

Health and Well Being Board Agenda



3.00 pm Thursday, 13 September 2018
Committee Room No. 1, Town Hall,
Darlington. DL1 5QT

Members of the Public are welcome to attend this Meeting.

1. Introductions/Attendance at Meeting.
2. Declarations of Interest.
3. To hear relevant representation (from Members and the General Public) on items on this Health and Well Being Board Agenda.
4. To approve the Minutes of the Meeting of this Board held on 12 July 2018. (Pages 1 - 6)
5. Living Well Directory - Demonstration by Rob Dent and Sandra Feldon, Families Information Officers, Darlington Borough Council.
6. Health Protection Annual Report - Report of the Director of Children and Adult Services, Darlington Borough Council. (Pages 7 - 58)
7. Better Care Fund 2017/19 - Report of the Director of Children and Adult Services, Darlington Borough Council. (Pages 59 - 72)
8. Integrated Care Systems - Update by the Chief Clinical Officer, NHS Darlington Clinical Commissioning Group.
9. Delivering the Ageing Well Priorities:-
 - (a) Health and Well Being Plan Delivery - Report of the Director of Children and Adult Services, Darlington Borough Council. (Pages 73 - 76)
 - (b) Health and Well Being Plan 2017/22 - Improving Outcomes for Older People -

CCG and LA Key Priorities for 2018/19 - Presentation by the Director of Commissioning and Transformation, NHS Darlington Clinical Commissioning Group.

10. Healthwatch Darlington - Report of the Chief Executive Officer, Healthwatch Darlington. (Pages 77 - 82)
11. Darlington Cancer Profile - Report of the Director of Children and Adult Services, Darlington Borough Council. (Pages 83 - 96)
12. 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.
13. Questions.



Luke Swinhoe
Assistant Director Law and Governance

Wednesday, 5 September 2018

Town Hall
Darlington.

Membership

Councillor A J Scott
Councillor Harker, Leader of the Council, Leader of the Council and Efficiency and Resources Portfolio Holder
Councillor C L B Hughes
Councillor S Richmond
Councillor Mrs H Scott, Leader of the Main Opposition Party
Paul Wildsmith, Managing Director
Suzanne Joyner, Director of Children and Adults Services
Miriam Davidson, Director of Public Health
Dr Posmyk Boleslaw, Chair, NHS Darlington Clinical Commissioning Group
Andrea Jones, Chief Clinical Officer, NHS Darlington Clinical Commissioning Group
Karen Hawkins, Director of Commissioning and Transformation, NHS Darlington Clinical Commissioning Group
Paula Swindale, Head of Commissioning, NHS Darlington Clinical Commissioning Group
Ali Wilson, Chief Officer Darlington CCG
Diane Murphy, Chief Nurse, NHS Darlington Clinical Commissioning Group
Richard Chillery, Operational Director of Children's and Countywide Care Directorate, Harrogate and District NHS Foundation Trust

Jill Foggin, Communications Officer, County Durham and Darlington Foundation Trust
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
Jonathan Lumb, Darlington Secondary Schools Representative
Colin Martin, Chief Executive, Tees, Esk and Wear Valley Mental Health Foundation Trust
Dr Chris Mathieson, Clinical Governor, Primary Healthcare Darlington
Alison Slater, Director of Nursing, NHS England, Area Team
Charles Oakley, Office of the Police, Crime and Victims' Commissioner, Durham Police Area
Michelle Thompson, Chief Executive Officer, Healthwatch Darlington
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:-

- XXX

If you need this information in a different language or format or you have any other queries on this agenda please contact Lynne Wood, Elections Manager, 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

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HEALTH AND WELL BEING BOARD

12 July 2018

PRESENT – Councillor A J Scott (in the Chair); Councillors C L B Hughes and S Richmond, Suzanne Joyner, Director of Children and Adults Services and Miriam Davidson, Director of Public Health, Darlington Borough Council; Posmyk Boleslaw, Lisa Tempest and Sue Greaves, NHS Darlington Clinical Commissioning Group; Marion Grieves, Dean of Health and Social Care, Teesside University; Gillian Curry, County Durham and Darlington NHS Foundation Trust; and Dr Chris Mathieson, Clinical Governor, Primary Healthcare Darlington. (11)

ALSO IN ATTENDANCE – Hilary Hall, Project Management, Healthy New Towns; Graham Hall and Claire Compton, Project Co-ordinator, Routes to Work; and Simon Hart, Independent Chair, Darlington Children’s Safeguarding Board.(4)

APOLOGIES – Councillors Dixon and Mrs H Scott and Paul Wildsmith, Managing Director, Darlington Borough Council; Dr Andrea Jones, Chief Clinical Officer, Ali Wilson, Chief Officer, Karen Hawkins, Director of Commissioning and Transformation, and Diane Murphy, Director of Nursing and Quality, NHS Darlington Clinical Commissioning Group; Sam Hirst, Primary School Representative; Ron Hogg, Police, Crime and Victims’ Commissioner, Durham Police Area; Sue Jacques, Chief Executive, County Durham and Darlington NHS Foundation Trust; Rita Lawson, Chairman, VCS Strategic Implementation Group; Colin Martin, Chief Executive, Tees, Esk and Wear Valley Mental Health Foundation Trust; Richard Chillery, Operations Direction of Children’s and Countywide Care Directorate, Harrogate and District NHS Foundation Trust; Jonathan Lumb, Darlington Secondary Schools Representative; Michelle Thompson, Chief Executive Officer, Healthwatch Darlington; and Carole Todd, Darlington Post Sixteen Representative. (16)

HWBB56. DECLARATIONS OF INTEREST – There were no declarations of interest reported at the meeting.

HWBB57. REPRESENTATIONS – No representations were made by Members or members of the public in attendance at the meeting.

HWBB58. MINUTES – Submitted – The Minutes (previously circulated) of the meeting of this Health and Well Being Board held on 10 May 2018.

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

REASON – They represent an accurate record of the meeting.

HWBB59. HEALTHY NEW TOWNS - The Project Manager, Healthy New Towns, gave a presentation to update the Board on the Healthy New Towns project, including the progress made in respect of the three main workstreams of the project which included regeneration and housing (including the built environment and community activation), new models of care and digital as an enabler.

It was reported that the aim of the regeneration and housing workstream was to provide good quality home design, including the meeting of Lifetime Homes Standards; the built environment and public realm as public health enabler; and community engagement, empowerment and activation. Particular reference was made to the influences and design principles of the Local Plan which included well planned, high quality, sustainable places; an attractive place to live, work, visit and invest in; economic growth; and greater certainty around infrastructure. References were also made to the Local Plan Context; Eastern Growth Zone; delivery of the Red Hall Masterplan; Community Initiatives; and the aims for Red Hall and other challenged communities.

An update was given on the outputs to date from Phase One of the New Models of Care workstream, namely the development of GP Practices working in hubs and the sharing of 'back office' functions. Reference was made to the work included in Phases Two to Four, which were not mutually exclusive and may run in parallel.

The final workstream, digital as an enabler, would harness the advantages of digital information exchange to manage ever growing demand; release efficiencies; and empower and educate patients and residents. An update was given on the work that had been implemented to date.

Particular references were made to the legacy of the project; the project structure; and involvement in Phase Three of the New Models of Care workstream.

RESOLVED – That the thanks of the Board be conveyed to the Project Manager of Healthy New Towns, for her informative presentation.

REASONS – To convey the views of the Board.

HWBB60. ROUTES TO WORK – The Head of Community Safety, Darlington Borough Council, gave a presentation to the Board on 'Routes to Work', which was a three year pilot scheme aimed at supporting the 'hardest to help' to move back into, or towards work, by providing joined up services, centred around the individual.

Particular references were made to the funding of the scheme; the eligibility criteria; the key elements of the pilot; targets; the 'customer journey'; the potential clients; the Darlington Local Delivery Plan, including Governance arrangements; the Communications Plan; and the evaluation of the pilot.

Discussion ensued on the publicity of the pilot; the implications on people, particularly young people, of being given the wrong job; and the engagement with the clients.

RESOLVED – That the thanks of the Board be conveyed to the Head of Community Safety, Darlington Borough Council, for his informative presentation.

REASONS – To convey the views of the Board.

HWBB61. INTEGRATED CARE SYSTEMS (FORMERLY SUSTAINABLE TRANSFORMATION PLAN) – The Chair, NHS Darlington Clinical Commissioning Group, gave an update to the Board on the implementation of the Integrated Care Systems.

It was reported that communications had been produced which included a narrative pack, which would be shared with Local Authorities, and an animation which would be put on social media; the focus locally was on the integration of the six Clinical Commissioning Groups (CCG's), seven Local Authorities and Health Trusts; stated that there was now collaboration between five of the CCG's and those agencies; that workshops for the CCG's had been arranged to encourage and promote joint working; and highlighted the importance of having a locality focus.

A member of the public in attendance at the meeting asked a number of questions in respect of the Integrated Care System in respect of decision making, funding, what had been spent to date and whether the public would be informed of the costs. The Chair, NHS Darlington Clinical Commissioning Group, responded thereon.

RESOLVED – That the thanks of the Board be conveyed to the Chair, NHS Darlington Clinical Commissioning Group, for his informative presentation.

REASONS – To convey the views of the Board.

HWBB62. HEALTH AND WELL BEING PRIORITIES 2018/19 – The Director of Public Health, Darlington Borough Council, submitted a report (previously circulated) on the Health and Well Being Priorities for 2018/19.

The submitted report stated that in 2014 the Council had agreed that 'One Darlington Perfectly Placed', the Sustainable Community Strategy, would constitute the Health and Well Being Strategy for Darlington, with a suite of plans delivering the strategic objectives; the Health and Well Being Plan was once of those plans and it had been endorsed by the Board in October 2018; outlined the key priorities for 2018/19; and the actions for the NHS Clinical Commissioning Group and Darlington Borough Council to deliver those priorities.

RESOLVED - That the submitted report and priorities for 2018/19, as detailed in the submitted report, be noted.

REASONS – (a) In April 2017 The Health and Wellbeing Board agreed the Health and Wellbeing Plan 2017/2022 would take a "Life Course" approach. The Board's role as Children Trust Board means the plan covers the 0-19 years age group, as well as adults and older people.

(b) Priorities for action set out in the plan are derived from the Joint Strategic Needs Assessment and a Development Session held with Health and Wellbeing Board in April 2017. A verbal update on the plan's development was given in June and the Board had the opportunity to review the draft in September 2017.

(c) The Plan has a five year initial life, with annual Health and Wellbeing Delivery Plans which will inform the Health and Wellbeing Board agendas.

(d) Delivery of the Plan's objectives requires each partner to align their strategies and plans, to ensure focus and avoid either duplication of activity against the same objectives or activity which does not contribute to the delivery of the Health and Wellbeing Plan objectives.

HWBB63. TACKLING DOMESTIC ABUSE AND SEXUAL VIOLENCE IN DARLINGTON 'A BIG CONVERSATION' - The Director of Public Health, Darlington Borough Council, submitted a report (previously circulated) providing feedback from the 'Big Conversation' and shared planning session held on Wednesday 6 June 2018 on Tackling Domestic Abuse and Sexual Violence in Darlington.

The submitted report stated the planning session had been held in recognition that domestic abuse and sexual violence were areas of common concern to Darlington Borough Council and its partners; the session provided the opportunity for those organisations in attendance to describe current services and programmes that were in place and to share information and intelligence; and that the event was well attended by people from different sectors and organisations.

Particular reference was made to the vision for the Darlington Domestic Violence Abuse and Sexual Violence Action Plan which was for all the agencies to work together to reduce the prevalence of domestic abuse and sexual violence, to provide a co-ordinated community response which included preventative, support and protection services and dealt with perpetrators. It was reported that the plan, would be structured around four key objectives; the contributions from the event would be collated into that plan; and that the Community Safety Partnership would review the work in progress and share the plan with other key partnership boards

RESOLVED - That the update on local work to further develop a Domestic Abuse and Sexual Violence plan, as detailed in the submitted report, be noted.

REASON - Domestic abuse and sexual violence is a significant challenge in its scale, severity and impact across individuals, families, communities and organisations.

HWBB64. HEALTHWATCH DARLINGTON – The Chief Executive Officer, Healthwatch Darlington, submitted a report (previously circulated) updating the Board on its key statutory priorities and projects from April 2018 to June 2018.

The submitted report outlined the role of Healthwatch Darlington as a strong independent community champion which gave local people a voice that improved and enhanced health and social care provision on behalf of the people of Darlington and the statutory activities and projects it was involved with. Particular reference was made to the fifth Healthwatch Darlington Annual Report that had been published (also previously circulated).

RESOLVED – That the report and the progress made to date for Healthwatch Darlington, as detailed in the submitted report, be noted.

REASON – To enable the Board to consider the work of Healthwatch Darlington.

HWBB65. MENTAL HEALTH AND WORKPLACE – Submitted – A presentation on Mental Health and the Workplace, which made comparisons between Darlington, the North East and England as a whole in respect of employment, economic activity and unemployment and employment trends.

The presentation stated that working was good for health and well-being and physical and mental health was generally improved through work; being out of work had a negative impact on health and well-being; and that the gap between the employment rate for people supported by secondary mental health services and the overall employment rate was a good reflection on how well the local mental health system was enabling people with mental health conditions to achieve their employment potential.

It was reported that mental health was one of the biggest issues in the workplace today accounting for over 70 million working days lost each year and that employers could safeguard staff well-being by addressing problems before they became severe and supporting staff when issues emerged.

RESOLVED – That the presentation be noted.

REASON – To enable the Board to consider the work Mental Health and the Workplace.

HWBB66. DARLINGTON SUICIDE PREVENTION PLAN – The Director of Public Health, Darlington Borough Council, submitted a report (previously circulated) providing the Board with information on the refreshed Darlington Suicide Prevention Plan 2017/22 (also previously circulated), including the plan's implementation and governance arrangements, and providing an update on the NHS England Suicide Prevention Transformation fund allocation as part of the Mental Health Taskforce.

The submitted report stated that the Darlington Suicide Prevention Group, which was a multi-agency group, was established in 2017; the group had developed the Darlington Suicide Prevention Plan that aimed at facilitating a reduction in the suicide rate and provide better support to those bereaved or affected by suicide; the plan included a five year action plan; that the action plan was structured around six national key areas; and that there had been 36 suicides in Darlington between 2014 and 2016 which was a reduction of three on the previous three years.

RESOLVED – (a) That the report and the Darlington Suicide Prevention Plan 2017/22, as appended to the submitted report, be noted.

(b) The Darlington Suicide Prevention Plan 2017/22, as appended to the submitted report, be supported.

REASON - The Suicide Prevention Plan works towards the Health and Well Being Board's ambition for Living Well: Working with communities to live longer and healthier lives.

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HEALTH PROTECTION ANNUAL REPORT

SUMMARY REPORT

Purpose of the Report

1. To consider the Annual Health Protection Report published by the North East Health Protection Team (HPT), Public Health England, entitled 'Protecting the population of the North East from communicable disease and other hazards'. (2017/18)

Recommendations

2. It is recommended that the Board:
 - (a) Notes the contents of the North East Health Protection Team (HPT), Public Health England, 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 disproportionately resulting in poorer health.

Reasons

3. The recommendations are supported by the following reasons:
 - (a) To inform the Board on the work of HPT, Public Health England 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 North East HTP, Public Health England, entitled 'Protecting the population of the North East from communicable disease and other hazards' 2017/18.

Author: Paul Davison, PHE/Miriam Davidson, DBC

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 disproportionately 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 North East Health Protection Team (HPT) has produced its eighth 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 Public Health England.
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 i.e. 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 in 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 disease outbreaks of vaccine-preventable disease and provide expert support and 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 2017.
9. Health Protection Surveillance schemes include Healthcare Associated Infection (HCAI), Sexually Transmitted Infections (STIs) and the surveillance of Invasive Pneumococcal Disease (PID).

Control

10. Control relates to actions taken to minimise risk of the spread of disease and the actions taken to close an outbreak. Early reporting; early diagnosis and prompt treatment are essential. For some diseases the initial reporting is through local authority environmental health services.
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).

Emergency preparedness, resilience and response (EPRR)

14. PHE North East has a system in place for emergency preparedness. 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.
15. The PHE 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.
16. 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

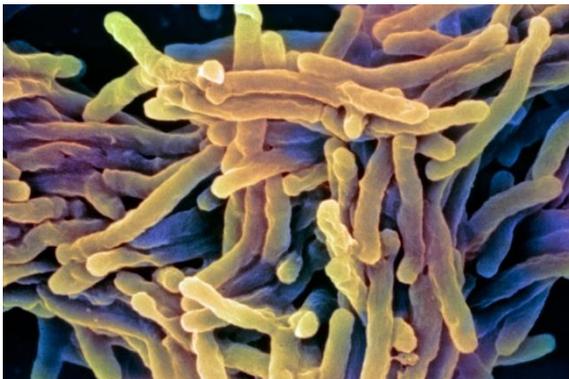
17. The PHE North East communication team works closely with local authorities and NHS bodies via the Public Health communication network. The PHE communications team continues to support the communications around the management of outbreaks and incidents.
18. It has also supported local and national 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.



Public Health
England

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

Annual Report 2017/18



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. Website: www.gov.uk/phe. Twitter: [@PHE_uk](https://twitter.com/PHE_uk), Facebook: www.facebook.com/PublicHealthEngland.

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Published: July 2018

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Foreword

Welcome to the eight Annual Report produced by the North East Health Protection Team (HPT).

As in previous years 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.

2017 has been a time of transition for the North East Health Protection Team. In September, Rachael Kain and Claire Stoker started work as senior nurses covering North of Tyne and Durham/Darlington respectively. We had three vacancies in the Acute Team that have been filled by Ali Boon-Chandler, Robert Seremani and Stephen Minto.

Dr Kirsty Foster remains on secondment working with national colleagues at Colindale on sexual health and blood-borne viruses while at the same time providing local leadership on sexual health for PHE North East. She has also been successful in being appointed as the local Training Programme Director.

We are confident that all of the changes made to the team in the last two years will ensure that we are able to continue to deliver safe and effective health protection services across the North East.

Summary of progress on 2017/18 priorities

The HPT identified seven 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 2017/18.	Achieved
2	Develop a North East TB Network vision statement and action plan to support the delivery of the national TB strategy.	Achieved
3	Convene two meetings of the newly formed North East TB Network.	Achieved
4	Complete the work on developing a local AMR action plan and launch at a cross-system event.	Achieved
5	Conduct mapping exercise to understand current local patterns of prescribing to ensure effective local action planning.	Achieved
6	Conduct a review of EpiNorth3 (local health protection surveillance system)	Ongoing
7	Produce health protection annual report for 2017/18	Achieved

Priorities for 2018/19

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 2018/19 have remained the same for a number of years and therefore our objectives continue to be framed in the same way. They are listed in Table F2.

Table F2: Local priorities for 2018/19

	Priorities
1	Continue to deliver effective health protection services in 2018/19.
2	Continue to consolidate the North East TB Network
3	Deliver the 2018/19 objectives as outlined in the NE TB strategy.
4	Deliver HP/STAC update session for DsPH and public health teams
5	Provide targeted support local authorities in meeting NO ₂ reduction targets and associated activities in improving air quality.
6	Finalise the review of EpiNorth3 (local health protection surveillance system)
7	Complete outputs from the IPD project
8	Produce health protection annual report for 2018/19

1. Introduction and recent developments

1.1. This report

This is the eighth Annual Report compiled by the North East Health Protection Team and outlines the key health protection issues in 2017/18 while identifying the priorities for 2018/19. 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 health protection is a collaborative activity across many different organisations and departments currently 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, 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 other 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 Epidemiology Service has now become the Field Service (FS) but they continue to collate information on communicable diseases from a wide variety 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 provides 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 Services

The North East field epidemiology team is one of eight similar teams around the country. These teams are nationally managed and co-ordinated but geographically dispersed. Their purpose is

to provide specialist epidemiological expertise to support Health Protection teams in field epidemiological investigations and surveillance.

In addition, the local field epidemiology 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 epidemiology team works closely with the HPT; jointly managing North East based surveillance systems and providing epidemiological components of incident investigations, in particular analytic studies.

We were delighted that Dr Petra Manley was appointed to lead the local field epidemiology team in September 2017 following the retirement of Dr Russell Gorton.

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

The Microbiology Services Division of Public Health England provides clinical microbiology services (diagnostic and specialist microbiology), food, water and environmental microbiology to the NHS and to the community at large. For the North East, these clinical laboratory services are located within the Newcastle upon Tyne Hospitals NHS Foundation Trust, and food, water and environmental services are delivered from the York Laboratory.

The clinical laboratory works in close collaboration with the Newcastle upon Tyne Hospitals NHS Foundation Trust department of microbiology and operates a number of joint services, notably enteric microbiology. It is linked to the network of PHE specialised laboratories across England and to major reference units in Colindale (London) and PHE Microbiology Research Services (Porton).

The provision of Public Health Microbiology Services (Laboratory and Professional support) has been subject to a tender process. The Health Protection Team and Field Services have had input into this process. At the time of writing this report final contract discussions were taking place with the successful organisation. During this period, arrangements remain in place with Newcastle Hospitals to support the Public Health Microbiology Service.

