



# BACK TO THE FUTURE

## ANNUAL REPORT

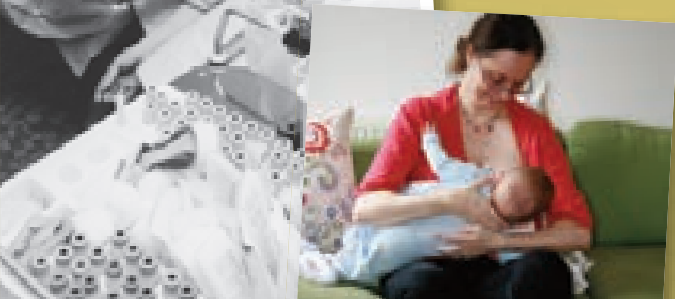
OF THE

DIRECTOR OF PUBLIC HEALTH FOR COUNTY DURHAM

AND THE

DIRECTOR OF PUBLIC HEALTH FOR DARLINGTON

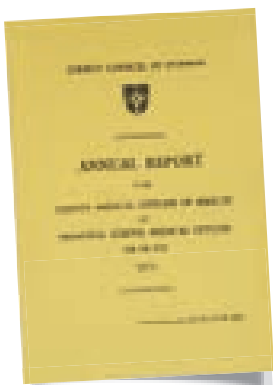
FOR THE YEAR 2011/12



# Introduction

Welcome to our final report as director of public health for County Durham and director of public health for Darlington. Since 2006, we have worked with our teams and a wide range of partners in the NHS, local authorities and voluntary sector to improve the health and wellbeing of residents in County Durham and Darlington. We have had mixed success. Whilst the rates of coronary heart disease continue to decrease, the gap between those people with the best health and those people with the worst health has not changed significantly. The challenge to tackle and reduce health inequalities across County Durham and Darlington remains.

From April 2013 some aspects of public health will become a local authority responsibility. Our public health team will split and predominantly move to Durham County Council and Darlington Borough Council. A small number of staff will move to Public Health England or the NHS Commissioning Board, both new organisations. The move to the local authority is not entirely new for public health as until 1974 public health services were located within a local authority. In 1973, Darlington was a County Borough and the surrounding area was covered by Darlington Rural District Council. In relation to the work of the County Medical Officer<sup>a</sup>, Durham County Council included areas that are now in Darlington, and areas that are now in Gateshead, South Tyneside, Sunderland, Hartlepool and Stockton.



Our theme for this year's annual report is both looking backwards and forwards. We are looking back to the time when public health was previously a local authority responsibility and in each chapter we have made reference to the report from the County Medical Officer of Health in 1973<sup>1</sup>. It is not possible to make direct comparisons between 1973 and the present day because of changes to the administrative boundaries and differences in how information was presented in 1973 and today. However, the extracts from the report illustrate the nature of the changes between then and now.

Each chapter of this report focuses on key areas of work for public health, such as lifestyle issues or the diseases that cause people in our communities to die prematurely. We have described the progress we have made since 2006. We also identify the further work we must continue to do in order to improve the health and wellbeing of the people who live in County Durham and Darlington and reduce health inequalities.

---

<sup>a</sup> The role of the county medical officer was undertaken by public health doctors and preceded the development of the role of director of public health.

An important aspect of future public health work will be addressing the six key policy objectives in Professor Sir Michael Marmot's report *Fair Society, Healthy Lives*<sup>2</sup>. In each of the report's sections we list the work that has been done to work towards these objectives. They have been colour coded throughout the document and are:

- **Give every child the best start in life.**
- **Enable all children, young people and adults to maximise their capabilities and have control over their lives.**
- **Create fair employment and good work for all.**
- **Ensure healthy standard of living for all.**
- **Create and develop healthy and sustainable places and communities.**
- **Strengthen the role and impact of ill health prevention.**

In the last chapter we identify key challenges for the future, from our new position in the two local authorities. We look forward to working with colleagues across the authorities. We also look forward to working with the NHS Commissioning Board, Clinical Commissioning Groups and Public Health England who will all have some public health responsibilities for the County Durham and Darlington communities.

Finally, we would like to take this opportunity to thank our teams and partners across both statutory and non-statutory organisations. In particular our partners in the third sector, for the commitment and work undertaken over the past few years to improve health and reduce health inequalities in both County Durham and Darlington. We look forward to leading and working with you all in the new public health world from 2013.



**Miriam Davidson**  
*Director of Public Health, Darlington*



**Anna Lynch**  
*Director of Public Health, County Durham*

## Acknowledgements

Thanks are due to:

- Liz Bregazzi, County Archivist at Durham County Council for her help in finding the *Annual Report of the County Medical Officer of Health and Principal School Medical Officer for the year 1973*, other documents and the black and white photographs on pages 29, 35 and 39.
- County Durham and Darlington NHS Foundation Trust for the photographs on pages 22, 23, 25, 29, 53, and 62.
- Open Arts Studio for permission to use artwork on pages 26 and 28 produced as part of arts on prescription in Darlington. Project managed by Darlington Borough Council.
- The proof readers Chris Woodcock and Mark McGivern.

Huge thanks also to Jane Beenstock, specialty registrar in public health, for her efforts in co-ordinating every aspect of this final director of public health (joint) annual report. A tremendous undertaking and much appreciated.

# Contents

<b>Chapter 1</b>	<b>The health of people in County Durham and Darlington</b>	<b>5</b>
<b>Chapter 2</b>	<b>The impact our lifestyles have on our health</b>	<b>11</b>
2.1	Working to reduce the harm caused by alcohol and substance misuse	11
2.2	Tobacco control	18
2.3	Tackling obesity and increasing levels of physical activity	23
<b>Chapter 3</b>	<b>Improving our mental health and physical health</b>	<b>26</b>
3.1	Mental health	26
3.2	Heart disease	29
3.3	Cancer	31
3.4	Vaccine preventable disease	35
3.5	Oral health	39
<b>Chapter 4</b>	<b>The impact of social and economic factors on health</b>	<b>42</b>
4.1	Health literacy	42
4.2	Supporting people in and out of work	45
4.3	Public health capacity building	48
4.4	Shaping the environment	51
<b>Chapter 5</b>	<b>Working with people in communities</b>	<b>53</b>
5.1	Children, young people and families	53
5.2	Military health	60
<b>Chapter 6</b>	<b>Our ambition for the future</b>	<b>62</b>
<b>Appendices</b>		<b>64</b>
	Appendix 1: Notes for the Marmot indicators	64
	Appendix 2: List of contributors	66

## Chapter 1

# The health of people in County Durham and Darlington



In 1973 the life expectancy for a person born in England was approximately 75 years for a woman and 69 years for a man<sup>3</sup>. This compares to life expectancy of someone born in 2012 to 82.6 years for a woman and 78.6 years for a man<sup>4</sup>. However, it should be noted that the way life expectancy is calculated now will not be exactly the same as in 1973.

The health of the people in County Durham and Darlington has improved significantly over recent years, but remains worse than the England average. Health inequalities remain persistent and pervasive. Levels of deprivation are higher and life expectancy is lower than the England average.

*The health of the people in County Durham and Darlington has improved significantly over recent years, but remains worse than the England average.*

**Table 1: Marmot indicator data for County Durham, Darlington, the North East and England in 2012**

See page 7 for the charts of this data

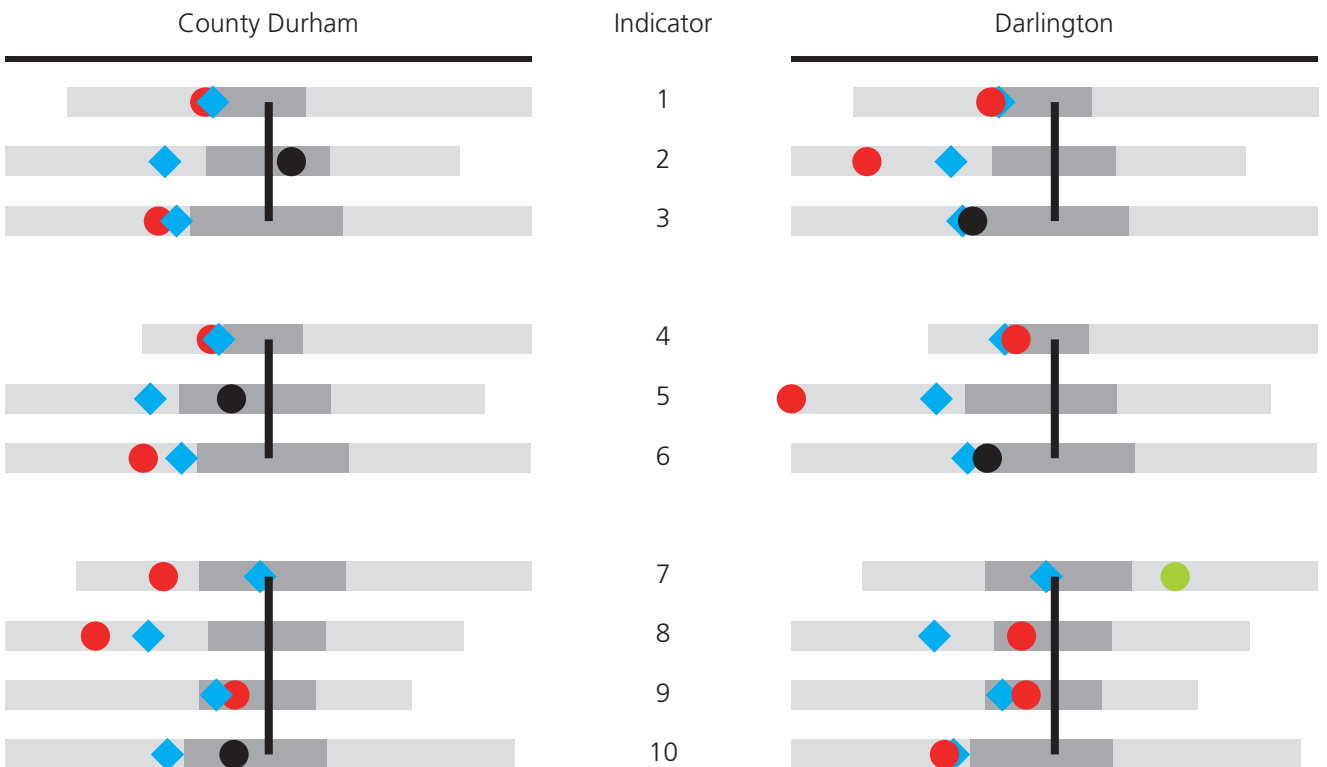
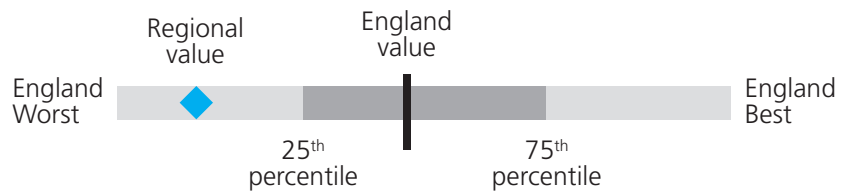
Indicator*	County Durham	Darlington	North East	England
1 Male life expectancy at birth (years)	77.0	77.0	77.2	78.6
2 Inequality in male life expectancy at birth (years)	8.2	14.6	12.0	8.9
3 Inequality in male disability-free life expectancy at birth (years)	14.7	13.8	14.1	10.9
4 Female life expectancy at birth (years)	81.0	81.5	81.2	82.6
5 Inequality in female life expectancy at birth (years)	6.7	11.6	8.5	5.9
6 Inequality in female disability-free life expectancy at birth (years)	13.0	11.2	11.8	9.2
7 Children achieving a good level of development at age 5 (%)	53.7	64.6	58.4	58.8
8 Young people not in employment, education or training (%)	10.4	7.4	9.3	6.7
9 People in households in receipt of means-tested benefits (%)	16.9	16.6	18.3	14.6
10 Inequality in percentage receiving means-tested benefits (% points)	32.4	39.9	39.0	29.0

\*Definitions of the indicators are in appendix 1

## Marmot indicators for local authorities in England, 2012. County Durham and Darlington

The chart below shows key indicators of the social determinants of health, health outcomes and social inequality that correspond, as closely as is currently possible, to the indicators proposed in Fair Society, Healthy Lives. Results for each indicator for County Durham and Darlington are shown below. On the chart, the value for these local authorities are shown as a circle, against the range of results for England, shown as a bar. See page 6 for the data for these charts.

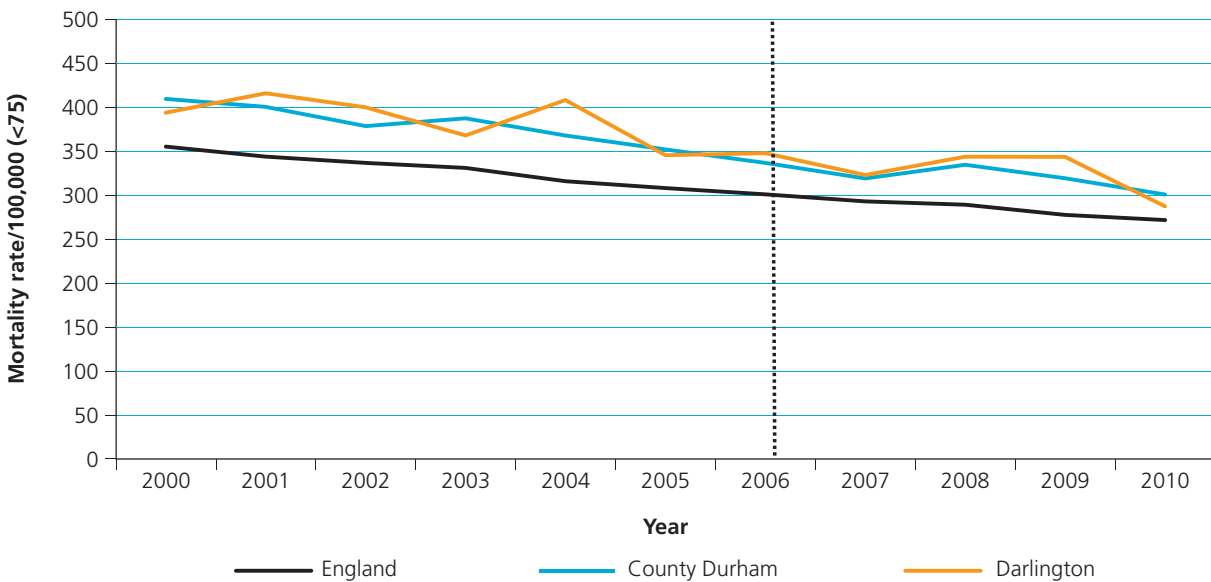
- Significantly better than the England value
- Not significantly different from the England value
- Significantly worse than the England value



The following charts show the directly age-standardised rates. This allows us to compare local rates with England. The lines for County Durham and Darlington are the rates that would occur if they had the same age structure as the population in England. It means the comparisons are clearer because they remove any differences in death rates that are affected by age. The dotted line indicates when NHS County Durham and Darlington was established.

The all-cause mortality rates for people aged under 75 years for the period 2008-10 in County Durham (302 per 100,000) and Darlington (288.6 per 100,000) were significantly higher than England (272.8 per 100,000). The under 75 all-cause mortality rates have been falling over time in County Durham and Darlington. Since 2000 rates have fallen by 27% in both County Durham and Darlington, compared to reductions of 26% in the North East and 24% in England.

**Chart 1: Mortality from all causes for people aged less than 75 years, directly age-standardised rates (DSR), in County Durham, Darlington and England from 2000 to 2010**

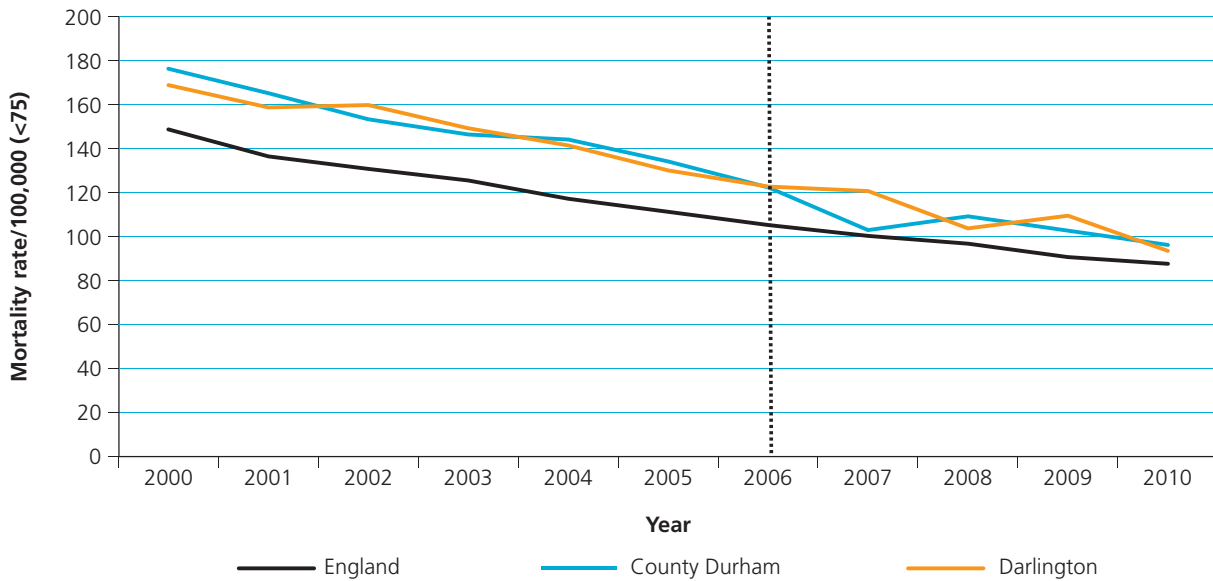


Mortality for causes considered amenable to health care<sup>b</sup> for the period 2008-10 in County Durham (103 per 100,000) and Darlington (102 per 100,000) were significantly higher than England (92 per 100,000). Since 2000 mortality rates for causes considered amenable to health care have fallen by 45% in County Durham, Darlington and the North East, compared to a 41% reduction in England.

<sup>b</sup> It is considered that death from some causes, such as measles in children aged 14 or less, should not occur if effective health care is provided. These conditions are known as ones amenable to health care.

