Darlington Borough Council

Public Health

October to December 2018 (Quarter 3) 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 schedule on page 5 sets out 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 help monitor and contribute to changes in the Key Indicators. They are collected by our providers and monitored by the Public Health team, on a quarterly basis, as part of the contract monitoring and performance meetings with the providers throughout the lifetime of the contract. They enable providers to be accountable for the services that they are contracted to provide to Darlington residents on behalf of the Authority. The contract indicators are also used to assure Public Health England of the delivery of the Mandated Services that are commissioned using the Public Health Grant. The Contract indicators presented within the Public Health performance framework are selected from the greater number of indicators that are contained with the individual Performance Management Frameworks for each of the Public Health contracts and are used to highlight where performance has improved or deteriorated and what actions are being taken.

Timetable of reporting of Key Public Health Indicators

This is the schedule of the reporting of the agreed Key Public Health indicators. This schedule ensures that the most up to date information is used in these indicators

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

	and stroke) in those aged less than 75 years per 100,000 population		
PBH 047	Total number of NHS Health Checks completed	Contract	37
PBH 057	Number of NHS Health Checks offered	Contract	38
PBH 060	(PHOF 4.07i) Age standardised rate of mortality from respiratory disease in persons less than 75 years per 100,000 population	Key	39

Quarter 3 Performance Summary

Key Indicators

Nine key indicators are reported this quarter; the majority demonstrate stable or improving trends largely in keeping with local/national rates and statistically similar rates to regional and CIPFA nearest neighbours The indicators are:-

- **PBH 013c** (PHOF 2.02(ii)) *% of all infants due a 6 – 8 weeks check that are totally or partially breastfed* – In 2017/18 in Darlington 32% of infants are totally or partially breastfed at 6 -8 weeks after birth. This has remained similar and was at 34% in 2016/17.

- **PBH 014** (PHOF 2.03) *% of women who smoke at the time of delivery* – In 2017/18 in Darlington 16% of mothers are recorded as smoking at time of delivery. This has improved, showing a decrease from 22% in 2010/11.

- **PBH 018** (PHOF 2.05ii) *Child development - Proportion of children aged 2-2.5years offered ASQ3 as part of the Healthy Child Programme or integrated review* – In Darlington in 2015/16 32% of eligible children were offered ASQ3 as part of their health review. This has significantly improved to 98% in 2017/18.

- **PBH035i** (PHOF 2.15i) *Successful completion of drug treatment - opiate users* – In Darlington in 2017 3.7% of those taking opiates, who were receiving structured treatment for their drug use, were abstinent or free from drugs at the end of their treatment and did not re-present to treatment within 6 months. This has increased from 2.8% in 2016.

- **PBH035ii** (PHOF 2.15ii) *Successful completion of drug treatment - non-opiate users* – In Darlington in 2017 20% of those taking drugs other than opiates, who were receiving structured treatment for their drug use, were abstinent or free from drugs at the end of their treatment and did not re-present to treatment within 6 months. This has reduced from 30% in 2016.

- **PBH035iii** (PHOF 2.15iii) *Successful completion of alcohol treatment* – In Darlington in 2017 25% of those who received structured treatment for their alcohol consumption were abstinent at the end of their treatment and did not re-present to treatment within 6 months.

- **PBH050** (PHOF 3.04) *People presenting with HIV at a late stage of infection* – In the period 2015 – 2017 17% of those who were diagnosed with HIV presented late. This is statistically significantly better than the national and regional averages.

- **PBH056** (PHOF 4.04ii) *Age standardised rate of mortality considered preventable from all cardiovascular diseases (inc. heart disease and stroke) in those aged less than 75 years per 100,000 population* – In Darlington the rate of reduction has slowed and is now similar to regional and national averages (2015-17 data).

- **PBH 060** (PHOF 4.07i) *Age standardised rate of mortality from respiratory disease in persons less than 75 years per 100,000 population* – Darlington is now statistically similar to England and national averages (2015-17 data).

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.

Contract Indicators

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 a total of 12 contract indicators which support the nine key indicators. Of these 12 indicators, **11** have maintained or exceeded targets or thresholds with only **1** (PBH013b) showing a reduction to below threshold. These are as follows:-

1. **PBH013 % of all infants for whom feeding status is recorded at 6-8 week check –** this shows continued high performance above the 95% target for this indicator.
2. **PBH013a % of all infants for whom feeding status is recorded at 6-8 week check totally breastfed at 6-8 weeks –** this shows that the rate of breastfeeding in infants in Darlington remains consistent over time. Those recorded as totally breastfed at 22% is consistent with the average of 22% from last year**.**
3. **PBH013b % of all infants for whom feeding status is recorded at 6-8 week check partially breastfed at 6-8 weeks –** this shows that the rate of breastfeeding in Darlington remains consistent over time. Those recorded as partially breastfed at 7.7% is lower than the average of 9.5% from last year and a reduction from 10.4% last quarter. This reduction is largely accounted for with an increase in those recorded as bottle fed from Q2.
4. **PBH015 Number of adults identified as smoking in the antenatal period –** This shows us the number of women who smoke in the antenatal period has reduced from Q2. There is still a significant number (41) known to be smokers in early pregnancy.
5. **PBH015a Number of smoking quit dates set –** This data shows us that there are increasing numbers of individuals who have made a positive step in quitting smoking in setting a quit date as part of a supported quit attempt.
6. **PBH015b % of successful smoking quitters at 4 weeks –** This data shows us that the Service has consistently achieved or surpassed the target of having 50% of those who set a quit date successful stop smoking for at least 4 weeks.
7. **PBH002 % of children who received a 2-2.5 year health review –** This data shows that almost all children in Darlington consistently receive this important review and developmental check before the age of 2.5 years.
8. **PBH045 Number of adults in alcohol treatment –** Compared to last year numbers have improved with a higher average number in treatment compared to last year.
9. **PBH051 % uptake of HIV testing –** The data shows that the uptake of HIV testing remains consistently high at around 80%.

10. **PBH049 % of those tested for chlamydia are notified within 10 days –** The data shows that performance has improved from the previous year and consistently achieved the target of >90%.
11. **PBH047 Total number of NHS Health Checks completed –** A greater number of individuals received a Health Check compared to the same period last year.
12. **PBH057 Total number of NHS Health Checks offered –** A greater number of individuals offered a Health Check compared to the same period last year

Comparison to Quarter 2 2018/19 Highlight Report

Those contract indicators that were highlighted in the Quarter 2 report are updated with the current position below:

PBH015a: This indicator was highlighted in the Q2 report due to 12 fewer quit dates being set in comparison to Q1. In Q3 37 clients set a quit date with the Service which is an improvement. This indicator continues to be monitored closely within quarterly contract meetings.

PBH015b: This indicator was highlighted in the Q2 report for the improvement in quit rate from 51% in Q1 to 62% in Q2. The quit rate has decreased in Q3 to 52%. This remains above the 50% target for successful quitters. Analysis indicates that the high quit rate in Q2 was likely the result of relatively lower numbers setting a quit date in that quarter (PBH015a). The quit rate is a key performance indicator and is discussed in quarterly contract meeting.

KEY PBH 013c – (PHOF 2.02(ii)) % of all infants due a 6 – 8 weeks check that are totally or partially breastfed

Definition: 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.

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

Denominator: Number of infants due for 6-8 weeks.

Latest update: 2017/18 **Current performance: 31.9%** **Target: 35%**

Contributory contract indicators:

- **PBH13** % of all infants whom feeding status is recorded at 6-8 week check
- **PBH 13a** % of all infants for whom feeding status is recorded at 6-8 week check totally breastfed at 6-8 weeks
- **PBH13b** % of all infants for whom feeding status is recorded at 6-8 week check partially breastfed at 6-8 weeks

Figure 1 CIPFA Nearest neighbours comparison

2.02ii - Breastfeeding prevalence at 6-8 weeks after birth 2017/18 Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	251,190	42.7*	42.6	42.8
Derby	–	4	1,351	44.4	42.7	46.2
Plymouth	–	9	1,143	40.3	38.5	42.1
Bolton	–	6	1,505	39.5	37.9	41.0
Warrington	–	14	804	37.9	35.9	40.0
Bury	–	10	788	37.4	35.4	39.5
Darlington	–	-	361	31.9	29.2	34.6
Tameside	–	11	875	31.2	29.5	32.9
Rotherham	–	12	930	30.4	28.8	32.1
Wigan	–	15	997	28.3	26.9	29.9
North East Lincolnshire	–	2	485	28.0	26.0	30.2
Calderdale	–	7	1,144	*	-	-
Dudley	–	3	895	*	-	-
Doncaster	–	13	970	*	-	-
St. Helens	–	5	458	*	-	-
Telford and Wrekin	–	8	-	*	-	-
Stockton-on-Tees	–	1	462	*	-	-

Source: Public Health England National Child and Maternal Health Intelligence Network

Compared with benchmark Better Similar Worse Not compared

What is the data telling us?

