Darlington Borough Council

Public Health

July - September (Quarter 2) Performance Highlight Report

2018-19

Public Health Performance Introduction

The attached report describes the performance of a number of Contract Indicators and a number of Key or Wider 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 increasingly scheduled to meet deadlines to inform the performance clinic reports.

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 2.01) Low birth weight of term babies
PBH 016	(PHOF 2.04) Rate of under 18 conceptions
PBH 033	(PHOF 2.14) Prevalence of smoking among persons aged 18 years and over
PBH 048	(PHOF 3.02) Rate of chlamydia detection per 100,000 young people aged 15 to 24
PBH 058	(PHOF 4.05i) Age-standardised rate of mortality from all cancers in persons less than 75 years of age per 100,000 population

Q2 Indicators

Indicator Num	Indicator description
PBH 044	(PHOF 2.18) Alcohol related admissions to hospital
PBH 046	(PHOF 2.22iv) Take up of the NHS Health Check programme-by those eligible
PBH 052	(PHOF 3.08) Antimicrobial resistance

Q3 Indicators

Indicator Num	Indicator description
PBH 013c	(PHOF 2.02ii) % of all infants due a 6-8 week check that are totally or partially breastfed
PBH 014	(PHOF 2.03) % of women who smoke at time of delivery
PBH 018	(PHOF 2.05) Child development-Proportion of children aged 2-2.5 years offered ASQ-3 as part of the Healthy Child Programme or integrated review
PBH035i	(PHOF 2.15i) Successful completion of drug treatment-opiate users
PBH 035ii	(PHOF 2.15ii) Successful completion of drug treatment-non opiate users
PBH 035iii	(PHOF 2.15iii) Successful completion of alcohol treatment
PBH 050 *	(PHOF 3.04) People presenting with HIV at a late stage of infection
PBH 056	(PHOF 4.04ii) Age-standardised rate of mortality considered preventable from all cardiovascular diseases (inc. heart disease and stroke) in those aged <75 per 100,000 population
PBH 060	(PHOF 4.07i) Age-standardised rate of mortality from respiratory disease in persons less than 75 years per 100,000 population

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

Q4 Indicators

Indicator Num	Indicator description
PBH 020	(PHOF 2.06i) Excess weight among primary school age children in Reception year
PBH 021	(PHOF 2.06ii) Excess weight among primary school age children in Year 6
PBH 024	(PHOF 2.07i) Hospital admissions caused by unintentional and deliberate injuires to children (0-4 years)
PBH 026	(PHOF 2.07i) Hospital admissions caused by unintentional and deliberate injuires to children (0-14 years)
PBH 027	(PHOF 2.07i) Hospital admissions caused by unintentional and deliberate injuires 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 2.10) Self-harm
PBH 054	(PHOF 4.02) Proportion of five year old children free from dental decay

	INDEX		
Indicator Num	**Indicator description**	**Indicator type**	**Pages**

Quarter 2 Performance Summary

Key Indicators

The key indicators reported this quarter concern alcohol related admissions, take-up of NHS Health Checks by those eligible and efforts to reduce prescribing in primary care settings to reduce antimicrobial resistance.

Performance among these three indicators at first glance looks mixed, however it is important to recognise that these indicators are overarching measures of key changes needed and are affected not only by local action, but by wider culture change and legislation.

PBH044 Admissions episodes for alcohol related conditions are now following the national trend yet remain statistically worse than the England benchmark and a mid-rank compared to our CIPFA neighbours.

PBH046 Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check are assessed cumulatively over a five year period. The aim is that within those five years 75% of the eligible population should be seen. Comparison to our CIPFA nearest neighbours is mid-rank, and similar to England average.

PBH052 Adjusted antibiotic prescribing in primary care by the NHS is a key public health issue globally. To tackle this, national targets to reduce antibiotic prescribing in primary care settings are set for each Clinical Commissioning Group (CCG). Locally it is difficult for the public health team to have an effect on this indicator. However, awareness campaigns around medicine use are promoted, and the re-fresh of the Pharmaceutical Needs Assessment (PNA) for the borough makes note of the role that pharmacies can play in advising correct medicine use and providing guidance on self-medication.

