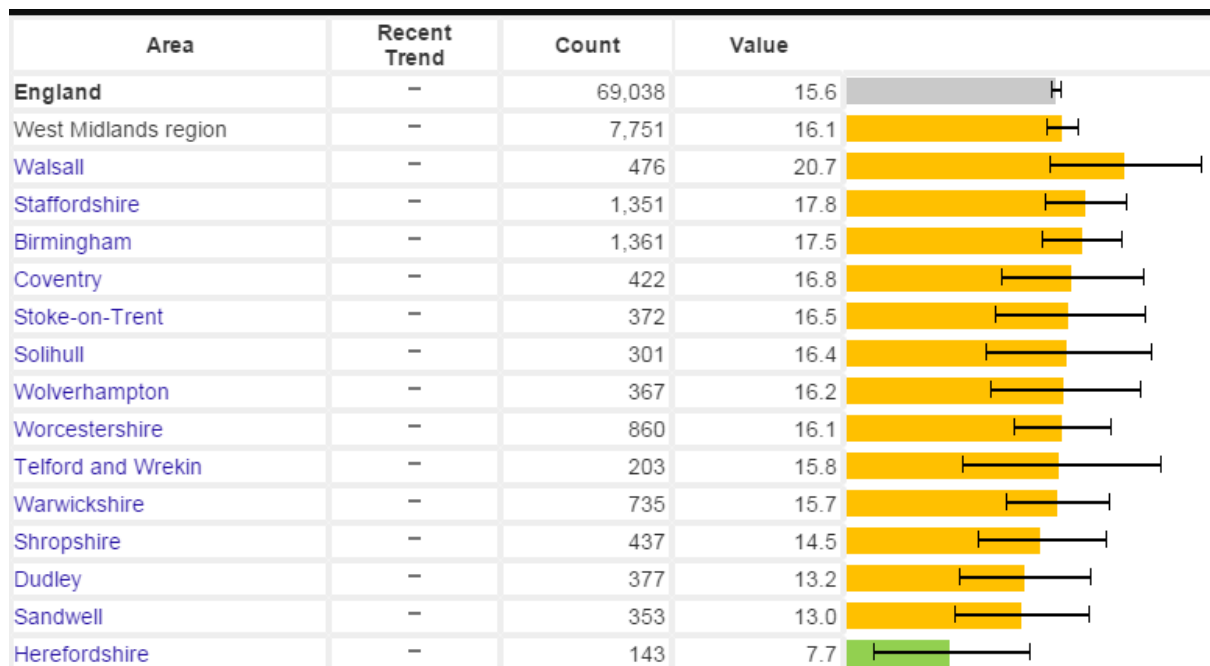
Figure 35 shows that the number of excess winter deaths in Coventry and Warwickshire are not significantly different to other local authorities in the region or the national average. However, nationally, our excess winter deaths are significantly higher than our European counterparts.

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<sup>15</sup> <http://nhfshare.heartforum.org.uk/RMAssets/HealthyPlaces/FuelPoverty/ToolkitJan2015.pdf>



