

AGENDA ITEM

REPORT TO HEALTH AND WELLBEING BOARD

REPORT OF DIRECTOR OF PUBLIC HEALTH

HEALTH PROTECTION REPORT 2018-19

SUMMARY

This annual Health Protection Report to the Health and Wellbeing Board reports on key issues and indicators for Health Protection for 2018-19.

RECOMMENDATIONS

1. The Stockton-On-Tees Health and Wellbeing Board are asked to note the annual Health Protection report and to consider any implications on the health and wellbeing of the population and health inequalities.
2. It is recommended that this report is circulated to the Adults' Health and Wellbeing Partnership and Children and Young People's Partnership for consideration.

DETAIL

1. Health protection seeks to prevent or reduce the harm caused by communicable diseases and minimise the health impact from environmental hazards such as chemicals and radiation. As well as major programmes such as the national immunisation programmes and the provision of health services to diagnose and treat infectious diseases, health protection involves planning, surveillance and response to incidents and outbreaks.

Health protection arrangements

2. Local authorities have a critical role in protecting the health of their population, both in terms of planning to prevent threats arising and in ensuring appropriate responses when things do go wrong. The Director of Public Health (DPH) is responsible for the local authority's contribution to health protection matters, including planning for and response to incidents that present a threat to the public's health. To carry this out, they liaise closely with the specialist health protection expertise available in Public Health England (PHE).
3. PHE has a responsibility to deliver the specialist health protection response, including the response to incidents and outbreaks, which is carried out through the Health Protection Team in the North East PHE Centre. These roles are complementary and both are needed to ensure an effective response. In practice this means that there must be early and ongoing communication between the PHE Centre and DPH regarding emerging health protection issues to discuss and agree the nature of response required and who does what in any individual situation.

4. The local health protection system therefore involves the delivery of specialist health protection functions by PHE and local authorities providing local leadership for health. In practice, local authorities and PHE work closely together as a single public health system. This joint working with clarity of responsibilities between them is crucial for the safe delivery of health protection.

Delivering health protection

5. There are four key components to the work of protecting the health of the population: prevention; surveillance; control; communication. All agencies have major roles in each of these components.
6. **Prevention** in communicable disease control is exemplified by immunisation but includes a wide range of activities such as promoting safe sex to prevent sexually transmitted diseases and needle exchange programmes to prevent transmission of hepatitis B and C in people who inject drugs. There is also a key role for Environmental Health teams within the local authority in several areas, including for example, food safety. For other hazards such as chemical incidents, prevention is about planning for incidents and emergencies and co-ordinating exercising and training.
7. **Surveillance** is dependent both on the system of disease notification from registered medical practitioners and on organism reporting from hospital laboratories plus a number of other information flows. Effective surveillance systems are essential in identifying trends and outbreaks and monitoring the outcome of control actions.
8. **Control** relates to the management of individual cases of certain diseases to minimise the risk of spread and the specific actions taken to control an outbreak of infectious disease. For other hazards or threats, advice can be provided to agencies co-ordinating the response, in particular on public health risk assessment and actions to protect the public.
9. **Communication** underpins prevention and control and includes the production of routine and ad hoc reports; the networks and groups to which all those involved in health protection contribute; proactive and reactive communications to the media and the communications response in urgent and emergency situations.

Prevention - immunisation and vaccine preventable disease

10. 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 a wide range of 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.
11. NHS England is responsible for commissioning local immunisation programmes. Screening and Immunisation Teams (SITs) employed by PHE 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.

12. PHE Centres lead the response to disease outbreaks of vaccine preventable disease and provide expert support and advice to the SITs.
13. Local Authorities are responsible for providing independent scrutiny and challenging the arrangements of NHS England, PHE and providers.
14. The Joint Committee on Vaccination and Immunisation (JCVI) has recommended the introduction of a universal HPV (Human Papilloma Virus) vaccination into England's national immunisation programme starting in 2019. Gardasil® should be offered routinely to all individuals in school year 8 (age 12 and 13 years) born from 1 September 2006 to 31 August 2007, through the school aged programme.
15. Taking all these changes into account, a summary of the current vaccination programmes in England (Autumn 2019) can be seen below:

