Altogether healthier

County Durham Health and Wellbeing Board

County Durham

Joint Strategic Needs Assessment 2014

NHS
North Durham
Clinical Commissioning Group

NHS
Durham Dales, Easington and Sedgefield
Clinical Commissioning Group

Durham County Council

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Introduction

The purpose of the County Durham Joint Strategic Needs Assessment (JSNA) is to provide a detailed overview of the current and future health and wellbeing needs of the people of County Durham. The Health and Social Care Act 2012 places clear duties on local authorities and Clinical Commissioning Groups (CCGs) to prepare a Joint Strategic Needs Assessment (JSNA).

The JSNA underpins the Sustainable Community Strategy and is intended to inform our priority and target setting to help ensure that we improve the health and wellbeing of the people within the county and reduce health inequalities.To help achieve positive outcomes for the local population, the County Durham JSNA aims to:

- Highlight areas where there is a need to improve health and wellbeing outcomes for the local community.
- Aid decision makers in targeting resources to both areas and services.
- Act as a resource document to support health and wellbeing planning and commissioning.
- Help inform our plans and strategies to provide a basis on which to plan for the achievement of local outcomes and targets.

The JSNA was first published in County Durham in 2008 by Durham County Council and NHS County Durham, with a subsequent update produced in 2009. The 2010/11 document was a full review of data and analysis structured around the 5 altogether themes in the Sustainable Community Strategy:

- Altogether Wealthier
- Altogether Better for Children and Young People
- Altogether Healthier
- Altogether Safer
- Altogether Greener

The JSNA 2011 included an in-depth analysis on health, social care and deprivation, and mental health, highlighting areas where we need to do more to improve people's health and wellbeing in County Durham, as well as looking at issues relating to drugs and alcohol, social care, smoking, physical activity, housing and how the local economy and crime can affect people's health and wellbeing. The 2012 JSNA refreshed the data and updated the key messages. The JSNA 2013 updated the data and relevant key messages and produced a summary document based on a life course approach.

The JSNA 2014 contains refreshed data and updated key messages. Throughout the JSNA 2014, the most recently available data has been applied. A variety of data sources have been used, for example nationally published statistics and activity levels, information based on the Census 2011, ONS population estimates and DCC population and household projections. The JSNA 2014 summary document has also been refreshed.

How to use the JSNA

The JSNA identifies ‘the big picture’ in terms of the health and wellbeing needs and inequalities which exist in County Durham. It will be used to inform future service planning, taking into account evidence of effectiveness.

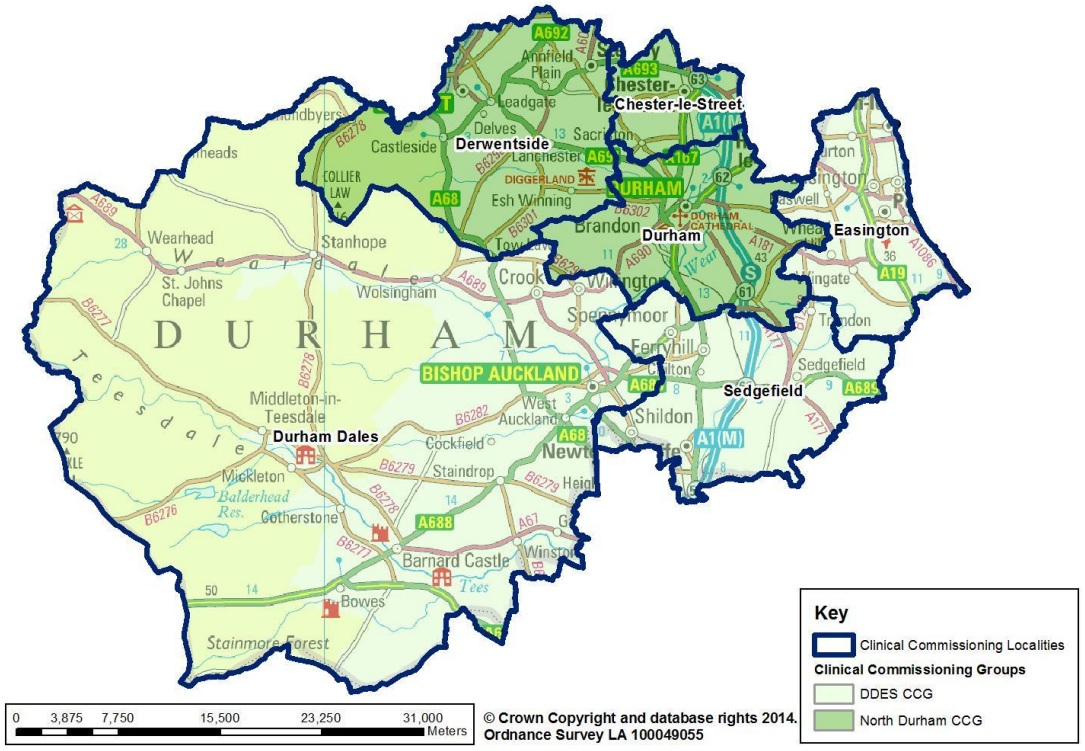
The JSNA 2014 has also been used to inform the refresh of the Joint Health and Wellbeing Strategy (JHWS) 2015-18 for County Durham, the Children, Young People and Families Plan, the Safe Durham Partnership Plan and Clinical Commissioning Group Commissioning Intentions.

Reporting geographies

Throughout this document a number of geographical areas are used to provide information for recognisable areas within County Durham. County Durham has been used as the main reporting geography, with comparisons being made with other neighbouring authorities, the North East and England where appropriate. Reference has also been made to a number of sub-county geographies to provide a more detailed account and highlight areas of greater need within the county. These sub-geographies are:

- 2 Clinical Commissioning Groups (CCGs):
  - North Durham
  - Durham Dales, Easington and Sedgefield (DDES).
- North Durham CCG is made up of Derwentside, Chester-le-Street and Durham CCG Constituencies.
- DDES CCG is made up of Durham Dales, Easington and Sedgefield CCG Localities.

Map 1: JSNA reporting geographies



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County Durham is a large and diverse area and in order to better understand specific localities, various additional profiles containing more detailed data for some indicators have been produced. Profiles for the 14 Area Action Partnerships are available online and further statistics can be found on the Durham County Council website www.durham.gov.uk/stats.

Life in County Durham

County Durham, along with other areas across the country, is experiencing an ever ageing population which is predicted to increase significantly over the next ten to twenty years. This will place increased demand on some services which may in turn require changes to service provision across the county and even the implementation of new ways of delivering services to this changing population.

However, an ageing population also presents various advantages. For example, in the years after retirement, older people have a chance to pursue new interests and hobbies and use their experience, skills and knowledge to contribute to the wellbeing of their local community, or to a specific interest group. This not only enhances their own personal health and wellbeing but also benefits their local community, neighbourhood or network.

Notes on the population data used in this section

Population estimates
ONS population estimates have been used throughout this section, (unless otherwise stated), and updated to include the latest estimates for 2013.

Population projections
For population projections, we have used the council's 2011 trend based projections in preference to those produced by ONS for 2011. This is not a matter of one set of projections being superior to the other, as both sets are valid within the context of the assumptions made to produce them. The principal difference arises from the estimation of fertility and how Durham University students influence the demography of the county. The Durham County Council trend-based projections use a fertility rate, (trend from figures for 2006 to 2011), which has been adjusted by removing the female students from the base population used in the calculation, following the assumption that in general there are only a small number of student pregnancies in any one year.

However it should be noted that population projections are not forecasts. They do not attempt to predict the impact that future government or local policies, changing economic circumstances or other factors might have on demographic behaviour.

The County Durham Plan
In addition to the trend projections described below, Durham County Council has commissioned policy–led projections. These are where aspirations for the population of the county are built into the projections by adopting a target population by 2030 for one of its key age cohorts, the working age population aged 16 to 64. The output from such models is the size of net migration and natural change required to achieve the adopted target. These scenarios are used within the County Durham Plan to model the connection between net migration, future job creation and the consequential number of additional dwellings required in the county by 2030.

The preferred scenario in the County Durham Plan reflects the economic aspirations of the council. It includes raising the employment rate to 73% and accommodating a

labour force growth target of 30,000 jobs for County Durham residents. Crucially, it is the size of the economy of County Durham which the plan is aiming to increase. It is forecast that 23,000 of the 30,000 jobs will be located in County Durham based on commuting patterns identified in Census data. This economic growth means that 31,400 net new dwellings are required for County Durham over the period of the plan. This translates to a total forecast population for County Durham of 570,500 by 2030, almost 10,000 more residents than DCC trend based projections. The difference between these trend based and policy led projections are detailed in Table 1.

The plan was submitted to the Planning Inspectorate and was subject to a formal examination in public in autumn 2014. Work is underway to consider the planning inspector's interim report and establish the next stages of the County Durham Plan.

Table 1: Projected population change between 2011 and 2030

	2011	2030	% change
DCC Trend Based Projections	513,000	560,700	9.3
County Durham Plan: Preferred Scenario	513,000	570,500	11.2

Introduction

County Durham is a place of distinctive character with a strong sense of its own identity. It has a proud and unique history having been settled since ancient times by the Romans, Angles, Saxons and Normans. Durham city developed as a centre of Christian worship in the 11th century with the completion of the cathedral, which now has world heritage status. The Bishops of Durham were granted both spiritual and secular powers by William I, effectively giving them the status of kings of the North East. The situation lasted up until the Reformation. Later, County Durham became a centre for the industrial revolution providing the country and developing empire with coal and steel. The area also saw the development of the world's first passenger steam railway in 1825.

In recent times, County Durham has undergone a large period of industrial change and restructuring. In common with the north of England, County Durham has experienced a large sectoral shift in its economy and has suffered from industrial decline. Three decades ago parts of the county were highly dependent on coal mining and steel production.

Today, Durham is a county of economic, cultural and environmental contrasts. It stretches from the remote rural North Pennine area of outstanding natural beauty in the West to the more densely populated Easington heritage coastline. The county covers an area of 2,226 km^2 (859 square miles) with 236,710 residential properties[1]. The key spatial legacy of the rise and fall of mining, steel and other heavy industries is the dispersed settlement pattern of towns and villages with a built environment which reflects the county's industrial past but which is separated by stretches of open countryside.

[1] Total chargeable dwellings for 2013/14 (as at 9 September 2013), Council tax levels set by local authorities in England 2013/14, Valuation Office Agency (VOA)

Commonly regarded as a predominantly rural area, the county varies in character from remote and sparsely populated areas in the west to former coalfield communities in the centre and east where villages tend to accommodate thousands rather than hundreds of people. Around 93% of the population lives east of the A68 road in approximately half of the county by area. There are 12 major towns in County Durham, each acting as a service centre for surrounding communities by providing employment, shopping and other services. 75% of housing stock is in the private sector. Two-thirds of the social sector housing stock is owned by the local authority. A quarter of the county's total social housing stock is located in the Sedgefield and Easington areas.

Latest population estimates

The Office for National Statistics (ONS) released its mid-2013 population estimates for local authorities in June 2014. From this first release the county population increased by 0.3% to 516,000 people between 2012 and 2013 and remains sixth within the single tier authorities, 10,400 people behind Bradford and 1,600 people ahead of Manchester (the 2012 figures were 10,100 and 3,500 respectively). The remainder of this Life in Durham section discusses demographic and geographic change with reference to 2013 data.

Table 2: 2013 single tier authority population ranks

		Population		
2013 Rank	**Authority**	**2011**	**2012**	**2013**
1	Birmingham	1,074,300	1,085,400	1,092,300
2	Leeds	750,700	757,655	761,500
3	Sheffield	551,800	557,400	560,100
4	Cornwall	533,800	537,900	541,300
5	Bradford	523,100	524,600	526,400
6	**County Durham**	**513,000**	**514,300**	**516,000**
7	Manchester	502,900	510,800	514,400

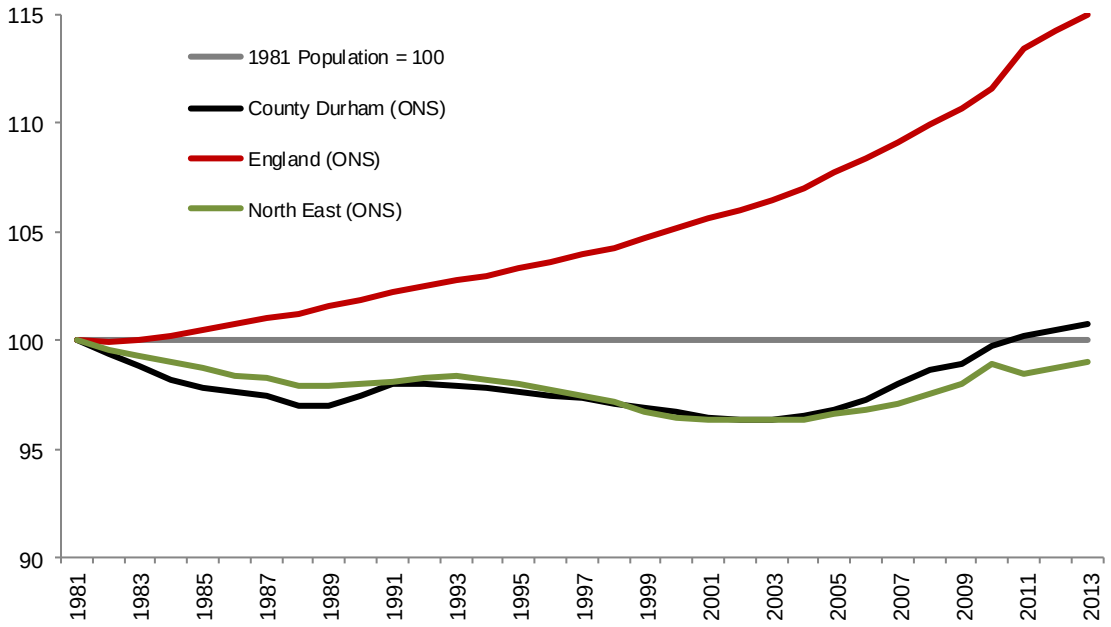
Source: ONS mid-year estimates

County Durham population – 2013

Baseline population – overall

Between 2001 and 2013 the population of County Durham increased by 4.5% from 493,700 to 516,000, higher than the 2.8% rise seen in the region but lower than the 8.8% seen across England and Wales. However, since 1981 the population of the county has remained relatively stable at around the 510,000 level. The county now has almost the same total population as it did 30 years ago. Growth trends in this period have tended to be very similar to the North East average, in contrast to growth nationally where England has grown by 15.1% over the same period as shown in Figure 1 below.

Figure 1: Population change 1981 to 2013 (change from 1981 base)



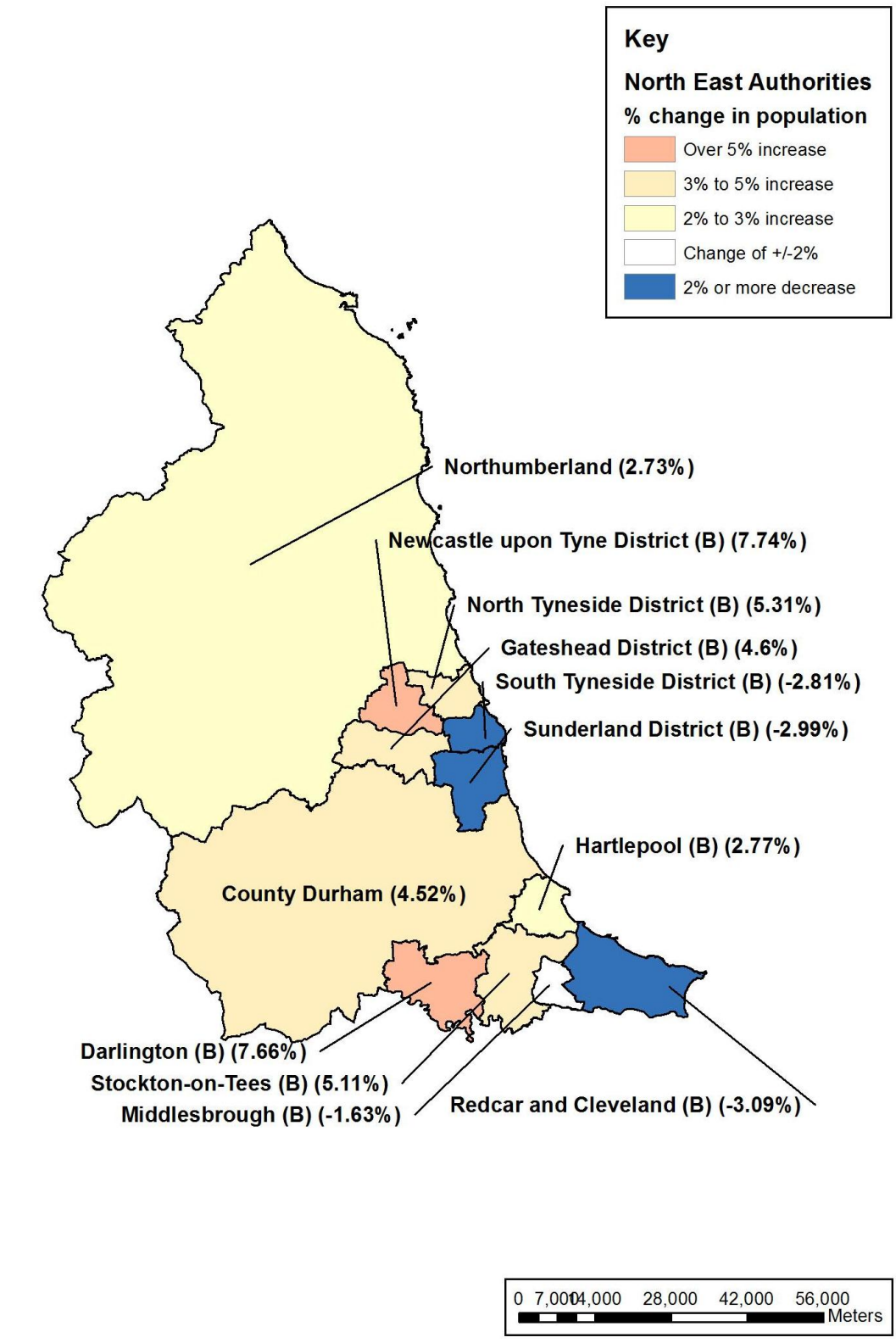
County Durham has seen the sixth largest population increase of the 12 local authorities in the North East as detailed below.

