Darlington Borough Council

Public Health

October – March (Quarter 3 & 4)

Performance Highlight Report

2021 - 22

Public Health Performance Introduction

The attached report describes the performance of a number of Contract Indicators and a number of Key Indicators.

Key Indicators are reported in different timeframes. Many are only reported annually and the period they are reporting can be more than a year in arrears or related to aggregated periods. The data for these indicators are produced and reported by external agencies such as ONS or PHE. The lag of reporting is due to the complexities of collecting, analysing and reporting of such large data sets. The following schedule (page 3) outlines when the data will be available for the Key indicators and when they will be reported.

Those higher-level population indicators, which are influenced largely by external factors, continue to demonstrate the widening of inequalities, with some key measures of population health showing a continuing trend of a widening gap between Darlington and England. For many of these indicators the Darlington position is mirrored in the widening gap between the North East Region and England.

Contract Indicators feed into the Key indicators, are collected by our providers and monitored as part of the contract monitoring and performance meetings held regularly. The Contract indicators within the Public Health performance framework form a selection from the vast number of indicators we have across all of our Public Health contracts. The contract monitoring meetings are scheduled to meet deadlines and inform the performance reports.

Impact of COVID-19 With the impact of COVID-19 and the implementation of government guidance some key performance indicators in contracts have been affected. This resulted in changes to the ways of working by providers to enable services to be delivered safely.

Timetable for "Key" Public Health Indicators

Please note the following is based on National reporting schedules and as such is a provisional schedule

Q1 Indicators

Indicator Num	Indicator description
PBH 009	(PHOF C04) Low birth weight of term babies
PBH 016	(PHOF C02a) Under 18's conception rate/1,000
PBH 033	(PHOF C18) Smoking prevalence in adults (18+) - current smokers (APS)
PBH 048	(PHOF D02a) Chlamydia detection rate/ 100,000 aged 15 to 24
PBH 058	(PHOF E05a) Under 75 mortality rate from cancer

Q2 Indicators

Indicator Num	Indicator description
PBH 044	(PHOF C21) Admission episodes for alcohol -related conditions (narrow)
PBH 046	(PHOF C26b) Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS health Check
PBH 052	(PHOF D10) Adjusted antibiotic prescribing in primary care by the NHS)

Q3 Indicators

Indicator Num	Indicator description
PBH 013c	(PHOF 2.02ii) Breastfeeding prevalence at 6-8 weeks after birth – current method
PBH 014	(PHOF C06) Smoking status at time of delivery
PBH 018	(PHOF 2.05ii) Proportion of children aged 2-2.5 years receiving ASQ-3 as part of the Healthy Child Programme or integrated review
PBH 035i	(PHOF C19a) Successful completion of drug treatment-opiate users
PBH 035ii	(PHOF C19b) Successful completion of drug treatment-non opiate users
PBH 035iii	(PHOF C19c) Successful completion of alcohol treatment
*PBH 050**	(PHOF D07) HIV late diagnosis (%)
PBH 056	(PHOF E04b) Under 75 mortality rate from cardiovascular disease considered preventable (2019 definition)
PBH 060	(PHOF E07a) Under 75 mortality rate from respiratory disease

Q4 Indicators

Indicator Num	Indicator description
PBH 020	(PHOF C09a) Reception: Prevalence of overweight (including obesity)
PBH 021	(PHOF C09b) Year 6: Prevalence of overweight (including obesity)
PBH 024	(PHOF C11a) Hospital admissions caused by unintentional and deliberate injuries to children (0-4 years)
PBH 026	(PHOF C11a) Hospital admissions caused by unintentional and deliberate injuries to children (0-14 years)
PBH 027	(PHOF C11b) Hospital admissions caused by unintentional and deliberate injuries to children (15-24 years)

For the indicators below update schedules are still pending (see detailed list tab for explanation)

PBH 029	(PHOF 2.09) Smoking Prevalence-15-year-old
PBH 031	(PHOF C14b) Emergency Hospital admissions for intentional Self-Harm)
PBH 054	(PHOF E02) % of 5 year old's with experience of visible obvious dental decay

**** Please note the figures in this indicator may be supressed when reported***

Quarter 3 & 4 Performance Summary

Key indicators reported in Q3 & Q4 are:

- PBH 013c (PHOF 2.02ii) Breastfeeding prevalence at 6-8 weeks after birth
- PBH 014 (PHOF C06) Smoking status at time of delivery
- PBH 018 (PHOF 2.05ii) Proportion of children aged 2-2.5years receiving ASQ-3 as part of the Healthy Child Programme or integrated review
- PBH 020 (PHOF C09a) Reception: Prevalence of overweight (including obesity)
- PBH 021 (PHOF C09b) Year 6: Prevalence of overweight (including obesity)
- PBH 024 (PHOF C11a) Hospital admissions caused by unintentional and deliberate injuries to children (0-4 years)
- PBH 026 (PHOF C11a) Hospital admissions caused by unintentional and deliberate injuries to children (0-14 years)
- PBH 027 (PHOF C11b) Hospital admissions caused by unintentional and deliberate injuries to children (15-24 years)
- PBH 035i (PHOF C19a) Successful completion of drug treatment – opiate users
- PBH 035ii (PHOF C19b) Successful completion of drug treatment – non-opiate users
- PBH 035iii (PHOF C19c) Successful completion of alcohol treatment
- PBH 050 (PHOF D07) HIV late diagnosis (%)
- PBH 056 (PHOF E04b) Under 75 mortality rate from cardiovascular disease considered preventable (2019 definition)
- PBH 060 (PHOF E07a) Under 75 mortality rate from respiratory disease

It is important to note that these Key indicators describe population level outcomes and are influenced by a broad range of different factors including national policy, legislation and cultural change which affect largely the wider determinants of health or through the actions of other agencies. Due to the long-time frame for any changes to be seen in these indicators the effect of local actions and interventions do not appear to have any effect on the Key indicators on a quarterly or even annual basis. Work continues to maintain and improve this performance by working in partnership to identify and tackle the health inequalities within and between communities in Darlington.

Quarter 3 & 4 Performance Summary

Contract Indicators Highlighted in Q3 & Q4 are:

The contract indicators included in this highlight report are selected where a narrative is useful to understand performance described in the Key indicators to give an insight into the contribution that those directly commissioned services provided by the Public Health Grant have on the high-level population Key indicators. There is a total of 5 indicators in Q4:

- PBH 015 –Number of adults identified as smoking in antenatal period
- PBH 037a – Number of young people (under 19) seen by Contraception and Sexual Health (CASH) Service
- PBH 037d – Number of young people (under 19) seen by Genitourinary Medicine (GUM) Service
- PBH 38 – Waiting times – number of adult opiates clients waiting over 3 weeks to start first intervention
- PBH 041 – Waiting times – number of adult alcohol only clients waiting over 3 weeks to start first intervention

COVID-19 impact on Q4 contract data

With the impact of COVID-19 and the implementation of government guidance some key performance indicators in all contracts have been affected. This resulted in changes to the ways of working by providers to enable services to be delivered safely.

KEY AND CONTRACT INDICATORS

KEY PBH 013c – (PHOF 2.02ii) Breastfeeding prevalence at 6-8 weeks after birth – current method

Definition: This is the percentage of infants that are totally or partially breastfed at age 6-8 weeks. Totally breastfed is defined as infants who are exclusively receiving breast milk at 6-8 weeks of age - that is, they are not receiving formula milk, any other liquids or food. Partially breastfed is defined as infants who are currently receiving breast milk at 6-8 weeks of age and who are also receiving formula milk or any other liquids or food. Not at all breastfed is defined as infants who are not currently receiving any breast milk at 6-8 weeks of age. The numerator is the count of the number of infants recorded as being totally breastfed at 6-8 weeks and the number of infants recorded as being partially breastfed. The denominator is the total number of infants due a 6-8 weeks check.

Numerator: Number of infants at the 6-8 week check who are totally or partially breastfeeding.

