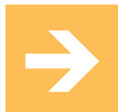
Public Health

A Shared Agenda In Darlington



Annual Report Of The Director Of Public Health Darlington 2014/2015

DARLINGTON BOROUGH COUNCIL

Public Health: A Shared Agenda in Darlington

Welcome to my second Director of Public Health (DPH) annual report following the transfer of public health duties and responsibilities from the NHS to local government, as part of the Health and Social Care Act (2012).

The first report '**Building Blocks for Good Health in Darlington : Annual Report of the Director of Public Health 2013/2014'** described some of the key health issues people face in Darlington and proposed key actions to improve the health of our population and to reduce health inequalities.

My first report outlined three recommendations to make progress on the above, including : **providing the best start in life for children, supporting families, addressing the causes of early deaths, promoting mental health and supporting adults in an independent and active old age.**

Communities have assets such as **skills, knowledge** and **social networks** that form the building blocks of good health and should be developed.

My recommendations included **redesign of public health programmes so that they improve integration** and finally, to understand community 'assets' with a focus on reducing social isolation.

In this annual report I provide an update on 2013/2014 and indicate ongoing recommendations in 2015/2016.

I have taken the theme of **'Public Health : A Shared Agenda'** to describe the partnership working that is necessary to tackle the causes of health inequalities. Local action by all sectors, not just NHS or the Council can help prevent men and women experiencing disadvantage over the course of their lives.

Communities have assets such as skills, knowledge and social networks that form the building blocks of good health and should be developed.

Where partnership working is not possible, different organisations can still try and align their strategies, communicate their priorities and share information so that there is a comprehensive approach across Darlington.

We use Public Health Outcomes Framework (a collection of indicators and outcomes for public health) as a benchmark for the Borough to compare local experience with other areas of England. We also establish local priorities based on our local needs. My report describes local progress on improving health and wellbeing and identifies the actions needed to influence the wider determinants of health.

The report describes the link between health inequalities and social inequalities and how action is needed across all the social determinants of health (e.g. housing, education, employment, poverty) over a person's lifetime. The social determinants are the conditions in which people in Darlington are 'born, grow, live, work and age'.

A great proportion of our work is still reactive, i.e. prevention at a secondary or tertiary level e.g. substance misuse treatment and recovery services or sexual health treatment services. Access to quality clinical care is a key contributor to positive health outcomes but our focus needs to **shift**, not only to promoting health behaviours but to move **upstream** and address the social causes of poor health.

Public Health in local government is mandated to shape local services, tackle health differences in communities and influence the wider or social determinants of health.

This is a **'shared agenda'**, where the Council public health team is working alongside Council departments, NHS and other public sector partners, community and voluntary partners and the private sector.

Miriam Davidson,
Director of Public Health, Darlington

Acknowledgements

I would like to thank the people who provided information and helped me produce this report;

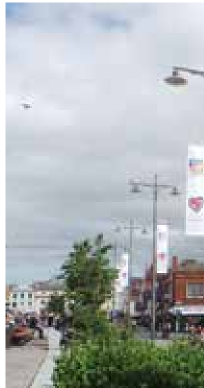
Thank you:

- Members of the Public Health Team, DAAT and Community Safety Team.
- Members of the Organisational Planning Unit (OPU).
- Infection Prevention and Control Team.
- Balance and Fresh.
- Members of the Regulatory Services, Environmental Health, Licensing and Leisure Services Teams.
- Tees Valley Public Health Shared Service.
- Public Health England, Health Protection Team, Consultant in Dental Public Health.
- Pauline Brown for administrative support.

Recommendations 2015/16

One Darlington: Best Start in Life

- Focus stop smoking support via the Baby Clear programme to reduce rates of smoking in pregnancy.
- Share Key Lines of Enquiry (KLOEs) about child obesity with partners across sectors.
- Develop an Oral Health Strategy as part of a Tees Valley wide approach.
- In partnership design and 'test' a 0-19 years pathway for health and wellbeing for children and young people.
- Share Key Lines of Enquiry about self-harm with partners across sectors
Explore a mental health resilience model with the Children and Young People Collective.



One Darlington: Health Behaviours and Prevention

The recommendations from last year's report are still current i.e.

- Address causes of early deaths by promoting physical activity, tackling harm caused by alcohol, tobacco control and promoting a balanced diet.
- The principle of mental health and emotional wellbeing should be included in all programmes for improvement.

Additional actions include:

- Consolidate the work on suicide audits, surveillance and prevention into a Darlington Suicide Prevention Plan.
- Use the Strategic Needs Assessment to understand local health variations within the Borough and propose actions to address the differences.

One Darlington: A Shared Agenda with NHS Partners

Public Health, Darlington CCG, NHS England and member practices should work together to ensure that all patients registered with their GP have access to initiatives to improve their health needs.

Informed by practice data, promote targeted prevention services, using practice registers as a monitoring tool for population health and health inequalities.

Support NHS services to act as a focus within local communities. Primary care should be supported in this role as a contribution to integrating services and promoting healthier communities.

One Darlington: The Social Causes of Poor Health

The Health and Wellbeing Board should recognise the impact of the way we live our lives as individuals, as well as population health.

All strategies and programmes for health and wellbeing should consider their potential impact on health inequalities.

Support all partners to recognise that tackling health inequalities requires action on the wider, social determinants of health.

An asset based approach is needed, where the assets of individuals, communities and organisations are built on to improve health.

One Darlington: Health Protection and Inequalities

- Health protection risks affect some individuals and communities disproportionally resulting in poorer health. Use the measures in place, such as the local partnerships to address the inequalities in health protection eg.
    - Under immunising of children
    - Groups disproportionately affected by some sexually transmitted infections
    - Travelling communities who have lower rates of immunisation
    - People who are homeless, substance dependent or living in overcrowded housing are at increased risk of some infections.
- Work closely with NHS England and PHE to improve overall uptake in screening and immunisation programmes with a focus on the most vulnerable groups. i.e. universal and targeted.

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Chapter 1

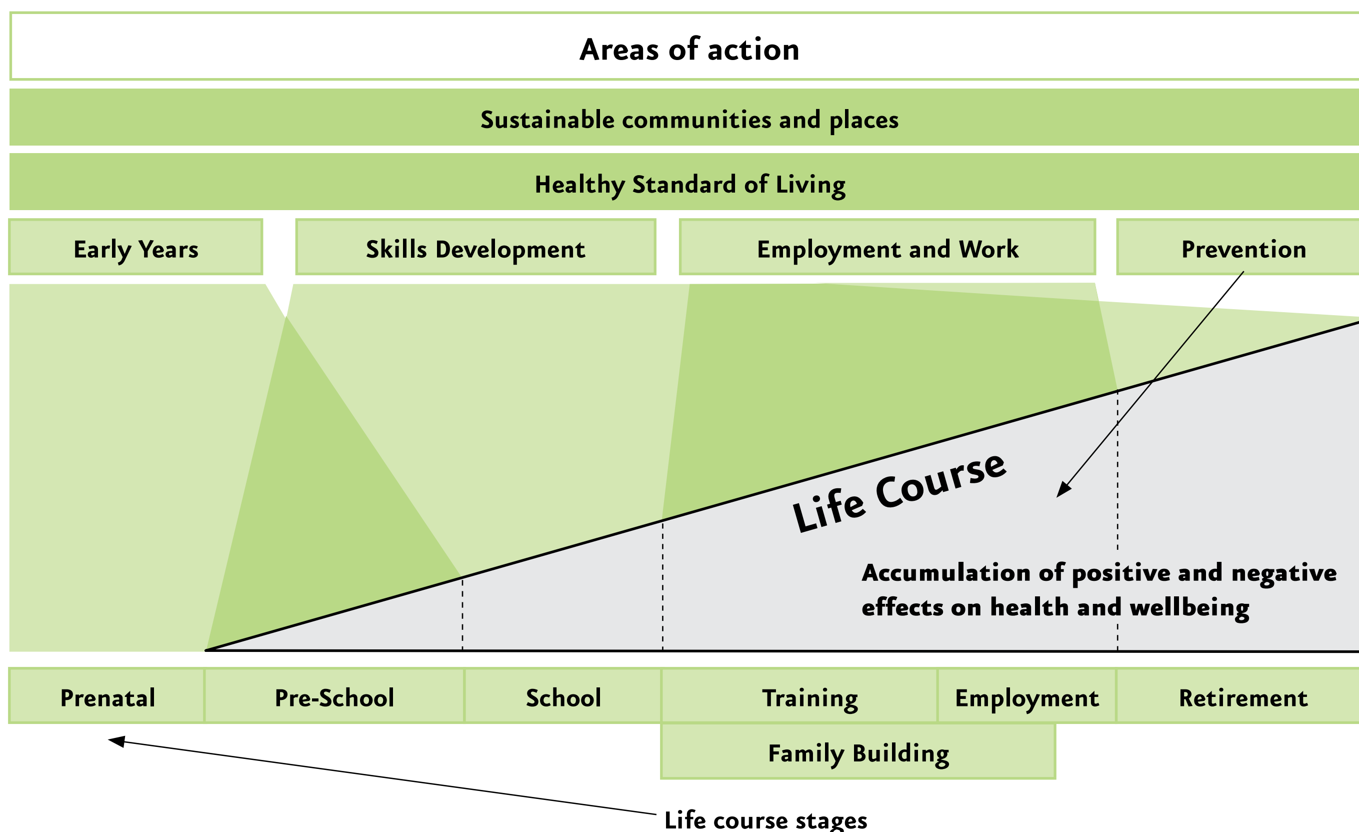
The Social Causes of Poor Health and Wellbeing

The Marmot Review (**'Fair Society, Healthy Lives' 2010**) set out evidence of the key elements that perpetuate health inequalities and proposals for action to address them. Marmot described the policy objectives for tackling health inequalities as:

- Give every child the best start in life
- Enable all children, young people and adults to make the most of their capabilities and have control over their lives
- Create fair employment and good work for all ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention[1]

Marmot also used a 'life course' approach to describe the cumulative effect disadvantage has throughout a lifetime. At all life stages, people are exposed to a range of positive and negative factors that have an impact on their health and wellbeing.

The Public Health team map the One Darlington: Perfectly Placed outcomes to the Marmot policy objectives to look for alignment, therefore tackling health inequalities.