Table 3: Population change in authorities in the North East region

Authority	2001	2013	% Change	Rank
Newcastle upon Tyne	266,200	286,800	7.74	1
Darlington	97,900	105,400	7.66	2
North Tyneside	192,000	202,200	5.31	3
Stockton-on-Tees	183,800	193,200	5.11	4
Gateshead	191,200	200,000	4.60	5
County Durham	**493,700**	**516,000**	**4.52**	**6**
Hartlepool	90,200	92,700	2.77	7
Northumberland	307,400	315,800	2.73	8
Middlesbrough	141,200	138,900	-1.63	9
South Tyneside	152,800	148,500	-2.81	10
Sunderland	284,600	276,100	-2.99	11
Redcar & Cleveland	139,200	134,900	-3.09	12

Source: ONS Population Estimates

Map 2: Population change in authorities in the North East region

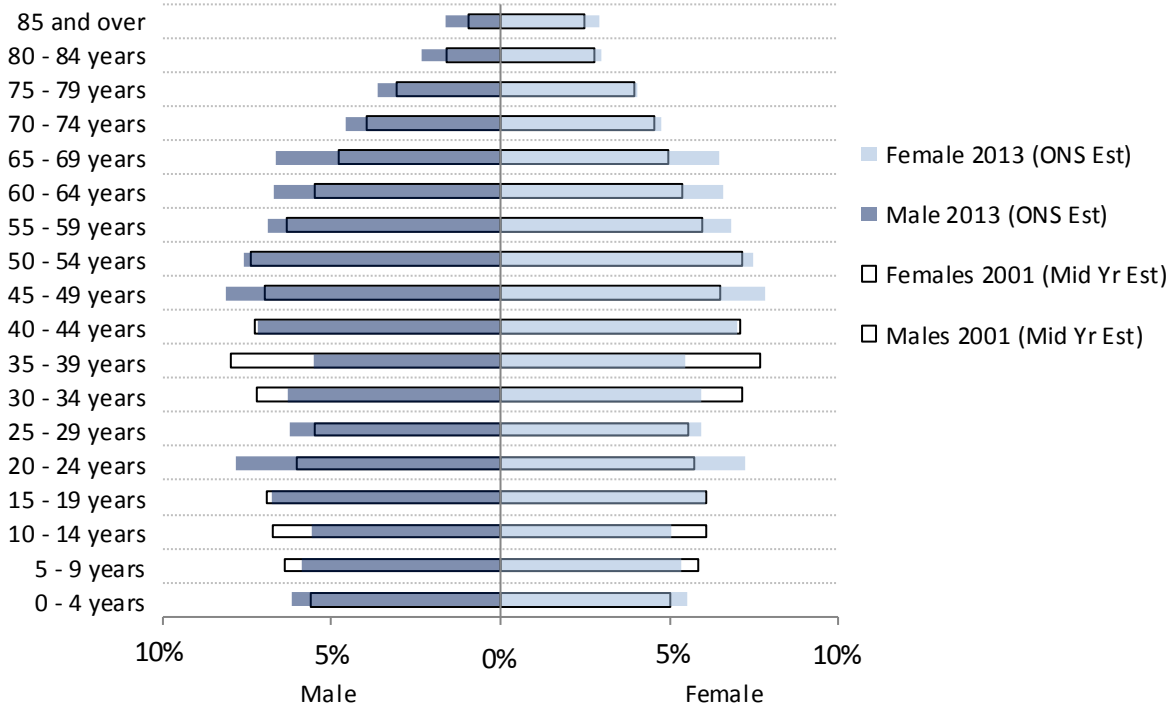


It should be noted that the county has grown at a slower rate than other large single tier authorities in England and Wales, particularly those in large urban areas.

This increase in the county's population is predicted to continue for the near future and the DCC trend based projections indicate that by 2021 the county's population will have increased 4.6% to 539,900 people, rising to 560,700 people by 2030, (an 8.7% increase from 2013).

As with other area and national trends, the county has an ageing population. There have been changes throughout the population age structure since 2001 as shown in Figure 2. They provide a more detailed picture of the changes in the ages of the county's population between 2001 and 2013 and onwards to 2030.

Figure 2: Population age pyramid for County Durham 2001 to 2013

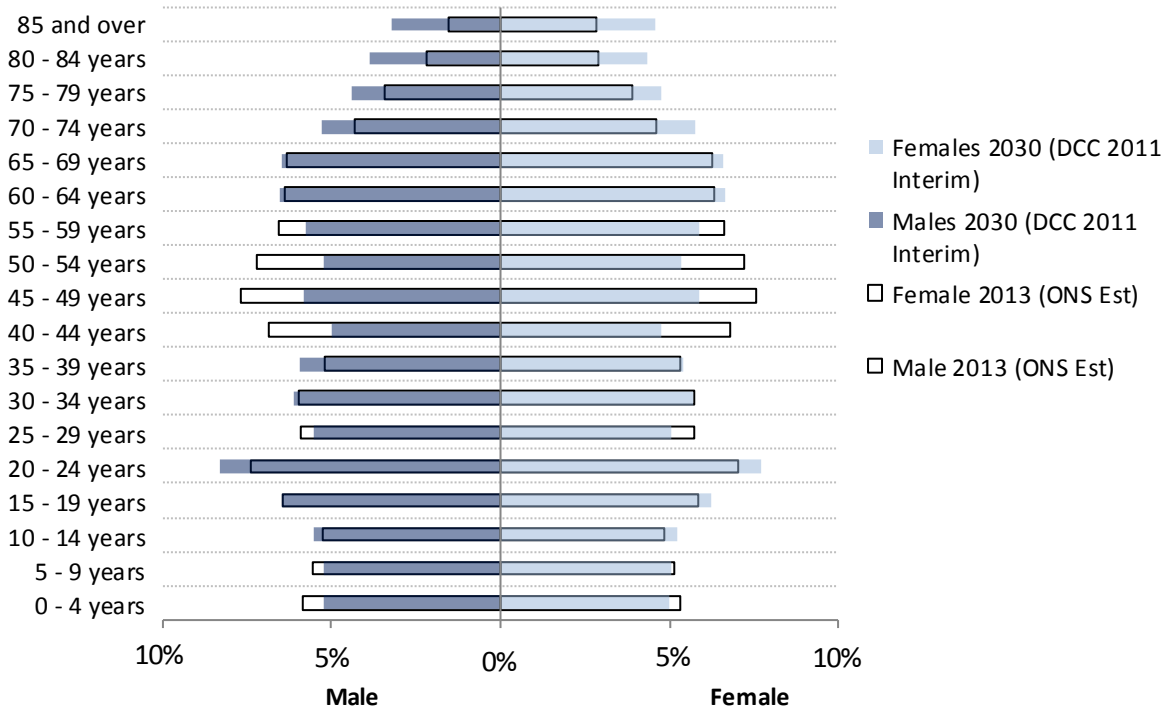


Some of the greatest increases in population between 2001 and 2013 were in the proportion of the population aged 45 years and over. These wide areas of the population pyramid follow the national trend and represent the post Second World War spike in births and the 1960s baby boom.

Since 2001 the population in the county aged 40+ years has increased by 14.1% (with increases of 10.7% regionally and 15.7% nationally), with the proportion of the 40+ population in the county increasing from 49.3% to 53.8% of the total population. In contrast, the under 40 years population has declined at county and regional levels by 4.8% and 4.6% respectively, with national trends indicating a 2.7% increase in this age group. The most notable changes to the County Durham population are in the youngest and oldest populations. The county's retired population has increased, while there has been a fall in the number of children aged 0 to 17.

Leading up to 2030, the reduction in the number of children will feed through to the working age group which will see a slight fall of 0.2% by 2030. As people aged 40+ age into retirement, the retired population (aged 65+) will increase by 39.8% over the same period from 99,000 to 138,400. Figure 3 details these changes to the county's age structure by 2030.

Figure 3: Population age pyramid for County Durham 2013 to 2030

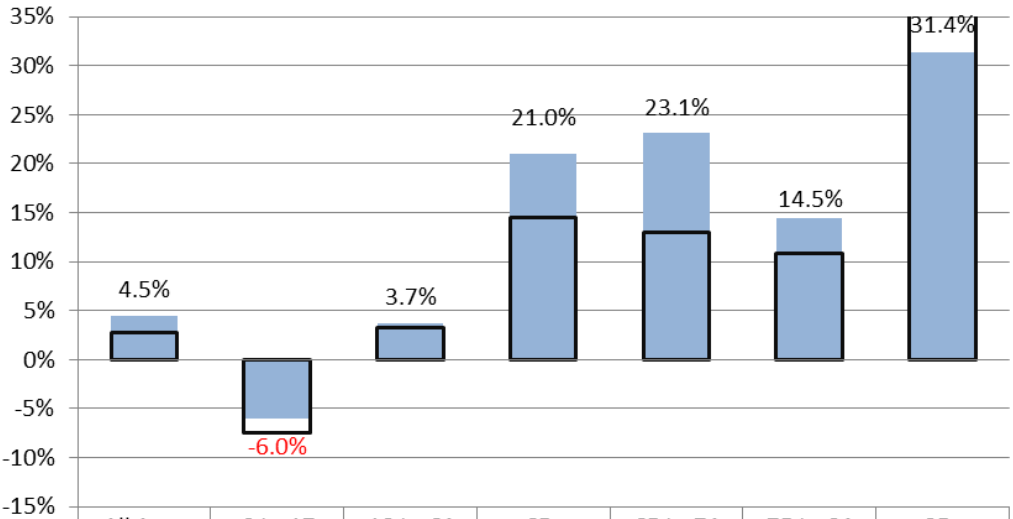


Population (2013) – main age groups

Figures 4 and 5 show how the age structure of the county has changed compared to the region and nationally since 2001. They show that the county has seen a fall in younger people, while the retired population continues to increase. This pattern is similar to that seen across the North East and England and Wales.

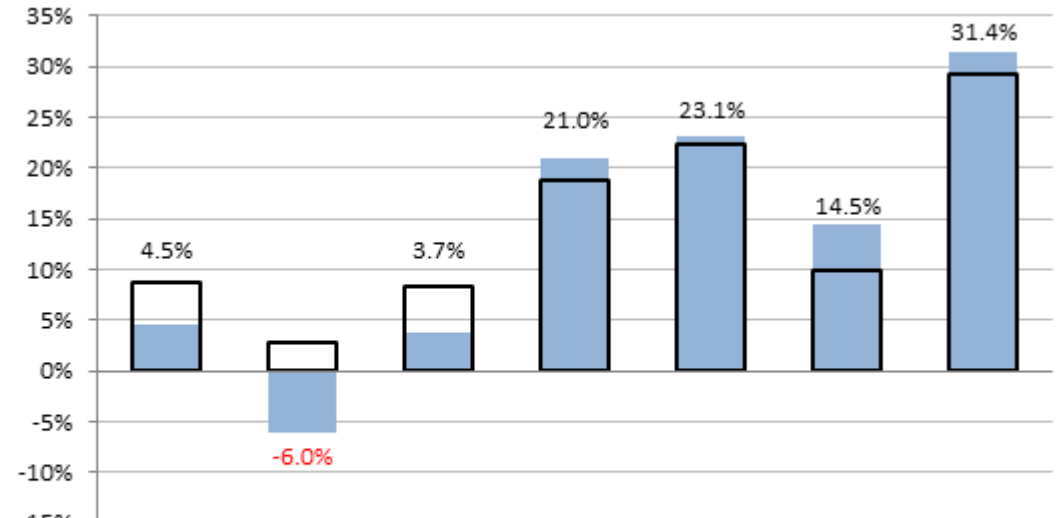
In addition, the DCC trend based population projections indicate that this pattern will continue until at least 2030.

Figure 4: Percentage population change between 2001 and 2013 in County Durham by broad age group compared to the North East



	All Ages	0 to 17	18 to 64	65+	65 to 74	75 to 84	85+
County Durham	4.5%	-6.0%	3.7%	21.0%	23.1%	14.5%	31.4%
North East	2.8%	-7.5%	3.3%	14.6%	13.0%	10.8%	35.2%

Figure 5: Percentage population change between 2001 and 2013 in County Durham by broad age group compared to England and Wales



	All Ages	0 to 17	18 to 64	65+	65 to 74	75 to 84	85+
County Durham	4.5%	-6.0%	3.7%	21.0%	23.1%	14.5%	31.4%
England & Wales	8.8%	2.8%	8.4%	18.8%	22.3%	9.9%	29.3%

The number of young people and children aged 0 to 17 has fallen 6% since 2001 from 106,500 to 100,200 and is due to a fall in the number of births after the 2001 Census following a national trend at that time. This fall in the 0 to 17 group is similar to that seen in the region (7.5% fall) while nationally there was an increase of 2.8% over the same period. Currently one in five people (19.4%) in the county are in this age group. This is predicted to remain stable up to 2030, however this represents a 6.5% rise in number to 106,700 by 2030.

The 0-4 year age group in County Durham increased 10.4% between 2001 and 2013 to 28,900 children but will see relatively little change by 2030 with only a 0.2% predicted fall in numbers.

Between 2001 and 2013 adults of working age (18 to 64) increased in the county by 3.7%, a rise of 11,400 people to 316,700 representing 61.4% of the total population in the county. Again this is similar to the rise seen regionally (3.3%) but is half that seen nationally (8.4%). DCC trend based predictions indicate that this proportion of the county's population will fall to 56.3% by 2030, a fall of 1,900 people or 0.6%.

The retired population (65+ years) in County Durham has increased by 21.0% since 2001, higher than regional (14.6%) and national (18.8%) increases. In County Durham 19.2% of the population (99,000 people) were aged 65+ in 2013, a rise from 16.6% in 2001 (81,800 people), which exceeds comparisons regionally (18.4%) and nationally (17.4%).

Predictions indicate that the 65+ population will increase by a further 17.3% by 2021 and by 39.8% by 2030 (from a 2013 base), an increase of 17,100 and 39,400 people respectively. This increasingly ageing population will see the proportion of the county's population aged 65 or over increasing from almost one in five people (19.2%, 2013) to nearly one in four people (24.7%, 2030).

Within the retired age group there have been significant changes to the age groups which are combined in the 65 and over population. The number of people in the county aged 65 to 74 increased by 23.1% between 2001 and 2013 to 55,500 and are predicted to rise to 62,200 by 2021 and then to 67,600 by 2030, a further increase of 21.8% (from 2013). This represents an increase in proportion from 10.8% to 12.1% by 2030.

The rise in the number of people aged 75 to 84 was also higher than seen regionally or nationally at 14.5%, (North East 10.8%, England and Wales 9.9%), a rise from 28,200 to 32,200 people. By 2021 predictions indicate that this will rise to 39,200 and then to 48,800 by 2030, increases of 21.4% and 51.5% respectively.

It is also important to note that the population aged 85+ has increased since 2001 by 2,700 people, a 31.4% increase (regionally 35.3% increase, nationally 29.3% increase). This group of people is predicted to increase by a further 31.1% by 2021 and nearly double in size (+95.2%) by 2030 to 22,000 people (from a 2013 base). This elderly age group now accounts for 2.2% of the population, similar to regional and national proportions, and will rise to 3.9% of the total population by 2030.

These increases in older people combined with the fall in the working age population will see significant changes to dependency ratios.

Clinical Commissioning Areas - Population[2] – 2013

Baseline population – overall

All Clinical Commissioning Localities (CCLs) and therefore Clinical Commissioning Groups (CCGs) have seen increases in overall population since 2001, with North Durham CCG increasing by 7.2% (16,400 people) compared to a modest increase in DDES CCG of 2.2% (5,900 people). Within North Durham CCG, Derwentside CCL and Durham CCL have seen the greatest increases of 8.2% (7,000 people) and 10.1% (8,900 people) respectively. Sedgefield CCL has the lowest increase across commissioning areas of 0.4% (300 people). The following charts detail the population changes between 2001 and 2013.

Figure 6a: Overall population change in North Durham CCG: 2001 to 2013

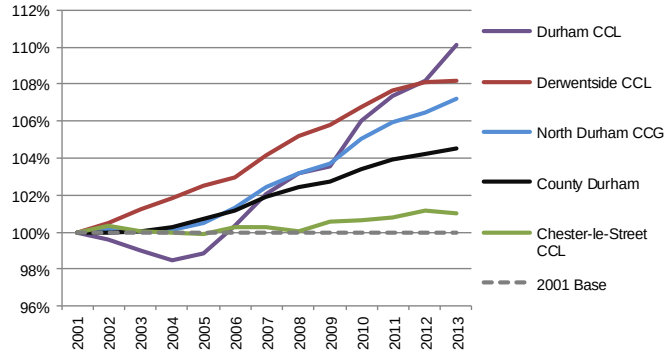
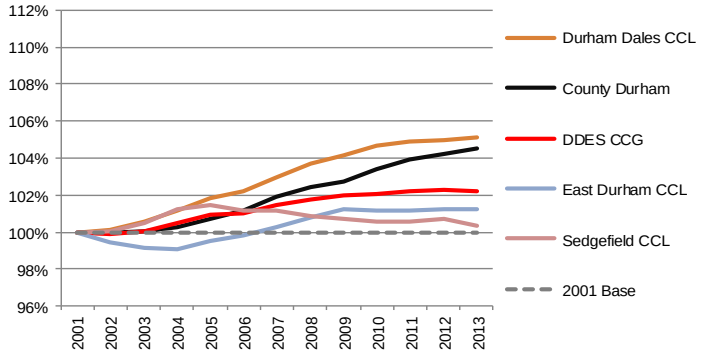


Figure 6b: Overall population change in DDES CCG: 2001 to 2013



Population (2013) – main age groups – 0 to 17

Both CCGs have seen a fall in this age group since 2001, with North Durham CCG falling by 3.1% (1,400 people) and DDES CCG falling by 8.2% (4,900 people). Only Derwentside CCL has seen an increase in this group since 2001 of 1.6% (300 people) while all other areas have seen falls of between 3.3% (500 people) in Durham CCL to 10.3% (2,300 people) in East Durham CCL.

Figure 7a: Population change in the 0 to 17 age groups in North Durham CCG: 2001 to 2013

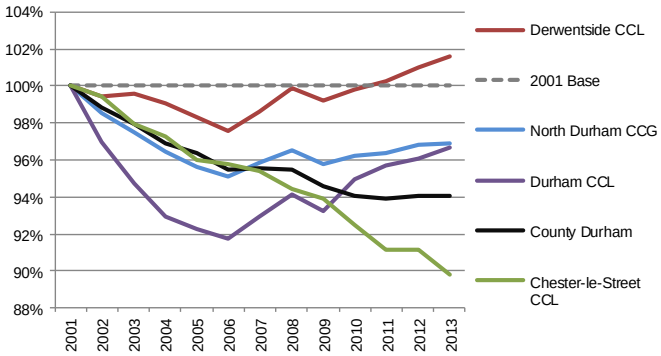
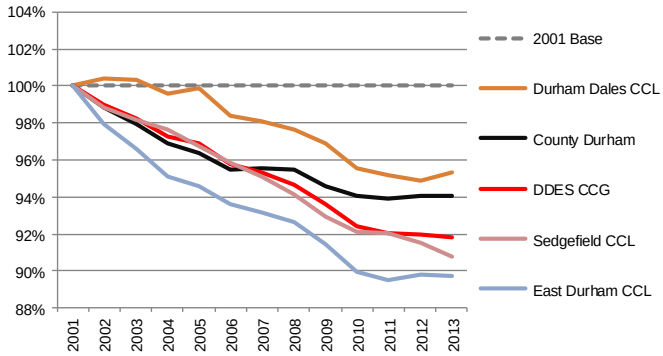


Figure 7b: Population change in the 0 to 17 age groups in DDES CCG: 2001 to 2013



[2] Population data for CCGs and CCLs are available through InstantAtlas reports on the Durham County Council website at http://www.durham.gov.uk/article/2395/InstantAtlas-interactive-reports .