This data (from 2017/18), shows that 31.9% of infants are totally or partially breastfed at 6 -8 weeks after birth. When compared to England the proportion of mothers who breastfeed their infants in Darlington is statistically significantly lower. However the proportion of mothers who breastfeed their infants in Darlington is statistically similar to the NE regional average.

Compared to our 16 statistical neighbours Darlington is ranked 6th. Six of our statistical nearest neighbours on Figure One show an asterisk in place of data; this means that Public Health England have 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.

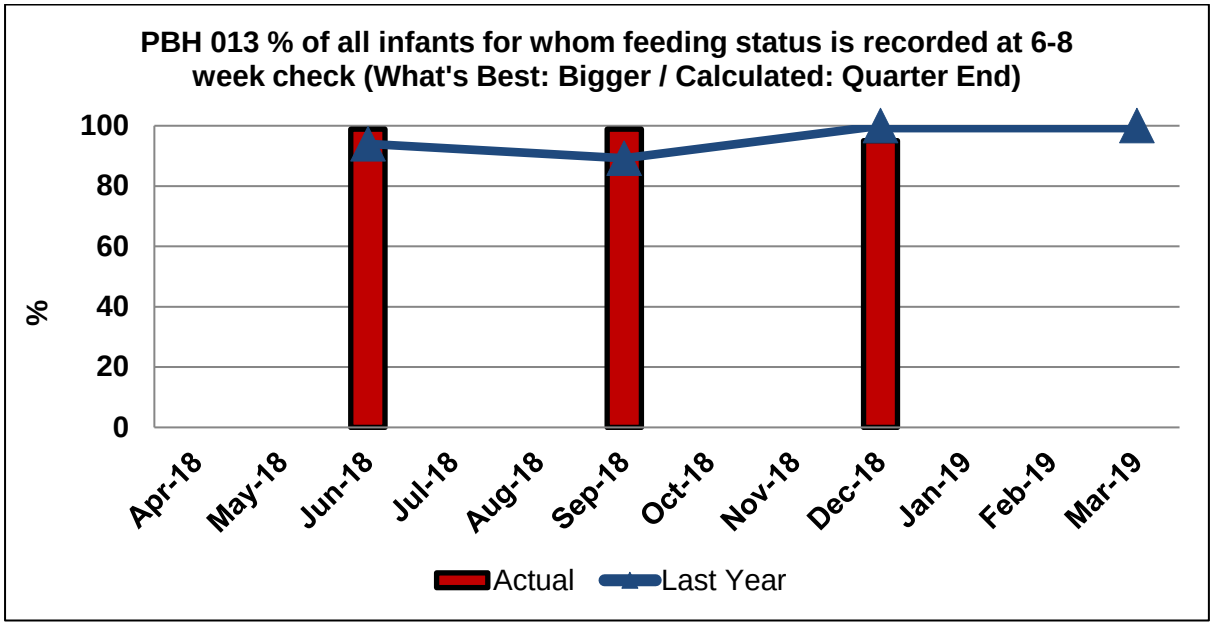
What are we doing about it?

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.

Contract Indicator:

PBH013 % of all infants for whom feeding status is recorded at 6-8 week check



Service Provider: Harrogate and District NHS Foundation Trust

What is the story the data is telling us?

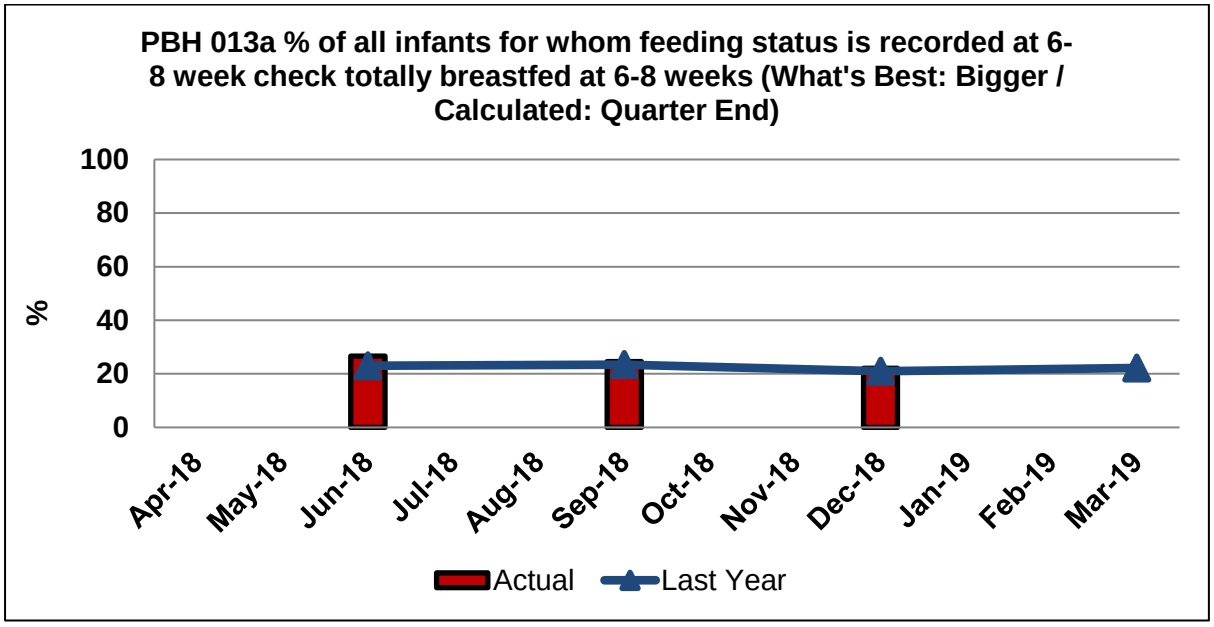
This data is telling us that the Health Visiting Service is achieving their target in seeing over 95% of new mothers at 6 – 8 weeks and proactively checking the feeding status during this visit. It also shows us that the overwhelming majority of mothers are receiving the visit by their Health Visitor within the mandated period and mothers and infants are receiving the appropriate advice and support for feeding, maternal mental health and infant development and are able to intervene in a timely fashion where there are problems.

What more needs to happen?

The Provider continues to maintain this performance in ensuring that the majority of mothers and infants receive a visit within this period and receive the support in relation to breastfeeding and other aspects of parenting.

Contract Indicator:

PBH013a % of all infants for whom feeding status is recorded at 6-8 week check totally breastfed at 6-8 weeks



Service Provider: Harrogate and District NHS Foundation Trust

What is the story the data is telling us?

The data shows that about 1 in 5 infants in Darlington are totally breastfed when their feeding status was checked by their Health Visitor. The graph shows that this is consistently been the ratio of infants totally breastfed in Darlington when they are between 6 – 8 weeks.

What more needs to happen?

Breastfeeding needs to be more widely promoted as a viable and achievable option for expectant mothers. The numbers of those breastfed at birth needs to be maintained into the first days and weeks of life. The variation in breastfeeding between different communities needs to be narrowed. The stigma of breastfeeding needs to be tackled in local communities, particularly those communities suffering the most deprivation.