Contract Indicators

Overall, most of the 27 contract indicators are sitting within the expected thresholds for Q2 2018/19.

Two indicators have been highlighted as exceptions for Q2; pertaining to the Stop Smoking Service.

The two stop smoking indicators highlighted show positive performance overall, but the narrative highlights steps needed to be taken to ensure this improvement in performance continues.

The new sexual health service was operational from 1st August 2018. The indicators in relation this Service (PBH 017, 037a and 037b) have remained separately reported for Q2. A discussion will be held with the Provider about future reporting arrangements, with regards to the merit of keeping these separate or combining the attendance figures.

Comparison to Quarter 1 Highlight Report

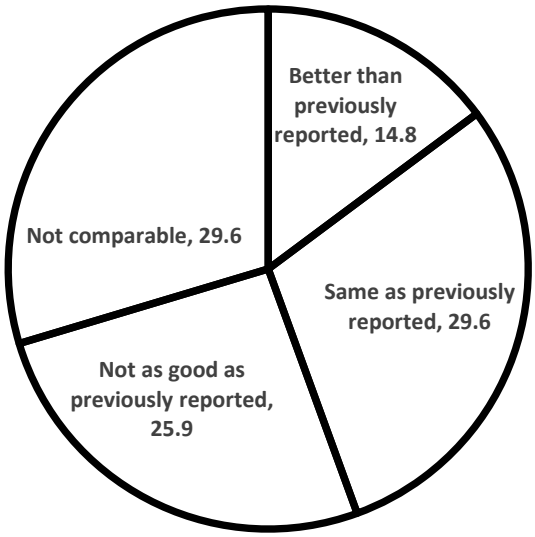
Progress on indicators that were highlighted as exceptions in Q1:

- PHB049: The percentage of those tested for chlamydia notified of their results within 10 working days continues to exceed the target of 90% reporting at 97% in Q2 2018/19.

- PHB012 and PHB013: Breastfeeding status recorded for infants at 10-14 days and 6-8 weeks continues to sit at 99% for both indicators against the 100% target. This equates to 277 of the 280 infants seen at 10-14 days having their feeding status recorded and 265 of 280 infants seen at 6-8 weeks having feeding status recorded.

- PHB012b and PBH013a: Q1 2018/19 showed increases in infants at 10-14 days who were partially breastfed and infants at 6-8 weeks who were totally breastfed. Both of these indicators have seen small decreases in Q2 2018/19, but remain within the expected thresholds.

The pie chart below shows the percentage of the performance of the 27 contract indicators in Q2 in comparison to Q1. It should be noted that almost a third of Public Health contract indicators are not comparable in this sense; that is, it is not simply a case of a figure representing whether something has performed “better” or “worse”.



PBH 044 - (PHOF 2.18) Admission episodes for alcohol-related conditions-Persons (narrow definition)

Definition: Hospital admissions for alcohol-related conditions (narrow definition), all ages, directly age standardised rate per 100,000 population European standard population.

Numerator- Admissions to hospital where the primary diagnosis is an alcohol-related condition or a secondary diagnosis is an alcohol-related external cause.

Denominator- ONS mid-year population estimates.

Latest data available: 769 per 100,000 (2016/17)

Target: No national target

Figure 1 - CIPFA Nearest neighbours comparison

2.18 - Admission episodes for alcohol-related conditions - narrow definition 2016/17 — Directly standardised rate - per 100,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	337,113	636	634	639
Stockton-on-Tees	–	1	1,698	901	859	945
Derby	–	4	2,074	890	852	930
St. Helens	–	5	1,524	867	824	912
Doncaster	–	13	2,461	824	791	857
Warrington	–	14	1,586	778	740	818
Darlington	–	-	802	769	717	825
Dudley	–	3	2,384	765	734	796
Tameside	–	11	1,563	729	693	767
Plymouth	–	9	1,796	718	685	752
Rotherham	–	12	1,791	702	669	735
Wigan	–	15	2,187	693	664	723
Bolton	–	6	1,844	693	661	725
North East Lincolnshire	–	2	1,056	675	635	717
Telford and Wrekin	–	8	1,091	673	633	714
Calderdale	–	7	1,274	624	590	660
Bury	–	10	1,017	564	530	600

Source: Calculated by Public Health England: Risk Factors Intelligence (RFI) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

Compared with benchmark Better Similar Worse Not compared

What is the data is telling us?