The routine immunisation schedule from Autumn 2019

Age due	Diseases protected against	Vaccine given and trade name		Usual site
Eight weeks old	Diphtheria, tetanus, pertussis (whooping cough), polio, <i>Haemophilus influenzae</i> type b (Hib) and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa	Thigh
	Pneumococcal (13 serotypes)	Pneumococcal conjugate vaccine (PCV)	Prevenar 13	Thigh
	Meningococcal group B (MenB)	MenB	Bexsero	Left thigh
	Rotavirus gastroenteritis	Rotavirus	Rotarix	By mouth
Twelve weeks old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa	Thigh
	Rotavirus	Rotavirus	Rotarix	By mouth
Sixteen weeks old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa	Thigh
	Pneumococcal (13 serotypes)	PCV	Prevenar 13	Thigh
	MenB	MenB	Bexsero	Left thigh
One year old (on or after the child's first birthday)	Hib and MenC	Hib/MenC	Menitorix	Upper arm/thigh
	Pneumococcal	PCV	Prevenar 13	Upper arm/thigh
	Measles, mumps and rubella (German measles)	MMR	MMR VaxPRO ² or Priorix	Upper arm/thigh
	MenB	MenB booster	Bexsero	Left thigh
Eligible paediatric age groups ¹	Influenza (each year from September)	Live attenuated influenza vaccine LAIV ^{2, 3}	Fluenz Tetra ^{2, 3}	Both nostrils
Three years four months old or soon after	Diphtheria, tetanus, pertussis and polio	DTaP/IPV	Infanrix IPV or Repevax	Upper arm
	Measles, mumps and rubella	MMR (check first dose given)	MMR VaxPRO ² or Priorix	Upper arm
Boys and girls aged twelve to thirteen years	Cancers caused by human papillomavirus (HPV) types 16 and 18 (and genital warts caused by types 6 and 11)	HPV (two doses 6-24 months apart)	Gardasil	Upper arm
Fourteen years old (school year 9)	Tetanus, diphtheria and polio	Td/IPV (check MMR status)	Revaxis	Upper arm
	Meningococcal groups A, C, W and Y disease	MenACWY	Nimenrix or Menveo	Upper arm
65 years old	Pneumococcal (23 serotypes)	Pneumococcal Polysaccharide Vaccine (PPV)	Pneumococcal Polysaccharide Vaccine	Upper arm
65 years of age and older	Influenza (each year from September)	Inactivated influenza vaccine	Multiple	Upper arm
70 years old	Shingles	Shingles	Zostavax ²	Upper arm

1. See Green book chapter 19 or visit www.gov.uk/government/publications/influenza-the-green-book-chapter-19 or www.nhs.uk/conditions/vaccinations/child-flu-vaccine/

2. Contains porcine gelatine.

3. If LAIV (live attenuated influenza vaccine) is contraindicated and child is in a clinical risk group, use inactivated flu vaccine.

For vaccine supply information for the routine immunisation schedule please visit www.imform.dh.gov.uk and check vaccine update for all other vaccine supply information.

immunisation

The safest way to protect children and adults

NHS

Selective immunisation programmes

Target group	Age and schedule	Disease	Vaccines required
Babies born to hepatitis B infected mothers	At birth, four weeks and 12 months old ^{1,2}	Hepatitis B	Hepatitis B (Engerix B/HBvaxPRO)
Infants in areas of the country with TB incidence $\geq 40/100,000$	At birth	Tuberculosis	BCG
Infants with a parent or grandparent born in a high incidence country ³	At birth	Tuberculosis	BCG
At risk children	From 6 months to 17 years of age	Influenza	LAIV or inactivated flu vaccine if contraindicated to LAIV or under 2 years of age
Pregnant women	During flu season At any stage of pregnancy	Influenza	Inactivated flu vaccine
Pregnant women	From 16 weeks gestation	Pertussis	dTaP/IPV (Boostrix-IPV or Repevax)

1. Take blood for HBsAg at 12 months to exclude infection.

2. In addition hexavalent vaccine (Infanrix hexa) is given at 8, 12 and 16 weeks.

3. Where the annual incidence of TB is $\geq 40/100,000$ – see www.gov.uk/government/publications/tuberculosis-tb-by-country-rates-per-100000-people