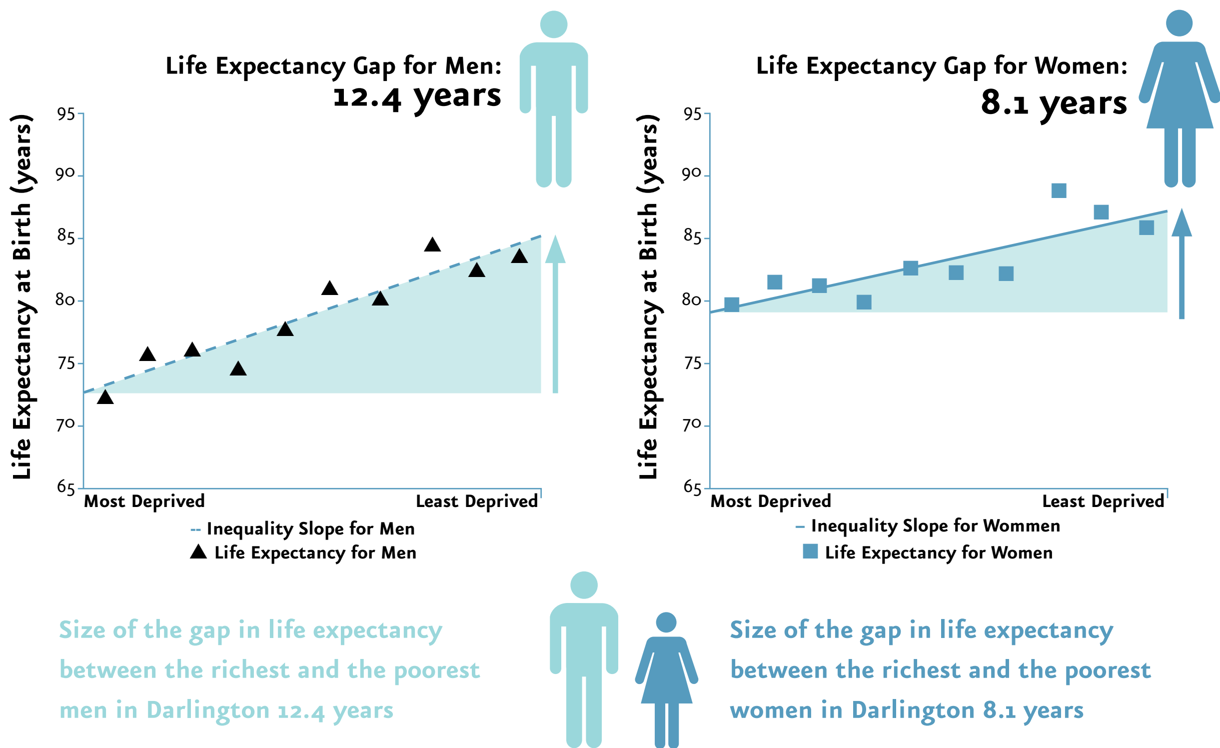


1 (Note 'Fair Society, Healthy Lives, The Marmot Review: www.instituteofhealthequity.org)

Demography

Life expectancy

The charts below show life expectancy for men and women in this local authority for 2010/2012. Each chart is divided into deciles (tenths) by deprivation, from the most deprived decile on the left of the chart to the least deprived decile on the right. The steepness of the slope represents the inequality in life expectancy that is related to the deprivation in this local area. If there were no inequality in life expectancy as a result of deprivation, the line would be horizontal



Premature deaths (before age 75 years)

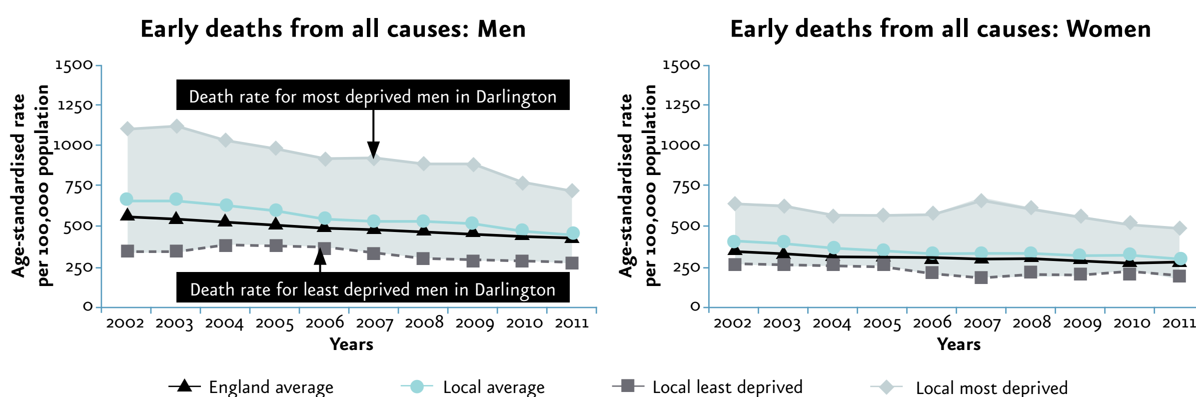
Public Health England provide a mapping tool ‘Longer Lives’ to show the differences between Local Authorities in the rates of premature deaths.

The most common causes of early deaths in Darlington are:

- cancer
- heart disease and stroke
- lung disease and liver disease

Premature deaths (before age 75 years)

These charts provide a comparison of the changes in early death rates (in people under 75) between this area and all of England. Early deaths from all causes also show the differences between the most and least deprived qunitile in this area. (Data points are the midpoints of 3 year averages of annual rates, for example 2005 represents the period 2004 to 2006).



Men

1. Trend over time in premature death rate
The Darlington rate is reducing but is still higher than England.

2. Inequalities in premature death rate
The gap is narrowing between Darlington and England.
The gap is narrowing between poorest and richest groups in Darlington.
Death rates are higher for men than women.

Women

1. Trend over time in premature death rate
The Darlington rate is reducing but is still higher than England.

2. Inequalities in premature death rate
The gap is narrowing between Darlington and England.
The gap is narrowing between poorest and richest groups in Darlington.
Death rates are lower for women than men.

The main contributors to early deaths are smoking, diet, physical inactivity, alcohol harm, high blood pressure and the cumulative impact of poverty.

Community Health Profile 2014

A population health profile gives us a picture of peoples health in Darlington as measured against 32 indicators. The profile includes:

- child health
- adult health
- life expectancy and causes of death
- a few indicators that reflect the social determinants of health

Public Health England

Darlington

Unitary Authority

This profile was produced on 8 July 2014

Health Profile 2014

Health in summary
The health of people in Darlington is varied compared with the England average. Deprivation is higher than average and about 21.7% (4,300) children live in poverty. Life expectancy for both men and women is similar to the England average.

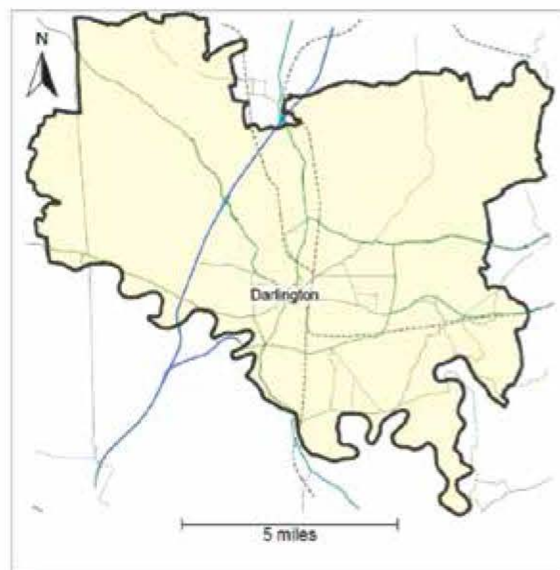
Living longer
Life expectancy is 12.4 years lower for men and 8.1 years lower for women in the most deprived areas of Darlington than in the least deprived areas.

Child health
In Year 6, 19.1% (200) of children are classified as obese. The rate of alcohol-specific hospital stays among those under 18 was 87.6*, worse than the average for England. This represents 20 stays per year. Levels of teenage pregnancy, breastfeeding and smoking at time of delivery are worse than the England average. Levels of GCSE attainment are better than the England average.

Adult health
In 2012, 29.3% of adults are classified as obese, worse than the average for England. The rate of alcohol related harm hospital stays was 778*, worse than the average for England. This represents 802 stays per year. The rate of self-harm hospital stays was 314.1*, worse than the average for England. This represents 324 stays per year. The rate of smoking related deaths was 333*, worse than the average for England. This represents 198 deaths per year. Rates of sexually transmitted infections, people killed and seriously injured on roads and TB are better than average. Rates of long term unemployment and drug misuse are worse than average. Rates of statutory homelessness and violent crime are better than average.

Local priorities
Priorities in Darlington include reducing health inequalities in cardiovascular disease, tackling alcohol related harm and improving mental health and wellbeing. For more information please visit www.darlington.gov.uk

* rate per 100,000 population



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OpenStreetMap contributors ODbL

Population: 105,000
Mid-2012 population estimate. Source: Office for National Statistics.

This profile gives a picture of people's health in Darlington. It is designed to help local government and health services understand their community's needs, so that they can work to improve people's health and reduce health inequalities.

Visit www.healthprofiles.info or scan this Quick Response code for more profiles, more information and interactive maps and tools.

