HEALTH AND WELLBEING BOARD

DATE: June 2025

ITEM NO.

Pregnancy and Early Years - Health and Wellbeing Strategy Deep Dive

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SUMMARY REPORT

Purpose of the Report

1. To facilitate meaningful discussion at the Health and Wellbeing Board for the Pregnancy and Early Years priorities as identified in the Joint Local Health and Wellbeing Strategy (2025 – 2029).

2. Ensure members understand the current position and how they, and their organisations, can support action locally.

Summary

3. The report is intended to support a deep dive review into the thematic priority of pregnancy and early years, with a focus on:

   (a) Agreed priorities
   (b) Related performance indicators
   (c) Health inequalities
   (d) Stakeholder engagement
   (e) Key actions taken and / or planned
   (f) Issues of concern or risk
   (g) Ask(s) of Health and Wellbeing Board partners.

Recommendation

4. It is recommended that members of the board: -
   (a) All organisations to consider actions they could take to better support health in pregnancy and early years, including identifying any opportunities to further develop partnership work in this area;
   (b) Integrate the offer of CO monitoring into everyday practice, including the referral pathway for smoking cessation services;
   (c) Work to make your organisation Breastfeeding Friendly, by engaging with the HDFT Specialist Infant Feeding team;
   (d) Where appropriate join the Injury Prevention Steering Group, to assist in the implementation of Injury Prevention Training for staff;

(e) The multi-agency steering group to take forward a whole systems approach to identify the key challenges relating to school readiness and agree an action plan that aligns with agreed priorities.
(f) Encourage all organisations to attend a multi-agency summit to identify actions to tackle smoking in pregnancy, with a particular focus on the areas with the highest rates.

Reasons

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

(a) They will support in achieving the ambitions of the Health and Wellbeing Strategy.
(b) They will help to address health inequalities, by identifying opportunities for collaboration and strengthening our partnership approach.

Dean Lythgoe, Secondary School Representative
Lorraine Hughes, Director of Public

Background Papers

Joint Local Health and Wellbeing Strategy (2025 – 2029)
https://www.darlington.gov.uk/media/22428/darlington-health-and-wellbeing-strategy.pdf

Author & Tel No.
Joanne Hennessey 406205

Council Plan	The recommendations and work areas being taken forward address priorities within the council plan.
Addressing inequalities	Where available data has been provided to understand health inequalities, and this has informed the development of work programmes.
Tackling Climate Change	There are no direct implications arising from this report, but efforts to reduce smoking and increase rates of breastfeeding will have positive environmental impacts.
Efficient and effective use of resources	The recommendations support the targeting of resources to areas of need and a focus on evidence based practice, which will help to achieve best value.
Health and Wellbeing	The proposals will support health and wellbeing outcomes, with a particular focus on the maternal and 0-5 outcomes and reducing health inequalities.
S17 Crime and Disorder	There are no implications arising from this report.
Wards Affected	All
Groups Affected	All
Budget and Policy Framework	There are no implications.
Key Decision	N/A

Urgent Decision	N/A
Impact on Looked After Children and Care Leavers	This report has no impact on Looked After Children or Care Leavers, although identified actions should impact positively on those who are pregnant or a parent of a child 0-5.

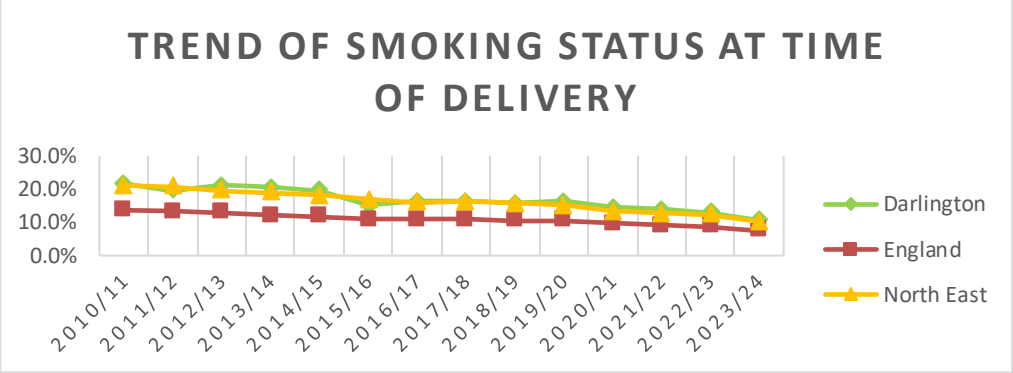
MAIN REPORT

Information and Analysis

6. The focus of the thematic deep dive is the priority of Pregnancy and Early Years, one of eight agreed priorities within the Joint Local Health and Wellbeing Strategy. The priority has six agreed ambitions, which are looked it in detail throughout the report.

Ambition One: Reduction in the proportion of mothers who are recorded as a smoker at the time of delivery

7. The graph below shows a comparison of the most recent data for smoking status at time of delivery (Smoking Profile | Fingertips | Department of Health and Social Care).



8. The data shows that although the proportion of mothers recorded as being smokers at the time of delivery is reducing, in 2023/24 this was 10.6%, compared to 10.2% in the North East and 7.4% in England.

9. Although the 2024/25 full year validated data is not yet available, provisional data for April 2024 to December 2024 indicates a continued improving trend in Darlington (and regionally and nationally). The following table shows the data for smoking status at time of delivery, in terms of the number of maternities, smoking status and % of women known to be smokers at time of delivery.

