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Health and Well Being Board Agenda

3.00 pm Thursday, 17 January 2019
Seminar Room, Dolphin Centre,
Darlington. DL1 5RP

Members of the Public are welcome to attend this Meeting.

1. Introductions/Attendance at Meeting.

2. Declarations of Interest.

3. To hear relevant representation (from Members and the General Public) on items on this Health and Well Being Board Agenda.

4. To approve the Minutes of the Meeting of this Board held on 13 September 2018. (Pages 1 - 6)

STOCKTAKE OF PRIORITIES

5. Director of Public Health Darlington Annual Report 2017 - 'Health Inequalities in Darlington : Narrowing the Gap' –
   Report of the Director of Children and Adults Services, Darlington Borough Council.
   (Pages 7 - 34)

6. Health and Well Being Plan Priorities:-

   (a) Starting Well - Children and Young People's Plan 2017/22 - Progress Report –
   Report of the Director of Children and Adult Services, Darlington Borough Council.
   (Pages 35 - 50)

   (b) Living Well –
   Linked to Director of Public Health Darlington Annual Report at Item No. 5 on this agenda.

(c) Ageing Well - Better Care Fund 2017/19 –
Report of the Director of Children and Adults Services, Darlington Borough Council.
(Pages 51 - 56)

7. Terms of Reference –
Report of the Director of Children and Adults Services, Darlington Borough Council.
(Pages 57 - 66)

URGENT / NORMAL BUSINESS

8. Special Educational Needs and Disability (SEND) Strategy –
Report of the Director of Children and Adults Services, Darlington Borough Council.
(Pages 67 - 106)

9. Integrated Care Systems - Update by the Chief Officer, NHS Darlington Clinical Commissioning Group.

10. Healthwatch Darlington –
Report of the Chief Executive Officer, Healthwatch Darlington.
(Pages 107 - 110)

11. SUPPLEMENTARY ITEM(S) (if any) which in the opinion of the Chair of this Board are of an urgent nature and can be discussed at the meeting.

12. Questions.

Luke Swinhoe
Assistant Director Law and Governance

Wednesday, 9 January 2019

Town Hall
Darlington.

Membership
Councillor Harker, Leader of the Council
Councillor C L B Hughes
Councillor S Richmond
Councillor A J Scott

Councillor Mrs H Scott, Leader of the Main Opposition Party
Paul Wildsmith, Managing Director
Suzanne Joyner, Director of Children and Adults Services
Miriam Davidson, Director of Public Health
Dr Posmyk Boleslaw, Chair, NHS Darlington Clinical Commissioning Group
Nicola Bailey, Chief Officer, Darlington Clinical Commissioning Group
Karen Hawkins, Director of Commissioning and Transformation, NHS Darlington Clinical Commissioning Group
Diane Murphy, Chief Nurse, NHS Darlington Clinical Commissioning Group
Richard Chillery, Operational Director of Children's and Countywide Care Directorate, Harrogate and District NHS Foundation Trust
Marion Grieves, Dean of Health and Social Care, Teesside University
Sam Hirst, Primary Schools Representative
Ron Hogg, Police, Crime and Victims' Commissioner, Durham Police Area
Sue Jacques, Chief Executive, County Durham and Darlington Foundation Trust
Rita Lawson, Chairman, VCS Strategic Implementation Group
Jonathan Lumb, Darlington Secondary Schools Representative
Colin Martin, Chief Executive, Tees, Esk and Wear Valley Mental Health Foundation Trust
Dr Chris Mathieson, Clinical Governor, Primary Healthcare Darlington
Alison Slater, Director of Nursing, NHS England, Area Team
Michelle Thompson, Chief Executive Officer, Healthwatch Darlington
Carole Todd, Darlington Post Sixteen Representative, Darlington Post Sixteen Representative

Since the last meeting of the Board, the following items have been sent to the Chair/Members of the Board:-

Invite – NHS Tees, Esk and Wear Valleys NHS Foundation Trust Stakeholder Event – 5 February 2019
News Release Dated 22 November 2018 – NHS England – North East Pioneering Health Service Goes National
Mid-Year Update for Stakeholders – Quality Account – NHS Tees, Esk and Wear Valleys NHS Foundation Trust

If you need this information in a different language or format or you have any other queries on this agenda please contact Lynne Wood, Elections Manager, Resources Group, during normal office hours 8.30 a.m. to 4.45 p.m. Mondays to Thursdays and 8.30 a.m. to 4.15 p.m. Fridays e-mail Lynne.Wood@darlington.gov.uk or telephone 01325 405803

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HEALTH AND WELL BEING BOARD

13 September 2018

PRESENT – Councillor A J Scott (in the Chair); Councillors Harker, C L B Hughes S Richmond and Mrs Scott and Miriam Davidson, Director of Public Health, Darlington Borough Council; Dr Andrea Jones, Chief Clinical Officer, Karen Hawkins, Director of Commissioning and Transformation and Paula Swindale, Head of Commissioning, NHS Darlington Clinical Commissioning Group; Richard Chillery, Operational Director of Children's and Countywide Care Directorate, Harrogate and District NHS Foundation Trust; Jill Foggin, County Durham and Darlington NHS Foundation Trust; Sam Hirst, Darlington Primary School Representative; Dr Chris Mathieson, Clinical Governor, Primary Healthcare Darlington; Charles Oakley, Office of the Police, Crime and Victims' Commissioner, Durham Police Area; Michelle Thompson, Chief Executive Officer, Healthwatch Darlington; and Carole Todd, Darlington Post Sixteen Representative. (16)

ALSO IN ATTENDANCE – Dr Deborah Wilson, Ken Ross, Public Health Principal and Rob Dent and Sandra Feldon, Families Information Officers, Darlington Borough Council. (4)

APOLOGIES – Paul Wildsmith, Managing Director and Suzanne Joyner, Director of Children and Adults Services, Darlington Borough Council; Posmyk Boleslaw, Chair, Ali Wilson, Chief Officer and Diane Murphy, Director of Nursing and Quality, NHS Darlington Clinical Commissioning Group; Marion Grieves, Dean of Health and Social Care, Teesside University; Ron Hogg, Police, Crime and Victims' Commissioner, Durham Police Area; Sue Jacques, Chief Executive, County Durham and Darlington NHS Foundation Trust; Rita Lawson, Chairman, VCS Strategic Implementation Group; Jonathan Lumb, Darlington Secondary Schools Representative; Colin Martin, Chief Executive, Tees, Esk and Wear Valley Mental Health Foundation Trust; Alison Slater, Director of Nursing, NHS England, Area Team. (12)

HWBB67. DECLARATIONS OF INTEREST – There were no declarations of interest reported at the meeting.

HWBB68. REPRESENTATIONS – No representations were made by Members or members of the public in attendance at the meeting.

HWBB69. MINUTES – Submitted – The Minutes (previously circulated) of the meeting of this Health and Well Being Board held on 12 July 2018.

The Director of Public Health reported at the meeting that a number of comments had been received on the Minutes from the meeting of the Board held on 12 July 2018, from the Independent Chair of the Darlington Children's Safeguarding Board, and that although the Minutes did not need to be amended, his comments were to give assurance and clarification to the Board, from a Safeguarding perspective.

RESOLVED – That the Minutes be approved as a correct record.

REASON – They represent an accurate record of the meeting.

HWBB70. LIVING WELL DIRECTORY - The Families Information Officers, Darlington Borough Council, gave a demonstration to the Board on the Living Well Directory. The Directory was divided into four main areas, namely SEND Local Offer; Community and Leisure Activities; Support to Children; and Support to Adults. It was reported at the meeting that feedback on those categories was being sought and contact information was contained within the website to submit any comments. Business Cards for the Directory were circulated at the meeting.

Discussion ensued on the challenges of keeping the directory up to date; the information available through the directory; access to the directory; its marketing; and the assessment and evaluation of the directory.

RESOLVED – That the thanks of the Board be conveyed to the Families Information Officers, Darlington Borough Council, for their informative demonstration.

REASONS – To convey the views of the Board.

HWBB71. HEALTH PROTECTION ANNUAL REPORT – The Director of Children and Adults Services submitted a report (previously circulated) requesting that consideration be given to the eighth Annual Health Protection Report (also previously circulated) published by the North East Health Protection Team (HPT), Public Health England, entitled 'Protecting the population of the North East from communicable disease and other hazards' 2017/18.

The submitted report stated that the Annual Report summarised the various health protection functions of Public Health England (PHE); successful health protection required strong working relationships both at the North East and local level; and that there were four elements to the work of PHE in protecting the health of the population namely prevention, surveillance, control and communication.

Dr. Wilson, in presenting the Annual Report and work of the North East HPT, stated that Health Protection was the business of everyone; information was gathered from various sources; outlined a number of key activities for everyone; and outlined the highlights from 2017/18 under the four elements of work of PHE. Particular reference was also make to the impact that national and international incidents could have on the work of HPT's.

Discussion ensued on the winter flu vaccine and its effectiveness.

RESOLVED – (a) That the contents of the North East Health Protection Team (HPT), Public Health England annual report, entitled 'Protecting the population of the North East from communicable disease and other hazards', as appended to the submitted report, be noted.

(b) That the health protection risks that affect some individuals and communities disproportionally resulting in poorer health, be recognised.

REASONS – (a) To inform the Board on the work of HPT, Public Health England to deliver safe and effective health protection services.

(b) The report provides evidence to the Director of Public Health in support of their assurance role.

HWBB72. BETTER CARE FUND 2017/19 – The Director of Children and Adults Services submitted a report (previously circulated) updating the Board on delivery of the 2017/19 Better Care Fund (BCF) submission and associated plans; providing the Board with a year end position on the Fund at the end of 2017/1; an overview of the changes to the expenditure plan for 2018/19; and providing information to the Board on the updated guidance received in July 2018, in respect of the second year of the plan.

The submitted report outlined the current position and work undertaken to date on the seven broad workstreams, established to support the delivery of the BCF priorities; outlined the areas where the additional iBCF grant funding was being used; and provided a summary of the 2017/18 (year end) national monitoring report, including updates on the four BCF metrics and implementation on the High Impact Change Model. The monitoring report required confirmation that Darlington had complied with the national conditions attached to BCF. It was reported at that meeting that one metric had not been met, namely transfer of care, which was mainly due to out of Borough placements.

Particular reference was made to the work of the BCF Darlington Delivery Group which monitored local delivery of the BCF and had reviewed a number of schemes, resulting in specification changes, contract changes and scheme cessation, all of which were reflected in the updated expenditure plan for 2018/19 (also previously circulated).

It was reported that Operational Guidance had been published in July 2018, which gave the opportunity to amend or update targets for the four metrics and reflect any changes to the expenditure plan arising from the scheme reviews and contract changes; stated there were no plans to make any changes to the non-elective admissions target; residential admissions and ASCOF2B targets were part of the Council's policy framework and would be changed in line with the refreshed performance framework; Delayed Transfer of Care targets were being refreshed nationally; and that the no revisions to the BCF plans were required other than in relation to metric for Delayed Transfers of Care (DTOC), but that plans could be amended to modify or decommission schemes or increase investment. Although a number of schemes had been received in Darlington there was no impact on the BCF financial envelope as a whole, and as such, there was no requirement to submit a refreshed expenditure plan, but one had been prepared for local monitoring.

Discussion ensued on the signposting of services and the assistance that was available through Healthwatch; supporting carers and young carers and the monitoring and evaluation of the success of that support; the Community Contract; and delayed transfers.

RESOLVED – (a) That the progress to date on delivering 2017/19 Better Care Fund objectives, as detailed in the submitted report, be noted.

(b) That the delivery of the Better Care Fund within the financial envelope in 2017/18 and the plans to continue delivery with minimal alteration in 2018/19, as detailed in the submitted report, be noted.

(c) That the position in respect of the national metrics and the actions taken, as detailed in the submitted report, be noted.

REASONS – (a) The two-year plan remains in place with delivery progressing well; new guidance issued in June has not required any amendment or addition. Scheme reviews during the year have led to small changes in the expenditure plan for 2018/19 but not at a material level.

(b) There is an expectation that a further plan will be required for 2019/20 but no guidance has yet been received.

(c) This report summarises the current position.

HWBB73. INTEGRATED CARE SYSTEMS – Submitted – The narrative and communications pack for the NHS Organisations in North Cumbria and the North East, on integrating and optimising healthcare services to meet local need and maximise stability.

The Chief Clinical Officer, NHS Darlington Clinical Commissioning Group stated that the Communications Pack was the first one for the North East; there was a commitment to provide regular updates; and that next pack would focus on the work and progress of the workstreams.

An update was given to the Board on the implementation of the Integrated Care Systems (ICS) and in providing the update it was reported that the Clinical Commissioning Groups (CCG's) were confident that they were moving in the right direction in relation to coming together; a development support package would be provided; the key themes emerging from the diagnostic that had been undertaken included clinical need, engagement, primary care and communication; the Board would be kept up to date with progress; and that Alan Foster would be the regional lead. The aim was to have one accountable officer across the ICS footprint; eradicate duplication as far as possible; and that key organisations would work better together.

Discussion ensued on the challenging financial position of some of the CCG's included in the North Cumbria and North East ICS footprint; need for local focus; consultation with the public; and the importance of informing the various organisations of key messages at the same time to ensure consistency of approach.

RESOLVED – (a) That the thanks of the Board be conveyed to the Chief Clinical Officer, NHS Darlington Clinical Commissioning Group, for her informative presentation.

(b) That the thanks of the Board be conveyed to Ali Wilson, Chief Officer, NHS Darlington Clinical Commissioning Group for her work with the Board.

REASONS – To convey the views of the Board.

HWBB74. DELIVERING THE AGEING WELL PRIORITIES - (1) Health and Well Being Plan Delivery – The Director of Children and Adults Services submitted a report (previously circulated) updating the Board on the delivery of the 'Ageing Well' area of the Health and Well Being Plan.

The submitted report outlined the principles that the Health and Well Being Plan followed; its delivery and monitoring; stated that there were four outcomes specified for work under the 'ageing well' part of the plan namely, reducing social isolation, delaying the onset of support needs, supporting independence and ensuring intermediate and transitional care outside of hospital were effective; and that the key priority area for action in 2018/19 was Intermediate and Transitional Care.

RESOLVED – That the progress to date on delivering outcomes in the 'Ageing Well' part of the plan, be noted.

REASONS – (a) In April 2017 the Health and Wellbeing Board agreed the Health and Wellbeing Plan 2017/22 would take a 'Life Course' approach. The Board's role as Children Trust Board means the plan covers the 0 -19 years age group, as well as adults and older people.

(b) Priorities for action set out in the plan are derived from the Joint Strategic Needs Assessment and a Development Session held with Health and Wellbeing Board in April 2017.

(c) The Plan has a five year initial life, with priorities identified for each year which will inform the Health and Wellbeing Board agendas.

(d) Delivery of the Plan's objectives requires each partner to align their strategies and plans, to ensure focus and avoid either duplication of activity against the same objectives or activity which does not contribute to the delivery of the Health and Wellbeing Plan objectives.

(2) Darlington Health and Well Being Plan 2017/22 – Ageing Well: Improving Outcomes for Older People – Clinical Commissioning Group and Local Authority Key Priorities for 2018/19 - The Director of Commissioning and Transformation and the Head of Commissioning, NHS Darlington Clinical Commissioning Group, gave a presentation to the Board on the Joint Actions being undertaken in respect of the 'Ageing Well' priority and improving outcomes for older people, namely reducing social isolation; delaying the onset of support needs; supporting independence; and ensuring intermediate and transitional care outside of hospital was effective.

It was reported that an Integration Board was in place in Darlington; it was important to recognise and involve partners to ensure a systems approach; a group would be set up, including Healthwatch, to map services; and stated that there was a lot of working on-going in partner organisations, some of which was joint working and some work was being done in isolation, in respect of the priority.

Discussion ensued on consultation and engagement with the public and the involvement of the Council's Scrutiny Committee.

RESOLVED - That the thanks of the Board be conveyed to Director of Commissioning and Transformation and the Head of Commissioning, NHS Darlington Clinical Commissioning Group, for their informative presentation.

REAON – To convey the views of the Board.

HWBB75. HEALTHWATCH DARLINGTON – The Chief Executive Officer, Healthwatch Darlington, submitted a report (previously circulated) updating the Board on its key statutory priorities and projects from July to August 2018.

The submitted report outlined the role of Healthwatch Darlington as a strong independent community champion which gave local people a voice that improved and enhanced health and social care provision on behalf of the people of Darlington and the statutory activities and projects it was involved with.

RESOLVED - That the report be noted.

REASON - To enable the Board to consider the work of Healthwatch Darlington.

HWBB76. DARLINGTON CANCER PROFILE – The Director of Children and Adults Services submitted a report (previously circulated) providing the Board with a high level overview of cancer need and outcomes for Darlington with reference to the Cancer Profile for Darlington (also previously circulated).

The submitted report stated that cancer had been identified as the second greatest contributor to premature mortality in Darlington; a two year review of cancer services had been launched in 2016, in order to identify opportunities for improvement in patient care and outcomes and to inform commissioning intentions; and as part of the review a cancer profile for Darlington had been produced.

Particular reference was made to the findings from the review which included the fact that there was a strong correlation between prevalence of cancer and deprivation; although screening rates remained good there are signs of a long term reduction in the uptake of cancer screening programmes; overall cancer mortality in Darlington was worse than England and rising; and that there was a worrying proportion of people being diagnosed through emergency department, with poorer experiences and outcomes.

The Director of Commissioning and Transformation, NHS Darlington Clinical Commissioning Group stated that data was 'old data' and that performance was now above target; outlined the current position with the regard to the post diagnostic support available; and the work that been undertaken to reduce waiting times.

RESOLVED – (a) That the impact of Cancer on Darlington and the inequalities in the distribution of cancers and outcomes, as detailed in the submitted report, be noted.

(b) That the improvement work underway, including work to improve access to screening and early diagnosis and treatment, as detailed in the submitted report, be noted.

REASONS – (a) Cancer is a significant contributor to premature mortality in Darlington.

(b) There are significant inequalities in incidence, prevalence and outcomes for cancer in Darlington.

(c) Improvements in cancer performance will improve outcomes and contribute to reducing premature mortality for Darlington residents.

HEALTH AND WELL BEING BOARD
17 JANUARY 2019

DIRECTOR OF PUBLIC HEALTH DARLINGTON ANNUAL REPORT 2017 'HEALTH INEQUALITIES IN DARLINGTON : NARROWING THE GAP'

SUMMARY REPORT

Purpose of the Report

1. To share with Health and Well Being Board the 2017 statutory report from the Director of Public Health. This is the fourth annual report, attached at **Appendix 1,** following the transfer of public health responsibilities from the NHS to local government, as part of the Health and Social Care Act (2012).

Summary

2. Good health is unevenly distributed across our country, our region and our town, and the life expectancy gap between the richest and poorest wards in Darlington is almost twelve years. These and other health inequalities affect our residents at every stage of the life course – in childhood, in adult life, and in old age, with our most disadvantaged citizens consistently experiencing worse outcomes than their more affluent counterparts. This fourth annual report from the Director of Public Health explores the breadth and extent of these 'health gaps', and proposes measures to narrow them, drawing on our health assets and working across a number of sectors to address the socioeconomic factors that determine so much of our health and wellbeing.

Recommendation

3. It is recommended that the Board note the Director of Public Health Darlington Annual Report 2017 entitled 'Health Inequalities in Darlington : Narrowing the Gap', and forward comments as invited to the Director of Public Health.

Reasons

4. The Health and Social Care Act 2012 stipulates the responsibility of the Director of Public Health to provide an annual report and for Council's to publish that report.

Suzanne Joyner
Director of Children and Adults Services

Background Papers

Health Inequalities in Darlington : Narrowing the Gap, Annual Report of the Director of Public Health, Darlington 2017

Miriam Davidson : Extension 6302

S17 Crime and Disorder	There are no implications arising from this report.
Health and Well Being	The report has recommendations to improve the health and wellbeing of the whole population.
Carbon Impact	There are no implications arising from this report.
Diversity	There are no implications arising from this report.
Wards Affected	All
Groups Affected	All
Budget and Policy Framework	There are no implications arising from this report.
Key Decision	N/A
Urgent Decision	No
One Darlington: Perfectly Placed	Falls under, 'More people healthy and independent', 'Children with the best start in life' 'More people active and involved' 'Enough support for people when needed'
Efficiency	There are no implications arising from this report.
Impact on Looked After Children and Care Leavers	This report has no direct impact on Looked After Children or Care Leavers

MAIN REPORT

Information and Analysis

4. The life expectancy of those living in the North of England, has for the first time in a generation, started to slow down and in some cases reverse. Whilst life expectancy has been falling in the North, it has been improving in the South, increasing the health inequalities across the country.

5. Darlington experiences health inequalities across all indicators related to child health, smoking, alcohol misuse as well as the factors which affect healthy life expectancy. The cumulative impact of health inequalities is a matter of 'life and death'.

6. Some of the most effective changes need to be addressed at a national level e.g. fiscal policy and legislation but local actions that improve equity of access to services and a focus on improving health in vulnerable groups would make an important contribution to preventing further increases in health inequalities.

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

8. Darlington is rich in health assets e.g. green space, diverse leisure offer and many voluntary and community organisations who provide informal and formal support across the population.

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

Annual Report Recommendations

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

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

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

13. An approach public sector organisations in Darlington could adopt is to consider the impact of key decisions and all policies on bot health and healthy inequalities.

