Director of Public Health

Annual Report 2005

involving people
improving health
INTRODUCTION

I am pleased to present my second annual report of the Director of Public Health for Middlesbrough Primary Care Trust. In my first report (2003-2004) I highlighted the key factors that influence and often determine the health of people living in Middlesbrough and Eston as well as describe some of the actions we are taking to address these determinants.

Since my previous report, I am pleased to announce that Middlesbrough Primary Care Trust and Middlesbrough Council have developed a joint public health strategy to tackle the main underlying health determinants of people living in our area. I have therefore taken the step to use my annual report to publish this joint Public Health Strategy.

The purpose of the strategy is to set out the broad aims and objectives around nine specific areas that, if achieved, will contribute to a substantial improvement in the health and a significant reduction in the health inequalities of people living in Middlesbrough.

There are already existing plans and structures in place that will contribute to the broad aims of this strategy. For example, Middlesbrough Primary Care Trust has published its Business Plan, Middlesbrough Council its Corporate Performance Plan, and the Middlesbrough Local Strategic Partnership has published its Community Strategy. Each of these strategic documents includes specific actions that each organisation is planning to take to improve the health of people living in Middlesbrough. There are also many other plans and activities taking place locally that will contribute towards the broad aims of this public health strategy. So, whilst this public health strategy will highlight what is already included in these other plans, the purpose of producing a document such as this is to highlight and summarise the important work that is taking place, describe how it will contribute to the broad aims of this strategy and make all this accessible to the people of Middlesbrough.

The strategy focuses on many individual and behavioural determinants of ill health. This approach is consistent with the current public health white paper, Choosing Health, and also links into the Mayor’s priority reduction areas of which alcohol abuse, fatty food, stress related illness, heart disease, stroke, obesity, smoking and road traffic accidents are particularly relevant here.

Many of the specific aims included in this strategy are based around national targets. Many of the national targets run until 2010. We have extended these locally to 2015. Given the greater burden of ill health in Middlesbrough compared with the national average, we need to achieve over and above these national targets if the health of people in Middlesbrough is to become more like the national average. Thus the national targets have been ‘stretched’ to take into account the health-gap between the Middlesbrough average and the average for England and Wales. This means, in health terms, we must improve at a faster
rate compared with the rest of the country if we are to make progress in reducing the substantial ‘health gap’ that exists between Middlesbrough and the rest of the country. With these challenges ahead, in June 2005 the Primary Care Trust agreed a £3m public health investment plan to support the objectives of this public health strategy.

The priority funding areas that Middlesbrough PCT has agreed over the next 3 years are shown in Tables 1 and 2 on the following pages. These are the investment areas that the PCT believes should receive priority funding and that will contribute to the greatest health gain across the whole population.

Public Consultation
Two public consultation events were held in June 2005 and attended by almost 100 people. Participants at the events were divided into groups based on the themed areas contained within this strategy. Groups were then asked to prioritise a series of interventions, focused around the themed area, using a fixed and nominal resource of £1000. Groups were also able to suggest further interventions to be included in this priority setting exercise. This exercise was repeated eight times, with different groups for each themed area, and the result combined.

The interventions considered to be of highest priority are described within this document. An electronic questionnaire survey was also conducted which elicited participants’ views on various aspects of public health policy. Where relevant, the results of this survey are included within the text. Public opinion such as this should be taken into account when planning services and allocating resources.

Some of these interventions and actions may already be included in other strategies. The purpose of highlighting them here is to bring particular attention to areas of activity that we feel will make a significant contribution to improving the overall health of the Middlesbrough population. An appendix has been included that describes the breadth of current work that is taking place under each theme.

And Finally
The information presented in this report relates to the boundaries of Middlesbrough PCT. The Government’s Choosing Health white paper on public health stipulated that each year a limited factual report on the health status of communities within local government boundaries would be produced in a single format for data from 2005 onwards. However, this more detailed report covers the period 2004-06 as a formal DPH report and also includes our strategy for improving health in Middlesbrough. The NHS is undergoing rapid change and the publication of this strategy to improve the health in Middlesbrough is important and will hopefully provide a sense of continuity and direction for the future.

I would like to thank the many people who have helped to produce this document. In particular I wish to acknowledge my gratitude to Dr Mark Reilly, Public Health Specialist, and his team for the excellent information upon which much of this report is based and also Dr Peter Heywood, Consultant in Public Health Medicine, for his excellent work in overseeing the production of the report and the public health strategy.

Table 1. Recurring Funding 2005–2008

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Table 2. Non-Recurring Funding 2005–2008

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4. Tackling Health Inequalities

4.1 National and Local Context

Collectively, the people of Britain are healthier now than at any other point in history. We are living longer and have more years of good health than ever before. The same can be said of the people of Middlesbrough. However, despite this excellent progress in recent decades, there are some important differences in the health of individuals and populations. So whilst the overall health has been improving, the health of the least and less well off has been improving more slowly than the rest of the population. In some cases, it has been getting worse. This is what we mean by health inequalities. Tackling the determinants or causes of health inequalities requires a different approach to simply tackling the determinants or causes of ill health.

Health is influenced by many factors including individual behaviour (the focus of much of this strategy document), access to health services as well as the wider determinants of health such as income, employment, housing and environmental factors. These determinants of health vary across a population depending on a person's social position within society (whether measured by socio-economic status, ethnicity, gender or sexuality). The result of this unequal distribution of health determinants is health inequality. Tackling health inequalities is therefore about tackling the unequal distribution of these health determinants within the population. It is about ensuring a fairer and more equal society, where people with the least access to resources and opportunities are able to enjoy the standard of living and the opportunities that many take for granted.

People living in material or social disadvantage are likely to have the greatest need for health and social services, are more likely to suffer from ill-health and die as a consequence of the disadvantage they experience. Middlesbrough experiences greater levels of deprivation compared with the national average, and as such experiences a greater burden of poor health within the population.

Whilst life expectancy continues to increase year on year, life expectancy for both men and women living in Middlesbrough is lower than the average for England & Wales. In Middlesbrough men can expect to live to age 73 and women to age 79 years. This compares with an England and Wales average of 75.7 years for men and 80.4 years for women. Men in Middlesbrough have some of the lowest life expectancies at birth of all populations in the Strategic Health Authority area. Low life expectancy is concentrated in the most deprived areas. Conversely, high life expectancy is concentrated in the least deprived areas. Mortality from common diseases is significantly greater in people living in Middlesbrough compared with the England average. For example deaths from lung cancer is 50% greater, deaths from colorectal cancer is 30% greater, deaths from circulatory disease is 16% greater, deaths from stroke is 12% greater, and deaths from suicide and undetermined deaths is 42% greater compared with the England average.

Dental disease remains a major public health problem in young children and an important example of inequalities in health. Despite overall improvements in oral health, probably due to the use of fluoridated toothpaste, better nutrition and improved dental services, tooth decay in younger children has not improved to the same extent. In fact in some instances it is getting slightly worse. In Middlesbrough PCT the average number of decayed, missing or filled teeth (dmft) in 5 year olds was 2.28 in 1999 but in the last survey in 2003 it was 2.38. The Middlesbrough figure is above the national average of 1.49 and did not meet the 2003 Department of Health target of 1.00. In addition, within Middlesbrough there are huge disparities in dental health between neighbourhoods. In five year old children in 2003/2004 the dmft in St Hilda’s was over three times higher than the dmft of children living in Brookfield.

The Index of Multiple Deprivation 2004 (IMD 2004)* is a comprehensive measure of deprivation. The IMD 2004 ranks Middlesbrough LA 11th out of 354 local authorities in the country for the proportion of the population living in the most deprived 10% of electoral wards in the country. For the Middlesbrough Council area, the IMD 2004 health and disability domain indicates that 14 electoral wards

*The Index of Multiple Deprivation 2004 is a commonly used and comprehensive measure of deprivation that enables the extent of deprivation to be quantified and compared with other areas on the basis of the geographical area in which people live. The index uses approximately 36 separate indicators of people’s experiences and outcomes covering seven key domain areas such as income; employment, health and disability, education, skills and training, housing and services; living environment; and crime.
Reducing inequalities in health is a major priority of the present government and highlighted in the recent white paper Choosing Health. National floor targets have incorporated targets to reduce inequalities in health (see below). Reducing inequalities in health is also one of the functions of Primary Care Trusts (PCTs) and therefore a priority. This is also reflected in Middlesbrough PCT’s business plan and local delivery plan.

4.2 Aim

To reduce the overall health differences between the least well off and the best off in Middlesbrough.

4.3 National Targets

4.3.1 Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between routine (non-manual) and manual groups and the population as a whole

4.3.2 Starting with local authorities, by 2010 to reduce by at least 10 per cent the gap between the fifth of areas with the lowest life expectancy at birth and the Middlesbrough population as a whole

4.4 Local Targets for Middlesbrough

4.4.1 To achieve an infant mortality rate that is not higher than the national average by 2010

4.4.2 To reduce the difference in age-specific mortality rate for all cancers, circulatory disease and stroke in adults under 75 between routine and manual groups and the population as a whole by 2015

4.4.3 To reduce by at least 15 per cent the gap between the fifth of areas with the lowest life expectancy at birth and the Middlesbrough population as a whole by 2015

4.4.4 To reach a consensus decision between Middlesbrough Council, Middlesbrough Primary Care Trust and other partners on the appropriate application of Health Impact Assessments for all major initiatives and policies taking place within the Middlesbrough area

4.5 Key delivery mechanisms

- Middlesbrough Primary Care Trust Local Delivery Plan and Business Plan
- Middlesbrough Council Service Plans
- Directorate of Health Improvement and Public Health, Middlesbrough PCT
- Middlesbrough Partnership Community Strategy
- Voluntary Sector Organisations (e.g. Stroke Association, Take Heart, Middlesbrough Voluntary Development Agency)
- Children and Young People’s Plan
- Neighbourhood Renewal Fund
- Older Housing Strategy
- Older Person’s Partnership
- Middlesbrough Council Scrutiny Function
- Home Energy Conservation Act Programme
- Local Agenda 21 Action Plan

4.6 Current and Future Actions

The appendix on page 30 describes a range of actions and activities taking place within Middlesbrough that will contribute towards reducing inequalities in health. Given the current health gap that exists between the Middlesbrough population and England and Wales as a whole, a wide range of ambitious, evidence-based policies and initiatives need to be developed and delivered. Many of the determinants of health inequalities are not directly health related such as educational attainment, economic wealth and employment. The Middlesbrough Partnership (and more specifically the Health Theme Group of the Partnership) will play a vital role in bringing together key stakeholders and organisations to develop and deliver such policies and initiatives. Evaluating local, regional and national policies will also be important. As well as developing and implementing policies and initiatives to improve the overall health of the Middlesbrough population, we need to ensure that specific policies are in place that will reduce health inequalities (by bringing the health of the poorest in society up to the level enjoyed by the majority) and that the current policies and initiatives are not contributing towards increasing health inequalities. The Middlesbrough Healthy Living Centre will play an important role here. In addition, greater use of Health Impact Assessments (HIA) and Health Equity Audits (HEA) should be encouraged in the evaluation of policies and initiatives.
This strategy focuses on many of the common behavioural determinants of health. It will be important therefore that all delivery mechanisms as well as current and future policies and initiatives, relating to these determinants, consider the impact of such policies and initiatives on health inequalities.

