DELIVERING OUR COMMUNITY PLAN

HEALTHY COMMUNITY INDICATOR BASELINES & SUPPORTING INFORMATION

Healthy Community

Long-term outcome: People are making positive lifestyle choices. They are more resilient and better equipped to cope with life's challenges.

Three indicators are being used to monitor progress towards the healthy community long-term outcome for the borough:

- Gap in life expectancy between most deprived areas and the borough overall. Source: NI Health and Social Care Inequalities Monitoring System, NISRA, Department of Health
- Number of preventable deaths per 100,000 population (age standardised preventable mortality rate). Source: NI Health and Social Care Inequalities Monitoring System, NISRA, Department of Health
- Percentage of people who participate in sport or physical activity on at least one day a week. Source: Continuous Household Survey, NISRA, Department for Communities

Data Development: The Community Plan noted a data development need for indicators around general health and mental wellbeing.

Links to Programme for Government Framework – working draft (January 2018): The number of preventable deaths per 100,000 population is a draft Programme for Government indicator.

Indicator: Gap in life expectancy between most deprived areas and the borough overall

Life expectancy is the most commonly used measure to describe the health of the population. Life expectancy at birth is the expected years of life at time of birth based on mortality patterns in the period in question. It is based on the average death rates over a three year period.

In 2014-16, male life expectancy in the borough overall was 79.2 years, while in the most deprived areas it was 76.0 years, giving a gap in life expectancy of 3.1 years for males. Female life expectancy in the borough was 82.5 years, while in the most deprived areas it was 81.2 years, giving a gap of 1.4 years for females.

The gaps for both males and females have remained similar since 2010-12.

Figure 1. Gap in life expectancy at birth (years) between most deprived areas in the borough and the borough overall, for males and females, 2010-12 to 2014-16. Source: NI Health and Social Care Inequalities Monitoring System, NISRA, Department of Health.

Male Life Expectancy at Birth	2010-12	2011-13	2012-14	2013-15	2014-16	RAG Status
Northern Ireland	77.7	78.0	78.3	78.3	78.5	Improved
Armagh City, Banbridge and Craigavon	78.0	78.5	78.9	78.8	79.2	Improved
Armagh City, Banbridge and Craigavon Deprived	74.6	75.0	75.5	74.9	76.0	Improved
Armagh City, Banbridge and Craigavon-NI Gap	-0.3	-0.4	-0.6	-0.5	-0.6	No Change
Armagh City, Banbridge and Craigavon Deprivation Gap	**3.5**	**3.4**	**3.3**	**4.0**	**3.1**	**No Change**
Armagh	76.6	77.1	77.6	77.5	78.0	Similar to LGD
Banbridge	78.6	78.7	78.5	78.7	79.0	Similar to LGD
Craigavon	77.2	78.0	78.6	79.4	79.4	Similar to LGD
Cusher	80.2	81.3	80.9	80.2	79.9	Similar to LGD
Lagan River	81.1	80.6	82.2	81.4	82.1	Better than LGD
Lurgan	77.4	78.1	78.1	79.2	79.5	Similar to LGD
Portadown	76.6	77.0	77.8	76.9	77.7	Similar to LGD

Table 1. Male life expectancy at birth (years) and gaps, 2010-12 to 2014-16. Source: NI Health and Social Care Inequalities Monitoring System, NISRA, Department of Health.

Female Life Expectancy at Birth	2010-12	2011-13	2012-14	2013-15	2014-16	RAG Status
Northern Ireland	82.1	82.3	82.3	82.3	82.3	No Change
Armagh City, Banbridge and Craigavon	82.5	82.7	82.4	82.4	82.5	No Change
Armagh City, Banbridge and Craigavon Deprived	81.1	81.1	81.4	81.2	81.2	No Change
Armagh City, Banbridge and Craigavon-NI Gap	-0.4	-0.4	-0.1	-0.1	-0.2	No Change
Armagh City, Banbridge and Craigavon Deprivation Gap	**1.4**	**1.6**	**1.0**	**1.1**	**1.4**	**No Change**
Armagh	82.2	82.0	81.2	81.1	81.3	Similar to LGD
Banbridge	82.7	83.1	82.6	82.3	83.0	Similar to LGD
Craigavon	82.6	83.0	83.1	81.9	81.8	Similar to LGD
Cusher	83.0	82.6	83.2	82.8	83.0	Similar to LGD
Lagan River	84.1	84.5	85.1	84.5	84.1	Similar to LGD
Lurgan	83.0	83.0	82.4	82.4	82.6	Similar to LGD
Portadown	81.1	81.2	80.8	82.1	81.9	Similar to LGD

Table 2. Female life expectancy at birth (years) and gaps, 2010-12 to 2014-16. Source: NI Health and Social Care Inequalities Monitoring System, NISRA, Department of Health.

Life expectancy in Northern Ireland for men and women continues to rise, with the gender gap closing.

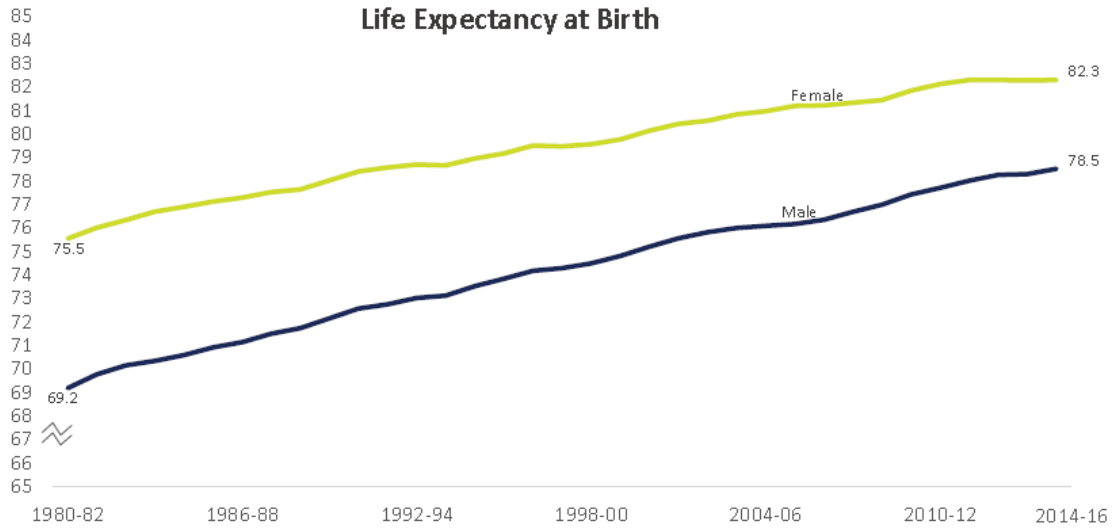

Figure 2. Life expectancy at birth, Northern Ireland, 1980-82 to 2014-16. Source: ONS National Life tables via NI in Profile report, NISRA.

Healthy Life Expectancy at Birth

Healthy life expectancy is an estimate of the number of years lived in "Very good" or "Good" general health, based on how individuals perceive their general health (in the NI Health Survey).

In Northern Ireland in 2014-16 healthy life expectancy at birth stood at 59.1 years for males and 60.9 years for females. Healthy life expectancy has remained similar over the last five years for both males and females.

In 2014-16 the gap in healthy life expectancy between Northern Ireland overall and the most deprived areas was 8.5 years for males and 8.2 years for females. There has been no change in the gaps for both males and females over the last five years.

Healthy life expectancy estimates at NI level are subject to a confidence interval of around +/- 0.7 years and at deprivation quintile level of around +/- 1.7 years and this has been considered when describing changes in figures over time.

Male Healthy Life Expectancy	2010-12	2011-13	2012-14	2013-15	2014-16	RAG Status
Northern Ireland	58.5	58.4	58.7	58.4	59.1	No Change
Deprivation Quintiles						
1 (Most Deprived)	51.3	51.3	51.2	51.1	50.6	Declined
5 (Least Deprived)	63.2	63.1	63.4	63.0	64.3	No Change
Inequality Gaps						
Most-Least Deprived	11.9	11.8	12.2	11.9	13.7	No Change
Most Deprived-NI	7.2	7.1	7.5	7.3	8.5	No Change
Female Healthy Life Expectancy	**2010-12**	**2011-13**	**2012-14**	**2013-15**	**2014-16**	**RAG Status**
Northern Ireland	61.6	61.6	61.7	61.0	60.9	Declined
Deprivation Quintiles						
1 (Most Deprived)	53.7	53.8	53.4	53.1	52.7	Declined
5 (Least Deprived)	66.5	67.8	68.0	67.5	65.7	No Change
Inequality Gaps						
Most-Least Deprived	12.8	14.0	14.6	14.3	13.0	Fluctuated
Most Deprived-NI	7.8	7.9	8.3	7.9	8.2	No Change

Table 3. Healthy life expectancy at birth and inequality gaps, Northern Ireland, 2010-12 to 2014-16. Source: Health Survey via NI Health and Social Care Inequalities Monitoring System, NISRA, Department of Health.

Further information to supplement the indicator: Gap in life expectancy between the most deprived areas and the borough overall is included below.

Physical Activity

The Chief Medical Officer's recommended level of physical activity per week is 150 minutes or more of moderate aerobic activity, or 75 minutes or more of vigorous activity or an equivalent combination of the two.

The NI Health Survey 2016/17 showed that over half of respondents aged 19 or over in NI (55%) met these recommendations. While more than a quarter (26%) were inactive.

Females (51%) were less likely than males (61%) to meet the recommended levels.

Those in the most deprived areas (44%) were less likely than those in the least deprived areas (63%).

Those age 55 and over were less likely to meet recommendations, aged 55-64 years (47%), 65-74 years (41%), and in particular, those aged 75+ years (10%).

Smoking

The NI Health Survey showed that a fifth (20%) of adults smoke cigarettes (2016/17). This fell from 22% in 2015/16. Smoking prevalence has shown a downward trend since 1983 falling from a third to a fifth of adults.

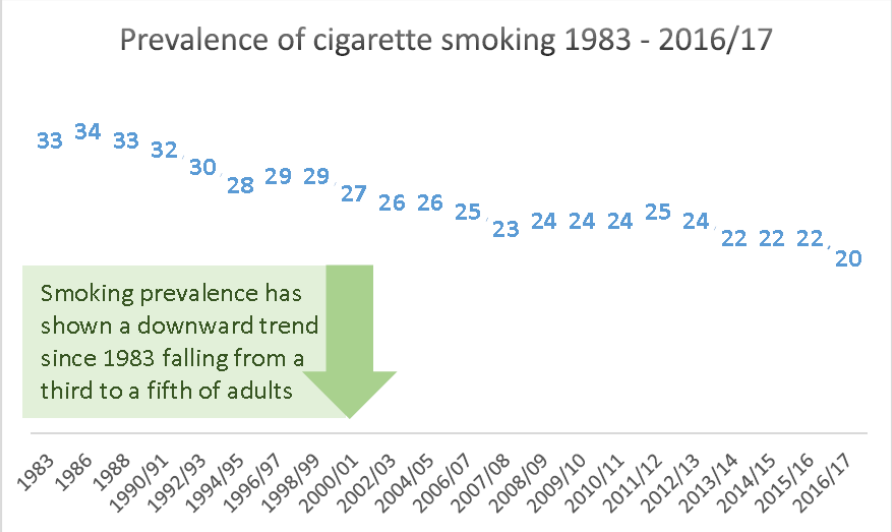

Figure 3. Percentage of people (aged 16+) who currently smoke cigarettes, Northern Ireland, 1983 to 2016/17. Source: NI Health Survey, NISRA, Department of Health.

Levels of smoking were similar by gender, males 20% and females 19%.

By age, those aged 75+ had lower levels of smoking, at 7%.

Those living in the most deprived areas were almost 3 times as likely (32%) as those in the least deprived areas (11%) to smoke.

Stopping smoking: 62% of smokers want to stop and 75% of smokers have tried to stop.

Body Mass Index

Body Mass Index (BMI) is a widely used indicator of body fat levels that is calculated from a person's height and weight. BMI is calculated by dividing weight (kilograms) by the square of height (metres). As part of the NI Health Survey, height and weight measurements are sought from individuals at participating households.

The survey showed in 2016/17 that 36% of respondents were overweight and a further 27% were obese. These levels were similar to the previous year, but there has been a general upward trend in obesity over the last decade.

Both overweight and obesity rates were similar by deprivation quintiles.

Deprivation quintile	Overweight	Obese
Most deprived	37%	26%
Quintile 2	34%	28%
Quintile 3	36%	27%
Quintile 4	36%	27%
Least deprived	36%	25%
Total	**36%**	**27%**

Table 4. Percentage of respondents aged 16+ who were overweight or obese, Northern Ireland, 2016/17. Source: Health Survey NI, NISRA, Department of Health.

A quarter of children aged 2-15 years were overweight or obese (17% being overweight and 8% obese).

Employment and Skills

Information from the 2011 Census at Northern Ireland level showed that 30% of those who were unemployed had no qualifications, compared to 12% of employees.

While 13% of those who were unemployed had level 4 qualifications and above, compared to 35% of employees.

	Economically Active				
	Total	Employee	Self-employed	Unemployed	Full-time students
No qualifications	15%	12%	22%	30%	6%
Level 1 qualifications	13%	13%	12%	19%	11%
Level 2 qualifications	17%	16%	13%	17%	30%
Apprenticeship	5%	4%	11%	6%	2%
Level 3 qualifications	15%	15%	12%	12%	38%
Level 4 qualifications and above	31%	35%	25%	13%	12%
Other qualifications	4%	5%	5%	4%	1%
All usual residents aged 16 to 74 Economically Active	**100%**	**100%**	**100%**	**100%**	**100%**

Table 5. Highest level of qualification for economically active, usual residents aged 16-74. Source: Table DC6501NI, Census 2011, NISRA.