Recommendation 1 – Best Start in Life

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

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

Recommendation 2 - Living and Working Well

15. Address barriers to quality employment and promote inclusive growth e.g. Routes to Work and similar initiatives.

16. Promote a healthy work force including good mental health e.g. via Darlington Cares, employers network.

17. Implement the practice of Making Every Contact Count (MECC), triggering brief conversations about workplace health.

Recommendation 3 – Healthy Ageing

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

    (a) Promote a whole system approach to supporting older adults to remain independent and healthy

    (b) Recognise the impact of social isolation, fuel poverty, transport and poverty on health and well being

    (c) Reinforce prevention across the life course recognising the negative cumulative impact of inequalities

Health Inequalities in Darlington:

Narrowing the Gap

Annual Report of the Director of Public Health

Darlington 2017

DARLINGTON BOROUGH COUNCIL

DARLINGTON

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Foreword by Miriam Davidson

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

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

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

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

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

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

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

Acknowledgements

My thanks particularly to **Dr Malcolm Moffat** for his research and preparation and also to the many people who have contributed to this report including:

Pauline Brown, Support Assistant

Zoe Foster, Analyst Public Health

Hilary Hall, Healthy New Towns Project Manager

Judith Hurst, Personal Assistant

Abbie Metcalfe, Business Officer

Rachel Osbaldeston, Public Health Portfolio Lead

Ken Ross, Public Health Principal

Tracey Sharp, Independent Consultant in Public Health

Xentrall Design and Print

Key Messages

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

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

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

Recommendation 1 – Best Start in Life

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

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

Recommendation 2 - Living and Working Well

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

Recommendation 3 – Healthy Ageing

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

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

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

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

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

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

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

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

Chapter 1: Health and Inequality

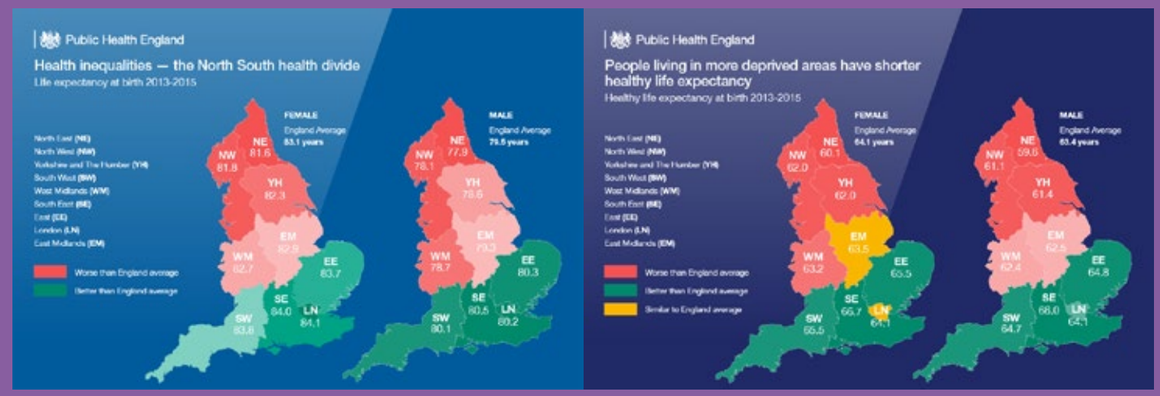


Figure 1. The North South health divide (PHE)

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

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

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

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

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

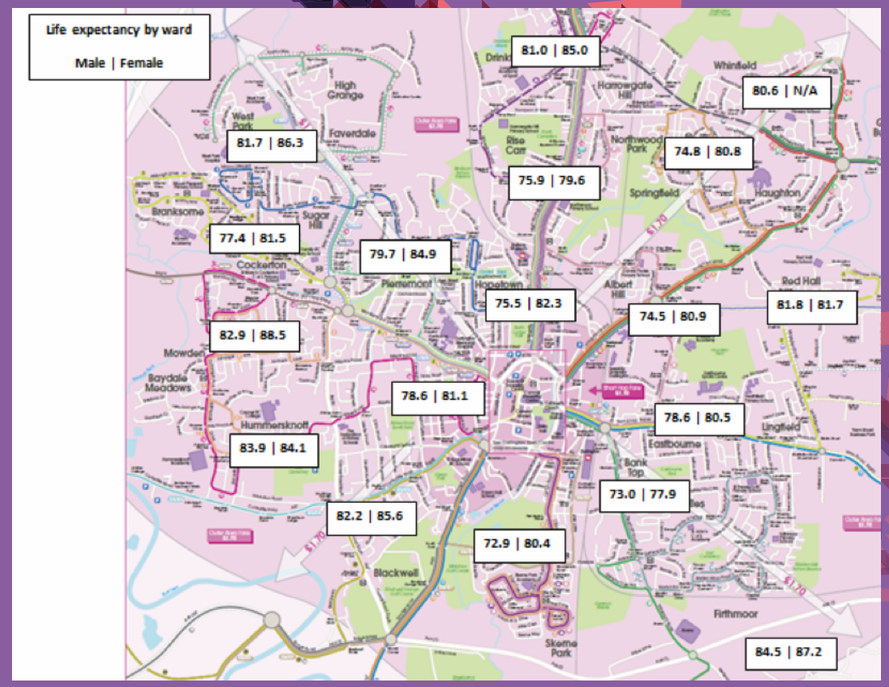


Figure 2. Life expectancy by ward

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

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

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

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

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

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

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

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

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

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

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

Click here to view the Children and Young Peoples Plan

Early Years and School

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

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

Pregnancy and Birth

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

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

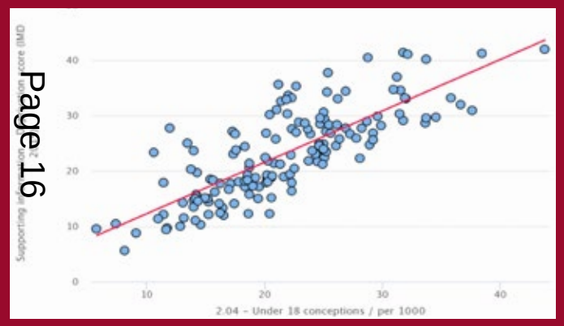


Figure 3. Under 18 conception rate is positively correlated with IMD (PHE)

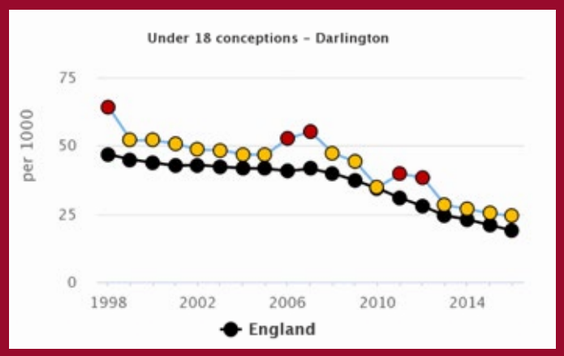


Figure 4. Under 18 conceptions in Darlington, 1998-2016 (PHE)

Smoking in Pregnancy

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

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

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

Breast Feeding

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

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

School Readiness

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

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

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

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

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

Tooth decay

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

Obesity

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

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

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

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

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

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

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

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

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

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

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

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

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

Chapter 3: Adult health

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

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

Employment

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

Housing

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

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

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

Crime

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

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

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

Click here to view the One Darlington: Perfectly Safe Plan

Mental health and wellbeing

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

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

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

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

Self Harm

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

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

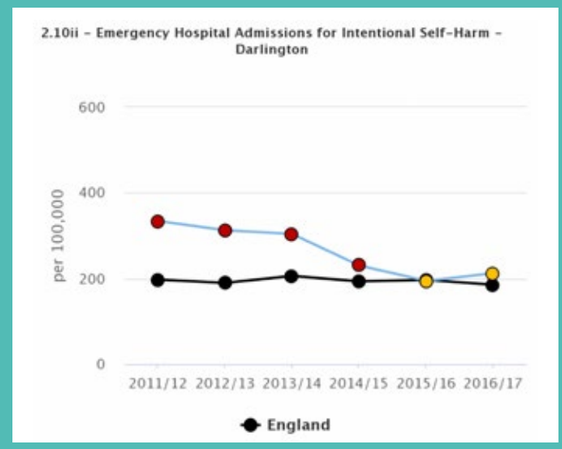


Figure 5. Emergency Hospital Admissions for Intentional Self-Harm, Darlington/England 2011-2017 (PHE)

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

Physical health and illness

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

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

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

Cancer

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

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

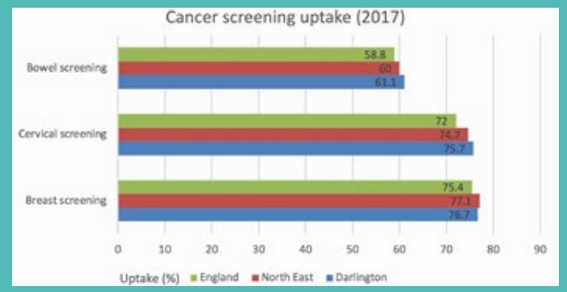


Figure 5. Cancer screening uptake, 2017 (PHE)

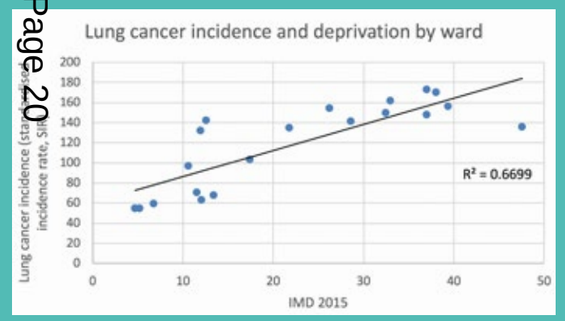


Figure 6. Lung cancer incidence by ward is positively correlated with IMD (localhealth.org.uk, PHE)

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

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

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

Emergency Hospital Admissions

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

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

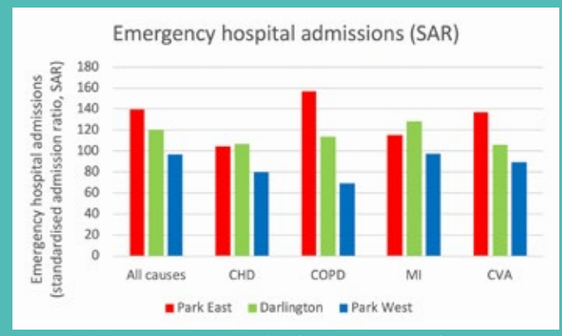


Figure 7. Emergency Hospital Admissions using the Standardised Admissions Rate (localhealth.org.uk, PHE)

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

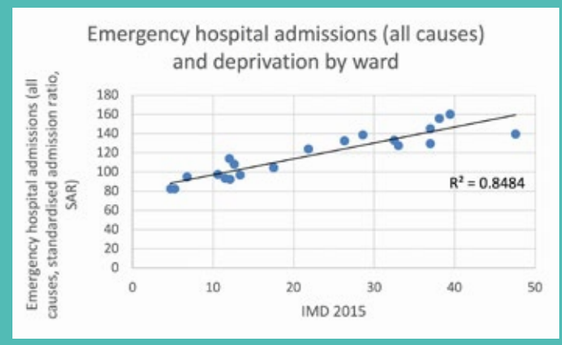


Figure 8. Emergency hospital admissions rate is positively correlated with IMD (localhealth.org.uk, PHE)

NHS Health Checks

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

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

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

Behavioural risk factors

Obesity

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

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

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

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

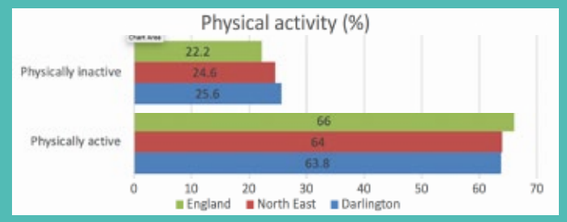


Figure 9. Percentage of the population that is physically active and physically inactive, 2016/17 (PHE)

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

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

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

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

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

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

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

Smoking

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

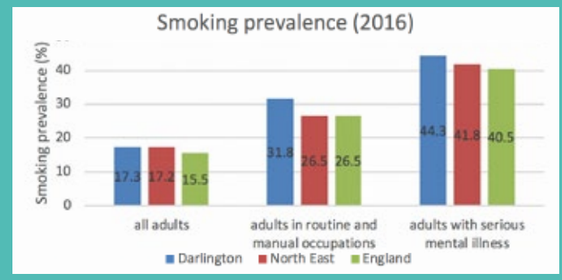


Figure 11. Smoking prevalence in defined population subgroups, 2016 (PHE)

Alcohol

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

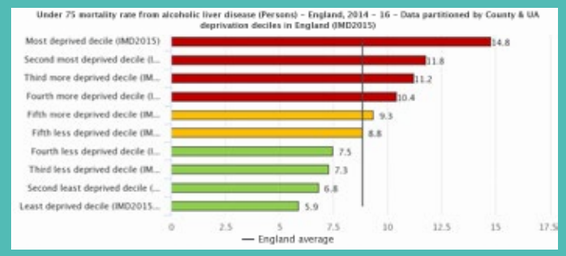


Figure 12. Under 75 mortality rate from alcoholic liver disease by deprivation decile in England, 2014 (PHE)

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

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

Drug Misuse/ Substance Misuse

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

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

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

Multiple Risk Factors

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

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

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

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

Chapter 4: Ageing in Darlington

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

Falls and Fractures

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

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

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

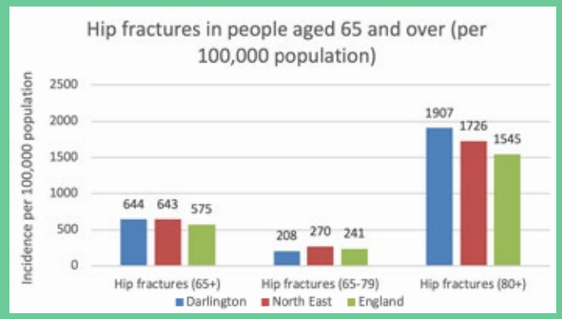


Figure 13. Hip fractures in people aged 65 and over, 2016/17 (PHE)

Sight Loss

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

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

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

Dementia

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

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

Flu vaccination

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

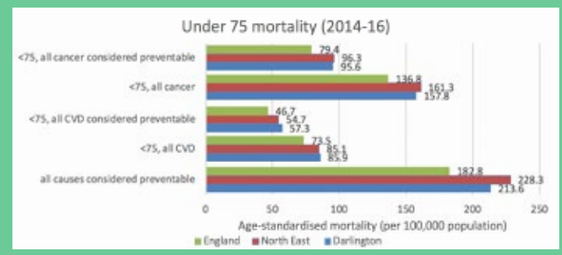
Despite poor flu vaccination uptake, between 2014-16 the mortality rate in Darlington from a range of specified communicable diseases, including influenza, was 8.8 per 100,000 population, the lowest rate in the region (12.0) and lower than the national mortality rate for infectious diseases (10.7).

Mortality

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

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

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



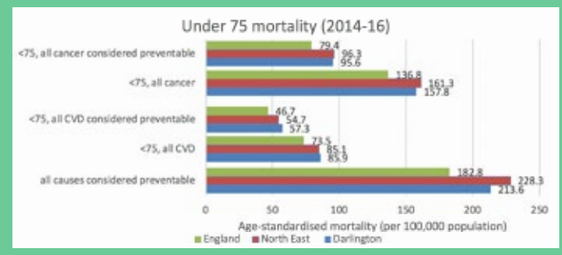


Figure 14. Under 75 mortality, 2014-16 (PHE)

Excess Winter Deaths

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

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

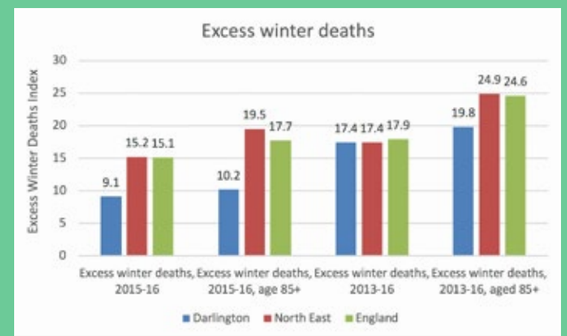


Figure 15. Excess winter deaths, 2013-16 (PHE)

Chapter 5: Darlington: Healthy New Towns

Healthy New Towns Darlington

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

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

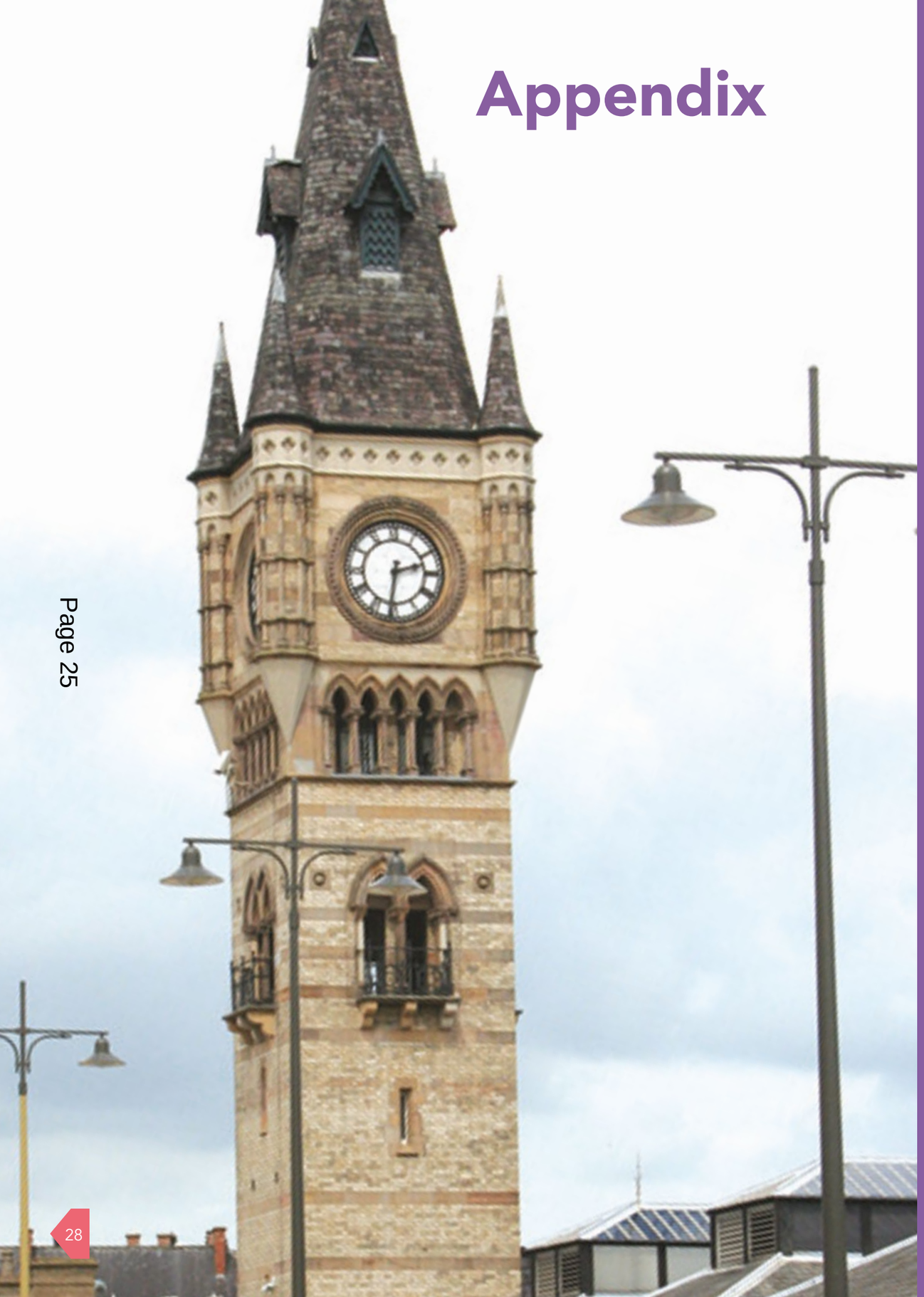
There are four main areas of work within the Healthy New Towns programme :

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

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

Community Strengths

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



Appendix

Appendix 1: Child health indicators “league table”

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

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

Appendix 2: Data Tables

Chapter 2: Child Health and Early Years

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

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

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

Chapter 3: Adult Health : Living and Working Well

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

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

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

Behavioural risk factors

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

Chapter 4: Healthy Ageing in Darlington

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

Figures and tables

Figure 1. The North South health divide (PHE)
Figure 2. Life expectancy by ward
Figure 3. Under 18 conception rate is positively correlated with IMD (PHE)
Figure 4. Under 18 conceptions in Darlington, 1998-2016 (PHE)
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Figure 10. Percentage of the population that is physically active and physically inactive, 2016/17 (PHE)
Figure 11. Density of fast food outlets by deprivation decile in England, 2014 (PHE)
Figure 12. Smoking prevalence in defined population subgroups, 2016 (PHE)
Figure 13. Hip fractures in people aged 65 and over, 2016/17 (PHE)
Figure 14. Under 75 mortality, 2014-16 (PHE)
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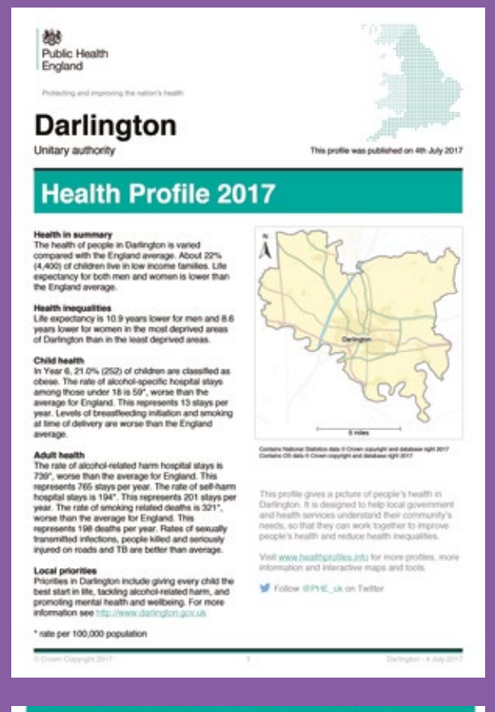
Table 1. Life expectancy and IMD 2015 by ward (localhealth.org.uk, PHE)
Table 2. Data from the National Child Measurement Programme, 2013-16 (localhealth.org.uk, PHE)
-Table 3. Percentage of people who reported having a limiting long-term illness or disability in the 2011 census (localhealth.org.uk, PHE)
-Table 4. Percentage of the population aged 16+ with a BMI of 30+, percentage of the population aged 16+ that binge drink and percentage of the population aged 16+ that consume 5 or more portions of fruit and vegetables per day (all modelled estimates 2006-8, localhealth.org.uk, PHE)

Appendix 3: Health Profile for Darlington 2017

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


Public Health England

Protecting and improving the nation's health

Darlington

Unitary authority

This profile was published on 4th July 2017

Health Profile 2017

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

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

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

Adult health
The rate of alcohol-related harm hospital stays is 739*, worse than the average for England. This represents 765 stays per year. The rate of self-harm hospital stays is 194*. This represents 201 stays per year. The rate of smoking related deaths is 321*, worse than the average for England. This represents 198 deaths per year. Rates of sexually transmitted infections, people killed and seriously injured on roads and TB are better than average.

