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Health and Well Being Board Agenda

DARLINGTON BOROUGH COUNCIL

3.00 pm Thursday, 28 November 2019
Committee Room No. 1, Town Hall, Darlington. DL1 5QT

Members of the Public are welcome to attend this Meeting.

1. 3.00 Introductions/Attendance at Meeting.

2. 3.05 Declarations of Interest.

3. 3.10 To hear relevant representation (from Members and the General Public) on items on this Health and Well Being Board Agenda.

4. 3.15 To approve the Minutes of the Meeting of this Board held on 4 July 2019 (Pages 1 - 6)

LIVING AND AGEING WELL

5. 3.20 Mental Health and Autism Update and Suicide Prevention Update – Report of Director, Durham, Darlington and Tees Mental Health and Learning Disabilities CCG Partnership and Report of Director of Public Health (Pages 7 - 26)

6. 3.40 Winter Planning – Presentation by Director of Performance, County Durham and Darlington NHS Foundation Trust (Pages 27 - 40)

7. 4.00 Health Protection Annual Report – Report of Director of Children and Adults Services (Pages 41 - 96)

8. 4.20 Integrated Care Systems - Update by the Chief Clinical Officer, NHS Darlington Clinical Commissioning Group.

9. 4.30 Terms of Reference –
Report of Director of Children and Adults Services
(Pages 97 - 106)

FOR INFORMATION

10. Annual Report of the Director of Public Health 2018/19 - Healthy New Towns: Darlington –
Report of Director of Public Health
(Pages 107 - 152)

11. Better Care Fund 2019/20 –
Report of Director of Children and Adults Services
(Pages 153 - 156)

12. Health and Well Being Board response to Prevention Green Paper consultation –
Verbal update by Director of Public Health

13. Carers Update –
Report of Director of Children and Adults Services
(Pages 157 - 186)

14. SUPPLEMENTARY ITEM(S) (if any) which in the opinion of the Chair of this Board are of an urgent nature and can be discussed at the meeting.

15. Questions.

Luke Swinhoe
Assistant Director Law and Governance

Wednesday, 20 November 2019

Town Hall
Darlington.

Membership
Councillor Crudass, Cabinet Member with Children and Young People Portfolio
Councillor Mills, Cabinet Member with Adult Social Care Portfolio
Councillor Tostevin, Cabinet Member with Housing, Health and Partnerships Portfolio
Councillor Harker
Councillor Mrs H Scott, Leader of the Council
Suzanne Joyner, Director of Children and Adults Services

Miriam Davidson, Director of Public Health
Dr Posmyk Boleslaw, Chair, NHS Darlington Clinical Commissioning Group
Nicola Bailey, Chief Officer, Darlington Clinical Commissioning Group
Michael Houghton, Director of Commissioning Strategy and Delivery, NHS Darlington Clinical Commissioning Group
Steve White, Interim Police, Crime and Victims' Commissioner, Durham Police Area
Richard Chillery, Operational Director of Children's and Countywide Care Directorate, Harrogate and District NHS Foundation Trust
Sam Hirst, Primary Schools Representative
Sue Jacques, Chief Executive, County Durham and Darlington Foundation Trust
Rita Lawson, Chairman, VCS Strategic Implementation Group
Jonathan Lumb, Darlington Secondary Schools Representative
Colin Martin, Chief Executive, Tees, Esk and Wear Valley Mental Health Foundation Trust
Alison Slater, Director of Nursing, NHS England, Area Team
Dr Amanda Riley, Chief Executive Officer, Primary Healthcare Darlington
Michelle Thompson, Chief Executive Officer, Healthwatch Darlington
Stephen Cummings, Dean of School of Health and Life Sciences, Teesside University
Carole Todd, Darlington Post Sixteen Representative, Darlington Post Sixteen Representative

Since the last meeting of the Board, the following items have been sent to the Chair/Members of the Board:-

- Invite – Darlington Memorial Hospital – Event to unveil memorial sculpture, 26 November 2019
- Letter – St George's Medical Practice – Closure of Dispensary
- North East and North Cumbria ICS Briefing Event 4 November – Presentation
- Stakeholder Briefing – NHS consultations paused due to General Election announcement - Stroke Rehabilitation Services and Inpatient Rehabilitation (Ward 6) at Bishop Auckland Hospital
- Launch of two public consultations in County Durham and Darlington - Stroke Rehabilitation Services and Inpatient Rehabilitation (Ward 6) at Bishop Auckland Hospital
- Stakeholder briefing – County Durham and Tees Valley Clinical Commissioning Groups Merger Plans
- Quarterly Update for Stakeholders – Quality Account – Tees, Esk and Wear Valley NHS Foundation Trust
- Consultation for England and Wales on the impact of tobacco laws introduced between 2010 and 2016
- Integrated Care System Memorandum of Understanding
- Invite - Darlington Childhood Healthy Weight Plan - Launch and Partnership Session, 24 September 2019
- Darlington Primary Care Network Non-Executive Lay Member Vacancy

If you need this information in a different language or format or you have any other queries on this agenda please contact Hannah Fay, Democratic Officer, Resources Group, during normal office hours 8.30 a.m. to 4.45 p.m. Mondays to Thursdays and 8.30 a.m. to 4.15 p.m. Fridays e-mail hannah.fay@darlington.gov.uk or telephone 01325 405801

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Agenda Item 4

HEALTH AND WELL BEING BOARD

Thursday, 4 July 2019

PRESENT – Councillor Tostevin (Cabinet Member with Housing, Health and Partnerships Portfolio) (Chair), Councillor Crudass (Cabinet Member with Children and Young People Portfolio), Councillor Mills (Cabinet Member with Adult Social Care Portfolio), Councillor Harker, Councillor Mrs H Scott (Leader of the Council), Miriam Davidson (Director of Public Health), Nicola Bailey (Chief Officer) (Darlington Clinical Commissioning Group), Michael Houghton (Director of Commissioning Strategy and Delivery) (NHS Darlington Clinical Commissioing Group), Alex Sinclair (Director of Commissioning, Strategy and Delivery) (NHS Darlington Clinical Commissioning Group), Jon Carling (Office fof Durham Police, Crime and Victims' Commissioner), Jill Foggin (Communications Officer, County Durham and Darlington Foundation Trust), Sarah Hackett (Chief Executive) (Tees Valley YMCA), Jonathan Lumb (Darlington Secondary Schools Representative), Dr Amanda Riley (Chief Executive Officer) (Primary Healthcare Darlington), Levi Buckley (Tees Esk and Wear Valleys Foundation Trust) and Michelle Thompson (Chief Executive Officer) (Healthwatch Darlington)

ALSO IN ATTENDANCE – Christine Shields (Assistant Director Commissioning, Performance and Transformation), Ken Ross (Public Health Principal) (Public Health), Lynne Wood (Elections Manager) and Hannah Fay (Democratic Officer)

APOLOGIES – Suzanne Joyner (Director of Children and Adults Services), Marion Grieves (Dean of Health and Social Care) (Teesside University), Sam Hirst (Primary Schools Representative), Ron Hogg (Police, Crime and Victims' Commissioner) (Durham Police Area), Sue Jacques (Chief Executive) (County Durham and Darlington Foundation Trust), Rita Lawson (Chairman) (VCS Strategic Implementation Group), Colin Martin (Chief Executive) (Tees, Esk and Wear Valley Mental Health Foundation Trust) and Ann Baxter (Independent Chair) (Darlington Safeguarding Adults Partnership Board)

HWBB1 DECLARATIONS OF INTEREST.

There were no declarations of interest reported at the meeting.

HWBB2 TO CONSIDER THE TIMES OF MEETINGS OF THIS BOARD FOR THE MUNICIPAL YEAR 2019/20 ON THE DATES AS AGREED IN THE CALENDAR OF MEETINGS BY CABINET AT MINUTE C110/FEB/19

RESOLVED – That meetings of this Health and Well Being Board be held at 3.00 pm for the remainder of the 2019/20 Municipal Year.

HWBB3 TO HEAR RELEVANT REPRESENTATION (FROM MEMBERS AND THE GENERAL PUBLIC) ON ITEMS ON THIS HEALTH AND WELL BEING BOARD AGENDA.

No representations were made by Members or members of the public in attendance at the meeting.

HWBB4 TO APPROVE THE MINUTES OF THE MEETING OF THIS BOARD HELD ON 17 JANUARY 2019

Submitted – The Minutes (previously circulated) of the meeting of this Health and Well Being Board held on 17 January 2019.

In respect of Minute HWBB27/Jan/19, the Chair reported at the meeting that further amendments were required to be made to the Terms of Reference for this Board and that those amendments would be brought to the next meeting of the Board for further consideration.

RESOLVED – That the minutes be approved as a correct record.

REASON – They represent an accurate record of the meeting.

HWBB5 INTEGRATION BOARD GOVERNANCE ARRANGEMENTS

The Director of Children and Adults Services submitted a report (previously circulated) requesting that consideration be given to the proposed governance arrangements for the Integration Board (also previously circulated).

The submitted report stated that following an amendment to the terms of reference for this Board, the responsibility for the day to day issues of this Board had been passed to the Integration Board and outlined the proposed governance arrangements and how they related to the strategic, operational and joint commissioning working groups, various Boards and Strategies and to this Board.

It was reported at the meeting that following the introduction of the 'life course' approach by this Board, the role of the Integration Board had been strengthened, to ensure that there were robust arrangements in place; the terms of reference of the Integration Board had been reviewed; new Governance Arrangements had been proposed; a number of groups would feed directly into the Integration Board; and that the Integration Board would take a 'forward planning' approach.

Particular reference was made at the meeting on how any information would be fed back to Members of the Council.

RESOLVED – That the governance arrangements for the Integration Board, as appended to the submitted report, be noted.

REASON – To inform the Board of the governance arrangements for the Integration Board.

HWBB6 STARTING WELL: GIVING EVERY CHILD THE BEST START IN LIFE

In introducing the reports below, the Director of Public Health reminded Members of the 'life course' approach that had been adopted by this Board, and stated that the focus of this meeting would be 'Starting Well: Giving Every Child the Best Start in Life'.

(1) DARLINGTON CHILD HEALTH PROFILE 2019

The Director of Public Health submitted a report (previously circulated) informing the Board of the key messages contained within the Darlington Child Health Profile 2019.

The submitted report stated that the Darlington Child Health Profile 2019 reported data from 2017/18 to provide a snap shot of child health in Darlington to enable comparisons to be made against regional and England averages; the profile was designed to help understand local need and enable services to be planned, in order to improve health and reduce health inequalities; the profile provided an overview of the health and wellbeing of children in relation to 32 indicators; and that the indicators fell into five broad domains, namely premature mortality, health protection, wider determinants of ill health, health improvement and prevention of ill health. Particular reference was made to the fact that the health and wellbeing of children in Darlington was generally worse than the England average, with eleven indicators for Darlington being worse than the England average.

In presenting the report the Director of Public Health stated that the childhood immunisation rates amongst two year olds in Darlington were above the recommended coverage rate of 90 per cent; 88.8 per cent of children in Darlington were up to date with immunisations which was in keeping with the England average; the proportion of 16 to 17 year olds not in education, employment or training in Darlington was statistically significantly better than the national and regional average; the rate of 10 to 17 year olds in Darlington coming into contact with the youth justice system remained similar to the England average and had fallen in Darlington since 2010; and outlined the priorities to improve the health and wellbeing of children and young people in Darlington and reduce inequalities in health between Darlington and England.

Discussion ensued hospital admissions; the figures for attendance at Accident and Emergency; and the Urgent Care Treatment Centre.

RESOLVED – That the Darlington Child Health Profile 2019 report be noted, and further reports be received as appropriate to lines of enquiry.

REASON – To inform the Board of the key messages in the Darlington Child Health Profile 2019.

(2) DARLINGTON HEALTHY LIFESTYLE SURVEY

The Director of Public Health submitted a report (previously circulated) updating the Board on the results and key messages from the Darlington Healthy Lifestyle Survey and informing the Board that the Healthy Lifestyle Survey was being reviewed.

The submitted report stated that the survey gathered and analysed information from children and young people in Darlington about their attitudes and behaviours across a range of health related topics; that this information was used to inform strategic planning service delivery and practice; and that the results were used to challenge peer pressure and negative stereotypes of young people.

In presenting the report the Public Health Principal outlined the key messages from

the survey for the academic year 2018/19; stated that the survey had been undertaken by 6560 pupils aged between 9 and 16 years of age across 23 primary and seven secondary schools; the results indicated that young people in Darlington largely understood the health information and messages they received; and that they acted on the information and messages through exhibiting positive attitudes and health seeking behaviours.

It was reported that a review of the survey was underway which focussed on revisiting the core Social Norms principles and purpose of the survey and that a programme of engagement was underway which included a series of questionnaires and focus groups to inform the next survey in the new academic year.

RESOLVED – (a) That the results of the survey, be noted, and considered in future discussions in relation to young people's priorities.

(b) That the current review of the Healthy Lifestyle survey, be supported, and any recommendations be considered at a future meeting of the Board.

REASON – (a) The survey is an annual process using an established methodology and provides a 'snap shot' of the attitudes and beliefs and self- reported health behaviours of young people in Darlington.

(b) The survey has been running in Darlington for a number of years and it has been identified that the survey has become large and complex to administer and complete. Work is required to revisit the size and identify the key questions and themes for the survey to achieve the original purpose.

(3) CHILDREN AND YOUNG PEOPLE'S PLAN 2017/2022 - PROGRESS REPORT

The Director of Children and Adults Services submitted a report (previously circulated) updating the Board on the progress to date against the delivery of the Children and Young People's Plan 2017-2022.

The submitted report stated that the Children and Young People's Plan (CYPP) was one of the identified delivery plans within the Sustainable Community Strategy (SCS); the Plan identified the key actions to be taken to deliver the agreed SCS priority of the best start in life for every child; a multi-agency steering group (MASG) had been established to bring together key partners to ensure effective monitoring and delivery of the plan; and provided an update on the progress of the Year Two priorities.

Discussion ensued on Priority 3, in relation to accessing Child and Adolescent Mental Health Services and managing the expectations of those people who use the service.

RESOLVED – That the progress to date on delivering the Children and Young People's Plan 2017/22, as detailed in the submitted report, be noted.

REASON – To update the Board on the progress made to date on the Children and Young People's Plan 2017/22.

HWBB7 INTEGRATED CARE SYSTEM - UPDATE BY THE CHIEF CLINICAL OFFICER, NHS DARLINGTON CLINICAL COMMISSIONING GROUP.

The Chief Officer, NHS Darlington Clinical Commissioning Group (CCG), gave an update to the Board on the Integrated Care System (ICS) for the North East and Cumbria; outlined the background and purpose of the ICS and Integrated Care Partnerships (ICP) key challenges; the features and key principles of ICS Partnership Assemblies; key benefits to local people; the proposals for new clinical commissioning groups for the Tees Valley and Durham CCG's; the current arrangements; what CCG's do; the reasons for the changes; the proposals for change; key principles and expected benefits; and including the next steps.

The Chief Executive Officer, Healthwatch Darlington reported at the meeting that a significant piece of work had been undertaken in respect of the NHS Long Term Plan which included local Healthwatch from 14 areas, seeking thoughts on the priorities of the ICS and ICP; that a report was due to be published; and that Healthwatch Darlington would also be co-ordinating local Healthwatch from five areas to gather thoughts on the proposed CCG merger.

RESOLVED – That the thanks of the Board be conveyed to the Chief Officer, NHS Darlington Clinical Commissioning Group, for her update.

REASON – To convey the views of the Board.

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County Durham and the Tees Valley
Clinical Commissioning Groups

Mental Health and Autism

Local Service Provision - DARLINGTON CCG

Report to Darlington Health and Wellbeing Board

28th November 2019

Mike Brierley, Director,
Durham, Darlington and Tees Mental Health and Learning Disabilities CCG Partnership

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This report summarises key activity in Darlington during the 2018-19 financial year, updated to reflect activity commenced in the 2019-20 financial year. Members are asked to note the content and make any recommendations or comments on the content.

The purpose of the report is to provide a stocktake of current provision in Darlington which is intended to stimulate discussion about future strategic planning and operational delivery. This can then be fed into the CCG and wider partner work programmes both locally in Darlington and across the wider Tees/Durham area.

Darlington services for people are based upon a Healthy New Towns approach, focused on three key areas:

- Regeneration - Including economic well-being, healthy travel and estates regeneration (new buildings)
- New models of care - Including the development of care hubs, cultural change and standardisation
- Digital technology - Including patient self-management modules and teleconsulting

Darlington's Health and Wellbeing Plan 2017-2022 describes how the town was named as one of the top 10 places to live in the UK and the clear ambition for Darlington, as set out in *One Darlington: Perfectly Placed*, the shared strategy across public, private, voluntary and community sector partners.

The New Models of Care approach is underpinned by proactive and preventative self-care and early intervention at every stage to support continued independence.

Preventing mental ill health is a joint strategic priority for all partner agencies across the statutory and voluntary sector and is key objective contained within the; Sustainable Community Strategy: One Darlington Perfectly Place, Children and Young People's Strategy, and the Future in Mind workstream.

These strategic priorities are underpinned by several multi-agency working groups, which include a joint strategic commissioning group. Early intervention and prevention in relation to mental ill health is a shared commissioning priority between Health and Social Care.

Tees, Esk & Wear Valley NHS Foundation Trust in partnership with carers and carers' organisations have developed the Triangle of Care at West Park Hospital in Darlington and at other hospitals in the Trust's area. This is a therapeutic alliance between service user, staff and carer that promotes safety, supports recovery and sustains wellbeing.

Tees, Esk and Wear Valleys NHS Foundation Trust are committed to delivering recovery orientated services and have developed a three year strategy aimed at embedding recovery principles into their policy and practice.

The Local Authority has a number of contracts in place for services such as: mental health day opportunities, residential care, nursing care, short breaks and domiciliary support. A number of people also have a Direct Payment and they use this to commission their own support.

Autism Specific Services

Children and Young People

The CCG have just invested money into TEWV to enable them to increase the number of autism assessments for children & young people. This will enable the waiting time to be reduced.

To support the needs of the children & their families during the waiting period, further investment has been made through the Future in Mind Local Transformation Plan budget to provide support and training to families.

The Future in Mind Local Transformation Plan includes a review of the autism pathway in 2019-20 and move to a 'needs led' model.

These work programmes are expected to lead to service improvements. Co-production in the programme includes consultation with the Parent Carer Forum and joint production of a questionnaire to understand the gaps within the current system and identify additional support needs.

Darlington Borough Council and the CCG are currently taking forward a needs led approach between health, education and social care.

Adult Services

A service improvement workshop was held with partners in November 2019. This highlighted current processes and value stream mapping to identify what works well and what doesn't work well currently

As a result, an algorithm for new pathway across full TEWV footprint was designed which represents a culture shift and would reduce assessment time by 5-6 hours and starts the assessment process as soon as a referral comes into CMHT as opposed to not starting assessment until the referral reaches specialist team.

The proposed model looks at how the CMHT's can support the diagnostic assessment process and provide post diagnostic support for those which are diagnostically less complex. More complex referrals will continue to be referred into the specialist Autism team.

The proposed model is something that is currently being piloted in Redcar and evaluated in January 2020.

Community Mental Health Teams across CCG areas are:

Specialist Community Mental Health Teams for Affective disorders (multi-disciplinary service for people with severe and complex mood related mental health problems).

Specialist Community Mental Health Teams for Psychosis (multi-disciplinary service for people with severe and complex psychotic mental health problems).

Mental Health Access service (first point of contact for referrers).

Mental Health Crisis Team (multi-disciplinary service for people with complex mental health conditions who are in crisis requiring an urgent response).

Mental Health Home Treatment service (multi-disciplinary service to support people in their own home as an alternative to hospital admission).

Intensive Home Support Service (psychologically led service for Older People in mental health crisis who exhibit complex and high risk behaviours).

Older peoples Community Mental Health Team (for assessment and treatment of older adults with complex mental health conditions).

Assertive Outreach service (to offer more intensive ongoing support for people with severe and enduring mental health problems who are vulnerable or prone to rapid relapse).

Early Intervention in Psychosis service (multi-disciplinary service aimed at people aged between 14 and 35 years who experience a first episode of psychosis, specialising in focussed family work and psycho-education alongside judicial use of antipsychotic medication).

Acute Hospital Liaison Service (specialist multi-disciplinary mental health service operating 24/7 within the acute trust to assess, treat, and help manage people with mental health conditions who present at the acute hospital, offering signposting to specialist mental health services or other provision where appropriate).

Stepping forwards – an assertive community based service which aims to target those vulnerable individuals who have frequent contact with services through A&E, Police, MH Crisis teams but who struggle to engage with appointments and follow up.

Carers Support Services, commissioned jointly by the Council and Darlington CCG, are provided by Darlington Association on Disability (DAD) and DISC. The DAD Carers Support Service provides information, advice and support to all adult carers, plus awareness raising about carers' issues and training for health and social care staff.

There are a total of 1523 carers registered with the carers service and of these 154 are caring for someone with mental ill health aged 18 - 64.

DISC Darlington Young Carers Service aims to reduce the impact of caring for young carers up to the age of 25 by offering one to one support, activities, support groups and respite in addition to information, advice and guidance, whole family support and advocacy.

Baby bereavement – emotional support for bereaved parents.

Recovery College - A local recovery college has been commissioned to support the recovery approach.

Community eating disorders service, specialist community team providing treatment and support for people with eating disorders (primarily anorexia nervosa and bulimia nervosa.

Inpatient Services are:

Adult acute mental health wards for assessment and treatment of complex mental health problems.

Psychiatric Intensive Care ward for people in an acute phase of mental illness with very high risk behaviours.

Male Locked Rehabilitation for men who exhibit high risk behaviours relating to their mental health problems and require inpatient care for a longer period of time.

Female locked rehabilitation for women who exhibit high risk behaviours relating to their mental health problems and require inpatient care for a longer period of time.

Specialist mental health rehabilitation for people who require longer periods of mental health treatment, up to 18 months.

Specialist mental health rehabilitation for people who require longer term in-patient treatment, 18 months plus.

Inpatient assessment and treatment services, including acute, intensive care, challenging behaviour and rehabilitation services.

Service Delivery

There are two main hospitals within County Durham & Darlington; Lanchester Road Hospital in Durham and West Park Hospital in Darlington.

Services include a wide range of community based assessment and treatment services including primary care, liaison, crisis intervention, assertive outreach, community affective disorders and psychosis teams and eating disorders; mental health services for people with a sensory impairment (deafness) and Attention Deficit Hyperactivity Disorder (ADHD); Primary care psychological therapies (working with partners).

There is a specialist regional North East and North Cumbria eating disorder inpatient services for adults, with “step up” and “step down” day hospital services for County Durham and Darlington patients and inpatient services as part of a national consortium and community based services to military veterans.

Public Health led the Self Assessment Framework (SAF) on autism for Darlington and hold the response plan. As of Apr 2019 in Darlington, 222 children were on the existing ASD waiting list. The longest wait for assessment was 63 weeks and the average wait for assessment was 28 weeks. This is a key focus for ongoing work in the programme and TEWV NHS Trust are leading on a service development programme for 2019-20.

The Local Authority also has a number of contracts in place for services such as: mental health day opportunities, residential care, nursing care, short breaks and domiciliary support. A number of people also have a Direct Payment and they use this to commission their own support.

There is also a Carers Emergency Support Service commissioned jointly by Darlington Borough Council, Durham County Council, Darlington CCG and the 2 Durham CCGs and provided by Unique Home Care. This enables carers who have registered previously with the Service to access support should an emergency arise.

The Council has range of external service commissions which play an integral role in supporting personal resilience, health and wellbeing across the whole population including a 0-9 Service supporting emotional and physical health, housing support, young carer support, day opportunities, independent living skill development for people with Special Educational Needs and/or Disabilities (SEND), and Psychological Wellbeing Practitioner support for Care Leavers.

The Durham County wide Crisis Care Concordat and Prevention Concordat partnership groups are well established.

Service Performance

In Darlington, all targets for access and recovery are being met at 100% or exceeded where targets are set as a percentage.

The main national and local delivery data is included in the tables below:

QUALITY INDICATOR	STANDARD	2016/17	2017/18	2018/19	YTD 2019/20
					To Sept 19
ACCESS TO PSYCHOLOGICAL THERAPY (IAPT)					
PROPORTION OF PEOPLE THAT ENTER TREATMENT AGAINST THE LEVEL OF NEED IN THE GENERAL POPULATION	19.20%	19.9%	16.3%	16.11%	21.91%
PROPORTION OF PEOPLE WHO COMPLETE TREATMENT WHO ARE MOVING TO RECOVERY	50.0%	47.2%	53.1%	53.24%	50.70%
OF THOSE INDIVIDUALS COMPLETING TREATMENT - %AGE OF WHICH HAD A REFERRAL TO TREATMENT WITHIN 6 WEEKS	75.0%	80.1%	89.9%	100.00%	100.00%
OF THOSE INDIVIDUALS COMPLETING TREATMENT - %AGE OF WHICH HAD A REFERRAL TO TREATMENT WITHIN 18 WEEKS	95.0%	96.3%	98.6%	100.00%	100.00%
EARLY INTERVENTION IN PSYCHOSIS					
%AGE OF FIRST EPISODES IN PSYCHOSIS WHO COMMENCE A PACKAGE OF CARE WITHIN 2 WEEKS OF REFERRAL	56.0%	66.7%	40.7%	71.79%	61.11%
CRISIS SERVICES					
%AGE OF ADMISSIONS TO INPATIENT SERVICES WHICH ARE GATE KEPT BY THE CRISIS SERVICE	95.0%	96.0%	96.7%	99.28%	95.59%
%AGE OF CRISIS REFERRALS SEEN WITHIN 4 HOURS	95.0%	97.7%	93.7%	97.03%	98.87%
MENTAL HEALTH LIAISON SERVICES					
%AGE OF ASSESMENTS IN A&E WHICH ARE UNDERTAKEN WITHIN 1 HOUR OF REFERRAL	90.0%	NA	95.4%		
%AGE OF ASSESMENTS UNDERTAKEN ON WARDS WITHIN 24 HOURS OF REFERRAL	90.0%	NA	97.2%		
CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)					
PROPORTION OF EATING DISORDER PATIENTS SEEN WITHIN 4 WEEKS OF REFERAL FOR NICE APPROVED TREATMENT (ROUTINE)	79.0%	NA	57.1%	91.67%	100.00%
PROPORTION OF EATING DISORDER PATIENTS SEEN WITHIN 1 WEEK OF REFERAL FOR NICE APPROVED TREATMENT (URGENT)	83.0%	NA	100.0%	100.00%	-
%AGE OF PATIENTS SEEN FACE TO FACE WITHIN 4 HRS BY SUITABLY TRAINED PRACTITIONER (URGENT RESPONSE - CRISIS)	90.0%	NA	87.2%	89.60%	90.20%
PERCENTAGE OF CYP AGED 0-18 WITH A DIAGNOSABLE MENTAL HEALTH CONDITION WHO ARE RECEIVING TREATMENT FROM NHS FUNDED COMMUNITY SERVICES	34.0%	NA	31.9%	55.43%	100.53%
CARE PROGRAMME APPROACH					
MIXED SEX ACCOMMODATION BREACH (NUMBER OF EPISODES OF MIXED SEX ACCOMMODATION - SLEEPING)	0			0	0
PERCENTAGE OF CPA DISCHARGES FOLLOWED UP WITHIN 7 DAYS	95.0%	96.7%	98.5%	98.73%	99.05%
PERCENTAGE OF CPA USERS WITH A CRISIS PLAN IN PLACE (AMH)	90.0%	97.9%	99.1%	99.02%	99.2%
PERCENTAGE OF CPA USERS WITH A CRISIS PLAN IN PLACE (OPMH)	90.0%	100.0%	100.0%	100.00%	100.00%
PERCENTAGE OF PATIENTS WHO ATTENDED A FIRST APPOINTMENT WITHIN 9 WEEKS OF REFERRAL (AMH)	90.0%	97.7%	95.6%	97.21%	97.1%

Darlington CCG Financial Information

TEWV NHS Trust are the provider of the services for Darlington CCG although there is partnership work ongoing with schools and the local authority on a joint commissioned children and young people's service due to be in place in this financial year.

In Darlington, CCG spend for children and young people's mental health services has increase every year in line with the Future in Mind transformation funding and Mental Health Investment Standard (MHIS).

Darlington CCG spends 11.5% of its Mental Health spend (excluding Learning Disabilities & Dementia) on children and young people's services which is in line with other CCGs in the region.

Annual CCG spend from 2016 to 2020 (forecast) is detailed below:

2016-17 £1.573m

2017-18 £1.632 +3,8% (v +2% MHIS increase)

2018-19 £1.803m +10.5% (v 2.8% MHIS increase)

19-20 £1.908 +5.8% (v +5.7% MHIS increase)

NOTE: Local Authority service spend is not included.

APPENDICES:

A report detailing CCG commissioned programmes for mental health, learning disabilities and autism in the 2018-19 financial year is attached as appendix A.

HEALTH AND WELL BEING BOARD
28 NOVEMBER 2019

SUICIDE PREVENTION UPDATE: FOR INFORMATION

SUMMARY REPORT

Purpose of the Report

1. To update Board members on the Suicide Prevention Plan for Darlington.

2. To update Board members on the local position around suicide.

Summary

3. The action plan for the Darlington Suicide Prevention Group was initially developed in 2016 and following a number of key regional and local workstreams and attached resources, it is currently being refreshed and will be concluded by April 2020.

4. Suicides are not inevitable, in most cases they can be prevented. Suicide rates in England have increased since 2007, making suicide the main cause of death for men under 50 years. The death of someone by suicide has a devastating and lasting effect on families, friends, and the wider community.

5. In Darlington suicide rates remain higher than the national and regional average with a rate per 100,000 population of 13.1 compared to 9.6 (England) and 11.3 (North East). The latest suicide audit for Darlington (2016-18) looks in more detail at the 29 cases within that period to draw out emerging trends, patterns and the wider social determinants of those individuals who have died by suicide in recent years as an evidence base to inform preventative measures and practice.

6. The North East and North Cumbria (NENC) Suicide Prevention Network is a collaboration of regional partners and have developed a regional multi-agency plan 2019/24 - *Suicide Prevention is everyone's business - Every Life Matters* linked into national suicide prevention strategy.

7. The Darlington Suicide Prevention Group is well established and provides a multi-agency approach to suicide prevention in Darlington. Representatives from public health, CCG, TEWV and a range of voluntary and community sector organisations meet bi-monthly to take ownership of the local action plan and to monitor and respond to changing trends in terms of local suicide rates. NHS England funding has been allocated to each local authority area via the NENC network to support this work covering a range of workstreams.

8. A revised early alert system for coordinating information around every suspected suicide in Darlington has been established to ensure timely capture of relevant

and appropriate information and to provide up to date evidence to inform local plans.

Recommendation

9. It is recommended that: -

   (a) The Board accept the update on suicide prevention plans for Darlington and note the revision of the action plan in April 2020

   (b) Support the actions set out in the report to implement a whole system approach to suicide prevention across Darlington

Reasons

10. The recommendations are supported by the following reasons: -

   (a) Suicide remains a high public health priority and local authorities have a responsibility alongside key partners, to implement and deliver local suicide prevention plans

   (b) In line with national and regional strategy, there is a drive to reduce the overall suicide rate with funding attached to encourage local multi-agency action

Miriam Davidson
Director of Public Health

Background Papers

Darlington Suicide Audit 2016-2018 available on request

Becky James
Public Health Portfolio Lead
Darlington Borough Council
01325 406728

S17 Crime and Disorder	There are no implications arising from this report.
Health and Well Being	Local areas have a responsibility to put in place suicide prevention plans
Carbon Impact and Climate Change	There are no implications arising from this report.
Diversity	There are no implications arising from this report.
Wards Affected	All
Groups Affected	All – however suicide audit shows males aged between 40 – 69 years are most at risk
Budget and Policy Framework	No Council budget implications
Key Decision	No
Urgent Decision	No
One Darlington: Perfectly Placed	Aligned – More people healthy and independent
Efficiency	No efficiencies identified
Implications for Looked After Children and Care Leavers	No impact

MAIN REPORT

DARLINGTON SUICIDE PREVENTION UPDATE

Background

1. The purpose of this report is to update on the Darlington Suicide Prevention plan and local position. The action plan for the Darlington Suicide Prevention Group was initially developed in 2016 and following a number of key regional and local workstreams and attached resources, it is currently being refreshed and will be concluded by April 2020. A copy of the original plan can be viewed for information at Appendix 1.

The National Context

2. The National Suicide Prevention Strategy for England was launched in 2002 with the aim of supporting a national reduction in suicide rates. The renewed strategy *Preventing Suicide in England: A Cross-Government outcomes strategy to save lives* was published in 2012 (with a 2017 update), focuses on preventing suicide through a public health approach and establishes the case for locally developed multiagency strategies and action plans.

3. Suicides are not inevitable, in most cases they can be prevented. Suicide rates in England have increased since 2007, making suicide the main cause of death for men under 50 years. The death of someone by suicide has a devastating and lasting effect on families, friends, and the wider community.

North East and North Cumbria Suicide Prevention Network

4. The North East and North Cumbria (NENC) Suicide Prevention Network is a collaboration of regional partners and is accountable to the overarching steering group for the North East and North Cumbria Integrated Care System (ICS) Mental Health work stream. The ICS framework aims to transform the way services are delivered to people across the North East and North Cumbria, supporting the provision of a more integrated approach to health and social care. The NENC Suicide Prevention network have developed a regional multi-agency plan 2019/24 - *Suicide Prevention is everyone's business - Every Life Matters.* The aims of the plan are to:

(a) To reduce the number of suicides including in high-risk groups, and by a minimum of 10% by 2021, in all areas across the ICS.
(b) To reduce the incidence of self-harm and repeated self-harm.
(c) To reduce the impact of self-harm and suicide.
(d) To reduce the stigma of self-harm and suicide

Darlington Prevalence

5. The chart below shows how Darlington compares to the England average and the rest of the North East in terms of the most recent suicide rate per 100,000 population. Although actual numbers are low for Darlington (29 deaths in the latest 3-year audit), with a rate of 13.1, comparatively it sits higher than the England average (9.6) and the North East average (11.3). Middlesbrough is the only North East local authority area with a higher rate.

Table 1: North East Suicide Rate per 100,000 population 2016-18

Area	Recent Trend	Count	Value
England	–	14,047	9.6
North East region	–	779	11.3
Middlesbrough	–	54	15.6
Darlington	–	36	13.1
County Durham	–	176	12.8
North Tyneside	–	70	12.6
Hartlepool	–	29	11.6
Northumberland	–	91	11.3
Sunderland	–	82	11.1
Redcar and Cleveland	–	36	10.8
Newcastle upon Tyne	–	78	10.6
Stockton-on-Tees	–	48	9.2
Gateshead	–	46	8.7
South Tyneside	–	33	8.3

Figure 2: Suicide rate for Darlington per 100,000 population 2001 - 2018

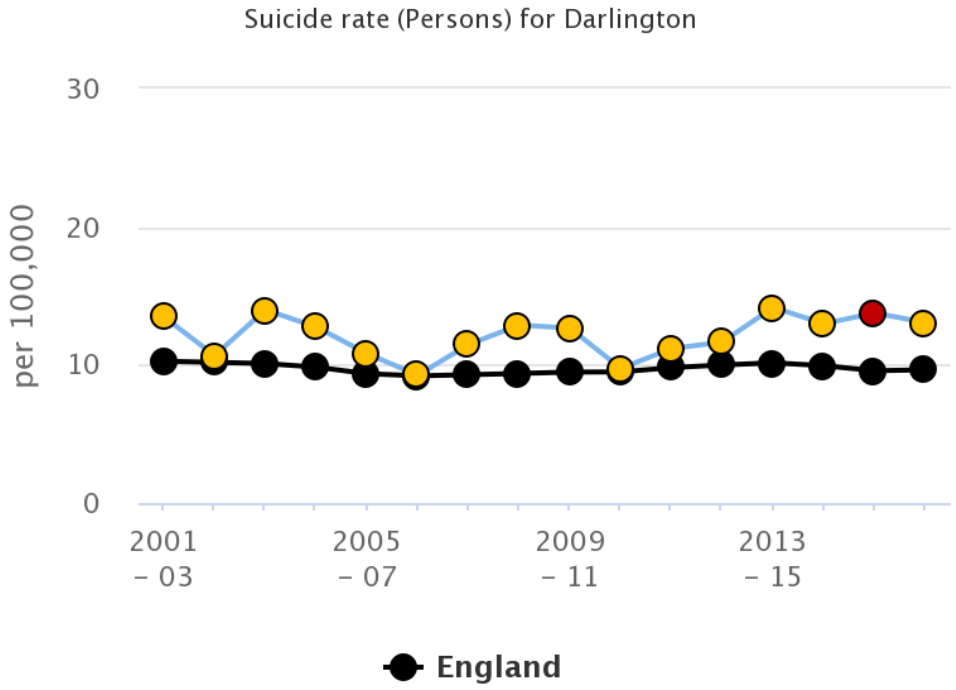


Figure 3: Suicide rate for Darlington per 100,000 population 2001 - 2018

Period		Darlington				North East region	England
		Count	Value	Lower CI	Upper CI		
2001 - 03	●	35	13.5	9.4	18.8	11.3	10.3
2002 - 04	●	28	10.7	7.1	15.5	12.0	10.2
2003 - 05	●	36	14.0	9.8	19.4	12.0	10.1
2004 - 06	●	33	12.7	8.7	17.9	11.3	9.8
2005 - 07	●	29	10.8	7.2	15.6	10.1	9.4
2006 - 08	●	25	9.3	6.0	13.7	9.9	9.2
2007 - 09	●	31	11.5	7.8	16.3	10.0	9.3
2008 - 10	●	35	12.9	8.9	17.9	10.2	9.4
2009 - 11	●	35	12.7	8.8	17.6	10.9	9.5
2010 - 12	●	27	9.7	6.4	14.2	11.0	9.5
2011 - 13	●	31	11.2	7.6	15.9	11.9	9.8
2012 - 14	●	32	11.6	8.0	16.5	12.3	10.0
2013 - 15	●	39	14.2	10.1	19.4	12.4	10.1
2014 - 16	●	36	13.0	9.1	18.0	11.6	9.9
2015 - 17	●	38	13.7	9.7	18.9	10.8	9.6
2016 - 18	●	36	13.1	9.1	18.1	11.3	9.6

Source: Public Health England (based on ONS source data)

Darlington compared to CIPFA neighbours

6. The chart below shows how Darlington compares to its CIPFA neighbours – those areas that are statistically nearest to Darlington - in terms of the suicide rate per 100,000 population. Darlington ranks as one of the higher rates amongst its CIPFA neighbours.