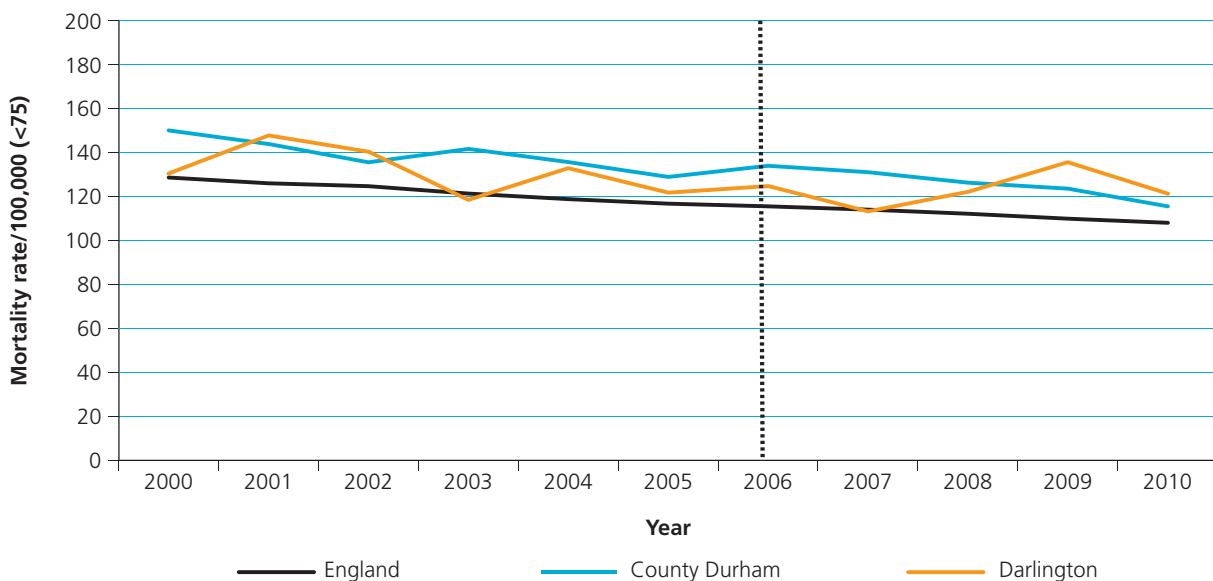


**Chart 2: Mortality from causes considered amenable to health care, directly age-standardised rates (DSR), in County Durham, Darlington and England from 2000 to 2010**



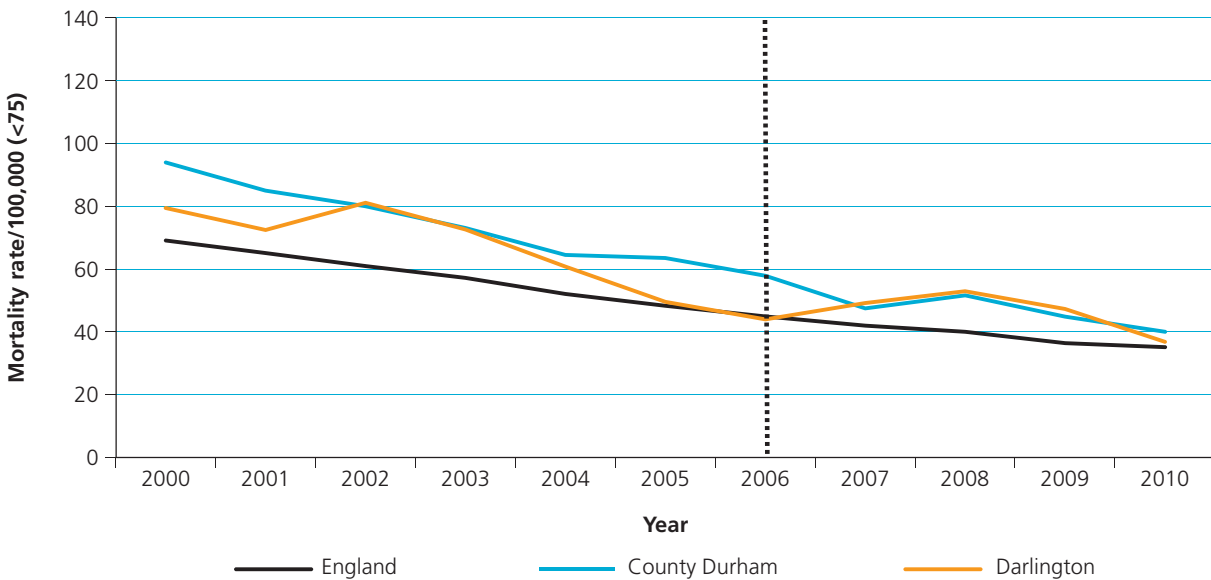
The under 75 all cancer mortality rates for the period 2008-10 in County Durham (122 per 100,000) and Darlington (126 per 100,000) were significantly higher than England (110 per 100,000). Premature all cancer mortality rates have been falling over time in County Durham and Darlington. Since 2000 rates have fallen by 23% in County Durham and by 7% in Darlington, compared to reductions of 20% in the North East and 16% in England.

**Chart 3: Mortality from all cancers for people aged less than 75 years, directly age-standardised rates (DSR), in County Durham, Darlington and England from 2000 to 2010**



The under 75 coronary heart disease (CHD) mortality rates for the period 2008-10 in County Durham (45.5 per 100,000) and Darlington (45.7 per 100,000) were significantly higher than England (37.2 per 100,000). Premature CHD mortality rates have been falling over time in County Durham and Darlington. Since 2000 rates have fallen by 57% in County Durham and by 54% in Darlington and the North East, compared to a reduction of 49% in England.

**Chart 4: Mortality from coronary heart disease for people aged less than 75 years, directly age-standardised rates (DSR), in County Durham, Darlington and England from 2000 to 2010**



For readers who would like to find out more about the health of our communities in County Durham and Darlington, we would direct you to the County Durham Joint Strategic Needs Assessment (<http://www.durham.gov.uk>) and the Darlington Single Needs Assessment (<http://www.darlington.gov.uk>) which contain more detailed information.

## Chapter 2

# The impact our lifestyles have on our health



## 2.1 Working to reduce the harm caused by alcohol and substance misuse

The County Medical Officer of Health's report in 1973<sup>1</sup> made no reference to problems caused by alcohol or drug misuse. In the section describing the work on preventing ill-health, concerns were mainly related to nutrition and dental health.

County Durham and Darlington have significantly higher rates of alcohol related hospital admission for men, women and young people as well as a higher proportion of adults that binge drink compared to the England average. The alcohol related hospital admission rate has been steadily rising over the period 2002/03 to 2010/11. In County Durham the rate of admissions has increased by 157.9% and in Darlington by 154.3%. However early indications for 2011/12 show the rate of the increase is starting to reduce.

Alcohol is strongly linked to crime, anti-social behaviour, domestic abuse, family breakdown, worklessness, poor parenting, ill health and early death. Substance misuse, in particular opiate and crack misuse, is linked to the same negative factors listed for alcohol.

**Table 2: Mid-point estimates of prevalence of opiate and/or crack users aged 15-64 years for County Durham, Darlington and England in 2009/10**

Prevalence estimates by drug	County Durham		Darlington		England	
	Number	Rate per 1,000 population 15-64 years	Number	Rate per 1,000 population 15-64 years	Number	Rate per 1,000 population 15-64 years
Opiate and crack users	2,874	8.6	705	10.9	306,150	8.9
Upper limit*	3,831	11.4	802	12.4	316,916	9.2
Lower limit*	1,925	5.7	658	10.1	299,094	8.7

\* The upper and lower limits are the 95% confidence intervals which indicate that we can be 95% certain that the prevalence will fall between the upper and lower limit.

Source: National Treatment Agency for Substance Misuse – JSNA (Joint Strategic Needs Assessment) Support Pack for Strategic Partners. [www.nta.nhs.uk](http://www.nta.nhs.uk)

### Work to reduce these problems

NHS County Durham and Darlington hosts the County Durham drug and alcohol commissioning team and the Darlington drug and alcohol action team (DAAT) on behalf of the respective partnerships. Most of the commissioning of drug and alcohol services is undertaken by these two teams. Over the past six years NHS County Durham and Darlington has secured £3.66 million recurring investment for preventing alcohol related harm and for alcohol treatment services.

As alcohol impacts on a range of organisations, NHS County Durham and Darlington has worked with many partners to develop the alcohol harm reduction strategies including the police, local authorities, probation, fire and rescue, and the voluntary sector. The first strategies were launched in Darlington in 2008 and in County Durham in 2009 accompanied by action plans which are updated annually with priorities identified. The local work has been informed by a comprehensive alcohol health needs assessment which has been used to inform the Joint Strategic Needs Assessment (Durham) and Single Needs Assessment (Darlington).

The model for the alcohol treatment services across County Durham and Darlington has been developed and commissioned in line with the *National Models of Care for Alcohol Misuse*<sup>5</sup> and NICE guidance.

Current government policy focuses on moving people successfully out of treatment and integrating them back into communities and wider society. The drug and alcohol commissioning teams have been working with providers to ensure new people starting treatment are given recovery plans, which provide recovery as a clear end goal of treatment.

## Examples of the achievements

### Give every child the best start in life

Five years ago policies were put in place to prioritise work with pregnant women who had problems with substance misuse. As a result services for pregnant women have been joined up to more specifically address their needs.

A social norms approach to alcohol and drug education was introduced in secondary schools. This tackles inaccurate beliefs about alcohol use. The approach specifically challenges peer pressure and undermines any sense that alcohol use and misuse is normal. The importance of social norms work is to feedback to young people the actual behaviours of their peers so they can appreciate this is different to commonly held perceptions. As a result in Darlington, there have been reductions in reported alcohol and drug use for each of the last four years. There is also evidence to show that young people are increasingly aware that most of their peers don't use alcohol or drugs<sup>6</sup>.

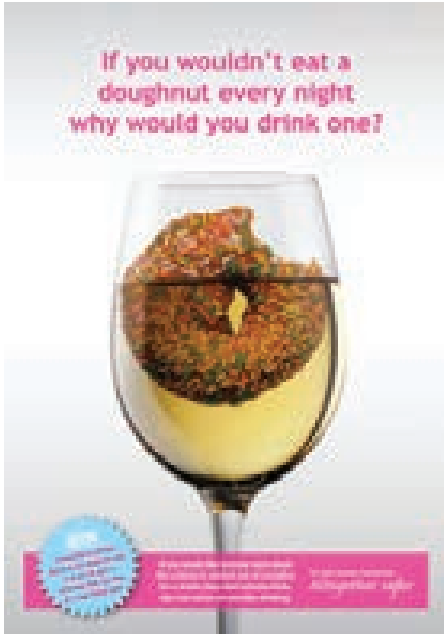
### Enable all children, young people and adults to maximise their capabilities and have control over their lives

In 2011 in County Durham a quasi-residential 12 step abstinence based recovery centre was developed, which detoxifies individuals from all illegal drugs including substitute medication. They then start a therapeutic programme for between 12 to 24 weeks. The Recovery Academy Durham (RAD) has had 77 people referred to the service, five of whom have graduated and now act as ambassadors for the service, inspiring others who are starting on their recovery journey. The RAD has also supported other initiatives such as:

- Recovery Academy Durham (Her Majesty's Prison (HMP) Durham – I wing). This started in January 2012, providing a 17 bedded residential rehabilitation unit delivering a 12 step programme of recovery to support prisoners in achieving abstinence. Four people have graduated so far.
- The recovery banner which was produced by Bearpark Artists, a local cooperative. The artists involved groups of service users both within the prison and community in the design and production of the banner. The finished product was unveiled at Durham Miner's Gala, with people in recovery carrying and following the banner, showcasing the positive image of recovery within the county.

A needs assessment in Darlington showed that there was a significant unmet need for young people with substance misuse issues, mainly alcohol misuse. Accordingly, the local substance misuse treatment service for young people (SWITCH) was redesigned. Increased investment allowed the service to be relocated to discreet premises. Planned successful exits from the service have almost doubled in the last five years and the numbers accessing treatment have gone up for five consecutive years.

4Real is the young people's substance misuse service in County Durham. It provides a multi-agency approach to the identification, assessment, referral and treatment of children and young people who are at risk of substance misuse related harm. A range of services are offered to support children and interventions for young people to move away from dependence on substances. These include; psychosocial interventions, residential treatment, pharmacological interventions, specific family approaches and specialist harm reduction services.



< Using the calorie content of alcohol to try and affect alcohol consumption among a target group.

Alcohol brief intervention > pilot with pharmacies delivering emergency contraception.



Most young people can have their needs met in universal or targeted services. However, access to specialist substance misuse support is required for young people who have been assessed as requiring specialist substance misuse interventions to meet their needs.

Breaking the cycle is a new service in Durham that is a partnership with Addaction, Zurich Community Trust and Lloyds TSB to provide an integrated approach to working with families. This will be one of 27 sites nationally, but the first to include prison-based provision as part of the wider criminal justice pathway. It aims to provide a whole family approach to treatment and recovery.

The early intervention team (EIT) is an award winning service having achieved Investors in Families and Investors in Children awards. It has also been nominated for a European award. The team works within the wider community alcohol service (CAS) in County Durham, offering support to the children of those accessing CAS treatment.

### Create fair employment and good work for all

A recovery-oriented adult treatment system has been developed in Darlington which focuses on clients leaving treatment no longer drinking alcohol or using illicit drugs. It prepares clients for education, training and employment. This includes work with Jobcentre Plus to share information with a potential employer and the client. Similarly, to support people back into education, employment and training in Durham, those who provide treatment services are working with Jobcentre Plus staff to meet the employment-related needs of clients.

The Durham recovery and wellbeing centre (DRAW) opened in September 2011 to provide support for those leaving alcohol services who are abstinent. The centre provides a community drop in facility, promotes mutual aid, provides opportunity for education and training and promotes wellbeing. Peer mentors are key to the success of the centre and training is available to help others through the treatment journey.

## Ensure healthy standard of living for all

The recovery-oriented treatment system focuses on sustainable outcomes, not only around abstinence from drugs and alcohol but also lifestyle outcomes around family, relationships, accommodation, education, training and employment. People who use the services have been involved in developing them.

North East primary care trusts<sup>c</sup> have commissioned Balance, the North East alcohol office which leads on integrated marketing campaigns across the region. This has resulted in work with the media to highlight the impact of alcohol and regular lobbying for changes in legislation.

A social marketing plan was implemented to work with priority groups. For example, helping women understand the impact of alcohol on their calorie intake, raising alcohol awareness amongst the public sector workforce, a wine lovers campaign and Know Your Limits targeted at the 18-24 year old age group.

Frontline practitioners have been trained in identification and brief advice (IBA) including GPs, pharmacists, children's workers, fire service personnel, police officers and housing officers. This means that they have the skills to explain to patients or clients the harms of excessive alcohol consumption and how they can reduce their alcohol consumption.

A locally enhanced service for alcohol related issues has been in operation for three years for people aged 16-39 years old. In Durham 88% of GP practices and in Darlington 82% of GP practices have participated. Since its implementation 33,415 patients have been screened about their alcohol use.

Alcohol screening of offenders on arrival has commenced at Her Majesty's Prison (HMP) Durham. Those identified as possible dependent drinkers are offered access to a structured alcohol programme. The programme is delivered in preparation for release as part of a resettlement programme.

An alcohol arrest referral scheme has been piloted where offenders who have been arrested for an alcohol related offence are screened in police custody and where appropriate referred to treatment services.

An alcohol treatment requirement orders scheme diverts people from possible custody, to a structured programme delivered jointly by probation services and the voluntary sector. This scheme has received national recognition from the Butler Trust<sup>d</sup>.

---

<sup>c</sup> Primary Care Trusts (PCTS) are the NHS organisations that have been responsible for commissioning services from hospitals and other organisations to meet the health needs of their local population.

<sup>d</sup> The Butler Trust Awards are prestigious awards which recognise and celebrate outstanding practice by people working in prisons, youth justice, probation and criminal justice social work, throughout the UK. <http://www.thebutlertrust.org.uk/>.

## Strengthen the role and impact of ill health prevention

A pilot is underway to assess the feasibility and effectiveness of delivering alcohol screening for women and girls accessing pharmacies for emergency contraception. Pharmacists have also expanded alcohol screening to target patients during medicine reviews and those who regularly attend for gastric problems, falls and high blood pressure.

In Darlington funding from the early implementation (EI) programme via the Department of Health increased capacity for brief intervention training, piloted a street-paramedic scheme and delivered publicity and marketing campaigns.

Evaluation and research has been undertaken with both Durham University and Newcastle University to examine how well pilot schemes with young people, in pharmacies and with paramedics have worked. This has contributed to the national evidence base.

The County Durham community alcohol service was remodelled following the review and is delivered by eight providers. For adults the providers are; County Durham and Darlington NHS Foundation Trust (CDDFT), Durham Alliance for Community Care (DACC), Durham Tees Valley Probation Trust, Intrahealth, Janice Kirby (YOU TURN), North East Council on Addictions (NECA) and Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV). For young people the providers are; Durham County Council, Developing Initiatives Supporting Communities (DISC), NECA, TEWV and SERCO Health. A partnership board has been established to ensure joint working across all providers. The service is made up of integrated teams comprising of nurses, hospital liaison team, social workers, counsellors, recovery workers, health support workers, prison outreach workers, probation officers and trainers. Additionally there is a dedicated service to support families.

Darlington community alcohol service operated successfully for three and a half years before being re-commissioned as an integrated service with drugs - in line with the national drug strategy guidance on treatment for dependent drinkers. North East Council on Addictions (NECA) are the lead provider of the service and, in partnership with Northern Engagement into Recovery from Addiction Foundation (NERAF) a peer support organisation, offer a diverse range of recovery-oriented interventions including: prescribing, psycho-social, criminal justice, community detoxification, structured day care, assertive outreach, peer mentoring and access to mainstream and specialist wraparound support services such as housing, education, training and employment.

The Cardiff model identifies violence and alcohol related attendances at emergency departments. It is being used locally to share anonymous data with the police to inform licensing decisions for pubs and nightclubs across County Durham and Darlington.

The drug and alcohol recovery team works in all four County Durham prisons. They provide the full range of evidence based clinical interventions, alongside psychosocial, rehabilitation and educational opportunities.



## Future challenges

- Following the launch of the Government's alcohol strategy in 2012, Durham County Council and Darlington Borough Council will need to review and update their local strategies and action plans.
- Respond to national consultation documents and lobby for a 50p minimum unit price for alcohol and restriction on alcohol advertising to young people.
- Continue to implement the social norms work.
- Ensure integration with other strategies including sexual violence, teenage pregnancy, violent crime, anti-social behaviour, domestic abuse and reducing reoffending.
- Work with the local safeguarding children's boards to deliver work on the relationship between alcohol, drugs and sexual exploitation.
- Undertake further work to understand drug and alcohol misuse in groups such as gypsies and travellers, people who are homeless, pregnant women, veterans, those with dual diagnosis and lesbian, gay, bisexual and trans (LGBT).
- Ensure a seamless transfer of the commissioning of drug and alcohol services into the local authority.
- Evaluate alcohol screening and delivery of brief advice in primary care and pharmacies.
- Work with clinical commissioning groups to provide increased support for those individuals who are repeatedly admitted to hospital as a result of alcohol.
- Continue to develop the harm reduction services and improve links to mental health services.
- Ensure pathways into, through and out of prison have clear opportunities for those using drugs or alcohol to receive support to overcome their addiction, achieve sustained recovery and live crime free lives.
- Improve links with housing, education and employment to optimise opportunities which enhance and support individuals and communities.