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

* rate per 100,000 population

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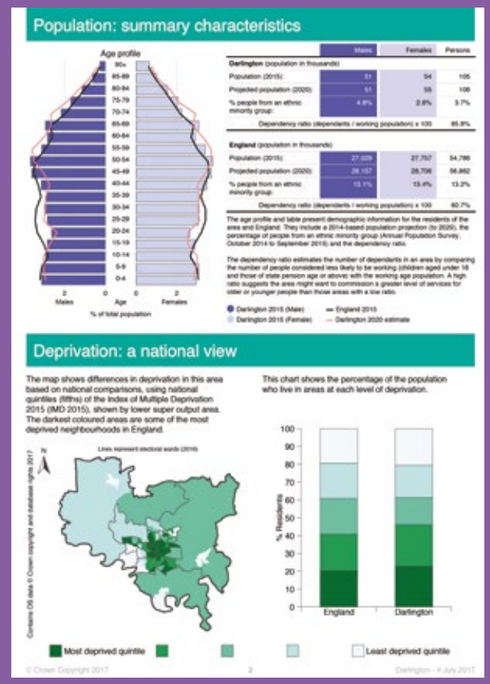
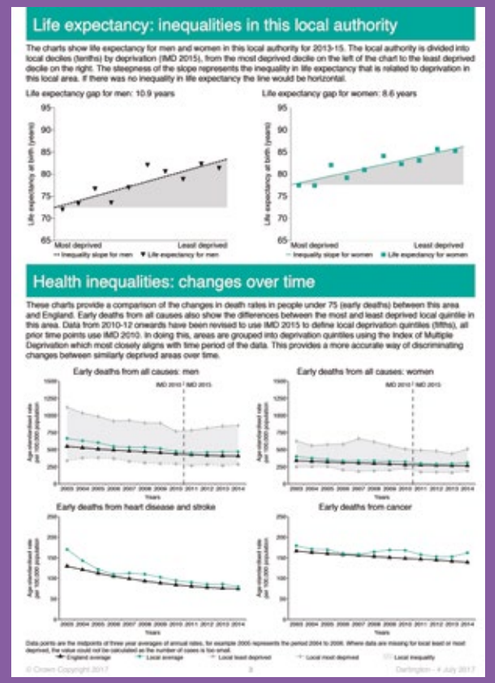
Contains OS data © Crown copyright and database right 2017

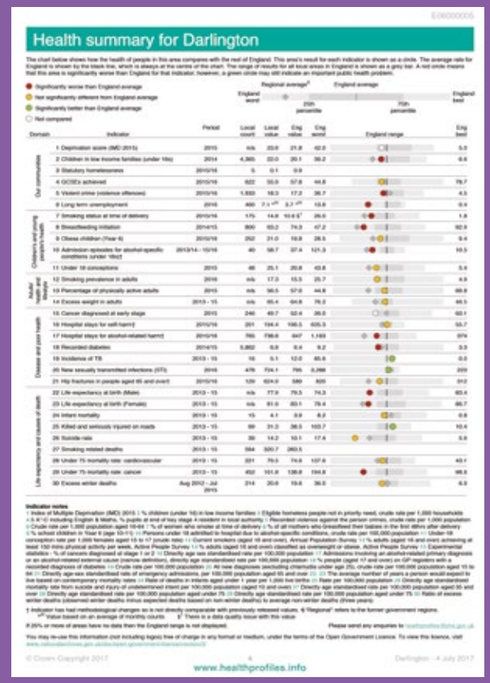
This profile gives a picture of people's health in Darlington. It is designed to help local government and health services understand their community's needs, so that they can work together to improve people's health and reduce health inequalities.

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

Follow @PHE_uk on Twitter







1. Deprivation

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

Life expectancy at birth :

- 2013-2015

Men 77.9 years **Women** 81.9 years

- 2014-2016

Men 78.2 years **Women** 82.1 years

2. Inequalities in life expectancy at birth

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

- 2013-2015

Men 10.9 years **Women** 8.6 years

- 2014-2016

Men 11.7 years **Women** 8.5 years

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

Trend over time in premature death rate

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

Inequalities in premature death rate

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

4. Overview of routinely available annual indicators

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

- The lowest number of red indicators (11).
- The highest number of amber indicators (12) making it the most similar local district to England.

5. Priorities to reduce inequalities in health and wellbeing

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

a) Employment and regeneration

- Deprivation
- Long-term unemployment

b) Maternal and child health

- Smoking status of mothers during pregnancy
- Breastfeeding initiation at birth

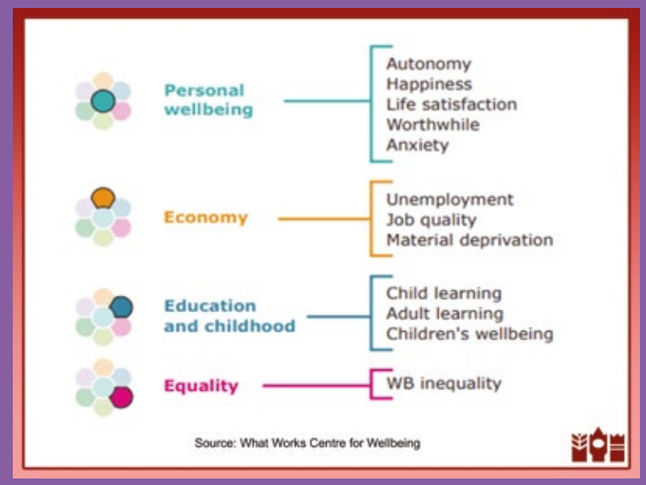
c) Adult nutrition and misuse of alcohol and drugs

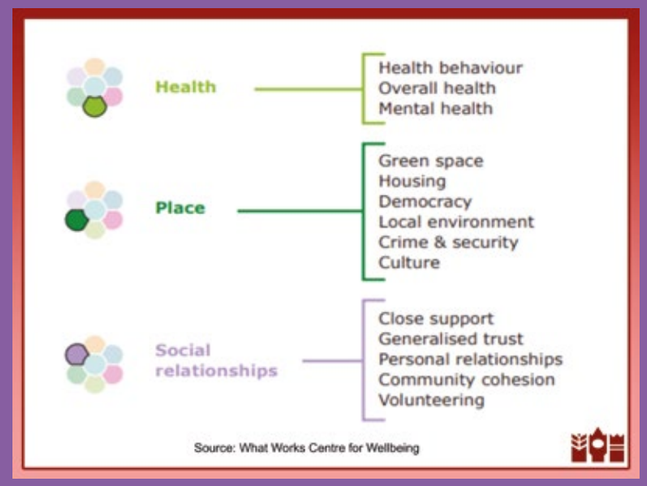
- Poor adult nutrition (and the implications for higher rates of obesity, diabetes and blood pressure)
- Hospitalisation for harm caused by excess alcohol consumption
- Drug misuse

d) Mental health

- Hospitalisation for self-harm

Appendix 4 : Measuring Inequality : Local Framework for Wellbeing





Appendix 5 : Emergency Hospital Admissions

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

Appendix 6 : Wellbeing Indicators

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

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

Appendix 7 : Data for Premature Mortality

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

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

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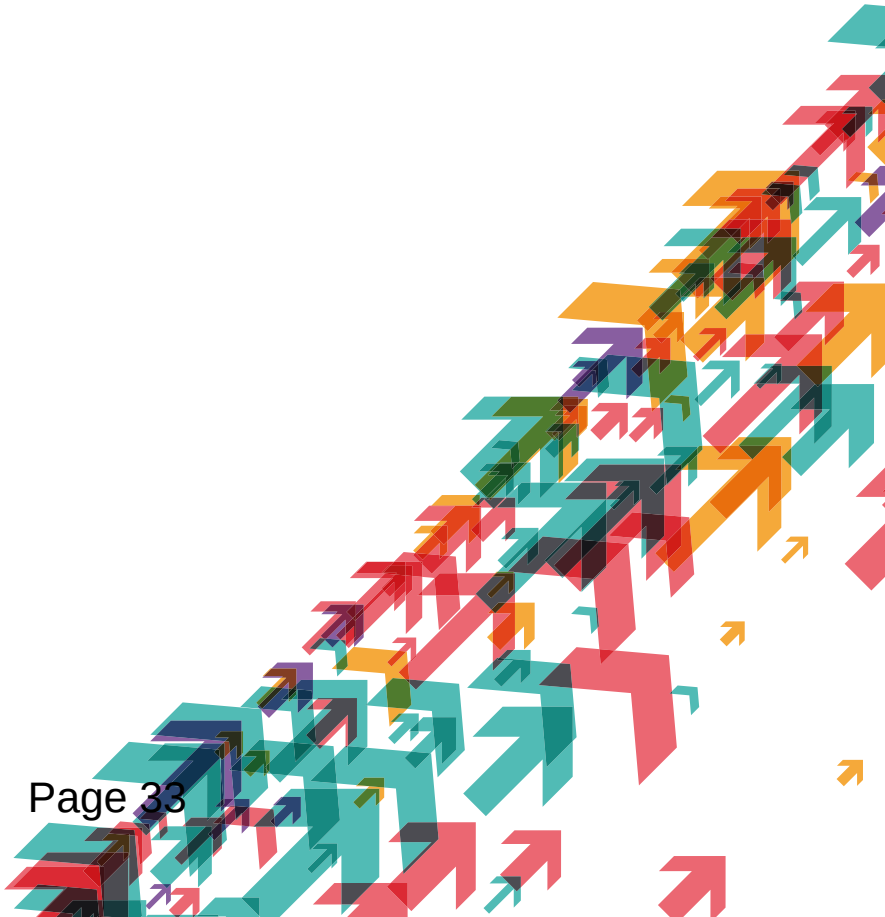
View the Darlington JSNA here



DARLINGTON BOROUGH COUNCIL

DARLINGTON

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HEALTH AND WELL BEING BOARD
17 JANUARY 2019

STARTING WELL
CHILDREN AND YOUNG PEOPLE'S PLAN 2017- 2022 – PROGRESS REPORT

SUMMARY REPORT

Purpose of the Report

1. This report provides an update to the Health and Wellbeing Board on the progress to date against the delivery of the Children and Young People's Plan 2017-22.

Summary

2. The Children and Young People's Plan (CYPP) is one of the identified delivery plans within the Sustainable Community Strategy (SCS) and identifies what key actions will be taken to deliver the agreed SCS priority of the best start in life for every child.

Recommendation

3. It is recommended that Health and Well Being Board note the report.

Suzanne Joyner
Director of Adult and Children Services

Background Papers

No background papers were used in the preparation of this report.

Christine Shields: Extension 5819

S17 Crime and Disorder	N/A
Health and Well Being	Children's social care is central to well-being
Carbon Impact	None
Diversity	If significant changes are required an EIA will be undertaken
Wards Affected	All
Groups Affected	Children and young people
Budget and Policy Framework	MTFP
Key Decision	No
Urgent Decision	No
One Darlington: Perfectly Placed	Aligned
Efficiency	New ways of delivering support and care of the capacity to generate efficiency
Impact on Looked After Children and Care Leavers	This report impacts on all children and young people including looked after children or care leavers

MAIN REPORT

Information and Analysis

Summary

4. The CYPP 2017-22 was adopted by Council on 29th September 2017 and since being adopted a professionally designed version of the plan has been produced and published.

5. The front and back cover of the plan was designed by Jonathan Raiseborough, a young person with autism who is an award-winning artist who created a series of stunning illustrations for Darlington's new Children and Young Peoples Plan (CYPP).

6. The plan was officially launched via a photoshoot on the 16th March at Longfield School and a celebration event was also held on 11th April 2018. 147 children and young people attended the event.

7. The following agencies were present on the day of the event;

   (a) **YMCA –** provided an information stall on the services and activities they provide with the main focus being around their new initiative in which they are working with young people to develop and provide youth venues and activities around Darlington.

   (b) **DISC –** provided an information stall on their Young Carer project.

   (c) **Switch –** provided information on alcohol and drug awareness.

   (d) **Darlington Youth Partnership –** the newly elected member of Youth Parliament was present to promote the Darlington Youth Parliament, his manifesto and encouraged families to share any views on growing up in Darlington.

   (e) **Darlington College –** promoted college courses and provided the astronaut origami and helped children create their own cloud slime.

   (f) **Library –** provided an information stall on the activities and services provided at Crown Street and Cockerton Library. Children could also colour in and create a rabbit head band and were asked to draw round their hands in coloured paper, cut the hand out and attached it to a giant rainbow using the CYPP initials to form the rainbow.

   (g) **Scouts –** provided information on the scout movement in Darlington, how to get involved and what activities children and young people can experience as a scout.

8. In addition a number of local activity providers delivered the following activities:

   (a) Inclusion Archery, table tennis, boxercise, Cool Kids Yoga, BigLittleGigs.
   (b) Giana mandalas, Scrap Studio Arts.

Multi-Agency Steering Group (MASG)

9. Chaired by the Assistant Director for Commissioning, Performance and Transformation a multi-agency steering group (MASG) has been established to bring together key partners to ensure effective monitoring and delivery of the Children's and Young People's Plan, and to encourage and strengthen links between the plan and professional bodies. The delivery of the plan is not just the responsibility of the Local Authority but is partnership approach, owned by all stakeholders from a range of statutory agencies. This Group currently meets on a quarterly basis.

Delivery of the plan

10. The plan contains the following priority actions for the next five years:

    (a) Increase breastfeeding rates and reduce the incidence of smoking at the time of delivery.

    (b) Reduce obesity levels.

    (c) Improve the mental health and emotional wellbeing of all children and young.

    (d) Reduce the number of children and young people living in poverty

    (e) Improve school attendance and attainment.

    (f) Increase the number of young people in work, education or training.

    (g) Strengthen families to reduce the need for statutory intervention

11. As this is a five year plan, it was agreed by the MASG to have a year one focus on two of the priority actions and an action plan was developed. An update on progress is detailed below.

Priority 3: Improve the mental health and emotional wellbeing of all children and young people

12. A delivery plan has been developed for this priority, the lead for this is a member of staff from the NHS Clinical Commission Group (CCG) and a member of the MASG. Progress against the delivery plan is currently on track and is summarised below:

13. Darlington has participated in the Anna Freud School Link Programme which brings mental health leads from schools together with clinicians from specialist mental health services to work on joint solutions for improving the mental health of children and young people. A number of workshops have been held which were successful and improved relationships between the two partners and resulted in a comprehensive action plan to for continued improvement being developed.

14. There continues to be a strong social media campaign utilising posters and literature designed by young people from Darlington.

15. The results from the Healthy Lifestyle survey showed that the young people of Darlington generally feel happy. There is a small minority who do not have the protective factors; supportive family, safe environment, peer support, who report to be less happy. Improvement action plans are in place where necessary.

16. Darlington CCG is eligible to apply for the Trailblazer funding which is the government's response to the Green paper on supporting the mental health needs of children in schools. We are working as a multi-agency partnership to pull this bid together, submission date is 17th September 2018.

17. Initial discussions have been held with Workforce development to move towards a multi-agency training approach for mental health & wellbeing. This will ensure that all front line staff from a number of agencies receive training in identifying needs in children.

18. From September, plans are in place to develop, in partnership with schools, a bespoke webpage for schools and colleges to access with mental health links and guidance. A pilot will begin with CAMHS and Early Help in a small number of schools and Darlington are participating in the Anna Freud school link programme for the second time.

Priority 6: Increase the number of young people in work, education or training

19. Youth unemployment was selected as a priority for the CYPP Multi-Agency group following an analysis of data which placed Darlington in the top 10 local authority areas for the rate of 18 to 24 year olds unemployment claimants

20. Analysis was subsequently undertaken by the Policy Team to uncover the underlying reasons for this seemingly poor performance. This showed that Darlington is a net exporter of young people between the ages of 18 to 24 largely due to the fact there is not a university in the borough and once this was accounted for, Darlington is largely in line with the regional average for the proportion of young people who are unemployed.

21. The analysis also showed that there is a consistent cohort of approximately 500 young people claiming unemployment benefits, with around 40 per cent of this cohort claiming for longer than six months.

22. The underlying reasons for long-term unemployment of young people are complex, and often the result of issues experienced during childhood, such as growing up in households with generational unemployment, poor attainment at school and living in communities which feel disconnected from the local economy.

23. In light of these findings, it was agreed by the Multi Agency Steering Group that the priority of youth unemployment should be replaced by child poverty, which is often the root cause of many poor health and social outcomes and is projected to increase significantly over the next few years, both nationally and within Darlington.

Year Two Priorities

24. The priority actions for year two will be:

    (a) **Priority action 4** – Reduce the number of children and young people living in poverty (as mentioned in 13 above) and continue into year two with the
    (b) **Priority action 3** – Improve the mental health and emotional wellbeing of all children and young people.

Scorecard

25. A scorecard has been developed which contains a number of key performance indicators to measure delivery of the priority actions as detailed in the plan. The scorecard is attached at **Appendix One.**

26. Attached at **Appendix Two** is a summary of performance against each indicator within the scorecard. Overall when comparing performance against the last available data, 18 indicators have improved from the previously recorded data, 3 have remained the same and 20 have seen a reduction in performance. For 8 of the indicators 2017/18 data is the only data available therefore comparison with previous years is not possible. It should be noted that in most cases the performance indicators are outcome based and therefore not in direct control of those delivering services, many also require long term intervention in order to measure impact. On this basis it is not expected that the delivery plans will have a significant impact on these indicators within this first year of the plan, therefore these will be monitored over the five year period of the plan. Quarterly performance management is therefore focussed on the delivery plans against the priority actions and ensuring that they are progressing as expected.