Follow @healthprofiles on Twitter

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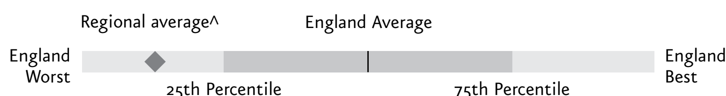
- 🔴 **Significantly worse than England average**
- 🟡 **Not significantly different from England average**
- 🟢 **Significantly better than England average**



Domain	Indicator	Local No Per Year	Local value	Eng value	Eng worst	England best
Our communities	1 Deprivation	28,788	27.4	20.4	83.8	0.0
	2 Children in poverty (under 16s)	4,300	21.7	20.6	43.6	6.4
	3 Statutory homelessness	0	0.0	2.4	33.2	0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths)	750	64.8	60.8	38.1	81.9
	5 Violent crime (violence offences)	886	8.4	10.6	27.1	3.3
	6 Long term unemployment	1,036	15.7	9.9	32.6	1.3
Children's and young people's health	7 Smoking status at time of delivery	277	21.1	12.7	30.8	2.3
	8 Breastfeeding initiation	790	60.2	73.9	40.8	94.7
	9 Obese children (Year 6)	200	19.1	18.9	27.3	10.1
	10 Alcohol-specific hospital stays (under 18)	20	87.6	44.9	126.7	11.9
	11 Under 18 conceptions	73	38.2	27.7	52.0	8.8
Adults' health and lifestyle	12 Smoking prevalence	n/a	21.3	19.5	30.1	8.4
	13 Percentage of physically active adults	n/a	53.3	56.0	43.8	68.5
	14 Obese adults	n/a	29.3	23.0	35.2	11.2
	15 Excess weight in adults New indicator in 2014	165	62.9	63.8	75.9	45.9
Disease and poor health	16 Incidence of malignant melanoma	15	13.9	14.8	31.8	3.6
	17 Hospital stays for self-harm	324	314.1	188.0	596.0	50.4
	18 Hospital stays for alcohol related harm	802	778	637	1,121	365
	19 Drug misuse	779	11.4	8.6	26.3	0.8
	20 Recorded diabetes	5,712	6.7	6.0	8.7	3.5
	21 Incidence of TB	2	3.8	15.1	112.3	0.0
	22 Acute sexually transmitted infections	738	699	804	3,210	162
	23 Hip fractures in people aged 65 and over	118	533	568	828	403
Life expectancy and causes of death	24 Excess winter deaths (three year)	43	13.1	16.5	32.1	-3.0
	25 Life expectancy at birth (Male)	n/a	78.7	79.2	74.0	82.9
	26 Life expectancy at birth (Female)	n/a	82.7	83.0	79.5	86.6
	27 Infant mortality	5	4.0	4.1	7.5	0.7
	28 Smoking related deaths	198	333	292	480	172
	29 Suicide rate New indicator in 2014	9	8.7	8.5		37.4
	30 Under 75 mortality rate: cardiovascular	82	90.5	81.1	144.7	37.4
	31 Under 75 mortality rate: cancer	140	158	146	213	106
	32 Killed and seriously injured on roads	35	32.8	40.5	116.3	11.3

Darlington 2014

Worse than England	🔴	**13**
Not different from England	🟡	**12**
Better than England	🟢	**6**
	No value	**1**
	Total	**32**

The range of indicators in 2014 and 2013 were similar but not identical.

New indicators in 2014 are:
No.15 – Excess weight
No.29 – Suicide

The main headlines from the 2014 Health Profile :

The main headlines...

1. Deprivation

Darlington has a lower proportion of population in the most affluent national quintile and a higher proportion of population in the most deprived national quintile.

2. Inequalities in life expectancy at birth

The size of the gap in life expectancy between the richest and the poorest people in Darlington is:

- 12.4 years for men
- 8.1 years for women

3. Inequalities in premature deaths (under age 75 years)

Trend over time in premature death rate

- The local rate is reducing but is still higher than England both for men and women.

Inequalities in premature death rate

- The gap is narrowing between Darlington and England both for men and women.
- The gap is narrowing between the poorest and richest groups in Darlington but more so for men than for women.
- Death rates are higher for men than women.

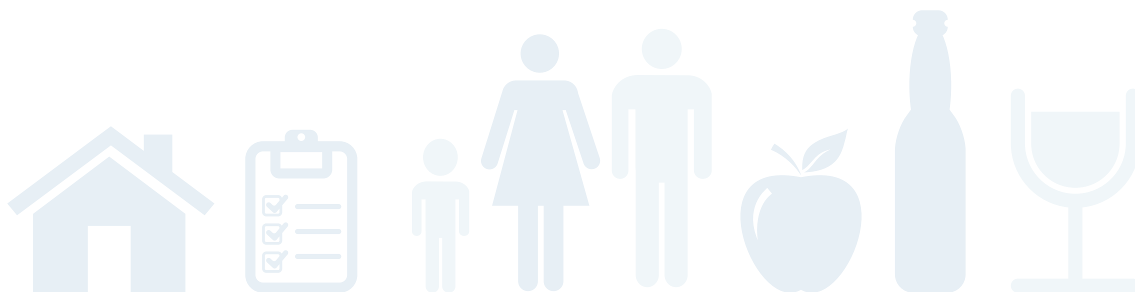
4. Emergency admission to hospital (by ethnicity)

Levels of emergency admissions (total population)

- The rate of emergency admissions in Darlington for the whole population is statistically significantly higher than England.

Levels of emergency admissions (by ethnic group)

- The rate of emergency admissions in Darlington is statistically significantly higher than England for the white and Asian populations but not for other ethnic minority groups.
- The rate of emergency admissions in Darlington is statistically significantly higher in the Asian population than the white population even although both are still higher than England.



5. Overview of routinely available annual indicators

When compared with the other local authorities in Tees Valley in 2014, Darlington has:

- The lowest number of red indicators.
- The highest number of green indicators.
- The best GCSE rates.
- A level of obesity that is higher than might be expected for the population.
- A relatively safe environment reflected by low road traffic injuries and violent crime.

6. Priorities to reduce inequalities in health and wellbeing

To continue to reduce inequalities in health between Darlington and England, attention needs to focus on indicators that reflect risks to health and wellbeing that are consistently significantly worse locally than in England:

1. Employment and regeneration

- Deprivation
- Long-term unemployment

2. Maternal and child health

- Smoking status of mothers during pregnancy
- Breastfeeding initiation at birth
- Under-18 conceptions

3. Adult nutrition and misuse of alcohol

- Poor adult nutrition (and the implications for higher rates of obesity, diabetes and blood pressure)
- Hospitalisation for harm caused by excess alcohol consumption.

Best Start in Life

'Building Blocks for Good Health - Update on Recommendation 1 2013/14'

'Focus on interventions to provide children the best start, support women and families to stop smoking, take a life course approach to obesity, continue interventions to reduce teenage pregnancy and raise awareness of alcohol related harm'

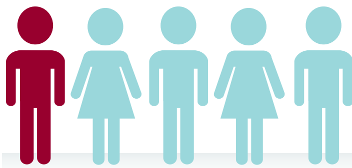
The early years are critical in creating positive foundations for lifelong social, emotional and physical health as well as education and economic achievement.

The economic case for investment in prevention and early intervention is strong, and factors to be addressed include parental mental health, poor diet, alcohol, smoking or drug misuse, domestic abuse and an unstable home environment.

Infant mortality rates in Darlington remain lower than the England average, however, a focus needs to be continued on a healthy pregnancy.

The 'Baby Clear' programme to reduce maternal smoking is a key activity which provides women and families with support from midwifery services. Given the Darlington rates and smoking at time of delivery this is a key priority.

Breastfeeding rates remain low (62.9%) compared to the English average (73.9%), this is a 'shared agenda' with Darlington Clinical Commissioning Group (DCGG).



1 in 5

affected in Year 6 (aged 10 to 11 years) in Darlington.

Child Obesity

Obesity is estimated to affect approximately one in every five children in Year 6 (aged 10 to 11 years) in Darlington.

The National Child Measurement Programme (NCMP) measures the height and weight of children in Reception class (aged 4 to 5 years) and Year 6 (aged 10 to 11 years). Families are contacted and offered support where children have been identified as overweight or obese. The NCMP is a 'mandated' responsibility of the council and is delivered by the local NHS Acute Trust School Nursing Service.

National Child Measurement Programme

Reception: Prevalence of obesity Darlington 2006 -2014		
Year	Percentage(%)	England Average
2006/07	10.71	9.89
2007/08	9.99	9.64
2008/09	8.94	9.60
2009/10	8.79	9.83
2010/11	9.93	9.44
2011/12	9.36	9.49
2012/13	8.51	9.27
2013/14	11.31	9.48

Prevalence of obesity (BMI greater than 95th centile of the UK90 growth reference) among children in Reception (age 4-5 years)

Year 6: Prevalence of obesity Darlington 2007 - 2014		
Year	Percentage (%)	England Average
2006/07	20.95	17.49
2007/08	20.46	18.31
2008/09	19.89	18.33
2009/10	19.43	18.74
2010/11	16.80	19.04
2011/12	18.00	19.20
2012/13	19.12	18.92
2013/14	18.71	19.09

Prevalence of obesity (BMI greater than 95th centile of the UK90 growth reference) among children in Year 6 (age 10-11 years)

Comparison to England Average
Better
Similar
Worse

Oral Health

The level of dental decay in children aged five years is a useful indicator of the success of a range of programmes and services that aim to improve the general health and wellbeing of young children.

In the 2012 National Dental Survey of five year olds, 64% of children in the Darlington sample took part (consented). When comparing a range of measures of disease among five year olds in Darlington with the rest of the local authorities in the North East, only Middlesbrough, Sunderland and Redcar and Cleveland have a worse experience.

Local authority	Average d3mft	% with decay experience	Average d3mft in those with decay experience
Middlesbrough	1.71	41.5	4.13
Sunderland	1.32	36.9	3.56
Redcar and Cleveland	1.30	35.9	3.62
Darlington	1.20	29.4	4.09
Stockton-on-Tees	1.12	31.9	3.52
NORTH EAST	1.02	29.7	3.43
ENGLAND	0.94	27.9	3.38
County Durham	0.93	27.2	3.43
Northumberland	0.92	27.6	3.31
South Tyneside	0.88	27.7	3.18
North Tyneside	0.83	29.3	2.82
Newcastle upon Tyne	0.75	22.6	3.33
Gateshead	0.72	25.8	2.80
Hartlepool	0.56	19.6	2.88

Darlington has levels of teeth decay that are higher than the average for England.

There is variation across the Borough with higher proportions of children with dental disease living in the most disadvantaged areas.

The two most common dental diseases are largely preventable (caries and decay, gum - periodontal disease).

In 2015/2016, Darlington will be part of a Tees Valley collaboration to develop a Tees Valley Oral Health Strategy.

Key Oral Health Messages

- Brush teeth last thing at night
- Brush on at least one other occasion (both with a fluoride toothpaste)
- Cut down on sugary foods and drinks
- Visit dentist

Reducing Teenage Pregnancy

Rates in teenage (15 to 17 years) pregnancy in Darlington have been reducing compared with the baseline (1998). It is still higher than the England average and given the potential for poor outcomes for both mother and baby, it remains a priority for action.

It is a **'shared agenda'** with colleagues in education, youth services, housing, NHS and community and voluntary sectors.

Conception Rates

	Baseline 1998	2013	% change
England	46.6	24.3	47.9
North East	56.5	30.6	45.8
Darlington	64	28.1	56.1
Hartlepool	75.6	33	56.3
Middlesbrough	66.5	40.5	39.1
Redcar	58.3	33.2	43.1
Stockton	48.3	33.5	30.6

Conception rate per 1,000 women in age group

Stakeholder events in 2014 brought partners from a range of sectors and communities together to agree priorities for action to prevent teenage pregnancies, promote aspiration and resilience, ensure provision of contraception services and support for young parents.

Alcohol

While the rate of young people under 18 years who have been admitted to hospital because they have a condition wholly related to alcohol decreased in 2010-2013, admission rates remain higher than the England average. Action to address this will continue, including the **Darlington Healthy Lifestyles Survey** as the basis for positive messages.