Indicator: Number of preventable deaths per 100,000 population (age standardised preventable mortality rate)

Using the Office for National Statistics (ONS) definition - a death is preventable if, in the light of understanding of the determinants of health at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided by public health interventions in the broadest sense.

The borough's preventable death rate was 190 deaths per 100,000 population for the period 2012-16, this is slightly better than the rate for NI (205 per 100,000 population).

The preventable death rate in the borough has been improving over time; however levels remain higher in the most deprived areas (294 per 100,000 population). Lurgan (217) and Portadown (220) District Electoral Areas had higher preventable death rates than the borough overall (190).

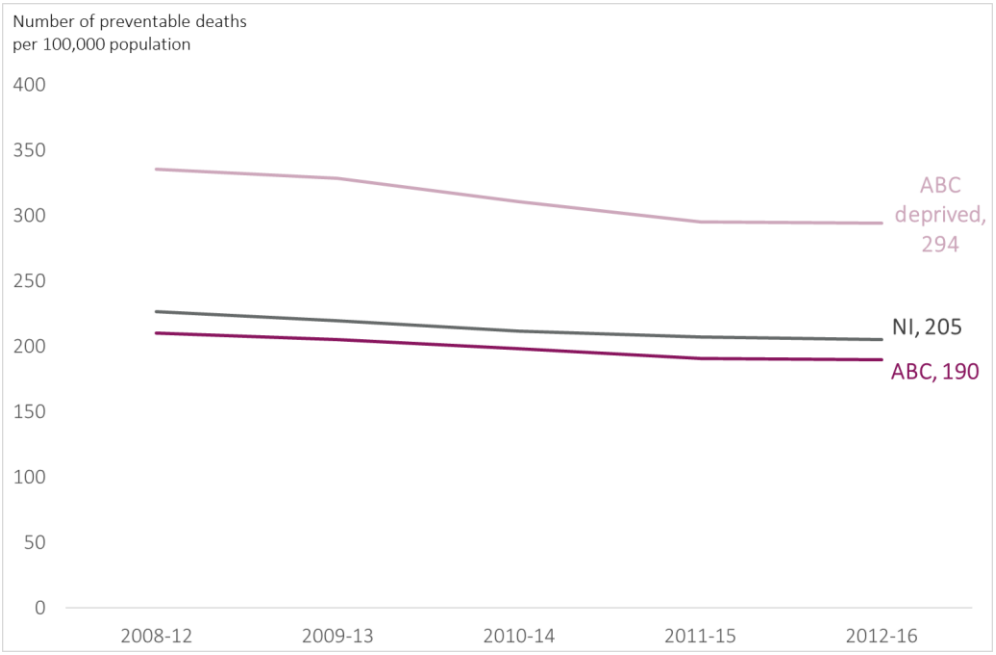

Figure 4. Number of preventable deaths per 100,000 population, Armagh City, Banbridge and Craigavon Borough (overall and most deprived areas) and Northern Ireland, 2008-12 to 2012-16. Source: NI Health and Social Care Inequalities Monitoring System, NISRA, Department of Health.

Standardised Death Rate - Preventable	2008-12	2009-13	2010-14	2011-15	2012-16	RAG Status
Northern Ireland	226	220	211	207	205	Improved
Armagh City, Banbridge and Craigavon	**210**	**205**	**198**	**191**	**190**	**Improved**
Armagh City, Banbridge and Craigavon Deprived	336	329	311	295	294	Improved
Armagh City, Banbridge and Craigavon-NI Gap	-7%	-7%	-6%	-8%	-8%	No Change
Armagh City, Banbridge and Craigavon Deprivation Gap	60%	60%	57%	55%	55%	No Change
Armagh	217	234	224	199	199	Similar to LGD
Banbridge	199	196	188	185	190	Similar to LGD
Craigavon	238	230	205	196	194	Similar to LGD
Cusher	171	157	161	161	149	Better than LGD
Lagan River	140	140	133	132	136	Better than LGD
Lurgan	242	228	233	217	217	Worse than LGD
Portadown	238	225	216	223	220	Worse than LGD

Table 6. Number of preventable deaths per 100,000 population and gaps, 2008-12 to 2012-16. Source: NI Health and Social Care Inequalities Monitoring System, NISRA, Department of Health.

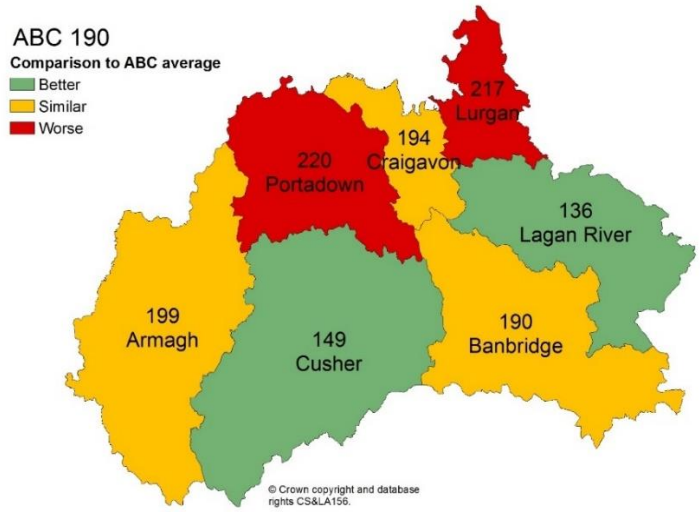

Figure 5. Number of preventable deaths per 100,000 population, District Electoral Areas in Armagh City, Banbridge and Craigavon Borough, 2012-16. Source: NI Health and Social Care Inequalities Monitoring System, NISRA, Department of Health.

In the five year period 2011-2015, the leading causes of preventable deaths in the borough were cancer, ischaemic heart disease and suicide/undetermined.

	Males	Females	Total
Neoplasms	317	314	631
Ischaemic heart disease (IHD)	250	94	344
Suicide/Undetermined	126	35	161
Accidental	85	60	145
Chronic obstructive pulmonary disease (COPD)	56	46	102
Alcohol Related	72	28	100
Diabetes	25	15	40
Transport Accident	27	10	37
DVT	12	11	23
Aortic aneurysm	15	6	21
Other causes	16	9	25
Total	**1,001**	**628**	**1,629**

Table 7. Causes of preventable deaths in Armagh City, Banbridge and Craigavon Borough, 2011-2015. Source: Demographic Statistics, NISRA. Note within Neoplasms, the leading cause was Neoplasm of trachea/lung with 277 total deaths.

In Northern Ireland over the last few decades deaths from heart disease have fallen substantially, while deaths from cancer have increased.

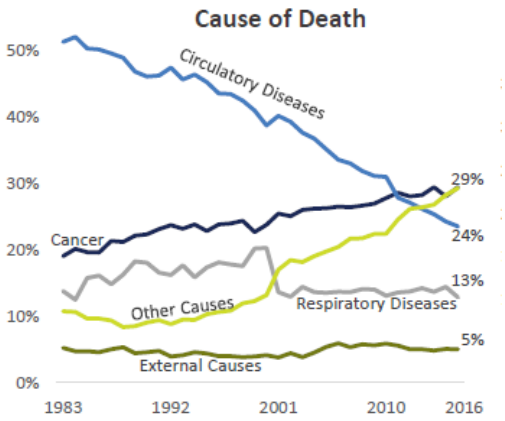

Figure 6. Cause of death, Northern Ireland, 1983 to 2016. Source: Registrar General Annual Report via NI in Profile report, NISRA.

Cancer

In collaboration with the Northern Ireland Cancer Registry, Macmillan Cancer Support has developed a Local Cancer Intelligence tool[1] to help people understand the changing cancer population.

Incidence - Between 2010 and 2014, there was an average of 589 new cancer diagnoses for every 100,000 people per year in the Borough; this is similar to the NI average of 592.

Incidence refers to the number of people who are diagnosed with cancer in a certain period of time. The incidence rates are 'age-standardised', this means they take into account age differences in the underlying populations and provide meaningful comparisons.

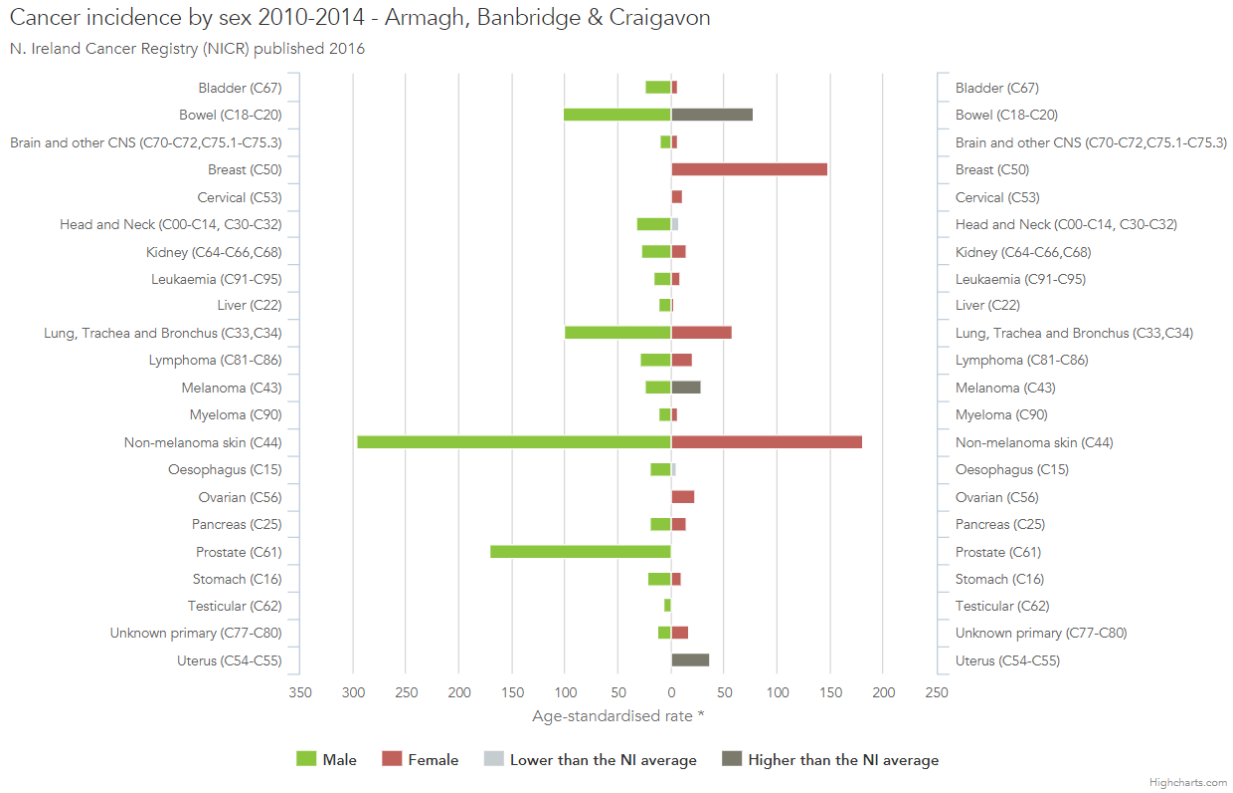

Figure 7. Cancer incidence by sex and cancer type, 2010-2014, Armagh City, Banbridge and Craigavon Borough. Source: N. Ireland Cancer Registry via Local Cancer Intelligence tool, Macmillan.

As the population ages, incidence rates in the UK continue to rise. However, there are variations between different areas of the country, segments of the population and types of cancer, and not all groups will see increased rates. For example, male lung cancer incidence rates have been decreasing in recent years.

Mortality - Mortality is the number or rate of deaths in a given population in a defined time period (usually a year). The mortality rates shown below are known as 'age-standardised'. This means they take into account age differences in the underlying populations and provide meaningful

[1] Local Cancer Intelligence tool: http://lcini.macmillan.org.uk/Council/Armagh-Banbridge-and-Craigavon

comparisons. They relate to all deaths registered with cancer mentioned as the underlying cause of death.