Denominator: Number of infants due for 6-8 week checks

Latest update: 2020/21 **Current performance: 34.4%**

Figure 1 - All North East region comparison

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	262,777	47.6*	47.5	47.7
North East region	↑	8,506	35.4	34.8	36.0
Newcastle upon Tyne	↑	1,563	53.1	51.3	54.9
North Tyneside	–	827	42.1	39.9	44.3
Gateshead	–	731	41.8	39.5	44.1
Northumberland	↑	979	40.3	38.3	42.2
Middlesbrough	↑	551	34.4	32.1	36.8
Darlington	→	344	34.4	31.5	37.4
Redcar and Cleveland	↑	363	31.0	28.4	33.7
County Durham	→	1,353	30.2	28.9	31.6
Sunderland	→	627	25.8	24.1	27.5
Hartlepool	–	219	24.7	22.0	27.7
South Tyneside	–	334	23.1	21.0	25.3
Stockton-on-Tees	–	615	*	-	-

Source: PHE's interim reporting of health visiting metrics

Compared with Neighbrs average ▪▪▪ Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

What is the data telling us?

This data (from 2020/21), shows that that there is no significant change to the trend for breastfeeding prevalence at 6-8 weeks after birth. 34.4% of infants are totally or partially breastfed at 6-8 weeks after birth. Compared to our North East neighbours Darlington is

ranked 6th. Statistically similar to the North East and statistically worse than England. Figure 1 show an asterisk in place of data; this means that the data has not published these authorities' data for data quality reasons.

Why is this important to inequalities?

The evidence base shows that there are significant health benefits for the mother and child including reduced infections as an infant and lower probability of obesity later in life. For the mother breastfeeding lowers the risk of developing breast and ovarian cancers. Breastfeeding is less prevalent in lower socioeconomic communities resulting in mothers and infants missing out on the known health benefits. This is a contributing factor in poorer health outcomes for both children and adults.

What are we doing about it?

Increasing the rates of breastfeeding is a key performance indicator within the 0-19 contract provided by Harrogate and District NHS Foundation Trust.

The Health Visiting team provides a proactive offer of structured breastfeeding help for new mothers during their first visit 10-14 days following the birth. The Health Visiting team also provide a range of extra support, including extra visits and calls, to new mothers who are identified as experiencing difficulties with breastfeeding.

During Covid the Health Visiting team have supported new mums virtually and offer telephone and face time support, where required.

KEY PBH 014 - (PHOF C06) Smoking status at time of delivery

Definition: The number of mothers known to be smokers at the time of delivery as a percentage of all maternities. A maternity is defined as a pregnant woman who gives birth to one or more live or stillborn babies of at least 24 weeks gestation, where the baby is delivered by either a midwife or doctor at home or in a NHS hospital.

Numerator: Number of women known to smoke at time of delivery.

Denominator: Number of maternities where smoking status is known.

Latest update: 2020/21 **Current performance: 14.4%**

Figure 2 - All North East region comparison

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	51,840	9.6	9.5	9.7
North East region	↓	3,207	13.3	12.9	13.7
County Durham	→	704	15.5	14.5	16.6
Sunderland	→	379	15.1	13.8	16.6
Middlesbrough	↓	228	14.5	12.8	16.3
Stockton-on-Tees	→	270	14.4	12.9	16.1
Redcar and Cleveland	↓	174	14.4	12.6	16.5
Hartlepool	→	122	14.4	12.2	17.0
Darlington	→	133	14.4	12.3	16.8
South Tyneside	↓	189	13.3	11.7	15.2
Newcastle upon Tyne	↓	339	11.7	10.6	12.9
Gateshead	↓	218	11.6	10.3	13.2
Northumberland	→	251	10.3	9.2	11.6
North Tyneside	→	200	9.9	8.7	11.3

Source: Calculated by PHE from the NHS Digital return on Smoking Status At Time of delivery (SATOD)

Compared with Neighbrs average: Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

What is the data telling us?

The data (from 2020/21) shows that there is no significant change to the trend for women who smoke at time of delivery. 14.4% of mothers are known to be smokers at time of delivery. Compared to our North East neighbours Darlington is ranked 7th. Statistically similar to the North East and statistically worse than England.

Why is this important to inequalities?

Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother both in the short term and longer term. Being smoke free in pregnancy is a significant contribution to the best start in life. Smoking prevalence, including in pregnancy, is higher in more deprived areas. This means that infants born to mothers who are smoking at pregnancy are more likely to be exposed to the effects of tobacco in the womb and at home when they are born. This can affect the health outcomes

of the baby and increase the likelihood of specific diseases throughout their life and into adulthood.

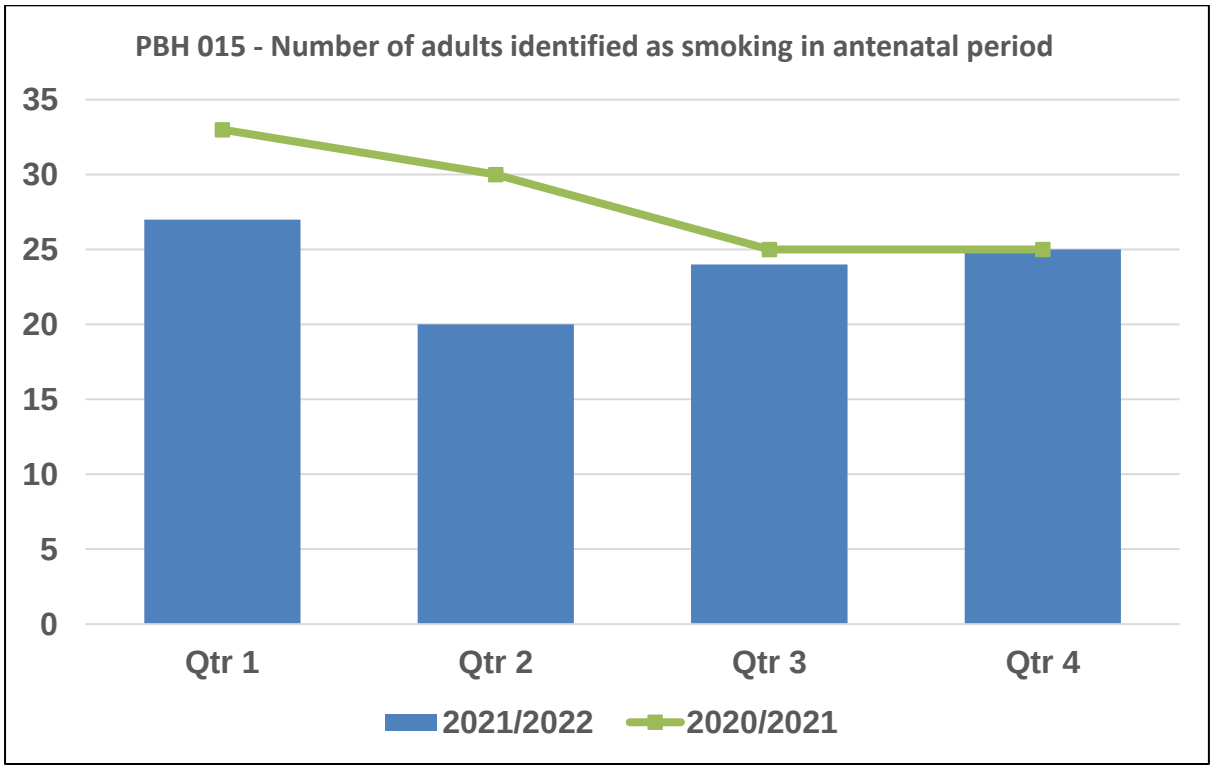
Increasing the proportion of mothers who do not smoke during pregnancy will provide communities with the benefits of reduced harm from smoking, improve outcomes and reduce health inequalities.

What are we doing about it?

The Stop Smoking Service has a contractual focus on reducing smoking at time of delivery. There are contractual incentives to support the service in improving the percentage of pregnant women who access the Specialist Service and who successfully quit from the most deprived wards. This includes training of midwives and other professionals in identifying women who smoke and particularly pregnant women and then to provide an evidence-based intervention to help them address their smoking. The Service and the Public Health team are also working with partners to support the implementation of smoke free policies in workplaces and public spaces, including local public services.

CONTRACT PBH 015: Number of adults identified as smoking in the antennal period

Figure 3 -



Service Provider: County Durham and Darlington NHS Foundation Trust

What is the data telling us?

The data shows a decrease of women who are recorded as smokers while pregnant for Q1-3 from last year, with Q4 being the same as last year. This means that more unborn babies are exposed to the harm from tobacco before they are born. This data needs to be considered with caution due to the impact of COVID-19 on the ante-natal visits.

What more needs to happen?