Since 2008, Darlington has had a greater rate of admissions to hospital due to diseases caused by alcohol consumption than England average. Compared to our geographical neighbours in the North East, Darlington has a lower rate of admissions to hospital due to diseases caused by alcohol consumption.

When compared to our CIPFA neighbours (Figure 1), a wider range of local authorities that are statistically most similar, Darlington's rate is in the top third of the ranking for admissions.

Why is this important to inequalities?

Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions. Alcohol misuse is estimated to cost the NHS about £3.5billion per year and £2billion annually to wider society through lost working days, costs for social care, housing, police and the criminal justice services.

Alcohol-related admissions can be reduced through local interventions but requires action across partners. Reducing alcohol-related harm is one of Public Health England's seven priorities for the next five years (Reference: "Evidence into Action" report 2014).

What are we doing about it?

The Authority commissions NHS Health Checks via GP Practices. An "Audit C" alcohol screening tool is conducted as part of every NHS Health Check within Darlington which can help identify persons who are hazardous drinkers or have active alcohol related disorders. GP's can then provide individualised advice and guidance on risk.

The Council also supports national campaigns aimed at raising awareness and reducing consumption in the population. Examples include Dry January which was widely promoted by partners and via Council media channels. Wider partnership work with the CCG and other organisations support this wider awareness work.

For those with hazardous or harmful drinking that require support the Council commissions a Recovery and Wellbeing Service which provides evidence based interventions to stabilise and support individuals to make the changes in their behaviours that may reduce their harmful drinking and the associated risks.

PBH 046 - (PHOF 2.22iv) Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check, who received an NHS Health Check.

Definition: The 5 year cumulative percent of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check.

Numerator: Number of people aged 40-74 eligible for an NHS Health Check who have received an NHS Health Check in the five year period.

Denominator: Number of people aged 40-74 eligible for an NHS Health Check who were offered an NHS Health Check in the five year period.

Latest data available: 48.4% crude rate (2013/14 to 2017/18)

Target: Offer to 75% of eligible persons over 5 year period

Figure 2 - CIPFA nearest neighbours' comparison

2.22iv - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check 2013/14 - 17/18

Crude rate - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	6,864,964	48.7	48.7	48.7
Rotherham	–	12	34,566	77.1	76.3	77.9
Bury	–	10	41,919	72.6	71.9	73.3
St. Helens	–	5	19,049	56.1	55.3	56.9
Dudley	–	3	54,632	55.1	54.6	55.6
Calderdale	–	7	33,775	54.6	54.1	55.2
Doncaster	–	13	38,615	53.2	52.7	53.7
Warrington	–	14	32,086	51.2	50.6	51.8
Tameside	–	11	25,507	49.3	48.7	49.9
Darlington	–	-	16,425	48.4	47.7	49.2
Derby	–	4	29,735	47.3	46.8	47.9
Bolton	–	6	68,241	45.9	45.5	46.2
Stockton-on-Tees	–	1	26,662	45.1	44.5	45.6
Telford and Wrekin	–	8	15,891	44.1	43.4	44.8
Plymouth	–	9	26,253	42.6	42.1	43.2
Wigan	–	15	43,992	40.2	39.8	40.5
North East Lincolnshire	–	2	12,088	39.8	39.1	40.5

Source: Public Health England

Compared with benchmark Better Similar Worse Not compared

What is the data telling us?

Figure 2 shows that compared to our statistical CIPFA neighbours, Darlington ranks 9th out of 16 authorities.

For this indicator Darlington is performing statistically similar to the England average and statistically better than the North East.

Why is this important to inequalities?

A high take up of NHS Health Checks is important to identify early signs of poor health leading to opportunities for early interventions.

