DARLINGTON BOROUGH COUNCIL

NHS Darlington

Joint Strategic Needs Assessment **2008**

Contents

Foreword

Undertaking a Joint Strategic Needs Assessment is the joint responsibility of the Directors of Children's Services, Adult Services and Public Health.

The JSNA will significantly contribute to the future direction of Adult Social Care as we move towards personalised services. Using the JSNA as a common database with partners will help us plan "joined up" or integrated services together, so that individuals have more choice and control.

Recently the Darlington Children's Trust reviewed the needs of the children and young people in the Borough. That analysis combined with the JSNA provides a powerful tool for defining priorities and shaping future services for children and young people and their families.

This first JSNA for Darlington has drawn data from a variety of sources in health and the local authority to describe the health and wellbeing needs of the local population. The JSNA is a resource which can inform the delivery plans of the "One Darlington: Perfectly Placed" (SCS) themed Groups. The JSNA is an ongoing process and future assessments will inform the delivery of the Local Area Agreement.

Cliff Brown
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1. Introduction

1.1 Origins of the Joint Strategic Needs Assessment (JSNA)

The Commissioning Framework for Health and Wellbeing, published by the Government in March 2007, introduced the idea of a Joint Strategic Needs Assessment (JSNA). The Local Government and Public Involvement in Health Act (November 2007) describes the requirement on Local Authorities and Primary Care Trusts to produce a JSNA of the health and wellbeing of their local community. Undertaking a JSNA is the joint responsibility of the Directors of Children's Services, Adult Services and Public Health. Darlington Borough Council and Darlington Primary Care Trust have worked together to produce this JSNA. The JSNA is an ongoing process and findings from subsequent strategic assessments will inform the delivery of One Darlington: Perfectly Placed (SCS).

This first JSNA is not a commissioning plan, it is a resource to inform commissioning, along with other information. The JSNA draws data from a variety of sources with a focus on bringing together information from health and local authorities to highlight the key issues. Key issues are those which affect a lot of people or have a significant impact on the health and wellbeing of those affected by them and can be changed by local action, for example, via the LAA.

1.2 JSNA and Health Inequalities

The aim of the JSNA is to describe the future health and wellbeing needs of the local population of Darlington to inform the strategic direction of service delivery to meet those needs.

This includes identifying inequalities i.e. the avoidable differences in needs between groups of local people. For men in Darlington the difference in life expectancy is between the best and worst wards 14.4 years; for women it is 10.1 years (Source: North East Public Health Observatory/ Director of Public Health Annual report 2007/08).

The reasons for the differences in health within Darlington and between Darlington residents and the rest of England are complex. The following summary has been adopted in Darlington as a framework for developing strategies to tackle health inequalities:

- Inequalities in opportunity – poverty, family, education, employment and environment (the wider determinants of health).
- Inequalities in lifestyle choices – smoking, physical activity, food, drugs, alcohol and sexual activity.
- Inequalities in access to services for those who are already ill or have accrued risk factors for disease.

(Source: Annual Report of Director of Public Health 2006/07)

1.3 Timescale

This first JSNA has focused on some key health and social issues; future assessments will draw on a wider range of information.

The time cycle of the JSNA is at least three years although we will apply local discretion in Darlington to update elements of the JSNA to inform the "refreshing" of the short term delivery plans of the Sustainable Community Strategy.

1.4 Our Vision

'One Darlington : Perfectly Placed' is our vision for Darlington for 2021. It is our Sustainable Community Strategy, created by the people of Darlington and is distinctively about the Borough.

It is a vision of a community that respects its unique heritage and retains its local character, friendliness and quality of life. It is also about making the most of the potential for greater prosperity, opening up aspiration and equality of opportunity for everybody, whilst building a genuinely sustainable, cohesive and caring community borough-wide.

One Vision – Two Priorities

This vision for Darlington has guided and formed the basis of the Joint Strategic Needs Assessment. The two components of the vision, One Darlington and Perfectly Placed, represent our priorities for the community. These priorities, focusing on people and on place, will be used to test and steer all of our projects and programmes to make sure that they are helping to achieve the vision.

The 'One Darlington' priority is about people and ensuring that everyone has equality of opportunity, irrespective of income or where they live. It is about narrowing the gaps in health, educational attainment and prosperity that currently exist across the Borough and building a stronger, diverse community that reinforces shared values of respect, caring and commitment. Darlington is 'Perfectly Placed' in terms of its location and accessibility, poised to maximise its opportunity to attract business investment and increase employment and wage levels.

The Delivery Themes and Work Strands

Five themes have been defined for organising and co-ordinating programmes of work to deliver the vision. These are:

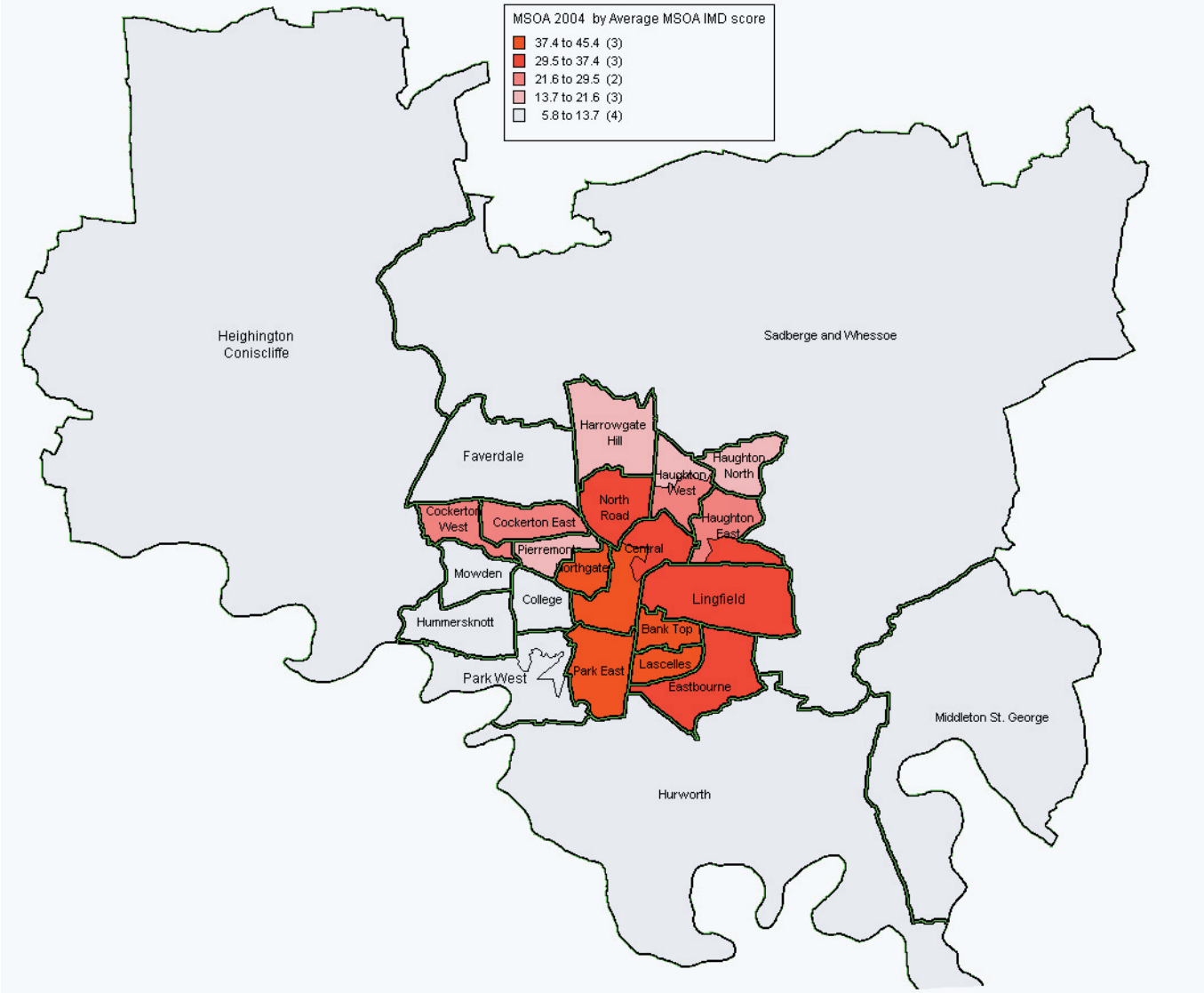
- Prosperous Darlington
- Aspiring Darlington
- Healthy Darlington
- Greener Darlington
- Safer Darlington.

The themes were developed around the issues and aspirations identified through consultation, data collection and Enquiry Group processes, with key input from major stakeholders. Especially pertinent to the JSNA will be the Healthy Darlington theme group, which has defined a series of work strands including:

- Narrowing health gaps
- Access to sport and Leisure
- Healthy Workplaces
- Obesity in Young People
- Emotional Health
- An Ageing Population.

However, the Sustainable Community Strategy and governance arrangements have been developed to ensure that crosscutting agendas are identified and implemented across all themed groups. As such, key areas of the health agenda will be carried out across all themed groups.

The framework of the JSNA has been aligned to the above structure as a means of organising the data and presenting key issues to inform the relevant themed groups.


MSOA 2004 by Average MSOA IMD score
37.4 to 45.4 (3)
29.5 to 37.4 (3)
21.6 to 29.5 (2)
13.7 to 21.6 (3)
5.8 to 13.7 (4)
Heighington
Coniscliffe
Sadberge and Whessoe
Harrowgate Hill
Faverdale
Haughton North
Haughton West
North Road
Cockerton West
Cockerton East
Haughton East
Pierremont
Central
Northgate
Mowden
College
Lingfield
Hummersknott
Bank Top
Park East
Lascelles
Park West
Eastbourne
Middleton St. George
Hurworth

1.5 Acknowledgements

This report has built on the experience gained from developing Public Health reports, Darlington Borough Council and Darlington Primary Care Trust reports. Quantitative and qualitative data has been assembled from local surveys, local routine data and relevant national data sources. Staff from Darlington Borough Council Children's Services, Darlington Primary Care Trust, Darlington Borough Council Adult Services and Communities Services, Darlington Borough Council Regeneration, Policy Unit and the Public Health Service worked together to produce the first phase of a JSNA for Darlington.

We are most grateful to:

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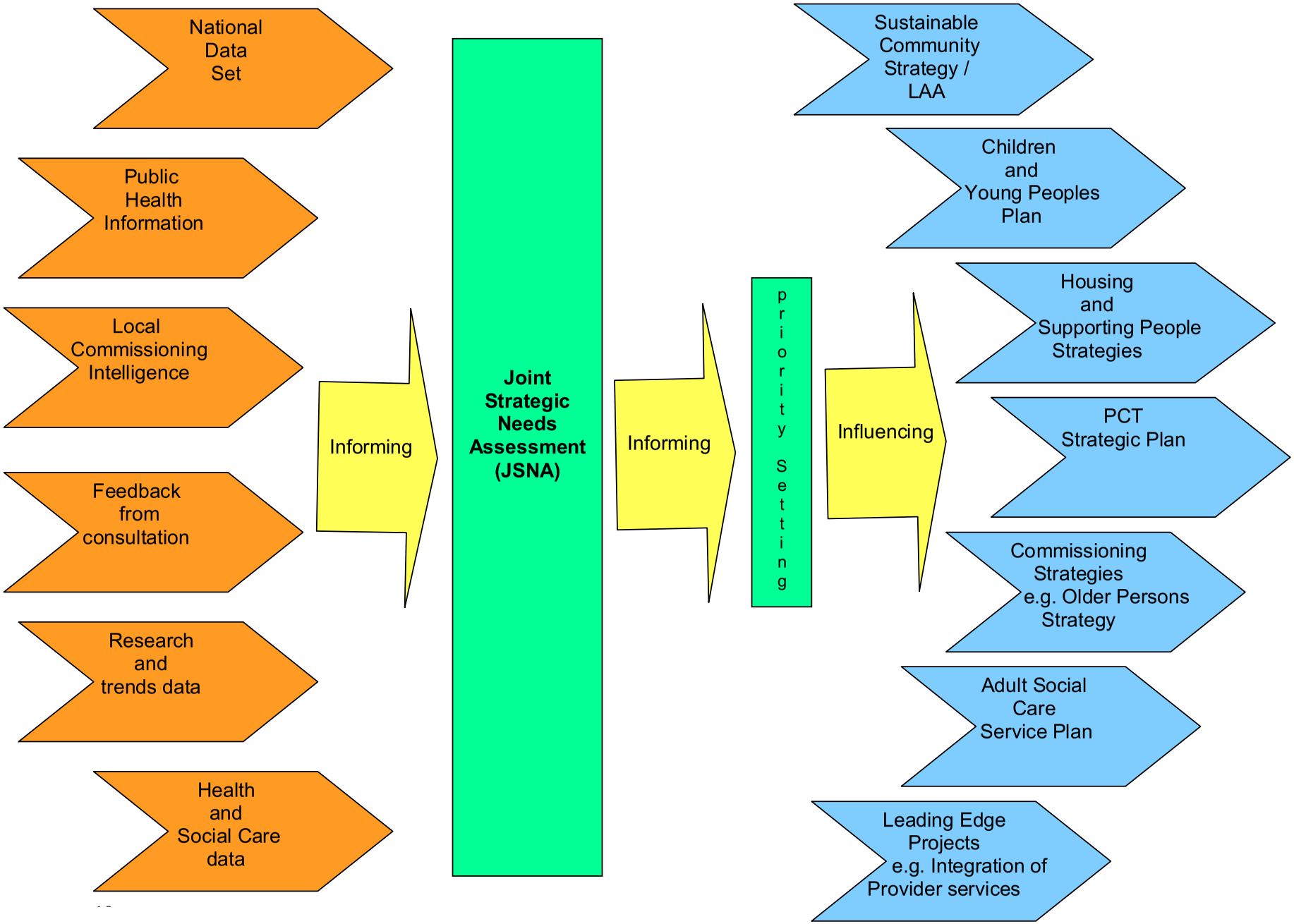
Lucy Wheatley	Children's Health Joint Commissioner
Owen Wilson	Policy Officer, Transport Policy
Ruth Bennett	Obesity and Physical Activity Strategy Lead
Rachel Osbaldeston	Food and Health Practitioner


National Data Set
Public Health Information
Local Commissioning Intelligence
Feedback from consultation
Research and trends data
Health and Social Care data
Informing
Joint Strategic Needs Assessment (JSNA)
Informing
priority Setting
Influencing
Sustainable Community Strategy / LAA
Children and Young Peoples Plan
Housing and Supporting People Strategies
PCT Strategic Plan
Commissioning Strategies e.g. Older Persons Strategy
Adult Social Care Service Plan
Leading Edge Projects e.g. Integration of Provider services

2. Darlington: The Place

2.1 Urban/Rural Classification

Darlington is situated in the North East of England and forms part of the Tees Valley sub-region which as a whole comprises five unitary authorities and has a population of around 650,000 people. Darlington borough is a compact area of some 76.2 square miles, comprising the town of Darlington and a number of surrounding villages. The borough has a population of around 98,600 people living in 45,000 households (Office for National Statistics 2004).

The borough retains its market town character and functions as a sub regional centre for employment, shopping and culture. The town has a wide catchment area of up to 20 miles from the town centre and attracts people from neighbouring North Yorkshire and south Durham.

Geography affects health. The imagined "rural idyll" can in reality mean expensive housing, fewer jobs and training opportunities, and poor access to a range of services from schools and shops to pharmacies and hospitals. In urban areas other issues such as air pollution, poor housing, and road traffic accidents are more common.

There are many different ways of classifying rural/urban areas but this report uses work from the Rural and Urban Definitions Project, sponsored by the Office for National Statistics, the Department of Environment, Food and Rural Affairs, the Department for Communities and Local Government, the Countryside Agency and the National Assembly for Wales. Two types of classification were produced. The first classifies small areas on the basis of the settlement form (urban and fringe, small town, village, hamlet and dispersed dwellings) and the second on whether the area is included in the 5% most sparsely populated areas of England. The second classification provides categorically grouped summaries for larger areas, such as local authority districts. In addition to the population density and settlement form, this also considers the extent to which small towns serve a rural hinterland. Table 2.1 describes the urban-rural geography of Darlington, the North East and England.

Details of the classifications can be found at: http://www.defra.gov.uk/rural/ruralstats/rural-definition.htm

Table: 2.1 Urban-Rural Geographies

Area	Darlington	North East	England
Total Population	97,000	2,514,700	49,142,100
Major Urban Population	0	879,400	15,999,100
Large Urban Population	0	365,400	6,741,800
Other Urban Population	85,900	513,100	13,175,500
Total Urban Population (excluding Large Market Town population)	85,900	1,757,900	35,916,500
Large Market Town Population	0	280,500	3,716,900
Rural Town Population	5,400	312,700	4,449,000
Rural Town Population (including Large Market Town population)	5,400	593,200	8,165,900
Village Population	4,800	106,000	3,533,600
Dispersed Population	1,600	57,600	1,526,100
Total Rural Population (including Large Market Town population)	11,800	756,700	13,225,700
Rural% (including Large Market Town population)	12%	30%	27%

Source: Department for Environment, Food and Rural Affairs, 2004 (with data from the 2001 Census)

2.2 Access to Services

Access is a key issue in relation to health and in its broadest sense would cover physical access, communication problems, social and cultural barriers, and psychological issues.

Almost 90% of the population live in the urban area, however there are 10% who live in rural areas, 1% who are more than 4km from a doctors surgery and 2% who are more than 4km from a supermarket. The Social Exclusion Unit report, Making the Connections: Report on Transport and Social Exclusion identified several barriers to accessibility, including:

- Long travel times
- Remote location of facilities and services
- Poor quality and level of public transport services
- Limited travel horizons (not having enough confidence to travel)
- Lack of physical accessibility
- Affordability.

Accessibility should be a key early consideration before decisions are made on the location of key services.

2.3 Access to Transport

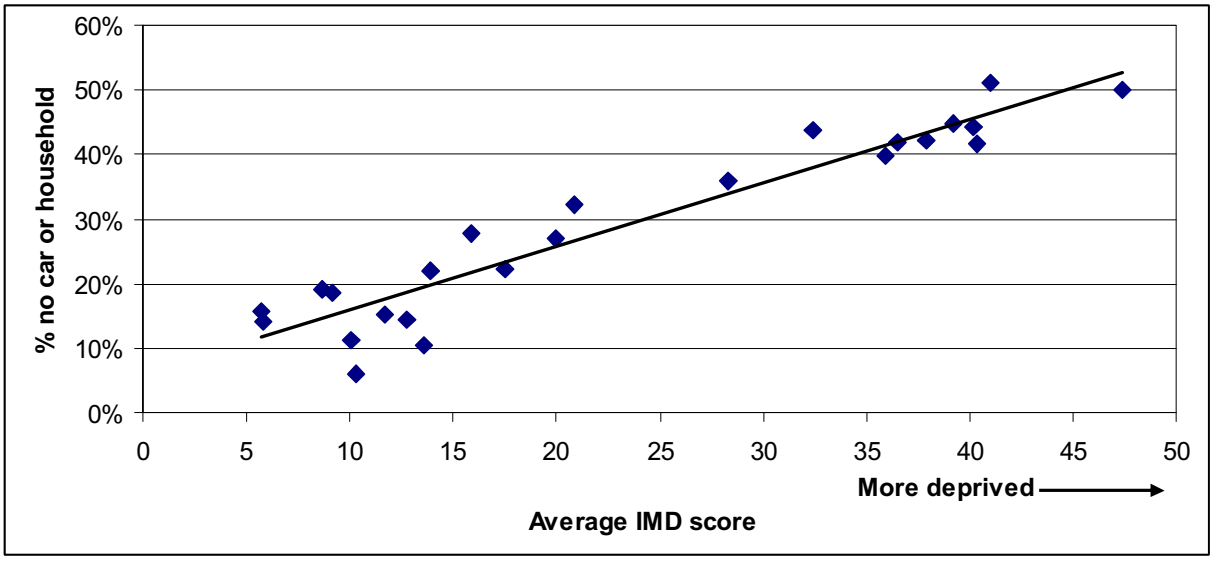
Transport has major health and social impacts – through levels of physical activity undertaken, social networks, accidents, effects on air pollution and access to services. As noted in "Making the case: improving health through transport" (published by the Health development Agency in 2005, http://www.healthandtransportgroup .co.uk/articles/ makingcase_health_transport .pdf), transport can also have a significant impact upon health inequalities both directly (e.g. children from the most deprived social class are five times more likely to die as pedestrians than children in the least deprived social class, and exposure to air pollution is more common in the most deprived areas) and indirectly (e.g. through the influence of planning decisions to accommodate car access).

Darlington was one of three UK locations chosen by the government to promote sustainable transport through its Local Motion scheme. The programme has been producing positive outcomes that buck national trends, for example:

- single occupancy car trips have been reduced by 9%
- cycling has increased by 65%
- walking has increased by 15%
- the use of public transport has increased by 2%.

The condition of roads in Darlington has significantly improved and we are on track to meet or surpass statutory targets for road casualty reduction.