Population (2013) – main age groups – 18 to 64

Both CCGs have seen a rise in this age group since 2001, with North Durham CCG increasing by 5.8% (8,400 people) and DDES CCG increasing by 1.9% (3,100 people). Derwentside CCL and Durham CCL have seen the largest increases in this age group since 2001 of 7.6% (4,000 people) and 9.3% (5,400 people) respectively, while both Chester-le-Street CCL and Sedgefield CCL have both seen a fall in this group of 3.1% (1,000 people) and 1.4% (700 people) respectively.

Figure 8a: Population change in the 18 to 64 age groups in North Durham CCG: 2001 to 2013

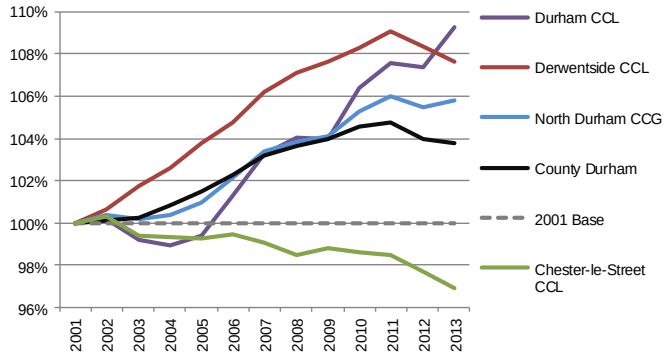
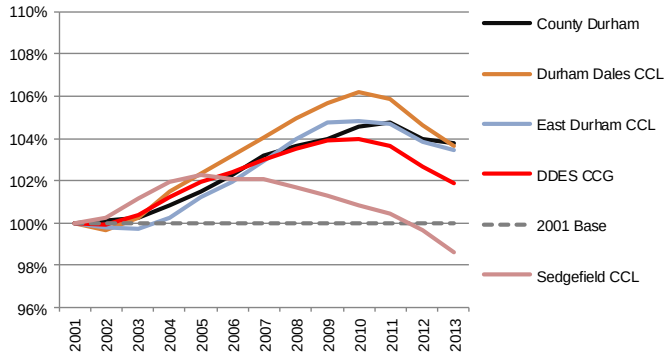


Figure 8b: Population change in the 18 to 64 age groups in DDES CCG: 2001 to 2013



Population (2013) – main age groups – 65+

As with the overall population and in line with changes within the county, all commissioning areas have seen large increases in this age group since 2001, with Chester-le-Street CCL seeing the largest percentage increase of 33.3% (2,800 people) closely followed by Durham CCL with a 31.2% (4,000 people) increase over the same period. Again North Durham CCG has seen the largest percentage increase in this age group with an increase of 26.4% (9,500 people) compared to a 16.8% (7,700 people) increase in DDES CCG.

Figure 9a: Population change in the 65+ age group in North Durham CCG: 2001 to 2013

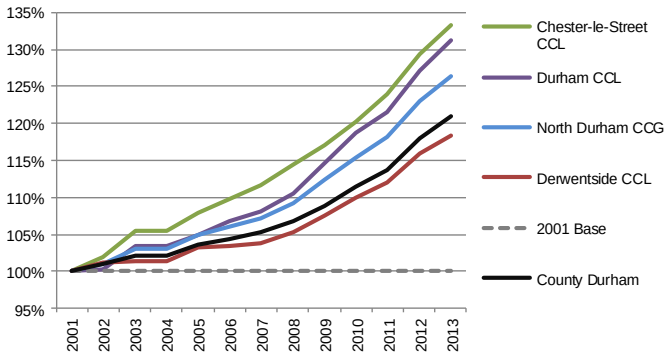
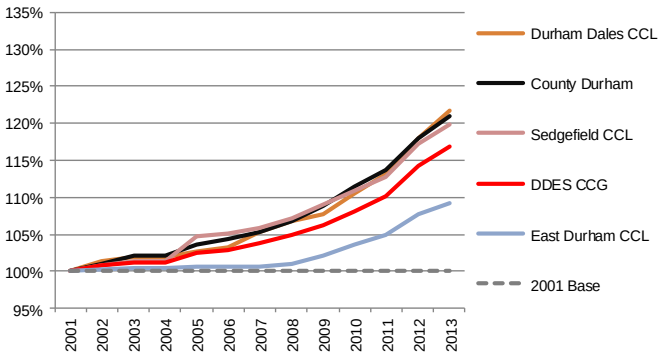


Figure 9b: Population change in the 65+ age group in DDES CCG: 2001 to 2013



Population (2013) – main age groups – 85+

As with the 65+ age group all commissioning areas have seen increases in the 85+ group, with an increase of 33% (1,500) in DDES CCG and 29.5% (1,200 people) in North Durham CCG. Increases of 50% (600 people) were seen in Sedgefield CCL and 39.1% (500 people) in Durham CCL.

Figure 10a: Population change in the 85+ age group in North Durham CCG: 2001 to 2013

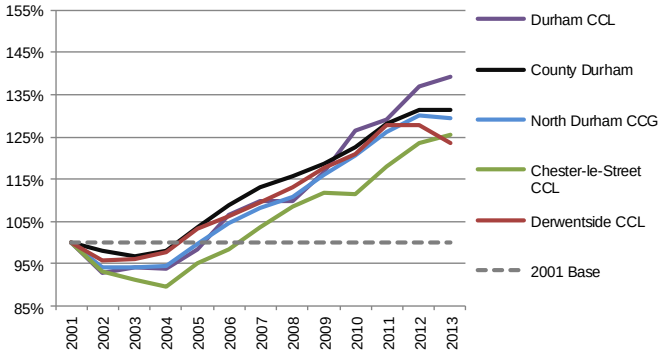
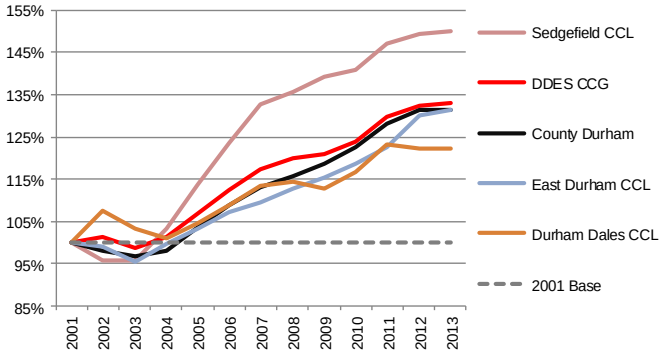


Figure 10b: Population change in the 85+ age group in DDES CCG: 2001 to 2013



Dependency ratios

The growth in the number of older persons combined with a falling working age population will inevitably cause fiscal and service provision problems locally, regionally and nationally within the health and social care sectors. These pressures can be succinctly shown by the dependency ratio, which expresses those who are children and of retirement age as a ratio to working adults[3].

Since 2001 County Durham's overall dependency ratio increased slightly from 617 dependents per 1,000 working age adults to 629 in 2013. However these ratios have fallen slightly regionally (North East has fallen from 635 to 626) while nationally they have increased from 626 to 631. However, as the population ages through to 2030 in the county, this ratio will increase to 776.

With the increase in the retired population, the older person dependency (number of people aged 65+ to working age adults) ratio has increased from 268 to 313 older dependents per 1,000 working adults, a 16.6% rise which is higher than both the regional and national increases. (North East has increased 10.9% from 270 to 299 older dependents, England and Wales by 9.6% from 259 to 284).

However, because of an ageing population, DCC trend based population projections indicate that in County Durham the older people dependency ratio will continue to rise from 304 to 439 by 2030.

[3] The dependency ratio compares how many people there are in the area who are assumed to be working age (16 to 64) against both the number of children (aged 0 to 15) and those of retirement age (aged 65+). Within this document the calculation uses the age groups detailed above: children aged 0 to 17, retired people aged 65+ and working adults aged 18 to 64. A high dependency ratio implies that an area is suffering from the effects of its age structure, with children and the elderly unable to contribute to service provision in the ways that those of working age do. Instead they can be liable to put pressure on local services such as schooling, health, and social care.

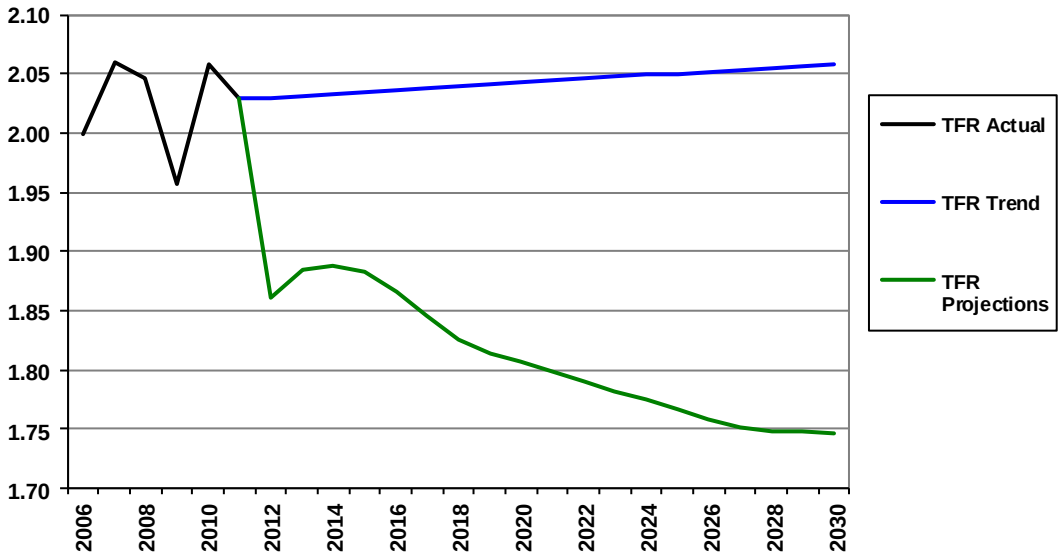
Positive aspects of an ageing population
An ageing population presents various advantages. The Local Government Association has highlighted that, by valuing the contribution that older people make to their communities, it is possible to see the increasingly ageing population as an opportunity. For example, an estimated 65% of volunteers are aged 50 or over (House of Lords: Ready for Ageing? - Select Committee on Public Service and Demographic Change). In the years after retirement, older people have a chance to use their experience, skills and knowledge to pursue new interests and to create organisations, activities and networks to support these interests. Many older people are also involved in the care and support of others – 25% of carers are aged 60 or over, and, by 2030, projections suggest that the number or carers aged 65+ will increase by 30.6% from 14,911 in 2014 to 19,481 (Projecting Older People Population Information 2014).

Fertility and mortality
The total fertility rate (TFR) in England and Wales saw a steady decline during the 1990s, to a low of 1.63 in 2001 and then gradually increased between 2001 and 2008. From 2008 the national TFR has remained relatively stable, fluctuating between 1.90 and 1.94 children per woman, peaking in 2010.

Over this period the TFR in County Durham has remained above the national figure and the latest figures for 2011 give a live births total of 5,829. This is one of the highest annual figures recorded for the county during the recent revival in fertility, and 22.3% higher than the post-war low of 4,768 recorded in 2001.

The chart below shows the recent changes in the TFR for the county and two trend predictions for the fertility rate up to 2030. The increasing trend line is a projected forward rate based on TFRs from 2006 to 2011 and indicates that the underlying fertility rate for the county shows no evidence at the moment of reducing in the fashion suggested by the latest national fertility rate projections. The decreasing line shows the trend predictions from the DCC trend based population projections, which are based on national predictions on how fertility rates will change over the next 20 years. (These national predictions are based on data from 2010).

Figure 11: Change in the total fertility rate and trend prediction to 2030



Households

The county saw a modest increase of 7.5% in its number of dwellings between 2001 and 2011, with a corresponding rise in the number of household spaces of 7.9%, (16,300 dwellings/17,100 household spaces). These increases are similar, as the county has relatively few dwellings with multiple households. With the increase in household spaces, those both occupied and unoccupied have also increased by similar percentages, 7.9% and 8.0% respectively.

DCC trend based household projections based on 2011 Census data and the interim DCC trend based population projections indicate that the number of households in the county will continue to rise, with an additional 11,100 households by 2021 and 22,500 households by 2030 (from a 2011 base). This represents an increase of 5% and 10% respectively.

Changes in the age structure detailed above and household composition have resulted in a small decrease (3.7%) in the average household size since 2001, from 2.32 to 2.24 persons/household space.

Household composition

Overall there was a 15.5% increase in the number of single person households, (9,935 additional households) in the county between 2001 and 2011, compared to a 10% increase regionally and 8.7% increase nationally. This is, in part, due to the increase in single person working age households of 38.6%, (11,000 households), who were aged 16 to 64.

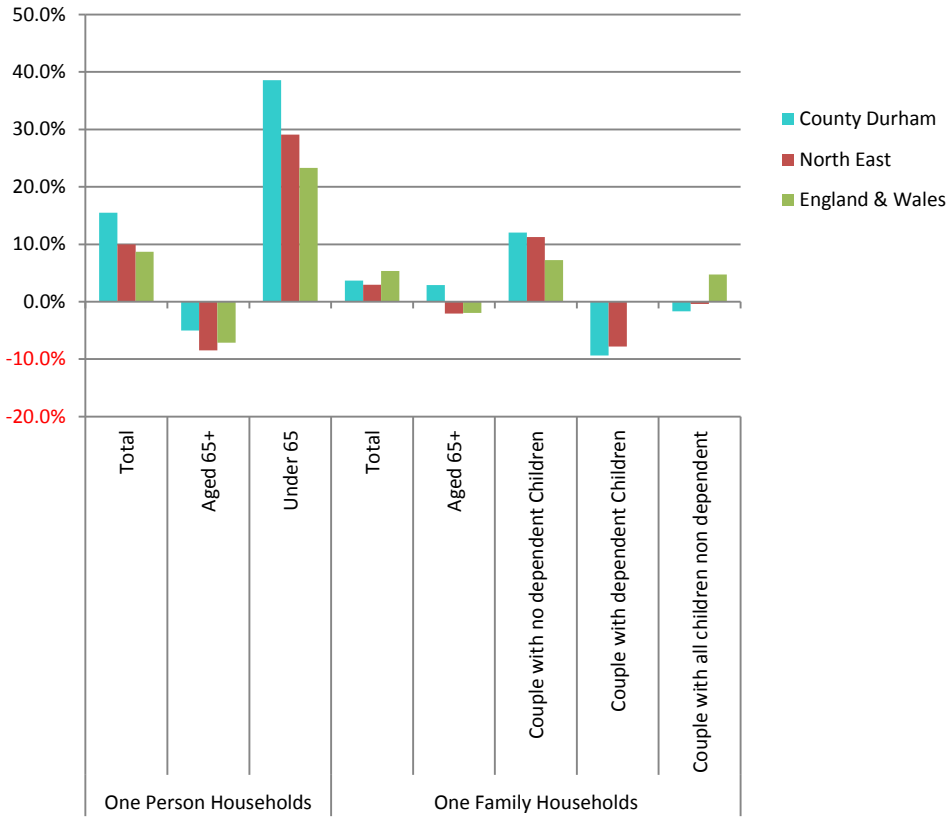
Single person households are projected to continue to increase from 70,000 in 2011 to 72,100 in 2013, and then to 81,800 (DDC projections) by 2030, which reflects an increase of 3% and 16.7% respectively from 2011.

Retired (aged 65+) single person households decreased by 5% between 2001 and 2011, (1,600 households). This fall in retired single person households is similar to the rise in the number of people in communal establishments, (1,200 people) between 2001 and 2011, suggesting an increase in older people entering residential care.

However, this group is predicted to rise from 30,500 households in 2011 to 35,800 in 2021 and then to 40,100 in 2030, increases of 10.6% and 23.8% respectively from 2011. In numbers, this increase will account for 72.3% of the total increase in single person households by 2030.

The number of family households in the county increased by 3.7% (5,000 households) compared to 2.9% in the region and 5.3% nationally between 2001 and 2011. The increase is primarily due to an increase of 21.1% in lone parent households (4,400 households) which is higher than that seen in the region and nationally (16.8% and 20.6% respectively). Figures also suggest that the 12.1% increase in couple households with no dependent children and corresponding falls in couple households with children of 9.4% are due to changes in societal attitudes and the recent economic downturn, with more couples choosing to live together before having children; this is also due to the changes in the ageing population and the increase in male life expectancy.

Figure 12: Percentage change in one person and one family households



DCC trend based projections indicate that by 2030 family households will rise by a further 5.2% to 145,800 households and will mainly be through an increase in lone parent households of 59.6%, (an increase to 28,600 households), while couple family households fall by 2.8%, (a decrease of 3,400 households).

The number of retired (aged 65+) family households also increased over this time period by 2.9%, which is an increase of over 500 households. However, across the North East region and nationally this group fell between 2001 and 2011 by 2.1% and 1.9% respectively. DCC trend based predictions indicate that there will be 11,700 more family households occupied by older couples aged 65+ by 2030, which is a 41.6% increase in older couple households over the projection period. In overall terms this equates to 49.2% of the net increase in households predicted.

With the expansion of Durham University and with more people entering higher education, due to the fall in employment opportunities following the recession in 2008, the number of households composed of full-time students has increased by 103.9% from over 700 to over 1,500 households. This is higher than across the region or nationally (82.3% and 57% respectively).

Social isolation

As the number of single person households and of entirely retired households increases there is an increasing risk of social isolation amongst these populations. With increasing isolation there are also other risks which can affect these groups including increased health and mental health issues, increased poverty (particularly amongst single households) and increased vulnerability to crime. However, it is important to note that social isolation can and does affect other areas of society including the young, ethnic groups and lesbian, gay, bisexual and transgender groups.

Ethnicity

In 1991 only 0.6% of the population in the county was recorded as having a non-white ethnic background, which increased to just over 1% in 2001 and then to 1.85% in 2011. This is an increase from 2,900 people to 9,500 between 1991 and 2011. The main concentrations of people from non-white ethnic backgrounds appear to be from the Durham City area, in particular the student population.