Encouraging smokers to quit on the streets of Darlington

## 2.2 Tobacco control

In 1973, the County Medical Officer<sup>1</sup> reported that campaign literature about a range of topics, including smoking, was delivered to all “education establishments... on 6 occasions during the year” (p.57). As this section shows, efforts to tackle the problems of smoking have continued. However, these efforts are now based on evidence that has emerged about the importance of wider tobacco control activity to achieve a reduction in smoking across the population.

### Give every child the best start in life

Smoking in pregnancy is harmful to the unborn child and is a cause of fetal mortality, low birth weight, preterm delivery<sup>7</sup> and increases the risk of congenital anomalies<sup>8</sup>. It contributes to poorer health in later life. In the UK, smoking causes an estimated 5,000 miscarriages, 300 perinatal deaths<sup>e</sup> and 2,200 preterm<sup>e</sup> deliveries per year<sup>9</sup>. In the last six years the percentage of women smoking during pregnancy has reduced in County Durham by 2.9% and in Darlington by 4.4%. However, in 2011/12, in County Durham 21.9% and in Darlington 19.6% of women were smoking during pregnancy.

<sup>e</sup> The report defines a perinatal death as one “that occurs between 20 weeks (or 24 weeks) of pregnancy and the first week of life” (p.43). “A preterm delivery is usually defined as birth before 37 weeks of pregnancy” (p.44).

**Table 3: Number and percentage of women smoking at the time of delivery in County Durham and Darlington between 2006/07 and 2011/12**

Year	Primary Care Trust			
	County Durham		Darlington	
	Number	(%)	Number	(%)
2006/07	1,289	(24)	293	(24)
2007/08	1,250	(23)	274	(21)
2008/09	1,277	(23)	272	(20)
2009/10	1,218	(22)	278	(20)
2010/11	1,292	(23)	291	(22)
2011/12	1,212	(21)	257	(20)

Source: The Information Centre, Statistics on Women's Smoking Status at Time of Delivery

The stop smoking service and maternity services in the local hospitals and community services have worked together to provide women who smoke in pregnancy with the information and support they need to help them stop smoking.

Babies and young children exposed to second-hand smoke have a higher risk, than those not exposed, from respiratory infections, middle ear infections, asthma, meningitis and cot death. Children brought up in families where one or more family members is a smoker, are three times more likely to become smokers themselves<sup>10</sup>.

A regional initiative, called Smokefree Families (SFF) was launched in 2009. SFF aim to raise awareness of the harm second-hand smoke causes children, particularly in their home and in cars. The initiative trains frontline staff to work with families and raise the issue of smoking in the home in a non-confrontational way. The County Durham and Darlington co-ordinator has delivered training to a range of frontline staff, 33 in County Durham and 35 in Darlington.

### Create and develop healthy and sustainable places and communities

In 2005 NHS County Durham and Darlington (along with the other North East PCTs) were the first to fund a regional dedicated office for tobacco control. Named Fresh - Smokefree North East it works with the two local tobacco alliances, Smokefree County Durham and Smokefree Darlington, and other local partners to address the World Health Organisation (WHO) six strands of tobacco control. Intensive lobbying activity and tobacco advocacy nationally has led to;

- implementation of smoke-free workplaces and public places legislation for England (2007),
- legislation raising the age of tobacco sales to 18 years (2007),
- picture warnings on cigarette packaging (2008),
- legislation for the removal of vending machines selling cigarettes (2011), and
- legislation for removal of tobacco sales displays in shops (2012).

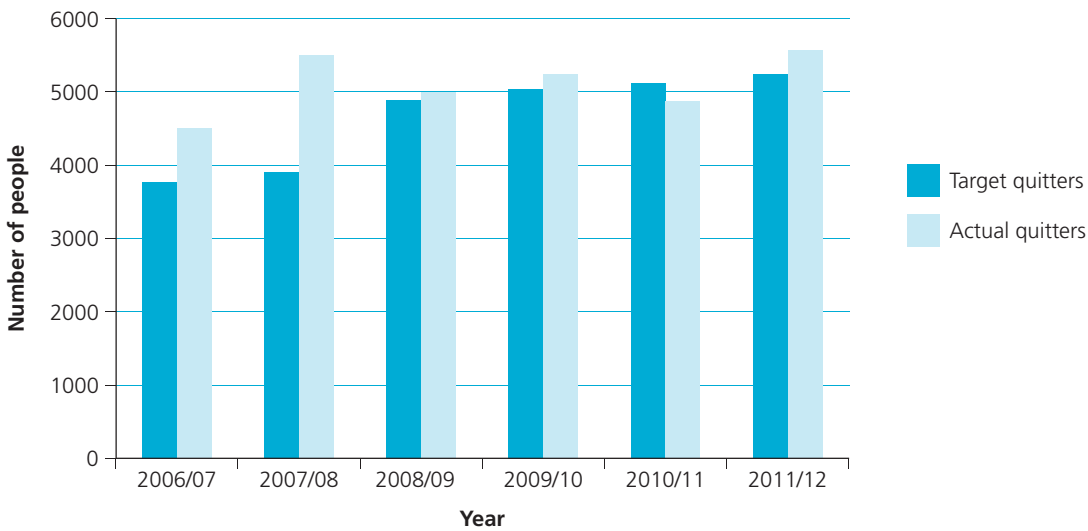
The work of the tobacco control alliances has contributed to the reduction of the number of adults who smoke in the North East from 29% in 2005 to 21% in 2010. This is double the decrease in England, where the rates have dropped from 24% in 2005, to 20% in 2010<sup>11</sup>. Local seizures of illicit tobacco in County Durham and Darlington have resulted in arrests and prosecutions of local ‘tab houses’ selling cigarettes and loose tobacco. It is likely that as a result fewer cigarettes and loose tobacco were sold in local communities and to young children.

The Cockerton West Community Partnership with the Darlington Tobacco Alliance developed a smoking and health project for two schools in Darlington (Mount Pleasant and Darlington School of Maths and Science). Pupils produced an eleven minute DVD which explains the health risks to children of breathing second hand cigarette smoke. It explores how standardising plain packaging of cigarettes will help protect children from tobacco brand advertising.

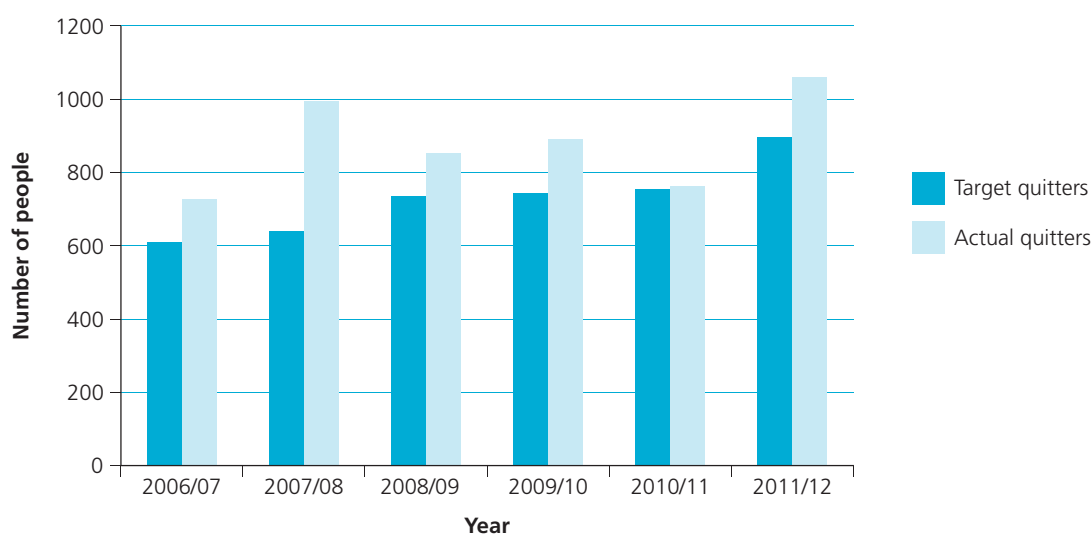
### Strengthen the role and impact of ill health prevention

County Durham and Darlington’s stop smoking service is one of the most successful services in the country. Year on year the service has achieved and exceeded national targets. As Chart 5 shows, this has resulted in 35,981 smokers stopping smoking since 2006 (30,692 in County Durham and 5,289 in Darlington).

**Chart 5: Number of people using the stop smoking services in County Durham, who have stopped smoking (quitters) compared to the target, between 2006/07 and 2011/12**



**Chart 6: Number of people using the stop smoking services in Darlington, who have stopped smoking (quitters) compared to the target, between 2006/07 and 2011/12**



Smokers wanting to quit now have access to support from 163 outlets across County Durham (138 outlets) and Darlington (25 outlets). This is either in groups, one to one sessions or as a drop-in service. They are available in venues such as GP surgeries, community centres, pharmacies, children centres, hospitals and leisure centres. A dedicated stop smoking service in local hospitals was developed in 2011. Between August 2011 and March 2012, 1,426 patients (634 Darlington, 729 Durham and 63 Bishop Auckland) were referred from the hospital wards.

Programmes that help people stop smoking during a hospital stay and include follow-up support for at least one month after discharge are effective<sup>12</sup>. People who smoke are more likely to experience post-operative complications and slower wound healing, resulting in the need for further surgery, a longer hospital stay and increased cost to the health service. The benefits of stopping smoking before surgery include; decreased risk in heart and breathing complications after surgery, quicker wound healing, and quicker recovery.

### Future challenges

- Continue to raise the profile of smoking and pregnancy across all agencies to ensure pregnant smokers seek access to support. Explore new approaches to engaging with women in order to understand why some pregnant smokers do not make contact with the service, and if they do why a high number do not stop smoking.
- Continue to work with partner agencies to reduce the risk to children of second-hand smoke.
- Continue to commission services that influence tobacco issues at a national, regional and local level.
- Maintain the two tobacco control alliances so they can co-ordinate work to reduce tobacco consumption locally and respond to national initiatives such as the consultation for standardised plain packaging.
- Develop the model already used in Darlington to engage more local communities in activities that will reduce the number of children and adults who smoke.
- Work with County Durham and Darlington NHS Foundation Trust to support people with a planned surgical operation to stop smoking before they are admitted to hospital.



## 2.3 Tackling obesity and increasing levels of physical activity



In 1973, the County Medical Officer<sup>1</sup> was describing the work done to provide chiropody services for adults which was free for 'aged persons' (p. 35). Combating obesity and increasing levels of physical activity is a relatively recent addition to public health activities.

Obesity results from the interaction between many factors and increases the risk of heart disease, stroke, type 2 diabetes, hypertension and some cancers. It can reduce life expectancy on average by nine years through premature death. Maternal obesity can lead to complications in child birth for both mother and baby. Based on the Health Survey for England<sup>13</sup> estimates indicate an obesity prevalence of 28.6% in County Durham and 27.6% for Darlington, compared to an England average of 24.2%

Type 2 diabetes is the condition that will increase the most as obesity prevalence increases. Being overweight or obese, with a large waist circumference and low physical activity levels are risk factors for type 2 diabetes.

### Give every child the best start in life

In the last six years NHS County Durham and Darlington has worked with many organisations to;

- improve the diet of expectant mothers through the exchange of healthy start vouchers for vitamins and baby drops,
- produce a booklet explaining how to eat healthily during pregnancy, and
- train over 60 staff working with pregnant and post-natal women to offer advice about a healthy diet and the importance of physical activity.

There has been specific work to improve the diet and nutrition of babies and young children which includes the following.

- Producing infant feeding, weaning and healthy eating guidelines for babies and young children under 5, which are used by healthcare staff.
- Designing and distributing a resource pack to improve the nutritional content of packed lunches to all schools across County Durham and Darlington.
- Thirteen children's centres in County Durham and four in Darlington have achieved the healthy early years standard, an award from the Department of Health which builds on the national healthy schools standards for health improvement in settings with young children.
- The regional better health at work award included supporting women who are breastfeeding as one of its components.

## Ensure healthy standard of living for all

A number of food and health initiatives have focused on supporting specific groups of people and include the following initiatives:

- Providing practical healthy eating courses to 2,000 people who are at risk of heart disease, type 2 diabetes or cancer.
- Delivering 195 cook4life courses, a practical four week healthy eating course for adults with around 60% of participants over the age of 50.
- In care homes for older people, focus on under-nutrition (FoU) has provided training for at least 75% of healthcare staff using accredited open learning workbooks and a workshop. Catering staff are provided with a six week catering course at local colleges covering the nutritional needs of older people, menu planning, diabetes, fortified diets, altered consistency diets (pureed and soft), dementia and constipation.
- Within Darlington focus on under-nutrition (FoU) has been implemented in 19 of the 23 (83%) elderly care homes.
- The change4life national social marketing campaign has been gaining pace in County Durham and Darlington with an increasing range of local lifestyle services using the consistent healthy lifestyle message 'Eat Well, Move More, Live Longer'.
- In May 2012 NHS County Durham and Darlington commissioned a large scale slimming on referral service. The Weigh-Less scheme is a change4life initiative and is for adults who are clinically obese with a BMI of between 30 and 35.

Ensuring there are good opportunities for people to be more physically active is a key public health priority. Physical activity performed on a regular basis can deliver positive physical and mental health benefits, and reduce the risk of many chronic conditions including coronary heart disease, stroke, type 2 diabetes, cancer, and mental health problems. The following initiatives have been undertaken to make it easier for more people to become physically active:

- A cycling festival in Darlington during 2011 attracted over 450 cyclists. The pedal power series of cycle rides was a collaboration between Darlington Borough Council and NHS County Durham and Darlington.
- 255 people have been issued with a fitbug pedometer in Darlington. Fitbug is a programme that helps people track their steps and encourages healthy lifestyle behaviours such as healthy diet and increased physical activity. Results from the initial pilot of fitbug users demonstrated increased physical activity over the 12 week programme.
- Exercise on referral services receive over 4,000 referrals each year from primary and secondary care services across County Durham and Darlington with physical activity opportunities ranging from structured supervised sessions to community based group activities such as cycling.
- Public health funded physical activity programmes in the east of County Durham have attracted over 3,500 new participants each year and have had over 33,000 visits to their service in the 12 months leading up to April 2012.
- A countywide cycling scheme is in operation to enable adults and their families who may not have access to a cycle to enjoy the activity.
- In 2009 NHS County Durham and Darlington invested £4.5 million over three years to changing the physical activity landscape (CPAL) in County Durham. Managed through County Durham Sport the programme targets individuals between the ages of 40 and 74 at risk of heart disease. Over 10,000 people (including family members of those at risk of heart disease) have taken part. An independent evaluation has shown that 60% of the people who have registered with the programme are maintaining increased physical activity levels at six months.



For every £1.00 that has been invested in the programme, there have been benefits of £2.24 in savings associated with preventing or delaying the onset of heart disease<sup>14</sup>.

### Future challenges

- Deliver consistent healthy lifestyle messages through the change4life social marketing campaign.
- Through awareness raising and joined up service provision, work with partners to reduce the incidence of type 2 diabetes.
- Improve access to weight management services for those who are clinically obese.
- Enhance existing pathways into physical activity from primary care.
- Improve access to healthy food and nutritional advice to those people who are at particular risk from the harms associated with an unhealthy diet, such as people with diabetes, young children and women who are pregnant.
- Lobby for environmental improvements such as limiting the density of fast food outlets via the health and wellbeing boards.



## Chapter 3

# Improving our mental health and physical health



### 3.1 Mental health

A review of the 1973 County Medical Officer's Report<sup>1</sup> gives an indication of how our attitudes towards mental wellbeing have changed. For example, the term mental health is not found but there is a reference to children who are 'maladjusted' receiving care from psychiatrists (p.51). Today mental health has a much wider scope than psychiatry and is acknowledged to be as important as physical health for a person's wellbeing.

Since 2006, efforts have focussed on opportunities for individuals to improve their mental health and wellbeing from within the community. This has been tackled in a number of ways, including through health improvement activities and services, increasing access to people who can provide support and raising wider awareness of mental health issues amongst the general population.

## **Enable all children, young people and adults to maximise their capabilities and have control over their lives**

Social prescribing enables people to access non-medical sources of support from within their community. The aim is to improve wellbeing and reduce their risk factors for poor mental wellbeing, such as isolation, low self-esteem and lack of purpose.

Building on evidence from across the country, social prescribing options have focussed on the arts. Over 2,400 people in County Durham and Darlington have benefitted from social prescriptions for the arts including carers, those with long term conditions and new parents. Improvements in wellbeing are tracked using the Warwick Edinburgh mental wellbeing scale which provides an indication of how an individual perceives their wellbeing.

Mindfulness is a way of paying attention to what is happening in the present moment in our body, mind and the world around us. Doing this can help some people cope with stress and stressful events. A pilot mindfulness programme which aimed to reduce stress in people who were out of work or at risk of redundancy showed an average 30% positive shift in participants' mental wellbeing. This is now an on-going programme across County Durham and Darlington.

More recently work has focussed on increasing awareness and uptake of social prescribing from clinical referrers, such as GPs, as well as referrals directly from clients and the voluntary sector. The aim is to ensure social prescribing programmes are considered as an option for treatment alongside traditional care services.

## **Strengthen the role and impact of ill health prevention**

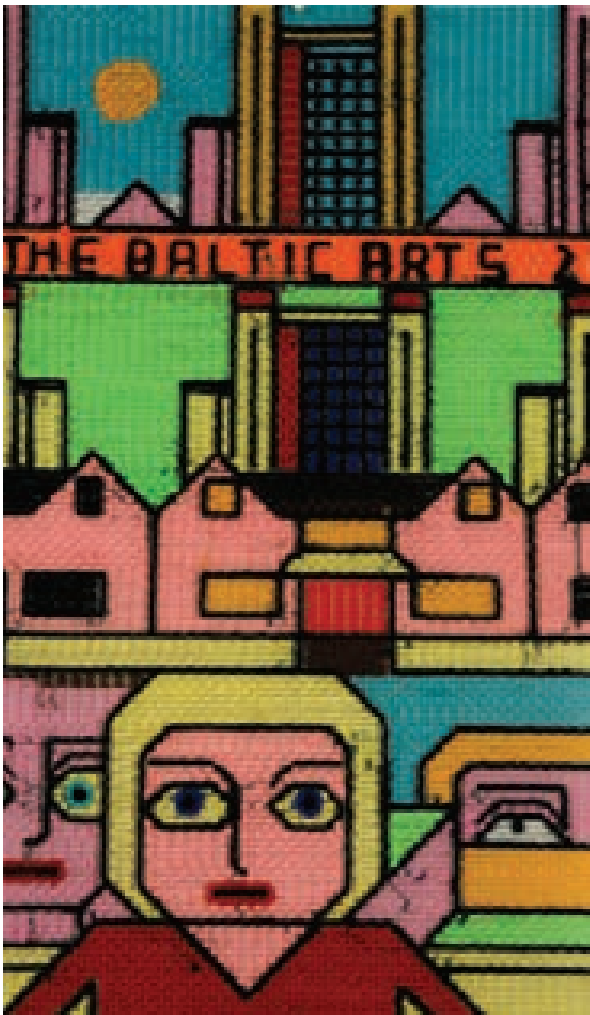
An independent review into higher than expected potential suicide cases between October 2008 and June 2009 in County Durham and Darlington, led to NHS County Durham and Darlington and partners implementing a real time alert system. This ensures the coroner's officers, police and others are able to advise the NHS immediately of any death which is a potential suicide case. As a result of implementing this system a further upward trend in potential suicides was identified between September and October 2010. The real time alert system enabled the partners to intervene quickly and develop a range of resources and services to address the increasing trend. This included a suicide prevention media campaign and resource pack, additional capacity for bereavement and debt advice services, a rapid response service based on the principles of ASIST (applied suicide intervention skills training), and the development of men's sheds<sup>f</sup> and community responders in the most vulnerable areas. More recently, the pass it on campaign was launched which aims to raise awareness of the suicide risk amongst men and encourage them to seek help.