Additional vaccines for individuals with underlying medical conditions

Medical condition	Diseases protected against	Vaccines required ¹
Asplenia or splenic dysfunction (including due to sickle cell and coeliac disease)	Meningococcal groups A, B, C, W and Y Pneumococcal Haemophilus influenzae type b (Hib) Influenza	Hib/MenC MenACWY MenB PCV13 (up to two years of age) PPV (from two years of age) Annual flu vaccine
Cochlear implants	Pneumococcal	PCV13 (up to two years of age) PPV (from two years of age)
Chronic respiratory and heart conditions (such as severe asthma, chronic pulmonary disease, and heart failure)	Pneumococcal Influenza	PCV13 (up to two years of age) PPV (from two years of age) Annual flu vaccine
Chronic neurological conditions (such as Parkinson's or motor neurone disease, or learning disability)	Pneumococcal Influenza	PCV13 (up to two years of age) PPV (from two years of age) Annual flu vaccine
Diabetes	Pneumococcal Influenza	PCV13 (up to two years of age) PPV (from two years of age) Annual flu vaccine
Chronic kidney disease (CKD) (including haemodialysis)	Pneumococcal (stage 4 and 5 CKD) Influenza (stage 3, 4 and 5 CKD) Hepatitis B (stage 4 and 5 CKD)	PCV13 (up to two years of age) PPV (from two years of age) Annual flu vaccine Hepatitis B
Chronic liver conditions	Pneumococcal Influenza Hepatitis A Hepatitis B	PCV13 (up to two years of age) PPV (from two years of age) Annual flu vaccine Hepatitis A Hepatitis B
Haemophilia	Hepatitis A Hepatitis B	Hepatitis A Hepatitis B
Immunosuppression due to disease or treatment ³	Pneumococcal Influenza	PCV13 (up to two years of age) ² PPV (from two years of age) Annual flu vaccine
Complement disorders (including those receiving complement inhibitor therapy)	Meningococcal groups A, B, C, W and Y Pneumococcal Haemophilus influenzae type b (Hib) Influenza	Hib/MenC MenACWY MenB PCV13 (to any age) PPV (from two years of age) Annual flu vaccine

1. Check relevant chapter of green book for specific schedule.

2. To any age in severe immunosuppression.

3. Consider annual influenza vaccination for household members and those who care for people with these conditions.

immunisation

The safest way to protect children and adults

NHS

Childhood immunisations

16. Vaccine coverage rates in for children (12 months) in Stockton were above the national and similar to the regional average. Uptake in the North East for the routine childhood immunisation programme remains amongst the highest in England.

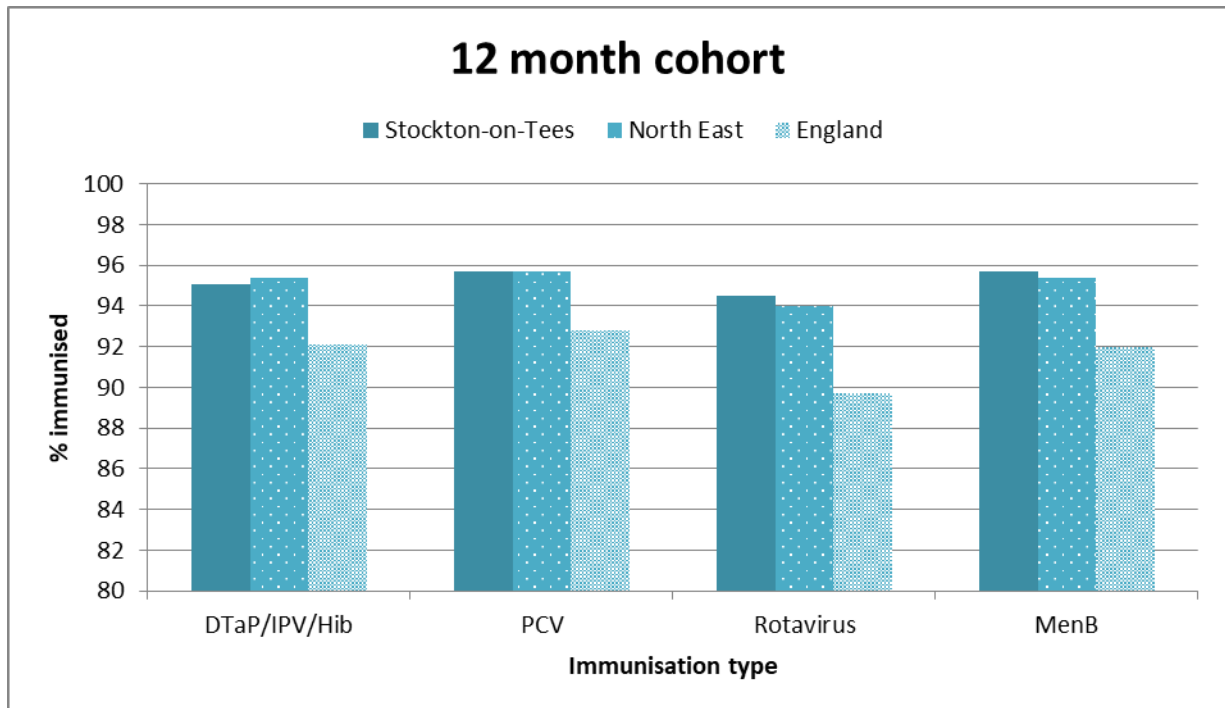


Figure 1 Vaccination coverage rates for children aged 12 months for 2018/19

12 month cohort	Stockton-on-Tees		North East	England
	Number	%	%	%
DTaP/IPV/Hib	2,043	95.1	95.4	92.1
PCV	2,046	95.7	95.7	92.8
Rotavirus	2,022	94.5	94.0	89.7
MenB	2,046	95.7	95.4	92.0

