Health Inequalities in Darlington:

Narrowing the Gap

Annual Report of the Director of Public Health

Darlington 2017

BOROUGH COUN

DARLINGTON

Table of Contents

Foreword by Miriam Davidson

In October 2017, Darlington hosted the Public Health England Due North Conference, an annual event that has a focus on the inequalities which challenge communities in the North of England.

While it was a timely reminder of the persistent challenges we face locally, it was also an opportunity to remind ourselves of strengths we have and to share some of the assets we have.

Darlington experiences health inequalities across all indicators related to child health, smoking, alcohol misuse as well as the factors which affect healthy life expectancy. The cumulative impact of health inequalities is a matter of 'life and death'. Some of the most effective changes need to be addressed at a national level e.g. fiscal policy and legislation but local actions that improve equity of access to services and a focus on improving health in vulnerable groups would make an important contribution to preventing further increases in health inequalities.

Action can be taken to improve the quality of housing, access to healthy food, safe environment and good working conditions. Alongside this is the potentially positive impact of 'normalising' increased physical activity, practising mental health resilience in all settings, 'de-normalising' the extent of the role of alcohol in our lives and 'Making Every Contact Count'.

My recommendations are set out with the intention of addressing inequality whether at a geographical level or the health inequality which is experienced across protected characteristics including ethnicity, gender, age and sexual orientation.

An approach public sector organisations (initially) in Darlington could adopt is to consider the impact of key decisions and all policies on wellbeing and health inequalities.

Despite our challenges, Darlington is rich in health assets, recognising the role all partners have to improve and protect the health of people in Darlington. I know we can achieve much in promoting a healthier and fairer Darlington when we tackle this together.

Acknowledgements

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Key Messages

My recommendations recognise that health is absolutely linked with wider determinants such as housing, income, education, employment and environment.

This report describes inequalities across the life course, structured around best start in life, living and working well and healthy ageing.

At a local level, health inequality can be tackled through asset based community development approaches, and there are a number of positive examples of this approach across partners in Darlington.

Recommendation 1 – Best Start in Life

Promote a whole system approach to improve children and young people's health and wellbeing outcomes across all settings.

- Identification of maternal issues e.g. including smoking
- Promotion of breastfeeding
- Provision of quality Personal Social and Health Education (PSHE)
- Implementation of local 'Healthy Weight' plan, including oral health, sugar reduction and promotion of activity

Recommendation 2 - Living and Working Well

- Address barriers to quality employment and promote inclusive growth e.g. Routes to Work and similar initiatives
- Promote a healthy work force including good mental health e.g. via Darlington Cares (an employer's network)
- Implement the practice of Making Every Contact Count (MECC), triggering brief conversations about workplace health

Recommendation 3 – Healthy Ageing

Take an asset-based approach to older people's health, recognising their contribution and skills and promoting the importance of ageing well.

- Promote a whole system approach to supporting older adults to remain independent and healthy
- Recognise the impact of social isolation, transport and poverty on health and well being
- Reinforce prevention across the life course recognising the negative cumulative impact of inequalities

Our Health and Wellbeing Plan for Darlington 2017-2022 has a strong focus on the need to address inequalities and the importance of doing so through 'upstream' activity and addressing the wider determinants of health. It is an approach that identifies and builds upon Darlington's strengths and assets.

Health in All Policies (HiaP) has been defined as 'an approach to public policies across sectors that systematically considered the health implications of decisions, seeks synergies and avoids harmful impacts to improve population health and health equity'.

The Council, and partners, could adopt the above approach to consider the impact of key decisions and all policies on both health and health inequalities.

Actions arising from Director of Public Health Annual Report 2016: Recommendations

In my last report, I highlighted the issue of mental wellbeing in children and young people. My recommendations resulted in a range of activities by partners throughout the year and examples are tabled below.

Recommendation in 2016	Actions in 2017
(i) All organisations consider the 'Best Start in Life' principles when they are designing and delivering services for children and young people in Darlington.	• NHS commissioners ensure maternity services support good maternal and perinatal mental health in order to ensure positive wellbeing in children. • The revised Children and Young People Mental Health and Wellbeing Strategy now includes a key work stream on support for the most vulnerable.
(ii) Private, public and voluntary sectors build strength and resilience in children and young people through local plans that develop sustainable, connected communities and promote social networks.	• The Children and Young People Plan (2017 2022) for Darlington has a mental health focus in year 1. • Cyber Squad, an internet safety project, has been rolled out in several primary schools in Darlington.
(iii) Raise the profile of the importance of mental health and emotional wellbeing in all settings. Each setting or organisation to consider how to do this via their respective services.	• More than 50 staff have received training in Youth Mental Health First Aid. This includes teachers, teaching assistants, school nurses and Early Help staff. • Mindful Schools training was delivered to over 35 teachers in Darlington; they are now delivering this to children and young people in schools. • The Children and Young People Mental Health and Wellbeing Strategy includes a key work stream on resilience building.
(iv) All agencies support the 'parity of esteem' between physical and mental health through reducing stigma to improve access to universal and mainstream provision for those diagnosed with a mental health condition	• An anti-stigma campaign was delivered using posters designed by Darlington College students and displayed on bus stops across the town and on social media during Mental Health Awareness week and World Mental Health Day 2017. The campaign received positive support, Facebook posts reached over 20,000 people and tweets almost 5,000.

Chapter 1: Health and Inequality

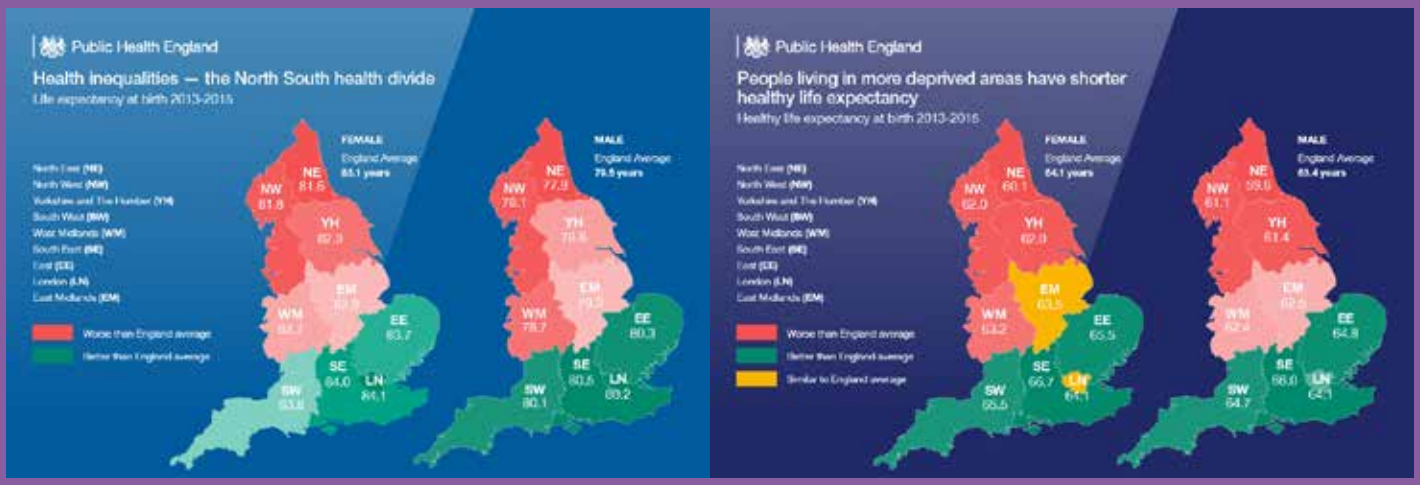


Figure 1. The North South health divide (PHE)

Many interconnected factors determine our health – from the genes we inherit to the socioeconomic circumstances in which we are raised, live and work, to the healthcare that we receive in moments of illness and disease. Unpicking these factors and demonstrating how those that predispose to both good and bad health are unequally distributed across our borough will be central to this report. Differences in life expectancy have been used to demonstrate the association between deprivation and health since the very earliest days of formal epidemiology in the 1840s.

People living in our most economically-deprived communities are not only more likely to have significantly shorter life expectancies when compared to those living in our most affluent communities, they're also more likely to have shorter healthy life expectancies – that is, they are more likely to develop life-limiting illnesses and disabilities at a younger age than their counterparts living in less deprived areas.

The images from Public Health England confirm the geographical divide in life expectancy and healthy life expectancy that continues to exist in our country – in 2013-15, men in the North East lived on average for 2.6 fewer years than men in the South East, and for women the difference was 2.4 years. For healthy life expectancy, the regional gap between the North East and the South East is even more concerning.

Darlington is the second best-performing local authority regionally for both male and female life expectancy, at 78.2 years for men and 82.1 years for women, but still falls well short of the averages for England (79.5 and 83.1 years respectively).

There is considerable variation in life expectancy within the area. Darlington is a relatively compact town, easily travelled on bus – but as the city bus map demonstrates, men in Hurworth can expect to live 11.6 years longer than males in Park East, and women in Mowden will live, on average, for ten years longer than females in Bank Top.

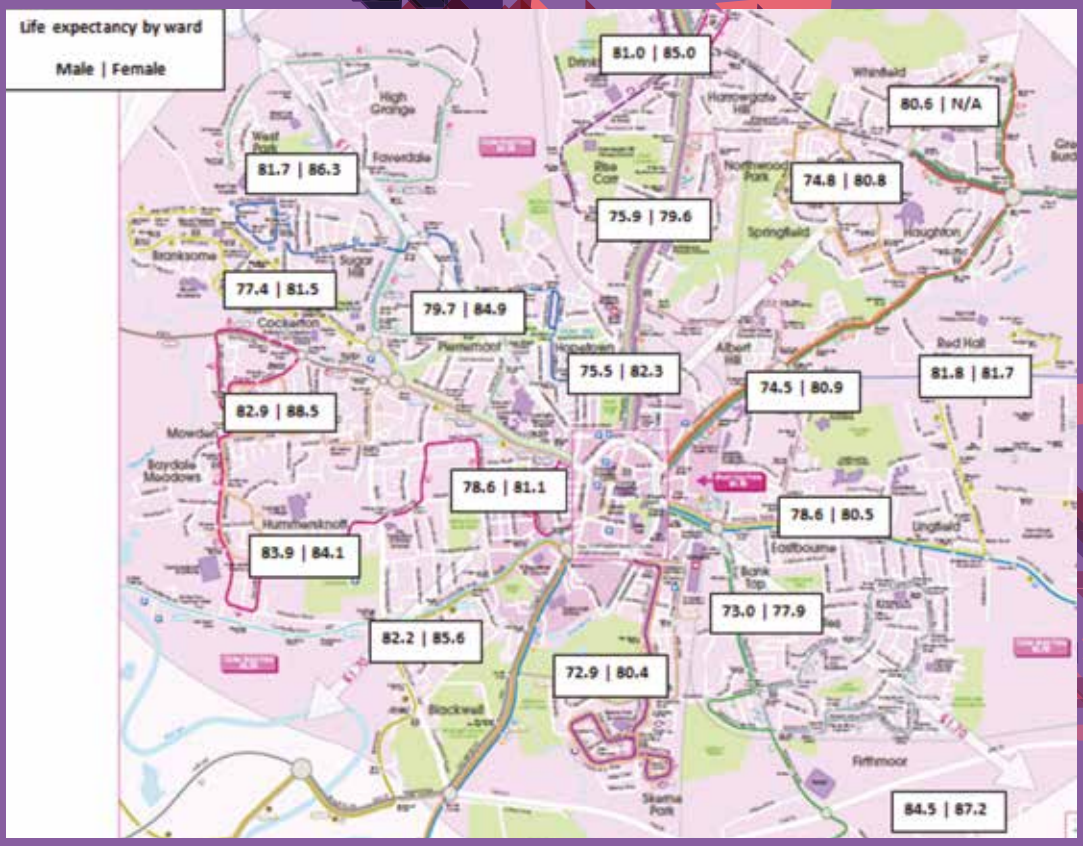


Figure 2. Life expectancy by ward

More recent data for 2014-16 shows that the inequality gap in male life expectancy for Darlington remains stable at 11.7 years, but for women it has improved to 8.5 years. However, inequalities in healthy life expectancy are even wider with an inequality gap in healthy life expectancy of 18.4 years for men and 15.0 years for women, some of the highest figures in the region. Some of our people can expect to enjoy good health for almost two decades less than more affluent residents.