**Case Study 1: “Healthy Living in Middlesbrough” (Middlesbrough’s Healthy Living Centre)**

Middlesbrough’s Healthy Living Centre programme of projects is an excellent example of a locally based initiative targeted at disadvantaged areas with the aim of providing health information and opportunities to enable people to gain more control over their lives and find positive solutions to improve their own health. The Healthy Living in Middlesbrough projects focus on the health needs of young people and provide a wide range of innovative projects addressing many of the underlying determinants of poor health and health inequalities such as physical activity, dietary behaviour, mental health and wellbeing.

**Case Study 2. Improving Oral Health in Middlesbrough (Brushing for Life Scheme)**

This scheme is targeted to improve the oral health of the youngest children living in areas of social and economic deprivation. It aims to encourage parents to start brushing their children’s teeth as soon as they emerge in the mouth. Dental packs containing a toothbrush, fluoridated toothpaste and an information leaflet are distributed by Health Visitors to parents with children aged 8 months, 18 months and 36 months. National funding for this scheme was due to end in March 2006 however this scheme will now be rolled out to all parents with children under three years in Middlesbrough PCT.

### 4.7 Public Consultation

The public consultation event highlighted additional areas of intervention for consideration and/or priority funding. These will need to be carefully considered as part of any future action planning by the Directorate of Public Health and Health Improvement and the Middlesbrough Partnership. Areas for intervention that were considered to be the greatest priority by those attending the event were as follows (in order of priority):

- Practical parenting courses delivered in areas of greatest need
- Targeted outreach and education work in disadvantaged communities
- Improved quality of environment in disadvantaged areas
- Targeting the elderly in uptake of energy-efficiency measures, to reduce cold-related fatalities
- Promoting employment and training opportunities to increase the employment of Middlesbrough residents
- Water fluoridisation for every person living in Middlesbrough
- Addressing the health and social-care needs of the BME community

### 4.8 Survey

Housing and education are important determinants of health inequalities. Almost all participants agreed or strongly agreed that everybody in Middlesbrough should live in a warm, dry house by 2010. Furthermore, more than 80% of participants agreed or strongly agreed that money should be invested to ensure that every child leaves school with a qualification. Such results are perhaps unsurprising. Participants were also asked their views on the most appropriate methods to improve population health. The results highlighted the tension between reducing public choice (e.g. through public health legislative measures) and increasing choice (as demonstrated by the recent white paper Choosing Health). For example, more than 60% of participants agreed or strongly agreed that legislation should be used to reduce choice to improve overall population health. Subsequent questions showed that 86% of participants agreed or strongly agree that population health should be improved by helping people to make better choices and 56% of participants agreeing or strongly agreeing that people should be free to make unhealthy choices. No criticism should be levelled at those participating in the survey. The results do demonstrate the complex nature of some public health improvement approaches and perhaps the need for a broad range of approaches.
5. Reducing smoking prevalence and the harmful effects of tobacco

5.1 National and Local Context

Smoking is the single biggest cause of preventable death and disease in the UK and responsible for more than 120,000 deaths each year – equating to 328 deaths every day or 14 deaths every hour³. Smoking is also the principal reason for the inequalities in death rates between affluent and disadvantaged areas in the UK⁴.

For example, the North East Public Health Observatory has recently estimated that 33% of all premature deaths in the Tees Valley are attributable to smoking⁵. Reducing the number of people who smoke will reduce mortality and morbidity from coronary heart disease, lung cancer and stroke in particular and contribute to reducing inequalities in health.

The North East of England has the highest smoking rate in the country. Tobacco use remains the number one cause of preventable death and ill health in the region, with 15 people dying each day because of their smoking habit. Between 28% and 34% of adults in Middlesbrough smoke⁶ with the prevalence consistently above the national average. Using data from local and national surveys⁷, it is estimated that 200 million cigarettes are smoked by adults within the Middlesbrough PCT area each year at an annual cost of £46 million. This is equivalent to 0.5 million cigarettes smoked each day at a daily cost of £116,000.

Smoking is also patterned by socio-economic position, such that across many of the more socio-economic deprived wards in Middlesbrough, smoking prevalence amongst adults is still in the region of 40% to 50%. The burden of ill-health due to smoking is indicated by the higher death rates from lung cancer, circulatory disease and stroke as described in section 1.

Reducing smoking prevalence and the harmful effects of tobacco smoke is a government priority and highlighted in key documents such as Smoking Kills and more recently Choosing Health. Regionally and locally, there is much activity taking place through the Smoke Free North East initiative, the Smoke Less Middlesbrough Initiative and the Middlesbrough Tobacco Forum. Encouraging smokers to quit and achieving a smoke-free environment is therefore a priority.

5.2 Aims

5.2.1 To develop and implement a tobacco control strategy for Middlesbrough

5.2.2 To implement improvements in stop smoking initiatives to achieve significant reductions in the numbers of people smoking

5.2.3 To reduce the prevalence of smoking in areas of highest dependence as measured by the percentage differential

5.3 National Targets

5.3.1 To reduce the smoking prevalence in England to 21% by 2010

5.3.2 To achieve a 6% reduction in the proportion of mothers who continue to smoke during pregnancy by 2005/2006

5.4 Local Targets for Middlesbrough

5.4.1 To achieve a smoking prevalence across Middlesbrough that is equivalent to the national average by 2015

5.4.2 To ensure the ward with the highest smoking prevalence in Middlesbrough is no more than 10% above the average for Middlesbrough by 2015

5.4.3 All enclosed public places in Middlesbrough to be smoke-free by 2008 (subject to legal power available)

5.4.4 All confined public spaces (such as bus shelters, pavement cafes and stadia) to be smoke free by 2008 by promoting a voluntary commitment to a smoke-free environment in Middlesbrough

5.5 Key delivery mechanisms

- Smoke Free North East Partnership
- Middlesbrough Tobacco Control Forum
- Stop Smoking Services
- Smoke-less Middlesbrough Campaign
- Sure Start

¹ Estimated from the Tees Health & Lifestyle Survey 2000 and the Middlesbrough Town-wide Survey 2004
² Estimates using the Tees Health & Lifestyle Survey 2000 and extrapolating data from the Health Survey for England 2003
5.6 Current and Future Actions

The appendix describes a range of actions and activities taking place within Middlesbrough that will contribute towards reducing smoking prevalence and the harmful effects of tobacco. Given that smoking has such a significant impact on the health and health inequalities of people living in Middlesbrough, ambitious strategies will need to be developed and implemented. Good examples that require continued support are the work with Middlesbrough Football Club and the work of the Middlesbrough Tobacco Control Forum with local businesses (see Case Study 3). A further national example is the recent legislation to ban smoking in all enclosed public places. The evidence for the health benefit of banning smoking in all enclosed public places is compelling with recent data from New York and Ireland to support such an approach. Regional and local delivery mechanisms are essential for ensuring legislation is fully implemented and enforced. The majority of smokers (more than two-thirds) want to quit. Department of Health and Office for National Statistics. Statistics on smoking: England, 2003. London: Office for National Statistics and evidenced based initiatives such as this are welcome and will help smokers to quit whilst at the same time protecting those who do not smoke.

**Case Study 3: Action on Tobacco Control in Middlesbrough**

Middlesbrough PCT has been working closely with Middlesbrough Football Club to achieve a smoke-free environment. For the first time, during the 2005–6 football season, the Riverside Stadium will be entirely smoke-free.

The Middlesbrough Tobacco Control Forum (MTCF) has a key role in influencing public opinion, local businesses and policy makers. An example of good local practice is the promotion of the National Clean Air Awards by the MTCF whereby 60 businesses have been awarded the Mayor’s commendation award and are working towards a smoke-free working environment and 2 businesses have achieved silver awards.

5.7 Public Consultation

The public consultation event highlighted additional areas of intervention for consideration and/or priority funding. These will need to be considered as part of any future action planning by the Middlesbrough Tobacco Control Forum, Middlesbrough PCT Stop Smoking Services and the Smoke-less Middlesbrough campaign. Areas for intervention that were considered to be the greatest priority by those who attended the event were as follows (in order of priority):

- Smoking ban in public places with or without specific exemptions
- Increase the provision of local ‘Stop Smoking Services’
- Antenatal targeted anti-smoking interventions
- Mass media campaigns aimed at an adolescent audience
- Peer led school-based anti-smoking interventions
- Complete smoking ban in all workplaces and schools

5.8 Survey

Those participating in the survey felt strongly about the effects of second-hand smoke and the rights and responsibilities of smokers. The majority of participants (93%) felt that smokers should have the right to smoke but also the responsibility not to harm others. Almost all participants (97%) agreed or strongly agreed that no infant child or adult should be exposed to second-hand smoke. At the time of the survey, more than 70% of participants would prefer to see legislation introduced to ensure a complete smoking ban in all enclosed public places without exemptions.

6. Tackling obesity

6.1 National and Local Context

Obesity is the second biggest cause of preventable death and disease in the UK and if current trends continue, is likely to overtake smoking as the single biggest cause of preventable death. Preventing obesity will have a major effect on mortality and morbidity within the population. Physically active people have a 20–30% reduced risk of death and up to 50% reduced risk of coronary heart disease, stroke, cancer and type 2 diabetes. The costs of obesity are significant. It is estimated that the total cost of the consequences of obesity amounts to £2.6 billion with 18 million days of sickness attributed to obesity each year. Direct treatment costs to the NHS are estimated at £0.5 billion a year.

A commonly used measure to define obesity is the body mass index (BMI), defined as weight (kg)/height (m²). Adults with a BMI between 25–30 kg/m² are classified as overweight and those with a BMI greater than 30 kg/m² classified as obese. National surveys indicate that more and more adults are becoming obese and overweight. Currently, it is estimated that 65% of adult males and 55% of adult females are overweight or obese. Just under a quarter of adult men and women are obese. More worryingly, these trends are being seen among children.

To give some indication of the size of the problem locally, using data from local and national surveys, we would estimate that in order for the adult population of Middlesbrough PCT to lose enough weight to be within normal limits (BMI <25kg/m²) the population needs to lose approximately 700 tonnes in body weight.

National surveys indicate that between 1995 and 2003, the prevalence of obesity among children aged 2 to 10 rose from 9.9% to 13.7%. During the same period, the percentage of children aged 2 to 10 who were overweight (which also include those who were obese) rose from 22.7% to 27.7%. The North East of England also has the highest prevalence of obese children in England with an estimated 18.3% of children aged 2 to 10 being obese. During 2005, Middlesbrough PCT undertook a BMI survey involving all schools within the Middlesbrough PCT area. The results indicate that approximately 36% of children in Year 7 (11/12 year olds) and 28% of children in Year 10 (14/15 year olds) are obese or overweight. A fifth of all Year 7 children were obese.

The results therefore indicate that the prevalence of obesity and overweight in children living in Middlesbrough is substantially higher than the national average.