'The majority (86%) of Darlington residents felt strongly that alcohol should not be served at school events'

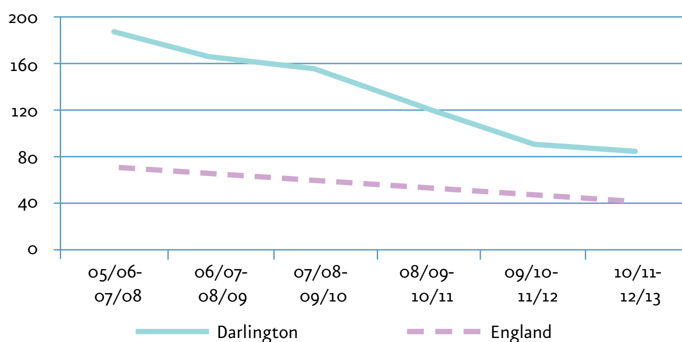
2014 Public Perceptions Survey

(North East Alcohol Behaviour and Perceptions Survey 2014)

Young people and alcohol

In comparison with the 2005/06 - 2007/08 period, the rate of young people under 18 who are admitted to hospital because they have a condition wholly related to alcohol such as alcohol overdose is lower in the 2010/11 - 2012/13 period. The admission rate in the 2010/11 - 2012/13 period is higher than the England average.

Young people aged under 18 admitted to hospital with alcohol specific conditions (rate per 100,000 population aged 0-17 years)



Data source: Public Health England (PHE)

Young people aged under 18 years

Darlington admissions to hospital are reducing at a faster rate than England but still remain twice as high and are statistically significantly higher than England.

An average of **20** young people were admitted to hospital each year for 2010/11 - 2012/13. (27 for 2008-11)

Substance Misuse

Young People's Services

In 2014/15, 100% of young people were seen within a national target of 15 days. Out of a target of 100 for 2014/15, 74 young people were seen by Switch. Of these, 68 left in a planned way, which was 80% of the target.

The most common substances used were cannabis (55%) and alcohol (40%). The average age was 15 ½ and 42% of clients were female. In 2015/16, the DAAT will work with the provider NECA, Trading Standards and Public Health England to understand the impact of the new psychoactive substances.

Mental Health

Resilience is the ability to adapt well in the face of adversity. It is important because it allows us to overcome negative experiences. There is a large body of research supporting the importance of building resilience throughout childhood.

The Darlington Children and Young People's Collective is concerned to build resilience with young people, in partnership with other networks who work for and with children and young people.

'Warm and nurturing relationships between children and the adults in their lives are the most important factor in developing resilience and overcoming potential negative effects of daily stress.'[2]
An examination of reports of self-harm in young people commenced in 2014 and will be a key line of enquiry in 2015.

Recommendations 2015/2016

One Darlington: Best Start in Life

- Focus stop smoking support via the Baby Clear programme to reduce rates of smoking in pregnancy.
- Share Key Lines of Enquiry (KLOEs) about child obesity with partners across sectors.
- Develop an Oral Health Strategy as part of a Tees Valley wide approach.
- In partnership design and 'test' a 0-19 years pathway for health and wellbeing for children and young people.
- Share Key Lines of Enquiry about self-harm with partners across sectors
- Explore a mental health resilience model with the Children and Young People Collective.

2 Note – *American Psychologist Association*

Chapter 4

'One Darlington : Health Behaviours and Prevention'

Life expectancy at birth continues to improve in Darlington and more people are living healthier and longer lives, however, real challenges remain to reduce the gaps in life expectancy within the Borough and between Darlington and the England average.

The national public health outcomes framework includes an objective for reducing the number of people living with preventable ill health and dying prematurely. Within this objective it is expected that the gap between deprived and more affluent communities will be narrowed.

In 2013 Public Health England launched a mapping tool : **'Longer Lives'**[3]. This mapped the variation of premature deaths by local authorities across England and identified the common causes of premature deaths (i.e. deaths in people aged under 75 years). The most common causes of early deaths in Darlington are:

- cancer
- heart disease and stroke
- lung disease
- liver disease

The main contributors to the early deaths are smoking, poor diet, physical inactivity, alcohol, high blood pressure and the impact of poverty. Addressing the above factors is crucial to reducing premature mortality in Darlington. Much is already being done to address those factors, some actions are described below.

Director of Public Health Annual Report 2013/14

'Building Blocks for Good Health : Update on Recommendation 2

- Address causes of early deaths : alcohol, tobacco, lack of physical activity and diet
- Escalate effort in areas with poorer health outcomes
- Include the principle of mental and emotional wellbeing in programmes
- Promote an independent and active old age

3 (NOTE - Public Health England, Longer Lives 2013)

Health Checks

A Darlington Health Check is a face to face risk assessment and risk management programme aimed at men and women aged 40 to 74 years (with no existing cardiovascular disease or diabetes) to assess their risk of developing cardiovascular disease. The assessment involves measuring the main causes of premature death. These are high blood pressure, smoking, high cholesterol, obesity, poor diet, physical inactivity and alcohol harm.

The programme is led by the Council and delivered mainly in the 11 GP practices. Practices are expected to target approximately 20% of the eligible population each year to make sure 100% coverage is achieved over a five year period

Health Checks 2013/14

- Appointments offered (of total eligible population of 32,155) - 24.7% (7,900 individuals)
- Appointments received (of total eligible population of 32,155) - 10.9% (3,485 individuals)
- Percentage of people that received an NHS Health Check of those offered 2013/2014 = 44.1%

The above information shows the number and percentage of the eligible population invited to attend for a health check in 2013/14.

It indicates that across Darlington, practices invited more than the 20% annual target population and that practices carried out health checks in 44% of the eligible population which is 51.1% of the annual target population.

It is not included in this report but there is a wide variation between practices in the number of health checks carried out. A report on the variation has been shared with the Clinical Commissioning Group. There is a risk that wide variation would contribute to a widening of health inequalities.

In 2014/15 the Council has invested in 'Healthy Darlington', a wellness service model which is based in the Dolphin Centre and has outreach activities in targeted communities. 'Healthy Darlington' includes lifestyle information, advice and support. The focus of the programmes is to support people (children and adults) to be more active and address diet. The approach is underpinned by behaviour change theory. The 'Hub' at the Dolphin Centre operates a one-stop shop for accessing a range of programmes. Launched in October 2014, a report on a full year operation will be included in the DPH Annual Report for 2015/16.

Workplace Health

North East
Better Health
at Work Award

Darlington invests and participates in the Better Health at Work Award (BHAWA), a scheme operating across the North East with all Local Authorities.

Positive workplace health helps employees and employers. The BHAWA includes training for workplaces on positive mental health and stress management. In 2014/15, workplaces in Darlington promoted with their employees the following campaigns:

- mental health
- smoking cessation
- physical activity
- men's health
- healthy eating
- back pain management
- drug and alcohol awareness

Smoking and Tobacco Control

Smoking is the single biggest cause of inequalities in life expectancy between the most deprived and least deprived people in Darlington. Smoking rates are much higher in some social groups, including those with the lowest incomes and they suffer the highest burden of smoking related illness and death.

In Darlington 19.1% of adults are estimated to smoke. This estimate rises for people employed in routine and manual occupations i.e. 31.5%. Deaths and illnesses attributable to smoking in Darlington are higher than the England average for heart disease, lung cancer, stroke and chronic obstructive pulmonary disease.

Darlington Borough Council commissions stop smoking services as a part of tobacco control. In 2013/14 1,632 people accessed support of which 55% quit (n=903), this was an increase on 2012/13.

In 2014/15 a revised model of support was introduced, based on individuals accessing local support, in community locations such as GP Surgeries and Pharmacies. There is also a specific service for pregnant women accessing services in the hospital.

A focus in 2015/16 will be to support women and their families to stop smoking as part of preconception and antenatal care.

Smoking Related Information: PHE Tobacco Profile

Compared with benchmark:

- Better
- Similar
- Worse

Indicator	Period	Darlington		Region	England	England		
		Count	Value	Value	Value	Worst	Range	Best
Smoking Prevalence (IHS)	2013	-	19.1%	22.3%	18.4%	29.4%		10.5%
Smoking prevalence - routine & manual	2013	-	31.5%	29.7%	28.6%	47.5%		16.5%
Successful quitters at 4 weeks	2013/14	903	4,977	4,216	3,524	1,251		8,946
Successful quitters (CO validated) at 4 weeks	2013/14	755	4,161	3,377	2,472	515		6,950
Completeness of NS-SEC recording by Stop Smoking Services	2013/14	1,630	100%	91.8%	86.2%	25.2%		100%
Smoking status at time of delivery	2013/14	250	20.4%	18.8%	12.0%	27.5%		1.9%
Low birth weight of term babies	2012	24	1.9%	2.7%	2.8%	5.0%		1.5%
Smoking prevalence age 15 years - regular smokers	2013	-	-	-	8%	-	-	-
Smoking prevalence age 15 years - occasional smokers	2013	-	-	-	10%	-	-	-
Lung cancer registrations	2010-12	236	80.1	107.8	76.0	146.8		40.1
Oral cancer registrations	2010-12	34	11.1	14.7	13.2	21.5		8.1
Deaths from lung cancer	2011-13	199	66.4	86.5	60.2	111.6		32.3
Deaths from chronic obstructive pulmonary disease	2011-13	170	56.2	71.7	51.5	101.0		26.8
Smoking attributable mortality	2011-13	582	322.4	371.9	288.7	471.6		186.6
Smoking attributable deaths from heart disease	2011-13	62	34.0	37.4	32.7	65.5		20.6
Smoking attributable deaths from stroke	2011-13	24	12.9	13.6	11.0	21.5		7.2
Smoking attributable hospital admissions	2012/13	1,067	1,760	2,459	1,688	2,884		906
Cost per capita of smoking attributable hospital admissions	2011/12	2,312,356	37.8	48.8	38.0	59.3		23.0
Accidental fires ignited by smoking related materials	2012/13	-	-	-	3,143	-	-	-
Fatalities from accidental fires ignited by smoking materials	2012/13	-	-	-	73		-	-
Indicative tobacco sales figures (£ millions)	2013	-	£31.1	-	£15,446.1	-	-	-
Smoking prevalence modelled estimates - regular smokers aged 11-15 years	2009-12	245	3.8%	-	3.1%	4.7%		1.1%
Smoking prevalence modelled estimates - regular smokers aged 15 years	2009-12	140	10.6%	-	8.7%	12.7%		3.2%
Smoking prevalence modelled estimates - regular smokers aged 16-17 years	2009-12	495	17.6%	-	17.7%	20.7%		5.7%
Smoking prevalence modelled estimates - occasional smokers aged 11-15 years	2009-12	98	1.5%	-	1.4%	2.4%		0.5%
Smoking prevalence modelled estimates - occasional smokers aged 15 years	2009-12	55	4.2%	-	3.9%	5.3%		1.4%
Smoking prevalence modelled estimates - occasional smokers aged 16-17 years	2009-12	174	6.2%	-	5.8%	7.8%		2.2%

Alcohol

Alcohol continues to be our drug of choice in the North East.