The regional and local Maternity Services Public Health Prevention Plan has a focus on reducing the harm to children from tobacco during and after pregnancy. County Durham and Darlington Foundation Trust (CDDFT) are implementing some key actions including more focussed training and support for midwives in brief interventions, better screening and automatic referral to specialist services, better access to pharmacotherapies and more consistent support for mothers throughout pregnancy.

More actions are recommended including seamless referral to Stop Smoking Services and more advanced smoking cessation training by midwives. These actions will be undertaken by CDDFT Maternity Services across the Trust and supported by partners including the Clinical Commissioning Group and the Public Health team.

KEY PBH 018 (PHOF 2.05ii) Proportion of children aged 2-2.5years receiving ASQ-3 as part of the Healthy Child Programme or integrated review

Definition: Proportion of children aged 2-2½yrs receiving ASQ-3 as part of the Healthy Child Programme or integrated review.

Numerator: Total number of children for which the ASQ-3 is completed as part of their 2-2½ year review.

Denominator: Total number of children who received a 2-2½ year review by the end of the period.

Latest update: 2020/21 **Current performance: 99.5%**

Figure 4 - All North East region comparison

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	391,683	85.2*	85.1	85.3
North East region	→	21,155	85.8	85.3	86.2
South Tyneside	–	1,471	100	99.7	100
Darlington	↑	1,094	99.5	98.9	99.8
Middlesbrough	→	1,770	98.6	98.0	99.1
North Tyneside	↑	2,046	97.8	97.1	98.3
Sunderland	–	2,541	97.3	96.6	97.8
Stockton-on-Tees	–	1,817	97.3	96.4	97.9
County Durham	→	4,218	95.8	95.2	96.4
Redcar and Cleveland	–	1,226	95.7	94.5	96.7
Gateshead	–	1,672	91.3	89.9	92.5
Northumberland	→	2,410	89.5	88.2	90.6
Hartlepool	→	410	50.4	46.9	53.8
Newcastle upon Tyne	→	480	17.7	16.3	19.2

Source: OHID using interim reporting of health visiting metrics: https://www.gov.uk/government/collections/child-and-maternal-health-statistics#health-visitor-service-delivery-metrics

Better 95% | Similar | Worse 95% | Not compared | Data quality concerns

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

What is the data telling us?

This data (from 2020/21), shows that there is an increasing and improving trend for the proportion of children aged 2-2.5years receiving ASQ-3. 99.5% received and AQQ-3 as part of the Healthy Child programme or integrated review. Compared to our North East neighbours Darlington is ranked 2nd. Statistically better than the North East and England.

Why is this important to inequalities?

Children from the most disadvantaged communities have a poorer experience in the first years of life and experience the most inequalities throughout childhood and adulthood. The Ages and Stages Questionnaire (ASQ3) provides a comprehensive assessment of child

development including motor, problem solving and personal development. This provides an indication of the effectiveness and impact of services for 0-2 year olds but can also provide information for the planning for the provision of services for children over 2 years. The universal provision of ASQ3 assessments ensure that those from deprived communities who may have accumulated developmental deficits are identified at an early stage before they enter primary education at age 5.

What are we doing about it?

The current provider of 0-19 services (Harrogate and District NHS Foundation Trust) has worked to improve the timely completion of the 2-2.5 year check, its application and recording of the ASQ3 and its outcomes. This has shown consistent improvement from 87.9% of children receiving an ASQ3 for 2016/17 to 97.6% of children in 2017/18 to 97.7% in 2018/19 and 99.4% in 2019/20. The Service has surpassed the set target of 95%.

The Service has also continued to ensure that the assessment is of high quality through training and development of their staff. The Provider is working with Education and Early Years settings to ensure that individuals with poor scores are identified and with parental consent, are referred to specialist services for furthermore focused assessment and early intervention.

KEY PBH 020 – (PHOF C09a) Reception: Prevalence of overweight (including obesity)

Definition: Proportion of children aged 4-5 years classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.

Numerator: Number of children in Reception (aged 4-5 years) classified as overweight or obese in the academic year. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.

Denominator: Number of children in Reception (aged 4-5 years) measured in the National Child Measurement Programme (NCMP) attending participating state maintained schools in England.

Latest update: 2019/20 **Current performance: 25.8% (Reception)**

Figure 5 - All North East region comparison

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	91,723	23.0	22.8	23.1
North East region	→	5,560	24.8	24.3	25.4
Middlesbrough	→	245	31.0*	28.0	34.4
Redcar and Cleveland	→	425	30.1	27.7	32.5
Hartlepool	→	220	29.9*	26.6	33.2
Gateshead	↑	260	29.4*	26.7	32.7
Newcastle upon Tyne	→	740	26.0	24.4	27.6
North Tyneside	→	575	25.8	24.1	27.7
Darlington	→	290	25.8	23.4	28.6
County Durham	→	1,095	24.9	23.7	26.3
South Tyneside	→	335	23.2	21.0	25.4
Sunderland	→	635	22.1	20.7	23.7
Stockton-on-Tees	→	265	21.6*	19.6	24.2
Northumberland	↓	470	19.3	17.8	20.9

Source: NHS Digital, National Child Measurement Programme

Better 95% | Similar | Worse 95% | Not compared | Data quality concerns

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

KEY PBH 021 – (PHOF C09b) Year 6: Prevalence of overweight (including obesity)

Definition: Proportion of children aged 10-11 classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.

Numerator: Number of children in Year 6 classified as overweight or obese in the academic year. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.

Denominator: Number of children in Year 6 (aged 10-11 years) measured in the National Child Measurement Programme (NCMP) attending participating state-maintained schools in England.

Latest update: 2019/20 **Current performance: 37.8% (Year 6)**

Figure 6 - All North East region comparison

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	172,831	35.2	35.1	35.3
North East region	→	9,460	37.5	37.0	38.1
South Tyneside	→	660	40.0	37.6	42.3
Middlesbrough	→	650	40.0	37.7	42.5
Newcastle upon Tyne	→	1,150	39.6	37.8	41.4
Hartlepool	→	280	39.4*	36.0	43.1
Redcar and Cleveland	→	560	39.0	36.7	41.7
Gateshead	→	780	38.5	36.5	40.8
Darlington	→	470	37.8	35.1	40.5
County Durham	→	1,735	37.6	36.1	38.9
Sunderland	→	1,095	36.9	35.1	38.6
North Tyneside	→	805	36.2	34.1	38.1
Stockton-on-Tees	→	440	34.8*	32.4	37.6
Northumberland	→	835	33.0	31.2	34.9

Source: NHS Digital, National Child Measurement Programme

Better 95% | Similar | Worse 95% | Not compared | Data quality concerns

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

What is the data telling us?

This data (from 2019/20) shows that that there is no significant change to the trend for Reception prevalence of overweight (including obesity). 25.8% of reception children aged 4-5 years were classified as overweight or obese. Compared to our North East neighbours Darlington is ranked 7th. Statistically similar to the North East and statistically worse than England.

This data (from 2019/20) shows that that there is no significant change to the trend for year 6 prevalence of overweight (including obesity). 37.8% of year 6 children aged 10-11 years

were classified as overweight or obese. Compared to our North East neighbours Darlington is ranked 7th. Statistically similar to the North East and England.

Why is this important to inequalities?

The risk of obesity in adulthood and risk of future obesity-related ill health are greater as children get older.

There is concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. Studies tracking child obesity into adulthood have found that the probability of overweight and obese children becoming overweight or obese adults increases with age.

The health consequences of childhood obesity include increased blood lipids, glucose intolerance, type 2 diabetes, hypertension, increases in liver enzymes associated with fatty liver, exacerbation of conditions such as asthma and psychological problems such as social isolation, low self-esteem, teasing and bullying.

What are we doing about it?

The Childhood Healthy Weight Plan for Darlington aims to increase the proportion of children leaving primary school with a healthy weight. This plan works with partners including parents, schools and other agencies to take a whole systems approach to reducing childhood obesity.

There are key performance indicators (KPIs) within the 0-19 Public Health Services contract which will have an influence on this indicator. For Reception aged children the 0-5 Health Visiting team provides specific visits and focussed work in the first weeks and months of life to support new mothers making choices around breastfeeding, infant feeding and weaning to reduce the risks of infants becoming obese before they start in reception. Due to the impact of COVID-19, appointments have taken place virtually, unless it has been necessary for a Health Visitor to make a visit in person, in those cases full PPE has been worn.