Table 1 Vaccination coverage rates for children aged 12 months for 2018/19

DTaP	Diphtheria, tetanus and acellular pertussis
IPV	Inactivated polio vaccine
Hib	Haemophilus influenzae type b
MenC	Meningitis C
PCV	Pneumococcal conjugate vaccine
MMR	Measles, mumps and rubella
MenB	Meningococcal Group B

17. Vaccine coverage rates in for children (24 months) in Stockton were above the national and regional averages.

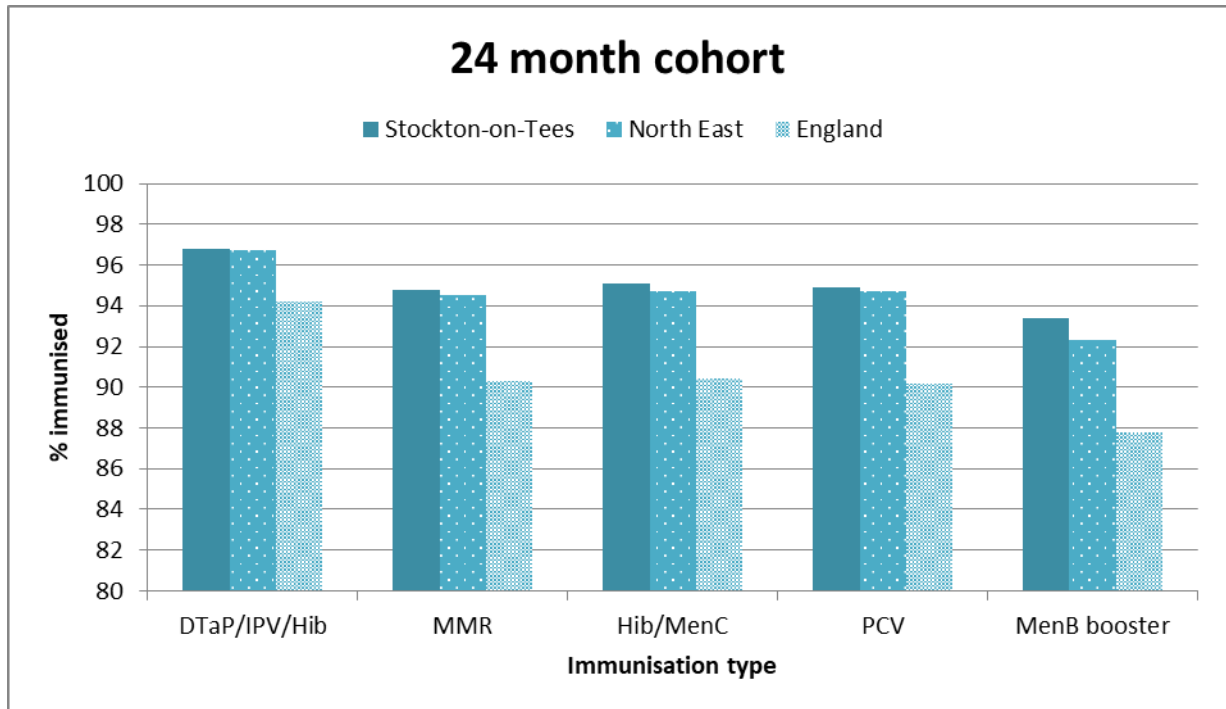


Figure 2 Vaccination coverage rates for children aged 24 months for 2018/19

24 month cohort	Stockton-on-Tees		North East	England
	Number	%	%	%
DTaP/IPV/Hib	2,213	96.8	96.7	94.2
MMR	2,167	94.8	94.5	90.3
Hib/MenC	2,173	95.1	94.7	90.4
PCV	2,170	94.9	94.7	90.2
MenB booster	2,136	93.4	92.3	87.8

Table 2 Vaccination coverage rates for children aged 24 months for 2018/19

18. Vaccine coverage rates in for children (5 years) in Stockton were above the national and similar to the regional average for most vaccines. Vaccine coverage for DTaP/IPV and MMR (1st and 2nd dose) was below the regional but above the national average.