In 2015 Darlington had an IMD score of 23.6, worse than the average for England (21.8) and placing Darlington in the fifth more deprived decile, which, similarly to life expectancy data is better than most of our North East neighbours. However, there is considerable variation by ward, with IMD scores ranging from 4.7 in Mowden to 47.6 in Park East.

[1]Deprivation refers to unmet needs caused by an inequitable allocation of resources of all kinds, not just financial. The English Indices of Deprivation 2015 use 37 separate indicators, organised across seven distinct domains of deprivation which incorporate income deprivation, employment deprivation, health deprivation and disability, education, skills and training deprivation, barriers to housing and services, living environment deprivation and crime to calculate the Index of Multiple Deprivation 2015 (IMD 2015). This is an overall measure of multiple deprivation experienced by people living in an area.

LA Ward	IMD 2015	Male LE at birth	Female LE at birth
Bank Top & Lascelles	38.1	73	77.9
Brinkburn & Faverdale	12	81.7	86.3
Cockerton	33	77.4	81.5
College	6.8	78.6	81.1
Eastbourne	28.6	78.6	80.5
Harrowgate Hill	12.6	81	85
Haughton & Springfield	26.3	74.8	80.8
Heighington & Coniscliffe	10.6	79.9	83.6
Hummersknott	5.2	83.9	84.1
Hurworth	12.1	84.5	87.2
Mowden	4.7	82.9	88.5
North Road	37	75.9	79.6
Northgate	39.4	75.5	82.3
Park East	47.6	72.9	80.4
Park West	13.4	82.2	85.6
Pierremont	21.8	79.9	84.9
Red Hall & Lingfield	37	81.8	81.7
Sadberge & Middleton St George	11.5	79.4	82.1
Stephenson	32.5	74.5	80.9
Whinfield	17.5	80.6	-

Table 1. Life expectancy and IMD 2015 by ward (localhealth.org.uk, PHE)

Chapter 2: Children and Young People: Best Start in Life

"What happens during these early years, starting in the womb, has lifelong effects on many aspects of health and well-being… Later interventions, although important, are considerably less effective if they have not had good early foundations." (Professor Sir Michael Marmot, 2010)

The strongest determinants of child health are social, educational and economic factors i.e. circumstances in which children in Darlington are conceived, born and raised. We must make sure that children in our poorest communities are not left behind and poverty is the most important determinant of children and young people's health in Darlington.

Mid 2016 ONS estimates indicate that 21.3% of the population are under 18 years.

Children and young people from minority ethnic groups account for 6% of all children living in the area, compared with 22% in the country as a whole. The largest minority ethnic groups of children and young people in the area are Asian and mixed. The proportion of residents identifying themselves as Gypsy and Travellers in the 2011 Census was three times higher than the national average but equates to only 0.3% of the population. The proportion of children and young people with English as an additional language in primary schools is 5% (the national average is 19%), and in secondary schools it is 4% (the national average is 14%).

The Children and Young People's Plan 2017-22 is a rich source of information about how partners make a collective effort to make a positive difference to the lives of children and young people.

Click here to view the Children and Young Peoples Plan

Early Years and School

Infant mortality, the rate of deaths in infants aged under one year per 1,000 live births (IMR), is an indicator of the general health of whole populations. A number of factors, including low birth weight, prematurity and deprivation have been implicated in infant mortality, and the trend of increasing risk of death with increasing deprivation persists even when all other risk factors are accounted for.

The overall infant mortality rate in Darlington is 3.3, lower than the IMR for the North East (3.7) and for England (3.9).

Pregnancy and Birth

Becoming pregnant under the age of 18 carries significant risks to mother and baby, and is both a cause and a consequence of health inequalities. Both mother and child are at increased risk of living in poverty. Babies born to young mothers are at increased risk of both stillbirth and of death before the age of one, and mothers under 20 have a 30% higher risk of postnatal depression and of poor mental health for up to three years after giving birth.

Under 18 conception rates in Darlington have followed the declining trend seen across England, more than halving from 64.0 per 1,000 population in 1998 to 24.1 per 1,000 population in 2016. The local rate is above the national rate of 18.8 but compares favourably with the North East average (24.6) and with most of our local neighbours. Within Darlington the under-18 conception rate varies between wards in association with deprivation, from 3.1% of all conceptions in Northgate (IMD 39.4) to 0% in some of the areas more affluent communities.

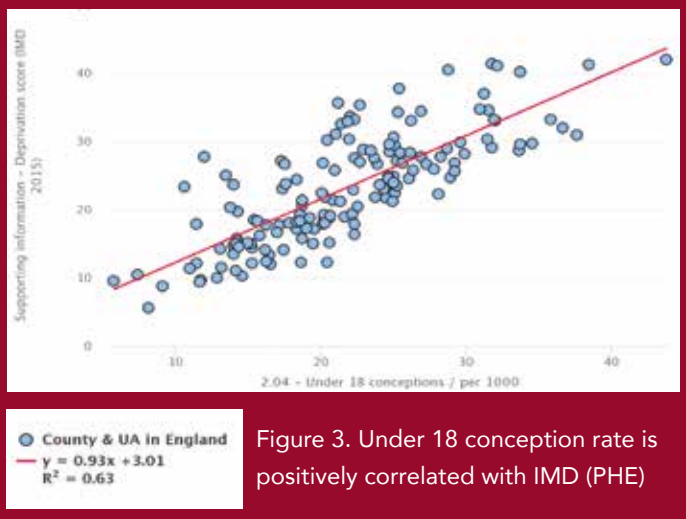


Figure 3. Under 18 conception rate is positively correlated with IMD (PHE)

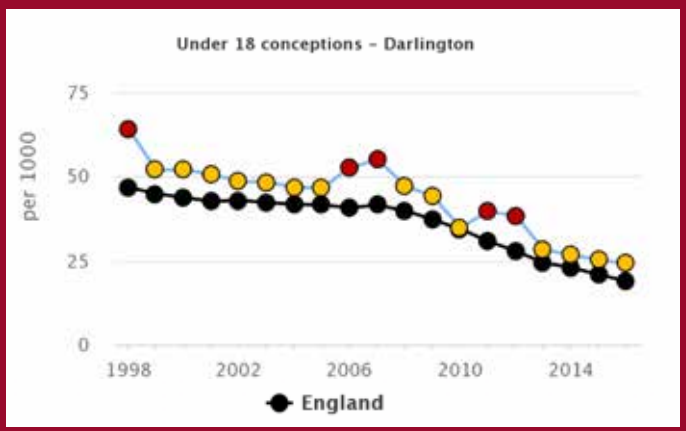


Figure 4. Under 18 conceptions in Darlington, 1998-2016 (PHE)

Smoking in Pregnancy

In 2016, 3.4% of babies born at term in Darlington had a low birth weight – one of the highest rates in the region and in excess of local and national averages (3.0% and 2.8% respectively).

Smoking during pregnancy remains an important public health challenge. Babies born to mothers who smoke are more likely to be born in poor health and maternal smoking after birth is associated with a threefold increase in the risk of sudden infant death. Smoking during pregnancy is a major health inequality with rates significantly higher in socially disadvantaged groups, and the children of smoking parents are more likely to become smokers themselves.

In 2016/17 16.2% of pregnant women in our Borough were smokers at the time of delivery, similar to the regional figure of 16.1% but significantly higher than the rate for England (10.7%).

Breast Feeding

The World Health Organisation recommends that "…infants should be exclusively breastfed for the first six months of life to achieve optimal growth, development and health." Breastfeeding reduces rates of infectious illnesses in infants, provides health and developmental benefits, and protects women against some risk of breast and ovarian cancers in later life. Research has shown that breastfeeding duration is associated with deprivation – typically, women in more deprived areas do not continue to breastfeed for as long as women in more affluent communities.

In 2015/16 63.1% of new mothers breast fed in the first 48 hours of life in that period, better than the regional rate of 57.9% but significantly behind the national figure of 74%. Breastfeeding prevalence at 6-8 weeks after birth for 2016/17 paints a similar picture – only 34.3% of new mothers in Darlington breastfeed their babies 6-8 weeks following delivery, compared to 31.4% in the North East and 44.4% in England.

School Readiness

This refers to a measure of early years development that takes into account communication and language, physical development, personal, social and emotional development, literacy and mathematics.

Darlington outperforms England and the North East on this indicator – In 2018 72.6% of children in Darlington achieve a good level of development by the end of reception, compared to 71.5% nationally and regionally. However, we know that inequality limit a person's prospects from their earliest years, and children from poorer backgrounds are less likely to have achieved a good developmental level by reception year.

In later years, achieving good GCSEs, including English and Maths at grades 5 or above, is an important predictor of wellbeing in adult life. Educational qualifications will to some extent determine an individual's job prospects, income and housing options. The association between challenging material circumstances and low educational attainment is more acute for Looked After Children.

The Department for Education have introduced a new Attainment 8 score (schools get a score based on how well pupils have performed in up to 8 qualifications, which include English, maths, 3 English Baccalaureate qualifications including sciences, computer science, history, geography and languages, and 3 other additional approved qualifications). In 2017 the average Attainment 8 Score for Darlington secondary schools was 45.3, this was above the England all school average of 44.6%. However, when measuring progress between key stage 2 and key stage 4 (Progress 8) Darlington performance is below average. Provisional data for 2018 shows a similar performance.

Darlington's educational challenges are similar to many of its neighbours in the North East. The majority of children in Darlington start school ready and achieve a good level of development in early years settings. At Key Stage 1 pupils in Darlington outperform their peers nationally in many indicators. The proportion of children achieving a Good Level of Development has increased year on year since 2014 and very positively, in the Early Years, the inequality gap has been reducing year on year for the last three years. At the end of primary school attainment is at or around the national average. However at the end of the secondary school Darlington children have made less progress than their peers in other areas. It is important to note that this performance is to some extent recovered at Key Stage 5.

Tooth decay

Tooth decay is a significant cause of morbidity in children. It is the most common cause of hospital admission among children aged between five and nine, and is linked to pain, poor sleep, and time absent from school. Major dental health inequalities persist, and children from more deprived areas are at increased risk of suffering poor oral health and tooth decay. In Darlington, 35.4% of five year olds had dental decay in 2014/15, compared to 28% regionally and 24.8% nationally.

Obesity

Obesity in childhood not only predisposes children to a range of serious medical conditions in later life (including Type II Diabetes, cardiovascular disease and several cancers), but is also associated with disability, impaired social and emotional wellbeing, bullying and low self-esteem. Risk accumulates through childhood – disadvantaged children in Reception are twice as likely to be overweight, while disadvantaged children aged 11 years may be up to three times as likely to be overweight/obese as those children in more affluent communities.

In Darlington, 25% of 4-5 year olds had excess weight in 2016/17, similar to the regional rate of 24.5% but in excess of the rate for England (22.6%). The proportion of children with excess weight aged 10-11 years is greater – 36.7% of these children in Darlington had excess weight in 2016/17, compared to 37.3% regionally and 34.2% nationally.

Geographical differences in child health measures exist between neighbouring communities in Darlington – childhood obesity rates in Reception and Year 6 are up to three times higher in some wards.

As in adulthood, a teenager's weight is determined by input and output – the food they consume and the calories they burn through physical activity.

	Obese children (reception)	Children with excess weight (reception)	Obese children (year 6)	Children with excess weight (year 6)
Bank Top & Lascelles	14.8	29.5	25.4	40
Brinkburn & Faverdale	8.4	22.6	17.3	31.9
Cockerton	12	27.9	21.2	33.4
College	4.5	16.6	11.2	23
Eastbourne	15.3	27.8	20.7	37.4
Harrowgate Hill	13.3	28.5	18.9	38.6
Haughton & Springfield	10.6	23.6	24.7	37.7
Heighington & Coniscliffe	5.6	18.3	12.1	30
Hummersknott	8.1	19.4	12.6	27
Hurworth	6.6	20.1	19.6	32.9
Mowden	8.1	19.4	12.6	27
North Road	14.1	27.1	22.4	34.9
Northgate	10.7	21.5	20.8	32.9
Park East	10	24.9	24.2	37.8
Park West	7.6	20.4	14.5	27.8
Pierremont	7.8	22.4	25.2	43.1
Red Hall & Lingfield	10	22.7	23.2	36.7
Sadberge & Middleton St George	6.4	19.7	17.5	32.1
Stephenson	10.4	23.3	23.3	36.9
Whinfield	7.8	21	17.4	31.5

Table 2. Data from the National Child Measurement Programme, 2013-16 (localhealth.org.uk)

Smoking in adolescence affects health behaviours in later life, and is strongly associated with increased morbidity and mortality. Most smokers begin smoking in childhood.