The 0-19 Public Health Services contract also contains specific KPIs in relation to the delivery of the National Child Measurement Programme (NCMP). In previous years the Service usually achieved 96% participating in reception and 98% in year 6, in the NCMP. This includes the proportion of children in each age group measured and the proportion of parents of those children who take part in the NCMP who receive a personalised letter informing them of the results and what this might mean for the health of their child. There is also a KPI in this contract that measures any intervention that the School Nurse may implement with the family as a result of their result. This is beyond the advice and signposting of the family to potential interventions that are designed to help children achieve a healthy weight.

In the past year however due to the disruption to the school year by the COVID19 pandemic and the high rates in young people, the NCMP nationally and locally has not been able to achieve the uptake of previous years. The provider had plans in place to ensure as much as practicable, there was an offer for measurement for as many children and young people in the borough. This involved offers of weekend sessions and catch up sessions to schools. From April 2021, the programme continues to be delivered in all schools.

KEY PBH 024 - (PHOF C11a) Hospital admissions caused by unintentional and deliberate injuries to children (0-4 years)

KEY PBH 026 - (PHOF C11a) Hospital admissions caused by unintentional and deliberate injuries to children (0-14 years)

KEY PBH 027 - (PHOF C11b) Hospital admissions caused by unintentional and deliberate injuries to children (15-24 years)

Definition: Crude rate of hospital admissions caused by unintentional and deliberate injuries in children aged under 5 years, under 15 years and 15-24 years per 10,000 resident population aged under 5 years, under 15 years and 15-24 years.

Numerator: The number of finished emergency admissions (episode number = 1, admission method starts with 2), with one or more codes for injuries and other adverse effects of external causes (ICD 10: S00-T79 and/or V01-Y36) in any diagnostic field position, in children (aged 0-4) (aged 0-14) and (aged 15-24). Admissions are only included if they have a valid Local Authority code. Regions are the sum of the Local Authorities. England is the sum of all Local Authorities and admissions coded as U (England NOS). Admissions that only include T80-98 or Y40-98, quality of care issues, in any field are excluded.

Denominator: Local authority figures: Mid-year population estimates: Single year of age and sex for local authorities in England and Wales; estimated resident population.

Latest Update: 2020/21

Current performance: 149.3 (0-4 years), 98.0 (0-14 years) and 144.8 (15-24 years) per 10,000

Figure 7 - All North East region comparison (0-4 years)

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	35,207	108.7	107.5	109.8
North East region	↓	1,995	143.8	137.6	150.3
North Tyneside	→	200	177.7	154.7	205.0
Newcastle upon Tyne	↑	290	177.0	156.6	198.0
Northumberland	→	225	155.1	136.8	178.2
Sunderland	→	220	153.1	132.2	173.2
Darlington	↓	85	149.3	116.1	180.8
County Durham	↓	370	144.2	130.3	160.1
South Tyneside	→	115	141.5	119.0	172.5
Middlesbrough	↓	130	137.8	113.2	161.4
Redcar and Cleveland	→	80	115.0	91.2	143.2
Gateshead	↓	115	113.0	91.5	133.5
Hartlepool	→	55	106.9	83.9	143.5
Stockton-on-Tees	↓	110	99.3	83.3	121.7

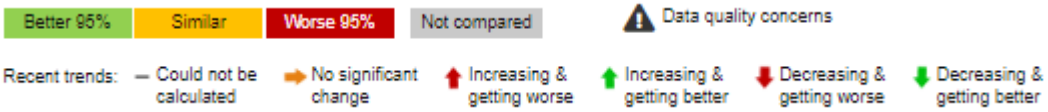


Figure 8 - All North East region comparison (0-14 years)

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	77,273	75.7	75.1	76.2
North East region	↓	4,505	100.4	97.5	103.4
Newcastle upon Tyne	→	630	125.4	115.4	135.2
North Tyneside	→	430	121.7	109.9	133.1
Northumberland	→	565	116.0	106.5	125.8
Sunderland	↓	475	102.8	94.2	113.0
South Tyneside	↓	260	102.2	89.7	114.9
Darlington	↓	185	98.0	83.4	112.1
County Durham	↓	815	95.2	88.8	101.9
Middlesbrough	↓	255	90.1	79.7	102.2
Redcar and Cleveland	↓	205	88.2	77.0	101.6
Gateshead	↓	285	86.7	76.6	97.0
Hartlepool	→	130	76.9	64.8	92.0
Stockton-on-Tees	↓	275	74.3	66.0	83.9

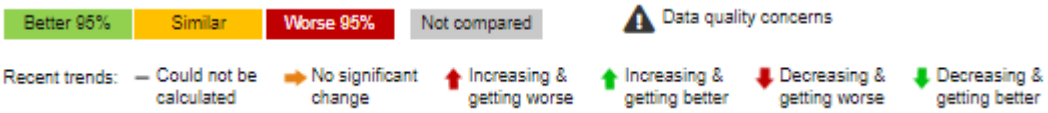


Figure 9 - All North East region comparison (15-24 years)

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	74,074	112.4	111.6	113.2
North East region	→	4,895	151.7	147.5	156.0
North Tyneside	↑	540	264.7	242.8	288.0
Northumberland	↑	705	233.7	216.4	251.2
Sunderland	↑	610	197.7	181.7	213.3
South Tyneside	→	245	156.3	138.5	178.4
Gateshead	→	355	155.8	140.0	172.9
Darlington	→	160	144.8	124.9	171.0
County Durham	→	905	136.3	127.8	145.8
Redcar and Cleveland	→	185	132.6	115.5	154.7
Stockton-on-Tees	→	240	120.4	106.6	137.7
Middlesbrough	→	210	110.5	96.5	127.0
Newcastle upon Tyne	→	640	102.9	95.2	111.3
Hartlepool	↓	90	87.5	72.1	109.7

Source: Office for Health Improvement and Disparities, using data from Hospital Episode Statistics (HES), NHS Digital for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2022, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS)

Better 95% | Similar | Worse 95% | Not compared | Data quality concerns

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

What is the data telling us?

This data (from 2020/21) shows that that that there is a decreasing and getting better trend for hospital admissions caused by unintentional and deliberate injury in children aged 0-4 year. 149.3 per 10,000 for emergency admissions for 0-4 years. Compared to our North East neighbours Darlington is ranked 5th. Statistically similar to the North East and statistically worse than England.

This data (from 2020/21) shows that that that there is a decreasing and getting better trend for hospital admissions caused by unintentional and deliberate injury in children aged 0-14 year. 98.0 per 10,000 for emergency admissions for 0-14 years. Compared to our North East neighbours Darlington is ranked 6th. Statistically similar to the North East and statistically worse than England.

This data (from 2020/21) shows that that that there is no significant change to the trend for hospital admissions caused by unintentional and deliberate injury in children aged 15-24 year. 144.8 per 10,000 for emergency admissions for 15-24 years. Compared to our North East neighbours Darlington is ranked 6th. Statistically similar to the North East and statistically worse than England.

Why is this important to inequalities?

Injuries are a leading cause of hospitalisation and represent a major cause of morbidity and premature mortality for children and young people. They are also a source of long-term health issues, including mental health related to experience(s).

It is estimated that across England one in 12 deaths in children aged 0-4 years old can be attributed to injuries in and around the home.

Available data for this age group in England suggests that those living in more deprived areas (as defined by the IMD 2015) are more likely to have an unintentional injury than those living in least deprived areas.

Preventing unintentional injuries has been identified as part of Giving Every Child the Best Start in Life priority actions.

What are we doing about it?

This issue requires system wide action with input from a range of different partners. Public Health undertook a piece of work in partnership with the CCG to undertake a detailed examination of the A+E and admission data, to identify any trends or commonalities to identify potential underlying reasons which may be driving this increased admission. Unfortunately, the impact of COVID-19 has delayed this piece of work.

The 0-19 Public Health Service have some specific actions and evidence-based interventions within the contract to contribute to the reduction of accidents in children. This includes working with parents at every visit and providing them with information, guidance and support in relation to home safety and accident prevention for their child. This will also include signposting or referral to other agencies or services for specific or targeted support for the family.

KEY PBH 035i - (PHOF C19a) Successful completion of drug treatment – opiate users

Definition: Number of users of opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of opiate users in treatment.

Numerator: The number of adults that successfully complete treatment for opiates in a year and who do not re-present to treatment within 6 months.