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Appendix One

	CHILDREN & YOUNG PEOPLE PLAN - SCORECARD													Latest data compared to			
CYPP Number	CYPP Theme	Indicator Num	Indicator Description	What is best	Measure of unit	Latest England Av	Latest North East Av	Latest Stat Neighbour benchmark	2013/14	2014/15	2015/16	2016/17	2017/18	Previous data	Latest England Average	Latest North East Average	Latest Statistical Neighbour
CYPP 001	Breastfeeding & Smoking	PBH 013c	(PHOF 2.02ii) % of all infants due a 6-8 week check that are totally or partially breastfed	Bigger	%	44.40	31.40	31.49	35.27	34.23	33.60	34.30		↑	↓	↑	↑
CYPP 002	Breastfeeding & Smoking	PBH 014	(PHOF 2.03) % of women who smoke at time of delivery	Smaller	%	10.70	16.10		20.39	19.60	15.00	16.20		↓	↓	↓	
CYPP 003	Breastfeeding & Smoking	PBH 015	Number of adults identified as smoking in antenatal period	Smaller	Num								35				
CYPP 004	Breastfeeding & Smoking	PBH 015a	Number of smoking quit dates set	Bigger	Num								198				
CYPP 005	Breastfeeding & Smoking	PBH 015b	% of successful smoking quitters at 4 weeks	Bigger	%								51.00				
CYPP 006	Obesity	PBH 020	(PHOF 2.06i) Excess weight among primary school age children in Reception year	Smaller	%	22.60	24.50	24.21	25.00	23.30	23.50	25.00		↓	↓	↓	↓
CYPP 007	Obesity	PBH 021	(PHOF 2.06ii) Excess weight among primary school age children in Year 6	Smaller	%	34.20	37.30	36.15	34.65	34.58	34.60	36.70		↓	↓	↑	↓
CYPP 008	Obesity	CYP 008	(PHOF 2.11iv) Proportion of the population meeting the recommended "5-a-day" at age 15	Bigger	%	52.40	46.80			44.60					↓	↓	
CYPP 009	Mental health & wellbeing	CYP 009	Prevalence of potential eating disorders among young people: Estimated number of 16 - 24 year olds	Smaller	Num				1,413								
CYPP 010	Mental health & wellbeing	CYP 010	Hospital admission rate for mental health illness for children per 100,000 population aged 0-17 years	Bigger	Per 100,000 pop	81.50	99.30		101.10	92.50	44.20	97.70		↑	↑	↓	
CYPP 011	Mental health & wellbeing	CYP 011	The Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) age 15-16 'What About YOUth' survey score	Smaller	%	47.60	47.60			46.80					↑	↑	
CYPP 012	Mental health & wellbeing	CYP 012	Percentage reporting general health as excellent	Bigger	%	29.50	30.90			29.70					↑	↓	
CYPP 013	Mental health & wellbeing	CYP 013	Estimated prevalence of mental health disorders in children and young people: % population aged 5-16	Smaller	%	9.20	10.00			9.80	9.80			↔	↓	↑	
CYPP 014	Mental health & wellbeing	CSC 251a	(PHOF 2.08ii) Percentage of children aged 5-16 who have been in care (LAC) for at least 12 months on 31st March whose score in the SDQ indicates cause for concern	Smaller	%	37.00	38.00			43.00		29.52	33.00	↓	↑	↑	
CYPP 015	Poverty	EDU 027	% of primary pupils eligible for and claiming free school meals	Smaller	%	13.70	18.90	17.14	19.10	18.80	17.90	18.50	17.70	↑	↓	↑	↓
CYPP 016	Poverty	EDU 028	% of secondary pupils eligible for and claiming free school meals	Smaller	%	12.40	16.50	14.72	16.70	16.70	14.90	14.40	13.50	↑	↓	↑	↑
CYPP 017	Poverty	CYP 017	% of primary pupils Free School Meals in the past 6 years	Smaller	%	24.50	31.60	29.24	29.40	30.30	31.30	30.20	30.00	↑	↓	↑	↓
CYPP 018	Poverty	CYP 018	% of secondary pupils Free School Meals in the past 6 years	Smaller	%	29.20	34.90	32.43	32.70	33.00	29.60	32.50	33.00	↓	↓	↑	↓
CYPP 019	Poverty	CHF 043	% of households with children whose economic activity status is classed as workless	Smaller	%	11.20	15.40		14.40	13.00	9.30	12.10		↓	↓	↑	
CYPP 020	Poverty	CYPP 020	% of pupils eligible for Pupil Premium	Smaller	Num	28.12	34.82					34.48	34.45	↑	↓	↑	
CYPP 021	Attendance & Attainment	EDU 008	% of 4 years olds total absence (6 Terms)	Smaller	%	5.10	5.20	4.92	4.80	5.60	5.50	5.10		↑	↔	↑	↓
CYPP 022	Attendance & Attainment	EDU 020	Total unauthorised absence from Primary schools	Smaller	%	1.10	1.20	1.13	0.70	0.80	0.90	1.10		↓	↔	↑	↑
CYPP 023	Attendance & Attainment	EDU 021	Total unauthorised absence from Secondary schools	Smaller	%	1.50	1.80	1.70	1.40	1.60	1.60	1.80		↓	↓	↔	↓
CYPP 024	Attendance & Attainment	EDU 022	State Funded Primary persistent absence rate (new definition from 2015/16 academic year)	Smaller	%	8.30	8.80	8.51			9.50	9.60		↓	↓	↓	↓
CYPP 025	Attendance & Attainment	EDU 023	State Funded Secondary persistent absence rate (new definition from 2015/16 academic year)	Smaller	%	13.50	14.70	13.91			15.70	17.80		↓	↓	↓	↓
CYPP 026	Attendance & Attainment	EDU 011	(PHOF 1.02i) - School Readiness: all children achieving a good level of development at the end of reception as a percentage of all eligible children. (Early Years Foundation Stage Profile (EYFSP))	Bigger	%	70.70	70.70	68.66	55.30	66.30	69.60	72.20		↑	↑	↑	↑
CYPP 027	Attendance & Attainment	EDU 015	% of all pupils reaching expected standard in Key Stage 2 for Reading, Writing & Maths	Bigger	%	64.00	67.00	65.60			56.00	61.00	65.00	↑	↑	↓	↓
CYPP 028	Attendance & Attainment	EDU 025	Key Stage 4 - Average Attainment 8 score per pupil	Bigger	Num	44.60	44.60	46.01		46.50	48.40	45.00		↓	↑	↑	↓
CYPP 029	Attendance & Attainment	EDU 026	Key Stage 4 - Average Progress 8 scores per pupil	Bigger	Num		-0.21	-0.15			-0.39	-0.23		↑		↓	↓

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CYPP Number	CYPP Theme	Indicator Num	Indicator Description	What is best	Measure of unit	Latest England Av	Latest North East Av	Latest Stat Neighbour benchmark	2013/14	2014/15	2015/16	2016/17	2017/18	Previous data	Latest England Average	Latest North East Average	Latest Statistical Neighbour
CYPP 030	Work, education or training	CYP 030	Skills gap in current workforce	Smaller	%	14.00		15.10	15.00		11.00			↑	↑		↑
CYPP 031	Work, education or training	PBH 007	(PHOF 1.05) 16 -18 year olds not in education, employment or training	Smaller	%	6.00	5.40					4.30			↑	↑	
CYPP 032	Work, education or training	CSC 290	% of Care Leavers not in education, employment or training (combined for 19, 20 and 21 year olds former relevant) *NOTE this refers to the Birthday Contact included in the CLA Statutory Return.	Smaller	%	40.00	43.00	45.50	30.91	32.14	31.00		43.00	↓	↓	↔	↑
CYPP 033	Work, education or training	CYP 033	% of offers of education or training made to 16 and 17 year olds	Bigger	%	94.70	96.70	96.44	92.10	95.70	96.30	95.50	96.00	↑	↑	↓	↓
CYPP 034	Statutory Intervention	CYP 034	Estimated prevalence of mental health disorders in children and young people: % population aged 5-16	Smaller	%	9.30	10.00	9.20		9.80	9.80			↔	↓	↑	↓
CYPP 035	Statutory Intervention	CYP 035	Estimated prevalence of emotional disorders: % population aged 5-16	Smaller	%	3.60	3.60	3.90		3.80	3.80			↔	↓	↓	↑
CYPP 036	Statutory Intervention	CYP 036	Estimated prevalence of conduct disorders: % population aged 5-16	Smaller	%	5.60	5.60	6.10		6.00	5.90			↑	↓	↓	↑
CYPP 037	Statutory Intervention	CYP 037	Hospital admissions as a result of self-harm (10-24 years)	Smaller	Per 100,000 pop	404.60	425.30		668.90	526.80	405.70	472.80		↓	↓	↓	
CYPP 038	Statutory Intervention	CSC 188	% of children becoming the subject of a Child Protection Plan (CPP) for a 2nd or subsequent time in the reporting period (within 2 yrs of previous CPP ceasing)	Smaller	%					2.40	6.00	1.94	6.50	↓			
CYPP 039	Statutory Intervention	CSC 189	% of children with a Child Protection Plan (CPP) for 2nd or subsequent time with no time restriction	Smaller	%	18.70	14.20				13.97	10.61	19.00	↓	↓	↓	
CYPP 040	Statutory Intervention	CYP 025	Abuse and neglect: Rate per 10,000 children subject of a child protection plan with initial category of abuse	Smaller	Per 10,000 pop	19.90	20.90					17.70	11.00	↑	↑	↑	
CYPP 041	Statutory Intervention	CYP 041	Abuse and neglect: Rate per 10,000 children subject of a child protection plan with initial category of neglect	Smaller	Per 10,000 pop	20.90	38.80					38.40	19.00	↑	↑	↑	
CYPP 042	Statutory Intervention	CSC 199b	% of Initial Child Protection Conferences resulting in a Child Protection Plan (CPP) due to one of the Key Parental Risk Factors being Domestic Abuse	Smaller	%						9.00	40.00		↓			
CYPP 043	Statutory Intervention	CSC 199d	% of statutory children's Single Assessments Completed in period where Domestic Violence was identified as a Risk Factor.	Smaller	%						10.00	15.48	27.00	↓			
CYPP 044	Statutory Intervention	CSC 200	Rate of looked after children (LAC) in our care per 10,000 of the 0-17 population as at end of month	Smaller	Per 10,000 pop	62.00	92.00	89.40	83.00	88.00	90.00	96.79	95.00	↑	↓	↓	↓
CYPP 045	Statutory Intervention	CSC 159	Number of Child in Need (CIN) cases year to date	Smaller	Num						1,330	3,464	1,959	↑			
CYPP 046	Statutory Intervention	CSC 182	Number of children subject to a child protection plan (CPP)	Smaller	Num				178	124	135	66	115	↓			
CYPP 047	Statutory Intervention	YOS 001	First time entrants to the youth justice system, rate per 100,000 young people (10-17 year old)	Smaller	Per 100,000 pop	292.00	334.00		459.92	347.29	347.00	494.00	360.00	↑	↓	↓	
CYPP 048	Statutory Intervention	YOS 002	Use of custody, number of custodial sentence's given per 1,000 young people (10-17 years)	Smaller	Per 1,000 pop	0.41	0.41		0.61	0.72	0.41	0.72	0.41	↑	↔	↔	
CYPP 049	Statutory Intervention	YOS 003	Frequency rate of proven re-offending by young offenders aged 10-17	Smaller	Per 1,000 pop	1.57	1.93		1.24	1.97	2.56	2.83		↓	↓	↓	

Increase breastfeeding rates and reduce the incidence of smoking at the time of delivery					
Indicator number	**Indicator description**	**Latest data compared to previous data**	**Latest data compared to latest England Average**	**Latest data compared to latest North East Average**	**Latest data compared to latest Statistical Neighbour**
PBH 013c	(PHOF 2.02ii) % of all infants due a 6-8 week check that are totally or partially breastfed	↑	↓	↑	↑
		% has improved from 2015/16 to 2016/17. It is better than the North East and Statistical Neighbour average and not the England. When using the Public Health Outcomes area profiling the % is significantly worse than the England average and significantly better than the regional average.			
PBH 014	(PHOF 2.03) % of women who smoke at time of delivery	↓	↓	↓	
		% has not improved from 2015/16 to 2016/17. It is worse than both the England and North East average. When using the Public Health Outcomes area profiling the % is significantly worse than the England average and not significantly different from the regional average.			
PBH 015	Number of adults identified as smoking in antenatal period				
		Only 2017/18 data available, no comparative information available.			
PBH 015a	Number of smoking quit dates set				
		Only 2017/18 data available, no comparative information available.			
PBH 015b	% of successful smoking quitters at 4 weeks				
		Only 2017/18 data available, no comparative information available.			
% of reportable indicators	**Better than ↑**	**50%**	**0%**	**50%**	**100%**
	Worse than ↓	**50%**	**100%**	**50%**	**0%**
	Same as ↔	**0%**	**0%**	**0%**	**0%**
Non reportable		**3**	**3**	**3**	**4**

Reduce obesity levels					
Indicator number	**Indicator description**	**Latest data compared to previous data**	**Latest data compared to latest England Average**	**Latest data compared to latest North East Average**	**Latest data compared to latest Statistical Neighbour**
PBH 020	(PHOF 2.06i) Excess weight among primary school age children in Reception year	↓	↓	↓	↓
		% has not improved from 2015/16 to 2016/17. It is worse than the England, North East and Statistical Neighbour average. When using the Public Health Outcomes area profiling the % is significantly worse than the England average and not significantly different from the regional average.			
PBH 021	(PHOF 2.06ii) Excess weight among primary school age children in Year 6	↓	↓	↑	↓
		% has not improved from 2015/16 to 2016/17. It is better than the North East average but not the England and Statistical Neighbour average. When using the Public Health Outcomes area profiling the % is not significantly different from the England or regional average.			
CYP 008	(PHOF 2.11iv) Proportion of the population meeting the recommended "5-a-day" at age 15		↓	↓	
		% has only data for 2014/15. It is worse than both the England and North East average. When using the Public Health Outcomes area profiling the % is significantly worse than the England average and not significantly different from the regional average.			
% of reportable indicators	**Better than ↑**	**0%**	**0%**	**33.3%**	**0%**
	Worse than ↓	**100%**	**100%**	**66.7%**	**100%**
	Same as ↔	**0%**	**0%**	**0%**	**0%**
Non reportable		**1**	**0**	**0**	**1**

Improve the mental health and emotional wellbeing of all children and young people					
Indicator number	**Indicator description**	**Latest data compared to previous data**	**Latest data compared to latest England Average**	**Latest data compared to latest North East Average**	**Latest data compared to latest Statistical Neighbour**
CYP 009	Prevalence of potential eating disorders among young people: Estimated number of 16 - 24 year olds				
		Only 2013/14 data available. There is no comparative data available			
CYP 010	(PHOF) Hospital admission rate for mental health illness for children per 100,000 population aged 0-17 years	↑	↑	↓	
		The rate has improved from 2015/16 to 2016/17. It is better than the England average but not the North East average. When using the Public Health Outcomes area profiling the % is not significantly different from the England or regional average.			
CYP 011	The Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) age 15-16 'What About YOUth' survey score		↑	↑	
		Only 2014/15 data available. % is better than both the England and North East average			
CYP 012	Percentage reporting general health as excellent		↑	↓	
		Only 2014/15 data available. % is better than the England but not the North East average.			
CYP 013	Estimated prevalence of mental health disorders in children and young people: % population aged 5-16	↔	↓	↑	
		% remained the same for 2014/15 to 2015/16. It is better than the North East but not the England average			
CSC 251a	(PHOF 2.08ii) % of children aged 5-16 who have been in care (LAC) for at least 12 months on 31st March whose score in the SDQ indicates cause for concern	↓	↑	↑	
		% has not improved from 2016/17 to 2017/18. It is better than the England and North East average. When using the Public Health Outcomes area profiling the % is not significantly different from the England or regional average.			
% of reportable indicators	**Better than ↑**	**66.7%**	**60%**	**40%**	**0%**
	Worse than ↓	**0%**	**40%**	**60%**	**0%**
	Same as ↔	**33.3%**	**0%**	**0%**	**0%**
Non reportable		**3**	**1**	**1**	**6**

Reduce the number of children and young people living in poverty					
Indicator number	**Indicator description**	**Latest data compared to previous data**	**Latest data compared to latest England Average**	**Latest data compared to latest North East Average**	**Latest data compared to latest Statistical Neighbour**
EDU 027	% of primary pupils eligible for and claiming free school meals	↑	↓	↑	↓
		% has improved from 2016/17 to 2017/18. It is not as good as the England and Statistical Neighbours and better than the North East average.			
EDU 028	% of secondary pupils eligible for and claiming free school meals	↑	↓	↑	↑
		% has improved from 2016/17 to 2017/18. It is not as good as the England and better than the North East and Statistical Neighbours average.			
CYP 017	% of primary pupils Free School Meals in the past 6 years	↑	↓	↑	↓
		% has improved from 2016/17 to 2017/18. It is not as good as the England and Statistical Neighbours and better than the North East average.			
CYP 018	% of secondary pupils Free School Meals in the past 6 years	↓	↓	↑	↓
		% has not improved from 2016/17 to 2017/18. It is not as good as the England and Statistical Neighbours but better than the North East average.			
CHF 043	% of households with children whose economic activity status is classed as workless	↓	↓	↑	
		% has not improved from 2015/16 to 2016/17. It is better than the North East but not the England average.			
CYP 020	% of pupils eligible for Pupil Premium	↑	↓	↑	
		% has improved from 2016/17 to 2017/18. It is not as good as the England and better than the North East average.			
% of reportable indicators	**Better than ↑**	**66.7%**	**0%**	**100%**	**25%**
	Worse than ↓	**33.3%**	**100%**	**20%**	**75%**
	Same as ↔	**0%**	**0%**	**0%**	**0%**
Non reportable		**0**	**0**	**0**	**2**

Improve school attendance and attainment					
Indicator number	**Indicator description**	**Latest data compared to previous data**	**Latest data compared to latest England Average**	**Latest data compared to latest North East Average**	**Latest data compared to latest Statistical Neighbour**
EDU 008	% of 4 years olds total absence (6 Terms)	↑	↔	↑	↓
		% has improved from 2015/16 to 2016/17. It is the same as the England, better than the North East and not as good as the Statistical Neighbours average.			
EDU 020	Total unauthorised absence from Primary schools	↓	↔	↑	↑
		% has not improved from 2015/16 to 2016/17. It is the same as the England, and better than the North East and Statistical Neighbours average. Unauthorised absence has been a growing trend throughout England in general and Darlington is in line with this and not disproportionately worse.			
EDU 021	Total unauthorised absence from Secondary schools	↓	↓	↔	↓
		% has not improved from 2015/16 to 2016/17. It is not as good as the England and Statistical Neighbours and the same as the North East average.			
EDU 022	State Funded Primary persistent absence rate (new definition from 2015/16 academic year)	↓	↓	↓	↓
		The rate has not improved from 2015/16 to 2016/17. It is not as good as the England, North East and Statistical Neighbours average.			
EDU 023	State Funded Secondary persistent absence rate (new definition from 2015/16 academic year)	↓	↓	↓	↓
		The rate has not improved from 2015/16 to 2016/17. It is not as good as the England, North East and Statistical Neighbours average.			
EDU 011	(PHOF 1.02i) - School Readiness: all children achieving a good level of development at the end of reception as a percentage of all eligible children. (Early Years Foundation Stage Profile (EYFSP))	↑	↑	↑	↑
		% has improved from 2015/16 to 2016/17. It is better than the England, North East and Statistical Neighbours average. When using the Public Health Outcomes area profiling the % is not significantly different from the England or regional average.			
EDU 015	% of all pupils reaching expected standard in Key Stage 2 for Reading, Writing & Maths	↑	↑	↓	↓
		Provisional % has improved from 2016/17 to 2017/18. It is better than the England but not as good as the North East and Statistical Neighbour average.			
EDU 025	Key Stage 4 - Average Attainment 8 score per pupil	↓	↑	↑	↓
		% has not improved from 2015/16 to 2016/17. It is better than the England and North East and not as good as the Statistical Neighbour average.			
EDU 026	Key Stage 4 - Average Progress 8 score per pupil	↓		↓	↑
		% has not improved from 2015/16 to 2016/17. It is not as good as the North East and better than the Statistical Neighbour average.			
% of reportable indicators	**Better than ↑**	**33.3%**	**37.5%**	**44.4%**	**33.3%**
	Worse than ↓	**66.7%**	**37.5%**	**44.4%**	**66.7%**
	Same as ↔	**0%**	**25.0%**	**11.2%**	**0%**
Non reportable		**0**	**1**	**0**	**0**

Increase the number of young people in work, education or training					
Indicator number	**Indicator description**	**Latest data compared to previous data**	**Latest data compared to latest England Average**	**Latest data compared to latest North East Average**	**Latest data compared to latest Statistical Neighbour**
CYP 030	Skills gap in current workforce	↑	↑		↑
		% has improved from 2013/14 to 2015/16. It is better than the England and Statistical Neighbour average.			
PBH 007	(PHOF 1.05) 16 -18 year olds not in education, employment or training		↑	↑	
		% is better than both the England and North East average. When using the Public Health Outcomes area profiling the % is significantly better from the England and regional average.			
CSC 290	% of Care Leavers not in education, employment or training (combined for 19, 20 and 21 year olds former relevant)	↓	↓	↔	↑
		% has not improved from 2015/16 to 2017/18. It is better than the Statistical Neighbours the same as the North East and not as good as the England average.			
CYP 033	% of offers of education or training made to 16 and 17 year olds	↑	↑	↓	↓
		% has improved from 2016/17 to 2017/18. It is better than the England but not as good as the North East and Statistical Neighbours average.			
% of reportable indicators	**Better than ↑**	**66.7%**	**75%**	**33.3%**	**66.7%**
	Worse than ↓	**33.3%**	**25%**	**33.3%**	**33.3%**
	Same as ↔	**0%**	**0%**	**33.3%**	**0%**
Non reportable		**1**	**0**	**1**	**1**

Strengthen families to reduce the need for statutory intervention					
Indicator number	**Indicator description**	**Latest data compared to previous data**	**Latest data compared to latest England Average**	**Latest data compared to latest North East Average**	**Latest data compared to latest Statistical Neighbour**
CYP 034	Estimated prevalence of mental health disorders in children and young people: % population aged 5-16	↔	↓	↑	↓
		% has remained the same from 2014/15 to 2015/16. It is not as good as the England or Statistical Neighbours and better than the North East average.			
CYP 035	Estimated prevalence of emotional disorders: % population aged 5-16	↔	↓	↓	↑
		% has remained the same from 2014/15 to 2015/16. It is not as good as the England or North East and better than the Statistical Neighbours average.			
CYP 036	Estimated prevalence of conduct disorders: % population aged 5-16	↑	↓	↓	↑
		% has improved from 2014/15 to 2015/16. It is not as good as the England or North East and better than the Statistical Neighbours average.			
CYP 037	Hospital admissions as a result of self-harm (10-24 years)	↓	↓	↓	
		The rate has not improved from 2015/16 to 2016/17. It is not as good as the England or North East average.			
CSC 188	% of children becoming the subject of a Child Protection Plan (CPP) for a 2nd or subsequent time in the reporting period (within 2 yrs of previous CPP ceasing)	↓			
		% has not improved from 2016/17 to 2017/18.			
CSC 189	% of children with a Child Protection Plan (CPP) for 2nd or subsequent time with no time restriction	↓	↓	↓	
		% has not improved from 2016/17 to 2017/18. It is not as good as the England or North East average.			
CYP 025	Abuse and neglect: Rate per 10,000 children subject of a child protection plan with initial category of abuse	↑	↑	↑	
		The rate has improved from 2016/17 to 2017/18. It better than the England or North East average.			
CYP 041	Abuse and neglect: Rate per 10,000 children subject of a child protection plan with initial category of neglect	↑	↑	↑	
		The rate has improved from 2016/17 to 2017/18. It better than the England or North East average.			
CSC 199b	% of Initial Child Protection Conferences resulting in a Child Protection Plan (CPP) due to one of the Key Parental Risk Factors being Domestic Abuse	↓			
		% has not improved from 2016/17 to 2017/18.			
CSC 199d	% of statutory children's Single Assessments Completed in period where Domestic Violence was identified as a Risk Factor.	↓			
		% has not improved from 2016/17 to 2017/18.			
CSC 200	Rate of looked after children (LAC) in our care per 10,000 of the 0-17 population as at end of month	↑	↓	↓	↓
		The rate has improved from 2016/17 to 2017/18. It is not as good as the England, North East and Statistical Neighbours average.			