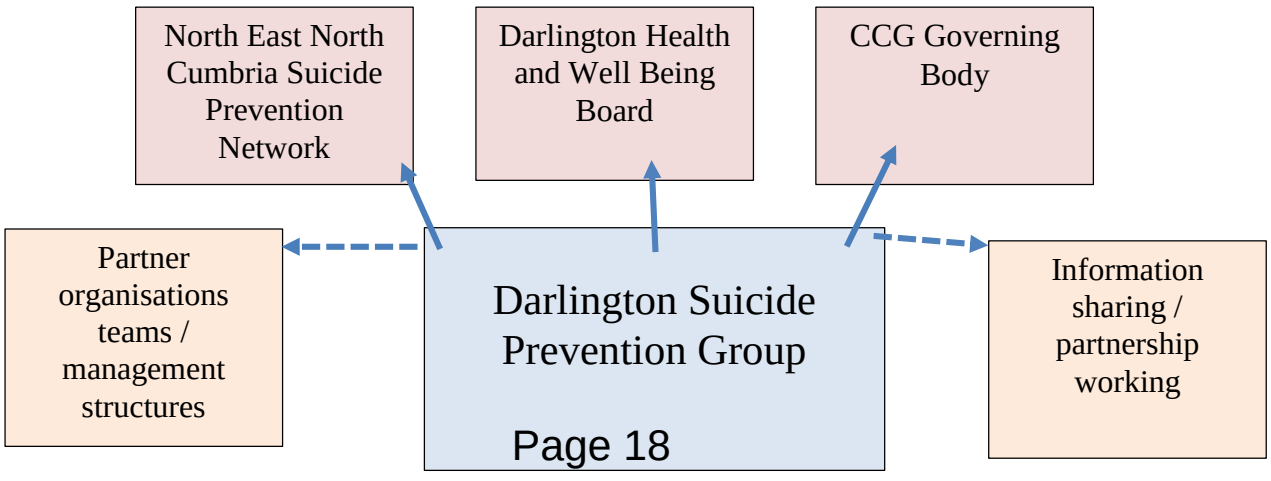
Figure 4: CIPFA Neighbours Suicide Rate per 100,000 population 2016-18

Area	Recent Trend	Neighbour Rank	Count	Value
England	–	-	14,047	9.6
Neighbours average	–	-	-	-
St. Helens	–	5	75	16.1
Rotherham	–	12	87	13.1
Darlington	–	-	36	13.1
Calderdale	–	7	68	12.5
Doncaster	–	13	98	12.3
Wigan	–	15	106	12.3
Bolton	–	6	87	11.7
Tameside	–	11	68	11.6
Dudley	–	3	80	9.7
Telford and Wrekin	–	8	44	9.7
North East Lincolnshire	–	2	40	9.6
Plymouth	–	9	68	9.6
Bury	–	10	45	9.3
Stockton-on-Tees	–	1	48	9.2
Derby	–	4	51	7.7
Warrington	–	14	41	7.2

Darlington Suicide Prevention Group

7. The Darlington Suicide Prevention Group is well established and provides a multi-agency approach to suicide prevention in Darlington. Representatives from public health, CCG, TEWV and a range of voluntary and community sector organisations meet bi-monthly to take ownership of the local action plan and to monitor and respond to changing trends in terms of local suicide rates. In terms of accountability this group feeds into the regional NENC suicide prevention network via public health representation, into Darlington Borough Council through the Health and Well Being Board and via the CCG Governing Body.

Figure 5 – Accountability



Suicide Prevention Action Plan

8. The Darlington action plan was developed in 2016. In line with the priorities included in the all age suicide prevention strategy *Preventing suicide in England; a cross government outcomes strategy to save lives*, the key priorities of the local plan include:

(a) Reduce the risk of suicide in key high-risk groups
(b) Tailor approaches to improve mental health in specific groups
(c) Reduce access to the means of suicide
(d) Provide better information and support to those bereaved or affected by suicide
(e) Support the media in delivering sensitive approaches to suicide and suicidal behaviour
(f) Support research**,** data collection and monitoring

9. A number of local actions within each of these areas have been identified and taken forward via multi-agency and collaborative working. Following a strengthened focus and drive to work more joined up across the region as part of the ICS framework, several new opportunities around suicide prevention have come to the fore to strengthen the work being carried out within Darlington.

Resources

10. NHS England funding has been allocated to the NENC network to support suicide prevention work in each local area. This funding has been provided on a 2-year programme 2018- 2020 to fund the following key areas of work:

(a) Suicide Audit
(b) Grass Roots small grants
(c) Workforce Development and training
(d) Postvention
(e) Team Talk

Suicide Audit

11. As part of the national strategy it is recommended that each area carries out an audit to draw out emerging trends, patterns and the wider social determinants of those individuals who have died by suicide in recent years as an evidence base to inform preventative measures and practice. These have been carried out on a 3-year basis with the latest data covering 2015 – 2018.

12. Summary information shows that 29 people took their own life in Darlington in this 3-year period. Of those 29:

(a) 79% were male
(b) 21% were female

(c) 76% were aged between 40 and 69 years
(d) 38% were employed at the time of their death
(e) 83% were single (including individuals who were widowed, divorced or separated)
(f) The most common method was by hanging

13. Given the small number of cases, it is not possible to draw any statistically significant trends or to rely on this data to exclusively identify those groups most at risk or the most significant contributing factors. It does however, provide a snapshot of the local profile, informs local planning and contributes to the work ongoing to tackle the issue. The information from the audit will be used by the Darlington Suicide Prevention Group to inform the update and review of the local action plan.

Grass Roots small grants

14. Funding was made available in 2018/19 to support organisations across Darlington to deliver projects that supported the aims of the Darlington Suicide Prevention plan. Bids were invited between £500 and £5,000 and four voluntary sector organisations were successful in securing funding. Projects included the development of a Men's Shed, mental health awareness training, bespoke support groups and support and access into employment. The second round of this funding for 2019/20 was promoted and closes at the end of November 2019.

Workforce Development and Training

15. To build capacity across the system, funding has been allocated to workforce development aligned to suicide prevention building on the findings of local audits and to allow areas to respond to identified gaps and local need. In Darlington, the audit highlighted similar numbers of those employed and unemployed and there is a need to have a whole system approach to tackling the issue so that key partners including the private sector, schools, DWP and the public and voluntary sector are enabled to raise awareness, build resilience and inform their workforce, clients and wider community.

Postvention

16. There is strong evidence to show that those bereaved by suicide are more at risk of suicide themselves. Part of local action planning needs to consider how family and friends are supported with the right information and advice. As numbers in Darlington are low this is a key issue to ensure that those partners who are best placed to offer this support have consistent and correct information and signposting at the right time.

Team Talk

17. A regional programme of work has been developed to look at linking in with grass roots sports clubs in the Durham, Darlington and Tees areas to raise awareness around mental health, suicide, build resilience and reduce stigma, thinking about taking the key messages to places where people go and feel comfortable in a supported environment. As a locality group there is opportunity to link into this to determine how this is rolled out and which groups and clubs to target.

Early Alert System

18. Whenever there is a suspected suicide, the Police as first responders, complete an initial CID27 form and send it to the Coroner's Office. Historically this information was then sent to NECs on behalf of the CCG who would summarise the information, send a summary to the public health team and send an audit tool requesting follow up information from the relevant GP practice. This system was often problematic in terms of keeping timely up to date information and sometimes there were missed opportunities between agencies.

19. As of 1st October 2019, a revised system has been implemented whereby the public health team will receive notifications direct from the Coroner's Office. This will minimise the transfer of information and allow for a real-time log of all suspected suicides to be maintained. Public Health will also be responsible for requesting primary care information on a revised, shorter form.

20. Routinely the logged data will be cross checked with the Coroner's Office to check which suspected suicides were confirmed at verdict. This will remove the need to conduct out a full 3-year audit as all the information required will be recorded within the early alert system. An annual summary will be produced to inform the Suicide Prevention Planning Group.

21. It is intended that the early alert system for reporting of drug related deaths in Darlington is aligned to the revised Suicide system utilising the good working relationship with the Coroner's Office.

APPENDIX 1

Darlington Suicide Prevention Plan 2017-2020
Updated May 2019

1. Reduce the risk of suicide in key high-risk groups					
	Key Area of Action	**Desired Outputs**	**Co-ordinators/ Leads**	**Timescale**	**Update**
1a	Men are a high-risk group in Darlington. Reducing risk in men, especially in middle age by developing treatment and support settings that men are prepared to use	Scoping and delivery of, 'Men's Sheds' in Darlington which provide opportunities for men to create networks of support Delivery of regional Mental Health Resilience through Football project. This programme works with football clubs to engage men in mental health improvement through sport.	Darlington Suicide Prevention Group Public Health England & NEMHDU	2018 2017	DBC Public Health grants given to three VCS agencies to establish men's shed projects in Darlington. Team Talk NENC programme being commissioned to tap into grass roots sports clubs.
1b	Mental Health Service Users are a high-risk group in Darlington	Scoping and delivery to a commitment to a, 'zero suicide ambition' within the mental health trust IAPT & Crisis Review Suicide Rapid Response Service	Darlington Suicide Prevention Group Including CCG and TEWV NECS MIND/Insight	2016 2018 Ongoing	IAPT review ongoing Suicide Rapid service decommissioned by Darlington CCG but continues in Durham run by Mind.

	2. Tailor Approaches to improve mental health in specific groups				
	Key Area of Action	**Desired Outputs**	**Co-ordinators/ Leads**	**Timescale**	**Resource**
2a	There is a national and local focus on improving the mental health of children and young people (CYP) through the national *Future in Mind* (FIM) strategy and local CYP mental health transformation plan as well as mental health being a focus of the Darlington Children & Young People's Plan (CYPP)	Delivery of mental anti-stigma campaign to CYP Mindful Schools delivery Mental Health First Aid Training to school staff and school nurses. Samaritans, 'Step by Step Service' Distribution and delivery of *Help When We Needed It Most: How to Prepare for And Respond to Suicide in Schools and Colleges* Darlington Mind Self-Harm Prevention Project for Children and Young People	Darlington Suicide Prevention Group Samaritans MIND Tees Valley YMCA	2017 2016-2017 2017 On-going	Future in Mind Funding was used to deliver an anti-stigma campaign in colleges and MHFA for school staff. Mind YP self-harm prevention project delivered to 3000 children in Darlington schools. Funding ends in Jul 19 – extension requested with BBC Children in Need – decision Jul19
2b	Improving mental health in those who are vulnerable due to economic circumstances eg. unemployed, in financial hardship, homeless	Awareness raising of mental health in local businesses to reduce stigma and support individuals back into work and within the workplace e.g. Mental Health First Aid (MFHA) and ASIST training	Darlington Partnership, Darlington Cares, Public Health	2018	Darlington Partnership had MH as their theme for 2017. DBC Public Health funding free MHFA courses from grants.

		Liaise with statutory and voluntary organisations who work with those affected to ensure signposting of support Raise Awareness of resources & training Promote reducing the risk of suicide: a toolkit for employers			Toolkit never produced.
2c	People who misuse alcohol and/or drugs are an important group to target interventions towards due to increased risk.	Work with local treatment services provider to offer awareness training in order to increase knowledge of staff. Including ASIST, safeTALK, MHFA Link with drug related death group to facilitate any shared learning.	NECA & Public Health Public Health	2018-20 2016	Considered as part of new substance misuse service.
2d	Explore the roll out of the GP and Primary Care Suicide prevention awareness e-learning programme	Increased awareness of mental health and reducing stigma	NHS England, Darlington CCG, LA Leads	2018	To be taken forward in 2019/20
3. Reduce access to means of suicide					
	Key Area of Action	**Desired Outputs**	**Co-ordinators/ Leads**	**Timescale**	**Resource**
3a	The majority of suicides in Darlington happen within the home but Darlington has a busy railway station where prevention work is very important.	Support & learn from the Rail Industry Suicide Prevention Programme (Samaritans, British Transport Police & Network Rail) to reduce suicide on the railways.	Darlington Suicide Prevention Group	2017 onwards	Mind invited to talk to railway staff at Darlington on suicide prevention in 2018

3b	Suicide Prevention to be considered at design stage	Encourage local authority planning to include health and safety consideration Reference to prevention work in strategies and master plans	DBC Planning department	2018 onwards	To be taken forward
4. Provide better information and support to those bereaved or affected by suicide					
4a	Recently bereaved to suicide are a high risk vulnerable group.	Support for those recently bereaved by suicide with advice and guidance Promotion use of PHE guidance 'Help Is At Hand'	VCS Coroner's Office Public Health	2018/19	Joint work proposed with Mind and DBC Public Health funded by CCG for Suicide Audit in 2019-20
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour					
5a	There are important issues to consider when covering suicide in the media. Inappropriate reporting of suicide may lead to imitative or 'imitational' behaviour.	Promotion of Samaritans, '*Media Guidelines for Reporting Suicide'* to all partners Increase positive mental health attitudes in the media and promote help seeking behaviour	Darlington Suicide Prevention Group DBC Communications Team	2018/19	Regular press releases issued by Mind. DBC funding Mind to deliver 24 free half day emotional resilience courses in Darlington in 2019-20.
6. Support Research, Data Collection and Monitoring					

	Key Area of Action	Desired Outputs	Co-ordinators/ Leads	Timescale	Resource
6a	Production of timely annual Darlington suicide audit	Identification of high risk groups, patterns and areas locally	Public Health, Police & Coroner's office	2018/19	Suicide Audit completed November 2019
6b	Ensure local suicide early alert system for potential suicides	Identification of and timely intervention for potential clusters Robust intelligence and recording system to learn from attempted suicides	GPs, NECS & Public Health	2016 onwards 2018/19	Further work needs to be done by CCG/NECS as part of GP training.
6c	Mental Health Service Users are a high risk group in Darlington	Work with Darlington MHN to understand and improve the physical health improvement opportunities for those with mental health conditions	Darlington Mental Health Network (MHN)		Work ongoing

Winter Planning

Nichola Kenny, Director of Performance

Health and Well-being Board
November 2019

Aims of the plan….

NHS
County Durham and Darlington
NHS Foundation Trust

- Ensure the Trust has the ability to respond effectively and quickly to increased seasonal demand.
- Maintain the highest standards of patient safety and patient experience
- Deliver the Trust's regulatory and contractual requirements including:
  - Improvement towards A&E 4 hour standard c>90%
  - Sustained performance for delayed transfers of care
  - Reduction in Long Stay Patients (LSP) by 42% as per the nationally set target. Long Stay Patients are deemed to be any patient with a length of stay of 21 days or more.
  - Ongoing reductions in ambulance handovers so there are none greater than 1 hour
  - Ongoing reduction in ambulance patients diverted away from the hospital
- National flu campaign requirement to vaccinate at least 80% of Trust staff
- Deliver the plan within the available physical and financial resources available.

Context: Acute Service Pressures A&E Activity & RTT, incl. Cancer

County Durham and Darlington NHS Foundation Trust

A&E – Below standard performance

Apr- Aug 2019 compared to Apr-Aug 2018 our ED attendances are up 9.8% (DMH 13.1%; UHND 6.9%)

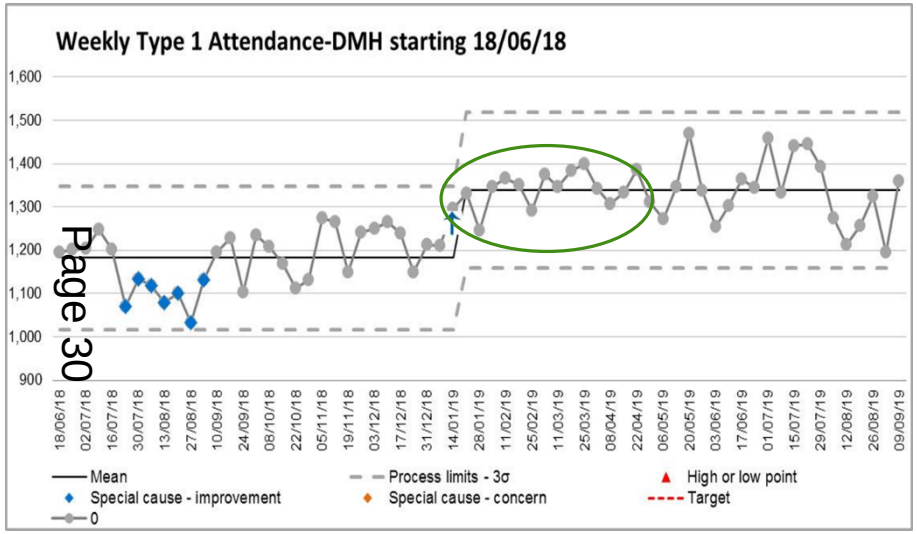
- Increased demand both sites
- Disproportionate number of ambulance arrivals into UHND (Compared to region), but going down in volume overall
- Increased acuity – Type 1s up 20% (in July), both sites but more notable in DMH
- Some increased in activity due from Friarage services changes
- Average daily admissions increased
- Growth in >65yrs
- Non-elective trauma has increased – putting pressure on all beds and elective programme

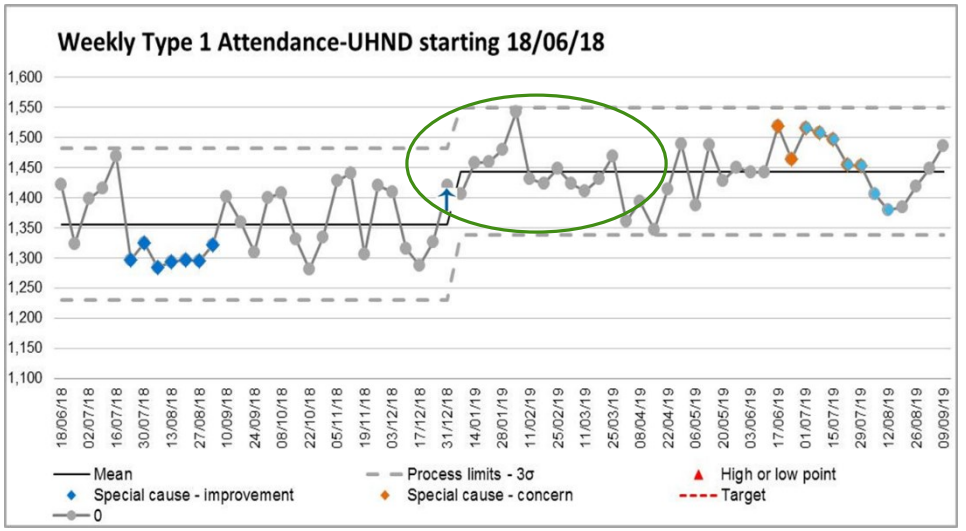
RTT –Below standard performance trust-wide

- Recovery plans in place at speciality level
- Important to protect elective programme and outpatient capacity

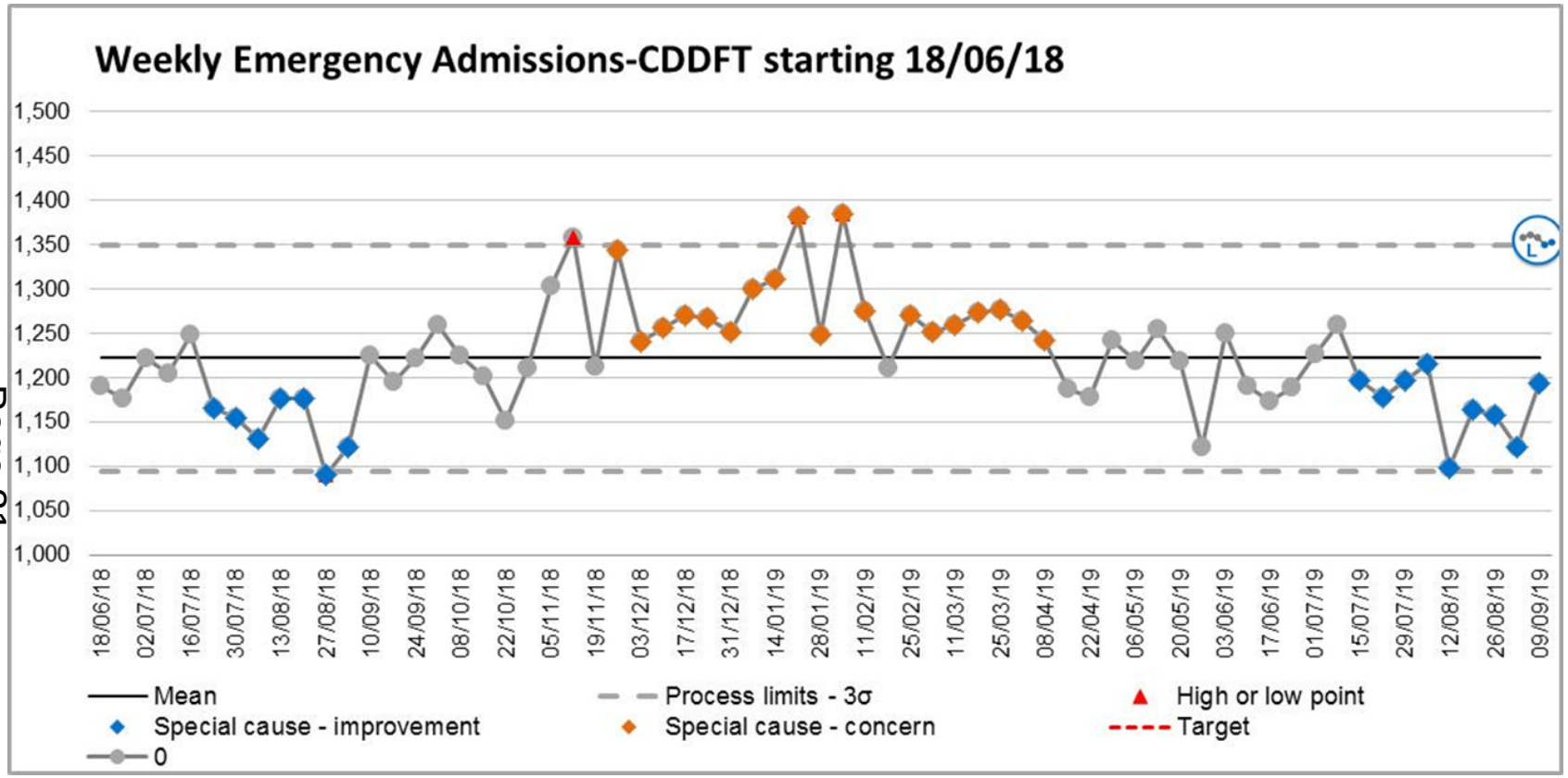
Step change in activity Jan through to Mar

NHS
County Durham and Darlington
NHS Foundation Trust





Same pattern with emergency admissions



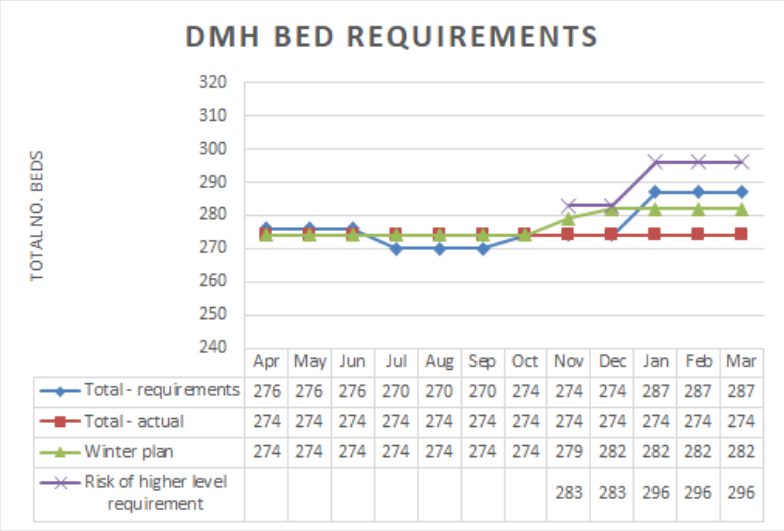
System Response

- Developing our system winter plan
  - Opening up of resilience beds /escalation beds
  - Reduced elective programme (plans to increase capacity at BAGH)
  - Safe staffing plan
  - Proactive communications and awareness raising of other alternative services to ED
  - Enhanced service provision by all partners
- Launch of our Perfect Quarter Initiative.

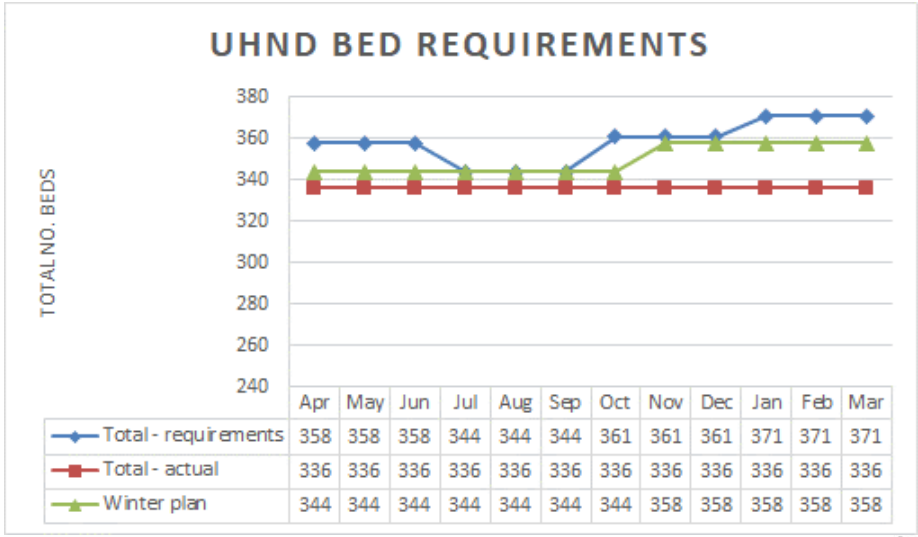
  This programme brings together all the lessons learned from previous initiatives, including Perfect Months, the Transforming Emergency Care programme and #nextstephome to maximise performance in ED and patient flow through the non-elective pathway.
- Testing of partner BCPs
- Flu campaign

County Durham and Darlington NHS
NHS Foundation Trust

Additional bed capacity



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total - requirements	276	276	276	270	270	270	274	274	274	287	287	287
Total - actual	274	274	274	274	274	274	274	274	274	274	274	274
Winter plan	274	274	274	274	274	274	274	279	282	282	282	282
Risk of higher level requirement								283	283	296	296	296



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total - requirements	358	358	358	344	344	344	361	361	361	371	371	371
Total - actual	336	336	336	336	336	336	336	336	336	336	336	336
Winter plan	344	344	344	344	344	344	344	358	358	358	358	358

Reduced elective programme

- **The elective programme will be reduced to Cancers and Urgents from w/c 23 December for three weeks.**
- **There are plans to increase surgical capacity for Trauma and Orthopaedics at Bishop Auckland Hospital as soon as works can be complete. Recruitment has already commenced. This will help post winter and with winter recovery of the programme.**
- **To date the Trust has experienced a series of service disruptions to the elective programme and there is an ongoing risk that planned recovery could be disrupted further due to winter pressures.**
- **Current planning for the surgical programme is to reopen from 13 January 2020, but restrictions may need to be retained for a longer period and this will be dynamically assessed.**

Safe staffing

- **Work is ongoing to finalise the staffing plan.**
- **Recruitment is ongoing to secure both qualified and unqualified nurses and the medical workforce.**
- **Support is being secured from the corporate nursing team and opportunities are being created for non-clinical staff to volunteer their support on the wards. This could be to support with nutrition and sociable eating, helping to make beds, collect scripts or engage in social conversation with patients**.
- **Development of a package of support for staff**
  - Weekly payment for bank only staff maintained and substantive staff reverting back to monthly
  - Robust approach to health and well-being making use of all tools available to support staff in personal and team resilience.
- **Pool of HCAs to provide enhanced care for patients**
- **Use of bank and agency nurses**

Safe staffing – Medical workforce

- IMS Consultant Resilience Team in place to oversee Medical Beds on Ward 17 (UHND) and the 18 allocated beds from surgery (DMH).
- Plans to stand down all other clinical activity for that week.
- Borders outside of the resilience wards will be managed by the base wards as normal process -buddy arrangements. It has been agreed through the Clinical Implementation and Review (CIR) group of consultants on each site that for winter the resilience team will look after all or any boarders if there are any.
- The Physician of the Day (POD) will be responsible, as per current arrangements, to review any patients in Day Surgery or Gynae beds at Weekends, noting that this pulls them away from AMU if additional resource cannot be secured.
- Appointment of six Junior doctors to predominantly support Ward 17 in UHND and the Allocated surgical beds in DMH as part of resilience team and aiming to source 7 day cover.
- Subject to funding an availability the additional cover will be sought:
  - 7 day cover of resilience ward ie extra consultant on weekends for 5 hrs (0800-1300) to cover wards / AMU.
  - Additional Consultant to provide Senior Consultant review hours into ED and later into the evening on AMU/RAMAC.
  - Additional junior twilight shift in ED

As a minimum additional cover is being sought for 26-31 December and 1-5 January as a minimum.

System Response

- Significant investment c£2million in to mobilising winter schemes
- New/ enhanced services:
  - Community Rehabilitation Team, currently recruiting (contribute to reducing LoS and freeing up acute bed capacity)
  - Increased Same Day Emergency Care (SDEC) activity
  - Embedded IC+ service from July 2019, with stand alone overnight nurse service from September 2019
  - Introduction of COPD App to support self-care/management
  - Consultant Connect to facilitate Urgent Care Advice for GPs- requires evaluation
  - Trusted assessors via brokerage service
  - Extra re-ablement packages and additional spot purchase step up/down beds
  - Increased social work (assessment officers)
  - Extended primary care appointment availability bank holiday dates

Areas of ongoing work:

- Iterative safe staffing plan
- Performance forecasting
- Financial plan
- Communications strategy
- On-call arrangements
- Revised and strengthened approach to escalation
- Health and Well-being - support to front-line teams

Next steps

- **LADB** – 18th October
  Review of all partner winter plans

- **Finalise system's responses to winter plan**

- **Review and act on the work of the UEC Summit to further influence shape winter mitigation**

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HEALTH AND WELL BEING BOARD
28 NOVEMBER 2019

HEALTH PROTECTION ANNUAL REPORT

SUMMARY REPORT

Purpose of the Report

1. To consider the Annual Health Protection Report published by the Public Health England North East Health Protection Team (HPT), entitled 'Protecting the population of the North East from communicable disease and other hazards' (2018/19)

Recommendations

2. It is recommended that the Board:

   (a) Notes the content of the Public Health England North East Health Protection Team (HPT), Annual report 2018/19 entitled 'Protecting the population of the North East from communicable disease and other hazards'.

   (b) Recognises that health protection risks affect some individuals and communities disproportionally resulting in poorer health.

Reasons

3. The recommendations are supported by the following reasons:

   (a) To inform the Board on the work of the Public Health England North East HPT, to deliver safe and effective health protection services.

   (b) The report provides evidence to the Director of Public Health in support of their assurance role.

Suzanne Joyner
Director of Children and Adults Services

Background Papers

Report of the Public Health England North East HPT, entitled 'Protecting the population of the North East from communicable disease and other hazards' 2018/19.

Author: Paul Davison, PHE / Jon Lawler, Public Health Registrar, 01325 406205

S17 Crime and Disorder	There are no implications arising from this report.
Health and Well Being	The report has recommendations to improve the health and wellbeing of the whole population by protecting health.
Carbon Impact	There are no implications arising from this report.
Diversity	There are no implications arising from this report.
Wards Affected	All
Groups Affected	Health protection risks affect some individuals and communities disproportionally resulting in poorer health.
Budget and Policy Framework	There are no implications arising from this report.
Key Decision	No
Urgent Decision	No
One Darlington: Perfectly Placed	Health protection covers all themes of One Darlington: Perfectly Placed
Efficiency	There are no implications arising from this report.
Impact on Looked After Children and Care Leavers	There are no issues contained within the report that will have implications on Looked After Children or Care Leavers.

MAIN REPORT

Information and Analysis

4. The Public Health England North East Health Protection Team (HPT) has produced its ninth annual report, entitled ‘Protecting the population of the North East from communicable disease and other hazards’. The report summarises the activity of the various health protection functions of the HPT.

5. Successful health protection requires strong working relationships at the North East and local level.

6. There are four elements to the work of Public Health England (PHE) in protecting the health of the population, prevention, surveillance, control and communication.

Prevention

7. Immunisation remains one of the most effective public health interventions for protecting individuals and the community from serious diseases. NHS England is responsible for commissioning local immunisation programmes and accountable for ensuring local providers of services meet agreed population uptake and coverage levels.

   (a) Screening and Immunisation Teams (SITs) employed by Public Health England centres and embedded within NHS England provide local leadership and support to providers in delivering improvements in quality and changes in the programmes. The SITs are also responsible for ensuring that accurate and timely data is available for monitoring vaccine uptake and coverage.

   (b) Public Health England centres lead the response to outbreaks of vaccine-preventable disease and provide expert support an advice to the SITs.

   (c) Local Authorities are responsible for providing independent scrutiny and challenging the arrangements of NHS England, PHE and providers.

Surveillance

8. Effective surveillance systems are essential to identify trends in, and outbreaks of, communicable diseases and to monitor the outcome of control actions. The HPT uses information from a wide variety of sources including local authorities. Appendix 1 in the Main Report provides a summary of the main communicable disease cases reported in the North East during 2018.

9. Health Protection Surveillance schemes include Healthcare Associated Infection (HCAI), Sexually Transmitted Infections (STIs) and Invasive Pneumococcal Disease (IPD).

Control

10. Control relates to actions taken to minimise the spread of disease following either a single case or an outbreak and includes actions taken to control an outbreak. Early reporting, early diagnosis and prompt treatment are essential. For some diseases the initial reporting is through local authority environmental health services. Chapter 4 in the Main Report provides detailed information about key infectious diseases in the North East.

11. Outbreaks of infectious diseases are relatively common and community-based outbreaks are managed through an agreed local operational response by the HPT, local authorities and the NHS. Considerable effort is also put into the prevention of outbreaks through the inspection role of environmental health officers, NHS and PHE roles in relation to immunisation and infection control and the monitoring actions of other bodies such as water companies.

12. The most common outbreaks are of vomiting / diarrhoea in care homes and outbreaks of food poisoning possibly associated with restaurants or catered events.

13. Public health action is taken to control the outbreak by any combination of controlling the source of the organism (e.g. better hygiene in a food premises),

ceasing exposure (e.g. withdrawing a food from sale, hygiene and cleanliness in care homes), breaking the chain transmission (e.g. by treatment of cases, isolation of cases in hospital) and reducing vulnerability (e.g. by immunisation or antibiotic prophylaxis).

Health protection in a prison setting

14. Prison settings are important for health protection due to the number of vulnerable prisoners held in close proximity which can allow infections to spread easily. Public Health in Prisons North East meetings provide a forum for the discussion and dissemination of relevant public health issues.

15. Within the North East, blood borne virus (hepatitis B and C and HIV) testing continues, a pilot of syphilis testing has been undertaken and a TB baseline audit completed.

Emergency preparedness, resilience and response (EPRR)

16. PHE North East has a system in place for emergency preparedness and responding to communicable disease and other hazards or threats. Multi-agency Local Resilience Forums (LRFs) operate at strategic and sub-group levels. In addition, PHE is actively involved in the work of the NE Local Health Resilience Partnership (LHRP) and the Health and Social Care Resilience Groups.

17. PHE North East maintains internal plans for response to a range of incidents. These are linked to national plans and supporting materials. The most likely incidents to have a public health impact and require a significant multi-agency response are a large fire, chemical release of major outbreak of a communicable disease.

18. The responsibility for the Science and Technical Advice Cell (STAC) plan, activation and management rests with PHE. The STAC Plan is in place and Directors of Public Health provide the STAC chair role through an on-call rota. Annual updates and exercises are available for Directors of Public Health.

Communication

19. The PHE North East communication team works closely with local authorities and NHS bodies via the Public Health communication network. The PHE communications team continues to support the communications around the management of outbreaks and incidents.

20. It has also supported local and national outbreaks of measles, norovirus and scarlet fever and prepared communication plans to address concerns and raise awareness. The team has also played an active role in helping to disseminate public health messages during emergency situations and has worked closely with its communication colleagues in local resilience forums to respond to incidents such as fires and floods.

Environmental issues

21. Public Health England supports stakeholders including members of the public in responding to acute and chronic non-infectious environmental public health issues

including fires, chemical contamination of the environment. The Public Health England Environmental Hazards and Emergencies (EHE) provides expert advice and support during chemical incidents that have the potential to threaten people's health.

22. Although air quality has improved over recent decades, air pollution has a significant impact on public health in England and is associated with worsening of asthma, decreased lung function, increased numbers of hospital admissions and reduced life-expectancy.

23. During 2018/19 in the North East, the HPT and EHE have provided support and responses to chemical incidents and enquiries including water contamination, fires at industrial premises and chemical exposures, delivered training and supported local authorities in developing business cases for work plans to improve air quality.