---

<sup>f</sup> Based on the Australian shed movement, Men's Sheds aim to; provide a link between community health and wellbeing provision and the many men who have no regular contact with those networks, establish a place for men that enables social interaction and activities to maintain health and wellbeing, provide a focal point in the community for the identification of men's health issues and actions to resolve those issues.

## Future challenges

- The mindfulness programme is a popular choice for clients and the future scale of the service will require review.
- There remains significant work to do to tackle inequalities for those with mental health problems. A partnership approach with service users and carers is essential to address this.
- Develop and improve social prescribing opportunities. Improve the range of social prescribing options available and develop local evidence and pathways to enable social prescribing to become part of the mainstream offer to our communities.
- Clinical commissioning groups<sup>9</sup> will be supported to become involved in the work to prevent people taking their own lives.



Artwork in this section was produced as part of arts on prescription in Darlington.

<sup>9</sup> Clinical commissioning groups are being set up following the recent Health and Social Care Act and will be responsible for commissioning the majority of NHS services in England.

## 3.2 Heart disease



In 1973 when Dr Stanley Ludkin was the County Medical Officer for Health<sup>1</sup>, cardiovascular disease (CVD) – heart attacks, strokes and other health problems caused by narrowing of the arteries – was the single biggest cause of death. One of the greatest achievements in health care since that time is the substantial decrease in deaths from CVD. This decrease began in the 1960s and since the 1970s CVD mortality rates have fallen by 70%. During this time there has developed a much better understanding of the factors that can influence the development and progression of vascular diseases. There is now a range of effective, evidence based treatments to treat the condition.

Despite this success, CVD remains the single biggest cause of death in County Durham and Darlington, responsible for about a third of all deaths. Mortality rates from CVD are significantly higher than the national rate which is 167 deaths per 100,000 population. The 2008-10 CVD mortality rate in County Durham for all persons was 190.8 per 100,000 and the 2008-10 CVD mortality rate in Darlington for all persons was 182.5 per 100,000. The impact of social and economic factors are substantial. The mortality rate in 2008-10 for persons who live in the most deprived areas of County Durham was 237.1 per 100,000. This is 1.2 times greater than the overall mortality rate for County Durham and 1.6 times greater than the mortality rate for persons who live in the least deprived areas of County Durham<sup>15</sup>. The mortality rate in 2008-10 for persons who live in the most deprived areas of Darlington was 259.6 per 100,000. This is 1.4 times greater than the overall mortality rate for Darlington and 2.0 times greater than the mortality rate for persons who live in the least deprived areas of Darlington<sup>16</sup>.

**Table 4: Mortality rates for cardiovascular disease 2008-10 for County Durham, Darlington and England**

	Mortality rate per 100,000 population		
	County Durham	Darlington	England
Rate for all persons	190.8	182.5	167
Rate in most deprived areas	237.1	259.6	229.6

Sources: Cardiovascular disease PCT health profile – County Durham. South East Public Health Observatory. Cardiovascular disease PCT health profile – Darlington. South East Public Health Observatory.

## Ensure healthy standard of living for all

What are the factors behind the dramatic fall in mortality from CVD over the past four decades, and will these factors continue to bring down the mortality rate and narrow the health inequalities between different areas?

Modern cardiovascular treatments have played an important role. The quality and outcomes framework for primary care data shows that GP practices in County Durham and Darlington achieve outcomes above the national average on blood pressure control, lowering cholesterol, and treating heart patients with preventative drugs such as aspirin and beta blockers. The management of patients needing emergency treatment for heart attacks and strokes has improved dramatically since 1974. Today in County Durham and Darlington, over 99% of patients with a sudden heart attack (STEMI) receive reperfusion treatment in hospital (this restores circulation to the heart muscles), with a median time from a call for help to treatment of 103 minutes – lower than the national average time. The development of thrombolysis (clot-busting drugs) for the emergency treatment of patients who have had a stroke has dramatically improved patient outcome. Recent changes to the way in which this service is provided in County Durham and Darlington has significantly increased the proportion of patients receiving this treatment and reduced the time from call for help to treatment.

## Strengthen the role and impact of ill health prevention

The treatments for cardiovascular disease have played an important role in the decline of mortality rates. However, it is important to recognise that about a half of all CVD related deaths occur outside hospital before any emergency care can be given. Often this sudden event is the first sign of CVD. The biggest contribution to the fall in CVD mortality is from changes to lifestyle and diet. The best estimate suggests that between 45% and 75% of the decline in mortality can be attributed to changes in lifestyle and risk factors, and the remaining 25-55% to improved treatments.

### Future challenges

- There is a worrying trend, with some evidence, that the CVD mortality rate in younger adults in England and Wales is levelling off. Levels of smoking in young people, particularly among young women; rising levels of obesity and the earlier development of type 2 diabetes are contributing to this. To maintain the reduction of CVD mortality rates and reduce the health inequalities caused by these conditions there needs to be a change of emphasis. Therapeutic interventions such as revascularisation and thrombolysis will make only a modest impact.
- The biggest impact will come from population-wide changes in lifestyle and diet. The impact of all the efforts on tobacco control has resulted in dramatic falls in smoking rates but this must be maintained, especially toward preventing young people taking up smoking. Fresh – the North East regional tobacco control office – has led the way in developing integrated policies across the region resulting in the biggest fall in smoking rates in England. The same effort must be given to encourage and support changes in people's diet and to promote more exercise.

## 3.3 Cancer

The County Medical Officer's report in 1973<sup>1</sup> did not focus on disease areas, or note which diseases were leading to premature deaths. The diseases that did feature were ones that are infectious, such as measles. These days public health is also very concerned with those diseases that lead to premature death.

Much has changed in the past six years. Cancer services both nationally and locally continue to give world class treatment and care. However, there has been a shift in approach to the reduction of early deaths from cancer with a focus on cancer awareness and earlier diagnosis. The national cancer plan<sup>17</sup>, focussed on prevention, diagnosis and treatment; setting out new ways of working to streamline cancer services around the needs of the patient. It set ambitious targets of improving cancer five year survival rates to be in line with the best in Europe.

It was with the cancer reform strategy<sup>18</sup> that the cancer agenda shifted to be much more inclusive of public health approaches to reducing early deaths from cancer. Cancer prevention initiatives such as smoking cessation programmes have featured in cancer strategies over the previous few years. However, such primary prevention programmes are a long term approach to reducing cancer mortality rates and the shift in approach to reducing early deaths is welcome.

Screening programmes which have been in place for many years were re-examined, prompting an age expansion of breast screening programmes in 2007, the introduction of digital mammograms and more sophisticated techniques in the cervical screening programme. The roll-out of a national bowel cancer screening programme in 2007 added to the cancer screening suite of services.

The biggest change in approach was the focus on awareness and earlier diagnosis advocated by the cancer reform strategy. It proposed that cancer survival rates in the UK would never be in line with the best in Europe while people continued to present later. The strategy set out plans for a national awareness and earlier diagnosis initiative (NAEDI) which was to form the main strand of cancer related work.

This approach has been taken up enthusiastically across County Durham and Darlington. One of the first uses of the nationally validated cancer awareness measure (CAM) which charts knowledge and awareness of cancer signs, symptom and services in communities was carried out locally in 2009. On the basis of these results the talking about cancer service has been developed, which is one of the only dedicated cancer awareness services in the country.

## Enable all children, young people and adults to maximise their capabilities and have control over their lives

In order for people to have control over their lives, they need knowledge of an issue and the support to act on that knowledge. Knowledge levels across County Durham and Darlington were assessed leading to the introduction of the talking about cancer service in those communities with the lowest knowledge of cancer and the greatest number of early deaths from cancer. The approach is to use community infrastructures, workplaces and community volunteers alongside paid staff to raise awareness of the signs and symptoms of cancer and at the same time provide support for individuals to take action.

Since the work started in 2009, the service has worked with 38,059 individuals and taken part in 1,645 community events, engaging with 28 community volunteers. Alongside this, the service has been working to support primary care services to ensure professionals are aware of their activities and use the approach.

This work has resulted in a marked increase in awareness in these communities within the first 18 months of work. In addition, the latest figures available for early deaths from cancers show that County Durham’s rate has fallen again and is now well ahead of target. Darlington shows a much bigger drop in mortality rates than Durham and after a few disappointing years is now well on track to meeting targets. Chart 7 shows the rate that we have been aiming to reach and compares those target rates with the actual rates that have been achieved. In County Durham, the mortality rates show that in 2009 and 2010 the death rate per 100,000 people aged under 75 was better than the target rate. In Darlington mortality rates have also started to decrease from 2009, though they are higher than the target rates. However, because the numbers in Darlington are relatively small, rates can be erratic with a few numbers making large differences to rates.

**Chart 7: Cancer mortality rates, actual and target, for people aged 75 years and under, in County Durham and Darlington between 2005 and 2010**



Source: NHS County Durham and Darlington performance monitoring department



## Ensure healthy standard of living for all

The financial burden on individual and families can be considerable so Durham County Council in partnership with the charity Macmillan and NHS County Durham and Darlington established a specific cancer related welfare rights service. This has brought in an extra £3.5 million annually in additional welfare benefits for patients. In Darlington, Macmillan services have worked closely with County Durham and Darlington NHS Foundation Trust, the Citizen's Advice Bureau and NHS County Durham and Darlington.

## Create and develop healthy and sustainable places and communities

The talking about cancer service supports the development of healthy and sustainable communities through community volunteers and working through community venues.

## Strengthen the role and impact of ill health prevention

The primary prevention of cancer through smoking cessation and tobacco control has long been a key activity in public health. New areas relating to the primary prevention of cancer, namely obesity and alcohol use, have come to the fore over the last six years and work is being undertaken in these areas. Cancer screening programmes continue to perform well.

- Coverage rates for cervical screening (table 5) continue to be above target and better than the England average.
- Bowel cancer screening (table 6) has been successfully rolled out across County Durham and Darlington. Recently uptake rates have dipped as the screening programme becomes established as a call and recall system.
- Breast screening rates (table 7) have remained consistent despite the extra work involved in the age extension to the programme and the conversion to digital screening.

**Table 5: Percentage of the eligible population who have had an adequate cervical test in County Durham, Darlington, the North East and England between 2006/07 and 2010/11. National target is 80%**

	2006/07 %	2007/08 %	Year 2008/09 %	2009/10 %	2010/11 %
<b>County Durham</b>	80.1	80.8	81.9	81.4	80.8
<b>Darlington</b>	79.3	80.2	81.3	81.4	81.0
<b>North East</b>	80.2	80.0	80.5	80.1	79.5
<b>England</b>	79.2	78.6	78.9	78.9	78.6

Source: NHS County Durham and Darlington performance monitoring department

**Table 6: Percentage of the eligible population who have had a bowel screening test in County Durham and Darlington, between 2009/10 and 2011/12**  
National target is 60%

	Year		
	2009/10 %	2010/11 %	2011/12 %
<b>County Durham</b>	62.03	59.19	58.92
<b>Darlington</b>	61.66	58.30	57.58

Source: NHS County Durham and Darlington performance monitoring department

**Table 7: Percentage of the eligible population who have had breast screening in County Durham and Darlington, between 2007/08 and 2010/11**  
National target is 70%

	Year			
	2007/08 %	2008/09 %	2009/10 %	2010/11 %
<b>County Durham</b>	80.2	79.8	80.0	79.8
<b>Darlington</b>	77.6	77.4	77.7	77.7

Source: NHS County Durham and Darlington performance monitoring department

Energy and resources should be focused on promoting cancer awareness and earlier diagnosis as this will have the greatest impact on earlier treatment and improved survival rates.

### Future challenges

- Engage with clinical commissioning groups, health and wellbeing boards and local authorities on the cancer agenda, particularly on earlier diagnosis.
- Promote cancer screening uptake through social marketing activities and monitoring rates, aiming to improve uptake rates to be among the best in England.
- Push for accurate staging data<sup>h</sup> from foundation trusts (hospitals).
- Reduce cancer services waiting times and ensure excellent performance.

<sup>h</sup> This is the way of describing how far a cancer tumour has developed and how far it has spread.

## 3.4 Vaccine preventable disease



Vaccines are one of the most important ways to protect children and other vulnerable groups in our communities from serious disease and harm. Successful implementation of comprehensive population based immunisation programmes results in a fall in the number of cases of infectious diseases and the associated harms. In 1973 the County Medical Officer of Health<sup>1</sup> reported, as we are today, on the numbers of children who receive vaccinations. Measles and Rubella are still vaccinations that are given to children today to provide protection.

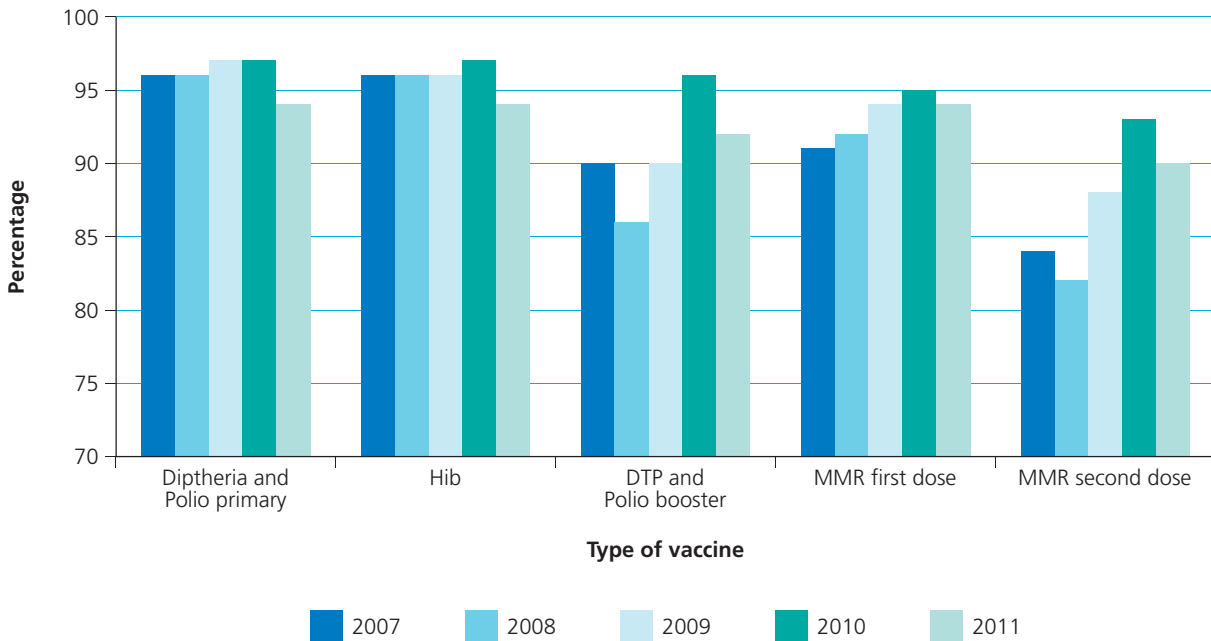
Most immunisation programmes depend on the majority of individuals receiving the vaccination and becoming immune to the disease. This provides protection to the whole population, even the minority who are not immunised. This is called herd immunity. Most immunisation programmes require at least 95% of the population to be immunised to achieve this level of protection. Immunisation programmes are effective at preventing disease. This can lead to people forgetting how serious these diseases can be and this increases the challenge of people getting vaccinated. Immunisation is an important way in which individuals and communities can be protected from serious disease.

The immunisation rates in County Durham and Darlington for most of the programmes are good when compared to the England average or the North East region. However, too many of the key diseases have immunisation rates below 95%. This means protection is not as effective as it could be. This can be seen within the childhood immunisation rates for both County Durham and Darlington for children aged five years for the key vaccines in the childhood schedule (the vaccines recommended for children).

***“No other measure taken by man, apart from the provision of safe drinking water has saved more lives than immunisation.”***

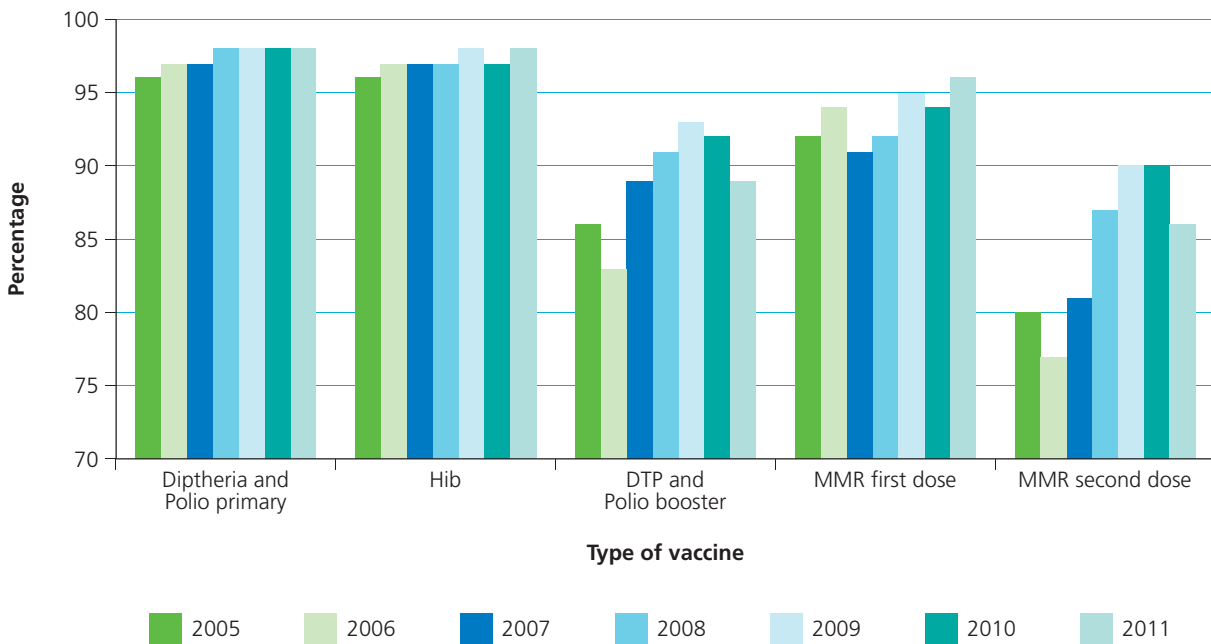
*(Kassianos, in ‘Immunisation: childhood and travel health’<sup>19</sup>)*

**Chart 8: Percentage of children immunised with recommended vaccines by their 5th birthday between 2007 and 2011 in Durham<sup>i</sup>**



Note: NHS County Durham and Darlington did not exist in its current configuration before 2006, so there is no comparable data for Durham until 2007.