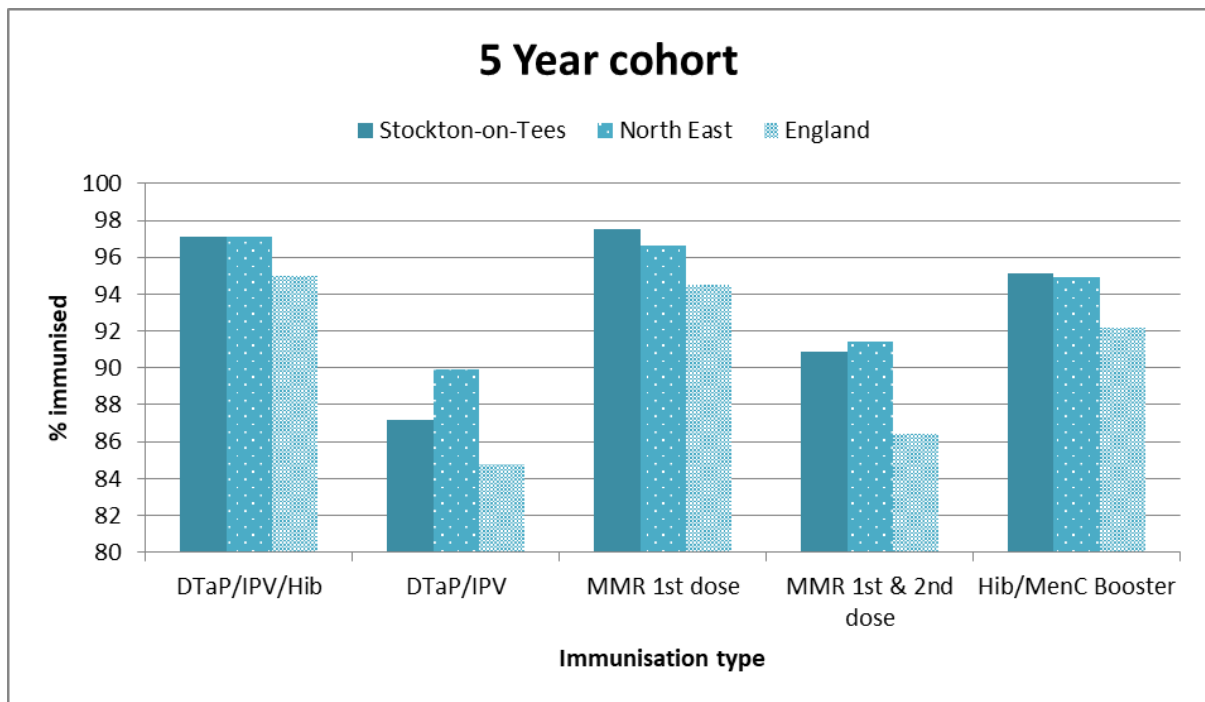


Figure 3 Vaccination coverage rates for children aged 5 years for 2018/19

5 year cohort	Stockton-on-Tees		North East	England
	Number	%	%	%
DTaP/IPV/Hib	2,371	97.1	97.1	95.0
DTaP/IPV	2,129	87.2	89.9	84.8
MMR 1st dose	2,380	97.5	96.6	94.5
MMR 1st & 2nd dose	2,220	90.9	91.4	86.4
Hib/MenC Booster	2,321	95.1	94.9	92.2

Table 3 Vaccination coverage rates for children aged 5 years for 2018/19

Control - specific diseases

Gastroenteric disease

19. Stockton Borough has seen the following cases of disease in 2018/19: campylobacter is the commonly seen cause of bacterial food poisoning, typically affecting several hundred individuals per year (312) in Stockton-on-Tees. Other bacterial causes of gastroenteric disease are less common and trends are difficult to comment on at local level due to the relatively low numbers and hence often significant fluctuation in rates (for small amounts of cases) from year to year.

		2018/19	
		Stockton-on-Tees	North East
Salmonella enteritidis	No:	11	128
	Rate:	5.6	4.8
Salmonella typhimurium	No:	6	61
	Rate:	3.0	2.3
Salmonella other	No:	11	157
	Rate:	5.6	5.9
Escherichia coli o157	No:	<5	56
	Rate:	<5	2.1
Campylobacter	No:	312	3272
	Rate:	158.2	123.1
Cryptosporidium	No:	17	377
	Rate:	8.6	14.2
Giardia	No:	43	329
	Rate:	21.8	12.4
Shigella	No:	8	56
	Rate:	4.1	2.1

Table 4 Numbers and incidence (annualised rate per 100,000 population) of selected gastroenteric diseases/organisms for 2018/19

Note: All rates calculated from mid-2018 population estimates from ONS

Vaccine Preventable Disease/ Exanthema

20. In 2018/19, there were less than 5 confirmed cases of measles or mumps and no confirmed cases of rubella in Stockton-on-Tees. It is important to maintain MMR vaccination rates to ensure there are no cases in the future.