The majority of the ethnic population in the county has an Asian background and accounts for 51.3% of the ethnic population, with 32.7% from mixed backgrounds, 7.4% from a Black/African/Caribbean background and 8.7% from other backgrounds, (the 2001 proportions were broadly similar at 49.1%, 30.8%, 7.9% and 12.0% respectively). The charts below show the distribution of ethnicity within the county and in comparison to the region and national distributions.

Figure 13: Proportion of the ethnic population by ethnic group in County Durham 2011

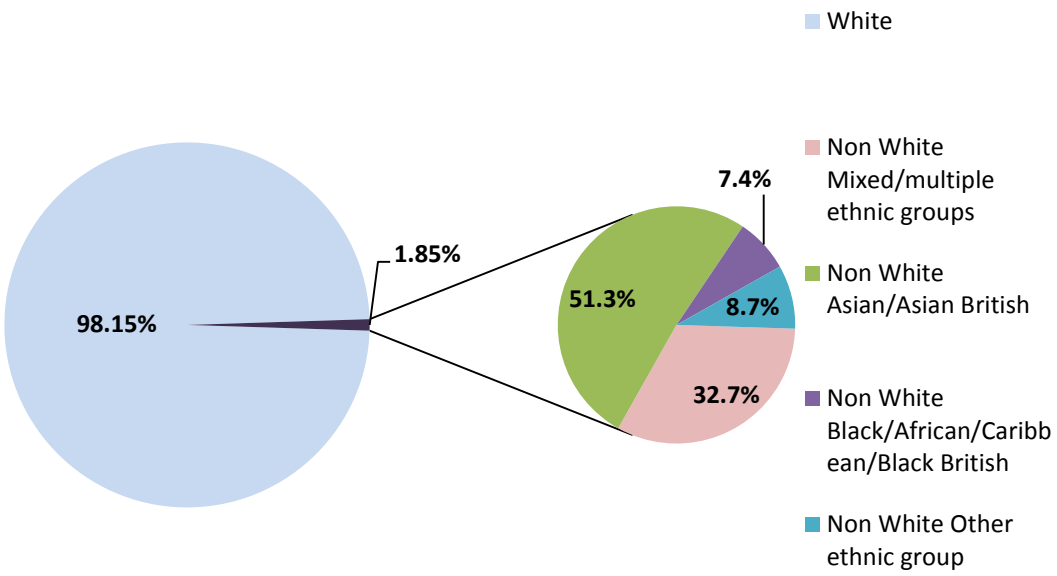
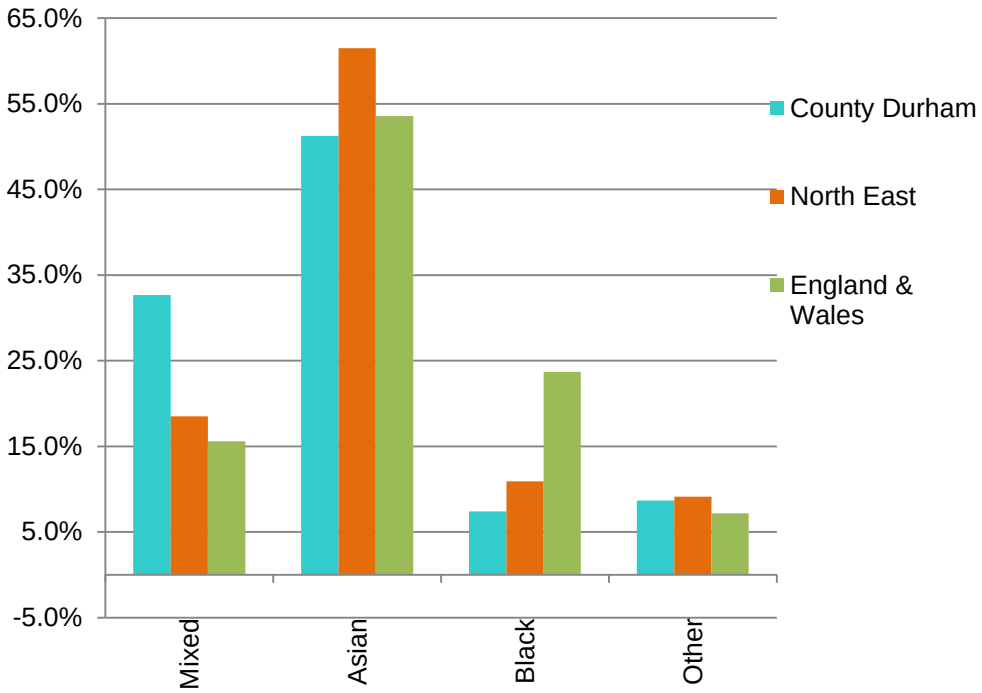


Figure 14: Proportion of the ethnic population by ethnic group 2011



Within the white population 1.4% were from European countries outside of the UK, with the largest proportion (22.9% of these people) living in Durham City, 11.2%

living in Consett, 7.1% in Newton Aycliffe, 6.1% in Seaham and 5.5% in Bishop Auckland, with the remainder distributed around the other settlements in the county.

Religion and belief

The 2011 Census figures showed that almost three in four (72%) County Durham residents answering the question on religion were Christian, which is almost 42,500 people less than in 2001 when the percentage for Christians was 83.5%. Around a fifth (21%) said that they had no religion, more than double the 2001 proportion. Those who recorded their religion as Buddhist, Hindu, Jewish, Muslim and Sikh or said that they had 'other religious beliefs' make up just over 1% of the population. Around 6% of people did not answer this question on the latest Census.

Sexual orientation

There are no reliable figures showing the local profile of sexual orientation. However national estimates[4] are that between 5% and 7% of the population are lesbian, gay or bisexual.

Health

There has been little change in the county, regionally or nationally in the proportion of the population with a limiting long term illness (LLTI) in 2011, with only small changes seen in these areas, however the percentage of the population in the county reporting a LLTI was greater than that reported in the region and nationally. The number of people in North Durham CCG with a LLTI increased by 2.7% between 2001 and 2011 while DDES CCG reported a small decrease of 1.6%, mainly due to a 7.9% fall in Easington CCL. Details of these changes are given in the table below.

Table 4: Changes in the number of people reporting a LLTI by CCG and CCL (Census)

	Population	Count	Proportion[1]	% Change[2]	Change: Number
North Durham CCG	**240,244**	**51,800**	**21.6**	**2.7**	**1,400**
Derwentside CCL	91,752	21,600	23.5	1.8	400
Chester-le-Street CCL	54,117	11,700	21.6	1.1	100
Durham CCL	94,375	18,500	19.6	4.9	900
DDES CCG	**272,998**	**69,500**	**25.5**	**-1.6**	**-1,100**
Durham Dales CCL	90,097	21,100	23.4	5.4	1,100
Easington CCL	95,131	26,700	28.1	-7.9	-2,300
Sedgefield CCL	87,770	21,700	24.7	0.4	100
County Durham	**513,242**	**121,300**	**23.6**	**0.2**	**300**
North East	**2,596,886**	**562,200**	**21.6**	**-1.7**	**-9,500**
England and Wales	**56,075,912**	**10,048,400**	**17.9**	**5.9**	**563,600**

Source: 2011 Census

1. Proportion of the total population in the area.

2. Percentage change in people with a LLTI 2001 to 2011.

[4] Stonewall 2012

Self-reported very good/good general health from the 2011 Census shows that the county still falls behind the region and England and Wales, with 75.8% of the population reporting very good/good health (North East 77.3% and England and Wales 81.2%). Table 5 below provides further details.

Table 5: General health by CCG and CCL

	General Health[1]				
	Very Good	**Good**	**Fair**	**Bad**	**Very Bad**
North Durham CCG	**44.2**	**33.5**	**15.1**	**5.6**	**1.6**
Derwentside CCL	41.5	34.0	16.3	6.3	1.9
Chester-le-Street CCL	43.8	33.7	15.4	5.5	1.5
Durham CCL	47.1	32.7	13.8	5.0	1.4
DDES CCG	**40.7**	**33.4**	**16.9**	**7.0**	**2.0**
Durham Dales CCL	42.0	34.1	16.0	6.2	1.7
Easington CCL	39.7	32.0	17.7	8.2	2.4
Sedgefield CCL	40.5	34.1	16.9	6.6	2.0
County Durham	**42.4**	**33.4**	**16.1**	**6.3**	**1.8**
North East	**44.0**	**33.3**	**15.2**	**5.8**	**1.7**
England and Wales	**47.1**	**34.1**	**13.2**	**4.3**	**1.3**

Source: 2011 Census

1. Proportion of the total population in the area.

Nationally, the number of older people living with a limiting long term illness is predicted to rise (39.4%) by 2030. (Source: POPPI, July 2014)

Table 6: People aged 65 and over with a LLTI, projected to 2030

	2014	**2015**	**2020**	**2025**	**2030**
Total population aged 65 and over with a limiting long term illness whose day-to-day activities are limited a little	27,956	28,574	31,303	34,498	37,939
Total population aged 65 and over with a limiting long term illness whose day-to-day activities are limited a lot	31,617	32,346	35,947	40,509	45,110
Total population aged 65 and over with a limiting long term illness	59,573	60,920	67,250	75,007	83,049

(Source: POPPI, July 2014)

Provision of unpaid care

While the county and region reported a small reduction in people providing up to 19 hours of unpaid care per week of 2.2% and 3.4% respectively, nationally the figure increased by 3.1%.

Overall there has been an increase in the proportion of the population providing some level of unpaid care, with a 4.9% increase in the county, 3.5% in the North East and 11.2% in England and Wales. The largest increases were seen in Derwentside CCL (8.8%) and Durham Dales CCL (9.1%) as detailed below.

Table 7: Changes in the provision of unpaid care CCG and CCL

	Population	Count	Proportion[1]	% Change[2]	Change: Number
North Durham CCG	**240,244**	**27,100**	**11.3**	**7.0**	**1,800**
Derwentside CCL	91,752	10,700	11.7	8.8	800
Chester-le-Street CCL	54,117	6,400	11.8	3.2	200
Durham CCL	94,375	10,000	10.6	7.9	700
DDES CCG	**272,998**	**33,000**	**12.1**	**3.3**	**1,100**
Durham Dales CCL	90,097	10,600	11.8	9.1	900
Easington CCL	95,131	11,800	12.4	-1.5	-200
Sedgefield CCL	87,770	10,600	12.1	3.5	400
County Durham	**513,242**	**60,100**	**11.7**	**4.9**	**2,800**
North East	**2,596,886**	**286,400**	**11.0**	**3.5**	**9,800**
England and Wales	**56,075,912**	**5,800,200**	**10.3**	**11.2**	**582,400**

Source: 2011 Census

1. Proportion of the total population in the area.

2. Percentage change in people providing some unpaid care 2001 to 2011.

These three areas (county, region, national) all reported an increase in people providing 20 to 50 hours unpaid care per week of 15.9%, 16.9% and 35.1% respectively. People providing unpaid care for 50 hours or more per week also increased by 16.4% in the county, 14.0% in the North East and 25.0% in England and Wales.

Deprivation

Since the 1970s the Department of Communities and Local Government and its predecessors have calculated various local measures of deprivation in England, with the latest release in 2010. It is important to note that these statistics are a relative measure of deprivation, not affluence, and to recognise that not every person in a highly deprived area will themselves be deprived. Equally, there will be some deprived people living in the least deprived areas.

Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial. The English Indices of Deprivation attempt to measure a broader concept of multiple deprivation, made up of several distinct dimensions, or domains, of deprivation.

The English Indices of Deprivation 2010 use 38 separate indicators (see Table 8 below), organised across seven distinct domains of deprivation which can be combined, using appropriate weights, to calculate the Index of Multiple Deprivation 2010 (ID2010). This is an overall measure of multiple deprivation experienced by people living in an area and is calculated for every Lower layer Super Output Area in England. A LSOA is an area with an approximate population of 1,500 persons and there are 32,482 LSOAs in England. The ID2010 can be used to rank every LSOA in England according to their relative level of deprivation.

Table 8: Breakdown of ID2010 indicators by domain

Domain	Indicators
Income (22.5% of overall index)	Adults and children in Income Support families Adults and children in income-based Jobseekers Allowance families Adults and children in Pension Credit (Guarantee) families Adults and children in Child Tax Credit families Asylum seekers receiving subsistence/accommodation support
Employment (22.5% of overall index)	Claimants of Jobseeker's Allowance Claimants of Incapacity Benefits Claimants of Severe Disablement Allowance Claimants of Employment and Support Allowance Participants in New Deal for under 25s Participants in New Deal for 25+ Participants in New Deal for Lone Parents
Health (13.5% of overall index)	Years of Potential Life Lost Comparative illness and disability ratio Acute morbidity Mood or anxiety disorders
Education (13.5% of overall index)	KS2 attainment KS3 attainment KS4 attainment Secondary school absence Staying on in education Entry to higher education Adult skills
Barriers to housing services (9.3% of overall index)	Geographical barriers: Road distance to a GP Supermarket or convenience store Primary school Post Office Wider Barriers Overcrowding Housing affordability Homelessness
Crime (9.3% of overall index)	Recorded crime rates for the following composite indicators: Burglary Violence Theft Criminal damage
Living environment (9.3% of overall index)	Indoors living environment: Housing in poor condition Houses without central heating Outdoors living environment: Air quality Road traffic accidents

Source: Indices of Deprivation 2010

Around 1 in 10 people (11.4%) in the county live in the top 10% most deprived areas nationally. This rises up to nearly half the population (45.5%) experiencing some form of deprivation when extended to the top 30% most deprived areas. Nationally the figures are 10% and 30%.

Within the Clinical Commissioning Localities / Constituencies there are wide inequalities with regards to deprivation, particularly within Easington where nearly three quarters of the population (74.1%) live in deprived areas. Sedgefield also experiences high deprivation levels where 50.2% of the population live in deprived areas. Of all the six localities, only Durham has a lower percentage of population living in deprived areas than those nationally at 20.8%, (details by locality are given below).

In terms of deprivation, County Durham is a diverse area and it should be noted that pockets of relative deprivation exist across the county, even in less deprived Clinical Commissioning Localities such as Durham and Chester-le-Street which contain some communities experiencing consistently high and intense levels of multiple deprivation.

Table 9: Population living in deprived areas by CCL and CCG

	Proportion[1] of the area's population living in LSOAs:		
	Not deprived	Top 10% most deprived nationally	Top 30 % most deprived nationally
North Durham CCG	**66.8**	**2.0**	**33.2**
Derwentside CCL	55.2	1.8	44.8
Chester-le-Street CCL	64.1	2.9	35.9
Durham CCL	79.2	1.7	20.8
DDES CCG	**43.9**	**19.6**	**56.1**
Durham Dales CCL	57.5	20.5	42.5
Easington CCL	25.9	28.5	74.1
Sedgefield CCL	49.8	9.0	50.2
County Durham	**54.5**	**11.4**	**45.5**

Source: Indices of Deprivation 2010, ONS 2008 Population Estimates.

1. Proportion of the total population in the area.

Key messages

- One of the key challenges in delivering services in County Durham is scale. The county has the sixth largest population of all single tier local authorities in the country.
- Since 2001 the county's population has grown by 4.5%, with the strongest growth in North Durham CCG, particularly in the Derwentside and Durham City localities.
- The council's population projections suggest these increases in the county's population for the foreseeable future.
- The county has an ageing population and changing demographic structures which are likely to affect the scale of needs for health and social care services.
- The 65+ age group will increase from almost one in five people in 2013 to nearly one in four people by 2030, an increase of 39.8% from 2013, (Projections for England suggest that the 65+ population will increase by 42% over the same period).

- The proportion of the county's population aged 85+ is predicted to almost double (+95.2%) by 2030. (Projections for England suggest that the 85+ population will increase by 85% over the same period).
- These increases in the older population in County Durham are predicted to be greatest in the male population.
- The number of young people will increase by 6.5% by 2030, reversing some of the declining trends seen prior to 2011. Projections for England suggest that the 0-17 population will increase by 8.3% by 2030.
- DCC trend based projections indicate that the proportion of the county's population aged 18-64 is predicted to fall to 56.3% by 2030 (a fall of 1,900 people or 0.6% of the total population).

Altogether Better for Children and Young People

1. Introduction

Across County Durham there are some very specific needs for services to support children and young people to achieve positive outcomes. Children and young people are our future and it is vital that we foster a multi-agency approach to tackling the *causes* of negative outcomes. The specific needs for children and young people have been identified through performance indicators which perform worse than comparators, including statistical neighbours (e.g. local authorities which share similar characteristics to Durham) or through higher than average numbers of children and young people requiring certain services. In addition, local, regional and national research and the feedback we have gathered from children, young people and families have been used to identify need.

A vision for children's services in County Durham
In County Durham, a vision for service has been emerging over a number of years, which is that:-

- All partners will work together to empower families and communities, using the minimum necessary statutory intervention.
- We will work to avoid need by offering effective preventative services, identifying need early and offering practical support. Where a child's wellbeing or safety is compromised, we will act swiftly to ensure that safeguards are in place, including use of legal powers where unavoidable.

If we succeed in working in this way, we believe the numbers of children who need to be looked after and those with a protection plan will decrease, and we will increase the number of families receiving help at an earlier level.

A framework of need has been developed, setting out clearly the support required at each level of need. This has been further developed alongside the 'Durham Staircase' of need, which is a tool used to simplify and illustrate for all partners the levels of need.

County Durham has been on a transformation journey over the past number of years. A number of pilot projects have been run in Children's Services since 2009: the Family Pathfinder, the Pre-Birth Assessment pilot, the Children in Need pilot and the Team Around the School pilot. Learning from these has driven broader reform of structures and processes, and will continue to do so as reform progresses. The One Point service was created in 2011. This brought together a range of early help services, including community health services, to provide an integrated response to early need with a single point of access. Early intervention and involvement services and children's social care services were brought together into a single Children's Services in October 2013. This created the conditions necessary to move ahead in a co-ordinated way across the whole continuum of need.