Obesity prevention is a key government priority and received a major focus within the recent white paper Choosing Health. For the first time, the government has set a national public service agreement target (PSA) for reducing obesity in childhood (see below). The PSA target is a shared government commitment between the Department of Health, Department of Transport and the Regions and the Department for Culture, Media and Sport. Obesity prevention has therefore become a cross-governmental priority and reflects the breadth of areas, policies and interventions that influence and determine obesity. Such wider environmental determinants need to be considered as part of an overall strategy for tackling obesity.

In 2004, Middlesbrough PCT published its first obesity strategy and is working in partnership with a number of other organisations to prevent and treat obesity within the Middlesbrough PCT population. Other local plans will also play a key role in preventing obesity such as Middlesbrough Council’s Active Middlesbrough Plan, Local Transport Plan and Open Spaces Strategy.

6.2 Aim

Through the implementation of the obesity strategy, achieve a planned reduction in the prevalence of obesity among adults and children living in Middlesbrough through initiatives which encourage physical activity and a healthy diet.

*The precise methods for defining obesity in children are different compared with adults. For the purposes of this report overweight and obesity are defined as having an age-sex specific BMI greater than the 85th and 95th centiles of the 1990 UK reference population respectively.

6.3 National Target
Halt the year on year rise in obesity in children under the age of 11.

6.4 Local Targets for Middlesbrough
6.4.1 To ensure that the prevalence of obesity in children under the age of 11 is no greater than the national average rate by 2015
6.4.2 To reduce by 50% the prevalence of obesity among children under the age of 11 (using the Middlesbrough PCT height and weight survey (2005) in Year 7 children as baseline) by 2015
6.4.3 To reduce the prevalence of obesity among adults aged 16 to 75 to 20% by 2015 (using the Tees Health & Lifestyle (2000) survey as baseline)
6.4.4 To enable 70% of population to be physically active by 2020 (5 x 30 minutes per week)

6.5 Key delivery mechanisms
- Directorate of Health Improvement and Public Health
- Middlesbrough Council Service Plans
- Middlesbrough Partnership
- Obesity Strategy Group & Childhood subgroup
- Healthy Schools Programme
- General Practice
- Sure Start
- Local Transport Plan & Middlesbrough Cycling Strategy
- Healthy Living Centre

6.6 Current and Future Actions
The appendix describes a range of actions and activities taking place within Middlesbrough that will contribute towards preventing obesity. The membership of the obesity strategy group includes partners from all the key organisations who have a major role in contributing to a reduction in obesity. The strategy group will continue to develop interventions and services in line with national recommendations, evidence and local need. Many of the Healthy Living Centre initiatives contribute towards tackling obesity and encouraging physical activity and a good diet such as the ‘Kidz Power’ project, the Healthy Eating & Mentoring Project and the Community Centre Activities. The PCT has already undertaken a pilot BMI surveillance programme in school children. The continuing surveillance of obesity in children will now be a requirement for all PCTs and is essential for monitoring trends over time in obesity and the effectiveness of local policy initiatives or interventions. The PCT, with its partners, will look to develop on-going BMI surveillance in line with national guidance. Addressing the broader, environmental determinants of obesity that influence dietary and physical activity behaviours within the Middlesbrough population will be an important role of the Obesity Strategy Group.

Case Study 3: Free Swimming in Middlesbrough
For the second year running, Middlesbrough PCT has provided funding to enable all children and young people under 16 to enjoy free swimming at four separate locations within the PCT area during the summer holidays. This innovative project has been supported by Middlesbrough Council, Tees Valley Leisure and Redcar & Cleveland Partnership. A recent evaluation has demonstrated the project to be immensely successful and welcomed by children, young people, parents and teachers. Discouraging sedentary behaviour is possibly one of the most important types of intervention to tackle childhood obesity. Encouraging and ‘normalising’ physical activity in this way will make an important contribution towards reducing childhood obesity.
6.7 Public Consultation

The public consultation event highlighted additional areas of intervention for consideration and/or priority funding. These will need to be considered as part of any future action planning by the Obesity Strategy Group. Areas for intervention that were considered to be the greatest priority by those who attended were as follows (in order of priority):

- Multifaceted school-based interventions
- Safe play areas for children in every residential area in Middlesbrough
- Non-commercial vending machines in schools
- Improve access to services for weight management, healthy foods and family orientated leisure
- Free swimming
- Challenge the marketing of unhealthy food
- Mandatory physical exercise in schools

6.8 Survey

Those participating in the survey were asked their views about two potential interventions to encourage physical activity. The majority of participants (93%) agreed or strongly agreed that all children should be allowed free entry to all swimming baths during school holidays. As a way of encouraging further physical activity, participants were asked whether parking should be restricted within 400 yards of a school to ensure parents and children walk at least 1/2 mile a day when using the car. Almost two-thirds (64%) of participants agreed or strongly agreed that such measures should be introduced. Whilst such a measure should be considered, it may not be practical or possible. However, public opinion such as this does highlight the need to think creatively or even radically at the broader environmental measures that could be introduced to encourage greater physical activity for everyone.

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7. Reducing teenage pregnancies

7.1 National and Local Context

The UK has the highest rate of teenage pregnancies in Western Europe. During 2000 in England, 39,000 under 18 year olds became pregnant with 45% of these pregnancies ending in legal abortion. In the same year there were approximately 8000 conceptions to under 16s, with 55% of these pregnancies ending in legal abortion.

The consequences of teenage pregnancy are enormous. Teenage mothers are less likely to finish their education and more likely to end up as single parents bringing their children up in poverty. There are large differences in the teenage pregnancy rate between young women from different socio-economic groups. Girls and young women from the lowest socio-economic groups have almost 10 times the risk of becoming teenage mothers compared with girls and young women from the highest socio-economic groups. Young people with below average achievement levels at ages 7 and 16 have significantly higher risk of becoming teenage parents.

Teenage pregnancy has a significant and negative impact on education and employment opportunities and the infant mortality in children of teenage parents is 60% higher than for babies born to older mothers. For the Middlesbrough Council area, the under 18 conception rate is 38% greater than the national average and the under 16 conception rate is 46% greater than the national average (2002 data).

The National Teenage Pregnancy Unit was established in 1999 as a cross-government unit with the purpose of implementing the Social Exclusion Unit’s report on Teenage Pregnancy. Two national targets were published in 1999 (see below) – one of which (teenage pregnancy reduction target) is held jointly between the Department of Health and the Department for Education and Skills and is also a national PSA for local government. Locally, a Teenage Pregnancy Strategy for Middlesbrough was published in 2001. The Middlesbrough Teenage Pregnancy Strategic Partnership Board is responsible for implementing the strategy and action plan through its planning group.

7.2 Aim

To achieve a reduction in teenage pregnancies through the implementation of the Middlesbrough Teenage Pregnancy Strategy.

7.3 National Targets

7.3.1 Halve the under 18 conception rate in England by 2010

7.3.2 Increase the participation of teenage mothers in education, training or work to 60% by 2010 to reduce the risk of long term social exclusion.

7.4 Local Targets for Middlesbrough

7.4.1 To reduce the under 18 conception rate in Middlesbrough from the 2003 baseline of 57.9 per 1000 females aged 15–17 to no more than 5% above the national average by 2015

7.4.2 To reduce the under 16 conception rate in Middlesbrough from the 2002 baseline of 11.5 per 1000 females aged 13–15 to no more than 5% above the national average by 2015

7.4.3 To reduce the differential conception rate between wards such that the under 18 conception rate in the ward with the highest rate is no more than double the rate of the ward with the lowest rate by 2015

7.5 Key delivery mechanism

- Middlesbrough Teenage Pregnancy Strategy Partnership Board and Planning Group
- Middlesbrough Partnership
7.6 Current and Future Actions

The appendix describes a range of actions and activities taking place within Middlesbrough that will contribute towards reducing teenage pregnancy. The Middlesbrough Teenage Pregnancy Strategy Partnership Board has produced an action plan (2001-2011), which is continuously updated, and describes the specific interventions and initiatives. An analysis of aggregated ward level data (2000-2002) by the Middlesbrough Teenage Pregnancy Strategy Planning Group identified that 50% of <18 conceptions occurred in seven wards and 70% in ten wards. All of these wards were in the fifth most deprived wards in Middlesbrough. Targeted community based interventions are being implemented and prioritised in these areas in particular. A vast array of initiatives are on-going in a wide variety of settings and with different population groups (e.g. working with schools, teachers, parents, community groups, Sure Start programmes, BME community groups, contraceptive and sexual health clinics, antenatal and postnatal services etc). The Raising Hope campaign led by the Mayor of Middlesbrough will also have an important impact on the wider determinants of teenage pregnancies in the longer term by increasing educational attainment and creating greater opportunities for children and young people to achieve their ambitions in the future.

7.7 Public Consultation

The public consultation event highlighted additional areas of intervention for consideration and/or priority funding. These will need to be considered as part of any future action planning by the Middlesbrough Teenage Pregnancy Strategy Partnership Board and Planning Group. Areas for intervention that were considered to be the greatest priority by those who attended were as follows (in order of priority):

- Improved school based sex education
- Youth development programmes
- Improved sexual health and family planning services
- Community based education programmes in youth clubs
- Sexual health education introduced into primary schools
- Programmes to help parents talk about sex with their children
8. Improving sexual health

Sexually transmitted infections (STIs) are an important public health problem that threatens the health and fertility of both men and women. Over the last 10 years, the diagnoses of genital chlamydia have doubled and chlamydia infection rates in both men and women are as high as 12-15% in some studies. Furthermore, the rate of chlamydia infection in young men is now the same as the infection rate in young women. The economic, social and psychological consequences of sexually transmitted infections are significant.

The government is committed to improving sexual health as highlighted in Choosing Health and the National Strategy for Sexual Health and HIV (Human Immunodeficiency Virus). Locally, the South Tees Sexual Health Strategy as well as the Teenage Pregnancy Strategy and the Healthy Schools Programme will have an important role to play in improving the sexual health of adults and young people.

8.2 Aim

To improve the sexual health and reduce the prevalence of sexually transmitted infections among adults and young people living in Middlesbrough through the actions identified in the South Tees Sexual Health Strategy.