This is being achieved by:-

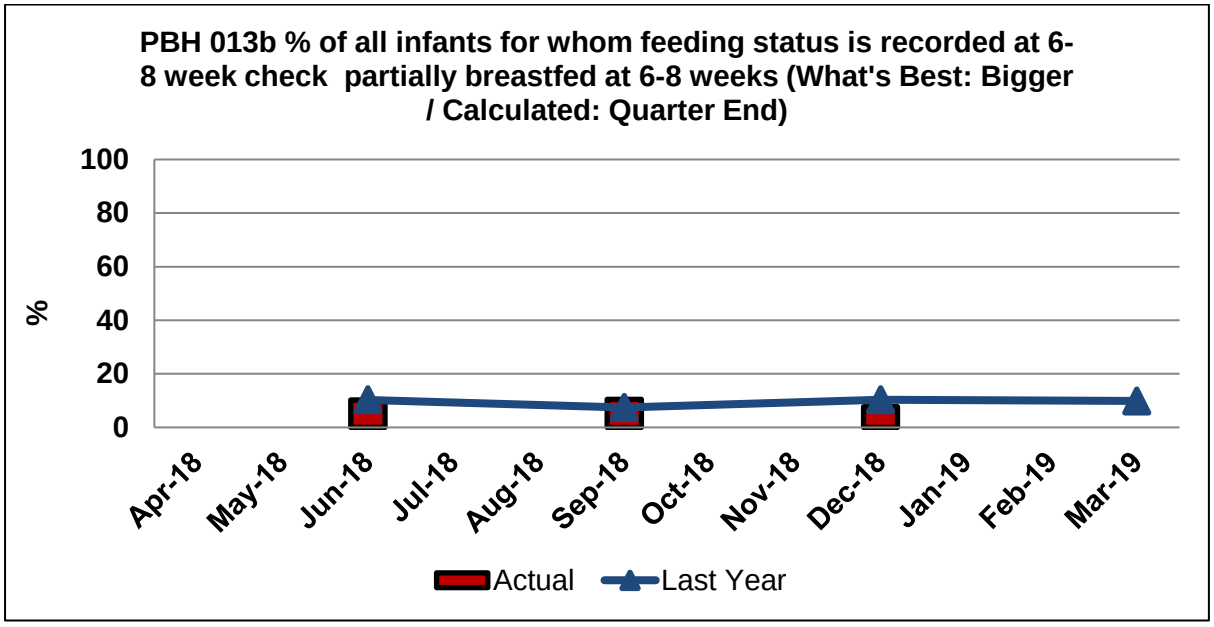
- Improving the number of ante-natal notifications to the HV service by the midwifery service to ensure an intervention by 24 weeks of conception.
- Improving the information and advice provided to expectant mothers, their partners and families to promote breastfeeding as a feeding option and support them in that decision.
- Improving the promotion and support provided to new mothers by the Midwifery team to breastfeed at delivery and maintain this within the first 10 days from birth
- Health Visiting Service continues to work to support new mothers to maintain and consolidate breastfeeding following handover from midwifery at 10-14 days, providing

assessment and rapid access to support to identify problems and provide timely support to the parent.

- 0-19 service achieve and maintain GOLD accreditation from UNICEF for Breastfeeding support for Darlington including leading work on promotion of breastfeeding in the wider community.

Contract Indicator:

PBH013b % of all infants for whom feeding status is recorded at 6-8 week check partially breastfed at 6-8 weeks



Service Provider: Harrogate and District NHS Foundation Trust

What is the story the data is telling us?

This data shows us that less than 1 in 10 infants are partially breastfed when they are 6 – 8 weeks. There has been a reduction from 10.4% in Q2 to 7.7% in Q3. This means that the infant is getting some of the benefits from breastfeeding but this is now supplemented by other artificial methods. Those partially breastfed do contribute to the overall numbers counted as 'breastfed' generally. This reduction can be largely accounted by an increase in those infants recorded as totally bottle-fed compared to Q2.

What more needs to happen?

Similar to PBH013a in ensuring more children are breastfed by this date and supporting new mothers and families to breastfeed.

KEY PBH 014 – (PHOF 2.03) % of women who smoke at the time of delivery

Definition: The number of mothers known to be smokers at the time of delivery as a percentage of all maternities.

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

Denominator: Number of maternities where smoking status is known.

Contributory contract indicators:

- **PBH015** Number of adults identified as smoking in the antenatal period
- **PBH015a** Number of smoking quit dates set
- **PBH015b** % of successful smoking quitters at 4 weeks

Latest update: 2017/18 Current performance: 16.2% Target: less than 11%

Figure 2-CIPFA nearest neighbours comparison

2.03 - Smoking status at time of delivery New data 2017/18 Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	64,391	10.8	10.7	10.9
Warrington	↓	14	178	8.8	7.6	10.1
Plymouth	↓	9	287	10.9	9.8	12.1
Bury	↓	10	264	12.0	10.7	13.4
Calderdale	→	7	309	13.5	12.1	14.9
Dudley	↓	3	488	14.4	13.2	15.6
Bolton	↓	6	532	14.6	13.5	15.8
St. Helens	↓	5	292	15.0	13.5	16.7
Wigan	↓	15	536	15.5	14.3	16.7
Doncaster	↓	13	482	15.6	14.4	16.9
Tameside	↓	11	393	15.8	14.4	17.3
Darlington	↓	-	176	16.2	14.1	18.5
Derby	→	4	484	16.2	14.9	17.5
Stockton-on-Tees	→	1	323	17.0	15.4	18.7
Telford and Wrekin	↓	8	348	17.2	15.7	19.0
Rotherham	↓	12	521	19.9	18.4	21.5
North East Lincolnshire	→	2	390	22.1	20.2	24.1

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

Compared with benchmark Better Similar Worse Lower Similar Higher Not compared

What is the data telling us?

The data shows that there continues to be an overall downward trend for women who smoke at time of delivery but 1 in 6 infants will be born to a mother who smokes. In comparison to our 16 statistically similar neighbours Darlington is ranked 11th.

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.

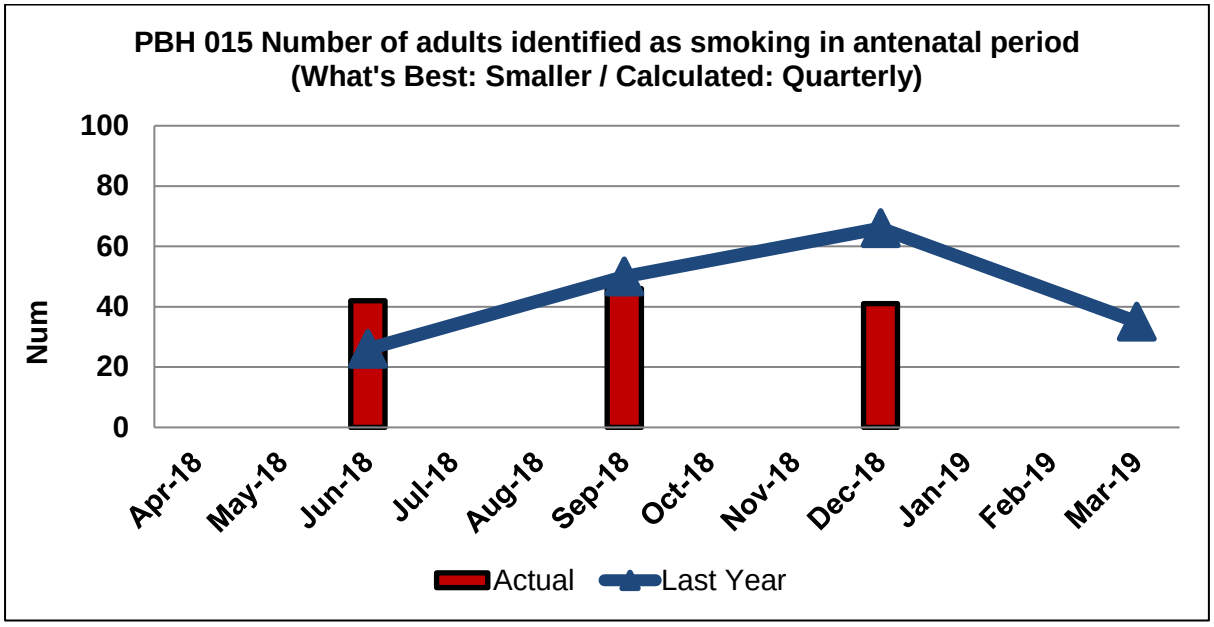
Increasing the proportion of mothers who do not smoke during pregnancy will provide communities with the benefits of reduced harm from smoking, improve outcomes and reduce health inequalities.

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 Indicator:

PBH015 Number of adults identified as smoking in the antenatal period



Service Provider: Harrogate and District NHS Foundation Trust

What is the story the data is telling us?