Local Authority Region	Maternities (all)	Maternities (with a known smoking status)	Women known to be smokers at time of delivery (Number)	Women known to be smokers at time of delivery (*Percentage*)
England	383,515	354,820	20,550	*5.8*
North East	17,200	16,450	1,230	*7.5*
Darlington	755	735	40	*5.4*

Source: NHS Digital, Statistics on Women's Smoking Status at Time of Delivery: Data tables - NHS England Digital

Identification and accurate recording of smoking status

10. Work has taken place across County Durham and Darlington NHS Foundation Trust (CDDFT) midwifery teams to ensure smoking status is accurately recorded, so that all pregnant smokers are referred into the Tobacco Dependency in Pregnancy (TDiP) Pathway.

11. The number of women without a smoking status recorded at time of delivery has reduced from approximately 10% in 2021-2022 to 0% throughout the whole of 2024-25, which improves the quality of data reporting.

12. CO monitoring is now undertaken for every pregnant person, at every antenatal contact. This is gold standard practice (and above the standards described in NICE guidance).

Ongoing improvements to the Tobacco Dependency in Pregnancy pathway

13. Engaging with women at the earliest stage in their pregnancy, to check their smoking status and refer them to evidence-based stop smoking support - early-bird maternity clinics are now in place and all staff have been trained to check smoking status and refer to stop smoking services. Between April 24 and February 25, nearly 50% (187/398) of referrals were from Early-bird maternity clinics.

14. Opt-out model in place for all pregnant smokers – a referral to stop smoking support is the default.

15. Responsive services - all people referred receive an appointment for stop smoking support within 24hrs of being referred.

16. Extending the stop smoking support offer – work is underway to include vapes as one of the available quit aids alongside NRT. This has now been approved, with training for staff underway and the offer is being operationalised.

17. Maximising opportunities to engage / re-engage with pregnant smokers - every ante-natal appointment is used as a further opportunity to check smoking status, undertake CO monitoring and refer/re-refer people back into stop smoking support.

Raising awareness of the Tobacco Dependency in Pregnancy Service; Supporting Pregnant people and their partners to stop smoking; and reducing the stigma associated with Smoking in Pregnancy:

18. Lots of work has been undertaken on this theme, for example working with the maternity and neonatal voices partnership to develop the 'maternity highlights' communication that celebrates pregnant people who have successfully stopped smoking whilst pregnant. This helps to raise awareness, tackle stigma and shift the focus to understanding smoking as an addiction and recognising the achievement of quitting. This has included engagement with pregnant women to develop the maternity highlights communication.

19. Harrogate and District NHS Foundation Trust (HDFT) Health visitors in Darlington offer stop smoking advice/education at antenatal contacts. CO monitoring is led by the midwifery service in this antenatal period but is also now being offered by the Health Visitor, with a good take up to date.

Ambition Two: Address the health inequalities in rates of smoking during pregnancy across Darlington

20. An audit and data analysis process has been undertaken by CDDFT to better understand inequalities in rates of smoking in pregnancy across Darlington. This has resulted in the following targeted work to address inequalities (in areas of deprivation and with inclusion health groups):

    a) Data and intelligence has been used to work with midwifery teams in specific geographic areas or working with particular population groups.
    b) Targeted work with at risk groups, including people using drugs and alcohol and from specific inclusion groups.
    c) Work within the Gypsy Roma Traveller (GRT) community in Darlington to support people to access stop smoking support and raise awareness of the vape offer.
    d) Targeted multi-agency work has been undertaken to reduce Sudden Unexpected Infant Deaths following a thematic review identifying smoking as a key risk factor. This included the development of a system wide communications and awareness campaign, with a health literacy lens.
    e) Dedicated Health Inequalities midwife in post providing leadership and taking forward specific actions to address inequalities.

21. A quality improvement project has been undertaken to understand the smoking at time of booking (SATOB) and smoking at time of delivery (SATOD) data within CDDFT on a Middle Super Output Area level. This allowed our teams to understand where inequalities exist in relation to tobacco dependency in pregnancy. This work has also explored rates in relation to different patient groups, for example the rates of smoking in patients with diabetes, raising the profile of TDIP with healthcare professionals.

22. CDDFT have obtained funding for 1 year from the Local Maternity and Neonatal Systems (LMNS) to provide a pregnancy anticipatory care model. Maternity Connectors will be employed by the Pioneering Care Partnership to empower pregnant women and their families to take control of their health and wellbeing. Connectors will give time to parents

to focus on 'what matters to me' and take a personalised approach to their health and wellbeing, connecting people to community groups and statutory services, for practical and emotional support.

23. Maternity Connectors will be aligned to CDDFT's Community Midwifery Team. The post holders will work to strengthen an individual's personal resilience, helping them to address the wider determinants of health, such as debt, poor housing and health in pregnancy. The Connectors will work with targeted groups of pregnant people who have been identified as having complex social needs, providing high intensity support. Smoking cessation is a priority area, specifically for those families who are not engaging with support. The post holder will liaise with a variety of partners, community and voluntary organisations across the geographical patch and the wider family health team.