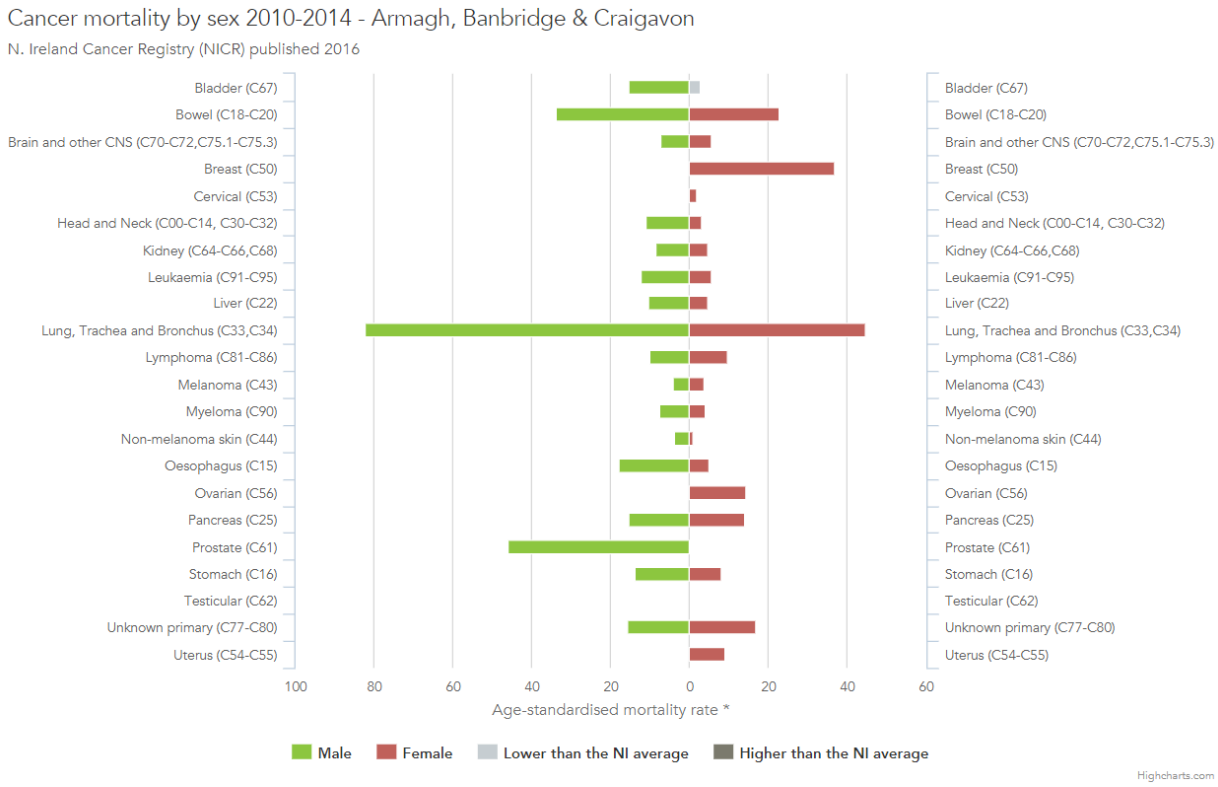

Figure 8. Cancer mortality by sex and cancer type, 2010-2014, Armagh City, Banbridge and Craigavon Borough. Source: NI Cancer Registry via Local Cancer Intelligence tool, Macmillan.

Notes on indicator data

The NI Health and Social Care Inequalities Monitoring System (HSCIMS) developed by the Information Analysis Directorate within the Department of Health, covers a range of different health inequality/equality based projects conducted for both the region as well as for more localised area levels. Baseline information presented is taken from the Health Inequalities Annual Report 2018.

Life Expectancy Estimates
NISRA publish the official life expectancy estimates at NI, Local Government District and Parliamentary Constituency level. The HSCIMS publishes at further levels to allow for assessment of inequality gaps between different areas/population groups, including deprivation analysis. Life expectancy at birth is the expected years of life at time of birth based on mortality patterns in the period in question. It is based on the average death rates over a three year period.

Standardised Death Rates
This is calculated by directly age standardising the average death rate in NI over a given period, due to specific causes of death (selected according to ICD-10 classification) to the 2013 European Standard Population. Some death rates relate to those under the age of 75 as indicators of premature mortality for specific diseases. This is because deaths at older ages are often difficult to attribute definitively to a single underlying cause and the chances of death are more affected by coexisting medical conditions and other factors. The selection of age limits should not be taken to

mean that deaths from the selected causes for older persons are considered unavoidable, or that the condition will not respond well to treatment in older people.

Causes of death have been categorised as preventable in line with the Office for National Statistics (ONS) definition. A death is preventable if, in the light of understanding of the determinants of health at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided by public health interventions in the broadest sense.

Deprivation Classification

The deprivation classification used in Health Inequalities Annual Report 2018 report is based on the Northern Ireland Multiple Deprivation Measure (NIMDM) produced by NISRA. The 2017 NIMDM has been applied to all newly published figures, specifically the latest two years / data points in the time series presented for each indicator. All other data points are based on the 2010 NIMDM. Although the 2017 NIMDM is available at small area level it was decided to continue using the SOA classification within the HSCIMS to ensure continuity and comparability with the back series of data and across indicators. In addition, all analysis presented is based on multiple deprivation rather than any specific deprivation domain.

RAG Status

An assessment of change over time is indicated for health outcomes and inequality gaps. It should be noted that any indicated changes are open to interpretation.

Indicator: Percentage of people who participate in sport or physical activity on at least one day a week

In Armagh City, Banbridge and Craigavon Borough , 47% of adults participated in sport or physical activity on at least one day a week in in the period 2013/14 – 2015/16, similar to the level in the previous rolling three year period (45%). These are also similar to levels in NI (48% for both rolling three-year periods).

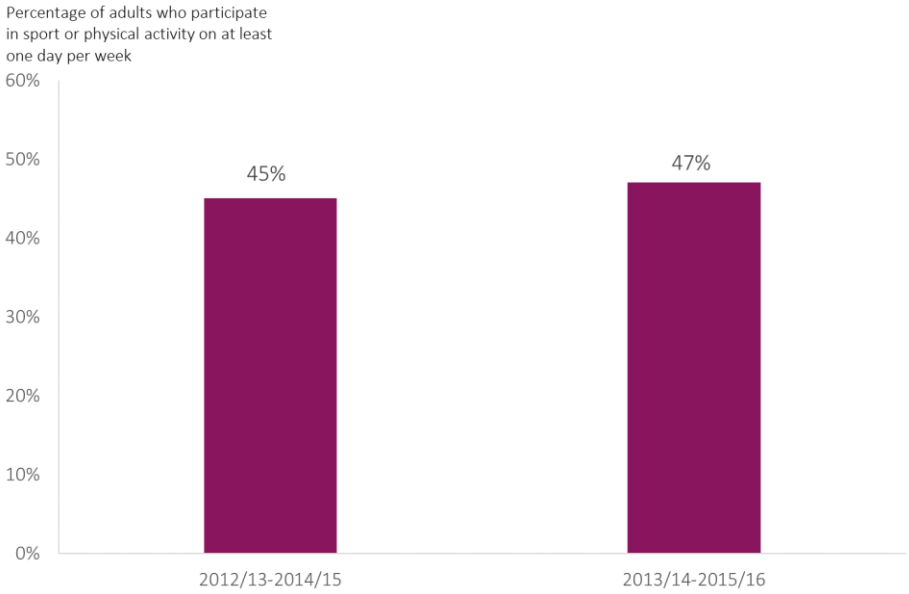

Figure 9. Percentage of adults who participate in sport or physical activity on at least one day per week, 2012/13-2014/15 and 2013/14-2015/16, Armagh City, Banbridge and Craigavon Borough and Northern Ireland. Source: Continuous Household Survey, NISRA, Department for Communities. Note - does not include walking for recreation.

Percentage of adults who participate in sport or physical activity on at least one day per week	2012/13-2014/15	2013/14-2015/16
Armagh City, Banbridge and Craigavon	45%	47%
Northern Ireland	48%	48%

Table 8. Percentage of adults who participate in sport or physical activity on at least one day per week, 2012/13-2014/15 and 2013/14-2015/16, Armagh City, Banbridge and Craigavon Borough and Northern Ireland. Source: Continuous Household Survey, NISRA, Department for Communities. Note - does not include walking for recreation.

In Northern Ireland in 2016/17, while 48% of adults normally participated in sport at least one day per week, levels of sport participation were lower for women, older adults, adults with a disability and adults living in the most deprived areas.

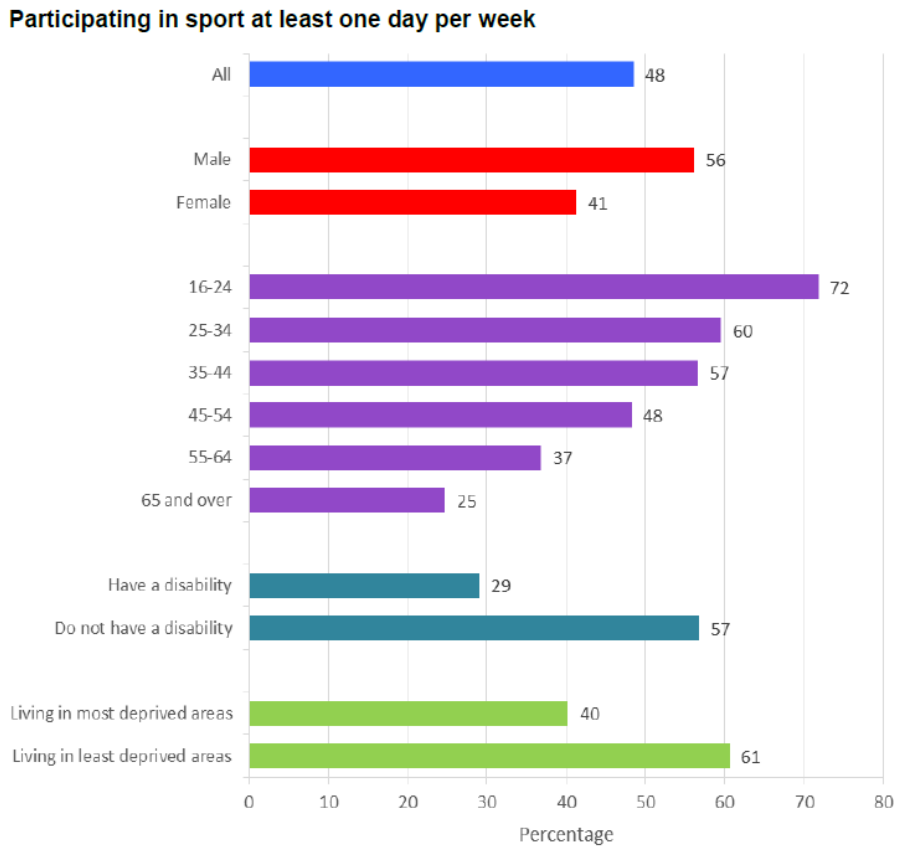

Figure 10. Percentage of adults (aged 16 and over) participating in sport at least one day per week, Northern Ireland, 2016/17. Source: Continuous Household Survey 2016/17, NISRA, Department for Communities. Note excludes adults who only walk for recreation.

Notes on indicator data

The Continuous Household Survey (CHS) is a Northern Ireland wide household survey administered by Northern Ireland Statistics and Research Agency (NISRA). The survey covers respondents aged 16 and over.

The question on the number of days normally participating in sport each week was not included on the CHS in 2011/12.

The indicator is an estimate based on sample surveys, as such the estimates from it are subject to sampling error and care should be taken when making inferences from them. The table below shows confidence intervals and base achieved sample sizes for the estimates. Engagement rates are calculated based on three year rolling averages. Comparisons should not be made across the years provided due to overlapping samples.

Normally participates in sport on at least one day per week	2012/13-2014/15			
	%	Confidence intervals		Base
		Lower limit	Upper limit	
Armagh City, Banbridge and Craigavon	45%	42.2%	47.6%	1,277
Northern Ireland	48%	46.7%	48.6%	10,726

Normally participates in sport on at least one day per week	2013/14-2015/16			
	%	Confidence intervals		Base
		Lower limit	Upper limit	
Armagh City, Banbridge and Craigavon	47%	44.7%	50.2%	1,280
Northern Ireland	48%	46.7%	48.7%	10,387

Table 9. Confidence intervals and achieved base sample sizes for estimates of percentage of adults who participate in sport or physical activity on at least one day per week, 2012/13-2014/15 and 2013/14-2015/16, Armagh City Banbridge and Craigavon Borough and Northern Ireland. Source: Continuous Household Survey, NISRA, Department for Communities.

Sport participation in the last year and in previous four weeks

In Northern Ireland levels of sport participation within the last year and previous four weeks has been similar over time.

More than half of adults (54%) participated in sport at least once within the last year. This proportion has remained fairly stable over the last seven years, following an initial decline between 2007/08 and 2008/09.

Since first recorded in the 2011/12 Continuous Household Survey, around four out of every ten adults have taken part in sport at least once within the previous four weeks, with 42% in 2016/17.

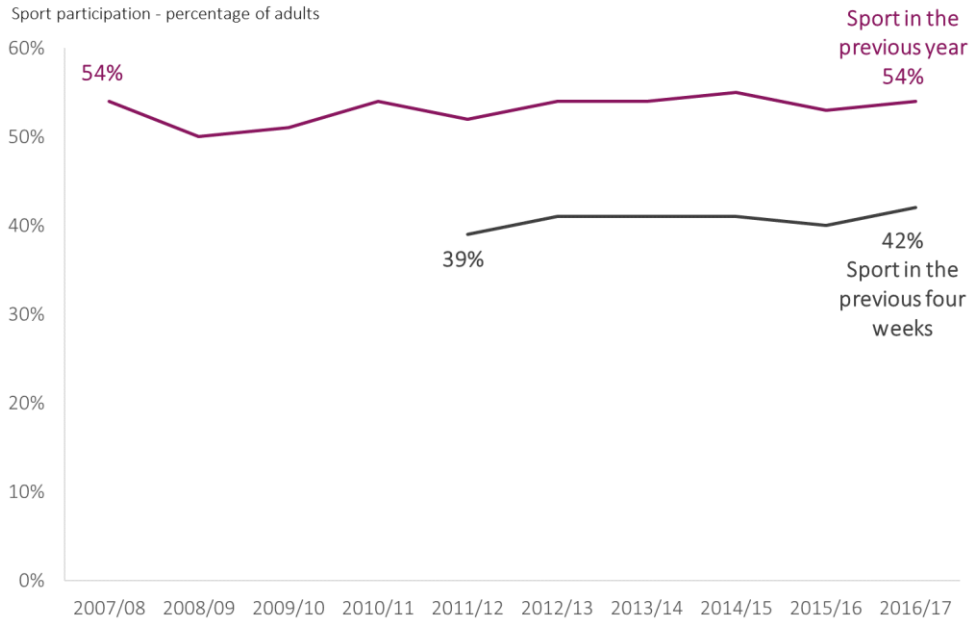

Figure 11. Percentage of adults (aged 16 and over) participating in sport in the last year and in the last four weeks, Northern Ireland, 2007/08 to 2016/17. Source: Continuous Household Survey, NISRA, Department for Communities. Note - does not include walking for recreation.