At 31%, Darlington has more carless households than the national average (27%) and people in these households will find it more difficult to travel to shops, employment, healthcare and social services. The graph below also shows that people in the more deprived parts of Darlington are significant more likely to live in households with no car or van.



Key messages:

- Darlington Borough comprises the town of Darlington and a number of surrounding villages.
- 88% of the population live in the urban neighbourhoods, and 12% live in rural areas.
- Nearly a third (31%) of Darlington households have no car or van, and this is much more common in deprived areas.
- As a result of Local Motion, there has been a substantial increase in cycling and walking
- Accessibility should be an early key consideration before decisions are made on the location of key services

3. Darlington: The People

Good estimates of the resident population are vital to facilitate planning of health and social care services at local level and provide denominators for epidemiological analyses. Showing proportions of the population in each age group allows comparisons to be drawn, for example, about the relative impact that young people may have upon health and care services. Appendix 1, Tables 1-3, describing the population of Darlington by age and ward and the proportions of male and female populations by age group.

In line with the 2001 Census data, Darlington's future population is expected to remain fairly stable. However more recent changes to the birth rate reveal counter trends to the 2001 Census predictions. On the whole the Darlington population profile closely resembles the national profile, however, there is a smaller proportion of young adults in Darlington than in England overall. Long term projections show the working age population reducing over time while the population of retirement age is increasing. It is anticipated that by 2015 over 19% of the population will be aged 65 years or older.

3.1 Black and minority ethnic populations

Table 4 in the One Darlington: Perfectly Placed Appendix shows the number of people usually resident in Darlington at the time of the 2001 Census, the number who were classed as White British and the number classified in a different way (i.e. including Black, Asian, mixed race and other white non-British residents). The Health Survey for England indicates that Black and Minority Ethnic (BME) groups are more likely to report ill-health and that ill-health among BME people starts at a younger age than in the White British population. Patterns of ill-health among BME communities are extremely diverse and vary between men and women and between regions. Patients from BME groups are more likely to report negative experiences within the health services. Older service users from a BME group accessing adult social care make up 0.99% and those going on to receive services is 0.86%.

In Darlington people from Black and Minority Ethnic (BME) backgrounds make up 2.1% of the population, although this figure does not include the majority of Gypsies and Travellers who constitute the largest BME group. There is a significant community of people of Bangladeshi origin. Migration from the east European countries of the newly expanded European Community is a recent phenomenon for which there is not yet definite data. Proxy indicators, for example national insurance and doctors' registrations suggest this new demographic group numbered over 1000 people at the beginning of 2008.

Most Travellers based in Darlington live on recognised sites and are of Romany descent. Whist there is no census information available to identify Traveller numbers, officers within Children's Services who support the welfare of Traveller children estimate that there are approximately 2000 people in Darlington who could claim to have a Traveller or Gypsy background. This figure includes those who live in bricks and mortar as well as in caravans.

3.2 Future populations

Across England, the total population is projected to increase by over 10% over the next 25 years and this will have a significant impact upon health and social care services and how they are delivered.

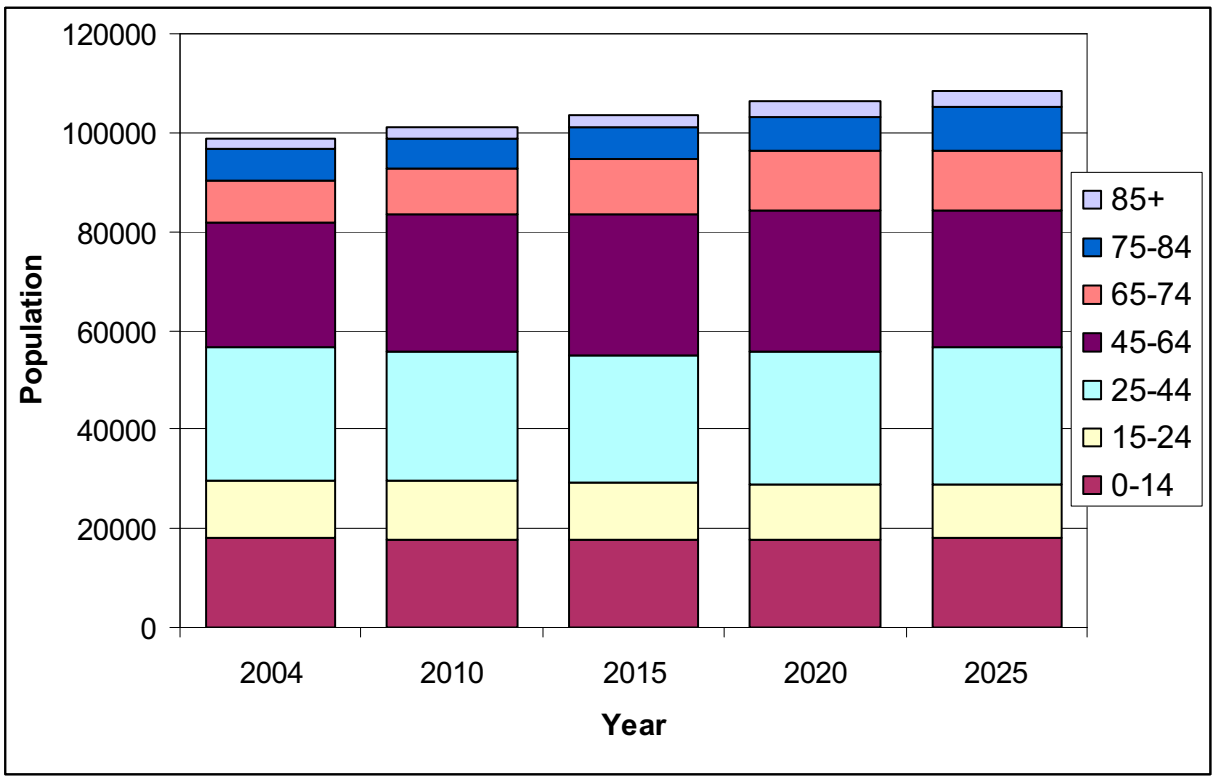
This indicator shows trend based projections of population estimates, which means assumptions for future levels of births, deaths and migration are based on observed levels over the previous five years. They show what the population will be if recent trends in these factors continue. The projections do not take into account any future policy changes that have not yet occurred. They are constrained at a national level.

Table 3.1: Darlington Population by Age Group

	Darlington population estimates					Percentage of the total population				
Age group	2004	2010	2015	2020	2025	2004	2010	2015	2020	2025
0-14	18200	17500	17500	17700	18000	18.5%	17.3%	16.9%	16.7%	16.6%
15-24	11300	12100	11600	11000	11000	11.5%	12.0%	11.2%	10.4%	10.1%
25-64	52200	53900	54400	55600	55400	53.0%	53.2%	52.5%	52.3%	51.1%
65-74	8800	9400	11100	11900	12100	8.9%	9.3%	10.7%	11.2%	11.2%
75-84	6100	5900	6400	7100	8500	6.2%	5.8%	6.2%	6.7%	7.8%
85+	2000	2400	2600	2900	3500	2.0%	2.4%	2.5%	2.7%	3.2%
Total	98600	101200	103600	106200	108500	100.0%	100.0%	100.0%	100.0%	100.0%

Source: National Statistics, 2004-based long term Subnational Population Projections for England

The chart below shows the projected changes by population age group over time in graphical form.

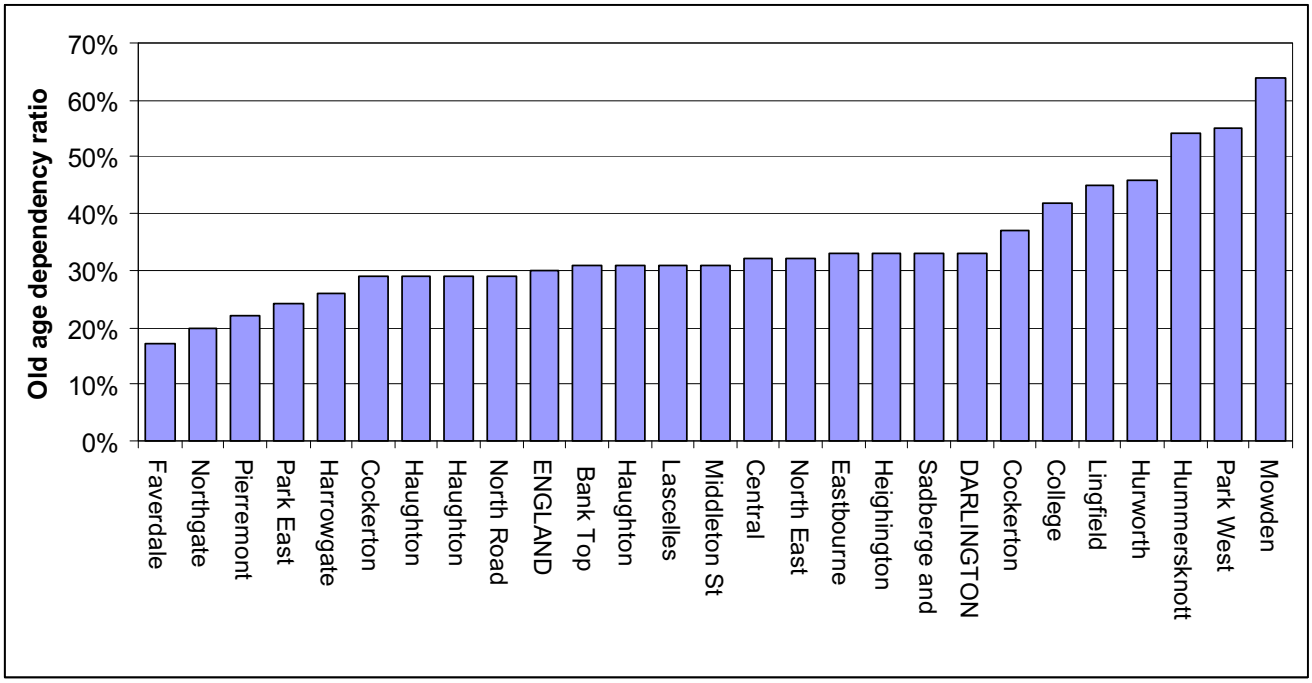


An important implication of the ageing population for health and social care services is the effect it will have upon the workforce required to provide care and support to those who need it. Dependency ratios relate the number of people who are predicted to be dependent to the number of people who are expected to support that dependency in some way. Nationally, the old age dependency ratio is expected to increase from 30% to around 48% in 2044, raising questions about how the health and social care workforce can continue to maintain the living standards of pensioners.

The old age dependency ratio is defined as the ratio of the number of people over the state pension age (60 for females and 65 for males) to those of working age (between 16 and pension age), expressed as a percentage. The higher the old age dependency ratio in an area, the more difficult it will be to staff health and social care services to meet the needs of the growing elderly population.

Table 3.2: Old Age Dependency Ratio for Darlington Wards

Ward	Old age dependency ratio
Bank Top	31%
Central	32%
Cockerton East	29%
Cockerton West	37%
College	42%
Eastbourne	33%
Faverdale	17%
Harrowgate Hill	26%
Haughton East	31%
Haughton North	29%
Haughton West	29%
Heighington and Coniscliffe	33%
Hummersknott	54%
Hurworth	46%
Lascelles	31%
Lingfield	45%
Middleton St George	31%
Mowden	64%
North Road	29%
Northgate	20%
Park East	24%
Park West	55%
Pierremont	22%
Sadberge and Whessoe	33%
Darlington	33%
North East	32%
England	30%



3.3 Life expectancy at birth

All cause mortality is a fundamental and probably the oldest measure of the health status of a population. It represents the cumulative effect of the prevalence of risk factors, prevalence and severity of disease, and the effectiveness of interventions and treatment. Differences in levels of all-cause mortality reflect health inequalities between different population groups, e.g. between genders, social classes and ethnic groups.

Life expectancy at birth is chosen as the preferred summary measure of all cause mortality as it quantifies the differences between areas in units (years of life) that are more readily understood and meaningful to the audience than those of other measures. Life expectancy at birth is a summary measure of the all cause mortality rates in an area in a given period. It is the average number of years a new-born baby would survive, were he or she to experience the particular area's age-specific mortality rates for that time period throughout his or her life.

Mortality data at a ward level is using small numbers and consequently small changes in the number of death may have some impact on the ranking of wards. The highest and lowest 2001-5 ward level life expectancy figures for Darlington differed by 14.4 years for men and 10.1 years for women.

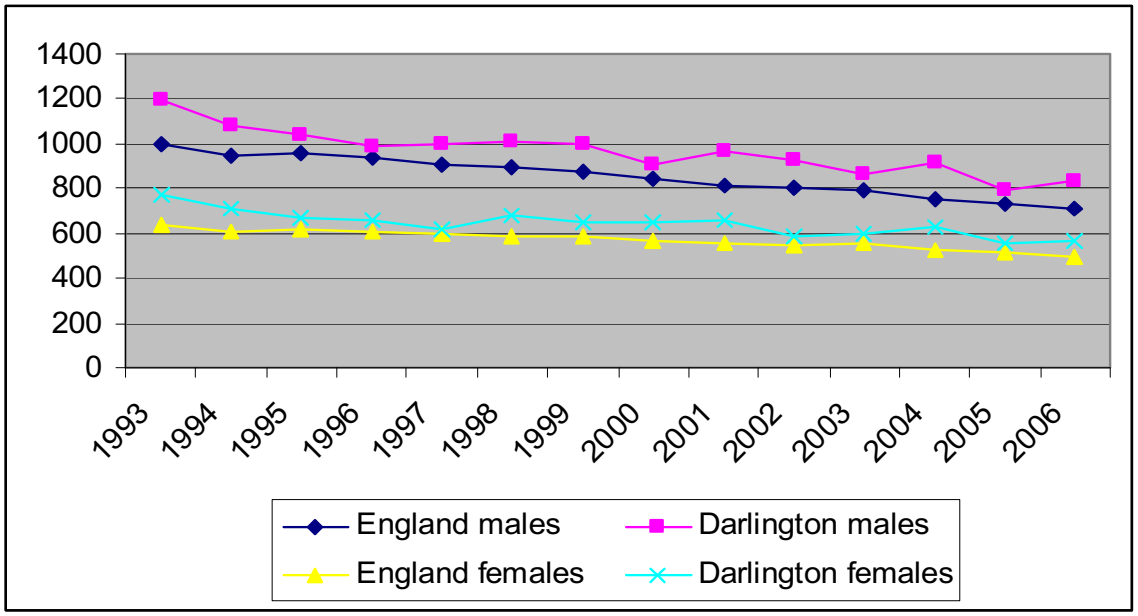
Table 3.3: Male and Female Life Expectancy

Area	Male life expectancy	Female life expectancy
Darlington	75.2	80
North East	75.8	80.1
England	77.3	81.6

Source: National Statistics, 2004-2006

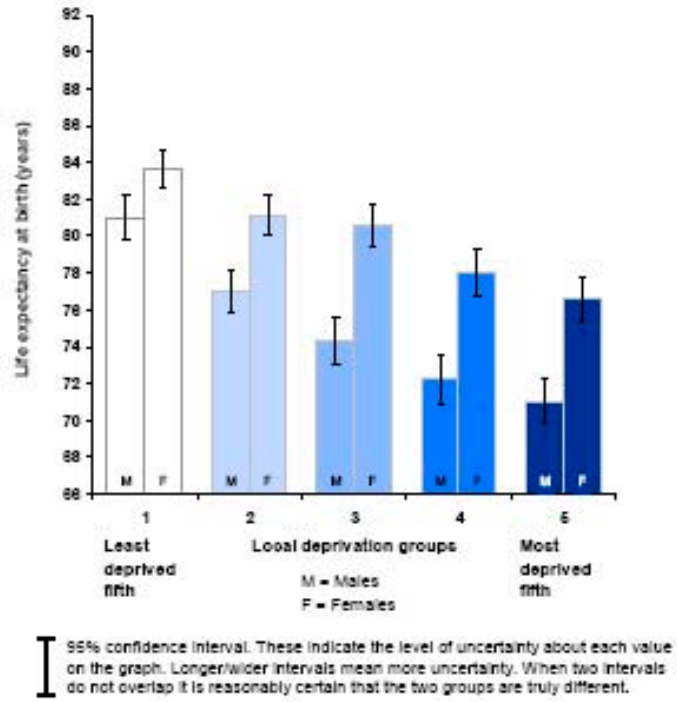
3.4 All age all cause mortality at district and ward level

All age all cause mortality is a good proxy for life expectancy and is being used to measure progress towards meeting the life expectancy target. Table 3.4 below shows mortality from all causes, directly age-standardised rate, all ages, per 100,000 European Standard population.



Health Inequalities a Local Perspective

Inequalities in life expectancy (2002-2006) for men and women who live in areas with different levels of deprivation (within this local authority).



95% confidence interval. These indicate the level of uncertainty about each value on the graph. Longer/wider intervals mean more uncertainty. When two intervals do not overlap it is reasonably certain that the two groups are truly different.

Key messages:

- The Darlington population closely resembles the national profile, however there is a smaller proportion of young adults in Darlington than in England overall.
- The population of retirement age is increasing.
- People from Black and Ethnic Minority backgrounds make up 2.1% of the population. In addition, there are approximately 2,000 people in Darlington who have a Traveller or Gypsy background.
- Levels of health and deprivation vary across Darlington.

4. Prosperous Darlington

The relationship between employment, the economy and health status is not straightforward. However, the performance of the economy gives a good indication of both levels of employment and prosperity in the general population. In particular, levels of employment provide an indication of the health of the working age population.

Employment is often a reflection of the health status of individuals, but also of the probability of being in work with a given health status (Working for a Healthier Tomorrow 2008). There is a strong evidence base showing that work is generally good for physical and mental health and wellbeing, whereas worklessness is associated with poorer physical and mental health.

Job retention, return to work and reintegration are important goals and outcomes of health care and rehabilitation in order to reduce health inequalities, improve health and wellbeing for the working age population and offer improved life opportunities.

Work which is safe and accommodating can be therapeutic and can reverse the adverse health effects of unemployment.

The ability to earn a higher income is on the whole likely to have a beneficial effect on the individual and their family, just in the same way that ill or poorer health generally leads to worklessness, long term health problems and poverty.

It is widely acknowledged that participation in work is one of the main routes to social inclusion and eradicating poverty. The Government aims to have an employment rate of 80% in order to increase economic productivity, reduce poverty and to better deal with the long term health effects of an ageing population in the UK.

Darlington Adult Social Care is developing employment and volunteering opportunities for people with a learning disability. The benefits include promoting independence, wellbeing and social inclusion.

4.1 Multiple Deprivation

The Department for Communities and Local Government commissioned the Social Disadvantage Research Centre (SDRC) at the Department of Social Policy and Social Work at the University of Oxford to create a small area level measure of multiple deprivation. The Index of Multiple Deprivation (IMD) 2007 is the latest version of this measure, and comprises seven domain indices:

- Income Deprivation
- Employment Deprivation
- Health Deprivation and Disability
- Education, Skills and Training Deprivation
- Barriers to Housing and Services
- Crime
- Living Environment Deprivation.

The model of multiple deprivation which underpins the IMD 2007 is based on the idea of distinct dimensions of deprivation which can be recognised and measured separately. These are experienced by individuals living in an area. People may be counted in one or more of the domains, depending on the number of types of deprivation that they experience. The overall IMD is conceptualised as a weighted area level aggregation of these specific dimensions of deprivation. The average IMD score for Darlington indicates that it is slightly more deprived than the England average, but the level of relative deprivation decreased between 2004 and 2007.

Table 5 in Appendix 1 shows estimated national ward level results from Index of Multiple Deprivation (IMD), out of 7,932 English wards (1 is most deprived). The IMD was published at lower-layer Super Output Area (SOA) level, and results shown here are for Darlington wards have been estimated by the Tees Valley Joint Strategy Unit, and therefore do not form part of the official results.

4.2 Overall Employment Rate

Darlington has the highest Gross Value Added (GVA) per capita of any North East authority. The Darlington Gateway strategy has created over 2000 new jobs since 2003. Unemployment has fallen at almost 3 times the national rate over the last 4 years. An issue for Darlington is its relatively low wage levels.

Average earnings of people in Darlington have increased in recent years but are still 7.1% lower than the Tees Valley average and 17.7% lower than the average for Great Britain (2006). The increase in the number of young people completing an apprenticeship is below the national average (Darlington 22.8%, national average 47.7%).

Table 4.2: The actual number of people in employment

LA	Number of working age total population	Number of working aged employed	Percentage of working age population employed
Darlington	58300	44800	76.8%
North East	1041300	730100	70.1%
England	1041300	730100	70.1%

Source: Annual Population Survey, NOMIS 2006/07

4.3 People falling out of work and on to Incapacity Benefit

Worklessness is both a major contributor to the health inequalities in Darlington and an adverse outcome of those inequalities. Table 3 in Appendix 2 indicates the reasons for people claiming Incapacity Benefit.
A mental health condition was cited by 44% of incapacity benefit claimants on their reason for claiming incapacity benefit (compared to 41% for England). Table 2 in Appendix 2 shows the number of people starting to claim Incapacity Benefit in the 6 months prior to May 2007.