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.

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. Health protection in the prison setting

In 2017 the North East HPT and Health and Justice Public Health Specialist identified the need for a forum for the discussion and dissemination of issues relating to public health within the North East custodial estate and to further develop the public health agenda within the North East prison system. An initial Public Health in Prisons North East meeting was held in June 2017 and participants were very supportive of the approach.

Further meetings are now being chaired by one of the Consultants in Health Protection. The meetings allow for the dissemination and discussion of key material and learning relating to health protection and infection control; opportunities for individual prisons to share learning and good practise in relation to public health; CPD for prison staff and commissioners in relation to public health; strategic recommendations to the commissioners of healthcare service and others (including governors) on issues relevant to public health. In December 2017 a training session on managing outbreaks in prisons was well received by prison commissioners and providers. An audit of dental provision in prisons was presented and discussed at the April 2017 meeting.

1.8. Whole genomic sequencing (WGS)

WGS has been introduced into routine public health practice. Public Health England (PHE) are world leaders in the use of WGS for infectious diseases. From 2012, WGS pipelines have been developed and implemented for routine identification and typing of selected organisms isolated from humans. As of 2018, PHE routinely sequences human isolates of *Salmonella*, *E. coli*, *Shigella*, *Listeria* and *Mycobacterium tuberculosis* 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*; a pipeline for *Staphylococcus aureus* is currently under development to be incorporated into routine public health practice.

WGS of gastrointestinal organisms is now 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 epidemiology team, has developed reports that highlight clusters of genetically similar organisms. The National GI team also produces a national overview of five SNP clusters which the local field epidemiology team also monitors for activity. In general, clusters of two or more cases within five SNPs are assessed using exposures previous collected to gauge if a common source is present.

The WGS of TB has recently been rolled out to all of England. The North has been producing WGS of TB for longer i.e. from 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.

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 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 13 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 is accountable for ensuring local providers of services will 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 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.

A historical vaccine development and introduction timeline of the routine vaccine programme is shown in figure 2.1. Following advice 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 2017/18:

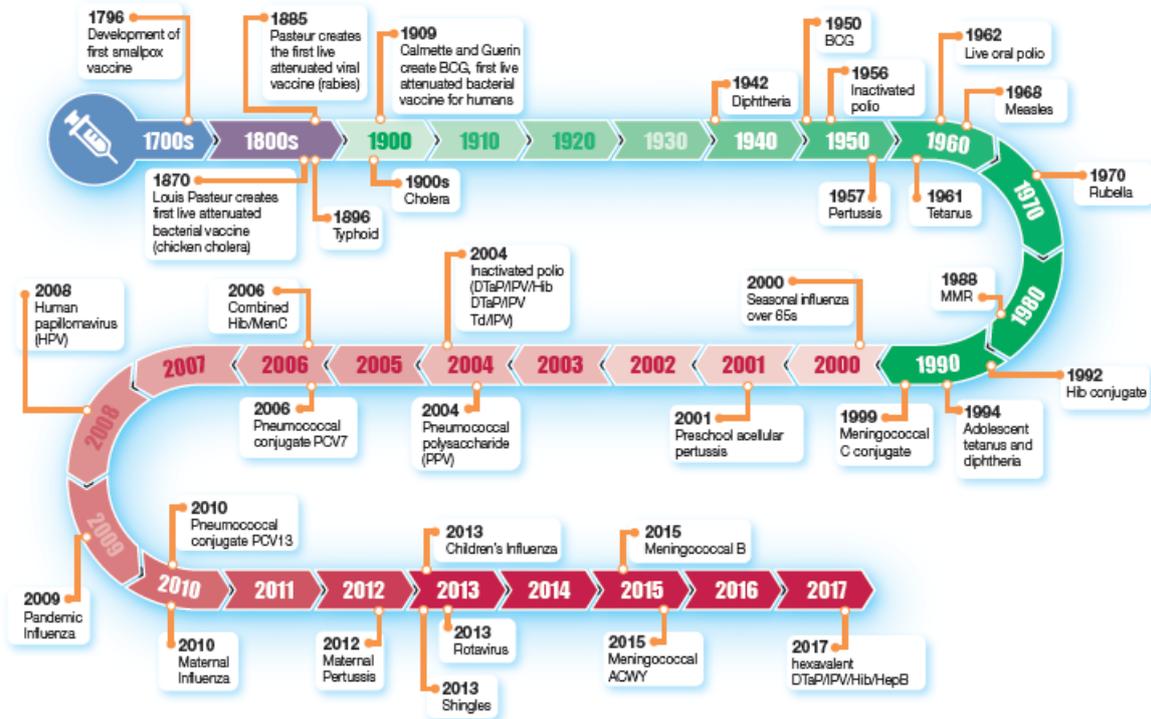
Hepatitis B at-risk (new born babies)

New born babies whose mother has Hepatitis B are at increased risk of contracting the disease. The number of recommended doses has been reduced to three, removing the third dose at 2 months. This was an in-year change effective from 30 October 2017.

Meningococcal B (Men B) infant

This programme is for three doses of vaccine at 2, 4 and 12 months (in line with the childhood immunisation programme), with a catch-up element in place for children up to 2 years who can be vaccinated on an opportunistic basis.

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



Coverage rates

Uptake in the North East for the routine childhood programme remains among the highest in England: In Quarter 3 (Oct-Dec) 2017:

- By aged 12 months, 95.1% of children in the North East (93.1% in England) 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.
- By 24 months, 94% (91.1%) had received measles, mumps and rubella (MMR) vaccine (dose 1).
- By 5 years, 92.2% (87.3%) had received two doses of MMR.
- By 5 years, 91.5% (85.9%) had received diphtheria, tetanus, polio booster. (DTaP/IPV Booster)

The vaccination programme 2017/18

At the time of writing this report there was no significant change in the national programme planned for 2018/19.

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 Cumbria and North East 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 (HCAs).
- 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 other sources are risk assessed by HPT staff and public health action taken as indicated. 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 2017 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 legislation¹ 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 epidemiology 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 tells microbiologists in the NHS about new and emerging resistance problems and how far they have spread. Enhanced Carbapenamase producing Enterbacteriaceae (CPE) surveillance was introduced in 2015.

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 continues to produce 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.

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.

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 March 2019.

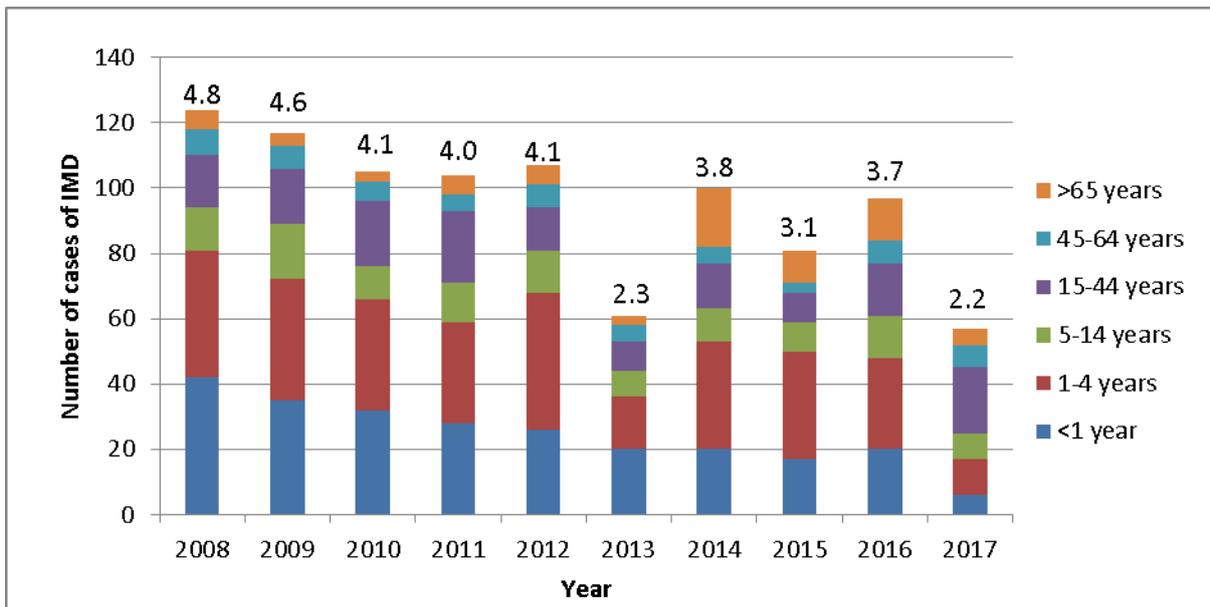
4. Control – specific diseases

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 2008 to 2017.



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 2017

Local Authority	Number of cases	Rate (per 100,000)
County Durham	8	1.5
Darlington	2	1.9
Gateshead	3	1.5
Hartlepool	4	4.3
Middlesbrough	5	3.6
Newcastle upon Tyne	4	1.4
North Tyneside	2	1.0
Northumberland	3	0.9
Redcar and Cleveland	6	4.4
South Tyneside	4	2.7
Stockton-on-Tees	3	1.5
Sunderland	12	4.3
North East Total	56	2.1

*Rate uses local authority population figures for 2016

Serogroup group B still remains accountable for the majority of cases in the North East, in line with national figures. In 2017 there was a 46% reduction in Men B cases being reported compared to 2016. In 2017 there was a reduction in Men W135 cases by 70% compared to the previous year 2016. This is most likely due to the introduction of the school leavers Men ACWY vaccine programme which was initiated in 2015, due to the dramatic increase in Men W cases.

Table 4.2: Laboratory confirmed cases of meningococcal disease by serotype for 2008 to 2016

Serogroup	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
B	83	68	53	62	48	31	33	38	39	21
W135	2	1	1	3	3	4	12	13	23	7
Y	3	1	3	0	4	3	4	4	5	2
C	1	0	0	0	3	1	2	1	5	5
Z	0	0	0	0	0	0	0	0	0	0
Ungrouped	34	45	46	34	48	22	48	25	24	21
North East Total	123	115	103	99	106	61	99	81	96	56

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 incidence in young adults aged 15 to 19 years old.

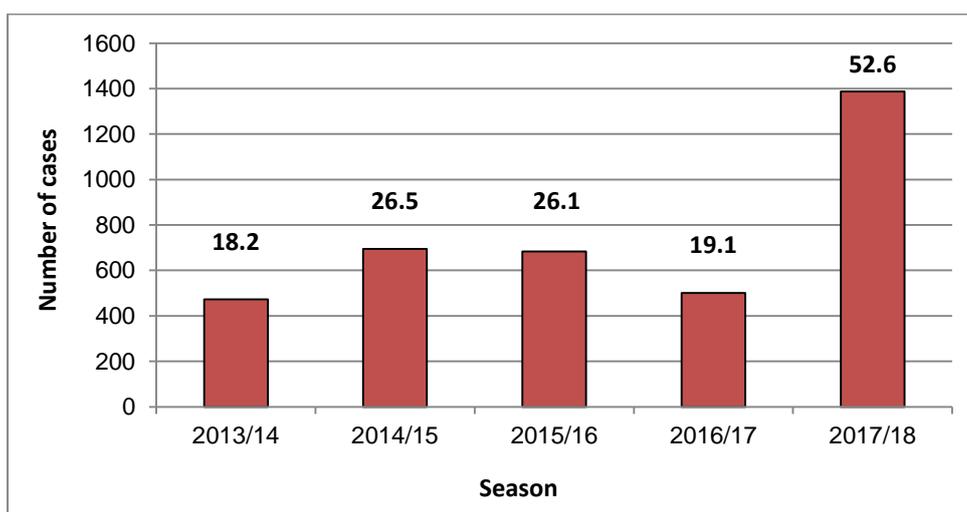
4.2. Invasive Group A streptococcal disease (iGAS) and scarlet fever

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.

An increase in notifications of scarlet fever was observed in the 2014/15 season (695 cases; 26.5 per 100,000 vs. 18.2 per 100,000 in 2013/2014; Figure 4.2), with notifications remaining high in 2015/16 (684 cases). After slight decrease in notifications in 2016/17 (501 cases), there was a 177% increase in notifications in the 2017/18 season (1,388 cases; 52.6 per 100,000). This was the highest number of notifications over the past 5 seasons.

Figure 4.2: Number* of cases of scarlet fever in the North East and overall rate by season[‡], from 2013/2014 to 2017/2018



* 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.

Quarterly notifications of scarlet fever were higher in Q1-Q3 2016 than during the same period in 2015 (Table 4.3). In 2016 there were 1,131 notifications: around 20% more than in 2015 and an increase of five cases on the previous peak in 2014. In 2017 the number of notifications remained above expected levels, but a decrease was observed in the total number of cases when compared with 2016. Notifications began to increase in Q4 2017 with a 138 % increase observed when compared with Q4 2016. This increasing trend in notifications continued in Q1 2018, with 949 cases reported; a 207% increase from Q1 2017 and the highest number of cases reported in the previous six years.

Table 4.3: Scarlet fever notifications to NE PHE Centre, Quarter 1 2013-2018

Year	Quarter				Total
	1	2	3	4	
2013	193	127	30	72	422
2014	330	498	112	203	1,143
2015	466	243	85	162	956
2016	491	367	127	146	1,131
2017	309	189	128	348	974
2018	949				

Data from EpiNorth3. Cases by referral date.

Note that there are small differences to figures quoted in previous annual reports for pre-2018 data due to additional data cleaning and case reclassification which has been undertaken in 2017/18.

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.

The incidence of iGAS in the NE rose significantly in 2013 and has remained elevated with a peak of 167 cases reported in 2015. In 2017, 122 cases were reported, which represents a slight decrease from 2016 (161). As with scarlet fever notifications, there was a substantial increase in cases in Q1 2018, with 78 notifications in Q1 2018 compared with 28 in 2017. This was slightly higher than the previous peak in notifications in Q1 2016.

Table 4.4: Invasive Group A streptococcal disease reported to NE PHE Centre, Quarter 1 2013-2018

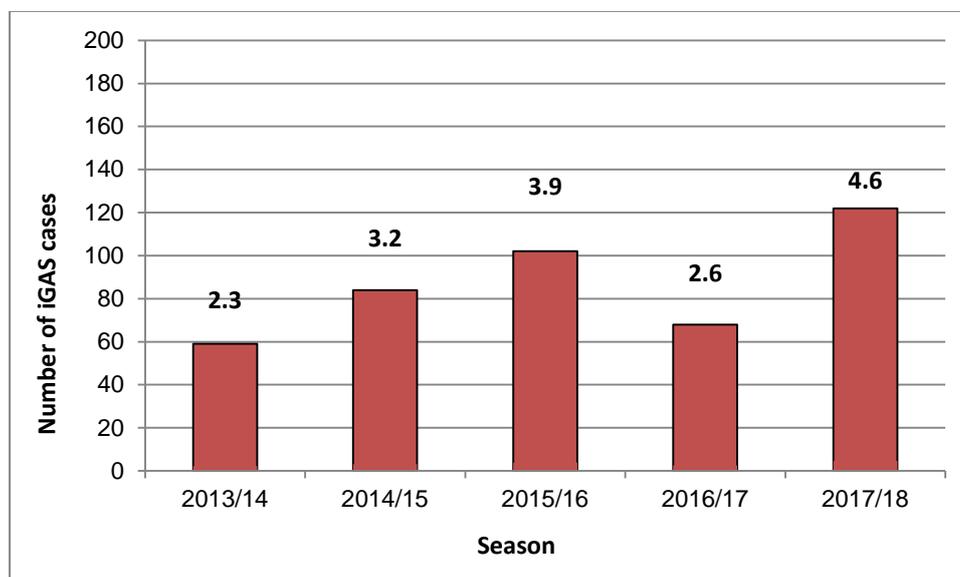
Year	Quarter				Total
	1	2	3	4	
2013	36	56	14	24	130
2014	30	32	25	21	108
2015	51	54	29	33	167
2016	63	45	25	28	161
2017	28	30	29	35	122
2018	78				

Data from HPZone. Cases by referral date.

Note that there are small differences to figures quoted in previous annual reports for pre-2018 data due to additional data cleaning and case reclassification which has been undertaken in 2017/18.

iGAS infections have a seasonal pattern with the highest incidence from December to April. Since 2013/2014 there has been an increase in the number of iGAS cases with the exception of 2016/2017. However, the rate of cases rose substantially in 2017/2018 to 4.6 per 100,000.

Figure 4.3: Number of cases of invasive Group A Streptococcus (iGAS) in the North East and overall rate[‡] by season*, from 2013/2014 to 2017/2018



* 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

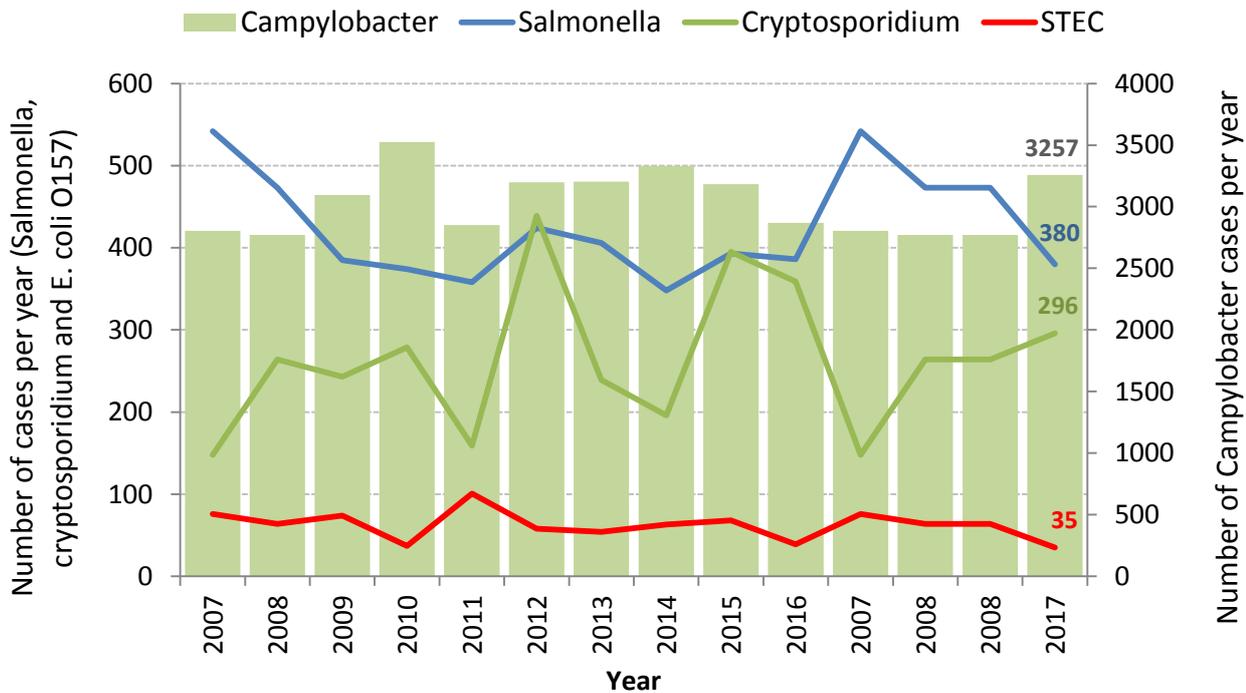
A number of organisms can cause gastrointestinal infection of which campylobacter and salmonella are the bacteria most commonly identified by laboratories. A large number of viral gastrointestinal infections occur but most are never laboratory confirmed as symptoms are usually short-lived. Food poisoning outbreaks are described in Section 5. The majority of the NE HPT’s work on gastrointestinal infections relates to individual sporadic cases of infection.

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 (35 cases in 2017), but the prevention 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 2017 there were no serious outbreaks of STEC in the North East but there were a number of family clusters of cases.

Campylobacter infection is by far the most common bacterial cause of gastrointestinal infection reported regionally causing more than 75% of all cases. Reducing the numbers of campylobacter cases requires actions at all stages of meat (particularly chicken) production and processing from the farm all the way to, and within, the home. There were 388 more cases in 2017 compared to 2016 (3,257 vs 2,869). Case numbers have fluctuated between 2,772 and 3,525 cases over the past ten years.

Salmonella is the second most common bacterial cause of gastrointestinal infection. All cases of salmonella are investigated by the HPT and the local authority EHOs. The trend in number of cases has been fairly 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 2007 to 2017



Cryptosporidium infection is the most common protozoal gastrointestinal infection. Infection is often acquired from contact with contaminated animals or 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 2017 there were no significant outbreaks of cryptosporidiosis in the North East.

Other less common causes of food poisoning such as *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 North / PHE seasonal influenza vaccination report 2017/18.

Seasonal influenza

Moderate to high levels of influenza activity were seen in the community in England during the 2017-18 season with co-circulation of influenza B and influenza A(H3).³ Weekly rates of GP consultations for influenza like illness (ILI) were higher and exceeded the baseline threshold for longer (week 51 2017 to week 12 2018) when compared with the 2016-17 season (figure 4.5).³ Activity peaked in week 03 2018 at 54.1 per 100,000 population which was the highest peak since the 2010/11 season.³

A very high impact was seen in acute trusts in terms of laboratory confirmed hospital and ICU/HDU admissions.³ Hospital activity peaked in week 02 of 2018 and was higher than the previous 6 seasons.³ Just over half (52%) of admissions to ICU/HDU were due to influenza A with the remainder due to influenza B.³ Of those influenza A viruses that were typed, the majority were influenza A(H3N2).