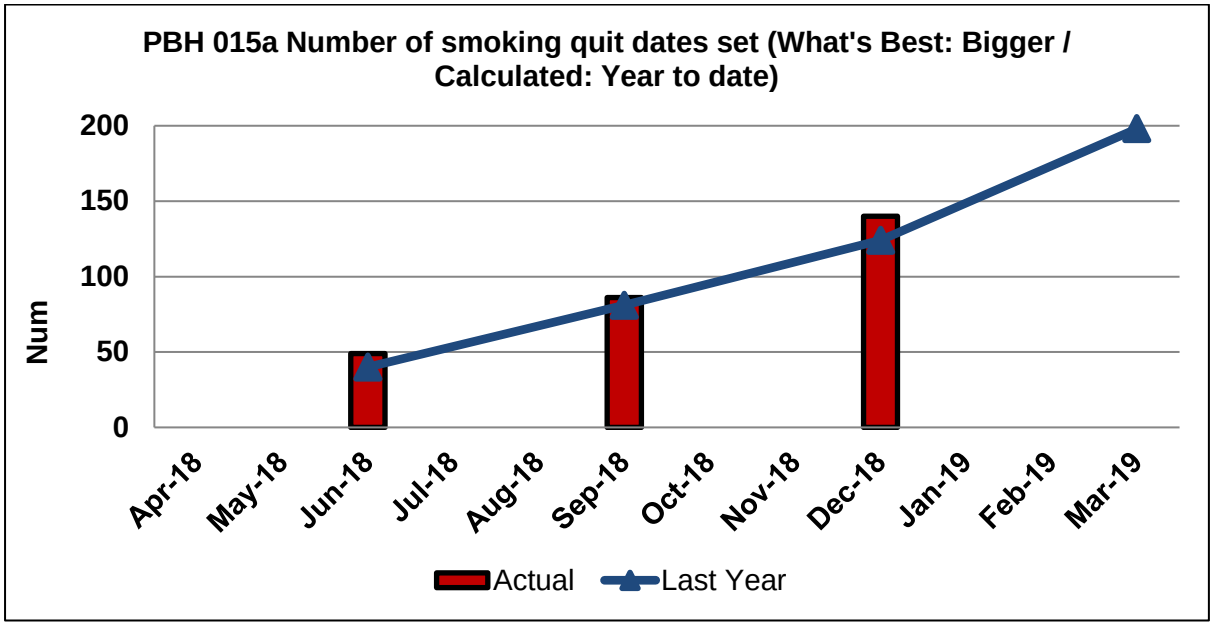
This data is showing us the number of women who smoke in the antenatal period are identified by Health Visitors during their antenatal visit at 24 weeks. It has reduced from Q2, showing that there is still a significant minority of women in Darlington who are smoking when they are pregnant.

What more needs to happen?

The numbers of notifications of pregnancy to Health Visiting from Midwifery needs to improve. The Health Visiting team is working with Midwifery to improve the timeliness of this notification so that they can schedule a visit with the expectant mother before 24 weeks and provide an intervention around smoking. The Specialist Stop Smoking Service is being more heavily promoted to midwifery teams and primary care teams to increase the offer of specialist support and increase the numbers of referrals to this service. More work needs to be done by all teams involved in the pregnancy pathway to identify those women who quit without support to provide them with access to resources and information to support them quitting.

Contract Indicator:

PBH015a 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?

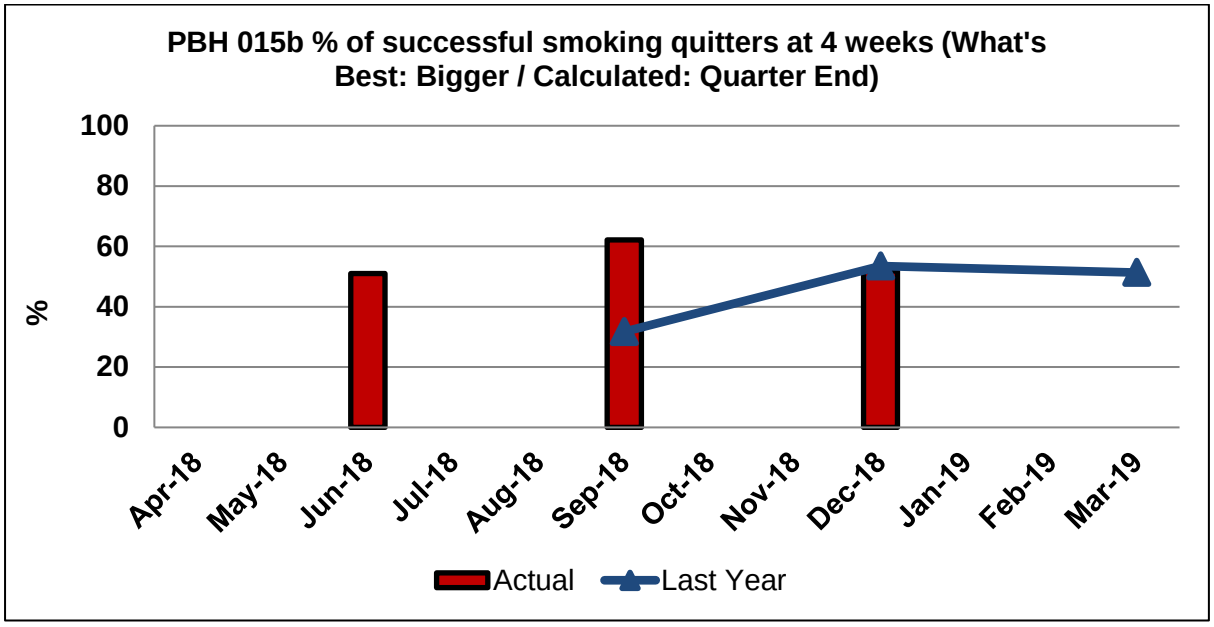
This data shows us that the increasing numbers who have made a positive step in setting a quit date. This has improved since last year with the cumulative increase showing the same trajectory. The numbers actively planning to stop is increasing at a similar rate year on year. The improvement in numbers at the same point last year shows that the Specialist Stop Smoking service is recruiting more individuals who are actively planning to stop smoking.

What more needs to happen?

The Service is working to promote the offer of support and improve access. This includes working with those who see smokers regularly, such as nurses, GPs and social care staff to encourage them to refer more of those who smoke into the specialist service.

Contract Indicator:

PBH015b % 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?

This data shows us that the Service has consistently achieved or surpassed the target of having 50% of those who set a quit date successful stop smoking for at least 4 weeks. Compared to the same period last year the proportion of those successfully quit at 4 weeks is similar. This data also shows the effectiveness of the specialist model in maximising success in quit attempts compared to non-specialist models, with quit rates exceeding the target of 50%.

What more needs to happen?

The Service needs to maintain the focus on providing access to the specialist service to more quitters so that they can benefit from the high quit rates. This includes wider promotion and awareness of the effectiveness of the Service to encourage smokers to use this Service in their attempt to quit. The Service will continue to train individuals and professionals in the community in brief interventions to support behaviour change in smokers so that they are more motivated to quit when they do use the specialist service ensuring a continuation of these high quit rates.

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

Definition: Percentage of children who received a 2-2.5 year review in the period for whom the ASQ3 is completed as part of their 2-2.5 year review

Numerator: Total number of children for which the ASQ-3 is completed as part of their 2-2.5 year reviews.

Denominator: Total number of children who received a 2-2.5 year review by the end of the period.

Contributory contract indicators:

- **PBH002** % of children who received a 2-2.5 year health review (quarterly)

Latest Update: 2017/18 **Current performance: 97.6%** **Target: 95%**

Figure 3-comparison to CIPFA nearest neighbours

2.05ii - Proportion of children aged 2-2½yrs receiving ASQ-3 as part of the Healthy Child Programme or integrated review 2017/18

Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	454,992	90.2	90.1	90.3
St. Helens	–	5	1,630	100	99.8	100
Dudley	–	3	3,307	100	99.9	100
Plymouth	–	9	2,124	98.4	97.8	98.9
Bolton	–	6	3,632	98.3	97.9	98.7
Darlington	–	-	1,111	97.6	96.6	98.4
Tameside	–	11	2,618	95.6	94.7	96.3
Calderdale	–	7	1,844	93.1	91.9	94.2
North East Lincolnshire	–	2	611	92.7	90.5	94.5
Telford and Wrekin	–	8	1,684	91.8	90.5	93.0
Derby	–	4	2,781	91.6	90.6	92.6
Doncaster	–	13	3,011	90.5	89.5	91.5
Rotherham	–	12	2,431	88.6	87.3	89.7
Bury	–	10	1,498	68.2	66.2	70.1
Stockton-on-Tees	–	1	1,930	*	-	-
Warrington	–	14	1,694	*	-	-
Wigan	–	15	2,033	*	-	-

Source: National Child and Maternal Health Intelligence Network, Public Health England

Compared with benchmark Better Similar Worse Lower Similar Higher Not compared

What is the data telling us?