6.8% of 15 year olds in Darlington described themselves as regular smokers in 2014/15, and 2.2% as occasional smokers – almost one in ten 15 year olds in Darlington are current smokers. This compares favourably with the North East (regular smokers 7.5%; occasional smokers 2.6%) but Darlington lags behind England, where 5.5% of 15 year olds regularly smoke and 2.7% occasionally smoke. In the Healthy Lifestyles Survey (2016/17) references to vaping have increased.

Fewer than half (44.6%) of 15 year olds in Darlington consume the recommended five portions of fruit and vegetables a day, compared to 46.8% in the North East and 52.4% in England.

Injuries to children (deliberate and unintentional) are a leading cause of hospitalisation and mortality in young people and may be associated with absence from school and lasting effects on mental health. Rates of hospital admission for injury in young people in Darlington are significantly greater than elsewhere in the North East and in England.

A&E attendances in 0-4 year old children are more frequent in more disadvantaged wards, ranging from 730.2 per 1,000 population in Mowden and Hummersknott wards to 1,362.8 in Red Hall and Lingfield. The A&E attendance rate in under 5's for England is 551.6 per 1,000 population, lower than every ward in Darlington. Children in Darlington are accessing more secondary care than children elsewhere in the country.

Positively, 4.3% of 16-17 year olds in Darlington are not in employment, training or education compared to 5.4% in the North East and 6.0% in England, and fewer 10-17 year olds in Darlington enter the youth justice system (319.2 per 100,000 population) than across the North East (409.8) and England (327.1).

Areas with the best outcomes for children and young people are the areas with the lowest levels of deprivation as per the IMD 2015. The areas where children face the greatest challenges have higher levels of deprivation. The challenge we face is tackling the socioeconomic determinants of poor health and creating a healthier, opportunity-rich environment in which our children and young people can thrive.

Chapter 3: Adult health

"Getting people into work is of critical importance for reducing health inequalities. However, jobs need to be sustainable and offer a minimum level of quality to include not only a decent living wage but also opportunities for in-work development, the flexibility to enable people to balance work and family life, and protection from those adverse working conditions that can damage health." (Professor Sir Michael Marmot, 2010)

Health and wellbeing in adulthood are to a large extent determined by the environment in which we are born, grow up and learn. A 2016 study found that adolescence and early adulthood were particularly sensitive periods for the emergence of health inequalities – accessing good employment is protective of health while low-status, low-income employment or unemployment has a negative impact on physical and mental wellbeing. The relationship between unemployment and poor health operates in both directions – poor health increases the likelihood of unemployment which in turn increases the risk of worse health in the future.

Employment

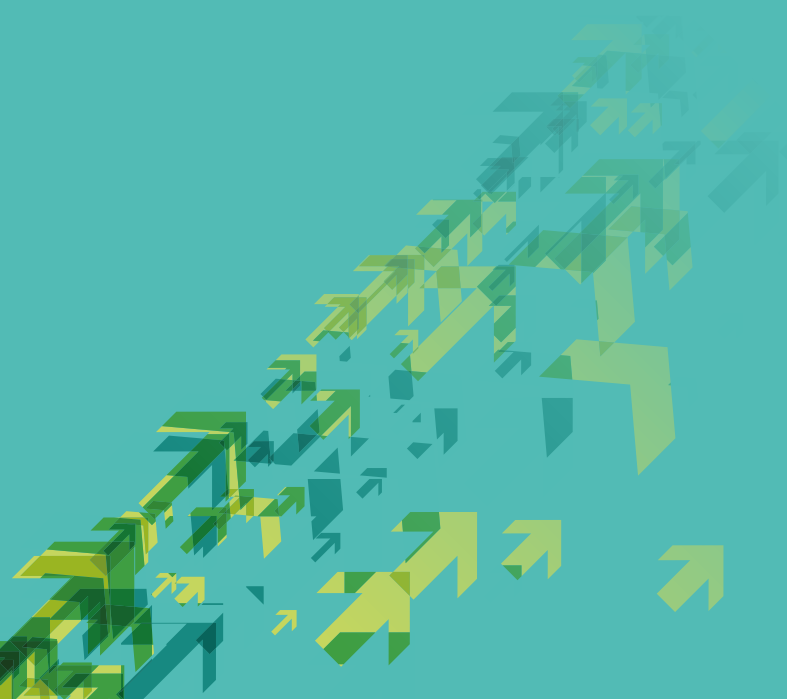
In 2016/17, 75% of working age people in Darlington were in employment, higher than regional (69.8%) and national (74.4%) employment rates. However, gaps in the employment rate among vulnerable groups present challenges in guaranteeing equitable access to the benefits of work. The percentage employment gap between those with a long-term condition and the overall employment rate in Darlington in 2016/17 was 20.7% while the gap for those people in contact with mental health services was 66%. The employment gap for people with a learning disability was higher at 70.7%.

Housing

Access to adequate housing is a determinant of good health, and poor housing, whether due to overcrowding, housing insecurity, poorly-kept housing or homelessness, constitutes a risk to health. A 2006 study by Shelter found that children in poor housing were at increased risk of experiencing a range of health problems including anxiety and depression, meningitis and asthma.

Homeless people are among the most vulnerable and disadvantaged in our society. Positively in 2016/17, 0.3 households per 1,000 in Darlington resided in temporary accommodation, significantly lower than the national figure of 3.3 per 1,000. Disadvantaged groups are also more likely to live in adequate housing in Darlington than elsewhere in the country. 85.8% of adults with a learning disability lived in stable and appropriate accommodation in Darlington in 2016/17, as opposed to 81.1% in the North East and 76.2% in England, and 69% of adults in contact with secondary mental health services in Darlington were suitably housed in the same period (North East 63%; England 54%).

However, there are challenges. In 2016, 13.7% of Darlington households experienced fuel poverty which occurs when a household needs to spend more than 10% of its income on energy to maintain satisfactory levels of heating. Fuel poverty is linked to living at low temperatures, which in turn is associated with a number of negative health outcomes.



Crime

Crime can damage the lives of those who suffer its consequences and those who perpetrate. It is a public health issue due to the impacts on individuals, families and the wider community.

In 2016/17 there were 44.4 episodes of domestic abuse related violence and crime in Darlington per 1,000 population, significantly more than elsewhere in the region (32.6) and the country (22.5). Similarly, there were 54.2 hospital admissions for violence (including sexual violence) per 100,000 population between 2013-2017, marginally better than the North East rate of 58.6 but worse than the rate for England (42.9).

The Darlington Community Safety Partnership is a multi agency partnership which addresses key community safety priorities.

Click here to view the One Darlington: Perfectly Safe Plan

Mental health and wellbeing

The Mental Health Foundation's report (2018) evidences that material inequality, social inequality and health inequality all lead to and perpetuate mental health inequalities. A social gradient exists in mental illness, with people living in poorer socio economic circumstances at increased risk of poor mental health. The crucial importance of adolescence and early adulthood is also re-emphasised – childhood adversity accounts for around a third of future mental health problems and 50% of mental health problems are established by the age of 14 and 75% by the age of 21.

Measuring emotional wellbeing is not as straightforward as collecting data on hospital admission rates or other physical health measures, but it is an essential component of population health. People with higher wellbeing have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health.

In all measures of self-reported wellbeing Darlington fares poorly when compared to average regional and national rates – the percentage of people with a low score for happiness, life satisfaction and self-worth was higher in Darlington than in the North East and England in 2016/17, as was the percentage of people with a high score for self reported anxiety. However, mean scores of wellbeing are generally in keeping with regional and national rates, and the percentage of Darlington residents reporting low happiness, low life satisfaction and low self-worth has decreased since 2011.

There is an established link between loneliness and poor mental and physical health. In 2016/17, 47.1% of adult social care users in Darlington reported having as much social contact as they would like (North East 49.2%; England 45.4%) 37.3% of adult carers responded positively to the same question (North East 44.8%; England 35.5%).

Self Harm

In 2014/15 5.9% of Darlington residents were in contact with secondary mental health services, higher than figures for the North East (5.5%) and England (5.4%). Self-harm is an expression of personal distress that is associated with a significant and persistent risk of future suicide – suicide risk is increased 49-fold in the year after self-harming[4]. It is also known to be more common among women, young people, the LGBT community and people living in deprived urban areas. In 2016/17 there were 212 hospital admissions for intentional self-harm per 100,000 population in Darlington, lower than the emergency admission rate for the North East (231.9) but higher than the rate for England (185.3). Although there has been a significant reduction in the rate of hospital admissions for intentional self-harm in Darlington since 2011, the most recent data shows some increase in the number of emergency admissions since 2015/16.

The suicide rate in Darlington (at 13.1 per 100,000 in 2014-16) is higher than the regional rate of 11.6 and also higher than the national rate of 9.9. Suicide is the biggest killer of men under 50 as well as a leading cause of death in young people and new mothers. People living in areas of socioeconomic deprivation are more likely to be subject to circumstances such as poor health, unemployment, poor living conditions, poor educational attainment and social isolation that increase their risk of suicidal behaviours.

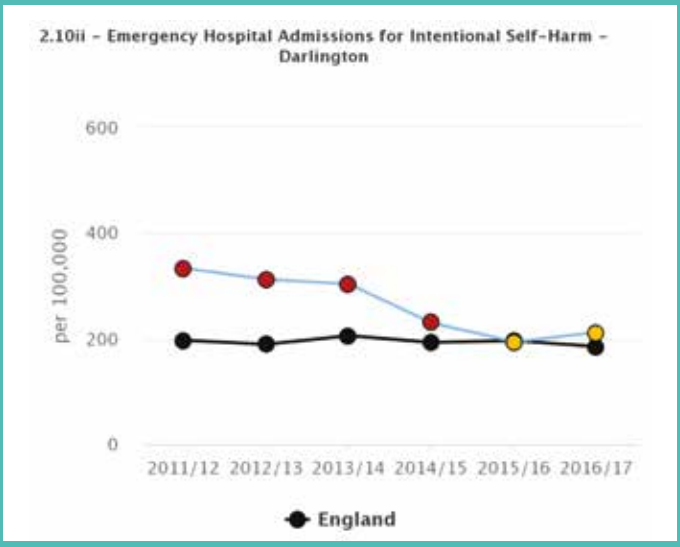


Figure 5. Emergency Hospital Admissions for Intentional Self-Harm, Darlington/England 2011-2017 (PHE)

[4]Department of Health, Mental Health, Disability and Equality Division, Preventing suicide in England: Third annual report on the cross-government outcomes strategy to save lives, 2015.

Physical health and illness

Nationally, one in three of the working age population report having at least one long term health condition and over half of people with a long term health con dition state that their health is a barrier to the type or amount of work they can do.

Ward	Long-term illness or disability (%)
Bank Top & Lascelles	22.2
Brinkburn & Faverdale	13.8
Cockerton	24.8
College	15.5
Eastbourne	18.7
Harrowgate Hill	15.2
Haughton & Springfield	24.9
Heighington & Coniscliffe	15.7
Hummersknott	20.7
Hurworth	18.4
Mowden	20.3
North Road	21.5
Northgate	19.8
Park East	20.8
Park West	17.8
Pierremont	16.6
Red Hall & Lingfield	21.7
Sadberge & Middleton St George	17.7
Stephenson	26.6
Whinfield	19.5

Table 3. Percentage of people who reported having a limiting long-term illness or disability in the 2011 census (localhealth.org.uk, PHE)

Cancer

The relationship between cancer and deprivation is complex, but the reality remains that disadvantaged groups are more likely to die from some cancers (such as breast and prostate) and several cancers (including lung and oesophageal) are more common in disadvantaged populations.

A report published by Cancer Research UK highlighted the extent and the persistence of inequalities in cancer incidence and outcome and noted that these inequalities often related to lifestyle factors, perception of risk, awareness of cancer symptoms and access to health services.