8.3 National Targets

8.3.1 To reduce by 25% the number of newly acquired HIV infections and gonorrhoea infections by the end of 2007

8.3.2 All Genito-Urinary Medicine (GUM) clinic attendees to be offered an HIV test at their first screening for STIs with a view to increasing uptake to 60% by end 2007

8.3.3 Reducing by 50% the number of previously undiagnosed HIV infected people attending GUM clinics who remain unaware of their infection after their visit by the end of 2007

8.3.4 Increase uptake of 1st dose of hepatitis B vaccine in identified high-risk groups to 90% by end 2006

8.3.5 Increase uptake of all 3 doses of hepatitis B vaccine to 70% by end 2006

8.4 Local Targets

8.4.1 All national targets (above) have been adopted locally

8.4.2 Implement recommendations from the review of Tees GUM service by March 2006

8.4.3 Ensure that all women requesting a termination of pregnancy and meeting the legal requirements are admitted to hospital within 3 weeks of the first appointment with the GP or referring doctor

8.4.4 Establish a local Chlamydia screening programme by 2008

8.4.5 Implement National Institute for Health and Clinical Excellence (NICE) guidelines on long acting reversible methods of contraception

8.5 Key delivery mechanism

- South Tees Sexual Health Strategy
8.6 Current and Future Actions

The South Tees Sexual Health Strategy Group continues to review progress towards the local targets. In addition, the group is in the process of rolling out the National Chlamydia Screening programme across Teesside. The programme will be run as an opportunistic screening programme but if successful, should make a significant contribution to reducing infection rates of genital Chlamydia – now the most common sexually transmitted infection in the UK. A successful programme will therefore reduce the number of women with pelvic inflammatory disease, ectopic pregnancy and sub-fertility. Appendix 1 describes further actions and activities taking place within Middlesbrough that will contribute towards improving sexual health within the Middlesbrough population. Other areas of work via the South Tees Sexual Health Strategy Group that are worthy of note include the following:

- Needs Assessment of adult survivors of sexual abuse. An assessment of current service provision has been undertaken, service gaps have been identified and a business case is being prepared to develop local services
- Teesside Sexual Health Referral Centre (SARC). Middlesbrough PCT has contributed funding towards establishing a Sexual Assault Referral Centre (SARC) on Teesside. The centre is due to open in February/March 2006

8.7 Public Consultation

The public consultation event highlighted additional areas of intervention for consideration and/or priority funding. These will need to be considered as part of the current action planning by the South Tees Sexual Health Strategy Group and are described in the previous section (Reducing Teenage Pregnancies).
9. Encouraging sensible drinking

9.1 National and Local Context

Alcohol misuse is responsible for up to 22,000 premature deaths each year in England. Of these, alcohol misuse is an important determinant in up to 1000 suicides each year. The costs to the NHS are significant – alcohol misuse is responsible for 1 in 26 NHS bed days, 40% of all A&E admissions (70% at peak times) and a total cost to the health service estimated at £1.7 billion each year. The Prime Minister’s Strategy Unit now estimates that alcohol misuse costs around £20 billion each year with the costs of crime and anti-social behaviour estimated at £7.3 billion.

The social consequences resulting from binge and chronic drinking are well recognised. In England each year, there are approximately 1.2 million violent incidents related to the misuse of alcohol – around half of all violent crimes. About a third of all domestic violent incidents (360,000 per year) are linked to alcohol misuse. Approximately 17 million working days are lost through alcohol related absence with an annual cost of productivity lost estimated at £6.4 billion.

Alcohol use is increasing among young people and particularly binge drinking. Young people are drinking twice as much today as they did ten years ago. In 2003, an estimated 49% of 15 year olds had drunk alcohol in the week prior to interview. Whilst there is no clear consensus on the precise definition of binge drinking, the definition of ‘heavy drinking’ used by the Office for National Statistics (ONS) is commonly used as a proxy measure for binge drinking. The ONS defines ‘heavy’ drinking as eight or more units for men and six or more units for women on at least one day in the week.

Using regional and national data sets, Middlesbrough’s adults drink approximately 50 million pints of alcohol (or equivalent) each year. This is equivalent to 26 million litres or 5.5 million gallons each year. Using the proxy definition of binge drinking as those who drink more than twice the daily recommended amounts on at least one occasion in the week, we would estimate that there are more than 40,000 binge drinkers in Middlesbrough. On the ‘heaviest drinking day of the week’, Middlesbrough’s adults drink almost 400,000 pints of alcohol.

The social benefits of moderate alcohol consumption are well recognised – it encourages socialising and it is enjoyable and relaxing. Moderate alcohol consumption also reduces the risk of death from coronary heart disease and ischaemic stroke for adults over 40 years. Alcohol consumption is quite different from smoking for example (where there is no safe limit) and moderate consumption should continue and be encouraged. However, there are too many young people and adults in Middlesbrough who are consuming alcohol in a way that it is having a detrimental impact on themselves, their families and their communities.

The national Alcohol Harm Reduction Strategy for England was published in March 2004 and describes strategic actions under four key areas (see below). The government’s commitment to tackling alcohol related problems was re-iterated in Choosing Health with a commitment to; support the implementation of guidance and training for all health professionals in identifying alcohol related problems; pilot approaches to targeted screening and brief intervention in primary care, hospital settings and A&E; and similar approaches in the criminal justice setting. Locally, the Alcohol Theme Group of the Safer Middlesbrough Partnership has been tasked with developing an Alcohol Strategy for Middlesbrough. The Alcohol Strategy is responsible for delivering strategic medium and long-term problem solving solutions and to support and complement the work of the four geographically based problem solving groups. The group is led by Middlesbrough PCT and takes action on the four core themes of education, enforcement, treatment, and working with the trade to promote responsible drinking in line with the national strategy’s key areas.

†† Estimates using the Tees Health & Lifestyle Survey 2000 and extrapolating data from the Health Survey for England 2003
9.2 Aims
To reduce the harm caused from alcohol-related crime and disorder, to reduce alcohol-related health problems in Middlesbrough and to promote sensible drinking through the development and implementation of an Alcohol Strategy for the Middlesbrough area.

9.3 National Targets
9.3.1 To reduce the harm caused by alcohol misuse in England through:
- Improved, and better targeted education and communication
- Better identification and treatment of alcohol problems
- Better coordination and enforcement of existing powers against crime and disorder
- Encouraging the industry to continue promoting responsible drinking and to continue to take a role in reducing alcohol related harm

9.4 Local Targets
9.4.1 The Middlesbrough Alcohol Strategy is currently being developed and will adopt the same structure as the Alcohol Harm Reduction Strategy for England.
9.4.2 Challenging local targets will be set with and appropriate performance indicators and timescales.
9.4.3 Increase the number of alcohol-free zones within the Middlesbrough area.

9.5 Key delivery mechanisms
- Alcohol Theme Group of the Safer Middlesbrough Partnership
- Alcohol Strategy and Action Plan
- Middlesbrough Partnership
- Middlesbrough Council Service Plans, Corporate Performance Plan and Licensing Structure
- Neighbourhood Renewal Fund

9.6 Current and future actions
The Alcohol Theme Group of the Safer Middlesbrough Partnership is currently developing the Alcohol Strategy and Action Plan for Middlesbrough and will be published by April 2006. Four theme groups will be developing specific actions relating to education, enforcement, treatment, and working with the trade to promote responsible drinking.

9.7 Public Consultation
The public consultation event highlighted additional areas of intervention for consideration and/or priority funding. These will need to be considered as part of the current action planning by the Alcohol Strategy Group. Areas for intervention that were considered to be the greatest priority by those who attended were as follows (in order of priority):
- Zero tolerance towards premises selling alcohol to children with licences revoked immediately
- Levy from the national drinks industry
- Better education – start educational awareness in primary schools
- Improve training amongst health care professionals
- Reduce the glamour of alcohol through proactive educational campaigns
- Increased involvement of health professionals in screening and identifying those who need assistance
- Increased promotion of cheaper soft drinks
- Improved local detoxification facilities
9.8 Survey

Those participating in the survey were asked a number of questions relating to alcohol sales and consumption. More than 80% of participants agreed or strongly agreed that scarce resources should be used to reduce alcohol consumption amongst school children. More than two-thirds of participants (68%) agreed or strongly agreed that children should be excluded from school if under the influence of alcohol. Measures such as the use of breathalysers within schools were generally not supported by those participating in the survey. Considering broader legislative measures, the majority of participants (88%) agreed or strongly agreed that premises found guilty of selling alcohol to children should have their licenses revoked automatically and with immediate effect. The majority of participants (80%) also agreed or strongly agreed that there should be no drinking in public places (except immediately outside pubs, cafes and restaurants) across the whole of Middlesbrough.
10. Reducing drug misuse

10.1 National and Local Context

There is an estimated 1/4 million problematic drug users in England and Wales giving rise to substantial health, social and economic costs to society\(^1\). The UK government estimates that problematic drug users account for between £10 billion and £18 billion a year in social and economic costs with each problem drug user in England and Wales costing around £35,500 per person each year\(^2\). The financial saving to the community of a heroin user in treatment is estimated to be between £12,775 and £17,885. In addition to problematic drug users, it is estimated that approximately 4 million people use at least one illicit drug and 1 million people use at least one Class A drug (such as ecstasy, heroin and cocaine). The strong links between crime and drug misuse are well established. In 1988, the government published its first National Drugs Strategy\(^3\) which was updated in 2002. The national strategy aims to address this significant problem through four broad areas: prevent young people from using drugs; reducing the prevalence of drugs on the streets; reducing drug-related crime; and reducing the demand for drugs by reducing the number of problematic drug users. The Updated National Drugs Strategy along with another key document – Every Child Matters: Change for Children – sets the policy framework for tackling Britain’s drugs problem. A joint approach to tackling drug misuse is developing between three government departments – the Department for Education and Skills, the Home Office, and the Department of Health with priority areas including the development of universal, targeted and specialist services to reduce the harm caused by drugs.

The challenge to tackling problematic drug misuse and preventing drug use in Middlesbrough is great. The Drug Action Team of the Safer Middlesbrough Partnership estimates that there are approximately 1600–1800 problematic drug users in the Middlesbrough area with the vast majority (85%) in touch with tier 2 and tier 3 services. The majority of problematic drug users are male (69%) and most commonly between the ages of 25–44 (70%). In a local survey of 175 problematic drug users, 59% of the women were involved in prostitution.

10.2 Aim

To reduce the harm caused by drug use and reduce the number of young people experimenting with drug taking

10.3 National Targets

The Updated National Drugs Strategy outlines a number of aims and objectives under four broad areas: (1) Preventing today’s young people from becoming tomorrow’s problematic drug users; (2) Reducing the supply of illegal drugs; (3) Reducing drug-related crime and its impact on communities; (4) Reducing drug use and drug related offending through treatment and support and reducing drug-related death through harm minimisation

10.4 Local Targets

10.4.1 To reduce by 50% the number of problematic drug users in Middlesbrough (from a 2004/5 baseline) by 2015

10.5 Key delivery mechanisms

- Young Person’s Joint Commissioning Group
- Middlesbrough Safer Communities Partnership Adult Drug Treatment Plan
- Adult Joint Commissioning Group & Drug Action Team
10.6 Current and Future Actions

The Drug Action Teams of the Safer Middlesbrough Partnership have produced a detailed adult treatment plan running until 2008. The treatment strategy includes a number of different targets (to 2008) such as increasing the number of problematic users accessing services, increasing the provision of these services, increasing assessments in custody suites, improving hepatitis B vaccination rates and hepatitis C testing in drug users and increasing the number of referrals from prison into treatment services. The longer term objective is clearly to see a reduction in the numbers of problem drug users. This is a very ambitious target and one that may require further and more radical interventions to achieve this. Tackling some of the wider underlying determinants will undoubtedly have an important impact such as increasing educational attainment across all schools in Middlesbrough, but particularly those with the lowest results. Improving employment opportunities for young people and increasing economic wealth is likely to have an important impact in the context of the wider regeneration of Middlesbrough and its surrounding areas. The work of the Middlesbrough Partnership is therefore seen as vital if we are to achieve a genuine reduction in problem drug use and the associated consequences.