The latest data for 2017/18 at 97.6% is statistically significantly better than the England and Regional figures. In comparison to CIPFA nearest neighbours, Darlington is ranked 5th. This has demonstrated a significant improvement from 2015/16.

Why is this important to inequalities?

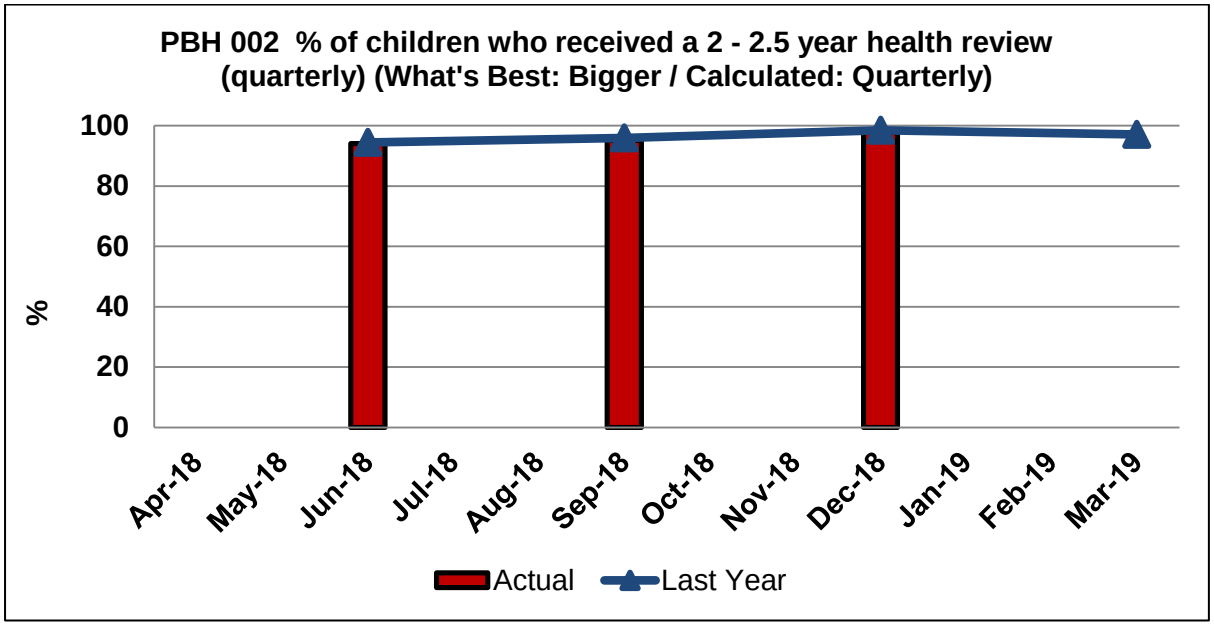
Children from the most disadvantaged communities have a poorer experience in the first years of life and experience the most inequalities throughout childhood and adulthood. The Ages and Stages Questionnaire (ASQ3) provides a comprehensive assessment of child development including motor, problem solving 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. 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 further more focused assessment and early intervention.

Contract Indicator:

PBH002 % of children who received a 2-2.5 year health review (quarterly)



Service Provider: Harrogate and District NHS Foundation Trust

What is the story the data is telling us?

This data shows that 98% of all children in Darlington receive this important review and developmental check before the age of 2.5 years.

What more needs to happen?

The Provider continues to work to ensure this level of provision and universal access to this review and continues to maximise the effectiveness of this intervention for children.

KEY PBH035i (PHOF 2.15i) – 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 six 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: 2017 **Current performance: 3.7%** **Target: 5%**

Figure 4- Comparison CIPFA nearest neighbours

2.15i - Successful completion of drug treatment - opiate users 2017 Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	9,260	6.5	6.4	6.6
Calderdale	→	7	57	8.5	6.6	10.9
Warrington	→	14	44	8.3	6.2	10.9
Telford and Wrekin	→	8	38	7.0	5.2	9.5
Derby	↓	4	76	7.0	5.6	8.7
Dudley	→	3	55	6.1	4.7	7.9
Bury	→	10	29	6.0	4.2	8.5
St. Helens	→	5	40	5.9	4.3	7.9
Plymouth	↓	9	66	5.3	4.2	6.7
North East Lincolnshire	↓	2	39	5.2	3.8	7.1
Bolton	↓	6	57	4.5	3.5	5.8
Wigan	→	15	45	4.4	3.3	5.8
Rotherham	↓	12	41	4.2	3.1	5.6
Doncaster	↓	13	58	4.1	3.2	5.3
Stockton-on-Tees	→	1	43	4.1	3.1	5.5
Darlington	↓	-	16	3.7	2.3	6.0
Tameside	↓	11	29	3.5	2.4	4.9

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the National Drug Treatment Monitoring System

Compared with benchmark Better Similar Worse Lower Similar Higher Not compared

What is the data telling us?

The data shows a downward trend for Darlington in the number of successful completion of drug treatment for opiate users since 2013. This reflects a similar downward trend for both England the NE Region over the same period however the rate of reduction has been faster in Darlington but remained statistically similar to England until 2016. There has been an improvement from 2.8% in 2016 to 3.7% in 2017 with Darlington now statistically similar to England and the NE Region.

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 Recovery and Wellbeing Service contract and is monitored within the contract monitoring. The Provider has been working with the Public Health team to understand the underlying causes of this reduction in successful completions. This has included reviewing the categorisation and recording of successful completions as well reviewing the offer of interventions available including opiate substitution prescribing. Local data indicates that there has been an improvement in the numbers of successful completions in the local service. In Q2 in 2018/19 data indicates that there have been 29 successful completions for adult opiate clients, in comparison to 14 at the same time period in 2017/18. This indicator will continue to be monitored closely.

The Public Health team worked with NECA and Public Health England 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.

KEY PBH035ii (PHOF 2.15ii) – Successful completion of drug treatment - non-opiate users

Definition: Number of users of non-opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within six 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: 2017 **Current performance: 20.2%** **Target: 30%**

Figure 5- Comparison CIPFA nearest neighbours

2.15ii - Successful completion of drug treatment - non-opiate users 2017 Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	19,106	36.9	36.5	37.3
Doncaster	↑	13	61	45.9	37.6	54.3
Dudley	↑	3	142	42.5	37.3	47.9
Wigan	↑	15	257	41.6	37.8	45.5
Calderdale	→	7	77	39.7	33.1	46.7
Telford and Wrekin	↑	8	91	39.1	33.0	45.4
Bury	→	10	87	38.5	32.4	45.0
Derby	↑	4	91	37.0	31.2	43.2
St. Helens	↑	5	91	35.8	30.2	41.9
Warrington	→	14	57	35.4	28.4	43.1
Stockton-on-Tees	→	1	74	35.1	29.0	41.7
Bolton	→	6	142	32.9	28.6	37.4
Rotherham	→	12	46	31.5	24.5	39.4
North East Lincolnshire	→	2	50	27.2	21.3	34.0
Plymouth	→	9	55	26.3	20.8	32.7
Darlington	↓	-	22	20.2	13.7	28.7
Tameside	↓	11	50	19.7	15.3	25.0

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the National Drug Treatment Monitoring System

Compared with benchmark Better Similar Worse Lower Similar Higher Not compared

What is the data telling us?

The data shows a declining trend in successful completion of drug treatment for non-opiate users in Darlington. As of 2017, Darlington is now statistically significantly lower than the England average (but remains similar to regional average).

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 indictor is monitored as a key performance indicator as part of the contract monitoring processes.

The provider has been working with the Public Health team to understand the underlying causes of this reduction in successful completions. This has included reviewing the categorisation and recording of successful completions as well reviewing the offer of interventions available but also the patterns of drug use in the community in Darlington to ensure that treatment options match consumption patterns.

Local information for Q2 in 2017/18 showed that 4 service users had successfully completed treatment for non- opiate use in Darlington. For the same period (Q2) in 2018/19 there were 16 successful completions. This indicates that there is likely to be an improvement in this indicator when official data is published later in 2019. This indicator will continue to be monitored closely in quarterly performance meetings.

KEY PBH035iii – (PHOF 2.15iii) 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 six 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.