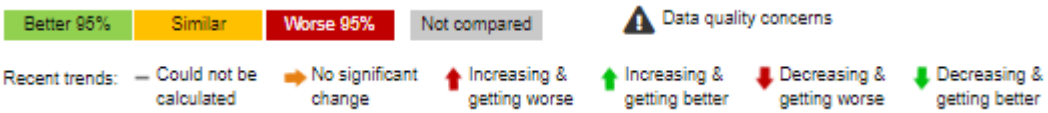
Denominator: The total number of adults in treatment for opiate use in a year.

Latest update: 2020 **Current performance: 3.1%**

Figure 10 - All North East region comparison

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	6,701	4.7	4.6	4.9
North East region	↓	350	3.3	3.0	3.7
County Durham	→	81	5.5	4.4	6.8
Sunderland	→	42	4.7	3.5	6.3
Redcar and Cleveland	→	21	3.8	2.5	5.7
Gateshead	↓	38	3.7	2.7	5.1
Northumberland	→	34	3.3	2.4	4.6
North Tyneside	↓	19	3.3	2.2	5.2
Hartlepool	↓	19	3.1	2.0	4.8
Darlington	→	13	3.1	1.8	5.2
South Tyneside	→	13	3.0	1.7	5.0
Newcastle upon Tyne	→	36	3.0	2.1	4.1
Stockton-on-Tees	↓	22	2.3	1.5	3.5
Middlesbrough	→	12	0.9	0.5	1.6

Source: Calculated by Office for Health Improvement and Disparities (OHID): using data from the National Drug Treatment Monitoring System



What is the data telling us?

This data (from 2020) shows that that there is no significant change to the trend for Successful completion of drug treatment – opiate users. 3.1% of opiate users successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months. Compared to our North East neighbours Darlington is ranked 8th. Statistically similar to the North East and England.

Why is this important to inequalities?

There is a strong correlation between deprivation and rates of substance misuse, including opiates. The most deprived communities suffer the most impact from substance misuse including poverty, family breakdown, homelessness, anti-social behaviour and crime and disorder. National data shows that there are lower rates of successful completions for drug treatment for opiate users in the most deprived communities.

What are we doing about this?

This is a key performance indicator within the STRIDE (Support, Treatment and Recovery In Darlington through Empowerment Service) service contract and is monitored within the contract monitoring.

We Are With You took over the Service delivery in August 2020.

The Public Health team has continued to work with We Are With You to understand if there are any unique characteristics of the local drug using population or changes in the wider system, including changes to benefits and other local services that might have contributed to the faster decrease in completions in Darlington compared to other areas.

The Service delivery model focusses on supporting sustained recovery in the community. This model uses the most up to date evidence and models of best practice to provide the best support to those who use substances in Darlington.

KEY PBH 035ii - (PHOF C19b) Successful completion of drug treatment – non-opiate users

Definition: Number of users on non-opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of non-opiate users in treatment.

Numerator: The number of adults that successfully complete treatment for non-opiates in a year and who do not re-present to treatment within 6 months.

Denominator: The total number of adults in treatment for non-opiate use in a year.

Latest update: 2020 **Current performance: 18.0%**

Figure 11 - All North East region comparison

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	18,699	33.0	32.6	33.4
North East region	→	1,241	30.0	28.6	31.4
County Durham	→	288	38.1	34.7	41.7
Stockton-on-Tees	→	93	36.8	31.1	42.9
North Tyneside	↑	130	35.6	30.9	40.7
Redcar and Cleveland	→	105	31.1	26.4	36.2
Middlesbrough	↑	127	29.4	25.3	33.9
South Tyneside	↓	55	27.5	21.8	34.1
Northumberland	→	90	27.0	22.5	32.0
Gateshead	↓	84	26.3	21.7	31.3
Sunderland	↑	98	25.9	21.8	30.6
Hartlepool	→	58	25.1	20.0	31.1
Newcastle upon Tyne	→	89	22.1	18.3	26.4
Darlington	→	24	18.0	12.4	25.4

Source: Calculated by Office for Health Improvement and Disparities (OHID): using data from the National Drug Treatment Monitoring System

Better 95% | Similar | Worse 95% | Not compared | Data quality concerns

Recent trends: — Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

What is the data telling us?

This data (from 2020) shows that that there is no significant change to the trend for Successful completion of drug treatment – non opiate users. 18.0% of non-opiate users successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months. Compared to our North East neighbours Darlington is ranked 12th. Statistically worse than the North East and England.

Why is this important to inequalities?

National data shows lower rates of successful completion for drug treatment for non-opiate users in some of the most deprived sections of the population and the impact of substance misuse is greater in deprived communities.

What are we doing about this?

This is a key performance indicator within the STRIDE (Support, Treatment and Recovery In Darlington through Empowerment Service) service contract and is monitored within the contract monitoring.

We Are With You took over the Service delivery in August 2020.

The Public Health team has continued to work with We Are With You to understand if there are any unique characteristics of the local drug using population or changes in the wider system, including changes to benefits and other local services that might have contributed to the faster decrease in completions in Darlington compared to other areas.

The Service delivery model focusses on supporting sustained recovery in the community. This model uses the most up to date evidence and models of best practice to provide the best support to those who use substances in Darlington.

KEY PBH 035iii - (PHOF C19c) Successful completion of alcohol treatment

Definition: Number of alcohol users that left structured treatment successfully (free of alcohol dependence) who do not then re-present to treatment within 6 months as a percentage of the total number of alcohol users in structured treatment.

Numerator: The number of adults that successfully complete structured treatment for alcohol dependence in a year and who do not re-present to treatment within 6 months.

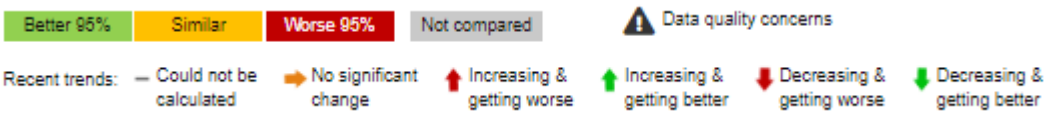
Denominator: The total number of adults in structured treatment for alcohol dependence in a year.

Latest update: 2020 **Current performance: 19.0%**

Figure 12 - All North East region comparison

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	26,703	35.3	35.0	35.7
North East region	→	1,635	30.7	29.5	32.0
Redcar and Cleveland	→	115	37.5	32.2	43.0
North Tyneside	→	167	36.5	32.2	41.0
County Durham	→	349	34.6	31.7	37.5
Hartlepool	→	73	34.4	28.4	41.1
Stockton-on-Tees	→	118	34.2	29.4	39.4
Gateshead	↓	146	31.6	27.5	36.0
South Tyneside	→	107	29.5	25.0	34.4
Middlesbrough	→	78	29.2	24.1	34.9
Newcastle upon Tyne	→	116	27.2	23.2	31.6
Sunderland	→	152	25.9	22.5	29.6
Northumberland	↓	174	25.7	22.6	29.2
Darlington	→	40	19.0	14.3	24.9

Source: Calculated by Office for Health Improvement and Disparities (OHID): using data from the National Drug Treatment Monitoring System



What is the data telling us?

This data (from 2020) shows that that there is no significant change to the trend for Successful completion of alcohol treatment. 19.0% of alcohol users left structured treatment successfully (free of alcohol dependency) who do not then re-present to treatment again within 6 months. Compared to our North East neighbours Darlington is ranked 12th. Statistically worse than the North East and England.

Why is this important to inequalities?

National data suggests that those living in the most deprived communities are less likely to complete treatment for alcohol than those living in the least deprived communities. National data and the evidence suggest that although overall consumption of alcohol between the more affluent and deprived communities is similar the patterns of consumption including the strength of alcohol, is different. More deprived communities tend to show patterns of binge drinking with high strength alcohol. The evidence shows that

the impact of alcohol harm is greater in the more deprived communities with worse health outcomes including early deaths and diseases related to alcohol, and worse social and economic outcomes including crime and disorder and anti-social behaviour.

Improving the access to effective treatment for alcohol addiction for those in the most deprived communities is essential in reducing the inequalities in outcomes such as healthy life expectancy for these communities.

COVID 19 has impacted on people staying at home and drinking alcohol, which has seem an increase in the number of individuals presenting to the Service seeking support and treatment.

What are we doing about this?

This is a key performance indicator within the STRIDE (Support, Treatment and Recovery In Darlington through Empowerment Service) service contract and is monitored within the contract monitoring.