CSC 159	Number of Child in Need (CIN) cases year to date	↑			
		The number has improved from 2016/17 to 2017/18.			
CSC 182	Number of children subject to a child protection plan (CPP)	↓			
		The number has not improved from 2016/17 to 2017/18.			
YOS 001	First time entrants to the youth justice system, rate per 100,000 young people (10-17 year old)	↑	↓	↓	
		The rate has improved from 2016/17 to 2017/18. It is not as good as the England or North East average. • The number of young people identified as First Time Entrants being referred to the YOS continues to be low. The year-end (Apr 17 – Mar 18) total of 29 represent a 21.6% reduction compared with 2016/17 (35 in total). In the period April 17 – March 2018 the YOS have had 110 young people referred to the service for diversionary disposals i.e. Pre Caution Disposals (79) and Restorative Disposals (31). 90% success rate in terms of you people not reoffending.			
YOS 002	Use of custody, number of custodial sentence's given per 1,000 young people (10-17 years).	↑	↔	↔	
		The rate has improved from 2016/17 to 2017/18. It is not as good as the England or North East average. • In relation to the use of custody, overall the YOS have been successful in their sentencing and bail assessments and proposals to the court whereby 97% of young people appearing before the court have received a community sentence or granted bail. As with any incidents where custody is being considered the YOS Management Team scrutinise and ensure that all alternative options have been deliberated. Consideration to ensure public protection and risk of harm to the community is paramount.			
YOS 003	Frequency rate of proven re-offending by young offenders aged 10-17	↓	↓	↓	
		The rate has improved from 2016/17 to 2017/18. It is not as good as the England or North East average. The proven reoffending position as of July 2018 (new 3 month measure tracks Apr-Jun 17 Cohort) is 31%, 15 out of 48 young people in the tracking period have reoffending committing a further 62 offences. 69% success rate where young people have not gone on to re-offending.			
% of reportable indicators	**Better than ↑**	**46.7%**	**18.2%**	**27.3%**	**50%**
	Worse than ↓	**40.0%**	**72.7%**	**63.6%**	**50%**
	Same as ↔	**1.3%**	**9.1%**	**9.1%**	**0%**
Non reportable		**0**	**5**	**5**	**12**

HEALTH AND WELL BEING BOARD
17 JANUARY 2019

AGEING WELL
BETTER CARE FUND 2017 - 19

SUMMARY REPORT

Purpose of the Report

1. To update Health and Well Being Board on delivery of the 2017-19 Better Care Fund (BCF) submission and associated plans.

2. To update the Board on any updated guidance received before the date of the meeting in respect of how BCF will continue into 2019/20.

Background

3. As reported to this Board in September 2018 the BCF plan 2017-2019 has seven broad workstreams to support the delivery of the BCF priorities in the areas of:

   (a) Improving healthcare services to Care Homes:
   (b) Equipping people to be resilient and self-reliant through Primary Prevention/Early intervention, and Care Navigation
   (c) Intermediate Care and improvements to reablement and rehabilitation services; further
   (d) Improving Transfers of Care through the implementation of the High Impact Change Model,
   (e) New models of Care and personalisation of services including through technology and domiciliary care;
   (f) Supporting carers and delivering DFG adaptations.
   (g) Improving Dementia Diagnosis and post diagnosis support

4. The two-year plan remains in place.

Recommendation

5. The Health and Well Being Board is asked to

   (a) Note the progress to date on delivering 2017-19 Better Care fund Objectives.

   (b) Note the position in respect of BCF 2019/20.

   (c) Note the position in respect of the national metrics and the actions taken.

Reasons

6. The recommendations are supported by the following reasons:-

(a) The two-year plan remains in place with delivery progressing well; new guidance issued in June 2018 has not required any amendment or addition. Scheme reviews during the year have led to small changes in the expenditure plan for 2018/19 but not at a material level.

(b) There is an expectation that a further plan will be required for 2019/20 but no guidance has yet been received.

(c) This report summarises the current position.

Suzanne Joyner
Director of Children and Adults Services

Background Papers
The Better Care Fund narrative plan 2017 - 2019

Pat Simpson : Extension 6082

S17 Crime and Disorder	Not applicable
Health and Well Being	The Better Care Fund is owned by the HWBB
Carbon Impact	None
Diversity	None
Wards Affected	All
Groups Affected	Frail elderly at risk of admission/re-admission to hospital
Budget and Policy Framework	Budgets pooled through a s75 agreement between DBC and Darlington CCG
Key Decision	No
Urgent Decision	No
One Darlington: Perfectly Placed	Aligned
Efficiency	New ways of delivering care have the capacity to generate efficiencies
Implications on Looked After Children and Care Leavers	None

MAIN REPORT

Healthcare services to Care Homes

7. A BCF Darlington Care Home Commissioning Delivery Group continues to meet, to aid closer working of health and social care commissioners to support the residential care sector.

8. Early results from the intensive MDT (led by GP, with CPN, community matron, and therapist input) at every home, every month are positive but longer term evaluation/ feedback is required. The MDT reviews residents who have had an unplanned admission, three unplanned community matron visits, had a fall, or had an adverse medications management event, with the objective of making recommendations that reduce the risk of a further unscheduled admission.

Primary prevention and care navigation, equipping people to be resilient and self-reliant

9. The care coordination scheme, known as health and wellbeing facilitators is to be delivered through Primary Healthcare Darlington, the GP Federation. Scheduled to be mobilised in March/April 2019, with objectives of supporting frail older people identified by GPs and Social Workers as having the potential to benefit from access to community based support and resources through the development of a personalised wellbeing plan, which in turn will empower people to self-care and self-manage to reduce reliance on health and social care services.

10. This service and the facilitators delivering the service will benefit from plans for the further development and improvement of the comprehensive directory of resources and community assets for Darlington. Livingwell.Darlington is up and running, and a steering group is now in place to provide oversight of improvements, prioritising promotion and further developments in the service for Darlington residents.

Intermediate Care

11. An improved reablement pathway is currently being prepared for implementation at the Council.

12. In parallel, the joint Strategic Commissioning Group (comprising commissioners from the CCG and DBC) has developed a vision for the transformation of Intermediate care and will, during 2019, establish a group to design a model for the future provision of this vital service. This is a priority area of work for both the Health and Wellbeing Board and the BCF Delivery Group, and the model, once designed, will come to the Board for approval prior to mobilisation.

13. A deep dive into the mechanism of collecting the ASCOF 2B data has been completed and a new collection and analysis process is now being embedded. This will ensure that the data is robust and reliable and able to be used to inform service improvement.

Transfers of Care: High Impact Change Model

14. Patient flow and discharge planning is pivotal, and work to implement the high impact changes will continue. Darlington is on track to be "established" in each of the eight changes by the end of March 2019, in line with national expectations. The Local Authority and health partners have been working together on discharge planning and delivery for a number of years and the BCF Transfers of Care delivery group is focusing on patient flow.

15. The BCF Darlington Transfers of Care group brings together hospital, commissioning and provider representatives to further progress the work. This group has "ownership" of the High Impact Change model, and has developed a system-wide action plan. A good practice case study of the way DBC social workers are embedded in the DMH discharge team is being presented at the regional BCF workshop in Newcastle at the end of January.

Dementia

16. New schemes to improve diagnosis of dementia in minority communities, and to offer activities including singing for the brain, swimming from the brain and brain games have been commissioned.

Additional iBCF Grant Plan

Maintaining the Core Service during transformation

17. The new grant funding (£2.1m in 17/18 and £1,4m in 18/19) is being used to offset expenditure on current pressures and demand to ensure sustainability (50%) while the service undergoes transformation (50%). This has reduced the immediate ASC budget pressure and will achieve a more financially stable position for ASC in the medium term when a transformed service can operate sustainably within its resources.

18. In 18/19 key areas where the grant was used include the Rapid Response Service, which expedites the discharge of people from hospital, the engagement of external consultant support to identify where change will result in improved service and increased efficiency, and the supernumerary review team examining every package of care and identifying where change would benefit the person.

19. Planning to make best use of the grant meant its use didn't get under way until mid-17/18. Consequently we will be seeking permission to roll some of it into 19/20.

20. 19/20 schemes include a significant programme of workforce development, embedding the strength-based approach, and the implementation of the renewed reablement service.

Transforming the service

21. In 17/18 the main uses to which the iBCF additional grant put down the foundations - the extensive review of our reablement service, the implementation of agile working, and support for the new community asset and resource directory Livingwell.Darlington.

22. This year we have built on those foundations through the implementation of the new reablement pathway, and improving the first point of contact.

Performance and Monitoring

Summary of the 2018/19 Q3 national monitoring report

23. All monitoring requirements in 18/19 have been met on time, and endorsed by the Director of Children and Adults, Darlington Borough Council and the Chief Officer, NHS Darlington Clinical Commissioning Group on behalf of the Health and Wellbeing Board. The third quarter monitoring report is due to be submitted on 25 January 2019.

24. The monitoring report required confirmation that Darlington complies with the national conditions attached to BCF

    (a) Plans are jointly agreed
    (b) Planned contribution to social care from the CCG minimum contribution is agreed in line with the Planning Requirements
    (c) Agreement to invest in NHS commissioned out of hospital services
    (d) Managing transfers of care
    (e) Funds Pooled through a s75 agreement

25. It also reported that Darlington is on track to meet three of the four metrics, being off track only in respect of ASCOF 2B – the number of people referred to Social Care Reablement who are still at home 91 days after their hospital discharge. This metric has been subject to a significant overhaul this year and the new collection procedure is still bedding in.

26. The three metrics on which Darlington is fully on track are

    (a) Non elective admissions – Q2 is on track and Q3 projecting to be close
    (b) Permanent admissions to care homes – continues to be much better than target
    (c) Delayed Transfers of Care – continues to exhibit excellent performance, which reflects the close working relationship between DBC and the discharge team at DMH.

27. An update on the High Impact Change Model implementation was also required, and shows that Darlington is on track to be “established” in all changes by the end of March, as required nationally.

28. In terms of current activity implementing the HICM, key actions are being delivered by all parts of the BCF plan, and other programmes in the health and social care system. For example, blockages to early discharge planning, and trusted assessors are being addressed through an “Action on A&E” project (known as “Project Margaret”) involving the whole health and social care system, and improvements to multi agency discharge team include the use of iBCF funding to support rapid response social care.

Local delivery monitoring

29. Locally, BCF delivery is managed through the BCF Darlington Delivery Group, which meets monthly, with input from performance and finance colleagues who also attend quarterly, in line with the national reporting schedule.

30. A number of schemes have been reviewed, resulting in specification changes, contract changes or scheme cessation.

Length of Stay

31. NHS England and NHS Improvement have set out their ambition for reducing long stays in hospital by 25% earlier this year, to reduce patient harm and bed occupancy.

32. The current BCF guidance advises that whilst this ambition is not part of BCF, they expect BCF plans to support delivery of this reduction through the continuing focus on delivery of the local DToC expectations and through the implementation of the High Impact Change Model in relation to systems to monitor patient flow, seven day services and trusted assessors (changes two, five and seven).

33. National partners will give consideration to applying additional requirements for 2019/20 (still awaited), including through the BCF where appropriate, for local areas and NHS bodies that have made insufficient progress in reducing the number of people experiencing long stays in hospital during 2018/19.

BCF 2019-20

34. The expectation at the time of preparing this report is that a one year BCF plan for 2019-20 will be required, with minimal change from what is currently planned, probably with the inclusion of a Length of Stay metric as described above. Operational guidance has not yet been received however, neither has a policy framework, so a verbal update will be given at the Meeting if that guidance has been received by that time. The guidance is expected at the same time as the five-year indicative CCG allocations, publicised as coming in “early January”.

35. We also expect some consultation document on the degree to which BCF has had a positive impaction on driving transformation change and moves towards integration. Again, if this is received before the meeting, a verbal update will be given.

HEALTH AND WELL BEING BOARD
17 JANUARY 2019

HEALTH AND WELL BEING BOARD – TERMS OF REFERENCE

SUMMARY REPORT

Purpose of the Report

1. To consider amendments to the Terms of Reference for the Health and Well Being Board.

Summary

2. Revised governance arrangements and Terms of Reference for the Health and Well Being Board were considered and approved by the Board at its meeting held on 10 May 2018. When approving the Terms of Reference the Board agreed to review them on a regular basis. The Terms of Reference are attached to the report at Appendix 1, with a number of proposed minor changes highlighted.

Recommendation

3. It is recommended that:-

   (a) the Terms of Reference, appended to the submitted report, be approved, with the inclusion of the following amendments, namely:-

      (i) the Darlington Integration Board overseeing the delivery of local plans to ensure that they are in line with the Joint Needs Assessment and Joint Health and Well Being Strategy;
      (ii) the deletion of the NHS Darlington Clinical Commissioning Group's Chief Clinical Officer from the Membership of the Board;
      (iii) the deletion of Darlington Borough Council's Chief Executive/Managing Director from the Membership of the Board; and
      (iv) the Vice Chair of the Board will be the Chair of the NHS Darlington Clinical Commissioning Group.

   (b) the board consider any further changes to be made, at this time, to the Terms of Reference, following the stocktake or priorities.

Reasons

4. The recommendations are supported by the following reasons :-

   (a) To enable the Terms of Reference to be updated with a number or minor changes.

(b) To enable the Board to consider any further amendments to the Terms of Reference, following the stocktake of priorities.

Suzanne Joyner
Director of Children and Adults Services

Background Papers
No background papers were used in the compilation of this report.

Lynne Wood : 01325 405803.

S17 Crime and Disorder	There are no implications arising from this report.
Health and Well Being	This proposed collaborative project will provide improvements for health and well being of residents with Long Term Conditions.
Carbon Impact	There are no implications arising from this report.
Diversity	There are no implications arising from this report.
Wards Affected	All
Groups Affected	All
Budget and Policy Framework	N/A
Key Decision	N/A
Urgent Decision	N/A
One Darlington: Perfectly Placed	N/A
Efficiency	N/A
Implications for Looked After Children and Care Leavers	There are no direct implications for Looked After Children or Care Leavers contained within the report.

MAIN REPORT

Information and Analysis

5. The current Terms of Reference for the Health and Well Being Board were considered and approved by the Board at its meeting held on 25 April 2017. A number of minor changes were made to the Terms of Reference when they were re-considered by the Board at its meeting held on 10 May 2018.

6. A number of minor changes are proposed, namely :-

   (a) the Darlington Integration Board overseeing the delivery of local plans to ensure that they are in line with the Joint Needs Assessment and Joint Health and Well Being Strategy;
   (b) the deletion of the NHS Darlington Clinical Commissioning Group's Chief Clinical Officer from the Membership of the Board;
   (c) the deletion of Darlington Borough Council's Chief Executive/Managing Director from the Membership of the Board; and
   (d) the Vice Chair of the Board will be the Chair of the NHS Darlington Clinical Commissioning Group.

7. Members of the Board may wish to consider further amendments to the Terms of Reference due, in part, to the changing landscape of the Clinical Commissioning Group, and following the stocktake of priorities discussed earlier on this agenda. Those changes could include the frequency and focus of future meetings of the Board.

Outcome of Consultation

8. No consultation, other than with the Health and Well Being Board, has been undertaken on the contents of this report.

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DRAFT

Darlington Health and Wellbeing Board

Terms of Reference

The Darlington Health and Wellbeing Board brings together key local leaders to improve the health and wellbeing of the population of Darlington and reduce health inequalities through:

(a) Developing a shared understanding of the health and wellbeing needs of its communities from pre-birth to end of life including the health inequalities within and between communities.
(b) Providing system leadership to secure collaboration to meet these needs more effectively.
(c) Having strategic influence over commissioning decisions across health, public health and social care encouraging integration where appropriate.
(d) Recognising the impact of the wider determinants of health on health and wellbeing.

It will:

(a) Maintain the Joint Strategic Needs Assessment, including the Pharmaceutical Needs Assessment to provide an evidence base for future policy and commissioning decisions.
(b) Produce a Joint Health and Wellbeing Plan, taking a life-course approach, in the context of One Darlington: Perfectly Placed which is the overarching Health and Wellbeing Strategy for the Borough.
(c) Oversee delivery of local commissioning plans by Darlington Integration Board to ensure that they are in line with the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy
(d) Embed the Children and Young People agenda in the work of the Board and fulfil the role of the Darlington Children's Trust
(e) Liaise with NHS England as necessary
(f) Encourage integrated working between health and social care commissioners including, where appropriate, supporting the development of arrangements for pooled budgets, joint commissioning and integrated delivery under Section 75 of the National Health Service Act 2006
(g) Oversee the Better Care Fund [1]
(h) Encourage close working between health and social care commissioners and those responsible for the commissioning and delivery of services related to the wider determinants of health

[1] Given that some members of the Board represent provider organisations, strategic funding decisions relating to the Better Care Fund are delegated to the Pooled Budget Governance Board, which is a commissioner-only body

Membership

Darlington Borough Council Portfolio Holder with a remit covering Health (Chair)
Darlington Borough Council Portfolio Holder with a remit covering Adult Services
Darlington Borough Council Portfolio Holder with a remit covering Children Services
The Leader of Darlington Borough Council
Leader of Darlington Borough Council Opposition Group
Darlington Borough Council Director, Children and Adults Services
Darlington Borough Council Director of Public Health
One representative of the Healthwatch Darlington Board
NHS Darlington Clinical Commissioning Group Chair
NHS Darlington Clinical Commissioning Group Chief Officer
NHS Darlington Clinical Commissioning Group Director of Commissioning
NHS Darlington Clinical Commissioning Group Chief Nurse
One representative of Tees, Esk and Wear Valley Mental Health Foundation Trust
One representative of County Durham and Darlington NHS Foundation Trust
One representative of Harrogate and District NHS Foundation Trust
One representative of NHS England
One representative of the Board of Primary Healthcare, Darlington
County Durham Police, Crime and Victims' Commissioner
Dean of the School of Health and Social Care, Teesside University
One representative of the Community and Voluntary Sector
One representative of Darlington Primary Schools
One representative of Darlington Secondary Schools
One representative of Darlington post 16 years education

Political proportionality does not apply to membership of the Board. Its makeup and operation complies with the 2012 The Health and Social Care Act 2012, comprising at least one Councillor of the local authority, the directors of adult and children social services for the local authority, the director of public health for the local authority, a representative of the Local Healthwatch organisation for the area of the local authority, a representative of each relevant clinical commissioning group. It also allows the local authority to include others as it thinks appropriate.

All members of the Board are accountable to the organisation/ sector which appointed them. Each member has a responsibility to communicate the Board's business through their respective organisation/ sector's own communication mechanisms.

Each Board member can nominate a named substitute. Substitutes must be from the same organisation/ sector as the Board member and be of sufficient seniority and empowered by the relevant organisation/ sector to represent its views; to contribute to decision making in line with the Board's Terms of Reference and to commit resources to the Board's business.

If a member of the Board misses three consecutive meetings without giving apologies, their continued membership of the Board will be reviewed with the organisation that they represent.

In carrying out its business the Board may, if required

(a) Establish one or more sub-committees to carry out any functions delegated to it by the Board.
(b) Establish one or more time limited task and finish groups to carry out work on behalf of the Board.
(c) Carry out any other functions delegated to it by Darlington Borough Council under Section 196(2) of the Health and Social Care Act 2012.

Chairing

The Chair of the Board will be the Darlington Borough Council Portfolio Holder with a remit covering health.

The Vice Chair of the Board is appointed by the Board and will be the Chair of the NHS Darlington Clinical Commissioning Group.

Voting Arrangements

It is expected that most decisions will be agreed by consensus but, where this is not the case, then only those members listed as voting members may vote. Voting on all issues will be by show of hands.

Organisation	**Position**
Darlington Borough Council	Council Members, Director of Children and Adults Services, Director of Public Health
Darlington Clinical Commissioning Group	Chair, Chief Officer, Director of Commissioning, Chief Nurse
Darlington Healthwatch	

The Chair of the Board shall have a second or casting vote.

Meeting arrangements

The Board will meet six times a year. The Chair of the Board, in consultation with the Vice Chair, can convene special meetings of the Board as appropriate.

All business of the Board shall be conducted in public in accordance with Section 100A of the Local Government Act 1972 (as amended). When the Board considers exempt information and/or confidential information is provided to Board members in their capacity as members of the Board all Board members agree to respect the confidentiality of the information received and not disclose it to third parties unless required to do so by law or where there is a clear and over-riding public interest in doing so.

Some information may have to be included and discussed in a confidential session of the Board in accordance with the procedures and protocols promoted by the provisions of the Data Protection Act 1998. Confidential documents will be clearly marked ‘Confidential’.

The quorum for meetings shall be three voting members and must include at least one Darlington Borough Council Councillor and one representative of the Clinical Commissioning Group.

Where a decision is required before the next Board meeting, the Chair may act on recommendations of officers in consultation with the Vice Chair through the following process:

(a) circulation of details of the proposed decision to all Board members for consultation;
(b) there being clear reasons why the decision could not have waited until the next full Board meeting; and
(c) the decision will be recorded and reported to the next full Board meeting.

Agenda and reports will be available online no fewer than five working days before the meeting.

All voting members of the Board are governed by the code of conduct/ professional standards of the organisation/ sector that they represent.

Relationships between partnerships

Work has been conducted to be clear about the relationships between key partnerships in Darlington with a focus on safeguarding, community safety, health and wellbeing.

A structural review of the Darlington Community Safety Partnership (CSP) was conducted in 2016. During the review, particular attention was paid to areas of common interest across the Darlington Safeguarding Children’s Board, Darlington Safeguarding Adults Partnership Board and the Community Safety Partnership.

Each of the partnerships considered areas of common interest and agreed the most appropriate governance arrangements that will provide assurance to each partnership.

Collaborative working is promoted across all partnerships. The function and activities of the Darlington Safeguarding Children’s Board are part of the wider context of Darlington’s Health and Wellbeing Board arrangements. Its work contributes to the wider goals of improving the wellbeing of all children and young people.

The Darlington Safeguarding Adults Partnership Board has three core duties as per the Care Act 2014. The Board must publish a strategic plan, an annual report and commission safeguarding adult reviews as appropriate.

The Independent chairs of both Safeguarding Boards will present their annual reports to the Health and Wellbeing Board which gives the Health and Wellbeing Board the opportunity to seek assurances of the safeguarding arrangements in place and the effectiveness of those arrangements.