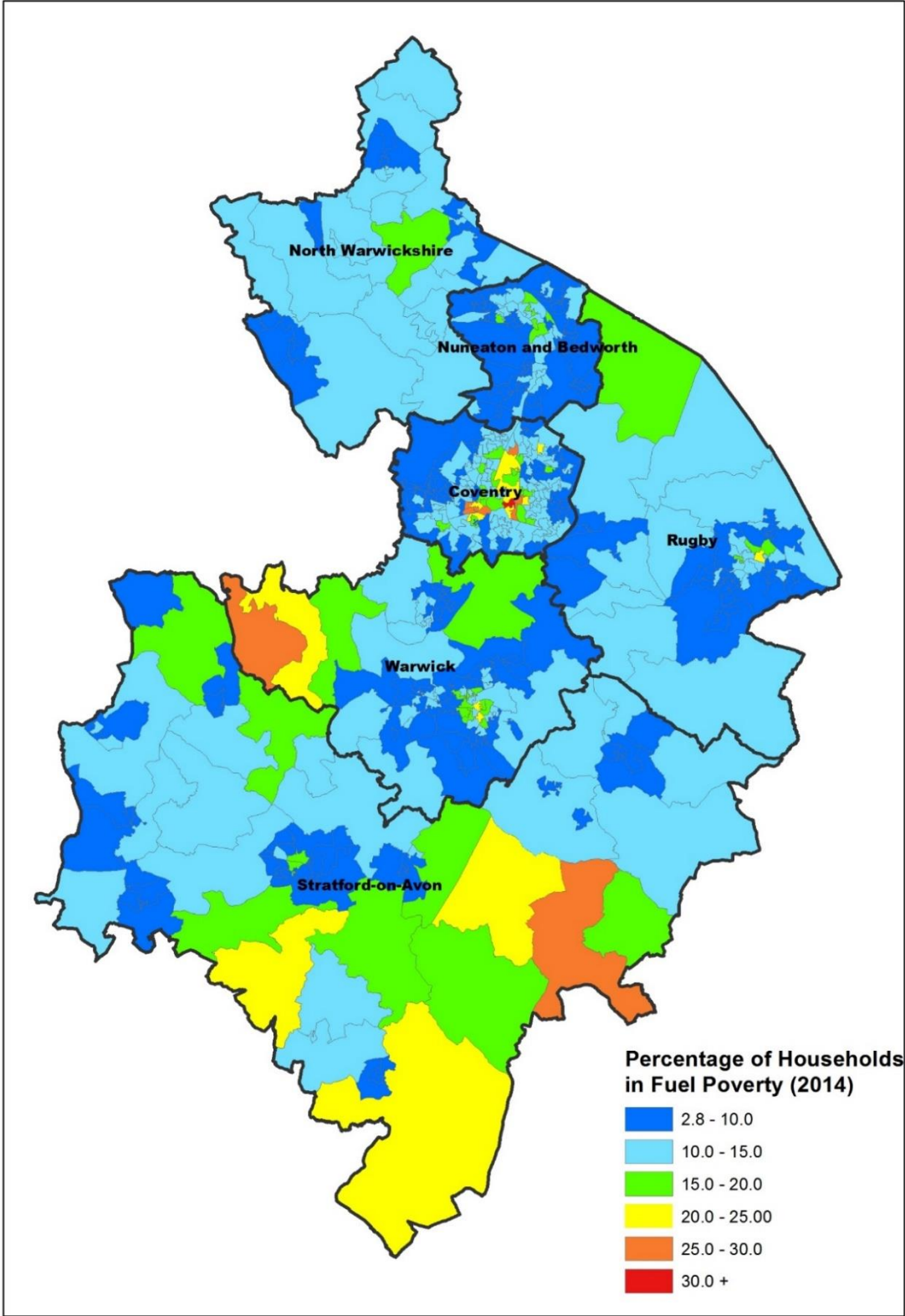
**Figure 35. Excess winter death index 3 years (2011-14)**



Source: Office for National Statistics: Public Health England Annual Births and Mortality Extracts