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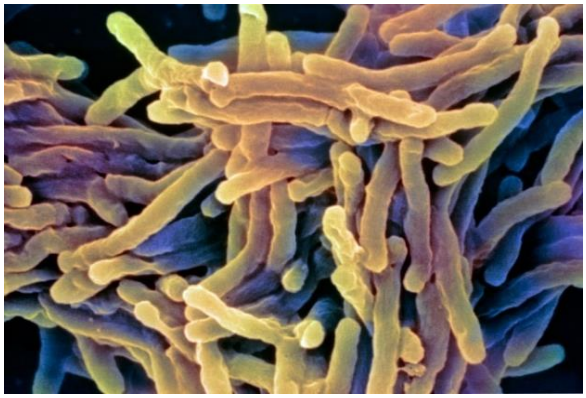
Public Health England

Protecting the population of the North East from communicable disease and other hazards

Annual Report 2018/19



About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

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Contents

Foreword

Welcome to the ninth annual report produced by the North East Health Protection Team (HPT). This report summarises the activity of the various health protection functions of PHE. It also provides evidence to Directors of Public Health in support of their assurance role.

Over the course of the last year the HPT have continued to provide an effective health protection response to the people of the North East. We have continued the patch-based structure with a consultant and senor nurse/practitioner aligned to north of Tyne, south of Tyne, Durham and Darlington and Tees Valley. There is no intention to change this arrangement which has work well for many years.

Perhaps one of the most significant changes that has occurred over the last year has been the increased public perception of the importance of environmental public health. There has been a renewed focus on air quality, particularly in relation to air pollution caused by traffic emissions and the requirement for several local authorities to produce plans to reduce nitrogen dioxide (NO^2) concentrations by introducing Clean Air Zones. It has also been a year when the reality of the threat to public health from climate change has been widely acknowledged and the urgent need for action more fully understood. Several local authorities in the North East, along with other institutions, have declared a 'climate emergency' and work is going on across the North East to ensure that heath and care organisations are taking their responsibilities seriously to meet carbon reduction targets.

The merger of NHS England and NHS Improvement is also significant. PHE has introduced a new post of Regional Director of Public Health to work alongside the new NHS management arrangements in the seven regions. At the time of writing this report work is taking place to agree the precise working arrangements for these posts. However, it is hoped that having public health input at such a senior level will strengthen public health interventions by the NHS.

Finally, like all public sector organisations PHE is facing a reduction in its budget. For 2019/20 we have tried to protect front-line services as much as possible and we will continue to do so.

We hope that this report is informative and helpful. If you have any comments on the content or format, please let us know.

Paul Davison
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June 2019

Summary of progress on 2018/19 priorities

The HPT identified eight local high-level priorities for 2017/18, as detailed in table F1.

Table F1: Summary of progress on 2016/17 objectives.

	Priorities	Outcome
1	Continue to deliver effective health protection services in 2018/19.	Achieved
2	Continue to consolidate the North East TB Network	Achieved
3	Deliver the 2018/19 objectives as outlined in the NE TB strategy.	Partially achieved
4	Deliver HP/STAC update session for DsPH and public health teams	Achieved
5	Provide targeted support local authorities in meeting NO_2 reduction targets and associated activities in improving air quality.	Achieved
6	Finalise the review of EpiNorth3 (local health protection surveillance system)	Achieved
7	Complete outputs from the Invasive Pneumococcal Disease project	Achieved
8	Produce a health protection annual report for 2018/19	Ongoing

Priorities for 2019/20

The first function of Public Health England (PHE) is to protect local populations from infectious diseases and other hazards to health. It does this at a national level through its national functions and at a local level through health protection teams (HPTs). PHE's high-level objectives for 2019/20 have been revised to include action on improving air quality. Our objectives continue to be revised to take this into account.

Table F2: Local priorities for 2019/20

	Priorities
1	Continue to deliver a safe and effective health protection service to the people of the North East in 2019/20.
2	Review the TB Network action plan to ensure a continued focus on reducing TB rates in the North East through early identification, increased treatment completion and reducing secondary transmission.
3	Chair the national task and finish group on supporting TB control in low incidence areas.
4	Deliver HP/STAC update session for DsPH and public health teams
5	Promote awareness of and action on climate change as a major public health threat and advocate for the implementation if mitigation and adaptation interventions.
6	Support NHS Trust microbiologists across the North East to review existing CPE screening and management protocols and to consider harmonisation across Trusts
7	Conclude the IPD project and complete the necessary outputs.
8	Produce a health protection annual report for 2019/20.

1. Introduction and recent developments

1.1. This report

This is the ninth Annual Report compiled by the North East Health Protection Team. It outlines the key health protection issues in 2018/19 and identifies the strategic priorities for 2019/20. It follows the format of last year's report in aligning the information with the four key components of health protection activity namely: prevention, surveillance, control and communication.

1.2. Health protection arrangements

Effective public health protection is a collaborative activity involving a range of organisations and departments including local authority public health teams and environmental health departments, acute and mental health NHS Foundation Trusts, services within PHE regionally and nationally, NHS England and NHS Improvement, water companies, the Department for Environment, Food and Rural Affairs (DEFRA), the Environment Agency, prisons, universities, clinical commissioning groups and the independent sector, particularly care homes. The success of health protection in the North East reflects the effective partnership working between all the agencies involved.

PHE delivers the following health protection functions in the North East:

- The North East Health Protection Team (NE HPT) delivers a 24/7 response to communicable disease incidents and environmental threats. The consultants and senior nurses work on a patch basis in hours: North of Tyne; South of Tyne and Wear; County Durham and Darlington; Tees.
- The Field Service continue to collate information on communicable diseases from a wide range of sources in order to give early warning of outbreaks, enable monitoring of interventions and trends and provide expert advice on epidemiological studies.
- Emergency preparedness, resilience and response functions support the NHS, the Local Health Resilience Partnership and the three multi-agency Local Resilience Forums in the North East in planning, exercising and responding (24/7) to a range of threats as part of a national team.
- The North East has a PHE communications team who are part of the national communications division and whose role includes assisting with delivery of proactive and reactive information and advice on health protection issues to the public.
- PHE commissions specialist laboratory services located in Newcastle upon Tyne Hospitals NHS Foundation Trust. Food, Water and Environmental Services are delivered from the York Laboratory.

1.3. Field Service

The North East Field Service (FS) team is one of seven similar teams across the country. These teams are nationally managed and co-ordinated but geographically dispersed. Their

purpose is to provide specialist epidemiological and public health microbiological expertise to support Health Protection teams in field epidemiological investigations and surveillance.

In addition, the local Field Service team undertakes research and development of the evidence base for health protection to inform actions aimed at the control of infectious diseases and health effects from exposure to environmental hazards.

The North East Field Service (FS) team works closely with the HPT; jointly managing North East based surveillance systems and providing epidemiological components of incident investigations, and analytic studies.

In 2019, the FS teams from the North East and Yorkshire and the Humber merged under a single management structure. This decision was taken in order to ensure that Field Services were able to meet their reduced financial targets for 2019/20, but also to provide increased resilience across both areas.

1.4. The PHE Public Health Laboratory Service in Newcastle upon Tyne and York

Since last year's report there has been a change in the process for delivering local public health microbiology services. These are now commissioned rather than directly provided by PHE. Following a tendering process Newcastle upon Tyne Hospitals NHS Foundation Trust was successful in winning the tender to provide the service and this commenced formally in November 2018. The HPT is part of the contract monitoring group. Food, Water and Environmental laboratory services continue to be delivered from the York Laboratory.

Contact details for local laboratories are listed in Appendix 3.

1.5. Education and training

The HPT and FS have a well-established track record in delivering teaching and training in a variety of settings. This includes formal support to the Public Health Training Scheme; delivering health protection elements of local post-graduate degrees in Public Health; teaching and examining on the Newcastle University degree programme in medicine; and providing supervised placements to a range of undergraduate and post-graduate medical trainees. The HPT also contributes to training sessions at hospital trusts, local authorities and NHS England as well as formal presentations at conferences and seminars. Further details can be found in Section 10.2.

1.6. Delivering health protection

There are four key components to the work of PHE in protecting the health of the population in the North East: prevention; surveillance; control; communication. Other agencies have major roles in all these components. Each of these themes is the subject of separate section in this report.

1.7. Whole genomic sequencing (WGS)

WGS continues to be an integral part of public health investigation and practice. As of 2019, PHE routinely sequences human isolates of Salmonella, *E. coli*, Shigella, Listeria, *Mycobacterium tuberculosis and S. aureus* as part of its surveillance activities. Other pipelines for sequencing have been developed but are not in routine use: *Clostridium difficile, Neisseria gonorrhoeae*, Campylobacter, Yersinia and Vibrio.

WGS of gastrointestinal organisms is well established. Single nucleotide polymorphism (SNP) addresses are used to summarise the genetic information allowing easier interpretation. The Health Protection Team, working closely with the local Field Service team, has developed reports that highlight clusters of genetically similar organisms. The national Gastrointestinal Team also produces a national overview of five SNP clusters which the local Field Service team also monitors for activity. In general, clusters of two or more cases within five SNPs are assessed using exposures previously collected to gauge if a common source is present or if further investigation may be required.

The WGS of TB has recently been rolled out to all of England although we have had this capability for since November 2016. For TB, the nomenclature and interpretation of clusters is different to GI organisms as clusters are defined as being within 12 SNPs and are given a specific cluster number, so no SNP addresses are used. The process is also slightly different as there are TB cluster investigators that assess the severity and speed of growth of the clusters. They also indicate when new cases are added to clusters and when public health action should be considered. The HPT and the FS team are working together with other stakeholders to introduce an automated report summarising individual TB clusters.

There is also a process in place to request WGS in outbreak situations where the results will directly impact the public health measures. This is used when the organism causing the outbreak is not routinely sequenced but where there is evidence to indicate the utility of WGS in the situation. Requests are rapidly peer reviewed to ascertain their scientific and practical feasibility.

WGS is fast becoming one of the most important pieces of evidence in public health investigations. Interpretation of WGS can be complex but there are resources to help with the interpretation of SNP addresses and national colleagues who can provide explanations and strength of associations in practice.

2. Prevention – communicable disease

2.1. Immunisation and vaccine-preventable diseases

Immunisation remains one of the most effective public health interventions for protecting individuals and the community from serious diseases. The national routine childhood immunisation programme currently offers protection against 14 different vaccine-preventable infections. In addition to the routine childhood programme, selective vaccination is offered to individuals reaching a certain age or with underlying medical conditions or lifestyle risk factors.

Programme delivery

NHS England is responsible for commissioning local immunisation programmes and accountable for ensuring local providers of services deliver against the national service specification and meet agreed population uptake and coverage levels as specified in the Public Health Outcomes Framework and Key Performance Indicators.

- Screening and Immunisation Teams (SITs) employed by Public Health England centres and embedded in NHS England and Improvement provide local leadership and support to providers in delivering improvements in quality and changes in the programmes. The SITs are also responsible for ensuring that accurate and timely data is available for monitoring vaccine uptake and coverage.
- Public Health England centres lead the response to disease outbreaks of vaccine-preventable disease and provide expert support and advice to the SITs.
- Local Authorities are responsible for providing independent scrutiny and challenging the arrangements of NHS England, PHE and providers.

Figure 2.1. shows a timeline of vaccine development and introduction of the routine vaccine programme. Following recommendation from the Joint Committee on Vaccination and Immunisation (JCVI) there have been some changes to the existing programmes of England's national immunisation programme for 2018/19:

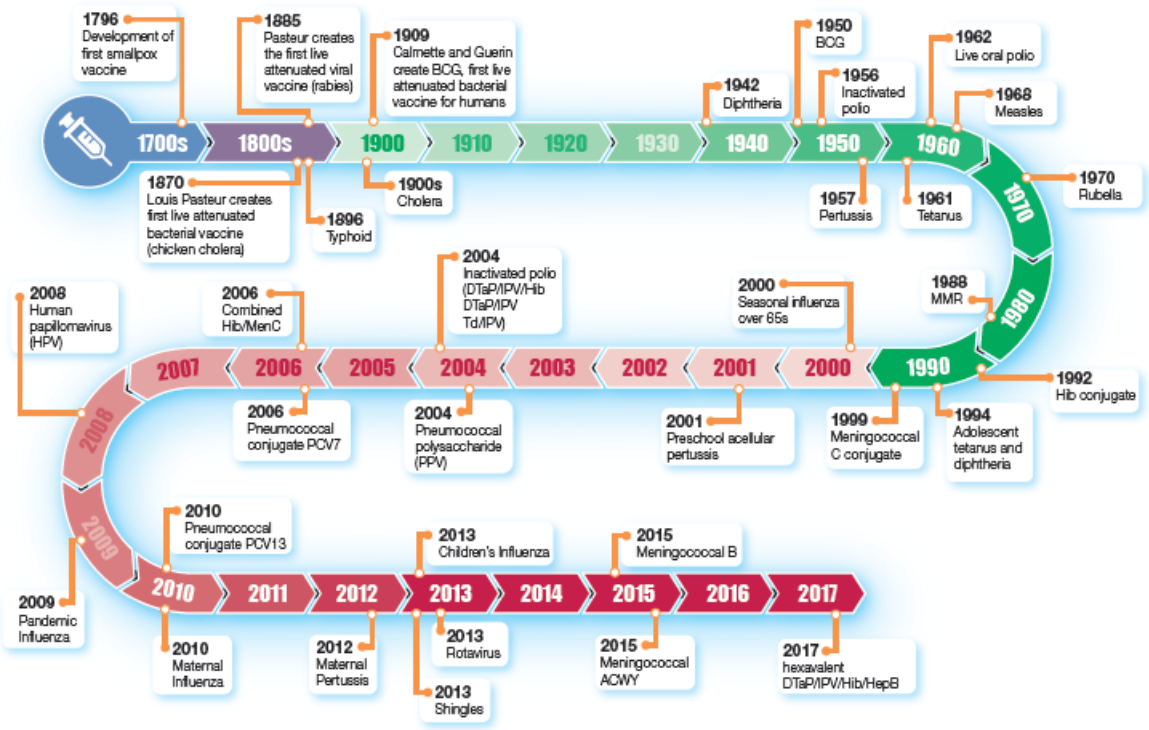
Meningococcal ACWY (MenACWY) The adult 18-25-year programme was removed on 1 April 2018.

Meningococcal ACWY (MenACWY) completing dose - the cohort has been extended to include additional school leavers not previously covered by the previous programme.

Shingles routine patients are eligible from the day they turn 70 years, they do not have to be 70 on the 1 September of the relevant year.

Shingles catch up patients aged 78 years on 1 September 2016. Patients previously eligible remain eligible for vaccination until their 80th birthday. The shingles vaccine is now offered all year round to eligible patients.

Figure 2.1. Historical vaccine development and introduction of the routine vaccine programme



Public Health England 2018

Coverage rates

Uptake in the North East for the routine childhood programme remains among the highest in England: In Quarter 3, 2018: (Oct-Dec 18)

- By aged 12 months, 95.5% of children in the North East (92.1% in England, 93.2 England excluding London) had received a full primary course of diphtheria, tetanus, pertussis, polio, haemophilus influenza type b vaccines. DTaP/IPV/Hib
- By 12 months, 90.1% (84.7%) had received meningitis C vaccine. *Note this is not on the schedule now.*
- By 24 months, 93.7% (90% in England, 91.8 England excluding London) had received measles, mumps and rubella (MMR) vaccine (dose 1).
- By 5 years, 92.1% (86.5% in England, 89 England excluding London) had received two doses of MMR.
- By 5 years, 90.4% (85.3% in England, 87.9 England excluding London) had received diphtheria, tetanus, polio booster. (DTaP/IPV Booster)

2.2. Planning

The HPT works with local authorities, NHS organisations and a range of other agencies on a regular basis to develop and review plans for the prevention, surveillance and control of communicable disease. Much of this work is undertaken at a 'patch' level (North of Tyne, South of Tyne and Wear, County Durham and Darlington, and Tees) and increasingly at local

authority level. Regular multi-agency meetings are held to share information, supported by a series of routine reports.

PHE staff also attend a wide range of NHS planning and monitoring meetings and clinical networks and lead or attend task groups on specific diseases (such as TB or sexually transmitted diseases) or specific settings (such as colleges, universities or prisons). More detail on some of these activities is provided in section 5.

The HPT works closely with NHS England and NHS Improvement on planning for a range of serious and major incidents, developing joint response plans. Further detail is provided in section 6.

3. Surveillance – communicable disease

3.1. Data flows

Effective surveillance systems are essential to identify trends in, and outbreaks of, communicable diseases and to monitor the outcome of control actions. The HPT uses information from a wide variety of sources including:

- Laboratory reports for a nationally determined list of organisms.
- Formal notifications of suspected infectious diseases from registered medical practitioners and informal notifications from a range of healthcare workers.
- Clinician reports of patients where urgent action may be needed to protect contacts.
- Genito-urinary medicine clinics providing anonymised details of cases of sexually transmitted infections (STIs).
- Hospital trusts reporting cases and incidents of healthcare associated infections (HCAIs).
- Local authorities providing results of investigations into diseases which may be foodborne and intelligence about cases and outbreaks, usually of suspected food poisoning.
- Prison healthcare staff reporting certain suspected diseases and possible outbreaks.
- Care homes reporting illness in residents or staff, usually cases of diarrhoea and/or vomiting, but also respiratory disease outbreaks or other infections.
- Reports from other settings such as schools and nurseries with concerns about possible outbreaks of flu-like illness, diarrhoea and/or vomiting, or illnesses with a rash.
- Results of investigations by the NE HPT.
- Other ad-hoc contacts.

Case reports from notifications, laboratory reports and information from other sources are risk assessed by HPT staff and public health action taken as required. All cases or incidents requiring public health action are entered on HPZone, the PHE case management system.

Laboratory-confirmed cases, notifications of infectious disease and reports of certain other suspected diseases of local public health interest are entered on EpiNorth3, the North East surveillance system, which is used for cluster and exceedance detection, trend analysis and routine and ad-hoc reporting. The outputs trigger and guide further investigations and assist in identifying common exposures and/or outbreaks.

Appendix 1 provides a summary of the main communicable disease cases reported in North East residents in 2018 and Appendix 2 a summary of the surveillance reports which are routinely provided to local authorities and other partner organisations.

Information is provided securely to national PHE surveillance systems for the production of national statistics and reports. PHE receives and processes identifiable personal information under specific legislation[1] and the notification of infectious diseases legislation.[2] All PHE staff

1 Regulation 3. The Health Service (Control of Patient Information) Regulations (2002)
2 Health Protection (Notification) Regulations 2010

have a contractual requirement to protect the confidentiality of this information which is the same as that applied to NHS staff.

3.2. Healthcare associated infection (HCAI) surveillance

In England, it is mandatory for hospital trusts to report on the HCAI Data Capture System all cases of blood stream infection caused by meticillin-resistant *Staphylococcus aureus* (MRSA) and methicillin-sensitive *Staphylococcus aureus* (MSSA), gram-negative bacteraemias caused by *E. coli, Klebsiella spp*., *P. aeruginosa* and infections with *C. difficile* (CDI). This is monitored by the local Field Service team who produce monthly reports. From April 2013 reports have been sent to local trusts, clinical commissioning groups and NHS England area teams. Other infections (which make up the majority) are reported on a voluntary basis e.g. hospital norovirus outbreaks.

Another health protection surveillance scheme is Surgical Site Infection, which helps hospitals monitor their own rates of post-surgical infection (mainly orthopaedic) and compare themselves with similar organisations.

Additionally, PHE, in collaboration with the Department of Health and Social Care, runs the Resistance Alert System, which informs microbiologists in NHS Trusts about new and emerging resistance problems and how far they have spread. Surveillance of Carbapenamase Producing Enterbacteriaceae (CPE) is also in place.

3.3. Surveillance of sexually transmitted infections (STIs)

PHE collates anonymised information from genito-urinary medicine/sexual health clinics and non-specialist service on the number of sexually transmitted infections (STIs) and sexual health screening tests and treatments. The quality of data reported from the North East remains high.

PHE NE produces quarterly STI bulletins and includes additional local information to the nationally produced Spotlight report on STIs and HIV in the North East. The annual local authority sexual and reproductive health profiles (LASERs) are produced nationally and are available through the HIV and STI Web Portal. Detailed information on a range of sexual health indicators can also be reviewed on the PHE Fingertips tool:
https://fingertips.phe.org.uk/profile/sexualhealth

The GUMCAD2 system collects information on STI testing and diagnosis in GUM and non-specialist settings, including primary care. The HPT and field epidemiology team, together with the PHE NE Sexual Health facilitator, continue to work with local services to ensure completeness of reporting to this system. New developments in the GUMCAD surveillance system are being introduced in the coming year which will give more detailed information on risk factors and partner notification activities.

3.4. Surveillance of invasive pneumococcal disease (IPD)

An enhanced invasive pneumococcal disease (IPD) surveillance system was established by the NE HPT in 2006 to investigate the epidemiology of IPD. This project is funded to the end of June 2019.

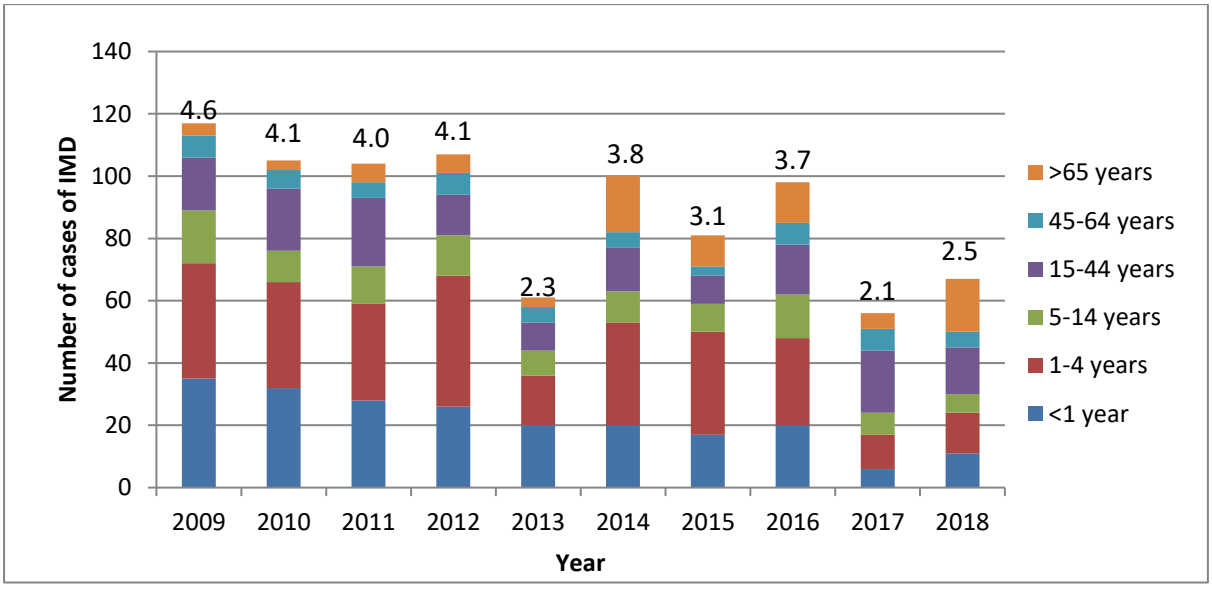
4. Control – specific diseases

Early diagnosis by clinicians, prompt treatment of cases and early reporting by microbiologists and clinicians to the NE HPT are essential in enabling prompt public health action for diseases such as meningococcal infection. For other diseases such as gastrointestinal infections, initial reporting may be through local authority environmental health officers.

4.1. Meningococcal meningitis and septicaemia

Meningococcal meningitis and septicaemia (blood poisoning) are serious illnesses that mainly occur in children and young adults and can sometimes cause long-term disability and death.

Figure 4.1: Number of cases of invasive meningococcal disease (IMD) in the North East by age group and overall rate from 2009 to 2018.



The numbers above the bars show the overall rate of cases of IMD per 100,000 in the North East. Approximately 10% of adults carry meningococcal bacteria without developing illness. Meningococcal disease does not spread easily from person to person and is usually acquired from a very close contact that remains well. Cases of meningococcal disease can result in considerable anxiety.

HPT staff identify close contacts of each case to offer them advice, information and chemoprophylaxis (preventive antibiotics) if required. They also support schools, colleges, universities and workplaces where a student or staff member has been diagnosed with meningococcal disease. Linked cases and outbreaks of meningococcal disease are uncommon.

Table 4.1: Number and rate of cases of meningococcal disease by local authority for 2018

Local Authority	Number of cases	Rate (per 100,000)
County Durham	7	1.3
Darlington	3	2.8
Gateshead	12	5.9
Hartlepool	4	4.3
Middlesbrough	4	2.8
Newcastle upon Tyne	9	3.0
North Tyneside	3	1.5
Northumberland	3	0.9
Redcar and Cleveland	11	8.1
South Tyneside	3	2.0
Stockton-on-Tees	2	1.0
Sunderland	6	2.2
North East Total	**67**	**2.5**

*Rate uses local authority population figures for 2017

Serogroup group B still accounts for most cases in the North East, this is in line with the national picture. In 2017 there was a significant reduction in Men B cases being reported compared to previous years and this lower rate has also been observed in 2018. In 2017 there was a reduction in Men W135 cases by 70% compared to 2016. In 2018 there was an increase it the number of cases reported from 7 to 12. In 2018 there was a 40% reduction in Men C cases being reported compared to 2017.

Table 4.2: Laboratory confirmed cases of meningococcal disease by serotype for 2009 to 2018

Serogroup	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
B	68	53	62	48	31	33	38	39	21	21
W135	1	1	3	3	4	12	13	23	7	12
Y	1	3	0	4	3	4	4	5	2	2
C	0	0	0	3	1	2	1	5	5	3
Z	0	0	0	0	0	0	0	0	0	0
*Probable	45	46	34	48	22	48	25	24	21	29
North East Total	**115**	**103**	**99**	**106**	**61**	**99**	**81**	**96**	**56**	**67**

*Probable cases - No laboratory confirmation, treated on clinical diagnosis.

Meningococcal disease can affect all age groups, but the highest rates of disease are in children under five years of age, with a peak incidence in those under one year of age. There is a second peak in young adults aged 15 to 19 years old.

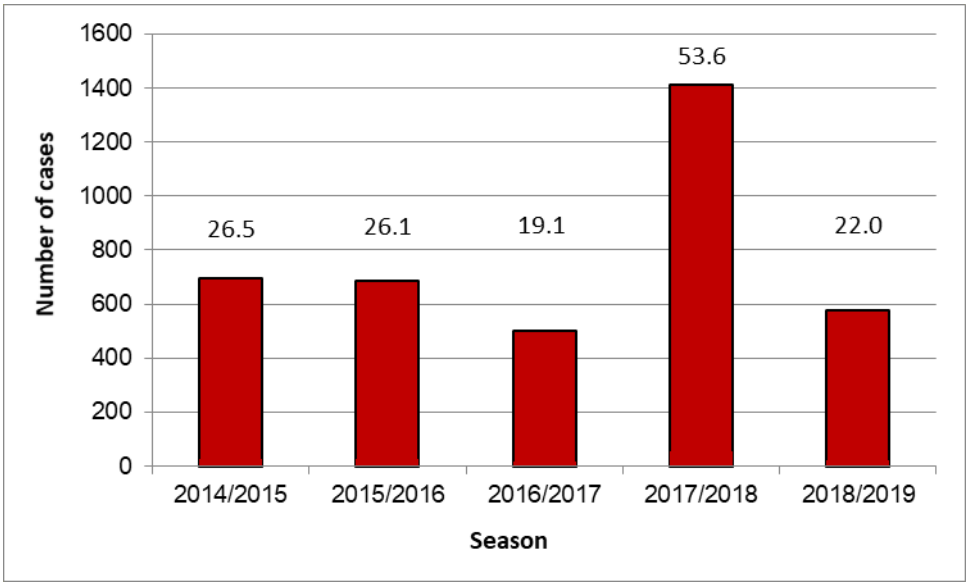
4.2. Invasive Group A streptococcal disease (iGAS) and scarlet fever

Group A streptococcal (GAS) infections are very common and usually produce mild illness easily treated with antibiotics.

Scarlet fever is a rash illness caused by GAS, which mainly affects children. Although usually mild, scarlet fever can occasionally lead to serious complications, which are to a large extent preventable by treatment with antibiotics. Cases of scarlet fever are notifiable to PHE.

Following an increase in notifications in 2014/15 (26.5 per 100,000 vs. 18.2 per 100,000 in 2013/14, the rate to date has remained high. In the 2017/18 season there was a 182% increase in notifications of scarlet fever (1413 cases; 53.6 per 100,000). This was the highest number of notifications over the past five seasons. However, in 2018/19 the rate decreased to 22.0 per 100,000 (579 cases), which was comparable to the rates observed in the 2016/17 and 2015/16 seasons.

Figure 4.2: Number* of cases of scarlet fever in the North East and overall rate by season≠, from 2014/2015 to 2018/2019



* Seasonal data covers the period from week 14 to week 37.
≠ The numbers above the bars show the overall rate of notifications of scarlet fever per 100,000 in the North East.

Quarterly notifications of scarlet fever were comparable in 2014, 2015 and 2016, with the highest number of cases reported in Q1 and Q2, as expected given the seasonal nature of the infection. However, in 2017, notifications in Q4 were higher than in Q1 and Q2. Increased notifications were observed in both Q1 and Q2 2018, with 908 notifications in Q1 and 704 in Q2; a 193% and 272% increase from Q1 and Q2 2017 respectively. Notifications from Q3 2018 onwards were in line with 2014-2016 figures.

Table 4.3: Scarlet fever notifications to NE PHE Centre by quarter, 2014-2019

Year	Quarter				Total
	1	2	3	4	
2014	330	498	112	203	**1,143**
2015	466	243	85	162	**956**
2016	491	367	127	146	**1,131**
2017	309	189	128	341	**967**
2018	908	704	136	212	**1,960**
2019	305				

Data from EpiNorth3. Cases by referral date.

Invasive Group A streptococcal (iGAS) infection is defined as the isolation of group A streptococci from a normally sterile site (for example in the bloodstream). It encompasses a range of diseases including necrotising fasciitis, septic arthritis, meningitis and pneumonia. The infection is serious, with a case fatality rate of approximately 15-20% within one week of diagnosis.

When cases of iGAS are reported by clinicians to the North East PHE Centre, the HPT undertake a risk assessment and provide advice and/or recommend treatment to close community contacts.

In 2013, the incidence of iGAS rose significantly in the North East and nationally and has remained elevated since. As with scarlet fever notifications, there was a substantial increase in cases in Q1 2018, with 78 notifications compared with 28 in 2017. Overall, 189 cases were notified in 2018, a 52% increase in notifications from 2017 (124 cases). Notifications from Q1 2019 were lower than Q1 2018 (43 vs. 78 cases).

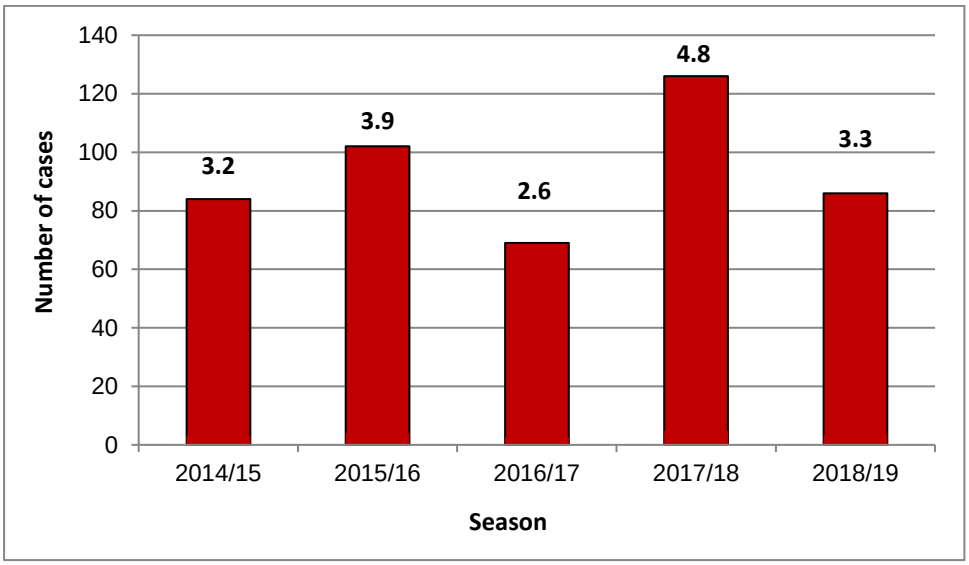
Table 4.4: Invasive Group A streptococcal disease reported to NE PHE Centre by quarter, 2014-2019

Year	Quarter				Total
	1	2	3	4	
2014	30	32	25	21	**108**
2015	51	54	30	33	**168**
2016	63	45	25	28	**161**
2017	29	30	30	35	**124**
2018	78	54	24	33	**189**
2019	43				

Data from HPZone. Cases by referral date.

iGAS infections tend to have a seasonal pattern with the highest incidence from December to April. In 2017/2018 the rate of iGAS infections rose substantially in the North East from 2.6 per 100,000 in 2016/17 to 4.8 per 100,000. In 2018/19 this rate had decreased to 3.3 per 100,000, which was comparable to the rate observed in the 2014/15 and 2015/16 seasons.

Figure 4.3: Number of cases of invasive Group A Streptococcus (iGAS) in the North East and overall rate≠ by season*, from 2014/2015 to 2018/2019



** Seasonal data covers the period from week 14 to week 37.*
≠ The numbers above the bars show the overall rate of cases of iGAS per 100,000 in the North East.

4.3. Gastrointestinal infections including food poisoning

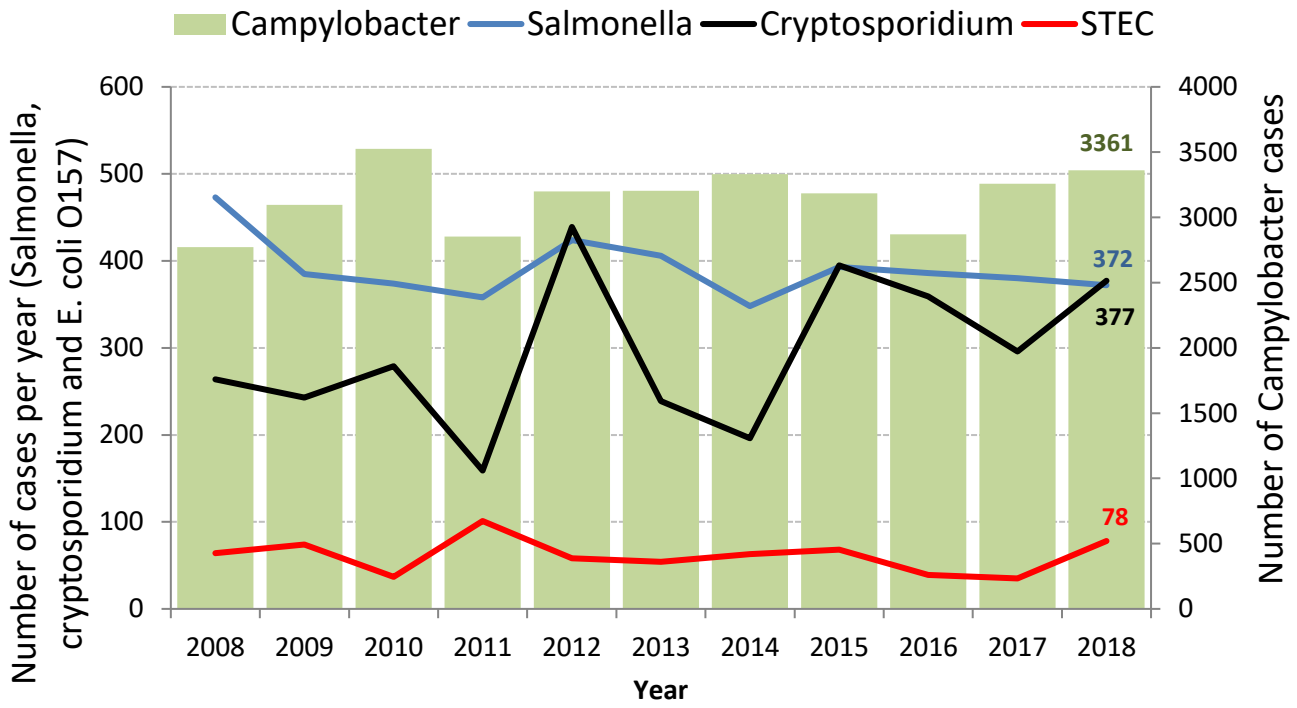
A number of organisms can cause gastrointestinal infection of which campylobacter and salmonella are the bacteria most commonly identified by laboratories. Many viral gastrointestinal infections occur but most are not laboratory confirmed as symptoms are usually short-lived. The majority of the NE HPT's work on gastrointestinal infections relates to individual sporadic cases of infection. Gastrointestinal infections are spread by the faeco-oral route which can include via food, water, sexual contact or from contact with an infected person or animal or contact with a contaminated environment. Food poisoning outbreaks are described in Section 5.

Shiga toxin-producing Escherichia coli (STEC) infection is caused by the consumption of contaminated food, milk and water or from contact with animals or their faeces. *E. coli* O157 are the commonest bacteria causing STEC infection. It is an important infection as only a small number of bacteria are required to cause illness and infection in young children and older people can result in serious complications including kidney failure and is sometimes fatal. The number of cases of STEC infection in the North East each year is relatively small with 78 cases in 2018, but recent changes to laboratory testing methods has increased the number of cases reported. The prevention and control of cases remains very important due to the risk of severe illness. Every case of STEC is rigorously investigated by the HPT and the relevant local authority environmental health officers. In 2018 there were several family clusters associated with animal contact which shows how easily the infection can be transmitted in households and other settings.

Campylobacter infection is by far the most common bacterial cause of gastrointestinal infection reported regionally causing more than 80% of all cases. Reducing the numbers of campylobacter cases requires national and local actions at all stages of meat (particularly chicken) production and processing from the farm all the way to, and within, the home. The number of campylobacter cases in 2018 increased to 3,361.

Salmonella is the second most common bacterial cause of gastrointestinal infection. In the North East all cases of salmonella are investigated by the HPT and the local authority EHOs. The trend in number of cases has been unchanged in recent years with increases in some years associated with local or national outbreaks.