21. Whooping cough (pertussis infection) can be particularly dangerous in small infants and this is why a programme of vaccination for pregnant women exists in order to prevent transmission to the new-born babies. There were fewer than 5 confirmed cases of whooping cough in Stockton-on-Tees.

22. Meningococcal disease can be particularly serious and often causes much anxiety amongst parents. Rates have been falling in recent years and vaccination now includes serogroups B and W for certain age groups. There were fewer than 5 confirmed case of meningococcal disease in 2018/19 in Stockton.

2018/19				
			Stockton-on-Tees	North East
Measles	Confirmed	No:	<5	15
		Rate:	<5	0.6
	Reported / suspected	No:	22	188
		Rate:	11.2	7.1
Meningococcal disease	Confirmed	No:	<5	28
		Rate:	<5	1.1
	Reported / suspected	No:	<5	60
		Rate:	<5	2.3
Mumps	Confirmed	No:	<5	71
		Rate:	<5	2.7
	Reported / suspected	No:	38	504
		Rate:	19.4	19.1
Rubella	Confirmed	No:	0	<5
		Rate:	0.0	<5
	Reported / suspected	No:	0	17
		Rate:	0.0	0.6
Whooping cough	Confirmed	No:	<5	69
		Rate:	<5	2.6
	Reported / suspected	No:	10	202
		Rate:	5.1	7.7

Table 5 Number and incidence (annualised rate per 100,000 population) of cases of common vaccine preventable diseases and other exanthema reported in 2018/19

Note: All rates calculated from mid-2018 population estimates from ONS

Other selected organisms

23. There were no cases of legionella and fewer than 5 cases of hepatitis A or listeria in Stockton-on-Tees in 2018/19, however, there were 17 confirmed cases of hepatitis B and 40 cases of hepatitis C. Key elements of protection against hepatitis are provided though Hep A and B immunisation programmes of at risk groups and needle exchange programmes via local drug services.

2018/19			
		Stockton-on-Tees	North East
Hepatitis A	No:	<5	10

	Rate:	<5	0.4
Hepatitis B	No:	17	213
	Rate:	8.7	8.1
Hepatitis C	No:	40	683
	Rate:	20.4	25.9
Legionella	No:	0	19
	Rate:	0.0	0.7
Listeria	No:	<5	16
	Rate:	<5	0.6

Table 6 Numbers and incidence (annualised rate per 100,000 population) of other selected diseases/organisms for 2018/19

Note: All rates calculated from mid-2018 population estimates from ONS

Tuberculosis

24. During 2016-18, there was an average of 10 tuberculosis cases reported per year in Stockton-on-Tees at a rate of 5.1 per 100,000. This was similar to the North East rate of 4.4 per 100,000 and below the England rate of 9.2 per 100,000.

Sexual Health

25. In 2018, all sexually transmitted infection (STI) rates in Stockton-on-Tees were lower than the North East average apart from Syphilis (36 cases). Chlamydia infections were the most common STI with 588 cases, followed by genital warts and genital herpes (115 cases) and gonorrhoea with 105 cases.

		Stockton-on-Tees	North East
Gonorrhoea	No:	105	1760
	Rate:	53.4	66.5
Chlamydia	No:	588	8735
	Rate:	299	330
Syphilis	No:	36	245
	Rate:	18.3	9.3
Genital warts (first episode)	No:	115	2464
	Rate:	58.5	93.2
Genital herpes (first episode)	No:	115	1600
	Rate:	58.5	59.0

Table 7 Number and incidence per 100,000 population of cases of common sexually transmitted infections reported in 2018 (Jan-Dec)

Control - outbreaks

Care home outbreaks

26. Outbreaks of illness are relatively common in the care home setting. These are typically viral outbreaks with person to person spread in a closed setting. As can be seen in Table 8, there were 18 such outbreaks in 2018/19 in Stockton-on-Tees.

Year	Month	Stockton-on-Tees	NE
2018	April	2	26
	May	0	16
	June	2	18
	July	0	8
	August	1	10
	September	3	11
	October	2	19
	November	0	27
	December	1	31
2019	January	2	48
	February	1	27
	March	3	27
Total		18	291

Table 8 Number of gastrointestinal outbreaks in care homes by month and Local Authority

27. The causative organism in care home outbreaks is most commonly norovirus, though other viral causes such as rotavirus, astrovirus and sapovirus can be seen. However often no organism can be identified, either because samples could not be obtained or they did not test positive in the laboratory. There can be occasional outbreaks linked to food production such as from *Clostridium perfringens* or *Salmonella*.