Results from the Young Persons' Behaviour and Attitudes Survey showed in 2016 in Northern Ireland, almost all young people (99%) had taken part in sport or physical activity at least once within the year. Over nine out of every ten (96%) young people had been involved in sport or

physical activity within the last week. The Young Persons' Behaviour and Attitudes Survey (YPBAS) is a school-based survey carried out among year groups 8-12 (ages 11-16).

	Sport in the last year	Sport in the last week
2007	98%	95%
2010	100%	97%
2013	99%	96%
2016	99%	96%

Table 10. Percentage of young people (aged 11-16) participating in sport in the last year and in the last week, Northern Ireland, 2007/08 to 2016/17. Source: Young Persons' Behaviour and Attitudes Survey, NISRA, Department for Communities.

Most popular sports/physical activities

Walking for recreation (41%) was the most popular sports/physical activities with 42% participating within the previous 4 weeks. Keepfit, Aerobics, Yoga, Dance exercise (10%), Swimming or diving (8%) and Jogging (8%) were the next popular sports/physical activities.

	All	Male	Female
Walking for recreation	42%	35%	49%
Keepfit, Aerobics, Yoga, Dance exercise	10%	5%	15%
Swimming or diving	8%	7%	10%
Jogging	8%	9%	6%
Weight training/ Lifting or body building	7%	10%	4%
Cycling for recreation	7%	10%	4%
Football	6%	13%	0%
Golf, pitch and putt, putting	4%	7%	1%
Snooker, pool or billiards	3%	5%	1%
Tenpin bowling	2%	2%	2%

Table 11. Top 10 sports/physical activities participated in within the previous 4 weeks by gender, Northern Ireland, 2016/17. Source: Continuous Household Survey 2016/17, NISRA, Department for Communities.

Factors that put you off participating in sport more

Just over a fifth of adults (22%) stated that nothing puts them off participating more in sport. However just over a third (34%) stated that they didn't have enough time to participate more or would rather do other things with their time. Other reasons include "I have a medical condition/disability" (19%), "I'm not fit / I get tired easily" (15%), "I'm not interested in sport or physical activity" (14%) and "The weather is bad" (13%).

Factors that put you off participating in sport more	All	Male	Female
I don't have enough time / I would rather do other things with my time	34%	31%	38%
I have a medical condition / disability	19%	18%	19%
I'm not fit / I get tired easily	15%	14%	16%
I'm not interested in sport or physical activity	14%	13%	16%
The weather is bad	13%	13%	13%
Nothing	22%	26%	18%

Table 12. Main factors that put you off participating in sport more, Northern Ireland, 2016/17. Source: Continuous Household Survey 2016/17, NISRA, Department for Communities.

The Chief Medical Officer's recommended level of physical activity per week is 150 minutes or more of moderate aerobic activity, or 75 minutes or more of vigorous activity or an equivalent combination of the two. The Health Survey 2016/17 showed that over half of respondents aged 19 or over in NI (55%) met these recommendations. While more than a quarter (26%) were inactive.

Walking for recreation

While 'Walking for recreation' is not included in the overall sport participation figures, information is available from the Continuous Household Survey.

In Northern Ireland in 2016/17, nearly half of adults (47%) had walked for recreation within the previous year. In contrast to the demographic pattern seen with the overall sport participation rates, a higher proportion of females (54%) than males (40%) had walked for recreation.

Around one sixth of adults (16%) had not participated in sport but had walked for recreation within the previous year. A higher proportion of non-sport participating females (23%) had walked for recreation than non-sport participating males (10%). When considering age groups, the pattern is also somewhat different than that seen when analysing sport participation. Walking for recreation rates peak among the 45-54 year age group (55%), whilst rates for 65 years and over are similar to those for the youngest adult age group 16-24 years.

However, analysis by disability and deprivation shows that relatively fewer adults with a disability and adults living in the most deprived areas walk for recreation.

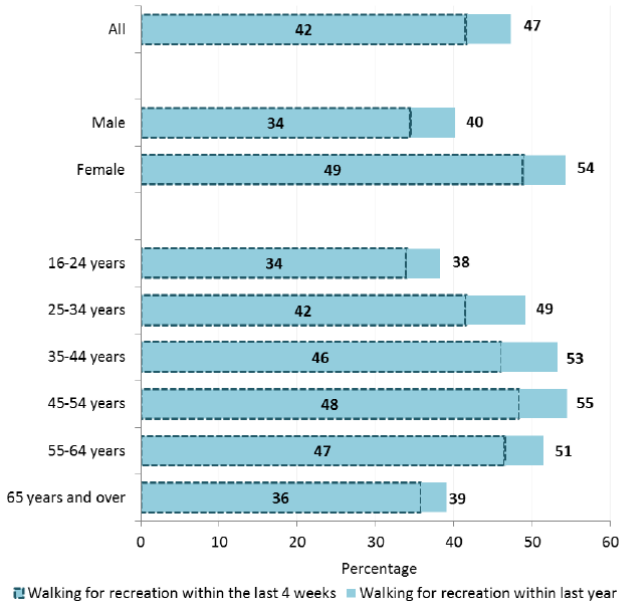

Figure 12. Percentage of adults (aged 16 and over) walking for recreation in the last four weeks and in the last year, Northern Ireland, 2016/17. Source: Continuous Household Survey, NISRA, Department for Communities.

Over the last six years, the proportion of adults who indicated that they walked for recreation within the previous year has increased from 36% in 2011/12 to a peak of 50% of adults in 2014/15. The 2016/17 figure (47%) has seen the proportion remain constant when compared with the 2015/16 figure.

Similarly, within the same time frame, the proportion of adults who had walked for recreation within the previous 4 weeks increased from 28% in 2011/12 to a peak of 43% in 2014/15. The 2016/17 results show a similar proportion at 42%.

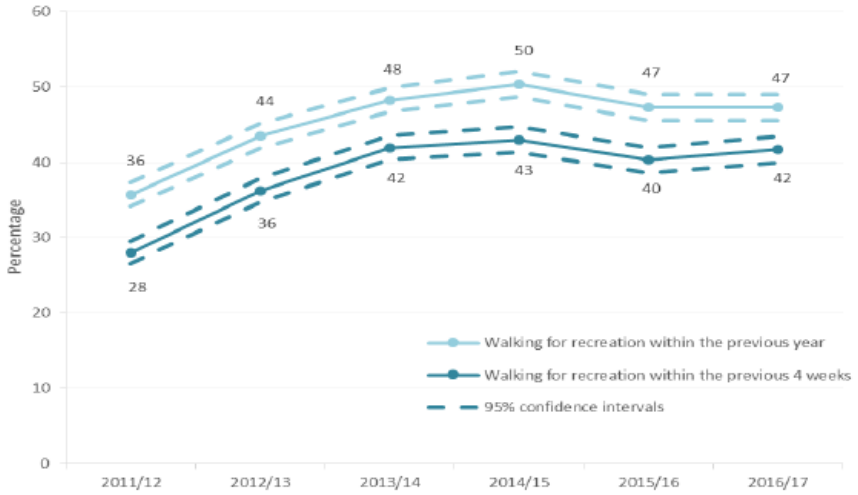

Figure 13. Percentage of adults (aged 16 and over) walking for recreation in the last four weeks and in the last year, Northern Ireland, 2011/12 to 2016/17. Source: Continuous Household Survey, NISRA, Department for Communities.

General Health

The NI Health Survey asked questions on general health and longstanding illnesses.

Looking at results for 2016/17, 73% of adults in NI described their health as 'good' or 'very good'. A similar level to 2010/11 (73%).

Results were similar by gender (males 75%, females 72%). A decline in general health rating was observed with increasing age, for example, 89% of 16-24 year olds reported good or very good health, compared to 47% of those 75+ years.

Respondents in the most deprived areas were less likely to describe their health as good or very good (60%) than those in the least deprived areas (80%).

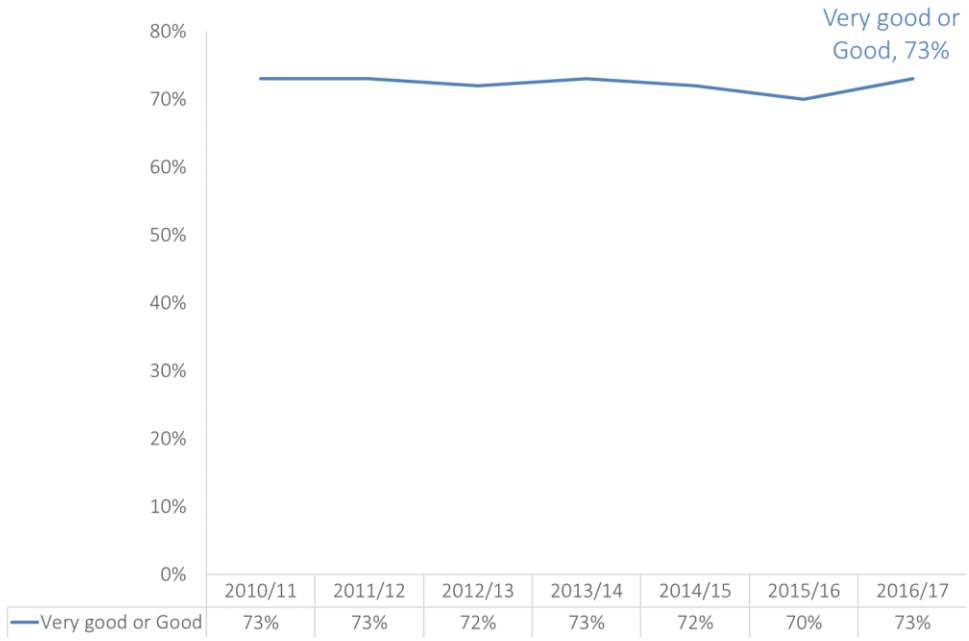

Figure 14. Percentage of people (aged 16+) reporting good or very good health, Northern Ireland, 2010/11 to 2016/17. Source: NI Health Survey, NISRA, Department of Health.

In 2016/17, 42% reported a longstanding illness (30% limiting and 12% non-limiting longstanding illness).

There has been a gradual increase in respondents reporting limiting longstanding illness over recent years. Females (33%) are more likely to report a limiting longstanding illness than males (27%).

Those in the older age-groups are more likely to report a limiting longstanding illness, as are those in the most deprived areas with 42% of those in the most deprived areas reporting a limiting long-standing illness compared with 26% of those in the least deprived areas.

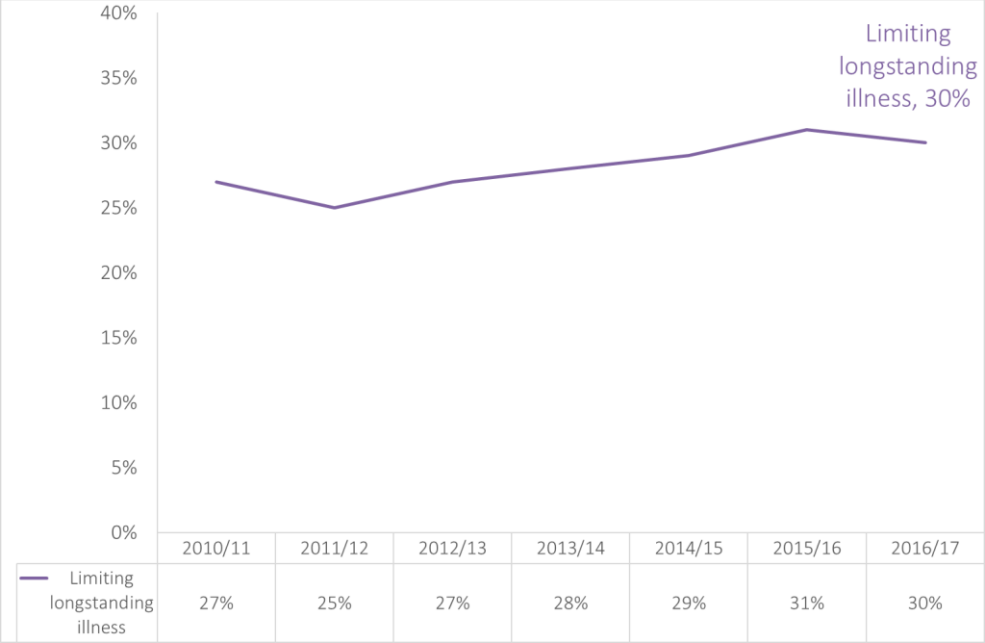

Figure 15. Percentage of people (aged 16+) reporting limiting longstanding illness, Northern Ireland, 2010/11 to 2016/17. Source: NI Health Survey, NISRA, Department of Health.

The 2011 Census asked a range of general health questions. Four fifths of people in the Borough had good or very good general health, with the highest proportions of good health in Lagan River and lower proportions in Lurgan and Portadown District Electoral Areas.