Overall, influenza B positivity peak in week 02 2018 with the highest age specific positivity seen in 5-14 year olds and influenza A(H3) positivity peaked in week 52 2017 with the highest age-specific positive in the 65+ age group.³ The majority of circulating B strains were antigenically similar to the Northern Hemisphere quadrivalent vaccine strain and the majority of circulating A(H3N2) and A(H1N1) strains similar to the Northern Hemisphere trivalent/quadrivalent vaccine strains.³

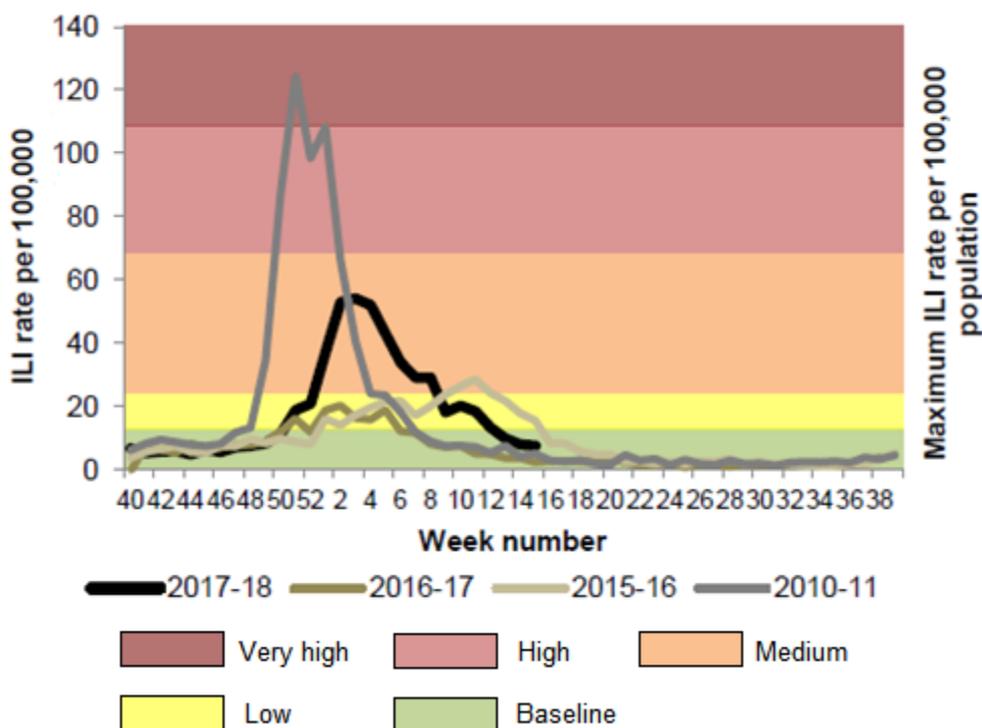
In common with previous A(H3N2) dominated seasons the impact was predominantly seen in older adults with most reports of respiratory outbreaks originating from care homes and the majority of admissions being in adults aged 65+ years. Between week 40 2017 and week 15 2018, 2,095 outbreaks of acute respiratory illness were reported in the UK to PHE (of which 1,650(78.9%) occurred in care homes) compared to 1,114 in 2016/17.³ In the North East a total of 49 outbreaks of influenza like illness were reported during the 2017/18 season, the majority (47) of which were in care homes/centres.

A total of 320 confirmed influenza deaths were reported in England between week 40 2017 and week 15 2018.³ Levels of excess all-cause mortality were similar to the 2016 to 2017 season but lower than the 2014 to 2015 season in which influenza A(H3) and influenza B also dominated.³

³ PHE. Surveillance of influenza and other respiratory viruses in the UK: Winter 2017 to 2018. May 2018. Available at:

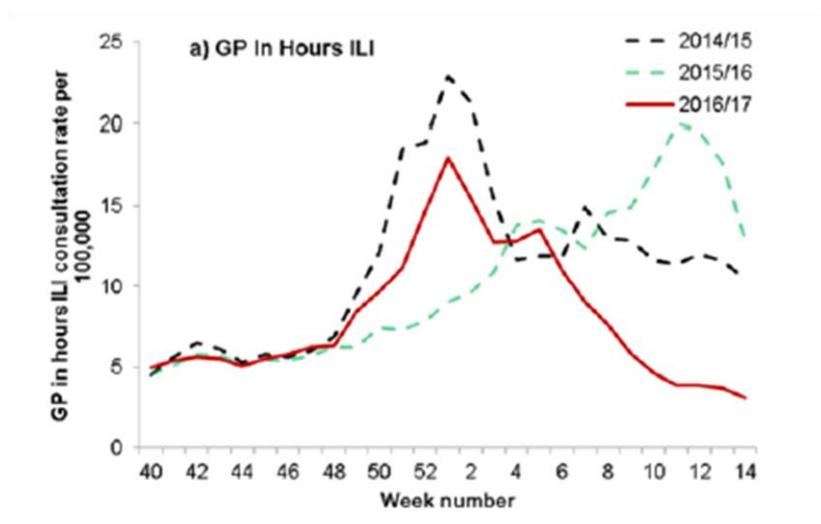
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/710483/Surveillance_of_influenza_and_other_respiratory_viruses_in_the_UK_2017_to_2018.pdf

Figure 4.5: Weekly all age GP influenza-like illness rates for 2017 to 2018 and past seasons, England (RCGP). Source: Adapted from PHE Flu annual report: winter 2017 to 2018



In common with previous H3N2 seasons (the last of which was 2014/15), the impact was predominantly seen in older adults with a high proportion of outbreaks (78%) occurring in care homes.³ The number and rate of hospital admissions for confirmed influenza cases peaked in week 05 2017 (161 admissions, 2.6 per 100,000 population trust catchment area).³ This peak was lower than the previous influenza season (2015/16) but higher than the last influenza A(H3N2) dominated season (2014/15). ICU/HCU admissions of confirmed influenza peaked in week 01 2017, the majority of which (95%) were due to influenza A. ICU admission occurred in all age groups but just under half (44%) of admissions were aged 65+ years.³

Figure 4.6: GP in-hours consultation rates for ILI winter 2016 – 2017.



Pandemic influenza

A pandemic of influenza infection may occur when a new flu virus circulates to which few people have any existing immunity. No specific pandemic influenza preparedness activities have been held in the North East since September 2017 although national LRF pandemic flu workshops were attended by colleagues from the North East LRFs.

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.

In 2017/18 a number of wild bird incidents of influenza A(H5N6) were reported across different PHE Centres in England. Sequencing data suggest that these viruses were of a European lineage not associated with cases of human illness to date and distinct from the more pathogenic strain seen in Asia.

No incidents have been reported in the North East in the 2017/18 season. 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 2012.³ 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. In 2017/18, three possible cases of MERS-

CoV were reported to the North East HPT all of whom tested negative. No positive cases have been reported in the UK since February 2013.

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

The most common sexually transmitted infections in the North East remain chlamydia, genital warts, herpes, gonorrhoea and syphilis. As noted in previous reports, STIs affect certain groups of the population more than others; infections in young people account for over 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 such as black Africans.

The main roles of PHE with regard to sexual health and HIV are surveillance of infections (see section 3.3), strategic work with partners to tackle the rising levels of sexually transmitted infections and HIV, and response to outbreaks.

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 2017, the most recent published STI and HIV figures (available <https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables> and <http://fingertips.phe.org.uk/profile/sexualhealth>)

During 2017/18 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.

Overall numbers of STIs in the North East in 2016

There were 18,121 new diagnoses (9540 M; 8567 F) of STIs in the North East in 2017, a slight increase (2%) from 2016. The overall rate is 687 / 100, 000 population (lower than the England rate of 762 / 100, 000). Within the region, rates at local authority level range from 473 per 100, 000 to 1,194 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 (702 and 649 per 100 000 residents respectively). There is more detail on these data in the Spotlight on STIs report.

Chlamydia

Chlamydia remains the most common STI in the region. The number of chlamydia cases diagnosed in North East residents increased by 6% in 2017 (8,554 cases) compared to 2016 figures (8,947), the rate of infection (362 per 100,000 population) is slightly lower than the overall England rate (367/100,000).

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 continued to increase in the North East with a 3% rise from 1,738 cases in 2016 to 1,815 cases in 2018; although the increase has slowed compared to previous years it is important to recognise that there has been a 39% increase since 2013. Over half of the cases (1,016 cases) were in men and within this group 525 were in men who have sex with men (MSM).

The concerns about antibiotic resistance in gonorrhoea continue; there has been an outbreak of highly resistant gonorrhoea in England over the past year; three cases of this strain were seen in the North East in early 2017. Investigations did not discover any links between the cases; however clinicians and laboratories remain vigilant for further cases.

Syphilis

The number of syphilis cases in the North East rose by almost 30% in 2017, from 156 cases in 2016 to 206 cases in 2017. 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 (170 / 206 new cases), a greater number of cases are also being seen in heterosexuals and the number of female cases (36 cases) was the highest since 2013.

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 in the population and the importance of surveillance and **close** networks with clinicians to identify changes in the patterns of infection in the community.

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.

HIV

The North East has a relatively low number of cases of HIV infection. In 2016 (the latest data available) 142 people were newly diagnosed with HIV; this was the highest number of new diagnoses since 2012. This brought the total of people living with HIV in the North East to 1,797.

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 2016/17 include:

- Thirty-seven per cent of newly diagnosed cases of HIV in 2016 were diagnosed 'late' or 'very late', which has a significant impact on long-term health outcomes. Late diagnosis remains an important challenge for the region, as well as for England as a whole 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.
- Twenty-two per cent 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
- 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 (in particular 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. An effective vaccine is available that can provide pre and post-exposure protection against hepatitis B infection. Where indicated, medical treatment of chronic infection may be effective in more than 50% of cases.

The North East Health HPT provides direct public health advice in relation to cases of acute hepatitis B and their contacts. In 2017 a total of 14 cases of acute infection were reported in the North East (see table below) compared to 16 cases in 2016, 8 cases in 2015, 16 cases in 2014 and 17 cases in 2013. The median age of cases was 44.5 years. Sexual transmission was the most likely route of exposure for 11 (79% of cases), with these cases reporting sex between men and women as the most likely source. During 2017, 200 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.

Hepatitis C (HCV) infection

It is estimated that around 160,000 people in the United Kingdom have chronic hepatitis C virus (HCV) infection, many of whom are unaware that they are infected. 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 in the United Kingdom. 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 to prevent HCV but people with HCV infection can benefit from the protection offered by hepatitis A and B vaccines.

There have been major developments in hepatitis C 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. Hepatitis C treatment in England is now being delivered through NHS Operational Delivery Networks (ODNs) which were established during 2015. In 2017, 465 newly detected hepatitis C cases were reported to the North East HPT, giving a rate of 17.8 per 100,000. This was considerably higher than the regional rate reported in 2016 (9.2 per 100,000), and was the highest rate reported in the 2013-2017 period, reversing a general decreasing trend in reporting in the region since 2012. It is important to note that changes in the number of laboratory reports of HCV may be reflective of changes in testing uptake and reporting, rather than variation in disease incidence.

Table 4.5: Acute Hepatitis B cases reported to the North East Health Protection Team in 2017

	Male	Female	Total
Number (%)	7 (50%)	7 (50%)	14
Median age (range)	48.5 (19-63)	44 (23-56)	44.5 (19-63)
Ethnicity			
- White British	6	5	11
- Unknown	1	2	3
Most likely place of transmission			
- UK	2	5	7
- Outside UK	1	0	1
- Not known	4	2	6
Most likely Source			
- Heterosexual sex	5	6	11
- Sex between men	0	0	0
- Unknown/other	2	1	3

In England, against a background of rising HCV-related mortality that was predicted to increase in the future, the first fall in deaths in over a decade has been sustained with a 3% fall in deaths from HCV-related end-stage liver disease and hepatocellular carcinoma between 2014 and

2016. This suggests that increased treatment with new DAA drugs may be starting to have an impact.

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. An enhanced prison-based screening and referral pathway for HCV (and also HBV, HIV and syphilis) has been successfully implemented in all North East prisons. PHE North East continues to actively support the North East and Cumbria Hepatitis C ODN to ensure effectively delivery of treatment in the region.

4.7. Tuberculosis

There were 110 cases of TB reported to the Enhanced Tuberculosis Surveillance System (ETS) in North East residents for the calendar year of 2017 (provisional data), which is slightly lower than the finalised figure for the calendar year of 2016 (124). As 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.

On the basis of the finalised 2016 data, the North East remains one of the lowest incidence regions in England, with 4.7 cases per 100,000 population (compared with an incidence in England of 10.2 cases per 100,000 population). However, this figure masks considerable in-region variation: for example, Newcastle has 15.7 cases per 100,000 population, and Middlesbrough 9.3 per 100,000. 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 three 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 do more in the North East despite our low incidence.

The cohort of TB patients in the North East has its specific challenges, 16% have identified social risk factors (vs 11% in England as a whole); and 4.9% have HIV co-infection (vs 3.8% in England as a whole). 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. Most North East pulmonary TB cases complete their treatment within 12 months. 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 (42%) 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 (71% 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 wrote to GPs across the North East highlighting the possibility of TB diagnoses in UK-born residents, and sharing the details of their local TB

nursing team. This was backed up by some targeted social media work which received good levels of engagement.

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.

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)

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.

As reported in previous Annual Reports the North East Health Protection Team and Field Services have been conducting enhanced surveillance on IPD since 2006. After ten years of collecting data this has now ceased and over the next twelve months the data will be analysed and a series of final reports produced. The 2018/19 Annual report will contain a summary of the key findings of this research.

4.9. Healthcare associated infection (HCAI)

Prevention and control of healthcare associated infections (HCAIs) is the responsibility of provider organisations. PHE supports organisations in this work in a number of ways.

The local field epidemiology 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 Enterobacteriaceae (CPE), a complex set of rules and 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 in a given year with financial and other penalties should these targets fail to be reached.

The Health Protection Team (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 2017/18 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

Antimicrobial resistance remains a growing threat to public health. 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 has 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. In March 2018, PHE arranged a regional cross-system educational event on antimicrobial resistance which was well-attended and highly rated by participants.

The majority of hospital Trust laboratories in the North East electronically report the results of antibiotic sensitivity tests from microbiological specimens. 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. New Quality Premiums have been introduced for CCGs, encouraging them to reduce the total number of GNBSIs in their population. In addition, there is a Government ambition to reduce the number of healthcare associated GNBSIs by 50% by 2020.

Carbapenemase-producing enterobacteriaceae (CPE) are a large family of gram-negative bacteria which are able to 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. The number of CPE cases is also carefully monitored by PHE's Field Service on behalf of the NHS.

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 very common but the disease (vomiting and some diarrhoea) is almost always self-limiting. Concern is higher in relation to an outbreak where more serious disease occurs, for example, *E. coli* O157 can cause serious illness including kidney damage.

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 incidents in hospitals.

5.2 Numbers and types of incidents

In total, in 2017/18, the NE HPT was involved in investigating and where necessary managing **168** community outbreaks, incidents and clusters (including non-GI care home incidents). There were also **327** outbreaks of gastrointestinal illness in care homes, compared with **250** in 2016/17.

This involved **18** incident /outbreak control teams being established by the HPT (19 in 2016/17). These incidents/outbreaks comprised a range of pathogens including norovirus, salmonella, campylobacter, influenza, pneumococcal disease, hepatitis A and tuberculosis.

There was also a range of different premises involved including schools, hotels/restaurants, pubs, activity centres, care homes and a butcher's shop.

Particular outbreaks of note were:

- A salmonella outbreak linked to a butcher's shop
- A salmonella outbreak linked to a restaurant
- Two norovirus outbreaks linked to the same activity centre
- Two combined influenza and pneumococcal outbreaks in care homes
- A campylobacter outbreak linked to a hotel

5.3 Hospital incidents/outbreaks

Incidents and outbreaks occurring in hospitals are the primary responsibility of NHS trusts and the response is led by the trust Director of Infection Prevention and Control. However, the HPT provides advice and support, calling in national advice as needed. In 2017/18 the HPT provided support in **12** significant incidents (compared with 19 in 2016/17, 19 in 2015/16, 16 in 2014/15 and 21 in 2013/14).

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 – 44 up to 31/03/18

5.4 Gastrointestinal illness in care homes

In 2017/18 there were 327 outbreaks of GI illness in care homes compared with 250 in 2016/17, 275 in 2015/16, 328 in 2014/15, 259 in 2013/14 and 346 in 2012/13 (based on date of report).

The outbreaks comprised:

- **270** probable/ confirmed Norovirus
- **33** Sapovirus
- **11** Rotavirus
- **7** probable/confirmed Clostridium perfringens
- **2** Astrovirus
- **2** Campylobacter

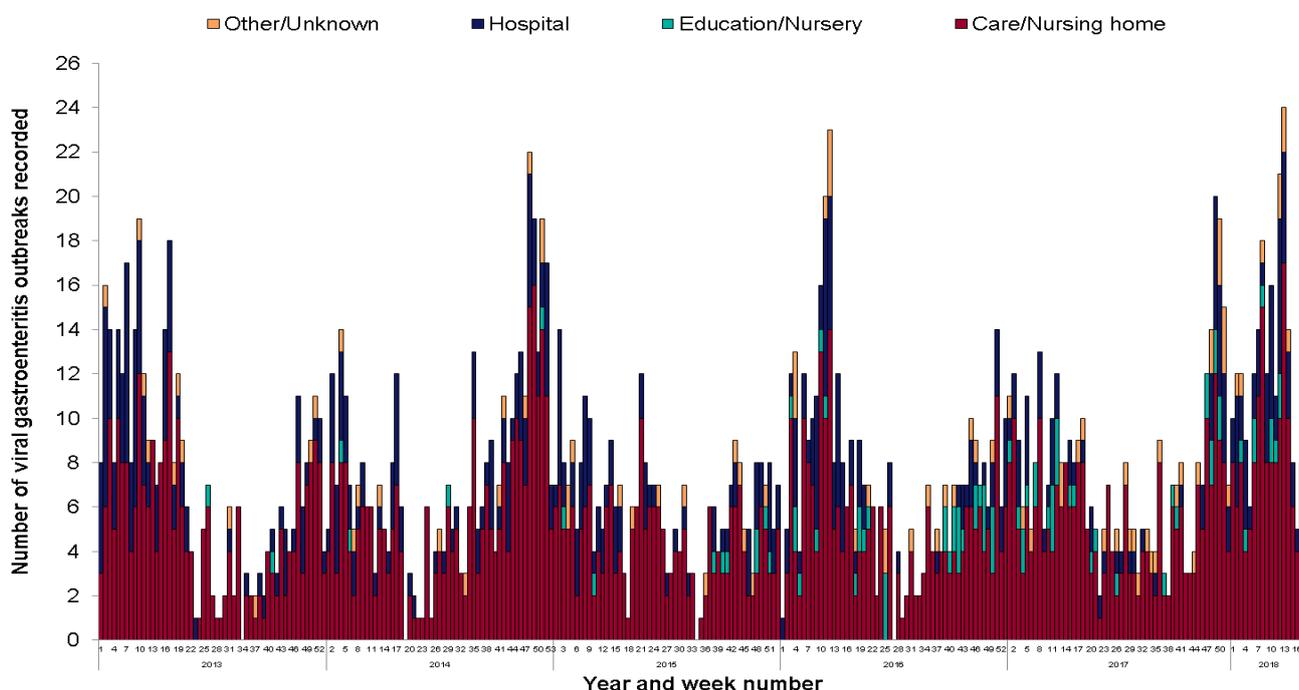
- 1 Adenovirus
- 1 unknown

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 epidemiology team provides a weekly report on gastrointestinal infectious diseases (figure 5.1 next page). This shows all gastrointestinal infectious disease outbreaks across the North East, demonstrating the variation seen by season and also between years.

Figure 5.1: All reports of gastrointestinal infectious disease outbreaks (suspected or confirmed) by setting in North East week 1, 2013 to week 18, 2018



6. Emergency preparedness, resilience and response (EPRR)

6.1. Preparedness

Structures and processes

The PHE Centre 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, in particular threats related to terrorism, national expert advice and rapid escalation will be immediate.

The PHE Centre delivers these functions through the HPT and the Emergency Preparedness Manager (EPM). The HPT second on-call rota provides a senior level, 24/7, response to major incidents and emergencies in the North East, supported by the EPM on a 24/7 regional (North of England) rota. The PHE's 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 PHE Centre is represented on the three multi-agency Local Resilience Forums (LRFs) at strategic, tactical and sub group levels. The NE 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 within the NE has continued throughout 2017/18 with full support from the PHE Centre who currently hold the positions of Chair of the NE Training and Exercising Chairs Group and Vice-chair of the NE CBRN Group.

The PHE Centre is 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 and Tees).

The PHE Centre continues to maintain a strong collaborative working relationship with the NHS England Cumbria and the North East EPRR team including a joint work-plan covering areas such as risk, sustainability and seasonal flu.

