Public Health England

Health Protection Report
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News

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New data resource for those commissioning sexual and reproductive health services

April 2014 saw the launch of a new online data resource from Public Health England (PHE), the *Sexual and Reproductive Health Profiles* [1]. This interactive tool is designed to support local authorities, public health leads and CCGs to monitor the sexual and reproductive health (SRH) of their populations and the contribution of local public health related systems.

Presented as interactive maps, charts and tables, the Profiles provide a snapshot of sexual and reproductive health data across a range of areas such as teenage pregnancy, abortions, contraception, HIV, sexually transmitted infections and sexual offences. The tool also includes wider influences on sexual health and teenage conception such as alcohol use, education and deprivation level.

The Profiles data are grouped into six domains: Key Indicators; HIV and STIs; Reproductive Health; Teenage Pregnancy; Wider Determinants of Health; and All Indicators. The Key Indicators provide an overview of sexual and reproductive health and include those in the Public Health Outcomes Framework.

Geographic breakdowns include: local authority (upper and/or lower tier), England, region, PHE Centre, ONS cluster group and deprivation decile (upper tier local authorities grouped into 10 levels of deprivation).

The Profiles tool provides useful new options to compare a local authority with others and benchmark against the average for England, PHE centre, region, type of area or deprivation level. It also lets users view all indicator trends for their local authority or all local authority trends for a single indicator as well as further information regarding the indicators. Users can easily download the underlying data to an Excel file to perform their own operations.

The Profiles tool brings together and replaces three tools that pre-dated the formation of PHE: Sexual Health Balanced Scorecard; Sexual Health Profiles; and Teenage Pregnancy Profiles. An outline calendar of indicator updates, including plans to extend the range of indicators and their presentation as data and functionality become available [2].

Early signs indicate that the tool is already proving useful to local sexual health facilitators who have used it in workshops to look at overview figures and wider indicators for teenage conception. Local sexual health and teenage pregnancy leads are using the Profiles alongside other information resources to evaluate teenage pregnancy initiatives in their areas. Local authority sexual health commissioners have been alerted by the tool to the surprising extent of pelvic inflammatory disease admissions in their area, while local authority public health analysts are using the underlying data to generate local reports.

General enquiries and comments should be directed by email to: profilefeedback@phe.gov.uk.

References

1. The tool is available from the Sexual and Reproductive Health Profiles webpages: at http://fingertips.phe.org.uk/profile/sexualhealth .

2. Sexual and Reproductive Health Profiles: planned indicator updates 2014/2015, http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317141001274.

BSMT annual scientific meeting report

Over 150 biomedical and medical scientists attended the recent British Society for Microbial Technology annual scientific meeting in London concerned with the scientific, economic and behavioural challenges posed by the threat of antimicrobial resistance in healthcare and public health [1]. The meeting, a response to the Chief Medical Officer for England's 2013 annual report that compared the AMR threat to humanity with global warming and terrorism, covered UK and European antibiotic stewardship initiatives and related scientific developments; the veterinary perspective; the views of the pharmaceutical industry; and the current state of knowledge on the AMR threat in respect of specific pathogens and disease groups.

In an introductory presentation, the Deputy Chief Medical Officer for England, John Watson, described how the UK's cross-government AMR strategy 2013-2018 [2] is being implemented. This is under the supervision of a high-level steering group that will, among other tasks, produce annual progress reports and develop outcome measures for the strategy; it will also encourage global cooperation, foster R&D and promote high standards of antibiotic stewardship so as to extend the useful life of existing treatments – key aims of the strategy and themes that were elaborated on by other conference speakers. Implementation faced many challenges, Watson said, including the need for improved surveillance, diagnostics,

pharmaceutical product development and antibiotic stewardship. On the subject of surveillance, he noted the establishment of a new English Surveillance Programme for Antimicrobial Usage and Resistance (ESPAUR) among whose aims is to better collate data on antibiotic use in primary and secondary care and investigate possible correlations with antimicrobial resistance trends and infection rates.

Providing the veterinary perspective, Veterinary Medicines Directorate chief executive Peter Borriello noted EU Commission activity, in particular the fact that, of the 12 components of the Commission's action plan, five are veterinary-specific – including the aims of improved surveillance and more prudent use in antimicrobials in veterinary medicine.