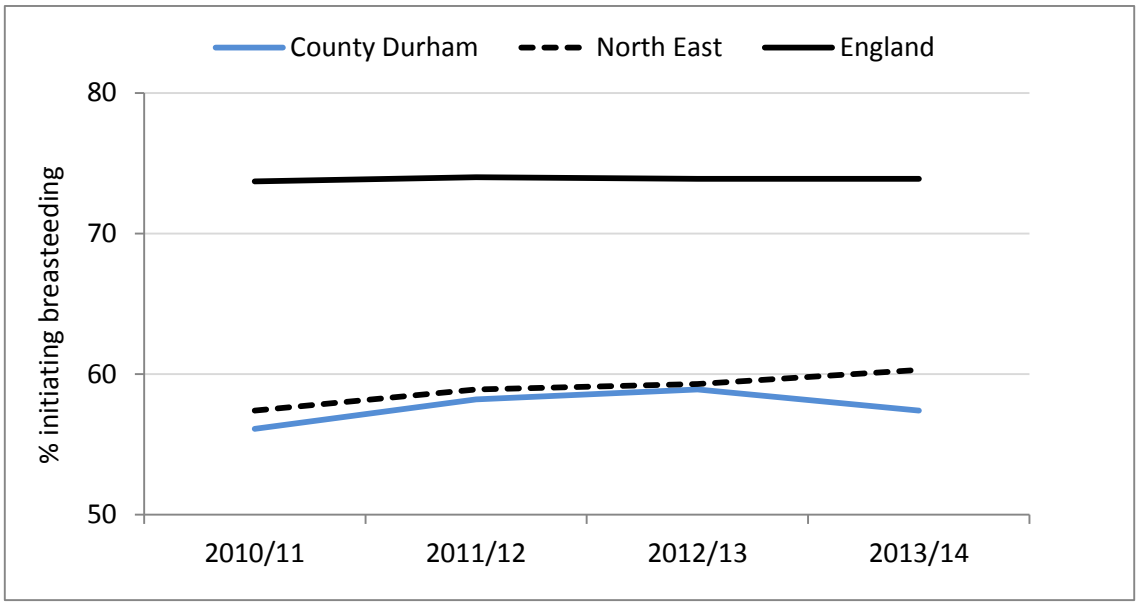
2. What are the levels of need?

The following information provides an analysis of the needs of children and young people in County Durham.

Breastfeeding
There is a clear association between reduced rates of breastfeeding and deprivation. Breastfeeding duration has been found to be associated with socio-economic indicators and levels of multiple deprivation (Brown et al., 2010).

There are acknowledged links between sustained breastfeeding and a reduced risk of childhood obesity. There is significant reliable evidence to demonstrate that breastfeeding is a major contributor to public health and has an important role to play in reducing health inequalities.

Figure 15: Breastfeeding initiation, County Durham, North East and England, 2010/11 to 2013/14

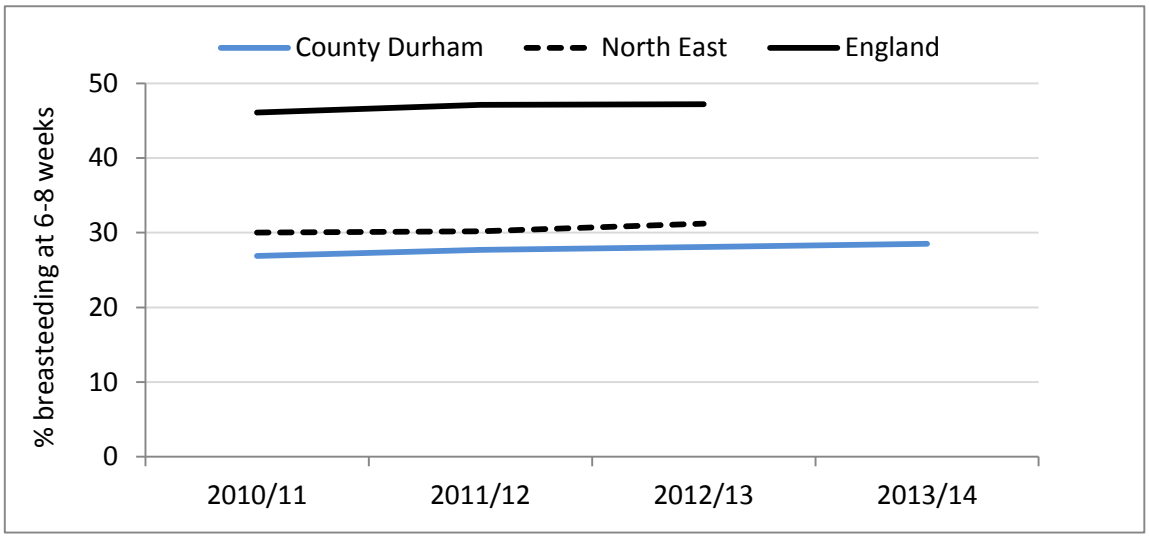


	2010/11	2011/12	2012/13	2013/14
County Durham	**56.1**	**58.2**	**58.9**	**57.4**
North East	57.4	58.9	59.3	60.3
England	73.7	74	73.9	73.9

Source: Public Health Outcomes Framework, Public Health England, February 2015

Breastfeeding initiation and prevalence is lower in County Durham than England and the North East. The proportion of women who start to breastfeed in County Durham (57.4%) is significantly lower than the England average (73.9%) and has been so over time. Breastfeeding initiation in County Durham fell from 59.3% in 2012/13 to 57.4% in 2013/14.

Figure 16: Breastfeeding prevalence at 6-8 weeks, County Durham, North East and England, 2010/11 to 2013/14



	2010/11	2011/12	2012/13	2013/14
County Durham	**26.9**	**27.7**	**28.1**	28.5
North East	30	30.2	31.2	-
England	46.1	47.1	47.2	-

Source: Public Health Outcomes Framework, Public Health England, February 2015

Breastfeeding prevalence at 6 to 8 weeks from birth has been rising slowly over time in County Durham. The proportion of women breastfeeding at 6 to 8 weeks in County Durham has risen from 26.9% in 2010/11 to 28.5% in 2013/14. The figure for 2012/13 (28.1%) remains lower than the national average (47.2%). A national and regional figure for 2013/14 was unavailable at the time of writing.

Excess weight in children

Excess weight (overweight and obese) is a key public health issue, posing a major health challenge and risk to future health and wellbeing (such as increased rates of type 2 diabetes, heart disease) and life expectancy in County Durham.

In childhood, excess weight can directly cause mobility problems, hypertension and abnormalities in glucose metabolism (Department for Children Schools and Families and Department of Health 2009). In addition there may be emotional issues related to low self-esteem. The stigmatisation of obesity which is heightened in adolescence may lead to bullying or exclusion from the peer group.

Very rapid weight gain in early childhood is also associated with later obesity independent of birth weight (Power and Jefferis, 2002 and Jones et al, 2007). Overweight young people have a 50% chance of being overweight adults and, unless childhood obesity is addressed, this is likely to increase demand on the NHS and adults services due to the health problems associated with adult obesity.

In 2011, the new national strategy for obesity 'Healthy Weight, Healthy Lives: A call to action on obesity in England', set a new ambition to achieve a sustained downward trend in overweight children by 2020 (Department of Health, 2011).

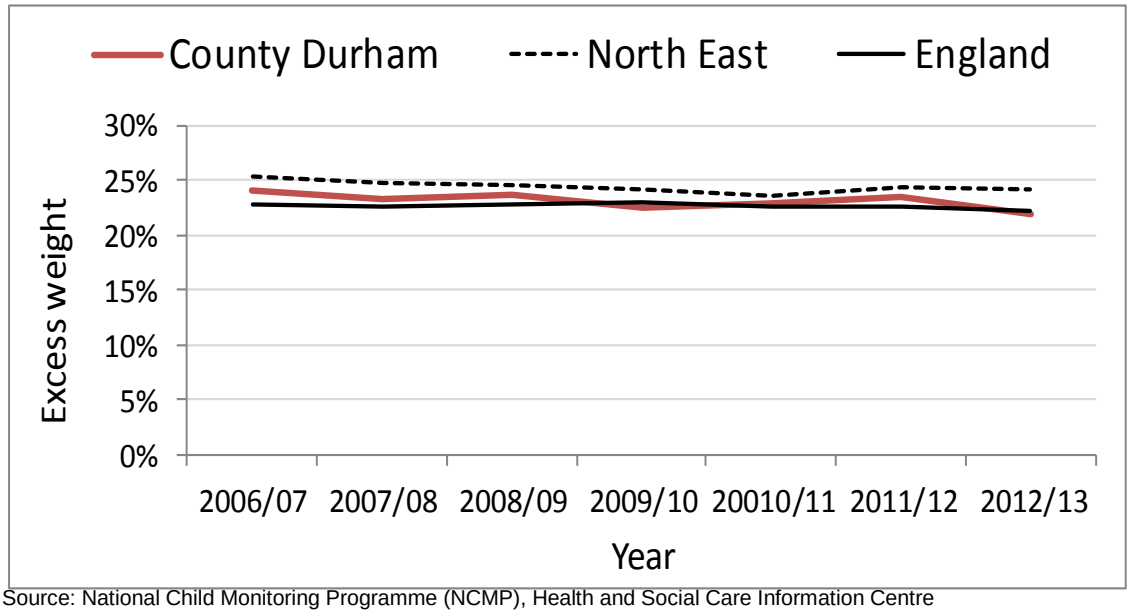
Levels of obesity in County Durham are worse than the England average and disproportionately affect the least well off in year 6.

The National Child Measurement Programme (NCMP), delivered by the school nursing service, is an important element of the work programme on childhood obesity. The school nursing service is responsible for assessing and determining individual and local needs. The service leads and delivers the Healthy Child Programme 5-19, using evidence-based practice to support children and young people. The service promotes a number of national priorities such as supporting healthy schools; promoting good mental health and wellbeing for children and their families; increasing population vaccination cover; reducing tooth decay in children; addressing excess weight in 4-5 and 10-11 year olds; promoting sexual health and contraception; reducing smoking prevalence in 15 year olds and addressing alcohol and drug misuse.

Every year, as part of the NCMP, children in reception and year 6 are weighed and measured during the school year to inform local planning and delivery of services for children. This also gathers population-level surveillance data to allow analysis of trends in growth patterns and obesity.

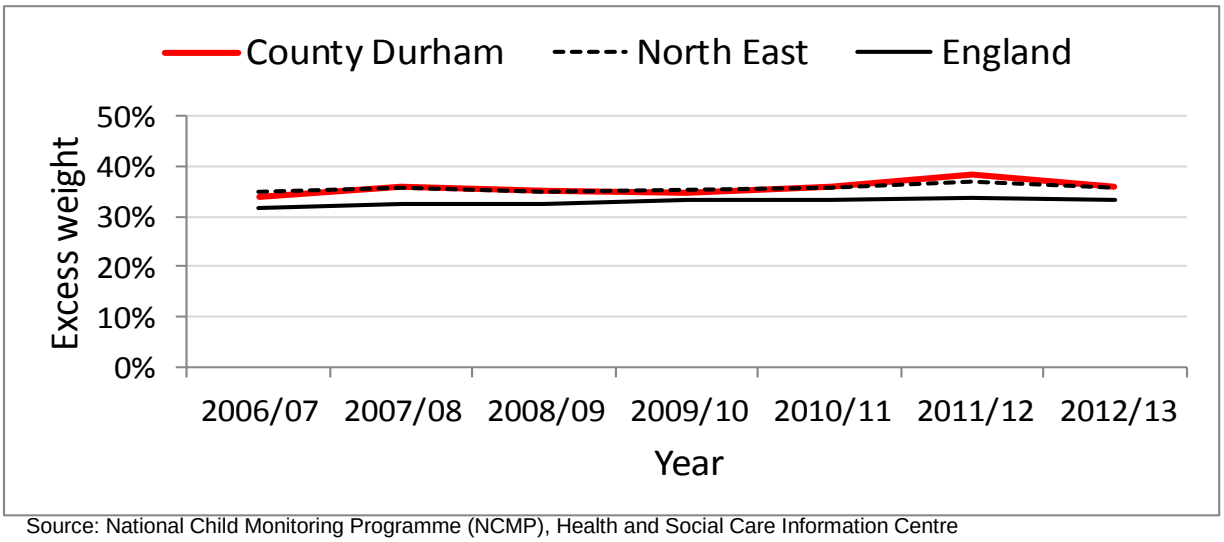
In County Durham, excess weight in children of reception age is not significantly different to England or the North East (Figure 17). Prevalence of excess weight in reception experienced a gradual decline in both County Durham and the North East. Nationally, prevalence at reception age has experienced little variation over time.

Figure 17: Prevalence of excess weight in children aged 4-5 (reception), England, the North East and County Durham, 2006/07 to 2012/13



Source: National Child Monitoring Programme (NCMP), Health and Social Care Information Centre

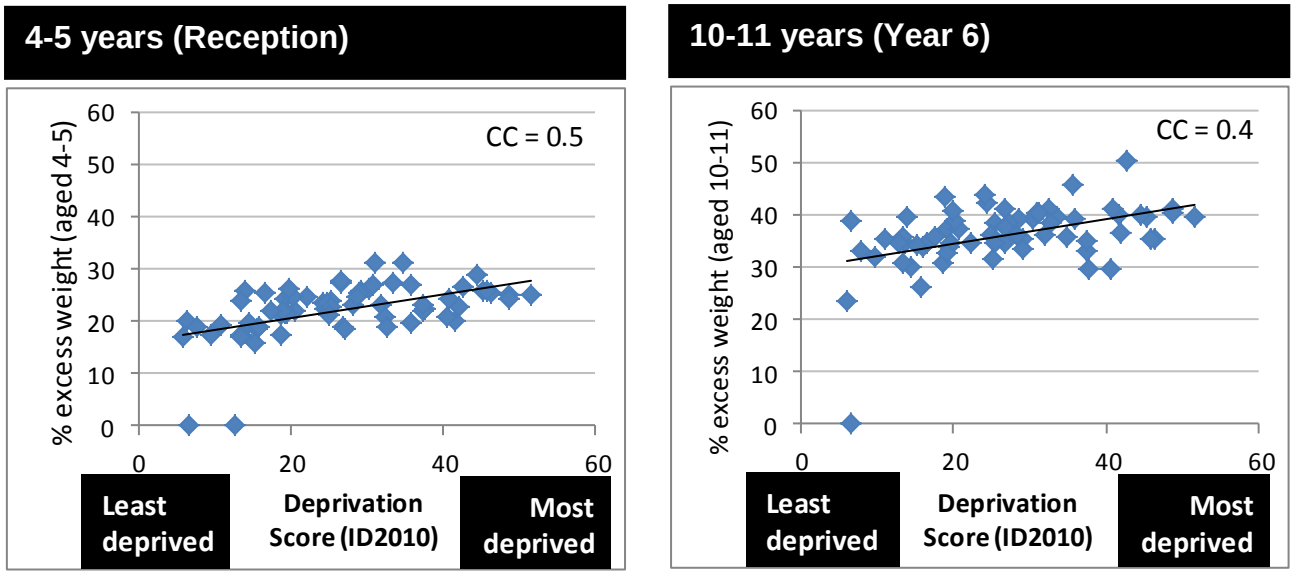
Figure 18: Prevalence of excess weight in children aged 10-11 (year 6), England, North East and County Durham, 2006/07 to 2012/13



Source: National Child Monitoring Programme (NCMP), Health and Social Care Information Centre

Prevalence of excess weight for 10-11 year olds in County Durham (35.9%) is significantly higher than England (33.3%), but not significantly different to the North East. Prevalence of excess weight for children in year six has seen little variation over time either locally, regionally or nationally. In County Durham, the proportion of children classified as being of excess weight in year 6 is around 50% of those children in reception.

Figure 19: Excess weight prevalence by school year, 2010/11-2012/13, and deprivation score (overall score, ID2010), County Durham MSOAs



Source: National Child Monitoring Programme (NCMP), Health and Social Care Information Centre

Locally the distribution of childhood obesity rates is unequal, although the relationship to deprivation is moderate for those aged 4-5 (CC=0.5) and weaker for those aged 10-11 (cc=0.4).

In terms of supporting and educating children and young people to make healthy food choices, the take-up of school lunches in both primary and secondary schools is

measured. The take-up of school lunches in primary schools in 2011 was significantly higher (65.5%) than in secondary schools (54.4%).

Physical activity levels for children in County Durham are significantly higher than the English average. 56.7% of children in years 1 – 13 spend at least 3 hours per week on high quality PE and school sport compared to 55.1% nationally (Child Health Profile 2013). Data is no longer available in the 2014 Profile.

Teenage conceptions

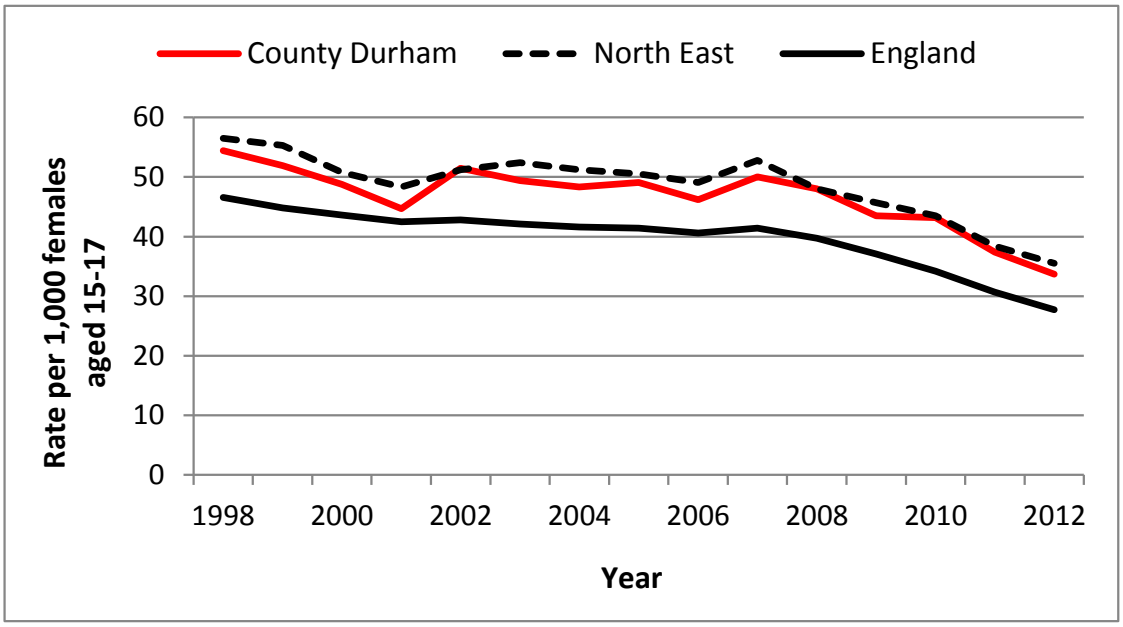
Teenage pregnancy is a significant public health issue, impacting on inequalities, social exclusion, as well as the life chances and health and wellbeing of teenage parents and their children.

Over the last 10 years, approximately 100 babies were born to teenage mothers in County Durham each year. Young people can be competent parents, but long term studies show that children born to teenagers are more likely to experience a range of negative outcomes in later life (such as higher accident rates, higher mortality rates and increased likelihood of behavioural problems) and they are up to three times more likely to become teenage parents themselves.

Prevention of under-18 conception gives children a better start. Teenage pregnancy is strongly associated with the most deprived and socially excluded young people. Difficulties in young people's lives, such as poor family relationships, low self-esteem and unhappiness at school also put them at greater risk.