Plans

The PHE 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.

The PHE Centre contributes to LRF plans for a range of incidents. There are a number of major industrial sites in the North East which are required to produce Control of Major Accident Hazards (COMAH) off-site 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 PHE Centre continues ensure that COMAH and REPPiR plans for the NE 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. The North East PHE Centre STAC Activation Plan is in place and Directors of Public Health have agreed to continue providing the STAC chair role through an on-call rota with honorary contracts in place.

The PHE Centre is currently leading in the development of a new NE CBRN Tactical Framework with colleagues across the NE and internally worked on a national project to standardise Incident Coordination Centre (ICC) planning.

Exercises and training

PHE Centre staff are actively engaged in supporting the planning and management of multi-agency exercises across the region. In 2017/18, these exercises included a range of scenarios such as terrorist attack, rabies, cyber-attack and loss of power. Exercises are at either tactical or strategic level.

Internally the PHE Centre has played into a national exercise to test the new National Incident and Emergency Response Plan along with a workshop looking at business continuity in the case of a widespread power outage.

In 2017/18 the annual STAC update offered to Directors of Public Health and the annual Health Protection update for local authority public health staff were combined into a single full day event. This event was successfully delivered in May 2017 covering outbreak case studies, influenza and lessons learned from STAC exercise among other topics.

Internally within the Centre training is regularly delivered on EPRR Awareness for all staff and the PHE Centre led on the development of new standardised national ICC training modules.

LHRP Audit

In July 2017 a letter was sent to LHRP co-chairs across the country from PHE, NHS England and the Association of Directors of Public Health requesting LHRPs to participate in an assurance exercise. This assurance exercise was the result of a House of Commons Select Committee report on the public health system post 2013 publicised in September 2016. The questionnaire provided covered health protection capabilities such as outbreak response, radiation and avian influenza. The PHE Centre worked closely with NHS England Cumbria and the North East and the local health system to agree a response to the audit which was open and honest. Following submission of the NE response, the LHRP has agreed to review areas reported as partial or noncompliance with a view to adding to the LHRP work plan any appropriate local solutions. We are currently awaiting responses from national teams on areas highlighted in our response as being national issues. It is expected that this audit will be repeated in 2018/19.

6.2. 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, calling the PHE Centre 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.

In 2017/18, the majority of alerts received by the EPMs required an initial risk assessment only, with no further action required to protect the population. There were however a number of more significant incidents requiring acute HPT response including fires at waste recycling facilities and a chemical incident.

7. Communications team

The PHE North East communications team is part of the national communications directorate but is embedded within local services. It serves PHE's broader health and wellbeing remit as well as supporting colleagues within health protection and healthcare public health.

During 2017/18 the team worked closely with communication colleagues in our North East local authorities and NHS England via the public health communications network and wider communication set-ups.

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 campylobacter, salmonella and cryptosporidium. The team has supported multi-agency responses to TB within various community settings; including supporting social media work to raise awareness of late diagnosis. Media interest and public concern around seasonal influenza was particularly heightened in 2017/2018 and the team supported the dissemination of reassurance messaging and national data both publically and via stakeholder engagement.

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.

Severe weather incidents across the year have been supported by the communications team who have cascaded appropriate emergency planning messaging with stakeholders for incidents such as the extreme cold weather experienced this winter.

The team, working in partnership with public health communications network facilitates mutual support and shared learning and this partnership is instrumental in providing key public relations support to a range of national marketing campaigns such as Keep Antibiotics Working, Smokefree NHS, Stay Well This Winter, Stoptober, One You, Be Clear on Cancer and Change4Life. As well as supporting national campaigns and initiatives the team works closely with north east communications colleagues to support a range of local initiatives and campaigns.

8. 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 has been commissioned by Government to review the evidence for effective and cost-effective interventions in a variety of domains and provide practical recommendations for actions that will significantly reduce harm from air pollution and this work is ongoing.

The EHE department covers all of England - the support listed below is specific to the North East. In 2017/18 CRCE EHE and the HPT have:

- Supported local authorities in developing business cases for work plans to address nitrogen dioxide exceedances, and ideally in parallel deliver wider health co-benefits by encouraging active travel and reducing the burden of air pollution more generally.
- With the Health and Wellbeing team, provided evidence base support for the Healthy New Towns programme, with Darlington being one of the ten demonstrator sites.
- Provided 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.

- Provided advice to both the Environment Agency and a member of the public in relation to long standing complaints arising from emissions to air from a plastics manufacturer.
- CRCE have updated or provided new 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. As part of this work, CRCE has also worked closely with the North East Emergency Preparedness Manager to ensure that relevant emergency plans that involve chemical risks remain current and accessible to staff.
- Developed scenarios for local and national exercises and supported the Health Protection Team in exercises with Scientific Technical Advice Cells for white powder and COMAH incidents.
- Delivered training at local universities.
- Provided training to Health Protection staff, in particular to Specialist Trainees.
- With the Environment Agency, delivered a training day on contentious sites for public health trainees, with guests from local authority Environmental Health teams to provide additional case studies and context.
- Worked with the North East Ambulance Service and the Environment Agency to develop an experiment to provide better risk assessments for chemically contaminated patients.
- Worked with Northumbrian Water in formulating a study to evaluate and improve awareness of lead sources for new mothers utilising a “making every contact count” approach via health visitors.

9. Improving the quality of health protection services

9.1. 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 165 questionnaires were posted in 2017 and 115 returned (69%).

A summary of the key findings are as follows:

- 90% had contacted the HPT either once or twice in the previous 12 months.
- 98% said they were given the appropriate amount of information.
- 98% said that they had understood the advice given 'a lot' or 'completely'.
- 99% 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 satisfaction than was reported last year and reflect the positive experience people have when interacting with the team.

9.2. Research and Development

As in previous years, in 2017/18 the HPT and the local field epidemiology team have actively engaged in a number of research projects. In addition, staff produced reports, presentations and posters to disseminate the lessons from key incidents and outbreaks to professional audiences outside the North East.

Publications in 2017/18 included:

- Papers in peer review journals – 9
- Oral presentations at national/international conferences – 1
- Poster presentations at national/international conferences – 6

Further details of publications are included in appendix 4.

Appendix 1: Notifications and other reports of infectious disease in North East residents in 2017

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	20	3.8	344	65.9	2	0.4	8	1.5	81	15.5
		Darlington	6	5.7	15	14.2	6	5.7	2	1.9	10	9.5
		Total	26	4.1	359	57.2	8	1.3	10	1.6	91	14.5
	North of Tyne	Newcastle upon Tyne	6	2.0	276	93.1	0	0.0	4	1.3	51	17.2
		North Tyneside	9	4.4	103	50.7	1	0.5	2	1.0	28	13.8
		Northumberland	9	2.8	124	39.2	5	1.6	3	0.9	50	15.8
		Total	24	2.9	503	61.7	6	0.7	9	1.1	129	15.8
	South of Tyne & Wear	Gateshead	13	6.4	108	53.6	2	1.0	3	1.5	41	20.3
		South Tyneside	8	5.4	33	22.1	0	0.0	4	2.7	26	17.4
		Sunderland	10	3.6	49	17.6	1	0.4	12	4.3	54	19.4
		Total	31	4.9	190	30.2	3	0.5	19	3.0	121	19.2
	Tees	Hartlepool	7	7.5	10	10.8	0	0.0	4	4.3	1	1.1
		Middlesbrough	11	7.8	37	26.4	3	2.1	5	3.6	5	3.6
		Redcar and Cleveland	8	5.9	26	19.2	0	0.0	6	4.4	1	0.7
		Stockton-on-Tees	19	9.7	56	28.6	0	0.0	3	1.5	12	6.1
		Total	45	8.0	129	22.9	3	0.5	18	3.2	19	3.4
	Total		126	4.8	1,181	44.8	20	0.8	56	2.1	360	13.7
	England & Wales	Total	1693 ²	2.9	7,722 ²	13.2	362 ²	0.6	657 ²	1.1	3302 ²	5.7

1 Data source: EpiNorth3, 2017 data, Diagnosis (confirmed, probable and possible cases)

2 Data source: NOIDS, 2017 data used. Local and national data are not comparable, only cases which have been notified by a registered medical professional are included in the national data.

3 Data source: HPZone 2017 data for England only

4 SGSS, 2017 data. Includes cases confirmed by NHS laboratories only.

5 Data source: HPZone 2017 data for England only. Includes reported infections of hepatitis A, B, C and E.

6 Data source: Enhanced Tuberculosis Surveillance (ETS), 2017 data.

7 Data source: Enhanced Tuberculosis Surveillance (ETS), 2017 data for England only.

All rates are per 100,000 population, calculated using mid-year population estimates for 2016 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	10	1.9	83	15.9	675	129.3	77	14.7	5	1.0
		Darlington	0	0.0	26	24.6	143	135.4	11	10.4	0	0.0
		Total	10	1.6	109	17.4	818	130.3	88	14.0	5	0.8
	North of Tyne	Newcastle upon Tyne	2	0.7	41	13.8	345	116.4	32	10.8	1	0.3
		North Tyneside	3	1.5	22	10.8	258	126.9	11	5.4	1	0.5
		Northumberland	3	0.9	30	9.5	393	124.4	35	11.1	1	0.3
		Total	8	1.0	93	11.4	996	122.1	78	9.6	3	0.4
	South of Tyne & Wear	Gateshead	1	0.5	36	17.9	177	87.8	23	11.4	0	0.0
		South Tyneside	3	2.0	20	13.4	125	83.7	17	11.4	0	0.0
		Sunderland	1	0.4	38	13.7	238	85.6	37	13.3	0	0.0
		Total	5	0.8	94	14.9	540	85.9	77	12.2	0	0.0
	Tees	Hartlepool	0	0.0	14	15.1	117	126.1	8	8.6	1	1.1
		Middlesbrough	3	2.1	27	19.2	257	183.1	15	10.7	1	0.7
		Redcar and Cleveland	5	3.7	22	16.2	268	197.9	18	13.3	4	3.0
		Stockton-on-Tees	1	0.5	25	12.8	260	132.9	12	6.1	0	0.0
		Total	9	1.6	88	15.6	902	159.8	53	9.4	6	1.1
	Total		32	1.2	384	14.6	3,256	123.5	296	11.2	14	0.5
	England & Wales	Total	666 ³	1.2	9,631 ⁴	16.5	57,462 ⁴	98.4	4,624 ⁴	7.9	316 ⁴	0.5

1 Data source: EpiNorth3, 2017 data. Confirmed diagnosis.

2 Data source: NOIDS, 2017 data used. Local and national data are not comparable, only cases which have been notified by a registered medical professional are included in the national data.

3 Data source: HPZone 2017 data for England only

4 SGSS, 2017 data. Includes cases confirmed by NHS laboratories only.

5 Data source: HPZone 2017 data for England only. Includes reported infections of hepatitis A, B, C and E.

6 Data source: Enhanced Tuberculosis Surveillance (ETS), 2017 data.

7 Data source: Enhanced Tuberculosis Surveillance (ETS), 2017 data for England only.

All rates are per 100,000 population, calculated using mid-year population estimates for 2016 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	3	0.6	14	2.7	56	10.7	4	1	8	1.5
		Darlington	0	0.0	5	4.7	19	18.0	0	0.0	2	1.9
		Total	3	0.5	19	3.0	75	11.9	4	0.6	10	1.6
	North of Tyne	Newcastle upon Tyne	4	1.3	53	17.9	52	17.5	8	2.7	32	10.8
		North Tyneside	1	0.5	9	4.4	18	8.9	5	2.5	6	3.0
		Northumberland	0	0.0	8	2.5	26	8.2	5	1.6	5	1.6
		Total	5	0.6	70	8.6	96	11.8	18	2.2	43	5.3
	South of Tyne & Wear	Gateshead	1	0.5	24	11.9	64	31.7	3	1.5	9	4.5
		South Tyneside	2	1.3	13	8.7	34	22.8	4	2.7	1	0.7
		Sunderland	2	0.7	14	5.0	28	10.1	3	1.1	16	5.8
		Total	5	0.8	51	8.1	126	20.0	10	1.6	26	4.1
	Tees	Hartlepool	0	0.0	11	11.9	17	18.3	1	1.1	2	2.2
		Middlesbrough	0	0.0	31	22.1	40	28.5	0	0.0	19	13.5
		Redcar and Cleveland	0	0.0	7	5.2	7	5.2	2	1.5	3	2.2
		Stockton-on-Tees	0	0.0	26	13.3	11	5.6	0	0.0	7	3.6
		Total	0	0.0	75	13.3	75	13.3	3	0.5	31	5.5
	Total		13	0.5	215	8.2	372	14.1	35	1.3	110	4.2
	England & Wales	Total	1,333 ⁵	2.4	5,083 ⁵	9.2	6,428 ⁵	11.6	1,181 ⁵	2.1	5,083 ⁷	9.2

1 Data source: EpiNorth3, 2017 data. Diagnosis (confirmed, possible and probable)

2 Data source: NOIDS, 2017 data used. Local and national data are not comparable, only cases which have been notified by a registered medical professional are included in the national data.

3 Data source: HPZone 2017 data for England only

4 SGSS, 2017 data. Includes cases confirmed by NHS laboratories only.

5 Data source: HPZone 2017 data for England only. Includes reported infections of hepatitis A, B, C and E.

6 Data source: Enhanced Tuberculosis Surveillance (ETS), 2017 data.

7 Data source: Enhanced Tuberculosis Surveillance (ETS), 2017 data for England only.

All rates are per 100,000 population, calculated using mid-year population estimates for 2016 from the Office of National Statistics (ONS)

Appendix 2: Schedule of routine PHE North East surveillance reports

	Output¹	Frequency	Email Recipients
Reports sent to external partners	SGSS Trust Feedback Report (SGSS Weekly Laboratory report)	Weekly	HPT, FET NE, LPHM, ATMs
	Influenza and influenza-like illness (ILI) Bulletin	Weekly	HPT, FET NE, LPHM, SIT, PHE Regional Office, CCGs, NHSE, ATMs, emergency planners, others
	Infectious Intestinal Disease (IID) Bulletin	Weekly	HPT, FET NE, LPHM, SIT, PHE Regional Office, CCGs, NHSE, ATMs, emergency planners, others
	Seasonal Respiratory Disease Report	Weekly	HPT, FET NE, LPHM, virologists, contributing ATMs
	HCAIs Monthly Summary	Monthly	HPT, FET NE, SIT, LPHM, ICNs, ATMs
	IPD Laboratory Audit Report	Monthly	FET NE, LPHM, ATMs
	Health Protection Surveillance Report (former DsPH Report) ²	Quarterly	HPT, FET NE, LPHM, SIT, DsPH, LA EHOs, ATMs
	Care Home outbreak report	Quarterly	HPT, FET NE, DsPH,
	Vaccine Preventable Diseases (VPD) Bulletin	Quarterly	HPT, FET NE, LPHM, SIT, DsPH, ATMs
	Anti-Microbial Resistance (AMR) Report	<i>Quarterly (under review)</i>	HPT, FET NE, LPHM, ATMs, ICNs
	Sexual Health Bulletin	Quarterly	HPT, FET NE, LPHM, SH Leads, DsPH, ATMs, GUM consultants, ID physicians
	Spotlight Report STI	Annual-September	HPT, FET NE, LPHM, SH Leads, DsPH, ATMs, GUM consultants
	Spotlight Report HIV	Annual-December	HPT, FET NE, SH Leads, DsPH, ATMs, GUM consultants, ID physicians
	LASER report (STI)	Annual-December	HPT, FET NE, DsPH
	Annual TB Report	Annual-November	HPT, FET NE, LPHM, TB leads, TB clinicians, ATMs
	Campylobacter Report	Annual-February	HPT, FET NE, LPHM, LA EHOs, ATMs
Salmonella Report	Annual-March	HPT, FET NE, LPHM, LA EHOs, ATMs	
Annual Hepatitis C Report	Annual-January	HPT, FET NE, LPHM, DsPH, ID physicians, virologists, ODN, Drug action teams	

	<i>Output¹</i>	<i>Frequency</i>	<i>Email Recipients</i>
	Annual Hepatitis B Report	Annual-March	HPT, FET NE, DsPH, ID physicians, virologists, ODN, Drug action teams
	IPD Annual Report	Annual-March	HPT, FET NE, LPHM, ATMs, ID physicians, GP via CCG
<i>Reports for HPT/FET NE</i>	EpiNorth3 Exceedance Alert	Daily	HPT, FET NE
	EpiNorth3 Typing Coincidence Alert	Daily	HPT, FET NE
	EpiNorth3 Postcode Coincidence Alert	Daily	HPT, FET NE
	EpiNorth3 Exceedance Report	Weekly	HPT, FET NE
	EpiNorth3 Postcode sector Report	Weekly	HPT, FET NE
	E piNorth3 Exposures Exceedance Report	Weekly	HPT, FET NE
	EpiNorth3 Weekly Case Summary Report	Weekly	HPT, FET NE
	SGSS Quarantined Data Report	Weekly	HPT, FET NE
	COVER data charts	Quarterly	HPT, FET 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)	FET NE	Field Epidemiology Team North East
ATMs	Acute Trust Microbiologists	ICNs	Infection Control Nurses
SIT	Screening & Immunisation Team	LPHM	Lead Public Health Microbiologist
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 FES)

Papers published in peer review journals

- Houseman C, Hughes GJ, Chapman KE, Wilson D, Gorton R. **Increased incidence of Invasive Pneumococcal Disease, North East England, 2015/2016**. *Emerging Infectious Diseases*, 2017; 23 (1): 122-126
- Wilson D, Dolan G, Aird H, Sorrell S, Dallman TJ, Jenkins C, Robertson L, Gorton R. **Farm-to-fork investigation of an outbreak of Shiga toxin-producing Escherichia coli O157**. *Microb Genom*. 2018. doi: 10.1099/mgen.0.000160
- Dolan G, Chauhan M, Foster K, Basta M, Bushby S, White C, Verlander NQ, Gorton R. **Factors associated with repeat diagnosis of syphilis in genitourinary medicine (GUM) clinic attendees in the North East of England, 2002-2014**. *Int J STD AIDS*. 2018. <https://doi.org/10.1177/0956462418757554>
- Henderson M, Howard SJ; **Screening for latent tuberculosis in UK health care workers**, *Occupational Medicine*, Volume 67, Issue 8, 2 December 2017, Pages 641–643, <https://doi.org/10.1093/occmed/kqx119>
- Howe B, Kirsty K, Waldram A, Hussey J. Challenges in the management of syphilis in pregnancy: completing a multicentre audit cycle with mixed outcomes. *International Journal of STD & AID*. 2018; 29(4):418-420
- Waldram A, Dolan G, Ashton PM, Jenkins C, Dallman TJ. Epidemiological analysis of Salmonella clusters identified by whole genome sequencing, England and Wales 2014. *Food Microbiol*. 2018;71:39-45.
- Kanagarajah S, Waldram A, Dolan G, Jenkins C, Ashton PM, Carrion Martin AI, Davies R, Frost A, Dallman TJ, De Pinna EM, Hawker JI, Grant KA, Elson R. Whole genome sequencing reveals an outbreak of Salmonella Enteritidis associated with reptile feeder mice in the United Kingdom, 2012-2015. *Food Microbiology*. 2018 May; 71:32-38. doi: 10.1016/j.fm.2017.04.005. Epub 2017 Apr.
- Waldram, A., Vivancos, R., Hartley, C. & Lamden, K. Prevalence of Giardia infection in households of Giardia cases and risk factors for household transmission. *BMC Infect. Dis*. 2017; 17(1):486.
- Kwiatkowska RM, Manley P, Sims B, Lamagni T, Ready D, Coelho J, Alsaffar L, Beck CR, Neely F. Outbreak of group A Streptococcus emm94.0 affecting people who inject drugs in southwest England, April 2017. *Am J Infect Control*. 2018 Feb; 46(2):238-240.

Oral presentations on research to conferences

- Helen Bagnall, M. Henderson, R. Chalmers, G. Dolan: Use of gp60 subtyping in the investigation of cryptosporidiosis cases linked to two swimming pools, and the identification of a rare subtype of *Cryptosporidium hominis*, England, October 2016. ESCAIDE. November 2017

Poster presentations on research to conferences

- Hope Simpson, Jonathan Lawler, Sarah Morey, Russell Gorton, Manoj Valappi, Stuart McPherson. Mapping treated and untreated hepatitis C infections in the North East of England to facilitate the strategic development of hepatitis C services. British Association for the study of the liver. September 2017

- K Houseman, K Chapman, P Manley, R Gorton, D. Wilson, G.J. Hughes. Decreasing 30-day mortality following invasive pneumococcal disease, north east of england, 2006–2016. PHE Research and Science Conference. March 2018
- K Houseman, K Chapman, P Manley, R Gorton, D Wilson, GJ Hughes: Decreasing 30-day mortality following invasive pneumococcal disease, north east of england, 2006–2016. Five Nations Conference. March 2018
- Helen Bagnall, Petra Manley, Joan Henderson, Russell Gorton: Exposing exposures: automation of infectious disease exposure exceedance reporting in the North East of England. PHE Research and Science Conference. March 2018
- Helen Bagnall, Petra Manley, Joan Henderson, Russell Gorton. Exposing exposures: automation of infectious disease exposure exceedance reporting in the North East of England. Five Nations Conference. March 2018
- P Acheson, E Grunert, J Kinsella-Shenton, K Stoker, S Ziolkowski, H Bagnall. Campylobacter parfait – an old favourite with a novel twist. Five Nations Conference. March 2018

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.