4.4 Limiting long-term illness

The 2001 Census asked respondents to assess whether they had a limiting long-term illness, health problem or disability which limits their daily activities or the work they can do, including problems that are due to old age. While this indicator reflects individuals own perceptions of their health, this indicator tends to correlate well with mortality rates, deprivation levels and the number of incapacity benefit claimants.

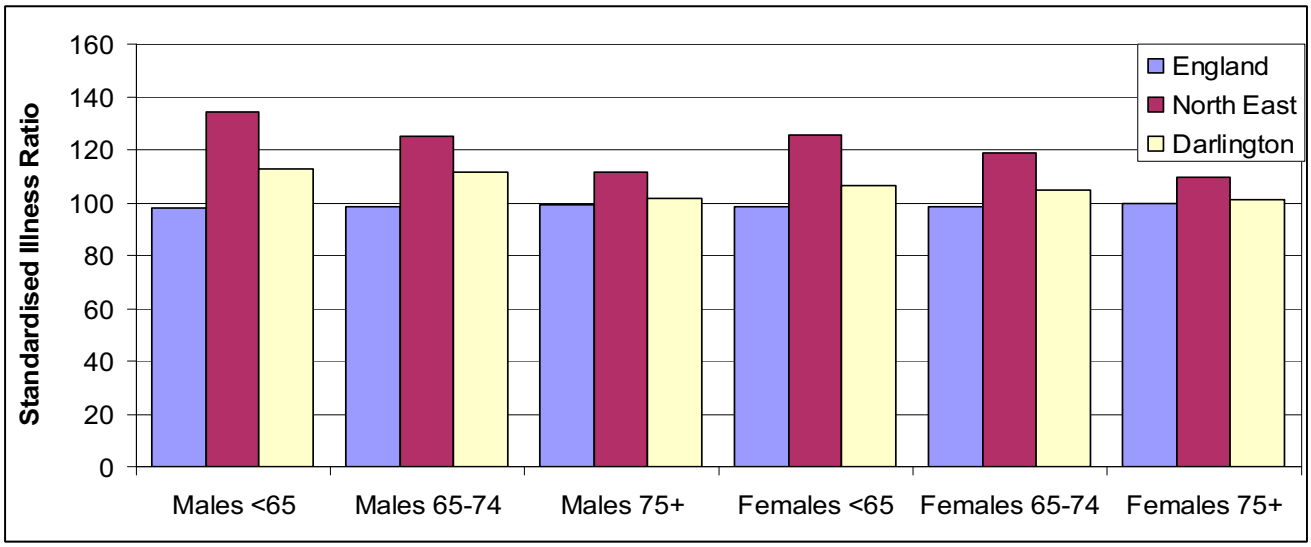
Table 4.3 below shows the number of people who classed themselves as having a limiting long-term illness in the 2001 Census, along with the proportion that those people form of the total population. Standardised Illness Ratios (SIRs) are calculated by multiplying age specific and sex specific illness rates for England and Wales by corresponding resident populations for each age group.

Table 4.3: Long-Term Limiting Illness

Area	People with a limiting long-term illness	Percentage of the population with a limiting long term illness	Standardised illness ratio
Darlington UA	18605	19.3	107.2
North East	546726	22.1	123.7
England	8369174	17.3	98.5

Source: 2001 Census, Office for National Statistics & Compendium of Clinical & Health Indicators

The graph below shows Standardised Illness Ratios by age group and gender for Darlington, the North East and England. SIRs are consistently higher than England for all gender and age groups, but lower than North East Ratios.



4.5 Poverty

The wider determinants of health, for example education, employment, environment, family and poverty are experienced unequally between population groups in Darlington. People who experience material disadvantage are likely to suffer poorer health and an earlier death compared to the rest of the population.

Table 4.4 indicates the percentage of children living in families receiving means tested benefits. Darlington has less than the regional average but more than the England average. The pattern is similar for older people living in poverty.

Table 4.4: Children Living in Poverty

Local Authority	Proportion of children living in poverty	Proportion of older people living in poverty
Darlington	23.7%	20.1%
North East	26.0%	23.4%
England	22.5%	18.3%

Source: Index of Multiple Deprivation, Department of Communities and Local Government, 2007

4.6 Housing Tenure

Poor housing has considerable and wide ranging adverse health impacts, to which children are particularly vulnerable; damp housing worsens respiratory disease and poor housing has been shown to be particularly detrimental to child development.

Darlington Borough Council reports no non-decent homes and high efficiency ratings for council homes. Table 4.5 shows relatively high rates of owner occupation in Darlington and low rates of rented housing.

Table 4.5: Household Tenancy

Area	Total Households	Owner Occupied Owned Outright	Owner Occupied Mortgage or Loan	Owner Occupied Shared Ownership	Rented Council	Rented Housing association, social landlord	Rented Other
Darlington	42327	28.9%	42.4%	0.3%	14.3%	3.8%	1.9%
North East	1066246	25.3%	37.9%	0.4%	22.4%	5.3%	2.5%
England	20476785	29.2%	38.9%	0.7%	13.2%	6.1%	3.2%

Source: National Statistics, 2001 Census

4.7 Living Arrangements / Overcrowding

A household occupancy rating provides a measure of under-occupancy and over-crowding. For example, a value of -1 implies that there is one room too few and that there is overcrowding. A one person household is assumed to require three rooms. Where there are two or more members in a household it is assumed they require a minimum of two communal rooms plus a bedroom for each couple, each lone parent and any other person aged 16 or over. Separate bedrooms are also required for boys and girls aged over 10 years. Darlington has good quality council housing stock, has a robust housing strategy and has developed a public/private partnership. 465 people on the council's waiting list for re housing have been awarded bedroom shortage points.

Table 4.6: Household Occupancy

Area	All Households	Occupancy rating of minus 2 or less	Occupancy rating of minus 1	Occupancy rating of zero	Occupancy rating of plus 1	Occupancy rating plus 2 or more
Darlington	42310	1.0%	3.4%	16.3%	27.4%	52.0%
North East	1066273	1.1%	4.0%	18.9%	30.1%	45.9%
England	20477109	2.1%	5.0%	18.2%	25.5%	49.1%

Source: National Statistics, 2001 Census

4.8 Homelessness

Homeless people have very high rates of mental illness (30-50%), TB, skin diseases and respiratory diseases. Children of homeless families living in temporary accommodation are more likely to have mental and behavioral problems, and have high hospital admission rates for accidents and infectious diseases. No rough sleepers were found during the last census.

Table 4.7 shows the number of families who have applied for support from Local Authorities and been accepted as being homeless and in priority need, per 1,000 households. Note that this indicator clearly identifies only a subset of the true homeless population although Darlington has in place a range of specialist supported accommodation and floating support schemes.

Table 4.7: New Homeless Households/1000 Households

Local Authority	Number per 1000 households
Darlington LA	1.2
North East	4.4
England	3.5

Data Source: Department for Communities and Local Government, 2006/07

Key messages:

- People who experience material disadvantage are likely to have poorer health and an earlier death compared to the rest of the population
- People in work enjoy better physical and mental health than those without work.
- The Darlington Gateway Strategy has created over 2,000 new jobs since 2003.
- Darlington is more deprived than the national average, and while the Borough is becoming more prosperous, pockets of deprivation still exist.
- Forty four per cent of claimants cited a mental health condition as the reason for claiming Incapacity Benefit.
- The percentage of children living in poverty in Darlington is higher than the national average.
- The average earnings of people living in Darlington have increased but are still 17.7% lower than the average for Great Britain.

5. Aspiring Darlington

There is a focus on children and young people in this section of the JSNA, however future JSNAs will include adult and life long learning and the role of Third Sector, arts and culture in developing aspiration. The Children and Young People's Plan 2008-2011 (CYPP) is the key document which covers all services for families, children and young people aged 0-19 years and those up to 25 years who have a disability.

The CYPP brings together the learning from previous plans, the self assessments which were done in preparation for the Joint Area Review in 2008, an analysis of data against each of the Every Child Matters themes and a summary of community consultations. In effect the JSNA in relation to children and young people is largely encapsulated in The Children and Young People Plan 2008-2011, the accompanying needs analysis and The Children and Young People's Plan Section 2: Priorities 2008-11 Planned Activity. There are five priorities in the CYPP. Each priority is broken down into a number of discreet actions which in turn comprise the Action Plan for the CYPP. They evidence the close partnership thinking working between Darlington's Children's Trust and the JSNA.

5.1 Current births

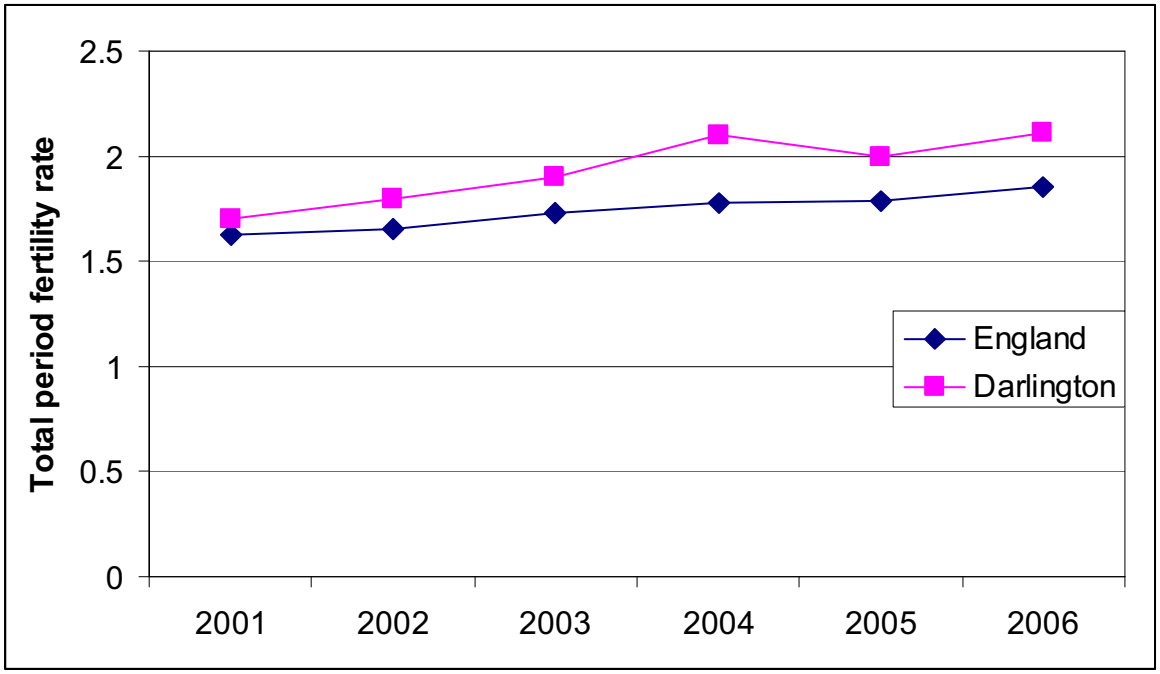
The future population depends in part upon changes in birth rates over time. Nationally, both the number of live births and the total period fertility rate have been increasing since 2001. A change in the birth rate will impact upon all services, particularly the caseloads of midwives, health visitors, general practices, Children's Services (both education and social care services) and Sure Start Children's Centres. The following table shows the number of births by the age of the mother for 2006.

Table 5.1: Births by Age of Mother

	Ages 11-15	Ages 16-19	Ages 20-24	Ages 25-34	Ages 35-39	Ages 40+	All ages
England number	1154	41264	120221	344642	105701	22766	635748
Darlington number	5	103	288	676	180	30	1282
England percentage	0.2%	6.5%	18.9%	54.2%	16.6%	3.6%	100%
Darlington percentage	0.4%	8.0%	22.5%	52.7%	14.0%	2.3%	100%

Source: National Statistics, 2006

The Office for National Statistics predicts that the total number of births in Darlington is will decrease from approximately 1,200 in 2005 to around 1,110 in 2025. However, anecdotal information suggests that Darlington is not following the trend of decreasing birthrates and it is suggested that this is as a result of the immigration of people from Eastern European countries. This is backed up by the following graph, which shows a Total Period Fertility Rate (the sum of the age-specific fertility rates for five-year age groups between ages 15-44, multiplied by 5) for Darlington which is higher than that for England and rising.



5.2 Looked After Children

The term "Looked After Children" (LAC) describes the group of children who are in the care of local authorities. A high proportion of children in care are there because they have suffered abuse or neglect. Consequently, looked after children are recognised as a particularly vulnerable group within society. Within Darlington, 6.4% of young people were looked-after at 31 March 2007. This number varies slightly on a weekly basis. Darlington is host to 80-100 LAC at any one time who are in care to other Local Authorities. This has implications for children's services, particularly from health and education perspectives.

There are two main reasons for children being in local authority care:

1. children who are subject to a care order made by the courts under section 31 of the Children Act 1989 (about 65% of all looked-after children) (for the courts to grant a care order they have to be satisfied that a child is suffering or would suffer 'significant harm' without one)
2. children who are accommodated by the local authority on a voluntary basis under section 20 of the Children Act 1989 (about a third of all looked-after children).

42% of looked-after children return home within six months. The system aims to support rehabilitation back into families where that is possible.

Absence from school of looked after children has reduced from 14.1% to 8.5% The long term stability of looked after children is below the national average. Looked after children with more than 3 placements in the year is 15% higher in Darlington than national average at 12%

Table 5.2: Looked After Children

Area	All Children	Male	Female	Under 1	16 and Over	Looked after per 10,000 Population
Darlington	140	90	60	10	20	60
North East	3250	1800	1480	210	480	60
England	60030	33400	26610	2930	11830	60

Source: Government Office and Local Authority, 31 March 2007

5.3 Health Care of Looked after Children (proportion having dental checkup)

Children and Young People looked after by Darlington Borough Council have high rates of uptake for a combined health assessment and dental check – 94% in 2006 compared to the national average..

5.4 Immunisation Rates

Immunisation remains one of the most important weapons for protecting individuals and the community from serious diseases. There has been concern about the fall in the uptake of the Measles, Mumps and Rubella (MMR) immunisation in recent years. Uptake of MMR across England at 24 months was 85% in 2005/06. The target for uptake of all immunisations is 95%, referred to as 'herd immunity'. At this level of uptake, vaccination in the wider community provides protection to unvaccinated individuals. Immunisation rates for children by their 2nd and 5th birthdays are higher in Darlington compared to England averages.

Table 1 in Appendix 3 shows the proportion of children that have received the following immunisations by their 2nd birthday:

1. Diphtheria/Tetanus/Polio/Pertussis/HiB, offered at 3-4 months
2. Meningitis C primary course, offered at 3-4 months
3. Mumps, Measles and Rubella (MMR) first dose, offered at 12-13 months.

Childhood immunisation rates in Darlington are higher than England rates, but concern remains that MMR vaccination rates for 2 year olds have remained fairly constant in recent years and have not yet regained the high coverage rates achieved in the 1990s.

5.5 Oral health of young people

Oral diseases are largely preventable but many people suffer unnecessary pain and discomfort because of poor oral health. National surveys of children's oral health are undertaken every 10 years, with some local surveys carried out more frequently. This indicator shows the mean number of teeth per child in the whole age-group (five and 14 year olds) which are either actively decayed and require treatment or which were treated for decay

either by extraction or filling, i.e. the mean number of teeth which were affected by decay.

Table 2 Appendix 3 shows a summation of the mean number of decayed/missing/filled teeth (DMF). Higher numbers indicate poor dental health, but low numbers may reflect the fluoridation of water in some areas. In Darlington the average number of DMF teeth for children aged 14 years is higher than the England average.

5.6 Teenage conception rates

The Government's Teenage Pregnancy Strategy aims to reduce the 1995-7 under 18 conception rate by 55% by 2010. Some teenage pregnancies are unplanned, some are unwanted and some represent the low aspirations of young women. Evidence shows that having a baby at a relatively young age can damage young women's health and well-being and limit their future prospects, while children born to young mothers also have a range of negative outcomes such as higher accident rates, higher mortality rates and increased likelihood of behavioural problems. Darlington has strong partnership working and service development around reducing teenage pregnancy. The teenage pregnancy self assessment action plan has prioritised "hot spot" areas to focus work. Darlington is one of the top 3 performers in the region.

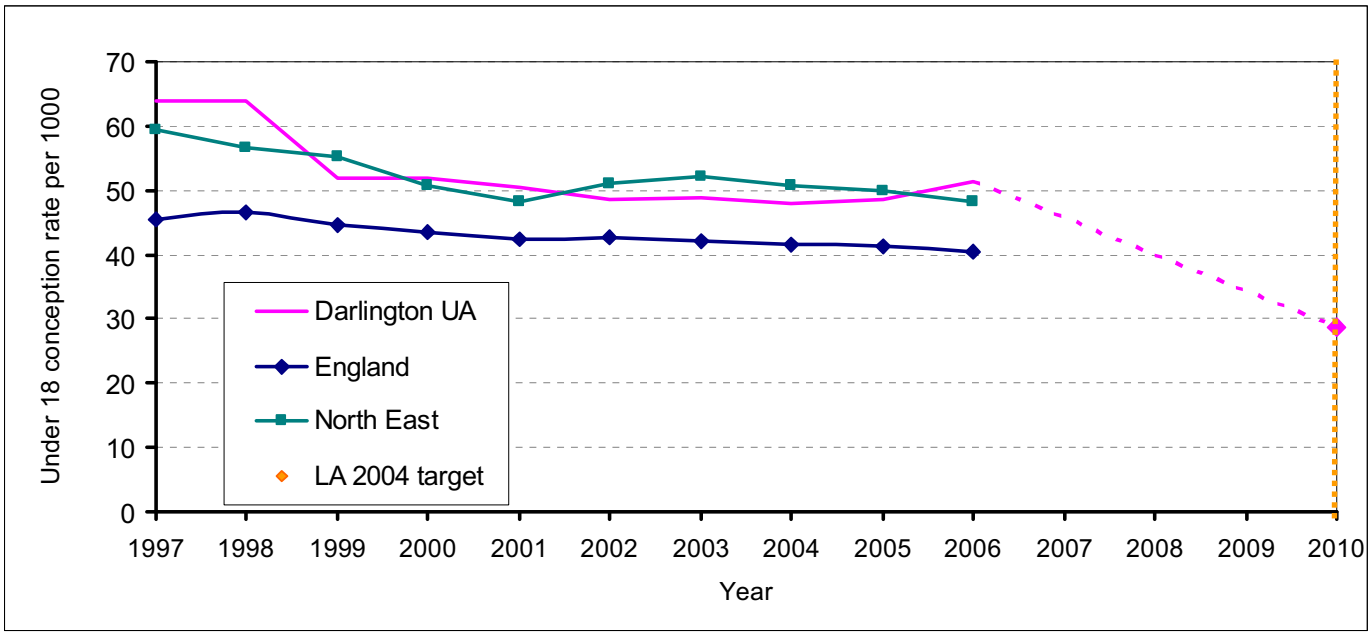


Table 5.3: Teenage Conception Rates

	1998		2006		1998-2006
	Number	**Rate (%)**	**Number**	**Rate (%)**	**% change**
England	41,089	46.6	41,768	40.9	-13.3%
North East	2,731	56.5	2,385	48.8	-13.6%
Darlington	116	64.0	108	55.3	-13.6%

The Teenage Pregnancy Partnership Board, consulting with young people, their families and the communities that serve them has developed a systematic approach to ensuring that the local teenage pregnancy strategy, prevention and support action plan is evidence based, performance managed and young person focused.

5.7 Smoking status of women at time of delivery

Smoking in pregnancy carries great risks for mothers as well as their children. It can lead to many debilitating and chronic conditions as well as placing greater risk of mortality during pregnancy and delivery, for both mother and child. Differences in smoking between socioeconomic groups contribute to continuing health inequalities. There are effective interventions to increase the smoking cessation rate throughout pregnancy and every opportunity should be taken to signpost and support expectant mothers into smoking cessation services.

Table 5.4: Smoking in Pregnancy

Area	**% mothers smoking at the end of pregnancy**
Darlington	24.2%
England	16.1%

Source: Department of Health, 2006/07

5.8 Obesity among primary school age children

The UK is experiencing an epidemic of obesity affecting both adults and children. Among boys and girls aged 2 to 15, the proportion who were classified as obese increased from 10.9% in 1995 to 18.0% in 2005 among boys, and from 12.0% to 18.1% among girls. For those aged 2 to 10, the increase over the same period was from 9.6% to 16.6% for boys and 10.3% to 16.7% for girls.

There is concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. Obesity is associated with low self esteem, bullying and exclusion from the peer group. A range of physical problems may also develop.

Children are defined as obese if their Body Mass Index (BMI) is above the 95th centile of the reference curve for their age and sex according to the UK BMI centile classification. Consumption of fruit and vegetables amongst children in Darlington is lower compared to the rest of England.