Some teenage pregnancies are unplanned, some are unwanted and some represent the low aspirations of young women. Evidence shows that having a baby at a relatively young age can damage young women's health and wellbeing and limit their education and career prospects.

Figure 20: Conception rate per 1,000 females aged 15-17 years, 1998 to 2012, England, North East and County Durham



Source: Conception Statistics, Office for National Statistics, 2014

Teenage conception rates (15-17 year olds) in County Durham (33.7) remain higher than the national rate (27.7) but are lower than the North East (35.5). The absolute gap between County Durham and England has fallen from 7.8 per 1,000 (1998 baseline) to 6 per 1,000 (2012). Teenage conception rates to 2012 have seen similar levels of reduction from the 1998 basline. The rate in County Durham has fallen by 38% compared to a 41% reduction in England and 37% in the North East.

For under-16 conceptions (13-15 year olds) the County Durham rate has varied across the years and in 2012 was higher than England, the North East and similar council averages.

Oral health

Good oral health is essential for everybody's wellbeing. Poor oral health can affect someone's ability to eat, speak, smile and socialise normally, for example, due to pain or social embarrassment. Prevention of dental disease and oral health rehabilitation are essential to secure the health of our population. There is a significant burden of ill health from oral disease within our population, from the development of new disease and maintenance of restorations.

Oral health problems include gum (periodontal) disease, tooth decay (dental caries), tooth loss and oral cancers.

Many of the risk factors – diet, oral hygiene, smoking, alcohol, stress and trauma – are the same as for many chronic conditions, such as cancer, diabetes and heart disease. As a result, interventions which aim to tackle these risk factors (taking a 'common risk factor approach') will improve general health as well as oral health (Watt and Sheiham 2012).

Children's tooth decay at age 5 in County Durham in 2011/12 (0.93%) was not significantly different to England (0.94%) and was lower than the North East (1.02%). However, there are wide variations in the oral health of 5 year old children across areas of the county.

Immunisations and vaccinations

Immunisation can protect individuals and communities from serious infectious diseases and has caused dramatic improvements in health with diphtheria, tetanus, whooping cough (pertussis), measles and polio now rare in many countries. After the availability of clean water, it is the most effective public health intervention globally for saving lives and promoting good health.

All children in the UK are offered vaccinations against key diseases, as part of the national childhood immunisation schedule. Vaccinations can prevent children from getting serious diseases which can kill or cause long-term health problems. Vaccinated babies are much less likely to suffer the devastating consequences of disease. Immunisations are commissioned by NHS England and the role of the Director of Public Health County Durham is to provide assurance to the Health and Wellbeing Board on how these programmes are being delivered locally.

It is important to ensure that the immunisation service is equitable and accessible to all, avoiding intervention generated health inequalities, which can emerge if effective

public health interventions are not used fairly and equally by different population groups. There is evidence that many efforts to improve health and prevent disease may disproportionately benefit less disadvantaged groups or communities. Often those with higher incomes or more education are better able to make use of opportunities for improving health / preventing disease, such as immunisation programmes.

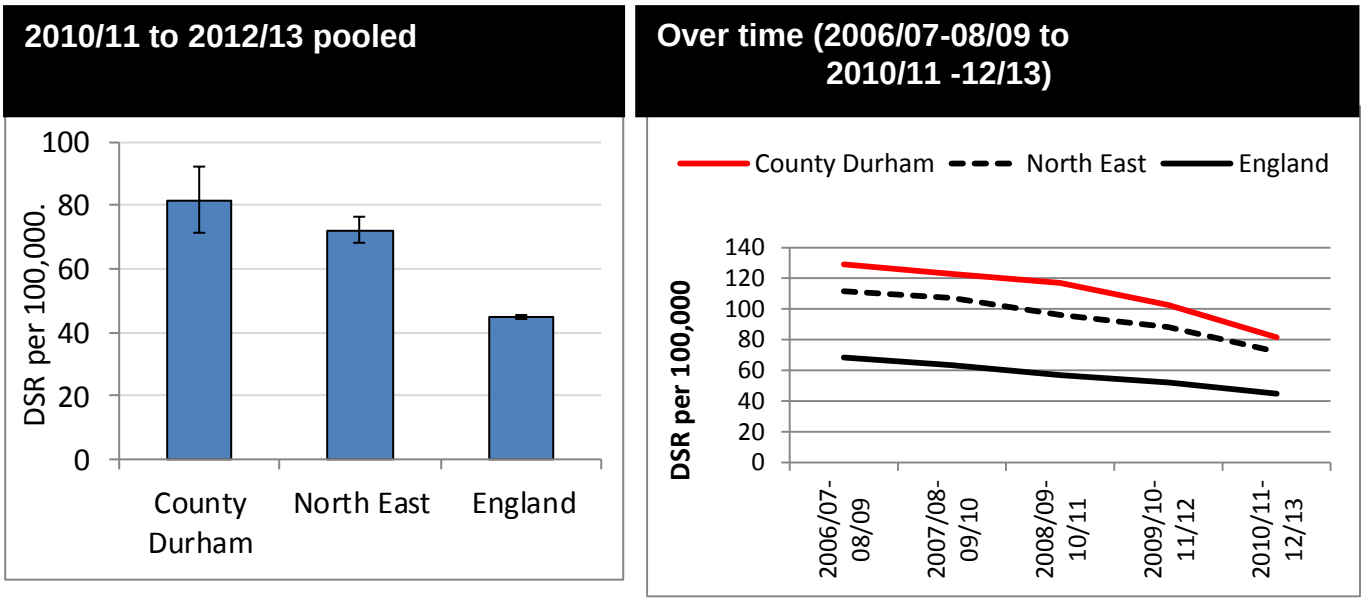
In County Durham, vaccination coverage for many childhood diseases is significantly better than England and the North East:

- 96.1% of those eligible received their first dose of the MMR immunisation by the age of two (2012/13), which was higher than England (92.3%) and the North East (94.1%).
- 93.3% of children in County Durham received their second dose of MMR immunisation by the age of five (2012/13), which was higher than England (87.7%) but lower than the North East (97.1%).
- 97.1% of eligible children received the completed course of Meningitis C vaccine by their first birthday, which was higher than England (93.9%) and the North East (96%).

Alcohol and drugs

Young people who drink alcohol are more likely to fall behind at school, play truant, become a victim or perpetrator of violence / anti-social behaviour and increase their sexual risk-taking behaviour.

Figure 21: Under 18 alcohol-specific hospital admission rate per 100,000 persons, 2010/11-2012/13 pooled and over time (2006/07-2008/09 pooled to 2010/11-2012/13, England, North East and County Durham.



Source: County Durham LAPE 2014 (Local Alcohol Profiles for England), Public Health England

Under 18 alcohol specific hospital admission rates per 100,000 are significantly higher in County Durham (81.5) than England (44.9), and higher than the North East rate (72.2). County Durham is ranked 18th worst out of 326 local authorities. Rates have been falling over time in County Durham, the North East and England.

Proportionally this decrease has been greater in County Durham (37%) than the North East (35%) and England (34%).

Nationally, nearly half (48.0%) of underage drinkers report that they obtain alcohol from their parents. Young people are now regularly drinking higher strength drinks including spirits. Although fewer young people are drinking, those doing so are drinking more frequently and consuming higher strength drinks.

Data from the annual Children and Young People's Survey 2014 show that 20.8% of young people who participated in the survey (year 9 only) always/sometimes drank alcohol. 2.2% of young people responded that they always/sometimes took drugs (year 9 only).

Studies suggest that socially excluded groups of young people, such as school truants and excluded pupils, offenders, children in the care of local authorities and those with parents who use drugs, tend to report higher rates of drug use than other young people.

Cannabis use in the UK has been declining for several years, and the decline has been greatest in younger age groups, although recently there has been a levelling off. The decline in cannabis use is seen in surveys of both school children and adults. Data from ESPAD (the European School Project on Alcohol and other Drugs: a survey of school children conducted across much of Europe) also show the marked decline in prevalence of cannabis use among 15 to 16 year old schoolchildren in the UK between 2003 and 2011.
In England, the prevalence of problem drug use has recently started to decline due to a reduction in problem opiate use. Since the decline in problem drug use is driven by a decrease in both the prevalence rate and number of drug users in the younger age groups, it appears that the number of new users is also decreasing (A fresh approach to drugs: The final report of the UK Drug Policy Commission, October 2012).

The most recent County Durham Children's Health Profile (March 2014) identifies that although the rate of admission to hospital for substance abuse (aged 15-24) in Durham has dropped from 105.6 per 100,000 in 2009-12 to 94.6 in 2010-13, it is still above the national rates of 75.2

Data from the NHS National Treatment Agency for Substance Misuse show that 31.0% (636) of those adults receiving treatment have children who live at home, whilst 21.0% (434) are parents but do not live with any children. Parental substance misuse and the links with children becoming subject to a child protection plan / looked after are well recognised. (Further information can be found in the Altogether Safer section).

In 2013/14, 23.8% of all offences were alcohol related compared to 25.9% in 2012/13. A total of 306 offences were alcohol related, which is a 20.1% reduction on the previous year. This reduction is also reflected in the number of young people committing alcohol related offences, where there was a 21.5% decrease from 233 to 183 young people. With the exception of Sedgefield, a reduction in the number of

alcohol related offences committed was also seen at local level (former Local Children's Board areas), with the biggest decrease seen in Easington (44.6%).

Table 10: Alcohol related offences committed by local area

Local Area	10-17 years Population*	2012/13		2013/14		% change (in number of offences) against 2012/13
		Number of offences	Rate per 1,000 10-17 year olds	Number of offences	Rate per 1,000 10-17 year olds	
Chester le Street/Durham	12,186	68	5.6	55	4.5	-19.1%
Derwentside	8,216	84	10.2	54	6.6	-35.7%
Easington	9,381	74	7.9	41	4.4	-44.6%
Sedgefield	8,424	73	8.7	88	10.4	20.5%
Wear/Tees	8,425	84	10.0	68	8.1	-19.0%
County Durham	46,632	383	8.2	306	6.6	-20.1%

Source: Careworks, CDYOS Case Management System

*mid 2010 ONS population estimates

The most frequent alcohol related offences committed across the county were public order (77), and violence against the person (77) accounting for just over half of all alcohol related offences committed during 2013/14. 56.8% of all public order offences were alcohol related, compared to violence where 30% of offences were alcohol related.

Whilst 23.8% of all offences across the county were alcohol related, some differences occur at local level with both Sedgefield (26.6%) and Easington (24.1%) having higher percentages than the county.

Both Chester-le-Street/Durham and Sedgefield areas saw an increase, from the previous year, in the percentage of offences which were alcohol related (rising from 21% in 2012/13 to 23.2% in 2013/14 for Chester-le-Street/Durham and 21% to 26.6% in Sedgefield).

The county rate for alcohol related offences is 6.6 per 1,000 10-17 years population, down from 8.2 per 1,000 in the previous year. When broken down to former Local Children's Board (LCB) level there are differences, with the lowest rate recorded in Easington (4.4) and the highest rate in Sedgefield (10.4). This is also reflected in Sedgefield's percentage of alcohol related offences (26.5%), which is the highest across the former LCB areas; and it is the only area to have experienced an increase in the number of alcohol related offences compared with the previous year.

There are differences when alcohol related offending is broken down by age group:

- 32.6% of all offences committed by young people aged 16 or over were alcohol related, compared to 17.8% and 2.6% for 14-15 year olds and 10-13 year olds respectively. All age groups saw a reduction in the number of alcohol related offences committed when compared to 2012/13.

- 76.1% of alcohol related offences were committed by young people aged 16 years or over (at the time of the offence), which is an increase on the previous year (68.1%). However, both the 10-13 and 14-15 year age groups saw a reduction on the previous year (from 2.6% to 1.6% and from 29.2% to 22.2% respectively).

Safeguarding and looked after children services
Local authorities have a responsibility to respond to all children who are identified as being in need, or in need of protection. This means that children and young people who are suffering from harm, abuse and neglect are quickly identified, and that information is shared appropriately to afford them protection and ensure access to appropriate services, in line with assessed need.

Single assessment
County Durham now has a single point of access for children's services, replacing the pre-CAF (Common Assessment Framework), the CAF, the initial assessment and the core assessment. This helps to ensure that referrers and families can get early help from services quickly, avoiding unnecessary referrals where they are not required. This means that professionals in other agencies do not need to make the judgement but can instead discuss cases with social care professionals who will make a decision, based on available evidence, as to whether an early help assessment or full assessment is required. The new service is consistent in its decision making, applying an appropriate response which is proportionate to need. Effective action at an early help stage through First Contact will lead to a reduction in inappropriate referrals to social care services. From September 2014 an electronic version of our Single Assessment has been available to partners, to further enhance our information-sharing processes. The new assessment can, if appropriate, build into a comprehensive record including specialist assessments suitable for use in court.

Children who run away or go missing from home or care
Local authorities are responsible for protecting children when they go missing, either from their family home or from local authority care. It is thought that approximately 25% of children and young people who go missing are at risk of serious harm. There are particular concerns about the links between children running away and the risks of sexual exploitation. Missing children may also be vulnerable to other forms of exploitation, to violent crime, gang exploitation, or to drug and alcohol misuse. Looked after children who go missing from their placements are particularly vulnerable. In 2013/14, County Durham had 35 children go missing from care for a period of 24 hours or more; for 81 separate episodes in total. The majority of children who go missing, however, are not looked after and go missing from their family home.

Local authorities should have:
- A lead manager in place with strategic responsibility for children who run away or go missing.
- A Runaway and Missing From Home and Care Protocol.
- A clear definition of a child who has run away.
- A Local Safeguarding Children Board (LSCB) with a system in place to monitor prevalence of and the responses to children who go missing,

including gathering data from LSCB members and other local stakeholders in order to understand trends and patterns.
- Effective working relationships with the local police force.
- Effective partnerships with the voluntary sector, relevant specialist services and information about national level resources, e.g. helplines for missing children.
- Clear procedures in place to offer return interviews when a missing child is found.
- Support services in place for children and their families.
- A strategy to prevent children from running away and to deal with repeat runaways.

Referrals
When a child or young person requires a specialist service, a social care referral is received, an assessment undertaken and a decision is made on whether or not a service is required.

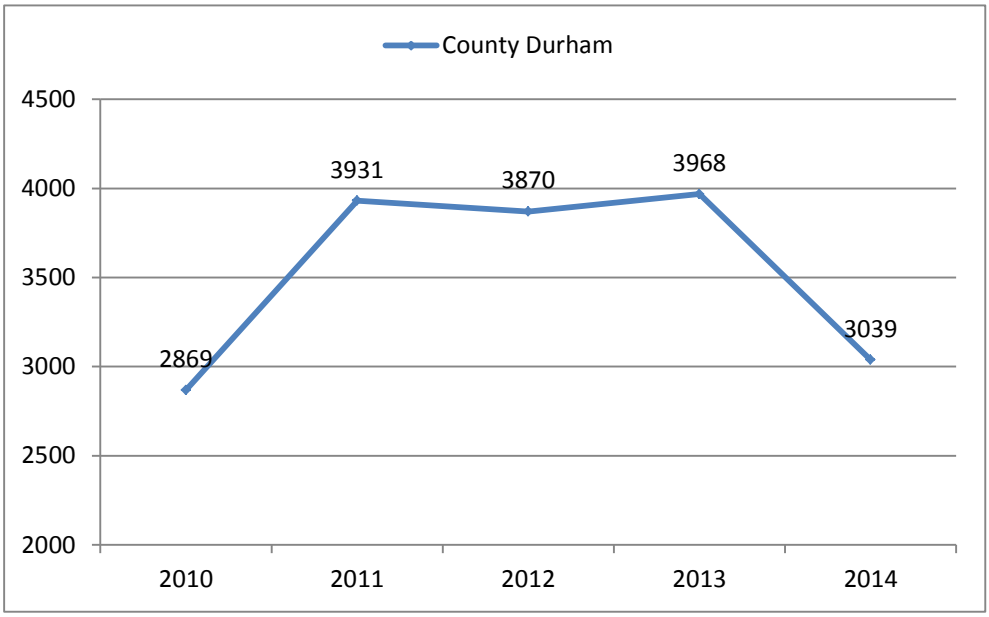
In 2013/14 County Durham received 6,516 children in need referrals, a rate of 650.0 per 10,000 population aged under 18. This is an increase compared to 4,379 in 2012/13, a rate of 436.2

Further investigation of this increase highlighted that the operation of the Central Referral Unit (CRU) has clearly impacted on the number of contacts and referrals in social care from Police sources.
In 2013/14 the number of children in need re-referrals was higher in County Durham at 27.4% than England (23.4%) or North East averages (22.9%).

Children in need
Children in need are defined in law as children who are aged under 18 and:
- Need local authority services to achieve or maintain a reasonable standard of health or development.
- Need local authority services to prevent significant or further harm to health or development.
- Are disabled.

Figure 22 below shows the total number of children in need which has increased from 2,869 in 2009/10 to 3,968 in 2012/13 – an increase of 38.4%. Data indicates that this figure has fallen to 3,039 in 2014.

Figure 22: Total number of children in need as at 31st March each year 2010/14



Source: SFR, children in need local authority tables 2010-13.

Table 11 provides a breakdown of numbers of children in need by primary need types. It clearly indicates that 'abuse or neglect' is the most significant type of primary need encountered across the county. Frequently, 'neglect' is associated with the incidence of parental mental ill-health and impacts on outcomes for children and young people. There is a strong association with child neglect, particularly when combined with substance misuse and domestic violence.

Table 11: Children in need, by primary need as at 31st March each year 2010/11 – 2013/14

Need Type	2010/11	2011/12	2012/13	2013/14
Abuse or neglect	2,253	1,653	1,957	1,561
Child's disability or illness	479	185	259	305
Parent's disability or illness	75	60	114	71
Family in acute stress	358	186	319	209
Family dysfunction	463	192	547	343
Socially unacceptable behaviour	141	93	199	205
Low income	15	3	3	3
Absent parenting	35	19	25	25
Not stated/missing/unknown	112	1,479	545	317
Total	**3,931**	**3,870**	**3,968**	**3,039**

Source: DfE Published LA Tables
Where low numbers exist in the table (i.e. less than 6) a notional figure of 3 has been used and the total amended accordingly.