Contributory contract indicator:

- **PBH045** Number of adults in alcohol treatment

Latest Update: 2017 **Current performance: 24.7%** **Target: 38%**

Figure 6- Comparison CIPFA nearest neighbours

2.15iii - Successful completion of alcohol treatment 2017

Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↑	-	30,140	38.9	38.6	39.3
Dudley	↑	3	237	52.1	47.5	56.6
Telford and Wrekin	↑	8	209	49.9	45.1	54.6
Calderdale	↑	7	152	48.3	42.8	53.8
St. Helens	↑	5	196	48.2	43.3	53.0
Doncaster	↑	13	137	46.3	40.7	52.0
Rotherham	↑	12	174	43.0	38.2	47.8
Wigan	↑	15	373	41.7	38.5	44.9
Warrington	↑	14	228	41.3	37.3	45.5
Derby	↑	4	219	37.3	33.5	41.3
Bury	↓	10	115	35.5	30.5	40.8
Bolton	→	6	185	34.6	30.7	38.7
Plymouth	↑	9	118	33.1	28.5	38.2
North East Lincolnshire	→	2	82	31.8	26.4	37.7
Stockton-on-Tees	↑	1	142	29.7	25.8	34.0
Darlington	→	-	43	24.7	18.9	31.6
Tameside	↓	11	65	18.2	14.5	22.5

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the National Drug Treatment Monitoring System

Compared with benchmark Better Similar Worse Lower Similar Higher Not compared

What is the data telling us?

The data shows that in Darlington there has been a decreasing trend in the proportion of those successfully completing alcohol treatment since 2014, this trend accelerated from 2016 with Darlington now statistically lower than England although statistically similar to the NE Region.

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.

What are we doing about this?

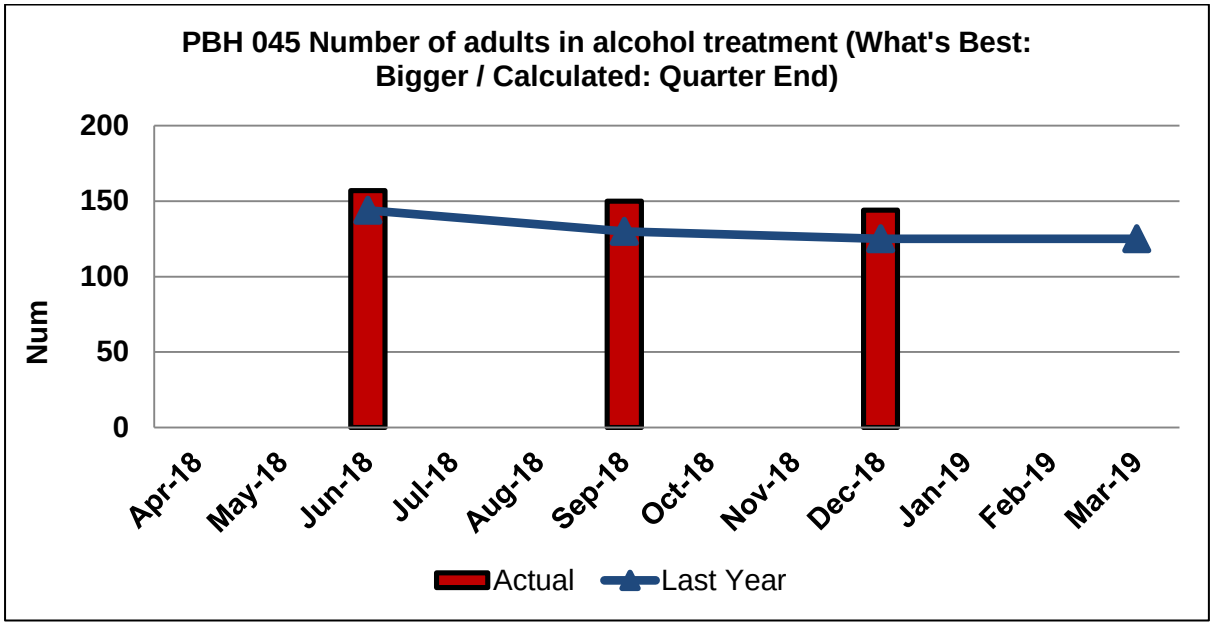
This indictor is monitored locally as part of the contract monitoring for the integrated recovery and wellbeing service. The Public Health team has been working with the provider and Public Health England nationally to identify underlying causes for this reduction. This included Darlington treatment services taking part in a national study to examine common factors that contribute to the reduction in those accessing and completing treatment for alcohol. The provider has adopted recommendations and findings and is using best practice to improve numbers accessing services as well as examining patterns of consumption. The work identified that it is likely that the levels of dependence and complexity in Darlington are higher than expected.

There is also evidence to suggest that there is low levels of awareness and understanding of the local alcohol service provision in potential clients and professionals. The provider is working to improve awareness of the local service and tailor the treatment offer towards the more dependant clients as well as working with other services to develop pathways to better manage the complexity.

Local data for Q2 2018/19 shows 48 service users have successfully completed treatment for alcohol use in Darlington compared to 38 clients in the same period in 2017/18. This indicates that it is likely that performance will improve for 2018/19.

Contract Indicator:

PBH045 Number of adults in alcohol treatment



Service Provider: NECA

What is the story the data is telling us?

The data shows that compared to last year the numbers have increased, with an average of 150 individuals in treatment for this year compared to an average of 131 for last year. Overall there is a steady decline in the numbers accessing treatment over the year.

What more needs to happen?

The Provider is working to improve the profile and awareness of the alcohol treatment service. This includes developing more effective referral pathways with health and social care professionals. The provider is working with voluntary sector partners in engaging with 'mutual aid' organisations such as Alcohol Anonymous and the 12 Steps programme, to provide a broad range of treatment and recovery options for those with alcohol dependence that are sustainable and more convenient for clients.

KEY PBH050 – (PHOF 3.04) People presenting with HIV at a late stage of infection

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 and with known residence-based information.

Numerator: Number of adults (aged 15 years or more) newly diagnosed with HIV infection with a CD4 count less than 350 cells per mm3 within 91 days and who are resident in England. Three-year combined data.

Denominator: Number of adults (aged 15 years or more) newly diagnosed with HIV infection with CD4 counts available within 91 days and who are resident in England. Three-year combined data.

Contributory contract indicator:

- **PBH051** % of uptake of HIV testing

Latest Update: 2015-17 **Current performance: 16.7%** **Target: 50%**

Figure 7- Comparison CIPFA nearest neighbours

3.04 - HIV late diagnosis 2015 - 17 Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	4,461	41.1	40.2	42.1
Darlington	–	-	1	16.7	0.4	64.1
Dudley	–	3	9	29.0	14.2	48.0
St. Helens	–	5	6	33.3	13.3	59.0
Bury	–	10	7	35.0	15.4	59.2
Plymouth	–	9	15	39.5	24.0	56.6
Derby	–	4	25	41.7	29.1	55.1
Doncaster	–	13	16	42.1	26.3	59.2
Bolton	–	6	21	43.8	29.5	58.8
North East Lincolnshire	–	2	5	45.5	16.7	76.6
Telford and Wrekin	–	8	11	45.8	25.6	67.2
Rotherham	–	12	15	48.4	30.2	66.9
Tameside	–	11	18	50.0	32.9	67.1
Stockton-on-Tees	–	1	7	50.0	23.0	77.0
Wigan	–	15	17	56.7	37.4	74.5
Warrington	–	14	10	62.5	35.4	84.8
Calderdale	–	7	13	65.0	40.8	84.6

Source: Public Health England

Compared with benchmark Better Similar Worse Lower Similar Higher Not compared

What is the data telling us?

The data shows that less than 1 in 6 (16.7%) of those diagnosed with HIV in Darlington over two years (2015 and 2017), were at a late stage of infection. This is statistically significantly better to both England and the NE regional average. Compared to our 16 statistical neighbours Darlington is ranked 1st. This shows that services provided for those who have increased risk of exposure to HIV are accessible and effective with most receiving a diagnosis at an earlier stage. The numbers of those presenting an HIV diagnosis in Darlington are relatively small.

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?