Figure 4.4: Reported cases of campylobacter, cryptosporidium, salmonella and VTEC infection in North East residents from 2008 to 2018



Cryptosporidium infection is the most common protozoal gastrointestinal infection reported. Infection is often acquired from contact with contaminated animals, with animal faeces in the environment or from contaminated food or water. The incidence varies from year to year and in 2012 and 2015 there were large national outbreaks including increased incidence in North East residents. In 2018 there were no significant outbreaks of cryptosporidiosis in the North East.

Other gastrointestinal infections. Other less common causes of gastroenteritis and food poisoning such as shigella, *Clostridium perfringens, Staphylococcus aureus*, listeria and yersinia are also investigated. The severity of illness which can be caused by some infections such as listeria means that there is a higher level of concern about even a small number of cases.

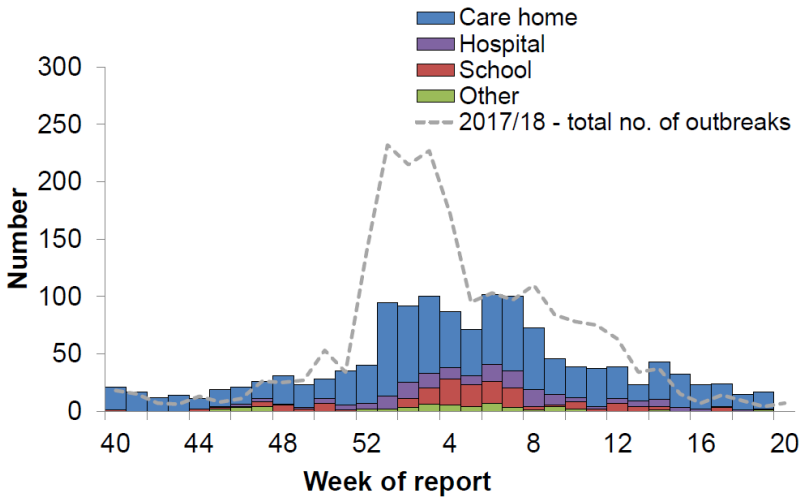
4.4. Influenza

This section should be read alongside the joint NHS England and NHS Improvement and PHE seasonal influenza vaccination report 2018/19.

Seasonal influenza

During the 2018-19 season, influenza A(H1N1)pdm09 and A(H3N2) co-circulated, with A(H1N1)pdm09 dominated for much of the season. The number of outbreaks of acute respiratory illness reported in closed settings in the UK (1,340) was lower than during the 2017/18 season (2,149) [figure 1], the majority (70%) being reported by care homes.[3] The number of outbreaks reported in care homes was, however, higher than the number reported in 2015/16, the last A(H1N1)pdm09 dominated season. In the North East a total of 40 outbreaks of influenza like illness (ILI) were reported (80% from care homes) compared with 49 in the 2017/18 season.

Figure 4.5: Weekly number of acute respiratory outbreaks by institution, UK[1]



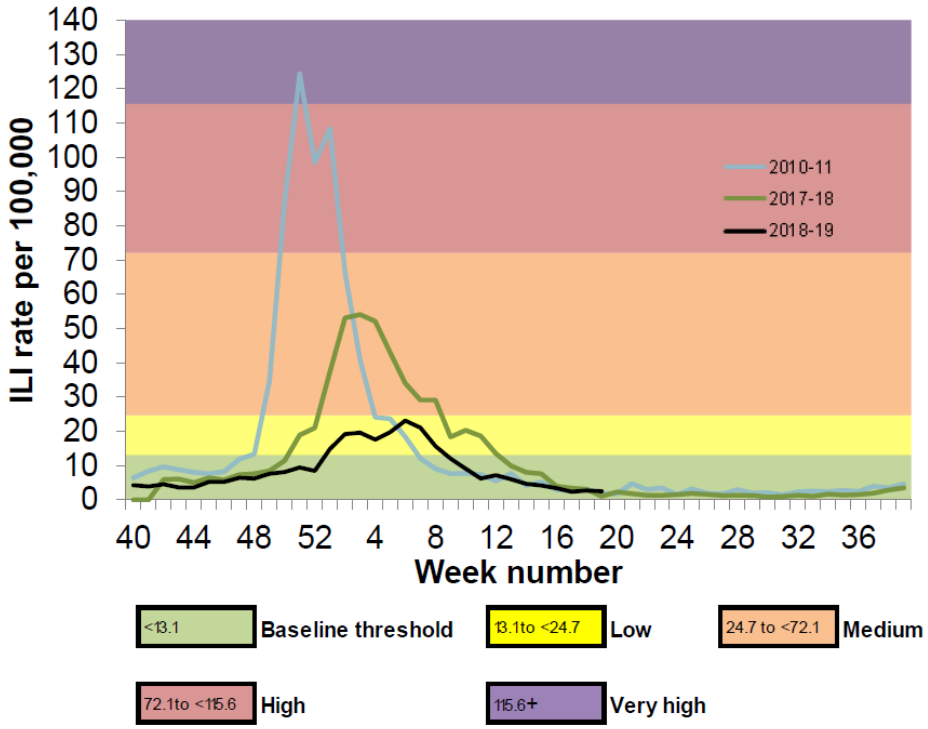
Rates of influenza-like illness (ILI) were observed at low intensity levels in the community. Weekly GP consultations for ILI in England exceeded the baseline threshold for an 8-week period (weeks 1-8 2019), with activity peaking at 23.1 per 100,000 in week 6 2019. This was lower and later than the peak in the 2017-18 season (54.1 per 100,000, week 03 2018) [figure 2][1] and similar to the peak activity observed in 2015/16 (28.7 per 100,000), the last A(H1N1)pdm09 dominated season.

In keeping with previous A(H1N1)pdm09 dominant seasons, a moderate to high impact was observed in secondary care. The weekly rate of hospitalised cases remained above the baseline between week 51 2018 and week 15 2019, activity peaking in week 6 2019 (6.87 per 100,000 trust catchment population).[1] This was lower than the peak activity observed in 2017/18 (9.20 per 100,000 trust catchment population), but higher than the peak activity observed during the last A(H1N1)pdm09 dominated season (3.4 per 100,000). A total of 2,924 influenza confirmed admissions to ICU/HDU were reported in England from week 40 2018 to week 15 2019, the majority of which were influenza A (2,898; 99%).[1] Where subtyped, 834 (29%) were influenza A(H1N1)pdm09 and 204 (7.0%) influenza A(H3N2). [1] The number of admissions to ICU/HDU in England was slightly lower when compared to the 2017/18 season

[3] PHE. Surveillance of influenza and other respiratory viruses in the UK. Winter 2018 to 2019. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/805563/Surveillance_of_influenza_and_other_respiratory_viruses_in_the_UK_2018.pdf

(3245) and higher than the number observed in 2015/16 (2190) which was the last A(H1N1)pdm09 dominated season. In common with previous A(H1N1)pdm09 dominant seasons young adults were primarily affected with the number of ICU/HDU admission being greatest in the 45-64-year age group. The rate of influenza admissions to ICU/HDU was highest in 45-64-year olds for influenza A(H1N1)pdm09 and in 75+ year olds for A(H3N2).[1]

Figure 4.6: Weekly all age GP influenza-like illness consultations rates for 2018-19, England (RCGP).



A total of 273 influenza deaths in ICU were reported in England from week 40 2018 to week 15 2019.[1] No statistically significant excess mortality was observed during the 2018/19 season in England and levels of all-cause mortality were the lowest seen since 2013-2014.[1]

Since week 40 2018, the PHE Respiratory Virus Unit characterised 959 influenza A(H1N1)pdm09 viruses, 237 A(H3N2) viruses and 3 influenza B viruses. [1] Antigenic and genetic characterisation of viruses suggested that there was a close match between circulating and vaccine A(H1N1)pdm09 and A(H3N2) strains.[1]

Pandemic influenza

A pandemic of influenza infection may occur when a new flu virus circulates in a population without any existing immunity. No specific pandemic influenza preparedness activities have been held in the North East since September 2017.

Avian influenza

Avian influenza is an infectious disease of birds caused by the influenza A virus. Human infections with avian influenza are rare although some strains such as H5N6, H5N1 and H7N9 have been associated with human illness.

Since June 2017, there have been no detections of avian influenza in poultry or kept birds in the UK. Between January and June 2018, the H5N6 strain of avian influenza was confirmed in 21 wild birds, none in the North East of England.[4]

There continue to be challenges in arranging the prompt sampling of exposed and symptomatic persons and arrangements for the prescription and dispensing of anti-viral prophylaxis to those exposed to avian influenza which are being discussed with NHS England.

Middle Eastern Respiratory Syndrome Coronavirus (MERS-CoV)

The World Health Organisation (WHO) first reported cases of MERS-CoV in September 2012. MERS-CoV is a viral respiratory illness, characterised by fever and cough, progressing to severe pneumonia. It has been noted to cause large outbreaks particularly within healthcare settings. Most cases have occurred in the Middle East with some secondary transmission (including cases in the UK) following importation. One imported human case of MERS-CoV infection was detected in the UK in August 2018. Two possible cases of MERS-CoV were reported to the North East HPT in 2018/19 both of whom tested negative.

4.5. Surveillance of sexually transmitted infections (STIs) and HIV

The most common sexually transmitted infections in the North East continue to be chlamydia, genital warts, herpes, gonorrhoea and syphilis. Certain groups of the population are affected by poor sexual health more than others; infections in young people account for almost 60% of all STIs, although young people only make up 12% of the population. Higher rates of some STIs also occur in some minority ethnic communities; it is important that these inequalities are monitored, and the findings used to inform how both prevention and treatment services are delivered.

The main health protection aspects of PHE's role regarding sexual health and HIV are surveillance of infections (see section 3.3), strategic work with partners to tackle the rising levels and inequalities in STIs & HIV and coordinating the investigation and control of clusters and outbreaks of infections.

More detailed information about the patterns of infection is reported in the North East Spotlight reports on STIs and HIV. Data presented in this section are from 2018, the most recent published STI and HIV figures (https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables and http://fingertips.phe.org.uk/profile/sexualhealth).

During 2018/19 PHE North East has continued to support the wider public health and commissioning system in the region through a series of workshops on sexual and reproductive health data, commissioning of services and workforce development and training.

[4] PHE. Avian influenza (bird flu). Available at: https://www.gov.uk/guidance/avian-influenza-bird-flu

Overall numbers of STIs in the North East in 2016

There were 17,115 new diagnoses of STIs in the North East in 2018, a decrease (-7%) from 2017. The overall rate is 647/100,000 population (lower than the England rate of 805/100,000). Within the region, rates at local authority level range from 481 to 946 per 100,000 residents). The rate of new STIs in younger adults are much higher (> 3,000/100,000 in both 15-19 year and 20-24-year age groups) and 95% of diagnoses are made in people of white ethnicity. The rates of new STIs are similar in women and men (644 and 648 per 100,000 residents respectively). More detail on these data will be published in the Spotlight on STIs report later in 2019.

Chlamydia

Chlamydia remains the most common STI in the region. The number of chlamydia cases diagnosed in North East residents decreased by 11% in 2018 (8,825 cases) compared to 2017 figures (9,946), the rate of infection (333 per 100,000 population) is lower than the overall England rate (392/100,000).

The Public Health Outcomes Framework includes the diagnosis rate of chlamydia as one of its targets. This measure combines the coverage of screening programmes with the number of people diagnosed with the infection and has been designed to measure whether screening initiatives are reaching those most at risk. The target is 2,300 diagnoses per 100,000 population (in 15–24-year olds). Achievement of this target has fallen over the past year; further work is taking place with commissioners, services and the sexual health team in PHE NE to understand the reasons for this decline.

Gonorrhoea

The number of gonorrhoea cases fell in 2018 compared to the previous year in the North East with a 3% decrease from 1,815 cases in 2017 to 1,751 cases in 2018; although cases have decreased in the last year it is important to recognise that there has been a 39% increase since 2013. Over half of the cases (1,029 cases) were in men and within this group over 500 were in men who have sex with men (MSM).

The concerns about antibiotic resistance in gonorrhoea continue; in the last year, two cases of extensively drug resistant (XDR) gonorrhoea were diagnosed in England. Both were associated with sexual contact abroad and there were no onward transmissions in the UK, however this again highlights how important the effective diagnosis, including specimens taken for culture, correct treatment and test of cure are in the control of this organism.

Syphilis

The number of syphilis cases in the North East rose by 21% in 2018, from 206 cases in 2017 to 249 cases in 2018. This continuing rise follows a pattern of year-on-year increase since 2010. Although numbers of cases are much lower than chlamydia or gonorrhoea diagnoses, the potential long-term consequences of syphilis infection mean that this is a development that requires public health action.

There are increasing number of cases in older residents (>45y old men and women). Although new diagnoses are still predominantly seen in MSM (173 / 218 new cases in men), a greater number of cases are also being seen in heterosexuals.

A national action plan https://www.gov.uk/government/publications/syphilis-public-health-england-action-plan, bringing together the key actions needed to tackle the continuing rise in cases across England was published in June 2019. These recommendations will be reviewed by sexual health networks (public health and clinical) and a North East action plan drawn up.

Public health concerns

The increase in gonorrhoea and continuing high numbers of syphilis cases highlights the need to remain vigilant to the trends of infection and the importance of surveillance. Close collaborative working between public health and clinical teams are critical in promptly identifying changes in the patterns of infection in the community and coordinating actions required.

The continuing priority for public health and health protection in the North East is to ensure that commissioners and providers continue to work together to identify common areas for action, to tackle the rise in STIs, in particular gonorrhoea and syphilis, in a consistent, collaborative and effective way across the region.

Understanding the pressures on services and the changing ways in which they are delivered, the changing demographics of population accessing services and new behavioural factors that affect people's sexual health are all crucial in the work to protect and improve the public's sexual health.

HIV

The North East has a relatively low number of cases of HIV infection. In 2017 (the latest data available) 104 people were newly diagnosed with HIV; this was a marked fall in numbers of new diagnoses compared to recent years (26% lower than 2016) and represented 3% of new diagnoses in England. In 2017, there were 1,808 people living with HIV in the North East.

There have been large falls in numbers of new diagnoses across the country, particularly in London where targeted actions were put in place to increase the frequency of testing in higher risk groups. It is too early to say whether this fall in new diagnoses represents a similar pattern but is encouraging news which will be closely monitored.

As with other STIs, HIV infection affects some groups of the population disproportionately and it is important that services and prevention work reflect the pattern of infection in local populations.

Key issues about HIV in 2018/19 include:

- 40% of newly diagnosed cases of HIV in between 2015 - 2017 were diagnosed 'late' or 'very' late', which has a significant impact on long-term health outcomes. Heterosexuals were more likely to be diagnosed late (52% of males, 43% of females) than MSM (35%). By ethnic group black Africans were less likely to be diagnosed late than the white population (35% and 42% respectively).
- Late diagnosis remains an important challenge for the region, as well as for England and PHE is supporting work through the HIV Clinical Network to explore the reasons for late diagnosis and put in place actions to increase testing and improve early diagnosis.

- 44% of those living with diagnosed HIV in the North East were aged between 35 and 49 years, and 38% were aged 50 years and over (up from 21% in 2008).
- 14%* of people newly diagnosed with HIV in 2016 had acquired their infection within the preceding four to six months (classed as 'recent' infections) highlighting the need to continue the work to prevent transmission of infection (* where specimen tested for avidity)
- An increase in transmission amongst men who have sex with men (MSM), following several years where heterosexual transmission was greater than that in MSM.

It is important that the focus on preventing infection is maintained along with improving rates of HIV testing in non-specialist settings to ensure that those who have HIV are diagnosed promptly and offered effective treatment and support and advice about reducing risks to others.

All 12 local authorities in the North East continue to participate in the HIV Home Sampling programme; a nationally coordinated project, which aims to increase testing in high risk, hard to reach groups and so aid earlier diagnosis of HIV in these groups. Work is continuing to review in more detail who is using this service, how to target messages about testing in those most at risk/need and ensure services are meeting those needs.

4.6. Hepatitis B and C infections

Hepatitis B (HBV) infection

The hepatitis B virus (HBV) causes hepatitis (inflammation of the liver) and can also cause long term liver damage. Many people have no symptoms while others experience a flu-like illness, tiredness, joint pains, and a loss of appetite. Other symptoms may include nausea and vomiting. Acute infection can be severe causing abdominal discomfort and jaundice. Mortality during the acute phase of infection is less than 1%.

The virus may be transmitted by contact with infected blood or body fluids such as through household or sexual contact with an infected person. The virus can be spread by the following routes:

- Sharing the use of contaminated equipment during injecting drug use.
- Vertical transmission (mother to baby) from an infectious mother to her unborn child
- Sexual transmission
- Receipt of infectious blood (via transfusion) or infectious blood products (for example clotting factors)
- Needlestick or other sharps injuries (particularly those sustained by hospital personnel)

About 90% of cases recover fully from the acute infection and develop immunity. The remaining 10% develop chronic hepatitis B which is frequently asymptomatic, and cases may be unaware of their infection. Many chronic hepatitis B cases remain infectious and are at risk of developing cirrhosis and liver cancer in later years. A safe and effective vaccine is available that can provide pre and post-exposure protection against hepatitis B infection. The vaccine has also been routinely available as part of the NHS vaccination schedule since 2017 and is offered to all babies at 8, 12 and 16 weeks of age.

The North East Health HPT provides direct public health advice in relation to cases of acute hepatitis B and their contacts. In 2018, a total of 16 cases of acute infection were reported in

the North East (see table below) compared to 14 cases in 2017, 15 cases in 2016, 7 cases in 2015 and 15 cases in 2014.

There was an increase in the number of young adults diagnosed with acute hepatitis B with a median age of 27.5 years observed in 2018 compared to 44.5 years in 2017. Heterosexual sexual transmission was the most likely source of infection for most cases and it was identified that a number of cases were local university students. The HPT worked with partners including the local authority public health team and GUM services to raise awareness in the local student population.

During 2018, 183 new diagnoses of chronic hepatitis B infection were reported across the North East. Written public health advice is given for chronic cases and their contacts via the treating clinician.

Table 4.5: Acute Hepatitis B cases reported to the North East Health Protection Team in 2018

	Male	Female	Total
Number (%)	9 (56%)	7 (44%)	16
Median age (range)	24 (19-56)	35 (18-67)	27.5 (18-67)
Ethnicity			
- White British	4	4	8
- Mixed – White and Black Caribbean	0	1	1
- Not known	5	2	7
Most likely place of transmission			
- UK	6	7	13
- Outside UK	1	0	1
- Not known	2	0	2
Most likely Source			
- Heterosexual sex	6	4	10
- Sex between men	0	0	0
- Unknown/other	3	3	6

Hepatitis C (HCV) infection

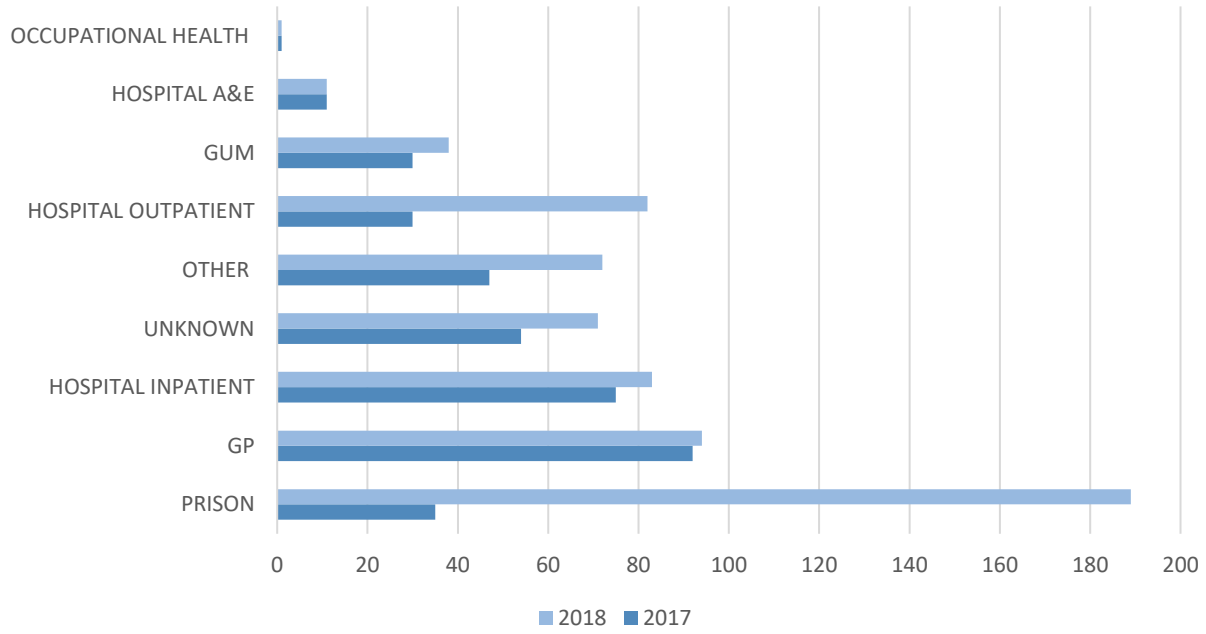
Most recent estimates suggest that there are around 113,000 people in England living with hepatitis C virus (HCV) infection. HCV is transmitted mainly through exposure to blood, blood-contaminated equipment or much more rarely by sexual intercourse or from mother-to-baby. Injecting drug use remains the most important risk factor for HCV infection, being cited as the risk in around 90% of all laboratory reported infections where risk factors have been disclosed. Although most people with acute HCV infection do not have any symptoms, 80% develop chronic infection and may develop cirrhosis, liver failure or liver cancer 20-40 years later. There is no vaccine available to prevent HCV.

In May 2016, the UK signed up to the WHO Global Health Sector Strategy (GHSS) on Viral Hepatitis which commits participating countries to the elimination of HCV as a major public health threat by 2030. There have been major developments in HCV treatments over recent years with the advent of highly effective and well tolerated directly acting antiviral (DAA) drugs. If diagnosed, most patients can be cured of their infection. HCV treatment in England is delivered through NHS Operational Delivery Networks (ODNs) which were established in 2015.

In 2018, 641 newly detected hepatitis C cases were reported to the North East HPT, giving a rate of 24.2 per 100,000 population. This was considerably higher than the regional rate

reported in 2017 (11.8 per 100,000). However, it is important to note that changes in the number of laboratory reports of HCV may be reflective of changes in testing uptake and laboratory reporting, rather than variation in disease incidence. The inclusion of dried blood spot test results from North East prisons following the rollout of the bloodborne virus (BBV) opt-out bloodborne testing programme, has likely contributed to the increase observed in 2018, (Figure 4.7).

Figure 4.7: Hepatitis C cases reported to the North East Health Protection Team in 2017 and 2018 by referral source



As in previous years, our key public health actions are to continue work on prevention and increase detection and treatment of hepatitis B and C, especially among high risk groups such as injecting drug users and prisoners. PHE North East also continues to actively support the North East and Cumbria Hepatitis C ODN to ensure effective delivery of treatment in the region.

4.7. Tuberculosis

There were 122 cases of TB reported to the Enhanced Tuberculosis Surveillance System (ETS) in North East residents for the calendar year of 2018 (provisional data), which is slightly higher than the finalised figure for the calendar year of 2017 (110). The increase could be partly explained by an increase in reporting. TB treatment typically takes many months to complete, and many cases require extensive contact tracing and screening, these incidence figures somewhat under-represent the amount of work done by TB services across the North East.

Based on the finalised 2017 data, the North East remains one of the lowest incidence regions in England, with 4.2 cases per 100,000 population (compared with an incidence in England of 9.2 cases per 100,000 population). However, this figure masks considerable in-region variation: for example, Newcastle has 10.8 cases per 100,000 population, Middlesbrough 13.5 per 100,000 while County Durham has 1.6 and South Tyneside 0.7 per 100,000 population, (See Appendix 1). The North East incidence of TB in UK-born children, which is used as a proxy for

recent UK transmission of TB, is 0.9 per 100,000 – half the comparable figure for England (1.8 per 100,000).

However, while the national incidence has shown a sustained significant decrease for four consecutive years, incidence in the North East has remained relatively static (subject to expected year-to-year variation). If we are to eradicate TB as a cause of public health concern, as per the WHO ambition, then we need to focus on early detection, improving treatment completion and continue to minimise secondary transmission.

The cohort of TB patients in the North East has its specific challenges, 16% have at least one social risk factors with homelessness the most prevalent followed by drug use. 1% have HIV co-infection, a reduction from 3.5% in 2016. Despite this, compared to the figures for England, the median time from onset of symptoms to starting treatment is shorter, and a smaller proportion of TB patients in the North East are lost to follow-up. 80% of drug-sensitive pulmonary TB cases complete their treatment within 12 months (provisional 2017 data). This is testament to the hard work undertaken and effective therapeutic relationships built by TB teams across the North East. Successful treatment on the first attempt contributes to the low incidence of antibiotic resistant TB in the North East (3% of cases).

Almost half of TB cases in the North East (44%) are from the White ethnic group, and a high proportion of these cases were UK-born. A greater proportion of UK born cases than non-UK born cases have pulmonary TB (60% vs 49%) with an attendant risk of transmission to others, and the average time from symptom onset to diagnosis is also longer in UK-born cases than non-UK born cases. As a result of this, we continue to work with primary care colleagues to raise awareness of the possibility of TB in UK-born residents.

TB is one of PHE's national priorities, as reflected in the Collaborative Tuberculosis Strategy for England 2015-2020. The North East and Yorkshire and The Humber TB Control Board oversees delivery of the TB Strategy across these two regions, and to help provide assurance that appropriate TB services continue to be commissioned and that the community TB nursing services are fully supported. Work is underway to consider how we retain a focus on TB treatment and control when the TB strategy ends in 2020.

We have continued to have good levels of engagement from clinical teams in the North East TB Network, which was re-established in 2016. This brings together hospital respiratory teams, community TB nurses, local authorities, CCGs and PHE on a bi-annual basis. This allows us to think collectively about our approach to TB across the region, and to take collective action to ensure that TB cases in the North East are swiftly detected and effectively treated.

4.8. Invasive Pneumococcal Disease (IPD)

In last year's Annual Report, we reported that 2018/19 would be the final year of enhanced surveillance on IPD which commenced in 2006 when the 7-valent PCV (PCV7) was introduced into the UK childhood immunisation programme. Data collection ceased in 2018 and the research project will finish at the end of June 2019 with a final report summarising the key findings and outputs from this research. This section contains a summary of the initial findings.

IPD is a serious infection caused by Streptococcus pneumoniae. The most common manifestations of IPD are bacteraemic pneumonia, septicaemia and meningitis. IPD

disproportionately affects young children, older aged adults and individuals with a weakened immune system. Two vaccines protecting against common pneumococcal serotypes are currently licensed in the UK: the 13-valent Pneumococcal Conjugate Vaccine (PCV), which is included in the childhood immunisation programme, and the 23-valent Pneumococcal Polysaccharide Vaccine (PPV23), which is recommended to all individuals aged ≥65 years and to clinically defined risk groups aged 2-64 years.

In 2006/07 the incidence of IPD across the North East population was estimated to be 12.0 per 100,000 population (307 cases). The incidence fell year on year, reaching its lowest point in 2013/14 (6.5 per 100,000 population; 170 cases), due to significant declines in the number of cases caused by serotypes contained in PCVs. This pattern was observed in all age groups due to the direct and indirect protection (herd immunity) provided by PCVs. However, the decline in PCV serotypes coincided with the emergence of non-PCV serotypes resulting in an increase in incidence for the first time in 2014/15 (8.8 per 100,000), suggesting that the maximum benefit of the PCV7/PCV13 programme may have been achieved. By 2017/18 the incidence had risen to 12.8 per 100,000 population. The increase in cases was most pronounced in older adults but was also seen in other age groups.

When looking at specific serotypes, three serotypes (serotype 3 contained in PCV13; serotypes 8 and 12F contained in PPV23) have emerged as the predominant serotypes circulating in the North East population. Together these serotypes accounted for 51% of all cases and 43% of cases ≥65 years in 2017/18.

There has been a small but significant decline in the 30-day case fatality rate following infection. The proportion of individuals (under 65) in clinical risk groups who developed IPD and were reported to have previously been immunised remains low (34%) in 2017/18. Together these findings highlight the need for continued surveillance of the distribution of pneumococcal serotypes; regular evaluation of national immunisation schedules; and further efforts to increase immunisation coverage in order to tackle the persistent burden of IPD.

Figure 4.8. Stacked incidence of IPD in the North East by vaccine-type and sero-type.

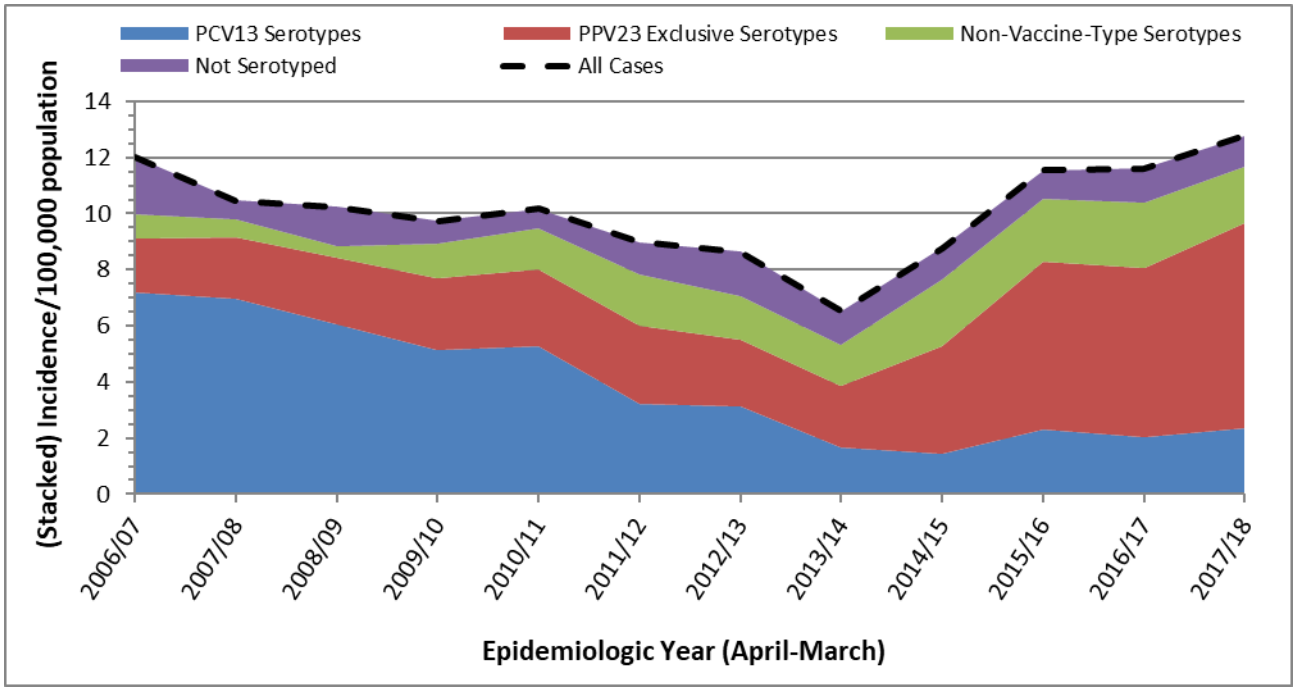
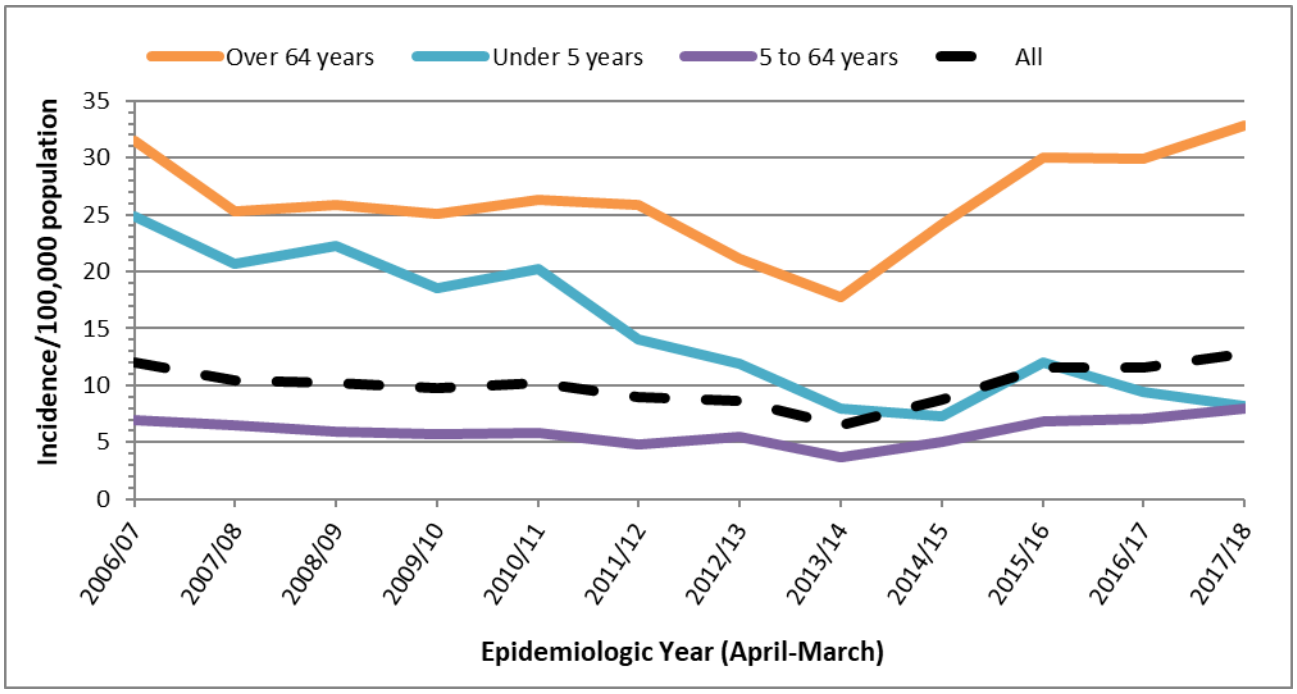


Figure 4.9 Incidence of IPD in the North East by age group.



4.9. Healthcare associated infection (HCAI)

Prevention and control of healthcare associated infections (HCAIs) is the primary responsibility of provider organisations. PHE supports organisations in this work in a number of ways. The local FS team supports the collection of surveillance data on a number of commonly healthcare-associated infections using a number of systems, as discussed in chapter three. The data generated through these systems is then adopted by the NHS. For organisms such as *Clostridium Difficile* and Carbapenemase Producing Enterobacteriacae (CPE), a complex set of rules (including appeals) are applied to this data, through which NHS Trusts, CCGs and NHS England collectively 'assign' cases of infection to Trusts (implying that these are healthcare associated infections) or to communities (implying that these are community-acquired sporadic cases of infection). Typically, Trusts have targets for the number of 'Trust assigned' cases of these infections occurring each year with financial and other penalties should these targets fail to be reached.

The HPT supports Trusts through providing expert guidance on outbreaks and incidents in Trusts, especially where these outbreaks involve pathogens more commonly associated with community outbreaks. For example, in 2018/19 the HPT supported Trusts with outbreaks of influenza and norovirus.

The HPT also provides public health input into Infection Prevention and Control Committees across all acute and mental health Trusts in the North East.

4.10. Antimicrobial Resistance

In January 2019, a new cross-government five-year action plan for AMR was launched, along with a twenty-year vision. These plans underline that antimicrobial resistance is a growing threat to public health, and that a wide range of factors, including indiscriminate use of antibiotics in medicine

and wider society over many years, mean that antimicrobial resistance is now reaching a critical point.

NHS England retains the primary leadership role for managing the health aspects of antimicrobial resistance. In the North East, PHE supports the antimicrobial resistance agenda through surveillance and local expert advice.

Most hospital Trust laboratories in the North East electronically report the results of antibiotic sensitivity tests from microbiological specimens to PHE. This data, along with clinical and pharmacological expertise, is used to allow NHS microbiologists to refine hospital and community antibiotic formularies, ensuring that patients are given the most appropriate empirical antibiotic treatments before the sensitivities of their specific isolate are known.

Nationally and internationally, there is an increasing focus on blood stream infections caused by gram negative bacteria, frequently referred to as Gram Negative Blood Stream Infections (GNBSI). There are fewer antibiotic options for gram negative organisms and the proportion of gram-negative organisms resistant to existing antibiotics is growing. There is a Government ambition to reduce the number of healthcare associated GNBSIs by 50% from a 2016 baseline by 2020/21. Quality Premiums have been introduced to incentivise CCGs to oversee work across the whole health economy to achieve this reduction. In the North East, this has included work to improve resident hydration in care homes in order to reduce the incidence of gram-negative urinary tract infections which can develop into gram negative blood stream infections.

Carbapenemase-producing enterobacteriaceae (CPE) are a large family of gram-negative bacteria that can break down carbapenem antibiotics, which are commonly used to treat gram-negative infections. Outside of the North East, there have been large hospital outbreaks of CPE organisms, and so all Trusts now have special infection control arrangements for CPE cases. In 2018/19, the Field Services and HPT have also been working together to support Trusts across the region to consider reviewing and harmonising their approach to screening patients for CPE colonisation and protocols for isolation of high-risk or screen-positive patients. This work, informed by national CPE guidance, aims to result in greater harmonisation of practices between Trusts.

5. Control - responding to communicable disease outbreaks and incidents

5.1 Overview

Outbreaks of infectious diseases are relatively common and community-based outbreaks are managed through an agreed local operational response by the NE HPT, local authorities and the NHS. Considerable effort is also put into the prevention of outbreaks through activities such as the inspection role of environmental health officers, NHS and PHE roles in relation to immunisation and infection control and the monitoring actions of other bodies such as water companies.

Some organisms are implicated relatively often in outbreaks such as norovirus (winter vomiting virus). Outbreaks of norovirus are common but the disease (vomiting and some diarrhoea) is almost always self-limiting. Concern is higher in relation to outbreaks involving organisms which are associated with a greater burden of morbidity or even mortality: for example, *E. coli* O157 can cause serious illness including kidney damage, particularly among children.