Ambition Three: Fewer women returning to smoking after they have had their baby, to reduce the risk of harm from second hand smoke

24. The existing Tobacco Dependency in Pregnancy Pathway is outlined below:

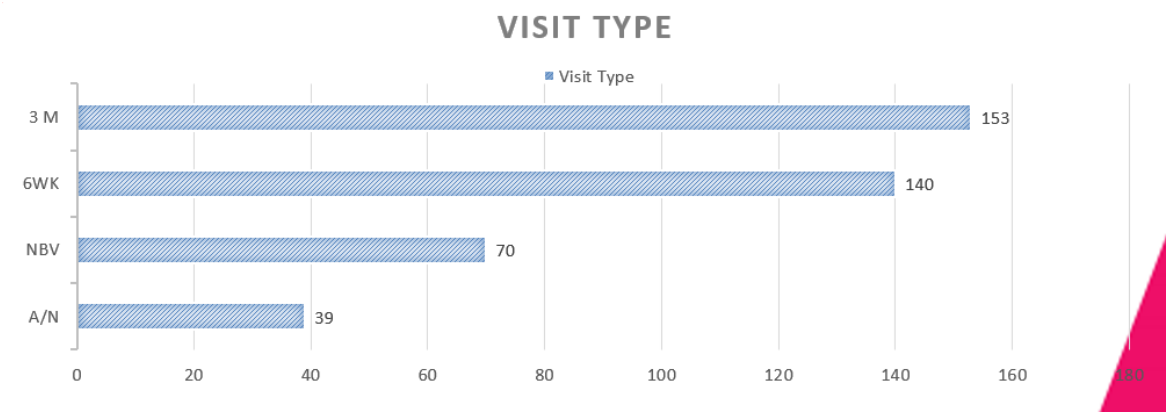
    a) Opt-out stop smoking referral in place at all contacts, including at time-of-delivery and post-natal.
    b) Post-natal CO monitoring at Day 5 and referrals are made to the community Stop Smoking Service (SSS).
    c) Pathway in place to offer partners who smoke support via community SSS.

25. There are strong pathways in place between midwifery and health visiting teams to ensure smokers, those making a quit attempt or recently quit, and their partners are supported throughout the post-natal period.

26. Health Visitors are routinely offering and encouraging CO monitoring at the new birth, 6-8 week, 3–4-month, 9-12 month and 2-2.5 year visits.

27. Home safety assessments are also used to support education around the dangers of smoking and second-hand smoke. Smoking indoors, regardless of it is near a window or by the back door, still poses a risk to babies as tobacco smoke can linger in the air for up to five hours after a cigarette is extinguished.

28. The table below shows the uptake of CO monitoring within the service. So far this year 25 referrals have been made to the Stop Smoking Service and 402 CO readings have been recorded.



Ambition Four: Build upon the momentum of increasing rates of breastfeeding in Darlington, to ensure this includes wards which have rates of breastfeeding which are amongst the lowest in the country

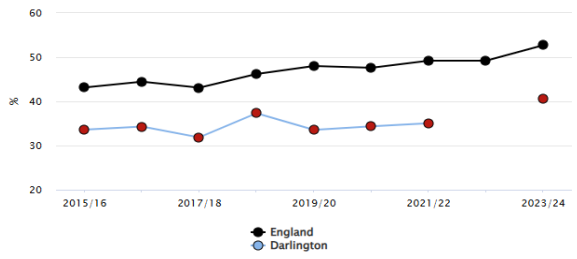
29. The data below highlights the breastfeeding rates from 2015 through to the 2023/2024 reporting year. Data shows a gradual increase over the period. However, the Darlington rates are still lower than England. (Fingertips | Department of Health and Social Care)

Breastfeeding prevalence at 6 to 8 weeks - current method

Proportion - %

Show confidence intervals Show 99.8% CI values

▶ More options



Recent trend: ➡ No significant change

Period		Darlington Count	Value	95% Lower CI	95% Upper CI	North East	England
2015/16	●	407	33.6%*	31.0%	36.3%	31.4%*	43.2%*
2016/17	●	385	34.3%	31.6%	37.1%	31.4%	44.4%*
2017/18	●	361	31.9%	29.2%	34.6%	32.1%*	43.1%*
2018/19	●	400	37.3%	34.5%	40.2%	33.6%	46.2%*
2019/20	●	321	33.5%	30.6%	36.6%	34.4%*	48.0%*
2020/21	●	344	34.4%	31.5%	37.4%	35.4%	47.6%*
2021/22	●	357	35.1%	32.2%	38.1%	35.7%	49.2%*
2022/23		-	*	-	-	36.7%	49.2%*
2023/24	●	405	40.6%	37.6%	43.7%	38.5%	52.7%*

Source: OHID, based on interim reporting data for universal health visiting services

Indicator Definitions and Supporting Information

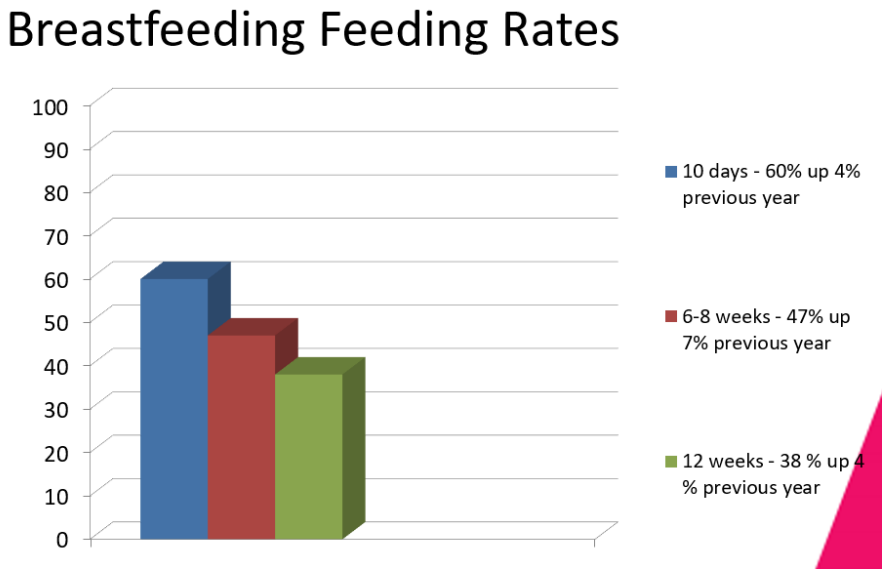
30. HDFT have started to monitor their breastfeeding data at ward level as well as at population level. This will ensure equitable support throughout the town. To support this there has been an increase in support available in community venues.