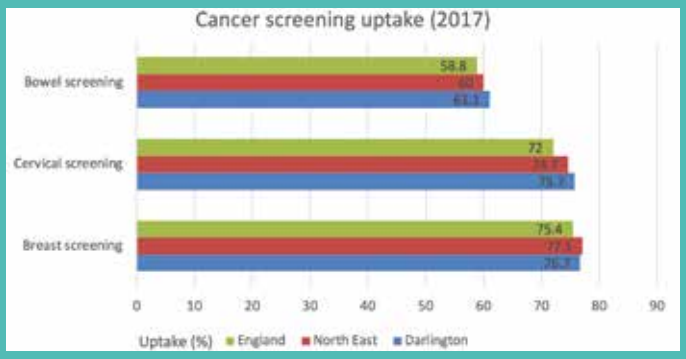


Figure 5. Cancer screening uptake, 2017 (PHE)

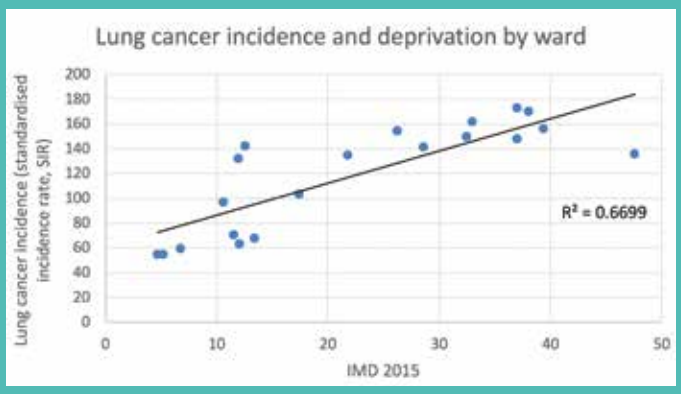


Figure 6. Lung cancer incidence by ward is positively correlated with IMD (localhealth.org.uk, PHE)

National cancer screening programmes exist for breast cancer, cervical cancer and bowel cancer. Cancer accounts for around a quarter of all deaths in England and cancer screening reduces the number of cancers that are diagnosed at an advanced stage. Figure 6 shows that while Darlington's cancer screening uptake compares favourably with rates in the North East and England, cervical screening coverage does not meet the 80% target for uptake and has been in decline for several years.

In 2015 49.7% of cancers were diagnosed at an early stage in Darlington, compared to 52.3% in the North East and 52.4% in England.

There is considerable variation in cancer incidence in Darlington, with relatively low cancer incidence in wards such as Mowden (IMD 4.7) to very high incidence in bowel and lung cancers in more deprived wards such as North Road (IMD 37), Bank Top and Lascelles (IMD 38.1). The association with deprivation is strong for lung cancer, a condition associated with tobacco smoking in more than 90% of cases – lung cancer occurs more commonly in more deprived wards.

Emergency Hospital Admissions

Data is available for emergency hospital admissions for patients presenting with coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD), myocardial infarction ('heart attack', MI) and cerebrovascular accident ('stroke', CVA), using the standardised admission ratio. (See Appendix 5)

Emergency admission to hospital is more common in wards with a high IMD – in Park West (IMD 13.4) emergency admissions are below the level expected in all domains, while in Park East (IMD 47.6) they are consistently higher.

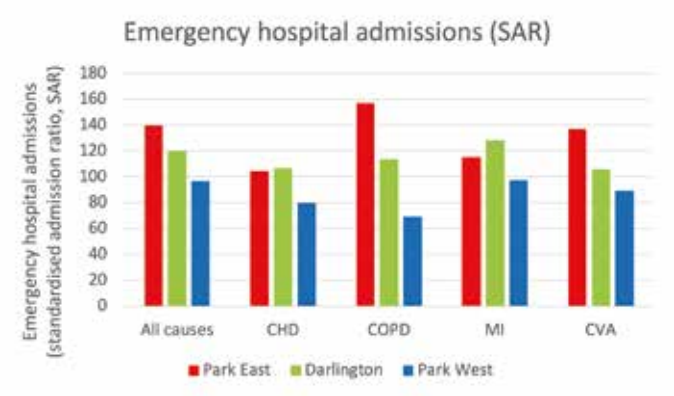


Figure 7. Emergency Hospital Admissions using the Standardised Admissions Rate (localhealth.org.uk, PHE)

For all causes, there is a clear correlation – the emergency admission ratio increases in association with a higher IMD.

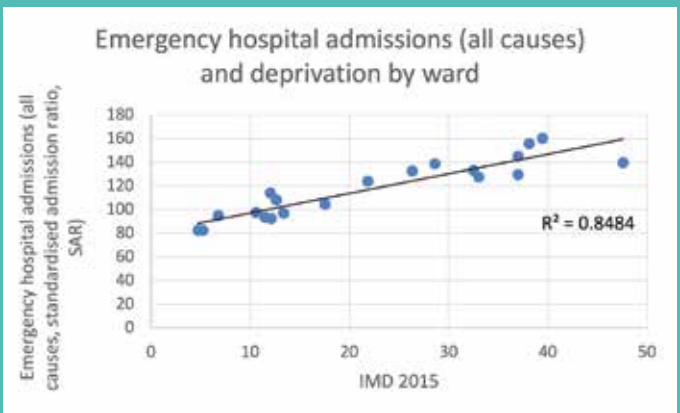


Figure 8. Emergency hospital admissions rate is positively correlated with IMD (localhealth.org.uk, PHE)

NHS Health Checks

Delivery of the NHS Health Checks programme is a mandated responsibility of the council. It was introduced to address seven modifiable risk factors most commonly associated with cardiovascular disease (CVD). Heart disease is more common in poorer communities, and the risk factors in question are also more prevalent among disadvantaged communities. The NHS Health Check is an important part of our efforts to address health inequality.

The Darlington programme performs well, i.e. in the four year period from 2013/14 to 2016/17, 89.8% of the eligible population in Darlington was offered a NHS health check, compared to 75.4% in the North East and 74.1% in England.

Those living in the most disadvantaged areas of Darlington have lower life expectancy with higher mortality from heart disease, lung cancer and chronic lower respiratory diseases. Smoking and obesity are key risk factors for these conditions.

Behavioural risk factors

Obesity

In 2015/16, 71.7% of adults in Darlington were classified as overweight or obese, compared to 66.3% in the North East and 61.3% in England – Darlington has the highest rates of overweight/ obesity in the North East.

Overweight and obesity is linked to an increased risk of developing type 2 diabetes, high blood pressure, heart disease, stroke, and several cancers, and often occurs in association with mental illness and social exclusion. Some groups are more likely to be overweight than others – people with disabilities, some minority ethnic groups and people from more deprived areas.

Diet and physical activity are determined to some extent by environmental factors, e.g. the availability and affordability of healthy food and access to green space. This refers to the obesogenic environment, 'the sum of influences that the surroundings, opportunities, or conditions of life have on promoting obesity in individuals or populations'. The evidence suggests that disadvantaged communities tend to be more obesogenic – for the people living in these communities, making less healthy choices may be affected by circumstances beyond individual control.

In 2016/17, 63.8% of adults in Darlington were physically active, engaging in at least 150 minutes of moderate physical activity per week as per the advice of the Chief Medical Officer. However, 25.6%, more than a quarter of local residents, were physically inactive, with fewer than 30 minutes of moderate physical activity per week.

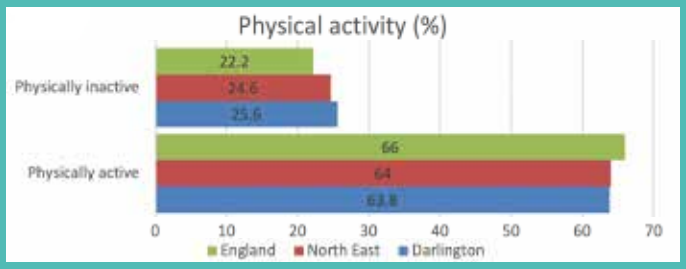


Figure 9. Percentage of the population that is physically active and physically inactive, 2016/17 (PHE)

Physical activity is associated with better physical and mental health that is to some degree independent of its association with weight. However, environmental factors play a part in determining the extent to which people are able to engage in physical activity.

In 2015-16, 20.3% of Darlington residents used outdoor spaces for exercise and health reasons, compared to 17.3% of people elsewhere in the North East and 17.9% in England. Darlington has fewer serious injuries on its roads than elsewhere in the country (30.7 per 100,000 population; North East 33.9; England 39.7) and has relatively low levels of particulate air pollution (percentage of mortality attributable to air pollution 3.5%; North East 3.5%; England 4.9%).

In 2015/16, 58.1% of Darlington residents ate the recommended five portions of fruit and vegetables per day on a usual day, compared to 57.1% in the North East and 56.8% in England.

Food eaten outside the home tends to be higher in calories, and this is particularly the case with food bought from fast food outlets. Evidence indicates that fast food outlets are often clustered in more deprived areas.

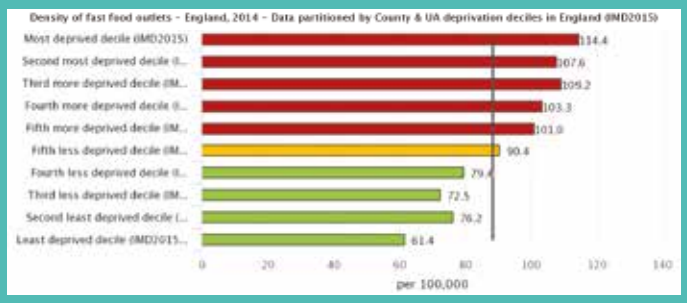


Figure 10. Density of fast food outlets by deprivation decile in England, 2014 (PHE)

In 2014, Darlington had 117.7 fast food outlets per 100,000 population, in excess of the regional figure of 102.4 and significantly greater than the figure for England of 88.2.

More recent data from 2017 shows that the number of hot food outlets in Darlington has increased to 148.6 per 100,000 population and the England figure has also risen to 96.1.

Smoking

In 2016, 17.3% of adults in Darlington identified as current smokers. However almost twice as many Darlington residents in routine and manual occupations were smokers and almost three times as many adults with serious mental illness smoked tobacco. Smoking remains the leading cause of preventable death.

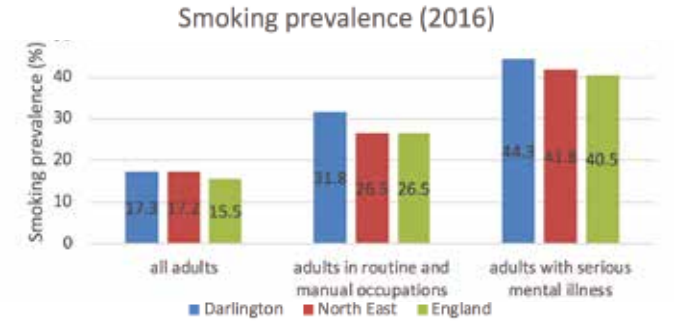


Figure 11. Smoking prevalence in defined population subgroups, 2016 (PHE)

Alcohol

10 million people in England drink alcohol at levels that pose a danger to their health, and alcohol misuse is now the most important risk factor for ill-health and premature mortality among adults aged 15-49. The average age at death of those dying due to an alcohol specific cause is 54.3 years.

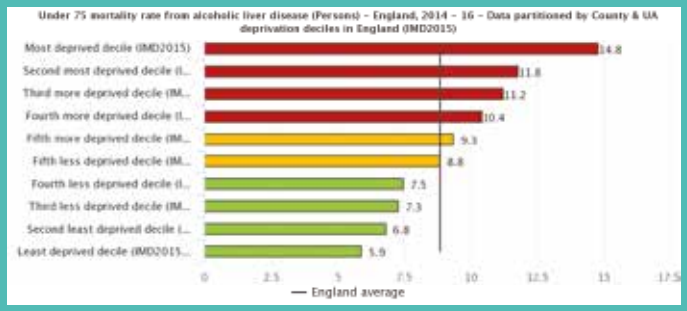


Figure 12. Under 75 mortality rate from alcoholic liver disease by deprivation decile in England, 2014 (PHE)

In 2011-2014, 33.7% of adults in Darlington drank more than the recommended amount of alcohol per week (14 units as per the advice of the Chief Medical Officer). This is in contrast to 30.3% of people in the North East and 25.7% of people in England drinking unsafe amounts. Similarly, 24.3% of Darlington residents binge-drink on their heaviest drinking day, compared to 22.9% in the North East and 16.6% in England.

For those who seek treatment, 36.7% of clients successfully completed alcohol treatment in Darlington in 2016, compared to 30.8% in the North East and 38.7% in England. Rates of alcohol-related mortality (48.7 per 100,000; North East 55.7; England 46.0) and alcohol-specific mortality (11.3 per 100,000; North East 16.4; England 10.4) in Darlington are the lowest in the region but marginally higher than national rates.

Drug Misuse/ Substance Misuse

Substance misuse accounts for a significant proportion of premature mortality in the UK, with one in nine deaths among people in their 20s and 30s related with drug misuse.