**Chart 9: Percentage of children immunised with recommended vaccines by their 5th birthday between 2005 and 2011 in Darlington<sup>i</sup>**

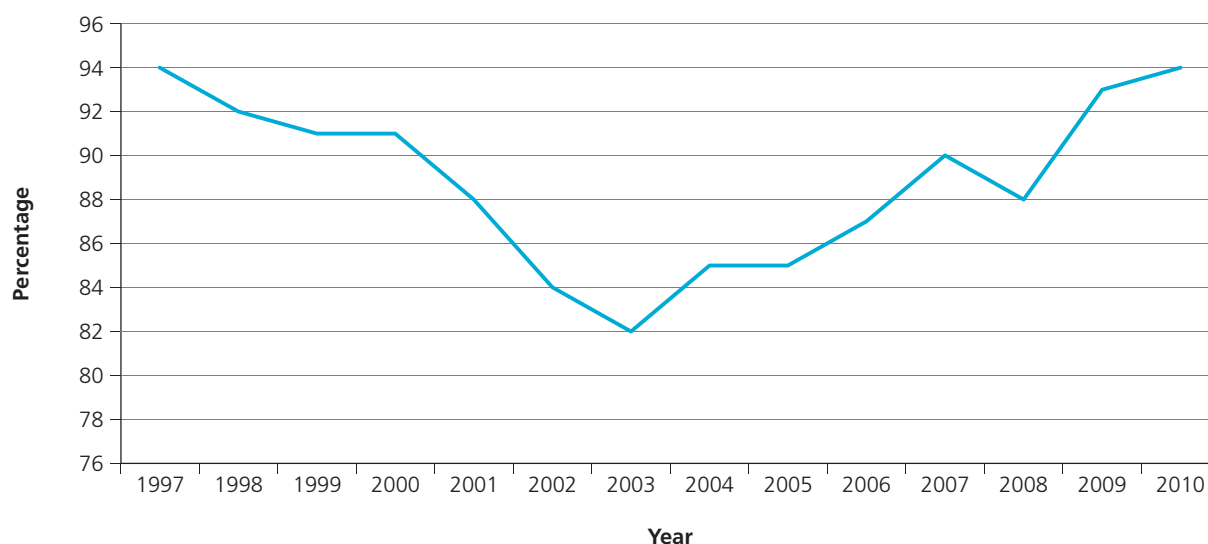


<sup>i</sup> DTP is the vaccine that protects against Diphtheria, Tetanus and Pertussis (whooping cough). Hib is the vaccine that protects against Haemophilus influenzae type b which 'is a bacterial infection that can cause a number of serious illnesses such as pneumonia or meningitis, especially in young children'. MMR is the vaccine for measles, mumps and rubella. Web page NHS Choice <http://www.nhs.uk/conditions/hib/Pages/Introduction.aspx> accessed 17.7.12.

## Measles

Most cases of measles are avoidable through effective immunisation programmes. Following the unproven link with autism uptake of the measles, mumps and rubella (MMR) vaccine has started to recover. Although the North East has relatively good uptake rates, they are still not good enough to provide the best level of protection. In response to this re-emerging threat an MMR catch-up programme was started in 2008 nationally. Primary care trusts and GPs identified individuals not up to date with their MMR vaccination and offered a catch-up immunisation to reduce the risk of a measles epidemic. There are particular challenges in increasing MMR uptake in communities that traditionally have been less connected with healthcare services, such as the gypsy roma traveller communities. Despite improvements in the uptake rate, it has not yet achieved the 95% coverage of the population which is needed to provide maximum protection.

**Chart 10: Percentage uptake of measles, mumps and rubella (MMR) vaccine among 2 year old children in County Durham and Darlington between 1997 and 2010**



## Human Papilloma Virus (HPV)

The HPV is a commonly occurring infection, which is spread by direct physical contact. Infection is usually short lived, lasting on average a few months without any obvious symptoms. However, persistent infection causes cell changes which have been linked to the cause of cervical cancers in women. Rates of cervical cancers peak in women in their mid to late thirties. Due to the long timescale in the development of the disease, these are linked to infections acquired in the late teens and early twenties, when HPV is most prevalent.

An HPV vaccine was introduced as a national immunisation programme in 2008. The vaccine protects against the two highest risk types of HPV (types 16 and 18), which on their own have been linked with 70% of cervical cancers. It has been estimated that successful implementation of this vaccination programme will save around 400 lives per year in England<sup>20</sup>. In County Durham and Darlington the HPV vaccine is provided by the local school nursing teams and is offered to every year 8 girl in every secondary school in County Durham and Darlington.

## Influenza

The winter of 2009/10 featured the emergence of the H1N1v pandemic influenza (flu) virus, known as swine flu. This was a new strain of flu that emerged in Central America and quickly spread across the globe arriving in the UK in the summer of 2009. As there was no vaccine available in the UK until October 2009, the initial response over the summer months was aimed at reducing the onward transmission of the virus and providing access to supportive treatments for those presenting with flu like symptoms. This included the widespread distribution of anti-viral medicines to symptomatic patients.



The swine flu virus affected different sections of the community to those high-risk groups affected by seasonal flu. Younger adults and children were more likely than older people to go to their GP with flu-like symptoms and some of them needed to be admitted to hospital because of the severity of their infection. Even though swine flu was circulating widely over this time, the other strains of seasonal (or winter) flu were still present and capable of causing ill health and early deaths in the at-risk<sup>k</sup> groups in the population. For this reason the seasonal flu vaccination programme continued to run as usual in parallel with an extensive pandemic flu vaccination programme.

Vaccination of frontline healthcare workers against influenza significantly lowers rates of flu-like illness, hospitalisation and mortality in health care settings. It reduces rates of influenza among staff which in turn reduces the level of sickness absence. This is particularly important when responding to the specific pressures that winter brings.

As H1N1 will remain the dominant strain of flu circulating in the community for a number of years it has been included into the seasonal flu vaccine for future winter campaigns. With the known clinical characteristics of the H1N1 strain, it not only remains vital to maintain uptake in the older population but also to increase significantly seasonal flu immunization uptake in those who are aged under 65. With the uptake from the 2011/12 season at around 75% County Durham and Darlington have made steady progress over recent years in increasing the numbers of people who receive seasonal flu vaccines and with the uptake standing at 74% for the over 65s and around 53% for those under 65s who are at greater risk the recommendation of the World Health Organisation (WHO) of an uptake of 75% of those over receiving seasonal flu vaccine is yet to be achieved. Efforts continue to improve the uptake to ensure that all those eligible benefit from the protection of a flu vaccination in subsequent years.

A complete report about communicable diseases and other hazards is produced by the Health Protection Agency in their annual review. It will be published on their website [www.hpa.org.uk](http://www.hpa.org.uk).

<sup>k</sup> At risk groups include people aged over 65 years and people who have an underlying health condition, such as asthma or heart disease, which makes them more likely to have harmful effects from flu.

## 3.5 Oral health



In 1973 Durham County Council<sup>1</sup> was responsible for providing dental care to school children. They inspected the teeth of pre-school and school age children, and carried out over 20,000 fillings. At that time 60% of 12 year old children in the north who took part in the dental health survey<sup>21</sup> had some active decay in their teeth, and 69% of them had fillings. Differences in how information is recorded means it is not possible to make direct comparisons with dental health in 1974 and today. However, the figures in table 8 below give an indication of how the dental health of children has improved in recent times.

**Table 8: Average number of decayed, missing and filled (DMFT) teeth in children aged 12 years old in England, County Durham and Darlington in 1996 and 2007/08**

Area	Year	
	1996	2007/08
County Durham	1.21	1.01
Darlington	*	1.13
England	0.97	0.74

\* At this time information about children in Darlington was recorded as part of County Durham or Tees.

Source: British Association for the study of Community Dentistry (BASCD) <http://www.bascd.org/oral-health-surveys>

### Give every child the best start in life

The last six years have seen fundamental change in the provision of mainstream NHS dental services. Before 2006, general dental practitioners provided care under a system which closely resembled a social insurance scheme. They contracted with the NHS on a national basis to provide dental services to individuals and submitted claims for payment for each individual they saw. Dental practitioners had full autonomy to establish practices where they wanted to, open when they wanted to and in many cases determine which patients they decided to see. This led to historical inequities in access to NHS dental services nationally, with more dental practices in prosperous areas rather than the poorer areas where patients have higher needs.

In 2006 NHS County Durham and Darlington extended its responsibilities for oral health when they also became responsible for ensuring the provision of all primary dental care. NHS County Durham and Darlington was able to direct where services should be located and link this to community need. This addressed the need for equitable access to services and the needs of those children with the highest oral health care requirements. New practices were developed where there are high levels of dental disease, especially amongst children, and poor levels of access. These were established in; Coundon, Stanhope, Darlington, Bowburn, Esh Winning, South Hetton, Willington, Brandon and most recently NHS County Durham and Darlington is going out to tender for a new service in the Chester le Street area.

Historically there were insufficient orthodontic services in the area. NHS County Durham and Darlington has increased local investment to radically improve access by expanding existing services in both Darlington and Durham City. Outreach services are being developed in Crook, Bishop Auckland, Stanley and Easington to ensure that treatment has a maximum impact on the lives of young people and is as accessible as possible.



## Strengthen the role and impact of ill health prevention

This has been done in collaboration with local communities to develop oral health promotion activity in general dental practices. Greater use of services has been promoted by funding high street general practices to undertake work in the community. This has included oral health promotion work as well as funding open events for dental practices. At these events children from local schools, children's centres and sure start schemes, along with their parents and carers, have been introduced to dental practices in a relaxed and fun way. Parents and carers were able to discuss oral health issues and exemptions from dental charges without having to make a formal appointment. Practices have been funded to develop specific preventative skills for children around the use of fluoride varnish.

### Future challenges

- Undertake regular oral health needs assessment of children to determine their levels of dental disease. A survey<sup>22</sup> of 12 year old children's oral health in 2008/09 showed that 27% of 12 year old children in County Durham and 33% in Darlington had active dental decay. It is disappointing that despite good uptake of care for children in this age group, particularly in Darlington where over 70% of children had seen a dentist in the last 12 months, levels of active disease remain high.
- Ensure all areas have adequate access to dental care. Utilisation of NHS dental services is only at or above the English average of 56% in 16 out of 135 wards in County Durham, and 4 out of 24 wards in Darlington. In County Durham in 2010/11, 48% of the population of County Durham attended an NHS dentist. In Darlington 50% of the population had attended a dentist in the North East<sup>23</sup>. There is still work to be done to secure access to dental care for all residents.
- The transfer of public health to the local authorities of County Durham and Darlington provides the opportunity to effectively reach children and families in the more socially excluded and hard to reach sections of our community who have the highest levels of dental disease. We know that in both County Durham and Darlington, as nationally, when the level of deprivation in a community increases, the use of dental services decreases.

*Outreach orthodontic services are being developed in Crook, Bishop Auckland, Stanley and Easington to ensure that treatment has a maximum impact on the lives of young people and is as accessible as possible.*

## Chapter 4

# The impact of social and economic factors on health

The absence of the work described in this section from the 1973 County Medical Officer of Health's report<sup>1</sup> illustrates how public health has developed since then. It is now recognised that fundamentally health is affected by a range of social and economic factors including a person's employment status and level of education. This chapter demonstrates how public health has worked with many people in partner organisations including Durham County Council and Darlington Borough Council to tackle the wider factors that affect a person's health.

The extensive evidence base on health inequalities, most recently synthesised in *Fair Society, Healthy Lives*<sup>24</sup> and the World Health Organisation (WHO) Commission on Social Determinants of Health<sup>25</sup>, demonstrate the need for policy makers to focus actions on the social determinants of health as the most effective way of addressing the issue.

A recent consultation<sup>26</sup> defined the social determinants of health as 'the causes of the causes of health inequalities. These are the conditions in which people are born, grow, live, work and age. What happens within an individual's social context, during the early years, education, income, skills development, employment and work within communities all impact on their health and length of life.'

## 4.1 Health literacy

### **Enable all children, young people and adults to maximise their capabilities and have control over their lives**

Health literacy describes the extent to which a person can "understand and use information in ways which promote and maintain good health"<sup>27</sup>. The Department of Health developed a toolkit to improve health literacy and NHS County Durham and Darlington took part in phase two of the national pilot. NHS County Durham and Darlington worked with Darlington College, HMP Durham, The Bridge Women's Education, Education in the Community and some staff in Durham County Council. Achievements included 'some marked changes in knowledge levels'<sup>28</sup> for learners in two of the projects. Between 2007 and 2009, 188 people started the course and 86% (n=161) completed it. By the end of the course, between 40% and 60% of people had progressed by at least one level.



The Chester-le-Street campaign for learning/partnership for community learning and inclusion, brings together public, community and voluntary sector partners to provide educational or learning programmes. In 2009 NHS County Durham and Darlington asked Northumbria University to explore individual and group accounts of the effectiveness (or otherwise) of this partnership approach to lifelong learning. Their report<sup>29</sup> focused on the importance of accessibility and inclusivity of the learning events that were established, particularly for participants who faced a variety of challenging life circumstances.

Since 2008 educational attainment across all key stages in Darlington has continued to improve, building on past performance. Continuing improvement in the number of young people achieving both level 2 and level 3 qualifications by the age of 19 has also been evident. However these overall improvements in performance mask the achievement gaps which still exist between certain vulnerable groups, for example, looked after children, children with special education needs and those with learning difficulties and disabilities. The achievement gap at key stage 2 between pupils eligible for free school meals reversed in 2011. The picture is similar for the achievement gap between pupils with a special education need (SEN) and non-SEN pupils.

Darlington has a disproportionately high traveller population. Children of travellers at key stage 2 perform significantly worse than their peer group. However, from 2011 this gap had begun to decrease with a drop of 7.3% between 2010 and 2011.



Many of the families that come into contact with family learning and parenting programmes have low skill levels and need more support than families with higher skill levels. Darlington has higher than average skill levels (level 1 to level 4 and above). However, there is still a significant proportion (11.5%) of the population with no qualifications.

As part of the reducing teenage conception strategy for Darlington, NHS County Durham and Darlington in partnership with Darlington Borough Council

provided a dedicated personal social and health education (PHSE) coordinator to ensure that high quality, age appropriate and evidence based sex and relationship lessons were integrated into the curriculum of all primary and secondary schools. This was to provide children and young people with a sound knowledge base to help them develop the decision making skills to make healthy choices about sex and relationships as they get older. This helped reduce the risks of future teenage conceptions and the impact on life chances and opportunities. The healthy schools standard was achieved in all schools in Darlington as per a local area agreement.

Key partners and agencies in Darlington including NHS County Durham and Darlington worked to provide a range of information for the public about healthy lifestyles and wellbeing, particularly advice and support to a range of people with disabilities, from diverse backgrounds, cultures, religious and ethnic groups and sexual orientation. This included the black, minority, ethnic (BME) development workers who provided information and support for people from black and minority ethnic communities with mental health needs, and raised awareness of mental health issues within these communities.

### Future challenges

- Health literacy should be included in any emerging Lifelong Learning strategy.
- The work on community learning and inclusion has shown that early work needs greater understanding and embedding in any life learning strategy or plan. The concept of scaling up innovative interventions that are shown to work is also critical.

## 4.2 Supporting people in and out of work

### Ensure healthy standard of living for all

“Having insufficient money to lead a healthy life is a highly significant cause of health inequalities, there is a clear relationship between wealth and health - the wealthier you are the healthier you are likely to be”<sup>30</sup>. NHS County Durham and Darlington commissioned the Citizens Advice Bureau (CAB) in County Durham to provide a service to people with a health condition whose GP, or other member of the health care team, recognised their condition could potentially be improved by referral to a CAB advisor. The advisors help people with income or benefit problems. During 2011-12 the service achieved over £2.5 million in financial gain for local people. For every £1 invested in the service, £9.58 was found for a local person<sup>31</sup>.

NHS County Durham and Darlington supported the development of single credit union across Darlington to give more residents access to a bank account and safe credit. This was supported by a Darlington-wide campaign to improve financial literacy through the use of community roadshows targeted at those communities where household income were lowest and levels of benefit claims were greatest. NHS County Durham and Darlington also worked with the financial inclusion forum to inform residents, particularly those on low incomes or in social housing, about the risks of high interest short term loans and highlighted the impact of illegal money lending. NHS County Durham and Darlington has worked in partnership with local GPs in Darlington and the Citizens Advice Bureau to provide income advice and debt management services to people with a health condition.

Public health commissioned a health at work award programme via the health improvement service which supports local businesses and their employees. This is delivered in partnership with local business, the local authorities, Darlington Strategic Partnership and County Durham and Darlington NHS Foundation Trust.

Following an assessment of staff health needs, health improvement practitioners offer training, advice and support for workplaces. This has led to actions that can improve health such as developing healthy workplace policies, healthy eating canteens, staff health checks, on site smoking cessation services, and lunchtime physical activity. Mental health at work is a key feature and online training modules and the *Mindful employer charter* are used to support this important area.