10.7 Public Consultation

The public consultation event highlighted additional areas of intervention for consideration and/or priority funding. These will need to be considered as part of the current action planning by the Young Person’s Joint Commissioning Group and the Safer Middlesbrough Partnership. Areas for intervention that were considered to be the greatest priority by those who attended were as follows (in order of priority):

- Prevention interventions that influence a positive change in attitudes, norms & behaviours
- Improved treatment services for drug misusers, more treatment options and better access
- School-based targeted interventions in all secondary schools
- Universal prevention programmes in preference to targeted programmes
- Priority given to tackling ‘gateway’ drugs
- Enable communities to ‘voice’ their opinions and encourage greater involvement in drug issues
- Interventions to reduce supply – greater investment to reduce supply
- Increase police interventions i.e. testing in schools, sniffer dogs, targeting dealers
- Primary school targeted interventions

10.8 Survey

Those participating in the survey were asked a number of questions relating to drug use, particularly amongst young people. Of note, the majority of participants (83%) agreed or strongly agreed that the parents of children who commit an alcohol, drug or violent offence should be offered a compulsory skills course. Almost three-quarters of participants agreed or strongly agreed that parents should also be responsible for the financial consequences of their child’s actions. Whilst such questions are quite specific, they do perhaps highlight the need to include parents at all levels in the issues surrounding drug misuse among young people.
11. Preventing unintentional injuries

11.1 National and Local Context

Each year in the UK, more than 6 million people visit an Accident and Emergency Department and more than 700,000 people are admitted to hospital due to a non-fatal injury. Whilst the leading causes of death in the UK are from coronary heart disease and cancers, it is estimated that injuries are responsible for the greatest burden of disability among healthy individuals – more than cancer, heart disease or stroke.

The vast majority of injuries are entirely preventable and not simply an ‘accident’ or chance occurrence. Hence, the preferred terminology is that of unintentional injuries. Whilst affecting people of all ages, children are disproportionately affected more than any other group. Unintentional injuries are the single biggest killer in children aged 1 to 16 years and the majority of these are road traffic related injuries. Routine road injury statistics report that each year, 3500 people are killed each on Britain’s roads and a further 250,000 people are injured. Of these, more than 4000 children are killed or seriously injured each year (there were 171 childhood deaths during 2003). The burden of ill-health caused by non-fatal injuries is also significant, particularly in the young. Unintentional injuries also vary according to socio-economic status. Children living in some of the most deprived areas of the country are exposed to greater risks of injury and experience greater numbers of injuries compared with children living in the more affluent areas. Children from unskilled families are five times more likely to die from an unintentional injury compared with children from a professional family. Deaths from residential fires show the steepest social-class gradient of all injury types. Using the Registrar General Social Classification, the mortality rate from residential fires in children under 16 is 15 times greater in children from families in the lowest social class (V) compared with children from families in the highest social class (I). Furthermore, children in social class V are five times more likely to die from a road traffic injury compared with children in social class I.

Injury reduction, and specifically road-injury reduction, has been highlighted in a number of government documents such as Saving Lives (2000) and Tomorrow’s Roads: Safer for Everyone (2001). More recently, the policy framework around developing comprehensive services for all children, Every Child Matters, considers safety as one of its key priority outcome areas (‘Staying Safe’) and will be important vehicle for ensuring appropriate interventions and services are in place to protect children from the risks of injuries on the roads and at home.

Between 1994 and 1998 in Middlesbrough, there were 751 transport injuries each year on average – of these 65 were killed or seriously injured. It is recognised that routinely reported data underestimates the true picture (due to the under-reporting and under-recording of road traffic injuries) and the number of seriously injured casualties should be increased by a factor of 2.8. In Teesside, Cleveland Police lead on the work of the Cleveland Casualty Reduction Group – a partnership group of different organisations aiming to reduce the number of road injuries locally.

Injuries are also an important cause of morbidity and mortality in older people. Each year, more than 3000 people aged over 65 die as a result of a fall. In 2001, the National Service Framework for Older People set out new standards and service models of health and social care for older people. Standard six focused on reducing the number of falls in older people which result in serious injury and ensuring effective treatment and rehabilitation for those who have fallen. As a result of the NSF (and related NHS performance milestones) Middlesbrough PCT has appointed a falls coordinator who will manage an integrated falls service, which is nearing completion.
11.2 Aim
To reduce the number of unintentional injuries in children and adults living in Middlesbrough.

11.3 National Targets
11.3.1 To reduce by 2010 the number of people killed/seriously injured on the roads by 40%
11.3.2 To reduce by 2010 the number of children killed/seriously injured on the roads by 50%
11.3.3 To reduce by 2010 the number of slight injuries on the roads by 10%
11.3.4 To deliver items of equipment and undertake minor adaptations within 7 working days of the decision to supply them

11.4 Local Targets
In addition to national targets:
11.4.1 To reduce to zero the number of childhood deaths on Middlesbrough's roads, over a full 3-year period, by 2015
11.4.2 To reduce to zero, the number of childhood deaths from residential fires in Middlesbrough, over a full 3-year period, by 2015
11.4.3 To reduce by 50% the number of deaths from falls in people over 65 (from a baseline 2005) by 2015.

11.5 Key delivery mechanisms
- Cleveland Casualty Reduction Group
- Middlesbrough Council Service Plans
- Middlesbrough Community Strategy
- Sure Start & Children’s Centres
- Cleveland Fire Brigade & Cleveland Police
- Middlesbrough Transport Partnership
- Urban Safety Management Strategy
- Children and Young Peoples Partnership and Plan
- Middlesbrough Council Performance Plan
- National Service Framework for Older People Local Implementation Team and Falls Strategy
- Middlesbrough PCT Public Health Locality Teams (Health Visitors)
those participating in the survey were asked questions relating to traffic speed reduction across middlesbrough. there is good evidence that traffic speed reduction saves lives and reduces the severity of injuries to both vehicle passengers and pedestrians. there was not strong support for a blanket 20mph speed limit across the whole of middlesbrough (excluding major arterial routes). more than half of participants disagreed or strongly disagreed with such an approach. however, there was strong support for introducing a 20mph speed limit around all middlesbrough schools during the day. the majority of participants (86%) agreed or strongly agreed with such an approach. the logistics of implementing such an approach are clearly not straightforward. however, there is good evidence that 20mph speed limits not only contribute to injury reduction (particularly cycle and pedestrian injuries) but also to public perception of improved road safety and therefore a greater propensity to walking to school.

11.7 Public Consultation
The public consultation event highlighted additional areas of intervention for consideration and/or priority funding. these will need to be considered as part of the current action planning by various groups responsible for preventing unintentional injuries. areas for intervention that were considered to be the greatest priority by those who attended were as follows (in order of priority):

- Smoke detector in every house
- Home, pharmacological, medical & OT assessment for all >65 falls seen at A&E
- 20mph speeding zone around all schools during day
- Integrated road safety and skill training programmes in all schools
- Promotion of cycling and walking in communities
- Interventions in the elderly to prevent falls including an audit of older peoples’ homes
- Standard risk assessments by all LA & Health workers visiting older peoples’ homes

11.8 Survey
Those participating in the survey were asked questions relating to traffic speed reduction across middlesbrough. there is good evidence that traffic speed reduction saves lives and reduces the severity of injuries to both vehicle passengers and pedestrians. there was not strong support for a blanket 20mph speed limit across the whole of middlesbrough (excluding major arterial routes). more than half of participants disagreed or strongly disagreed with such an approach. however, there was strong support for introducing a 20mph speed limit around all middlesbrough schools during the day. the majority of participants (86%) agreed or strongly agreed with such an approach. the logistics of implementing such an approach are clearly not straightforward. however, there is good evidence that 20mph speed limits not only contribute to injury reduction (particularly cycle and pedestrian injuries) but also to public perception of improved road safety and therefore a greater propensity to walking to school.
12. Improving mental health and well being

12.1 National and Local Context

Whilst this is the final chapter in this Public Health Strategy, in many ways it should be first. The WHO European Declaration on Mental Health (2005) states “There is no health without mental health. Mental health is central to the human, social and economic capital of nations and should therefore be considered as an integral and essential part of other public policy areas such as human rights, social care, education and employment. Mental health and mental well being are fundamental to the quality of life and productivity of individuals, families, communities and nations, enabling people to experience life as meaningful and to be creative and active citizens.” We would endorse this view fully.

There are significant challenges to improving the mental health and well-being of the Middlesbrough population. No single individual or organisation can achieve this alone – it must involve the partnership of a number of organisations working towards the goal of improving the mental health and well-being of all people in Middlesbrough.

Mental health problems are common however. It is estimated that at any one time, 16% of adults aged 16 to 74 have a neurotic disorder such as depression, anxiety, panic attacks, phobias, obsessive compulsive disorders or a combination of two or more – in other words, one in six of the population. More serious psychotic disorders are much less common, affecting approximately 4 per 1000 adults aged 16–64. Mental health problems in older people (over 65s) are also very common. It is estimated that up to 40% of GP attendees, 50% of general hospital patients, and 60% of care home residents suffer from a common mental health problem.

The trend in the death rate from suicide and undetermined injury is often used as a proxy indicator for population mental health. Suicide rates are highest among 20–24 year olds and ranks consistently as one of the leading causes of death for adolescents between 15 and 19 years of age. In young people aged 15–24 years, suicide accounts for 30% of all deaths. Suicides rates are also patterned according to socio-economic status. The suicide rate among men aged 20–24 in social class V is four times as high as that in men in social class I. The relationship between socio-economic status and suicide is likely to be mediated through a number of different factors such as poor housing, unemployment, social fragmentation and living alone. Nationally, suicide rates have been declining in all age-groups. Unfortunately, the decline has not been seen in the Middlesbrough population. Between 2001–2003 the age-standardised mortality rate for suicides and undetermined deaths was more than 80% greater than the England and Wales average (15.86 per 100,000 vs. 8.77 per 100,000). Annual trends in standardised mortality ratios for suicides and undetermined deaths have shown a consistent increase in men over the last decade, and little change in women.

The national policy framework surrounding improving mental health and well being is considerable. Specific policy documents are worth highlighting here. In 1999, the government published the National Service Framework for Mental Health describing the national standards and service models required to ensure improvements in services and mental health outcomes for people with mental health problems and their carers. For the first time in England, a National Suicide Prevention Strategy was published in 2002 to be implemented by the newly established National Institute for Mental Health. More recently, progress towards the standards set out in the NSF were described in the National Service Framework for Mental Health: Five Years On and the government has also published recently a policy document focusing on Standard 1 of the NSF (mental health promotion) – Making it possible: Improving Mental Health and Well-being in England. The extent of this policy framework means there is a vast amount of good work taking place nationally and locally, which we believe will make a significant contribution to improving the mental health and well-being of the population as well as achieving a reduction in the number of suicides and undetermined deaths.
12.2 Aim
To improve the mental health well-being within the people of Middlesbrough.