European and global initiatives in antimicrobial susceptibility testing and AMR surveillance were reviewed by Gunnar Kahlmeter, previously chair of the European Committee on Antimicrobial Susceptibility Testing, who welcomed the recent WHO global report on surveillance [3] which drew attention to very high levels of antimicrobial resistance in all WHO regions and, in many countries, the paucity of AMR information relating to pathogens of major public health importance and the need for development of surveillance systems.

Afternoon sessions included presentations on: resistance in tuberculosis; the threats from companion animals; and the specific issue of testing for carbapenemase-producing enterobacteriaceae.

AMR in TB was discussed by Ian Laurenson, director of the Scottish Mycobacteria Reference Laboratory, who reviewed the extent to which case reports, UK and globally, demonstrated both incidence of the multi-resistant strains (MDR), that emerged in the early 1980s, and extensively-resistant strains (XDR), that emerged in the 2000s. Laurenson discussed the very high costs – in both financial and public health terms – of MDR TB and XDR TB. The need for standardisation of resistance-testing methods was one of the challenges being tackled, for example by the WHO. However, despite the availability of improved diagnostics, the management of diagnosis, treatment and infection control remain challenges in many situations of poverty, overcrowding, and social and political upheaval.

In a final presentation, Neil Woodford, head of the antimicrobial resistance and healthcare associated infections reference unit, PHE-Colindale, considered the state of development of microbiology tests for the detection of carbapenemase-producing enterobacteriaceae. He said there is international consensus that carbapenem resistance will remain a critical AMR threat

for the next decade – resistance already being present and increasing in a number of organisms, the “big five” carbapenemases being: KPC, IMP, VIM, NDM and OXA-48. Woodford said the availability of rapid diagnostic tests was important for quickly identifying infected or colonized patients – to expedite patient management, infection control measures and prevent onwards transmission – because traditional sensitivity test methods were too slow for this purpose. Although there is currently no single “best method” he noted the importance of the standard approach prescribed in the UK Standards for Microbiology Investigations (SMIs): ‘Laboratory Detection and reporting of Bacteria with Carbapenem-hydrolysing Beta lactamases (Carbapenemases)' [4], a revision of which is due later this year.

The presentations from these and other speakers at the meeting are available from the BSMT's website [5].

References

1. “Antimicrobial resistance: a bitter pill to swallow”, BSMT 29th annual scientific meeting, PHE-Colindale, 16 May 2014.

2. DH (2013). “UK five year Antimicrobial Resistance Strategy 2013 to 2018”. See also, *HPR* **7**(37).

3. First WHO global antimicrobial resistance surveillance report, *HPR* **8**(20).

4. UK SMIs may be freely accessed via the link: UK Standards for Microbiology Investigations.

5. BSMT website, http://www.bsmt.org.uk/asm/asm29.php.

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Infection report

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Immunisation

Herpes zoster (shingles) immunisation programme 2013/14: cumulative coverage data (provisional) for England to end-April 2014

This report presents provisional vaccine coverage data for the first eight months of the Herpes zoster (shingles) immunisation programme that commenced in September 2013. These data show continued improvement in vaccine coverage in the three months to the end of April 2014, with the routine cohort coverage increasing 8.2% to 54.8% and the catch-up cohort coverage increasing 7.6% to 53.1% since the last data published to the end of January.

Background

Following recommendation by the Joint Committee on Vaccine and Immunisation (JCVI), a routine national shingles immunisation programme started on 1 September 2013 [1]. Eligible individuals for the routine cohort are those who were aged 70 on 1 September 2013 (ie born between 2 September 1942 and 1 September 1943). A catch-up programme is also running, and in the first year is aimed at those aged 79 on 1 September 2013 (ie born between 2 September 1933 and 1 September 1934).

After August 2014, the national shingles immunisation programme will run for the same period as last year, ie from 1 September 2014 to 31 August 2015 [2]. As in the first year of the programme, a catch-up campaign will also run in 2014/15, this time for those aged 79 and 78 on 1 September 2014. Eligible patients who have not yet received shingles vaccine during the 2013/14 programme can be vaccinated up until 31 August 2014, but no later. The key factor to consider when deciding on eligibility is the patient's age, in years, on 1 September 2014 [2].