The NHS Health Check programme is a mandated service. It aims to help prevent heart disease, stroke, and diabetes and kidney disease. All those aged between 40 and 74, who have not been diagnosed with one of these conditions are invited to have an NHS Health Check every five years.

The burden of heart disease is not equally shared in the population with a greater morbidity and mortality from heart disease in the more deprived communities.

A regular NHS Health Check enables an individual risk assessment of cardiovascular disease to be undertaken and provides an opportunity for early intervention and prevention strategies with individuals. Improvements in those who receive an NHS Health Check will eventually contribute to reducing the worst effects of cardiovascular disease in the population.

Providing NHS Health Checks for those communities who would benefit the most would help reduce health inequalities in the most deprived areas.

What are we doing about it?

Performance is monitored quarterly, with an annual target for each GP Practice to offer a health check to 20% of the eligible population (40-74 year olds) annually. This is incentivised to encourage the GP Practices to offer a health check to the maximum number eligible. Other data shows that the underlying quarterly rate of those taking up the NHS Health Check invite has been increasing faster compared to both England and regional neighbours, closing the gap between England and Darlington.

PBH 052 – (PHOF 3.08) Adjusted antibiotic prescribing in primary care by the NHS

Definition: Annual total number of prescribed antibiotic items per STAR-PU (Specific Therapeutic group Age-sex weightings Related Prescribing Unit)

Numerator: Total number of antibiotic items prescribed in practices located within the area. An item is an antibiotic (from British National Formulary Section 5.1) that is prescribed in a primary care setting.

Denominator: Total of STAR-PU* units for practices located within the area.

*STAR-PU are weighted units to allow comparisons adjusting for the age and sex of patient's distribution of each practice. These variables vary significantly and it is important to make necessary adjustments.

Latest data available: 1.27 per STAR-PU (2017)

Target: Darlington CCG 10% reduction target 2017/18

Figure 3 - CIPFA nearest neighbours' comparison

3.08 - Adjusted antibiotic prescribing in primary care by the NHS 2017

Indirectly standardised ratio - per STAR-PU

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	33,649,015	1.04	1.04	1.04
St. Helens	–	5	154,346	1.37	1.37	1.38
Tameside	–	11	161,382	1.29	1.28	1.29
Darlington	–	-	77,852	1.27	1.26	1.28
Rotherham	–	12	177,618	1.20	1.20	1.21
Bolton	–	6	201,951	1.20	1.20	1.21
Wigan	–	15	211,864	1.18	1.18	1.19
Calderdale	–	7	143,752	1.17	1.17	1.18
Doncaster	–	13	208,986	1.15	1.15	1.16
Bury	–	10	130,777	1.15	1.15	1.16
Stockton-on-Tees	–	1	126,749	1.13	1.13	1.14
Warrington	–	14	133,684	1.11	1.10	1.11
North East Lincolnshire	–	2	105,728	1.10	1.09	1.11
Dudley	–	3	207,433	1.10	1.09	1.10
Plymouth	–	9	171,855	1.06	1.06	1.07
Derby	–	4	160,564	1.03	1.03	1.04
Telford and Wrekin	–	8	96,116	0.95	0.94	0.95

Source: STAR-PU data is downloaded in report form from NHS Business Service Authority (NHS BSA). STAR-PU data is supplied from NHS Digital to NHS BSA as age & sex adjusted prescribing data. For more information please visit the NHS Digital website.

What is the data telling us?

The rate of reduction of antibiotic prescribing within the local NHS is worse than both England and the North East average and the rate of reduction is slower. In terms of performance against nearest neighbours, Darlington is 3rd highest in the ranking.

This indicator is part of a larger group of indicators and measures for the NHS which is part of the Antimicrobial Resistance (AMR) five year strategy to slow the growth of antimicrobial resistance in the population. This is only one indicator from a larger group of indicators that cover a complex topic area.

Why is this important to inequalities?

Antimicrobial resistance (AMR) is the ability of bacteria to become immune to antibiotics. Without effective antibiotics the success of routine treatments such as surgery and cancer chemotherapy will be reduced significantly.