In 2016, 30.2% of non-opiate users in Darlington successfully completed treatment (North East 27.4%; 37.1%). However, among opiate users only 2.8% of participants completed treatment, compared to 5.2% in the North East and 6.7% in England.

In 2014-16 there were 4.2 deaths from drug misuse in Darlington per 100,000 population. This rate is in keeping with the national rate (also 4.2) and the lowest in the North East where there were 7.2 drug deaths per 100,000 population in 2014 16.

Multiple Risk Factors

The table below summarises ward level data showing the estimated proportions of the population that binge-drink, eat healthily, and are obese. Thirteen wards are worse than the England average across all three domains, and no ward is better than the England average in all three.

	Obese Adults (%)	Binge-drinking adults (%)	Healthy-eating adults (%)
Bank Top & Lascelles	29.9	29.8	19.3
Brinkburn & Faverdale	28.6	28.4	22.9
Cockerton	30.8	29.8	18.6
College	18.4	25.5	34.6
Eastbourne	31.6	25.7	17.5
Harrowgate Hill	30.7	26.6	21.9
Haughton & Springfield	28.1	26.8	20.9
Heighington & Coniscliffe	25.3	26.4	29.1
Hummersknott	22.6	21.3	31.5
Hurworth	25.5	33.3	27.9
Mowden	22.6	21.3	31.5
North Road	29.9	33.8	20.3
Northgate	27.7	29.1	21.3
Park East	27.4	29.2	20.7
Park West	21.8	24.5	30.5
Pierremont	28	35.8	23.8
Red Hall & Lingfield	31.1	25.4	19.1
Sadberge & Middleton St George	25.5	31.6	28.2
Stephenson	30.9	26	19.1
Whinfield	28.8	30.7	23
Darlington	27.7	28.5	23.5
England	24.1	20	28.7

Table 4. Percentage of the population aged 16+ with a BMI of 30+, percentage of the population aged 16+ that binge drink and percentage of the population aged 16+ that consume 5 or more portions of fruit and vegetables per day (all modelled estimates 2006-8, localhealth.org.uk, PHE)

Multiple unhealthy risk factors increase mortality risk significantly and are experienced more in our most disadvantaged communities.

Chapter 4: Ageing in Darlington

By ONS estimates 19.7% of Darlington's population was aged 65 years and above in 2016. As our population ages, and the demographic profile of our society changes, addressing the health inequalities that accumulate during life will be an increasingly urgent public health priority.

Falls and Fractures

Falls are the leading cause of emergency hospital admissions in older people, and serious falls may result in injury and disability with life-changing consequences for the individuals concerned and their families. The impacts of a hospitalisation following a fall are considerable, for the person and their family and also in terms of the wider economic costs.

Data for 2016/17 shows that fewer people are admitted to hospital following a fall in Darlington than elsewhere in the region and in England – there were 1,991 hospital admissions due to falls in people aged 65 and over per 100,000 population (North East 2,264; England 2,114), with 1,057 falls per 100,000 population in people aged 65-79 (North East 1,119; England 993) and 4,699 falls per 100,000 population in people aged 80 and over (North East 5,584; England 5,363).

Data from the same period concerning hip fractures, a serious consequence of falls in older people that results in one in three people moving into long-term care, shows that any more people aged 80 and over suffer hip fractures in Darlington than elsewhere in the North East and England.

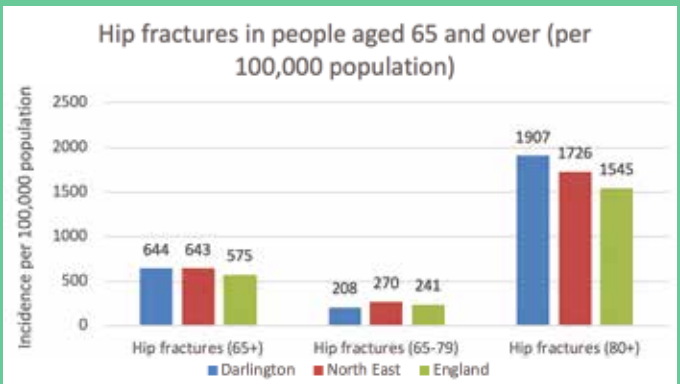


Figure 13. Hip fractures in people aged 65 and over, 2016/17 (PHE)

Sight Loss

Although visual impairment can affect people of any age, it is an important cause of disability in older people and is associated with health inequalities and deprivation as well as being linked to an increased risk of depression, loss of independence and falls. Up to 50% of blindness and sight loss could be prevented if diagnosed and treated in time.

In 2016/17 there were 153.4 cases of age related macular degeneration among people aged 65 and over in Darlington per 100,000 population, compared to 141.1 cases per 100,000 in the North East and 111.3 cases per 100,000 in England. Rates of glaucoma among people aged 40 and over are among the highest in the region – 23.1 per 100,000 population in Darlington compared to 16.0 in the North East and 13.1 in England. There were 61.5 new sight loss certifications per 100,000 population in Darlington in 2016/17 (North East 54.7; England 42.4).

In 2017, the Darlington Health and Partnership Scrutiny Committee promoted eye health messages including uptake of regular eye tests.

Dementia

The term 'dementia' is used to describe symptoms including memory loss and problems with reasoning, perceptions and communication skills. A serious risk of developing dementia rises from one in 14 over the age of 65 years to one in six over the age of 80 years. Age is the strongest known risk factor for dementia but it is not inevitable and preventative action is needed to reduce future prevalence. Nine modifiable risk factors have been identified which could prevent more than a third of dementia cases : low educational level in childhood, hearing loss, hypertension, obesity, smoking, depression, physical social activity, isolation and diabetes

In 2017, the estimated dementia diagnosis rate in Darlington among people aged 65 and over was 79.5%, higher than rates for the North East (75.6%) and England (67.9%).

Flu vaccination

The flu vaccine is offered annually to some population groups (including people aged 65 and over) who are at greatest risk of developing serious flu complications, and high levels of uptake ease pressure on primary and secondary care services during the flu season. The target uptake in people aged 65 and over is 75% coverage. In 2016/17, 70.6% of people aged 65 and over in Darlington received the flu vaccination, similar to the national rate (70.5%) but lagging behind the North East (72.4%). However, coverage among other high risk groups was low –46.5% of high risk individuals in Darlington had the vaccination in 2016/17 (North East 49.5%; England 48.6%).

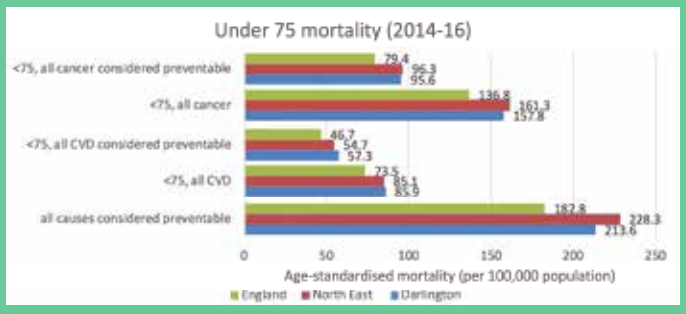
Despite poor flu vaccination uptake, between 2014 16 the mortality rate in Darlington from a range of specified communicable diseases, including influenza, was 8.8 per 100,000 population, the lowest rate in the region (12.0) and lower than the national mortality rate for infectious diseases (10.7).

Mortality

Mortality considered 'preventable' refers to deaths that could potentially have been avoided in all or most cases by risk factor/behaviour modification. The two graphs below summarise the extent of premature (under 75) and preventable mortality in Darlington due to cardiovascular disease (CVD), cancer, liver disease and respiratory disease, benchmarked against average mortality rates for the North East and England.

In all domains, Darlington is better than the North East but not compared to the average for England. There is a higher incidence of preventable and premature mortality in Darlington than in many other areas of the country.

Older people living in more deprived wards are significantly more likely to die from preventable and avoidable conditions at a younger age than their counterparts in more advantaged parts of Darlington.



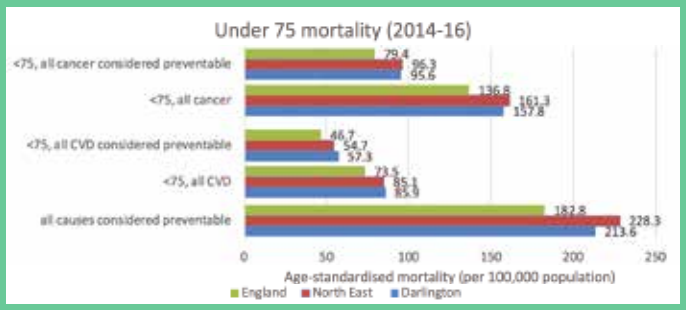


Figure 14. Under 75 mortality, 2014-16 (PHE)

Excess Winter Deaths

The number of excess winter deaths in a given year depends on a range of factors, including average temperatures, rates of communicable diseases such as flu, and other factors such as the health resilience of the local population. Research suggests that many winter deaths could be preventable.

The graph below summarises excess winter death data for one year (2015-16) and for a three-year period (2013-16), using the excess winter deaths index (the ratio of extra deaths during the winter months compared with expected deaths). In 2015-16 Darlington reported significantly lower excess winter death figures than the North East and England, though the gap is narrower for 2013-16.

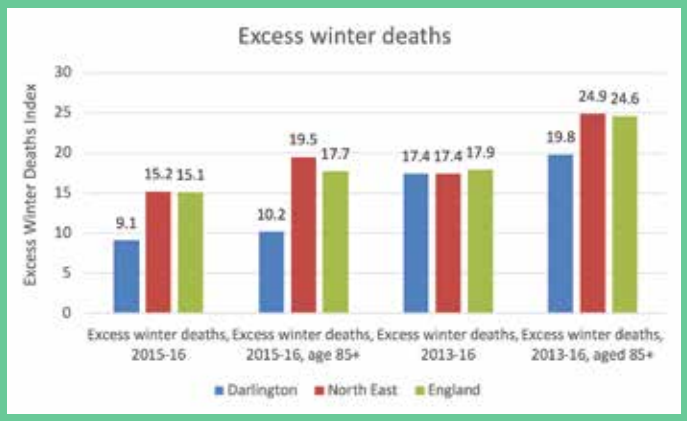


Figure 15. Excess winter deaths, 2013-16 (PHE)

Chapter 5: Darlington: Healthy New Towns

Healthy New Towns Darlington

Darlington is a Healthy New Town (HNT), one of ten sites designated nationally by NHS England in 2016, recognising the partnership across Darlington Borough Council, NHS partners, private sector and academic partners.

The HNT project in Darlington has become an important mechanism through which to deliver the Borough's Sustainable Community Strategy – "One Darlington, Perfectly Placed" – it recognises the contribution of creating a sense of place in neighbourhoods that people can identify with and feel part of, and also recognises the vital role of people and community-based assets in building social capital which is key to the delivery of health improvement and the reduction of inequalities.

There are four main areas of work within the Healthy New Towns programme :

- Built environment
- Community development
- New Model of Care (Health and Social Care)
- Digital (underpinning all the above).

As the theme of this Annual Report is about narrowing the gaps in health inequality, the focus below is on the element of Community Development.

Community Strengths

- Consultation with community and delivery of the masterplan for the Red Hall estate - leading to investment in housing, environment and facilities;
- Promotion of active lifestyles through improved walking experience including 'art work' street furniture;
- Delivery of bespoke activities programme aimed at families in response to feedback – creating opportunities for supporting family and social interaction at no/low cost without need to source/ fund childcare;
- School participation in 'walk to school' campaign, delivery of 'Bikeability' scheme in primary school
- Delivery of Holiday Hunger/healthy eating scheme and investigation of a community garden scheme to grow fresh produce locally
- Delivery of #Iwill Campaign and youth provision facilitated through the YMCA - the programme of activities is being driven by the views of the young people
- Involvement of primary school children in cultural activities centred around their community through Groundwork and Tees Valley Arts to celebrate their local heritage and culture reinforcing that sense of identity
- Delivery of wide range of Learning and Skills sessions into the community centre and through mechanisms such as Step Forward Tees Valley aimed at building confidence, access and active signposting to support services and help in gaining access to local employment and training opportunities

Appendix 1: Child health indicators "league table"

Ward level data concerning child health indicators can be combined to compile a "league table" of child health in Darlington, covering 15 domains including child poverty, birth weight, developmental and educational attainment, obesity, and risk of injury and A&E attendance in children and young people. The results below are clear – the areas with the best outcomes for children and young people are also the areas with the lowest levels of deprivation as per the IMD 2015. Conversely, the areas where children face the greatest challenges are the parts of our town with the highest levels of deprivation.