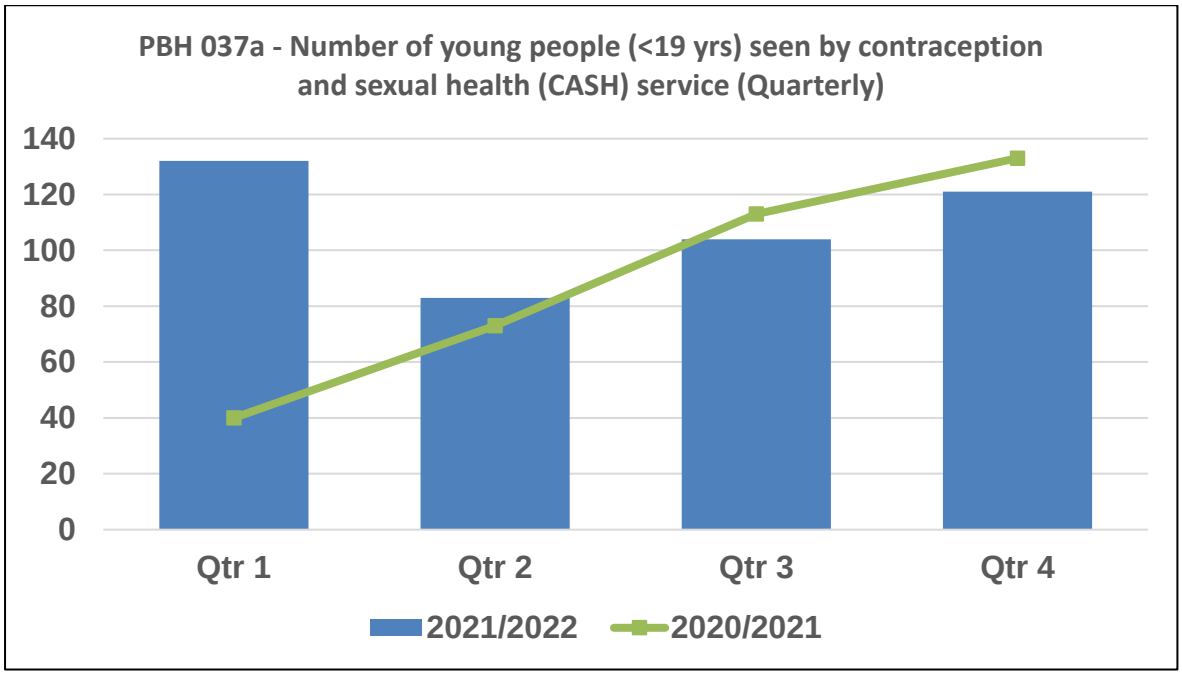
We Are With You took over the Service delivery in August 2020.

The Public Health team has continued to work with We Are With You to understand if there are any unique characteristics of the local drug using population or changes in the wider system, including changes to benefits and other local services that might have contributed to the faster decrease in completions in Darlington compared to other areas.

The Service delivery model focusses on supporting sustained recovery in the community. This model uses the most up to date evidence and models of best practice to provide the best support to those who use substances in Darlington.

CONTRACT PBH 037a: Number of young people (<19 yrs) seen by contraception and sexual health (CASH) services (Quarterly)

Figure 13 -



Service Provider: County Durham and Darlington NHS Foundation Trust

What is the data telling us?

The data shows an increase in the number of young people seen for Q1-2 with a decrease in the Q3-4 of the year compared to last year. These numbers need to be considered with caution due to the impact of COVID-19 on the service.

This means that the numbers of young people aged under 19 years who have been seen by the Contraceptive and Sexual Health (CASH) Service has slightly reduced from a total of 413 in 2019/20 to 359 in 2020/21. This shows that despite the impact of COVID-19 young people are confident in and able to better access this service and are making active choices about contraception.

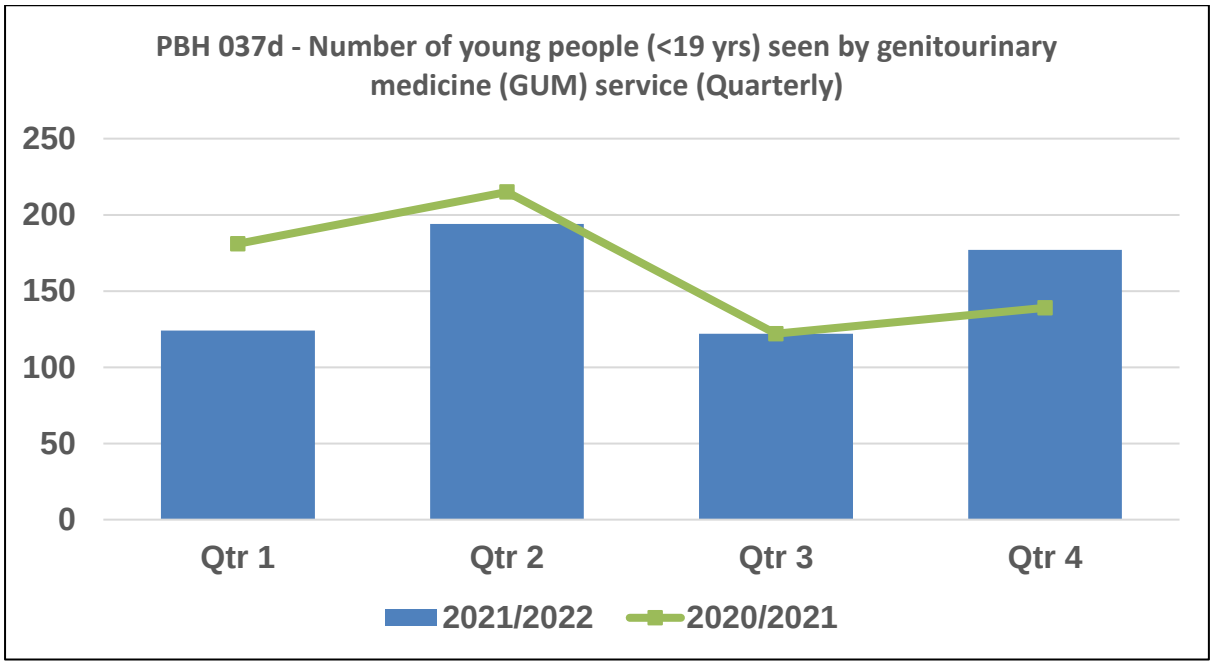
What more needs to happen?

The integrated Sexual Health Service contract has a single point of contact which streams and triages service users into the most appropriate Service, based on the presenting condition, along with a more flexible appointment system.

The Service offers an accessible service for young people and with the introduction of online services work continues to integrate this Service to ensure that all service users including young people get a consistent high-quality Service.

CONTRACT PBH 037d: Number of young people (<19 yrs) seen by genitourinary medicine (GUM) services (Quarterly)

Figure 14 -



Service Provider: County Durham and Darlington NHS Foundation Trust

What is the data telling us?

The data shows a decrease in the numbers of young people under the age of 19 years that were seen by the Sexual Health Services in Darlington Q1-2, the same number for Q3 and an increase for Q4 compared to the same period last year. This data needs to be considered with caution due to the impact of COVID-19 on the service.

There has been a corresponding increase in contraception attendance in this age group as a result of the single point of contact established with the new contract resulting in more efficient streaming of individuals into the right service.