One fifth (20%) of people (or 39,861 individuals) in the Borough had a long-term health problem or disability that limited their day-to- day activities, similar to NI at 21%. Within the Borough Lurgan and Portadown District Electoral Areas had slightly higher levels (22%), compared to Lagan River that had lower levels 16%. A similar pattern was shown when considering only 16-64 year olds. At a lower geographical level, Super Output Areas, levels of limiting long-term health problems ranged from 12% to 37%.

	Good or very good general health	Long-term health problem or disability limiting day-to-day activities	
	All	All	16-64 years
Super Output Area range	63% to 88%	12% to 37%	10% to 31%
District Electoral Area			
Armagh	80%	20%	16%
Banbridge	80%	20%	17%
Craigavon	80%	19%	17%
Cusher	82%	19%	15%
Lagan River	84%	16%	13%
Lurgan	78%	22%	18%
Portadown	78%	22%	18%
Armagh City, Banbridge & Craigavon	**80%**	**20%**	**17%**
Northern Ireland	**80%**	**21%**	**17%**

Table 13. General health and long-term health problem or disability limiting day-to-day activities. Source: 2011 Census, NISRA.

The 2011 Census asked residents about long-term (at least 12 months) conditions.

The most common conditions reported by residents were 'A mobility or dexterity difficulty (11%), followed by 'Long-term pain or discomfort' (10%). These were the same as levels for NI overall. Similar proportions were seen in each of the seven District Electoral Areas.

Type of Long-Term Condition	Armagh City, Banbridge and Craigavon		NI
	Number	%	%
A mobility or dexterity difficulty	22,092	11	11
Long-term pain or discomfort	19,667	10	10
Shortness of breath or difficulty breathing	15,845	8	9
A chronic illness	12,158	6	7
An emotional, psychological or mental health condition	10,553	5	6
Other condition	9,870	5	5
Deafness or partial hearing loss	9,644	5	5
A learning, intellectual, social or behavioural difficulty	3,984	2	2
Frequent periods of confusion or memory loss	3,570	2	2
Blindness or partial sight loss	3,105	2	2
Communication difficulty	3,105	2	2
No condition	139,936	70	69

Table 14. Long-term conditions. Source: 2011 Census, NISRA.

Mental Wellbeing

Percentage of the population with a possible mental health problem

The General Health Questionnaire (GHQ) is a screening tool designed to detect the possibility of psychiatric morbidity in the general population. GHQ12 is a widely used standard measure of mental distress and mental ill-health consisting of 12 questions on concentration abilities, sleeping patterns, self-esteem, stress, despair, depression, and confidence in the previous few weeks. It is scored on a range from 0 to 12, with a score of 4 or more (referred to as a 'high GHQ12 score') signifying possible mental health problem.

In 2016/17, 17% of NI Health Survey respondents had a high GHQ12 score which could indicate a mental health problem. The levels are similar over the most recent four years.

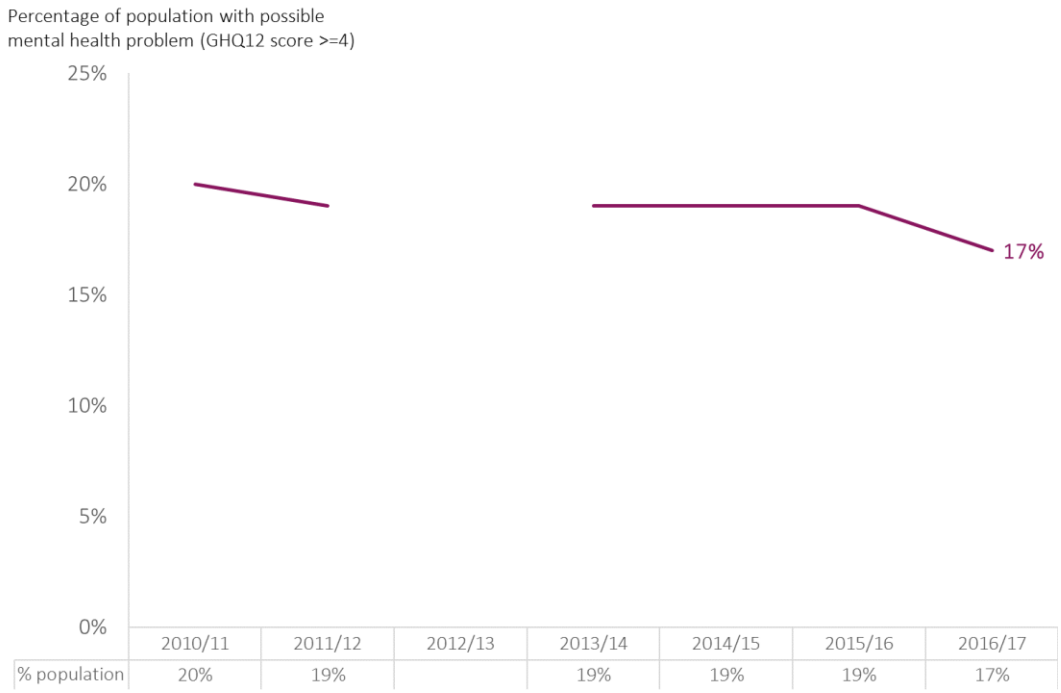

Figure 16. Percentage of population with a possible mental health problem (GHQ12 score of 4 or above), Northern Ireland, 2010/11 to 2016/17. Source: Health Survey NI, NISRA, Department of Health. Note - Questions not asked in 2012/13 Health Survey.

The proportion with a high GHQ12 score is similar by gender females 18% and males 16% in 2016/17; however, the proportion of females with a high GHQ12 score fell from 21% in 2015/16. Results for males have remained unchanged.

Respondents in the most deprived areas (27%) were almost twice as likely to record a high GHQ12 score as those in the least deprived areas (14%) in 2016/17.

Respondents in the Southern Health and Care Trust (13%) had lower levels than the Belfast Trust (22%) in 2016/17.

Respondents with a limiting long-standing illness were three times more likely to score highly on the GHQ12 (37%) than both those whose long-standing illness was not limiting (12%) and those who did not have a long-standing illness (11%) in 2015/16.

Analysis of 2015/16 data for Northern Ireland showed of those scoring highly on the GHQ12, a quarter had a diagnosed mental health problem and just under half were taking medication for stress, anxiety or depression.

GHQ12 score	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17		2016/17 95% confidence intervals		
0	50%	52%	Questions not asked	54%	53%	55%	56%		53.7%	to	57.7%
1 - 3	30%	28%		28%	28%	27%	27%		25.3%	to	28.9%
4+	20%	19%		19%	19%	19%	17%		15.6%	to	18.7%
Total	100%	100%		100%	100%	100%	100%				
Unweighted base	*3,873*	*4,115*		*4,139*	*3,739*	*3,577*	*2,347*				

Table 15. GHQ12 Scores, Northern Ireland, 2010/11 to 2016/17 and 95% confidence intervals for 2016/17. Source: Health Survey NI, NISRA, Department of Health. Note - Questions not asked in 2012/13 Health Survey.

The proportions of adults with a possible mental health problem was similar in Scotland (15%) and England (19%).

Scotland - In 2016, 15% of adults exhibited signs of a possible psychiatric disorder (GHQ12 score of four or more), the proportion remaining relatively static since 2003. Source: Scottish Health Survey 2016, Scottish Government.

England - The proportion of adults with probable mental ill health (GHQ12 score of four or more) has increased since 2012, from 15% to 19% (2016). Confidence interval 17.5% to 19.7%.Source: Health Survey for England 2016, NHS Digital.

Personal Wellbeing

Personal (or subjective) wellbeing concerns peoples' self-reported assessment of their own wellbeing, for example, by asking about their life satisfaction, happiness, and psychological wellbeing.

Since 2011, the Office for National Statistics has asked personal wellbeing questions to adults in the UK, to better understand how they feel about their lives. An individual's thoughts and feelings about their own quality of life is an important aspect of wellbeing – both personal and national. How satisfied people are with their lives, their levels of happiness and anxiety, and whether or not they think the things they do are worthwhile all have strong links with many elements of well-being, for example, people's health, employment and relationships.

The four Personal Wellbeing questions are:

- overall, how satisfied are you with your life nowadays?
- overall, to what extent do you feel the things you do in your life are worthwhile?
- overall, how happy did you feel yesterday?
- overall, how anxious did you feel yesterday?

People are asked to respond on a scale of 0 to 10, where 0 is "not at all" and 10 is "completely".

The proportion of people that rated very high for life satisfaction (38%), worthwhile (39%) and happy (42%) were similar. 46% of people rated their anxiety as very low.

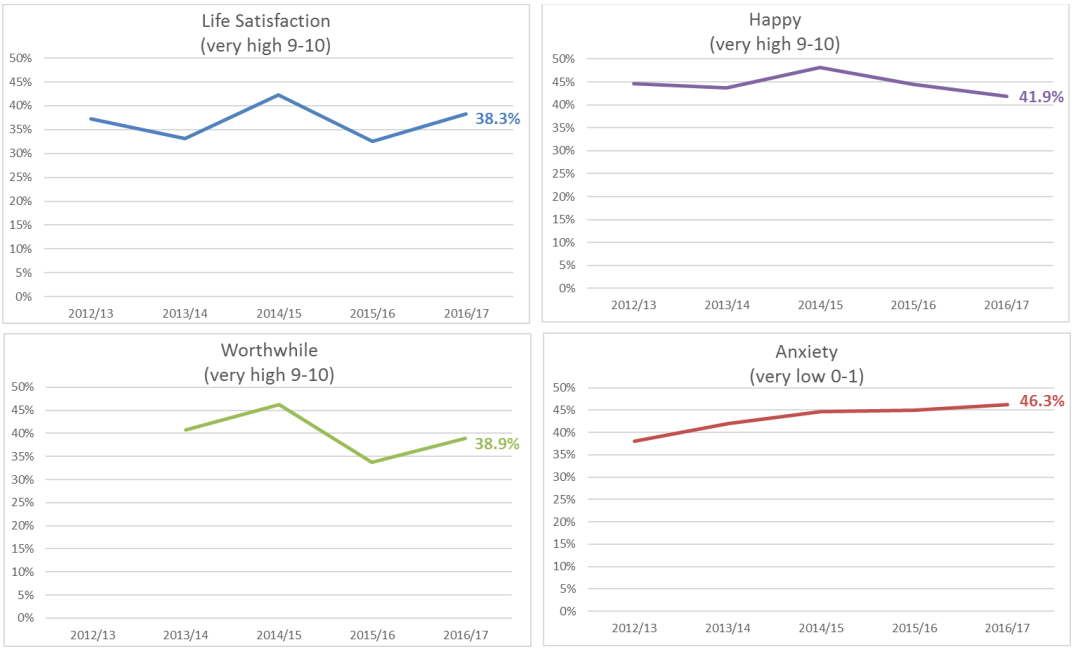

Figure 17. Proportion of people rating very high life satisfaction, happy, worthwhile, or very low anxiety, Armagh City, Banbridge and Craigavon Borough, 2012/13 to 2016/17. Source: Headline estimates of personal well-being, released 26th September 2017, Office for National Statistics (ONS). Note - Data for worthwhile 2012/13 has been suppressed as the co-efficient of variation (CV), which indicates the quality of a figure; is >20% or unavailable, or the sample size is insufficient.

	Very High (9-10)			Very Low (0-1)
	Life Satisfaction	Worthwhile	Happy	Anxiety
2012/13	37.3%	-	44.6%	38.0%
2013/14	33.2%	40.8%	43.7%	42.0%
2014/15	42.3%	46.3%	48.1%	44.7%
2015/16	32.6%	33.8%	44.5%	44.9%
2016/17	38.3%	38.9%	41.9%	46.3%

Table 16. Proportion of people rating very high life satisfaction, happy or worthwhile or very low anxiety, Armagh City, Banbridge and Craigavon Borough, 2012/13 to 2016/17. Source: Headline estimates of personal well-being, released 26th September 2017, Office for National Statistics (ONS).

As the personal wellbeing ratings are estimates from sample surveys they will have associated confidence intervals.

	Very High (9-10)			Very Low (0-1)
	Life Satisfaction	Worthwhile	Happy	Anxiety
2016/17	38.3%	38.9%	41.9%	46.3%
Lower limit	32.2%	33.0%	35.9%	40.4%
Upper limit	44.4%	44.7%	48.0%	52.3%

Table 17. Confidence intervals for proportion of people rating very high life satisfaction, happy or worthwhile or very low anxiety, Armagh City, Banbridge and Craigavon Borough, 2016/17. Source: Headline estimates of personal well-being, released 26th September 2017, Office for National Statistics (ONS). Note achieved sample size approximately 310.

There are significantly higher proportions of NI respondents reporting very high levels of life satisfaction, worthwhile and happiness than in the UK overall. In recent years there has also been a marked distinction in terms of anxiety, with latest figures indicating a greater proportion of NI respondents indicating very low levels of anxiety than is the case in the UK overall.

Gender

Looking at analysis of data for the UK, in the year ending September 2017, women reported higher life satisfaction, worthwhile and happiness ratings compared with men but also reported higher levels of anxiety.

Over time, women have consistently reported higher levels of life satisfaction and worthwhile every year, but have also reported higher levels of anxiety since ONS first began collecting data in 2011. For ratings of happiness, the gap between men and women has narrowed and, in the years ending September 2015 and 2016, there was no significant difference between the two groups. However, in the year ending September 2017, women again reported higher levels of happiness.