BETTER CARE FUND 2017 - 2019

Purpose of the Report

1. To update the Health and Wellbeing Board on delivery of the 2017-2019 Better Care Fund submission and associated plans.
2. To provide the Board with a Year End position on the Fund at the end of 2017/2018 and an overview of the changes to the expenditure plan for 2018/2019.
3. To update the Board on updated guidance received in July 2018 in respect of the second year of the plan.

Background

4. As reported to this Board in September 2017 the BCF plan 2017-2019 has 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.
 - (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.
5. The two-year plan remains in place and this report provides a mid-term update.

Recommendation

6. HWBB is asked to:
 - (a) Note the progress to date on delivering 2017-19 Better Care fund Objectives.
 - (b) Note the delivery of the Better Care Fund within the financial envelope in 2017/18 and the plans to continue delivery with minimal alteration in 2018/19.
 - (c) Note the position in respect of the national metrics and the actions taken.

Reasons

7. The recommendations are supported by the following reasons :

- (a) The two-year plan remains in place with delivery progressing well; new guidance issued in June has not required any amendment or addition. Scheme reviews during the year have led to small changes in the expenditure plan for 2018/19 but not at a material level.
- (b) There is an expectation that a further plan will be required for 2019/20 but no guidance has yet been received.
- (c) This report summarises the current position.

Suzanne Joyner
Director of Children and Adults

Background Papers

The Better Care Fund narrative plan 2017 - 2019

Pat Simpson : Extension 6082

S17 Crime and Disorder	Not applicable
Health and Well Being	The Better Care Fund is owned by the HWBB
Carbon Impact	None
Diversity	None
Wards Affected	All
Groups Affected	Frail elderly at risk of admission/re-admission to hospital
Budget and Policy Framework	Budgets pooled through a s75 agreement between DBC and Darlington CCG
Key Decision	No
Urgent Decision	No
One Darlington: Perfectly Placed	Aligned
Efficiency	New ways of delivering care have the capacity to generate efficiencies
Implications on Looked After Children and Care Leavers	none

Healthcare services to Care Homes

8. A BCF Darlington Care Home Commissioning Delivery Group has been established, to aid closer working of health and social care commissioners to support the residential care sector.
9. The GP Alignment Scheme has been reviewed as not all practices were taking part leading to inequitable access by homes. The new approach is delivered through the Federation and takes the shape of a monthly “ward huddle”. This is in the form of an intensive MDT (led by GP, with CPN, community matron, and therapist) at every home every month to review residents who have had an unplanned admission, three unplanned community matron visits, had a fall, or had an adverse medications management event. Recommendations are then made to the person's own GP.

Primary prevention and care navigation equipping people to be resilient and self-reliant

10. A social prescribing testbed, trialling a primary prevention approach, ran as planned to April 2018, with Wellbeing Navigators appointed from the voluntary and community sector, building on experience gained through the MDT approach at GP Practices. Lessons learned from the testbed have informed the development of a care co-ordination scheme to be delivered through the Federation. Implementing the new approach is currently on hold while the detail of the new community health contract are worked through, to ensure close and effective working.
11. Allied to this is the development and provision of a comprehensive directory of resources and community assets for Darlington. Livingwell.Darlington is up and running and efforts to ensure it is kept fully and effectively populated, and able to give easy access to information about community assets and resources.

Intermediate Care

12. An improved reablement pathway is currently being prepared for implementation at the Council.
13. In parallel the CCG has reviewed its step down provision through Community Hospitals and nursing homes (Ventress and Eastbourne). It will be changing its offer to ensure equitable provision and through the integrated care group started to look at whether something jointly can be commissioned in terms of an intermediate care bed base for Darlington. Work is underway to identify at the Council its current usage of beds for step-up provision and identify what is possible and desirable.
14. A deep dive into the mechanism of collecting the ASCOF 2B data is currently underway to ensure the data is robust and reliable and able to be used to inform service improvement.
15. A BCF Darlington Intermediate Care Delivery group is being established to ensure system-wide co-ordination.

Transfers of Care: High Impact Change Model

16. Patient flow and discharge planning is pivotal, and work to implement the high Impact Changes will continue. Monitoring delivery of the High Impact change model is now part of the quarterly monitoring required nationally. The Local Authority and health partners have been working together on discharge planning and delivery for a number of years and the BCF Transfers of Care delivery group is focusing on patient flow.
17. The BCF Darlington Transfers of Care group is in place, bringing together hospital, commissioning and provider representatives to further progress the work. This group has “ownership” of the High Impact Change model, and has developed a system-wide action plan.

New Models of Care

18. This workstream is the link between the New Models of Care Programme in Primary Care (the development of care hubs) with BCF delivery. Consequently the key deliverables are included in the Transfers of Care and Intermediate Care.

Supporting carers and delivering DFG adaptations

19. While part of the BCF pooled budget, the work to deliver support to carers and the DFG are led outside of BCF.

Dementia

20. New schemes to improve diagnosis of dementia in minority communities, and to offer activities including singing for the brain, swimming for the brain and brain games have been commissioned. Impact will become measureable from mid-year.

Additional iBCF Grant Plan

Maintaining the Core Service during transformation

21. Darlington Borough Council was ranked seventh in respect of social-care related delays to transfer of care on the NHS-social care interface dashboard (last updated December 2017). The Council is also a high spending authority by comparator group in terms of per-head of population expenditure on social care. These two circumstances are linked.
22. The new grant funding (£2.1m in 2017/18 and £1,4m in 2018/19) is being used to offset expenditure on current pressures and demand to ensure sustainability (50%) while the service undergoes transformation (50%). This will reduce the immediate Adult Social Care (ASC) budget pressure and achieve a more financially stable position for ASC in the medium term when a transformed service can operate sustainably within its resources.

23. In 2017/18 key areas where the grant was used include the Rapid Response Service, which expedites the discharge of people from hospital, the engagement of external consultant support to identify where change will result in improved service and increased efficiency, and the supernumerary review team examining every package of care and identifying where change would benefit the person.
24. In 2018/19 we anticipate these main uses to continue, albeit with a taper, and to include implementing changes identified by our external consultancy support, including a programme of workforce development.

Transforming the service

25. In 2017/18 the main uses to which the iBCF additional grant was put included the extensive review of our reablement service, the implementation of agile working through equipping staff with appropriate tools including laptops and table computers, support for new community asset and resource directory Livingwell.Darlington.
26. This year the focus will be on moving those deliverables forward. The implementation of the new reablement pathway will be a significant piece of work supported by iBCF grant. First point of contact is also undergoing improvement supported by the grant, and a portion of grant is reserved for delivering any local authority changes required through the delivery of external, whole system programmes such as New Models of Care and High Impact Change model implementation.

Performance and Monitoring

Summary of the 2017/18 Q4 (year-end) national monitoring report

27. All monitoring requirements in 2017/18 were met on time, and endorsed by Suzanne Joyner and Ali Wilson on behalf of the Health and Wellbeing Board. The final quarter monitoring report was submitted in April.
28. The monitoring report required confirmation that Darlington complies with the national conditions attached to BCF.
 - (a) Plans are jointly agreed.
 - (b) Planned contribution to social care from the CCG minimum contribution is agreed in line with the Planning Requirements.
 - (c) Agreement to invest in NHS commissioned out of hospital services.
 - (d) Managing transfers of care.
 - (e) Funds Pooled through a s75 agreement.

29. It also required an update on the four BCF metrics:

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements
NEA	Reduction in non-elective admissions	On track to meet target	At the time of reporting we have data for just one month of Q4. Q1 was not achieved	Q2 and Q3 achieved
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	At the time of reporting we have data for just one month of Q4	12 month rolling figure to January 2018 shows on track to deliver target. Rate of 600.7 against a target of 785.2
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Not on track to meet target	Some local difficulty with getting data flows from all stakeholders. Q3 performance shows 77.73% against a target of 80%	Local work to improve reablement pathway progressing well
Delayed Transfers of Care*	Delayed Transfers of Care (delayed days)	Not on track to meet target	At the time of reporting we have data for just one month of Q4. Performance deteriorated in Q3 with issues identified within local Mental Health Providers and Out of Area Providers.	Achieved Q1 and Q2

30. An update on the High Impact Change Model implementation was also required. The national submission for Q1 is given here:

		Maturity assessment					Narrative	
		Q2 17/18	Q3 17/18	Q4 17/18 (Current)	Q1 18/19 (Planned)	Q2 18/19 (Planned)	Challenges	Milestones met during the quarter / Observed impact
Chg 1	Early discharge planning	Plans in place	Plans in place	Established	Established	Established	Develop more robust pre-assessment in some specialisms. Review the current robustness of the pre-assessment to ensure it fully captures any potential discharge need. Identify any gaps.	Whole-system self-assessment against HICM and actions defined
Chg 2	Systems to monitor patient flow	Not yet established	Not yet established	Plans in place	Plans in place	Established	Improve surge management, particularly capacity matching – out of hospital at times of surge. Track down waits in the system. Complete work in the intermediate care area to better plan and commission step down and step up provision to speed patient flow out of hospital. An action plan for Opel 4 so less reactive and more predictive.	Whole-system self-assessment against HICM and actions defined
Chg 3	Multi-disciplinary/multi-agency discharge teams	Mature	Mature	Established	Established	Established	A whole-system self-assessment of HICM has led to a lower assessment than previously. Now we need to map current service capacity in relation to discharge, to identify any gaps. Explore the opportunities to develop an integrated team of dedicated staff to support people back home across Darlington. Explore opportunities for voluntary sector support.	Whole-system self-assessment against HICM and actions defined

		Maturity assessment					Narrative	
		Q2 17/18	Q3 17/18	Q4 17/18 (Current)	Q1 18/19 (Planned)	Q2 18/19 (Planned)	Challenges	Milestones met during the quarter / Observed impact
Chg 4	Home first/discharge to assess	Plans in place	Plans in place	Plans in place	Plans in place	Established	<p>Improve the re-admission of residents back to their care-home after discharge.</p> <p>Build trust in the community matron to keep an eye on the person in the care home.</p> <p>Especially re medication. Ensure care homes know they had someone who could sort medication.</p> <p>Solve the discharge medicines issue</p> <p>Red Bag scheme</p> <p>Identify clear pathways out of hospital: home, home with reablement, step-down intermediate care, long term care.</p>	Whole-system self-assessment against HICM and actions defined
Chg 5	Seven-day service	Plans in place	Plans in place	Plans in place	Plans in place	Established	<p>Develop an action plan to plug gaps. Darlington is ranked 117 of 150 on the NHS-social Care Interface Dashboard for weekend discharge of people 65+ who had an emergency admission.</p>	Whole-system self-assessment against HICM and actions defined
Chg 6	Trusted assessors	Not yet established	Not yet established	Plans in place	Plans in place	Established	<p>Investigation of the Scarborough system of a District-nurse led two stage assessment.</p> <p>Identify if community matrons could do this for Darlington, with the appropriate training.</p> <p>Plan to identify how we can develop this with existing resources, perhaps drawing on the previously successful DDES model.</p>	Whole-system self-assessment against HICM and actions defined
Chg 7	Focus on choice	Established	Established	Plans in place	Plans in place	Established	<p>A whole-system self-assessment of HICM has led to a lower assessment than previously. We need to agree and adopt one choice policy</p>	Whole-system self-assessment against HICM and actions defined
Chg 8	Enhancing health in care homes	Mature	Mature	Established	Established	Established	<p>Identify where there appear to be repeat issues in individual homes.</p>	Whole-system self-assessment against HICM and actions defined

31. In terms of current activity implementing the HICM, key actions are being delivered by all parts of the BCF plan, and other programmes in the health and social care system. For example, blockages to early discharge planning, and trusted assessors are being addressed through an “Action on A&E” project (known as “Project Margaret”) involving the whole health and social care system, and improvements to multi agency discharge team include the use of iBCF funding to support rapid response social care.

Local delivery monitoring

32. Locally, BCF delivery is managed through the BCF Darlington Delivery Group which meets monthly, with input from performance and finance colleagues who also attend quarterly, in line with the national reporting schedule.
33. A number of schemes have been reviewed, resulting in specification changes, contract changes or scheme cessation. These changes are reflected in an updated expenditure plan for 2018/19 (attached at **ANNEX A**).

The Operational Guidance published in July 2018: Metrics

34. The current BCF plan is agreed over two years, but additional guidance was released in July which gives us the opportunity to amend or update our targets for the four metrics and reflect any changes to the expenditure plan arising from scheme reviews and contract changes.
35. In Darlington we do not plan to make any changes to the non-elective admissions target as it is embedded in the CCG Operational Plan for this year. Our residential admissions and ASCOF2B targets are part of the Council’s performance framework so will be changed in line with the refreshed performance framework.
36. Delayed Transfer of Care targets are being refreshed nationally. The Government’s mandate to the NHS for 2018-19 has set an overall ambition for reducing delays to around 4,000 hospital beds occupied by patients delayed without discharge by September 2018.
37. All areas will be expected to agree a DTOC metric for 2018-19 that meets the nationally set HWB level expectations for 2018-19. Areas should plan based on the assumption that the expectation will be met by the end of September 2018 and that this level will be maintained or exceeded thereafter.
38. The new target for Delays to Transfers of Care in Darlington is set at five people delayed per day (five beds unnecessarily occupied each day). The new target is slightly more generous than previously, but system changes including the introduction of electronic assessment, discharge and withdrawal notices, and the associated agreement of how delay categories are interpreted in each locality is resulting in a short term increase in numbers of delays, while in fact the patient experience is unchanged, and in Darlington patient transitions out of hospital remain very smooth and timely. The BCF Darlington Transfers of Care Group is ensuring that all partners to discharge are working closely during this system change to ensure a common understanding and practice in terms of recordable

delays, and any delays reported in error are corrected.

39. As part of this work a formal process of ensuring the delays recorded as attributable to Social Care by Acute and Non-Acute Trusts is being finalised: such a process is already in place with Tees, Esk and Wear Valleys Foundation Trust.
40. It is important to remember that delays can be recorded not just from our “local” hospital trust CDDFT but from anywhere. There has been an increase in delays recorded by South Tees Hospital Trust for patients from Darlington in the past six months, for example: (delays attributed almost exclusively to NHS rather than Social Care). Consequently, once the new system is embedded with CDDFT, work will start with other Trusts to ensure data accurately reflects what happens “on the ground.”

The Operational Guidance published in July 2018: Narrative and expenditure plan Delivery Plans

41. The refreshed guidance advises that as Better Care Fund plans were agreed for two years (2017-18 and 2018-19), places are not required to revise their plans for 2018-19 other than in relation to metrics for DTOC as set out above. Places can, if they wish, amend plans to:
 - (a) Modify or decommission schemes
 - (b) Increase investment, including new schemes
42. There have been a number of scheme reviews in Darlington but with no impact on the BCF financial envelope as a whole, so we do not need to submit a refreshed expenditure plan. However, one has been prepared for local monitoring and is attached at ANNEX A (combined with 2017/18 outturn).

Length of Stay

43. NHS England and NHS Improvement have recently set out their ambition for reducing long stays in hospital by 25% to reduce patient harm and bed occupancy.
44. The refreshed BCF guidance advises that while this ambition is not part of BCF, they expect BCF plans to support delivery of this reduction through the continuing focus on delivery of the local DTOC expectations and through the implementation of the High Impact Change Model in relation to systems to monitor patient flow, seven day services and trusted assessors (changes two, five and seven). National partners will give consideration to applying additional requirements for 2019/20, including through the BCF where appropriate, for local areas and NHS bodies that have made insufficient progress in reducing the number of people experiencing long stays in hospital during 2018/19.

Submitted Plan 2017/18										2018/19 Plan								
Scheme	Scheme Name	Lead Commissioner	Provider	Sum to DBC where lead commissioner re: funding arrangements	Sum to CCG where lead commissioner re: funding arrangements	Sum to DBC where lead commissioner re: funding arrangements	Sum to CCG where lead commissioner re: funding arrangements	Final Outturn	BCF Uplift	Re-set of Contingency	Decommissioning / Review of pilot services	FYE	Contract Inflation	Agreed 18-19 schemes	18-19 Baseline	Pool 1 DBC	Pool 1 2 CCG	Pool 3 Cap
Dementia	Dementia Advisor	Local Authority	VCSE	£28,629		£28,629		£28,629					£544		£29,173	£29,173		
Dementia	Dementia schemes	Local Authority	VCSE	£50,000		£50,000		£50,000					£950		£50,950	£50,950		
Improving healthcare services to care homes	Mental Health Liaison - Care Home	CCG	tewv		£37,966		£37,966	£37,966					£38		£38,004		£38,004	
Improving healthcare services to care homes	Care Home Liaison	CCG	Primary care		£165,658		£93,600	£93,600							£93,600		£93,600	
Improving healthcare services to care homes	Community Matrons and HCAs	CCG	Comm. Health		£465,435		£465,435	£465,435					£465		£465,900		£465,900	
Improving healthcare services to care homes	Mental Health Liaison - Acute	CCG	tewv		£311,193		£311,193	£311,193					£311		£311,504		£311,504	
	Community Hospitals - Ventress	CCG	Comm. Health		£418,348		£432,288	£432,288							£432,288		£432,288	
	Community Hospitals - Eastbourne	CCG	Comm. Health		£230,640		£230,640	£230,640							£230,640		£230,640	
Intermediate care, reablement and rehabilitation	Community Hospitals - CDDFT	CCG	Comm. Health		£1,010,457		£1,010,457	£1,010,457					£1,010		£1,011,467		£1,011,467	
Intermediate care, reablement and rehabilitation	Community Stroke Services	CCG	VCSE		£20,000		£20,000	£20,000							£20,000		£20,000	
Intermediate care, reablement and rehabilitation	RIACT Health Staff	CCG	Comm. Health		£947,682		£947,682	£947,682					£948		£948,630		£948,630	
Intermediate care, reablement and rehabilitation	Falls and osteoporosis	CCG	Comm. Health		£18,319		£18,319	£18,319					£18		£18,337		£18,337	

Submitted Plan 2017/18										2018/19 Plan								
Scheme	Scheme Name	Lead Commissioner	Provider	Sum to DBC where lead commissioner re: funding arrangements	Sum to CCG where lead commissioner re: funding arrangements	Sum to DBC where lead commissioner re: funding arrangements	Sum to CCG where lead commissioner re: funding arrangements	Final Outturn	BCF Uplift	Re-set of Contingency	Decommissioning / Review of pilot services	FYE	Contract Inflation	Agreed 18-19 schemes	18-19 Baseline	Pool 1 DBC	Pool 1 2 CCG	Pool 3 Cap
Intermediate care, reablement and rehabilitation	Workforce Development	Local Authority	Local Authority	£4,200		£4,200		£4,200					£80		£4,280	£4,280		
Intermediate care, reablement and rehabilitation	Reablement staff	Local Authority	Local Authority	£942,600		£942,600		£942,600					£17,909		£960,509	£960,509		
Intermediate care, reablement and rehabilitation	Increase in Physical Activity	Local Authority	Local Authority	£2,000		£2,000		£2,000					£38		£2,038	£2,038		
Intermediate care, reablement and rehabilitation	Exercise after Stroke	CCG	Local Authority	£24,000		£24,000		£24,000			£-24,000			£9,000	£9,000	£9,000		
Intermediate care, reablement and rehabilitation	Sensory Loss Rehabilitation	Local Authority	Local Authority	£94,500		£94,500		£94,500					£1,796		£96,296	£96,296		
NMC: Personalisation, technology and dom care	Mental Health Team	Local Authority	Local Authority	£72,065		£72,065		£72,065					£1,369		£73,434	£73,434		
NMC: Personalisation, technology and dom care	Telecare (OOH Mobile Response)	Local Authority	Lifeline	£15,000		£15,000		£15,000					£285		£15,285	£15,285		
NMC: Personalisation, technology and dom care	Assitive Technology	Local Authority	tbc	£40,000		£40,000		£40,000					£760		£40,760	£40,760		
NMC: Personalisation, technology and dom care	Blue Badge OT Assessments	Local Authority	Local Authority	£50,000		£50,000		£50,000					£950		£50,950	£50,950		
NMC: Personalisation, technology and dom care	Community Equipment Service	Local Authority	Medequip	£295,506		£295,506		£295,506					£14,958		£310,464		£310,464	
NMC: Personalisation, technology and dom care	Equipment and Adaptations	Local Authority	Medequip	£360,000		£360,000		£360,000					£6,840		£366,840	£366,840		
NMC: Personalisation, technology and dom care	MH and Physical Disability Support Workers	Local Authority	Local Authority	£106,480		£106,480		£106,480					£2,023		£108,503	£108,503		