Shingles vaccine supply was subject to temporary limitations due to vaccine availability between September and December 2013, requiring the capping of orders from individual practices [3]. These problems have now been resolved, with the weekly cap on shingles vaccine orders being removed in March. The temporary supply problem is not expected to impact on the overall programme as the large number of pre-orders meant that even during the restrictions, significant quantity of vaccine was available in the system, and the programme is annual, rather than seasonal, so as previously mentioned, eligible patients can be vaccinated up until 31 August 2014.

Data on vaccine coverage are submitted through the ImmForm website and are monitored, validated and analysed by PHE. This is being carried out via 11 monthly automatic data uploads, and will be followed by an annual survey, to be completed after the first full year of the programme ends on 31 August 2014. This report provides provisional cumulative shingles vaccine coverage data for the first eight months of the programme and updates data published in February 2014 reporting coverage to end-January 2014. [4]

Participation and data quality

These data are provisional and subject to revision. Only data from those GP practices able to participate in automatic uploading are represented; this varies by month of the survey and by NHS England Area Team (AT), and within ATs by month. In April, data from only 80.2% of practices nationally were included. The drop in reporting practices was due to an issue affecting a proportion of practices using one GP IT system (figure 1). GP practice participation varied between ATs in April (from 65.1% to 98.3% of all practices in the AT). Monthly fluctuations in the number of practices reporting by AT mean that coverage estimates should be interpreted with caution (see table).

The vaccine coverage estimates are based on whole population denominators (ie all patients registered with the reporting practices and aged either 70 years or 79 years on 1 September 2013), and have not been adjusted to take into account the number of patients who have contraindications to the vaccine suggesting coverage amongst those who are truly eligible will be higher than what is reported here.

Provisional coverage data

Monthly cumulative shingles vaccine coverage data for the first eight months are presented below for England in figure 2, and by AT in figure 3 and the table. The data show:

- the percentage of English GP practices providing data;
- cumulative vaccine coverage for each AT for both the routine and catch-up cohorts up to April 2014;
- figures comparing uptake up to January 2014 with the most recent data up to April 2014;
- vaccine coverage among individuals not eligible for vaccine in the first year of the programme but who are likely to be included in future cohorts (April and January).

Figure 1: Proportion (%) of GP practices in England represented in shingles vaccine coverage monthly surveys, September 2013 to April 2014

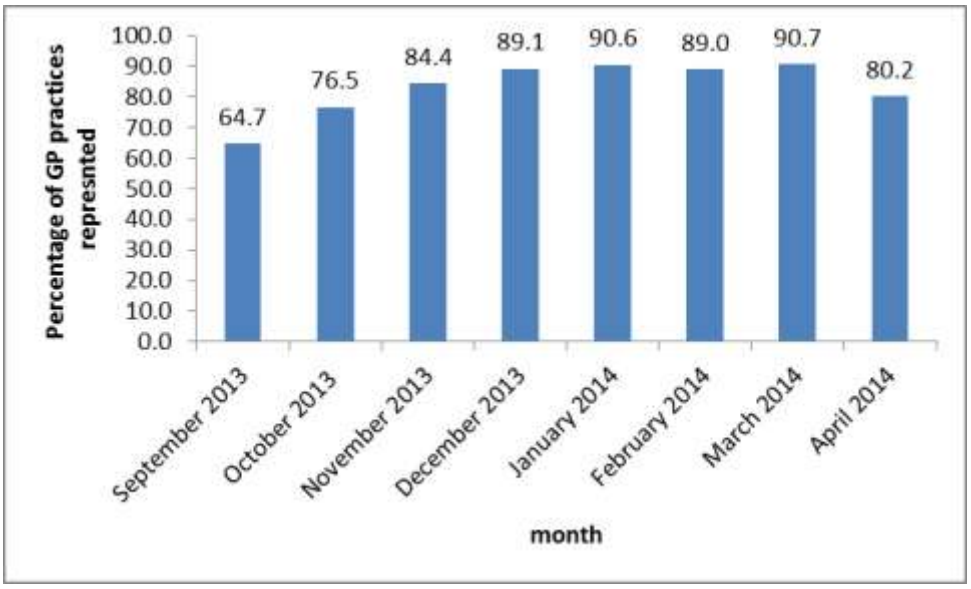


Figure 2. Cumulative monthly shingles vaccine coverage of the routine (70 years) and catch-up (79 years) cohorts, September 2013 to April 2014: England (provisional)