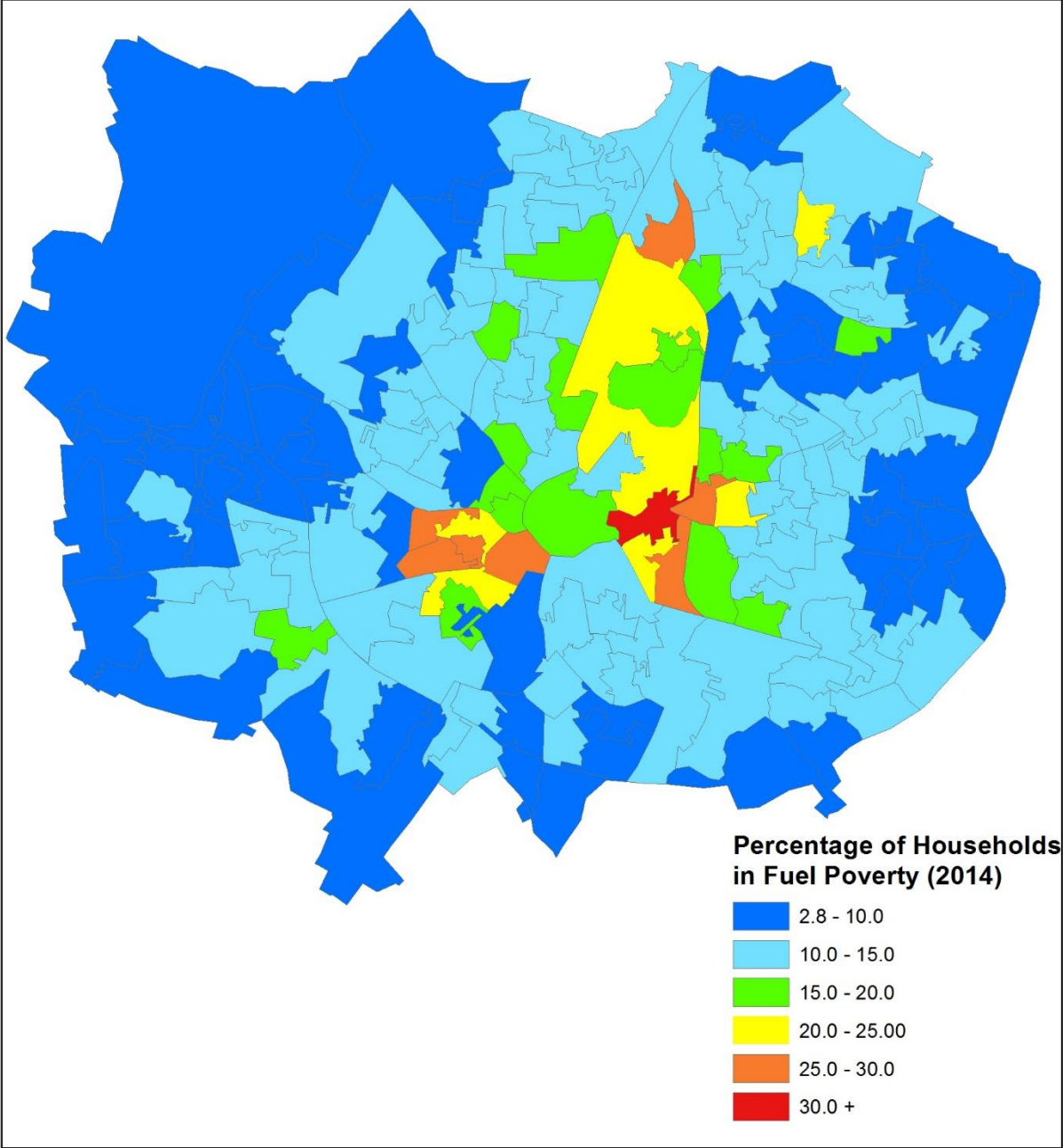
Figures 36 and 37 demonstrate the variation in fuel poverty across the sub-region. In Coventry, areas around the city centre and into the north and east of the City are highlighted as having particularly high levels of fuel poverty. In Warwickshire, areas in the south of Stratford-on-Avon District and east of Warwick District are noted as areas with high levels of fuel poverty.

Figure 36. Percentage of households in fuel poverty, Coventry and Warwickshire, 2014



Source: 2014 sub-regional fuel poverty data: low income high costs indicator. 30 June 2016. Department of Energy & Climate Change, available from: <https://www.gov.uk/government/statistics/2014-sub-regional-fuel-poverty-data-low-income-high-costs-indicator>

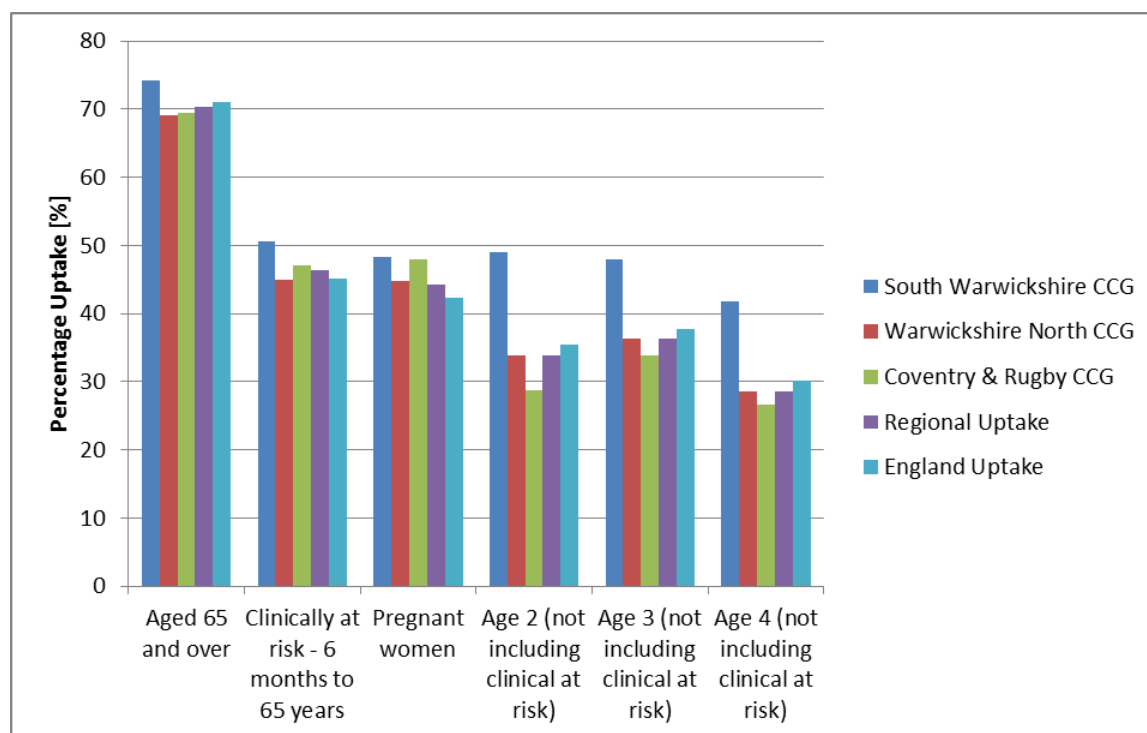
Figure 37. Percentage of households in fuel poverty, Coventry 2014