Risk assessment includes the organism (or probable organism), mode and ease of transmission, possible numbers exposed, setting and vulnerability of those exposed. The risk of an outbreak is higher in certain settings (e.g. prisons, schools, care homes) and among some groups.

The most common outbreaks are of vomiting/diarrhoea in care homes and outbreaks of food poisoning possibly associated with restaurants or catered events.

Public health action is taken to control the outbreak by any combination of controlling the source of the organism (e.g. better hygiene in a food premises), ceasing exposure (e.g. withdrawing a food from sale, hygiene and cleanliness in care homes), breaking the chain of transmission (e.g. by treatment of cases, isolation of cases in hospital) and reducing vulnerability (e.g. by immunisation or antibiotic prophylaxis).

In addition to managing community incidents and outbreaks, the HPT supports the management of certain incidents in hospitals, such as when outbreaks of notifiable diseases occur within hospital premises.

5.2 Numbers and types of incidents

In total, in 2018/19, the NE HPT was involved in investigating and where necessary managing 171 outbreaks, incidents and clusters (excluding GI care home outbreaks). This included 20 outbreaks in which formal incident /outbreak control teams were established by the HPT (compared with 18 in 2017/18). The causative agents in these outbreaks were widely varied, including norovirus, salmonella, *E. coli* O157, cryptosporidium, hepatitis A and tuberculosis. The premises involved also varied, including schools, restaurants, care homes, social clubs, a pet shop and a farm. Outbreaks of note in 2018/19 included:

- A cluster of *E coli* O157 cases among children who had visited a petting farm
- Two mass vaccination responses to hepatitis A cases in schoolchildren
- A community measles outbreak on Tyneside
- A pneumococcal outbreak in a care home
- A cryptosporidium outbreak associated with a pet shop

5.3 Hospital incidents/outbreaks

Incidents and outbreaks occurring in hospitals are the primary responsibility of NHS trusts and the response is typically led by the trust Director of Infection Prevention and Control. However, the HPT provides advice and support when necessary, calling in national advice as needed. In 2018/19 the HPT provided support in eight significant incidents (compared with 12 in 2017/18).

Norovirus

Norovirus outbreaks impact on the capacity of acute hospitals as a consequence of ward closures. This contributes significantly each year to 'winter-pressures'. Since January 2010 a voluntary reporting system for Norovirus has been in place with local figures reported below.

- 2010 – 79 outbreaks reported (under-reporting to new system)
- 2011 – 123
- 2012 – 240
- 2013 – 105
- 2014 – 90
- 2015 – 72
- 2016 – 83
- 2017 – 56
- 2018 – 74
- 2019 – 16 up to 31/03/19

5.4 Gastrointestinal illness in care homes

In 2018/19 there were 267 outbreaks of GI illness in care homes compared with 327 in 2017/18, 250 in 2016/17, 275 in 2015/16, 328 in 2014/15, and 259 in 2013/14 (based on the date the outbreak was reported).

A probable causative organism was identified in 101 of the 2018/19 care home outbreaks of GI illness:

- Norovirus in 84 outbreaks
- Astrovirus in 8 outbreaks
- Rotavirus in five outbreaks
- Sapovirus in two outbreaks
- *C. perfringens* in two outbreaks

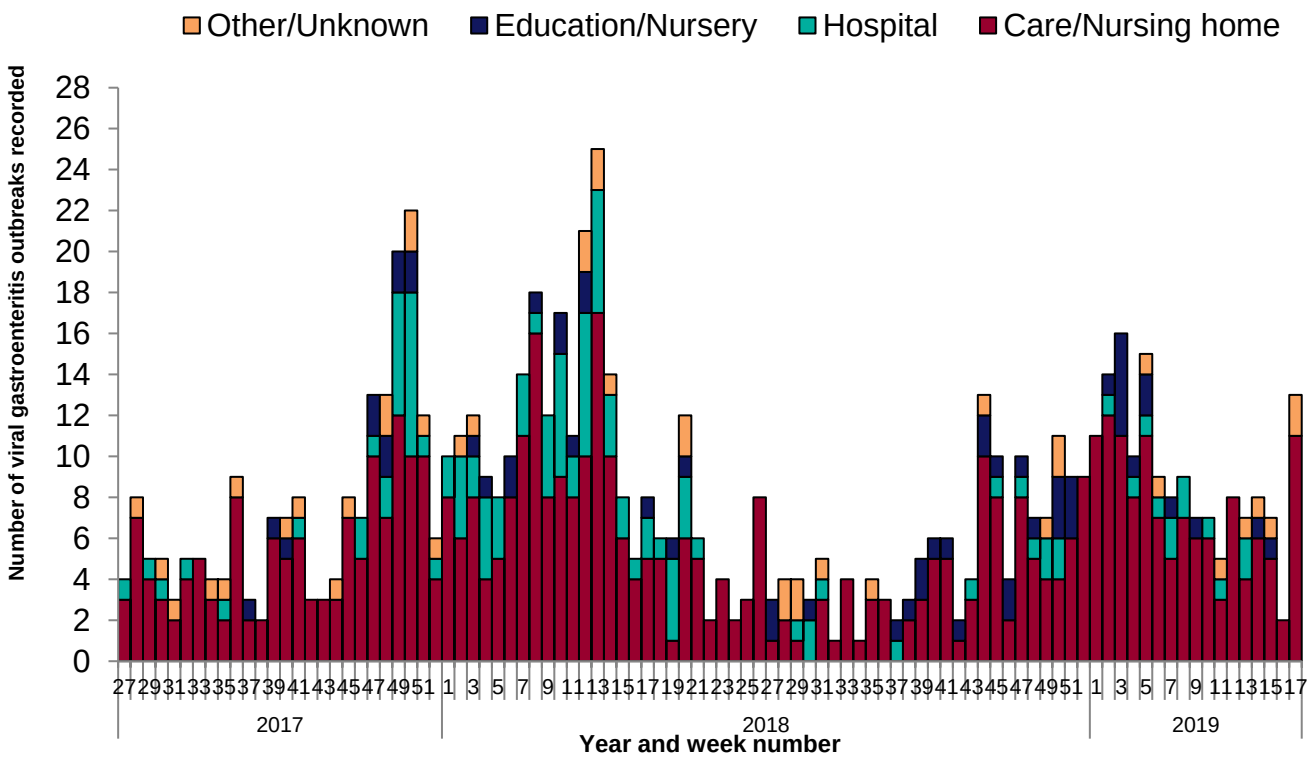
No pathogen was identified in the remaining 166 outbreaks, which were thought to be of viral cause.

When a care home contacts the HPT to report cases of vomiting and/or diarrhoea, an initial risk assessment is carried out to determine if further investigation is required to exclude a food source or other factors. If a viral outbreak is considered probable, then standard advice is given to follow the pre-circulated care home guidance. The local authority EHOs, hospital and community infection control nurses are informed routinely of outbreak occurrence and the closure of the home to admissions and discharges. EHOs would become actively involved if there is thought to be a food source or other organisms are potentially involved.

5.5 Overview of gastrointestinal infectious disease outbreaks

As part of routine winter surveillance, the local Field Service team provides a weekly report on gastrointestinal infectious diseases (Figure 5.1). This shows all gastrointestinal infectious disease outbreaks across the North East, demonstrating the variation seen by season and between years

Figure 5.1: All reports of viral gastrointestinal infectious disease outbreaks (suspected or confirmed) by setting in North East week 27, 2017 to week 17, 2019



6. Health protection in a prison setting

Prison settings are important for health protection due to the number of vulnerable prisoners held in close proximity which can allow infections to spread easily. Public Health in Prisons North East meetings which started in 2017 continued in 2018 and provide a forum for the discussion and dissemination of issues relating to public health within the North East custodial estate. In addition, two health protection training events were held in September and October 2018 for operational prison staff building on the work delivered in the previous year.

Blood-bourne viruses

Blood-borne virus work (hepatitis. B, C and HIV) has continued throughout the year. 4,500 dry blood spot tests were carried out in the seven prisons throughout 2018. Of those tested eight were found to be positive for hepatitis B, 367 cases of hepatitis, C and 17 cases of HIV. Approximately 81% of the new receptions entering the prison estate were offered a test and of those 23% engaged as part of their reception screening however this increased to 36% engagement when total tests are included. Further work is planned in the coming year to work with providers to increase the uptake rate of tests within the prisons. The Hepatitis C Trust has started recruiting for work within the prisons using a peer model approach to reduce stigma and increase testing.

Syphilis

The North East pilot of a universal offer of syphilis testing was started in April 2018 initially for six months but subsequently extended following a brief period where testing was halted. The pilot used dried blood-spot testing for syphilis in two North East prisons (HMP/YOI's Durham and Low Newton).

Since the start of the pilot 2,951 tests across the two prisons have been carried out and which identified two positive cases of syphilis that would not have been detected under the previous 'target tested' approach. Figure 1 illustrates the uptake rate of testing compared to the total number of receptions in each prison.

TB

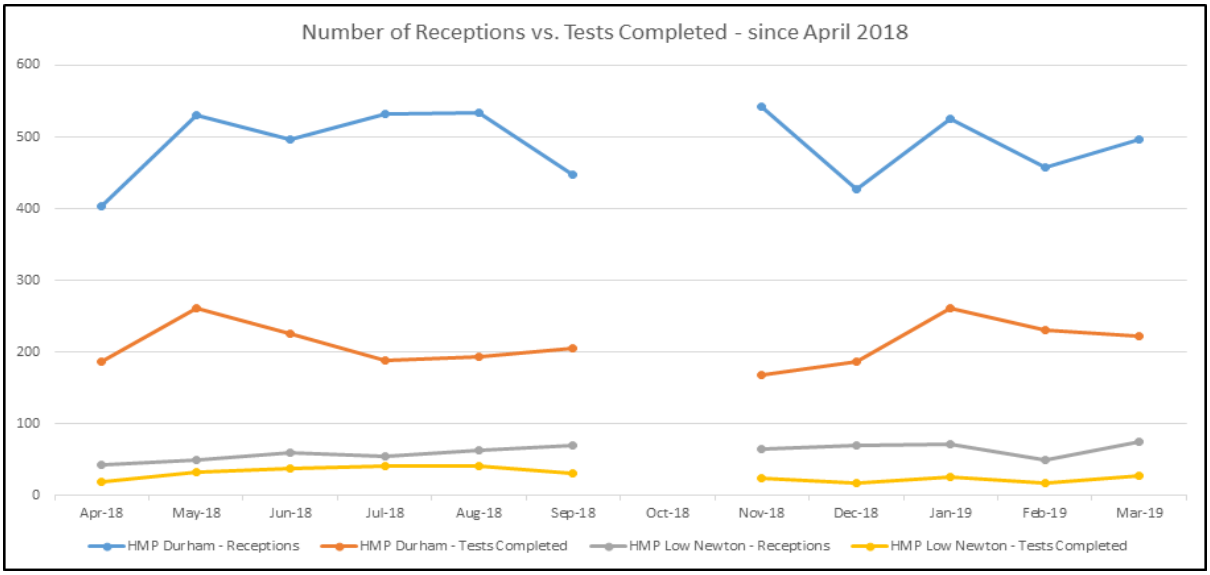
A TB baseline audit of all North East prisons was carried out by the Health and Justice lead and presented to the NEY&H TB Control board. Key findings and recommendations included:

- The number of reported TB cases within the North East prisons and community is low.
- There have been ten cases of TB within the North East Prisons since 2011
- There were 110 cases of TB within the NE community within 2017, 103 had information on a social risk factors (SRF) recorded. Of these, five had previous imprisonment as a SRF

- All staff need to be made aware of the signs and symptoms of TB and ongoing training support be available for staff as part of routine planning and preparation for prisoners with infectious diseases

As a result of this audit, further awareness training for prison staff is being arranged.

Figure 6.1: Number of syphilis tests completed as a proportion of receptions



7. Emergency preparedness, resilience and response (EPRR)

7.1. Preparedness

Structures and processes

PHE North East has internal systems for escalation of response to communicable disease and other hazards or threats. This enables progressive mobilisation of national specialist support and capacity. For some types of incident, particularly threats related to terrorism, national expert advice and rapid escalation will be immediate.

The centre delivers these functions through the HPT and the Emergency Preparedness Officer (EPO). The HPT second on-call rota provides a senior level, 24/7, response to major incidents and emergencies in the North East, supported by Emergency Planning Managers on a 24/7 regional (North of England) rota. The PHE national Centre for Radiation, Chemical and Environmental Hazards (CRCE) provides 24/7 support to local response with detailed information available on the PHE website.

The centre is represented on the three multi-agency Local Resilience Forums (LRFs) at strategic, tactical and sub group levels. The North East LRFs (Northumbria, County Durham & Darlington and Cleveland) coordinate planning, training and exercising in relation to a range of threats identified in their community risk registers. Development of cross-LRF working has continued throughout 2018-2019 with full support from the PHE Centre which is represented on the NE Chemical, Biological, Radiation and Nuclear (CBRN) group. The centre is also represented on and actively involved in the work of the North East Local Health Resilience Partnership (LHRP) and its two geographic Health and Social Care Resilience Groups (Northumbria and Durham, Darlington & Tees – of which the EPO is vice chair).

Plans

The centre maintains internal plans for response to a range of incidents. These are linked to national plans and supporting materials. The most likely incidents to have a public health impact and require a significant multi-agency response are a large fire, chemical release or major outbreak of a communicable disease.

There are a significant number of major industrial sites in the North East which are required to produce Control of Major Accident Hazards (COMAH) external plans as well as the nuclear power station at Hartlepool which is required to produce a plan under the Radiation Emergency Preparedness and Public Information Regulations (REPPIR). The centre continues to ensure that COMAH and REPPIR plans for the north east are consistent with PHE response arrangements.

The responsibility for the Science and Technical Advice Cell (STAC) plan, activation and management continues to rest with PHE although revised national guidance is expected. A North East PHE Centre STAC Activation Plan is in place and the Directors of Public Health

provide the STAC chair role through an on-call rota through honorary contracts with PHE. A review of these arrangements will take place in 2019/20 to consider national guidance.

Exercises and training

EPRR staff are actively engaged in supporting the planning and management of multi-agency exercises across the region. In 2018-2019, these exercises included a range of scenarios such as IED detonation, heatwave, reservoir breach, recovery, aircraft crash with chemical release. Exercises have taken place at both tactical and strategic levels.

Internally, EPRR staff have engaged in a national exercise to test EU exit preparations and attended a workshop to produce the Single Adverse Weather Plan for England and to update the hot and cold weather alerting system. Also, training was delivered on the updated National Incident Emergency Response Plan and the consequent review of the North East Centre Incident Response Plan. Staff also attended a refresher session on using Resilience Direct.

PHE EPRR Peer Review

A national EPRR assurance peer review took place in January 2019 and local arrangements were reviewed by the East Midlands. Their evaluation was positive and contained a number of minor recommendations for further improvement which the health Protection Management Team have accepted and are implementing.

7.2. Response

The PHE Centre is informed about non-infectious disease incidents through a number of alerting mechanisms. The main alerting protocol is from the North East Ambulance Service to the on-call EPM out of hours or the HPT in hours who triage the incident, escalating to patch consultant in hours (second on-call out of hours) according to agreed triggers. There are also agreed protocols with the Fire and Rescue Services. Certain incidents come directly to the HPT consultant on call.

8. Communications team

The PHE North East Communications team is part of the wider national PHE Communications directorate but also sits in the local centre to assist with long term communication planning, and internal and external stakeholder engagement.

The team use their local knowledge to inform national communications activity and use their expertise to respond to both local and national priorities. They work closely with NHS E, local authority and the wider public health system communication colleagues and provide 24/7 media relation support including frontline health protection work and emergency planning.

The team works closely with colleagues across the North to provide PR support to local and national campaigns and helps facilitate events, conferences and workshops. The team runs the North East social media account and provides media training to the wider public health system.

During 2018/19 the team worked closely with communication colleagues in our North East local authorities and NHS England via the public health communications network. It has also supported moves towards closer working via the Integrated Care Systems and Prevention communication workstreams.

The team has actively supported the management of outbreaks and incidents and is a key member of outbreak/incident control teams. This has included support for “high interest” outbreaks of Monkeypox and *E. coli* 0157. The team has supported multi-agency responses to influenza like illness, norovirus, scarlet fever and TB within various community settings; including supporting social media work to raise awareness of immunisation and prevention.

Working with the wider communications directorate the team has supported proactive work around measles outbreaks and helped promote key vaccination messages. It has also played an active role in helping to disseminate public health messages during emergency situations and has worked closely with its communication colleagues in local resilience forums to respond to incidents such as fires and heatwaves. The team has also worked closely across on emergency planning including close participation in Exercise Stephenson.

The team, working in partnership with the public health communication network facilitates mutual support and shared learning and this partnership is instrumental in providing key public relations support to a range of national and local marketing campaigns such as Keep Antibiotics Working, Clean Air Day, Smokefree NHS, Help Us Help You and World TB Day. As well as supporting national campaigns and initiatives the team works closely with north east communication colleagues to support a range of local initiatives and campaigns.

9. Environmental issues

Public Health England supports stakeholders including members of the public in responding to both acute and chronic non-infectious environmental public health issues.

The Environmental Hazards and Emergencies (EHE) department is a front-line department within the Centre for Radiation, Chemicals and Environmental hazards (CRCE). It provides expert advice and support to a range of stakeholders during acute and chronic chemical incidents which have the potential to threaten people's health. Such incidents could involve fires, chemical contamination of the environment, or exposure to chemical and poisons, including scenarios of deliberate release. EHE reviews the evidence base and develops and updates position statements and resources for air pollution episodes, local and regional air quality, and sites and facilities which can prove controversial or benefit from national coordination such as: energy from waste ('incinerators'), onshore oil and gas (e.g. shale gas), long running fires and high-risk waste sites.

Despite improvements in air quality over recent decades, air pollution still has a significant effect on public health in England. Short-term exposure can cause a range of effects including exacerbation of asthma, effects on lung function, increases in hospital admissions and mortality. Long-term exposure reduces life-expectancy, mainly due to increased risk of mortality from cardiovascular and respiratory causes as well as from lung cancer. Given the threat posed to the public's health by air pollution it is one of our top priorities to research, highlight and address. We are working with Government departments, local authorities, and the wider health community in support of the Government's ambition to reduce the burden of air pollution on public health.

Nationally, PHE have published a review of interventions for improving outdoor air quality and health, a comprehensive overview of actions that national and local government and others can take to improve air quality and health.

PHE has supported local councils and the Defra / Department for Transport (DfT) Joint Air Quality Unit (JAQU) with progression of plans to bring about compliant nitrogen dioxide (NO_2) levels, and ideally in parallel deliver wider health co-benefits by encouraging active travel and reducing the burden of air pollution more generally.

The EHE department covers all of England, with EHE staff locally also contributing to national workstreams and duty desk. In 2018/19 in the North East Region CRCE EHE and the HPT have:

- Supported local authorities in developing business cases for work plans to address nitrogen dioxide exceedances,
- Continued to provide support and advice in relation to health risks from a proposed gasification "energy from waste" plant.
- CRCE have provided consultation responses under environmental permitting, local planning and national significant infrastructure planning regimes. Note that CRCE have a risk-based agreement with the Environment Agency whereby only potentially significant bespoke permit applications are consulted upon.

- Provided support and responses on chemical incidents and enquiries on a range of subjects including water contamination, fires at industrial premises, and chemical exposures in various settings. Prompt advice regarding decontamination minimises health and health systems impacts. Contaminated land and chronic exposure cases may require input over a number of months, usually with expert assistance from PHE communications staff. Of particular note are the fire and diesel contamination at Evenwood, Co Durham fire and the Alex Smiles waste fire in Deptford, Sunderland.
- CRCE have provided initial reference sheets for COMAH sites as their off-site plans are updated, which provide initial site summaries and public health guidance for incidents at COMAH sites. Similarly, CRCE support multiagency contingency planning for high risk waste sites, such as the Alex Smiles site in Deptford Sunderland which had a major fire in May 2018, requiring setup of the national Air Quality Cell between PHE and Environment Agency (EA) and deployment of the EA's mobile monitoring teams for the acute phase of the incident.
- Developed scenarios for regional and national chemical exercises and supported the Health Protection Team in exercises with Scientific Technical Advice Cells for white powder and COMAH incidents.
- Delivered training to staff from the National Poisons Information Service in Newcastle to improve cooperation and alerting, for example for incidents where there are both clinical treatment and wider public health concerns, such as secondary exposure and contamination spread.
- Supported, presented at the South Tees Clean Air Strategy workshop.
- Delivered training at local universities.
- Provided training to Health Protection staff, and Specialty Trainees.

10. Improving the quality of health protection services

10.1. User satisfaction survey

The HPT have routinely surveyed users of the service since 2012. Questionnaires are sent to evaluate one in every ten enquiries. A total of 278 questionnaires were posted in 2018 and 154 returned (55%).

A summary of the key findings are as follows:

- 92% had contacted the HPT either once or twice in the previous 12 months.
- 98% said they were given the appropriate amount of information.
- 99% said that they had understood the advice given ‘a lot’ or ‘completely’.
- 97% said that they had confidence in the response from the health protection nurse/practitioner.
- 97% of responders rated their overall satisfaction as either good, excellent or above average.

These scores represent an even higher level of confidence than was reported last year and reflects the positive experience people have when interacting with the team.

10.2. Research and Development

Over the last year, the Health Protection Team and Field Service team have continued to engage in academic work in order to share findings from their practice.

Publications in 2018/19 included:

- Papers in peer review journals – 8
- Oral presentations at national/international conferences – 2
- Poster presentations at national/international conferences – 6

A scoping exercise was conducted amongst the team to identify future research and audit questions and a structured programme of audit has been introduced amongst the health protection nursing and practitioner team for the year going forward. This aims to develop academic skills amongst the team and embed a culture of quality improvement.

Further details of publications are included in Appendix 4.

Appendix 1: Notifications and other reports of infectious disease in North East residents in 2018

Region	Sub Region	Local Authority	Disease									
			Measles[1]		Mumps[1]		Rubella[1]		Meningococcal disease[1]		Whooping cough[1]	
			No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
North East	County Durham & Darlington	County Durham	41	7.8	111	21.2	2	0.4	7	1.3	40	7.6
		Darlington	5	4.7	12	11.3	1	0.9	3	2.8	3	2.8
		Total	46	7.3	123	19.5	3	0.5	10	1.6	43	6.8
	North of Tyne	Newcastle upon Tyne	31	10.5	75	25.4	2	0.7	9	3.0	17	5.7
		North Tyneside	15	7.3	53	25.9	1	0.5	3	1.5	12	5.9
		Northumberland	4	1.3	60	18.8	0	0.0	3	0.9	17	5.3
		Total	50	6.1	188	22.9	3	0.4	15	1.8	46	5.6
	South of Tyne & Wear	Gateshead	18	8.9	43	21.2	4	2.0	12	5.9	21	10.4
		South Tyneside	11	7.4	16	10.7	1	0.7	3	2.0	21	14.0
		Sunderland	13	4.7	43	15.5	0	0.0	6	2.2	35	12.6
		Total	42	6.7	102	16.2	5	0.8	21	3.3	77	12.2
	Tees	Hartlepool	9	9.7	17	18.3	0	0.0	4	4.3	0	0.0
		Middlesbrough	18	12.8	19	13.5	3	2.1	4	2.8	0	0.0
		Redcar and Cleveland	7	5.1	13	9.6	1	0.7	11	8.1	1	0.7
		Stockton-on-Tees	21	10.7	45	22.9	0	0.0	2	1.0	10	5.1
		Total	55	9.7	94	16.6	4	0.7	21	3.7	11	1.9
	Total		193	7.3	507	19.2	15	0.6	67	2.5	177	6.7
England & Wales	Total		2599[3]	4.4	6,735[3]	11.5	284[3]	0.5	268[3]	0.5	2,613[3]	4.4

1 Data source: EpiNorth3, 2018 data, Diagnosis (confirmed and probable cases).

2 Data source: EpiNorth3, 2018 data, Diagnosis (confirmed cases).
3 Data source: NOIDS, 2018 data used. Local and national data are not
4 Data source: HPZone 2018 data for England only.
5 Data source: SGSS, 2018 data. Laboratory confirmed cases only. Data for England only.
6 Data source: Enhanced Tuberculosis Surveillance (ETS), 2018 data.
7 Data source: Enhanced Tuberculosis Surveillance (ETS), 2018 data for England only.
All rates are per 100,000 population, calculated using mid-year population estimates for mid-2017 from the Office of National Statistics (ONS)

Region	Sub Region	Local Authority	Disease									
			E. coli O157[1]		Salmonella[1]		Campylobacter[1]		Cryptosporidium[1]		Legionellosis[1]	
			No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
North East	County Durham & Darlington	County Durham	14	2.7	85	16.2	616	117.6	90	17.2	2	0.4
		Darlington	1	0.9	19	17.9	110	103.4	11	10.3	0	0.0
		Total	15	2.4	104	16.5	726	115.2	101	16.0	2	0.3
	North of Tyne	Newcastle upon Tyne	8	2.7	51	17.2	355	120.0	35	11.8	0	0.0
		North Tyneside	7	3.4	33	16.1	295	144.3	29	14.2	4	2.0
		Northumberland	6	1.9	30	9.4	437	137.0	60	18.8	3	0.9
		Total	21	2.6	114	13.9	1,087	132.7	124	15.1	7	0.9
	South of Tyne & Wear	Gateshead	2	1.0	28	13.8	213	105.2	21	10.4	5	2.5
		South Tyneside	3	2.0	18	12.0	130	86.9	27	18.1	5	3.3
		Sunderland	4	1.4	41	14.8	263	94.9	29	10.5	2	0.7
		Total	9	1.4	87	13.8	606	96.3	77	12.2	12	1.9
	Tees	Hartlepool	4	4.3	10	10.8	135	145.1	8	8.6	0	0.0
		Middlesbrough	7	5.0	11	7.8	230	163.5	23	16.4	1	0.7
		Redcar and Cleveland	3	2.2	22	16.2	262	192.6	27	19.9	5	3.7
		Stockton-on-Tees	2	1.0	27	13.7	315	160.3	16	8.1	3	1.5
		Total	16	2.8	70	12.4	942	166.4	74	13.1	9	1.6
	Total		61	2.3	375	14.2	3361	127.1	376	14.2	30	1.1
England & Wales	Total		555[4]	1.0	9,935[5]	16.9	60,109[5]	102.3	5,201[5]	8.9	373[5]	0.6

1 Data source: EpiNorth3, 2018 data, Diagnosis (confirmed and probable cases).
2 Data source: EpiNorth3, 2018 data, Diagnosis (confirmed cases).
3 Data source: NOIDS, 2018 data used. Local and national data are not
4 Data source: HPZone 2018 data for England only.
5 Data source: SGSS, 2018 data. Laboratory confirmed cases only. Data for England only
6 Data source: Enhanced Tuberculosis Surveillance (ETS), 2018 data.
7 Data source: Enhanced Tuberculosis Surveillance (ETS), 2018 data for England only.

All rates are per 100,000 population, calculated using mid-year population estimates for mid-2017 from the Office of National Statistics (ONS)

Region	Sub Region	Local Authority	Disease									
			Hepatitis A[1]		Hepatitis B[1]		Hepatitis C[1]		Hepatitis E[1]		TB[6]	
			No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
North East	County Durham & Darlington	County Durham	0	0.0	16	3.1	101	19.3	7	1.3	15	2.9
		Darlington	0	0.0	10	9.4	16	15.0	1	0.9	5	4.7
		Total	0	0.0	26	4.1	117	18.6	8	1.3	20	3.2
	North of Tyne	Newcastle upon Tyne	2	0.7	66	22.3	104	35.2	10	3.4	39	13.2
		North Tyneside	0	0.0	11	5.4	32	15.6	9	4.4	9	4.4
		Northumberland	3	0.9	7	2.2	51	16.0	8	2.5	6	1.9
		Total	5	0.6	84	10.3	187	22.8	27	3.3	54	6.6
	South of Tyne & Wear	Gateshead	0	0.0	13	6.4	94	46.4	7	3.5	6	3.0
		South Tyneside	1	0.7	8	5.3	27	18.1	2	1.3	5	3.3
		Sunderland	0	0.0	19	6.9	49	17.7	4	1.4	9	3.2
		Total	1	0.2	40	6.4	170	27.0	13	2.1	20	3.2
	Tees	Hartlepool	0	0.0	5	5.4	17	18.3	1	1.1	4	4.3
		Middlesbrough	2	1.4	27	19.2	55	39.1	2	1.4	13	9.2
		Redcar and Cleveland	0	0.0	2	1.5	20	14.7	5	3.7	3	2.2
		Stockton-on-Tees	0	0.0	15	7.6	33	16.8	2	1.0	8	4.1
		Total	2	0.4	49	8.7	125	22.1	10	1.8	28	4.9
	Total		8	0.3	199	7.5	599	22.6	58	2.2	122	4.6
England & Wales	Total		741[4]	1.3	4,413[4]	7.9	6,057[4]	10.9	1,368[4]	2.5	4,668[7]	8.4

1 Data source: EpiNorth3, 2018 data. Diagnosis (confirmed and probable cases).
2 Data source: EpiNorth3, 2018 data, Diagnosis (confirmed cases).
3 Data source: NOIDS, 2018 data used. Local and national data are not
4 Data source: HPZone 2018 data for England only.
5 Data source: SGSS, 2018 data. Laboratory confirmed cases only. Data for England only
6 Data source: Enhanced Tuberculosis Surveillance (ETS), 2018 data.
7 Data source: Enhanced Tuberculosis Surveillance (ETS), 2018 data for England only.

All rates are per 100,000 population, calculated using mid-year population estimates for mid-2017 from the Office of National Statistics (ONS)

Appendix 2: Schedule of routine PHE North East infectious disease surveillance reports

	***Output*[1]**	***Frequency***	***Email Recipients***
Reports sent to external partners	SGSS Trust Feedback Report (SGSS Weekly Laboratory report)	Weekly	HPT, FS NE, CPHI, ATMs
	Influenza and influenza-like illness (ILI) Bulletin	Weekly	HPT, FS NE, CPHI, SIT, PHE Regional Office, CCGs, NHSE, ATMs, emergency planners, others
	Infectious Intestinal Disease (IID) Bulletin	Weekly	HPT, FS NE, CPHI, SIT, PHE Regional Office, CCGs, NHSE, ATMs, emergency planners, others
	Seasonal Respiratory Disease Report	Weekly	HPT, FS NE, CPHI, virologists, contributing ATMs
	HCAIs Monthly Summary	Monthly	HPT, FS NE, SIT, CPHI, ICNs, ATMs
	IPD Laboratory Audit Report	Monthly	FS NE, CPHI, ATMs
	Care Home outbreak report	Monthly	HPT, FS NE, DsPH,
	Health Protection Surveillance Report[2]	Quarterly	HPT, FS NE, CPHI, SIT, DsPH, LA EHOs, ATMs
	Vaccine Preventable Diseases (VPD) Bulletin	Quarterly	HPT, FS NE, CPHI, SIT, DsPH, ATMs
	Anti-Microbial Resistance (AMR) Report	*Quarterly (under review)*	HPT, FS NE, CPHI, ATMs, ICNs
	Report on Carbapenem-Resistant Enterobacteriaceae (CRE) and Carbapenemase-Producing Enterobacteriaceae (CPE)	Quarterly	HPT, FS NE, CPHI, ATMs
	Sexual Health Bulletin	Quarterly	HPT, FS NE, CPHI, SH Leads, DsPH, ATMs, GUM consultants, ID physicians
	STI Spotlight Report	Annual	HPT, FS NE, CPHI, SH Leads, DsPH, ATMs, GUM consultants, ID physicians
	HIV Spotlight Report	Annual	HPT, FS NE, CPHI, SH Leads, DsPH, ATMs, GUM consultants, ID physicians
	LASER report (STI)	Annual	HPT, FS NE, DsPH
	Annual TB Report	Annual	HPT, FS NE, CPHI, TB leads, TB clinicians, ATMs
	Campylobacter Report	Annual	HPT, FS NE, CPHI, LA EHOs, ATMs
	Salmonella Report	Annual	HPT, FS NE, CPHI, LA EHOs, ATMs

	Output[1]	*Frequency*	*Email Recipients*
	Annual Hepatitis C Report	Annual	HPT, FS NE, CPHI, DsPH, ID physicians, virologists, ODN, Drug action teams
	Annual Hepatitis B Report	Annual	HPT, FS NE, CPHI, DsPH, ID physicians, virologists, ODN, Drug action teams
	IPD Annual Report	Annual	HPT, FS NE, CPHI, ATMs, ID physicians, GP via CCG
Reports for HPT/FET NE	EpiNorth3 Exceedance Alert	Daily	HPT, FS NE
	EpiNorth3 Typing Coincidence Alert	Daily	HPT, FS NE
	EpiNorth3 Postcode Coincidence Alert	Daily	HPT, FS NE
	EpiNorth3 Exceedance Report	Weekly	HPT, FS NE
	EpiNorth3 Postcode sector Report	Weekly	HPT, FS NE
	E piNorth3 Exposures Exceedance Report	Weekly	HPT, FS NE
	EpiNorth3 Weekly Case Summary Report	Weekly	HPT, FS NE
	SGSS Quarantined Data Report	Weekly	HPT, FS NE

1. EXCLUDES Internal communication reports, internal audit reports and forwarded national reports. All reports are disseminated via email (except for LASER reports that are available through SH portal)

2. Stakeholder reports contain data for the following organisms/diagnoses; Salmonella, E. coli O157, Campylobacter, Cryptosporidium, Giardia, Shigella, Meningococcal disease, measles, mumps, rubella, pertussis, Hepatitis A, B & C, Listeria, Legionella, TB, Scarlet fever, Invasive Group A Streptococcus(iGAS).

Abbreviation	**Description**	**Abbreviation**	**Description**
HPT	Health Protection Team (PHEC NE)	FS NE	Field Service North East
ATMs	Acute Trust Microbiologists	ICNs	Infection Control Nurses
SIT	Screening & Immunisation Team	CPHI	Consultant in Public Health Infection
CCGs	Clinical Commissioning Groups	SH Leads	AT and CCG and clinical network Sexual Health Leads
LA EHOs	Local Authority Environmental Health Officers	NHSE	NHS England
DsPH	Directors of Public Health	ODN	Hepatitis C Operational Delivery Network
ID	Infectious Diseases		

Appendix 3: The PHE Public Health Laboratory Service in Newcastle upon Tyne and York

Location and contact details

The laboratory is located at Freeman Hospital, Newcastle.

PHE Laboratory Service	Direct line:	0191 282 1150
Level 2	Or via:	0191 233 6161 (Hospital Switchboard)
Freeman Hospital	On call:	Request on-call scientist/medical officer
High Heaton	Fax:	0191 213 7289
Newcastle upon Tyne		
NE7 7DN		

Please note that food, water and environmental samples are examined in the:

PHE FW&E Laboratory
Block 10
The National Agri-food Innovation Campus
Sand Hutton
York
YO41 1LZ

Tel: 01904 468948
Fax: 01904 468082

Appendix 4: Publications and presentations (HPT and FS)

Papers published in peer review journals

- Campbell H, Gupta S, Dolan G, Kapadia S, Kumar Singh A, Andrews N, Amirthalingam G. 17/09/2018. J. Med. Microbiol. 67(10):1426-1456 doi:10.1099/jmm.0.000829 **Review of vaccination in pregnancy to prevent pertussis in early infancy**. Journal of Medical Microbiology
- Houseman C, Chapman KE, Manley P, Gorton R, Wilson D, Hughes G. (2019). Decreasing case fatality rate following invasive pneumococcal disease, North East England, 2006-2016. Epidemiology amd Infection. 147.10.1017/S0950268819000657. **Decreasing case fatality following invasive pneumococcal disease, North East England, 2006-2016**. Epidemiology & Infection.
- A. Waldram1, J. Lawler2, C. Jenkins3, J. Collins4, M. Payne4, H. Aird5, M. Swindlehurst5, G. K. Adak6, K. Grant3, D. Ready3, R. Gorton1 and K. Foster2 Epidemiology and Infection 1–8. https://doi.org/10.1017/ S095026881800225X. **Large outbreak of multiple gastrointestinal pathogens associated with fresh curry leaves in North East England, 2013**. Epidemiology & Infection
- Richard Elson,1,2* Adedoyin Awofisayo-Okuyelu,2 Trevor Greener,3 Craig Swift,1 Anaïs Painset,1,2 Corinne Francoise Laurence Amar,1 Autilia Newton,4 Heather Aird,5 Mark Swindlehurst,5 Nicola Elviss,5 Kirsty Foster,6 Timothy J. Dallman,1,2 Ruth Ruggles,1 and Kathie Grant1,2. Journal of food protection, vol. 82, no. 1, 2019, pages 30–38. **Utility of Whole Genome Sequencing to Describe the Persistence and Evolution of Listeria monocytogenes Strains within Crabmeat Processing Environments Linked to Two Outbreaks of Listeriosis**. Journal of Food Protection
- K Fenton ,1 A Cropp,1 M Chauhan,1 K Foster,2 J Harwood,1 C Lyth,1 DA Price,3 M Valappil1 and D Weiand1. HIV Medicine (2018), 19, e77 DOI: 10.1111/hiv.12673. **Earlier diagnosis of HIV infection through visual HIV testing prompts**. HIV Medicine
- Maeve K. Lalor1,2, Nicola Casali3,4, Timothy M. Walker5, Laura F. Anderson1, Jennifer A. Davidson1, Natasha Ratna1, Cathy Mullarkey6, Mike Gent7, Kirsty Foster8, Tim Brown3, John Magee9,10, Anne Barrett9, Derrick W. Crook5,11, Francis Drobniewski3,4, H. Lucy Thomas1 and Ibrahim Abubakar1,2. Eur Respir J 2018; 51: 1702313 [https://doi.org/10.1183/13993003.02313-2017. **The use of whole-genome sequencing in cluster investigation of a multidrug resistant tuberculosis outbreak**. European Respiratory Journal
- Bridie Howe,* Medhat Basta, Kirsty Foster, Umo Esen, Richard Ellis, Jane Hussey. European Journal of Obstetrics & Gynecology and Reproductive Biology 219 (2017) 131–136. **Primary syphilis in pregnancy mistaken for genital herpes: A preventable cause of congenital syphilis**. European Journal of Obstetrics & Gynaecology and Reproductive Biology
- A Bhagey1, K Foster2, S Ralph1, AWardropper1, C White1, V Wholey1 and S Duncan1. International Journal of STD & AIDS 2018, Vol. 29(10) 1007–1010. **High prevalence of anti-hepatitis A IgG in a cohort of UK HIV-negative men who have sex with men: implications for local hepatitis A vaccine policy**. International Journal of STD & AIDS

Oral presentations on research to conferences

- Nicola Love, Deborah Wilson, Claire Stoker: Salmonella outbreak linked to a rural butcher shop with unusually severe clinical presentation, February-March 2018, North East England. European Scientific Conference on Applied Infectious Disease Epidemiology
- Michelle Henderson, Simon Howard: Screening for latent tuberculosis in UK healthcare workers. UK TB Educational Symposium, London

Poster presentations on research to conferences

- Kate Houseman, Kaye Chapman, Deborah Wilson. Decreasing 30 day mortality following invasive pneumococcal disease, North East of England 2006-2016. 5 Nations Health Protection Conference
- Peter Acheson, Kelly Stoker. Campylobacter parfait – an old favourite with a novel twist. 5 Nations Health Protection Conference
- Stephanie Baker, Gayle Dolan. Increasing the participation in oral fluid surveillance for measles cases reported to the North East Health Protection Team. 5 National Health Protection Conference
- Eve Hamilton, Simon Howard. To treat or not to treat? A complex decision in TB care. Federation of Infection Societies Conference, Gateshead
- Rachael Kain, Simon Howard. The measles on the bus goes round and round: community and hospital infection control lessons from a small measles outbreak on Tyneside. Healthcare Infection Society Annual Conference, Liverpool
- Kelly Stoker, Gayle Dolan. Outbreak of Pneumococcal and Influenza infection in a care home in the North East of England January 2018. Healthcare Infection Society Annual Conference, Liverpool

Audits

The local field epidemiology team undertake regular audit and quality checks for routine surveillance data including SGSS lab reporting, HPZone and EpiNorth 3 data and TB data reported to ETS.