Emergency preparedness, resilience and response (EPRR)

28. Emergency planning aims, where possible, to prevent emergencies occurring and when they do occur good planning should reduce, control or mitigate the effects of the emergency. It is a systematic and ongoing process which should evolve as lessons are learnt and circumstances change.

29. It is the responsibility of the local authority to prepare emergency plans to detail its response to a major incident or emergency.

30. The Major Incident Response Plan has been reviewed and updated for 2019 in accordance with Section 5 of Emergency Preparedness – Guidance on Part 1 of the Clinical Contingencies Act (2004), its associated Regulations and non-statutory arrangements.

31. The plan aims to allow for flexible management and adaptability to a wide range of circumstances. In addition it provides a means of coordinating the activities of all council staff and partners engaged in responding to major emergencies such as to

provide support to initial responder, maintain essential services and lead on post incident recovery.

32. A Cleveland Incident Recovery Plan details the mechanisms and protocols by the Local Resilience Forum in the event of an incident requiring a restoration phase. Local authorities lead the recovery process. Recovery training and exercises for SBC have been led by the Emergency Planning Unit
33. The council is represented on multiagency planning and strategic groups such as the Cleveland Local Resilience Forum (LRF). The LRF coordinates planning, training and exercising in relation to a range of threats identified in their community risk register.
34. There have been no major incidents in Stockton in 2018/19.

Environmental Health

35. The Environmental Health Unit has three main areas: Commercial, Environmental Protection and Animal Health and Welfare. These three areas cover a diverse range of issues including food safety and improving working conditions to reduce the occurrence of accidents and ill health, improving the quality of the environment for residents of Stockton-On-Tees; and pest control, animal welfare and investigating public nuisance.

Commercial Team

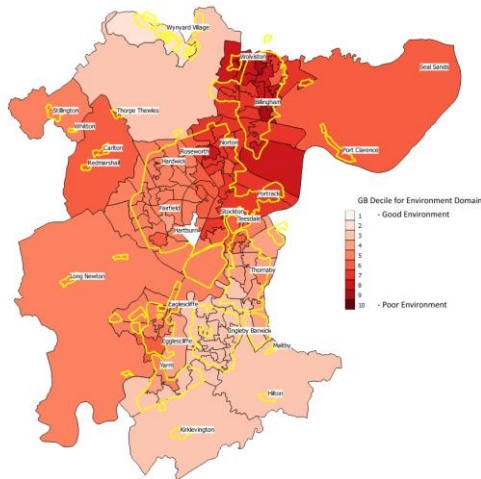
36. The Commercial Team undertook a total of 654 food safety inspections in 2018/9. Broad compliance was achieved in approximately 95% of these. The majority of the others required informal notices only.
37. A total of three formal notices were issued (Hygiene Improvement Notices), in addition to three simple cautions. A further eleven premises were 'Voluntarily Closed' due to poor standards; unfit foodstuffs were 'Voluntarily Surrendered' in thirteen premises.
38. All non-compliant premises are thoroughly investigated and either worked with to secure compliance or subject to further formal action as detailed above.
39. The team carried out 484 bacteriological samples during the year and responded to food safety requests for service. These included 422 complaints about premises and 43 food complaints. In terms of investigation of notified infectious disease, there were a total of 412 food poisoning notifications.
40. The team provided food training across a range of levels including catering courses, hygiene awareness and allergen training. A total of 424 attendees were trained in level 2 Food Hygiene, 34 in level's 3&4 Food Hygiene and 45 on other courses including HACCP for manufacturers.

Environmental Protection Team

41. The Environmental Protection Team covers issues such as air quality, contaminated land and investigations into noise and statutory nuisances such as smoke, dust, fumes and industrial odours.
42. According to Public Health England, poor air quality is the largest environmental risk to public health in the UK. Evidence from the World Health Organization (WHO)