There is a tension between the role that alcohol plays for many as an enjoyable and sociable part of their lives and the contribution it makes to early deaths and preventable ill health. 44% of men and 41% of women who die from alcohol related causes in England are below the age of 55 years.

Alcohol is increasingly available, it is increasingly affordable and drinking at home is more common with less awareness of size of measures.

Alcohol related harm affects not only the individual but families, communities and wider life in Darlington through poor health, crime and disorder, domestic abuse, accidents, relationship breakdown and impact on parenting/neglect of children.

In Darlington Borough 319 premises are licensed to sell alcohol. 8 of those have a 24 hour licence.

In 2014, Balance relaunched the hard-hitting campaign, 'Tumour'. The campaign highlighted the links between alcohol and seven different types of cancer, with a new strand of activity focussing specifically on breast cancer. Evaluation showed that the campaign performed very strongly.

The **Dry January** campaign was supported by Darlington partners again in 2014/15. The campaign invites people to abstain from alcohol for 31 days, triggering conversations with family and friends about our relationship with alcohol.

In addition to winning the Alcohol Concern award for innovation for the second year running for the Dry Hatter's Tea Party event, Darlington also achieved the highest rate of people in the North East who signed up to Dry January 2015.

Alcohol Declaration

In January 2015, Leaders and Elected Mayors across the North East supported the pledge to take action and protect their local community from the harm caused by alcohol. The Declaration has been supported by key partnerships and networks in Darlington including the Community Safety Partnership, Strategic Partnership and Health and Wellbeing Board.

A programme of activity will be developed in 2015/2016 to deliver actions to implement the Declaration.

Drug Use

The estimated drug use in Darlington is higher than the England average. Nationally and locally drug use is responsible for significant illness, suffering and in some cases, early deaths.

Darlington : Drugs Use

- People receiving first treatment intervention, 95% seen in less than three weeks
- People receiving a subsequent intervention, 100% seen in less than three weeks
- Targets to bring individuals into effective treatment were exceeded
- Targets for successful completions improved but were not met and improvement plans put into place
- Main client group is 30-39 years, reflected in national trend

In 2014/15, the DAAT commissioned a new substance misuse service, a recovery focused, all substance, all age service. The service provider will work alongside community pharmacies where appropriate and with NHS services on shared care pathways. Tackling drug misuse and supporting people is a shared agenda with the organisations above, and with local authority services for children and adults, alongside the voluntary sector.

The DAAT continues to work with key stakeholders, including service users, family and carers and partner organisations, across the private, public and voluntary sectors, to address **prevention, treatment** and **control** as three strands to tackling substance misuse.

In 2015/16, a five year Darlington Substance Use Strategy will be developed in partnership with services and communities who share this agenda.

Cancer

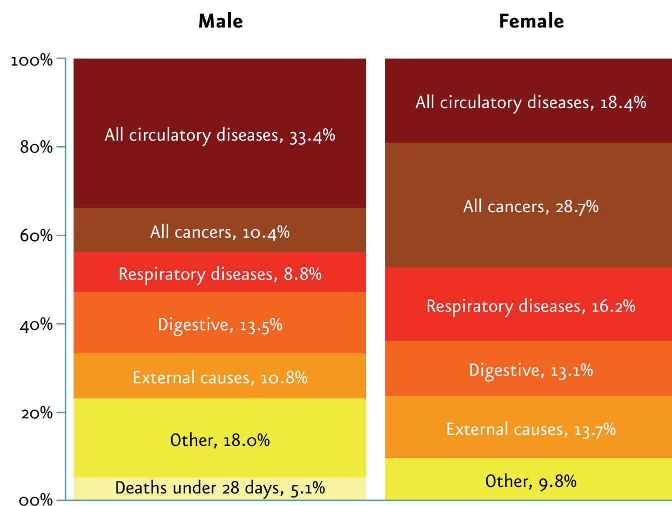
Cancer contributes to the life expectancy gap in Darlington.

Research by Cancer Research UK illustrates that a number of cancer cases in the UK could be prevented by known lifestyle and environmental factors:

- not smoking
- keeping a healthy weight
- cutting back on alcohol
- eating healthy, balanced diet, rich in fruit and veg
- avoiding sunbeds, excessive sunlight exposure

Cancer contribution to health inequalities gap

Life expectancy gap between the Most Deprived Quintile (MDQ) of **Darlington** UA and the local authority average by cause of death



Source: Public Health England Profiles

The diagram above shows an example of the health inequalities that exist in Darlington. It demonstrates the differences in health experiences between men and women in relation to the diseases that contribute to premature death. The diagram shows how cancers have a disproportionately greater contribution to early deaths in women than in men, while cardiovascular disease has disproportionately greater contribution to early deaths in men than in women. This informs us that when planning or delivering any interventions, programmes or services related to the prevention, diagnosis and treatment of disease in the population these differences between men and women, should be accounted for.

Addressing the key challenges in cancer is a **shared agenda** with the Darlington CCG, NHS Trusts, NHS England, GP's in Primary Care, communities and the voluntary sector.

Key challenges include:

- Creating the environment and opportunities for people to live healthier lives
- Improving awareness of cancer
- Promoting awareness of and making it easier for communities to access cancer screening
- Improving access for early detection of cancer in GP practices - about 60% of emergency presentations resulting in a new diagnosis of cancer come through A&E in England
- Supporting people living with cancer to improve quality of life
- Specific measures to halt the rise in cancer in women

Mental Health

'Good mental health is vital for people to live happy, productive and fulfilled lives'[4]

The responsibility for commissioning primary and secondary care mental health services and the treatment of self harm rests with the Clinical Commissioning Group.

The role of public health within the Council is to focus on the whole population (e.g. advocating a community resilience approach).

'No Health Without Mental Health' (DoH 2011) notes that at least **one in four** people will experience a mental health problem at some point in their lives and **one in six** adults has a mental health problem at any given time. **One in ten children** (aged 5-15 years) has a mental health problem.

Mental health disorders do not just affect individuals but also their families, friends and colleagues, it is the largest single cause of disability in the UK.

Sickness absence due to mental health problems costs UK economy £8.4 billion a year.[5]
Levels of mental ill health are projected to increase, it has been estimated that the cost of health services to treat mental illness could double over the next 20 years.

People at higher risk of suffering from poor mental health include:

- more deprived populations/communities
- people with poor educational attainment
- people who are unemployed
- older people who may be isolated or bereaved
- people with long term conditions, i.e. coronary heart disease
- people with learning disabilities

4 Note – Public Health England 2014
5 Note - PHE 'Community Mental Health Profile 2014'

In 2014/15 improving mental health via the workplace was a focus.

Darlington Partnership made mental health a priority in 2014 with a focus improving the mental health and wellbeing of the population throughout the workplace. Working with 'Darlington Cares' and supported by mental health expertise from MIND and TEWV, a project has been designed to enable larger businesses to support and mentor smaller organisations in the borough specifically related to positive HR practice in relation to mental health and the development of employee assistance programmes. Working with established local employers has led to a sustainable way to ensure mental health in the workplace remains a priority within Darlington.

Mindfulness based stress reduction was accessed via four courses in Darlington during 2013/14. We have continued to develop a Mindfulness offer in Darlington.

Darlington Open Arts studio offered art 'on prescription' in 2014/15 with expanding outreach service and the development of independent groups for those who have accessed the service we are seeking to make access to the arts a sustainable part of maintaining good health in Darlington as part of Darlington Healthy Living Hub.

In addition to the public mental health programmes which contribute to mental resilience in the community, the Council now also has responsibility for suicide prevention.

The Director of Public Health is responsible for monitoring suicide surveillance data from a population perspective. The number of deaths from suicide in Darlington, County Durham and Teesside is relatively low when compared to other causes of death. However, every collective effort should be taken to minimise the risk of suicide in our community.

Focus of work in 2015/16 should be to consolidate a suicide early alert system, review its process (including 'significant event audits') and bring the above actions together in a Darlington Suicide Prevention Plan.

Sexual Health

'Sexual health is not merely the absence of disease, it requires a positive and respectful approach to relationships...'[6]

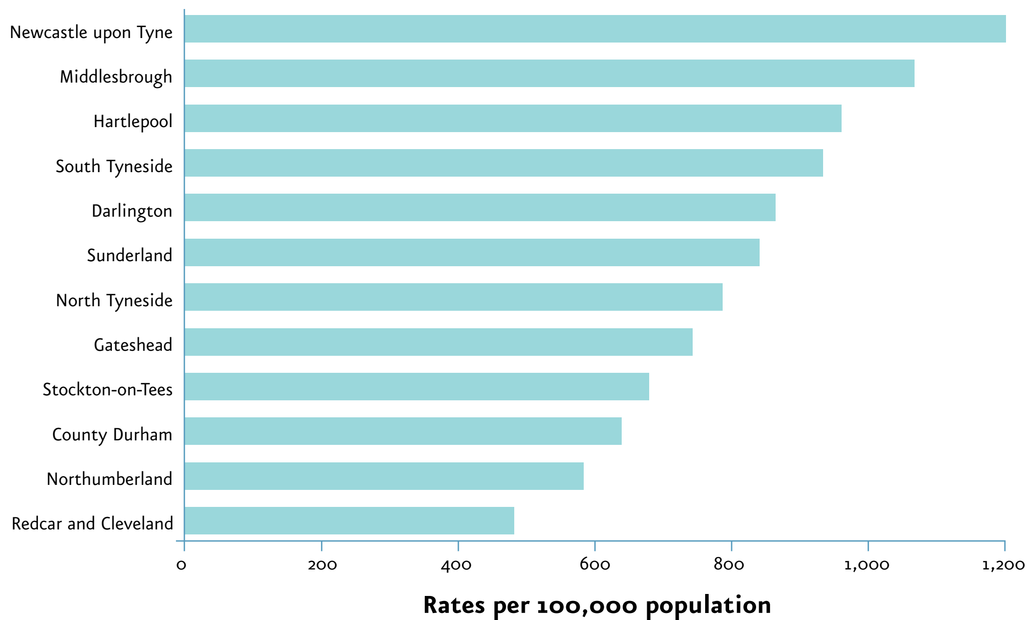
The public health responsibilities include sexual health services for contraception, Sexually Transmitted Infections (STIs) testing and treatment, HIV prevention and testing and sexual health promotion with communities e.g. schools, colleges, pharmacies etc.