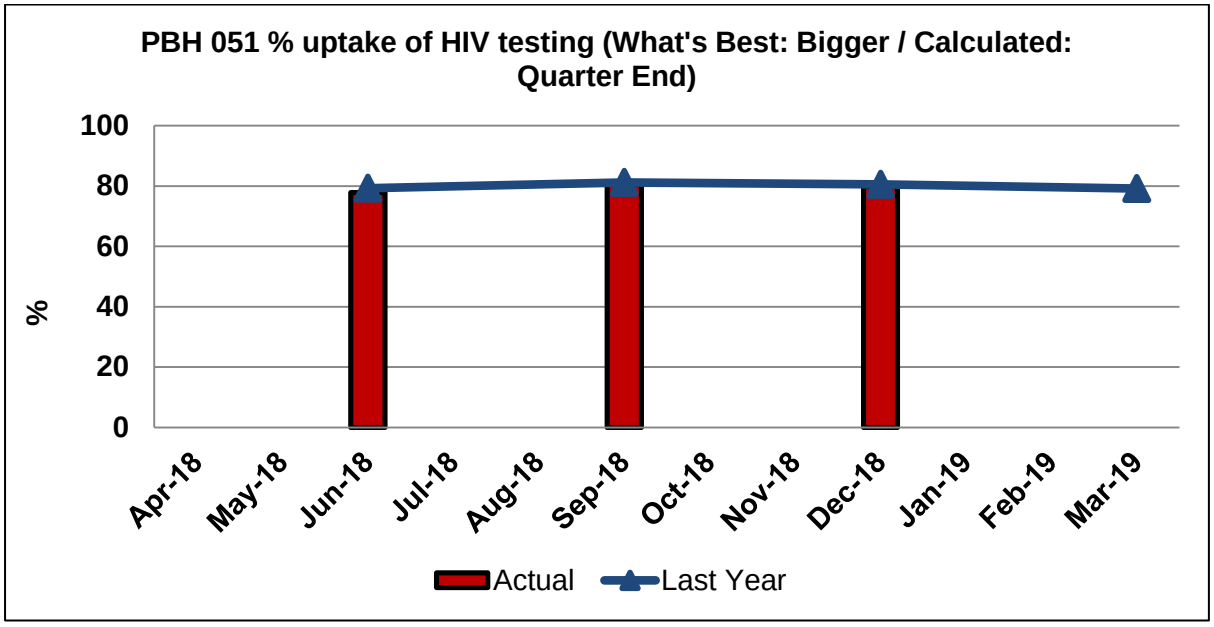
The Sexual Health Service provided by County Durham and Darlington NHS Foundation Trust includes Genito Urinary Medicine (GUM) Service. The Service has increased the proportion of new patients receiving a comprehensive sexual health screen including an HIV risk assessment. This identifies those who are 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 Recovery and Well-being Service 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 delivers a condom distribution programme (C-Card) in Darlington for those under 25 years to reduce the potential for exposure to HIV through unprotected intercourse.

Contract Indicator:

PBH051 % uptake of HIV testing



Service Provider: County Durham and Darlington Foundation Trust

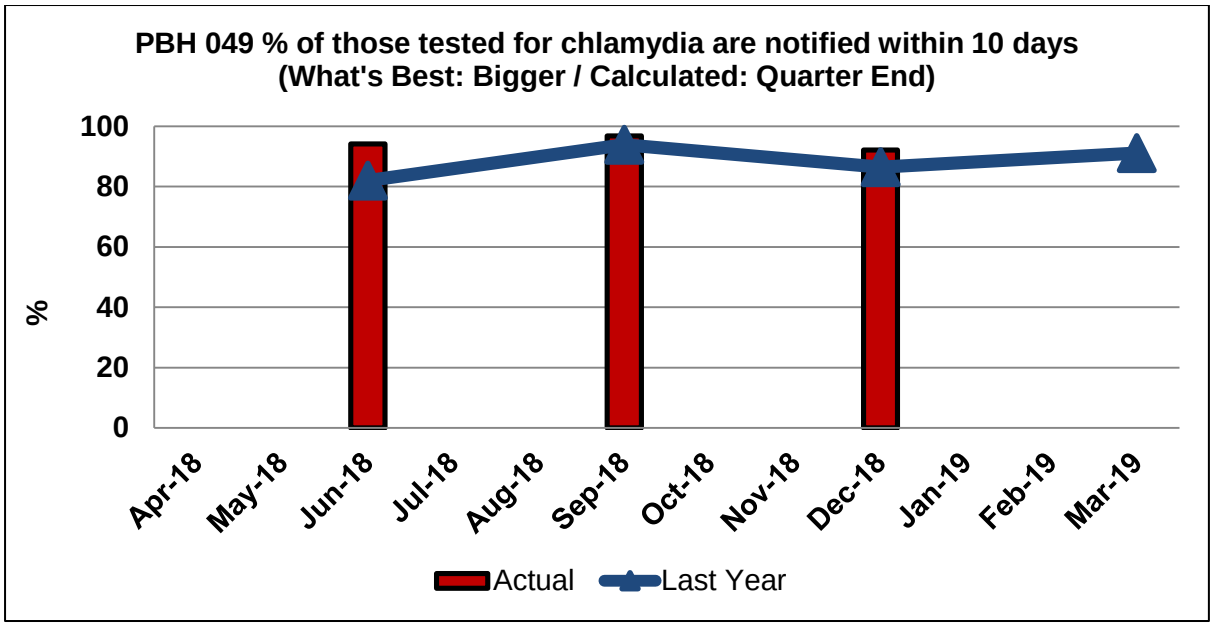
What is the story the data is telling us?

The data shows that the uptake of HIV testing by patients accessing our Sexual Health Services remains consistently high at around 80% of all those being provided with a Sexual Health screen. The uptake is consistent with the same period last year.

What more needs to happen?

This indicator is a key performance indicator is and is monitored and reviewed at every quarterly contract meeting by the Public Health team. The Provider is consistently offering HIV testing, with associated counselling and support, as part of the routine Sexual Health screen provided to new patients to maintain this high level of uptake. For those who do not access the Sexual Health Services directly there is an offer of a postal testing kit which directs the individual to the Sexual Health services to receive any results, both negative and positive, for an intervention and counselling and potentially for referral to treatment.

PBH049 % of those tested for chlamydia are notified within 10 days



Service Provider: County Durham and Darlington Foundation Trust

What is the story the data is telling us?

The data shows that the proportion of those tested for Chlamydia who are notified within 10 days of a negative or positive result, remains above the target of 90%. This period is higher (92%) than the same period last year (86%). The data also shows that performance has improved from the previous year.

What more needs to happen?

The Provider continues to ensure that the systems that are in place for timely notification remain robust. They continue to investigate individual breaches and apply the learning to the processes to improve performance.

KEY PBH056 – (PHOF 4.04ii) Age standardised rate of mortality considered preventable from all cardiovascular diseases (inc. heart disease and stroke) in those aged less than 75 years per 100,000 population

Definition: Age-standardised rate of mortality that is considered preventable from all cardiovascular diseases (including heart disease and stroke) in persons 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 I20-I26, I42.6, I71, I80.1-I80.3, I80.9, I82.9) 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).

Contributory contract indicators:

- **PBH047-**Total number of NHS Health Checks completed
- **PBH057-**Total number of NHS Health Checks offered

Latest Update: 2015-17 Current performance: 50.7 per 100,000 population

Target: 54 per 100,000

Figure 8- Comparison CIPFA nearest neighbours

4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable 2015 - 17 Directly standardised rate - per 100,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	64,127	45.9	45.6	46.3
Dudley	–	3	380	43.9	39.6	48.6
Stockton-on-Tees	–	1	232	46.4	40.6	52.8
Warrington	–	14	271	49.2	43.5	55.5
Derby	–	4	286	49.5	43.9	55.6
Telford and Wrekin	–	8	221	49.9	43.5	56.9
Darlington	–	-	146	50.7	42.8	59.6
Rotherham	–	12	379	52.6	47.5	58.2
Plymouth	–	9	348	53.5	48.0	59.4
Wigan	–	15	502	55.8	51.0	60.9
Doncaster	–	13	470	57.6	52.5	63.1
North East Lincolnshire	–	2	253	58.3	51.3	66.0
St. Helens	–	5	301	59.3	52.7	66.4
Calderdale	–	7	334	59.8	53.5	66.6
Bury	–	10	307	62.6	55.8	70.1
Tameside	–	11	392	67.6	61.1	74.7
Bolton	–	6	483	67.9	62.0	74.3

Source: Public Health England (based on ONS source data)

Compared with benchmark Better Similar Worse Lower Similar Higher Not compared

What is the data telling us?

The data shows that after a long period of reduction in the under 75 years mortality rate from cardiovascular diseases considered preventable in Darlington, the NE region and England the rate of reduction for Darlington has slowed. The table shows that Darlington is

statistically similar than England with a rate of 50.7 per 100,000 and is statistically similar to the NE regional average. The table shows that compared to our 16 statistical neighbours Darlington is ranked 6th.

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. This results in the prevalence in these communities being greater with access to and take up of preventative and early diagnosis poorer. This results in in those in the most deprived communities experiencing worse outcomes including 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 more likely to experience the worst outcomes.