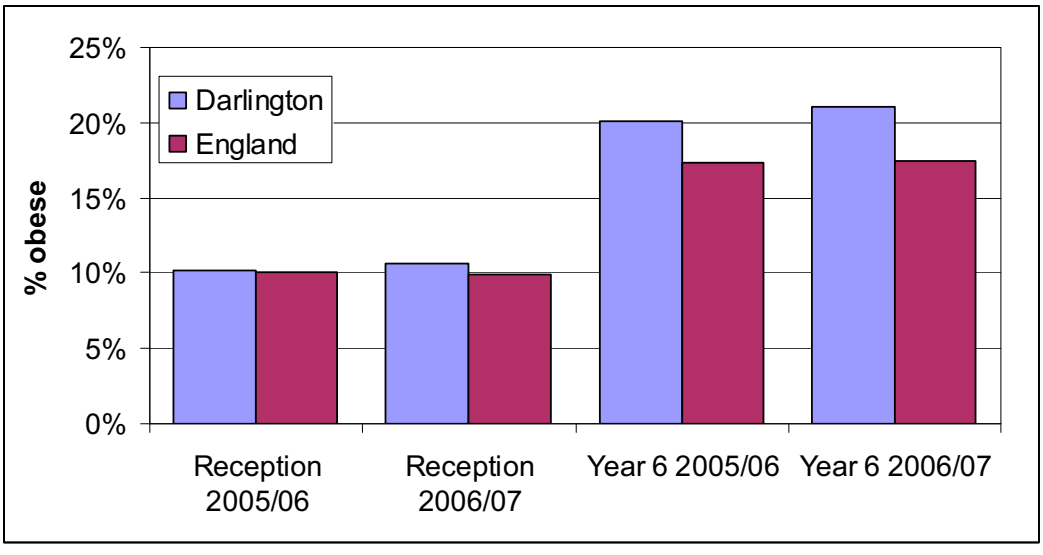
Obesity poses a major public health challenge and risk to future health, well being and life expectancy. Levels of obesity in children in Darlington are among the worst in England. The key priority for 2008/09 is for the Children's Trust to update the Tackling Obesity Strategy, developing Preventing Obesity, Promoting Physical Activity strategies for children and young people in Darlington. Further detail can be found in the Annual Report of the Director of Public Health – 2007/08.

The table shows the percentage of primary school age children in reception year (aged 4-5 years) and in year 6 who are known to be obese as a percentage of all children who had their height, weight and age recorded. The following graph shows that not only does Darlington have more obese children than the England average, but the prevalence is increasing more rapidly.

Table 5.5: Overweight & Obese Children

	Reception year		Year 6	
	% overweight	% obese	% overweight	% obese
Darlington	16.5	10.7	14.3	20.0
North East	14.4	10.9	14.9	19.9
England	13.0	9.9	14.2	17.5

Source: National Child Measurement Programme, 2006/07



5.9 Nutrition

The NHS Plan identified improvement in diet and nutrition as a central component of the Government's strategy to prevent deaths from heart disease and cancer.

Diet–related illnesses such as diabetes and obesity do not just increase the risk of serious illness, they can significantly undermine quality of life as well. Across Darlington, an estimated 31% of children eat three or more portion of fruit and vegetables a day compared with 38% of children across England (Health Survey for England 2000-2). Table 3 in Appendix 3 shows the synthetic estimates of diet at ward level. The estimates have been produced using a model-based method combining individual data from the Health Survey for England with area-level data from the 2001 Census and administrative data sets, and should be interpreted with caution.

5.10 Alcohol and Substance Misuse

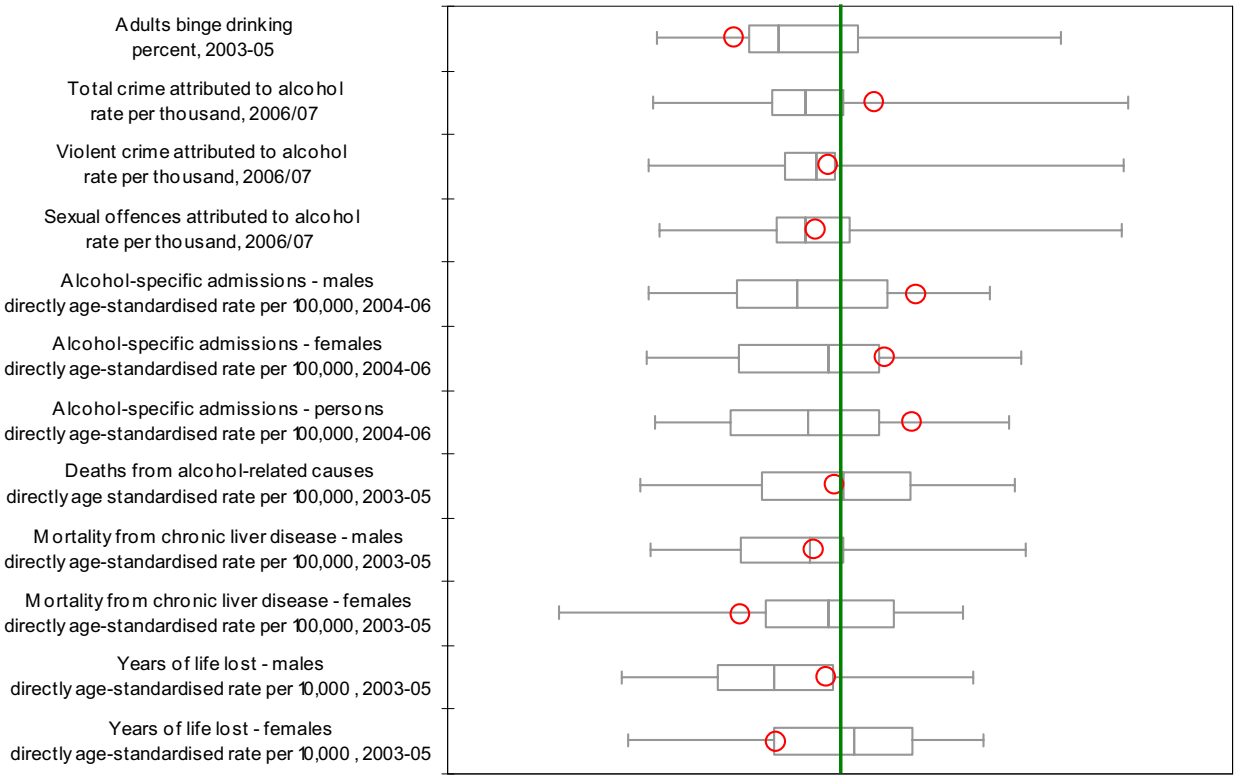
Three over-arching aims for work on alcohol misuse have been set in the North East (North East Regional Alcohol Advisory Group):

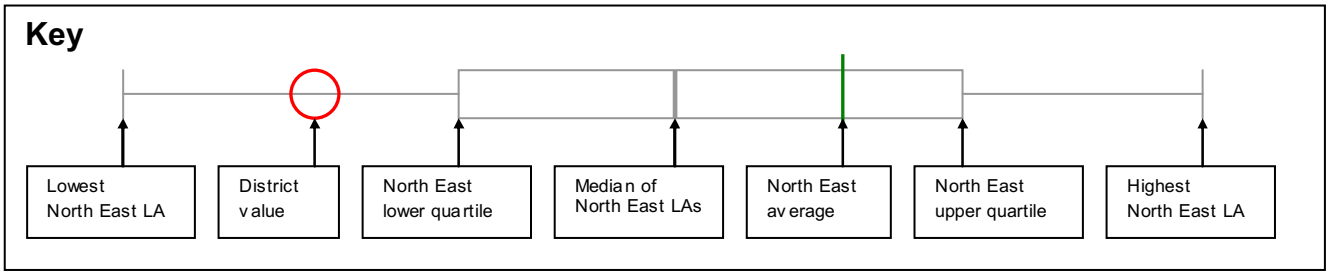
- taking a preventative approach to alcohol misuse
- providing treatment services for harmful, hazardous and dependent drinkers and their families and carers
- protecting the public by enforcing the law.

The regional strategy for health and wellbeing sets out a vision to increase the availability of brief interventions, develop comprehensive alcohol treatment and support services, use social marketing approaches to build the conceptual link between alcohol and domestic or public violence and in the longer term build public antipathy to drunkenness. A Regional Alcohol Office will lobby to increase taxation on alcohol, particularly to reduce excess usage, and for greater regulation of alcohol outlets and restrictions on cut-price sales (Government Office for the North East, 2008).

Estimated binge drinking in Darlington is significantly higher than in England. Hospital admission rates are rising with male rates and female rates highest in the younger age bands and particularly high for men. In 2006/07 there were 96 young people aged under 18 years receiving substance misuse treatment. Admissions to hospital of young people aged under 20 with mental health and behavioural disorders due to substance misuse is significantly higher than the England average. These and other indicators are highlighted in the chart below, which is taken from the Alcohol Profiles produced by the Public Health Intelligence North East network in 2008. The chart shows Darlington's measure for each indicator, as well as the regional and England averages.

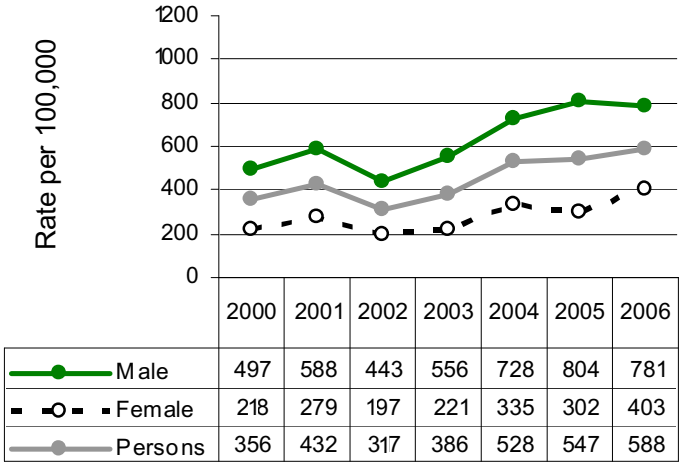
Alcohol Profile





	Admissions of local residents	Deaths of local residents
Definition	Alcohol-*specific* admissions as defined in Local Alcohol Profiles for England (*North West Public Health Observatory 2007*)	Alcohol-*related* deaths as defined by Office for National Statistics (*Health Statistics Quarterly, Autumn 2007*)
Disease classification	ICD-10 as defined above	ICD-10 as defined above
Source of data	Hospital Episodes Statistics	Public Health Mortality Files Clinical & Health Outcomes Knowledge Base
Period	2000-2006	2001-2006 1993-2005 (for disease sub-set time series)
Age standardisation	Rates calculated using mid-2006 population estimates	Rates calculated using mid-2006 population estimates
Hospital episodes count	Counts based on maximum of 1 admission per person per year and including only the first alcohol-specific diagnosis code for each case	

Alcohol-specific admission rates for Darlington males are significantly higher than regional rates and they are rising steadily.



	2000	2001	2002	2003	2004	2005	2006
Male	497	588	443	556	728	804	781
Female	218	279	197	221	335	302	403
Persons	356	432	317	386	528	547	588

Key messages:

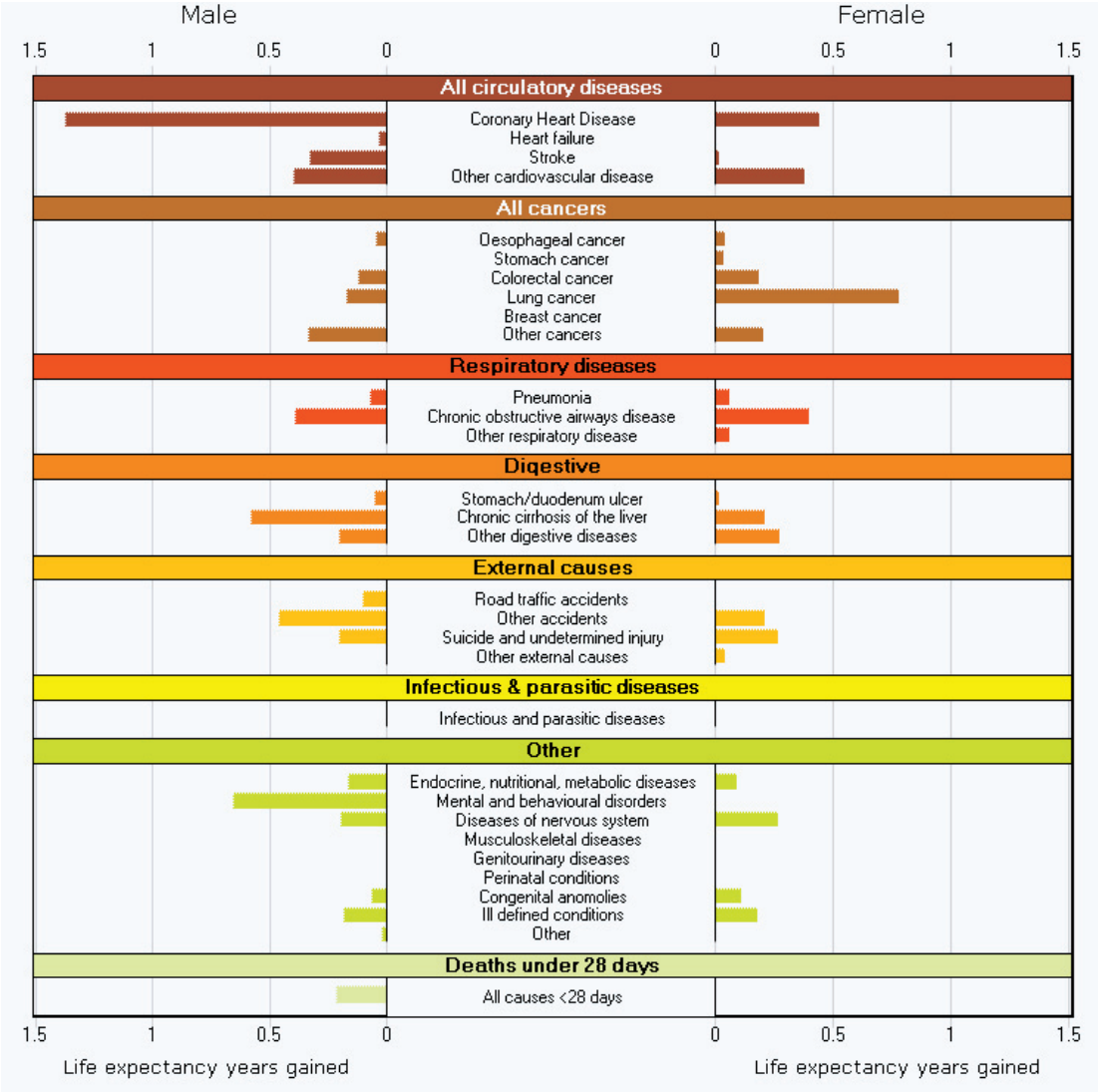
- Narrowing the gap in health inequalities will help children and young people to enjoy their childhood, achieve their learning potential and become happy and healthy adults and parents to the next generation.
- Infant mortality has been the same or slightly lower in Darlington than the national average (measured over a 3 year trend).
- The proportion of low birth weight babies is slightly below the national rate in Darlington at 6.2% in 2005
- In Darlington at reception 10.11% of children are obese and a further 18.06% are overweight.
- In Darlington by Year 6, 20.1% of children are obese and a further 14.8% are overweight.
- Consumption of five fruits/vegetables per day amongst children is low in Darlington (30.9%) compared to England (37.7%).
- Immunisation rates for children by their 2nd and 5th birthdays are higher in Darlington when compared with England averages.
- Emergency admissions to hospital for children aged 0-19 years are significantly higher in Darlington than the England average.
- The average number of decayed/missing/filled teeth for children aged 5 years at 1.80 (2003.04) is higher than the England average (1.49).
- The average number of decayed/missing/filled teeth for children aged 14 years at 1.69 (2003/04) is higher than the England average (1.43)
- All children and young people have the right to feel and to be safe from harm.
- All children and young people should benefit from high quality teaching, learning and leisure activities so that they can enjoy their childhood
- All children and young people should have the opportunity to contribute to their community and environment.
- All children and young people should be prepared for and prosper in adult life.

6. Healthy Darlington

6.1 Inequalities

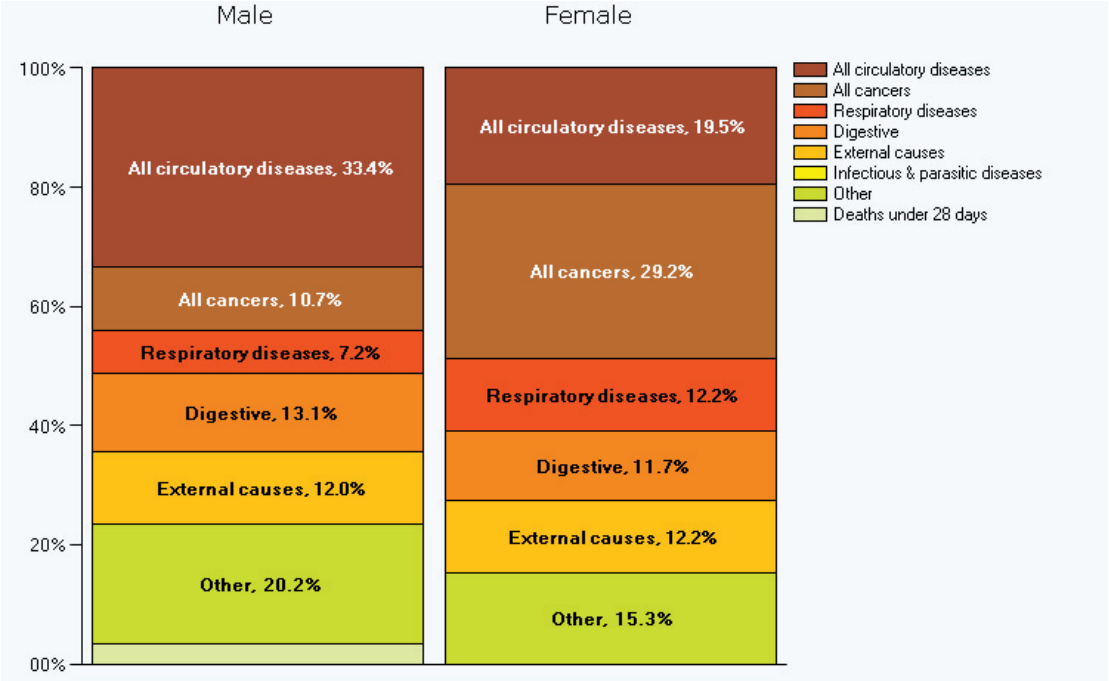
Levels of health and deprivation vary across Darlington with some areas being worse than England as a whole. Inequalities in health remain persistent and pervasive. Men and women from the least deprived areas of Darlington can expect to live longer than men and women from the most deprived areas.

The Health Inequalities Intervention Tool was developed by the London Health Observatory and the Department of Health to examine inequalities in life expectancy at Local Authority level. The tool focuses on the most deprived areas of each district, namely the 20% of Super Output Areas (geographical areas covering average populations of 1,500 people) that have the highest income deprivation (as measured using the Index of Multiple Deprivation 2007). The graph below shows the increase in life expectancy (in years) that would occur in the most deprived quintile of Darlington if it had the same mortality rate as England for each cause of death. The chart shows only those diseases where the most deprived quintile has a greater mortality rate than England; where there is no (or negative) excess mortality, no bar is shown on the charts.



The graph shows that for men in the most deprived parts of Darlington, the biggest improvements in life expectancy can be achieved by tackling coronary heart disease, followed by mental and behavioural disorders (including dementia and disorders due to the use of drugs and alcohol) and chronic cirrhosis of the liver. For women, the greatest reductions in the life expectancy gap would be achieved by tackling lung cancer, coronary heart disease, chronic obstructive airways disease and other cardiovascular disease. Note that, despite the relative importance of these disease categories, the number of deaths from these causes may still be quite small and therefore subject to substantial variation over time. The Health Inequalities Intervention Tool examines mortality rates and life expectancy over the period 2001-5, and while suicide and undetermined injury is identified as a major contributor to the female life expectancy gap for Darlington, only 16 deaths occurred over this period. The results must therefore be interpreted with caution.

The second diagram taken from the Health Inequalities Intervention Tool is a "scarf diagram", which shows the percentage contribution of various causes of death to the overall life expectancy gap between the most deprived quintile of each districts population and England as a whole. It reiterates the finding that cancers and circulatory diseases make the greatest contribution towards the life expectancy gap between Darlington and England.



6.2 People with learning disabilities

People with learning disabilities are a vulnerable group who suffer poorer health outcomes than the general population. The associated poor health outcomes include unrecognised and unmet health needs, higher rates of physical illness and a greater likelihood of premature death. The table below shows the number of people aged 18 and over who are on general practitioners learning disabilities registers as a percentage of the total registered population.

Note that this indicator depends upon people attending their general practice and on practice staff recording their information on computer, so may under-represent the true picture. It should be noted that in Darlington the prevalence rate is higher than the North East and significantly higher than the England prevalence rate.