Those with already compromised immune systems are more susceptible to infections. Very young children, older adults, those living with HIV or other chronic diseases or living with cancer would be most affected by increasing AMR. It is an increasingly serious threat to global public health that requires action across all government sectors and society.

Focusing on preventing infections, an essential component of public health, reduces the need for antimicrobials and therefore lowers the opportunity for antimicrobial resistance to develop.

What are we doing about it?

The Clinical Commissioning Group in Darlington (DCCG) has an action plan to help reduce antibiotic prescribing and is working with individual GP Practices to support them to reduce their prescribing of antibiotics. The CCG is also working with NHS England and other CCGs and hospitals in supporting information campaigns to reduce the demand and expectations for antibiotics from patients for relatively minor and self-limiting illnesses. This includes the regular winter pressures campaigns and plans.

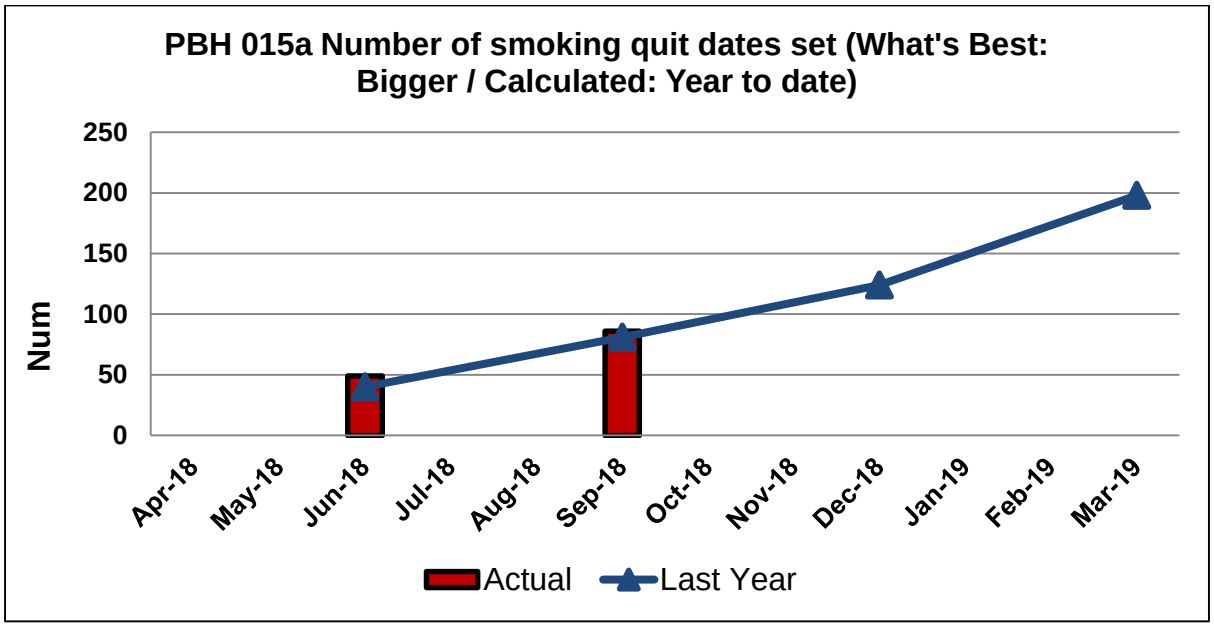
The public health team in Darlington supports the local CCG, NHS England and Public Health England in promoting the different awareness campaigns such as World Antibiotic Awareness Week and the seasonal influenza vaccination campaigns over the winter period. The Authority's role in providing animal health inspections also supports efforts to reduce AMR through ensuring animal welfare standards are applied locally.

The Pharmaceutical Needs Assessment for Darlington stresses that pharmacies have a key role in providing advice and guidance to the public on medicine use including antibiotics and can influence reduction in use.

The Director of Public Health Co-chairs the County Durham and Darlington Healthcare Associated Infections Steering Group.

Contract highlight report

PBH 15a Number of smoking quit dates set



Service Provider: NECA and County Durham and Darlington Foundation Trust

What is the story the data is telling us?