Ward	Score	IMD 2015
1. Mowden	33	4.7
2. Hummersknott	30	5.2
3. College	27	6.8
4. Hurworth	24	12.1
…		
17. Park East	-18	47.6
18. Red Hall and Lingfield	-18	37.0
19. Northgate	-21	39.4
20. Bank Top and Lascelles	-24	38.1

Appendix 2: Data Tables

Chapter 2: Child Health and Early Years

Domain	Period	Darlington	North East	England
Children in low income families (all dependent children under 20)	2014	21.4 (3/12)[5]	24.3	19.9
Children in low income families (under 16s)	2014	22.0 (3/12)	24.9	20.1
School readiness: the % of children achieving a good level of development at the end of reception	2016/17	72.2 (2/12)	70.7	70.7
School readiness: the % of children with free school meal status achieving a good level of development at the end of reception	2016/17	61.4 (1/12)	57.7	56.0
School readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check	2016/17	85.0 (J1/12)	82.2	81.1
School readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	2016/17	79.0 (1/12)	70.1	68.4
Pupil absence (% of half days missed)	2015/16	4.91 (10/12)	4.73	4.57
GCSE achieved 5 A*-C incl. English and Maths	2015/16	55.9 (7/12)	56.5	57.8
GCSE achieved 5 A*-C incl. English and Maths with FSM status	2014/15	24.7 (12/12)	30.5	33.3
First time entrants to the youth justice system (10-17 year olds per 100,000 population)	2016	319.2 (4/12)	409.8	327.1
16-17 year olds NEET or whose activity is not known	2016	4.3 (2/12)	5.4	6.0
LBW of term babies	2016	3.4 (J10/12)	3.0	2.8
BF initiation	2016/17	?	59.0	74.5

BF prevalence at 6-8 weeks after birth	2016/17	34.3 (5/10)	31.4	44.4
Smoking status at time of delivery	2016/17	16.2 (7/12)	16.1	10.7
Under 18 conceptions (rate per 1000)	2015	25.1 (4/12)	28.0	20.8
Under 18 conceptions: conceptions in those aged under 16 (rate per 1000)	2015	5.8 (5/12)	6.2	3.7
Proportion of children aged 2-2.5 years offered ASQ-3 as part of the Healthy Child Programme or integrated review	2016/17	87.9 (10/12)	93.1	89.4
Child excess weight in 4-5 year olds	2016/17	25.0 (9/12)	24.5	22.6
Child excess weight in 10-11 year olds	2016/17	36.7 (4/12)	37.3	34.2
Proportion meeting the recommended 5-a-day at age 15	2014/15	44.6 (9/12)	46.8	52.4
Hospital admissions caused by unintentional and deliberate injuries in children (0-14 years rate per 10,000)	2016/17	166.5 (10/12)	146.4	101.5
Hospital admissions caused by unintentional and deliberate injuries in children (0-4 years rate per 10,000)	2016/17	233.1 (11/12)	182.4	126.3
Hospital admissions caused by unintentional and deliberate injuries in young people (15-24 years rate per 10,000)	2016/17	185.8 (12/12)	151.5	129.2
Average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on 31st March	2015/16	14.3 (5/12)	14.5	14.0
% of children aged 5-16 who have been in care for at least 12 months on 31st March whose score in the SDQ indicates cause for concern	2015/16	37.8 (4/12)	40.3	37.8
Smoking prevalence at age 15 – current smokers	2014/15	9.0 (4/12)	10.1	8.2
Smoking prevalence at age 15 – regular smokers	2014/15	6.8 (5/12)	7.5	5.5
Smoking prevalence at age 15 – occasional smokers	2014/15	2.2 (3/12)	2.6	2.7
Infant mortality (rate of deaths in infants aged under 1 year per 1000 live births)	2014-16	3.3 (7/12)	3.7	3.9
Proportion of five year old children free from dental decay	2014/15	64.6 (9/12)	72.0	75.2

[5] Figures in brackets refer to Darlington's performance relative to other North East local authority areas. For example, 1/12 would mean that Darlington was the best-performing North East local authority in this domain, and 12/12 would mean that it was the worst. J refers to instances where Darlington's performance/rank is the same ('joint') as that of another North East local authority.

Chapter 3: Adult Health : Living and Working Well

Domain	Period	Darlington	North East	England
Adults with a LD who live in stable and appropriate accommodation	2016/17	85.8 (3/12)	81.1	76.2
Adults in contact with secondary MH services who live in stable and appropriate accommodation	2016/17	69.0 (6/12)	63.0	54.0
Gap in employment rate:				
- LT condition	2016/17	20.7 (1/12)	27.3	29.4
-LD	2016/17	70.7 (12/12)	64.5	68.7
-Contact with MH services	2016/17	66.0 (11/12)	61.8	67.4
Aged 16-64 in employment	2016/17	75.0 (2/12)	69.8	74.4

% of employees who had at least one day off in the previous week due to sickness absence	2014-16	1.7 (1/12)	2.3	2.1
% of working days lost due to sickness absence	2014-16	1.2 (J3/12)	1.5	1.2
Domestic abuse related incidents and crime (per 1,000)	2015/16	38.4 (J11/12)	30.4	22.1
Violent crime (including sexual violence) – hospital admissions for violence (per 100,000)	2014/15 – 2016/17	54.2 (2/12)	58.6	42.9
First time offenders (per 100,000)	2016	266.6 (11/12)	200.0	218.4
Re-offending levels - % of offenders who re-offend	2014	32.0 (9/12)	30.0	25.4
Complaints about noise (per 1,000)	2014/15	7.2 (9/12)	6.5	7.1
Statutory homelessness – eligible homeless people not in priority need (per 1,000)	2016/17	0.1 (1/7)	0.7	0.8
Statutory homelessness – households in temporary accom (per 1,000)	2016/17	0.3 (J5/7)	0.1	3.3
Fuel Poverty	2015	14.1 (10/12)	13.3	11.0
Social isolation - % of adult social care users who have as much social contact as they would like	2016/17	47.1 (10/12)	49.2	45.4
Social isolation - % of adult carers who have as much social contact as they would like	2016/17	37.3 (10/12)	44.8	35.5
Emergency hospital admissions for intentional self-harm	2016/17	212.0 (3/12)	231.9	185.3
Recorded diabetes	2014/15	6.8	6.7	6.4
Cancers diagnosed at early stage	2015	49.7 (8/12)	52.3	52.4
screening coverage				
-Breast	2017	76.7 (J6/12)	77.1	75.4
- Cervical	2017	75.7 (J5/12)	74.7	72.0
- Bowel	2017	61.1 (J3/12)	60.0	58.8
- AAA	2016/17	79.8 (7/12)	79.8	80.9
Cumulative % of eligible population aged 40-74 offered an NHS HC	2013/14-2016/17	89.8 (5/12)	75.4	74.1
…offered a HC who received a HC	"	45.7 (5/12)	44.9	48.9
…who received a HC	"	41.1 (5/12)	33.8	36.2
Self-reported wellbeing	2016/17			
- Low satisfaction score		6.0 (J9/11)	5.1	4.5
-Low worthwhile score		4.7 (5/9)	4.2	3.6
- Low happiness score		9.0 (7/12)	8.7	8.5
-High anxiety score		20.1 (8/12)	19.8	19.9
Incidence of TB (per 100,000)	2014-16	5.7 (6/12)	5.3	10.9
HIV late diagnosis	2014-16	45.4 (6/10)	46.7	40.1

Proportion of adults in contact with secondary MH services	2014/15	5.9 (10/12)	5.5	5.4
Suicide rate (per 100,000)	2014-16	13.1 (10/12)	11.6	9.9
Excess under 75 mortality in adults with serious mental illness	2014/15	444.5 (4/12)	461.2	370.0

Behavioural risk factors

Domain	Period	Darlington	North East	England
% of adults (18+) classified as overweight or obese	2015/16	71.7 (12/12)	66.3	61.3
% of physically active adults	2016/17	63.8 (5/12)	64.0	66.0
% of physically inactive adults	2016/17	25.6 (6/12)	24.6	22.2
Utilisation of outdoor space for exercise/health reasons (%)	2015-16	20.3 (3/11)	17.3	17.9
KSI casualties on England's roads (per 100,000)	2014-16	30.7 (6/12)	33.9	39.7
% of mortality attributable to particulate air pollution	2015	3.5 (J2/12)	3.5	4.7
Proportion of the population meeting the recommended '5-a-day' on a 'usual day'	2015/16	58.1 (5/12)	57.1	56.8
Average number of portions of fruit consumed daily	2015/16	2.65 (2/12)	2.56	2.63
Average number of portions of vegetables consumed daily	2015/16	2.72 (6/12)	2.72	2.68
Density of fast food outlets (per 100,000)	2014	117.7 (10/12)	102.4	88.2
Smoking prevalence in adults – current smokers	2016	17.3 (6/12)	17.2	15.5
Smoking prevalence in adults in routine and manual occupations – current smokers	2016	31.8 (4/12)	26.5	26.5
Smoking prevalence in adults with serious mental illness	2016	44.3 (10/12)	41.8	40.5
Successful completion of drug treatment – opiate users	2016	2.8 (12/12)	5.2	6.7
Successful completion of drug treatment – non-opiate users	2016	30.2 (5/12)	27.4	37.1
Deaths from drug misuse (per 100,000)	2014-16	4.2 (1/12)	7.2	4.2
% of adults drinking over 14 units of alcohol a week	2011-14	33.7 (9/12)	30.3	25.7
% of adults binge drinking on heaviest drinking day	2011-14	24.3 (9/12)	22.9	16.5
Successful completion of alcohol treatment	2016	36.7 (J3/12)	30.8	38.7
Alcohol-related mortality (per 100,000)	2016	48.7 (1/12)	55.7	46.0
Alcohol-specific mortality (per 100,000)	2014-16	11.3 (1/12)	16.4	10.4
Excess under 75 mortality in adults with serious mental illness	2014/15	444.5 (4/12)	461.2	370.0

Chapter 4: Healthy Ageing in Darlington

Domain	Period	Darlington	North East	England
Emergency hospital admissions due to falls in people aged 65 and over (per 100,000 population)	2016/17	1991 (5/12)	2264	2114
Emergency hospital admissions due to falls in people aged 65 and over – aged 65-79	2016/17	1057 (5/12)	1119	993
Emergency hospital admissions due to falls in people aged 65 and over – aged 80+	2016/17	4699 (5/12)	5584	5363
Estimated dementia diagnosis rate (aged 65+)	2017	79.5 (4/12)	75.6	67.9
Excess winter deaths index (single year, all ages)	2015-16	9.1 (3/12)	15.2	15.1
Excess winter deaths index (single year, age 85+)	2015-16	10.2 (2/12)	19.5	17.7
Excess winter deaths index (3 years, all ages)	2013-16	17.4 (7/12)	17.4	17.9
Excess winter deaths index (3 years, age 85+)	2013-16	19.8 (2/12)	24.9	24.6
Hip fractures in people aged 65 and over (per 100,000 population)	2016/17	644 (6/12)	643	575
Hip fractures in people aged 65 and over – aged 65-79	2016/17	208 (1/12)	270	241
Hip fractures in people aged 65 and over – aged 80+	2016/17	1907 (11/12)	1726	1545
Health related QOL in older people (score)	2016/17	0.725 (4/12)	0.709	0.735
Preventable sight loss:	2016/17			
- AMD (aged 65+, per 100,000)		153.4 (9/12)	141.1	111.3
- Glaucoma (aged 40+)		23.1 (11/12)	16.0	13.1
-Sight loss certifications		61.5 (9/12)	54.7	42.4
Mortality rate from causes considered preventable (per 100,000 population)	2014-16	213.6 (2/12)	228.3	182.8
Under 75 mortality rate from all CVD	2014-16	85.9 (6/12)	85.1	73.5
Under 75 mortality rate from CVD considered preventable	2014-16	57.3 (8/12)	54.7	46.7
Under 75 mortality rate from cancer	2014-16	157.8 (2/12)	161.3	136.8
Under 75 mortality rate from cancer considered preventable	2014-16	95.6 (4/12)	96.3	79.4
Under 75 mortality rate from liver disease	2014-16	22.1 (2/12)	25.2	18.3
Under 75 mortality rate from liver disease considered preventable	2014-16	18.4 (2/12)	22.3	16.1
Under 75 mortality rate from respiratory disease	2014-16	40.3 (4/12)	43.1	33.8
Under 75 mortality from respiratory disease considered preventable	2014-16	23.2 (5/12)	25.6	18.6
Mortality rate from a range of specified communicable disease, including influenza	2014-16	8.8 (1/12)	12.0	10.7
Population vaccination coverage – Flu (aged 65+)	2016/17	70.6 (9/12)	72.4	70.5
Population vaccination coverage – Flu (at risk individuals)	2016/17	46.5 (11/12)	49.5	48.6

Figures and tables

Appendix 3: Health Profile for Darlington 2017

Every year, Public Health England publishes health profiles for every Local Authority across the country. Below are the key headlines from the profile published in 2017.