Table 6.1: People with Learning Disabilities

Primary Care Trust	Number of People with Learning Disabilities	Prevalence per 100,000 practice patients
Darlington PCT	377	362
North East	9260	348
England	138598	259

Data Source: Quality and Outcomes Framework, Information Centre for Health and Social Care, financial year 2006/07

6.3 Older People

The population of England aged 65 and older is set to increase from 16% of the total population in 2005 to 22% in 2029. There are approximately 35,000 people currently living in Darlington who are aged 50 years or over. This figure is set to increase to over 40,000 by 2021. The critical issue is whether this expanding older population will live their lives in good physical and mental health, or in illness, distress and loss of independence. A range of supportive options are available, for example, extra care homes, life line services and assistive technology. In 2007 the Adult Social Care Community Equipment Service achieved 98.8% user satisfaction rate.

6.4 Older people living alone

Pensioners living alone are a potentially vulnerable group. It is important to ensure that they have a range of accessible services that maintain their independence, improve their quality of life and promote social inclusion. Fuel poverty is a particular concern for older people living alone because they may live in under-occupied premises, tend to have lower incomes and spend more time in the home. Fuel poverty is linked with a range of health problems including the increased risk of preventable winter death. At 7% Darlington has fewer private properties that fall into the category of fuel poverty compared to national average of 8%.

Table 4 in Appendix 3 shows the percentage of all households in an area, at the time of the 2001 Census, that consisted of a pensioner living on their own. A pensioner is defined as a man aged 65 years or over, or a woman aged 60 years or over.

6.5 Excess winter deaths, district level

Excess mortality in winter is an important public health issue in the UK, which can be reduced with effective intervention. This excess death is greatest in both relative and absolute terms in older people. Excess winter deaths are associated with cold weather but it has been observed that other countries in Europe especially the colder Scandinavian countries have relatively fewer excess deaths in winter compared to UK. Factors contributing to excess winter deaths include poor housing, poverty and behavioural response to cold. Respiratory and circulatory diseases contribute most to the increase in deaths seen during the winter months and excess winter death is higher in years with influenza epidemics. The risk of excess winter deaths can be reduced by ensuring adequate insulation and heating in houses especially in those occupied by the old. Provisional figures for 2005/2006 showed that there were 24,200 excess winter deaths in England and 90.5% of these were for those aged 65 and over. [Extract from APHO Indications of Public Health in the English Regions 9: Older People]. Excess winter mortality is calculated as winter deaths (deaths occurring in December to March) minus the average of non-winter deaths (April to July of the current year and August to November of the previous year). Table 6.2 shows the number of winter deaths in Darlington between 1999/2000 and 2004/05, along with the Excess Winter Deaths Index. The Index varies considerably from one year to the next in Darlington but across the total period 1999/2000-2004/05, Darlington had the lowest Excess Winter Deaths Index for any district in County Durham and Tees Valley. To reduce winter death rate further, residents at risk must be encouraged to have a flu jab, eat well, wear appropriate clothing in cold weather and claim all the benefits to which they are entitled.

Table 6.2: Excess Winter Deaths

	Excess Winter Deaths	Excess Winter Deaths Index
1999/00	102	27.6
2000/01	46	11.8
2001/02	32	8.2
2002/03	27	7.5
2003/04	65	17.5
2004/05	13	3.4

County Durham and Tees Valley Public Health Network: Cold Kills, December 2006

6.6 Older people supported to live at home

National policy has been to support people to live independently in their own homes, the development of services such as home help and care and meals services and day care as an alternative to residential accommodation. The vast majority of older people now live independently in their own homes and a proportion of this population will require a degree of support to maintain their independence. Table 6.3 outlines the distribution of intensive home support provided to social care clients. It shows the percentage of households receiving home care by total contact hours during the survey week for each sector of provider. Households receiving home care purchased with a direct payment are excluded. For all sectors the percentages are based on the total number of households receiving home help/home care derived from the sum of those receiving care from the Local Authority sector and those receiving care from the Independent sector. The total number of households has some double counting as it includes those households receiving care from more than one sector.

Table 6.3: Households Receiving Home Care

Area	Darlington	North East	England
All sectors > 10hrs no overnight	28	243	3294
All sectors > 10 hrs including overnight	-	20	372
LA > 10 hrs no overnight	39	309	3062
LA > 10 hrs including overnight	-	8	410
Independent > 10 hrs no overnight	22	220	3516
Independent > 10 hrs including overnight	1	42	457

Data source: Information Centre for Health and Social Care, survey week, September 2004

6.7 People who are deaf or hard of hearing

Councils with Social Services Responsibilities hold registers for people who are deaf or hard of hearing. Table 6.4 shows the number of people who are deaf or hard of hearing who have voluntarily registered with their local authority.

Table 6.4: People Registered Deaf or Hard of Hearing

Area	People registered deaf or hard of hearing
Darlington	439
North East	17610
England	213825

Source: Information Centre for Health and Social Care,2006

6.8 Blind and partially sighted people

Councils with Social Services Responsibilities hold registers for people who are blind or partially sighted. Table 6.5 shows the number of people who are blind or partially sighted who have voluntarily registered with their local authority council by age as a percentage of the total population.

Table 6.5: People Registered as Blind or Partially Sighted

Area	Number	%
Darlington	725	0.7
North East	15345	0.6
England	307655	0.6

Source Information Centre for Health and Social Care 2006

Population 2006-07 = 77,080 (calculation 725 / 77080 * 100 = 0.9%)
Population 2007-08 = 77,287 (calculation 570 / 77,287 * 100 = 0.7%
There was a data cleanse on the register last year which resulted in the reduced numbers.

Blue Badges

Blue badges are issued to people who have disabilities and to institutions such as care homes. Automatic eligibility is granted for those who:

- are claiming the higher rate of disability Living Allowance
- have a government issued car or a grant for their own car
- are eligible for War Pensioners mobility supplement
- are registered blind
- councils can also grant badges at their discretion usually based upon evidence from a medical examination or a letter from a GP.

Table 6.6 shows the numbers of automatic and discretionary badges that were granted for the period 31 March 2007.

Table 6.6: Blue Badges Issued

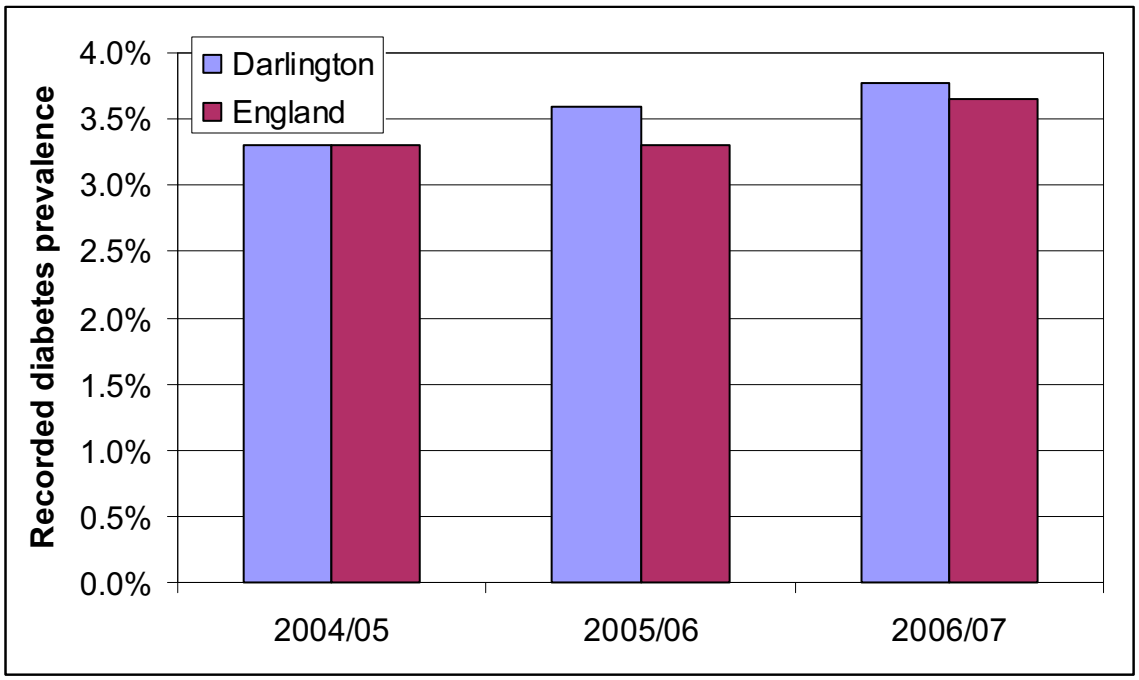
Area	Total Badges issued	Rate per 1000 of population	Retired % of the population	Issued to institutions	Issued to individuals: All	Automatic issues	Issued at discretion of LA
Darlington	6424	65	20	4	6420	1477	4943
North East	148714	58	19	14360	147278	65763	81515
England	2318367	46	19	28603	2289764	826044	1463720

Source: Department of Transport Blue Badge Survey 2007

6.9 Diabetes

People claiming benefits for ill-health represent mainly working age populations and only the tip of the iceberg of people with, for example, diseases of the respiratory or circulatory systems.

The following graph shows the increase in recorded prevalence of diabetes over the last few years. The recorded prevalence of diabetes is still higher than the recorded prevalence for England.



The Association of Public Health Observatories have taken data from national surveys and modelled it using local population data, to produce some estimates of actual (rather than recorded) disease prevalence. The table shows the number of people with diabetes estimated by models developed by the Yorkshire and Humber Public Health Observatory compared with the number of people with diabetes recorded on general practice systems. Despite the increase in diagnosis and/or recording of diabetes, there is still an estimated 0.7% of the population of the Darlington population (around700 people) who have diabetes but may not yet have it diagnosed.

Table 6.7: Estimated Prevalence of Diabetes

Area	Estimated population with diabetes	Estimated prevalence of diabetes
Darlington	4400	4.5%
North East	91000	4.7%
England	1201700	4.6%

Source: PBS tool commissioned by the Department of Health and Quality and Outcomes Framework Information Centre for Health and Social Care; Data modelled in 2005 using 2001 population data and a range of diabetes prevalence studies. Recorded general practice data is for financial year 2006/07. Adult obesity is a primary underlying factor in type 2 diabetes.

Table 6.8: Estimated and Recorded Prevalence of Diabetes

	Estimated prevalence of type 1 and type 2 diabetes			Recorded Prevalence 2006/07
	Persons	Male	Female	
England	4.5%	3.6%	5.1%	3.7%
North East	4.7%	3.9%	5.5%	3.8%
Darlington	4.6%	3.7%	5.3%	3.8%

Source: York PBS Diabetes Prevalence Model phase 2, June 2005; Quality and Outcomes Framework, Information Centre for Health and Social Care, 2006/07

6.10 Circulatory Diseases

6.10.1: Circulatory Disease Mortality Rates

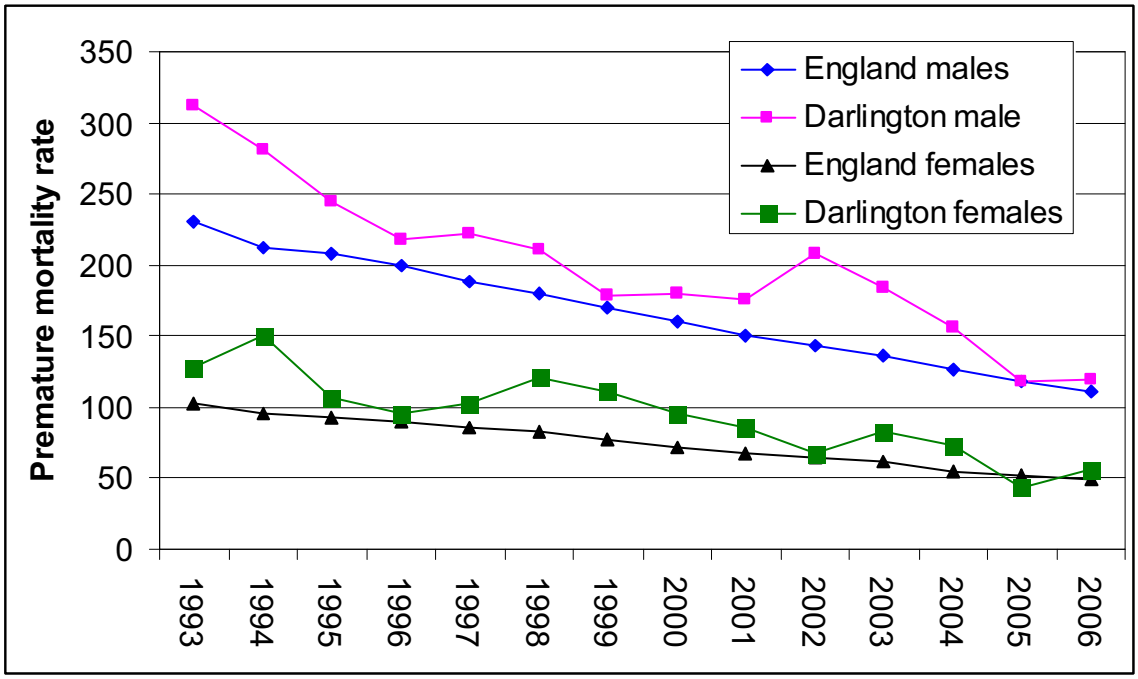
Circulatory diseases include heart diseases and stroke and they account for 40% of all deaths. They also account for 30% of all premature deaths, typically assessed as deaths before the age of 75. For evaluation purposes, death rates are adjusted for age and sex, using the procedure of direct standardization (the rate of events that would occur in a standard population if that population were to experience the age-specific rates of the subject population). This allows fair comparisons to be made both between areas and across time. A higher rate per 100,000 represents higher (worse) mortality in one area compared to another; a lower rate per 100,000 represents lower (better) mortality. The table below show that premature death rates from circulatory diseases have been decreasing across England and the North East, as well as in Darlington. It is also reassuring to note that the relative difference in premature death rates between Darlington and England have dropped from 32% in 1993 to 10% in 2006.

Table 6.9: Premature Mortality Rates from Circulatory Diseases Over Time

Area	Darlington	North East	England
1993	214.81	205.46	163.19
1994	211.40	191.08	150.95
1995	172.77	182.64	147.34
1996	153.91	175.90	142.35
1997	158.28	168.81	134.27
1998	163.68	162.77	129.54
1999	143.29	146.96	121.69
2000	135.80	135.73	114.07
2001	128.63	128.11	107.85
2002	135.36	122.49	102.75
2003	130.93	119.50	97.76
2004	113.53	108.89	89.69
2005	78.81	97.64	84.03
2006	86.97	92.81	79.00

Source: National Statistics and Compendium of Clinical and Health Indicators, 1993-2006

Premature death rates have been dropping for both men and women, but the gender gap in mortality remains. Within Darlington, the premature death rate for men is 145% higher than the rate for women.



6.10.2 Prevalence models: Estimated Number and Percentage of People with CHD and Hypertension

High blood pressure - hypertension - is a major risk factor for stroke, coronary heart disease and other illnesses such as kidney disease and aortic aneurysm. As part of the 2007/8 Local Delivery Plan (LDP) process the Association of Public Health Observatories (APHO) was commissioned by the Department of Health to produce PCT level prevalence estimates for coronary heart disease and for hypertension. It should be noted that these models are only intended to give indicative expected prevalence and are part of ongoing work to produce refined estimates. The recorded prevalence of hypertension in Darlington is 13% (Quality and Outcomes Framework 2006/07), indicating 12% of the local population (around 12,000 people) may have undiagnosed hypertension. The recorded prevalence of coronary heart disease is 4.4% suggesting a possible over-recording or underestimating of CHD prevalence.

Table 6.10: Estimated Prevalences of Hypertension and CHD

Area	Estimated prevalence of hypertension	Estimated prevalence of coronary heart disease
Darlington	24.7%	4.7%
England	23.8%	4.3%

Source: Estimates produced by the Association of Public Health Observatories, based on the Health Survey for England 2003

6.11 Cancer

Cancer treatments are improving dramatically. However for most cancers, the earlier a cancer can be diagnosed, the better the clinical outcomes. Screening programmes and awareness raising are vital in combating the disease. It is estimated that over half of all cancers could be prevented by changes to lifestyle, in particular smoking, obesity, alcohol use and over exposure to sunlight.

6.11.1 Premature deaths from all cancers

Cancer contributes significantly to the life expectancy gap across Darlington. There are multiple potential sources of inequality, which can impact on incidence, survival, mortality, patient experience or quality of life.

These include:

- exposure to infections linked to cancer
- genetic risk of developing cancer
- awareness and attitude to lifestyle risk factors for cancer
- uptake of prevention and screening services
- access to diagnostic and treatment services
- provision of information and support.

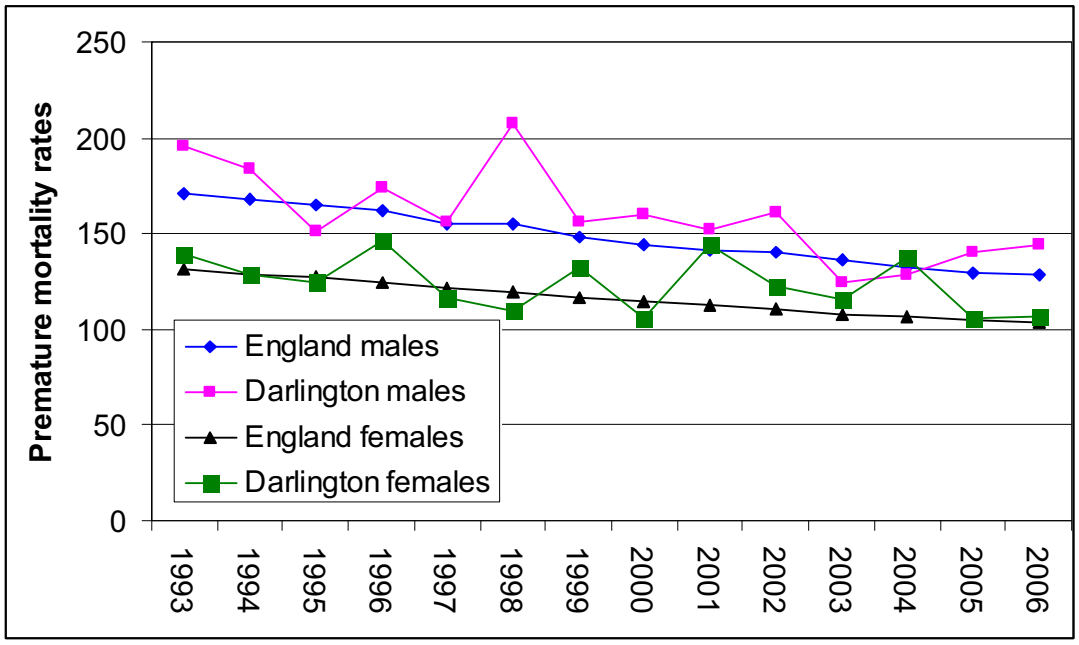
Table 6.10 the directly standardised mortality rate for people aged under 75 for all malignant neoplasms (ICD-10 C00-C97). These premature mortality rates have been dropping both for Darlington and for England. The relative difference in premature mortality rates between Darlington and England has also dropped from 10% in 1993 to 8% in 2006.

Table 6.11: Premature Mortality Rates for Cancer Over Time

Area	Darlington	North East	England
1993	164.82	181.33	149.56
1994	154.15	171.77	146.63
1995	136.02	167.10	144.21
1996	158.32	172.09	.142.18
1997	133.72	162.64	137.23
1998	155.66	165.72	135.96
1999	143.11	154.77	131.52
2000	130.47	154.17	128.66
2001	147.84	151.84	126.07
2002	140.51	144.73	124.76
2003	118.59	137.18	121.34
2004	132.91	138.33	118.82
2005	121.98	133.68	116.84
2006	124.98	135.92	115.54

Source: National Statistics and Compendium of Clinical and Health Indicators, 1993-20065.12.2.2 Cancer registrations

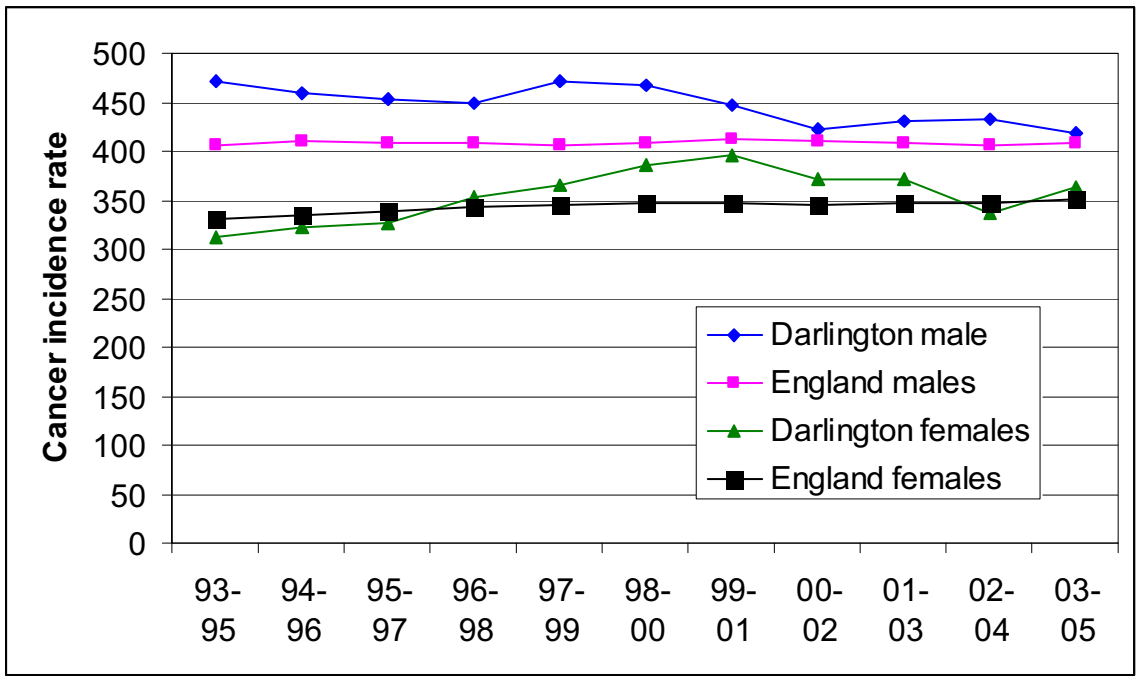
Both locally and nationally, the premature mortality rates for cancer remain higher for men than for women. This gender gap is consistently higher for Darlington than it is for England.