Table 12: Number and percentage of children in need parental risk factors identified at end of initial assessment for 2013/14

Parental Risk Factor	2013/14
Abuse or neglect	25.2%
Domestic violence	18.7%
Mental health	11.5%
Other	9.0%
Alcohol misuse	8.8%
Socially unacceptable behaviour	7.9%
Drug misuse	7.3%
No factors identified	5.2%
Learning disability	1.8%
Physical disability	1.7%
Child sexual exploitation	1.5%
Self-harm	0.7%
Missing	0.5%
Young carer	0.2%
Gangs	0.1%
Privately fostered	0.1%
Trafficking	0.0%
Unaccompanied asylum seeker	0.0%
Missing or invalid code	0.0%

Table 13: Number and percentage of children in need referrals by source type for 2013/14

Referral Source	2013/14
Police	37.6%
Health services	13.1%
Other	12.6%
Education services	8.8%
Local authority services	8.5%
Individual	6.6%
Schools	4.3%
Anonymous	4.2%
Other legal agency	3.1%
Housing	1.1%
Unknown	0.0%
Missing or invalid code	0.0%

Initial assessment

Where a referral requires further action, the child or young person will receive an initial assessment. This is a brief assessment which may lead to three types of outcome: no further action; the immediate provision of services; or a more detailed type of assessment (known as a core assessment) being carried out. This may be carried out even where there is immediate provision of services.

The number of children receiving an initial assessment in County Durham continues to rise. Numbers have increased from 3,500 to 5,460 between 2010/11 and 2013/14, (an increase of 56%), in line with the increase in the referral rate. This increase is reflected across all CCG localities / constituencies, with Chester-le-Street and Durham showing the highest increases of 105.4% and 68.4% respectively.

Table 14: Number of children receiving initial assessment by Clinical Commissioning Group Locality / Constituency, 2010/11 – 2013/14

CCG Locality/ Constituency	2010/11	2011/12	2012/13	2013/14	% Increase from 2010/11 to 2013/14
Chester-le-Street	273	282	392	561	105.4%
Derwentside	636	682	818	850	33.6%
Durham	358	347	407	603	68.4%
Durham Dales	619	602	808	1,031	66.5%
East Durham	889	1,020	1,129	1,331	49.7%
Sedgefield	725	751	1,004	1,085	49.6%
Total	3,500	3,684	4,558	5,460	56.0%

Source: SSID, distinct numbers assessed throughout the year

Core assessments

A core assessment is an in-depth assessment which addresses the central or most important aspects of the child's needs (Communities & Local Government 'National Indicators for Local Authorities and Local Authority Partnerships: Handbook of Definitions', May 2008).

As with the increased number of children receiving an initial assessment, Table 15 also shows that numbers of children receiving core assessments in County Durham continue to rise. Numbers have increased from 1,328 to 1,943 between 2010/11 and 2013/14 – an increase of 46.3% (615). Similar to initial assessments, this increase is reflected across all CCG localities, with Chester-le-Street showing a significant increase (101.1%) between 2010/11 and 2013/14.

Table 15: Number of children receiving core assessment by Clinical Commissioning Group Locality / Constituency, 2010/11 – 2013/14

CCG Locality/ Constituency	2010/11	2011/12	2012/13	2013/14	% Increase from 2010/11 to 2013/14
Chester-le-Street	101	113	178	203	101.1%
Derwentside	227	224	316	311	37.0%
Durham	142	157	147	213	49.7%
Durham Dales	221	195	235	348	57.5%
East Durham	379	482	554	551	45.4%
Sedgefield	258	263	260	317	23.0%
Total	1,328	1,434	1,690	1,943	46.3%

Source: SSID, distinct numbers assessed throughout the year

Child protection plans

Children who have a child protection plan are considered to be in need of protection; this includes protection from physical abuse, sexual abuse, emotional abuse and neglect. The plan will detail the main areas of concern, what action will be taken to reduce those concerns, how the child will be kept safe, and how we will know when progress is being made.

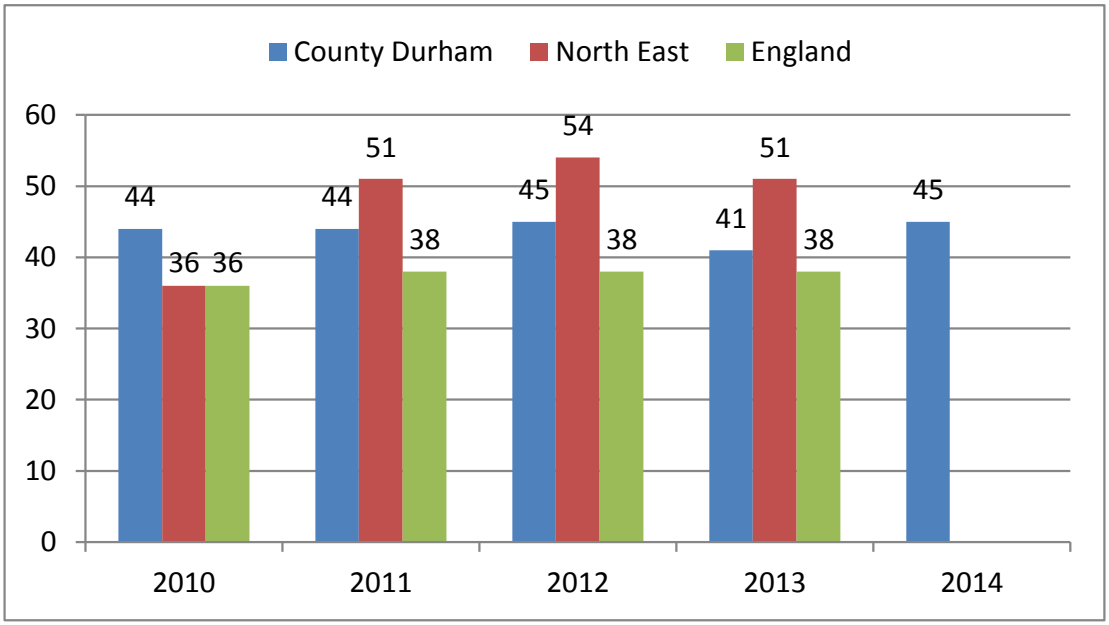
Of the 3,053 children in need as of 31st March 2014, 453 were subject to a child protection plan, a rate of 45.2 per 10,000 population. As of 30th September 2014 there were 385 children subject to a child protection plan, a rate of 38.4 per 10,000 population; this highlights a significant drop in the number of child protection plan cases throughout the first 6 months of 2014/15.

Table 16: Children subject to a child protection plan per 10,000 by Clinical Commissioning Group Locality / Constituency 2011/14 (as at 31st March)

CCG Locality / Constituency	Years				% difference 2011/14	Population 0-17 ONS population estimates	Rate per 10,000 population (aged under 18)
	2011	2012	2013	2014			
Chester-le-Street	21	17	25	20	-4.8	10,591	18.9
Derwentside	78	76	67	78	0.0	18,649	41.8
Durham	22	30	34	35	59.1	15,716	22.3
Durham Dales	66	43	57	85	28.8	17,519	48.5
East Durham	119	188	139	136	14.3	19,735	68.9
Sedgefield	86	69	66	66	-23.3	18,029	36.6
Not matched / out of country	52	32	21	33	-	-	-
County Durham	**444**	**455**	**409**	**453**	**2.0**	**100,239**	**45.2**

Source: SSID 2014, Mid-2012 0-17 ONS population estimates

Figure 23: Rate of children subject to a child protection plan as at 31st March each year per 10,000 population aged under 18, 2010 - 2014



Source: SFR, children in need local authority tables 2010/14

Table 17 shows that the percentage of children on the child protection list as a result of neglect has remained stable between 2013 and 2014 at 63.3% and 63.1% respectively. The table also shows that all the other categories of abuse have also remained stable when comparing figures for 2013 with 2014.

Table 17: Number and percentage of children subject to a child protection plan by initial category of abuse as of 31st March 2011 to 31st March 2014

Category of abuse	2011	2012	2013	2014
Neglect and likelihood of neglect	259 (58.3%)	299 (65.7%)	259 (63.3%)	286 (63.1%)
Physical abuse and likelihood of physical abuse	61 (13.7%)	90 (19.8%)	84 (20.5%)	95 (21.0%)
Emotional abuse and likelihood of emotional abuse	49 (11.0%)	31 (6.8%)	38 (9.3%)	43 (9.5%)
Sexual abuse and likelihood of sexual abuse	11 (2.5%)	23 (5.1%)	26 (6.4%)	29 (6.4%)
Multiple categories of abuse	64 (14.4%)	12 (2.6%)	2 (0.5%)	0 (0.0%)
Missing or unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	444	455	409	453

Source: SFR children in need local authority tables 2010-13 (and SSID 2014 where unavailable / not published)

During 2013/14, 50.3% of children subject to a child protection plan were aged less than 5 years.

Table 18: Number and percentage of children who became subject to a child protection plan, by age group, in 2013/14

Age Group At CPP Start Date	Number Of Children Who Became Subject To CPP In 2013/14 (Revised Based on CiN Census)	% Of Children Who Became Subject To CPP In 2013/14 (Revised Based on CiN Census)
Unborn	98	15.0%
Aged 0 - 1	70	10.6%
Aged 1 - 4	162	24.7%
Aged 5 - 9	171	26.1%
Aged 10 - 15	152	23.2%
16+	3	0.5%
Total	656	100.0%

Source: SFR children in need local authority tables 2010-13 (and SSID 2014 where unavailable / not published)

Child Protection Conferences

Data is collected regarding risk factors which are known to impact negatively on parenting and have therefore led to the children of the family becoming subjects of Initial Child Protection Conferences (ICPC). During 2014/15 there were 252 ICPCs and 71% had a risk factor recorded. 56% of ICPCs, where a risk factor is recorded, had at least one of the selected risk factors, as shown in Table 19.

While parental risk factors differ from area to area, the countywide position is that domestic abuse features in 16.67% (42 of 252) of initial child protection case conferences that have this recorded. Parental mental health, substance misuse and alcohol misuse are the next most common, countywide, factors leading to an ICPC, followed by learning disabilities.

Table 19: Parental risk factors leading to the necessity of initial child protection conference 1st April 2014 – 31th March 2015
(N.B More than one factor may apply to each conference)

Clinical Commissioning Locality	Mental ill health % (total)	Learning disability %	Alcohol misuse %	Domestic abuse %	Substance misuse %
Dales	8.11% (3)	25% (2)	18.18% (4)	14.29% (6)	15.63% (5)
Derwentside	21.62% (8)	12.5% (1)	27.27% (6)	26.19% (11)	15.63% (6)
Easington	27.03% (10)	25% (2)	9.09% (2)	21.43% (9)	31.25% (10)
North Durham	16.22% (6)	12.5% (1)	18.18% (4)	4.76% (2)	3.13% (1)
Sedgefield	24.32% (9)	12.5% (1)	22.73% (5)	30.95% (13)	25% (8)
Cross locality	2.7% (1)	12.5% (1)	4.55% (1)	2.38% (1)	6.25% (2)
County Durham	**37**	**8**	**22**	**42**	**32**

Through the County Durham Local Safeguarding Children Board, data is monitored on a quarterly basis with regard to the percentage of parental risk factors leading to child protection plans – both for initial conferences and for review conferences.

Table 20 shows the number of conferences where a specific parental factor was recorded during 2014/15.

Table 20: Number of conferences with specified parental factor (percentage of all conferences, initial and review (856), with specific risk factor recorded)

	Initial conference	Review conference
Parental factors relating to mental health issues	37 (4.32%)	143 (16.71%)
Parental factors relating to domestic abuse	42 (4.91%)	308 (35.98%)
Parental factors relating to alcohol misuse	22 (2.57%)	159 (18.57%)
Parental factors relating to substance misuse	32 (3.74%)	157 (18.34%)
Parental factors relating to risk to children	12 (1.4%)	60 (7.01%)

Domestic abuse

Domestic abuse impacts on all five Every Child Matters Outcomes: staying safe, being healthy, enjoying and achieving, making a positive contribution and achieving economic wellbeing.

Children as witnesses, victims or perpetrators of domestic abuse are more likely to continue this pattern of behaviour into adulthood. Early intervention can improve the long term effects of abuse, and can make long-term improvements both socially and financially across all statutory agencies. There is also a strong association between domestic violence and abuse and other forms of child maltreatment.

In July 2014, DCLG published 'Understanding Troubled Families' which outlines the scale of problems faced by such families. With regard to domestic abuse, the findings show that on entry to the programme, the sample of troubled families had the following characteristics:

- 29% of troubled families were experiencing domestic violence or abuse on entry to the programme. National estimates put the level of domestic violence among individuals at around 7% in a year.
- 62% of families experiencing domestic violence had a truanting child compared to 54% where there was no domestic violenc; and 39% of families experiencing domestic violence also had a young offender, compared to 31% where there was no domestic violence.

Some problems can be both cause and effect of troubled families' circumstances: 60% of families experiencing domestic violence included an adult with a mental health problem, compared with 40% where there was no domestic violence; and 41% of families where there was domestic violence included a child with a mental health problem, compared with 28% without a domestic violence problem.

The risks of domestic violence increase with the number of children and there was also a statistically significant association between having more than three children and there being an adult with a recent criminal conviction.

The top 3 reasons for referral are “Safeguarding Children”, “General Concern” and “Domestic Violence”. There have been considerable increases in each reason and collectively they account for 2,015 of the 2,352 increase in referrals.

Table 21: Numbers of referrals with a stated issue of safeguarding children, general concern or domestic violence

Referrals with a stated issue of:	2012-13	2013-14	Change	% Change
Safeguarding Children	1,435	2,455	1,020	71%
General Concern	1,689	2,291	602	36%
Domestic Violence	293	686	393	134%
Total	**3,417**	**5,432**	**2,015**	**59%**

Table 21 identifies that 2,455 referrals with a stated issue of “Safeguarding Children” were received in 2013/14. Having analysed the underlying data, it is apparent that 1,533 of these were received from the police (62%). The operation of the Central Referral Unit (CRU) has clearly impacted on the number of contacts and referrals in social care from police sources. Over 10,000 incidents of domestic abuse were recorded by the police in 2013/14. The CRU reports any incident of domestic violence where a child is present and those cases assessed by them as “moderate” or “significant risk” are received as referrals by the First Contact service. These cases may be recorded as “safeguarding children” or “domestic abuse”.

Although this development has increased the number of contacts and referrals to children’s social care, it is considered a positive development, since this need was previously unreported, despite violence occurring in the home. More effective police systems have strengthened our assurance in relation to these cases. Work is underway to build further on this development by creating a Multi-Agency Safeguarding Hub (MASH) in 2015.

Child sexual exploitation

Child sexual exploitation (CSE) has been identified as a key priority for County Durham’s Local Safeguarding Children Board (LSCB). CSE is child abuse, which can involve young people (under 18) being the victims of some of the most serious crimes, which can cause lifelong harm to victims. Like other forms of sexual violence, victims of CSE often do not disclose the abuse to others and it is up to professionals to know what CSE is, to be able to spot the signs in the young people they work with and to correctly follow LSCB child protection procedures in making referrals, which enable us to:

- Prevent the sexual exploitation of children.
- Identify, protect and support victims.
- Disrupt and prosecute perpetrators, securing justice for victims and obtaining convictions.

Analysis in County Durham has shown that:

- CSE generally involves the exploitation of children and young people by lone perpetrators. There have been no identified organised crime groups, gangs or groups in the county (as per definition within Office of Children's Commissioner's Findings).
- Of the young people who displayed risk factors associated with exploitation in 2013:

    - 25% was due to online CSE
    - 23% was due to inappropriate relationships
    - 14% was because they displayed risk taking behaviour
    - 12% were at risk of CSE in more than one situation
    - 12% were linked to a new emerging model around the grooming and possible exploitation of young people by workers within local businesses which were mainly fast food outlets

- Of the young people identified at risk, the majority were female (88%) although 12% were male. They were aged between 12-18 years but the most common age was 13.
- The greatest threat was from online CSE, whereby young people are targeted by perpetrators who can reside anywhere in the world. The young people are often contacted via social media and use various sites and applications such as KIK messenger, SnapChat and Facebook to communicate. The perpetrator will then groom the young person, persuade them to take sexual images or videos and share them with the perpetrator. In some cases the perpetrators have gone on to threaten and blackmail the young people that they will share these images if they do not commit further sexual acts or provide money or products.

High level achievements identified in the Safe Durham Partnership 2013 Strategic Assessment were:

- Increased referrals from practitioners to the Initial Response Team following training sessions to raise awareness of child sexual abuse and child sexual exploitation.
- Employment of a Child Independent Sexual Violence Advocate, two Child Sexual Exploitation workers by Barnardos (reaching about 130 young people and their families each year) and introduction of a police Sexual Violence Coordinator.

Children looked after

The term 'looked after' has a specific, legal meaning based on the Children Act 1989. A child is looked after by a local authority if he or she is provided with accommodation for a continuous period of more than 24 hours (under Section 20 and 21), or if he or she is subject to a care order (Children Act 1989, Part IV) and/or placement order.

Local authorities can provide children with accommodation under a wide range of circumstances, for example:

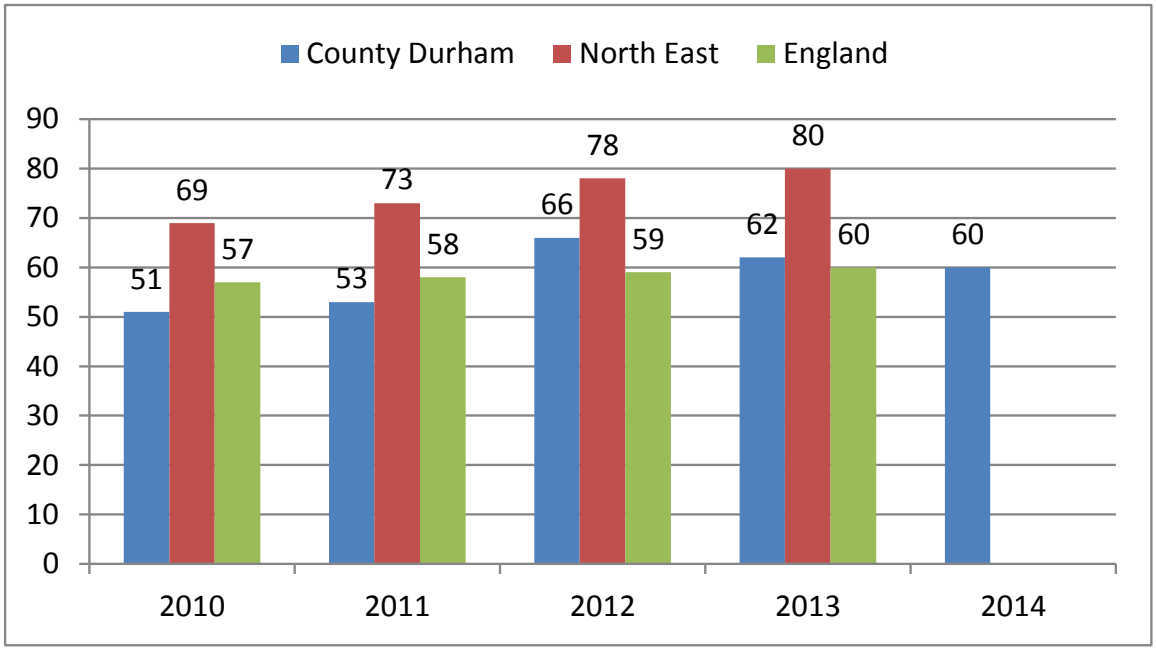
- As the result of an agreement between the local authority and the child's parents or guardians that being accommodated would be in the child's best interest.
- The child having been remanded to the care of a local authority by a criminal court.
- Because the child is helping the police with their enquiries.
- The child has been placed for adoption, and the local authority is acting as the adoption agency.
- The child is subject to a police protection order.