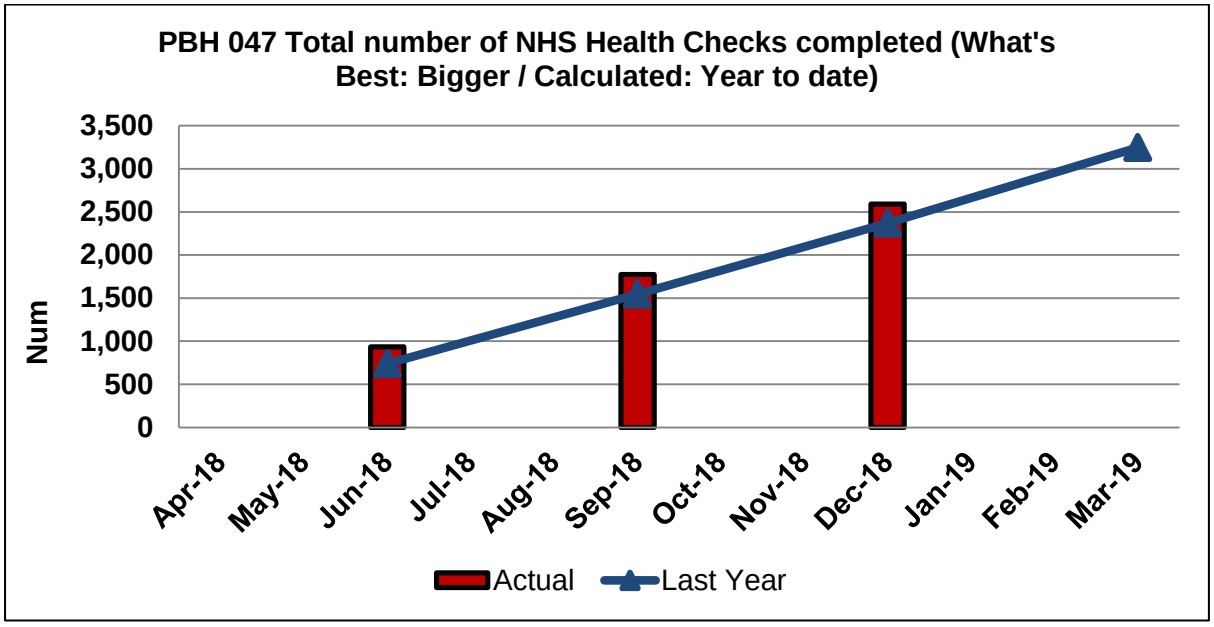
What are we doing about this?

The Authority, NHS England, Public Health England and the clinical commissioning group 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.

The local authority has commissioned a NHS Health Checks Service, which has been successful in providing a CVD screen to a significant proportion of those aged between 40 and 74 years to identify any risk factors and provide them with information and support to reduce their risks. This service has recently been re-procured with an emphasis on improving access and uptake in those in the highest risk groups in the most deprived communities. This contract commences 1st April 2019.

Contract Indicator:

PBH047 Total number of NHS Health Checks completed



Service Provider: Darlington GP Practices

What is the story the data is telling us?

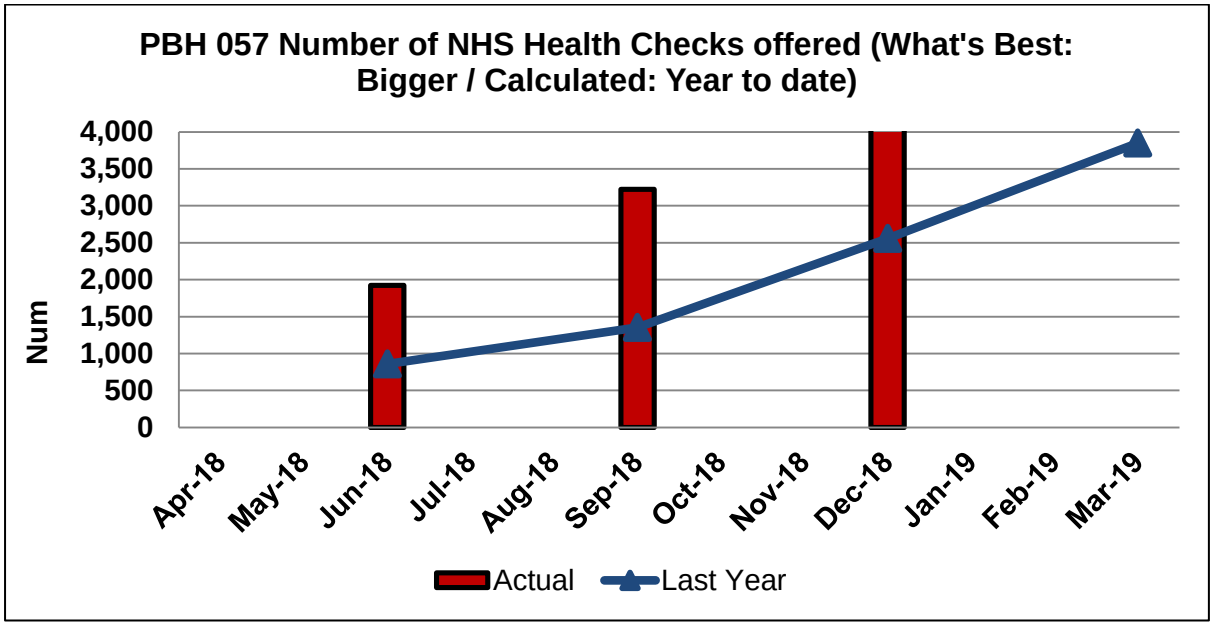
The table shows that to date that a total of 2,500 eligible individuals in Darlington have received a Health Check this year. This is a greater number compared to the same period last year.

What more needs to happen?

The current Providers continue to provide enough capacity to meet the demand for Health Checks in the population.

Contract indicator:

PBH057 Number of NHS Health Checks offered



Service Provider: Darlington GP Practices

What is the story the data is telling us?

The data shows that to date a total of 4,756 eligible individuals have been offered a Health Check in Darlington since the beginning of the year. This is a greater number than at the same period last year.

What more needs to happen?

Providers continue to consistently identify their eligible population and provide timely invitations to individuals for their Health Checks which highlight the benefits of the check.

KEY PBH 060 – (PHOF 4.07i) Age standardised rate of mortality from respiratory disease in persons less than 75 years per 100,000 population.

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).

Contributory contract indicators:

- **PBH015a** Number of smoking quit dates set
- **PBH015b** % of successful smoking quitters at 4 weeks
- **PBH047** Total number of NHS Health Checks completed
- **PBH057** Total number of NHS Health Checks offered

Latest Update: 2015-17 **Current performance: 40.8 per 100,000 population**

Target: 43 per 100,000

Figure 9- Comparison CIPFA nearest neighbours

4.07i - Under 75 mortality rate from respiratory disease 2015 - 17 — Directly standardised rate - per 100,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	47,634	34.3	34.0	34.6
Dudley	–	3	284	32.7	29.0	36.7
Warrington	–	14	202	36.6	31.7	42.0
Plymouth	–	9	257	39.3	34.6	44.4
Bury	–	10	194	39.7	34.3	45.7
Telford and Wrekin	–	8	173	39.8	34.0	46.2
North East Lincolnshire	–	2	174	40.5	34.7	47.0
Darlington	–	-	116	40.8	33.7	48.9
Calderdale	–	7	237	42.8	37.5	48.6
Derby	–	4	242	42.9	37.6	48.7
Stockton-on-Tees	–	1	218	43.7	38.0	49.9
Doncaster	–	13	373	45.7	41.2	50.6
Rotherham	–	12	341	47.1	42.2	52.3
Bolton	–	6	340	48.2	43.2	53.6
Wigan	–	15	441	49.0	44.6	53.8
Tameside	–	11	288	49.8	44.2	56.0
St. Helens	–	5	317	62.4	55.7	69.7

Source: Public Health England (based on ONS source data)

Compared with benchmark Better Similar Worse Lower Similar Higher Not compared

What is the data telling us?

The data shows that under 75 years mortality rate from respiratory disease in Darlington is now statistically similar to both England and the North East with a rate of 40.8 per 100,000. Compared to our 16 statistical neighbours Darlington is ranked 7th.

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 results in men from our most deprived communities statistically more likely to experience the greatest inequalities in 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 Authority takes 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 Services which identifies those with established respiratory disease as a priority group for specialist stop smoking support.