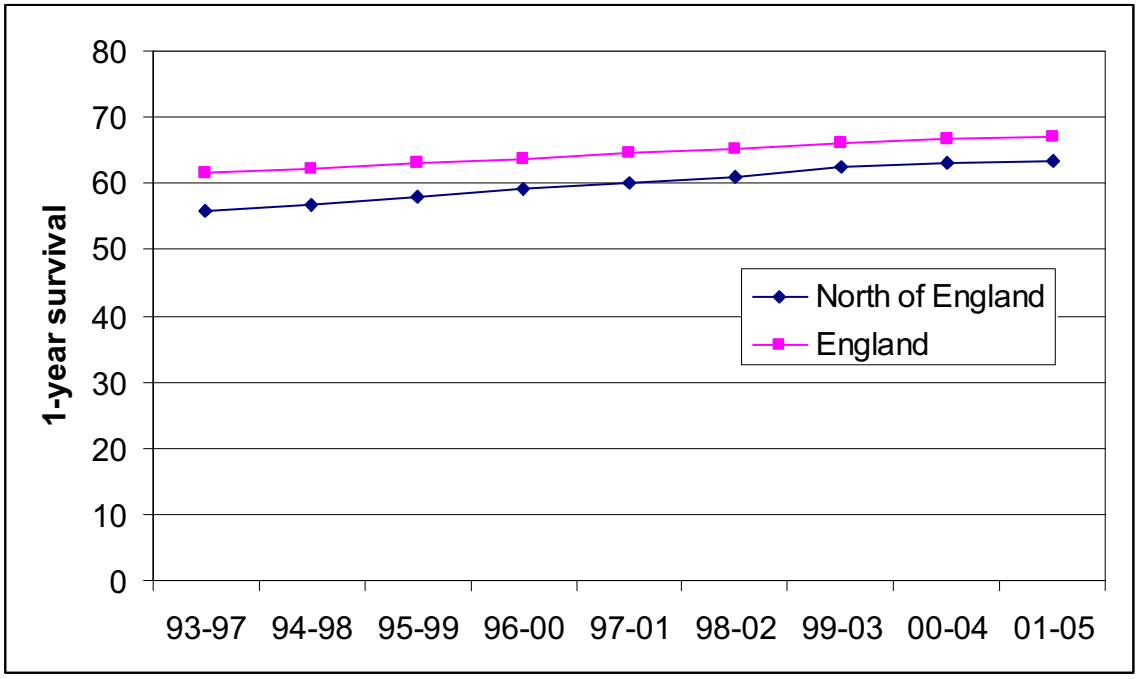


6.11.2 Cancer registration rates

A high cancer registration rate shows a high prevalence of cancer. Risk factors for cancer include smoking, high alcohol consumption, poor diet and exposure to sun. Areas with high cancer registration rates may want to focus on the prevention of these risk factors as well as encouraging people to attend screening services and raising awareness of early symptoms. Table 5 in Appendix 3 shows the number of registrations for all cancers excluding skin cancers other than malignant melanoma.

The graph below shows the variation in directly standardized cancer incidence rates by gender over time. While mortality rates have dropped over time, incidence rate have remained fairly consistent, indicating that cancer is no longer the death sentence it once seemed. The subsequent graph shows the rising one-year survival rates for both England and the North of England Cancer Network (which serves Darlington).





6.11.3 Cervical Screening and Breast Screening Uptake Rates

Cervical screening is not a test for cancer. It is a method of preventing cancer by detecting and treating early abnormalities which, if left untreated, could lead to cancer in a woman's cervix (the neck of the womb). Early detection and treatment can prevent 80 to 90% of cancers developing. National policy for the screening programme is that eligible women between the ages of 25 and 64 years should be screened every 3 to 5 years.

The coverage of the cervical screening programme is defined as the proportion of women eligible for screening who have had a test with a recorded result at least once in the previous 5 years. Women ineligible for screening and therefore excluded from both the numerator and denominator of the coverage calculation, are those whose recall has been ceased for clinical reasons (e.g. those who have had a hysterectomy). Coverage of the screening programme is best assessed using the 25-64 year age group as women may be first called at any time between their 20th and 25th birthdays.

Table 6.12: Cervical Screening Programme

	Eligible women	Coverage (%)
Darlington	24544	82.6
North East	631995	82.1
England	12804440	80.6

Source: National Statistics, 2003/4

Early diagnosis can have a major impact on breast cancer survival. Women aged between 50 and 64 are routinely invited for breast screening every three years and the national programme was extended to include women up to and including the age of 70 by 2004. In September 2000, the first research was published which demonstrated that the National Health Service Breast Screening Programme has lowered mortality rates from breast cancer in the 55-69 age group (NHS Cancer Screening Programmes Web Site: http://www.cancerscreening.nhs.uk.

The coverage of the breast screening programme is defined as the proportion of women eligible for screening who have had a test with a recorded result at least once in the previous 3 years. Women ineligible for screening and therefore excluded from both the numerator and denominator of the coverage calculation, are those whose recall has been ceased for clinical reasons (e.g. those who have had a bilateral mastectomy). Coverage of the screening programme is best assessed using the 53-64 year age group as women may be first called at any time between their 50th and 53rd birthdays.

Table 6.13: Breast Screening Programme

	Eligible women	Coverage (%)
Darlington	7099	76.3
North East	183483	73.6
England	3537760	75.0

Source: National Statistics, 2003/4

A pilot scheme in Darlington in 2008 is offering additional cervical screening clinics including Saturday mornings. Health Action Plans are being developed to support people with a learning disability to access the full range of health care services including breast screening.

6.11.4 Bowel Cancer Screening

The bowel cancer screening programme was launched in November 2007. Men and women aged 60-69 are invited to participate in bowel cancer screening once every two years.

More males than females were diagnosed with this cancer (<75 years 2002-2004).

6.12 Mental Health

Common mental health problems affect around 15% of the working age adult population. Often they are mild and self-limiting, but in more persistent cases help from general practitioners and psychological therapy services may be required. These problems appear in part in response to a range of life stresses, such as single parenthood, unemployment and financial pressures. Predictably, the number of people likely to suffer with them in the population therefore varies around the country.

Table 6 in Appendix 3 presents findings from the most recent ONS national psychiatric morbidity survey. Local estimates have been made from this on the basis of the regional and age-profile variations published. Levels of mental health problems are generally higher in poorer areas. Mental health and wellbeing community profiles are being produced by the Public Health Team of County Durham and Darlington Primary Care Trusts.

6.13 Dementia

The prevalence of dementia in the general population is highly predictable being dependent almost exclusively on age structure. Table 6.11 shows the likely number of people suffering from dementia locally, regionally and nationally in 2008, 2010 and then at five yearly intervals until 2025. It shows a large increase arising primarily as a consequence of the increased number of very elderly people. This largely elderly population may also be physically frail as well as having dementia.

Table 6.14: Estimated Prevalence of Dementia

	2008	2010	Increase 2008 to 2010	2015	Increase 2008 to 2015	2020	Increase 2008 to 2020	2025	Increase 2008 to 2025
Darlington	1221	1239	1.5%	1356	11.0%	1536	25.8%	1755	43.7%
North East	29668	30730	3.6%	33915	14.3%	38016	28.1%	43088	45.2%
England	587328	607249	3.4%	671656	14.4%	755951	28.7%	866297	47.5%

Source: Knapp M and Price M (2007)

6.14 Number of Carers

A carer is a person who provides unpaid support to family or friends. This could be caring for a relative or friend who is ill, frail, disabled or has mental health or substance misuse problems. Parents of disabled children are also included in this definition. At any one time 1 in 10 people in Britain is a carer. Carers UK research carried out in December 2006 indicates that every year, 37% of the population will have started caring that year and a similar proportion will have ceased. (For Darlington this equates to 3724 carers).

At the time of the 2001 census, there were 5.2 million carers in England and Wales (1:10 of the population), 21% (1.09 million) of whom provided care for 50 or more hours per week. In England, the North East had the highest proportion of carers (11%) and the county with the second highest proportion of carers was Durham (11.6%). Information in respect of Darlington shows that there were 10,064 carers, 2330 of whom were providing care for 50 or more hours per week. This was in excess of the previously estimated 8846 carers in Darlington. Of those 57 carers stated that their ethnicity was "white Irish", 45 "white other" and 122 from the "other BME" groups.

Carers were identified in all wards of the town, although some wards had higher concentrations of carers than others, as shown in Table 7 Appendix 4. Of particular note is that the 3 wards with highest numbers of carers are Park East (629), Haughton West (551) and Cockerton East (543). The three wards with the highest number of carers providing care in excess of 50 hours per week are Park East (187), Cockerton West (175) and Eastbourne (144). The three wards with the highest percentage of carers are Hummersknott (14%), Hurworth (13%) and Park West (13%)

Whilst the majority of carers are adults it should be noted that children and young people under the age of 18 also take on a caring role and are known as 'young carers'. In 2001 the census showed that there were 178 young carers aged 15 and under, but no data was available for those young carers aged 16 and 17 as they were included in the adult figures.

6.15 Social Care Clients Receiving Self Directed Support (Direct Payments and Individual Budgets)

Self Directed Support enables disabled people to decide for themselves how to use government resources to meet their social care needs instead of social services arranging the support on their behalf. The data cover those individuals and their families (including self-funders) who have access to a range of high quality information, advice and advocacy and support brokerage. Data covers the number of people receiving self-directed support. Table 5 in Appendix 2 shows the number of social care clients receiving Direct Payments per 100,000 population in 2006-07.

6.16 Timeliness of Social Care Assessment and Packages

Service users and carers should expect help and support to arrive in a timely fashion soon after their problems have been referred to social care. The table below shows how long people had to wait to have their needs assessed during 2006/07. It is calculated using two time lines, the first contact to start of assessment, the second the first contact to the completion of the assessment. The average is then taken to show how quickly people's needs are being assessed.

Table 6.15: Timeliness of Social Care Assessments

Local Authority	% where first contact to start of assessment is less than or equal to 2 days			% where first contact to completion of assessment is less than or equal to 28 days			Average %
	Total Waiting	Seen within 2 days	%	Total waiting	Seen within 2 days	%	
Darlington	1145	1175	97%	780	895	87%	92%
North East	23,170	26,759	87%	19,740	25,081	79%	83%
England	460,935	515,923	89%	357,747	452,945	79%	84%

Source: The Information Centre for Health and Social Care 2006/07

During 2005-06, an estimated 1.75 million clients received services provided, purchased, or supported by Councils with Social Services Responsibilities following a community care assessment, a rise of 2% since 2004-05. Around 76% of new older clients had received all services specified in their care plan within 2 weeks of their completed assessment. This exceeds part of the ministerial target that 70% of all social services for new clients aged 65 and over, following assessment, should be provided within 2 weeks. A further 11% waited up to 4 weeks for all services to be provided, giving a cumulative total of 87% compared to the ministerial target of 100% by December 2004.

Table 6.13 shows the percentage of new clients aged 65 and over for whom all services were put in place during the period by length of time from completed assessment to receipt of all services.

Table 6.16: Timeliness of Social Care Packages

Local Authority	Packages	Percentage
Darlington	511 of 592	86
North East	13,419 of 15,284	88
England	269,494 of 301,811	89

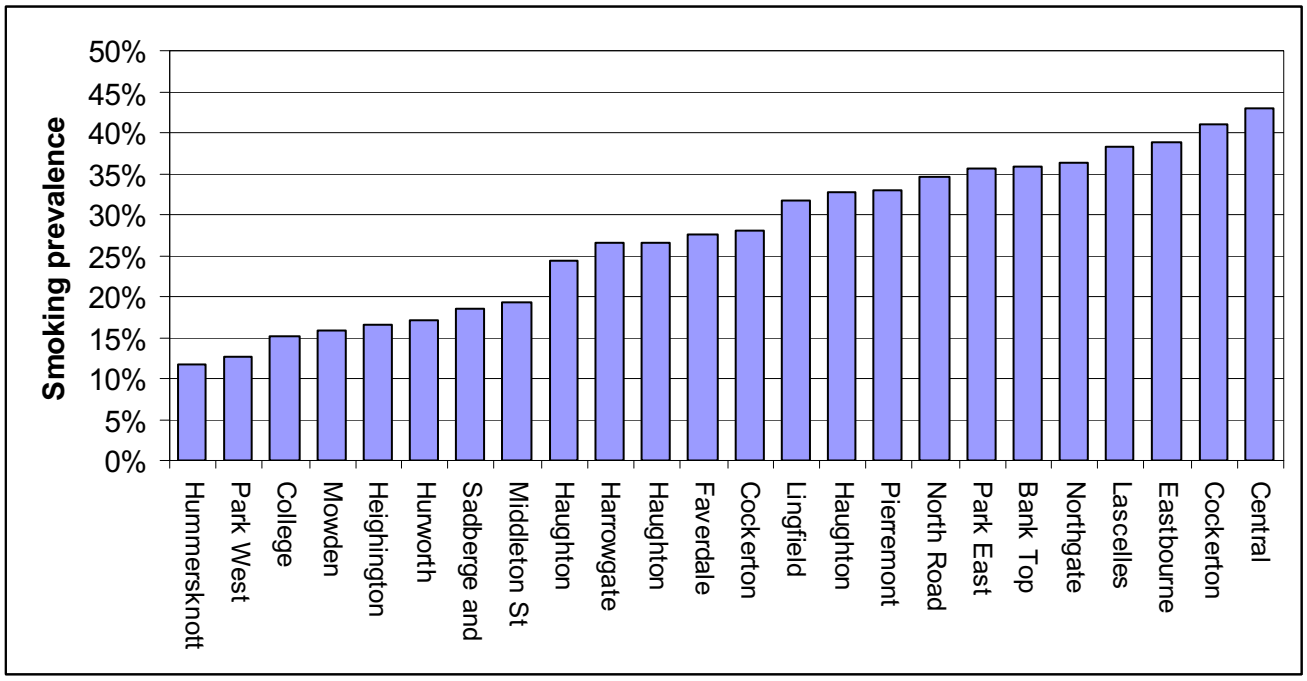
Source: Information Centre for Health and Social Care, 2006/07

6.17 Lifestyle

Lifestyle behaviours are known to have an impact upon health. This section of the report presents a small number of indicators relating to specific lifestyle factors known to have an impact upon health. The descriptions of indicators that follow are based upon information extracted from Health Profiles metadata documents and the Department for Communities and Local Government's draft definitions for the 198 national indicators for local authorities and local authority partnerships.

6.17.1 Tobacco Control and Stopping Smoking

Smoking remains the major cause of the lower life expectancy and higher cancer and heart disease rates in Darlington compared with the national average. An estimated 28% of adults in Darlington smoke compared with 24% of adults in England (modeled estimates from the Health Survey for England 2003-5) and around 190 Darlington residents die from smoking-related causes every year (Health Profile 2008). Synthetic estimates of smoking have been produced by modeling Health Survey for England data from 2000-2 at ward level and the results are shown in the Table 6.14.



The NHS Stop Smoking services have an excellent record in achieving targets in smoking cessation. A client is counted as a self-reported 4-week quitter if they have been assessed 4 weeks after the designated quit date and declares that he / she has not smoked even a single puff of a cigarette in the past two weeks.

The table below shows the number of self-reported 4-week smoking quitters aged 16 or older, per total population, aged 16 years and over.

Table 6.17: Smoking Quitters

	Number setting a quit date	Number successfully quit at 4 weeks (self report)	% successfully quit at 4 weeks (self report)	Number successfully quit (self-report) per 100,000 of population aged 16 and over
Darlington	1,503	728	48	914
North East	50,515	23,900	47	1147
England	600,410	319,720	53	785

Source: Information Centre for Health and Social Care, 2006/07

The Darlington Tobacco Alliance will continue to implement wider tobacco control as set out below:

- Reducing exposure to secondhand smoke;
- Effective stop smoking services;
- Media and educational campaigns;
- Reducing the availability and supply of tobacco products, licit and illicit;
- Tobacco regulation;
- Reduced promotion.

6.17.2 Adult participation in sport

The Darlington Sport and Physical Activity Strategy (2007-2011) has been developed by Darlington Borough Council and community partners.

The Health Survey for England (2005/06) reports that 11.6% of adults are physically activein the Table 6.14.

Table 6.18: Participation in Sport and Volunteering

Area	% of people who regularly participate in sport and recreation (3 days a week of 30 minutes moderate intensity exercise)	% of people who volunteer to support sport (at least one hour a week)
Darlington	21.0	4.3
North East	20.5	4.2
England	21.0	4.7

Source: Active People survey, Sport England, 2007

A refurbishment of the Dolphin Centre has led to 12% increase in satisfaction and 14% increase in users.

Key messages:

- The percentage of the population over 50 in Darlington is increasing;
- The proportion of the population in Darlington with Learning Disabilities is significantly higher than the national prevalence rate;
- The majority of Older People now liver independently in their own homes;
- Darlington has a higher percentage of the population receiving a Blue Badge than the rest of the North East of England;
- The prevalence of diagnosed diabetes in Darlington is higher than the national average;
- Cancers and circulatory diseases make the greatest contribution towards the life expectancy gap between Darlington and England;
- Smoking remains the major cause of the lower life expectancy within Darlington;
- A large rise in the number of people with Dementia is predicted;
- There are 10,064 carers in Darlington, 2,330 of who provide more than 50 hours care per week;
- The assessment of anyone needing social care in Darlington is completed faster than the North East and National average;
- The Active People Survey carried out by Sport England in 2007 indicated that 21% of adults in Darlington reported as regularly participating in moderate intensity activity at least 3 times a week.

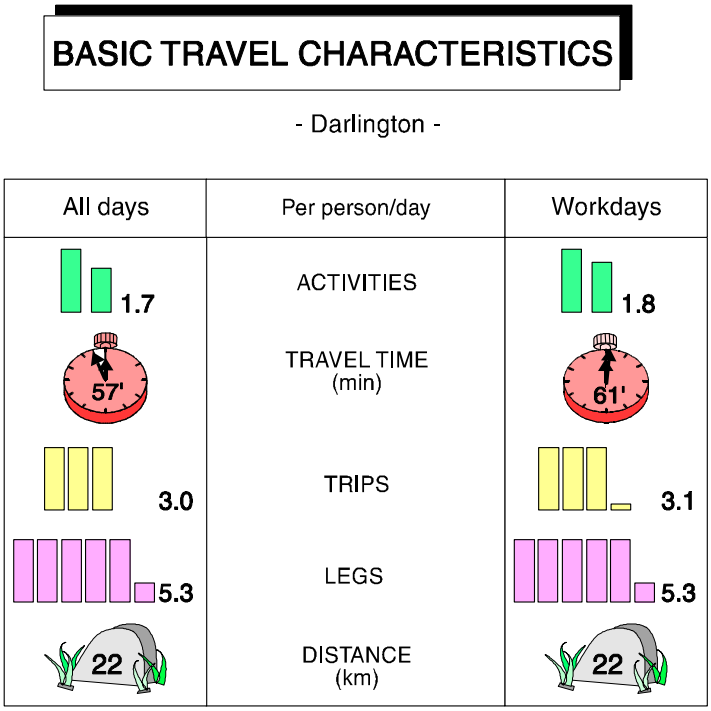
7. Greener Darlington

The Greener Darlington themed group of the Darlington Partnership aims to develop an attractive and achievable local environment and contribute to tackling global environmental challenges.

Developing transport networks contributes to a greener Darlington as well as contributing to the health and wellbeing of the population. People are encouraged to incorporate physical activity into their lives.