Submitted Plan 2017/18										2018/19 Plan								
Scheme	Scheme Name	Lead Commissioner	Provider	Sum to DBC where lead commissioner re: funding arrangements	Sum to CCG where lead commissioner re: funding arrangements	Sum to DBC where lead commissioner re: funding arrangements	Sum to CCG where lead commissioner re: funding arrangements	Final Outturn	BCF Uplift	Re-set of Contingency	Decommissioning / Review of pilot services	FYE	Contract Inflation	Agreed 18-19 schemes	18-19 Baseline	Pool 1 DBC	Pool 2 CCG	Pool 3 Cap
NMC: Personalisation, technology and dom care	Equipment and Adaptations	CCG	Medequip		£68,731		£157,017	£157,017							£157,017		£157,017	
Other	Palliative Care	CCG	Comm. Health		£161,681		£161,681	£161,681					£162		£161,843		£161,843	
Other	MSK	CCG	Comm. Health		£324		£324	£324			-£324				£0		£0	
Other	Project Management	CCG	Local Authority	£22,000		£22,000		£22,000							£22,000	£22,000		
Other	Project Management	Local Authority	Local Authority	£22,000		£22,000		£22,000							£22,000	£22,000		
Out of hospital	contingency	CCG			£222,942		£276,073	£276,073	£140,684	-£81,991	£55,349	-£22,634	-£65,600	-£9,000	£292,881		£292,881	
Personalised support/ care at home	DFG	Local Authority						£0							£0			
Care at Home: GP aligned to care homes Laptop usage and line rental charges		CCG					£7,480	£7,480							£7,480		£7,480	
Primary Prevention and Care Navigation	High Impact Users extensivist GP	CCG	Primary care		£11,025		£7,433	£7,433			-£11,025				-£3,592		-£3,592	
Primary Prevention and Care Navigation	CCG contribution to Good Friends	CCG	VCSE		£15,000		£15,000	£15,000			-£10,000				£5,000		£5,000	
Primary Prevention and Care Navigation	CAB _ Welfare Rights Service	CCG	VCSE		£25,000		£25,000	£25,000							£25,000		£25,000	
Primary Prevention and Care Navigation	Specialist Advocacy	CCG	VCSE		£25,000		£25,000	£25,000							£25,000		£25,000	
Primary Prevention and Care Navigation	Good Friends	Local Authority	VCSE	£15,000		£15,000		£15,000			-£10,000				£5,000	£5,000		
Primary Prevention and Care Navigation	Wellbeing facilitators primary care (social prescribing)	Local Authority	VCSE	£96,000		£96,000		£96,000				-£11,000		£100,000	£185,000	£185,000		

Submitted Plan 2017/18										2018/19 Plan									
Scheme	Scheme Name	Lead Commissioner	Provider	Sum to DBC where lead commissioner re: funding arrangements	Sum to CCG where lead commissioner re: funding arrangements	Sum to DBC where lead commissioner re: funding arrangements	Sum to CCG where lead commissioner re: funding arrangements	Final Outturn	BCF Uplift	Re-set of Contingency	Decommissioning / Review of pilot services	FYE	Contract Inflation	Agreed 18-19 schemes	18-19 Baseline	Pool 1 DBC	Pool 1 2 CCG	Pool 3 Cap	
social care	contingency	Local Authority		£81,991				£0		£81,991		£18,009		-£100,000	£0	£0			
Support for carers	Short Breaks for Disabled Children	CCG	Local Authority	£42,890		£42,890		£42,890					£815		£43,705	£43,705			
Support for carers	Carers Emergency Support	CCG	Unique	£5,196		£0		£0							£0	£0			
Support for carers	Adult Carers	Local Authority	VCSE	£50,875		£50,875		£50,875				£4,625			£55,500	£55,500			
Support for carers	Adult Carers	CCG	VCSE	£50,875		£50,875		£50,875				£4,625			£55,500	£55,500			
Support for carers	Carer Breaks	CCG	VCSE	£111,000		£111,000		£111,000					£2,109		£113,109	£113,109			
Support for carers	Young Carers (Info/advice/support)	CCG	Local Authority	£37,812		£37,812		£37,812				£3,188			£41,000	£41,000			
Support for carers	Young Carers (info/advice/support)	Local Authority	Local Authority	£37,813		£37,813		£37,813				£3,187			£41,000	£41,000			
Support for carers	Implementation of The Care Act	Local Authority	Local Authority	£293,000		£293,000		£293,000					£5,567		£298,567	£298,567			
Transfers of Care	Supported Discharge	Local Authority	Care Connect	£19,600		£19,600		£19,600					£372		£19,972	£19,972			
Transfers of Care	Reduction in Admissions to 24h Care (Discharge SW)	CCG	Local Authority	£120,000		£120,000		£120,000					£2,280		£122,280	£122,280			
Transfers of Care	Packages to facilitate discharge	Local Authority	Local Authority	£158,000		£158,000		£158,000					£3,002		£161,002	£161,002			
	TOTAL			£3,249,032	£4,155,401	£3,161,845	£4,242,588	£7,404,433	£140,684	£0	£0	£0	£0	£0	£7,545,117	£2,993,653	£4,551,464	£0	

HEALTH AND WELL BEING PLAN DELIVERY

SUMMARY REPORT

Purpose of the Report

1. To update on the delivery of the “Ageing Well” area of the Health and Wellbeing Plan.

Background

2. In 2014 it was agreed by Council and subsequently by the Health and Wellbeing Board that “One Darlington Perfectly Placed” – the sustainable community strategy – would constitute the Health and Wellbeing Strategy for Darlington, with a suite of plans delivering the strategic objectives.
3. The Health and Wellbeing Plan is one of these plans and was endorsed by the Health and Wellbeing Board in October 2017.
4. The plan sets out priorities for outcomes in three sections – Starting Well, Living Well and Ageing Well. This update covers the adult joint commissioning priorities for Ageing Well and actions to date.

Recommendation

5. HWBB is asked to note the progress to date on delivering outcomes in the “Ageing Well” part of the plan, reported in the presentation which accompanies this report.

Reasons

6. In April 2017 the Health and Wellbeing Board agreed the Health and Wellbeing Plan 2017/2022 would take a “Life Course” approach. The Board’s role as Children Trust Board means the plan covers the 0 -19 years age group, as well as adults and older people.
7. Priorities for action set out in the plan are derived from the Joint Strategic Needs Assessment and a Development Session held with Health and Wellbeing Board in April 2017.
8. The Plan has a five year initial life, with priorities identified for each year which will inform the Health and Wellbeing Board agendas.

9. Delivery of the Plan's objectives requires each partner to align their strategies and plans, to ensure focus and avoid either duplication of activity against the same objectives or activity which does not contribute to the delivery of the Health and Wellbeing Plan objectives.

Suzanne Joyner
Director of Children and Adults

Miriam Davidson
Ext 6203

Background Papers

The Health and Wellbeing Plan 2017 - 2022

Pat Simpson : Extension 6082

S17 Crime and Disorder	Not applicable
Health and Well Being	The Health and Wellbeing Plan is owned by the HWBB
Carbon Impact	None
Diversity	None
Wards Affected	All
Groups Affected	All
Budget and Policy Framework	Budgets pooled through a s75 agreement between DBC and Darlington CCG
Key Decision	No
Urgent Decision	No
One Darlington: Perfectly Placed	The Health and Wellbeing Strategy is embedded in One Darlington Perfectly Placed
Efficiency	New ways of delivering care have the capacity to generate efficiencies
Implications on Looked After Children and Care Leavers	None

MAIN REPORT

Role of the Health and Wellbeing Plan

10. The development of a Health and Wellbeing Plan for Darlington followed a number of principles:
 - (a) A “Life Course” approach: Starting Well, Living Well, and Ageing Well.
 - (b) Most people in Darlington do not need services to support their health and wellbeing, so this Plan includes addressing the underlying and environmental conditions that promote healthy lifestyles and resilience.
 - (c) Signposting to, rather than duplicating the content of, related delivery Plans.
 - (d) Maximising the existing structures, groups and channels in Darlington and minimising the need for new mechanisms.
 - (e) A five year initial life, with annual Health and Wellbeing Delivery Plans which will inform the Health and Wellbeing Board agendas.

Delivery and Monitoring

11. The Plan is largely delivered through other Plans. Key deliverables from those plans year by year are set out in the Action Plan.
12. Keeping the Board updated on progress is in line with the topical focus of different meetings of the Board; this update reflects joint commissioning priorities agreed across the CCG and Darlington Local Authority for “Ageing Well” 2018/19.

Ageing Well

13. There are four outcomes specified for work in the “Ageing Well” part of the Plan:
 - (a) Social isolation is reduced.
 - (b) The onset of support needs is delayed.
 - (c) Independence is supported.
 - (d) Intermediate and transitional care outside of hospital is effective and supports people’s journey out of hospital as well as keeping them from admission to hospital.
14. The Key priority area for action in 2018/19 is Intermediate and Transitional Care, although work will also be delivered which will impact the other required outcomes too.
15. In relation to Intermediate and Transitional Care, planned activity and projects will deliver four additional expected outcomes:
 - (a) Standards of care are consistent across Darlington
 - (b) Mental health is improved
 - (c) Conditions are created which support a healthy and well population
 - (d) Life expectancy is measurable improved
16. The presentation will update the Board on the current status.

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HEALTHWATCH DARLINGTON

SUMMARY REPORT

Purpose of the Report

1. The purpose of the report is to update Health and Wellbeing Board members on Healthwatch Darlington's key statutory priorities and projects for July 2018 to August 2018.

Summary

2. This report outlines Healthwatch Darlington's work, during the last 2 months, in championing the views of people in the Borough to influence and improve health and social care services.

Recommendation

3. It is recommended that Darlington Health and Wellbeing Board members accept this report for information and progress to date for Healthwatch Darlington.

Michelle Thompson
Chief Executive Officer Healthwatch Darlington

Background Papers

No background papers were used in the preparation of this report.

S17 Crime and Disorder	There are no implications arising from this report.
Health and Well Being	This report provides information about progress to date including work plan objectives to champion the views of people in the Borough to improve health and social care services.
Carbon Impact	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	This report contributes to the delivery of the objectives of the Community Strategy through the patient, carer and public voice.
Efficiency	N/A

MAIN REPORT

4. Healthwatch Darlington Ltd (HWD) is a strong independent community champion giving local people a voice that improves and enhances health and social care provision on behalf of the people of Darlington.

Statutory Activities/Projects

5. **Community Outreach** – Our Volunteer and Outreach Co-ordinator and our team of volunteers have been out in the community holding various information sessions. This has been giving patients and their families an opportunity to ask any questions they may have about local health and social care services. We've visited places such as:
- (a) 2 x Market stall days
 - (b) Age UK Day care group
 - (c) Education Village
 - (d) YMCA
 - (e) Dolphin Centre
 - (f) Redhall Community Centre (Tea and Toast Group)
 - (g) Pride Event
 - (h) Gold Tea Dance
 - (i) Coleridge Community Centre (Young Mums)

Example of conversations:

6. A person told HWD how they receive no support from mental health services as they have complex PTSD and no service will support them. They have been at crisis point on a few occasions and have self-harmed. The person said they get passed around services but never get support which they find very frustrating. The person wants to recover so they can eventually work again. The person was unaware of any other services apart from NHS services. HWD signposted the person to Mind, Humankind, Step Forward Tees Valley and Rethink. The person was pleased with this but asked why they had not been given this information before by NHS?
7. Another person spoke to HWD about their 17 year old relative who has decided to stop taking their medication for ADHD. The person is worried as their relative has become very anxious and depressed and doesn't think they will be able to get a job. The person told HWD that they don't know how to support their relative and would like them to get help. They mentioned their desire to help their relative find work so they can build their confidence. HWD signposted the person back to CAMHS and gave them information about Step Forward Tees Valley. The person thinks more support from mental health staff to check on their relative would have been helpful.
8. A person was looking for information about services that could support their young relative with their epilepsy diagnosis. Since the diagnosis their relative has become very depressed and the person also expressed concerns that they had received no support. The relative now lives in Cumbria for university and the person is worried the relative is not using health services. They were given no information after diagnosis and were not signposted to any other services. HWD signposted them to Epilepsy Action UK and Neuro Key. HWD also suggested that they contact Healthwatch Cumbria who will be able to give them information about local services to their relative's university.

9. **Planned outreach for September:**

- (a) Darlington College Fresher's Fayre x 2
- (b) Queen Elizabeth Sixth Form College Fresher's Fayre
- (c) Step Forward Tees Valley Women's Group
- (d) Darlington Memorial Hospital

10. **Training** – 7 new volunteers were inducted in July and then embarked on our popular 4 module in house training package delivered by our CEO Michelle Thompson covering the following topics:

- (a) **Introduction to Healthwatch Darlington**
 - (i) HWD Statutory Duties
 - (ii) Health and Social Care Environment
- (b) **Role of Volunteers**
 - (i) Where you fit
 - (ii) Your motivation

- (iii) HWD Volunteer Roles
- (c) **Listening Skills**
 - (i) Types of Listening
 - (ii) Communication Styles
- (d) **Representing Healthwatch Darlington**
 - (i) Types of Patient Leader
 - (ii) Engagement Cycle
 - (iii) Understanding our audiences

11. All volunteers completed the course and received certificates. Another 4 volunteers also completed external courses including Safeguarding Children and Safeguarding Adults.
12. **Enter & View:** Following on from our previous authorised visits into local care homes across Darlington regarding “What’s it like living in a care home?”, our Enter and View team will be busy conducting our next cohort of visits in September and a second report will be compiled shortly afterwards.
13. We are also working in partnership with Healthwatch County Durham, County Durham and Darlington NHS Foundation Trust (CCDFT) and the Quality Improvement Board (QIB) to suggest how they can support quality improvement within CCDFT, linked to the Measures of Success as agreed by the QIB October 2017. Enter and View visits will be conducted in wards or departments that have done very well or quite poorly in their most recent Friends and Family Test (FFT), to learn from those that have done well and share that learning with others who wish to improve.
14. **Volunteer of the Month:** Our Volunteer of the Month for June 2018 was Gill Waite. To read Gill’s interview please visit:
<http://www.healthwatchdarlington.co.uk/volunteer-month>
15. **Volunteer Hours:** During the last 2 months our wonderful volunteers have donated **199** hours of their time to Healthwatch Darlington!
16. **Surveys:** Our Children and Young Peoples Mental Health Survey (CYP and Parent/Carers) has received **115 responses (39 Parent/Carers 76 CYP)** and our engagement is set to continue into early September where we will be visiting colleges. This was identified as a top priority for people living in Darlington after 45% of 179 people told us this in our 'What's important to you?' survey.
17. **Focus Groups:** We held a focus group with NECA exploring individual’s experiences who have a drug and/or alcohol addiction trying to access mental health services. This was identified as a priority area in our 'What's important to you?' survey which we conducted earlier in 2018. NECA is a registered Charity whose key focus is to improve the lives of individuals and communities throughout the region. For over 40 years NECA have supported and enabled thousands of individuals to sustain long term Recovery from substances and Gambling misuse.

18. **DOT:** We continue to nurture closer connections with our community through our Darlington Organisations Together Network (DOT) which is a well-attended and popular conduit for community information and signposting. The network encourages smaller organisations to become stronger, more resilient and active and for all organisations no matter what size to work more closely with each other to avoid duplication and to complement each other's work in the community. The next meeting is Thursday 13th September 10am to 12pm. The Pease Suite, Dolphin Centre, Darlington.

19. **Meetings attended:**

- (a) Health Partnership Overview and Scrutiny
- (b) Carers Strategy
- (c) TEWV Quality Accounts
- (d) Darlington Integration Board
- (e) FRADE
- (f) Patient Experience Forum DMH
- (g) Darlington Partnership Executive Board
- (h) TEWV Engagement
- (i) Great North Care Record Conference
- (j) Darlington Partnership Meeting
- (k) Health and Wellbeing Board

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DARLINGTON CANCER PROFILE

SUMMARY REPORT

Purpose of the Report

1. To provide the Board with a high level overview of cancer need and outcomes for Darlington with reference to the Cancer Profile for Darlington.

Summary

2. Cancer is identified as the second greatest contributor to premature mortality in Darlington. In January 2016, a two-year review of cancer services in Darlington was launched by NHS Darlington CCG and Macmillan Cancer Support, in order to identify opportunities for improvement in patient care and outcomes, and to inform commissioning intentions for cancer services. As part of the review a Cancer Profile for Darlington was produced which provided a snapshot of the needs, outcomes and the performance of local services. It has also highlighted the impact of cancer on health inequalities and premature death rates.
3. The Darlington Cancer Profile "Cancer in Darlington: A Profile 2017" is attached as **Appendix A**.

Recommendation

4. It is recommended that:-
 - (a) The Health and Wellbeing Board note the impact of Cancer on Darlington and the inequalities in the distribution of cancers and outcomes.
 - (b) The Health and Wellbeing Board note the improvement work underway, including work to improve access to screening and early diagnosis and treatment.

Reasons

5. The recommendations are supported by the following reasons:
 - (a) Cancer is a significant contributor to premature mortality in Darlington.
 - (b) There are significant inequalities in incidence, prevalence and outcomes for cancer in Darlington.

- (c) Improvements in cancer performance will improve outcomes and contribute to reducing premature mortality for Darlington residents.

Suzanne Joyner
Director of Children and Adults

Background Papers

Cancer in Darlington: A Profile 2017

Ken Ross : Extension 6200

S17 Crime and Disorder	None
Health and Well Being	Impacts on life expectancy
Carbon Impact	None
Diversity	None
Wards Affected	All wards in Darlington
Groups Affected	All groups
Budget and Policy Framework	None
Key Decision	No
Urgent Decision	No
One Darlington: Perfectly Placed	More People healthy and independent, Enough support for people when needed
Efficiency	No implications
Implications on Looked After Children and Care Leavers	None

MAIN REPORT

Background

6. Cancer is a major health problem in Darlington, with higher rates of cancer incidence, higher rates of early death (under 75 years) from cancer, and worsening one-year survival outcomes reported when compared against the England rate.
7. More people are being diagnosed with cancer in Darlington than the England average, with the incidence rate now statistically higher than the England rate and marginally above the regional rate. The most recent available data (2009-10 to 2013-14) indicates that this rate continues to increase.

Incidence

8. Cancer is not a single disease but is a term that includes a range of different tumors and sites. The most common cancer diagnoses affecting people in Darlington includes Lung, Breast, Prostate, Colorectal, Bladder and Ovary.
9. When comparing cancer incidence in Darlington to that of England and the 10 CCG comparator areas, local rates appear to be largely consistent with both England and the 10 comparator CCG areas.
10. At a population level, analysis indicates that there is variation in the incidence of different cancer and tumor sites within the Borough with the incidence of some cancers to be particularly high within some of the most deprived wards in Darlington.

Prevalence

11. The number of people living with and beyond a cancer diagnosis is increasing. In Darlington, this number is higher than the England average. In terms of the numbers of people living with or beyond a cancer diagnosis in Darlington, there were approximately 2,800 individuals, or 2.6% of the local population in 2015-16 living with cancer. The majority of those living with cancer are likely to also have a long term condition. Those with a new diagnosis of cancer are significantly more likely to have regular contact with their GP for several months following their diagnosis.
12. At a population level cancer prevalence appears to be varied across the borough, with a strong correlation between prevalence and deprivation with evidence of increasing prevalence rates correlating with higher deprivation scores.
13. This suggests that cancer outcomes are varied across Darlington, with less deprived areas reporting better cancer outcomes for their patients. At a population level the highest levels of overall cancer mortality are reported in areas of high deprivation.

Screening and early diagnosis

14. Screening rates in Darlington are consistently high and most are statistically above the England rate. Local cervical screening rates continue to be statistically higher than the England rate, but with local rates mirroring a consistent national decline in uptake over the last 7 years. Indicators for bowel cancer screening activity in Darlington are also improving with work to improve uptake in vulnerable populations such as those with a Learning Disability.
15. Significant variation in the uptake of cancer screening exists across the borough. Although overall rates remain high, work is continuing to improve the awareness and uptake of cancer screening programmes in professionals and vulnerable or at risk populations.
16. Early diagnosis is vital for improved outcomes. This includes the time of initial referral by the GP as part of the cancer pathway for further investigation and review by a specialist. There will always be far more referrals than diagnosis as many of the signs and symptoms of cancer are similar to other less serious diseases. Reducing the time the patient waits and the quality of the initial referral, all contribute to better outcomes for the patient.
17. In terms of actions to improve early diagnosis and access to early treatment, Darlington continues to improve the local rate of referral through the two week wait urgent pathway and continues to maintain high quality referrals with an increasing number of cancers detected in those cases that are referred to the two week wait urgent pathway.
18. The need for continued attention on early identification and diagnosis is also reflected in the high numbers of patients being diagnosed for cancer via emergency presentation in Darlington, which continues to increase and is now both the highest rate in the region and statistically worse than the England rate. This suggests that opportunities exist to improve the proportion of people in Darlington who receive their cancer diagnoses at an earlier stage and through more planned routes such as their GP. Emergency presentation often accompanies later stages of presentation in patients with poorer experience and outcomes.
19. Better uptake of screening, better information about and recognition of signs and symptoms and a greater awareness of this profile can all contribute to reducing emergency presentations particularly at a late stage of disease.