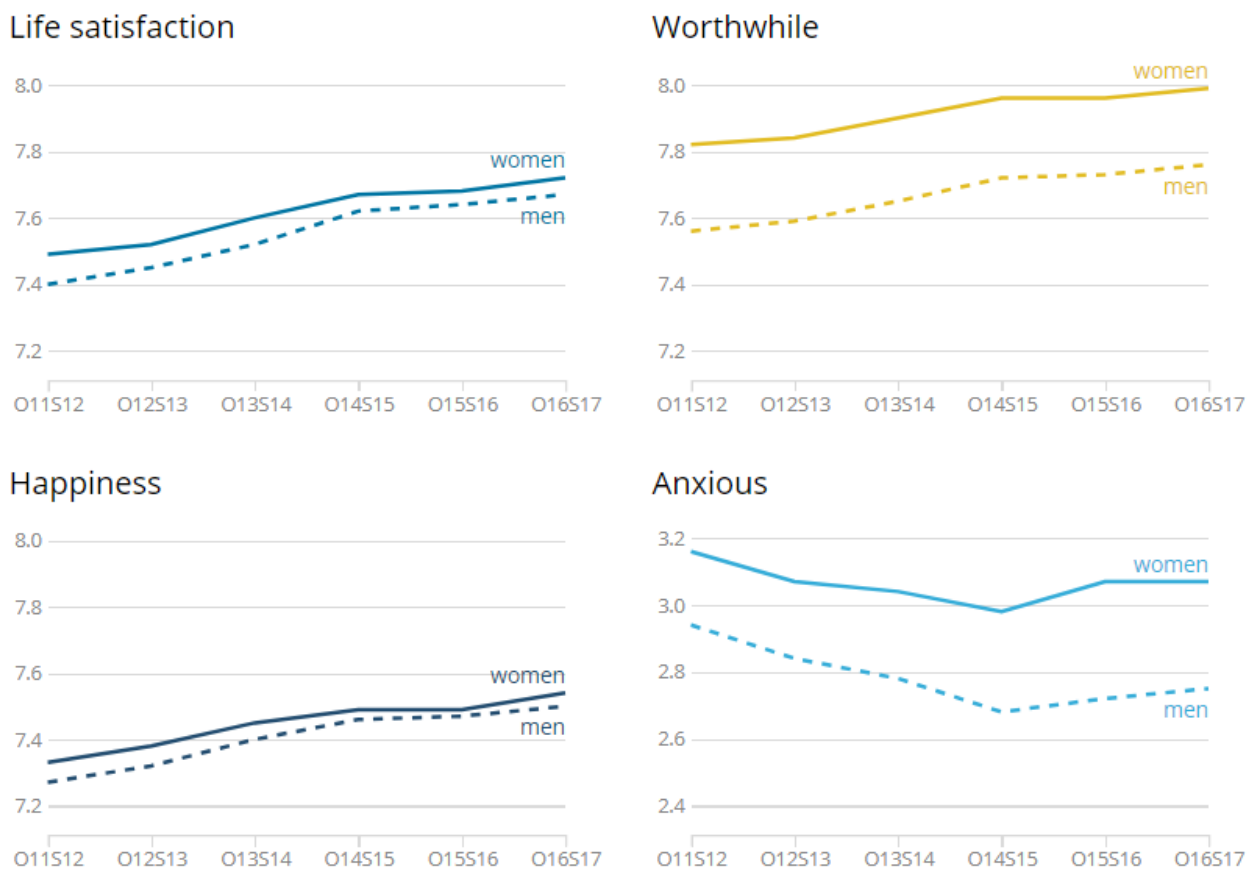

Figure 18. Average personal wellbeing ratings for males and females, year ending September 2012 to year ending September 2017. Source: Personal well-being in the UK: October 2016 to September 2017 report, Office for National Statistics (ONS).

Age

Analysis at a UK level by ONS[2] has shown overall, from about the age of 65 until at least our mid-70s, levels of personal wellbeing look very positive.

People in this age range give higher ratings that the things they do are worthwhile and higher happiness ratings on average than younger age cohorts. Specifically, looking at responses to the four personal well-being questions between October 2016 and September 2017:

- a higher proportion of those aged 16 to 19 and those aged 65 and over reported a high level of life satisfaction (9 to 10 out of 10) than those aged 20 to 24 and 30 to 59
- a higher proportion of those aged 65 to 79 reported a high level of worthwhile (9 to 10 out of 10) than those aged 16 to 64
- a higher proportion of those aged 65 to 84 reported a high level of happiness (9 to 10 out of 10) than all those aged 16 to 64
- a lower proportion of those aged 16 to 24 reported a low level of 'anxiety yesterday' (0 to 1 out of 10) than those aged 65 to 89.

[2]Measuring National Well-being: Quality of Life in the UK, 2018, Office for National Statistics.

The report describes how previous research has suggested that the relationship between age and aspects of personal well-being is Ushaped (David G. Blanchflower, Andrew J. Oswald, 2008). That is, our sense of personal well-being is highest among younger people and older people and is lowest among people in their middle years. The article 'At what age is Personal Well-being the highest?'[3] has provided a more detailed picture of the relationship between personal wellbeing and age than the widely accepted U-curve and found a notable decline in personal wellbeing scores for those aged 75 and over.

The report also notes that trends over time for each measure across age groups has not been explored. Differences between age groups may therefore relate to:

- cohort effects – where people born in different eras have different experiences and expectations
- the life course perspective – where moving through our lives we change the way we feel due to experiences
- socio-economic factors – such as differences in educational attainment, occupations and income between different age groups

It is also important to remember that age is just one of many factors that may contribute to differences in quality of life and not all the observed differences may be primarily due to age.

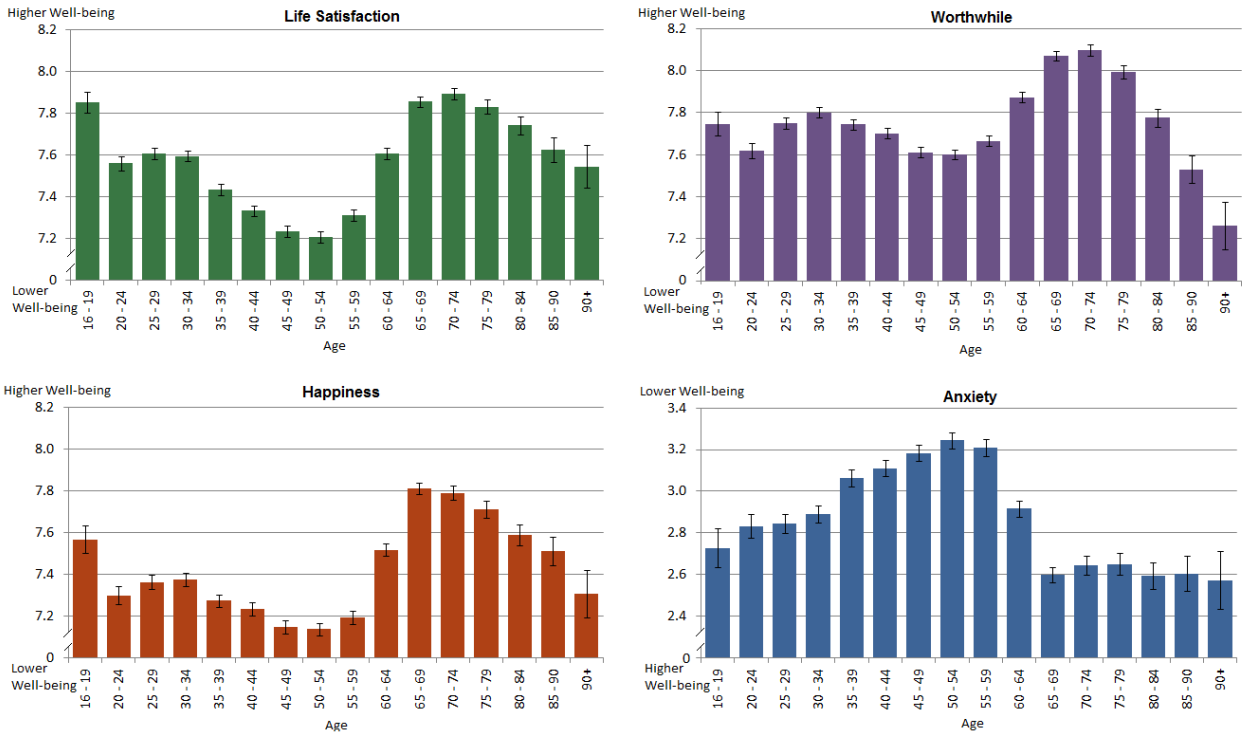

Figure 19. Average personal wellbeing ratings: by age, 2012 to 2015, UK, Source: Annual Population Survey (APS) - Office for National Statistics. Measuring National Well-being: At what age is Personal Well-being the highest? Article February 2016. Notes - 95% confidence intervals are displayed on the chart as error bars. Axis does not start at zero. Estimates shown are mean averages.

[3] https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/measuringnationalwellbeing/atwhatageispersonalwellbeingthehighest

Our relationships

Our personal relationships form the foundations of our social support networks and are important for both individual and community well-being. Having someone to rely on in times of adversity can help us cope better and be more resilient. In 2013 to 2014, 84.0% of people aged 16 and over reported having a spouse or partner, family member or friend to rely on if they had a serious problem[4]. Of those aged 75 and over, 88.7% reported having someone to rely on, a higher proportion than all other age groups (except those aged 65 to 74). The age group with the lowest proportion reporting having someone to rely on (76.2%) were those aged 16 to 24.

Related to a sense of social support, loneliness is another important issue which can have an important impact on our quality of life.

ONS carried out analysis of characteristics and circumstances associated with loneliness in England using the Community Life Survey[5]. In 2016 to 2017, there were 5% of adults in England who reported feeling lonely "often" or "always".

- Younger adults aged 16 to 24 years reported feeling lonely more often than those in older age groups.
- Women reported feeling lonely more often than men.
- Those single or widowed were at particular risk of experiencing loneliness more often.
- People in poor health or who have conditions they describe as "limiting" were also at particular risk of feeling lonely more often.
- Renters reported feeling lonely more often than homeowners.
- People who feel that they belong less strongly to their neighbourhood reported feeling lonely more often.
- People who have little trust of others in their local area reported feeling lonely more often.

Three profiles of people at particular risk from loneliness were identified:

- Widowed older homeowners living alone with long-term health conditions.
- Unmarried, middle-agers with long-term health conditions.
- Younger renters with little trust and sense of belonging to their area.

[4] Measuring National Well-being: Quality of Life in the UK, 2018, ONS: https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/measuringnationalwellbeing/qualityoflifeintheuk2018

[5] Loneliness - What characteristics and circumstances are associated with feeling lonely? ONS, 10 April 2018. https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/lonelinesswhatcharacteristicsandcircumstancesareassociatedwithfeelinglonely/2018-04-10#main-points

Contextual Information

Population

With a population of 210,300 in 2016, the borough is the second largest Local Government District (LGD) in terms of population size after Belfast, making up 11% of Northern Ireland's population.

The population of the borough is projected to continue to grow by 18,600 people or 9% - to around 228,900 - by 2026. This rate of growth is more than double that projected for Northern Ireland as a whole (4%). This is the largest population increase of the 11 LGDs in the ten years to 2026, in terms of the number of people, and the joint largest percentage increase with Lisburn and Castlereagh LGD.

The numbers in each of the three broad age groups - children, working age and older people are set to increase over the ten-year period.

- Ageing of the population is set to continue, with the borough population aged 65 and over projected to increase by 28% (i.e. 8,700 people).
- The number of children is projected to rise by 5% (2,300 children). The largest increase (both number and percentage) of the 11 LGDs. In contrast, the number of pre-school children (i.e. those aged 0-3) in the borough is projected to fall by 5% (600 children) over the decade.
- Growth of 6% is projected among the working age population (i.e. those aged 16-64).

The proportion of the population aged 65 and over in the borough is projected to overtake that of children by 2033 (20.4% and 20.1% respectively).

	Mid 2016 estimate		Mid 2026 projection		Population change mid 2016 to mid 2026	
	People	%	People	%	People	% change
0-15 years	46,800	22.3%	49,100	21.5%	2,300	4.9%
16-64 years	131,800	62.7%	139,400	60.9%	7,600	5.8%
65+ years	31,700	15.1%	40,400	17.7%	8,700	27.5%
All Ages	**210,300**	**100.0%**	**228,900**	**100.0%**	**18,600**	**8.9%**

Table 18. Projected population change by age groups 2016 to 2026, Armagh City, Banbridge and Craigavon Borough. Source: 2016 mid-year population estimates and 2026 population projections (2016 based), NISRA. Note – Figures may not sum due to rounding.

Health Inequalities

The 'Health Inequalities Annual Report 2018' provides information on health inequality gaps between the most and least deprived areas of NI, and within Local Government Districts (LGDs) across a range of indicators. 42 indicators are available at LGD level.

The borough has better health outcomes than the NI average on 20 indicators, most notably on respiratory, alcohol related and drug related admission rates.

The borough has worse health outcomes than NI average on 3 indicators – relatively small inequality gaps in prescription rates for antihypertensives and statins, and day case hospital admissions rates.

There are inequality gaps within the borough - the most deprived areas in the borough experience inequality gaps most notably for self-harm (102%), alcohol related (94%) and drug related (90%) admissions, teenage birth rates (96%) and alcohol specific mortality (94%).