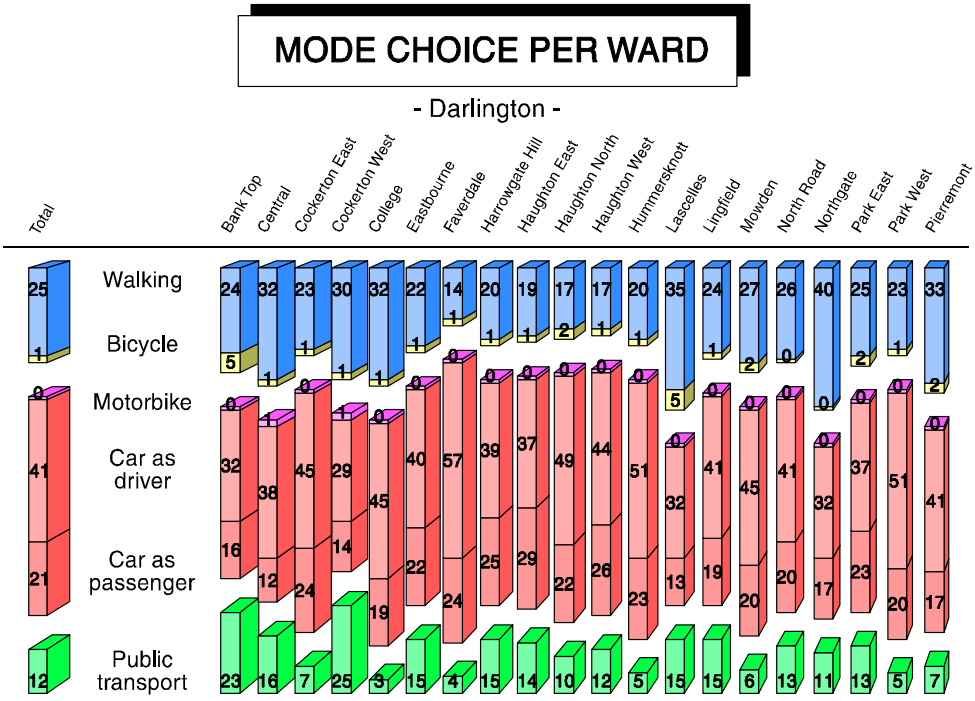
The Travel Behaviour Research Baseline Survey 2004 showed that on an average day Darlington residents make 3 trips covering an average distance of 22 kilometres.

Figure 7.1 Travel on an average day



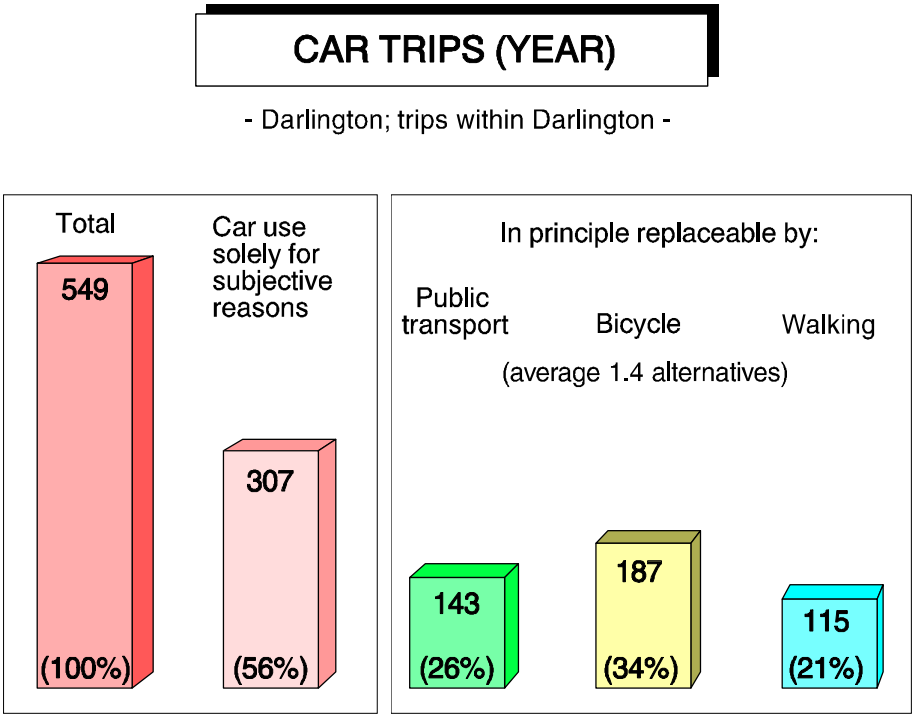
In 2004, only 12% of journeys were made on public transport and figure 7.2 shows the use of all transport methods. The car was used more often in Faverdale and Hummersknott. The car is used for 62% of all journeys including a third of all journeys of less than one kilometre.

Figure 7.2 Mode of transport used by ward of residence



Of all the car trips in Darlington in 2004, over half (56%) could made by other means. The most common reasons for not choosing sustainable travel were lack of awareness, poor perception of sustainable modes, cultural barriers and just not thinking about other options, rather simply maintaining habitual behaviour.

Figure 7.3 Car trips and alternative modes of transport



In 2004, Darlington was selected by the Department for Transport to be one of three Sustainable Travel Development Towns. The programme included funding for a range of initiatives which promote the greater use of sustainable modes of transport and it was given the name "Local Motion". Measures implemented through the Local Motion programme have focussed on:

- Providing the opportunity for urban residents (40,000 households in Darlington) to receive personal travel advice – with 29,000 people receiving advice so far
- Launching the Local Motion club to keep residents up to date with the programme and its development
- Employing a School Travel Plan Officer who has helped 30 schools to develop a travel plan and work is in progress with 7 more schools
- Providing free pedestrian and cycle training to schools and adults – in 2006/07 720 pupils and around 40 adults received cycle training, 2432 pupils received pedestrian training
- Helping local businesses to produce a travel plan – 23 have completed plans to date
- Raising awareness of sustainable transport through events, via the internet, by marketing and through the publication of free information such as bus, cycle and walking route maps.

After three years the Local Motion project has achieved reductions in car driver trips of around 9% (or 10,000 trips per day across the town), a 15% increase in walking journeys, a 6% increase in cycling trips and a 2% increase in public transport journeys.

Key messages:

- Local Motion work has resulted in a 15% increase in walking trips in the urban area.
- There has been a 65% increase in cycling trips in the urban area.
- The transport network aims to reduce the environmental impact of transport. For example by reducing the mode share of car driver trips.

8. Safer Darlington

Darlington today is a safe place. Between April and September 2007 there was a 19% reduction in total crime compared to the same period in the previous year. The Crime and Disorder Reduction Partnership is tackling concerns about crime and addressing anti-social behaviour. A priority for all partners is to address domestic abuse which is a serious crime with consequences for the individual, children and society. In 2007/08 1,622 incidents of domestic violence were reported (a rate of 16.33 per 1,000 population)

8.1 Drugs and Alcohol

The Darlington DAAT Board receives reports on the Adult Treatment Plan and Young Peoples' Substance Misuse Service regularly. In 2006/07 there were 250 new presentations for Tier 3 drug treatment (all ages) in Darlington and a total of 556 individuals received treatment. Adult clients aged 18 or over accounted for 493 of those in treatment. Of these adults:

- 78% were male and 22% female
- over half of these adults were aged between 25-34 years with 17% younger than this age group and 30% older
- 1.8% were from a non-white British ethnic group
- 69% had heroin as their main substance of misuse.

Local analysis of the drug misuse prevalence in Darlington (December 2007) concluded that services should be targeting more of the following for treatment:

- referrals from GPs or other sources
- women
- 18-24 year olds
- opiate/crack users
- referrals into the Drug Interventions Programme (DIP) particularly those aged 18-25 years.

The Young Persons Substance Misuse Service (SWITCH) was established in 2004 and since then has continued to show a substantial increase in numbers accessing Tier 3 drug and alcohol treatment.

Table 8.1: Young People Accessing Drug or Alcohol Treatment Services

	2003/04	2004/05	2005/06	2006/07	2007/08 (7 months)
Numbers into Tier 3 Drug/Alcohol Treatment (<18 years)	N/A	16	69	96	91

Source: DAAT Board Paper 2007

Alcohol

The Social Norm Study results (2007, DAAT) indicated similar results to the Tellus 2 Survey (2007) in relation to alcohol and young people. The results indicated higher estimates of alcohol consumption among young people in Darlington than the regional or national rates. The survey also indicated that 91% reported that they had never taken drugs.

Hospital admission rates for alcohol specific conditions for men and women are higher in Darlington than the North East as a whole. Estimated binge drinking in Darlington is significantly higher than in England. The Darlington Alcohol Strategy is to be revised in 2008. The table below shows alcohol specific hospital admissions, direct age standardised rate per 100,000 population, all ages, persons

Table 8.2: Alcohol Harm Related Hospital Admissions

Area	Persons admitted with alcohol related issues	Mid year population estimates	Alcohol-Harm Related Hospital Admission Rates
Darlington	447	99177	0.5%
North East	7626	1747220	0.4%
England	79606	26874677	0.3%

Source: Hospital Episode Statistics, 2006/07

8.2 Casualty Reduction

During 2007 there were 280 injury-producing accidents resulting in 384 casualties on roads in Darlington (Darlington Borough Council 2008: Casualty Reduction Statistics and Trends). These figures include all roads within the Borough boundary including the trunk roads and motorway managed by the Highways Agency.

This was the number reported to the Police however, as not all road accidents are reports, this figure must be regarded as a minimum. The table set out below identifies the breakdown of casualty severity over the last 3 years:

8.3 Casualties from Road Traffic Accidents

Table 8.3

				CHANGE from			
SEVERITY	**2005**	**2006**	**2007**	**2005**		**2006**	
Fatal	5	7	6	+1	+20%	-1	-14%
Serious	36	59	25	-11	-31%	-34	-58%
Slight	413	418	353	-60	-15%	-65	-16%
TOTAL	454	484	384	-70	-15%	-100	-21%

Source: Darlington Borough Council 2008: Casualty Reduction Statistics and Trends

How this compares against the national road safety targets for 2010

The Borough Council has adopted the Government target of reducing all KSI by 40%, child KSI by 50% and 'Slight' casualty rated by 10% from the 1994-1998 average by 2010. Current KSIs for Darlington are 34 for adults, 5 for children and 406 for 'Slight'.

Key messages:

- Residents say they feel safer and satisfaction around community safety has improved.
- There were fewer crimes committed in 2006/07 compared to 2003/04.
- Domestic abuse and harm caused by drugs and alcohol remain a concern.
- he Crime and Disorder Partnership has run Action Wheels and Summer Nights campaign to raise awareness.
- Alcohol harm related admissions to hospital are higher in Darlington than the national average.
- Binge drinking estimates for Darlington are significantly higher than the national average.

9. People's voices: What the community tells us

Darlington Primary Care Trust and Darlington Borough Council both have procedures for listening to and responding to what people in Darlington tell us.

Darlington PCT recognises the importance of listening to local people and the wider community.

9.1 Darlington Primary Care Trust

The PCT has worked closely with partners in the voluntary sector and local authority to gain a better understanding of local peoples' views of NHS services. In doing so the PCT has sought the views, opinions and concerns from a cross section of community groups, organisations and from members of the public. The process has involved consulting local forums, networks, local voluntary organizations and participating in scheduled events, for example the locality based Talking Together events.

The PCT treats all complaints seriously and makes every effort to resolve each on quickly and efficiently, whilst at the same time looking to learn and improve services as a result. All complaints are channelled through the PCT Complaints Manager. Complaints are reviewed on a quarterly basis, in anonymised format, by the Complaints Review Panel, which is chaired by the Trust Chair.

The NHS Complaints Regulations 2004 and Amendment Regulations 2006 require the PCT to acknowledge all complaints within two working days of receipt and to provide a full response from the Chief Executive within 25 working days.

The PCT seeks to learn from all complaints and to make improvements to services. Complaints are valued as an important source of information and feedback on our services. As a result of complaint investigations during the past year, a number of improvements and changes to services have been made.

The following are just a few examples of actions resulting from complaints:

- Changes introduced to the Retinal Screening Service to improve telephone access for patients and location of cameras. Two new dedicated patient telephone lines and staff to man these introduced from December 2007.
- Following a complaint regarding lack of communication with a patient's family, a communication sheet has been developed by the PCT to ensure that any changes in medication are communicated to a patient's family.
- District nurses to ensure that they provide adequate explanations before delivering care to patients' and to ensure patients' privacy and dignity at all times.

9.2 Darlington Borough Council

The Leading Edge Strategy challenges the council to, 'act as a champion' for the interest of the citizen, responding to changing needs and expectations to provide more personalised services. Community Engagement is at the heart of this way of working Communities in Control: real people, real power was launched in July 2008. The White Paper is about passing power to communities to drive real improvements.

Darlington Adult Social Services welcomes and responds positively to all comments, compliments, suggestions and complaints from whatever source as a means of demonstrating their commitment to working in partnership with service users, carers and the wider communities of Darlington.

Adult Social Care – Complaints, Comments and Compliment highlights

1. A total of 115 representations were recorded during the year 2007/2008.
2. 62% of all feedback were compliments about the staff or services (71 out of 115).
3. There were also eight enquiries where the issue was not pursued through the complaints process at the request of the individual (Complaint Related Enquiries - CREs).

9.3 Darlington Childrens Trust

Tell Us 2 Survey is an annual survey of children and young people conducted by Ofsted. The Tell Us 2 Survey is a key tool for children and young people to say what they think and what they feel about a whole range of issues including services. The Tell Us 2 Survey informed the development of The Children and Young People Plan 2008-2011.

Examples include:

- 84% of young people felt they were very healthy or quite healthy.
- 32% said they would like more and better information about drugs.
- 91% indicated that they had never taken drugs.

9.4 Community Surveys

Talking Together is an annual programme of twenty-four meetings which provides an opportunity for Darlington residents to, 'have their say' about issues that affect them. The events also provide an opportunity for the Council, the Police and PCT to find out what people think about changes to and improvements to service delivery. The Police, the Fire Brigade and staff from the PCT also attend.

Sustainable Community Strategy- six enquiry groups established to address key quality of life issues. They considered outcomes from forty-two consultation events. The events ranged from detailed focus groups to public meetings to market stall activities and road show events in different localities. Over one thousand people gave suggestions and views on how to make Darlington better. All of these views together with the findings from the Enquiry groups have informed the new sustainable Community Strategy for Darlington.

Community Strategy – One thousand and sixteen face to face interviews were conducted during August 2007 with residents aged eighteen years and over.

Tier 3 – is a group of young people which brings together representatives from existing groups of young people within the statutory and voluntary sector and the Member and Deputy Member of the Youth Parliament in Darlington.

Appendix 1 One Darlington: Perfectly Placed

Table 1. Population of Darlington by age and ward

Area	All Ages	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
Bank Top	3,757	231	239	234	219	242	236	250	276	294	233	251	201	176	160	163	139	111	102
Central	3,522	203	186	206	198	256	288	257	249	244	196	233	192	193	188	127	132	85	89
Cockerton East	5,213	313	375	361	321	230	371	425	476	443	319	290	281	230	218	185	176	103	96
Cockerton West	4,139	249	291	325	316	205	189	275	300	256	239	227	256	204	213	180	183	128	103
College	3,751	210	211	237	229	100	136	226	277	337	249	299	235	165	194	201	163	133	149
Eastbourne	5,066	344	358	405	315	282	243	372	380	372	300	304	294	309	245	189	182	103	69
Faverdale	1,653	153	104	92	65	58	218	254	214	149	91	51	50	64	38	23	15	5	9
Harrowgate Hill	6,084	365	373	418	397	271	400	582	542	489	377	384	406	325	230	201	150	105	69
Haughton East	4,173	297	274	338	315	216	223	263	287	267	288	327	228	206	154	154	141	110	85
Haughton North	3,430	138	175	238	221	170	219	230	211	257	317	332	223	168	153	157	127	67	27
Haughton West	5,473	315	385	419	313	287	289	393	470	453	397	390	333	257	220	163	201	113	75
Heighington and Coniscliffe	2,953	121	154	173	150	101	105	142	200	246	227	266	305	210	176	149	126	64	38
Hummersknott	3,544	125	196	233	202	83	69	121	250	274	299	284	301	210	232	226	176	146	117
Hurworth	3,388	124	169	221	177	124	138	160	212	225	247	292	331	253	178	171	188	97	81
Lascelles	3,561	218	228	245	240	218	203	254	288	262	190	240	202	157	170	129	121	97	99
Lingfield	3,599	200	231	242	231	157	161	208	250	260	231	234	233	213	221	222	170	78	57
Middleton St George	3,885	203	231	255	215	155	176	251	323	317	302	331	265	196	175	134	105	114	137
Mowden	3,652	138	185	189	202	101	79	194	255	246	221	279	271	283	331	248	218	148	64
North Road	6,001	342	395	428	362	367	420	503	472	449	363	382	305	276	238	216	224	154	105
Northgate	4,297	318	268	235	274	355	386	403	390	307	252	227	205	151	139	140	113	73	61
Park East	6,028	446	484	493	430	326	415	449	484	442	366	371	272	266	245	198	162	118	61
Park West	3,471	142	196	189	217	109	82	162	236	237	278	257	278	186	200	214	206	147	135
Pierremont	5,528	364	326	327	329	415	419	522	455	447	348	351	308	224	197	167	143	115	71
Sadberge and Whessoe	1,893	78	108	110	115	74	65	101	131	140	175	190	186	118	95	76	64	44	23

Source: Experimental statistics from the Office for National Statistics, mid-2002

Table 2. Proportion of the resident male population by age group

Local Authority (Upper Tier)	Total Male Resident Population 2005	Percentage Male 0-14 Resident Population 2005	Percentage Male 15-24 Resident Population 2005	Percentage Male 25-34 Resident Population 2005	Percentage Male 35-44 Resident Population 2005	Percentage Male 45-54 Resident Population 2005	Percentage Male 55-64 Resident Population 2005	Percentage Male 65-74 Resident Population 2005	Percentage Male 75+ Resident Population 2005
Darlington	47700	20%	12%	12%	15%	14%	13%	9%	6%
North East	1240500	18%	14%	12%	15%	14%	12%	9%	6%
England	24559900	19%	14%	14%	16%	13%	12%	8%	6%

Source: National Statistics, 2005

Table 3. Proportion of the resident female population by age group

Local Authority (Upper Tier)	1.1 Total Female Resident Population 2005	Percentage Female 0-14 Resident Population 2005	Percentage Female 15-24 Resident Population 2005	Percentage Female 25-34 Resident Population 2005	Percentage Female 35-44 Resident Population 2005	Percentage Female 45-54 Resident Population 2005	Percentage Female 55-64 Resident Population 2005	Percentage Female 65-74 Resident Population 2005	Percentage Female 75+ Resident Population 2005
Darlington	51100	17%	11%	12%	15%	13%	12%	9%	10%
North East	1309100	16%	13%	12%	15%	13%	12%	9%	9%
England	25506000	17%	13%	13%	15%	13%	12%	9%	9%

Source: National Statistics, 2005

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Darlington	47700	20%	12%	12%	15%	14%	13%	9%	6%
North East	1240500	18%	14%	12%	15%	14%	12%	9%	6%
England	24559900	19%	14%	14%	16%	13%	12%	8%	6%

Source: National Statistics, 2005

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Darlington	51100	17%	11%	12%	15%	13%	12%	9%	10%
North East	1309100	16%	13%	12%	15%	13%	12%	9%	9%
England	25506000	17%	13%	13%	15%	13%	12%	9%	9%

Source: National Statistics, 2005

Table 4. The number of people usually resident in Darlington at the time of the 2001 Census, the number who were classed as White British and the number classified in a different way.