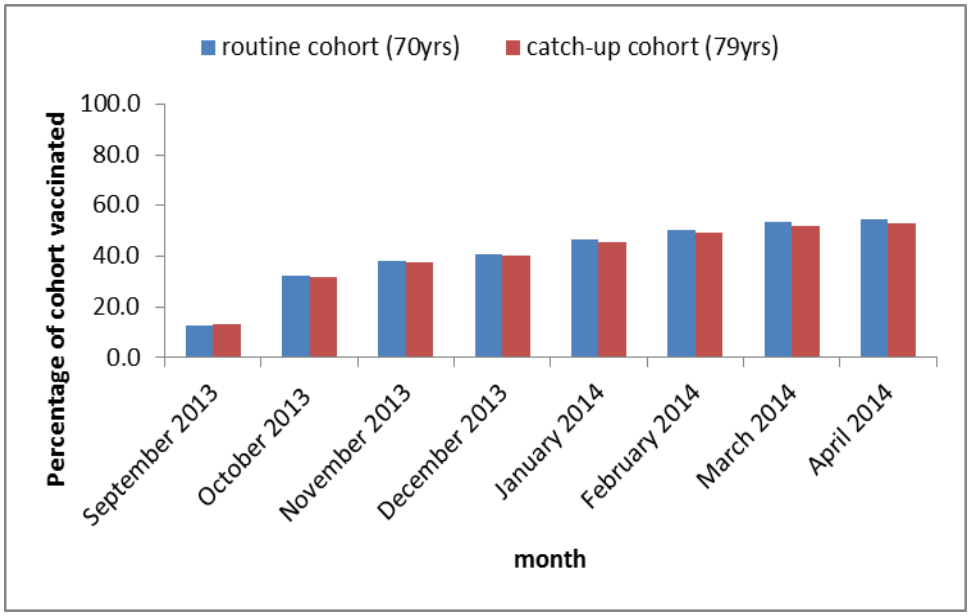
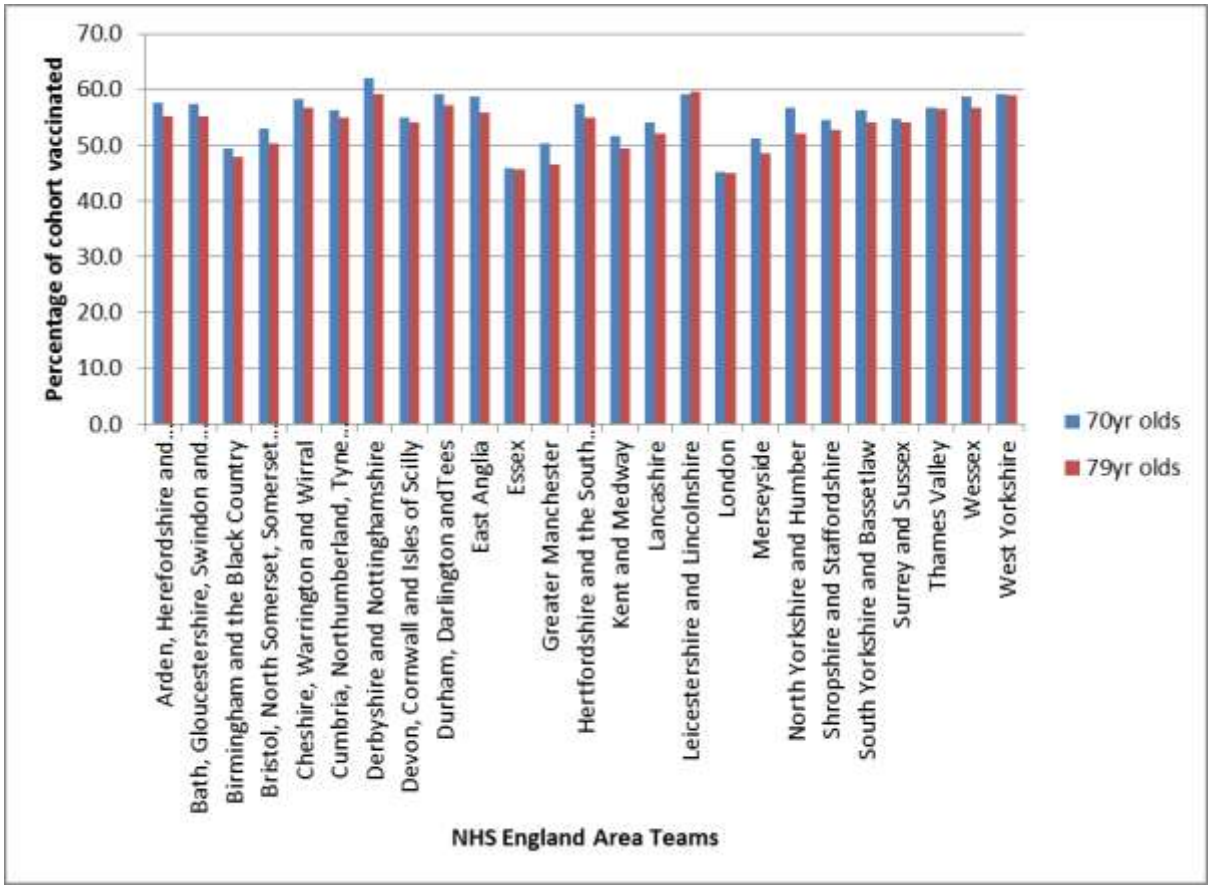