STIs are preventable, can cause long term health damage and disproportionately affect more vulnerable groups in the population. While the rate of 'Acute sexually transmitted infections' in Darlington is better (lower) than the England average this remains an area of high priority given the risks of poor sexual health, the social costs to individuals and communities and the relationship between sexual ill health and inequalities.

6 Note : World Health Organisation : 1975

Sexual ill health disproportionately affects people in poverty and social exclusion. The groups most affected are men who have sex with men, young people, those who are homeless and young people who are in, or leaving, care. The public health approach to the above vulnerable groups is to work with partners on the 'shared agenda' of promoting sexual health and accessible services e.g. Gay Advice Darlington Durham (GADD), First Stop and Looked After Children (LAC) services.

Rates of new STIs in each local authority in North East: 2013



Source: Data from Genitourinary Medicine clinics and community settings (for Chlamydia only)
Rates based on the 2012 ONS population estimates

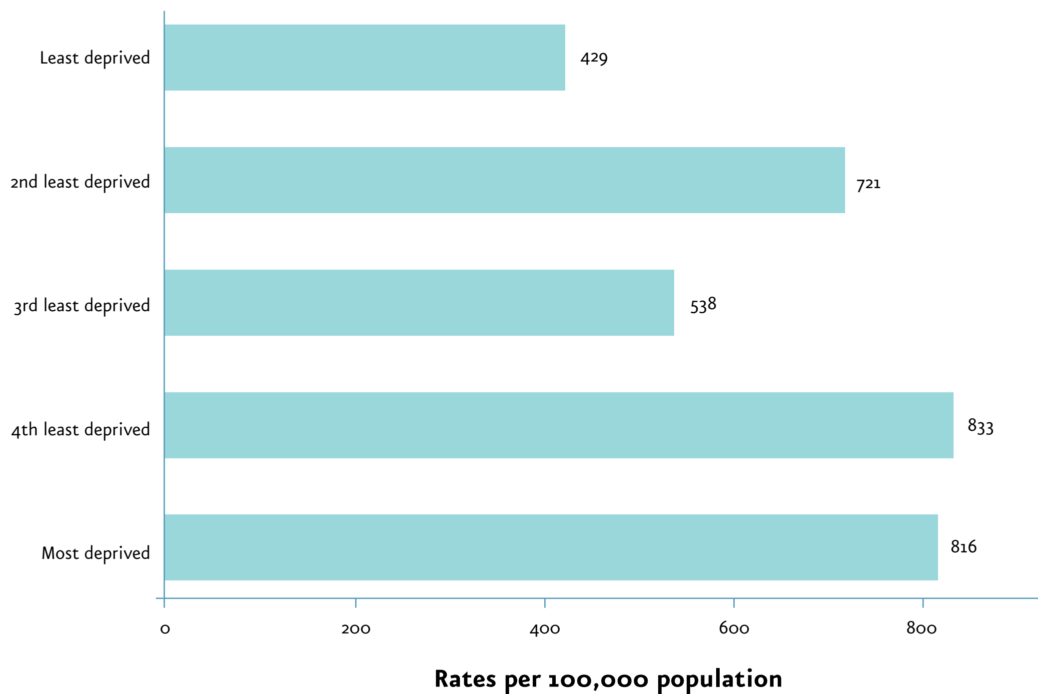
There is considerable geographic variation in the distribution of STIs across the North East region.

Effective treatment depends on safe, effective and accessible services being available to diagnose and treat those residents who have a STI. The table below shows which clinics were used by Darlington residents in 2013. The local clinic in Darlington Memorial Hospital was the most widely used by local residents with over 90% of locals choosing to attend this clinic. Only a small proportion of residents chose to attend other clinics in the surrounding area.

Percent of all attendances by Darlington residents at GUM clinics: 2013

Clinic name	% of all attendances Darlington
Memorial Hospital	91.6
Bishop Auckland General Hospital	3.5
University Hospital of North Durham	1.1
Newcastle General Hospital	1.0
The James Cook University Hospital	0.4

Rates of new STIs by deprivation category in Darlington (GUM diagnoses)



Source: Data from Genitourinary Medicine Clinics
Rates based on the 2011 ONS population estimates
Excludes chlamydia diagnoses made outside GUM

Growing Older: Ageing Well

The Darlington Good Friends scheme is a volunteering based, befriending programme supporting people in a range of practical ways to help them feel connected to a community, and maintain a level of independence in their home. Nationally recognised as an excellent partnership scheme, the model of Good Friends will potentially be extended in other sectors.

Many factors impact on ageing well including illness, mobility, diet, housing and the environment. Dignity in old age is important and ensuring this requires quality support and access to services. Support for carers, continuation of care and being treated as an individual are key priorities to improve the health and wellbeing of older people.

The Darlington ratio of 'excess winter deaths' is not significantly different to the England average and is similar to the regional average, however, the Age UK Fuel Poverty HE-AT project contributes by improving energy efficiency and signposting to other services.

Keep Warm: Keep Well Messages

- Protect against flu
- Heat well
- Eat well

The Darlington collaborative approach to the Better Care Fund (BCF) is to develop integrated health and social care and support for local people. The programme includes establishment of multi-disciplinary teams (MDTs) around primary care, support for frail elderly people with long term conditions and care home support.

The Darlington Ageing Well Network (DAWN) is a network of organisations, individuals and community groups who have a common aim of promoting a healthy older life in Darlington, led by the Cabinet member with the portfolio for Adults and Housing.

Recommendations 2015/16

One Darlington: Health Behaviours and Prevention

The recommendations from last year's report are still current i.e.

- Address causes of early deaths by promoting physical activity, tackling harm caused by alcohol, tobacco control and promoting a balanced diet.
- The principle of mental health and emotional wellbeing should be included in all programmes for improvement.

Additional actions include:

- Consolidate the work on suicide audits, surveillance and prevention into a Darlington Suicide Prevention Plan.
- Use the Strategic Needs Assessment to understand local health variations within the Borough and propose actions to address the differences.

One Darlington: A Shared Agenda with NHS Partners

Darlington Clinical Commissioning Group (CCG), NHS England, NHS Foundation Trusts and Primary Care (GP Practices) are key NHS partners. In their first year of operation (2013/14) the CCG's vision was established as, **'Working together to improve the health and wellbeing of the people of Darlington'.**

Representatives of all of the above partners are members of the Darlington Health and Wellbeing Board (HWB) which is responsible for promoting integration and partnership working between the NHS, social care, public health and other agencies. The HWB oversees the Strategic Needs Assessment (SNA) and delivery of the Sustainable Community Strategy which is also the Darlington Health and Wellbeing Strategy.

Core Offer

Under the Health and Social Care Act (2012) the Local Authority provides a 'core offer' to NHS commissioners. Since 2014, examples include:

- Jointly develop and maintain health improvement action plans underpinning key NHS and Council strategies e.g. mental health, substance misuse
- Jointly ensure protection arrangements are in place e.g. emergency planning, infection control
- Review evidence or conduct Health Needs Assessment (HNA) for particular conditions or disease groups e.g. fragility fractures, obesity, homelessness
- Modelling or advice on population segmentation e.g. background for Better Care Fund proposals, Public Health Profiles
- Commissioning support e.g. service pathway development and service design, interpretation of data, integrated commissioning
- Support in Individual Funding Requests (IFR) process
- Support the CCG to participate in refreshing the Strategic Needs Assessment of the population, with additional targeted needs assessment e.g. Pharmaceutical Needs Assessment in 2014/15, annual Community Health Profiles

Infection Prevention and Control

Infection prevention and control continues to be a national and local priority and is an essential element of public health commissioning and assurance. The Infection Prevention Control Team (IPCT) provides a service across County Durham and Darlington on behalf of the three Clinical Commissioning Groups, Durham County Council and Darlington Borough Council. The team is hosted by Durham Dales, Easington and Sedgefield Clinical Commissioning Group.

Local Authorities, through their Director of Public Health, require access to specialist infection prevention resource and advice. The IPCT delivers this through:

- Joint visits to services with directly commissioned beds.
- Sharing local intelligence with Local Authorities, safeguarding teams and the Care Quality Commission on the safety of residents in care homes.
- Partnership working with related groups across the health economy, monitoring policy and practice in acute, community teams, care homes, hospices, community hospitals and mental health hospitals, independent sector hospitals.
- Sharing information with NHS England Area Teams about the quality of service in primary care.

NHS Five Year Forward View (2014)

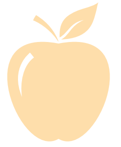
In December 2014, NHS England published **'The Forward View Into Action: Planning for 2015/16'.** The document describes the approach for delivering the above strategy explicitly stating, 'It is increasingly understood that tackling the causes of ill-health, empowering patients and engaging communities are all essential components of creating a sustainable NHS'[7]

Key messages from NHS England which reinforce a **'shared agenda'** for public health outcomes include:

- Incentivising and supporting healthier behaviour
- Local democratic leadership on public health
- Targeted prevention
- NHS support to help people get and stay in employment
- Workplace health
- Place-based approaches under the leadership of local authorities, working with local partners such as the clinical commissioning groups and local communities
- Developing local solutions that draw on all the assets and resources of an area, integrating public services and also building resilience in communities so that they take control and rely less on external support.