HEALTH AND WELL BEING BOARD
28 NOVEMBER 2019

HEALTH AND WELL BEING BOARD – TERMS OF REFERENCE

SUMMARY REPORT

Purpose of the Report

1. To consider amendments to the Terms of Reference for the Health and Well Being Board.

Summary

2. Revised governance arrangements and Terms of Reference for the Health and Well Being Board were considered and approved by the Board at its meeting held on 17 January 2019. When approving the Terms of Reference the Board agreed to review them on a regular basis. The Terms of Reference are attached to the report at Appendix 1, with a number of proposed minor changes highlighted.

Recommendation

3. It is recommended that:-

   (a) the Terms of Reference, appended to the submitted report, be approved, with the inclusion of the following amendments, namely:-

      (i) the deletion of the NHS Darlington Clinical Commissioning Group's Chief Nurse from the Membership of the Board;
      (ii) the deletion of a representative of the Board of Primary Healthcare from the Membership of the Board;
      (iii) the addition of Darlington Primary Care Network to the Membership of the Board;
      (iv) the School of Health and Social Care be renamed to School of Health and Life Sciences, Teesside University; and
      (v) the frequency of the Board meetings be increased to four meetings per year.

   (b) the board consider any further changes to be made, at this time, to the Terms of Reference.

Reasons

4. The recommendations are supported by the following reasons :-

   (a) To enable the Terms of Reference to be updated with a number or minor changes.

(b) To enable the Board to consider any further amendments to the Terms of Reference, as necessary.

Suzanne Joyner
Director of Children and Adults Services

Background Papers
No background papers were used in the compilation of this report.

Hannah Fay : 01325 405801.

S17 Crime and Disorder	There are no implications arising from this report.
Health and Well Being	This proposed collaborative project will provide improvements for health and well being of residents with Long Term Conditions.
Carbon Impact and Climate Change	There are no implications arising from this report.
Diversity	There are no implications arising from this report.
Wards Affected	All
Groups Affected	All
Budget and Policy Framework	N/A
Key Decision	N/A
Urgent Decision	N/A
One Darlington: Perfectly Placed	N/A
Efficiency	N/A
Implications for Looked After Children and Care Leavers	There are no direct implications for Looked After Children or Care Leavers contained within the report.

MAIN REPORT

Information and Analysis

5. The current Terms of Reference for the Health and Well Being Board were considered and approved by the Board at its meeting held on 25 April 2017. A number of minor changes were made to the Terms of Reference when they were re-considered by the Board at its meetings held on 10 May 2018 and 17 January 2019.

6. A number of minor changes are proposed, namely :-

(a) the deletion of the NHS Darlington Clinical Commissioning Group's Chief Nurse from the Membership of the Board;
(b) the deletion of a representative of the Board of Primary Healthcare from the Membership of the Board;
(c) the addition of Darlington Primary Care Network to the Membership of the Board;

(d) the School of Health and Social Care be renamed to School of Health and Life Sciences, Teesside University and;
(e) the frequency of the Board meetings be increased to four meetings per year.

7. Members of the Board may wish to consider further amendments to the Terms of Reference.

Outcome of Consultation

8. No consultation, other than with the Health and Well Being Board, has been undertaken on the contents of this report.

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Darlington Health and Wellbeing Board

Terms of Reference

1. The Darlington Health and Wellbeing Board brings together key local leaders to improve the health and wellbeing of the population of Darlington and reduce health inequalities through:

   (a) Developing a shared understanding of the health and wellbeing needs of its communities from pre-birth to end of life including the health inequalities within and between communities.
   (b) Providing system leadership to secure collaboration to meet these needs more effectively.
   (c) Having strategic influence over commissioning decisions across health, public health and social care encouraging integration where appropriate.
   (d) Recognising the impact of the wider determinants of health on health and wellbeing.

2. It will:
   (a) Maintain the Joint Strategic Needs Assessment, including the Pharmaceutical Needs Assessment to provide an evidence base for future policy and commissioning decisions.
   (b) Produce a Joint Health and Wellbeing Plan, taking a life-course approach, in the context of One Darlington: Perfectly Placed which is the overarching Health and Wellbeing Strategy for the Borough.
   (c) Oversee delivery of local commissioning plans by the Darlington Integration Board to ensure that they are in line with the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy
   (d) Embed the Children and Young People agenda in the work of the Board and fulfil the role of the Darlington Children's Trust
   (e) Liaise with NHS England as necessary
   (f) Encourage integrated working between health and social care commissioners including, where appropriate, supporting the development of arrangements for pooled budgets, joint commissioning and integrated delivery under Section 75 of the National Health Service Act 2006
   (g) Oversee the Better Care Fund [1]
   (h) Encourage close working between health and social care commissioners and those responsible for the commissioning and delivery of services related to the wider determinants of health
   (i) Undertake a strategic role, promoting joint working with partners.
   (j) Allow the day to day issues to be dealt with by the Integration Board.

[1] Given that some members of the Board represent provider organisations, strategic funding decisions relating to the Better Care Fund are delegated to the Pooled Budget Governance Board, which is a commissioner-only body

3. Membership

Darlington Borough Council Portfolio Holder with a remit covering Health (Chair)
Darlington Borough Council Portfolio Holder with a remit covering Adult Services
Darlington Borough Council Portfolio Holder with a remit covering Children Services
The Leader of Darlington Borough Council
Leader of Darlington Borough Council Opposition Group
Darlington Borough Council Director, Children and Adults Services
Darlington Borough Council Director of Public Health
One representative of the Healthwatch Darlington Board
NHS Darlington Clinical Commissioning Group Chair (Vice Chair)
NHS Darlington Clinical Commissioning Group Chief Officer
NHS Darlington Clinical Commissioning Group Director of Commissioning and Transformation
One representative of Tees, Esk and Wear Valley Mental Health Foundation Trust
One representative of County Durham and Darlington NHS Foundation Trust
One representative of Harrogate and District NHS Foundation Trust
One representative of NHS England
One representative of the Darlington Primary Care Network
County Durham Police, Crime and Victims' Commissioner
Dean of the School of Health and Life Sciences, Teesside University
One representative of the Community and Voluntary Sector
One representative of Darlington Primary Schools
One representative of Darlington Secondary Schools
One representative of Darlington post 16 years education

a) Political proportionality does not apply to membership of the Board. Its makeup and operation complies with the Health and Social Care Act 2012, comprising at least one Councillor, the Directors of Adult and Children Social Services and the Director of Public Health for the local authority, a representative of the Local Healthwatch organisation for the area of the local authority and a representative of each relevant clinical commissioning group. It also allows the local authority to include others as it thinks appropriate.

b) All members of the Board are accountable to the organisation/ sector which appointed them. Each member has a responsibility to communicate the Board's business through their respective organisation/ sector's own communication mechanisms.

c) Each Board member can nominate a named substitute. Substitutes must be from the same organisation/ sector as the Board member and be of sufficient seniority and empowered by the relevant organisation/ sector to represent its views; to contribute to decision making in line with the Board's Terms of Reference and to commit resources to the Board's business.

d) If a member of the Board misses three consecutive meetings without giving apologies, their continued membership of the Board will be reviewed with the organisation that they represent.

e) In carrying out its business the Board may, if required:
   i) Establish one or more sub-committees to carry out any functions delegated to it by the Board.
   ii) Establish one or more time limited task and finish groups to carry out work on behalf of the Board.
   iii) Carry out any other functions delegated to it by Darlington Borough Council under Section 196(2) of the Health and Social Care Act 2012.

4. Chairing

a) The Chair of the Board will be the Darlington Borough Council Portfolio Holder with a remit covering health.
b) The Vice Chair of the Board is appointed by the Board and will be the Chair of the NHS Darlington Clinical Commissioning Group.

5. Voting Arrangements

a) It is expected that most decisions will be agreed by consensus but, where this is not the case, then only those members listed as voting members may vote. Voting on all issues will be by show of hands.

Organisation	Position
Darlington Borough Council (7)	Council Members (5), Director of Children and Adults Services, Director of Public Health
Darlington Clinical Commissioning Group (3)	Chair, Chief Officer, Director of Commissioning and Transformation
Darlington Healthwatch (1)	

b) The Chair of the Board shall have a second or casting vote.

6. Meeting arrangements

a) The Board will meet four times a year. The Chair of the Board, in consultation with the Vice Chair, can convene special meetings of the Board as appropriate.

b) All business of the Board shall be conducted in public in accordance with Section 100A of the Local Government Act 1972 (as amended). When the Board considers exempt information and/or confidential information is provided to Board members in their capacity as members of the Board all Board members agree to respect the confidentiality of the information received and not disclose it to third parties unless required to do so by law or where there is a clear and over-riding public interest in doing so.

c) Some information may have to be included and discussed in a confidential session of the Board in accordance with the procedures and protocols promoted by the provisions of the Data Protection Act 1998. Confidential documents will be clearly marked 'Confidential'.

d) The quorum for meetings shall be three voting members and must include at least one Darlington Borough Council Councillor and one representative of the Clinical Commissioning Group.

e) Where a decision is required before the next Board meeting, the Chair may act on recommendations of officers in consultation with the Vice Chair through the following process:
    i) circulation of details of the proposed decision to all Board members for consultation;
    i) there being clear reasons why the decision could not have waited until the next full Board meeting; and
    ii) the decision will be recorded and reported to the next full Board meeting.

f) Agenda and reports will be available online no fewer than five working days before the meeting.

g) All voting members of the Board are governed by the code of conduct/ professional standards of the organisation/ sector that they represent.

7. Relationships between partnerships

a) Work has been conducted to be clear about the relationships between key partnerships in Darlington with a focus on safeguarding, community safety, health and wellbeing.

b) A structural review of the Darlington Community Safety Partnership (CSP) was conducted in 2016. During the review, particular attention was paid to areas of common interest across the Darlington Safeguarding Children's Board, Darlington Safeguarding Adults Partnership Board and the Community Safety Partnership.

c) Each of the partnerships considered areas of common interest and agreed the most appropriate governance arrangements that will provide assurance to each partnership.

d) Collaborative working is promoted across all partnerships. The function and activities of the Darlington Safeguarding Children's Board are part of the wider context of Darlington's Health and Wellbeing Board arrangements. Its work contributes to the wider goals of improving the wellbeing of all children and young people.

e) The Darlington Safeguarding Adults Partnership Board has three core duties as per the Care Act 2014. The Board must publish a strategic plan, an annual report and commission safeguarding adult reviews as appropriate.

f) The Independent chairs of both Safeguarding Boards will present their annual reports to the Health and Wellbeing Board which gives the Health and Wellbeing Board the opportunity to seek assurances of the safeguarding arrangements in place and the effectiveness of those arrangements.

g) The Darlington Community Safety Partnership (CSP) is a statutory partnership and reports progress to the Darlington Strategic Partnership on the One Darlington: Perfectly Placed theme of a 'Safe and Caring' community.

h) The CSP chair will present an annual report to both the Health and Wellbeing Board and Darlington Strategic Partnership.

i) A proposal from the work undertaken to develop a more co-ordinated approach across key partnerships is that the chairs of the key partnerships may meet at least twice a year to reduce duplication, strategically co-ordinate common priorities and to share relevant reports.

(Updated November 2019 - to be reviewed annually)

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HEALTH AND WELL BEING BOARD
28 NOVEMBER 2019

ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2018 / 2019
HEALTHY NEW TOWNS: DARLINGTON

SUMMARY REPORT

Purpose of the Report

1. To share the Annual Report of the Director of Public Health 2018/2019 which has a particular focus on the legacy of the Darlington Healthy New Towns programme.

Summary

2. Under the 2006 NHS Act (inserted by section 31 of the Health and Social Care Act (2012)) each Director of Public Health is required to produce, and the relevant local authority to publish, an annual report. The subject for discussion in the Annual Report 2018/2019 is Healthy New Towns, with a focus on legacy.

3. The report is structured around five chapters reflecting the key strands of the programme - setting the context, built and natural environment, community asset building, new models of care and evaluation of the programme.

4. The Annual Report is submitted for information purposes only at this stage and will be considered by this Board at its meeting scheduled to be held on 12 March 2020.

Recommendation

5. It is recommended that: -

   (a) Health and Well Being Board note the Annual Report of the Director of Public Health 2018/2019;

   (b) That the Annual Report of the Director of Public Health 2018/19 be received by the Health and Well Being Board at its meeting on 12 March 2020.

Miriam Davidson
Director of Public Health

Miriam Davidson: Extension 6203

Background Papers
No background papers were used in the preparation of this report

S17 Crime and Disorder	No specific impact
Health and Well Being	The key themes of the Healthy New Towns programme are wider determinants of health.
Carbon Impact and Climate Change	No specific impact.
Diversity	No specific impact.
Wards Affected	All
Groups Affected	A population approach.
Budget and Policy Framework	Not applicable
Key Decision	No
Urgent Decision	No
One Darlington: Perfectly Placed	The Healthy New Towns programme was aligned to the One Darlington: Perfectly Placed strategy.
Efficiency	Shared models of working across sectors
Impact on Looked After Children and Care Leavers	No specific impact.

Healthy New Towns Darlington

Annual Report of the Director of Public Health, Darlington 2018/19

"Bringing a healthy life to communities, bringing healthy communities to life"

DARLINGTON BOROUGH COUNCIL


DARLINGTON
FOOD&DRINK
FESTIVAL

Table of Contents

Miriam Davidson
Director of Public Health

Foreword

Welcome to the Annual Report of the Director of Public Health Darlington, 2018/2019.

I am pleased to share the report which is a focus on the Darlington experience and legacy of the Healthy New Towns. In 2016 Darlington was selected as one of 10 programme sites in England, chosen from over 100 applicants. Early thinkers who influenced the bid included Dr Jenny Steel, Timothy Crawshaw, Dr Ian Briggs,Ian Prescott and members of the Red Hall community.

Funding was awarded from NHS England for a programme to explore how the development of new places could improve health and wellbeing through the built environment, healthcare, service design and strong communities.

Our Darlington programme was a complex collaboration across the Council, County Durham and Darlington NHS Foundation Trust, Housing Developer, Academic partner, Digital Technology partner, NHS England, Darlington Clinical Commissioning Group and community leaders.

The NHS funding was key to accelerating plans and resourcing a range of activities, it also provided a 'match funding' to attract support for a number of related programmes.

While all partners were aware that the NHS funding was fixed term, the 'coalition of the willing' brought together the cumulative efforts of partners to improve health and wellbeing. At the final Healthy New Towns stakeholder event in March 2019, system leaders (Sue Jacques, County Durham and Darlington NHS Foundation Trust, Nicola Bailey, Darlington NHS Clinical Commissioning Group, Amanda Riley, Primary Healthcare Darlington and Paul Wildsmith, Darlington Borough Council) gave their commitment to maintaining the legacy of the programme.

Healthy New Towns Steering Group

Local Legacy

- More collaboration - health, housing, planning, digital and better appreciation of the inter-dependencies and contributions each can bring to the health and wellbeing agenda
- Local Plan and policies to influence development over the medium and longer term
- Stronger foundations for developing new care models as a collective approach and greater commitment to delivering integrated care
- Primary care acknowledged as heart of provision but more open to working at scale to build resilience and improved ability to meet the needs of 'Hub' populations
- Red Hall - foundations of community leadership and empowerment
- Lessons learned regarding neighborhood renewal

The Darlington Healthy New Towns partnership was delighted to be shortlisted finalists for two national awards - the LGC in the Public Health (2019) category and APSE Best Health and Wellbeing Initiative (2019).

LGC Awards 2019

apse service awards 2019

Acknowledgements

My thanks to the team of people who have contributed to this report -

- Becky James, Public Health Portfolio Lead
- Jon Lawler, Public Health Registrar
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- Michael Conway, PA
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- Pauline Brown, PA Support Assistant
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- Kerry Latchford, Xentrall Design and Print
- Special Thanks to Hilary Hall, Healthy New Towns Manager (2017-2019)

Hilary Hall
Healthy New Towns Manager

Actions Arising from the Director for Public Health Annual Report 2017-18: Recommendations

The 2017/18 report set out the following 3 recommendations:

Best Start in Life - promoting a whole system approach to improving children and young people's health and wellbeing outcomes across all settings

Living and Working Well - addressing barriers to employment, promoting a healthy workforce and implementing Making Every Contact Count

Healthy Ageing - taking an asset-based approach to older people's health promoting the importance of ageing well.

Examples of actions contributing to the above priorities include:

Ensuring the Darlington Stop Smoking service includes direct access to a specialist stop smoking advisor for pregnant women

The Local NHS Trusts are working towards becoming Smoke Free in 2019

The Darlington Health Visiting Team achieved the Gold standard for the UNICEF breastfeeding accreditation scheme

We are working with schools to prepare for statutory Relationship and Sexual Education guidance coming into effect in 2020 and using this as a key opportunity to embed key public health messages

Darlington Childhood Healthy Weight Plan launched, promoting a whole system approach to tackling childhood obesity across the borough. An action plan has been developed as a result of a multi-agency event

We are implementing a phased approach to rolling out Make Every Contact Count training for front line staff within Darlington Borough Council

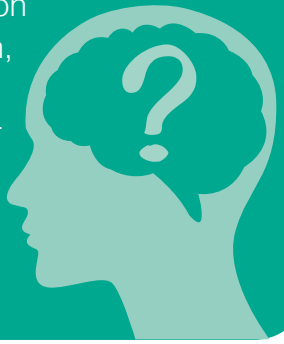
Work with Community Safety partners, including Voluntary sector, to plan together how to tackle drug and alcohol problems, drug related deaths, suicide prevention and domestic abuse (Big Conversation 2018)

Continued support for health and social care services delivering the Better Care Fund programmes so that people can manage their conditions and live independently

Integration and Better Care Fund

Darlington Sexual Health service offers open access to Prevention, testing and treatment

Healthy Workforce promoted with a focus on mental health, e.g. staff training, peer responders and wellbeing promotion



Joint work with HR and Occupational Health to promote free seasonal flu vaccinations for Darlington Borough Council staff

Chapter 1
What is a Healthy New Town?

The NHS launched the Healthy New Towns programme in 2015 to explore how the development of new places could provide an opportunity to create healthier and connected communities with integrated and high-quality health services.

In 2016 Darlington was selected to be one of ten demonstrator sites, from over 100 applicants. The ten demonstrator sites were at different stages of their development with diverse partnerships, health needs and inequalities.

The national aims of the programme were:

1. To shape new towns, neighbourhoods and communities to promote health and wellbeing, prevent illness and keep people independent;
2. To radically rethink delivery of health and care services, supporting learning about new models of deeply integrated, place-based care;
3. To spread learning and good practice to other local areas and other national programmes.

Healthy New Towns Darlington

The programme aimed to drive closer collaboration between Local Authorities, planners, developers and the NHS.

Why was NHS England investing in housing developments and planning?

- Shared agenda in preventing long term conditions and helping keep people independent;
- Significant evidence linking health to environment;
- Healthier individuals contribute to wider economy;
- Planning and housing are key components of a “whole systems” approach to improving health;
- The NHS can improve health and care infrastructure by liaising with developers;
- NHS strategy is increasingly place-based.

The places where people live have an impact on mental and physical health but that impact can be negative and linked to complex determinants of health such as income and education.

Why is the combining of housing and health such a key priority both nationally and locally?

In terms of housing, there is great pressure on local authorities to meet the five-year housing land supply in accordance with the National Planning Policy Framework. However, whilst there has been attention focused on the need to increase the rate of house building because there are problems with under-supply and affordability, alongside this there have also been growing concerns about the quality of the houses under development. The quality of housing can be either a greatly positive or negative contributor to health improvement.

According to the Health Foundation, 1 in 5 homes do not meet the decent standard in England. This goes up to 1 in 4 for private rentals. The King's Fund and National Housing Federation have estimated the cost of poor housing to the NHS is £1.4 billion per year (*Opportunities for sustainability and transformation partnerships*, D. Buck and S. Gregory, March 2018).

Evidence suggests that children living in cold, overcrowded or unsafe housing are more likely to be bullied, to have a longstanding health problem, and be below average in key academic achievement as a direct consequence of living in poor-quality housing (NatCen Social Research 2013). The Marmot Review team found that children living in cold homes are twice as likely to develop respiratory problems as those in warm homes and there are clear effects of fuel poverty on the mental health of adolescents.

Many issues around quality, including daylight, sound reduction, space standards, and amenity space, are not dealt with by current regulations. The All Party Parliamentary Group report 'More Homes, Fewer Complaints' (July 2016) - contains several recommendations including improving the systems in place to check quality and workmanship and developing a new quality culture within the construction industry.

The quality in the built environment must extend beyond the home itself and cover the surrounding neighbourhood. There is wide ranging and robust evidence that green spaces have measurably positive effects on people's health. People living in greener urban areas tend to be happier than people in areas with less urban greenery.

General health questionnaire scores have shown that people living in greener areas experience significantly lower levels of mental distress. There are strong links between the availability of green space and greater levels of physical activity.

Natural capital is one of the key determinants of health, and air quality is one area where great gains can be made. Trees and other vegetation can remove pollutants from the air and reduce atmospheric carbon dioxide thereby improving air quality.

Positive impact on health is gained from promoting physical activity and active lifestyles. Exploring ways of promoting active travel and designing active travel to meet local needs is a key Healthy New Towns principle.

Establishing healthy eating, access to affordable, attractive healthy food is a key element of the Darlington Childhood Healthy Weight Plan which is partly legacy from the HNT programme.

Children in Reception
(overweight including obese)

23.8% Darlington

25% North East

22.6% England

Children in Year 6
(overweight including obese)

33.6% Darlington

37.5% North East

34.3% England

Adults overweight or obese

68.3% Darlington

66.5% North East

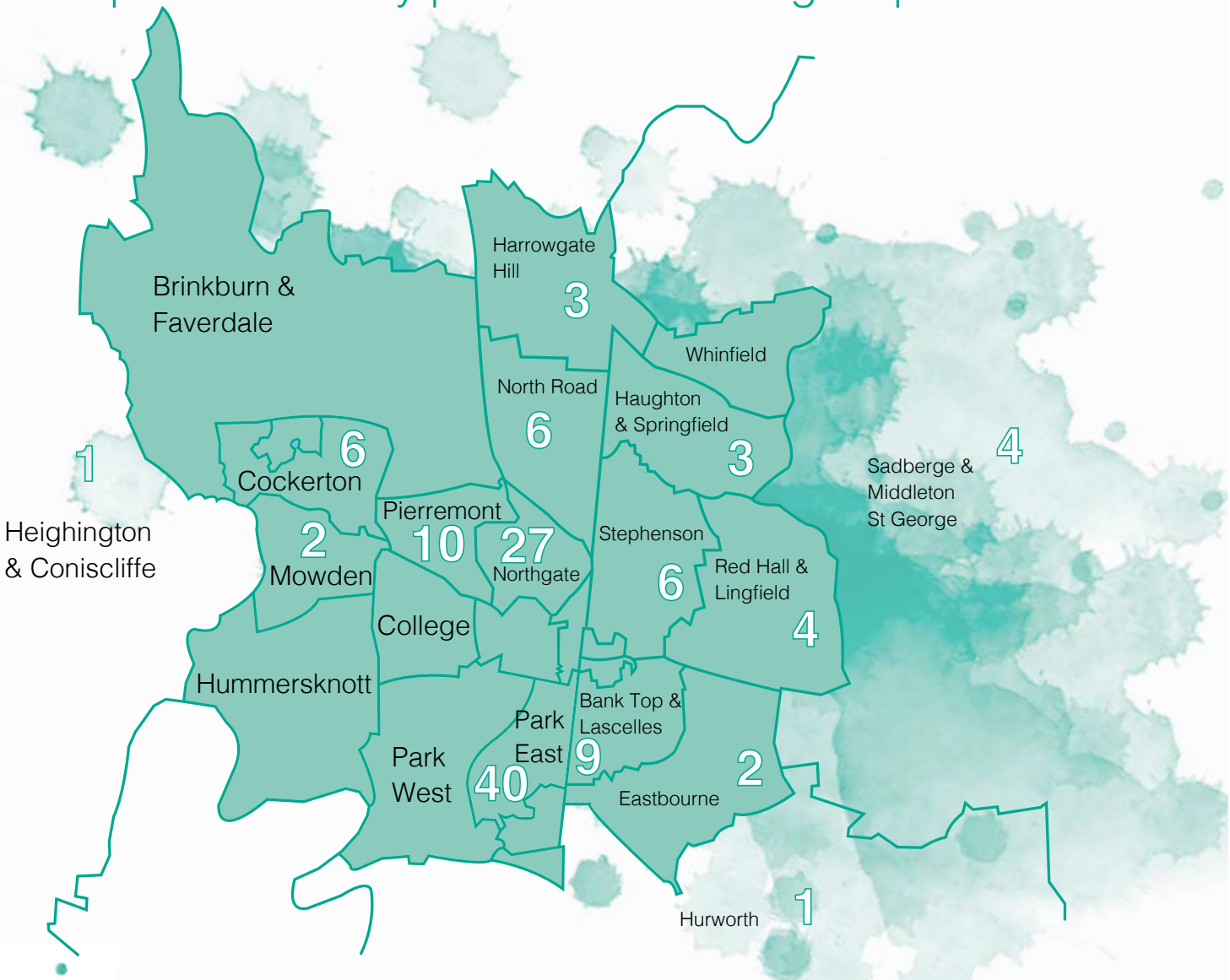
62% England

The increasing consumption of out-of-home meals has been identified as an important factor in the rising levels of obesity. Public Health England estimated, in 2014, that there were over 50,000 fast food and takeaway outlets in England.

Information and education are solid foundations for improving diet, however the growing body of international and national evidence is that more structural changes are needed i.e. the quality of the environment is hugely influential.

Over 50,000 fast food and takeaway outlets in England

Map 1: Take-away provision in Darlington per ward



How did the Healthy New Towns (HNT) programme fit with our strategic direction of improving the health of local people?

The NHS locally in Darlington was involved in the planning and initial thinking about Darlington as a pilot for Healthy New Towns. Dr Jenny Steel was particularly influential in shaping the original bid.

There is a recognition that the increasing need and demand for health and care services create an increasing cost to the individual and society. Long-term conditions are making a bigger contribution to health spending and hospital bed days.

Care models need to change to take account of the demand alongside understanding the other factors which can protect health, prevent some illnesses and slow the deterioration in health in a range of conditions.

There is an increasing concern about the widening inequalities between the health outcomes of those in the most disadvantaged communities compared with the more affluent and recognition that housing and the environment have a vital role in influencing change.

(Note, see Annual Report of the Director of Public Health 2017/2018, Health Inequalities in Darlington: Narrowing the Gap)

In many ways the HNT programme in Darlington was a natural development of thinking that had already started about taking a place-based approach to population health improvement.

Some of the challenges were:

- Although there was agreement that the current model of care would not be able to meet growing health needs in the future, there was not agreement on what it should look like.
- There was a general belief that harnessing the advantages of digital technology to help manage demand and assist care services to be more user-focused was positive - but needed clarity.
- There was an interest in bringing together local authority plans for housing expansion with health plans for jointly responding to the needs of local communities.

The Darlington (HNT) coalition of the willing

In response to the challenges above a HNT Steering Group was formed, a "coalition of the willing". This included local NHS partners, some private sector partners, (a national house builder, Keepmoat and a digital infrastructure provider, Inhealthcare) and Council representation of housing, public health and planning. An academic partner joined the Steering Group in 2017.

An initial stakeholder event in 2016 brought together representatives from voluntary and community organisations, Fire and Rescue service, Police, NHS, Council, Education and the private sector.

The "Healthy New Town Conversation" confirmed, in this initial 'pilot' phase of the programme, that we would set foundations for a way of working in partnership across Darlington that would leave a legacy that could be built on in future years.

The governance arrangements were approved by each partner organisation, with HNT progress reports shared with the Health and Wellbeing Board, Health and Partnerships Scrutiny Committee and NHS Executive Groups.

The HNT ambitions were broad and long term, although NHS funding was provided on a pilot basis in Year One (2016) and subsequently available two further years, the longer term view was provided by the context of the following strategies:

- Darlington Sustainable Community Strategy (2008-2026);
- Darlington Local Plan (2016-2036) (draft);
- NHS Five Year Forward View and subsequently the NHS Long Term Plan (2019).

Chapter 2
Built and Natural Environment

The Right Context

Our environment and surroundings are important determinants of health, supporting and incentivising activity and exercise, access to open, green and blue spaces, improving air quality and bio-diversity within our borough, enabling connectivity and social cohesion, access to employment, education and opportunities for social interaction and offering connections to facilities and services.

Pauline Mitchell
Assistant Director
Housing and Building Services
Darlington Borough Council

The value of good quality housing and its links to health have long been recognised:

- dating back to the Victorian times and key individuals such as Edwin Chadwick and the 1848 Public Health Act, which instituted major reforms in urban sanitation and public health;
- the 1909 Housing and Town Planning Act which recognised the link between housing squalor, over-density of slum housing and spread of disease;
- the introduction of the Town and Country Planning Act in 1947 (at the same time as the creation of the NHS in 1948) marked the key social values of the era immediately post war - i.e. that the state had a legitimate role in the development of land and the question of betterment, aiming to create a system capable of fulfilling the social, environmental and economic objectives of reconstruction and long term land management.

The HNT programme in many ways builds on that vast evidence base and history of public health improvement.

Before and after Red Hall development

Through the HNT Programme, Darlington Council recognised the opportunity to create the right environment to influence the quality of housing design and development so that it could be a positive contributor to health improvement through a variety of actions.

These have included:

- The assessment of housing needs for the town for the next 25 years and its economic growth plans;
- The designation of potential strategic allocation sites to ensure 5 year land supply;
- The creation of the Local Plan;
- Ongoing relationship development with potential developers within the town as well as plans for its own social housing stock.

As HNT Darlington was established, the Eastern Growth Zone development site was already in the early planning stages. This was the Keepmoat site at Red Hall on the east side of the town, located next to an existing social housing estate which had been earmarked for significant investment over the next ten years to promote regeneration and renewal. It was felt that this provided the ideal conditions for a public/private partnership aligned to achieving the same goals of improving health and social outcomes.

Planners and developers came together to collaborate on a design that would consider how the built and surrounding natural environment could support a health enabling neighbourhood. Keepmoat Homes also embraced this challenge by adapting their existing home designs to reflect life time home principles i.e. because of the way the houses are designed - at little or minimal cost the houses can be adapted to cater to the changing needs of occupants over their life course.

Keepmoat House Opening Ceremony at Red Hall, Darlington - February 2019

Darlington's Healthy New Town Design Principles

David Hand
Head of Planning, Policy Economic Strategy and Environment
Darlington Borough Council

Early work began to show real potential for better collaborative design of houses and some key principles started to emerge about what makes a great place in which to live - combining the immense amount of evidence that has been published on this subject nationally along with the more hands on experience of local planners and developers.

The output of that work has been the 6 HNT Darlington design principles that aim to represent high quality place design.

In summary these 6 design principles seek to define what makes a great place within which to live that supports people's physical and mental health and wellbeing. It is having access to:

- ***Blue and/or Green infrastructure*** - to promote recreation, exercise and activity, play, good air quality, conservation, social interaction spaces
- ***Local healthy food options*** - through local retail options or facilities to grow your own food
- ***Creating a sense of place and identity*** - a permeable, legible environment with landmarks, good wayfinding (including for those with heightened needs e.g. dementia), creating a sense of neighbourhood with natural surveillance and community
- ***Economy*** - good links to employment and education opportunities and to facilitate the needs of the local labour market as economic growth goes hand in hand with new developments, job creation, income flow and wealth creation
- ***Social Infrastructure*** - healthcare/education, local services and facilities, leisure and retail must be clustered together to create natural local centres within walking distance and which enhance opportunities for social integration and interaction
- ***Transport and Movement*** - the creation of a hierarchy within the design that encourages walking and cycling and use of public transport rather than a default to the private car and which supports access to employment, education, services and aids connectivity and social cohesion

Transport and Movement

- Transport, access and movement must be planned with the following hierarchy:
  1. Walking
  2. Cycling
  3. Public transport
  4. Rail
  5. Private cars, taxis and motorcycles.
- Facilities for those on foot or cycle must be provided in new developments and supported in existing neighbourhoods such as benches, cycle parking and adequate signage.
- Connectivity and safe, well lit, routes between neighbourhoods, local services and schools must be provided for new developments.

Social Infrastructure

- Healthcare, leisure, playing pitches, local services and retail must be clustered together into nodes with adequate public transport connections in local centres identified in the Local Plan.
- Local services, social infrastructure and local facilities must be provided in the first phases of development to establish a sense of community.
- The public realm must be high quality, benefit from natural surveillance and be means to connecting communities to each other and to facilities.
- Developments above a threshold of 100 units must demonstrate that there are local services and access to community facilities within 400-800 m (or 5-10 minutes walk) or that these will be created.

Economy

- New developments must ensure that there is access to good links to employment opportunities and that these are integrated into mixed-use areas wherever possible.
- New employment sites must be well connected to the walking and cycling network and the public transport system.
- New developments must take the opportunity to employ local labour and provide training and skills through their construction.
- Local and town centres should be supported to ensure that the local population can be served, with an emphasis on local centres providing for community needs.
- Flexibility should be built-in to new local centres to allow change of use to commercial over time.

Green Infrastructure

- New developments must protect, enhance and create multi-functional green-blue infrastructure to support human and natural life contributing to combatting the urban heat island effect, tackling air pollution, improving water quality and reducing flood risk. In providing green infrastructure, which should constitute 40% of the developable area the following hierarchy must be observed:

1. Habitats and Ecology
2. Flood and Water Management, and Air Quality
3. Access Recreation and Movement
4. Play and Education
5. Amenity and Landscaping

Local food provision and sports facilities are to be allocated separately.

Healthy Food Choices

- New developments must provide adequate opportunity for local food production either through the provision of private gardens, communal spaces or where there is a lack of provision identified.
- The establishment of hot-food takeways will be controlled in areas of over-concentration and where close to schools.
- The change of use of existing buildings to facilitate innovative approaches to local food production and distribution will be actively supported.
- Developments above a threshold of 100 units must demonstrate that there are local services and access to healthy food choices within 400-800 m (or 5-10 minutes walk).

Placemaking

- New developments must provide a legible and permeable environment that is easily understood and has clear signage and wayfinding*.
- Existing neighbourhoods and the historic environment must be conserved to ensure that local landmarks and key buildings and features can be used to orientate and be familiar*.
- Public spaces, streets and greenspaces must benefit from natural surveillance with a lack of clutter*.
- Car parking is to be accomodated in such a way so it does not interfere with walking and cycling*.
- The density of development must support good access to shops and services within 400-800m (or 5-10 minutes walk)*.

* Denotes measures that support a Dementia Friendly Environment

Influencing the Local Plan

During the HNT timeframes, detailed work has been undertaken by the council on its emerging Local Plan, underpinned by a health and wellbeing policy, which is due to be examined in 2020. This is a key milestone for Darlington, and may set the strategic framework for developments within the borough for the next 20 years and more. The Local Plan includes specific reference to the improvement of health and wellbeing plan including integrating the 6 design principles within it - setting the bar high for improving the quality of design in future developments.

Health and Wellbeing - influencing masterplans

Developers have been very open to integrating the HNT design principles into their masterplans for the sites and can see the added value of creating health enabling neighbourhoods that are attractive places within which to live. If Darlington can show that good quality design and development in this way is viable - both from the Keepmoat early example and future bigger developments, it helps to build the case for this as a way of working.

It is hoped that the Local Plan can become an exemplar that influences not just Darlington but has wider impact with other local authorities in their planning work. The development sites themselves over time will show just what is possible by joint working in this way and embracing the principles.