The Darlington Community Safety Partnership (CSP) is a statutory partnership and reports progress to the Darlington Strategic Partnership on the One Darlington: Perfectly Placed theme of a ‘Safe and Caring’ community.

The CSP chair will present an annual report to both the Health and Wellbeing Board and Darlington Strategic Partnership.

A proposal from the work undertaken to develop a more co-ordinated approach across key partnerships is that the chairs of the key partnerships may meet at least twice a year to reduce duplication, strategically co-ordinate common priorities and to share relevant reports.

(Updated January 2019 - to be reviewed annually)

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HEALTH AND WELL BEING BOARD
17 JANUARY 2019

SPECIAL EDUCATIONAL NEEDS AND DISABILITY (SEND) STRATEGY

SUMMARY REPORT

Purpose of the Report

1. This report asks the Board to consider the content of the updated Special Educational Needs and Disabilities (SEND) Strategy (2019-2022) (**Appendix 1**) which summarises the strategic plan for delivering better outcomes for children and young people with special educational needs.

2. The report also provides details of the outcome to the recent public consultation which sought views on the draft.

Summary

3. This report seeks to inform the Board of the content of the Special Educational Needs and Disabilities (SEND) Strategy 2019-2022. The strategy proposes a local vision along with priorities for the future provision and development of services to support children with SEND.

4. Further work on the draft strategy has commenced with the Clinical Commissioning Group (CCG) to develop the draft strategy so that it can be adopted by the Local Authority and CCG as a local area strategy for Darlington.

Recommendation

5. It is recommended that the Board:-

   (a) agree to the key objectives outlined in the draft SEND Strategy and support the development of a local area strategy; and

   (b) endorse a joint approach to delivering the SEND Strategy and the opportunity to work together on an integrated approach to SEND.

Reasons

6. The strategy provides a framework to drive the work of the SEND partnership in Darlington through to 2022 to deliver the best possible outcomes for children and young people with SEND and their families.

Suzanne Joyner
Director of Children and Adults Services

Background Papers

No background papers were used in the preparation of this report.

S17 Crime and Disorder	This report has no implications for Crime and Disorder
Health and Well Being	The SEND Strategy will contribute to improved outcomes for children and young people with special educational needs and/or a disability in the borough.
Carbon Impact	There are no issues which this report needs to address.
Diversity	The SEND Strategy will contribute to improved outcomes for children and young people with special educational needs and/or a disability in the borough
Wards Affected	Children and young people with SEND may live in any ward.
Groups Affected	Children and young people with special educational needs and/or disabilities
Budget and Policy Framework	This report does not represent a change to the budget and policy framework.
Key Decision	This is a key decision
Urgent Decision	Yes, so as not to delay start of consultation and meet various timescales.
One Darlington: Perfectly Placed	The report contributes to the Sustainable Community Strategy Priority 'the best start in life'.
Efficiency	There are no direct efficiencies to the Council from the information contained within this report.
Impact on Looked After Children and Care Leavers	The SEND Strategy will contribute to improved outcomes for children and young people with special educational needs and/or a disability in the borough a number of these children are Looked After Children or Care Leavers.

MAIN REPORT

The SEND Strategy

7. Darlington's Special Educational Needs Strategy 2017-2020 was approved by Cabinet on 5 December 2017. This updated version builds on progress to date, identifying what has been achieved and our priorities for action up to 2022.

8. The vision for the strategy is that it promotes inclusion, maximizes young people's opportunities to be independent and enables young people with special educational needs and disabilities to be recognised as fully integrated citizens with the ability to contribute to their local community.

9. The strategy has been written to respond to the key priorities set out in the SEND code of practice, and highlights local strategic aims associated with each priority area for implementation. These are set out below:

(a) **Early identification of need ensuring that the right children and young people are in the right placement with the right support**

Early identification and intervention is essential to prevent underachievement and improve outcomes and improve children's life chances.

(b) **Building capacity in mainstream settings to enable children and young people to be educated in appropriate settings locally**

Children and young people with SEND need to have good quality support in their mainstream and local settings so that they can achieve their academic potential and maintain their self-esteem and confidence.

(c) **Ensuring that children and young people are educated in their local community and have an effective preparation for adulthood and access to work and leisure opportunities**

Being educated in their local area enables pupils with SEND greater independence and a sense of contributing and belonging to their local community. Children and young people with SEND tell us that they want to make friends locally and access local facilities with their families.

(d) **Increasing achievement and improving outcomes for children and young people with SEND**

Address the underperformance in educational achievement across the Key Stages but particularly at Key Stage 4 through targeted interventions, appropriate curriculum, high quality training and effective quality assurance, monitoring and moderation.

(e) **Focus on effective collaboration, co-production and communication**

Ensuring that all policies, practices are co-produced with all stakeholders and with the active involvement of parent/carers and children and young people.

(f) **Achieving 'Best Value' (human, physical and financial resources) from all our services**

Effective, efficient and co-ordinated services that meet the needs of children and young people with SEND and their families. With increasing demand we must ensure that the right resources are going to the right children in the right place.

10. The SEND Strategy sets out our vision in Darlington for a well-planned continuum of provision from birth to age 25 that meets the needs of children and young people with SEND and their families, and that we expect every early years setting, post 16 provider, mainstream school and academy to have the capacity and confidence to deliver effective provision.

11. The strategy aims to identify children with SEND at the earliest possible opportunity and provide them with the support they need to make good educational progress and achieve good outcomes so that they and their families feel well supported. It recognises the importance of providing good training for all staff, whichever setting

they are working in, using the best expertise and knowledge, sharing best practice and by promoting a model of collaborative working and shared responsibility.

12. The strategy aims to ensure education, care and health services are delivered in an integrated way so that the experience of families accessing services is positive and children and young people's learning and development, safety, well-being and health outcomes are well promoted alongside their educational progress and achievement.

SEND in Darlington

13. The most recent published national data (from January 2017, published in SEN in England in July 2018) shows that 3.3% of Darlington pupils have an Education, Health and Care Plan (EHCP). This is above the North East average of 3% and above the England average of 2.8%.

14. The published data shows the profile of primary need in Darlington is different to that seen nationally. Most notably a higher proportion of school age children have social, emotional and mental health needs (SEMH) identified as their primary need than is the case nationally (19.9% of pupils in Darlington compared to 15.7% across England and 16% across the North East) (**Appendix 2 Figures 1 and 2**).

15. The contrast is particularly stark in the data for pupils with SEMH placed in specialist provision. Across England 13% of pupils with SEMH as a primary need are placed in a special school compared to 28.8% in Darlington. Darlington has the 4th highest proportion of pupils with SEMH as a primary need placed in a special school in England **(Appendix 2 Figure 3).**

16. Darlington has seen a significant rise in the total number of EHCPs in the last 3 years (**Appendix 2 Figure 4**). The number of plans has risen from 385 in January 2013 to 683 in January 2018. This equates to a rise of 77% during this time.

17. The increasing levels of EHCPs are more significant since the profile of placements for pupils is skewed towards high cost provision. Darlington places a smaller proportion of young people with EHCPs in mainstream schools than is the case across England (**Appendix 2 Figure 5).** In England 41.9% pupils with EHCPs are placed in mainstream schools compared with 30.6% in Darlington. Darlington also places a higher proportion of young people with EHCPs in Independent Special Schools (5.1% compared to 2.3% across the North East and 3.7% across England). The average cost of a placement at an independent special school is £70,000 per year.

18. This trend is more pronounced in relation to EHCPs issued in 2017. Darlington placed 9.8% of new EHCPs in Independent Special Schools in 2017 compared to 2.7% across the North East and 2.9% in England **(Appendix 2 Figure 6**). In 2017 Darlington had the 5th highest proportion of new EHCPs placed in Independent Special Schools in England.

Developing Local Provision

19. The SEND strategy identifies the key priority of providing high quality local provision. One of the key drivers for the placement of pupils in high cost out of borough independent placements is the lack of suitable local specialist provision.

20. The strategy identifies key areas of consideration of commissioning local provision to meet need and manage demand.

Type of Need	Phase	Delivery
Pupils with Social, Emotional and Mental Health Needs (SEMH)	Primary	Resource base in a primary schools setting
Pupils with Social Emotional and Mental Health Needs (SEMH)	Secondary	Resource base in a secondary setting or Alternative provision

Public Consultation

21. Following approval from Cabinet on 9th October 2018, a public consultation commenced on 17th October 2018 and ran to the 28th November 2018. The general public and key stakeholders were invited to participate in the consultation. A series of public consultation events were held at which the draft strategy was presented which outlined the key challenges and opportunities identified and questions for consultation. Surveys and key documents were also available online.

22. Consultation with Children and Young People was organised through the LA's participation officers and this included representatives from "Voices", "Next Steps", "Young Leaders" and school councils.

23. Health professional e.g. service leads (Occupational Therapy, Physiotherapy, Speech and Language Therapy, Audiology, Ophthalmology; etc.) were contacted directly as well as the Clinical Commissioning Group (CCG) and the North of England commission support unit.

24. A summary of the responders is outlined in the table below:

Table 1: Summary of responders to SEND public consultation

Response Type	Numbers
Total survey responses (including hard copy surveys received)	108
Public Events (including open health, social care and school meetings) number of attendees	99
Children and Young People Events – number of attendees	50
Total number of detailed written responses - Teachers of Deaf and Visually Impaired, Darlington Low Incidence Needs Service - National Deaf Children Society - Federation of Mowden Schools - Traveller Education and Attainment Service, Darlington - Parent/Carer - The Federation of Darlington Nursery Schools - Darlington CYP Scrutiny Committee - Carmel Education Trust - Darlington Association on Disability - Parent Carer Forum	11

25. The SEND strategy survey was built around the 6 draft key objectives. The table below outlines the responses received through the formal surveys received.

Table 2: Summary of responses to strategy objectives

Question: To what extent do you agree or disagree with the SEND Draft strategy objective of:	**Total agreed**	**Neither agree nor disagree**	**Total disagree**
Early identification of need ensuring that the right children and young people are in the right placement with the right support	92.41%	5.06%	2.53%
Building capacity in mainstream and specialist settings to reduce reliance on specialist out of area placements 0-25	80.00%	4.29%	15.71%
Ensuring that children and young people with SEND are educated in their local community and have effective preparation for adulthood and access to work and leisure opportunities	82.36%	5.88%	11.76%
Increasing achievement and improving outcomes for children and young people with SEND	90.77%	3.08%	6.16%
Focus on effective collaboration, co-production and communication	92.31%	1.54%	6.16%
Achieving Best Value (human, physical and financial resources) from all our services	87.30%	6.35%	6.34%

26. The consultation outcome will be considered by Cabinet on 5th February 2019.

Darlington Council Strategy for Special Educational Needs and/or Disability (SEND)

2019 - 2022

“THE BEST START IN LIFE”

OUR STRATEGY FOR IMPROVING OUTCOMES ACHIEVED BY CHILDREN AND YOUNG PEOPLE AGED 0-25 WITH SEND 2019 - 2022

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1. Executive Summary

Darlington's SEND Strategy 2019-2022 for improving outcomes for children and young people with SEND 0-25 giving them the 'best start in life' outlines the vision and key priorities for supporting Darlington's children and young people with SEND and their families.

Our vision for all children and young people with special educational needs and disabilities is that they have the right support and opportunities at the right time so that they become resilient, happy adults.

This is set within the national context and our statutory requirement to meet the needs of children and young people under the requirements of the Children and Families Act 2014 and our local context with the rising numbers of children who have a range of complex needs and the need to provide high quality and responsive services within financial constraints.

Darlington is fully committed to the children and young people with SEND and their families and strives to ensure that they receive the highest quality provision wherever possible. We have analysed our gaps in provision, used a range of data across services and settings and improved partnership working with a wide range of stakeholders. We endeavour to work closely with the Parent/Carer forum in all that we do.

We have identified our key objectives, priority actions, opportunities and challenges in meeting the growing needs and numbers of children and young people who have SEND. Our analysis of local need suggest we need to consider future commissioning to meet the following need:

- A revised role and remit for the Additional Resource Bases and outreach support in Primary and Secondary schools to reflect the growing numbers of children with communication and interaction, moderate learning difficulties and those with social, emotional and mental health needs
- A greater emphasis on an integrated therapeutic approach to the work in the resource bases and across all settings
- Multi-disciplinary Early Years Hub based in a primary school which has a remit for early identification and assessment to ensure that children can follow wherever possible mainstream provision across the Key Stages
- Increased emphasis on supporting children and young people who have mental health needs across all settings

- Vocational provision in Key Stage 4 for those young people who find the demands of the curriculum difficult and for whom a more practical and vocational route is more appropriate

It will be important that we have high quality specialist staff with the right skills, knowledge and experience in our settings who will be supported by a comprehensive workforce reform strategy across all services. We will need to align our services in line with our new SEND Ranges and to support schools and settings to effectively implement high quality interventions.

We will strive to ensure that there is equality of access to our services and that we have consistency and a continuum of high quality provision 0-25. Our children and young people with SEND and their families are pivotal to the success of this strategy. One of our key strategic objectives is effective collaboration, co - production and communication. We must always listen, communicate effectively and develop our current and future services together and in partnership – it is only then that we can truly develop the provision for which our children and young people with SEND richly deserve.

2. Introduction

The Children and Families Act 2014 introduced the biggest changes to Special Educational Needs and Disabilities (SEND) in a generation; a new statutory duty on the Local Authority (LA) to ensure that the views, wishes and feelings of children, young people and their parents/carers are at the centre of decision making and that they are given the right support and information in a timely manner to ensure they are able to participate in decisions which help them to achieve good outcomes.

Darlington's vision is to enable children and young people to have the best start in life. Our aspiration is that Darlington's children and young people aged 0-25 with SEND will aim high and achieve their full potential, grow up to be as independent as possible and become active citizens within their community. Our aim is to ensure that children and young people with SEND are well prepared for adulthood through access to employment, leisure and social activities that provide independence and high quality support for adult living. This document is our shared vision across Education, Health and Care in partnership and co -production with our families and young people. It sets out our next steps for improving outcomes and opportunities for every Darlington child and young person with SEND.

This strategy aims to meet the requirements of the Children and Families Act in a way that is ambitious, inclusive, realistic and person centred within a challenging financial context. It was developed with stakeholders responsible for implementing changes and with parents, carers and young people at the core.

Darlington was part of the Department for Education's Pathfinder programme which supported best practice in the implementation of the SEND reforms. Over the past year we have started to review all our provision for SEND to ensure that it is 'fit for purpose' and meeting the growing and complex needs of our young people. We have worked closely with schools, settings and services to engage all stakeholders and to start planning collectively and effectively together. We are using our analysis of our SEND data and will be seeking the views of our parents, carers and young people to 'future proof' our services and to recognise where our gaps are and to find solutions to our challenges. We have successfully developed and implemented our SEND Ranges across schools and services so

that we can more accurately assess need and to ensure that we have a 'graduated response' to meeting those needs. We have engaged partners in the discussions around funding and the changes that need to be made to ensure that we can get 'best value' out of all our resources.

We have good links across our multi-disciplinary services and recognise that we need to work more consistently. We are above the national average in our completion of Education Health and Care Plans (EHCPs) within the 20 week deadline but we need to improve our quality of plans, systems and processes and the involvement of parents and carers in the process.

All statements of special education need were successfully converted to Education, Health and Care Plans by the statutory March 2018 deadline.

Going forward we recognise that there is much to do to keep pace with demand, to improve the quality of provision further and to ensure that more children and young people can have the specialist support they need in local schools, post 16 providers, work placements and early years settings. We have a higher than average number of children and young people with EHCPs when compared with both regional and national averages and our growth in the number of plans over the past 4 years has been high.

Children and young people with SEND are achieving well in the Early Years and in Key Stage 2 with children with an EHCP and SEN Support making better progress than the EHC plan cohort nationally. Progress at key Stage 5 is good. However the performance at Key Stage 4 is a concern.

Some of our biggest challenges for this strategy are to ensure that we can improve support for children with Autism (ASD), Speech, Language and Communication Needs (SLCN) and Social, Emotional and Mental Health difficulties (SEMH), reduce the number of children with Moderate Learning Difficulties (MLD) in our special schools, increase our capacity in mainstream schools and in particular in our secondary schools to meet the needs of children and young people with SEND and to reduce our dependence on out of authority placements.

We must deliver this strategy in a way that is affordable and provides best value for money, whilst recognising the unprecedented increase in the number of children and young people supported by high needs funding and the corresponding increase in pressure on broader health and care services for those aged 0-25 years and beyond.

3. Our Vision and Philosophy for SEND Support and Provision in Darlington

Where possible we believe that every Darlington child and young person should be supported in the community where they live. We will achieve this though access to good quality local Early Years provision, schools, post 16 settings, work based training providers and employers. In addition to the right learning opportunities children and young people with SEND should be offered access to appropriate health and care support in response to their diagnosed needs whilst recognising and understanding the specific needs of the families.

We are committed to the following key priorities in order to deliver our vision:

- Early identification of need ensuring that the right children and young people are in the right placement with the right support
- Building capacity in mainstream settings to reduce reliance on specialist and out of authority placements 0-25
- Ensuring that children and young people are educated in their local community and have an effective preparation for adulthood and access to work and leisure opportunities
- Increasing achievement and improving outcomes for children and young people with SEND
- Focus on effective collaboration, co-production and communication
- Achieving 'Best Value' (human, physical and financial resources) from all our services

We are committed to safeguarding and protecting all children and young people with SEND. We want to provide a well-planned continuum of provision from birth to 25 and beyond. This means high quality and well-integrated services across education, health and social care which work closely with young people, their parents and carers and where individual needs are met without unnecessary bureaucracy or delay. We want the journey from childhood to adolescence and through to adulthood to be a good experience for all with young people taking informed risks, making choices, being challenged and challenging boundaries as part of their growing up journey.

In order to deliver our vision and key priorities we will:

- **Ensure a person centred approach to service delivery and that all our plans, services and policies are co-produced with families**
- **Have a local offer which helps children, young people and their families to plan and make choices about their support**
- **Ensure that the SEND Ranges are fully embeded and utilised in all settings and continue to focus on a 'Quality First' approach in our universal settings**
- **Provide systematic, proactive and appropriate early identification, early help and provision which will be available locally**
- **Ensure successful preparation for adulthood including supporting independence, independent living, training and employment**

- **Support the vision through effective workforce reform and outreach support services that are based on high quality interventions**
- **Establish clear pathways and effective transition between and across services**
- **Have a strong commitment at all levels to ensure effective partnership working and co-production happens**
- **Active involvement of all partners in developing excellent practice supporting each other to understand differing views, priorities, skills and talents**
- **Have effective Joint Commissioning Strategies which will provide greater synergy between and across services and will ensure accountability at all levels**
- **Put in place funding and support that is allocated fairly and openly**

4. Outcomes

The partnership between Education, Health and Social Care is strong and developing. Significant work has been undertaken to pull together data from various sources and to highlight where the gaps are in information so that this can be used to future proof services and provision.

The proportion of children and young people living in poverty is increasing and there is evidence of an increasing impact of alcohol on the population of Darlington. The proportional uptake of Free School Meals in Darlington is higher than the national average. Darlington has a significant Gypsy, Roma and Traveller (GRT) community with a higher than average number of pupils from this community being electively home educated.

Education/Attainment

Educational attainment is the foundation for opening future opportunities for all children and young people with SEND; however resilience, social networks and involvement in community activities are also key factors for a fulfilling and independent life.

In 2017, none of the small numbers of pupils with a statement/EHCP achieved a Good Level of Development (GLD) in Darlington. However, pupils at SEN Support level achieved better than the national average at 34% (national 27%). Overall for pupils with SEN, this equated to a higher percentage of pupils achieving a GLD than similar pupils nationally. In 2017 a higher proportion of SEN pupils in Darlington met the expected standard of phonic decoding when compared with the national average. The gap between Darlington and national results was particularly high for pupils with a statement/EHCP.

Key Stages 1 and 2

Key Stage assessments for KS1 and KS2 were reformed in 2016 with resulting outcomes being measured by 'Expected Standards' rather than the previously measured national curriculum levels. When compared to the national average, SEN pupils in Darlington performed less favourably at KS1 in 2017. However, maths was stronger for pupils with a statement or EHCP and reading was a particular strength in Darlington. Writing was a weakness overall across those pupils with SEN support and those with a statement or EHCP. In contrast to KS1, the attainment of SEN pupils at KS2 was stronger in Darlington for 2017 compared

to the national average. This was the case in all subjects with the exception of writing for pupils with a statement or EHCP. The results for SEN support pupils were higher than those in the North East and Statistical Neighbours with a national ranking of 25. However, the attainment of pupils with a statement or EHCP were at average when compared to regional neighbours.

Key Stage 4

New attainment indicators, including Attainment 8 and progress 8 were introduced in 2015/16. All SEN pupils in Darlington performed less well than their national comparators in all measures. For pupils with a statement or EHCP, Ebacc Attainment and English and Maths (basics) are the only two measures where Darlington were above the national average. Those on SEN support fell well below national averages on all measures.

Post 16 – Attainment by age 19

In 2017 attainment at Level 2, including English and Maths, by age 19 improved for young people without SEN needs. Attainment also improved for those with SEN support, whilst there was a decline for those with a statement or EHCP. In 2017 performance at Level 2 for those with a statement or EHCP was at 12.20 % and is below that of statistical neighbours (13.15%0 and national average (14.90%). For those with SEN support needs performance was at 27.0% which is well below our statistical neighbours at 35.65% and the national average at 37.0%. A similar pattern was seen for those whose attainment is at Level 3.

Preparation for Adulthood

Participation for 16 and 17 years olds

In 2017 (January) 91.58% of 16-17 year olds with SEN who were resident in Darlington were in education and training compared with 86.58% for our statistical neighbours and the national average being 87.52%. Darlington has a higher percentage of Post 16 students with EHCPs in Further Education provision compared with the national average. There is a higher than average percentage of Post 16 students with EHCPs in Post 16 specialist institutions than the North East and national averages.