Figure 3. Percentage of the routine (70 years) and catch-up (79 years) cohorts receiving shingles vaccine between 1 September 2013 and 30 April 2014 by Area Team (provisional)



Cumulative shingles vaccine coverage in England by age cohorts and Area Team: 1 September 2013 to 30 April 2014 *(data as at 31 January 2014)*

Area Team (code)	Per cent of practices reporting	Percentage of age cohort vaccinated		
		70 year old	79 year old	Future cohorts (67-69 yrs and 71-78 yrs)
Cheshire, Warrington and Wirral (Q44)	68.0 *(91.1)*	58.2 *(48.5)*	56.8 *(48.7)*	0.3 (0.3)
Durham, Darlington and Tees (Q45)	98.3 *(93.1)*	59.2 *(53.1)*	57.1 *(50.5)*	0.5 (0.3)
Greater Manchester (Q46)	69.6 *(74.6)*	50.4 *(44.9)*	46.5 *(42.5)*	0.5 (0.3)
Lancashire (Q47)	76.7 *(96.1)*	54.0 *(47.8)*	52.1 *(44.6)*	0.3 (0.2)
Merseyside (Q48)	65.1 *(75.7)*	51.3 *(43.8)*	48.5 *(40.6)*	0.5 (0.3)
Cumbria, Northumberland, Tyne and Wear (Q49)	74.8 *(83.6)*	56.3 *(48.9)*	54.9 *(47.3)*	0.5 (0.3)
N Yorkshire and Humber (Q50)	88.6 *(87.6)*	56.7 *(47.4)*	52.2 *(44.5)*	0.6 (0.4)
S Yorkshire and Bassetlaw (Q51)	87.0 *(90.3)*	56.2 *(46.9)*	54.1 *(44.1)*	0.6 (0.3)
W Yorkshire (Q52)	93.1 *(99.1)*	59.2 *(51.4)*	59.0 *(50.1)*	0.6 (0.4)
Arden, Herefordshire and Worcestershire (Q53)	71.4 *(92.2)*	57.7 *(50.3)*	55.2 *(48.2)*	0.4 (0.3)
Birmingham and Black Country (Q54)	83.0 *(92.6)*	49.5 *(42.7)*	47.9 *(41.0)*	0.6 (0.4)
Derbyshire and Notts. (Q55)	93.2 *(98.6)*	62.0 *(54.2)*	59.1 *(53.2)*	0.4 (0.3)
East Anglia (Q56)	89.0 *(94.2)*	58.8 *(48.5)*	55.8 *(46.7)*	0.5 (0.3)
Essex (Q57)	90.0 *(97.0)*	45.9 *(40.1)*	45.8 *(39.8)*	0.5 (0.3)
Hertfordshire and the S Midlands (Q58)	88.2 *(94.6)*	57.3 *(49.0)*	54.9 *(47.6)*	0.6 (0.4)
Leicestershire and Lincolnshire (Q59)	90.8 *(97.6)*	59.2 *(49.8)*	59.7 *(48.9)*	0.6 (0.4)
Shropshire and Staffordshire (Q60)	72.8 *(79.4)*	54.5 *(46.6)*	52.8 *(44.7)*	0.3 (0.2)
Bath, Gloucestershire, Swindon and Wiltshire (Q64)	88.7 *(93.4)*	57.5 *(48.0)*	55.2 *(46.6)*	0.5 (0.3)
Bristol, N Somerset, Somerset and S Gloucestershire (Q65)	75.0 *(88.3)*	52.9 *(40.6)*	50.4 *(40.9)*	0.4 (0.3)
Devon, Cornwall and Scilly Isles (Q66)	87.5 *(92.2)*	54.9 *(43.5)*	54.2 *(43.2)*	0.6 (0.4)
Kent and Medway (Q67)	73.6 *(86.6)*	51.7 *(43.5)*	49.5 *(43.3)*	0.4 (0.2)
Surrey and Sussex (Q68)	82.8 *(94.4)*	54.7 *(44.5)*	54.1 *(45.5)*	0.5 (0.3)
Thames Valley (Q69)	76.9 *(93.0)*	56.8 *(49.1)*	56.5 *(49.9)*	0.4 (0.3)
Wessex (Q70)	76.9 *(90.7)*	58.7 *(49.0)*	56.7 *(48.5)*	0.5 (0.3)
London (Q71)	74.2 *(91.3)*	45.3 *(40.7)*	45.1 *(40.7)*	0.9 (0.6)
ENGLAND	**80.2 *(90.5)***	**54.8 *(46.6)***	**53.1 *(45.5)***	**0.5 (0.4)**