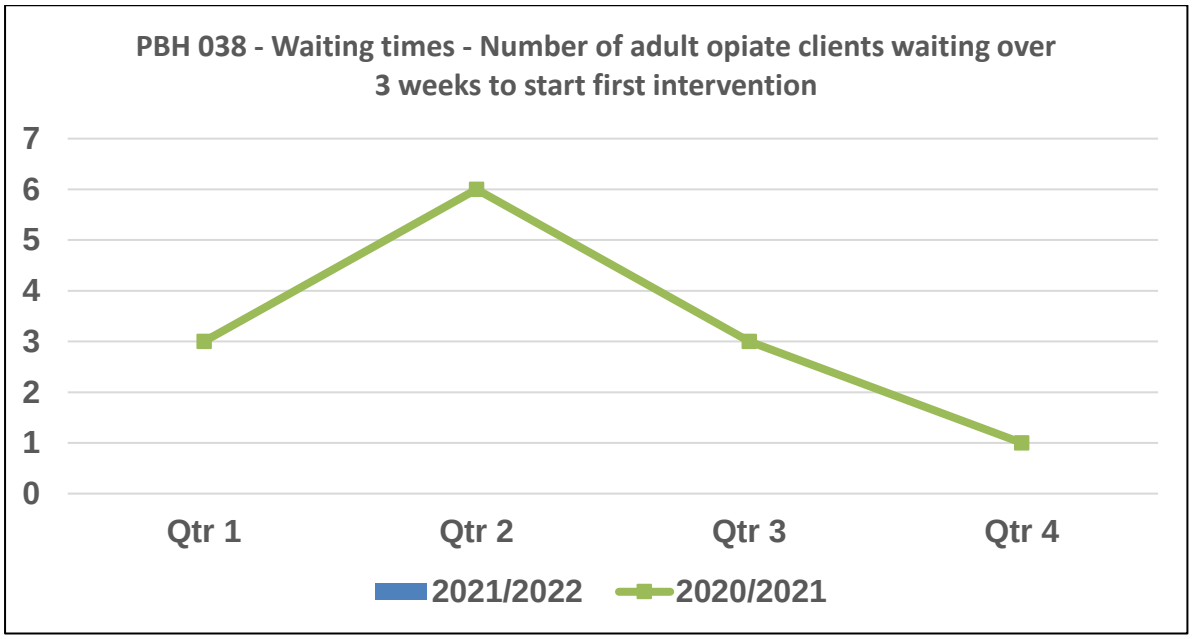
What more needs to happen?

The integrated Sexual Health Service contract has a single point of contact which screens and triages service users into the most appropriate Service, based on the presenting condition, along with a more flexible appointment system.

The Provider continues to work to ensure that GUM services remain accessible to young people. This includes implementing options such as postal testing for common diseases such as Chlamydia and offering condoms online. The Provider also offers other options for result notifications including text services. This reduces the requirement for young people to have make time or have to travel to visit the clinic for low risk or routine processes.

CONTRACT PBH 038: Waiting times – Number of adult opiate clients waiting over 3 weeks to start first intervention

Figure 15 -



*Waiting Times are based on time from assessment to first structured treatment intervention for those who started structured treatment.

Service Provider: We Are With You (WAWY)

What is the data telling us?

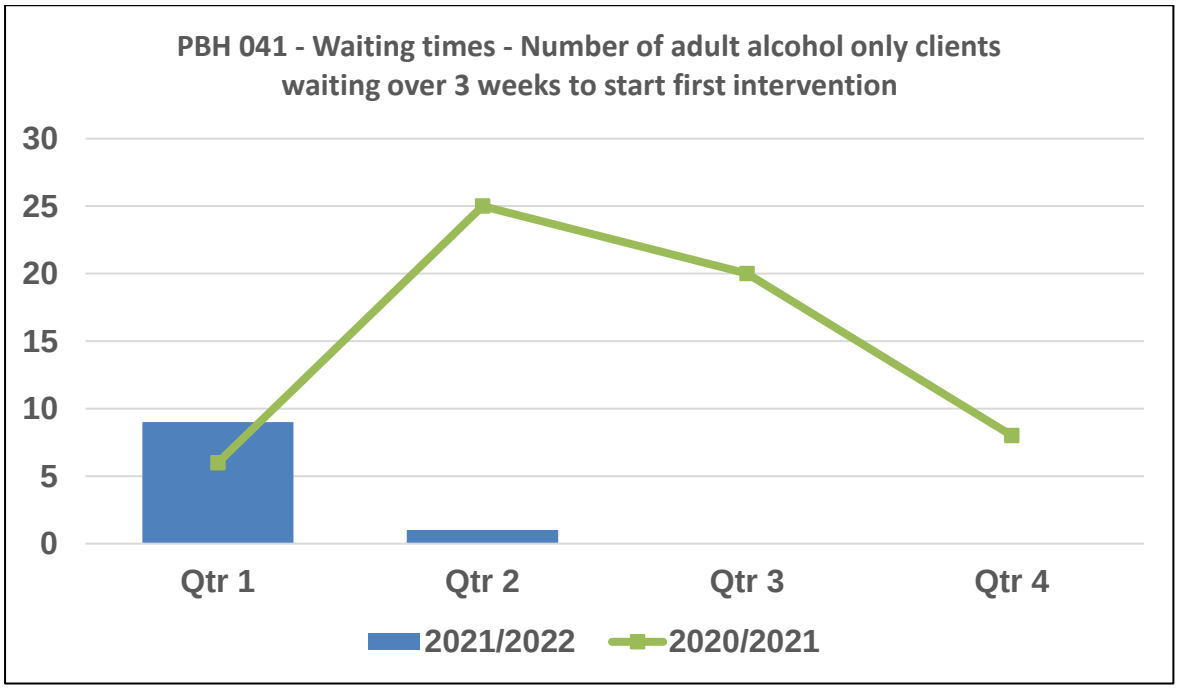
The data shows a decrease in the numbers of service users who waited over 3 weeks to start their first intervention for opiates compared to the last quarter and the same period last year. No service users waited more than 3 weeks to start their first treatment for opiate in all four quarters compared to 13 in the previous year.

What more needs to happen?

The Service has improved its assessment process and as a result waiting times have sustainably improved. All service users are assessed at first presentation and an appointment is booked for first structured treatment on the same day. The Provider continues to work to ensure that capacity is sufficient to meet demand and continues to monitor Does Not Attend rates.

CONTRACT PBH 041: Waiting times – Number of adult alcohol only clients waiting over 3 weeks to start first intervention

Figure 16 -



*Waiting Times are based on time from assessment to first structured treatment intervention for those who started structured treatment.

Service Provider: We Are With You (WAWY)

What is the data telling us?

The data shows an increase in Q1 in the numbers of service users who waited over 3 weeks to start their first intervention for alcohol compared to the last quarter and the same period last year, but a decrease for Q2-4. A total of 10 service users waited more than 3 weeks to start their first treatment for alcohol this year, compared to 59 in 2020/21.

What more needs to happen?

The Service has improved its assessment process and as a result waiting times have sustainably improved. All service users are assessed at first presentation and an appointment is booked for first structured treatment on the same day. The Provider continues to work to ensure that capacity is sufficient to meet demand and continues to monitor Does Not Attend rates.

KEY PBH 050 - (PHOF D07) HIV late diagnosis (%)

Definition: Percentage of adults (aged 15 years or more) diagnosed with a CD4 cell count less than 350 cells per mm^3 among all newly diagnosed adults with CD4 cell count available within 91 days of diagnosis. These include all reports of HIV diagnoses made in the UK, regardless of country of first HIV positive test (i.e. including people who were previously diagnosed with HIV abroad).

Data are presented by area of residence, and exclude people diagnosed with HIV in England who are resident in Wales, Scotland, Northern Ireland or abroad.

Numerator: Number of adults (aged 15 years or more) newly diagnosed with HIV infection with a CD4 count less than 350 cells per mm^3 within 91 days and who are resident in England. These include all reports of HIV diagnoses made in the UK, regardless of country of first HIV positive test (that is including people who were previously diagnosed with HIV abroad). Three-year combined data.

Denominator: Number of adults (aged 15 years or more) newly diagnosed with HIV infection with CD4 count available within 91 days and who are resident in England. These include all reports of HIV diagnoses made in the UK, regardless of country of first HIV positive test (i.e. including people who were previously diagnosed with HIV abroad). Three-year combined data.

Latest update: 2018-20 **Current performance: 16.7%**

Figure 17 - All North East region comparison

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	3,426	42.4	41.3	43.5
North East region	–	92	39.8	33.5	46.5
Sunderland	–	13	56.5	34.5	76.8
South Tyneside	–	8	53.3	26.6	78.7
Hartlepool	–	-	50.0*	6.8	93.2
Middlesbrough	–	6	46.2	19.2	74.9
Gateshead	–	10	43.5	23.2	65.5
North Tyneside	–	7	38.9	17.3	64.3
County Durham	–	17	37.8	23.8	53.5
Newcastle upon Tyne	–	18	34.6	22.0	49.1
Stockton-on-Tees	–	5	33.3	11.8	61.6
Northumberland	–	3	33.3	7.5	70.1
Redcar and Cleveland	–	2	25.0	3.2	65.1
Darlington	–	-	16.7*	0.4	64.1

Source: UK Health Security Agency (UKHSA)

Benchmarked against goal ■■■ <25% | 25% to 50% | ≥50% | Not applicable

Recent trends: – Could not be calculated ➡ No significant change

What is the data telling us?