In January 2018 Darlington was below its North East neighbours in the number of students with EHCPs undertaking supported internships (3), traineeships (0) and apprenticeships (0). Darlington however was the highest in the region in respect of students with EHCPs remaining in sixth form.

Employment Opportunities

Developing an improved process to ensure more effective tracking of students into sustained destinations and work is a priority. Young people with special educational needs and disabilities often struggle to get paid work when they leave education. This could be due to a lack of work experience opportunities and a lack of accessible information. There are a lack of work opportunities and career pathways for young people with SEND in Darlington. This remains a key priority in this strategic plan.

Good Health Outcomes

Young people with disabilities may experience greater vulnerability to secondary conditions, co-morbid conditions including for example age related conditions or illnesses. Barriers to good physical and mental health can include for example a lack of availability and access to leisure, cultural and other public facilities and transport. The JSNA has highlighted the significant emotional and mental health needs particularly in secondary for those students on SEN

support and those with EHCPs. Considerable work is being undertaken in this area across Health and Education. The Future in Mind programme has supported schools to be better skilled through the delivery of training in mindfulness and mental health first aid.

5. Achieving our Vision and Outcomes – The Key Enablers

1. Processes

- A well planned continuum of provision 0-25
- Effective EHCPs that accurately reflect the needs and targets for the child and or young person with individual needs being met without unnecessary bureaucracy and delay
- SEND panels and steering groups that meet regularly, have clarity over purpose, roles, remit and that are coherent with the child's needs at the centre
- Ensuring local SEND services are inclusive of and integrated with high quality NHS, community and voluntary services so that the experience of families accessing services is positive and children and young people's learning, development, safety, well-being and health outcomes are promoted alongside their educational progress and achievements
- Embed the use of the SEND Ranges across all settings

2. Infrastructure and Resources

- Business intelligence, systems of gathering data and ease of access to data will be key in delivering the strategy
- Effective monitoring, tracking and analysis of data and outcomes by stakeholders will be pivotal
- Strong strategic leadership across Education, Health and Social Care
- Utilising the SEND Capital grant and other SEND grants effectively in line with the SEND Strategy key Principles
- Effective partnership working with schools will be fundamental to develop more effective and innovative ways to use high needs funding in mainstream schools

3. People

- Effective workforce training and support from Early Years through to work based training providers and employers so that they have the capacity and skills to deliver a high quality provision
- A commitment from all to achieve the very best outcomes possible for children and young people which support inclusion, develop independence and successful preparation for adulthood

4. Joint strategic leadership and management

- Strong governance, clear commitment, accountability and challenge through the LA, schools governing bodies, SEND Steering Group, the Clinical Commissioning groups and the Health and Well Being Board
- A robust delivery plan that is published and effectively communicated and contributed to by all
- All teams and services working towards our strategy with budgets aligned to our strategic priorities

6. How the strategy was developed – Consultation & Data Analysis

Phase 1. Data and evidence gathering

Key hypothesis

1. Is our pattern of provision for children and young people with SEND suitable to meet changing needs?

2. Is this what parents and families want?

3. Is it affordable?

We have gathered and analysed:

- Data on the range of SEND in the area, recent trends and likely changes in the future
- Evidence on how effectively the current pattern of specialist educational provision meets needs in the area – through an analysis of resource base and specialist outreach provision
- Data on those children and young people who are in independent specialist provision and the reasons for this
- Patterns of attendance, punctuality and behaviours of children and young people with SEND including fixed term and permanent exclusions
- The needs of schools with regard to therapy requirements and what they commission already
- Our position with regard to the statutory requirements of the SEND Code of Practice
- The pattern of new assessments and the needs coming through from Early Years
- Health data and where the gaps are
- Comparisons within our NE region and how we compare with them and with national averages
- The various funding streams that support the services, resource bases, schools and specialist provision to assess an outline view of whether we are achieving 'best value'
- The various funding streams that are supporting mainstream provision
- Differing funding models that can be allocated to schools using the SEND Ranges as a guide

Close working partnerships have been established between schools, post 16 providers, services and the LA. The LA has led two key conferences on High Needs Funding and the findings of the review of the resource bases in schools and the outreach support services.

A core element was to gather evidence about what works well across the current system, areas for improvement and SEND provision mapping for the future across the whole life cycle from birth to young adulthood. The SEND Ranges have been developed to capture current evidenced based good practice and parent/carers, young people and

professionals views on what works well. All EHCPs have been moderated across all schools by the LA using the SEND ranges.

What Children Young People with SEND and their families have previously told us

'we want'

- To be listened to and have our views valued
- To have the needs of the whole family considered to help families have more choice and control to develop independence and resilience
- Competent and well trained staff with a good understanding of SEND
- Professionals to work collaboratively so that there is one conversation to support the family preventing duplication and fragmentation
- Help to navigate the system
- For children and young people with SEND to have a mentor to discuss how, where and when support should be provided
- Transparency about the range of services and support available and how to access them
- Clarity about accountability and what we can expect services to deliver

Phase 2: Analysis and shaping of emerging themes

Our analysis identified a number of common issues, falling into six overarching strategic themes and priorities and form the basis for this SEND Strategy:

- **Early identification of need ensuring that the right children and young people with SEND are in the right placement with the right support**
- **Building capacity in mainstream settings to reduce reliance on specialist and out of are placement 0-25**
- **Ensuring that Children and Young people are educated in their local community and have an effective preparation for adulthood and access to work/leisure opportunities**
- **Increasing achievement and improving outcomes for all**
- **Ensuring effective collaboration, co-production and communication**
- **Achieving Best Value for money across all our services: human, physical and financial**

The SEND Strategic Partnership was established with key partners including parents, health, schools, and other stakeholders. Senior Officers visited a wide range of schools and settings to gather thoughts and ideas from staff and leaders as to ways forward for the future.

Phase 3: Engagement

The Local Authority have organised a number of engagement events to seek views from a wide range of key stakeholders on the vision and priorities

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7. Population: some key facts

Darlington is a unitary authority and covers an area of approximately 200 square kilometres. Darlington's current population is 105,396, having risen by over 6% since 2001. Of this population, 39% are of working age (16-64 years old). Within this working age population 79% are economically active (in work or unemployed), 58% of these people work in the Borough and 21% commute out of the Borough to work.

Darlington is in the top 30% most deprived local authorities in England. It is ranked as the 97th most deprived area out of 326 on the index of multiple Deprivation 2015. The level of child poverty is worse than the England average with over 1 in 5 children under 16 years living in poverty. The concentration of children living in low income families is disproportionally evident in certain wards in the Borough. There are health issues in the borough relating to alcohol, smoking and diet resulting in differing life expectancies between electoral wards.

Darlington is an aspiring town with big ambitions for all of its children and young people to have the best start in life (Children and Young People's Plan 2017-2022). This plan supports the vision of creating the local sustainable community strategy 'One Darlington: Perfectly Placed' through building strong communities, growing the economy and achieving best value from all its resources. (Darlington's Sustainable Community Strategy 2008-2026 revised in 2014)

Darlington and the other four Tees Valley local authorities have collaborated to establish a Tees Valley Combined Authority (TVCA). The TVCA unites the five local authorities on key decisions that affect the Tees Valley, helping to strengthen the area and accelerate economic growth. In almost all indices, Darlington's economy has outperformed regional and national growth trends. Recent trends show an improving picture regarding the skills and productivity of Darlington residents with an increase in employment rate, average earnings, coupled with dramatic reductions in the claimant count and unemployment rate.

SEND facts and Figures – as of August 2018

- There are currently 731 active EHCPs for those SEND pupils who are the responsibility of Darlington Borough Council (as opposed to those EHCP pupils in Darlington Schools) these are broken down as follows – Pre-school 14, Primary 245, Secondary 266 and Post 16 206
- Over the last three years there has been a significant rise in assessments with

currently 122 new requests to date this year as opposed to 161 for the whole year 2017 and 122 for 2016

- Darlington is above national and regional average for the numbers of EHCPs. The numbers have risen significantly since 2014 from 410 to 731
- The most prominent primary needs are Moderate Learning Difficulties (MLD) and Autism (ASD) followed by Social Emotional and Mental health needs (SEMH) and then Speech, Language and Communication Needs (SLCN)
- In the Early years the primary needs are mostly ASD and MLD in terms of those children with EHCPs. However, current caseloads for the Early Years Service show there is a high proportion of young children coming presenting with communication and interaction as their broad area of need with the majority having a social communication need
- In the primary phase ASD and MLD are the highest areas of need followed by SLCN and SEMH. In the secondary phase the highest need is SEMH particularly in Years 10 and 11 followed by MLD and ASD. However, in the Post 16 phase the number of SEMH pupils decline and ASD and MLD are again the highest need
- The 2018 SEN2 published data shows that 39.1% of Darlington EHCP pupils were in a special school. This is 4.3% above the national average. 27% of Darlington EHCP pupils were in mainstream provision (excluding resource bases) and this is well below the national average of 34%
- There is a high incidence of MLD secondary aged pupils in special school placements of which the moderation of plans against the LA SEND ranges indicate that many of these pupils could be catered for in mainstream provision
- There is a high incidence of SEMH secondary aged pupils in independent placements. Moderation of these pupils' EHCPs suggests a number of these pupils may only be in independent provision due to a lack of suitable local provision
- The numbers of EHCP pupils in independent provision is only 2% of the EHCP cohort but costs are disproportionally high for this group. An increase in numbers is expected
- New assessment requests reflect the current primary need profile of ASD, MLD and SEMH however there has been a spike in SLCN requests and those are generally from Early Years
- There is one secondary Resource Base which supports Social and Communication Difficulties including ASD. There is a significant demand for SEMH and MLD specialist provision in the secondary phase
- For those Post 16 young people with EHCPs who are engaging in education, over 72% are learning in the college sector, 15% are in special school and just under 6% are in the independent sector
- Darlington has a higher than average persistent absence rate and this includes pupils on SEN support. 48% of the pupils with fixed term exclusions had SEN and the number of days lost because of fixed term exclusions was higher for children with SEN than those without. Half of the SEN students excluded had a primary need of SEMH
- In line with national trends there has been a significant rise in the number of parents electing to educate their children at home

8. The Policy Context

Our priorities for Children with SEND are shaped by the Children's and Families Act 2014 and within that the SEND Code of Practice 0-25 years. The Act sets out the responsibility to improve services, life chances and choices for vulnerable children and to support families. It underpins wider reforms to ensure that all children and young people can succeed, no matter what their background. The Act extends the SEND system from birth to 25, giving children, young people and their parents/carers greater control and choice in decisions and ensuring that their needs are properly met.

The new approach to special educational needs and disability makes provision for:

- children and young people and their families to be at the heart of the system
- close co operation between all the services that support children and their families through joint planning and commissioning of services
- early identification of children and young people with SEN and/or disabilities (SEND)
- a clear and easy to understand local offer
- support provided in mainstream settings where possible for children with more complex needs
- a co ordinated assessment of needs and a new 0-25 Education, Health and Care plan for the first time giving new rights and protection for the 16-25 year olds in further education and training comparable to those in school.
- a clear focus on outcomes and planning for a clear pathway through education into adulthood, including paid employment
- a focus on living independently and participating in their community
- increased choice and opportunity overall and families to be able to express a preference and the offer of a personal budget for those children and young people who have an EHC plan.

The Local Policy context

Darlington's Children and Young People's Plan 2017-2022 – The Best Start in Life covers all services for children, young people and their families. For young people leaving care, responsibility extends beyond the age of 20. For those with learning difficulties it extend to the age of 25 to ensure the transition to adult

services is properly planned and delivered. The plan sets out the following vision:

We will improve the quality of life for all and reduce inequality by ensuring we have:

- **children with the best start in life**
- **more business and more jobs**
- **a safe and caring community**
- **more people caring for our environment**
- **more people active and involved.**
- **Enough support for people when needed**
- **More people healthy and independent**
- **A place designed to thrive**

To do this we will:

- Build strong communities
- Grow the economy
- Spend every pound wisely

We can only achieve our aspirations for the future if we recognise that children and young people are our future. We need to ensure that Darlington is a place where:

- Al children and young people are safe from harm
- All children and young people have the tools to do well at all levels of leaning and have the relevant kills to be prepared for life
- All children and young people enjoy a healthy life
- All children and young people enjoy growing up
- All children and young people are listened to

The SEND Reforms are an important cornerstone for this work and ensures that the Children and Young People's plan is realised and embeded in all that we do.

This **SEND Strategy** aims to ensure that:

- we have a collective and shared vision and an agreed action plan across all services in partnership with families and their children.
- we have an effective needs analysis evidence base across education, health and care to help us plan and decide how best to use our resources
- we are constantly listening to the views, aspirations and ambitions of children and young people and their parents and carers. We aim to ensure co-production with parent/carers and young people when we develop and commission person centred services
- resources are used where we can measure best value and where they make the biggest difference
- pathways for children and young people and their families are clear, easy to understand and support effective planning in preparation for adulthood
- all our provision – settings and services are of high quality and are accessible across universal , targeted and specialist support
- we have speedy resolution of problems and disagreements

9. What We Have Achieved So Far – August 2018

Up to date our achievements include:

- Good performance on meeting the 20 week timescale for the completion of Education, Health and Care assessments
- Good working relationships and engagement between the LA and schools/colleges
- Effective training and support with SENCO's, Governors and other stakeholders
- The successful introduction of the SEND Ranges in schools and across settings and services supported by in depth high quality training and support
- Moderation of all EHCPs in all settings against the SEND Ranges which demonstrates excellent practice and commitment
- A review of the panels and an establishment of a vulnerable pupil panel. Panels have clear criteria and remit for operation
- A thorough review of the funding to schools and services which has been shared with schools and a plan/timeline in place for a revised funding formula to be in place next year
- Review of Resource Bases and outreach support services to ensure best value
- A gap analysis with regards to our SEND data across Education, Health and Care
- Strong partnership working between Education, Health and Social Care with an increasingly effective sharing of information
- Previous Parent/Carer feedback shows that the majority of parents feel that their views were taken into account by Education, Health and Care when their child is identified with SEND
- The quality and consistency of EHCPs is improving
- Joint commissioning statement of intent is in place and joint commissioning priorities are agreed
- Strong partnership with Health in developing a strategy for mental health in schools
- Designated Clinical Officer works closely across the partnership to support services in the identification and provision for of children and young people with SEND and in promoting the SEND agenda
- Personal Education Plans for children looked after are an area of strength

- Good Level of Development for SEND children in Early Years is 25% (national 23%), Key Stage 2 progress is strong with pupils with an EHCP and SEN support making better progress than the EHCP cohort nationally. Progress and retention at key Stage 5 is good with positive feedback from students and parents

10. Our Challenges and Opportunities

We continue to face a number of challenges, many of which reflect the national position:

- Attainment and progress for children and young people with SEND requires improvement in Key Stage 4
- There are a rising number of students with SEMH identified as their primary need
- There are a significant number of children being diagnosed with ASD and this is putting pressure on services. Those with communication and interaction needs are growing fast and our services are not in the right shape to respond
- Our Resource Bases require a new remit and focus alongside effective outreach support provision
- A lack of provision in the secondary phase for pupils with an identified need of SEMH and MLD
- The need for mental health support at universal and targeted level is evident
- Significant rise on the number of EHCPs
- Need to have an increase in employment opportunities and supported employment practice Post 16 and increase access to supported internships and apprenticeships
- Access to personal health budgets
- The increase in demand for specialist placements has meant there is significant pressure on High Needs Block funding
- A rise in the number of parents choosing to electively home educate their children

We can also take advantage of the following opportunities:

- Strong working partnerships across services and with schools and colleges and stakeholders
- Strong commitment to joint working and joint commissioning
- The creation of more local services and reduction in external placements would allow us over time to invest in more preventative and early intervention services for children with SEND
- The SEND Capital Grant presents the opportunity to increase capacity
- The SEND Ranges gives us a good start to hold settings to account and to ensure that the interventions are part of a graduated response with accountability
- A reshaped funding process for SEND in Darlington will give greater accountability for spend with improved consistency of funding across the Borough and savings on out of area placements

11. Our Strategy Priorities for SEND in Darlington (2019-2022) and High Level Action Plans

SEND STRATEGY OBJECTIVE 1

Early identification of need ensuring that the right children and young people are in the right placement with the right support.

What outcomes do we want to see?

- The percentage of children with SEND assessed in Early Years as achieving a Good Level of Development to increase year on year
- Children are better able to engage with the school's curriculum and more likely to reach their full potential at school
- Children and young people with SEND achieve well at every stage of their learning
- There is effective transition from each setting and each key stage
- All agencies working together in partnership to ensure that early identification and assessments have clear synergy
- Clear, accessible and up to date information is available through effective Local Offer and informed staff

Why is this important?

- Parents and carers have told us that it is their most important priority for their children to get the help and support they need at the earliest opportunity.
- Early identification and intervention is essential to prevent underachievement and improve outcomes and improve children's life chances
- Delay in the above can give rise to further learning difficulties and subsequently to a loss of self-esteem, frustration in learning and possibly to behaviour/ emotional difficulties

Key Priority Actions to achieve our objectives

1. Ensure support and intervention services are fully engaged in delivering the SEND agenda
2. Consideration to be given to developing an Early Years Hub with specialist support to ensure that the LA identifies needs through a multi-disciplinary approach at the earliest stage
3. All schools and settings to embed the SEND Ranges into practice and ensure that provision maps are detailed, costed and demonstrate the impact of interventions and pupil outcomes
4. Ensure the process of identification and assessment of need is effective and statutorily compliant and that effective training is in place across all services

5. Review panel structures to ensure that settings are held effectively to account
6. That all outcomes in EHCPs and Annual Reviews are clear, measurable, achievable and in line with the SEND Ranges
7. Review the designation of all specialist settings (Resource Bases and schools/colleges/work placement and employment) and support services to ensure that children and young people access the right provision with the right support
8. Further develop the positive work with parents, carers and families in ensuring that provision for the most vulnerable groups is of the highest quality
9. Parents, carers, families to receive high quality advice and support from SENDIASS to ensure their needs are being met
10. Review the Local Offer to ensure that it is accessible, easy to manage and to navigate
11. Develop more effective communication between Education, Health and Social Care services so that the right provision is commissioned and there is a joint approach to future planning.

SEND STRATEGY OBJECTIVE 2

Building capacity in mainstream and specialist settings to reduce reliance on specialist out of area placements 0-25

What outcomes do we want to see?

- Most children with EHCPs attend and achieve well in high quality local provision and are able to remain with their families in their local communities
- Children remain in contact with local services, as a result of remaining within local provision and so have continuity of support.
- There is an enhanced range of local specialist provision and reduced reliance on external specialist placements
- Reduced costs on out of area placements so that these monies can be more effectively utilised developing local high quality provision

Why is this important?

- Previously children and their families have told us us that they want high quality local services and choice
- Children and young people with SEND need to have good quality support in their mainstream and local settings so that they can achieve their academic potential and maintain their self-esteem and confidence
- Children and young people with SEND previously told us that they want to make friends locally and access local facilities with their families

Key Priority Actions to achieve this objective

1. Ensure through joint commissioning intentions that Resource Bases meet the growing complexity and increasing numbers of children and young people presenting with communication and interaction, social emotional and mental health, cognition and learning needs with a strong multi-disciplinary therapeutic input from Early Years through to Post 16/Post 19
2. Put in place an effective workforce reform strategy that will include training, mentoring, coaching and an action research programme highlighting the sharing of best practice
3. Review, further develop and effectively co-ordinate outreach services from specialist and multi-disciplinary settings to support mainstream provision 0-25
4. All settings have targets and expectations that effective inclusion and equality permeates throughout the organisation

SEND STRATEGY OBJECTIVE 3

Ensuring that children and young people with SEND are educated in their own local community and have an effective preparation for adulthood including access to appropriate work, training and leisure opportunities.

What outcomes do we want to see?

- Not in Education, Employment or Training (NEET) figures for pupils with SEND are at a minimum
- The percentage of children and young people with EHCPs who are being educated in mainstream settings as opposed to specialist provision to increase
- Parents report increasing confidence in the ability of mainstream schools/colleges/work based training providers to meet their child's needs
- Provision available to all young people with SEND aged 16-25 to access purposeful activities (including education, work experience, supported employment, supported internships, apprenticeships, training including voluntary and community projects)
- All young people with SEND have a clear destination pathway and that are able to make appropriate progress, whatever their starting point
- All young people have access to work related learning activities, as appropriate to their level of ability, to enable them to work towards paid employment wherever possible
- Through partnership working and joint commissioning arrangements for Post 16 SEND services are delivered in a co-ordinated and personalised way

Why is this important?

- Improved sense of worth and value for each young person
- Gives a clear pathway of opportunities and choice
- Enables greater independence and sense of contributing to our local community

Key Priority Actions to achieve this objective

1. Establish a clear pathway and effective transition arrangements 0-25 for all children and young people with SEND
2. Develop a wide range of opportunities and choice focusing on work, suitable employment and leisure activities
3. Ensure that children and young people with SEND have opportunities to engage in independent travel training and access support for independent living
4. That schools and specialist settings have a curriculum that prepares young people for the world of work and making effective contributions to their community
5. Close partnerships with work based training providers and employers to support their capacity to utilise the skills of young people with SEND

SEND STRATEGY OBJECTIVE 4

Increasing achievement and improving all outcomes for children and young people with SEND

What outcomes do we want to see?

- Increase attainment and achievement across all Key Stages
- All children and young people with SEND make at least good progress relative to their starting points
- The overall gap between attainment of children and young people with SEND and all children to reduce
- The number of children with SEND being excluded from school to reduce
- Good attendance of children and young people with SEND
- Children and young people with SEND to make clear, evidence based progress against their EHC Plan outcomes

The following outcomes that form the focus of this objective are written from the young person's perspective are:

- I have information about my health provision clearly explained to me
- I am learning how to manage my own health and well being
- I feel I am involved in planning and decision making about my health
- I have effective support networks with friends and family and in my school/college
- My care is co-ordinated and connected so people understand my needs and jointly meet them so that I don't have to keep telling my story.