31. The tables below show by ward the percentage of mothers breastfeeding across March and April 2025, for first feed of colostrum and at new birth visit. (Data from HDFT)

Breastfeeding by Ward

Ward	COLOSTRUM MARCH	BIRTH	COLOSTRUM APRIL	BIRTH
BANK Top / Lascelles	0%	50%	67%	78%
Brinkburn / Faverdale	38%	50%	25%	50%
Cockerton	67%	56%	100%	50%
College	83%	67%	67%	67%
Eastbourne	30%	50%	33%	44%
Harrogate Hill	67%	56%	100%	50%
Haughton / Springfield	100%	100%	25%	63%
Heighington / Coniscliffe	50%	100%	100%	100%
Mowden	0%	0%	No births	
North Road	86%	100%	25%	13%
Northgate	100%	100%	25%	55%
Park East	20%	20%	25%	75%
Park west	50%	50%	60%	80%
Pierremont	0%	75%	60%	80%
Redhall and Lingfield	0%	66%	0%	40%
Sadberge / MSG	67%	67%	50%	50%
Stephenson	50%	83%	33%	44%

32. The below graph outlines the breastfeeding rates for the 24/25 year. (Data from HDFT)



33. Over the past year HDFT have initiated a pilot at two GP surgeries, Denmark Street and Blackett's. The pilot has supported the transition of bringing forward the initial new birth visit from 10- 14 days, to offer it from day 8. Across both practices there has been an

increase in the rates of breastfeeding. There is a strong interest to pursue this across other areas of Darlington and share learning regionally – and potentially nationally.

34. In 2023, there was a re- brand and launch of the Breastfeeding Business Accreditation Scheme. This is ongoing in terms of the local training that can be provided by the specialist infant feeding team, as well as the physical award that can be displayed on site to celebrate a local business being infant feeding friendly.

35. In the last month HDFT have been given access to Badgernet, an electronic maternity healthcare record system. Whilst this is read only access, it will enable a more integrated and succinct handover between the two care systems. This will improve the quality of care for individuals and ensure the healthcare professional can share important information, which is personalised.

36. CDDFT have re-established the tongue tie service and established a specialist infant feeding clinic for complex infant feeding needs, which alternate between University Hospital North Durham (UHND) and Darlington Memorial Hospital (DMH) on a weekly basis. They have been very successful, and families are providing feedback which has been overwhelmingly positive.

37. Funding has been secured from Durham Family Hubs to train the infant feeding specialists and Midwifes to International Board Certified Lactation Consultant IBCLC standards and train a further infant feeding frenulotomy midwife, to provide some resilience in the tongue tie service.

38. The delivery of antenatal infant feeding workshops have been re-established across the CDDFT footprint wherever possible, accessible within a family hub or community venue. CDDFT received funding from Durham Family hubs for additional resources for antenatal workshops and have worked to produce a standardised workshop offer in line with UNICEF guidance. These workshops have been evaluated, and feedback is provided to leads on a quarterly basis to explore opportunities to improve further.

39. Additional Infant Feeding Maternity Support Worker posts have been established within the antenatal clinics utilising funding from Durham Family Hub. The project aim is to improve breastfeeding rates for women who are least likely to breastfeed due to social or medical complexities. There are two WTE in total, one is based in University Hospital North Durham and another in Darlington Memorial Hospital.

40. The Infant Feeding Maternity Support Worker roles provide additional infant feeding education in the antenatal period, alongside consultant clinics and ultrasound scans and wherever possible the team attend the ward to provide support during induction with colostrum harvesting and support with establishing breastfeeding in the immediate postnatal period.

41. Target groups include young parents, diabetics, smokers and women residing in the most deprived deciles. Breastfeeding initiation rates for women who have support from the

team are higher than those who do not. This offer is very well evaluated from pregnant women and their families.

42. The Council's Building Stronger Families team continue to work alongside the Midwifery team, to offer breastfeeding support as part of their targeted offer.

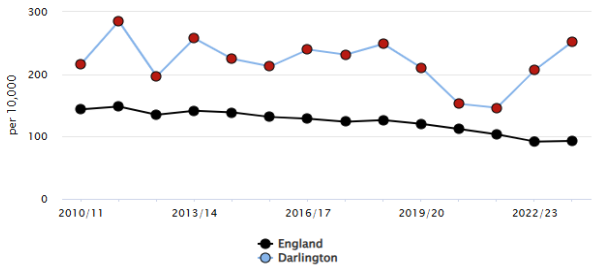
Ambition 5: Undertake an audit of hospital admission data for unintentional and deliberate injuries in children, to understand the cause and develop a local action plan

43. The tables and graphs below highlight the rates of hospital admission by unintentional and deliberate injuries in children 0-4 years and those aged 0- 14 years. Both indicators show that despite a reduction in the rates of admission (which could be due to the Covid-19 pandemic), they are rising again. There is a significant difference in the Darlington rates compared to the North East and England, for both age groups.

Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 4 years)

Crude rate - per 10,000

Show confidence intervals Show 99.8% CI values ▶ More options



Recent trend: ➡ No significant change

Period		Darlington Count	Value	95% Lower CI	95% Upper CI	North East	England
2010/11	●	142	216.4	182.3	255.1	197.4	143.4
2011/12	●	187	284.8	245.5	328.7	218.3	148.3
2012/13	●	130	196.7	167.1	236.8	189.6	135.1
2013/14	●	170	257.5	218.9	297.7	199.9	141.5
2014/15	●	145	224.6	190.9	265.9	206.8	138.7
2015/16	●	135	212.5	175.3	248.1	193.5	131.4
2016/17	●	150	239.5	199.7	277.6	184.2	128.8
2017/18	●	140	231.4	197.7	276.7	169.8	123.9
2018/19	●	145	248.5	208.2	290.6	168.9	126.5
2019/20	●	120	210.3	172.7	249.5	175.7	120.4
2020/21	●	85	152.4	118.6	184.5	145.8	112.1
2021/22	●	80	146.2	119.2	186.0	155.7	103.6
2022/23	●	115	206.5	173.7	251.8	136.3	92.0
2023/24	●	140	252.2	212.1	297.6	140.7	93.2

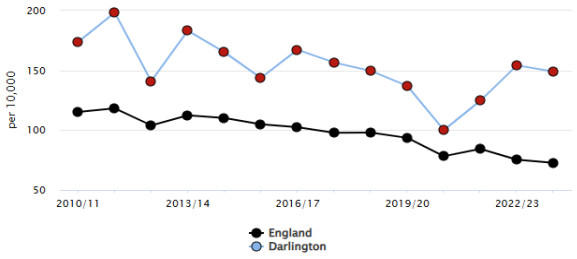
Source: OHID, based on NHS England and Office for National Statistics data

Indicator Definitions and Supporting Information

Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 14 years)

Crude rate - per 10,000

Show confidence intervals Show 99.8% CI values ▶ More options



Recent trend: ➡ No significant change

Period		Darlington Count	Value	95% Lower CI	95% Upper CI	North East	England
2010/11	●	327	173.8	155.5	193.7	158.0	115.2
2011/12	●	375	198.4	178.8	219.5	172.9	118.3
2012/13	●	265	140.9	124.4	158.9	147.0	104.0
2013/14	●	345	183.3	163.9	203.1	158.9	112.5
2014/15	●	310	165.2	147.8	185.2	163.1	110.1
2015/16	●	270	143.7	127.6	162.5	149.5	104.9
2016/17	●	315	167.3	149.3	186.8	147.4	102.4
2017/18	●	295	156.6	139.7	176.1	131.6	97.8
2018/19	●	280	149.6	133.6	169.3	129.1	98.1
2019/20	●	255	137.1	119.8	153.9	134.3	93.6
2020/21	●	185	100.1	85.2	114.5	102.3	78.2
2021/22	●	230	124.7	109.1	141.9	128.5	84.3
2022/23	●	285	154.2	135.8	172.0	116.3	75.4
2023/24	●	275	149.0	130.9	166.5	109.8	72.7

Source: OHID, based on NHS England and Office for National Statistics data

Indicator Definitions and Supporting Information

44. The below table shows our regional position regarding hospital admission by unintentional and deliberate injuries in children aged 0- 14 years.

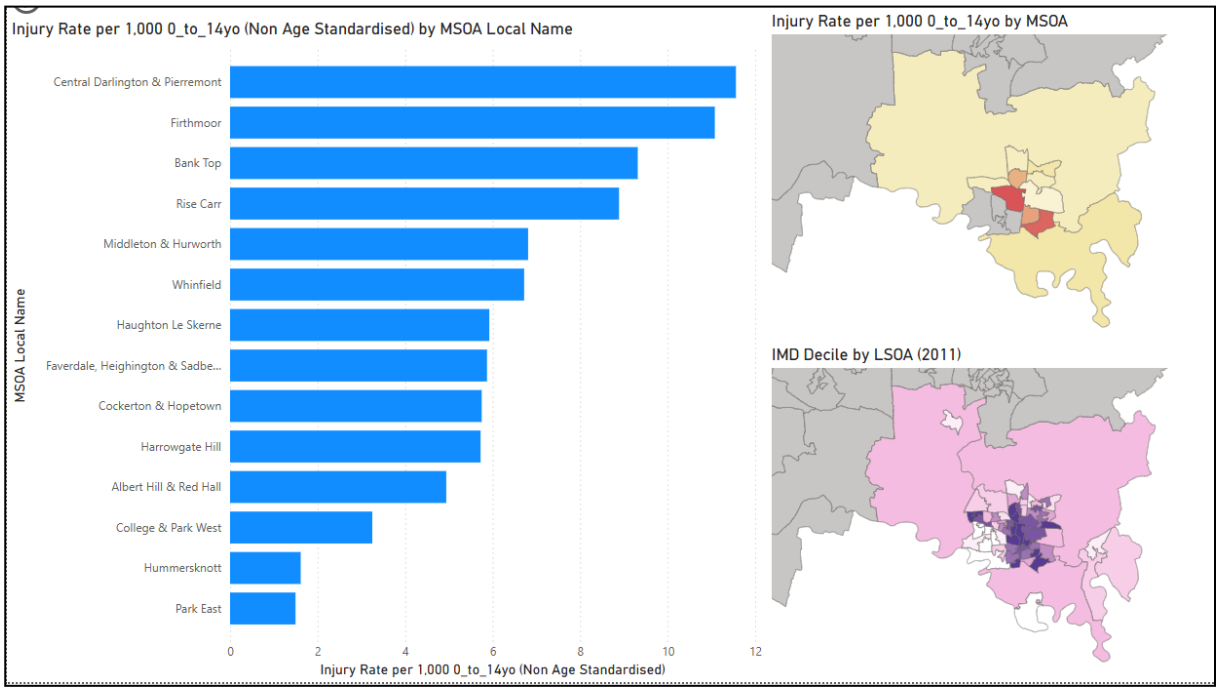
Area	Recent Trend	Count	Value
England	↓	72,293	72.7
North East region (statistical)	→	4,855	109.8
Darlington	→	275	149.0
North Tyneside	→	505	145.3
Northumberland	→	675	139.8
Newcastle upon Tyne	↓	590	117.0
Sunderland	→	525	114.7
Gateshead	→	345	104.9
South Tyneside	↓	245	97.8
County Durham	→	800	97.8
Redcar and Cleveland	→	220	97.7
Middlesbrough	↓	265	90.9
Stockton-on-Tees	→	290	80.0
Hartlepool	→	130	77.5