This data is from 2018-20. The trend could not be calculated for HIV late diagnosis. 16.7% of adults (aged 15 years and over) were diagnosed with a CD4 cell count less than 350 cells per mm^3 among all newly diagnosed adults with CD4 cell count available within 91 days of diagnosis. Compared to our North East neighbours Darlington is ranked 12^{th}. Statistically better than the North East and England against the benchmarked goal of <25%.

Why is this important to inequalities?

Late diagnosis is the most important predictor of morbidity and mortality among those with HIV infection. Those diagnosed late have a ten-fold risk of death compared to those diagnosed promptly and is essential to evaluate the success of expanded HIV testing. The evidence from local and national epidemiology and surveillance indicates that specific vulnerable groups are at greater likelihood of presenting late for HIV diagnosis.

What are we doing about this?

The Sexual Health Service provided by County Durham and Darlington NHS Foundation Trust includes Genito Urinary Medicine (GUM) Service. The Service has increased the proportion of new patients receiving a comprehensive sexual health screen including an HIV risk assessment. This identifies those who are most risk of exposure to HIV and provides the opportunity to provide them with targeted information, advice and support is provided to reduce the risk of exposure and reduce the risk of any future infection. There are also more routes to access HIV testing through the use of postal testing.

Groups that are identified as being at greater risk of HIV infection are targeted through the provision of a Blood Borne Virus (BBV) service, through our STRIDE contract. This includes a well-established and well used needle exchange to reduce the exposure HIV in those who inject drugs.

The Sexual Health Service also manages a condom distribution programme (C-Card) in Darlington for those over the age of 12years to reduce the potential for exposure to HIV through unprotected intercourse.

KEY PBH 056 - (PHOF E04b) Under 75 mortality rate from cardiovascular disease considered preventable (2019 definition)

Definition: Age-standardised rate of mortality that is considered preventable from all cardiovascular diseases (including heart disease) in persons aged less than 75 years per 100,000 population.

Numerator: Number of deaths that are considered preventable from all cardiovascular diseases (classified by underlying cause of death recorded as ICD codes I71, I10-I13, I15, I20-I25, I60-I69, I70 and I73.9 all at 50% of the total count. Registered in the respective calendar years, in people aged under 75, aggregated into quinary age bands (0-4, 5-9, …., 70-74).

Denominator: Population-years (aggregated populations for the three years) for people aged under 75, aggregated into quinary age bands (0-4, 5-9, …, 70-74).

Latest update: 2020 **Current performance: 32.6 (per 100,000)**

Figure 18 - All North East region comparison

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	14,413	29.2	28.7	29.7
North East region	→	854	33.6	31.4	36.0
Middlesbrough	→	48	41.4	30.5	55.0
Hartlepool	→	34	38.6	26.6	54.1
Gateshead	→	67	36.7	28.4	46.6
Sunderland	→	96	36.0	29.2	44.0
North Tyneside	→	74	35.8	28.0	45.0
County Durham	→	184	35.2	30.3	40.7
South Tyneside	→	53	35.1	26.2	46.0
Newcastle upon Tyne	→	74	33.8	26.5	42.5
Darlington	→	33	32.6	22.4	45.9
Stockton-on-Tees	→	52	28.5	21.2	37.4
Northumberland	→	103	28.1	22.8	34.1
Redcar and Cleveland	→	39	27.5	19.5	37.6

Source: Office for Health Improvement and Disparities (based on ONS source data)

Compared with Neighbrs average ▪▪▪ Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

What is the data telling us?

This data (from 2020) shows that that there is no significant change to the trend for Under 75 mortality rate from cardiovascular diseases considered preventable. 32.6 per 100,000 of deaths that are considered preventable from all cardiovascular diseases in people aged under 75. Compared to our North East neighbours Darlington is ranked 9th. Statistically similar to the North East and England.

Why is this important to inequalities?

The most deprived communities have the highest rates of modifiable or preventable CVD risk factors compared to the wider population. Prevalence in these communities is greater in the most deprived communities with take up of preventative and early diagnosis poorer. This results in those in the most deprived communities experiencing worse outcomes including late diagnosis which can result in emergency admission, disability and earlier deaths. Inequalities also exist between men and women, with men experiencing significantly worse rates and outcomes in relation to CVD than women. Therefore, men living in the most deprived communities in Darlington are most likely to experience the worst outcomes.

What are we doing about this?

The Authority and the Primary Care Network (PCN) is working to improve access to and take up of opportunities for the early identification and treatment of CVD in the population, particularly in those high-risk communities.

Primary Health Care Darlington manage the NHS Health Checks contract, through a sub-contracting arrangement with all 11 GP Practices in Darlington. The NHS Health Check offer has been impacted by Covid with GP Practices unable to send the high volume of invites out to people. NHS Health Checks have continued to be offered throughout the Covid pandemic at a reduced rate to those who have been in contract with their GP Practice. Numbers are expected to improve in the future.

KEY PBH 060 - (PHOF E07a) Under 75 mortality rate from respiratory disease

Definition: Age-standardised rate of mortality from respiratory disease in persons less than 75 years per 100,000 population.

Numerator: Number of deaths from respiratory diseases (classified by underlying cause of death recorded as ICD codes J00-J99) registered in the respective calendar years, in people aged under 75, aggregated into quinary age bands (0-4, 5-9, ….,70-74).

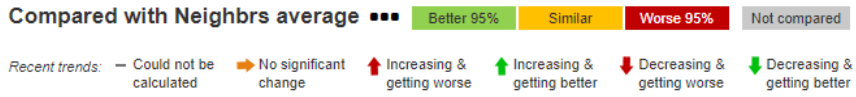
Denominator: Population-years (aggregated populations for the three years) for people of all ages, aggregated into quinary age bands (0-4, 5-9, …., 70-74).

Latest update: 2020 **Current performance: 38.9 (per 100,000)**

Figure 19 - All North East region comparison

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	14,516	29.4	28.9	29.8
North East region	→	959	37.2	34.9	39.6
South Tyneside	→	69	46.4	36.0	58.7
Middlesbrough	→	52	45.3	33.8	59.5
Sunderland	→	115	42.1	34.8	50.5
County Durham	→	225	42.0	36.6	47.8
Newcastle upon Tyne	→	90	41.2	33.1	50.7
Darlington	→	40	38.9	27.8	53.0
Redcar and Cleveland	→	55	38.5	28.9	50.1
Stockton-on-Tees	→	67	37.2	28.8	47.2
Hartlepool	→	31	35.2	23.9	50.0
Gateshead	→	64	34.3	26.4	43.8
North Tyneside	→	55	26.8	20.2	34.9
Northumberland	→	96	25.4	20.5	31.1

Source: Office for Health Improvement and Disparities (based on ONS source data)



What is the data telling us?

This data (from 2020) shows that that there is no significant change to the trend for Under 75 mortality rate from respiratory disease. 38.9 per 100,000 of deaths from respiratory diseases (classified by underlying cause of death) in people aged under 75. Compared to our North East neighbours Darlington is ranked 6th. Statistically similar to the North East and England.

Why is this important to inequalities?

National data shows that the under 75 years mortality rate for respiratory disease is not equally distributed across the population with those in the most deprived parts of the population having the worst rates of mortality. There are also inequalities between males and females, with males having the worst rates of mortality. This means that men from our

most deprived communities are statistically more likely to experience morbidity and premature mortality from respiratory disease.

What are we doing about it?

The Authority is proactive in a number of areas which can contribute to the reduction of this rate. Smoking tobacco is identified as the greatest single modifiable risk factor. The Authorities regulatory services takes proactive action to enforce smoke free legislation to reduce exposure to second hand tobacco smoke as well as monitoring and enforcing point of sale regulations for the sale of tobacco products.

Air pollution is identified as a significant risk factor in the development of lung disease and the Authority is active in action to monitor and reduce air pollution produced by homes, industry and transport. This includes considerations of the impact of pollution in local economic development plans.

The Public Health team commissions a range of primary prevention interventions supported by the School Nurse team through the PHSE curriculum which highlights the harms from tobacco. This is underpinned by the Healthy Lifestyles Survey which provides valuable opportunity for intervention in relation to smoking in young people. The survey also provides intelligence in relation to the attitudes and smoking behaviours of young people in Darlington.

The Public Health team also commission a Stop Smoking Service which identifies those with established respiratory disease as a priority group for specialist stop smoking support.