Why is this important?

- All children and young people with SEND will be able to achieve their full potential

Key Priority Actions to achieve this objective

1. Address the underperformance in educational achievement across the Key Stages but particularly at Key Stage 4 through targeted interventions, appropriate curriculum, high quality training and effective quality assurance, monitoring and moderation
2. Implement and embed a quality assurance framework across the LA to ensure that all EHCPs are of high quality
3. Ensure that all settings have high quality first teaching
4. Embed the SEND Ranges to ensure that all settings have an effective graduated response
5. Encourage schools to share best practice

SEND STRATEGY OBJECTIVE 5

Collaboration, Co-Production and Communication

What outcomes do we want to see?

- Transparency of all decision making
- Agreed common approaches
- A whole organisation/area approach where we all feel part of a team delivering the SEND Strategy

Why is this important?

- We want everyone to have 'trust' in all that we do
- We want all , but particularly parents, carers and young people to have confidence and respect in our future going forward together

Key Priority Actions to achieve this objective

1. Develop a communications policy in order to analyse and implement actions required to ensure that there is effective communication between all partners, parents, carers and young people
2. Ensure that all partners are aware of best proactive and supporting each other in understanding different views, priorities, skills and talents
3. Ensuring that the pupil and young people's voice is heard at all level.
4. Ensuring that all policies, practices are co-produced with all stakeholders and with the active involvement of the parent/carer forums and the children and young people
5. Demonstrate commitment at all levels to collaboration in partnership with parents, carers and families
6. Review the effectiveness and impact of the Local Offer and make change as appropriate
7. Hold schools and settings to account when the pupil and parent voice is not evidence in the assessment and review process
8. Provide on-going training and support to schools and other stakeholders in promoting pupil and parent engagement.

9. Young leaders and Parent/Carer groups to collaborate to produce a charter on excellence in co-production

SEND STRATEGY OBJECTIVE 6

Achieving Best Value for money from all our services – human, physical and financial resources with clear agreed commissioning intentions

What outcomes do we want to see?

- Effective, efficient and co-ordinated services that meet the needs of children and young people with SEND and their families

Why is this important?

- The High Needs Budget is finite
- We must ensure best value from the public purse
- With the increased numbers of children and young people coming through with significant needs we must ensure that the right resources are going to the right children in the right place

Key Priority Actions to achieve this objective

1. Joint Commissioning to provide increased targeted capacity for SEND within the Borough under the agreed commissioning intentions
2. Opportunity to pool budgets
3. Implement a new funding arrangement for SEND support in schools
4. Allocate the SEND Capital Grant in line with the SEND Strategy
5. Embed the SEND Ranges to ensure funding allocation for individual pupils in needs led

12. What Will Success for Children and Young People with SEND Look Like in 2021

The strategy will be deemed successful if:

- There are clear processes to identify children's needs early and partners communicate and co-ordinate services well
- We rely less on statutory assessment of children's special education needs and more on getting the right level of support when it is needed
- Reviews are thorough and lead to improvements in outcomes for the child or young person
- Children and young people with SEND can take part fully in all aspects of education, community, leisure and fun activities
- We meet children and young people's needs in mainstream settings wherever possible and when more specialist help is needed we are able to provide this in Darlington
- We use appropriate evidence based interventions so all children and young people with SEND make good progress with their learning, achievements and social and emotional development over time
- There is a well co-ordinated transition for children and young people at all key points
- Children and young people with SEND have high aspirations and we support them to be independent and well prepared for adult life
- We know that provision is improving outcomes; that aspirational yet realistic targets are agreed and progress towards them monitored; and that children and young people with SEND, and their parents and carer have been involved in setting and reviewing goals and outcomes
- The Local Offer is informative and accessible
- Our SEND provision forms part of a clear continuous high quality pathway where children and young people can access the right support and determine their destinations
- Children and young people with SEND and their families tell us that they are satisfied with services and that their needs have been met appropriately
- Our workforce have the right skills and competencies to meet the needs of children and young people with SEND
- There are strong multi-disciplinary partnerships in place which have mutual trust and respect and where communication is truly effective and decision making transparent

13. Taking the SEND Review Strategy Forward - Governance, Monitoring and Review

The delivery of our SEND Strategy is not the responsibility of a single agency or person. It is a partnership approach with collection accountability and collective responsibility owned by all stakeholders working with children, young people and their families. These include Health, Education, Social Care, work based training providers, employers, voluntary and community organisations and those responsible for the development of leisure and social activities.

Governance for the strategy will be provided by the Darlington Health and Wellbeing Board and the SEND Steering Group. The SEND Steering Group will provide the strategic drive, co-ordination and oversight by receiving regular performance and outcome indicator reports on progress against objectives.

The Health and Wellbeing Board will be responsible for ensuring that the SEND issues are embedded effectively throughout the relevant plans and in the delivery of the Health and Wellbeing Strategy.

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Figure 1: Pupils in Primary School by primary type of need

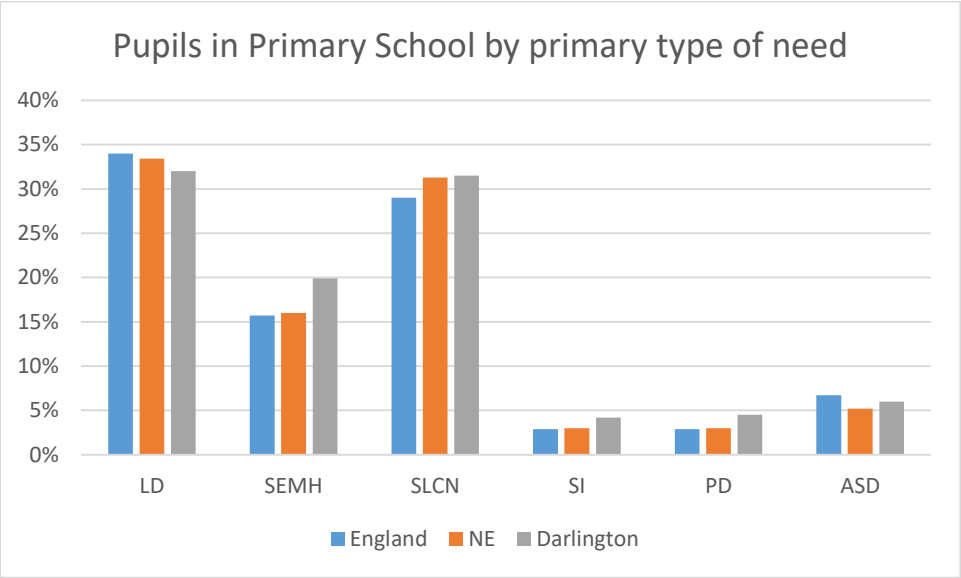


Figure 2: Pupils in Secondary School by primary type of need

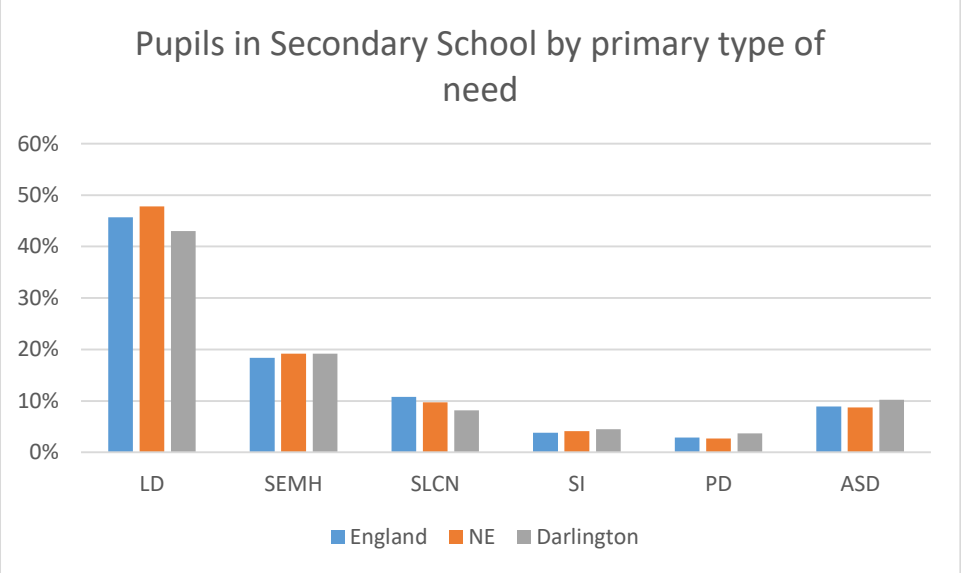


Figure 3: Pupils in Special School by primary type of need

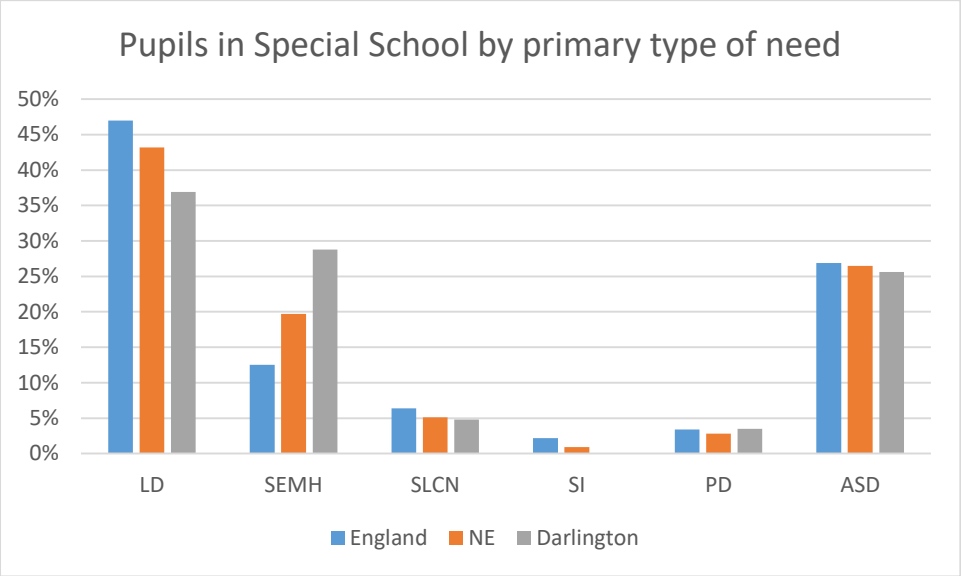


Figure 4: Number of statements or EHCPs in Darlington by year

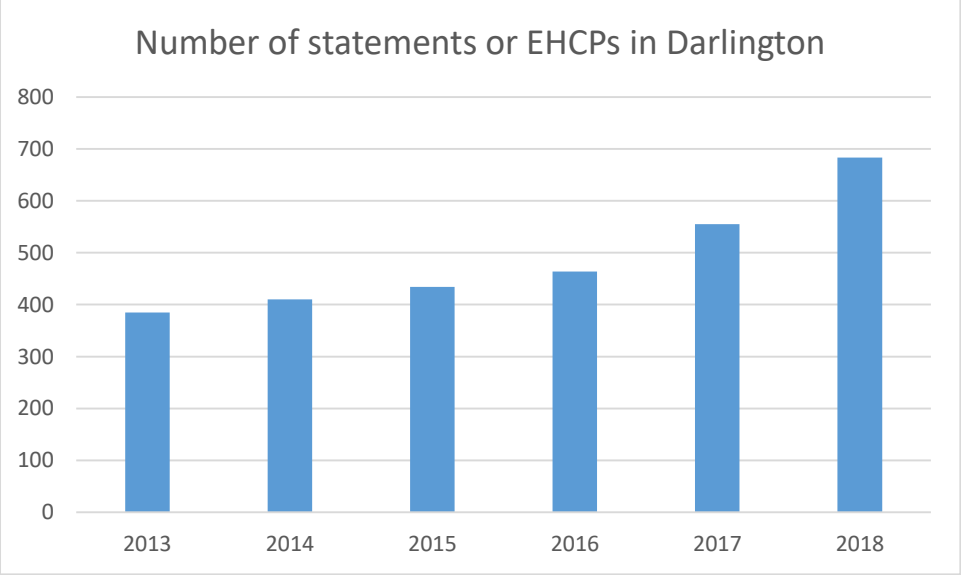


Figure 5: Placement of Pupils with ECHPs by type of provision

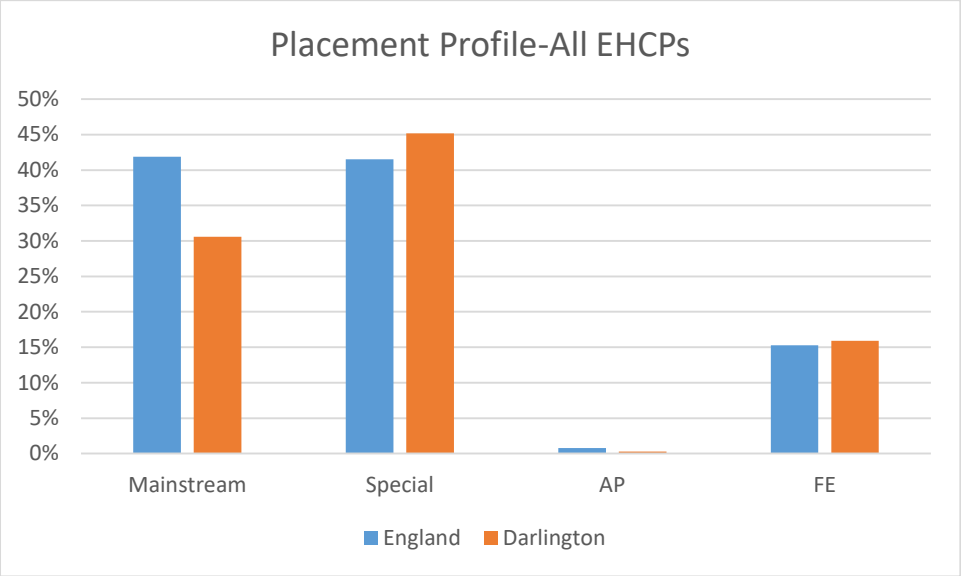
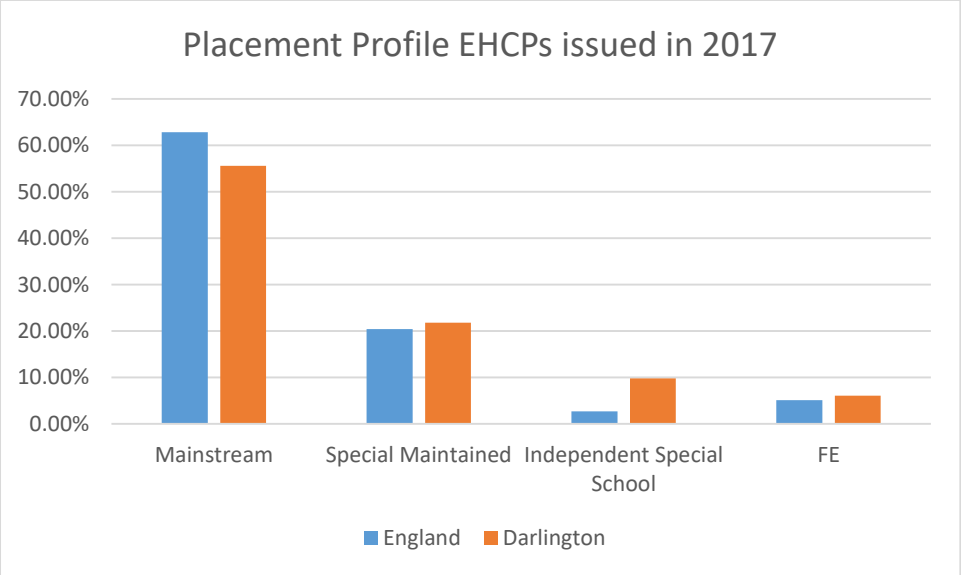


Figure 6: Placement of pupils with EHCPs by type of provision 2017



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HEALTH AND WELL BEING BOARD
17 JANUARY 2019

HEALTHWATCH DARLINGTON

SUMMARY REPORT

Purpose of the Report

1. The purpose of the report is to update Health and Wellbeing Board members on Healthwatch Darlington's key statutory priorities and projects for September 2018 to December 2018.

Summary

2. This report outlines Healthwatch Darlington's work, during the last 4 months, in championing the views of people in the Borough to influence and improve health and social care services.

Recommendation

3. It is recommended that Darlington Health and Wellbeing Board members accept this report for information and progress to date for Healthwatch Darlington.

Reason

4. The reasons are supported to enable the Board to consider the work of Heatlhwatch Darlington.

Michelle Thompson
Chief Executive Officer Healthwatch Darlington

Background Papers

There were no background papers used in the preparation of this report.

S17 Crime and Disorder	There are no implications arising from this report.
Health and Well Being	This report provides information about progress to date including work plan objectives to champion the views of people in the Borough to improve health and social care services.
Carbon Impact	There are no implications arising from this report.
Diversity	There are no implications arising from this report.
Wards Affected	All
Groups Affected	All
Budget and Policy Framework	N/A
Key Decision	N/A
Urgent Decision	N/A
One Darlington: Perfectly Placed	This report contributes to the delivery of the objectives of the Community Strategy through the patient, carer and public voice.
Efficiency	N/A
Impact on Looked After Children and Care Leavers	This report has no impact on Looked After Children or Care Leavers or amend

MAIN REPORT

5. Healthwatch Darlington Ltd (HWD) is a strong independent community champion giving local people a voice that improves and enhances health and social care provision on behalf of the people of Darlington.

Statutory Activities/Projects

6. **Community Outreach –** Our Volunteer and Outreach Co-ordinator and our team of volunteers have been out in the community holding various information sessions. This has been giving patients and their families an opportunity to ask any questions they may have about local health and social care services. We've visited places such as:

   (a) Gold Health Group – Havelock Centre
   (b) Darlington College – Health and Social Care Class
   (c) (Raise awareness and understanding of where to find information about health services).
   (d) Cockerton Library
   (e) Dolphin Centre
   (f) Sikh and West Asian Community Group (Wesley Court)
   (g) (Concerns about Hospital Discharge experience. Would like HWD to visit in January to conduct a focus group session.)
   (h) Living with and Beyond Cancer Event (1 of 5 events held across the Tees Valley)
   (i) Broom Tree Care and Share Group

(j) (Raised concerns about dental services becoming private. Concerns around NHS 111 and the coordination of helping patients to seek emergency dental care)
(k) Crown Street Library

7. **Volunteer activity includes**

(a) Attendance at all of the above outreach session, groups and events.
(b) Formed small task and finish group meetings to gather research and to discuss plans for NHS Continuing Health Care and Hospital Discharge engagement in January.
(c) Completed Cancer Awareness Training, Dementia Friends Training, Safeguarding and Patient Leadership.
(d) 2 new volunteers joined the team including supporting social media social isolation and cancer awareness raising online and two more are to be interviewed in the New Year.
(e) Regular office administration and help with report writing.
(f) Raising awareness in their own communities and signposting people to Healthwatch Darlington.

8. **Youthwatch**: They designed and launched their Stress Week poster in November which was positively received across social media by many public sector organisations as well a voluntary and community groups. In December they produced and developed a 'Loneliness at Christmas' campaign poster for children and young people in Darlington. This was launched week commencing 18th December and was recognised by DBC, Public Health and GP surgeries as well as voluntary and community groups. A request has been made to develop the poster to make it an all year round awareness raising poster for GP surgeries. BBC Radio Tees are to interview our young people in January about their volunteering activities for Healthwatch Darlington.

9. **'What's Important to you?' survey**: We have launched our 2018/19 survey for six months as we did last year to determine what is important to our community. We will use the data and other intelligence we have gathered over the course of 2018/19 to determine our work plan for 2019/20.

10. **Action Plan:** Our Action Plan for 2018/19 prioritised the following:

(a) **Social Care:**
  (i) **Enter and View** – Care Homes (What's it like to live in a Care Home – we visited 8 care homes and shared good practice as well as recommendations)
  (ii) **Continuing Health Care (CHC) (The last of our projects)**
  (iii) **Hospital Discharge** (The last of our projects)

(b) **Mental Health**
  (i) **Substance Misuse** (Report due to be published in January after feedback from TEWV)
  (ii) **Children and Young People** (Report due to be published in January after feedback from TEWV)

(c) **Cancer Services** (Living With and Beyond Cancer Event and Social Media Campaigns including awareness weeks in order to signpost people to help and

support)

(d) **Stroke Services** (focus group completed)

(e) **Chronic Obstructive Pulmonary Disease** (COPD) (Awareness raising and signposting people to help and support)

(f) **BME Health Inequalities** (GP Access to Interpreter Services – after publishing a report and meeting with NHS England highlighting the local problems regarding access, NHSE are now recruiting local interpreters to ensure the local dialect is spoken for those needing support via the service supplied to GP practices)

11. **DOT:** We continue to nurture closer connections with our community through our Darlington Organisations Together Network (DOT). Our weekly e-bulletins are proving very popular with other organisations asking us to include their information, events and services. We have centred ourselves as a convenient conduit for community information and signposting, encouraging smaller organisations to become stronger, more resilient and active and connecting with other smaller groups. This also helps us gather information to ensure the **Livingwell Directory** is up to date with as many community groups as possible.

12. **Ongoing Projects**: We have worked on the following external projects in 2018/19:

(a) **County Durham and Darlington NHS Foundation Trust** – We have worked closely with Healthwatch County Durham regarding Enter and View visits to local hospitals

(b) **Darlington CCG** – We host the Community Council

(c) **NECS** – We held Stroke Focus Groups in Autumn

(d) **NHS England** – We are to host a vascular focus group in Darlington as part of wider engagement with Healthwatch County Durham in their area.

(e) **Morrisons Trust** – We are to evaluate a Sports England project for the Morrisons Trust regarding exercise and employment.