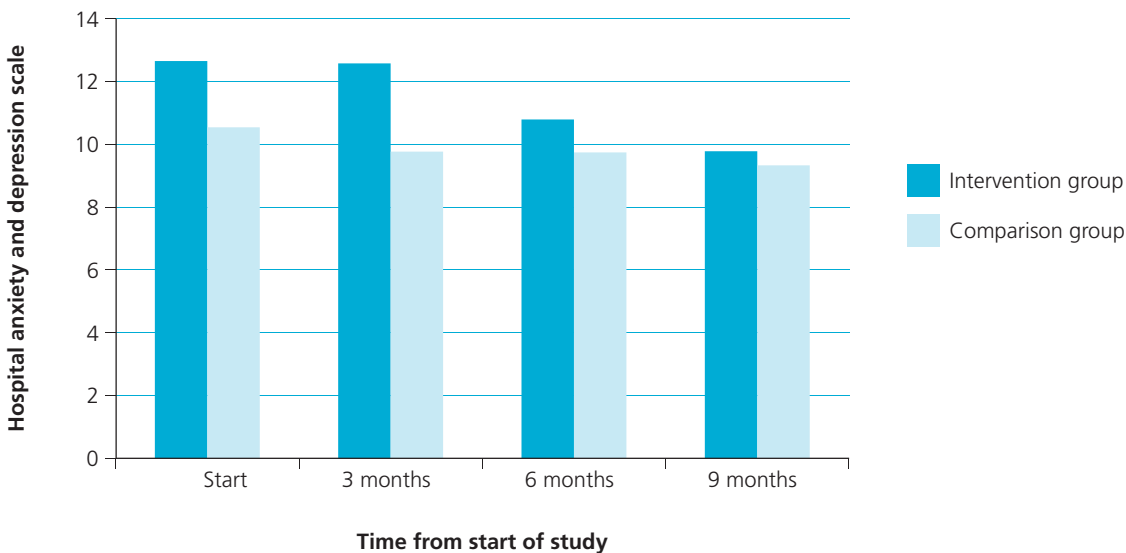
### Create fair employment and good work for all

Being in employment is beneficial to a person's health and being healthy increases the probability of being in work<sup>32</sup>. There is a strong evidence base showing that good work is generally beneficial for mental health and wellbeing, whereas worklessness is associated with poorer physical and mental health outcomes. Being out of work can exacerbate physical and mental health problems and increases the chance of social exclusion. In 2008, NHS County Durham and Darlington commissioned an innovative case management service. The aim of the service was to improve health and employability prospects for those people in receipt of incapacity benefit. This initiative was jointly developed with the University of Durham and included a strong focus on evaluation.

The initiative focused on individuals who had been receiving incapacity benefit (IB) or employment support allowance (ESA) for over three years. This is the group of people who have been unemployed for a long time and are regarded as the most distant from the labour market. The programme included Jobcentre Plus, Durham County Council and many third sector organisations as partners. The service was developed as a pilot and results to date have been encouraging with 456 individuals having used the service. Clients experienced a range of problems such as mental health problems (48%) and musculo-skeletal problems<sup>l</sup> (38%).

A comparative cohort study was carried out. Between September 2009 and June 2010, 360 people were asked questions about their work status and health. One group of people, the intervention group (n=131)<sup>m</sup> were seen regularly by Salus<sup>n</sup>. Participants in the intervention group also had support from other services such as physiotherapy and counselling. A different group of people, the comparison group (n=229) did not have any of this additional support. Both groups of people were asked the same questions at the start and end of the study period to see what changes had happened to their health and workability. The hospital anxiety and depression scale (HADS) was used to measure the differences in how participants felt at the start of the study and up to nine months after the start of the study. It showed a reduction of 25% in anxiety and 28% in depression within the intervention group. The pilot comes to an end in September 2012 and a final research report will be written in November 2012.

**Chart 11: Changes in the anxiety scores of the intervention and comparison groups from the start of the study to nine months after the start of the study**



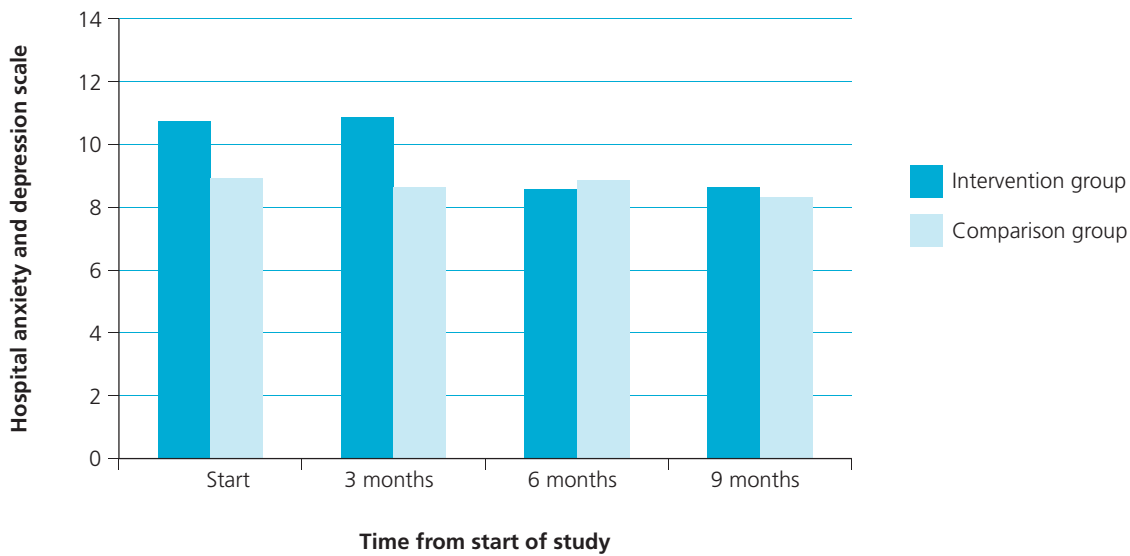
<sup>l</sup> These are problems that affect muscles and joints such as back pain.

<sup>m</sup> n refers to the number in this group.

<sup>n</sup> Salus is an NHS based provider of Occupational Health, Safety and Return to Work Services across the public and private sectors. It is the largest multidisciplinary service of the NHS and operates as a social enterprise model.

<http://www.salus.co.uk/Pages/default.aspx> accessed 10.7.12

**Chart 12: Changes in the depression scores of the intervention and comparison groups from the start of the study to nine months after the start of the study**



### Future challenge

- During an economic downturn, when employers' resources are stretched, engaging new workplaces in health programmes can prove a challenge. The support of strategic and business partnerships will be crucial in ensuring businesses achieve the benefits of investing in workplace health.

## 4.3 Public health capacity building

Capacity building involves training people who are not public health specialists to develop the skills to provide public health information and activities as part of their day to day work. It supports the ambition of every contact being a health improving contact.

### Strengthen the role and impact of ill health prevention

Over 3,000 staff across a range of organisations have been trained to deliver brief interventions and motivational interviewing in a range of topics including smoking, sexual health and nutrition. The development of a pilot health and wellbeing apprenticeship programme in east Durham, Durham and Chester-le-Street enabled 11 young people aged 16-18 years to access training and employment experience within health and wellbeing community programmes. This initiative is a way of building local public health capacity in the future workforce.

The 2004 Department of Health White Paper *Choosing Health: Making healthy choices easier*<sup>33</sup> proposed the development of a new health trainer role for improving health and reducing health inequalities. The key phrase in the document underpinning the health trainer programme is 'support from next door' rather than 'advice from on high'<sup>34</sup> which reflects the influence and power of communities where, in part, people's lives are affected by their ability to make healthy choices. County Durham and then Darlington were amongst the first in England to develop the programme which has four objectives. These are;

- engaging with people who don't access services, including people living in poorer areas who are afraid to go to see clinical staff because they think that they may be told off or judged for not being slimmer or fitter,
- expanding the wider public health workforce,
- helping people change their health-related behaviour, and
- supporting people to access services. These include activities such as blood pressure testing and getting involved in walking or other forms of physical activity and lifestyle programmes.

### Ensure healthy standard of living for all

Health trainers work with adults, but the impact on the families and children of their clients can be significant. For example, a client who lost over two stones in weight supported by her health trainer explained that the diets and activity levels of 17 people had been changed because of what she had learned. This included her husband and children, her parents, her sisters and their families. They had all begun to eat five portions of fruit and vegetables each day and were enjoying being more active.

Over the last five years new roles have been developed as part of the programme. Health trainer champions are volunteers who are trained to encourage people to use the health trainer service. Enhanced health trainers are trained to help people change their behaviours so they adopt healthier lifestyles, such as being more active. There are now over 50 health trainer champions in Durham and Darlington who support members of their communities in using services. Health trainer champions have learnt new skills and in some instances have been able to gain paid employment.





Health trainers with Anna Lynch, director of public health for County Durham

Health trainers use evidence based approaches<sup>35</sup> to support clients in identifying health issues that are important to them. They then plan for changes that they feel they can make. In this way people lose weight, engage in more physical activity, stop smoking and generally lead healthier lifestyles. They also achieve statistically significant changes in their confidence as they make changes<sup>36</sup>.

The programme has expanded over the last six years and there are now health trainers and health trainer champions working in the most deprived communities in County Durham and Darlington. They are working with communities that have specific health problems such as offenders, people with mental health problems, people in rural areas and most recently veterans. The veteran project is the only one of its type in the country and is an exciting development in County Durham and Darlington.

As part of the workplace health award programmes in place across County Durham and Darlington over 40,000 employees have been reached through awards including Darlington investors in health, County Durham working for health and the North East better health at work award. There are 345 health advocates trained as health champions across a range of sectors.

### **Enable all children, young people and adults to maximise their capabilities and have control over their lives**

One specific concern is that health inequalities amongst individuals with mental health problems remain significant. "People with mental health problems such as schizophrenia or bipolar disorder die on average 16–25 years sooner than the general population. They have higher rates of respiratory, cardiovascular and infectious disease and of obesity, abnormal lipid levels and diabetes. They are also less likely to benefit from mainstream screening and public health programmes"(p.23)<sup>37</sup>. In 2010, a pilot programme introduced a dedicated health trainer within a local mental health setting.

### **Strengthen the role and impact of ill health prevention**

Mental health first aid (MHFA) was launched in England in 2006 on the basis of an international evidence base. MHFA is the help and support given to someone in mental distress before professional help can be obtained. Like physical health first aid it trains lay people to provide urgent support in venues such as workplaces and leisure centres. MHFA provides practical skills, tackles misconceptions surrounding mental health and supports social inclusion through increasing the accessibility of community facilities for those with mental health problems. In partnership with Middlesbrough Council, NHS County Durham and Darlington secured lottery funding between 2008 and 2011 to train over 3600 mental health first aiders across the North East.

Implementation of the national time to change campaign started in 2009. A series of let's talk events challenged misconceptions and the general public were invited to join the mental health improvement team to talk about mental health issues. This approach received national recognition. Local mental health service users from a range of backgrounds also participated in a regional radio campaign in 2010 telling their stories of living with mental health issues. The campaign aimed to dispel myths about mental health.

Both recent health White Papers, *Liberating the NHS: Equity and Excellence*<sup>38</sup> and *Healthy Lives, Healthy People*<sup>39</sup>, recognise the core role that community pharmacists and their teams play in improving health. 2012 sees the launch of healthy living pharmacies where pharmacies will be awarded this status for offering a range of NHS services to people living or working in their area which help them improve and maintain their health and wellbeing. Each healthy living pharmacy will have at least one member of staff qualified as a health champion.

The healthy village project provides an example of working with people to improve their health. The project engaged with five villages and supported the provision of a range of activities identified by local people as things that they would like to do. For example, after a residential event one participant described the activity as "life changing". Two of the people who led projects in the villages have now undertaken health trainer training and are using their skills to support people to have the capacity and confidence to take more control over their health related behaviour.

### Future challenges

- The mental health first aid accredited trainers need to be maintained and supported to ensure mental health first aid is available in our communities.
- There is still stigma attached to mental health issues so campaigning and education within communities, schools, workplaces and within our own services must continue.
- As the new public health system develops in our local authorities, there will be more opportunities to engage with a wider workforce who have direct contact with local people and who can have a positive impact on individual health and wellbeing.
- Explore opportunities to link the health trainer programme to the work of the 14 area action partnerships and health networks in County Durham and the strategic partnership in Darlington.

## 4.4 Shaping the environment

### Create and develop healthy and sustainable places and communities

An assessment of the impact that County Durham Council's transport plan would have on health was carried out and NHS County Durham and Darlington produced a travel plan and a carbon management plan.



In order to help people get to their hospital appointment, two schemes were set up in which volunteers drive people to the hospital. Over 150 volunteers provide more than 16,000 journeys each year. The two schemes are provided by; the social resource centre (SRC), Ferryhill and they cover east Durham and Sedgefield, and the retired senior volunteer programme (RSVP, part of Community Service Volunteers) based in Chester-le-Street who cover Durham, Chester-le-Street, Derwentside and the Dales.

In 2009 two schemes, County Durham hotspots and Darlington HE-AT, were set up to reduce the number of people who die as a result of the cold winter weather, known as excess winter deaths. The schemes identify older residents who have underlying health conditions and link them to services that can assist with financial issues, grants, assess their home for signs of damp and mould and refer them to the fire service for a home safety check. To date, County Durham hotspots project has had 1,300 people have been referred to the service and 1,600 health and social care professionals have been trained to identify and refer people who may need help. The health and energy affordability team (HE-AT) in Darlington have provided 600 householders with advice on energy saving matters and helped them obtain £138,951 of grant funding resulting in improved thermal comfort for 111 people.

For the last four years, together with Durham County Council, NHS County Durham and Darlington has invested in supporting the organisations in the voluntary and community sector. These organisations provide community buildings, volunteers and help increase the knowledge, skills and experience of people living in the community. This helps build up social capital which is concerned with the connections between people and the extent to which this generates community action<sup>40</sup>. An individual's decision to engage with culture is set within a range of competing priorities shaped by their beliefs and values, but also by the opportunities available to them. The benefit they achieve from taking part is felt individually but also by the whole community, which is thereby strengthened. It is therefore desirable to improve access to cultural opportunities for everyone specifically for those at risk of exclusion; those who are most vulnerable. These groups include black, minority and ethnic groups (BME), particularly older people, who are half as likely to attend arts events as older people from non-BME groups,

households scoring low on socio-economic measures who are four times less likely to engage, people with lower educational attainment, social housing tenants who are a third less likely to engage, the unemployed and people with disabilities.

In Darlington cultural events have been offered to people with specific risks of health inequalities. This includes commissioning an arts on referral programme which is aimed at those patients with mild to moderate mental health conditions or who are at risk of exclusion. The local library service successfully provided a books on prescription service where individuals could have support and free access to a range of reading material which aimed to help an individual develop a feeling of control over their condition.

A key message from local engagement is that local environmental quality is very important to both residents and visitors of Darlington alike. Residents attach importance to the upkeep of parks and open spaces and that play areas in which children play are kept clean and maintained to correct standards. Having access to outdoor space for activities such as walking and growing fresh food through community-led developments of green spaces, parks and allotments, supports the outcomes associated with health strategies such as physical activity and nutrition.

NHS County Durham and Darlington has also worked with the borough council and other stakeholders in the Darlington cycling town initiative. This has resulted in a significant shift from journeys taken in Darlington using a car to journeys using a bicycle or walking.

Volunteers have been vital to many of the activities undertaken to improve the health of the population in Darlington, from health trainers and volunteer cooking instructors, to groups who remove snow from pathways and pavements for those who are elderly or infirm and at greatest risk from slipping and falling. NHS County Durham and Darlington has worked with Evolution, a local community organisation to develop the Healthy Darlington Network which coordinates the input and response of the voluntary sector to the health challenges in Darlington.

### Future challenges

- Link to local authority anti-poverty strategies to consolidate and provide a more focused approach to income, debt and welfare provision, regeneration and financial inclusion.
- Integrate the services that provide transport to hospitals in County Durham and Darlington.
- Evaluate the schemes trying to reduce excess winter deaths to see if they are targeting those who most need the service and to assess what impact the service has had on their health and wellbeing.
- Evaluate what effect the investment in building social capital has had on local communities.

## Chapter 5

# Working with people in communities

## 5.1 Children, young people and families



The 1973 County Medical Officer of Health's report<sup>1</sup> included sections about midwifery services, health visiting and the service provided by nurses who worked in schools. In 1973, 93% of women gave birth in hospital. In 2010 this figure had increased to 99% in County Durham and 98% in Darlington<sup>41</sup>. Other issues in the report were descriptions of the types of welfare foods provided such as Vitamin A, D and C drops suggesting a focus on nutritional supplements.

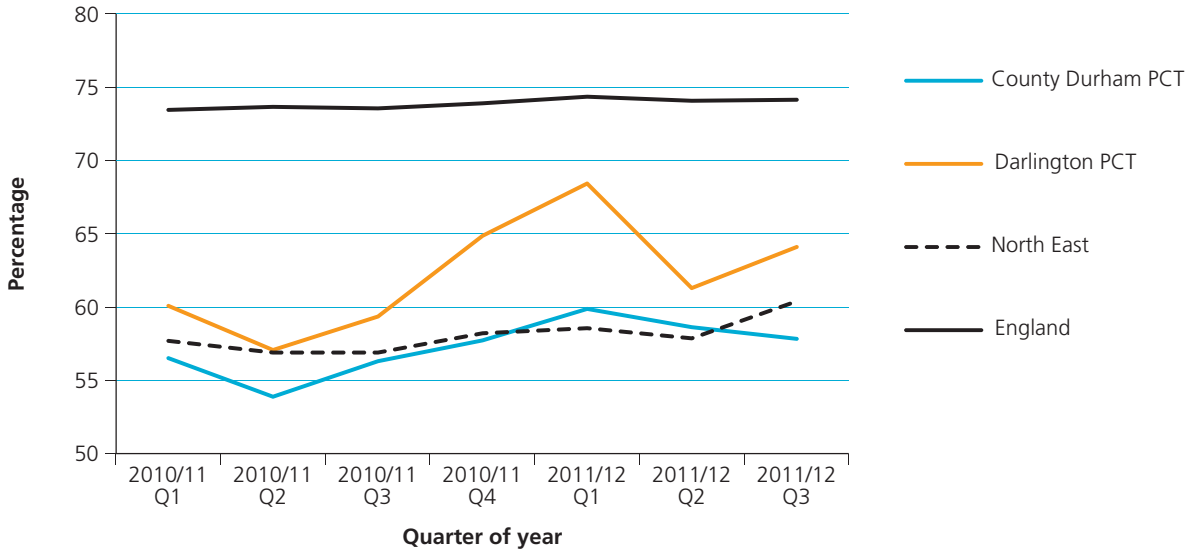
### Give every child the best start in life

*Maternity Matters*<sup>42</sup> was published by the Department of Health in 2007 and described the services that should be available for pregnant women. The aim was to have high quality, safe and accessible maternity services through the introduction of a new national choice guarantee for women. By the end of 2009, all women had the choice of the type of care they received, such as hospital or home births. The results of research into how to improve the rate of breastfeeding post-delivery suggested there should be; peer support, support from mainstream services, such as maternity, GP and health visiting services, in addition to raising education and awareness with mothers, fathers, the extended family and the public, including employers.

County Durham and Darlington have lower breastfeeding prevalence at initiation and six to eight weeks compared to the England average. Local targets have been set to increase breastfeeding initiation by 5% each year until March 2014. In Durham the target for breastfeeding initiation rates is 65% by March 2013 and 70% by March 2014. In Darlington the target for breastfeeding initiation rates is 73% by March 2013 and 78% by March 2014.