Public Health England

Darlington

Unitary authority

This profile was published on 4th July 2017

Health Profile 2017

Health in summary
The health of people in Darlington is varied compared with the England average. About 22% (4,400) of children live in low income families. Life expectancy for both men and women is lower than the England average.

Health inequalities
Life expectancy is 10.9 years lower for men and 8.6 years lower for women in the most deprived areas of Darlington than in the least deprived areas.

Child health
In Year 6, 21.0% (252) of children are classified as obese. The rate of alcohol-specific hospital stays among those under 18 is 59*, worse than the average for England. This represents 13 stays per year. Levels of breastfeeding initiation and smoking at time of delivery are worse than the England average.

Adult health
The rate of alcohol-related harm hospital stays is 728*, worse than the average for England. This represents 765 stays per year. The rate of self-harm hospital stays is 194*. This represents 201 stays per year. The rate of smoking related deaths is 321*, worse than the average for England. This represents 198 deaths per year. Rates of sexually transmitted infections, people killed and seriously injured on roads and TB are better than average.

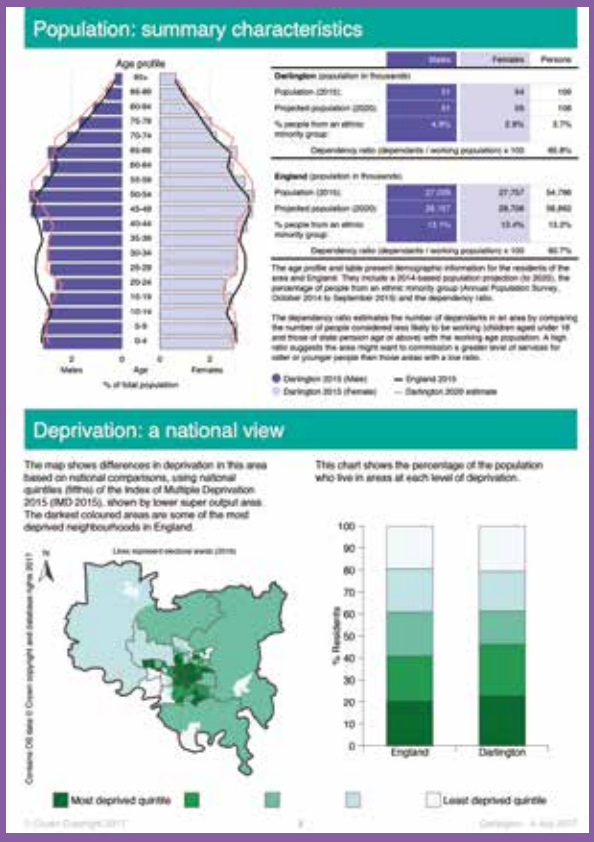
Local priorities
Priorities in Darlington include giving every child the best start in life, tackling alcohol-related harm, and promoting mental health and wellbeing. For more information see http://www.darlington.gov.uk

* rate per 100,000 population

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

Visit www.healthprofiles.info for more profiles, more information and interactive maps and tools.

Follow @PHE_uk on Twitter



Population: summary characteristics

Age profile

	Males	Females	Persons
Darlington (population in thousands)			
Population (2015)	51	54	106
Projected population (2020)	51	55	106
% people from an ethnic minority group	4.9%	3.9%	8.7%
Dependency ratio (dependents / working population) x 100			66.8%
England (population in thousands)			
Population (2015)	27,029	27,757	54,786
Projected population (2020)	28,157	28,706	56,862
% people from an ethnic minority group	13.1%	13.4%	13.2%
Dependency ratio (dependents / working population) x 100			60.7%

The age profile and table present demographic information for the residents of the area and England. They include a 2014-based population projection (to 2020), the percentage of people from an ethnic minority group (Annual Population Survey, October 2014 to September 2015) and the dependency ratio.

The dependency ratio estimates the number of dependants in an area by comparing the number of people considered less likely to be working (children aged under 16 and those of state pension age or above) with the working age population. A high ratio suggests the area might want to commission a greater level of services for older or younger people than those areas with a low ratio.

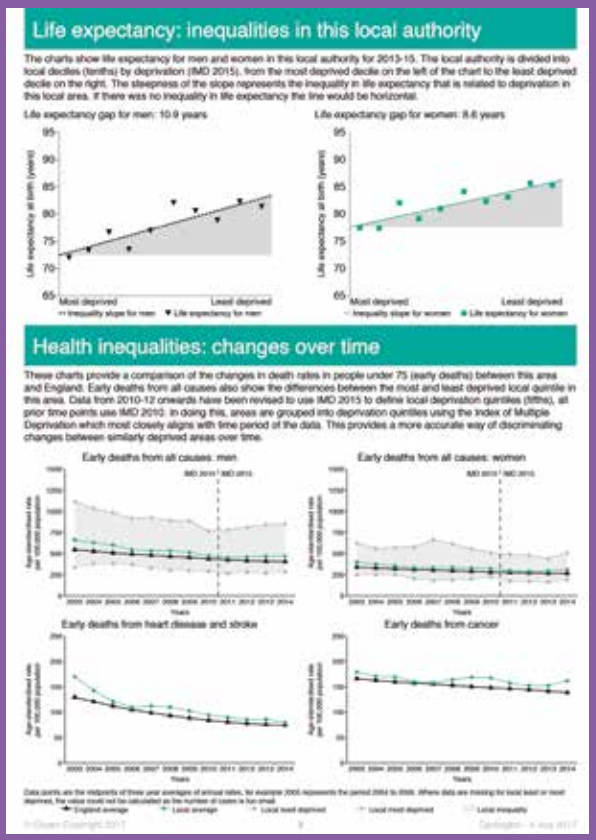
Darlington 2015 (Males) — England 2015
Darlington 2015 (Females) — Darlington 2020 estimate

Deprivation: a national view

The map shows differences in deprivation in this area based on national comparisons, using national quintiles (fifths) of the Index of Multiple Deprivation 2015 (IMD 2015), shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.

This chart shows the percentage of the population who live in areas at each level of deprivation.

Most deprived quintile — Least deprived quintile



Life expectancy: inequalities in this local authority

The charts show life expectancy for men and women in this local authority for 2013-15. The local authority is divided into local deciles (tenths) by deprivation (IMD 2015), from the most deprived decile on the left of the chart to the least deprived decile on the right. The steepness of the slope represents the inequality in life expectancy that is related to deprivation in this local area. If there was no inequality in life expectancy the line would be horizontal.

Life expectancy gap for men: 10.9 years

Life expectancy gap for women: 8.6 years

Life expectancy at birth (years)

Most deprived — Least deprived

Inequality slope for men — Life expectancy for men

Inequality slope for women — Life expectancy for women

Health inequalities: changes over time

These charts provide a comparison of the changes in death rates in people under 75 (early deaths) between this area and England. Early deaths from all causes also show the differences between the most and least deprived local quintile in this area. Data from 2010-12 onwards have been revised to use IMD 2015 to define local deprivation quintiles (fifths), all prior time points use IMD 2010. In doing this, areas are grouped into deprivation quintiles using the Index of Multiple Deprivation which most closely aligns with time period of the data. This provides a more accurate way of discriminating changes between similarly deprived areas over time.

Early deaths from all causes: men

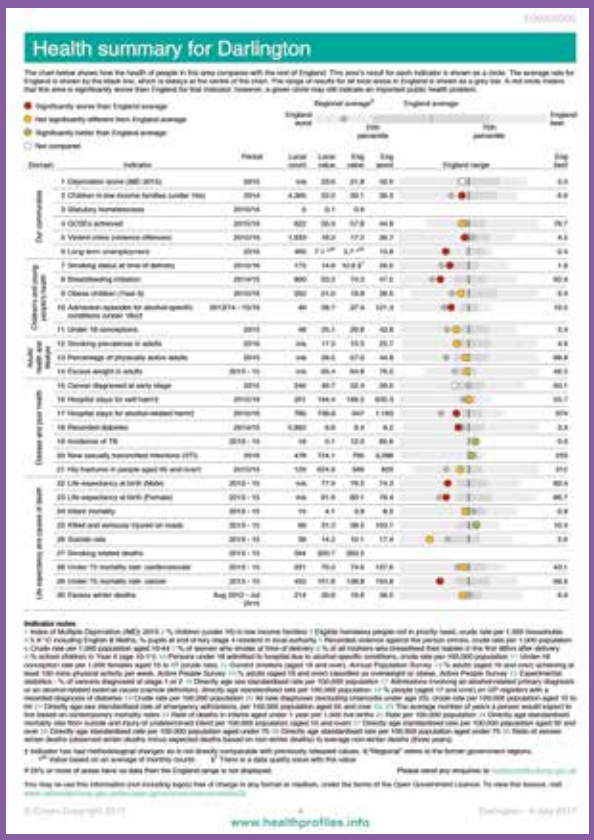
Early deaths from all causes: women

Early deaths from heart disease and stroke

Early deaths from cancer

Years

England average — Least deprived — Most deprived — Inequality



Health summary for Darlington

Significantly worse than England average
Not significantly different from England average
Significantly better than England average
Not compared

Regional average — England average — England best

Domain	Indicator	Period	Local count	Local value	Eng value	Eng worst	England range	Eng best
Our communities	1 Deprivation score (IMD 2015)	2015	n/a	23.0	21.8	42.4		0.4
	2 Children in low income families (under 16s)	2014	4,395	22.0	20.1	39.3		6.9
	3 Statutory homelessness	2015/16	0	0.1	0.9			
	4 GCSEs achieved	2015/16	622	55.5	57.8	44.8		79.7
	5 Violent crime (violence offences)	2015/16	1,533	16.2	17.2	38.7		4.5
	6 Long term unemployment	2015	460	2.1 (1.9, 2.3)	2.7 (2.7, 2.7)	13.8		0.4
Children's and young people's health	7 Smoking status at time of delivery	2015/16	170	14.9	10.8 (10.7, 10.9)	29.5		1.9
	8 Breastfeeding initiation	2014/15	800	53.3	74.5	47.3		92.9
	9 Obese children (Year 6)	2015/16	252	21.0	19.8	28.5		5.4
	10 Admission episodes for alcohol-specific conditions (under 18s)*	2012/13 - 15/16	49	59.7	37.4	121.3		10.5
	11 Under 18 conceptions	2015	46	25.1	20.8	42.8		5.4
Adults' health and lifestyles	12 Smoking prevalence in adults	2015	n/a	17.3	15.5	25.7		4.9
	13 Percentage of physically active adults	2015	n/a	59.5	57.0	44.8		66.8
	14 Excess weight in adults	2013 - 15	n/a	65.4	64.8	76.2		48.3
Disease and poor health	15 Cancer diagnosed at early stage	2015	346	49.7	52.4	28.0		63.1
	16 Hospital stays for self-harm	2015/16	251	194.4	189.3	630.3		65.7
	17 Hospital stays for alcohol-related harm*	2015/16	765	700.9	647	1,160		374
	18 Recorded diabetes	2014/15	6,800	6.8	6.4	9.2		3.9
	19 Incidence of TB	2013 - 15	19	9.1	12.5	80.4		0.4
	20 New sexually transmitted infections (STI)	2015	476	734.1	790	2,268		233
	21 Hip fractures in people aged 65 and over	2015/16	129	624.9	589	820		312
Life expectancy and causes of death	22 Life expectancy at birth (Male)	2013 - 15	n/a	77.9	79.5	74.2		82.4
	23 Life expectancy at birth (Female)	2013 - 15	n/a	81.9	83.1	78.4		86.7
	24 Infant mortality	2013 - 15	15	4.1	3.9	8.2		0.9
	25 Killed and seriously injured on roads	2015 - 17	66	31.3	39.6	103.7		10.9
	26 Suicide rate	2013 - 15	39	14.2	10.1	17.4		5.6
	27 Smoking related deaths	2014 - 15	594	300.7	289.9			
	28 Under 75 mortality rate: cardiovascular	2014 - 16	221	75.3	74.6	137.6		43.1
	29 Under 75 mortality rate: cancer	2014 - 16	432	151.8	138.8	193.8		98.9
	30 Excess winter deaths	Aug 2012 - Jul 2015	214	20.6	15.8	36.0		6.8

www.healthprofiles.info

1. Deprivation

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

Life expectancy at birth :

• 2013-2015

Men 77.9 years **Women** 81.9 years

• 2014-2016

Men 78.2 years **Women** 82.1 years

2. Inequalities in life expectancy at birth

The size of the gap in life expectancy within Darlington is:

• 2013-2015

Men 10.9 years **Women** 8.6 years

• 2014-2016

Men 11.7 years **Women** 8.5 years

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

Trend over time in premature death rate

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

Inequalities in premature death rate

• The gap is narrowing between Darlington and England both for men and women.