Outcomes

20. The overall rate of cancer mortality for Darlington is higher than the national rate with mortality rates for males continuing to rise faster than for women. Rates for one-year survival (all cancers) are statistically worse than the England.
21. Regarding site-specific mortality in Darlington, lung cancer is the most common cause of cancer-related death for males and females and persons overall. The second most common cause of cancer mortality was prostate cancer for males and breast cancer for females. A range of rarer and less common cancers were the

third most common causes of cancer death combined, for both males and females.

Conclusion

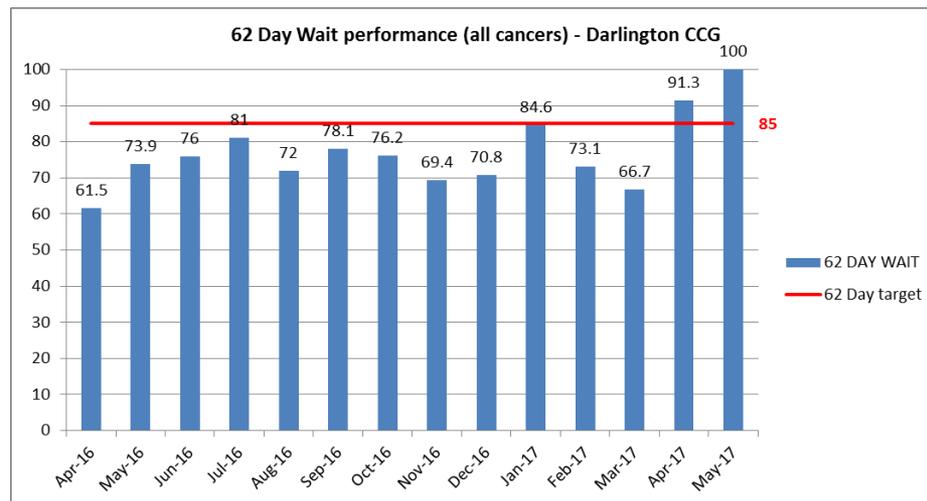
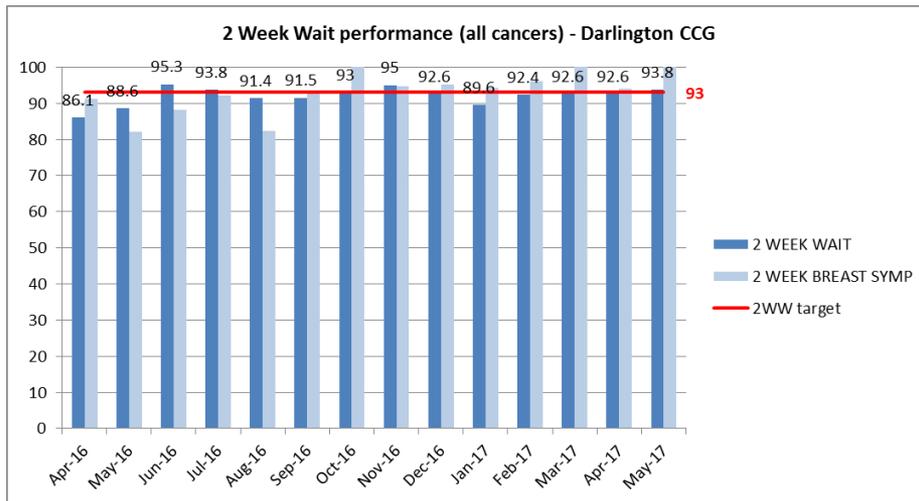
22. Cancer is a significant contributor to premature mortality and inequalities in Darlington. There are inequalities in the incidence, prevalence and mortality across common cancers in Darlington both between Darlington and England and within Darlington between the most and least deprived wards.
23. Screening rates in Darlington remain good compared to England although there are signs of a long term reduction in uptake of cancer screening programmes such as cervical screening. Early access to timely diagnosis in Darlington is improving with the numbers referred for two week wait increasing and detection rates improving.
24. Overall cancer mortality for cancer in Darlington is worse than England and rising, with males having a significantly greater increase compared to women. There is variation in mortality from cancers with Lung cancers contributing to the greatest proportion of cancer mortality for all cancers. There is variation between gender specific cancer with prostate being a significant contributor to cancer mortality for men and breast cancer being a significant contributor for cancer mortality for women.
25. There remains a worrying proportion of people in Darlington having their diagnosis of cancer through an emergency department, with significantly poorer experiences and outcomes for patients diagnosed via this route. This does indicate that work is required to continue to improve uptake of screening, awareness of signs and symptoms of common cancers and improved access to earlier diagnosis and treatment.

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Performance summary

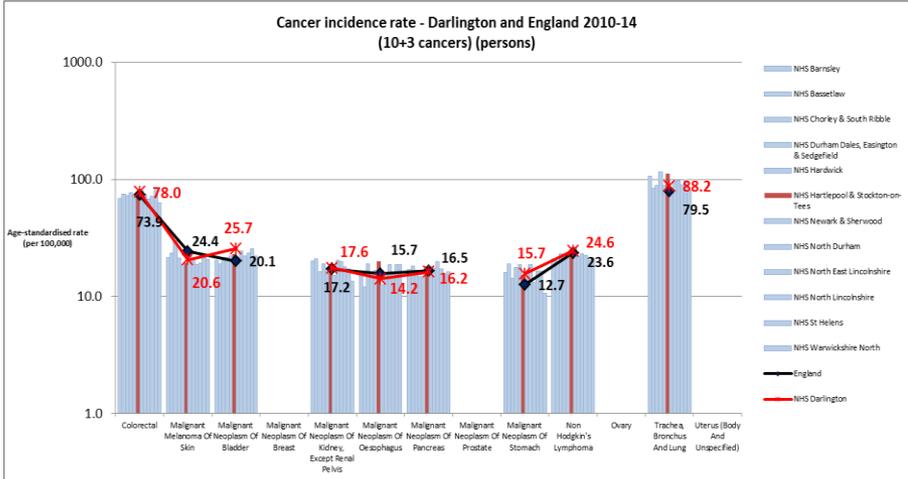
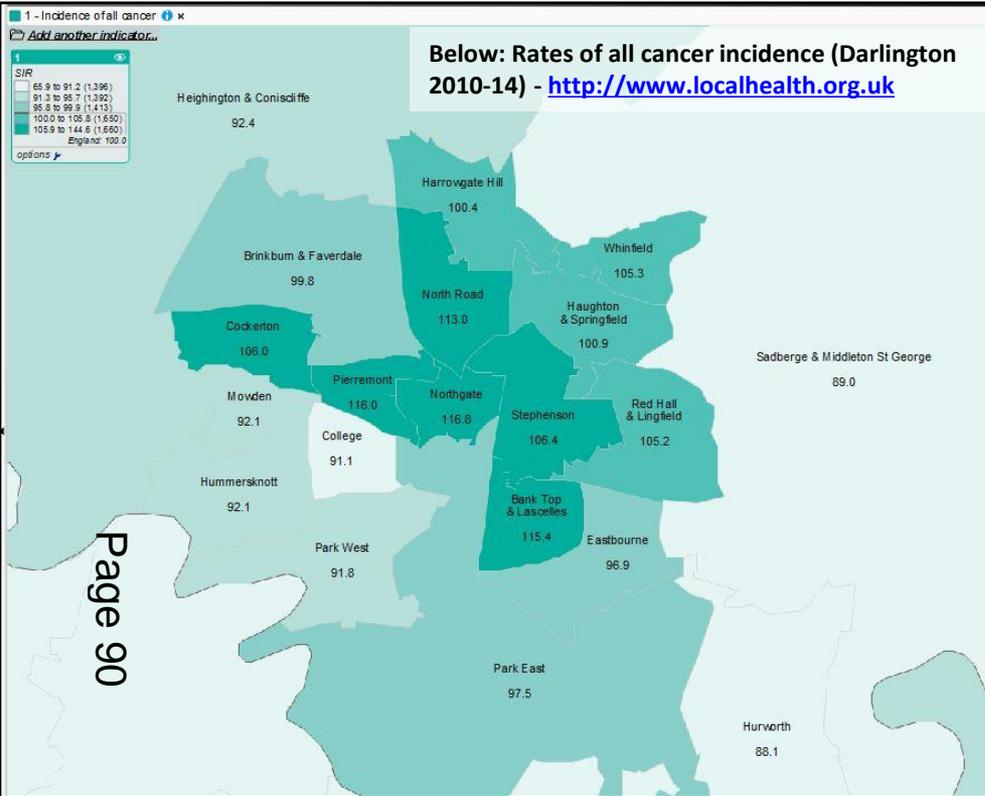
Indicator type	Indicator definition	Reporting period	England	Regional	Darlington	Preceding year	Trend
CCG IAF	Cancer diagnosed at early stage	2015	52.36%	-	49.69%	54.85%	↓
	People with urgent GP referral having definitive treatment for cancer within 62 days of referral	YTD 2017-18	81.9%	85.08%	96.00%	73.5% (16-17)	↑
	One year survival from all cancers	2014	70.4 %	-	66.1	66.3%	↓
	Cancer patient experience (average rating of care)	2017	8.7 (2016)	-	8.6 (2016)	8.7	↓
Quality Premium	4% improvement in early diagnosis of specific cancer sites between calendar years 2016 and 2017	tbc	tbc	tbc	tbc	tbc	tbc
	OR 60%> early diagnosis for all cancers						
Cancer Patient Experience Survey	Patient's average rating of care – see above	-	-	-	-	-	-
	Saw GP once / twice before being told had to go to hospital	2017	77% (2016)	-	78% (2016)	79%	↓
	Patient definitely involved in decisions about care & treatment	2017	78% (2016)	-	71% (2016)	77%	↓
	Practice staff definitely did everything they could to support patient	2017	62% (2016)	-	67% (2016)	65%	↑

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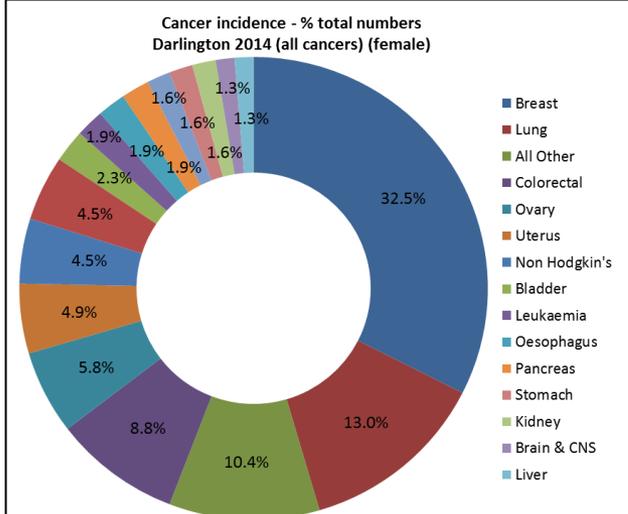
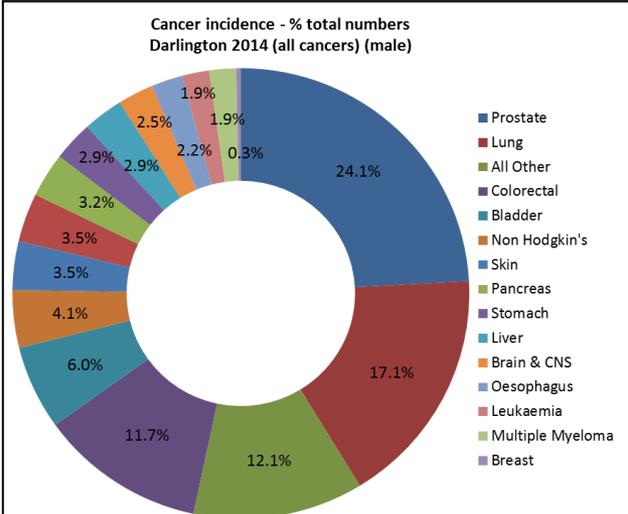
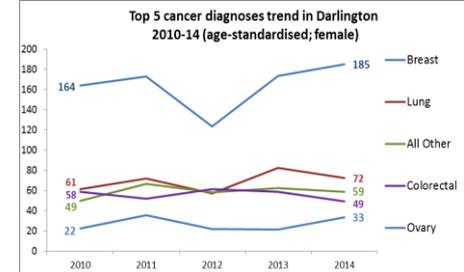
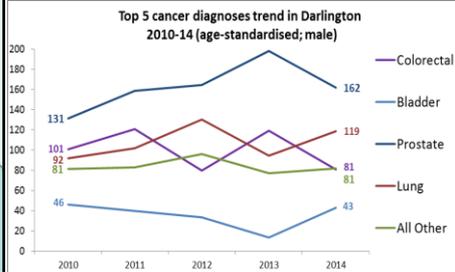


Cancer in Darlington: Incidence

Cancer incidence rates (10+3 cancers) – 2010-14



Cancer incidence trends 2010-2014: male [left]; female [right]

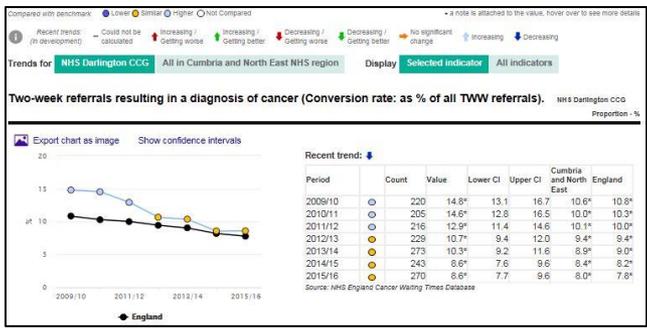
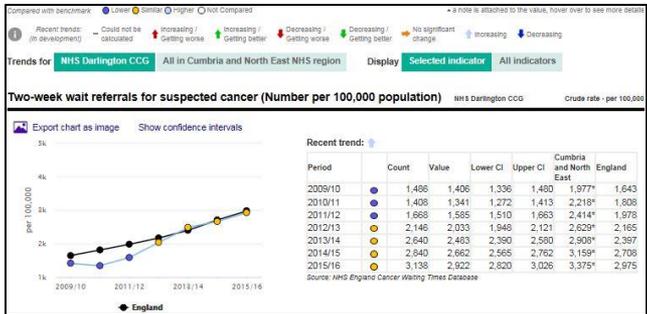


Cancer incidence – key points

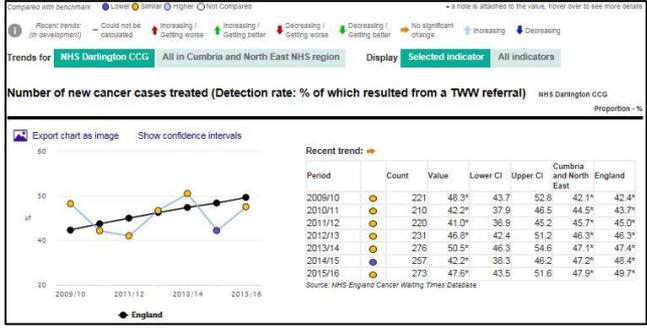
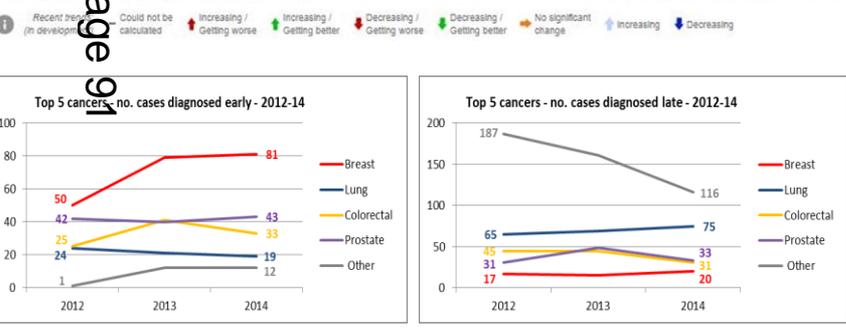
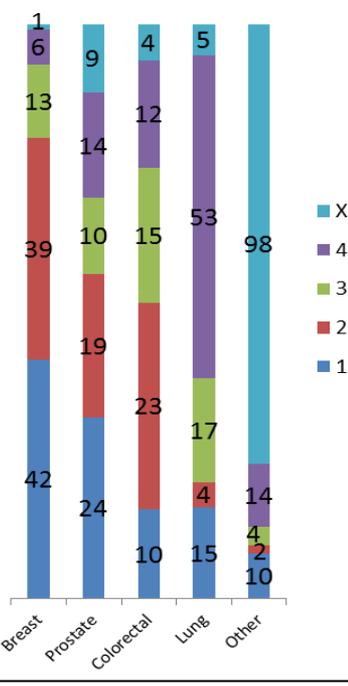
- 643 new cases in 2013-14 = 10.4% ↑ on 2012-13 = 4.6% ↑ on 2011-12
- ~2,800 people now living in Darlington with cancer diagnosis (prevalence)
- Incidence rate (605) statistically higher than England rate (515) per 100,000 (2013-14)
- Increasing incidence rates identified in Carmel, Denmark St, Moorlands, Orchard Court, Parkgate & Whinfield practices.
- Breast cancer now most common (16.2%) overall, then lung cancer (15.1%)
- Increasing rates of skin, breast, prostate & lung cancers identified

Cancer in Darlington: Screening & Referral

Indicator	Period	England	NHS Darlington CCG	A93034 - Blacketts Medical Pr...	A93031 - Carmel Medical Pract...	A93040 - Clifton Court Medica...	A93047 - Denmark Street Surge...	A93070 - Felix House Surgery	A93010 - Moorlands Surgery	A93013 - Neasham Road Surgery	A93006 - Orchard Court Surger...	A93641 - Parkgate Surgery	A93048 - Rockliffe Court Surg...	A93005 - Whinfield Medical Pr...
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %)	2015/16	72.5	72.4	73.1	60.8	64.0	74.7	72.6	77.8	65.1	61.7	59.0	73.1	77.8
Females, 50-70, screened for breast cancer within 6 months of invitation (Uptake, %)	2015/16	73.5	47.3	36.4	50.0	41.2	50.0	66.7	64.3	26.7	42.9	12.5	66.7	71.4
Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	2015/16	72.8	76.0	74.4	81.0	70.9	74.2	81.5	75.4	76.8	79.6	69.6	78.5	76.6
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)	2015/16	57.8	59.3	60.3	63.1	50.0	59.6	63.8	61.1	56.6	56.8	52.3	62.5	62.6
Persons, 60-69, screened for bowel cancer within 6 months of invitation (Uptake, %)	2015/16	55.6	58.0	60.1	60.4	48.4	56.3	65.6	60.3	56.2	55.0	52.9	60.0	62.4
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)	2015/16	58.5	60.5	62.2	63.3	51.5	60.9	65.1	62.3	57.4	57.0	52.1	64.8	64.4
Persons, 60-74, screened for bowel cancer within 6 months of invitation (Uptake, %)	2015/16	56.4	59.1	61.0	60.7	50.2	57.8	64.9	62.1	56.6	55.1	52.2	62.2	63.8