45. An audit has been undertaken by CDDFT to better understand the key reasons for hospital admissions in children for unintentional and deliberate injuries. The audit reviewed hospital admission data for 2023/24, for children aged 0-14 years who were admitted to hospital (either DMH or UHND).

46. Key messages and trends from the 2023/24 injury admission data for children aged 0-14 years who were admitted to CDDFT included the following:

a) Hospital admissions for unintentional and deliberate injuries remained an important reason for under 18 admissions to hospital (over 10% of all paediatric admissions).
b) More male than female children were admitted for unintentional & deliberate injuries; this is in line with national trends.
c) Hospital admissions for childhood injuries were higher in our most deprived communities, when compared to our least deprived communities.
d) Hospital admissions for injuries were higher in the summer months between May and September.
e) Rates of injury admission varied by geographical areas (using Middle Super Output Areas).
f) The top 3 diagnosis codes used for injury admissions were 'injuries to the head', 'poisoning by drugs, medicaments and biological substances' and 'injuries to the elbow and forearm'.

The graph below shows the 2023/24 rates of injury admissions to hospital (per 1,000 children) for 0–14-year-olds living in different areas across Darlington.



47. To better understand the key reasons for injuries within the local population and identify opportunities for prevention, the audit also provided a deep dive into 100 records.

48. The deep-dive audit of 100 records (aged 0-14 years) for admissions to CDDFT identified the following:

    a) 47% of the injuries occurred within the home (53% outside of the home).
    b) 89% of the children were admitted for unintentional injuries (10% were admitted for deliberate injuries, which includes self-harm, assault, etc.)
    c) Overall cause of injury:
        - 39% were due to falls (including falling from an object)
        - 12% were due to sporting injuries
        - 10% were due to poisonings
    d) The most common causes of injuries taking place inside the home were: poisonings, falls (which includes falls from objects), foreign body injuries and crush injuries.
    e) The most common causes of injuries taking place outside the home were: falls (including falls from something) and sporting injuries.
    f) 34% of the children included in the audit had attended CDDFT A&E within 12 months of their injury admission and many had multiple A&E attendances.
    g) 10% of the admissions reviewed in the audit were classified as deliberate injuries, with the majority of these being for self-harm, poisoning or overdose. All of these occurred in the home setting.

49. The key findings from the audit have now been shared with partner organisations, including Darlington Borough Council Public Health Team, Durham County Council Public Health Team and the HDFT 0-19 service.

50. Key areas of action being taken forward by CDDFT on injury prevention include:

    a) A further deep-dive audit being undertaken focusing on self-harm injury admissions in under 18 year olds, to identify any trends, opportunities for improved care or prevention.
    b) A literature review has been undertaken on what works to reduce unintentional injuries and this is now being reviewed with Darlington and County Durham public health teams, to help inform their local action plans.
    c) Systems approach to injury prevention; work is underway with the public health teams in Darlington and County Durham Councils to explore opportunities to work together to develop joint plans for reducing unintentional injuries.
    d) System wide injury prevention campaign; work is underway to develop a County Durham and Darlington communications campaign that utilises the data from the local audit to develop key messages and resources. These could then be used by all system partners to amplify key prevention messages in target population groups.
    e) Staff training and awareness for frontline staff in key services including Paediatrics, A&E and Maternity, with staff being encouraged to attend child safety/injury prevention training.
    f) Work is underway to improve pathways with community services to support targeted injury prevention work , including identifying any opportunities to improve the processes used to notify the 0-19 service when a child/young person attends hospital as an emergency.

51. Public Health in Darlington, in conjunction with CCDFT and Durham County Council's Public Health team, are working towards implementing the following actions:

    (a) Stakeholder engagement to establish an Injury Prevention Group; Darlington and Durham to work in partnership to bring together relevant partners and organisations to discuss accident prevention priorities and work together to reduce unintentional injuries. This will include sharing communications and awareness information, to ensure consistent messages are provided.
    (b) Training and awareness; unintentional injuries training provided by the Child Accident Prevention Trust is funded by Durham County Council from June 2025. Darlington has kindly been offered 70 training places for multi-agency completion. This will be reviewed following the training, to identify if a more targeted approach is need in Darlington.
    (c) Joint Strategic Needs Assessment – refresh the JSNA to include all relevant fingertips data relating to hospital admission for unintentional and deliberate injuries in children.
    (d) Access Hospital Episode Statistics (HES) data to gather more insight for Darlington.
    (e) Publish an action plan, detailing agreed local ambitions and actions.

Ambition 6: Increased levels of school readiness in children measured at the end of reception, including for children who have free school meal status and children with Special Educational Needs and Disabilities (SEND).