12.3 National Targets
12.3.1 To reduce the suicide rate by at least one fifth by 2010

12.4 Local Targets
12.4.1 To reverse the increasing trend in suicides, particularly in young men, and reduce the suicide rate by at least one quarter by 2015
12.4.2 Using available local data sources, to establish a robust measure of mental health within the population of Middlesbrough

12.5 Key delivery mechanisms
- Middlesbrough Health Promotion Implementation Plan
- Tees-wide Suicide Prevention Taskforce
- Middlesbrough Partnership
- NSF Local Implementation Teams for Mental Health and Older People
- Sure Start
- Learning Disabilities and Mental Health Partnership Board
- Voluntary Sector Organisations
- Middlesbrough Council Service Plans

12.6 Current and Future Actions
The Tees-wide Suicide Prevention Taskforce continues to implement locally the national suicide prevention strategy with the involvement of many partner organisations. The Middlesbrough Health Promotion Implementation Plan developed as a result of the requirements of Standard 1 of the mental health NSF. The plan will provide an important mechanism to address the expectations of the wider community and to ensure that health and social services promote mental health and reduce the discrimination and social exclusion associated with mental health problems. It is not possible to list the many voluntary organisations involved in supporting people with mental illness and promoting positive mental well-being – there are simply too many to mention. However, details of all local services can be found at The Good Mind Guide (www.goodmindguide.org) – a web-based resource produced by Redcar and Cleveland MIND providing a comprehensive guide to all services, groups and networks that contribute to improving people’s mental health in the Tees area. This is an excellent resource. Whilst many of the policy documents rightly focus on mental illness per se, there has been a noticeable shift in recent years away from viewing mental health in terms of illness towards the concept of mental well-being. Professor Louis Appleby, National Director for Mental Health, has summed this up well – “we need to broaden our focus from specialist mental health services to the mental health needs of the community as a whole.” This broadening of focus will mean that communities and local organisations, working together, will need to consider the wider determinants of mental health such as social cohesion, housing, employment, access to quality open space and community gardens as well as access to basic amenities, sports facilities and public transport.

12.7 Public Consultation
The public consultation event highlighted additional areas of intervention for consideration and/or priority funding. These will need to be considered as part of the current action planning by the Tees Suicide Prevention Group and the Middlesbrough Local Implementation Team. Areas for intervention that were considered to be the greatest priority by those who attended were as follows (in order of priority):
- Addressing the mental health needs of young people
- Group-based parenting programmes
- Increased support for services offering welfare and debt advice
- School projects raising mental health awareness
- Increased awareness education for all health professionals
- Public awareness campaign around good mental health and well being
- Challenging the stigma associated with mental illness
- Greater support for carers and families in crisis
13. Summary and Implementation

The burden of ill-health on the population of Middlesbrough is longstanding and well documented. There is now a greater focus on improving the health of our population than there has ever been before. This joint public health strategy is designed to pull together the big strands of work that will help make Middlesbrough a healthier place to live in years to come.

However, a strategy alone will not achieve this. If we are to be successful we must use all the means at our disposal to implement the measures set out in this strategy in order to achieve the targets we have set ourselves. Whilst this is a joint strategy between Middlesbrough Primary Care Trust and Middlesbrough Council, it is important to recognise that we have to engage businesses, community groups, voluntary sector organisations and above all the general public if we to be successful. Improving health is not just the business of the NHS and the Council, but everybody.

Much of the content of this document should be implemented through existing structures. As such it is our intention to establish a mechanism that ensures progress towards the targets described in this strategy by:

- ensuring that all areas of work addressing the targets are built into existing structures, business plans and service plans
- identifying a lead person for each work area (e.g. Health Inequalities, Smoking, Obesity etc) to facilitate this process
- asking the Health and Social Care Partnership (of the Middlesbrough Partnership) to establish a mechanism within the Partnership to performance manage progress towards the targets
- producing a progress report each year on the state of health of the Middlesbrough population
Appendix: Current projects, interventions & strategies

1. Tackling Health Inequalities

- Healthy Living Centre initiatives: All the Healthy Living Centre Projects were established on the basis of tackling health inequalities. Also: Men’s Health Project NRF Wards, Subsidised physical exercise at Council Leisure premises (town wide) PASSPORT TO HEALTH; Community Transport Scheme; tackling poverty
- Food safety: inspections, food standards sampling, food safety lectures and training, monitoring food labeling claims (e.g. low fat), food resource packs for schools, food safety public campaigns, target BME and other disadvantaged groups
- Mental Health Social inclusion Project – Mental Health Awareness
- Community Health Development Workers
- Concessionary rate leisure link cards to those on low incomes or in receipt of certain benefits
- The People Strategy (Middlesbrough Council) - contains a number of health promotion activities for Council employees and initiatives to promote employment of under-represented groups within the Council.
- Middlesbrough Healthy Schools Scheme; Stage two local priorities programme
- Middlesbrough PCT Easy Access Fund
- South Middlesbrough Young People’s Health Project
- Statutory Contaminated Land Strategy to clean up priority sites in Mbro
- Current Parks & Countryside events and activities target socially excluded sections of the community
- Green Spaces Strategy
- Private sector housing team enforce minimum housing standard requirements, register high risk properties
- Erimus Housing and other social housing providers working to Decent Homes Standard by 2010
- Winter Warmth Project [energy efficiency grants for elderly residents in NRF wards]
- Health Through Warmth Project delivers energy efficiency work to priority health cases
- Regeneration of WMNT housing stock
- Middlesbrough Environment City Health Translink project
- Reduced price services are currently available for people on means tested benefits. – e.g. Pest Treatment and Drainage Services
- WMNT Welfare Rights project and the East
- Middlesbrough NRF Team
- Council involved with Middlesbrough Network of Intermediaries and exploring ways in which they can support employment of local people.
- Decent Homes Target: For vulnerable people in private housing

2. Reducing the number of people who smoke

- Healthy Living Centre initiatives: Men’s Health Project NRF Wards, Tobacco Control “Smokeless”; Middlesbrough, Mentoring Project, Linx Project
- Links with existing indoor air quality work. – see smoking in homes comment
- ‘Smoke Less Middlesbrough Initiative’ and the East
- Middlesbrough NRF Team
- Council Physical & Mental Health Activities, Health Eating in Centre Projects; BME Men’s Health Project NRF Wards, LINX Project, Subsidised physical exercise at Council Leisure premises (town wide) PASSPORT TO HEALTH; Boro Buzz 2005 (youngsters into sport and physical activity; Tees Forest Allotment Projects; BME Men’s Health Project
- HOOP Dreams Project – promoting activity, healthy eating and healthy lifestyle
- Middlesbrough Healthy School Scheme
- Active Middlesbrough Strategy and Sport and Leisure Service plans
- Community Service volunteers working group
- Walk to school week
- Walking bus projects
- Safer routes to school
- School Travel Plans
- Obesity Strategy Group & Childhood Obesity Sub Group
- “Food in Schools” programme
- Environmental Health “Healthy Eating Project”
- National Fruit for Schools Scheme
- Walking your Way to Health Initiative (“Healthy Stepping”) [partnership project between M’bro Council and Middlesbrough PCT
- Comprehensive annual walks and events programmes in Green Flag Parks, Wildspace programme, Newham Grange Farm, Lingfield Countryside Centre
- Delivery Group for Children’s NSF (and linkages with CYPSP) to be considered jointly by Children, Families and Learning Dept and PCT
- Children and Young People Strategic Partnership & Every Child Matters ‘Be Healthy’ outcome
- Middlesbrough Environment City encourage physical activity through Middlesbrough Cycle Centre; maintenance & training courses; safe cycle workshops; guided cycle rides; Health Translink minibus service; Health walks maps; Environmental Play Project; composting project (supporting gardening activities)
- Going for Green project encourages gardening as a healthy activity
- Weight Management Sessions – local residents trained to deliver the sessions in the neighbourhood
- Water in Schools project – now rolled out across the town but piloted and support by WMNT
- Lifestyle Coordinator – Sport and Leisure Service.
- Schools Sports Partnership - involvement with the “Million Mile Challenge”

3. Tackling Obesity

- Healthy Living Centre initiatives: Healthy Eating in Communities, Kidz Power, Translink Project, Communities Centre Physical & Mental Health Activities, Health Eating Mentors, Berwick Hills Allotments East Middlesbrough, health walks, cycle track, organic food, school visits, Men’s Health Project NRF Wards, LINX Project, Subsidised physical exercise at Council Leisure premises (town wide) PASSPORT TO HEALTH; Boro Buzz 2005 (youngsters into sport and physical activity; Tees Forest Allotment Projects; BME Men’s Health Project
- HOOP Dreams Project – promoting activity, healthy eating and healthy lifestyle
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- Active Middlesbrough Strategy and Sport and Leisure Service plans
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- Water in Schools project – now rolled out across the town but piloted and support by WMNT
- Lifestyle Coordinator – Sport and Leisure Service.
- Schools Sports Partnership - involvement with the “Million Mile Challenge”
4. Teenage pregnancy
- Teenage Pregnancy Strategy Group
- Sex Ed Roadshow
- Council's involvement with schools (as an employer) through Employer Involvement Forum
- Community Contraceptive Services

5. Improving sexual health
- Sex Ed Roadshow in every secondary base and unit delivered by SRE core team
- Teenage Pregnancy Strategy Group & MHSS
- Sense CD Secondary resource – Middlesbrough Teenage Pregnancy
- Lucinder and Goddfrey Primary School resource
- Sep/Oct 05 pilot in 2 schools
- C:Card – Condom distribution
- School Nursing Service (e.g. Acklam Grange School work funded through WMNT)
- Current work in developing CYPSP
- Female Genital Mutilation awareness raising seminar
- Needs Assessment of adult survivors of sexual abuse
- Teeside Sexual Health Referral Centre (SARC)

6. Encouraging sensible drinking
- Healthy Living Centre Initiatives: Men's Health Project NRP Wards, Reducing Alcohol Harm and Risk Taking Behaviour, LINX project, Mentoring Project
- Middlesbrough Temperance Society (non alcoholic bar provision)
- Young People's Alcohol Strategy and Young People's Substance Misuse Joint Commissioning Group
- Extensive programme of test purchases with young volunteers to ensure retailers do not sell to children
- Promoting use of proof of age cards/connections card to reduce underage sales
- Supply of Connexions card readers to off license premises to reduce underage sales
- Provide alcohol awareness through schools PSE lessons
- Arrest referral services identifying those at risk of alcohol abuse

- Middlesbrough Council's Licensing Policy
- WMNT contracted with the Albert Centre – Counseling sessions, training local residents and working with the Youth Development Team (working with young people & alcohol)
- Use of surveillance equipment to detect under age sales in shops where young volunteers cannot operate effectively
- Provision of electronic proof of age card readers to assist retailers in enforcing "no id no sale" policy
- Alcohol free premises e.g. Council buildings

7. Reducing drug misuse
- MHSS Drugs Education
- Drug Education Team (working with all Middlesbrough schools and offering training to teachers and school staff)
- Young People’s Substance Misuse Joint Commissioning Group and services commissioned by them (including research on young people and drugs due to be completed shortly) Middlesbrough’s designation as a High Focus Area requires the Young People’s Joint commissioning group to develop an Action Plan with innovative options during May/June 2005
- ‘Dealer a day’ initiative (Cleveland Police)
- Targeted prevention services for young people
- Comprehensive training programmes in drugs awareness for frontline professionals
- Drug treatment capacity has been increased
- Arrest referral scheme enables prisoners to access drug workers and get fast track treatment
- Drug dealers are evicted from registered social landlord premises to reduce underage sales
- Drug dealers are evicted from registered social landlord properties and crack houses closed within 48 hours
- Work of SECONS
- Sure Start Programme providing parenting skills training to parents of drug misusers
- TNEY – Reducing Drugs and Alcohol Project providing an addiction Nurse, Family Support & the provision of a local clinic
- Lifeline – working with families to provide support and provide an outreach service