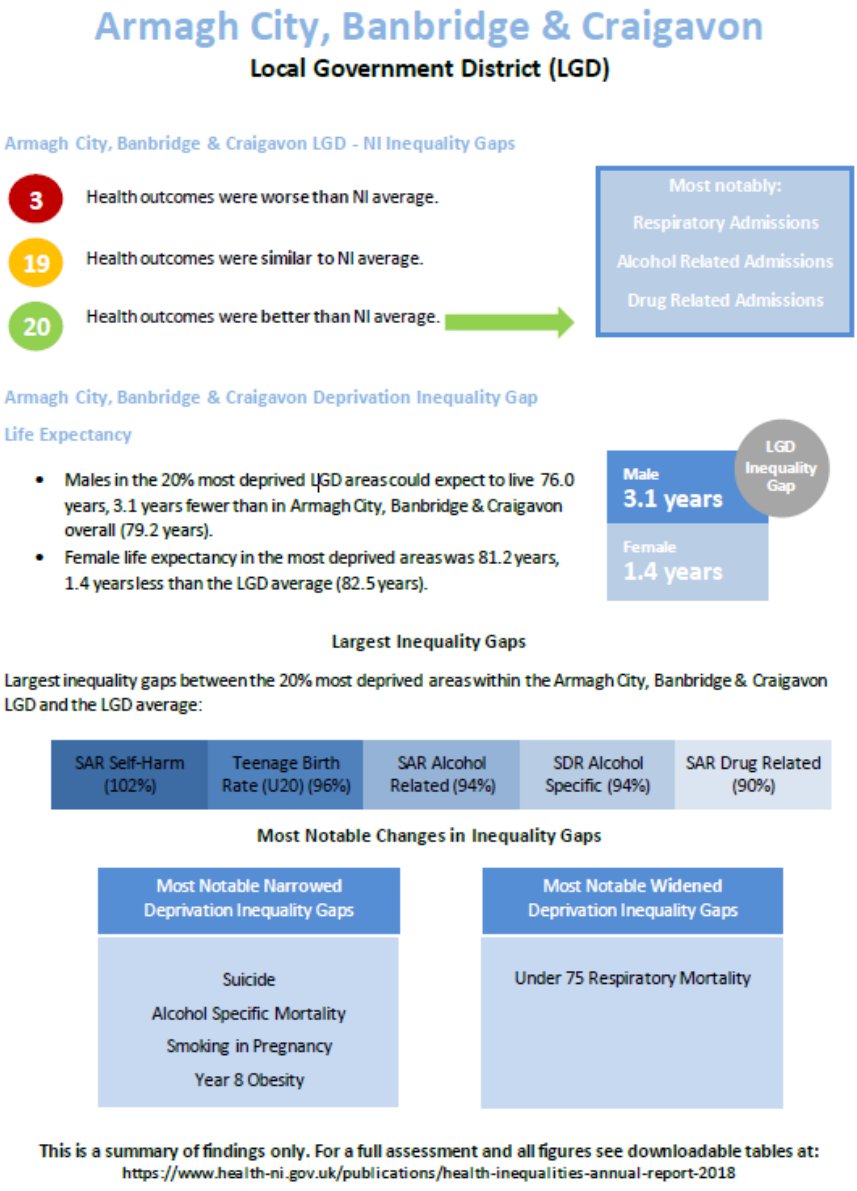

Figure 20. Armagh City, Banbridge and Craigavon Borough health inequalities. Source: Health Inequalities Annual Report 2018, NISRA, Department of Health.

Deprivation

The Northern Ireland Multiple Deprivation Measure (NIMDM) 2017 provides information for seven distinct types of deprivation, known as domains, along with an overall multiple deprivation measure (MDM). The NIMDM 2017 comprises of 38 indicators in total.

The NIMDM 2017 provides a mechanism for ranking areas within Northern Ireland in the order of the most deprived to the least deprived. However, they do not quantify the extent to which one area is more or less deprived than another.

The majority of results are presented at the Super Output Area (SOA) level. With each SOA in Northern Ireland being ranked, giving a relative measure of deprivation. The SOA ranked 1 is the most deprived while the SOA ranked 890 is the least deprived. Super Output Areas (SOAs) were a new geography that were developed by NISRA to improve the reporting of small area statistics. They have an average population size of 2,100.

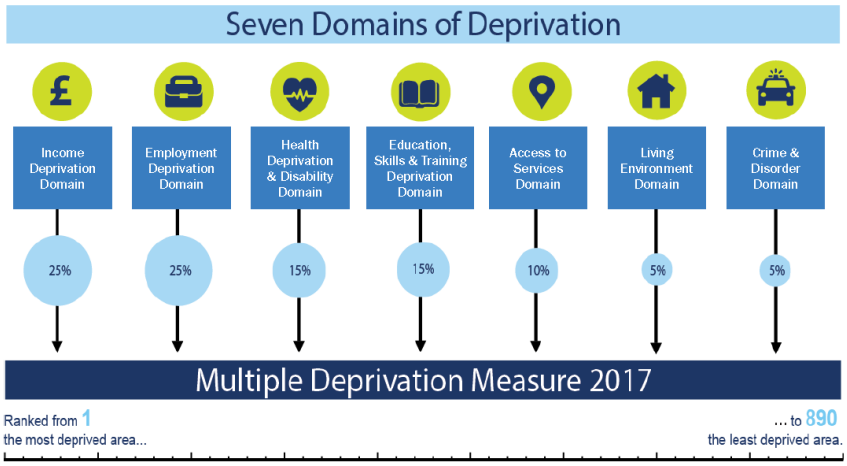

Figure 21. Seven domains of deprivation (including weights) that make up the multiple deprivation measure. Source: Northern Ireland Multiple Deprivation Measure 2017, NISRA.

When the 100 most deprived SOAs within NI are selected, 8 of these SOAs can be found in the borough, or 9% of our total 87 SOAs.

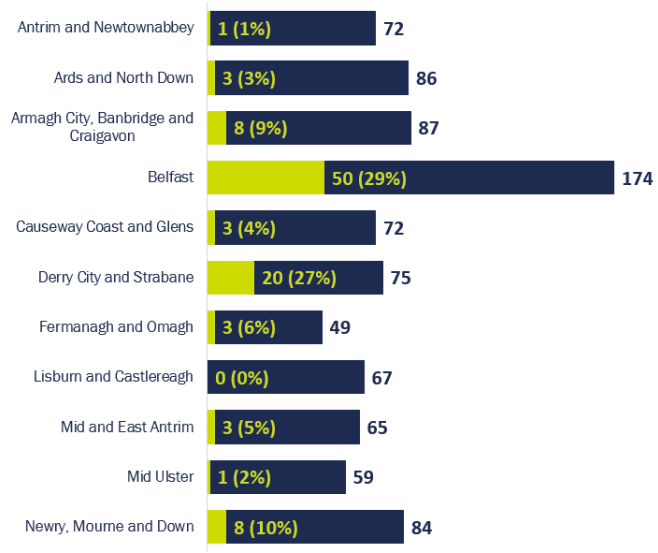

Figure 22. The 100 most deprived SOAs by LGD. Source: Northern Ireland Multiple Deprivation Measure 2017, NISRA.

The ten most deprived SOAs in the borough are shown below. The first eight (with ranks below 100) are in the top 100 most deprived in NI. While the top 10 are all urban areas, rural areas in the borough experience deprivation. For example, Keady SOA in Armagh (rank 125), just outside the top 10 in the borough (11th), is the 9th most deprived rural SOA in Northern Ireland on the multiple deprivation measure.

MDM	SOA	Location
14	Woodville 1	Lurgan
52	Drumgask 2	Craigavon
54	Court 1	Lurgan
61	Callan Bridge	Armagh
62	Church	Lurgan
73	Annagh 2	Portadown
81	Drumgor 2	Craigavon
83	Drumnamoe 1	Lurgan
108	Corcrain 2	Portadown
120	The Cut	Banbridge

Table 19. Top 10 most deprived SOAs in Armagh City, Banbridge and Craigavon on the Multiple Deprivation Measure. Source: Northern Ireland Multiple Deprivation Measure 2017, NISRA.

Most of the top 10 deprived areas in the borough in 2017 were also in the top 10 in 2010 and 2005. Three areas were new to the top 10 in 2017 – Church (Lurgan), Annagh 2 (Portadown) and The Cut (Banbridge). If an area has moved in or out of the top 10, this does not necessarily mean that the area is more or less deprived in absolute terms than they were in 2010 or 2005. The deprivation ranks provide relative spatial measures at a point in time.

2017	
MDM	SOA
14	Woodville 1
52	Drumgask 2
54	Court 1
61	Callan Bridge
62	Church
73	Annagh 2
81	Drumgor 2
83	Drumnamoe 1
108	Corcrain 2
120	The Cut

2010	
MDM	SOA
31	Drumnamoe 1
34	Drumgask 2
55	Drumgor 2
92	Woodville 1
99	Court 1
106	Callan Bridge
119	Corcrain 1
129	Drumgask 1
144	Court 2
152	Corcrain 2

2005	
MDM	SOA
41	Drumgask 2
63	Drumnamoe 1
65	Corcrain 2
74	Drumgor 2
87	Court 1
118	Woodville 1
119	Drumgask 1
124	Corcrain 1
128	Callan Bridge
130	Court 2

Table 20. Deprivation ranks for the 10 most deprived SOAs in Armagh City, Banbridge & Craigavon Borough in 2017, 2010 and 2005. SOAs new to top 10 in 2017 shaded in dark blue, SOAs in top 10 in all three time periods shaded in light blue. Source: Northern Ireland Multiple Deprivation Measure 2017, NISRA. Note 2010 ranks = 155 The Cut, 194 Church, 213 Annagh 2. 2005 ranks = 131 Church, 138 Annagh 2, 271 The Cut.

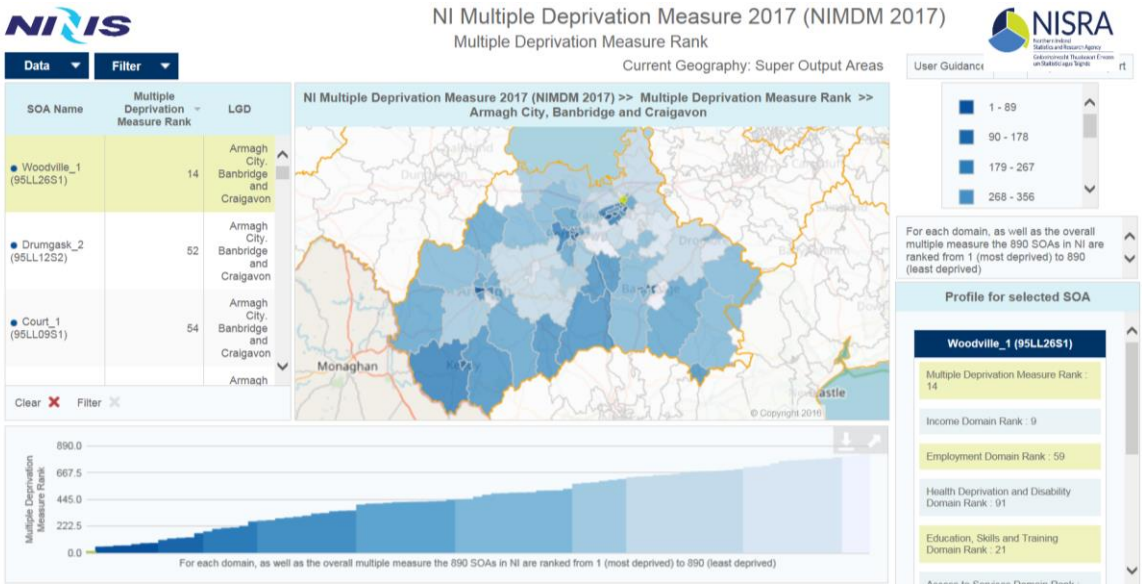

Figure 23. Multiple Deprivation in Armagh City, Banbridge and Craigavon Borough. Most deprived is shaded dark blue, least deprived is shaded light blue. Source: Northern Ireland Multiple Deprivation Measure 2017, NISRA.

MDM compared with individual domains

The 7 individual deprivation domains contribute to the MDM according to their weights. While the MDM provides an overall measure, it may mask some interesting and important variation in the domains. NISRA encourages users to consider both the Multiple Deprivation Measure and individual domains, especially when targeting specific types of deprivation, or choosing the tools to improve overall deprivation.

The circles below represent the 100 most deprived areas in Northern Ireland on the overall MDM and each of the 7 domains, and show the extent to which they overlap. The overlap of two circles represents the number of areas that are in the 100 most deprived areas according to the MDM, as well as in a domain-specific 100 most deprived areas. For example:

- The overlap is greatest for the Employment Deprivation Domain, sharing 83 areas with the MDM
- The Income Deprivation Domain shares 61 areas with the MDM
- The overlap is smallest for the Access to Services Domain, which shares 4 areas with the MDM

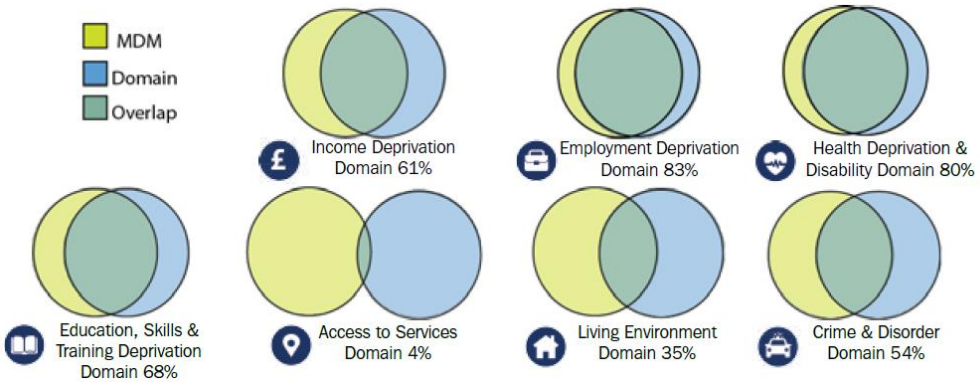

Figure 24. MDM compared with individual domains, Northern Ireland. Source: Northern Ireland Multiple Deprivation Measure 2017, NISRA.