• The gap is narrowing between the poorest and richest groups in Darlington for women but not for men.

4. Overview of routinely available annual indicators

When compared with the other local authorities in Tees Valley in 2017, Darlington has:

• The lowest number of red indicators (11).

• The highest number of amber indicators (12) making it the most similar local district to England.

5. Priorities to reduce inequalities in health and wellbeing

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

a) Employment and regeneration

• Deprivation

• Long-term unemployment

b) Maternal and child health

• Smoking status of mothers during pregnancy

• Breastfeeding initiation at birth

c) Adult nutrition and misuse of alcohol and drugs

• Poor adult nutrition (and the implications for higher rates of obesity, diabetes and blood pressure)

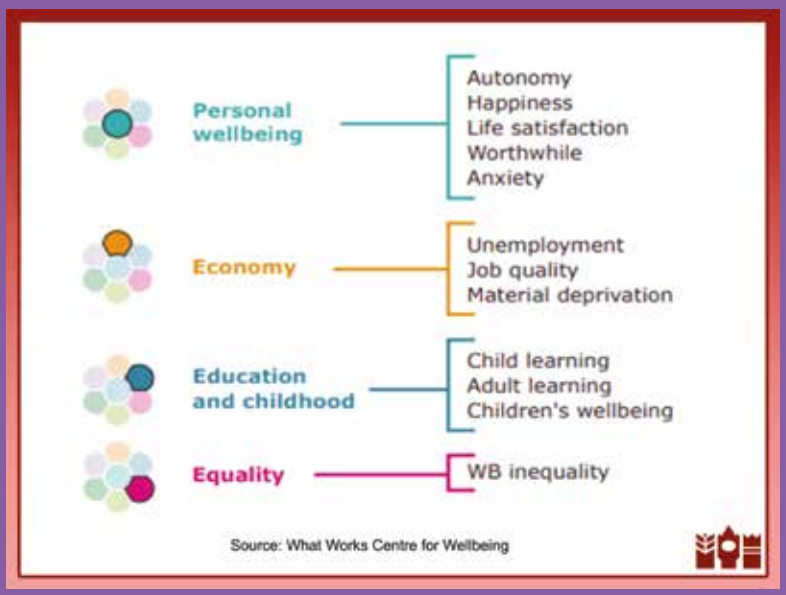
• Hospitalisation for harm caused by excess alcohol consumption

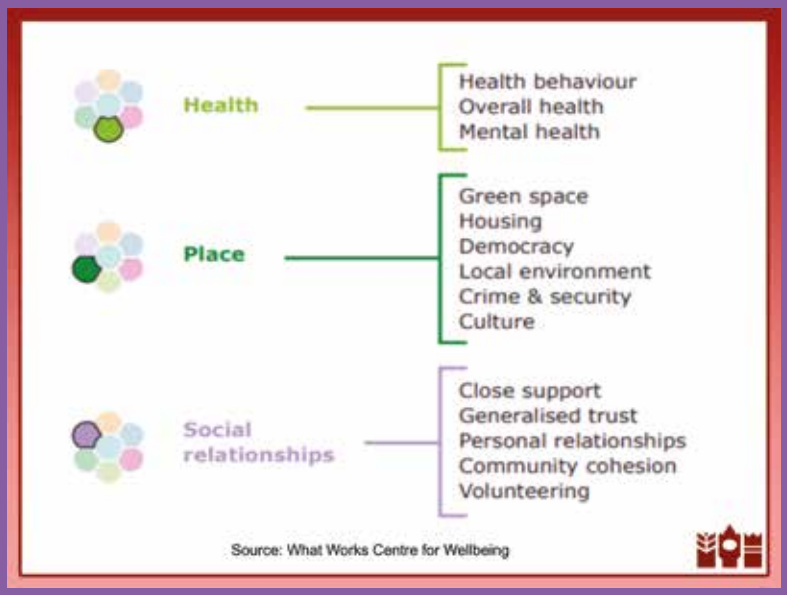
• Drug misuse

d) Mental health

• Hospitalisation for self-har

Appendix 4 : Measuring Inequality : Local Framework for Wellbeing





Appendix 5 : Emergency Hospital Admissions

	Emergency hospital admissions (all causes)	CHD	COPD	MI	CVA	IMD
Bank Top & Lascelles	155.9	146.6	192.7	168.5	130.3	38.1
Brinkburn & Faverdale	114.1	96	122.7	114	104.6	12
Cockerton	127.8	120.2	162.8	142.8	118.8	33
College	94.7	72.4	55.7	87.4	81.1	6.8
Eastbourne	139	137.2	193.7	163.7	115.4	28.6
Harrowgate Hill	108.1	105.6	97.1	129.5	100.1	12.6
Haughton & Springfield	132.5	109.9	95.4	130.2	126	26.3
Heighington & Coniscliffe	97.6	67.1	74.4	79.1	85.9	10.6
Hummersknott	82.5	85.8	52.6	110.6	80.4	5.2
Hurworth	92.5	81.6	44	104.5	72.1	12.1
Mowden	82.5	85.8	52.6	110.6	80.4	4.7
North Road	145.6	143.7	212.2	161.3	122.4	37
Northgate	160	170.8	168.9	215.1	129.1	39.4
Park East	139.8	104.3	156.8	115.4	137.2	47.6
Park West	97.1	80.2	69	97.4	89.2	13.4
Pierremont	123.9	124.3	87.1	152.7	108.4	21.8
Red Hall & Lingfield	129.8	123.9	144.9	157.9	133.3	37
Sadberge & Middleton St George	93.6	78.7	50.1	99.5	74.7	11.5
Stephenson	132.9	126.4	150.1	159.1	133	32.5
Whinfield	104.6	72.9	70.5	77.8	96.9	17.5
Darlington	120.1	106.8	113.6	128.2	106.2	23.6
England	100	100	100	100	100	21.8

Appendix 6 : Wellbeing Indicators

Domain	Period	Darlington	North East	England
Children in low income families (all dependent children under 20)	2014	21.4 (3/12)	24.3	19.9
Children in low income families (under 16s)	2014	22.0 (3/12)	24.9	20.1
School readiness: the % of children achieving a good level of development at the end of reception	2016/17	72.2 (2/12)	70.7	70.7
School readiness: the % of children with free school meal status achieving a good level of development at the end of reception	2016/17	61.4 (1/12)	57.7	56.0
School readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check	2016/17	85.0 (J1/12)	82.2	81.1
School readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	2016/17	79.0 (1/12)	70.1	68.4
Pupil absence (% of half days missed)	2015/16	4.91 (10/12)	4.73	4.57
GCSE achieved 5 A*-C incl. English and Maths	2015/16	55.9 (7/12)	56.5	57.8
GCSE achieved 5 A*-C incl. English and Maths with FSM status	2014/15	24.7 (12/12)	30.5	33.3
First time entrants to the youth justice system (10-17 year olds per 100,000 population)	2016	319.2 (4/12)	409.8	327.1
16-17 year olds NEET or whose activity is not known	2016	4.3 (2/12)	5.4	6.0
LBW of term babies	2016	3.4 (J10/12)	3.0	2.8
BF initiation	2016/17	?	59.0	74.5
BF prevalence at 6-8 weeks after birth	2016/17	34.3 (5/10)	31.4	44.4
Smoking status at time of delivery	2016/17	16.2 (7/12)	16.1	10.7
Under 18 conceptions (rate per 1000)	2015	25.1 (4/12)	28.0	20.8
Under 18 conceptions: conceptions in those aged under 16 (rate per 1000)	2015	5.8 (5/12)	6.2	3.7
Proportion of children aged 2-2.5 years offered ASQ-3 as part of the Healthy Child Programme or integrated review	2016/17	87.9 (10/12)	93.1	89.4
Child excess weight in 4-5 year olds	2016/17	25.0 (9/12)	24.5	22.6
Child excess weight in 10-11 year olds	2016/17	36.7 (4/12)	37.3	34.2
Proportion meeting the recommended 5-a-day at age 15	2014/15	44.6 (9/12)	46.8	52.4
Hospital admissions caused by unintentional and deliberate injuries in children (0-14 years rate per 10,000)	2016/17	166.5 (10/12)	146.4	101.5
Hospital admissions caused by unintentional and deliberate injuries in children (0-4 years rate per 10,000)	2016/17	233.1 (11/12)	182.4	126.3
Hospital admissions caused by unintentional and deliberate injuries in young people (15-24 years rate per 10,000)	2016/17	185.8 (12/12)	151.5	129.2
Average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on 31st March	2015/16	14.3 (5/12)	14.5	14.0

% of children aged 5-16 who have been in care for at least 12 months on 31st March whose score in the SDQ indicates cause for concern	2015/16	37.8 (4/12)	40.3	37.8
Smoking prevalence at age 15 – current smokers	2014/15	9.0 (4/12)	10.1	8.2
Smoking prevalence at age 15 – regular smokers	2014/15	6.8 (5/12)	7.5	5.5
Smoking prevalence at age 15 – occasional smokers	2014/15	2.2 (3/12)	2.6	2.7
Infant mortality (rate of deaths in infants aged under 1 year per 1000 live births)	2014-16	3.3 (7/12)	3.7	3.9
Proportion of five year old children free from dental decay	2014/15	64.6 (9/12)	72.0	75.2

Appendix 7 : Data for Premature Mortality

Ward level data indicates that premature death is more common in less affluent areas.

	Older people in deprivation	Deaths from all causes, aged <75	Deaths from all cancer, aged <75	Deaths from all CVD, aged <75	Deaths from all CHD, aged <75
Bank Top & Lascelles	30.8	182.4	176.4	234	206.6
Brinkburn & Faverdale	12.4	90.6	107.3	99.2	91.5
Cockerton	27.6	144.7	151	155.1	137.8
College	9.3	99.3	78	109	92.8
Eastbourne	23.6	126.8	107.2	117.6	128.4
Harrowgate Hill	13.4	77.7	82.1	85.9	87.4
Haughton & Springfield	23.8	147.7	140.8	149.2	116.1
Heighington & Coniscliffe	7	79.1	79.2	79.8	83
Hummersknott	8.1	64	69	36.8	33.4
Hurworth	8.4	59	85.2	55.3	62.7
Mowden	6.3	56.5	77.1	29.6	43.3
North Road	30.9	157.4	144	141.1	133.8
Northgate	25.8	155.3	138.2	236.6	133.4
Park East	32.7	161.2	122	178.4	159.7
Park West	8.5	68.9	82.6	43	33.6
Pierremont	14.8	93.5	125.9	28.6	31.5
Red Hall & Lingfield	22.5	97.4	84.2	87.2	79.8
Sadberge & Middleton St George	10	95.8	112.2	67.4	81.5
Stephenson	22.5	160.6	105.4	179.9	206.3
Whinfield	13.3	99.3	128.9	88	90.5
Darlington	17.6	113.3	112.4	110.8	103.5
England	16.2	100	100	100	100

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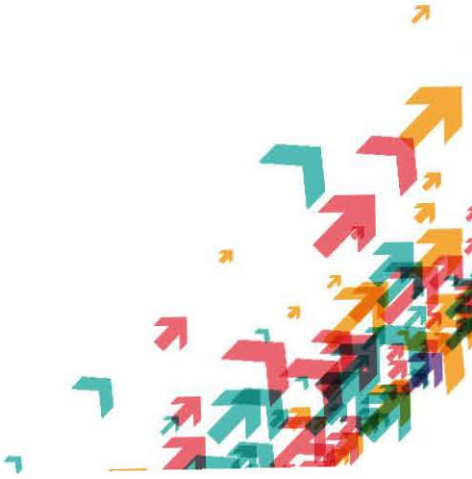

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