Area	All people	White british people		All others	
	Number	Number	Percentage	Number	Percentage
Bank Top	3754	3606	96%	148	4%
Central	3613	3399	94%	214	6%
Cockerton East	5081	4984	98%	97	2%
Cockerton West	4181	4123	99%	58	1%
College	3730	3609	97%	121	3%
Eastbourne	5089	4936	97%	153	3%
Faverdale	1513	1480	98%	33	2%
Harrowgate Hill	5895	5741	97%	154	3%
Haughton East	4130	4028	98%	102	2%
Haughton North	3467	3370	97%	97	3%
Haughton West	5514	5349	97%	165	3%
Heighington and Coniscliffe	2953	2885	98%	68	2%
Hummersknott	3587	3452	96%	135	4%
Hurworth	3404	3336	98%	68	2%
Lascelles	3519	3421	97%	98	3%
Lingfield	3537	3415	97%	122	3%
Middleton St George	3821	3725	97%	96	3%
Mowden	3642	3531	97%	111	3%
North Road	6051	5881	97%	170	3%
Northgate	4422	3920	89%	502	11%
Park East	6064	5757	95%	307	5%
Park West	3504	3391	97%	113	3%
Pierremont	5534	5406	98%	128	2%
Sadberge and Whessoe	1837	1804	98%	33	2%
Darlington UA	98800	94300	95%	4500	5%
North East	2549700	2412400	95%	137300	5%
England	50465600	42752600	85%	7713000	15%

Source: Census, National Statistics, 2001

Table 5. Index of Multiple Deprivation for Darlington

Ward	National Deprivation rank	Darlington Ranking
Bank Top	531	4
Central	264	1
Cockerton East	3642	14
Cockerton West	489	2
College	6319	22
Eastbourne	753	7
Faverdale	5670	19
Harrowgate Hill	4233	15
Haughton East	809	8
Haughton North	3195	13
Haughton West	2674	12
Heighington and Coniscliffe	5733	20
Hummersknott	7350	23
Hurworth	5078	18
Lascelles	579	5
Lingfield	1446	10
Middleton St George	4692	17
Mowden	7393	24
North Road	1073	9
Northgate	516	3
Park East	659	6
Park West	6120	21
Pierremont	2491	11
Sadberge and Whessoe	4369	16

Source: Original Index of Multiple Deprivation data – Department of Communities and Local Government, ward estimates by Tees Valley Joint Strategy Unit, 2007

Appendix 2 Prosperous Darlington

Table 1 Benefit claimants data by electoral ward

Area	Job Seekers Allowance		Incapacity benefits	
	Claimants	% of working age population	Claimants	% of working age population
Bank Top	85	4%	300	13%
Central	150	7%	435	19%
Cockerton East	65	2%	225	7%
Cockerton West	90	4%	345	15%
College	35	2%	105	5%
Eastbourne	140	4%	340	10%
Faverdale	15	1%	55	4%
Harrowgate Hill	80	2%	215	5%
Haughton East	100	4%	285	12%
Haughton North	45	2%	170	8%
Haughton West	50	2%	255	8%
Heighington and Coniscliffe	15	1%	85	4%
Hummersknott	15	1%	70	4%
Hurworth	25	1%	130	7%
Lascelles	90	4%	275	13%
Lingfield	40	2%	205	10%
Middleton St George	30	1%	155	6%
Mowden	20	1%	90	5%
North Road	140	4%	400	11%
Northgate	180	6%	360	13%
Park East	170	5%	415	11%
Park West	25	1%	115	6%
Pierremont	110	3%	265	7%
Sadberge and Whessoe	10	1%	65	5%
Darlington	1,725	3%	5,360	9%
England		2%		

Source: Benefit claimants data, NOMIS, May 2007

Table 2: The number of people starting to claim Incapacity Benefit in the last 6 months

Area	Total Incapacity/Severe Disablement Allowance claimants	New IB/SDA claimants in the last 6 months as a % of total claimants	
		Number	Percentage
Bank Top	310	25	8%
Central	460	30	7%
Cockerton East	225	15	7%
Cockerton West	345	25	7%
College	110	10	9%
Eastbourne	350	25	7%
Faverdale	55	5	9%
Harrowgate Hill	215	25	12%
Haughton East	290	25	9%
Haughton North	170	15	9%
Haughton West	260	30	12%
Heighington and Coniscliffe	85	5	6%
Hummersknott	70	5	7%
Hurworth	130	15	12%
Lascelles	280	35	13%
Lingfield	210	20	10%
Middleton St George	155	10	6%
Mowden	85	0	0%
North Road	405	25	6%
Northgate	360	55	15%
Park East	420	50	12%
Park West	115	10	9%
Pierremont	265	25	9%
Sadberge and Whessoe	65	10	15%
Darlington	5,435	495	9%
England	2,672,855	240,385	9%

Source: Department for Work and Pensions, NOMIS May 2007

Table 3: Incapacity benefit claimants by reason for claiming

Area	Total claimants	Mental illness		Nervous system		Respiratory or circulatory		Muscoskeletal		Injury, poisoning		Other	
	No.	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Bank Top	310	140	45%	20	6%	15	5%	60	19%	15	5%	60	19%
Central	460	260	57%	25	5%	20	4%	50	11%	25	5%	80	17%
Cockerton East	225	80	36%	15	7%	20	9%	50	22%	15	7%	45	20%
Cockerton West	345	150	43%	20	6%	30	9%	70	20%	20	6%	55	16%
College	110	65	59%	5	5%	5	5%	15	14%	0	0%	20	18%
Eastbourne	350	145	41%	20	6%	30	9%	85	24%	15	4%	55	16%
Faverdale	55	35	64%	0	0%	5	9%	10	18%	0	0%	5	9%
Harrowgate Hill	215	65	30%	10	5%	15	7%	60	28%	15	7%	50	23%
Haughton East	290	115	40%	25	9%	20	7%	65	22%	10	3%	55	19%
Haughton North	170	70	41%	15	9%	5	3%	30	18%	5	3%	45	26%
Haughton West	260	85	33%	15	6%	15	6%	55	21%	20	8%	70	27%
Heighington and Coniscliffe	85	35	41%	5	6%	5	6%	15	18%	5	6%	20	24%
Hummersknott	70	20	29%	5	7%	5	7%	15	21%	5	7%	20	29%
Hurworth	130	40	31%	25	19%	10	8%	15	12%	10	8%	30	23%
Lascelles	280	125	45%	15	5%	20	7%	60	21%	10	4%	50	18%
Lingfield	210	95	45%	10	5%	20	10%	35	17%	15	7%	35	17%
Middleton St George	155	65	42%	10	6%	15	10%	15	10%	5	3%	45	29%
Mowden	85	35	41%	10	12%	10	12%	15	18%	0	0%	15	18%
North Road	405	165	41%	20	5%	45	11%	90	22%	20	5%	65	16%
Northgate	360	190	53%	10	3%	20	6%	60	17%	20	6%	60	17%
Park East	420	195	46%	20	5%	30	7%	85	20%	20	5%	70	17%
Park West	115	55	48%	10	9%	5	4%	15	13%	5	4%	25	22%
Pierremont	265	135	51%	10	4%	20	8%	50	19%	10	4%	40	15%
Sadberge and Whessoe	65	15	23%	5	8%	5	8%	25	38%	0	0%	15	23%
Darlington	5,435	2,380	44%	325	6%	390	7%	1,045	19%	265	5%	1,030	19%
England	2,672,855	1,100,895	41%	164,570	6%	204,330	8%	471,620	18%	148,375	6%	583,065	22%

Source: Department for Work and Pensions, NOMIS May 2007

Table 4: Number of families who have applied for support from Local Authorities and been accepted as being homeless and in priority need, per 1,000 households.

Local Authority	Number per 1000 households
Darlington LA	1.200
North East	4.410
England	3.461

Source: Department for Communities and Local Government, 2006/07

Table 5: Number of People Receiving Direct Payments (age standardised)

Local Authority	People aged 18+ receiving direct payments per 100k population(age standardized)
Darlington LA	113
North East	124
England	103

Source: PAF Indicators 2006-07

Appendix 3 Healthy Darlington

Table 1: The proportion of children that have received the following immunisations by their 2nd birthday:

7. Diphtheria/Tetanus/Polio/Pertussis/HiB, offered at 3-4 months
8. Meningitis C primary course, offered at 3-4 months
9. Mumps, Measles and Rubella (MMR) first dose, offered at 12-13 months

Area	Proportion of Children Having Diphtheria, Tetnus, Polio, Pertussis and Hib Immunisation	Proportion of Children Having MMR Immunisation	Proportion of Children Having Meningitis C Immunisation
Darlington	96.0%	88.3%	94.5%
North East	95.2%	88.5%	95.4%
England	93.3%	85.2%	93.2%

Source: NHS Information Centre, based on returns to the COVER programme run by the Health Protection Agency, 2006/07

Table 2: A summary of the mean number of decayed/missing/filled teeth

	5 year olds (Deciduous (milk) teeth)	14 year olds (permanent teeth)
Darlington	1.80	1.69
England	1.49	1.43

Source: 5 year olds data from British Association for the Study of Community Dentistry 2003/4
14 year olds data from British Association for the Study of Community Dentistry 2002/3

Table 3. Synthetic estimates of diet at ward level

Area	Estimates of Fruit and Vegetable consumption for Children
Bank Top	**30.0**
Central	**32.0**
Cockerton East	**28.0**
Cockerton West	**29.2**
College	**41.7**
Eastbourne	**23.8**
Faverdale	**34.9**
Harrowgate Hill	**27.5**
Haughton East	**28.7**
Haughton North	**31.9**
Haughton West	**30.5**
Heighington and Coniscliffe	**33.5**
Hummersknott	**38.5**
Hurworth	**30.9**
Lascelles	**30.0**
Lingfield	**25.8**
Middleton St George	**37.4**
Mowden	**29.4**
North Road	**30.3**
Northgate	**37.9**
Park East	**27.8**
Park West	**37.6**
Pierremont	**31.0**
Sadberge and Whessoe	**31.1**
Darlington	**30.9**
England	37.5

Source: Synthetic estimates for 2000-2002 calculated by the National Centre for Social Research from the Health Survey for England

Table 4: Percentage of all households in an area, at the time of the 2001 Census, that consisted of a pensioner living on their own. A pensioner is defined as a man aged 65 years or over, or a woman aged 60 years or over

Area	All household	Single pensioner households	**% single pensioner households**
Bank Top	1739	331	**19%**
Central	1745	313	**18%**
Cockerton East	2122	318	**15%**
Cockerton West	1848	418	**23%**
College	1560	293	**19%**
Eastbourne	2220	320	**14%**
Faverdale	661	30	**5%**
Harrowgate Hill	2422	289	**12%**
Haughton East	1717	278	**16%**
Haughton North	1506	192	**13%**
Haughton West	2219	293	**13%**
Heighington and Coniscliffe	1236	162	**13%**
Hummersknott	1463	279	**19%**
Hurworth	1432	243	**17%**
Lascelles	1540	241	**16%**
Lingfield	1536	263	**17%**
Middleton St George	1432	164	**11%**
Mowden	1618	306	**19%**
North Road	2817	513	**18%**
Northgate	1950	260	**13%**
Park East	2620	356	**14%**
Park West	1545	358	**23%**
Pierremont	2597	334	**13%**
Sadberge and Whessoe	767	84	**11%**
Darlington	42309	6638	**16%**
North East	1066292	166717	**16%**
England	**20451427**	**2939465**	**14%**

Source: National Statistics, 2001 Census

Table 5: Registrations for all cancers excluding skin cancers other than malignant melanoma (ICD-10 C00-C97 excl. C44)

Area	All Cancers Directly age standardised rate for 3 year rolling period	Lung cancer Directly age standarised rate for 3 year rolling period	Breast cancer Directly age standarised rate for 3 year rolling period	Colorectal cancer Directly age standarised rate for 3 year rolling period
Darlington	766	111	90	87
North East	8366	1384	1182	1001
England	22275	3424	3292	2611

Source: Northern and Yorkshire Cancer Registry and Information Service, 2002-4

Table 6: Results from ONS psychiatric morbidity survey

Primary Care Trust	Total Population	Mixed anxiety depression	General anxiety disorder	Depressive Episode	Panic disorder	Obsessive-compulsive disorder	Phobias	Total number of people likely to suffer with a common mental health problem
Darlington	98778	5.3%	3.1%	2.0%	0.6%	0.6%	1.2%	10.4%
North East	2361909	6.6%	3.8%	2.4%	0.7%	0.8%	1.5%	13.0%
England	50075655	6.5%	3.3%	1.8%	0.5%	0.8%	1.3%	12.1%

Source: ONS National psychiatric morbidity survey

Table 7: Distribution of carers in all Darlington wards

Ward	No of carers in ward - highest to lowest	% of carers in each ward
Park East	629	10.4
Haughton West	551	10
Cockerton East	543	10.7
Harrowgate Hill	542	9.2
Eastbourne	518	10.2
North Road	514	8.5
Hummersknott	487	13.6
Pierremont	483	8.7
Haughton East	478	11.6
Mowden	461	12.7
Park West	460	13.1
Cockerton West	454	10.9
Hurworth	448	13.2
Haughton North	433	12.5
College	365	9.8
Heighington & Coniscliffe	361	12.2
Bank Top	361	9.6
Lingfield	351	9.9
Northgate	340	7.7
Lascelles	337	9.6
Middleton St George	332	8.7
Central	298	8.3
Sadberge & Whessoe	219	11.9
Faverdale	99	6.5

Source: ONS Census data

Table 8: Carers receiving a break as a percentage of all adults receiving services

Local Authority	Number of Carers Receiving a Carers Break	Number of Adults 18+ Receiving Services	Number of Carers
Darlington	352	3308	10.6%
North East	10876	101431	10.7%
England	177,750	1,525,648	11.7%

Source: PAF Indicators 2006-07

Influenza Immunisation

The flue virus changes its composition a little every year which is why there is an annual flu immunisation programme to ensure that the currently targeted groups for flue immunisation have adequate protection during the winter flu season. Annual immunisation against influenza is offered to:

- All people aged 65 years and over
- Those aged 6 months or over in a clinical risk group
- People who live in residential /nursing care settings
- People in receipt of a carer's allowance o those who are the main carer for an elderly or disabled person whose welfare may be at risk if the carer falls ill.

Uptake of flu vaccine in people aged 65 years and over in Darlington for 2006/07 was 75%. Figures for England stood at 74%. (Source: Information Centre for Health and Social Care – September 2007)

Sexual Health

Chlamydia

In October 2004 a Chlamydia screening programme was introduced to offer tests to all young people aged between 13 and 25 years whether or not they have symptoms. Chlamydia remains a high priority for action. It is a particular concern as it often causes no symptoms and infections will remain undiagnosed. It can cause serious chronic complications including pelvic inflammatory disease, tubal infertility and ectopic pregnancy.

Table 9: Number of people tested and diagnosed

	2005/06	2006/07	2007/08
Number tested	274	338	374
Number diagnosed	26	49	53
% diagnosed	9.49	14.49	14.97

Source: Chlamydia Screening Service

Table 10: Access to NHS funded abortions before 10 weeks gestation

	Total NHS funded abortions	NHS funded abortions under 10 weeks gestation	% of all NHS funded abortions under 10 weeks
Darlington	314	218	69
North East	6,633	4124	62
England	160,244	104,663	65

Source: Department of Health Abortion Statistics – 2006

Table 11: Hospital admissions by unintentional and deliberate injuries to children and young people

age range	total admissions	No. with unintentional or deliberate injury	%
0-4	1554	116	7.46
5-11	552	106	19.20
12-15	294	89	30.27
16-18	241	64	26.56
Grand Total	2641	375	14.20

Source: SUS (Secondary Uses Service) – Data relates to 01/10/07 – 30/09/07

Appendix 4 Greener Darlington

Table 1: The average road distance to services in Kilometers

Area	% >4kms from a doctors surgery	% >4kms from post office	% >4kms from primary school	% >4kms from supermarket
Bank Top	0%	0%	0%	0%
Central	0%	0%	0%	0%
Cockerton East	0%	0%	0%	0%
Cockerton West	0%	0%	0%	0%
College	0%	0%	0%	0%
Eastbourne North	0%	0%	0%	0%
Eastbourne South	0%	0%	0%	0%
Harrowgate Hill	0%	0%	0%	0%
Haughton East	0%	0%	0%	0%
Haughton West	0%	0%	0%	0%
Heighington	23%	0%	0%	70%
Hummersknott	0%	0%	0%	0%
Hurworth	1%	1%	1%	1%
Lascelles	0%	0%	0%	0%
Lingfield	0%	0%	0%	0%
Middleton St. George	0%	0%	0%	5%
Mowden	0%	0%	0%	0%
Northgate North	0%	0%	0%	0%
Northgate South	0%	0%	0%	0%
North Road	0%	0%	0%	0%
Park East	0%	0%	0%	0%
Park West	0%	0%	0%	0%
Pierremont	0%	0%	0%	0%
Sadberge	14%	0%	0%	32%
Whessoe	18%	0%	0%	23%
Darlington	1%	0%	0%	2%

Source: Countryside Agency, 2001

Table 2: The percentage of households in each Darlington ward that do not have access to a car or van.

Area	% households with no car or van
Bank Top	44%
Central	50%
Cockerton East	28%
Cockerton West	51%
College	19%
Eastbourne	42%
Faverdale	6%
Harrowgate Hill	22%
Haughton East	40%
Haughton North	22%
Haughton West	27%
Heighington and Coniscliffe	11%
Hummersknott	14%
Hurworth	15%
Lascelles	45%
Lingfield	36%
Middleton St George	14%
Mowden	16%
North Road	44%
Northgate	42%
Park East	42%
Park West	19%
Pierremont	32%
Sadberge and Whessoe	10%
Darlington	31%
England	27%

Source: National Statistics, 2001 Census

Appendix 5 Safer Darlington

Table 1: Alcohol Related Admissions

Area	Persons admitted with alcohol related issues	Mid year population estimates	Alcohol-Harm Related Hospital Admission Rates
Darlington	447	99177	0.5%
North East	7626	1747220	0.4%
England	79606	26874677	0.3%

Source: Hospital Episode Statistics 2006/07

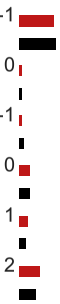
TABLE 2: RECORDED CRIME IN DARLINGTON

Recorded crime for six key offences

	2006-07	2007-08	% Change
Violence against the person	1,791	1,644	-8
Sexual offences	88	106	20
Robbery	93	58	-38
Burglary of a dwelling	576	469	-19
Theft of a vehicle	459	419	-9
Theft from a vehicle	1,596	987	-38

Reported crime per 1,000 population 2007-08

	Local	UK	Difference
Violence against the person	17	18	-1
Sexual offences	1	1	0
Robbery	1	2	-1
Burglary of a dwelling	5	5	0
Theft of a vehicle	4	3	1
Theft from a vehicle	10	8	2



Key

Graph: Red bar is local crime, black bar is national crime.

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References

1. The Commissioning Framwork for Health and Wellbeing, March 2008. At: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604
2. *One Darlington: Perfectly Placed* (Sustainable Community Strategy)
3. *Narrowing the gap in coronary heart disease and cancers:* County Durham and Darlington: Director of Public Health Annual Report 2007/08. June 2008.
4. Department for Environment, Food and Rural Affairs, 2004
5. Office for National Statistics, *2001 Census*
6. The Social Exclusion Unit, *Making the Connections: Report on Transport and Social Exclusion*, February 2003
7. The Social Exclusion Unit, *Making the Case: Improving Health through Transport*, 2002
8. *Annual Population Survey*, NOMIS 2006/07
9. Department of Communities and Local Government, *Index of Multiple Deprivation*, 2007
10. *Putting Children First*, Darlington Children and Young People's Plan 2008-2011
11. *Darlington Local Teenage Pregnancy Strategy*
12. *Tackling Obesity Strategy*, 2004
13. *Preventing Obesity, Promoting Physical Activity Strategy*, (In development)
14. *National Child Measurement Programme*, 2006/07
15. *Index of Multiple Deprivation*, 2007
16. London Health Observatory, *The Health Inequalities Intervention Tool*, June 2008
17. Information Centre for Health and Social Care, *Quality and Outcomes Framework*, Financial Year 2006/07
18. Association of Public Health Observatories, *Indications of Public Health in the English Regions 9: Older People*, 2008
19. County Durham and Tees Valley Public Health Network, Cold Kills, The Scale of excess winter deaths in Co. Durham and Tees Valley 1993-2003, November 2005
20. Information Centre for Health and Social Care, *Quality and Outcomes Framework*, Financial Year 2006/07
21. Department of Transport, *Blue Badge Survey 2007*.
22. Yorkshire and Humber Public Health Observatory, *PBS Diabetes Prevalence Model Phase 2*, 2005
23. *National Statistics and Compendium of Clinical and Health Indicators 1993-2006*
24. Knapp, M., Prince, M. et al. *Dementia UK (A report to the Alzheimer's Society on the prevalence and economic cost of dementia in the UK produced by King's College London and London School of Economics).* Alzheimer's Society: London, 2007.
25. *Health Survey for England 2003/05*
26. Association of Public Health Observatories, Darlington Health Profile 2008, At: http://www.apho.org.uk/resource/view.aspx?RID=52201
27. Darlington Sport and Physical Activity Strategy (2007-2011)
28. *Health Survey for England (2005/06)*
29. Sport England, *Active People Survey*, 2007
30. Socialdata/Sustrans, *DarlingtonTravel Behaviour Research Report 2004*. At: http://www.sustrans.org.uk/webfiles/travelsmart/Travel%20Behavioural%20Research%20Report%20Darlington%202004%20FINAL(revised).pdf
31. Darlington DAAT, *Board Paper*, 2007
32. Darlington DAAT, *Social Norm Study Results*, 2007
33. *Tell Us 2 Survey* (2007)
34. Department of Health, *Hospital Episode Statistics*, 2006/07
35. Darlington Borough Council, *Casualty Reduction Statistics and Trends*, 2008
36. Communities and Local Government, *Communities in Control: Real People, Real Power*, 2008
37. Experimental Statistics from the Office for National Statistics, mid 2002
38. Department of Communities and Local Government, *Index of Multiple Deprivation*, 2007
39. NOMIS, *Benefit Claimants Data*, May 2007
40. Commission for Social Care Inspection, *PAF Indicators 2006-07*
41. Office of National Statistics, *National Psychiatric Morbidity Survey*
42. Department of Health, *Abortion Statistics, England and Wales:* 2006

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