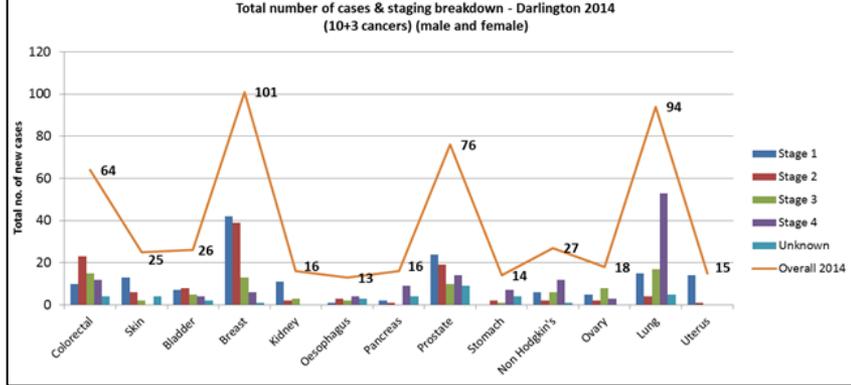


Top 5 cancers - D'ton 2014 % presenting stage



Screening & referral – key points

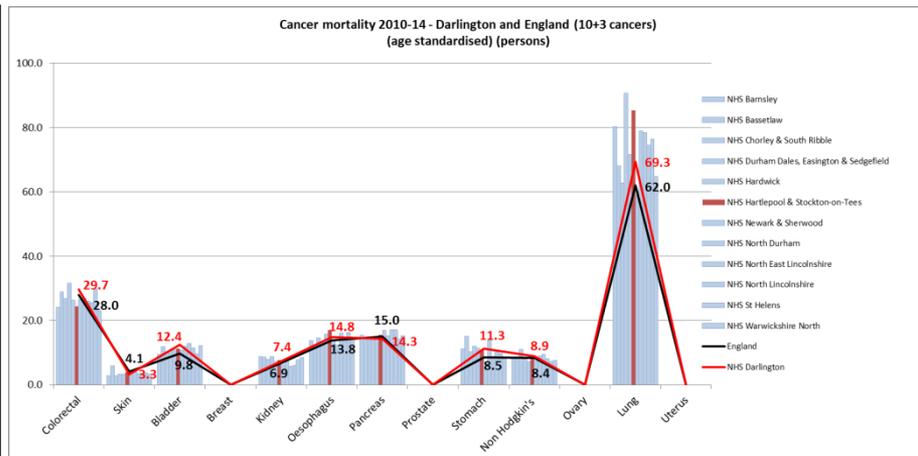
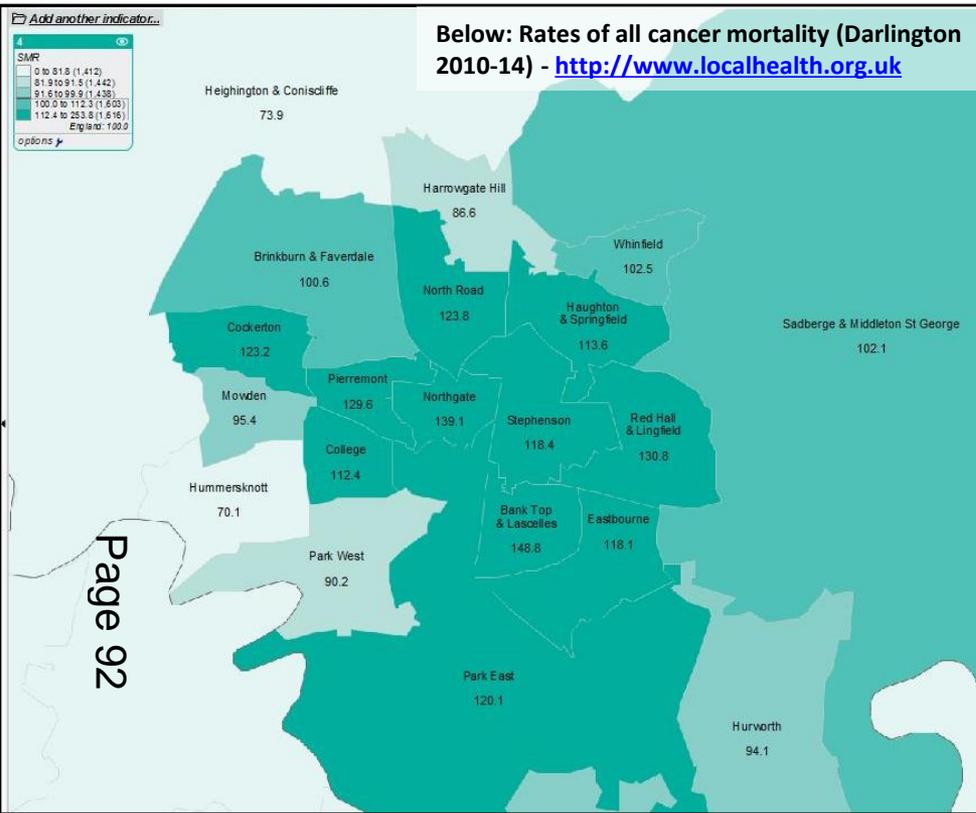
- Darlington screening activity for cervical and bowel cancers statistically above England rate and similar to region. Breast screening below England and statistically below regional rate
- Screening rates variable across Darlington practices, with lowest rates detected amongst practices with highest deprivation (Neasham Road; Clifton Court; Parkgate)
- 2 week wait referrals rate in Darlington is increasing (2,922 per 100,000) and is similar to England rate (2975 per 100,000), but remains 2nd lowest in NE&C region
- 2 week wait conversion rates are falling, but detection increasing: ~47% cancers detected by 2 week wait referral
- Darlington rate for stage 1 & 2 diagnosis 2nd highest in region, and above England rate, but with notable variation amongst tumour sites



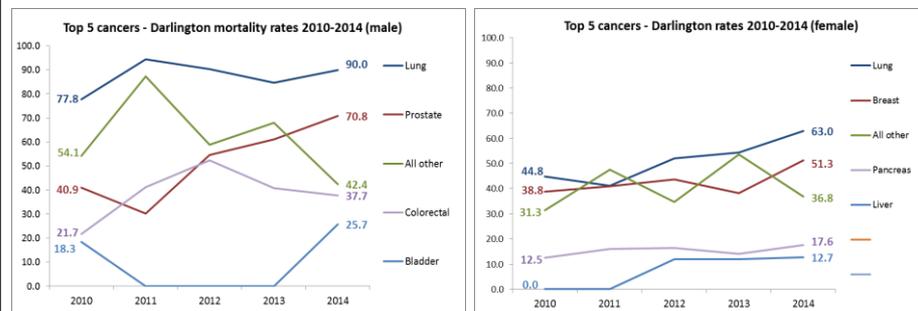
Cancer in Darlington: Mortality

Cancer mortality rates (10+3 cancers) – 2010-14

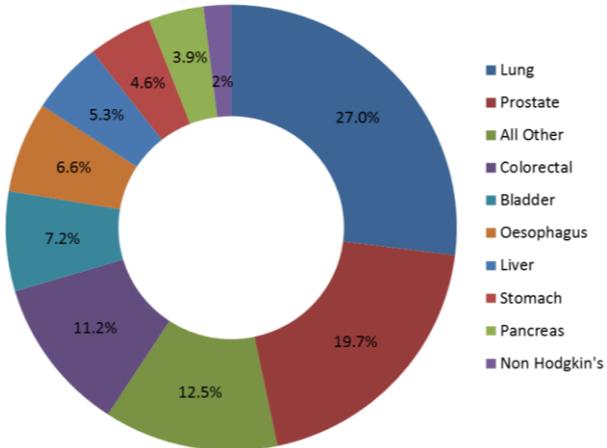
Below: Rates of all cancer mortality (Darlington 2010-14) - <http://www.localhealth.org.uk>



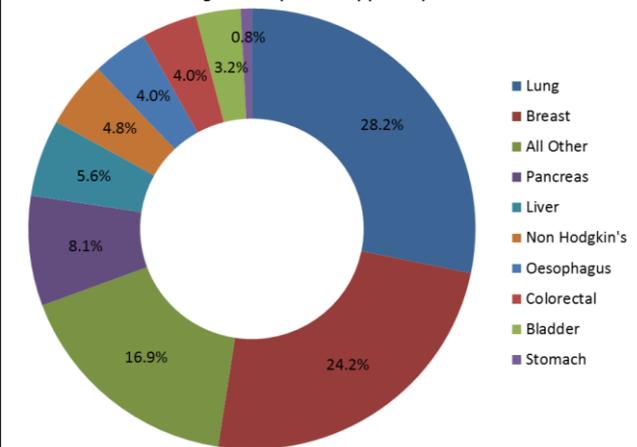
Cancer mortality trends 2010-2014 (age-standardised) (persons)



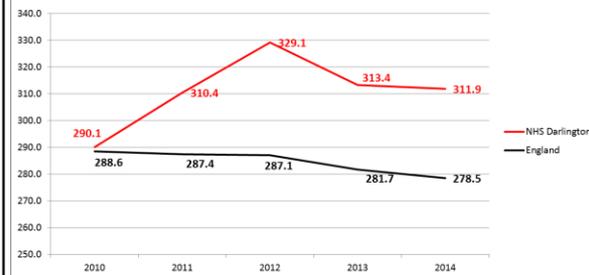
Cancer mortality rates - % of total numbers Darlington 2014 (all cancers) (male)



Cancer mortality rates - % of total numbers Darlington 2014 (all cancers) (female)



Age standardised mortality (all cancers)



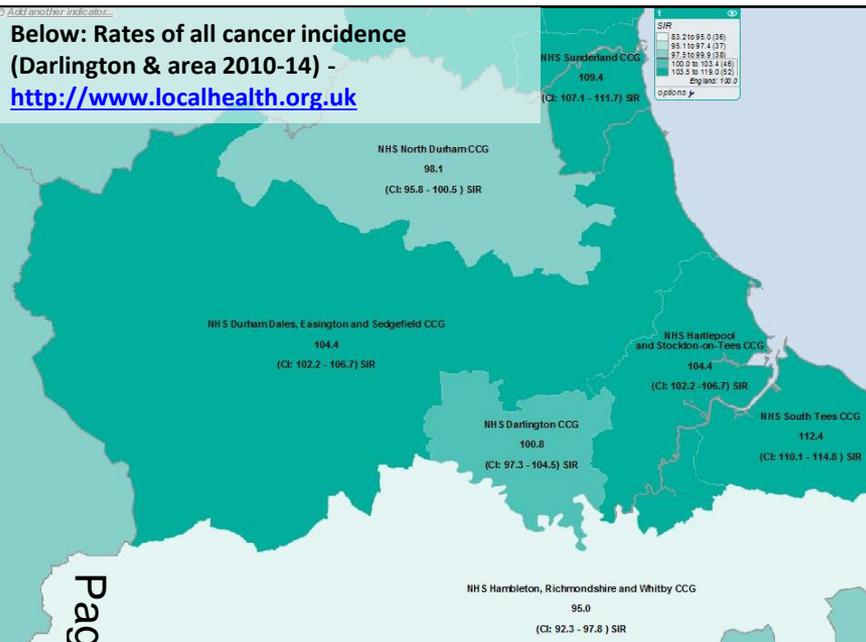
Cancer mortality – key points

- 311 cancer deaths in 2014
- Mortality rate in 2014 (311.9) statistically higher than England rate (278.5) – see above
- Increasing mortality rates for lung, breast & prostate cancers

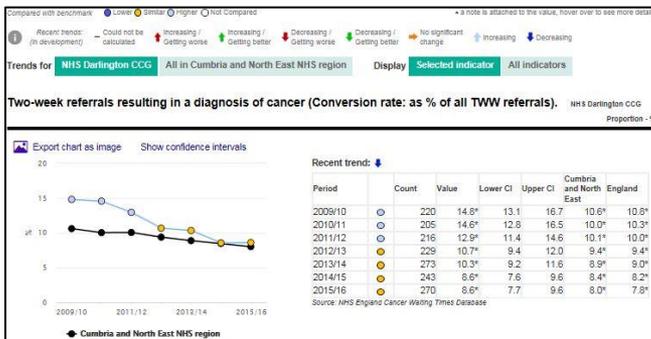
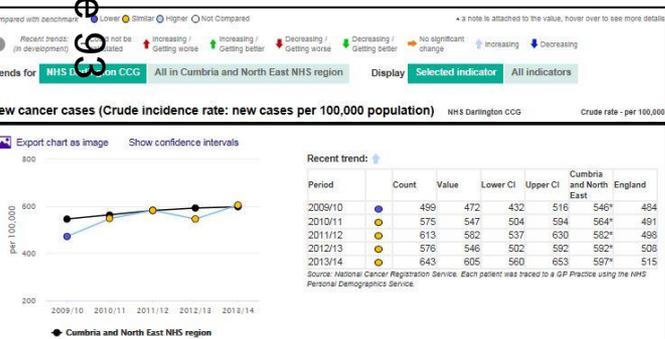
Cancer in Darlington: Regional Context (NE&C)

Regional cancer overview – Cancer Dashboard July 2017 (all cancers)

Below: Rates of all cancer incidence (Darlington & area 2010-14) - <http://www.localhealth.org.uk>

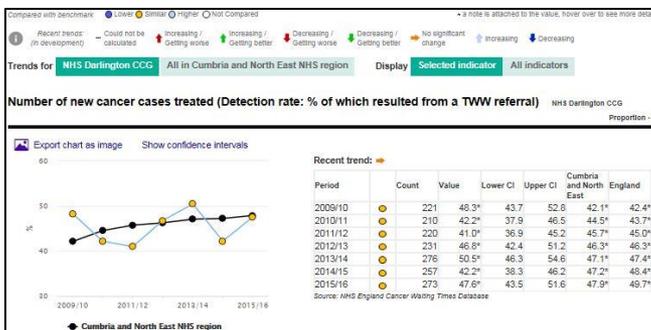
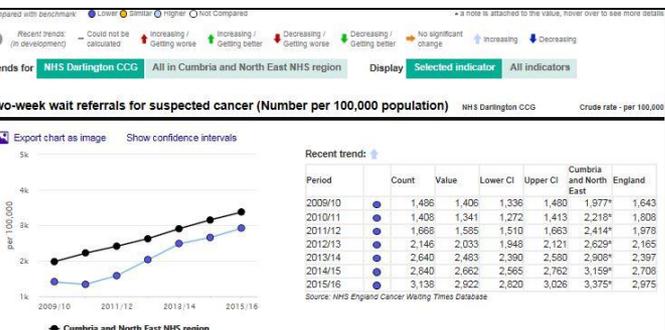


CCG area	Early diagnosis (stage 2 & 2)	Emergency Presentation	<75 mortality rate	<75 preventable mortality	1 yr. survival
Cumbria	51.04	107	131.3	84.5	69
Darlington	54.03	126	159.6	97.1	66.3
DDES	50.66	112	171.12	96.6	66
Hartlepool & Stockton	53.43	93	162.74	95.1	68
Newcastle Gateshead	49.62	102	170.76	113.8	68.6
North Durham	49.35	95	174.7	96.6	68.1
North Tyneside	47.81	125	166.4	106.8	67.9
Northumberland	55.42	114	149.91	79.7	69.2
South Tees	52.28	101	182.84	111	69.5
South Tyneside	53.14	100	181.09	98.5	68
Sunderland	52.43	122	177.34	102.8	68.7
NE&C region		107			
England	50.72 (2014 Q4)	89 (2015/16)	138.7 (2014)	81.1 (2013-15)	69.6 (2013)



Regional cancer overview – key points

- Darlington incidence (605) for 2013-14 statistically above England (515) rate, but similar to region (597)
- Darlington prevalence (2.6) for 2015-16 statistically above England (2.4) rate, but similar to region (2.7)
- Age-standardised rate for 2 week wait referrals 2nd lowest in region, but similar to England rate
- Emergency presentation highest in the region, and statistically higher than England (2013-14), with 1 year survival rates second lowest in region
- Darlington rate for stage 1 & 2 diagnosis 2nd highest in region, and above England rate
- Referral activity for breast, lung and lower GI statistically similar to England and regional rates, but statistically lower for skin cancers
- Darlington screening activity for cervical and bowel cancers statistically above England rate and similar to region. Breast screening below England and statistically below regional rate

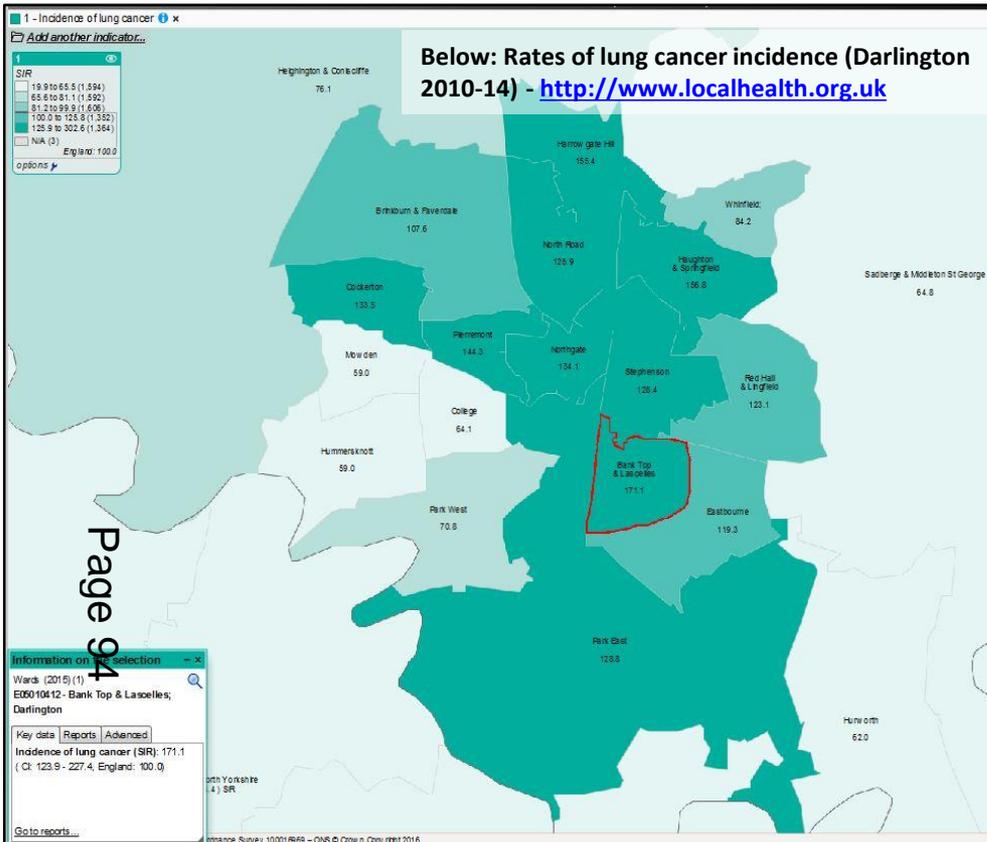


In Focus: Lung Cancer in Darlington

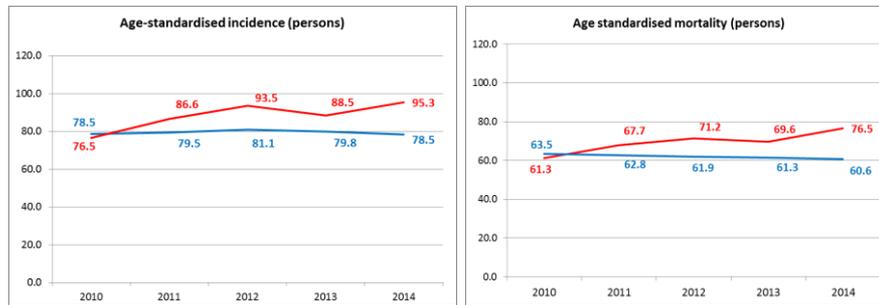
Lung cancer profile: NHS RightCare 2017

CCG area	Early diagnosis	Emergency Presentation	Non-elective spend	1 yr. survival
Barnsley	20.1	44	£1518	33.3
Bassetlaw	12.8	33	£1072	31.8
Chorley & South Ribble	25.5	29	£846	39.9
Darlington	20.2	31	£1510	32.5
DDES	24.5	42	£1160	32.1
Hardwick	18.9	32	£987	31.9
Newark & Sherwood	17.5	27	£884	38.4
North Lincs.	31.6	39	£700	30.8
North East Lincs.	22.3	36	£763	28.9
St Helens	24.1	31	£532	36.8
Warwickshire North	16.3	28	£1087	32.8
England	22.6 (2014)	28.1 (2006-13)	£963.3 (2015-16)	35.4 (2013)

Below: Rates of lung cancer incidence (Darlington 2010-14) - <http://www.localhealth.org.uk>



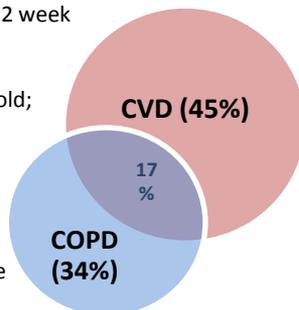
Lung cancer incidence & mortality 2010-2014 (Darlington & England)



Lung cancer patient profile – 2017 audit

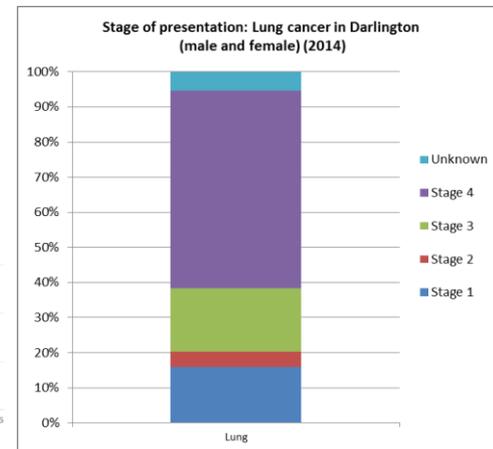
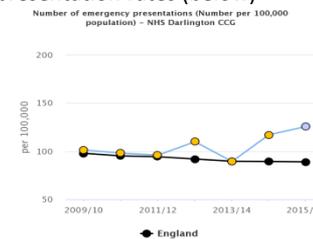
During a primary care audit of patients diagnosed with lung cancer in 2015-2017 (n=240), the following was identified:

- An estimated 48% were diagnosed at a late stage;
- An estimated 45% were referred on urgent 2 week wait pathways;
- Mean age of diagnosis was 72 years old;
- Mean age of death (n=142) was 72.2 years old;
- 87.1% of patients had smoking history;
- 45% had CVD & 34% had COPD;
- 17% had both CVD & COPD;
- Only 14.5% had no other co-morbidities;
- Patients had frequent contact with primary care, with very low non-attendance rates (3.4% DNA rate)



Lung cancer activity:

- 94 new lung cancer diagnoses 2014 (all cancers n=633)
- Accounts for ~15% of all cancer **diagnoses** and ~27% of all cancer **mortality** in Darlington (persons) (2014)
- Poor early diagnosis rates (20.2% - right), with rates **decreasing** (2012-14), but rising to 25.7% in 2015
- **Increasing** emergency presentation rates (below) – ~23% of all diagnoses in 2015/16 – affected by lung cancer?
- 132 lung referrals (2 week wait) in 2015-16
- Only 50% of patients referred quickly (CPES, 2016)



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