The overall coverage has been good in the first eight months of the campaign, with 54.8% of the routine (70 year old) cohort and 53.1% of the catch-up cohort (79 year old) having received the shingles vaccine (see table). Compared to preliminary data available at 31 March 2014 [7], this is an increase of 8.2% for the routine cohort and 7.6% for the catch-up cohort, demonstrating a continued gradual increase in coverage (table).

Vaccine coverage is relatively similar across most ATs ranging between 45% and 62% for the routine cohort (figure 3, table). Coverage exceeded 50% in 22 ATs (out of 25) compared to only four achieving this coverage in January. The three ATs who did not meet this level were London, Essex, and Birmingham and the Black Country. Similar or slightly lower coverage was achieved for the catch-up cohort (figure 3, table)

A very small proportion of vaccine has been given to future cohorts (67-69 year olds and 71-78 year olds) across England (table). This represents approximately 5.5% of all vaccine administered since the start of the campaign. Vaccination of non-eligible individuals is highest amongst 69 and 78 year olds at 2.5% and 2.0% respectively. This may be because individuals in these cohorts will turn 70 or 79 during the course of the campaign year, and are mistakenly called up for vaccination. However it is important to remember that as eligibility is based on age on 1 September, these patients are not eligible as part of the 2013/14 campaign, but would have been eligible for the 2014/15 campaign. As only one dose is recommended, those patients who have already received the vaccine should not be called up for vaccination again.

Conclusions

Vaccine coverage for both the routine and catch-up cohorts has continued to improve gradually in the three months from February to April 2014. Coverage should continue to rise during the remaining four months of the 2013/14 programme if those remaining eligible individuals are encouraged to present for vaccination. GPs and ATs should be actively engaging the current eligible cohorts to ensure they receive the vaccine by 31st August.

Further provisional cumulative coverage data will be published on a quarterly basis, with the finalised annual coverage data due to be published in autumn 2014.

References

1. Public Health England (2014). Introduction of shingles vaccine for people aged 70. *HPR* **7**(35): news, 30 August 2013. See also: "Introduction of shingles vaccine for people aged 70 and 79 years", DH/PHE guidance, 12 July 2013.

2. *Vaccine Update* no 211, https://www.gov.uk/government/publications/vaccine-update-issue-211-january-2014.

3. *Vaccine Update* no 210, https://www.gov.uk/government/publications/vaccine-update-issue-210-december-2013--2.

4. Public Health England (2014). Herpes zoster (shingles) vaccine programme 2013/14: provisional coverage data for England to end-January 2014. *HPR* **8**(8): immunisation, 28 February 2014.