**Chart 13: Trends in breastfeeding initiation rate (percentage) for all maternities<sup>o</sup> in County Durham, Darlington, the North East and England between 2010/11 and 2011/12**

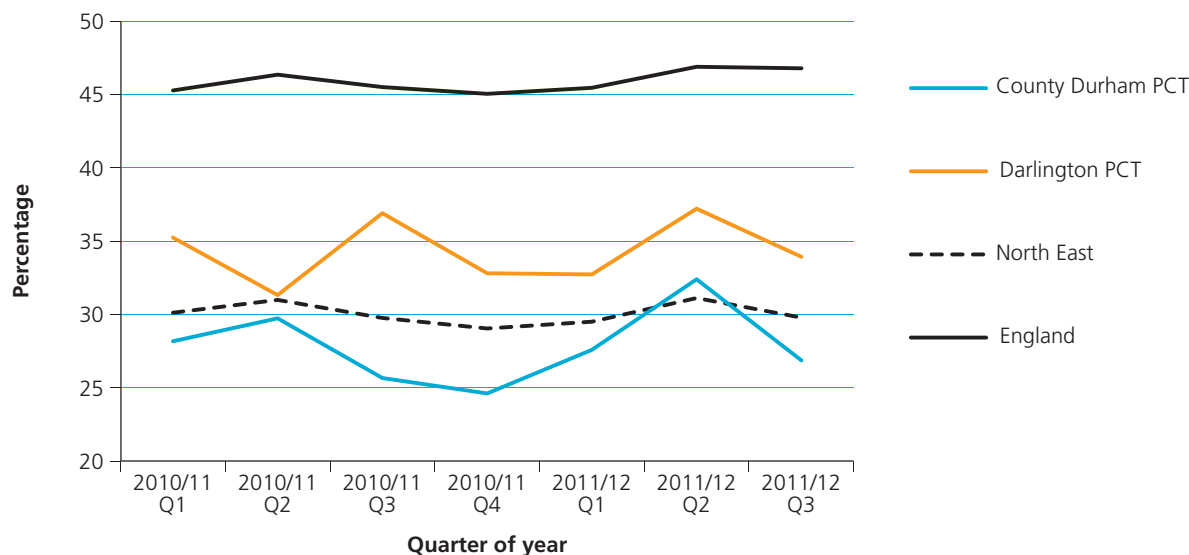
Scale starts at 50% to make the information easier to read



<sup>o</sup> A maternity is defined as a confinement resulting in the birth of one or more live-born or stillborn children. Therefore, the number of maternities is less than the total number of livebirths and still births. From UK National Statistics <http://www.statistics.gov.uk/hub/population/births-andfertility/maternities>

### Chart 14: Trends in breastfeeding prevalence rate (percentage) at 6-8 weeks as a percentage of all infants in County Durham, Darlington, the North East and England between 2010/11 and 2011/12

Scale starts at 20% to make the information easier to read



Source: Department of Health, *Integrated Performance Measure Return, 2012*

<http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performanceandstatistics/Integratedperformancemeasuresmonitoring/index.htm>

The start of life is a crucial time for children and parents. Good, well-resourced health visiting services help ensure families have a positive start, working in partnership with GPs, maternity and other health services, Sure Start children's centres and other early years services. A national expansion of health visitors is planned by 2015 and is being implemented locally.

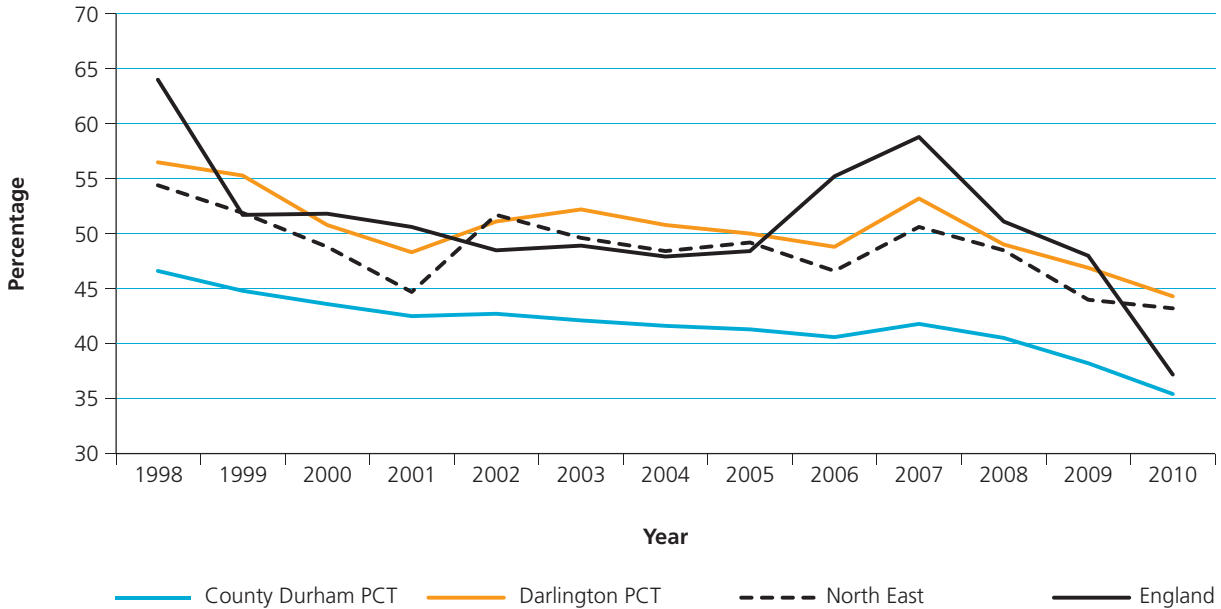
### Enable all children, young people and adults to maximise their capabilities and have control over their lives

Many initiatives have improved sexual health since 1974 including the introduction of highly active antiretroviral therapy (HAART) in 1996 that was shown to substantially reduce AIDS-related hospital admissions and death rates in both developed and developing nations.

The decline in teenage pregnancies began with the introduction of free contraception in the NHS in 1974. Multi-agency strategies focusing on access to services, raising aspirations, and sex and relationship education were implemented. As part of the healthy schools programme children learnt about peer pressure, risky behaviours and how to resist pressure. In the 1990s conception rates resumed their decline as services for young people were expanded. Chart 15 shows that in County Durham the rates of teenage pregnancy declined from 54.4 per 1,000 girls aged 15-17 years in 1998 to 43.2 per 1,000 in 2010. In Darlington the rates of teenage pregnancy declined from 64 per 1,000 girls aged 15-17 years in 1998 to 37.2 per 1,000 in 2010.

### Chart 15: Trends in under 18 conceptions (per 1,000 females 15-17 years) nationally, regionally and locally between 1998 and 2010

Scale starts at 30 to make the information easier to read



Source: Department of Education

<http://www.education.gov.uk/childrenandyoungpeople/healthandwellbeing/teenagepregnancy/a0064898/under-18-and-under-16-conception-statistics>

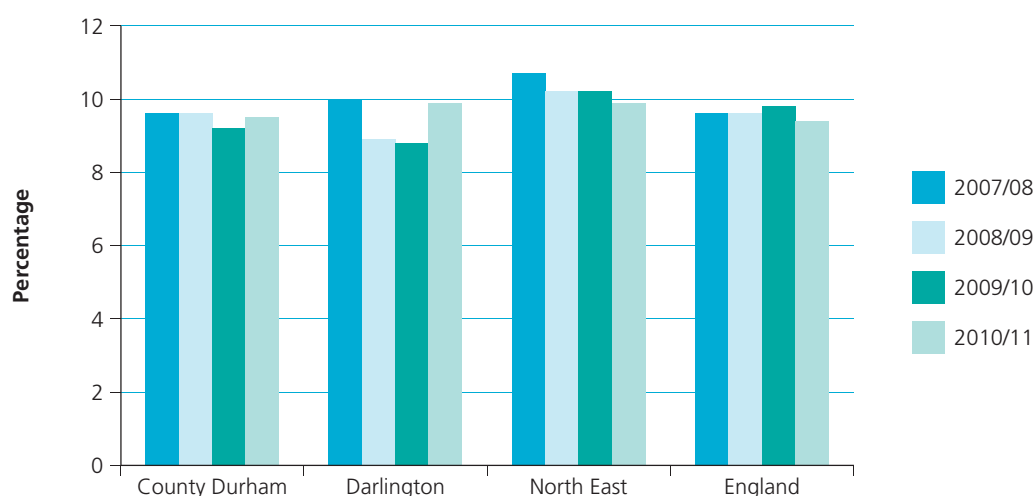
### Ensure healthy standard of living for all

Obesity in children and young people affects their current health and their future health as adults. Tackling obesity in children was made a Public Service Agreement (PSA) target incorporated in the *National Standards, Local Action: Health and Social Care Standards 2005/06 – 2007/08*<sup>43</sup> as one of the targets to tackle the underlying determinants of ill health and health inequalities by: ‘Halting the year on year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole’.

A multi-agency strategy to prevent obesity and treat children who are obese was developed locally. The figures in chart 16 show that obesity levels at both reception and year 6 have been sustained with a downward trend at year 6 for Darlington; however prevalence at year 6 remains higher than reception in line with the national picture.

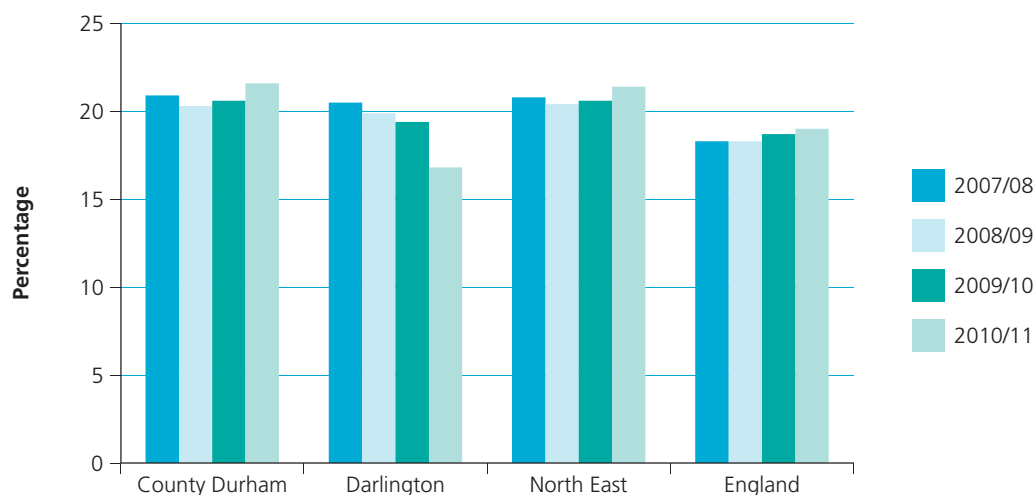


**Chart 16: Obesity prevalence (percentage of children measured) at reception age, nationally, regionally and locally between 2007/08 and 2010/11**



Source: The Information Centre, National Child Measurement Programme: England, 2010/11 school year  
<http://www.ic.nhs.uk/ncmp>

**Chart 17: Obesity prevalence (percentage of children measured) at year 6, nationally, regionally and locally between 2007/08 and 2010/11**



Source: The Information Centre, National Child Measurement Programme: England, 2010/11 school year  
<http://www.ic.nhs.uk/ncmp>

The publication of the national obesity strategy: *'Healthy Lives, Healthy People: A call to action on obesity in England'*<sup>44</sup> in October 2011 set targets to 'achieve a sustained downward trend in levels of excess weight in children by 2020'. Subsequently, current local strategies are being reviewed. It is planned to strengthen partnership working to support the childhood obesity pathway with greater emphasis on the wider determinants of health and social marketing for behavioural change.

## Strengthen the role and impact of ill health prevention

An important aspect of preventing ill-health is through the early identification of potential disease. This is done locally in a number of ways. The UK national screening committee (NSC) was established in 1996. Proposals for new screening programmes are assessed against a set of internationally recognised criteria which cover the condition in question, the test, the treatment options and the effectiveness and acceptability of the screening programmes. The fetal maternal and child health (FMCH) subgroup of the UK NSC addresses all aspects of antenatal, new-born and child health screening programmes. This includes reviewing the latest research evidence and, where necessary, specially convened multi-disciplinary expert groups are consulted.

The FMCH has two main strands of work:

- Quality information – for example, ensuring antenatal and new-born screening requirements inform the national programme for information technology.
- Programme specific issues – relating to implementation of individual screening programmes. These functions are undertaken by various programme specific subgroups.

There are six antenatal and new-born screening programmes that are delivered locally;

- fetal anomaly,
- infectious diseases in pregnancy,
- linked antenatal and newborn sickle cell and thalassaemia,
- newborn blood spot,
- newborn and infant physical examination, and
- newborn hearing screening.

The national Chlamydia screening programme was first introduced in 2003 offering an opportunistic service for 15-24 year olds in England. This screening programme was developed in County Durham and Darlington from 2004. The local programme has achieved consistently high numbers of people screened across County Durham and Darlington as shown in table 9. There has been a substantial increase in the number of Chlamydia screening tests undertaken by the local programme between 2007 and 2012. The local service pressure to achieve high volume screening has identified that opportunistic screening often relies on young people attending certain places such as colleges, or engaging in certain activities such as sports. This approach has the potential for the more disadvantaged to benefit the least<sup>45</sup>. The challenge is to ensure that health inequalities are not widened.

**Table 9: National Chlamydia screening programme, number of tests completed and positivity rate for County Durham and Darlington, 2007/08 to 2011/12**

Year	Primary Care Trust			
	County Durham		Darlington	
	Number of tests completed	Positivity rate# (%)	Number of tests completed	Positivity rate# (%)
<b>2007/08</b>	5,205	Not reported	629	Not reported
<b>2008/09</b>	9,898	10.8	2,068	10.4
<b>2009/10</b>	21,952*	5.3	4,025*	5.5
<b>2010/11</b>	28,790*	3.8	4,538*	3.6
<b>2011/12</b>	25,355*	3.7	3,410*	4.1

# This is the percentage of tests that were positive.

\* Tests included those taken in other venues, as well as the designated places for the screening programme (excluding tests taken in genito-urinary medicine clinics).

### Future challenges

- Commission children's and young people's obesity reduction programmes based on evidence of effectiveness.
- Provide public health support to health visitor services post-2013 when they will be commissioned by the NHS Commissioning Board.
- Review the range of commissioned sexual health services, including teenage pregnancy.
- Ensure an effective handover of commissioning responsibility for antenatal screening programmes to the NHS Commissioning Board.
- Develop the public health role of school nurses.

## 5.2 Military health



The health and wellbeing of the armed forces, veterans and their families is now recognised as a key NHS responsibility. The armed forces covenant sets out a number of health commitments which are a series of statements describing the standards military personnel and their families can expect from the NHS. Serving personnel and their families should experience no disadvantage in access to public services and enjoy the same standard of, and access to, healthcare as that received by any other UK citizen in their residential area.

Veterans who receive their healthcare from the NHS should receive priority treatment where it relates to a condition which results from their service in the Armed Forces, subject to clinical need.

### **Ensure healthy standard of living for all**

The nature, size and requirements of the veteran population have changed over time. The circumstances of future veterans will also be very different from those of many of today's veterans. There will be fewer veterans from the conscription era and a greater proportion of veterans will be former reservists. These changed circumstances will bring different expectations and requirements that will need to be reflected in the approach to veterans' issues. For example, demographic changes will have implications for veterans, as well as wider society in terms of the way in which support services will be provided for older people.

When servicemen and women leave the armed forces their healthcare is the responsibility of the NHS. All veterans are entitled to priority access to NHS hospital care for any condition, as long as it is related to their service, whether or not they receive a war pension. Veterans are encouraged to tell their GP about their veteran status in order to benefit from priority treatment. Veterans' needs are not identical and will be determined by factors such as their experience before their military service, during their military service and as a civilian, including their transition from military to civilian life.

NHS County Durham and Darlington has developed a plan to address the health needs of members of the armed forces, veterans and their families. It includes:

- A communications and engagement plan.
- Requiring County Durham and Darlington NHS Foundation Trust to identify military veterans and ensure they are getting the services they are entitled to. This is being monitored as part of the payment system between NHS County Durham and Darlington and County Durham and Darlington NHS Foundation Trust.
- A veterans awareness training programme has been delivered to NHS staff.
- The veterans wellbeing assessment and liaison service (VWALS) pilot service started in June 2012. The service aims to provide a prompt, effective, assessment, liaison and signposting service for military veterans and their families in the North East. The service provides an outreach team, based at Lanchester Road hospital.
- Finchale Training College has provided a support service for armed forces personnel making the transition from military to civilian life. They have also developed a health trainer programme development for veterans. These two services will be evaluated in 2012/13.

### Future challenges

- Health and wellbeing boards should be aware of the needs and co-ordinate service provision for military health.
- Increase awareness among primary care providers and GPs of the particular mental health needs of the ex-service personnel and particularly of the need for priority treatment for health care needs arising from their service.
- Primary care services and hospital trusts should take steps to improve awareness of veteran's mental health issues among health workers generally, including appropriate training and supervision.
- Some groups within the ex-service community may need special attention, including prisoners and early service leavers (those who leave the service after less than four years).

## Chapter 6

# Our ambition for the future



As some public health functions move into Durham County Council and Darlington Borough Council, we are excited about the opportunities that relate to the wider social and economic factors that have such an important impact on an individual's state of health. We also look forward to the opportunity to enhance current partnership working, develop new partnerships and through all of this maintain our position as independent advocates for the health of local people in County Durham and Darlington.

We know that of the children born in County Durham and Darlington in 1973, it is the ones who had a low birth weight followed by a rapid period of growth that are most likely to be the adults who are now most at risk from coronary heart disease<sup>46</sup>. It is important therefore that we work across the whole life course when we are designing and implementing public health interventions to improve health. Much of the coronary heart disease and type 2 diabetes in our communities is unnecessary and preventable<sup>47</sup>. The impact of the environment in which we live, the ease with which we can take exercise, the amount of alcohol that we consume and whether or not we smoke, all directly contribute to the extent to which we will have a healthy and disease free life. The opportunity to have an impact on and influence these factors and make changes for the better will sit with our two local authorities. We will be working more closely with colleagues in economic development, planning departments and adults and children's services; working with them to reduce the inequalities that exist within our communities. We want the health of people in County Durham and Darlington to be at least as good as that in the rest of England, and then better!

Over recent years there has been a growing body of evidence about which public health actions are most effective and we will ensure that we use best practice and successful interventions as we plan future work. Some public health interventions are important over the long term but others have immediate impact. For example, eight hours after someone stops smoking, nicotine and carbon monoxide levels in blood reduce by half and their oxygen levels have returned to normal<sup>48</sup>. After one year, "The excess risk of coronary heart disease is half that of a continuing smoker's"<sup>49</sup>. It is important that we use research and evidence based programmes to ensure the greatest impact and value for money.