7 The Forward View into Action: Planning for 2015/16, 2014 DoH

Darlington Clinical Commissioning Group Operational Plan 2014/15 - 2015/16		
Objective	Goal	Initiatives
Working together to improve the health and wellbeing of Darlington	Improve the health status of the people of Darlington	• Support a 'Healthy Darlington' by eating healthily and keeping active. • Tackle health inequalities, better support to socially disadvantaged communities and vulnerable groups • Improve both the mental and physical health of carers • Develop the 'Care Homes' project • Progress Community based Early Support Discharge for stroke services • Enhance palliative care to ensure that people have choice, dignity and respect
	Commission the right services in the right place Invest in primary care and services	• Deliver the programme of work within the Better Care Fund (BCF) • Continue to evolve multi-disciplinary teams to improve care, outcomes and support to the frail elderly and people with long term conditions • Continue to build capacity within the community • Establish closer working between primary and secondary care clinicians, including new ways of working, to deliver better care for people • Secure the co-location the urgent care centre with emergency services as the first step towards an improved model for urgent care and new models of care • Implement the care and treatment review programmes for people with learning impairments • Work with partners, patients and the public to deliver the agreed clinical standards in 'Securing Quality in Health Services' • Develop and implement the dementia and mental health strategies. • Support individuals to resolve chaos in service use • Improve children's emotional and mental health through service improvement and better transition to adulthood.
	Secure meaningful engagement with people	• Invest in primary care infrastructure and wrap care and services around practices • Improve access to primary and secondary care services seven days a week across all pathways • Provide structured engagement and feedback on care and services • Invest in local engagement with communities and businesses to secure volume for quiet voices i.e. working voices • The CCG Operational Plan acknowledges the important role the CCG has in addressing health inequalities



Recommendations 2015/16

One Darlington: A Shared Agenda with NHS Partners

- Public Health, Darlington CCG, NHS England and member practices should work together to ensure that all patients registered with their GP have access to initiatives to improve their health needs.
- Informed by by practice data, promote targeted prevention services, using practice registers as a monitoring tool for population health and health inequalities.
- Support NHS services to act as a focus within local communities. Primary Care should be supported in this role as a contribution to integrating services and promoting healthier communities.

Chapter 6

One Darlington: Health Protection and Inequalities

Health protection is a key domain of public health practice, i.e. 'protecting the public from infectious disease and other threats to health such as chemicals, radiation environmental health hazards, emergencies and major incidents'.

Under the Health and Social Care Act (2012) specific additional health protection responsibilities have been allocated to local authorities as part of their remit for public health. The Director of Public Health (DPH) for Darlington is responsible for the exercise of the Council's new public health functions. The main issues in relation to health protection include :

- Implementation of Emergency Preparedness Resilience and Response (EPRR) of both major and small scale incidents
- Joint work with Environmental Health services
- Quality assurance of Immunisation Programmes
- Quality assurance of Screening Programmes

Successful health protection requires strong working relationships at the local and North East level. Public Health England (PHE), Health Protection Team (HPT), NHS England and the CCG share plans and regularly test the arrangements in place. An update on the new system was reported to the Health and Wellbeing Board in January 2015.

Arrangements are in place to assure the Council that its responsibilities are being delivered, these include:

Screening and Immunisation	Darlington Public Health Team lead, links to NHS England Screening and Immunisation Groups. Quality Assurance reports and Incident Reports.
Infectious diseases and outbreaks including health care acquired infections	DPH does STAC on call, NE outbreak control meetings, County Durham and Darlington Area Health Protection Group, Durham and Darlington Influence Group, Health and Social Care HCAI Assurance Group.
Emergency preparedness resilience and response	Local Health Resilience Partnership (LHRP), Durham, Darlington Tees Valley, Local Resilience Forum, DBC Emergency Management and Recovery Coordination systems.

There are four elements to the work of Public Health England (PHE) in protecting the health of the population in the North East : **prevention, surveillance, control** and **communication.** Other agencies have a major role in each of these elements, including the Council.

In terms of **prevention**, the Local Authority is responsible for providing independent scrutiny and challenging the arrangements of NHS England, PHE and providers. Effective **surveillance** systems are essential in identifying trends, outbreaks and monitoring, the outcomes of the control actions put in place.

The Council uses information from PHE e.g. local authority sexual and reproductive health profiles to inform sexual health services commissioning. The Council Environmental Health services provide results of investigations into diseases which may be foodborne illness and information about cases and outbreaks.

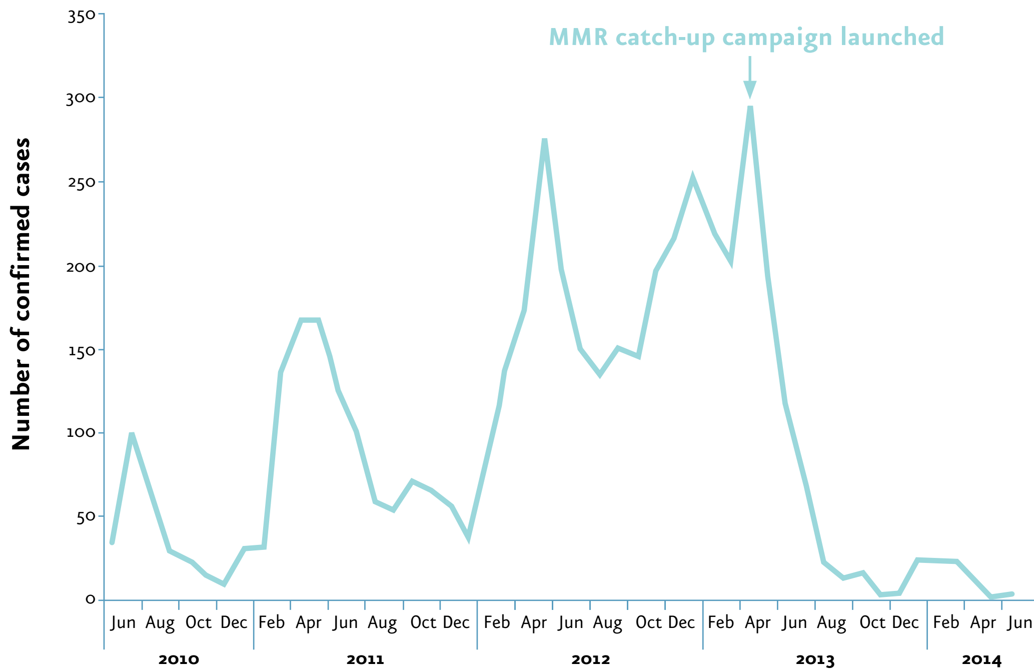
'Control' relates to actions taken to minimise risk of spread of a disease and the actions to close an outbreak. Early reporting, early diagnosis and prompt treatment are essential. For some diseases the initial reporting is via Environmental Health services.

Public Health England (PHE) produce a full North East Annual Report covering specific diseases, descriptions of communicable disease outbreaks and incidents, emergency preparedness, resilience and response (EPRR) update, environmental issues and a summary of **communications** support.[8]

Immunisation

Immunisation is one of the most effective and cost-effective public health interventions available. It provides protection to the other vaccinated individuals and to the wider community through 'herd immunity'. Keeping levels of coverage high is essential to prevent the spread of disease.

8 'Protecting the population of the North East from communicable diseases and other hazards' (June 2014)www.gov.uk/phe



The successful introduction of a measles, mumps & rubella catch-up campaign to vaccinate unprotected children had an immediate impact on the numbers of cases of measles.

MMR catch-up campaign introduced to protect children given a national fall in vaccine update due to media reports of alleged association with autism. As the graph indicates the campaign has had an immediate impact on numbers of cases of measles.

The WHO recommendation is to achieve at least 95% coverage of immunisations.

The uptake of the childhood immunisation programme in Darlington is generally favourable compared with national and regional uptake.

At five years of age, coverage of primary immunisation is at least 95% in Darlington, however, coverage for pre-school boosters is lower.

Three **adolescent vaccinations** are given as part of the routine schedule:

	2013 - 2014		
Local Authority	Td/IPV	Men C	HPV
Darlington	80.8%	82.1%	91.5%
Durham, Darlington Tees Valley	75.5%	75.2%	91.3%

Influenza

The influenza (flu) vaccination programme aims to protect those who are most at risk of serious illness or death should they develop flu and also to reduce the transmission of the infection. The risk of serious illness from flu is higher among children under six months, older people and those with a health condition, such as respiratory disease or cardiac disease.

Pregnant woman are at risk and vaccination is also offered to children and adults in clinical risk groups.

For 2014/15, the aim was:

- An uptake of 75% reached or exceeded for people aged 65 years and over.
- An uptake of 75% reached or exceeded for health and social care workers

Seasonal flu was overall higher in 2014/15 than in the last three flu seasons and activity persisted into March 2015. In the 2014/15 season, the flu vaccine has had reduced effectiveness.

Flu Vaccine Uptake

	2013 - 2014	
Local Authority	65 years and over	Under 65 years at risk
Darlington	72.8	47.0
Durham, Darlington Tees Valley (DDT)	73.6	48.4
England	72.8	50.3

Vaccine uptake for pregnant women was variable across the North East

Darlington	59.3%
DDT	48.5%
England	44.1%

Vaccine uptake for children aged two, three and four years was higher than the England average, however, the uptake in children in clinical at risk groups remained low.

Vaccine uptake in healthcare workers in 2014/15 was 54.9% nationally, both local NHS Trusts improved on 2013/14.

	2013/14	2014/15
County Durham and Darlington NHS Trust	76.0	76.6
Tees Esk and Wear Valley NHS Trust	39.9	42.1

In the Local Authority, 118 staff with a frontline social care type role were vaccinated.

Screening

Commissioning of national screening programmes is the responsibility of NHS England, with expert advice and strategic leadership by Public Health England. Local Authority DsPH requires assurance of screening programmes in their areas. Screening aims to identify in healthy people a disease or condition before it is apparent clinically, with the aim of intervening early to improve the outcome.

There are 11 national screening programmes, (6 relate to Antenatal and New-born screening). For full details please see "Durham, Darlington and Tees Screening and Immunisation Team Annual Report 2013/14".[9]

Cancer Screening Programmes

NHS Breast Screening	women 53 – 70 years	Target 70% minimum coverage
NHS Cervical Screening	women 24 – 64 years	Target 80% coverage
NHS Bowel Cancer Screening	men and women 60 – 74 years	Target 60% coverage

Darlington 2013/14

NHS Breast Screening	Achieved at least 70%
NHS Cervical Screening	Achieved the higher standard of 80%
NHS Bowel Cancer Screening	Exceeded Baseline Target 55%, but fell short of 60% higher standard

The national non-cancer screening programmes include antenatal and new-born, diabetic eye screening and abdominal aortic aneurysm.