52. Data is available nationally for development at age 2 to 2.5 years and at the end of Reception. (Fingertips | Department of Health and Social Care)

53. Figure 1 shows the percentage of children achieving a good level of development at age 2 – 2 ½ years, which shows Darlington is the highest in the North East and greater than the England average.

Figure 1

Child development: percentage of children achieving a good level of development at 2 to 2 and a half years 2023/24 — Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	343,677	80.4*	80.2	80.5
North East region (statistical)	↓	19,197	84.4	83.9	84.9
Darlington	→	996	92.1	90.3	93.5
Stockton-on-Tees	→	1,523	90.0	88.4	91.3
Redcar and Cleveland	→	1,035	87.8	85.8	89.5
Northumberland	↓	2,563	87.6*	86.4	88.7
Middlesbrough	↓	1,441	87.0	85.3	88.6
North Tyneside	→	1,604	86.9	85.3	88.4
Gateshead	↓	1,437	84.8	83.0	86.5
Sunderland	→	2,020	83.7	82.2	85.2
County Durham	↓	3,449	83.7	82.5	84.8
Hartlepool	↑	604	82.7*	79.8	85.3
Newcastle upon Tyne	↓	1,755	78.0	76.2	79.6
South Tyneside	↓	770	66.9	64.1	69.6

54. Figure 2 shows the percentage of children achieving a good level of development at the end of reception, with Darlington slightly below the North East and England averages.

Figure 2

School readiness: percentage of children achieving a good level of development at the end of Reception 2023/24 — Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	411,626	67.7	67.6	67.8
North East region (statistical)	–	18,340	66.8	66.2	67.3
Stockton-on-Tees	–	1,546	69.5	67.5	71.4
Northumberland	–	2,085	69.2	67.5	70.8
North Tyneside	–	1,550	68.1	66.2	70.0
South Tyneside	–	1,066	68.0	65.7	70.3
Gateshead	–	1,388	67.4	65.4	69.4
Sunderland	–	1,895	67.0	65.2	68.7
Redcar and Cleveland	–	898	66.9	64.4	69.4
County Durham	–	3,324	66.1	64.8	67.4
Darlington	–	746	65.7	62.9	68.4
Newcastle upon Tyne	–	2,019	65.6	63.9	67.2
Hartlepool	–	673	65.5	62.6	68.4
Middlesbrough	–	1,150	61.3	59.1	63.5

55. The data below shows the impact of free school meal status on school readiness, highlighting a disparity in development depending on free school meal status. Implementation of auto enrolment for free school meals is being explored in Darlington, which alongside increasing access to a hot school meal would further improve the robustness of this data.

56. Figure 3 shows the percentage of children with free school meal status achieving a good level of development at the end of reception. Darlington has one of the lowest proportions in the North East and the lowest across Tees Valley and is below the North East and England averages.

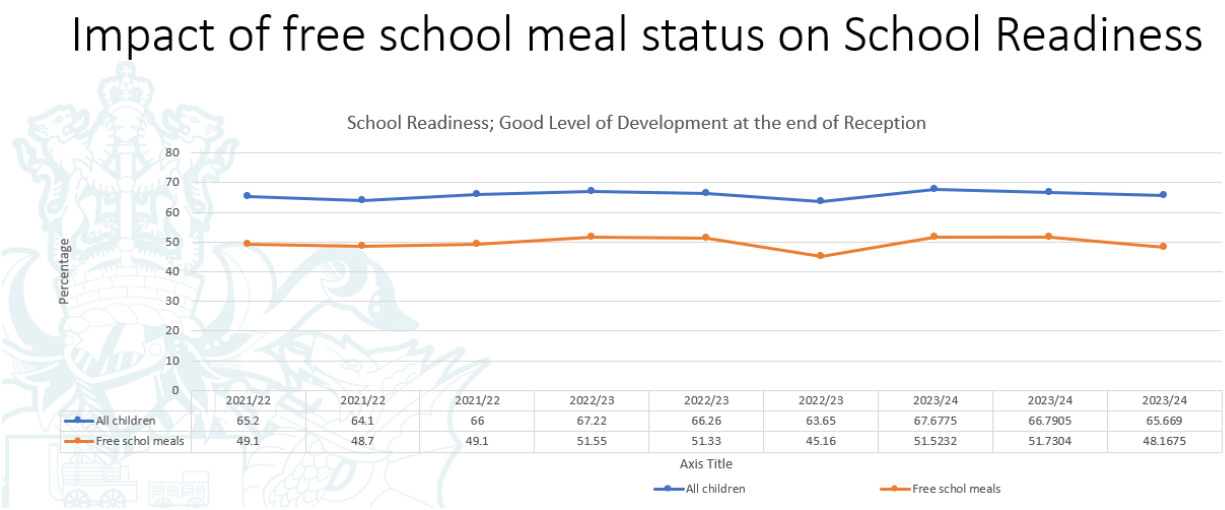
Figure 3

School Readiness: percentage of children with free school meal status achieving a good level of development at the end of Reception
2023/24