Employment and access to green spaces are also important for our physical and mental health. It is these types of issues we are keen to address by working with colleagues in the local authorities.

The role of the director of public health has evolved since 1974 when public health was last the responsibility of local authorities. Then the County Medical Officer was responsible for maternity and child health, ambulances, midwifery, home nursing and health visiting. Much has changed and our roles today encompass three main areas of public health practice<sup>50</sup>;

- health improvement,
- improving health and care services, and
- health protection.

In delivering or commissioning these public health functions our team of public health specialists use the following areas of public health practice;

- surveillance and assessment of the population's health and wellbeing,
- assessing the evidence of effectiveness of health and healthcare interventions, programmes and services,
- policy and strategy development and implementation,
- strategic leadership and collaborative working for health,
- health improvement,
- health protection,
- health and social service quality,
- public health intelligence, and
- academic public health.

Of course, there are other professionals in local authorities with some of these skills and we will work closely with them to provide the specialist public health focus, enhancing their capacity to improve health and reduce health inequalities.

A defining characteristic of the directors of public health role has been their acknowledged independence to report on the status of health within their local community. Our role as "independent advocate, champion and influencer for the population's health, focusing on the wider determinants of health"<sup>51</sup> (p.4) will continue in the new public health system.

We have a tremendous opportunity as we move out of the NHS and into local authorities and we hope to be able to look back in a few years and celebrate the changes and improvements to the health of communities in County Durham and Darlington.

## Appendix 1

### Notes for the Marmot indicators

The report the indicators are from and a more detailed Indicator Guide is available from the London Health Observatory website:

[http://www.lho.org.uk/LHO\\_Topics/national\\_lead\\_areas/marmot/marmotindicators.aspx](http://www.lho.org.uk/LHO_Topics/national_lead_areas/marmot/marmotindicators.aspx)

#### **Life expectancy at birth (indicators 1 and 4)**

Estimate of the average number of years of life expectancy at birth, based on current mortality rates.

Figures for England and the English regions were calculated using methods consistent with those used to calculate local authority figures.

*Time period: 2008-10 Source: Office for National Statistics (ONS)*

#### **Inequality in life expectancy (indicators 2 and 5)**

This indicator is the Slope Index of Inequality (SII) in life expectancy at birth, which represents the range in life expectancy across the whole population of the local authority (LA), from most to least deprived. An SII of 10 years, for example, indicates that life expectancy for the best-off in the LA is 10 years higher than for the worst-off in the same LA. The higher the value of the SII, the greater the inequality within the area.

Results were calculated by grouping lower layer super output areas (LSOAs) within each LA into deciles based on their Index of Multiple Deprivation 2010 score. Deciles each contain approximately a tenth of the LSOAs in the LA. The life expectancy for each decile was then calculated, based on deaths in the five-year period 2006-10. A statistical analysis of the relationship between these decile life expectancies and deprivation provides the SII – a single summary measure of social inequality in life expectancy across the local authority. The figure for England is the median value of the SII figures for all upper-tier local authorities. The figure for each English region is the median value of SII results for all upper-tier LAs within that region.

*Time period: 2006-10 Source: The Public Health Observatories in England, based on analysis of ONS mortality data and population estimates & Department for Communities and Local Government, Indices of Deprivation 2010.*

#### **Inequality in disability-free life expectancy (indicators 3 and 6)\***

Disability-free life expectancy (DFLE) is the average number of years a person could expect to live without an illness or health problem that limits their daily activities. This indicator is the Slope Index of Inequality (SII) in DFLE, which represents the range in DFLE across the whole population of the local authority (LA), from most to least deprived. An SII of 15 years, for example, indicates that DFLE for the best-off in the LA is 15 years higher than for the worst-off in the same LA. The higher the value of the SII, the greater the inequality within the area.

Results were calculated by ranking the middle layer super output areas (MSOAs) in each local authority by their level of deprivation using Index of Multiple Deprivation 2007 scores. A statistical analysis of the relationship between MSOA-level DFLE and deprivation provides the SII – a single summary measure of social inequality in DFLE across the local authority. The figure for England is the median value of the SII figures for all upper-tier local authorities. The figure for each English region is the median value of SII results for all upper-tier LAs within that region.

*Time period 1999-2003 Source: Slope Index of Inequality - London Health Observatory based on analysis of DFLE figures from ONS*

\* These figures are the same as those presented in the 2011 Marmot Indicators. ONS are



investigating the possibility of producing more recent statistics. The indicators will be updated when new data are released.

### **Children achieving a good level of development at age 5 (indicator 7)**

Percentage of children assessed by a teacher as having achieved a 'good level of development' in the year they turn five.

Figures for England and the English regions are the actual percentages for these areas.

*Time period: 2011 Source: Department for Education*

### **Young people not in employment, education or training (NEET) (indicator 8)**

Percentage of young people aged 16-19 who are not in education, employment or training (NEET).

Figures for England and the English regions are the actual percentages for these areas.

*Time period: November 2010 to January 2011 Source: Department for Education*

### **People in households in receipt of means-tested benefits (indicator 9)**

Percentage of people living in households in receipt of selected means-tested benefits.

Figures for England and the English regions are the actual percentages for these areas.

*Time period: 2008 Source: Income Domain of the Index of Multiple Deprivation 2010 – Department for Communities and Local Government; percentages for LAs - London Health Observatory*

### **Inequality in percentage in receipt of means-tested benefits (indicator 10)**

This indicator is the Slope Index of Inequality (SII) in the percentage of people in households in receipt of selected means tested benefits. It represents the range of benefit receipt across the whole population of the local authority (LA), from most to least deprived. An SII of 35 percentage points, for example, indicates that for the worst-off in the LA, the percentage of people receiving means-tested benefits is 35 percentage points higher than for the best-off in the same LA. The higher the value of the SII, the greater the inequality within the area. Results were calculated by grouping lower layer super output areas (LSOAs) within each LA into deciles based on their Index of Multiple Deprivation 2010 score. Deciles each contain approximately a tenth of the LSOAs in the LA. The percentage of people in households in receipt of benefits was calculated for each decile. A statistical analysis of the relationship between the decile percentages and deprivation provides the SII – a single summary measure of social inequality in receipt of means-tested benefits across the local authority. The figure for England is the median value of the SII figures for all upper-tier local authorities. The figure for each English region is the median value of SII results for all upper-tier LAs within that region.

*Time period: 2008 Source: Slope Index of Inequality - London Health Observatory based on analysis of the Income Domain of the Index of Multiple Deprivation 2010 from the Department for Communities and Local Government*

## Appendix 2

### List of contributors

Catherine Parker	Public Health Portfolio Lead
Catherine Richardson	Public Health Portfolio Lead
Chris Scorer	Public Health Capacity Building and Health Trainer Lead
Chris Woodcock	Social Marketing Manager
Christine Edgar	Personal Assistant to Directors of Public Health
Claire Sullivan	Consultant in Public Health
David Landes	Deputy Director of Public Health
Dawn Philips	Public Health Portfolio Lead
Dawnn Roe	Administration Coordinator
Dianne Woodall	Public Health Portfolio Lead
Esther Mireku	Public Health Portfolio Lead
Graeme Greig	Senior Public Health Specialist
Kate Jeffels	Joint Commissioning Unit Manager Drug and Alcohol Action Team, Darlington
Ken Ross	Senior Public Health Specialist
Lisa Lynch	Public Health Team Administrator
Lynn Wilson	Acting Consultant in Public Health
Mandy English	Strategic Alcohol Commissioning Manager, County Durham
Mark Harrison	Joint Commissioning Manager, Substance Misuse, County Durham
Michael Fleming	Public Health Epidemiologist
Michelle Baldwin	Public Health Practitioner
Mike Lavender	Consultant in Public Health Medicine
Nick Springham	Consultant in Public Health
Richard Holmes	NIHR Research Fellow / Honorary Specialty Registrar in Dental Public Health
Tim Wright	Public Health Portfolio Lead
Tony Walsh	Public Health Specialist

## References

- 1 County Council of Durham, 1973. *Annual Report of the County Medical Officer of Health and Principal School Medical Officer for the year 1973*. Reproduced by permission of Durham County Record Office, Durham County Record Office CC/HEALTH 461.
- 2 Marmot, M. 2010. *Fair society, healthy lives. Strategic review of health inequalities in England London*: Institute of Health Equity. <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review> Accessed 17.1.12.
- 3 Office for National Statistics, 1997, *English Life Tables No.15*. The Stationery Office. <http://www.ons.gov.uk/ons/rel/lifetables/decennial-life-tables/english-life-tables-no--15/index.html>
- 4 Web page. *Marmot Indicators for Local Authorities in England, 2012*, London Health Observatory. Accessed 18th August 2012. [http://www.lho.org.uk/LHO\\_Topics/national\\_lead\\_areas/marmot/marmotindicators.aspx](http://www.lho.org.uk/LHO_Topics/national_lead_areas/marmot/marmotindicators.aspx)
- 5 Department of Health and National Treatment Agency for Substance Misuse, 2006. *Models of care for alcohol misusers* (MoCAM) Department of Health. [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4136809.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4136809.pdf) Accessed 28.6.12
- 6 Darlington Drugs and Alcohol Action Team, 2012. *Six Schools Healthy Behaviours Survey 2011*.
- 7 Royal College of Physicians, 2010. *Passive smoking and children. A report by the Tobacco Advisory Group*.
- 8 Hackshaw A., Rodech C., and Boniface S., 2011. Maternal smoking in pregnancy and birth defects: a systematic review based on 173 687 malformed cases and 11.7 million controls. *Human Reproduction Update*. <http://humupd.oxfordjournals.org/content/early/2011/07/09/humupd.dmr022.full> Advanced access published July 11, 2011
- 9 Royal College of Physicians, 2010. *Passive smoking and children. A report by the Tobacco Advisory Group*.
- 10 Fuller E. (Ed), 2008. *Drug use, smoking and drinking among young people in England in 2007*, National Centre for Social Research. <http://www.ic.nhs.uk/webfiles/publications/sdd07/SDD%20Main%20report%2007%20%2808%29-Standard.pdf> Accessed 3.7.12.
- 11 Dunstan S. (Ed), 2012. *General Lifestyle Survey Overview: A report on the 2010 General Lifestyle Survey*. Office for National Statistics. <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-226919> Accessed 3.7.12.
- 12 Rigotti N., Munafo M.R., and Stead L.F., 2007. *Interventions for smoking cessation in hospitalised patients*. Cochrane Database of Systematic Reviews. <http://www.thecochranelibrary.com/userfiles/ccoch/file/World%20No%20Tobacco%20Day/CD001837.pdf> Accessed 3.7.12.
- 13 Health Profiles, 2012, Public Health Observatories. <http://www.apho.org.uk/resource/view.aspx?RID=50215&REGION=50150&SPEAR=> Accessed 12.7.12.
- 14 HelmePark Ltd, 2012. *Changing the Physical Activity Landscape. County Durham Sport and NHS County Durham. End of year progress report: 2011/2012*.
- 15 Cardiovascular disease PCT health profile – County Durham. South East Public Health Observatory. <http://www.sepho.org.uk/CVDprofiles.aspx> Accessed 16.7.12.
- 16 Cardiovascular disease PCT health profile – Darlington. South East Public Health Observatory. <http://www.sepho.org.uk/CVDprofiles.aspx> Accessed 16.7.12.
- 17 Department of Health, 2000. *The NHS Cancer plan: a plan for investment, a plan for reform*. [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4009609](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009609) Accessed 29.6.12.
- 18 Department of Health, 2007. *Cancer Reform Strategy*. [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_081006](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081006) Accessed 29.6.12.
- 19 Kassianos G.C., 2001. *Immunisation: childhood and travel health* 4th edition. Blackwell Science Ltd.

- <sup>20</sup> Department of Health, 2008. *Impact Assessment of introduction of HPV vaccine*. [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_087474.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_087474.pdf). Accessed 30.7.12.
- <sup>21</sup> Todd J.E., 1975. *Children's Dental Health in England and Wales, 1973*. Office of Population Censuses and Surveys Social Survey Division. HMSO.
- <sup>22</sup> North West Public Health Observatory NHS Dental Epidemiology Programme for England Oral Health Survey of 12 year old Children, 2008 /2009, online publication available at [www.nwph.net/dentalhealth/reports/Primary\\_care\\_trust\\_and\\_strategic\\_health\\_authority\\_results\\_tables.pdf](http://www.nwph.net/dentalhealth/reports/Primary_care_trust_and_strategic_health_authority_results_tables.pdf) Accessed 2011.
- <sup>23</sup> Landes D.P., 2012. *Access to Dental Care for residents of NHS County Durham and NHS Darlington provided by NHS dentists in the North East 2010 – 2011*. NHS County Durham and Darlington.
- <sup>24</sup> Marmot M., 2010. *Fair society, healthy lives. Strategic review of health inequalities in England London: Institute of Health Equity*. <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review> Accessed 17.1.12.
- <sup>25</sup> Commission on the Social Determinants of Health, 2008. *Closing the gap in a generation: health equity through action on the social determinants of health*. Geneva: World Health Organisation [http://www.who.int/social\\_determinants/thecommission/finalreport/en/index.html](http://www.who.int/social_determinants/thecommission/finalreport/en/index.html) Accessed 17. 7.12.
- <sup>26</sup> UCL Institute of Health Equity, 2012. *The role of the health workforce in tackling health inequalities: Action on the social determinants of health*, (p.5). <http://www.instituteofhealthequity.org/projects/what-a-nhs-workforce-can-do-to-tackle-health-inequalities> Accessed 17.7.12.
- <sup>27</sup> Nutbeam D., 2000. Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century. *Health Promotion International*, 15 (3), 259-267. <http://heapro.oxfordjournals.org/content/15/3/259.full.pdf+html> Accessed 28.6.12.
- <sup>28</sup> Tavistock Institute and Shared Intelligence, 2009. *Evaluation of the Second Phase of the Skilled for Health Programme: Final evaluation report* [http://www.tavinstitute.org/pdf/reports/32.Evaluation\\_of\\_the\\_Second\\_Phase\\_of\\_the\\_the\\_Skilled\\_for\\_Health\\_Programme\\_2008.pdf](http://www.tavinstitute.org/pdf/reports/32.Evaluation_of_the_Second_Phase_of_the_the_Skilled_for_Health_Programme_2008.pdf) Accessed 3.7.12.
- <sup>29</sup> Hill M. and Westrip S., 2010. *Securing lives & shaping futures: a qualitative investigation of a partnership approach to lifelong learning*. Northumbria University/Chester-le-Street Campaign for Learning, Durham County Council, Newcastle upon Tyne. <http://nrl.northumbria.ac.uk/1375/> Accessed 3.7.12.
- <sup>30</sup> Web page. Income and welfare UCL Institute of Health Equity. <http://www.instituteofhealthequity.org/themes/income-and-welfare> Accessed 28.6.12.
- <sup>31</sup> County Durham Citizen's Advice Partnership, 2012. *Annual Report, 2011-12*.
- <sup>32</sup> Black C., 2008. *Working for a healthier tomorrow - Dame Carol Black's review of the health of Britain's working age population*. Department of Health. [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_083560](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083560) Accessed 29.6.12.
- <sup>33</sup> Department of Health, 2004. *Choosing Health: Making healthy choices easier* [http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4094550](http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094550) Accessed 17.7.12
- <sup>34</sup> Web page. Health Trainers England. <http://www.healthtrainersengland.com/> Accessed 28.6.12.
- <sup>35</sup> Web page. Health Trainers Handbook. <http://www.dh.gov.uk> Accessed 29.6.12.
- <sup>36</sup> This is from monitoring data provided by service providers to the PCT.
- <sup>37</sup> HM Government, 2011. *No health without mental health: a cross-government mental health outcomes strategy for people of all ages*. [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_123766](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766) Accessed 27.6.12.
- <sup>38</sup> Department of Health, 2010. *Equity and excellence: Liberating the NHS* [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_117353](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353) Accessed 17.7.12.

- <sup>39</sup> Department of Health, 2011. *Healthy lives, healthy people: our strategy for public health in England* <http://www.dh.gov.uk/health/2011/07/healthy-lives-healthy-people/> Accessed 17.7.12.
- <sup>40</sup> Halpern D., 2005. *Social Capital*. Polity Press
- <sup>41</sup> Web page. *Vital Statistics: Population and Health Reference Tables (November 2011 update): Annual time series data*. Office for National Statistics. <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-238751> Accessed 16.7.12.
- <sup>42</sup> Department of Health, 2007. *Maternity Matters: Choice, access and continuity of care in a safe service*. [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_074199.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_074199.pdf) Accessed 29.6.12.
- <sup>43</sup> Department of Health, 2004. *National Standards, Local Action: Health and Social Care standards 2005/06 - 2007/08*. [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4086058.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4086058.pdf) Accessed 4.7.12.
- <sup>44</sup> Department of Health, 2011. *Healthy Lives, Healthy People: A call to action on obesity*. [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_130487.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_130487.pdf) Accessed 4.7.12.
- <sup>45</sup> Jackson C. A., Henderson M., Frank J.W. and Haw S.J., 2012. An overview of prevention of multiple risk behaviour in adolescence and young adulthood. *Journal of Public Health*, 34, i31-i40.
- <sup>46</sup> Barker D.J.P., 2012. Developmental origins of chronic disease, *Public Health*, 126, 185-189.
- <sup>47</sup> Marmot M., 2010. *Fair society, healthy lives. Strategic review of health inequalities in England London: Institute of Health Equity*. <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review> Accessed 8.6.12.
- <sup>48</sup> Web page. <http://smokefree.nhs.uk/why-quit/timeline/> Accessed 5.7.12.
- <sup>49</sup> Web page. <http://www.cancer.org/healthy/stayawayfromtobacco/guidetoquittingsmoking/guide-to-quitting-smoking-benefits> Accessed 5.7.12.
- <sup>50</sup> Webpage. Faculty of Public Health. [http://www.fph.org.uk/what\\_is\\_public\\_health](http://www.fph.org.uk/what_is_public_health) Accessed 3.7.12.
- <sup>51</sup> Wright J., Dunkley R. and Pittam G., 2010. *The Role of the Directors of Public Health in England – current and future contributions set in an historical perspective* (p.28). Solutions for Public Health. [www.sph.nhs.uk](http://www.sph.nhs.uk).

## Notes



## Your comments

If you have any comments on this document or would like further information please contact:

NHS County Durham and Darlington  
www.cdd.nhs.uk  
Telephone: 0191 301 1300  
Email: cd-pct.enquiries@nhs.net

For additional copies of this report please contact:

NHS County Durham and Darlington  
John Snow House  
Durham University Science Park  
Durham  
DH1 3YG  
Telephone: 0191 301 1300