Integrating with health

Dr Ian Briggs
JSR Management and Consulting Services

There has been early sharing of these plans with health colleagues to start the discussions on the implications for health demand and impact on health providers to inform their longer term planning. This is a much more integrated approach than has previously been the case with developers who are keen to understand the likely requirements that could be incorporated into masterplans ensuring appropriate access to services as populations develop over a long timeframe. One way the HNT project has sought to help with improved predicting and forecasting of need, has been to work with Durham University on a predictive model that can be used to model the impact of different growth scenarios - reflecting either a change in model of care, demographics or housing expansion on primary care provision.

Council Leading by Example

The council has also led by example in improving its own council stock. As part of the regeneration work at Red Hall some of the older housing stock was demolished and new houses were built in their place. These are built to a new design and offer better lifetime home principles/mobility standards than has been the case in the past. This improved accomodation has been received very well by residents and it certainly allows much more flexibility, being adaptable to changing needs and keeping people independent in their own homes for as long as possible.

In addition the council has invested significantly in refurbishing its other council owned houses in the area too, improving the look, feel and energy efficiency of the homes to make them cheaper to run and more attractive for residents.

The council now has a major council house expansion programme planned for the next 10 years with 1000 additional houses planned, the majority of which will build on residents' experience and will use the same high quality design. It is important that the council meets the same high standard in terms of modern housing that supports independence and wellbeing.

Example of new houses at Red Hall, Darlington

Contributing to National Learning - influencing policy

National Health Service: England, as a result of its HNT programme nationally and the experience of the demonstrator sites, has established a national developer network and aims to create a Healthy New Town Standard including a **Homes Quality Mark** that is awarded to places that meet the higher standards of design that promote health and wellbeing within the built environment. The work of demonstrator sites, like Darlington, has directly influenced these future plans and has recognised that other wider factors impact on health and wellbeing beyond the delivery of health and care services. The call for 'Garden Community' applications, the upcoming Housing White Paper and the revision of the National Planning Policy Framework are also recognising the value of place making. NHSE has published *'Putting Health into Practice'* - a document that collates learning from across the HNT Programme and all demonstrator sites, in order to help other areas learn about best practice and how to create healthier places - truly recognising the value of place making in improving population health.

Extract from: The NHS Long Term Plan

Appendix: How the NHS Long Term Plan supports wider social goals

Health and the environment

16. Looking beyond healthcare provision, the NHS has a wider role to play in influencing the shape of local communities. Through the Healthy New Towns programme, the NHS is playing a leading role in shaping the future of the built environment. In spring 2019 we will set out the principles and practice for Putting Health into Place guidelines for how local communities should plan and design a healthy built environment. These have been developed with a network of 12 housing developers who are committed to developing homes that fit these principles. This covers approximately 70,000 homes over the next 5 years. In 2019/20, NHS England will build on this by working with government to develop a Healthy New Towns Standard, including a Healthy Homes Quality Mark to be awarded to places that meet the high standards and principles that promote health and wellbeing. Embedding these principles within local planning guidance would ensure all future developments have a focus on design that support prevention and wellbeing.

Chapter 3
Community Asset Building

Creating healthy communities however, is not just about the built environment, it is very much about the people that live within those neighbourhoods and what they can do to support themselves and others in their communities to become more self-reliant, resilient, to raise aspirations and take advantage of opportunities.

Where did we focus?

The community development work within the HNT Programme has focused on an existing challenged area in the eastern fringe of the town, known as Red Hall. Three factors came together that made it an obvious focal point for this initial work through HNT:

- The identified need for regeneration and renewal of this community.
- The opportunities that the development of the eastern side of the town, with Red Hall at its heart, would bring. As well as the local Keepmoat development neighbouring the existing Red Hall community, there are draft longer term plans within the Local Plan for significant developments to the surrounding areas. This could provide opportunities including additional employment prospects for the existing Red Hall community which has traditionally been isolated on the edge of town.
- The obvious need to address long standing health and social inequalities that were so evident in the area.

Sarah Small
Community Activities Coordinator
Darlington Borough Council

The council and partners have sought to work from the grass roots up through the development of a Neighbourhood Renewal Strategy, Regeneration Programme and Masterplan all aligned to focus resources on both place and people to address:

- fuel poverty and energy efficiency of houses;
- image and reputation;
- improvements to housing and infrastructure within the area;
- opportunities for social interaction; and
- a sense of community and resilience.

The key objective of HNT in respect of community development was to provide an opportunity to try out ideas which, if successful, could be rolled out elsewhere in the borough. One of the mechanisms used initially to co-ordinate the work of partners working in Red Hall has been the Liaison Group including: a variety of council services, local councillors, Red Hall residents representatives, Department for Work and Pensions (DWP), Step Forward Tees Valley, Police, YMCA, Keepmoat, Groundwork, Tees Valley Arts and local Artists, Learning and Skills, Red Hall Primary School, Darlington Partnership and Darlington Cares.

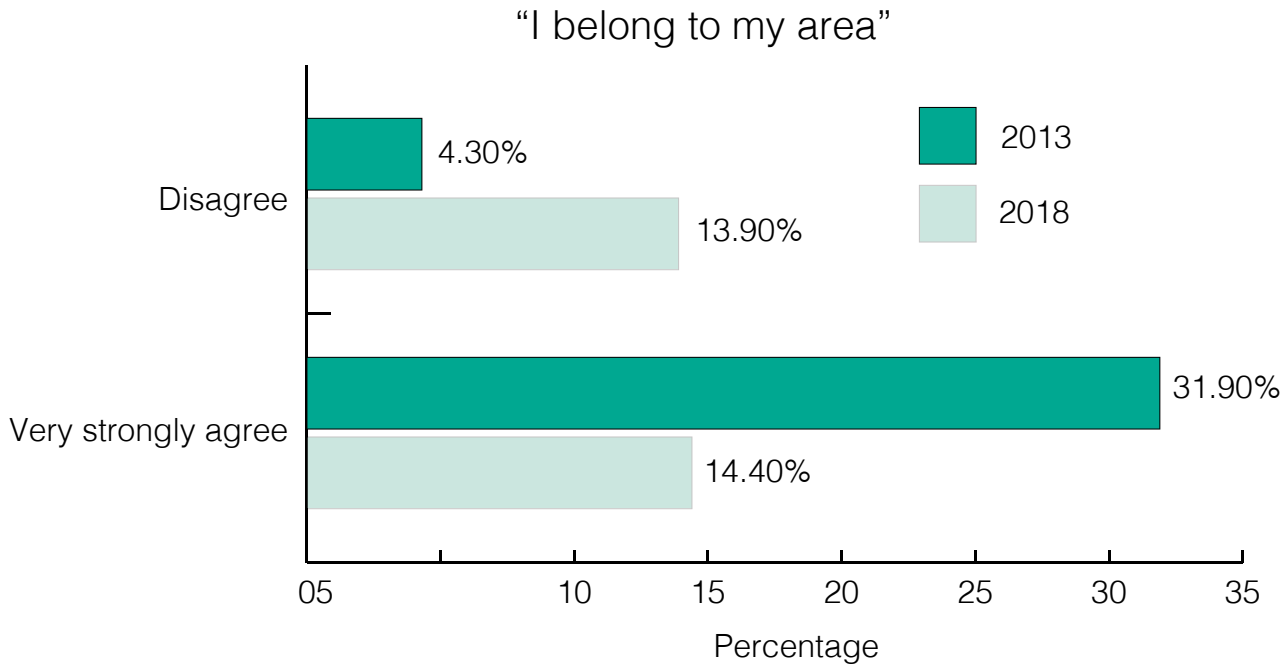
The community of Red Hall is on a journey that will take time; it is a difficult task for a community to move from a place of disengagement - to a place of trust and engagement - and then to active involvement, ownership and activation. Yet there are sure signs that this gradual evolution is taking place and the community is building its community assets and resilience. These are all a key part of a sense of health and wellbeing, a community feeling more in control and connected, with local community leadership, knowing where to access help and also how to become more self-reliant.

Smoothie bikes

Have we made a difference?

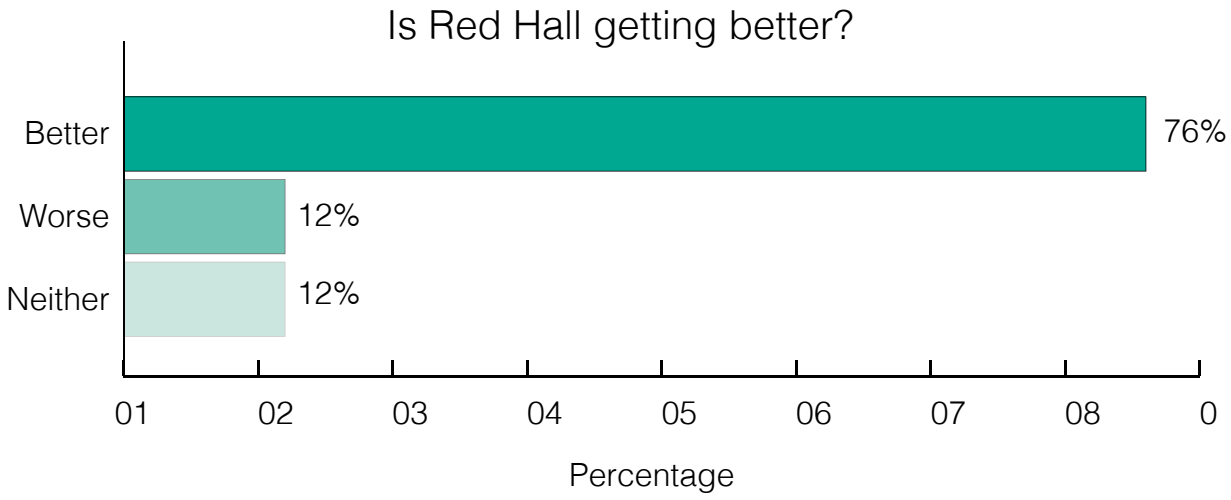
This cannot be borne out quickly through health statistics but through local survey data people are starting to report they can see a difference and Red Hall is feeling more like a community moving positively.

Within the council's community survey undertaken in January 2018 - residents at Red Hall showed an increase in the percentage who would very strongly agree that they belong to their local area compared to 2013:



Source - Darlington Borough Council Community Survey 2013 and 2018 (Red Hall ward)

- This is also borne out in figures from a survey with families at the local primary school in December 2018



Source - School Survey December 2018

It is appreciated that these are snapshots in time but it does indicate that the community is more positive about the area and the community working together which is a good indicator for social interaction, people feeling like they belong and is an important issue in terms of people's mental health and wellbeing.

A selection of images below capture some of the community activities that have taken place during the lifetime of the HNT project. These have been received well and there is a desire amongst residents for similar opportunities and activities to continue. As HNT national funding comes to an end, there continues to be investment in community development support at Red Hall. There is a priority of supporting local residents to come together to meet, plan activities and events, gain the skills and capacity to bid for external funding sources and develop local resources as these community assets will be key in providing community leadership and support over the longer term.

All ages enjoying the Summer Carnival

Getting fit through Boxercise

Legacy

The HNT project have left a legacy for Red Hall and other communities within Darlington.

A good example is the “holiday hunger” provision first started in Red Hall. This is now increasingly being rolled out to other communities in Darlington based on the experiences of what has worked well at Red Hall. Over the last two years similar holiday club experiences have been delivered to three other areas within Darlington combining not only the provision of healthy food to children that ordinarily would access free school meals during term time but also an extensive range of activities that have encouraged exercise, team work, social interaction and stimulation all in a fun way.

The feedback from both children and parents has universally been very positive and genuinely appears to fulfil a need not just in healthy eating but in opportunities for social interaction and growth that has a positive impact on the whole family.

Darlington Borough Council and partners are trying to build on these early successes to attract funding to expand this kind of provision. Through Darlington Cares, additional initiatives are being supported, harnessing resources and support from within the wider Darlington community, acting together to support this work.

Equally, building on an initiative offering free access to exercise opportunities within the community and support for “Bikeability” within the local primary school, further support will be going into the school to support children to access exercise and life skill acquisition opportunities such as cycling and swimming. This ensures that when the children are offered council provided lessons they are in fact familiar with and confident enough to take advantage of those opportunities. This has often not been the case in the past and can hold children back. These are just some of the ways that the project has been attempting to tackle social inequalities issues.

The HNT project has been committed to a community asset building approach which recognises the people in the community as key resources and assets to support that community develop and grow, building both the resilience and aspirations of its residents for the future. Local ownership is absolutely key and cannot be rushed.

Efforts have gone into trying to support residents develop their own group that can take greater ownership of community development. Indeed various community events, increasingly led by members of the community, have taken place. However, it has to be acknowledged that community development and activation takes time and must be supported from the grass roots up.

In understanding this, community development support will continue to work alongside residents beyond the timeframes of HNT to build confidence, ability and capacity to be able to plan, organise and deliver activities and events by themselves and for themselves going forward. Local residents are showing considerable enthusiasm for this approach.

Spreading the Learning

HNT impact is not just seen at Red Hall but the experiences and knowledge gained through the HNT project has helped to feed into wider borough discussions about priorities for resources going forward. This has included how, by working collectively together through the Darlington Partnership, we can support more challenged communities.

Chapter 4
New Models of Care

Dr Amanda Riley
Chief Executive
Primary Healthcare Darlington
and Clinical Director of the
Darlington Primary Care Network

As well as influencing the built environment and community development, the HNT project has also included partnership working with local health and care organisations to co-design a new model of care for Darlington that is genuinely owned by stakeholders.

At the outset of HNT there had been some work done to describe new ways of working with a well-attended conference taking place in 2015 across the health, care and wider third sector community, outlining a direction of travel. There was a desire for a more integrated way of working but the challenge was how to overcome some of the key barriers facing the health and care system, and how to start to realise a better, more joined up way of working on the ground.

Various strands of work have been taken forward during the lifetime of HNT.

Rebecca Thomas
Commissioning Manager
NHS South Tees CCG

Developing Primary Care

It has been recognised both locally and nationally that primary care should be at the heart of any new care model. Primary care are the gatekeepers often into the rest of the system and know their registered populations well. However, we face a shortage of GPs as well as other care staff in the UK. An increasing demand for health and care services, changing demographics including an ageing population, the presentation of many more people with multiple long term conditions that require a different approach and the development of new technology means more is possible.

Graeme Earl
Business Management Lead
NHS South Tees CCG

There is also an increasing understanding of the importance of patient education, taking a greater ownership in their care, making self-management easier and providing more convenience for patients.

In Darlington, over the last 3 years there has been a growing acknowledgement that primary care needs to be more resilient, be able to achieve economies of scale through working together and ensure we make the best use of limited resources and skills.

Increasingly across the UK, primary care has been starting to work together to better provide for population level management - typically across populations of 30-50,000 working together 'at scale'.

Darlington has been on this journey and the HNT programme supported practices to work together as virtual 'hubs' with an increasing number of initiatives being taken forward at this level. Public health-led needs analysis has developed health profiles for the various hub populations which will help to inform what services are required to be delivered locally at GP practice and hub level and which need to be delivered once at a Darlington level. Good, strong working relationships are key to this way of working. It takes time to develop but the Darlington primary care system is well placed to develop as a Primary Care Network in line with the NHS Long Term Plan.

Integrated Delivery

The development of a new model of care across partners including primary, community, social care and mental health is also providing opportunities to streamline workforce as integration brings the chance to do things once but better, reduce duplication and re-assess how staff are deployed. An early example of this more proactive way of planning and delivering care is the introduction of frailty multi-disciplinary teams and the care home service, which are already having an impact on hospital admissions and the need for unscheduled care.

The introduction of "Wellbeing Navigators" will also help to provide far more holistic care directing patients to a wide range of both formal and informal support that better meet their overall needs. This includes helping to reduce social isolation and loneliness rather than relying on a medical model of delivery. This reinforces that there are wider determinants of health that impact on health over and above the delivery of direct healthcare.

Supporting self-management, choice, convenience and control

Progress has been made with self-management initiatives including achieving some of the best on-line consultation uptake rates in the North East. This has proven to be very popular with patients offering convenience and choice in how they interact with their GP practice staff.

E-consultations

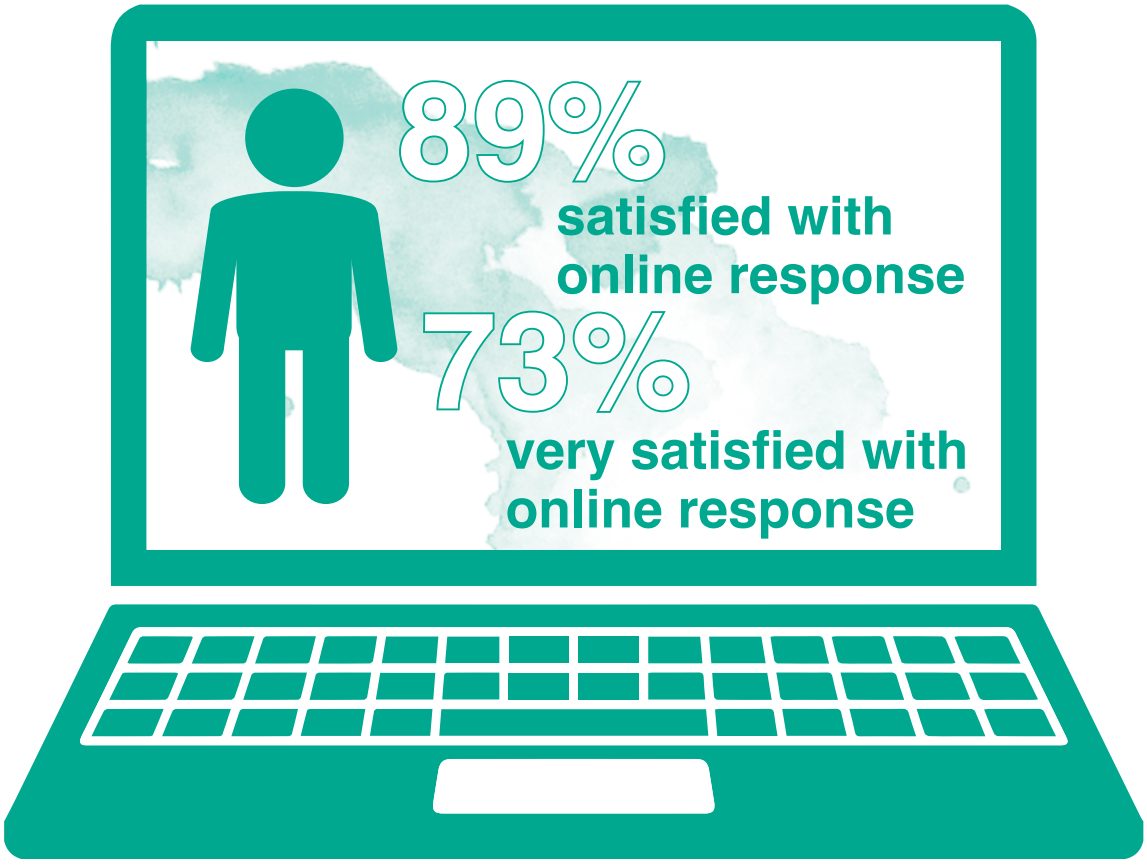
A few quotes from patients are included here which are typical of the feedback received to date:

"It was very convenient for me as a mum of 2 young children to do at home, outside of surgery opening times and I felt that I wasn't wasting the surgery's time as they were able to assess my needs and direct me to appropriate care"

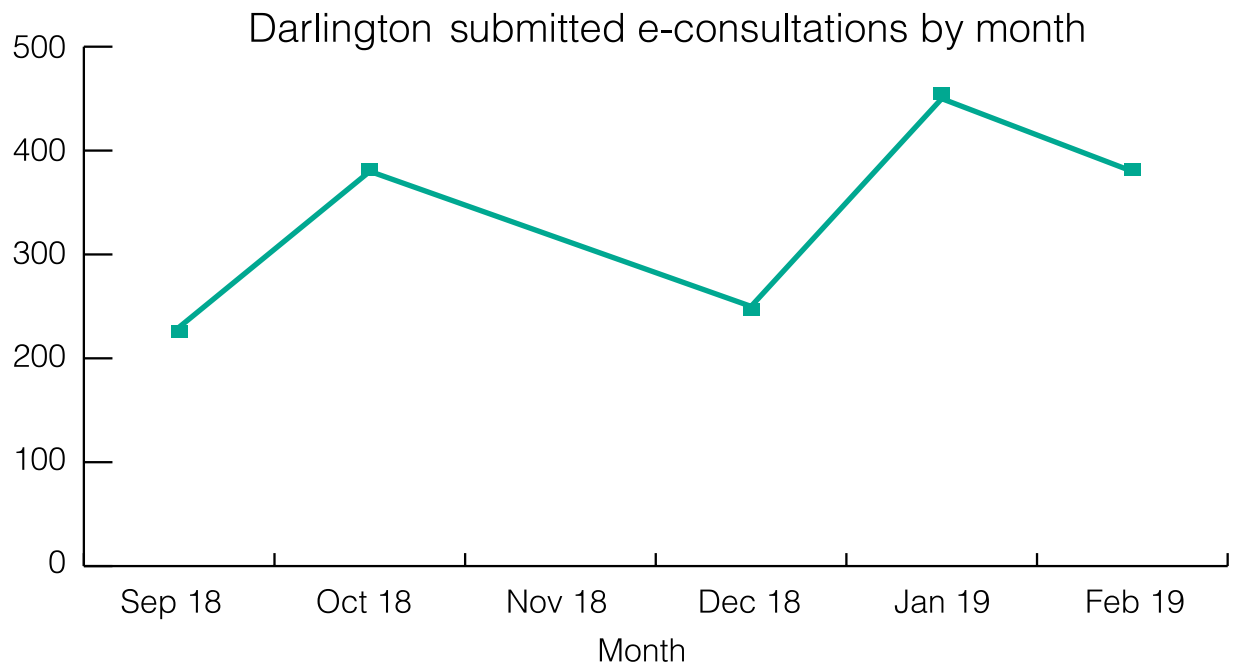
"I didn't need to take any time off work or travel to the surgery. Response was very quick and my question was fully answered"

"I think this is an excellent alternative to seeing a GP. Sometimes you don't want to take up a GP's time and know the solution is simple but previously the only quick way is to contact a GP"

The diagram overleaf shows the uptake in on-line consultations in a six month period and the upward trend. Primary care staff as well as patients gave positive feedback about how this form of consultation makes excellent use of clinical and administrative time whilst still dealing appropriately with the patient's concern. 89% of patients giving feedback in the first 6 months were satisfied with the response to their on-line request - of these 73% were very satisfied.



Darlington online consultations trend since launch Sept 2018



The start of behavioural health coaching for front line staff is helping them support patients, particularly with long term conditions, to better self-manage and take more personal control of their condition. Personalisation, integration and more upstream intervention are key goals for the new model of care work across Darlington, which HNT has helped to support.

Brynn Sage
Chief Executive
Inhealthcare

Digital Enabling

The HNT project started from the premise that we use digital means of support every day in most areas of our lives and yet we don't always harness the advantages of these in delivering healthcare and keeping patients informed and monitored. The key issue in addressing this is the ability to be able to exchange information quickly, securely and efficiently between patient and care professional and between staff groups.

The HNT programme has been instrumental in testing out the technology that can support a secure, clinically-led digital information exchange by working across different care boundaries. Through this work, Darlington partners understand how to streamline clinical pathways and importantly, give control back to residents and patients.

Ian Dove
Business Development Manager
County Durham and Darlington
NHS Foundation Trust

Evidence suggests that an informed and empowered person is far more likely to comply with their care plan and more likely to self-care, whilst knowing they have the back-up of professional support and that they can access information and support in a time and way convenient to them.

Increasingly we need to understand how we can use this technology to intervene and offer support further upstream and prevent health deterioration in the first place.

In the last two years since May 2017 there have been over 10,000 patients using digital health services in Darlington, over 140,000 interactions and over 30,000 appointments have been saved freeing up both staff and patient time, often by enabling the staff member and patient to interact remotely. This provides a much more convenient service with the patient choosing when and how to send information to the clinician to review. Where digital remote monitoring is available, for example in the anti-coagulation clinic at Darlington, staff have ongoing data available about the patient's condition, not having to rely on the patient's next presentation at clinic and self-reporting. In the pilot period for this service 71% of patients improved the time they spent in the right therapeutic range so 'digital' has good indications for improving clinical safety. It is also popular with the patients using the service, maintaining their independence out in the community, safe in the knowledge that monitoring is taking place.

over 10,000

Patients using digital health services in Darlington

over 140,000

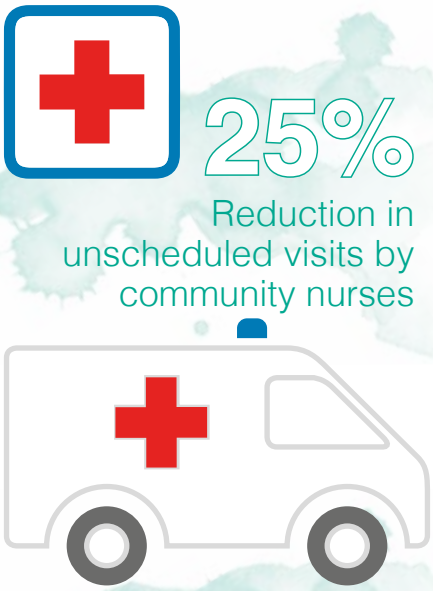
interactions &

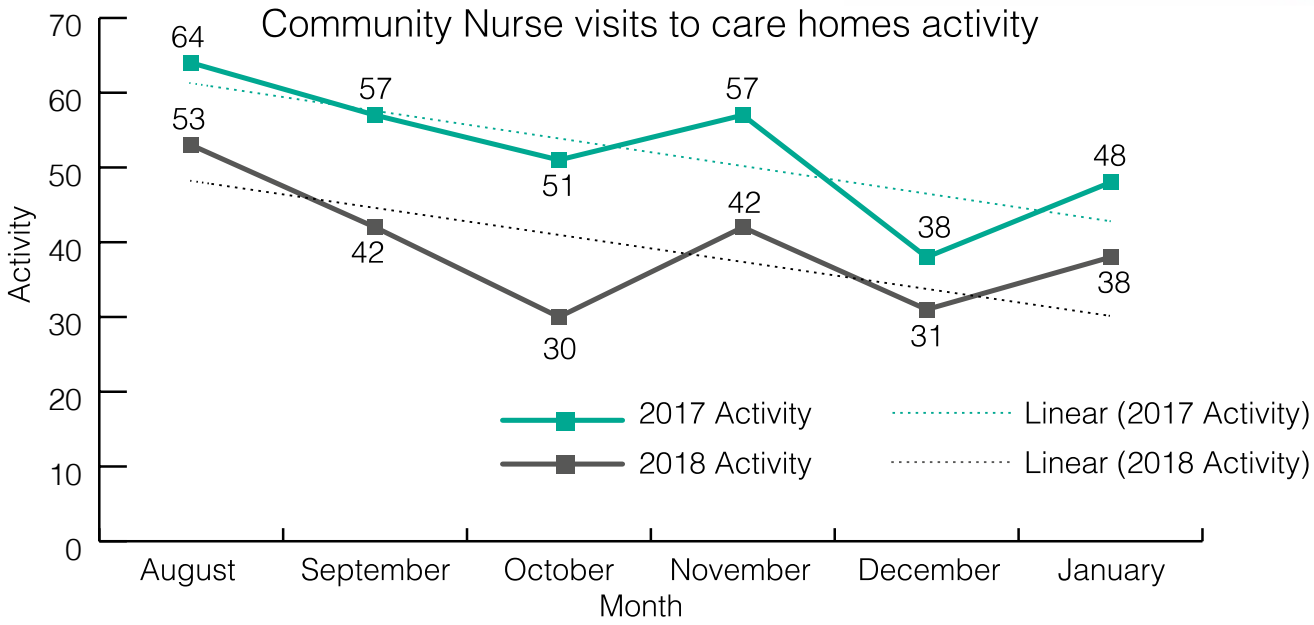
over 30,000

appointments saved

Care Homes

Importantly, digital is supporting new models of care work around integration and maintaining people in their own homes. The results look to be very promising - for example recently a digital e-referral service has been introduced to care homes in the Darlington area, connecting care homes more directly into the community nurse teams. Based on positive feedback and results this service is set to be rolled out across Darlington during 2019/20. In a 'pilot' care home - there has been a 25% reduction in unscheduled visits by community nurses (shown in the diagram below) and 31% reduction in hospital admissions over 6 months (during the hours of operation). Staff are feeling much more supported, this is maintaining residents in their own home, reducing pressure on acute services and reducing unscheduled care.





'Pilot' Care Home reducing unscheduled community nurse visits

HNT Darlington has provided leadership, vision and steer to the now emerging digital network and infrastructure to support the wide-scale implementation of digital pathways across the North East.

Chapter 5
Lessons from Darlington: Healthy New Towns - Evaluation

Dr Victoria Mcgowan
Author of the Evaluation Report

The Darlington collaboration of local organisations selected an academic partner, FUSE: The Centre for Translational Research in Public Health in partnership with the five North East Universities.

The evaluation design brief emphasised that a systems change evaluation was appropriate for monitoring complex change across partners from a range of sectors.

The academic partner participated fully in the programme (2017-2019) and the full evaluation report is available on the Council website. The evaluation recognises the complexity and ambition of the programme.

A number of the English Healthy New Town sites (including Darlington) with academic partners, have submitted a bid for funding for a longitudinal study to monitor changes over a longer period of time.

fuse The Centre for Translational Research in Public Health

Newcastle University

Darlington Healthy New Towns Evaluation - Key Messages

Despite numerous challenges during the development and implementation of the Healthy New Town (HNT) programme in Darlington, there is emerging evidence to suggest the initiative is on a journey to improve health outcomes over the longer term.

The programme has facilitated the development of new, and maintenance of existing, partnerships both within Darlington and the wider Tees Valley region which have been fundamental in attracting extra resources to further HNT work.

These partnerships have benefited from the creation of new spaces which have allowed stakeholders to develop innovative new ideas, reflect on emerging findings and adapt the programme accordingly. They have identified key trusted assets at the community level to continue building capacity among residents in Red Hall.

The HNT programme has perhaps been most successful in developing a learning space, although not protected from outside elements, the initiative has allowed stakeholders to develop new ideas, and work through a process of testing, learning, and adapting.

These spaces, for example, have facilitated a cultural shift among GP practices in the area to begin working at scale and in more integrated ways with wider health and social care partners through Primary Care Networks.

Moreover, a significant outcome of the programme has been the inclusion of HNT design principles in the draft local plan for Darlington which, if accepted at examination, will embed health within local policy.

Although the HNT programme has acted as a catalyst to accelerate ideas and innovations that were percolating before the HNT programme was announced, there is a risk that the dissolution of these spaces post-March 2019 will lead to stakeholders falling back into silo working due to existing work commitments. The HNT programme has provided resources and spaces for working collaboratively which should be maintained to ensure the journey to health improvements is realised.

The HNT programme has begun a journey starting from partnership and cross-organisation working, creation of new spaces, and attracting extra resources to facilitate improvements in health outcomes over the longer term.

Key points:

Overall the programme has provided a catalyst for change and facilitated partnership working to take action on the wider determinants of health. However, maintaining these partnerships beyond the life of HNT funding will require strategic leadership and resources to facilitate these positive collaborative networks and ensure the programme achieves the longer-term goals of a more prosperous, healthier, and equitable borough.

The programme acted as a catalyst to push forward innovative ideas that may not achieve clear quantitative outcomes in the short-term. Health outcomes are important, but they lie at the end of a complex causal pathway and may not manifest for some time.

Identifying intermediate factors that are associated with improvements in health and monitor alongside population health profiles were important. Factors such as community cohesion, perceptions of safety, increased employment, and educational outcomes may provide proxy outcomes that are strongly associated with longer term improvements in health.

Sharing learning from Darlington Healthy New Towns

A key aim of the national programme was that the ten pilot sites would share the experiences and learning throughout the programme.

Darlington contributed significantly throughout the three years, presenting and sharing system learning including:

- Presentation at conferences -

  Housing;

  Public Health;

  Town Planners;

  Communities and Local Government

  NHS events;

  Digital Technology events.
- Local stakeholder events were held each year to involve the range of wider partners across sectors, organisations and communities.

Putting Health into Place

Darlington HNT programme contributed to the learning from the full, English Healthy New Towns programme. A publication, "**Putting Health Into Place**" collates the learning from the programme, published as four documents:

- Executive Summary;
- Plan, Assess and Involve;
- Design, Deliver and Manage;
- Develop and Provide Healthcare.

"Putting Health into Place" (PHiP) is based on the learning of the ten sites and was produced by NHS England, The King's Fund, Public Health England, the Town and Country Planning Association and The Young Foundation.

www.england.nhs.uk/ourwork/innovation/healthy-new-towns

Case Study: Design Principles

From design principles to policy

Like many places, the Borough of Darlington has an ageing population and increasing health inequalities. To address this the council worked with a number of partners and external agencies during 2017 to include six Healthy New Towns design principles in the new Local Plan, these covered;

- Green infrastructure;
- Healthy food choices;
- Placemaking;
- Economy;
- Social infrastructure;
- Transport and movement;

The principles provide a framework against which planning applications will be assessed and have been used across the borough in planning and development management[1].

Applying the principles has been challenging where viability is marginal (value generated by the development is more than the cost of developing it), but they produced an early win: Keepmoat Homes used the principles in their design and access statement to support the planning application for the Red Hall Fairway development, demonstrating their real-world application.

[1] https://www.darlington.gov.uk/health-and-social-care/healthy-new-towns/

Case Study: Primary Care at Scale

Developing 'primary care at scale'

Darlington has strengthened primary and community care by clustering 11 local GP practices into three virtual hubs, each covering a population of between 30,000 and 50,000.

The hubs are working towards developing a Primary Care Network which will span the population of Darlington. In each hub, practices will work with other health and social care professionals to develop new services and pathways.

The hubs also provide a platform for working together on workforce development and technology, and for sharing premises, back office and other resources.

The hubs build on a strong history of partnership working in Darlington and a vision created through dialogue with all partners, including listening to patients about what is important to them.

Tangible changes made so far as a result of the development of primary care hubs, include giving people extended access to GP services outside core hours, seven days a week (delivered by the local GP federation from one centrally located hub), and trialling online consultations in eight of the 11 practices.

Furthermore community services have been re-procured in order to wrap teams around the needs of neighbouring populations.

Case Study: Digital Technology

Using digital technology to support self-management

Health and wellbeing services in Darlington have used digital technologies to collect clinical data remotely, avoiding the need for patients to attend an appointment. This was successfully trialled with patients taking warfarin (often prescribed to people at risk of developing a blood clot) and those at risk of malnutrition and under a dietician's care.

Anyone taking warfarin needs to have their INR levels tested regularly. INR - international normalised ratio - is the standardised measurement of the time it takes for blood to clot. In Darlington a digitally enabled INR pathway places the monitoring of INR levels in the hands of the patient through a digital device that remotely reports back to the primary care provider.

This change has had two primary impacts:

- Empowering patients to take control of their own health outcomes. This has resulted in more people keeping their INR levels within safe limits, and the risk of stroke decreasing.
- Reducing pressure on primary care by avoiding the need for frequent check-ups in general practice.

Implementing the new approach to INR testing and other digitally enabled pathways has exposed several potential barriers to change, including challenges associated with linking up IT systems across the different organisations involved. One of Darlington's core principles has been the use of open platforms based on national interoperability standards to allow data to be moved between different systems used by health and care providers. This supports better integration across organisations and more patient-centred care.

Key successes reported across the digital projects in Darlington include:

- patients feeling better supported and cared for
- improved clinical capacity due to improved triaging of patients and ability to plan caseloads
- patients meeting their goals more quickly
- improved self-management.

Patients using the digital INR pathway have said they value the freedom, control and knowledge they have gained regarding their condition.

Case Study: Landscape Architect

Ian Prescott
Land and Partnership Director
Keepmoat Homes

Long Term Benefits of Healthy New Towns

Long Term Benefits of Healthy New Towns encompass a range of elements which can be created through the landscape design of residential developments. When a client agrees to support the landscape design consultants, alongside other environmental professionals, such as ecologists, and promote these disciplines, Landscape Architects can work alongside other built environment professionals such as architects, engineers and transport planners to provide solutions to problems which offer an holistic response to problems. Direct long term benefits of Healthy New Town design include:

- High quality and attractive streetscapes - space for trees and verges as well as consideration of the sense of place which will result
- When a streetscape is attractive, it tends to be well used and therefore well activated . As a result it feels safe and residents enjoy it as their own.
- When residents feel safe and populate a space they take pride in it, don't drop litter, children are raised to value their environments and a healthy cycle of respect begins.
- Safe and enjoyable spaces are well used. When spaces are well used, people meet and a real sense of community begins to develop - families with children in the play spaces, choosing to walk to school or the shops through safe and active streets, residents get fresh air and exercise improving both physical and mental health.
- Opportunities to meet result in conversations, a sense of being rooted in a neighbourhood and a real community develops.

As Landscape Architects we have noticed that Keepmoat encourage early inclusion of our skills within their design teams, when considering a development. They also support the principles of sustainable design and encourage the landscape consultants to take an active and early role in guiding the design of residential development.

Southern Green, Landscape Institute Award Winners

DARLINGTON BOROUGH COUNCIL

Designed and produced by Central Shared Services Design & Print cas0012

HEALTH AND WELL BEING BOARD
28 NOVEMBER 2019

BETTER CARE FUND 2019/20: FOR INFORMATION

SUMMARY REPORT

Purpose of the Report

(a) To update Board members on the 2019/20 Darlington Better Care Fund Plan submission

(b) To update Board members of BCF plans beyond the current period.

Summary

1. The Better Care Fund (BCF) is a programme spanning both the NHS and Local Government which seeks to join-up health and care services so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible. It brings together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, and funding paid directly to local government, including the Disabled Facilities Grant (DFG), the improved Better Care Fund (iBCF) and the Winter Pressures grant.