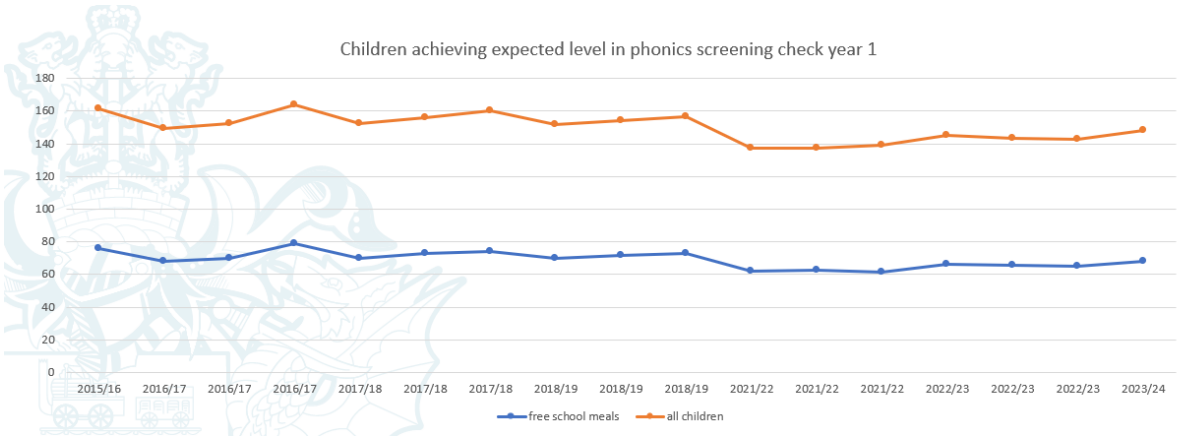
Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	53,951	51.5	51.2	51.8
North East region (statistical)	–	3,393	51.7	50.5	52.9
Hartlepool	–	183	54.3	49.0	59.5
Stockton-on-Tees	–	249	54.1	49.6	58.6
Redcar and Cleveland	–	163	53.6	48.0	59.1
Middlesbrough	–	315	53.6	49.5	57.6
County Durham	–	711	52.2	49.6	54.9
Newcastle upon Tyne	–	474	52.1	48.9	55.4
Gateshead	–	230	51.6	46.9	56.2
Sunderland	–	298	51.2	47.1	55.2
South Tyneside	–	229	50.1	45.5	54.7
North Tyneside	–	221	49.1	44.5	53.7
Darlington	–	92	48.2	41.2	55.2
Northumberland	–	228	48.1	43.6	52.6

Figure 4



57. Figure 5 shows the trends and variation for children achieving the expected level in phonics screening in Year 1, by Free School Meal Status.



58. A task and finish group has been established across the Council including relevant representatives from Education, Public Health, Building Stronger Families, SEND and Early Years, with engagement also from the 0-19 Service.

59. The group is working towards developing a local action plan, to address local needs and meet the priorities identified in the Council Plan, Health and Wellbeing Strategy and SEND Strategy.

60. The following key challenges have been identified:

    a) many children start school not toilet trained;
    b) staffing shortages in Early Years settings;
    c) inconsistent practices across nurseries;
    d) misalignment between parent and professional expectations;

61. As a result of initial findings, the following actions and ways of working have been agreed:

    a) work upstream to engage and identify concerns at earliest age;
    b) GLD (Good Level of Development) is the key benchmark;
    c) planned campaigns, surveys, and social media engagement;
    d) integrate school readiness guidance with admissions;
    e) implement best practice, such as
        - Babies Learn to Talk, Talk Boost
        - Tots Talking
        - emphasis on phonics and attention skills
        - ERIC training proposed for toileting support
        - BBC Tiny Happy People - potential local launch event and showcase of free evidence-based resources.

62. The Building Stronger families team offer a variety of sessions as part of their universal offer that support with school readiness, this includes Tots Talking (for 2-year-old children) and Early Years Workshops for 0-4 are under development. They also work alongside schools on a targeted intervention offer, informed by data and insight, with a focus on speech and language and toileting needs.

63. HDFT also play a significant role in supporting school readiness, from the ante natal contact with interventions such as the newborn behavioural assessment tool and across all mandated contacts. All visits cover an assessment of development and offer support to parents regarding the home learning environment. Parents are supported and encouraged to access any eligible nursery provision.

64. The Health Visiting team have regular nursery liaison to help inform an understanding of pre - school population needs identified outside of a home setting. When children reach 2.5 years of age they are offered an Ages and Stages Questionnaire (ASQ), which is generally completed with parents but can also be an integrated assessment within an Early Years setting, if it is agreed this is appropriate.

65. The table below shows the ASQ results for Darlington, as well as the comparisons for the North East and England. Whilst Darlington performs better than North East and England averages there is variation across the different domains, so in response to this data the team are offering a programme of sessions at Hopetown to support with weaning, toileting, behaviour and speech and language.

Indicator	Period	Darlington			North East	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Proportion of children aged 2 to 2½yrs receiving ASQ-3 as part of the Healthy Child Programme or integrated review	2023/24	→	1,082	99.3%	95.8%	93.3%*	58.2%		100%
Child development: percentage of children achieving the expected level in communication skills at 2 to 2 and a half years	2023/24	→	1,002	92.6%	89.1%	86.6%*	24.7%		96.0%
Child development: percentage of children achieving the expected level in gross motor skills at 2 to 2½ years	2023/24	↑	1,080	99.8%	95.5%	93.3%*	78.6%		99.8%
Child development: percentage of children achieving the expected level in fine motor skills at 2 to 2½ years	2023/24	→	1,066	98.5%	94.9%	93.3%*	73.6%		99.3%
Child development: percentage of children achieving the expected level in problem solving skills at 2 to 2½ years	2023/24	→	1,049	97.0%	93.5%	92.5%*	69.8%		98.4%
Child development: percentage of children achieving the expected level in personal social skills at 2 to 2 and a half years	2023/24	→	1,037	95.8%	92.6%	91.2%*	66.7%		100%
Child development: percentage of children achieving a good level of development at 2 to 2 and a half years	2023/24	→	996	92.1%	84.4%	80.4%*	22.8%		95.4%