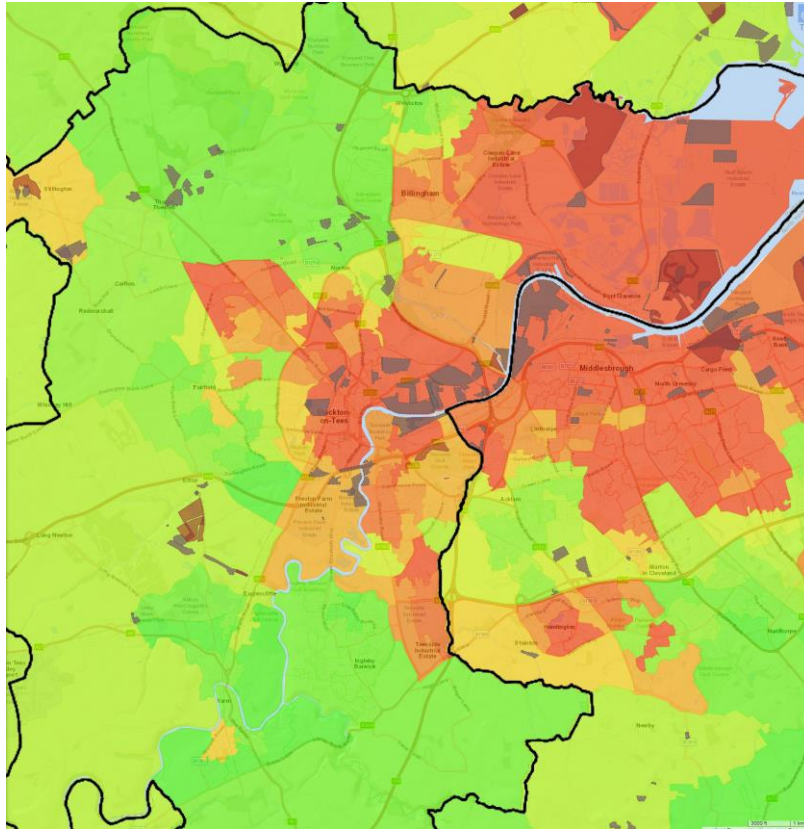
shows that older people, children, people with pre-existing lung and heart conditions, and people on lower incomes may be most at risk. Air quality has improved significantly in recent decades. Since 1970 sulphur dioxide emissions have decreased by 95%, particulate matter by 73%, and nitrogen oxides by 69%. Total UK emissions of nitrogen oxides fell by 19% between 2010 and 2015. Whilst air quality has improved significantly in recent decades, and will continue to improve thanks to the action we have already taken, there are some parts of our country where there are unacceptable levels of air pollution. Stockton-on-Tees has formally reviewed air quality since 2000 and the annual reports to Government show that there has been consistently good air quality compared to national objectives. As a result there has been no need to declare an 'Air Quality Management Area (AQMA)' to improve conditions.

- 43. Indicators from the public health outcomes framework associated with air quality suggest the level of particulate matter in the air in Stockton-on-Tees (6.9 µg/m³) is lower than national averages (8.9 µg/m³) and the mortality attributable to particulate matter (4.0% of mortality) is also lower than national average (5.1%).
- 44. A CDRC Indicators project. AHAH (the index of 'Access to Health Assets and Hazards') is a new multi-dimensional index developed by the CDRC for Great Britain measuring how 'healthy' neighbourhoods are. A domain within this index look at the quality of the environment including information based on levels of No₂, PM₁₀ and SO₂ (Defra 2015)
- 45. Within Stockton-on-Tees there is variation between different indicators associated with air quality and the environment. The combined score for these indicators were ranked and the decile each neighbourhood fell into is plotted below. There is a high proportion of neighbourhoods in Billingham scored relatively poorly compared to the rest of Great Britain for this index.



- 46. There are many sites in the borough that may require remediation to develop due to the contamination of land. Planning policy is in place to ensure any contamination will be removed before development can occur. There are also sites where there may be existing contamination due to historic uses such as landfill. This map plots current and historic landfill sites across the Borough overlaying

deprivation and shows a concentration of historic sites along the river Tees from Stockton to Billingham where deprivation is high.



47. There were 13.7 noise complaints per 1,000 residents in Stockton-on-Tees in 2015/16 which is significantly higher than the England average (6.3 per 1,000 residents) and all of the North East Local Authorities. This position is as a result of the Out of Hours noise service reaching its height of popularity and is operational 24hrs a day 7days a week.

FINANCIAL IMPLICATIONS

There are no direct financial implications of this update.

LEGAL IMPLICATIONS

There are no specific legal implications of this update.

RISK ASSESSMENT

Consideration of risk will be included in the narrative around any health protection issues, together with actions being taken to mitigate this risk.

SUSTAINABLE COMMUNITY STRATEGY IMPLICATIONS

Reporting on health protection issues and performance across Board organisations will have a positive impact on coordinated activity to deliver both the Sustainable Community Strategy and Joint Health and Wellbeing Strategy themes.

CONSULTATION

Consultation has been an integral part of generating priorities for action, through the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy development process.

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