Source: 2014 sub-regional fuel poverty data: low income high costs indicator. 30 June 2016. Department of Energy & Climate Change, available from: <https://www.gov.uk/government/statistics/2014-sub-regional-fuel-poverty-data-low-income-high-costs-indicator>

Seasonal flu vaccination uptake for target groups within the three local CCG areas are shown in Figure 38. A general trend of higher uptake for those age 65 and over compared with those in clinical risk groups is seen nationally and locally, with lower levels still of vaccinations given to children in the eligible age groups. Locally, uptake across all eligible groups has been highest in South Warwickshire CCG, and uptake in adult at-risk groups lowest in Warwickshire North CCG.

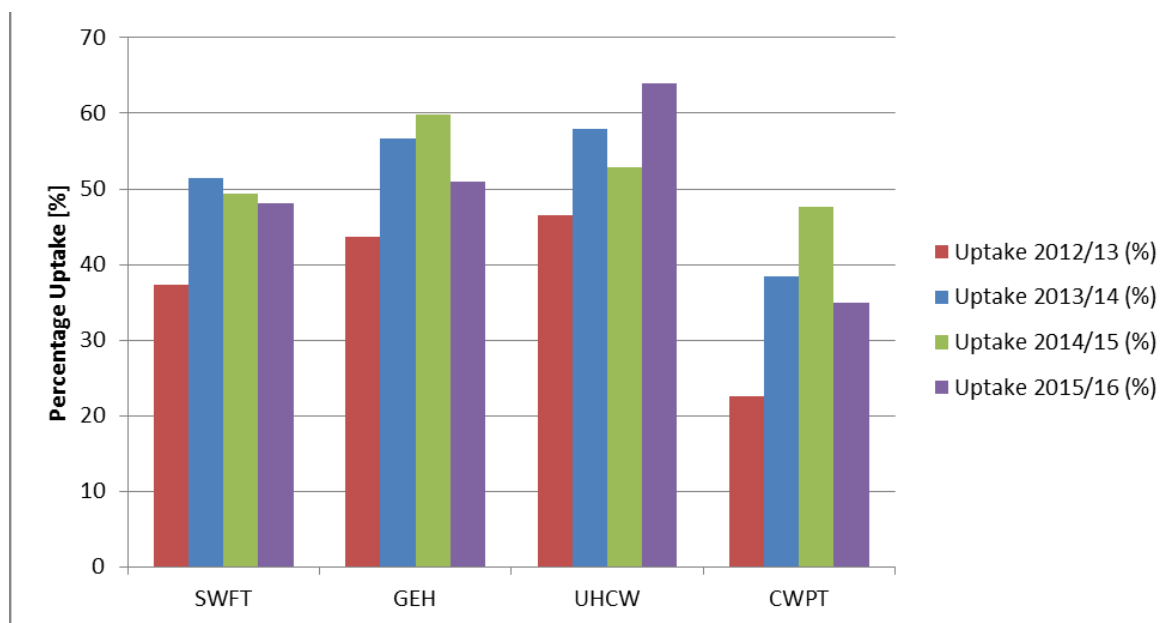
**Figure 38. Seasonal flu vaccine uptake 2015/16**



Source: Seasonal flu vaccine uptake in GP patients: 1 September 2015 to 31 January 2016. Public Health England: 25 February 2016. Available from: <https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-gp-patients-1-september-2015-to-31-january-2016>

Variation in seasonal flu vaccination uptake amongst healthcare workers over time and by NHS Trust can be seen in Figure 39. The most recent data shows highest uptake at University Hospitals Coventry and Warwickshire NHS Trust, and lowest rates at Coventry and Warwickshire Partnership Trust.