8. Preventing unintentional injuries
- Middlesbrough Healthy School Scheme – Safety Theme; School Travel plan and safer routes to school
- School Travel Plans, Walking buses, Kerbcraft, Walk to school weeks, cycle training, theatre in education, moving up packs for children moving between primary and secondary schools and new starter packs for new intakes
- Independent Living Project for Older People
- Falls Strategy
- Falls Prevention Initiatives – exercise classes
- Staying Safe Group – subgroup for Every Child Matters/CYPP
- Middlesbrough Environment City's cycle training programme
- Middlesbrough Environment City Community Engagement Programme in Cycling, in partnership with Middlesbrough Council Transport and Design Services – including cycle maintenance workshops, guided cycle rides, safe cycling workshops for schools and community groups to nationally recognised standards
- WMNT Key Routes Project – Traffic calming project around Newport Primary School, carried out through consultation with local residents and school children – complete April 05
Cleveland Casualty Reduction Group
Mobile CCTV to monitor ‘hotspot’ areas and can support with evidence in regards to traffic problems
Enforcement of firework storage and supply legislation. Incl. Licensing of traders, young volunteer test purchases, fireworks hotline to identify and deal with individuals illegally selling fireworks from home. Sampling and testing of fireworks to ensure that they meet the performance/noise restrictions placed upon them
Cleveland Fire Brigade: Home Fire Safety Checks and fitting of free smoke alarms in any home where the occupier asks for assistance
Cleveland Fire Brigade’s initiative to prevent 16 to 21 year olds & new drivers from becoming RTA victims
Middlesbrough’s Local Transport Plan aims to limit traffic increases
Staying Put Agency – delivering adaptations or repairs for disabled and older people in the private sector housing
Safe at Home Scheme – prevents unnecessary hospital admission and delayed discharge for older persons, funded by the Access 8 Systems Capacity Grant

9. Improving mental health and well being
ALL HLC projects include activities which are aimed at improving mental as well as physical health through confidence building, empowerment together with positive lifestyle messages. Also Men’s Health Project producing a wide range of activities to encourage positive well being, physically and mentally
NSF for Mental Health
CAMHS Group overseeing Young People’s mental health services (with specific targets in Children’s NSF)
Wildspace Programme creating Local Nature Reserves and providing opportunities for local communities to play an active role in developing these sites
Mental Health Social Inclusion Project – Mental Health Awareness
Partnership for Older People Project
Middlesbrough Environment City activities
MIND Project (funded through WMNT) – to provide a 1:1 service and developing support groups within WM area
RSVP – Befriending service to support older residents, some who are isolated in the area
Active for Life Group – Developed and supported through the Trust – as well as exercise it is used as a social gathering for older residents
Active Middlesbrough
Green Spaces Strategy
Trading Standards: provision of comprehensive confidential debt advice and negotiation service including referrals for enforcement where loan sharking and harassment of debtors is detected, allowing sufferers to regain control of their finances
Work with Education Officers to introduce “Debt Cred” initiative into schools to increase financial literacy and prevent debt occurring
Employee Assistance Programme: providing telephone counseling service and telephone information service providing legal and financial advice for council employees & families
Health for Life Distance Learning Programme – provides opportunity to learn more about benefits of exercise, but also to gain a NCFE Level 1 qualification – creating a skills pathway (NCFE Level 2 needed to work in Leisure Centres)
Housebound Service – delivering books to older people in their own homes to keep them mentally active for life group (older people) in West Middlesbrough Books on Prescription
References

5. NEPHO Occasional Paper No. 08 December 2004
24. Securing Better Mental Health for Older Adults. Department of Health 2005
This section contains a statistical profile of the state of health of the resident population of Middlesbrough.

1. Population ups & downs
   Population structure & change

2. Great expectations
   Life expectancy

3. Breathing new life
   Population fertility

4. Vulnerable groups
   Children, pensioners and non-white groups

5. Risky business
   Everyday risks to health

6. Miserable measures
   Material & social deprivation

7. See if we care
   Hospitalisation for treatment

8. Grave matters
   Population mortality

Data sources & availability
Most of the data has been obtained from nationally or locally available data sets. The main source is the Compendium of Health & Clinical Indicators published annually by the Department Health. The source for each item is identified beside the appropriate table or figure.

Inclusion of profile items
The items in the profile are not exhaustive but are those that constitute the minimum required to convey a fairly comprehensive impression of health in the population. The criteria for inclusion of material took into account such issues as availability of data for particular time periods; particular geographical areas; aspects of risk to health; and diseases that are preventable (cancer and heart disease).

Organisation of the profile
There is no ‘best’ way to present this material to meet the needs of all users. In this case, the items have been arranged in a broadly chronological – or ‘life-course’ – sequence from birth to death. This has the advantage of following the organisational framework of the ‘Population Health Outcomes Model’ proposed by the Department of Health as a method for structuring the vast array of information into a logical whole.

Clare Eynon
Public Health Intelligence Specialist

Mark Reilly
Public Health Specialist
The population 'pyramid', showing the distribution of population by age group, has a narrow base reflecting in large measure the reduction in the numbers of births since the late 1970s.


In the oldest age groups, women outnumber men by about 2:1 reflecting the additional years of life expectancy for women than men.

### Resident populations, Middlesbrough PCT, 2002

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<th>Females</th>
<th>Persons</th>
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<td>% E&amp;W</td>
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Source: ONS, Mid 2002 (revised)- Local Authority Population Studies – 09/09/04
Great expectations

Average life expectancy at birth, Primary Care Trusts, 1999-2001

In Middlesbrough men can expect to live to age 73 and women to age 79 years.

Men in Middlesbrough have some of the lowest life expectancies at birth of all populations in the Strategic Health Authority area.

Life expectancy for both men and women is lower than the average for England & Wales.
Breathing new life

Summary statistics for births, Middlesbrough, 1995-2003

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<td>1827</td>
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<td>Percentage births under 2,500 grams</td>
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<td>7.9</td>
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<td>10.0</td>
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<td>Number of Stillbirths</td>
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<td>9</td>
<td>10</td>
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<td>Stillbirth Rate (per 1,000 live &amp; still births)</td>
<td>8.9*</td>
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* denotes a rate calculated from less than 20 events

Source: Office of National Statistics (ONS) VS1

General fertility rates and numbers of live births, Middlesbrough, 1995-2003

General fertility rate, 1995-2003

PCT Live births, 1995-2003

Source: Office of National Statistics (ONS) VS1

Proportion of births under 2,500 grams, Middlesbrough, 1995-2003

The local general fertility rate has been very similar to the national rate since 1996. Since 1995, the proportion of low-weight babies has been higher than the national average. However, local rates have fallen slightly each year since 2001.

Source: Office of National Statistics (ONS) VS1
Breathing new life

Conception rates, females under 18 years, 1998-2002

Annual average conception rates, females under 18 years, Middlesbrough PCT wards, 2000-2002

Average conception rate per 1,000 by deprivation quintile, females aged under 18 yrs, County Durham & Darlington and Teesside, 1998 - 1999

Although under 18 conception rates have risen over the last two years, the rate is still below the high rates of the late 1990s (top graph)

Teenage conception rates are very strongly associated with poverty (bottom graph).
Vulnerable groups

Children

- Children under 15 acting as carers
- Dependent children living in workless households
- Dependent children with limiting long term illness

Pensioners

- Pensioner households with 2 or more people with limiting long term illness
- Pensioners living above ground floor
- Pensioners living alone

Source: 2001 Census
Vulnerable groups

Non-white groups

The proportion of population aged 16-74 in full time employment

The proportion of population aged 16-74 with no qualifications or qualification level unknown

Children

- Proportionally, there are more child carers in County Durham & Tees Valley than nationally. Over 1,350 (3.5%) under 16-year olds in Middlesbrough PCT provide care (E&W 2.4%).
- Middlesbrough PCT has the highest rate of children living in workless households (30.1%) in the SHA area, this is far higher than the national rate (17.6%).
- All PCTs in County Durham & Tees Valley have more children with a limiting long-term illness than the national average. There are more than 3,000 such children in Middlesbrough PCT area (7%); this again is much higher than that of England & Wales (4.3%).

Pensioners

- All PCTs in County Durham & Tees Valley have higher than average rates of pensioner households with 2 or more people suffering with a limiting long-term illness. Over 17% of pensioner households in Middlesbrough PCT fall into this category compared to the national average of 13.5%.
- Middlesbrough PCT has 1,600 pensioners (7.2%) living above ground floor level. This compares very favourably with the national figure of 10.3%.
- Almost one quarter of all male pensioners and 4 out of every 10 female pensioners in Middlesbrough PCT live alone. These figures are higher than the national average.

Non-white groups

- At the time of the Census, less than on third (32.5%) of the white and less than one fifth (19.9%) of the non-white population of Middlesbrough were in full time employment. These rates compared with the national rates of 41% and 32% respectively.
- Middlesbrough, like all other PCT areas within County Durham & Tees Valley, has proportionally more white people without qualifications than non-white (45.6% and 44.2% respectively).
Everyday risks to health

- Risk is part and parcel of life and many threats have the potential to harm health or even cause early death.
- The variety of risks to health can be classified in different ways (box opposite). Health is affected by more than lifestyle (behaviour) alone: the socio-economic circumstances of people as well as the quality of the environment are critical.
- Risks can be described in both words and numbers (figure below). Examples of some very different risks are illustrated numerically with a corresponding verbal description.
- The relative risk of death from smoking is about 40 times greater than death in a road accident and 50,000 times greater than death from a lightening strike.

Factors influencing health status

- Air quality
- Environment
- Water quality
- Fixed
- Lifestyle
- Social & economic
- Crime
- Access to services
- Fixed
- Lifestyle
- Social & economic
- Crime
- Access to services

The Risk Ladder

- Very high
- 1 in 100
- Death in one year from all causes of death
- Death from smoking 10 cigarettes per day for one year

- High
- 1 in 1,000
- Injury caused by epidural
- Death in road traffic accident in one year

- Moderate
- 1 in 10,000
- Death in accident at work

- Low
- 1 in 100,000
- Death caused by anaesthesia
- Death in rail crash

- Very low
- 1 in 1,000,000
- Death from new variant Creutzfeldt-Jakob disease
- Death by lightening strike
- Winning 6 balls in UK National Lottery

- Minimal
- 1 in 10,000,000

- Negligible
- 1 in 100,000,000

Examples of three risks to health (smoking, low educational attainment & unemployment) are shown opposite

Source: Adapted from British Medical Journal
Risky business

Smoking prevalence, persons aged 16+, 1998-01

- Smoking is the single greatest cause of avoidable illness and preventable death in this country.
- County Durham & Tees Valley SHA has one of the highest smoking prevalence rates in England & Wales.
- 34% of all deaths in County Durham & Tees Valley are attributable to smoking.
- It is estimated that more than one third of all adults in Middlesbrough smoke.