The most deprived SOAs within the borough on each of the seven domains and the overall multiple deprivation measure are shown below.

Northern Ireland Multiple Deprivation Measures 2017

Most deprived SOAs within ARMAGH CITY, BANBRIDGE AND CRAIGAVON LGD

INCOME		EMPLOYMENT		HEALTH AND DISABILITY		EDUCATION, SKILLS AND TRAINING	
Rank		Rank		Rank		Rank	
9	Woodville 1	42	Drumnamoe 1	31	Drumnamoe 1	21	Woodville 1
17	Church	59	Woodville 1	42	Drumgask 2	24	Drumgask 2
19	Annagh 2	67	Drumgask 2	64	Drumgor 2	33	Church
22	Keady	69	Court 1	67	Court 1	37	Drumgor 2
38	Callan Bridge	92	Court 2	91	Woodville 1	62	Drumnamoe 1
46	Derrynoose	98	Callan Bridge	100	Court 2	68	Court 1
86	Corcrain 2	107	Drumgor 2	121	Callan Bridge	81	Corcrain 2
93	Carrigatuke	119	The Cut	124	Drumgask 1	82	Ballybay
100	Corcrain 1	147	Corcrain 1	130	The Cut	93	Tavanagh
105	Court 1	170	Edenderry	145	Edenderry	97	Callan Bridge

ACCESS TO SERVICES		LIVING ENVIRONMENT		CRIME AND DISORDER		MDM MULTIPLE DEPRIVATION	
Rank		Rank		Rank		Rank	
18	Bannside	10	Woodville 1	7	Court 1	14	Woodville 1
33	Katesbridge	15	Annagh 2	15	The Cut	52	Drumgask 2
54	Derrynoose	58	Court 1	26	Drumgor 2	54	Court 1
64	Gransha	69	The Cut	27	Woodville 1	61	Callan Bridge
73	Derrytrasna 2	70	Corcrain 2	42	Annagh 2	62	Church
89	Killylea	83	The Mall	69	Callan Bridge	73	Annagh 2
96	The Birches 2	92	Callan Bridge	97	Court 2	81	Drumgor 2
98	Quilly	146	Drumnamoe 1	104	Church	83	Drumnamoe 1
100	Carrigatuke	151	Carrigatuke	125	Drumgor 1	108	Corcrain 2
101	Poyntz Pass	163	Milford	132	Edenderry	120	The Cut

For each domain, as well as the overall multiple measure the 890 SOAs in NI are ranked from 1 (most deprived) to 890 (least deprived).

Figure 25. Deprivation ranks for the most deprived SOAs in Armagh City, Banbridge & Craigavon Borough on 7 domains and multiple deprivation measure. Source: Northern Ireland Multiple Deprivation Measure 2017, NISRA.

Health Deprivation

The Health Deprivation and Disability Domain identifies proportions of the population whose quality of life is impaired by poor health or disability.

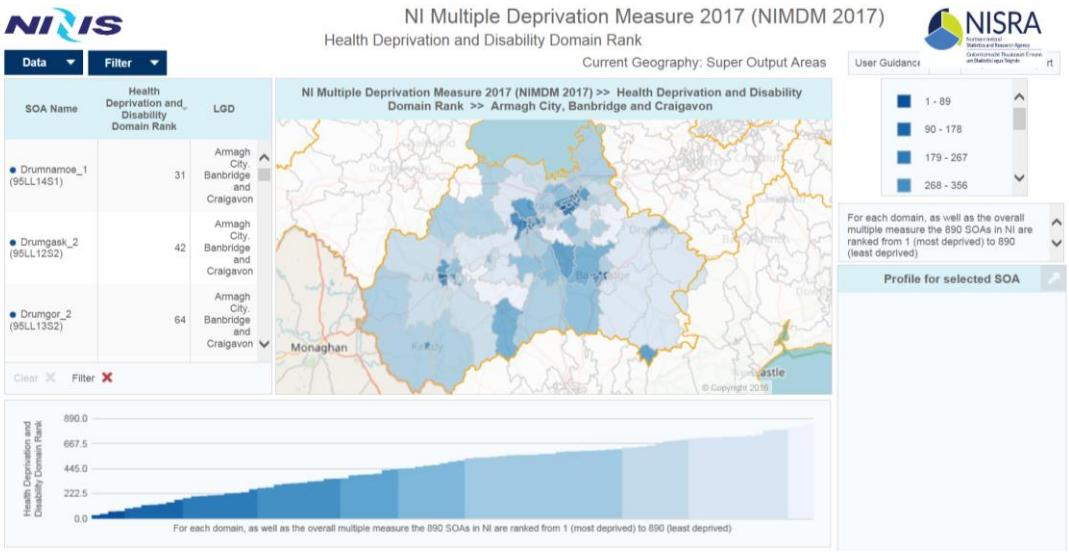

Figure 26. Health Deprivation in Armagh City, Banbridge and Craigavon Borough. Most deprived is shaded dark blue, least deprived is shaded light blue. Source: Northern Ireland Multiple Deprivation Measure 2017, NISRA.

Ranks are available for most of the indicators which make up the domains. For example looking at the top two most deprived areas in terms of health deprivation and disability a number of differences are seen. Drumnamoe 1 in Lurgan is ranked 3rd in NI in terms of Standardized ratio of people registered as having cancer (excluding non-melanoma skin cancers), while Drumgask 2 is ranked 342. In contrast Drumnamoe 1 is ranked 496 for Proportion of Singleton Births with Low Birth Weight while Drumgask 2 is ranked 55.

Indicator	Drumnamoe 1	Drumgask 2
Health Deprivation and Disability Domain	31	42
Standardized preventable death ratio (excluding Suicides)	27	311
Standardized physical health-related benefit ratio	24	31
Standardized ratio of people registered as having cancer (excluding non-melanoma skin cancers)	3	342
Standardized emergency admission ratio	68	198
Proportion of Singleton Births with Low Birth Weight	496	55
Standardized ratio of Children's Dental Extractions	30	14
Standardized ratio of people on multiple prescriptions on a regular basis	5	11
Standardized ratio of people with a long-term health problem or disability (Excluding Mental Health problems)	27	11
Combined Mental Health Indicator*	57	74

*Table 21. Deprivation ranks for Health Deprivation and Disability domain indicators, Drumnamoe 1 and Drumgask 2. Source: Northern Ireland Multiple Deprivation Measure 2017, NISRA. Note * - The Combined Mental Health Indicator includes: Standardised ratio of population in receipt of prescriptions for mood and anxiety disorders, Standardised suicide rate, Standardised rate of mental health inpatient stays, Standardised mental health related benefit ratio and Standardised proportion of people with Mental Health problems.*

SOA	Multiple Deprivation Measure Rank	Health Deprivation and Disability Domain Rank
Woodville 1	14	91
Drumgask 2	52	42
Court 1	54	67
Callan Bridge	61	121
Church	62	199
Annagh 2	73	228
Drumgor 2	81	64
Drumnamoe 1	83	31
Corcrain 2	108	211
The Cut	120	130
Keady	125	320
Corcrain 1	129	168
Tavanagh	164	225
Court 2	179	100
Ballybay	200	235
Drumgask 1	208	124
Derrynoose	212	569
Edenderry	224	145
Drumgor 1	262	273
The Mall	269	391
Carrigatuke	273	576
Downs	288	262
Poyntz Pass	294	568
Mourneview	301	183
Markethill	310	359
Rathfriland	328	311
Taghnevan	332	208
Gilford	347	302
Drumnamoe 2	351	202
Tandragee	353	448
Charlemont	403	545
Bannside	411	716
Ballyoran	412	278
Parklake	417	356
Brownstown 1	423	599
Abbey Park	424	315
Observatory	426	478
Edenderry 1	427	331
Banbridge West	430	354
Killylea	432	550
Killeen	443	635
Brownstown 2	447	335
Katesbridge	449	732

SOA	Multiple Deprivation Measure Rank	Health Deprivation and Disability Domain Rank
Killycomain	468	386
Loughbrickland	485	507
Lawrencetown	496	439
Ballymartrim	498	651
Dromore North	502	446
Fort	503	393
Loughgall	505	537
Donaghcloney 1	519	564
Gransha	520	722
Demesne 2	521	432
The Birches 1	534	721
The Birches 2	577	609
Annagh 1	583	543
Laurelvale	588	517
Milford	600	689
Derrytrasna 2	608	633
Kernan 2	616	567
Bleary 2	631	472
Rich Hill 2	637	493
Quilly	639	793
Aghagallon 1	649	557
Hamiltonsbawn 2	651	728
Hamiltonsbawn 1	657	815
Seapatrick	672	604
Knocknashane 1	678	577
Hockley	680	748
Edenderry 2	682	400
Aghagallon 2	684	593
Magheralin 2	689	695
Derrytrasna 1	697	462
Waringstown 1	715	729
Demesne 1	718	724
Donaghcloney 2	727	818
Magheralin 1	746	616
Waringstown 2	767	739
Woodville 2	772	600
Knocknashane 2	775	606
Kernan 1	780	669
Dromore South 1	785	619
Rich Hill 1	786	642
Dromore South 2	797	792
Ballydown 2	805	785
Ballydown 1	806	704
Bleary 1	825	841

Table 22. Deprivation ranks for the 87 SOAs in Armagh City, Banbridge & Craigavon Borough on the Multiple Deprivation Measure and Health Deprivation and Disability domain. Source: Northern Ireland Multiple Deprivation Measure 2017, NISRA.

Equality

An Equality Impact Assessment (EQIA) was completed on the community plan with the aim of ensuring that, in identifying and taking forward projects under the community plan, the council and its partners give due regard to the need to promote equal opportunity by addressing the inequalities within and between section 75 groups.

Feedback from stakeholder engagement, along with baseline data and other research reports were analysed to provide an insight into the potential impacts of the three strategic themes in the plan on people in the various section 75 groups. The EQIA highlighted some inequalities the community plan may help to address, those related to healthy outcomes are outlined below.

Religious Belief/Political Opinion - Results from the 2011 Census showed that there were self-reported differences in general health according to religion belonged to or brought up in. Those who were or had been brought up as Catholics were typically more likely than those who belonged to or had been brought up in Protestant denominations to assess their general health as either 'bad' or 'very bad'. The relative differences were more noticeable in the older age groups. For example, among those aged 45-64, 11% of Catholics, compared with 8.4% of Protestants, were in either 'bad' or 'very bad' general health. In addition, among those aged 65 and over, 18% of Catholics compared with 13% of Protestants were in either 'bad' or 'very bad' general health.

Racial Group - The All Ireland Traveller Health Study (University College Dublin, 2010) showed that the health status of Travellers is much poorer than that of the general population. There are disparities in life expectancy and other health and wellbeing outcomes for Travellers compared to settled people. For example male Travellers live on average to 61.7 years compared to non-Travellers who live to 76.8 years. The picture for female Travellers is a little better where life expectancy for female Travellers is 70.1 years compared to non-Travellers which is 81.6 years.

The Public Health Agency good practice guide for Black and Minority Ethnic (BME) groups (2010) describes how BME communities have strong cultural beliefs and practices, many of which promote health and wellbeing. However, some health issues and risk factors for disease and ill health are more prevalent in certain nationalities and cultures. For example diabetes is more prevalent in Asian and black ethnic groups (12.4% and 8.4% respectively) compared to Northern Ireland population (5.4%). Lithuania has the highest rate of suicide in Europe; Northern Ireland has the highest proportion of Lithuanians resident in the region per head of population compared with the rest of the United Kingdom.

Sexual Orientation - It was noted on the whole there is a lack of statistical data available on sexual orientation in Northern Ireland and within our borough.

Gender - Findings from the Continuous Household Survey 2014/15 shows that a higher proportion of males (63%) than females (47%) participated in sport.

Public Health Agency analysis of NISRA deaths data 2009-2014 shows that there are three DEAs that have a potentially avoidable premature death rate for males that is considerably higher than both the overall Council level and Northern Ireland average. The rates for females generally higher but less so than for males. These differences are the result of particularly high death rates in those aged 40 - 64 years in these areas.

Disability - The NI Sport and Physical Activity Survey 2010 published by Sport NI found that people with disabilities participate less (both in terms of frequency and duration) in sport than average. On average, people with disabilities, long-standing illnesses or infirmities spend half the amount of time on moderate intensity sport compared to an average adult (46 minutes compared to 87 minutes). However, the report notes the average age of people with disabilities is higher than the average of all adults and, as sport participation declines with age, this is one major factor associated with lower participation rates among disabled people.

Dependants - People with dependants are likely to face additional barriers to a range of life experiences, including employment, sport and art activities and access to health.

It was recognised in the EQIA that none of the section 75 groups operates as a silo and that people have multiple identities.