**Figure 39. Percentage uptake of influenza vaccination in healthcare workers by location (2012/13 to 2015/16)**



Seasonal flu vaccine uptake in healthcare workers: 1 September 2015 to 29 February 2016. Public Health England: 17 March 2016. Available from: <https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-healthcare-workers-1-september-2015-to-29-february-2016>

For 2016/17 there is an uptake ambition of 40-65% among the childhood cohorts, 55% for at risk clinical groups, and 75% for those aged 65 and over, and healthcare workers.<sup>16</sup>

**What will the strategy deliver?**

- **Reduce the number of households experiencing fuel poverty through increasing referrals to commissioned services that offer advice/support and physical interventions**, including ‘affordable warmth on prescription’ services to vulnerable, eligible households.
- **Increase uptake of Flu vaccinations in eligible groups** through annual campaigns, and engaging with frontline staff to recommend flu vaccinations.
- **Explore multi agency commissioning opportunities** to look at widening out affordable warmth initiatives.
- **Ensure an ongoing collaborative approach to planning for cold weather** across health and care services

<sup>16</sup>

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/529954/Annual\\_flu\\_letter\\_2016\\_2017.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/529954/Annual_flu_letter_2016_2017.pdf)

## Appendix 1 Coventry and Warwickshire Health Protection Strategy 2013-2015: Summarising Progress

Priority	Progress
Gastrointestinal diseases	<ul style="list-style-type: none"> <li>Regular local and regional fora in place where food safety and food poisoning are discussed</li> <li>Improvement in number of food premises classed as broadly compliant across the County and City (3* or above)</li> <li>Work ongoing nationally to review food poisoning and food safety in the home</li> </ul>
Viral Hepatitis	<ul style="list-style-type: none"> <li>Viral Hepatitis pathway for GPs developed and disseminated.</li> <li>Viral Hepatitis GP training slide pack developed and delivered.</li> <li>Neonatal Hepatitis B vaccination programme (of babies born to Hepatitis B positive mothers) continues to work well through a primary care model (with failsafes built in)</li> </ul>
TB	<ul style="list-style-type: none"> <li>Treatment completion rates increasing across Coventry and Warwickshire.</li> <li>Latent TB case finding programme established (nurse-led and working with primary care and community organisations supporting high risk groups).</li> <li>Audit programme for all TB cases established.</li> <li>Coventry and Warwickshire TB programme board established</li> <li>West Midlands TB Control board established (with significant current local input from Coventry and Warwickshire).</li> </ul>
Healthcare Associated Infection and Community Infection Control	<ul style="list-style-type: none"> <li>Healthcare associated infections continue to reduce in both hospitals and community settings in Coventry and Warwickshire.</li> <li>Independent infection control review commissioned by Directors of Public Health</li> <li>Establishment of process for conducting Root Cause Analysis of healthcare associated infections in the community in progress across Coventry and Warwickshire</li> <li>Multi-agency Outbreak Plan and Memorandum of Understanding developed</li> </ul>
Population Screening Programmes	<ul style="list-style-type: none"> <li>Screening and Immunisation Task and Finish Group established to look at effective partnership working between Local Authorities and Public Health England (including understanding of data required for understanding variation in uptake of programmes)</li> </ul>
Immunisation and Vaccination	<ul style="list-style-type: none"> <li>Childhood immunisation rates remain above national average in both Coventry and Warwickshire.</li> <li>A number of new vaccination programmes introduced (pertussis vaccination for pregnant women, rotavirus, Men ACWY programmes).</li> <li>A multi-agency communications group has been established, and which is supporting annual seasonal flu/cold weather campaigns.</li> </ul>
Sexually Transmitted Infections	<ul style="list-style-type: none"> <li>Integrated Sexual Health Service in Coventry and Warwickshire recommissioned, with a focus on reducing sexually transmitted infections and late diagnoses of HIV</li> </ul>
Air Quality	<ul style="list-style-type: none"> <li>Coventry and Warwickshire Air Quality Alliance established, and working together on joint projects focusing on improving air quality.</li> <li>Alliance comprises professionals from Transport, Planning, Environmental Health, Public Health and Public Health England.</li> </ul>