People claiming unemployment benefit as a percentage of the working age population, January 2004-January 2005

- Unemployment is strongly associated with the risk of illness throughout adult life: people who are unemployed are more likely to suffer from physical and mental illness and to die at an earlier age than people who have a job.
- The unemployment rate in Middlesbrough is consistently higher than the UK rate and in fact is almost double the national average.

Proportion of pupils gaining 5 or more GCSE grades A*-C, 1999-2004

- Educational attainment is strongly associated with health in later life: people with higher educational qualifications tend to have better paid jobs and have potentially more choices for healthy living than people in unskilled and manual jobs.
- The proportion of children who attain 5 or more GCSE grades (A*-C) in year 11 is consistently lower in Middlesbrough than in England.
- Since 1999, the gap between local and national experience has gradually narrowed. In 1999 for every 100 children achieving these grades nationally only 65 did so locally; by 2004 the local performance had improved and for every 100 children achieving these grades nationally 76 local children were achieving.
Miserable measures

Deprivation in Middlesbrough PCT, Index of Multiple Deprivation, 2004

Material and social deprivation makes people ill and reduces life expectancy.

Material and social deprivation increases the potential need for health and other services.

There are many different ways to measure deprivation but most reflect different aspects of need in relation to income, employment, educational attainment and health.

For Middlesbrough PCT, the Index of Multiple Deprivation (the most comprehensive and up-to-date data set) revealed that there were 18 electoral wards (out of 29) with health ranked within the poorest 10% of electoral wards in England.

Index of multiple deprivation
Health domain index

Material and social deprivation increases the potential need for health and other services.

There are many different ways to measure deprivation but most reflect different aspects of need in relation to income, employment, educational attainment and health.

For Middlesbrough PCT, the Index of Multiple Deprivation (the most comprehensive and up-to-date data set) revealed that there were 18 electoral wards (out of 29) with health ranked within the poorest 10% of electoral wards in England.

Key
Falls within top 10% of deprived wards nationally
Falls within 10%-50% of deprived wards nationally
Falls within 50%-100% of deprived wards nationally
### Miserable measures

#### Table: Estimated Index of Multiple Deprivation national rank, 2004

<table>
<thead>
<tr>
<th>Ward Name</th>
<th>LA Name</th>
<th>Estimated Index of Multiple Deprivation national rank, 2004</th>
<th>IM</th>
<th>Income</th>
<th>Employment</th>
<th>Health</th>
<th>Education</th>
<th>Barriers</th>
<th>Crime</th>
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</table>

| Actual number of wards in red zone | 15 | 15 | 18 | 18 | 0 | 16 | 2 | 99 |
| Expected number of wards in red zone | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 24 |
| Excess' number of wards in red zone | 12 | 12 | 15 | 15 | 0 | 13 | 0 | 75 |

**Key**
- Falls within top 10% of deprived wards nationally: Red
- Falls within 10%-50% of deprived wards nationally: Yellow
- Falls within 50%-100% of deprived wards nationally: Green

**Source:** Calculated by Tees Valley Joint Strategy Unit from The English Indices of Deprivation 2004
See if we care

Re-admission rates, selected specialities, Middlesbrough PCT, 2003/04

<table>
<thead>
<tr>
<th>Speciality</th>
<th>% Re-admissions</th>
<th>Expected % re-admissions</th>
<th>Ratio</th>
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<tr>
<td>Surgical Specialties</td>
<td>5.2</td>
<td>3.9</td>
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<tr>
<td>Obs &amp; Gynae</td>
<td>9.5</td>
<td>7.3</td>
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<tr>
<td>Medical Specialties</td>
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<td>2.3</td>
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<tr>
<td>Radiology</td>
<td>4.6</td>
<td>4.8</td>
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</table>

Unnecessary re-admissions to hospital after discharge wastes scarce resources and might lead to longer waits for planned surgery. There are many reasons why re-admission rates might be high. These include inappropriate early discharge; unforeseen complications of care; and insufficient care at home.

In-hospital mortality rate, coronary artery bypass graft (CABG), 2003/04

<table>
<thead>
<tr>
<th>Speciality</th>
<th>% mortality</th>
<th>Expected % mortality</th>
<th>Ratio</th>
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<tbody>
<tr>
<td>Hartlepool</td>
<td>3.6</td>
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<tr>
<td>Durham Dales</td>
<td>2.9</td>
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<tr>
<td>Middlesbrough</td>
<td>3.7</td>
<td>2.3</td>
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<tr>
<td>North Tees</td>
<td>2.3</td>
<td>1.7</td>
<td></td>
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<tr>
<td>Durham &amp; CLS</td>
<td>1.3</td>
<td>1.4</td>
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<td>Sedgefield</td>
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</tr>
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<td>Derwentside</td>
<td>0.0</td>
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<tr>
<td>Easington</td>
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The in-hospital mortality rate for surgery is influenced by many factors. The most important influences are likely to be the stage and severity of disease in the cases treated as well as the quality of surgical and post-operative care.

The mortality rates for CABG in Middlesbrough are higher than would be expected.

The organism Staphylococcus aureus is commonly found on the skin of healthy people and seems to cause no major problems. However if it gets inside the body, for instance under the skin or into the lungs, it can cause serious infections. Methicillin resistant Staphylococcus aureus (MRSA) is used to describe those examples of this organism that are resistant to commonly used antibiotics.

The data here shows the rate of MRSA reports per 100,000 bed-days in selected hospitals. Hand washing by staff between successive patients and by visitors before and after visits are vital weapons to control the spread of infection. Effective cleaning of hospitals is important too. In addition, antibiotics should not be used inappropriately.

The trends and levels of MRSA should be interpreted with caution as they are influenced both by the completeness of reporting and the complexity of case mix. Specialist hospitals treat people who have more complex illness that adds to the risk of MRSA.

Methicillin resistant Staphylococcus aureus (MRSA) reports, selected hospitals, 2001-2004
See if we care

Cancers (of all types combined) represent a great burden of sickness and early death in the community as well as an impact on NHS resources.

The charts on the left-hand side of this page, showing the rates of new cancers, give some indication of the differences in exposures to risk of cancer (such as smoking or diet or not using sunscreen) between the local population and the CD&TV average. This helps to determine what further primary prevention is required.

The charts on the right-hand side of this page, showing the cancer death rates, demonstrate that cancer is not an invariably fatal disease. Some cancers – such as lung cancer – have a very poor prognosis and the duration of survival is relatively short. Other cancers – such as those of the colon & rectum – have lower mortality and better survival rates. Differences in survival rates depend on many things. These might include the type of cancer and age of the person; the stage of tumour growth at the time of diagnosis; the capacity to treat effectively; and the quality of cancer care in hospital and at home.
Grave matters

Numbers and standardised mortality ratios (SMR) for selected causes of death, males and females, 2001-2002

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>ICD-10 code</th>
<th>Sex</th>
<th>Middlesbrough PCT</th>
<th>County Durham &amp; Tees Valley SHA</th>
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<tr>
<td></td>
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<td>Number</td>
<td>SMR</td>
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Source: Compendium of Clinical & Health Indicators, 2002
Note: SMRs that have been underlined are statistically significantly different from England & Wales
## Grave matters

Standardised mortality ratio (SMR) for selected causes of death showing statistically significant differences from England & Wales, males and females, Middlesbrough PCT 2001-2002

### Males

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<td>Accidents</td>
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</tr>
<tr>
<td>Lung cancer</td>
<td></td>
</tr>
<tr>
<td>All malignant neoplasms</td>
<td></td>
</tr>
<tr>
<td>All causes</td>
<td></td>
</tr>
<tr>
<td>Circulatory disease</td>
<td></td>
</tr>
<tr>
<td>Stomach cancer</td>
<td></td>
</tr>
<tr>
<td>Land transport accidents</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
</tr>
</tbody>
</table>

### Females

<table>
<thead>
<tr>
<th>Condition</th>
<th>SMR</th>
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</thead>
<tbody>
<tr>
<td>Lung cancer</td>
<td></td>
</tr>
<tr>
<td>Stomach cancer</td>
<td></td>
</tr>
<tr>
<td>Land transport accidents</td>
<td></td>
</tr>
<tr>
<td>All malignant neoplasms</td>
<td></td>
</tr>
<tr>
<td>All causes</td>
<td></td>
</tr>
<tr>
<td>Circulatory disease</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td>Colorectal cancer</td>
<td></td>
</tr>
<tr>
<td>Cervical cancer</td>
<td></td>
</tr>
<tr>
<td>Suicide &amp; injury undetermined</td>
<td></td>
</tr>
<tr>
<td>Breast cancer</td>
<td></td>
</tr>
<tr>
<td>Accidents</td>
<td></td>
</tr>
</tbody>
</table>

### Key

- **Statistically significantly different from England & Wales**
- **Not statistically significantly different from England & Wales**

Source: Compendium of Clinical & Health Indicators, 2002
Grave matters


<table>
<thead>
<tr>
<th>Age group</th>
<th>Middlesbrough PCT</th>
<th>County Durham &amp; Tees Valley SHA</th>
<th>Eng &amp; Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Rate</td>
<td>No.</td>
</tr>
<tr>
<td>*Perinatal (&lt;7 days &amp; stillbirths)</td>
<td>22</td>
<td>10.2</td>
<td>95</td>
</tr>
<tr>
<td>**Neonatal (&lt;28 days)</td>
<td>9</td>
<td>4.2</td>
<td>37</td>
</tr>
<tr>
<td>**Postneonatal (28 days - 1 yr)</td>
<td>7</td>
<td>3.3</td>
<td>23</td>
</tr>
<tr>
<td>**Infant (&lt;1 year)</td>
<td>16</td>
<td>7.5</td>
<td>60</td>
</tr>
<tr>
<td>***Childhood</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-4 years</td>
<td>7</td>
<td>42.5</td>
<td>41</td>
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<tr>
<td>5-14 years</td>
<td>6</td>
<td>12.2</td>
<td>42</td>
</tr>
</tbody>
</table>

Source: Compendium of Clinical & Health Indicators, 2003, ONS VS1

Infant deaths and rates per 1,000 live births, Middlesbrough, 1995-2003

- *Perinatal death rate*: number of deaths per 1,000 total births
- **Neonatal, postneonatal and infant death rate**: number of deaths per 1,000 live births
- ***Childhood death rate***: number of deaths per 100,000 resident children in age-band

In 2002 infant mortality at all stages was higher than national rates.
Mortality in children aged 1-4 was almost double the national average in 2001-2002 but rates in the 5-14 age group were on a par with England & Wales at this time.

Source: Office of National Statistics (ONS) VS1
Trends in mortality rates, circulatory disease & malignant neoplasms, ages under 75 yrs, 1993-2010

Circulatory disease
- Mortality trends locally are reducing in line with the national experience.
- Death rates are consistently higher for men than women.
- 2002 saw a dramatic reduction in local male mortality. The rate is now approaching the national average.
- For women, rates have fluctuated considerably, but have risen each year since 2000.

Malignant neoplasms
- Locally, death rate trends for men and women are reducing in line with the national experience.
- Local rates for men fell in 2002 to a new low rate of 166 per 100,000.
- There was a sharp rise in female mortality in Middlesbrough in 2002. This rate is almost equal to the local male rate and now exceeds not only the national female rate but also the male mortality rate.

Source: Compendium of Clinical & Health Indicators, 2002