Recommendations 2015/16

One Darlington: Health Protection and Inequalities

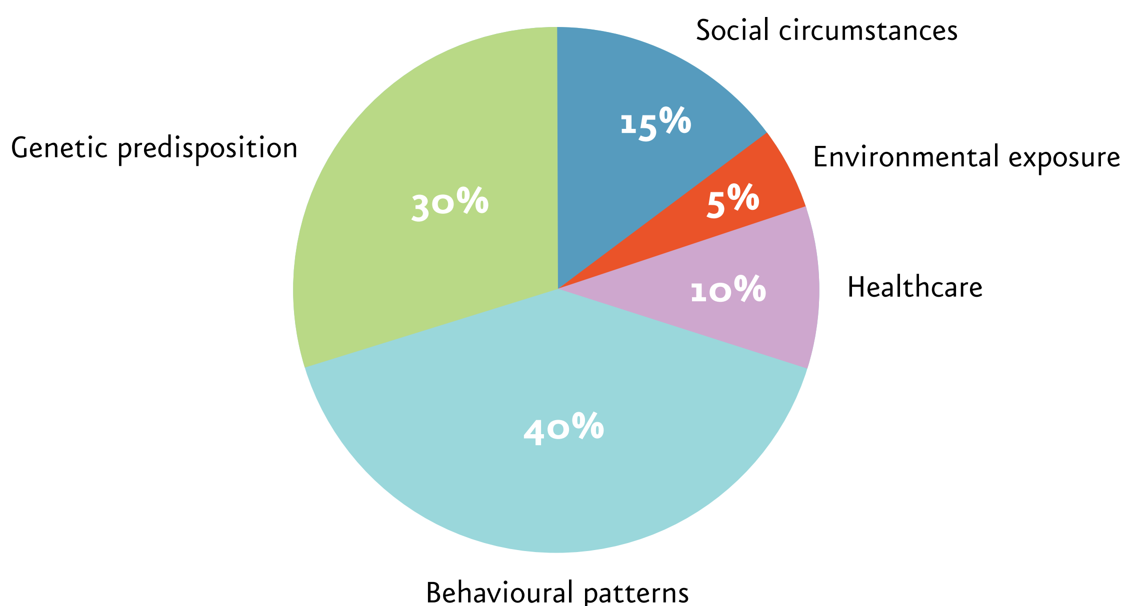
- Health protection risks affect some individuals and communities disproportionally resulting in poorer health. Use the measures in place, such as the local partnerships to address the inequalities in health protection e.g.
  - Under immunising of children
  - Groups disproportionately affected by some sexually transmitted infections
  - Travelling communities who have lower rates of immunisation
  - People who are homeless, substance dependent or living in overcrowded housing are at increased risk of some infections.
- Work closely with NHS England and PHE to improve overall uptake in screening and immunisation programmes with a focus on the most vulnerable groups. i.e. universal and targeted.

9 'Durham, Darlington and Tees Screening and Immunisation Team Annual Report 2013/14' NHS England.

One Darlington: The Social Causes of Poor Health

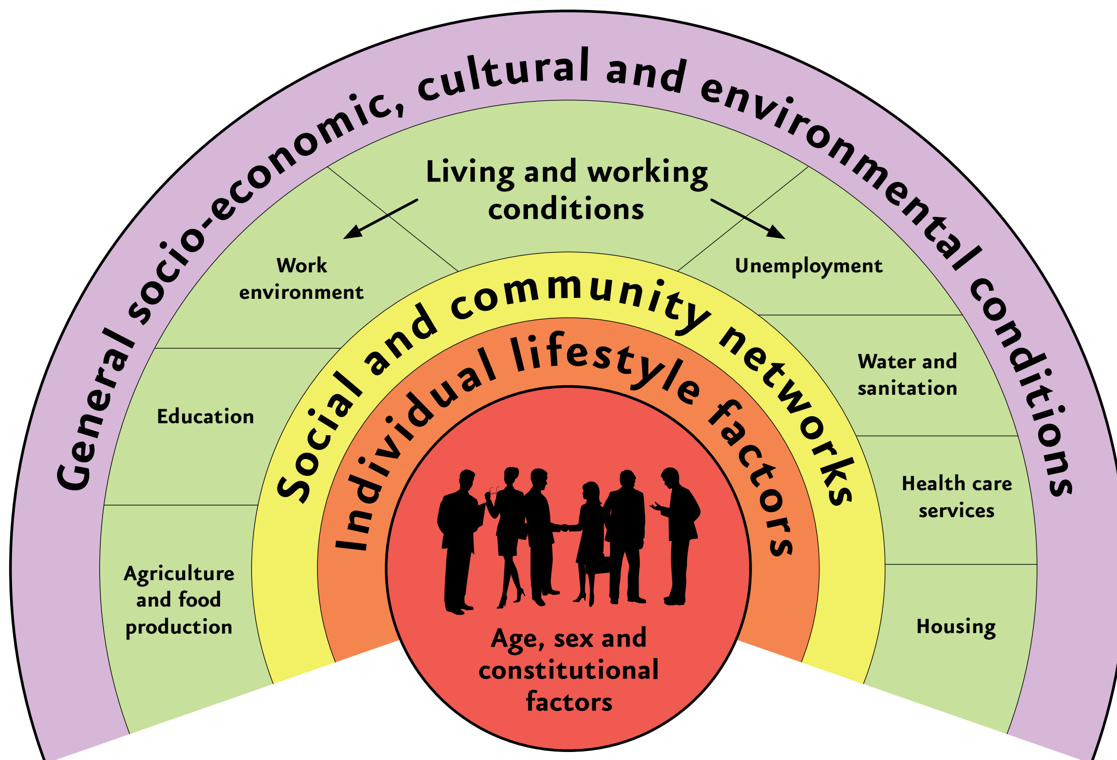
The Marmot Review **'Fair Society, Healthy Lives' (2010)** set out the evidence that health inequalities result from social inequalities and that action is needed across all the social determinants of health, including poverty, housing, education, environment, employment taking a 'life course' approach. These social or wider determinants of health have been described as 'the causes of the causes of health inequalities'. They are the 'conditions in which people are born, grow, live, work and age.'

Proportional contribution to premature death[8]



In the US, McGinnis et al show how healthcare plays an important though proportionately small role in preventing early deaths. Similar studies have supported these findings in the UK. Improving how we live our lives offers far greater opportunity for improving health.

Given that it is five years since the Marmot Review was published and that a social model of health, (Dahlgren and Whitehead 1991) has been recognised for more than 20 years it is clear that there are a number of barriers to the development of policies and interventions that are truly 'upstream' with a focus on prevention addressing the 'causes of the causes'.



Source: Dahlgren and Whitehead, 1991

Challenges to developing actions that address the social determinants of health through a life course include:

- The tension between pressure to meet a health target or healthcare related outcome and mainstreaming a focus on social factors.
- Government agencies at a national and local level need to work together to address issues not strictly relating to health or health budgets in the way they have been historically.
  The social determinants of health are outside the sphere of influence of a single agency of the NHS. There is more scope to influence the wider determinants of health by working in local government and also requires other stakeholders to work in partnership.
- One of the reasons why policy (national and local) focuses on behaviours rather than wider determinants is the length of time it takes to show outcomes. The outcomes of individual behaviour change tend to be easier to measure e.g. smoking cessation, weight loss, sexual infection treated etc.

While lifespan interventions lead to positive changes and good outcomes at an individual level the approach will not make significant impact on health inequalities because they do not address the causes of health inequalities.[10]

10 Hunter et al *Learning Lessons From The Past: Shaping A Different Future* 2009

Examples of social determinants affecting inequalities and health outcomes in Darlington

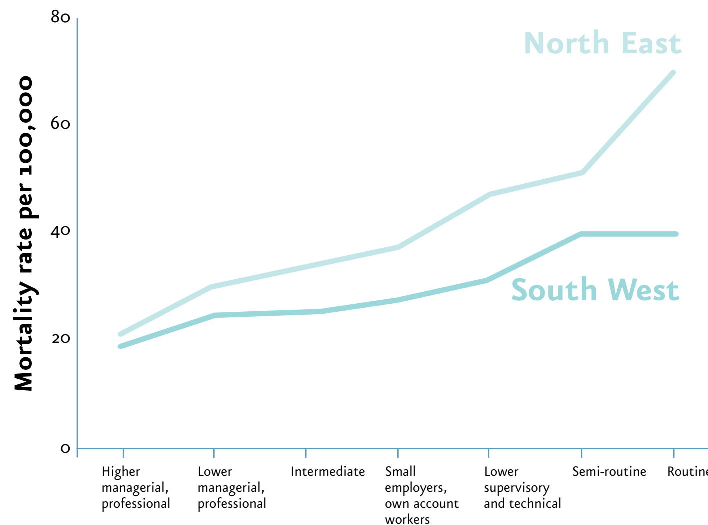
The Darlington Strategic Needs Assessment (SNA) should provide local information about differences in educational outcomes across the Borough, information about employment skills, levels of income, pattern of work, housing type and availability, green space and other environmental factors. The SNA will have some of this information but work may need to be done to provide an analysis in categories aligned to the Marmot Review.

Examples of work already underway to address the social determinants of health include:

- Planning services and public health connecting regarding housing development e.g. Red Hall.
- Public health links to Licensing Partnership, health protection, safeguarding and alcohol licensing.
- Financial Inclusion Strategy including partners from different sectors.
- Development of a 0 – 19 years 'pathway' to support families to 'give every child the best start in life'.
- Growing the economy, work to promote career aspiration, work experience and matching private sector employers with local education providers.
- Strong communities, a community asset based approach to developing wellbeing and resilience in communities who feel connected to their 'place' and feel safe.
  Active travel, legacy of Local Motion, environmentally positive and creates health gain and green spaces.
- Housing, homelessness and health audit initiated in 2014/2015, links to warmer and safer homes, (fuel poverty) and Safer Homes initiative of 2015/16 working with County Durham and Darlington Fire and Rescue Service.
- Public protection and regulatory services include the role of infection prevention and control, licensing, access to 'fast foods', safeguarding vulnerable children and adults. There is a responsibility for public health to be engaged in licensing although currently there is not a licensing objective directly relating to public health.

Strong opinions on the effect of others' behaviour

(North East Alcohol Behaviour and Perceptions Survey 2014)



Source: Office for National Statistics

There are stark health inequalities stemming from unemployment and socioeconomic status, as well as geography across the country.

Due North: Report of the Independent Inquiry on Health Equity for the North.

'Due North' was published in September 2014, it is the report of the inquiry on health equity for the North and builds on the Marmot Review focusing on three themes:

- a fair start for children
- the economy and welfare
- democratic and community empowerment

The report provides additional evidence on what actions are needed to address the social determinants of health on the scale needed to make a difference. It sets out challenges across sectors about actions they could deliver in order to tackle inequalities.[11]

Recommendations 2015/16

One Darlington: The Social Causes of Poor Health

- The Health and Wellbeing Board should recognise the impact of the way we live our lives as individuals, as well as population health.
- All strategies and programmes for health and wellbeing should consider their potential impact on health inequalities.
- Support all partners to recognise that tackling health inequalities requiring action on the wider, social determinants of health.
- An asset based approach is needed, where the assets of individuals, communities and organisations are built on to current improved health.

11 *'Due North' report of the Inquiry on Health Equity for the North (2014).*

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