2. As reported to the Board in January 2019, the 2019/20 plan continues with the seven broad workstreams to support the delivery of the BCF priorities in the areas of:

   (a) Improving healthcare services to Care Homes

   (b) Equipping people to be resilient and self-reliant through Primary Prevention/Early intervention, and Care Navigation

   (c) Intermediate Care and improvements to reablement and rehabilitation services; further

   (d) Improving Transfers of Care through the implementation of the High Impact Change Model

   (e) New models of care and personalisation of services including through technology and domiciliary care

   (f) Supporting carers and delivering DFG adaptations

   (g) Improving Dementia Diagnosis and post diagnosis support

3. The planning guidance for 2019/20 was published on 18th July 2019, with a final submission date of 27th September following approval by Local Health and Wellbeing Boards.

4. Following regional scrutiny of all BCF plans, it is expected that approval letters will be issued during December 2019.

5. As expected, publication of the guidance confirmed there were no major changes to the requirements for 2019/20 from 2017/19. This includes:

    - the 4 national conditions remain:
        - NC1: Jointly Agree Plan
        - NC2: Social Care Maintenance
        - NC3: NHS Commissioned out of hospital services
        - NC4: Implementation of the HICM Model for Managing Transfers of Care.

6. A breakdown of the funding package that makes up the BCF is below:

Funding Source	**Income**
DFG	£937, 154
Minimum CCG Contribution	£7,856,365
iBCF	£3,855,005
Winter Pressures	£501,172
Total	**£13,149,696**

The format of the 2019/20 template includes both in year allocations for DFG and Winter Pressures; whilst iBCF funding is shown for the lifetime of the scheme.

7. Confirmation is currently awaited on the future of BCF funding beyond the current period. It is not expected that this will be confirmed until early 2020.

8. In preparation for this an options exercise is currently underway across both CCG and the Local Authority based on a number of scenarios across all funded schemes.

Recommendation

9. It is recommended that:-

    (a) HWBB note the submission of the 2019/20 plan and expected timescales for approval
    (b) Note the current position in respect of BCF for 2020/21

Reasons

10. The recommendations are supported by the following reasons:-

    (a) The current year of the BCF plan is a continuation of previous years with the programme delivering well against the required metrics
    (b) Quarterly submissions will continue to be reported and submitted highlighting progress

Suzanne Joyner
Director of Children and Adults Services

Background Papers

Darlington Better Care Fund 2019/20 submission available on request

Paul Neil
Programme Manager
Darlington Borough Council
01325405960

S17 Crime and Disorder	There are no implications arising from this report.
Health and Well Being	The Better Care Fund is owned by the Health and Wellbeing Board.
Carbon Impact and Climate Change	There are no implications arising from this report.
Diversity	There are no implications arising from this report.
Wards Affected	All
Groups Affected	Frail elderly people at risk of admission/re-admission to hospital
Budget and Policy Framework	Budgets pooled through section 75 agreement between DBC and Darlington CCG
Key Decision	No
Urgent Decision	No
One Darlington: Perfectly Placed	Aligned
Efficiency	New Ways of Delivering Care
Implications for Looked After Children and Care Leavers	No impact

MAIN REPORT

Information and Analysis

11. The BCF metrics continue as in previous years with a supporting narrative setting out the overall plan in achieving or maintaining expected levels. These are detailed in the submission, but in summary:

    (a) Non-Elective admissions: NEA in the CCG Operating Plan was set by taking an agreed baseline and adjusting in line with predicted demand. Further adjustments were made for capacity and workforce planning, BCF/Efficiency scheme adjustments and the profile was adjusted for seasonal fluctuations. For Darlington CCG the baseline growth for 2019/20 was 5.8%, however net growth for NEA, which was submitted in the operating plan, was 3.4%. A

number of the 2019/20 BCF funded schemes will support the reduction of NEA

(b) Delayed Transfers of Care: performance continues to be very strong. Winter Pressures funding will be used to ensure performance continues during the seasonal pressures

(c) Residential Admissions: the reduction in rates to residential care continues to be supported by ongoing investment in maximising independence to enable people to live in the community. This is enabled by a range of provisions, including increased reablement capacity

(d) Reablement: The proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation services continues to be set at 84%, current performance being 79%. However, the recent transformation of the reablement pathway will apply clear criteria for accessing reablement which will have a positive impact on this indicator

Outcome of Consultation

12. The BCF Plan for 2019/20 has been discussed and agreed with partners across Health and Social Care and approved outside of a formal Board meeting, by the Chair and Vice Chair. Given this is a continuation year for the fund, there were no major issues raised.

HEALTH AND WELL BEING BOARD
28 NOVEMBER 2019

CARERS UPDATE

SUMMARY REPORT

Purpose of the Report

1. To provide information about carers in Darlington and an update on Darlington's Carers' Action Plan 2018 - 20.

Summary

2. The 2011 census identifies 11,048 carers in Darlington, 2758 (25%) of whom are providing care for 50 or more hours per week. 197 of these were aged 0-15 and the largest group of carers (37%) is those aged 50-64.

3. Darlington Carers' Strategy Steering Group (CSSG) has developed a Darlington Carers' Action Plan in response to the national Carers Action Plan which was published in June 2018. Darlington Carers' Action Plan is attached as Appendix 1.

Recommendation

4. It is recommended that:-

   (a) Members note the content of this report
   (b) Members act as champions for carers in Darlington and consider how to support progress of the carers' agenda in Darlington

Reasons

5. The recommendations are supported by the following reasons :-

   (a) To enable Darlington to respond to the requirements of the national Carers Action Plan

Suzanne Joyner
Director of Children and Adults Services

Background Papers

National Carers Action Plan 2018-20
Darlington Carers' Action Plan 2018-20

Lisa Holdsworth Ext 5861

S17 Crime and Disorder	There are no implications arising from this report.
Health and Well Being	Carers can experience poor health as a result of their caring responsibilities. Identifying and supporting carers contributes to supporting their health and wellbeing and the health and wellbeing of the people for whom they care.
Carbon Impact and Climate Change	There are no implications arising from this report.
Diversity	Caring affects all groups of people in Darlington
Wards Affected	All
Groups Affected	Carers are the group primarily affected
Budget and Policy Framework	N/A
Key Decision	N/A
Urgent Decision	N/A
One Darlington: Perfectly Placed	Supporting carers contributes to supporting the 'One Darlington' Healthy Darlington theme.
Efficiency	Research published by Carers UK in 2015 indicates that unpaid carers in Darlington provide support to the value of £224 million.
Impact on Looked After Children and Care Leavers	This report has no impact on Looked After Children or Care Leavers.

MAIN REPORT

Information and Analysis

6. The 2001 census identified 10,064 carers in Darlington, 2330 (23%) of whom were providing care for 50 or more hours per week.

7. By 2011, this number had increased to 11,048 of whom 2,758 (25%) were providing care for 50 or more hours per week. The largest group of carers (37%) are those aged 50-64.

Age	**Number**
0-15	197
16-24	543
25-34	915
35 -49	2807
50-64	4124
65+	2462

8. Darlington's Carers' Strategy Steering Group (CSSG) meets bi-monthly and its remit is to:

(a) lead on the development of Darlington's Carers' Strategy and Action Plan, taking into account national legislation and policy guidance and the views of local

carers, and to monitor progress on implementing it

(b) share good practice in relation to all carers, including parent carers and young carers

(c) ensure that the carer voice is heard and informs the development and delivery of support and services for carers in Darlington

9. The Group is co-chaired by Darlington Carers Support and Humankind Young Carers Service, which are commissioned jointly by the Council and Darlington CCG to provide:

(a) information, advice and guidance

(b) 1:1 support tailored to individuals' needs

(c) group activities to enable carers to meet others in similar situations and to take time out from their caring roles

(d) individual carer breaks

(e) awareness raising with health, social care and education professionals to raise the profile of all groups of carers and ways of meeting their needs

10. The national Carers Action Plan 2018-20 sets out the cross-government programme of work to support carers until 2020. It is structured around 5 themes, each of which includes a number of subheadings:

(a) Services and systems that work for carers: raising awareness of and promoting best practice amongst health professionals; raising awareness amongst social workers; supporting requirements of the 2014 Care Act and the 2014 Children and Families Act; personalisation; Mental Health Act 1983 and supporting carers.

(b) Employment and financial wellbeing: improve working practices; flexible working; returning to work; financial support.

(c) Supporting young carers: identification of young carers; improving educational opportunities and outcomes; improving access to support services; transition for young adult carers.

(d) Recognising and supporting carers in the wider community and society: technology and innovation; recognition of carers; community engagement; loneliness.

(e) Building research and evidence to improve outcomes for carers: research to improve the evidence base.

11. It should be noted that a number of these areas focus on the need to identify carers in health and community settings and in their education and workplaces, in order to be able to ensure that they are able to access the support and advice they need in a timely manner to enable them maintain their wellbeing and to manage their caring

role as effectively as possible.

12. Darlington Carers' Action Plan sets out the Darlington response to the national Carers Action Plan and identifies a number of key areas to progress:

    (a) Services and systems that work for carers including: continuation and development of work in GP surgeries to make them more carer friendly; link to the work already being undertaken by Dementia Friendly Darlington; providing access to training and development opportunities for carers; improving social work staff's awareness of carers' needs and the support available to them; continuing to enable carers to access carers breaks.

    (b) Employment and financial wellbeing including: review of access to Employers for Carers (EfC) membership for DBC employees and employees of Small and Medium Enterprises (SMEs) in Darlington; increased awareness of carers' rights and needs for employers in Darlington and individual working carers.

    (c) Supporting young carers including: continued awareness raising in schools and colleges and with health and social care professionals; review of DBC Young Carers Assessment and Young Carers Transition Assessment processes.

    (d) Recognising and supporting carers in the wider community and society including: development of carer friendly communities; widening access to the Carers Card; considering how to respond to the loneliness agenda in relation to carers; recognising and supporting hard to reach carers in Darlington.

    (e) Building research and evidence to improve outcomes for carers: considering survey outcomes and how to respond to them to improve support for carers in Darlington.

13. Members of the CSSG are currently working to deliver the actions identified. The focus of this work also reflects the need to identify carers in health and community settings and in their education and workplaces. Outcomes of this work include:

    (a) Continued awareness raising by Darlington Carers Support - a total of 457 new carers were registered from April 2018 – March 2019, 100 more than the same period the previous year.

    (b) An increase in referrals from GP surgeries to Darlington Carers Support (a total of 135 from April 2018 – March 2019).

    (c) A total 1349 carers were registered with Darlington Carers Support as at 11th November 2019.

    (d) Continued provision of a range of breaks tailored to individual need, both to people with eligible social care needs and through third sector providers with continued Better Care Fund (BCF) carer breaks funding. Commissioned Carers Support providers also offer flexible breaks to both individuals and groups.

    (e) Award of BCF carer breaks funding to widen access to the Carers Card in Darlington.

(f) Continuation of EfC membership jointly with Durham County Council. This has enabled the provision of a training session for DBC managers regarding the needs of working carers and how best to support them. Plans are also being made for the delivery of a joint session for SMEs and Health partners across County Durham and Darlington which will take place on 6th February 2020.

(g) A total of 142 young carers were supported by Humankind from 1st April 2018 – 31st March 2019. (138 of these were under 18 and 4 were aged 18-25).

(h) A total of 137 young carers were supported by Humankind from 1st April – 11th November 2019. (132 of these were under 18 and 5 were aged 18-25).

(i) As at 11th November 2019, 31 schools had achieved Young Carers Charter status. 4 more are on Amber and 5 are on Red. Work is ongoing by Humankind to encourage the remaining schools to achieve Charter status. In addition, Darlington College has also achieved Charter Status

(j) Work is ongoing to make changes to the Young Carers Assessment process with the intention that Young Carers Assessments will to be undertaken by Humankind. Discussions regarding how to implement this are in progress.

(k) Work is ongoing to develop a Young Carers Transition Assessment process.

Outcome of Consultation

14. Darlington's Carers' Strategy and Action Plan is developed and monitored by the CSSG taking into account the views of carer members of the group and the wider views of carers as relayed by the Carers Support providers.

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Darlington Carers' Action Plan 2018-20

Background

A new national Carers Action Plan 2018-20 was published by central government in June 2018. This Action Plan outlines the cross-government programme of work to support carers in England over the next two years and builds on the National Carers Strategy. It retains the strategic vision for recognising, valuing and supporting carers from 2008, which has been the vision of successive governments. It sets out the Government's commitment to supporting carers through 64 actions across five priorities emerging from the carers' Call for Evidence. The actions focus on delivery and tangible progress that can be made in the near future, and give visibility to the wide range of work that is planned or already underway across government to support carers, their families and those they care for.

The Action Plan is structured under the following headings (based on the feedback of the Call for Evidence):

- Services and systems that work for carers
- Employment and financial wellbeing
- Supporting young carers –
- Recognising and supporting carers in the wider community and society
- Building research and evidence to improve outcomes for carers

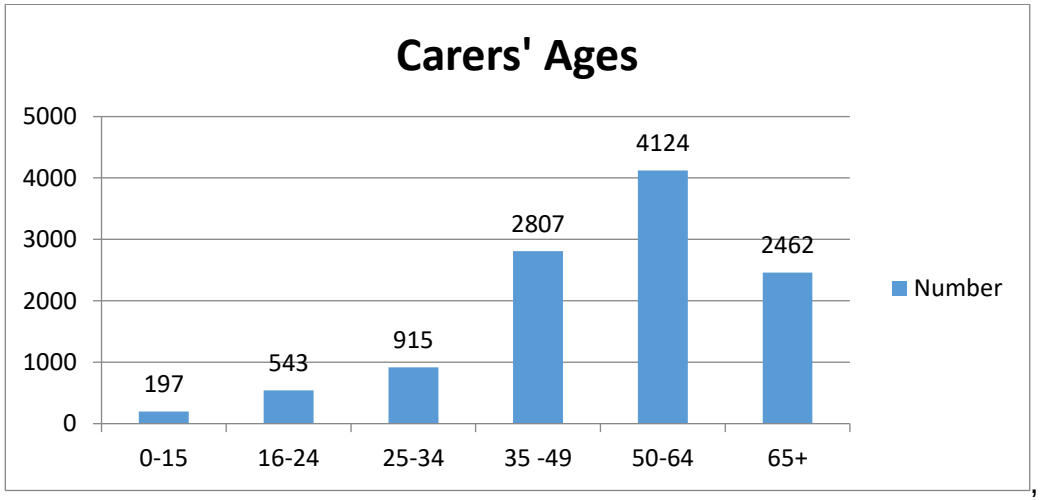
Darlington's Carers Action Plan has been developed by the Carers' Strategy Steering Group and is the localised response to the national Carers Action Plan.

Demographics

Number of carers in Darlington.

The 2011 census identified a total of 11,004 carers in Darlington.

The age breakdown is shown in the graph below.



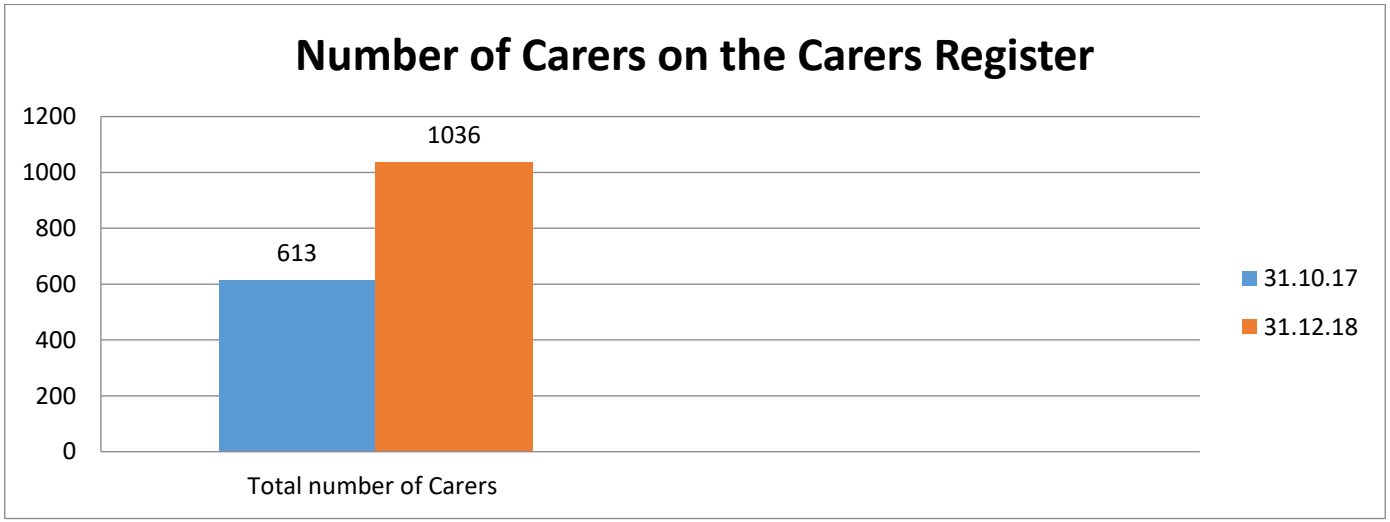
Carers Support Services in Darlington

There are 2 commissioned Carers Support Services in Darlington, one for young carers up to the age of 25 and one for adult carers, including parents of disabled children.

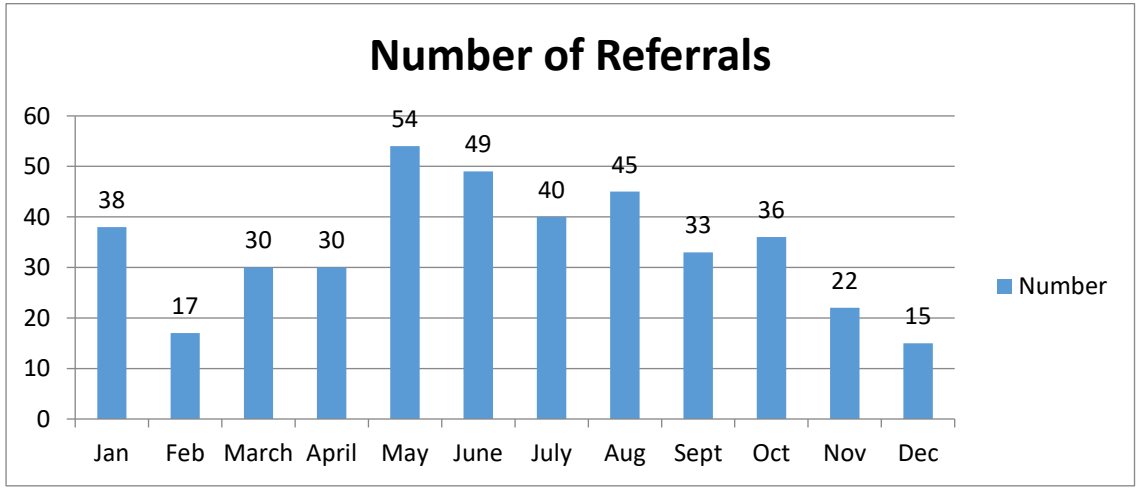
There is open access to both services.

Darlington Carers Support (DCS)

As at 31st December 2018, there were 1036 carers on the Carers Register held by Darlington Carers Support, an increase of 423 from the number on the register as at 31st October 2017.

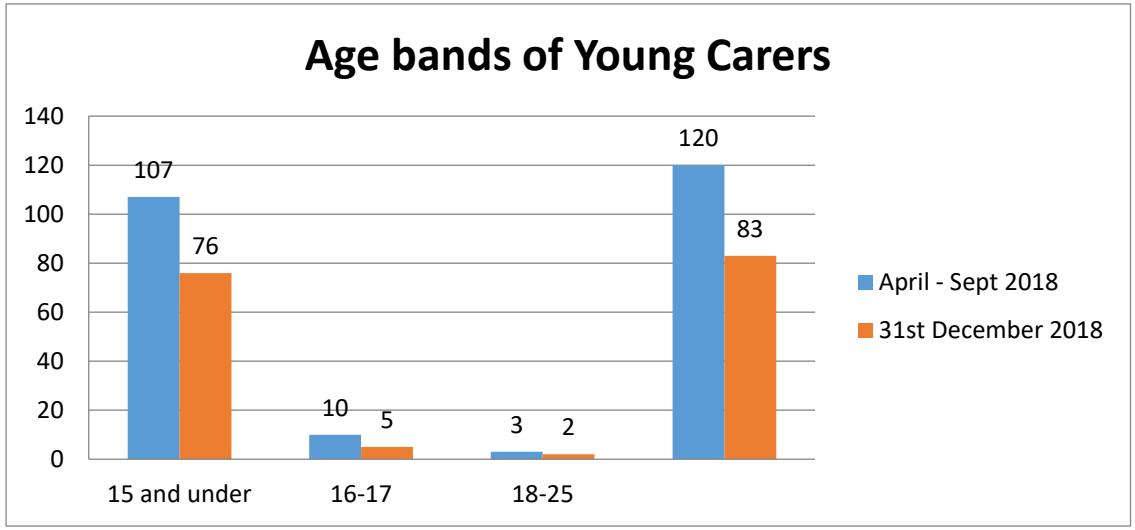


The Service received a total of 409 referrals from 1st January – 31st December 2018.

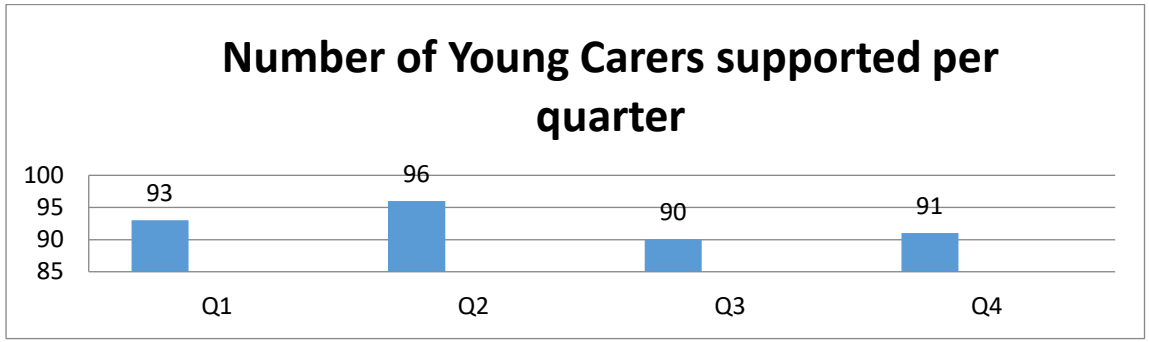


Darlington Young Carers (DYC)

A total of 120 young carers have been supported from 1st April – 31st December 2018 and 83 were in receipt of support as at 31st December 2018.



Between 90 and 96 young carers were supported each quarter.



Members of the Carers Strategy Steering Group (as at 14th February 2019).

Co – Chairs – Jenni Wood (DCS) and Emma Crawford - Moore (DYC)

Elaine Abbott	Carer
Catherine Bowman	Carer
Rosemary Berks	DAD
George Cree	Carer
Andi Cull	ARQ
Alison Donoghue	Darlington Carers Support
Lisa Holdsworth	DBC Commissioning
Kim Ingleby	Alzheimer's Society
Diane Lax	Healthwatch
Julie Nisbett	Age UK North Yorkshire and Darlington
Linda O'Neill	Darlington Young Carers
Deaglan Porteous	Darlington Mind
Councillor Sue Richmond	DBC
Deborah Robinson	St Teresa's Hospice
Josh Slack	DBC Commissioning
Christine Thompson	Darlington Mind
Sue Thorpe	DfE

Action Plan

Primary Theme	National Strategy Actions	Progress so far in Darlington	Action Points- to be explored and tasked to members of the group	By whom	Relevant Dates
1. Services and systems that work for carers	1.1 Carer Friendly GP Surgeries	1.1 Darlington Carer Support (DCS) and Young Carers (DYC) have identified link workers in all GP Surgeries, deliver regular presentations and build on the GP Carers Registers that are held by all surgeries. There are also notice boards/a carers corner in all surgeries.	1.1a. Attend 6 weekly West End Locality Partnership (WELP) Practice Manager meetings.	DCS and DYC	6 weekly
			1.1b. Attend the Annual Time Out session and include the Employers for Carers (EfC) information.	DCS, DYC	Annually
			1.1c. Darlington Association on Disability (DAD), DYC, DCS to keep noticeboards up to date in surgeries.	DAD, DYC, DCS	Quarterly
			1.1d. All services to update Living Well	All Strategy Group members	Annually

			Directory at least annually.		
	1.2 End of life care and bereavement support	1.2a. St Teresa's Hospice offers support to family/carers of anyone with a life limiting illness, through end of life care and following bereavement. This includes the provision of 1:1 support, support groups, complementary therapies and specialist support for children and young people. 1.2b. Alzheimer's Society staff accessed qualification in end of life. 1.2c. DYC offer targeted support and referrals to counselling services. 1.2d. DCS offer 6 months support and counselling services.	1.2a St Teresa's Hospice to: • seek funding for a social work and a social work assistant post. • pilot a "Time Out" workshop for carers, exploring such topics as self-care, communication styles & relaxation techniques • offer a social event for carers at Christmas. 1.2b To identify other organisations' plans going forward. 1.2c. Highlight gap in bereavement services and counselling across our networks.	ALL All Strategy Group members	March 2019 December 2018 and ongoing

	1.3 Armed Forces specialist support	1.3a. Veterans Society and Age UK North Yorkshire and Darlington (Age UK NYD) provide a Veterans Support Service for all veterans born before 1950.	1.3a. Ongoing support and signposting for veterans through Age UK veterans project and Café.	Age UK Veterans Project	Ongoing
			1.3b. DCS link with Triangle of Care and specialist provision at West Park.	DCS	Ongoing
			1.3c. Complete a scoping exercise of wider local and national agencies to access improved support.	Strategy Group to agree way forward	June 2019
	1.4. 2020 Dementia Challenge	1.4a. Dementia Friendly Darlington is working to ensure that Darlington is becoming increasingly dementia friendly. Some work has already taken place in the town centre and in Cockerton.	1.4a. Additional focused work in the town centre has been identified. This will include the delivery of Dementia Friends information sessions to businesses.	Members of Dementia Friendly Darlington	Ongoing
		1.4b. County Durham and Darlington NHS Foundation Trust (CDDFT) are working towards improving the environment for people with dementia	1.4b. CDDFT part of Dementia Friendly Darlington with ongoing initiatives.	CDDFT to update	September 2019

		and carers, staff training, audit and research to improve services.			
	1.5. Carers training and learning opportunities	1.5a. A range of training and learning opportunities is already in place, including training provided by DAD; DCS training i.e. first aid, dementia, “Stress less and relax”; DYC healthy eating training; Darlington ARQ; Alzheimer’s’ CRISP training; Mind self- help course	1.5a. Review current training offer to assess if there is overlap. Focus on core facilitation where possible. Link into Living Well Directory. Map out all training and look at joint sessions and bids	Strategy Group	Quarterly
			1.5b. DAD to continue to circulate info on Skills 4 Care funding and Community Foundation funded courses to Carers.	DAD	Ongoing
			1.5c. Invite Martin Webster to a future meeting to link in and update on Local Offer.	Lisa Holdsworth	Feb 2019

	1.6. Improve Social Work practice	1.6a. Sarah Gibbon from DBC operational staff attended an ADASS Regional Carers Network carers assessment workshop in August 2018 to explore good practice.	1.6a. A document was produced following this meeting which will be taken to the ADASS Branch meeting for sign off.	DBC	Ongoing
		1.6b. DBC carers assessment practice guidance has been drafted and issue is anticipated in January 2019.	1.6b. Issue is now likely to be in February 2019	DBC	Following review to update this
		1.6c. DYC and DCS deliver regular Carer Awareness sessions to DBC staff	Continue to deliver joint training/ awareness raising to Social Care and other relevant teams	DCS	As and when required
	1.7- Continue to enable carers to access Carer Breaks	1.7a. Carers are able to access carer breaks via a number of routes, including: • BCF carer breaks funding (via DAD, Darlington Mind, Age UK North Yorkshire and Darlington & St Teresa's Hospice); • Personalised breaks via DCS, DYC as part of their carer support contracts • carer breaks via DBC Adult Social Care if eligible needs are identified	1.7a. BCF carer breaks funding has been allocated annually. However, the BCF is currently under review. If the BCF continues to be available, the intention would be to maximise the availability of this or successor funding to	DBC	Ongoing

		following a care and support needs assessment of the person who needs care and support and a carer's assessment of their carer.	support the provision of carer breaks.		
		1.7b. DCS access funding for breaks from grant making bodies i.e. Carers Trust, Community Foundation etc.	1.7b. DCS will continue to access funding from wider grant making bodies i.e. Carers Trust	DCS	September 2019
	1.8. Mental Health Act 1983- Improve dignity and respect	1.8a. Darlington Mind works closely with carers, service users and key agencies to promote dignity and respect within all of its service provision. We work with a range of stakeholders to ensure those who are subject to the provision of the Mental Health Act are provided with a range of support systems, advocates, support workers and services which meet their particularly needs.	1.8a. Ongoing	Mind	Ongoing
		1.8b. DCS attend Triangle of care meetings with TEWV to influence and develop Carer recognition with this	1.8b. DCS will continue to engage with the Triangle of Care agenda and liaise with TEWV to ensure a stronger pathway to access support.	DCS	Ongoing

	1.9. Consultations with Carers to find out if the services and systems work for them	1.9a. Healthwatch's role is to gather information to influence decision making eg Care Home research. 1.9b. Mind consult with Carers accessing their dementia service. 1.9c. DCS use feedback and consult to find solutions to problems with services. 1.9d. DYC consult on service provision twice a year.	1.9. Pull together the local research and identify any common areas or concerns that the Strategy Group could take forward to influence improvements in services for Carers	Strategy Group research	
2. Employment and financial wellbeing	2.1a. Employers for Carers (EfC) membership	2.1a.- EfC umbrella membership is available to DBC and Durham County Council staff, health organisations and SME employers across County Durham and Darlington 2.1b. DCS and DYC utilise the EfC resources as part of their current contract 2.1c. A carers page is available on the DBC intranet	2.1a. DBC to review EfC membership and scope out possibility of further funding. Lisa Holdsworth to access the statistics of usage to aid this. 2.1b. DCS and DYC continue the promotion of the EfC resources until March 2019. 2.2c To be reviewed and updated annually	DBC DCS and DYC Lisa Holdsworth	March 2019 Ongoing March 2019 March 2019

		2.1d. DCS has access to regional employer support information.	2.1d. DCS to access the Gateshead Carers resources to support employers and employees across Darlington, also link to Carers Trust pilot in north east	DCS	March 2019
		2.1e. DYC and DCS to explore funding to develop work with employers across DBC area.	2.1e. DYC and DCS action.	DYC and DCS	Ongoing
	2.2 Job Centre partnership work	DCS, DYC, DAD all work with the local Job Centres including attending local events for Carers and delivering ongoing training and advice to Job Centre Staff.	2.2a. Work closely with CAB, Job centre plus and other relevant agencies to sign post carers and provide up to date information and benefit checks.	DYC, DCS, DAD	September 2019
	2.3 Carer Passport, policies and best practice	2.3a. DfE locally pioneered an in house Carer Support Network which is now national and seen as best practice. The Network had 102 members as at 20.11.18 and is also open to DBC staff. DFE also have Civil Service Carer Passport and Carer Charter which is	2.3a. Use the DfE best practice resources to support Strategy Group Members to consider adopting Carer Passports in house and look at policies.	2.3a. All members of Strategy Group to consider this	June 2019

		available to all staff. The wider Civil Service now adopted these. 2.3b. DCS now has in house Carer Passport for all staff. Other members of the Strategy Group have flexible work practices.			
	2.4 Carers Rights Day and Carers Week.	DCS coordinated Carers Week event 2018, all members of group held own events or worked in partnership in 2018. DCS held open office event for Carers Rights Day in partnership with NECA and CAB.	Strategy Group to work together on joint activities for both using a community access approach linking with employers, community groups and local events for 2019.	Strategy Group members	June and November 2019 and 2020
	2.5 Benefit and grant support	2.5a. DCS and DYC working with Job Centre to support those Carers claiming Carer benefits. Attending Carer events to promote the services and register new Carers. Delivering training to Job Centre staff regularly and attending monthly drop in with work coaches. DAD support Job Centre with Access to Work issues.	2.5a. Continue this work.	DCS and DYC	Ongoing
		2.5b. CAB working with DCS on “Darlo Millions” project	2.5b. Strategy group members to signpost to CAB	Strategy Group members	Ongoing

		2.5c. Age UK offer benefit support and advice.	2.5c. Age UK project	Age UK	Ongoing
	2.6 Raising awareness with local employers	2.6a- Annual Carers Rights Day activities to highlight working Carers rights in press, newsletters and local events, see 2.4 above for actions	2.6a To consider a partnership approach to employers when delivering Dementia Friends training, to include carer awareness. DCS to include EfC toolkit when delivering training to GP surgeries.	Strategy Group to plan future employer engagement activities	September 2019
		2.6b. Previous engagement with EE by DBC and DFE.	2.6b. Scope out future engagement with local employers	Strategy Group	June 2019
3. Supporting young carers	3.1 Schools work-identification	3.1. Deliver training through School Charter to schools to help with early identification of young carers.	DYC to continue to deliver training and promote the School Charter. 4 additional schools to achieve School Charter status.	DYC	Ongoing December 2019
	3.2 Awareness raising	3.2. Deliver training to other relevant agencies to help identify young carers and young adult carers.	Deliver 8 training sessions annually plus general awareness raising within other presentations.	DYC	Ongoing

			Provide update training as required	DYC	Ongoing
	3.3 Local authority- Education department	3.3. Ask Local authority education department what they are doing to achieve this goal	Contact Eleanor Marshall re Schools Link pilot.	DYC	April 2019
	3.4 Target seldom heard and isolated young carers	3.4. New young adult carers leaflet and awareness raising campaign to take place to raise referral rates into the service.	Engage the Mental Health Leads Network.	DYC	December 2018
		Darlington ARQ working to identify and support LGBT Young Carers.	Deliver training to Darlington ARQ.	DYC	November 2018
	3.5 NHS Young Carer Health Champion Programme	3.5. DYC exploring this but has no resources to do this so would need funding	Engage any of the free NHS Health Champion Events, plus look at a bid for funding a worker to target these areas.	DYC DYC	Ongoing July 2019
	3.6 CAMHs referral pathway	3.6. Darlington Mind receives referrals from a range of services, including from CAMHs but are not directly part of the CAMHs referral pathway.	Ongoing	Darlington Mind	Ongoing
		DYC has links with CAMHS	Engage with CAMHs Triangle of Care as this develops. Link with Victoria Wright.	DYC	December 2019

	3.7 Transitions from Young to Young Adult to Adult Carer	3.7a. Links with local colleges in place but need more resources to improve. Work ongoing between DYC, DCS and Horizons Young Adult Carers Service to support transitions.	3.7a. Disseminate reviewed DYC marketing and deliver a regular drop in at Darlington College and one off events in other providers as necessary. Also continue with internal referral pathways. 3.7b. Review of DBC Young Carers Assessment and Young Carers Transition Assessment processes	DYC DBC	January 2019 July 2019
4. Recognising and supporting carers in the wider community and society	4.1 Carer friendly communities	4.1a. Discount card in place which is well placed to build into a local Carer Community Passport, but more resources will be needed to develop this. However, carers are still not always recognised or referred for support.	4.1a. As part of the discount card review we can consider re launching the card and building on it as a community passport. Possible link with economic regeneration and Town Centre Manager Marion Ogle to take this forward.	Strategy Group to discuss and plan way forward	September 2019

			4.1b All agencies to work in partnership to promote recognition and referrals	ALL	Ongoing
	4.2 Healthy Ageing led by Age UK	4.2. Partners including AUKNYD are delivering services in line with core aims of the Healthy Ageing & Caring initiatives, including local access to support groups, respite opportunities including exercise and healthy eating, advocacy and information & advice which all contribute towards maintaining positive mental and physical wellbeing as we age.	All agencies to work in partnership to strengthen referral and signposting links to facilitate awareness of services which support the Healthy Ageing Campaign, particularly around services beneficial to Carers.	Strategy Group members	March 2019
	4.3 Changing Places Toilets initiative	4.3. There are Changing Places toilets in the ground floor lobby at the Dolphin Centre and the Out Patients Department at Darlington Memorial Hospital.	Ensure that carers are aware of these.	Strategy Group members	February 2019
	4.4 Loneliness Agenda	4.4a. All members of Strategy Group run projects, training, support groups and other events that work to prevent loneliness at present and intend to continue this work.	Consider how to respond to the cross-government loneliness strategy which was published in October 2018	Strategy Group members	March 2019

			Identify actions and review progress in 6 months		September 2019
		4.4b. DBC Living Well Directory aims to bring all the information together locally on what is available.	All groups to encourage use of the Living Well Directory to promote the Local Offer and utilise all available groups and resources to the maximum effect.	Strategy Group members	Ongoing
	4.5. Recognising and supporting hard to reach carers	4.5a. Work is ongoing to raise awareness of the needs of carers of people with dementia in the BAME and LGBT communities. This will also assist with raising the profile of all groups of carers in these communities.	Contracts in place until 22.4.19; + 1 extension clauses available until 22.4.20	Alzheimer's Society and Aapna Services	Ongoing
		4.5b. DCS working with GP Practices to launch a support group for Bangladeshi community	1st meeting has been arranged	DCS	Ongoing
5. Building research and	5.1a. Find out what local research has been gathered i.e. DOH,	5.1a. Need to gather examples of local, regional and national research and evidence any recent research by local	5.1a. Strategy Group to work together to discuss this and plan a way forward. Local	Strategy Group	June 2019

evidence to improve outcomes for carers	Local Authority. DWP, Universities, Regional research 5.1b. National Carers Survey 5.1c. DCS Carers Survey	voluntary sector organisations i.e. Healthwatch, CAB ARQ have students working with them who would be keen to take on some research. 5.1b. Data available on National Carers Survey which compares results regionally 5.1c- Information on outcomes for Carers accessing DCS service could be used to inform strategy group plans	research? Is there a local student that would like to do this as their dissertation? 5.1b. Group to look at this and decide if any action is needed	 Strategy Group DCS	 October 2019 June 2019

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