The data shows that the number of quit dates set in Q1 and Q2 2018/19 are marginally higher than the same time period 2017/18, which is a positive for the Service. However there were 12 fewer quit dates set in Q2 2018/19 compared to Q1 2018/19 and overall quit dates set are low.

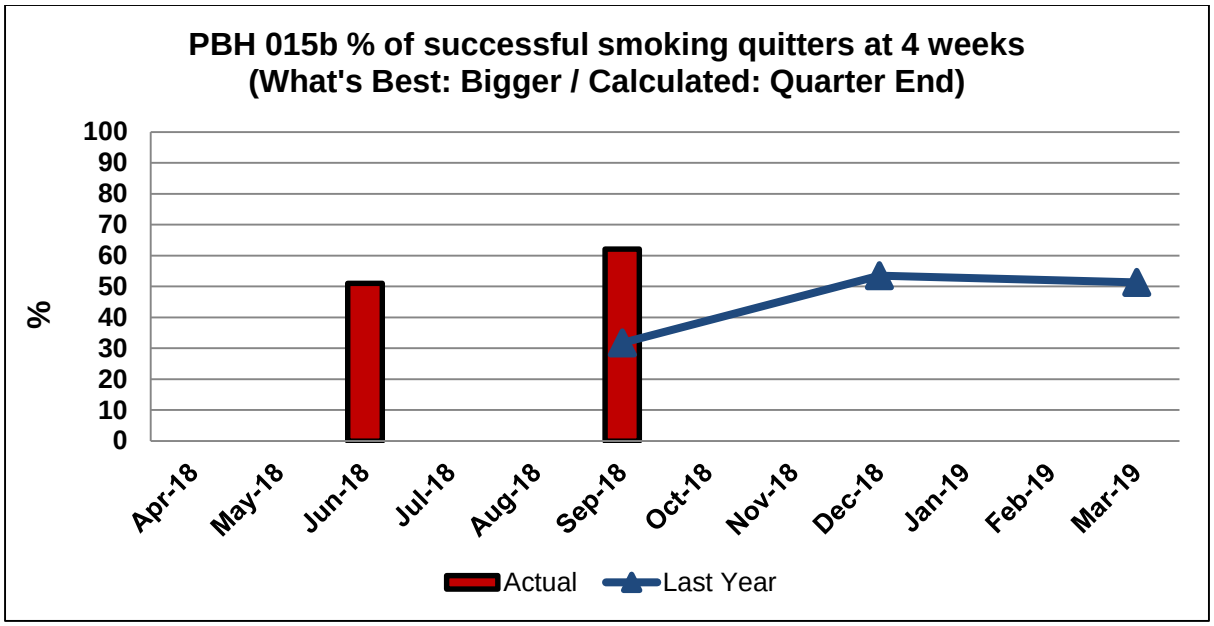
What more needs to happen?

Whilst the increase in number of quit dates being set as shown above is positive, internal quarterly contract monitoring of the Service shows that more needs to be done to generate referrals into the Service into actual quit dates being set by service users.

A discussion took place at the Q1 2018/19 quarterly contract monitoring meeting with the Service and it was highlighted that some service users did not realise that they had been referred to the Service, until the Service contacted them. Actions going forward were to liaise with clinical leads and to emphasise the importance of ensuring service users understand that a referral has been made to the Service. The Service will also raise awareness with community groups and parents with young children.

It is hoped that this will ensure more referrals attend the Service and set quit dates and this will be monitored throughout the contract monitoring meetings in 2018/19.

PBH 015b % of successful smoking quitters at 4 weeks



Service Provider: NECA and County Durham and Darlington Foundation Trust

What is the story the data is telling us?

The graph above shows that after a small decline in successful quits at 4 weeks towards the end of 2017/18 and into Q1 2018/19. The Service has improved quit rates to 62% successfully quit at 4 weeks in Q2 2018/19.

What more needs to happen?

The Service is continuing to promote the Service to boost referrals and increase the number of service users setting a quit date. Work is required to ensure that the higher number of quit dates set translates into higher numbers of successful quitters. This will be monitored over the coming year through quarterly contract meetings with the Service.