Types of looked after children accommodation include:

- Foster placements (including kinship care).
- Residential placements, i.e. children's home, special education schools, secure units, hostels.
- Youth offending institutes / prisons.
- Placed with parents.
- Supported lodgings.
- Independent living in preparation for adult life.

The rate of children in full time looked after care in County Durham is similar to England and lower than the North East. This has improved from March 2012, resulting from the implementation of the county's Looked After Children Reduction Strategy.

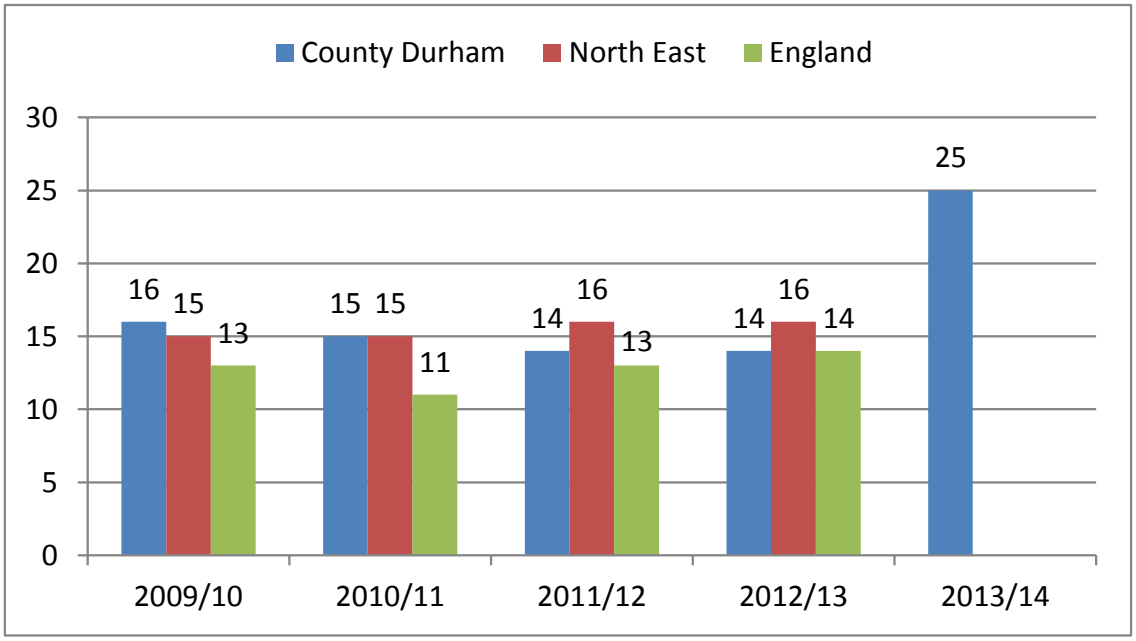
Figure 24: Rate of children looked after as at 31st March each year per 10,000 population aged under 18, 2011 – 2014



Source: SFR, children looked after rounded local authority tables 2013
Provisional SSDA903 CLA 2014 data only. Rate based on ONS mid-year 0-18 population estimate for Durham (100,239 persons).

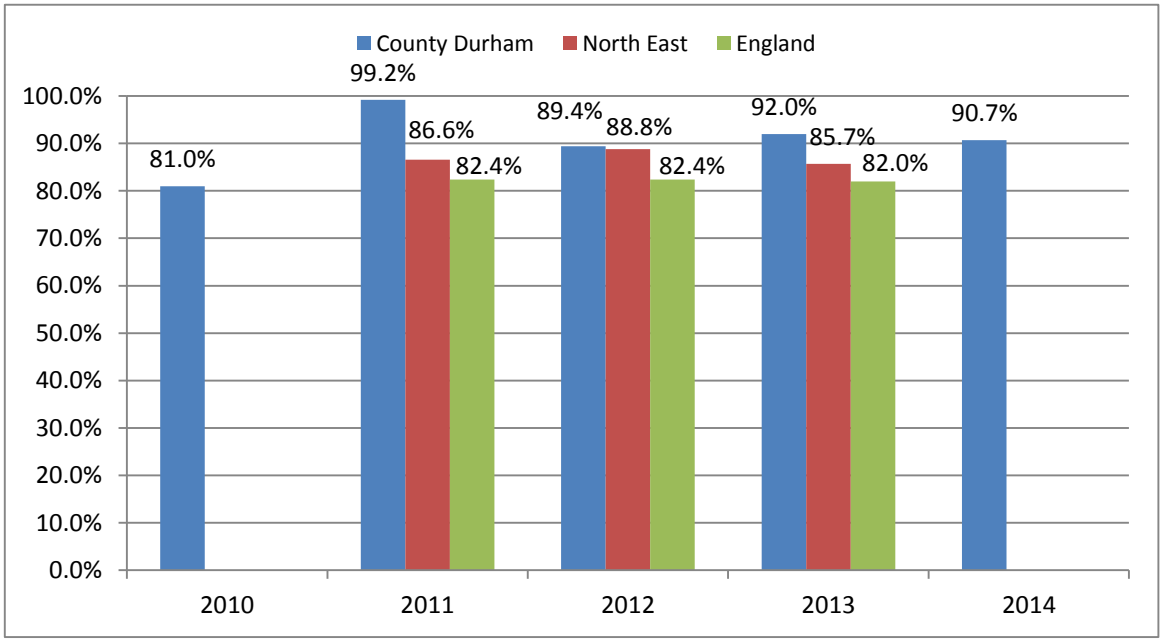
In 2013/14 County Durham had 73 children adopted from looked after care; this compared to 42 in 2012/13 (73.8% increase).

Figure 25: Percentage of children looked after who were adopted from care, as a percentage of all children looked after leaving care, by year



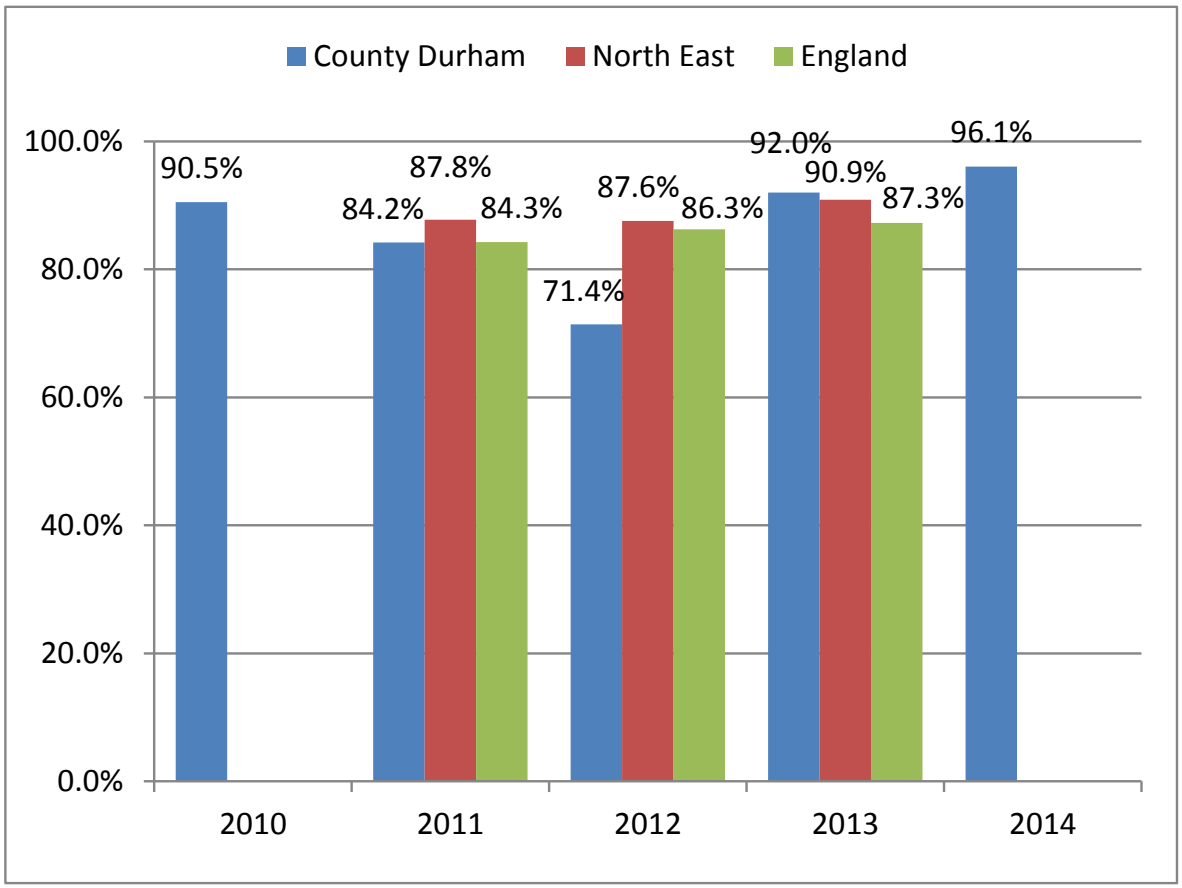
Source: Sourced from SFR children looked after rounded local authority tables 2013. Figures are as at 31st March each year. Provisional SSDA903 CLA 2014 data only. Rate based on ONS mid-year 0-18 population estimate for Durham (100,239 persons).

Figure 26: Percentage of children looked after who received required annual dental check



Source: Sourced data from SSDA903 CLA collection site. Figures are as at 31st March each year. Provisional SSDA903 CLA 2014 data only.

Figure 27: Number of children looked after who received required annual health assessment(s)



Source: Sourced data from SSDA903 CLA collection site. Figures are as at 31st March each year. Provisional SSDA903 CLA 2014 data only.

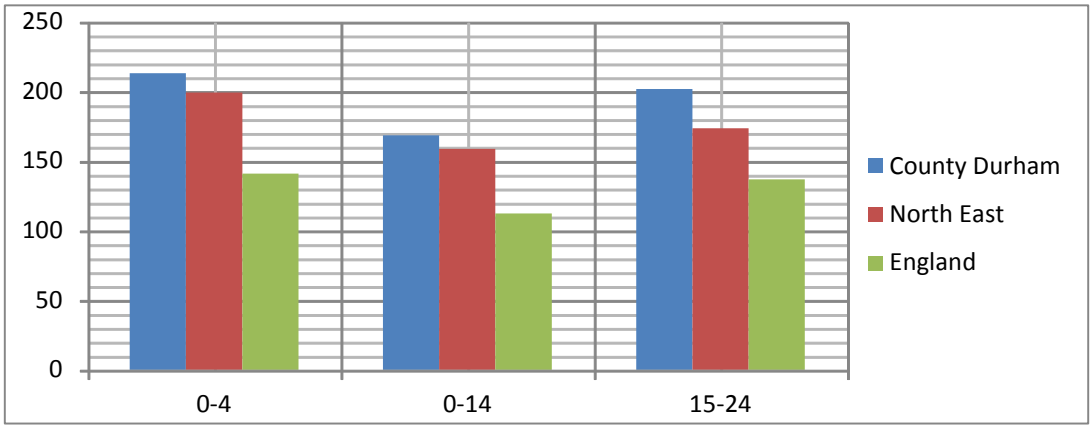
Unintentional injuries

'Every year, 1 million children under the age of 15 are taken to accident and emergency (A&E) units after injuries occur in the home, and many more are treated at home or by their GP' (NHS Choices, 2011). 'In the UK, injuries that occur in and around the home are the most common cause of death in children over the age of one' (NHS Choices, 2011).

Injuries occur as a result of the interaction between the child and his or her physical and social environment and are often preventable. National Institute for Health and Care Excellence (NICE) guidance identifies several factors which make some children more vulnerable than others. These include the child's age, whether he / she is disabled, has a learning difficulty, the family income and their home (NICE, 2010).

Figure 28: Crude hospital admission rate per 100,000 for unintentional and deliberate injury, young people (aged 0-4, 0-14 and 15-24), 2013/14, England, North East and County Durham.

	County Durham	North East	England
0-4	213.1	199.2	140.8
0-14	168.4	158.6	112.2
15-24	201.7	173.4	136.7



Source: Public Health Outcomes Framework, Public Health England

Hospital admission rates for unintentional injuries are significantly higher in County Durham than England but not significantly different to the North East. This is true for those aged 0-14 years.

Provision of care needs

Census returns show an increase (7.2%) in the number of carers aged under 15 in County Durham, providing between 20 and 49 hours a week of unpaid care between 2001 and 2011. There was a 0.2% decrease in the number of young carers providing between 1 and 19 hours of unpaid care a week and a 4.8% decrease in those providing more than 50 hours of unpaid care a week.

Table 22: Number of children and young people under 15 providing unpaid care in County Durham

Area	Carer providing 1-19 hours unpaid care per week	Carer providing 20 to 49 hours unpaid care per week	Carer providing 50 or more hours unpaid care per week	Total number carers providing unpaid care per week
North Durham CCG	**305**	**34**	**55**	**394**
Derwentside CCL	137	19	21	177
Chester le Street CCL	74	3	20	97
Durham CCL	94	12	14	120
DDES CCG	**530**	**85**	**45**	**660**
Durham Dales CCL	161	24	11	196
East Durham CCL	207	44	24	275
Sedgefield CCL	162	17	10	189
County Durham	**835**	**119**	**100**	**1,054**

Source: Census 2011

Disabled children

The number of disabled children and young people is growing globally due to advances in medicine and technology which prolongs life, according to the World Health Organisation and the World Bank.

In June 2013, County Durham's Health and Wellbeing Board signed up to the Disabled Children's Charter to ensure that the needs of disabled children are fully understood and that services are commissioned appropriately.

County Durham has 4,070 disabled children and young people in receipt of Disability Living Allowance, of which 358 are severely disabled and receive a statutory service from the Children and Young People's Disability Team (October 2014).

In the UK, there are 770,000 disabled children under the age of 16. That equates to one child in 20. The rate of children and young people (0-17) in receipt of Disability Living Allowance is higher in County Durham (44.6) than regionally (36.7) and nationally (31.4 per 1000 population).

The children and young people who receive a statutory service will in many cases have dual diagnosis. The two most prevalent types of disability are learning and communication:

- 66% had a learning disability.
- 47% had a communication disability.
- 39% had a behavioural disability.
- 34% had a diagnosis of autism / aspergers.

Specialist short breaks are available for children with a disability and have been re-commissioned to ensure increased choice and value for money. A new process for specialist commissioning was designed and implemented in 2014.

A review of major contracts to understand the impact of respite care services will be undertaken by the Clinical Commissioning Groups in 2015 and the council will review direct payments for children.

Educational attainment

Raising aspirations and achievement is a priority for all partners, as there are many factors which can impact on this, such as children and young people's enjoyment of learning, emotional wellbeing, being healthy, and feeling safe at home and in school. Engagement in learning also impacts on a wide range of outcomes and research has confirmed that people who are well educated and achieve high level qualifications generally enjoy better health, live longer, are happier and have greater economic prosperity. They are also better able to adapt to the changes in economic circumstances.

Children achieving a good level of development

Educational attainment or readiness for education is measured throughout a child's school-life, from age 4 to age 16 or more.

At the end of Reception year, teachers judge children's behaviour and understanding, and record an Early Years Foundation Stage (EYFS) Profile score for each child. The EYFS is a statutory framework for children's learning, development and welfare from birth to the end of the academic year in which they turn 5. It was changed in 2013 and now covers: Communication and Language; Physical Development; Personal, Social and Emotional development; Literacy; Mathematics; Understanding the World; and Expressive Arts & Design. There are various Early Learning Goals within each area, each with a top score of 3. The maximum total score a child can be given is 51.

The DfE report on the gap between the lowest attaining 20% of children at the end of reception and the rest of the year group, as a percent of the average score of the larger group. In Durham, the mean score of the lowest 20% of children in 2014 was 20.2, compared to an England result of 22.5. The median score of the rest of our year group was 34, giving a gap of 40.6%.

Table 23: Early Years Foundation Stage profile narrow gap (lowest 20%) (former NI92) 2009/10 – 2013/14

	2009/10	2010/11	2011/12	2012/13	2013/14
National	32.7%	31.4%	30.1%	36.6%	33.9%
Durham	36.7%	34.7%	33.4%	42.8%	40.6%
Statistical Neighbours					
Sunderland	32.9%	32.4%	30.6%	39.4%	36.1%
Wakefield	33.5%	33.5%	30.2%	38.3%	36.5%
Barnsley	34.4%	31.2%	31.4%	37.8%	37.9%
Darlington	35.9%	35.6%	32.8%	42.5%	42.7%
Gateshead	32.1%	32.7%	28.9%	34%	29.5%
St. Helens	31.3%	31.1%	28.8%	38.6%	36.1%
Doncaster	32%	32%	30.7%	37.4%	40.5%
Stockton	34.4%	31.8%	31.7%	41.3%	37%
Wigan	33%	31.6%	30.7%	41.3%	41%
North Tyneside	28.7%	29.5%	31.4%	36.5%	33.2%

Source: NCER/KEYPAS and DfE 2014 Statistical First Release 39

Achievement of 5 or more A*-C GCSEs

In 2013/14, 65.0% of County Durham's pupils achieved 5 or more GCSEs at A*-C (or the equivalent), compared to 63.8% of all pupils nationally. These results are not directly comparable to results in 2012/13 due to policy changes at the Department for Education. The same is true for the percentage achieving 5 or more A*-Cs including English and Maths GCSEs. In Durham 57.6% of pupils at the end of secondary school achieved this in 2013/14, compared to 56.6% of pupils nationally.

Table 24: Percentage of pupils achieving 5 or more A*-C GCSEs

CCG Locality / Constituency	Years				
	2009/10	2010/11	2011/12	2012/13	2013/14
Chester-le-Street	88	92.5	89.9	87.2	68.0
Derwentside	84	91.4	87.7	90.9	62.5
Durham	86.2	88.9	90.5	91.3	67.4
Durham Dales	88.6	91	92.8	92.4	63.9
Easington	82.4	86.2	92	90.2	64.0
Sedgefield	79.1	85	88.2	90.2	61.4

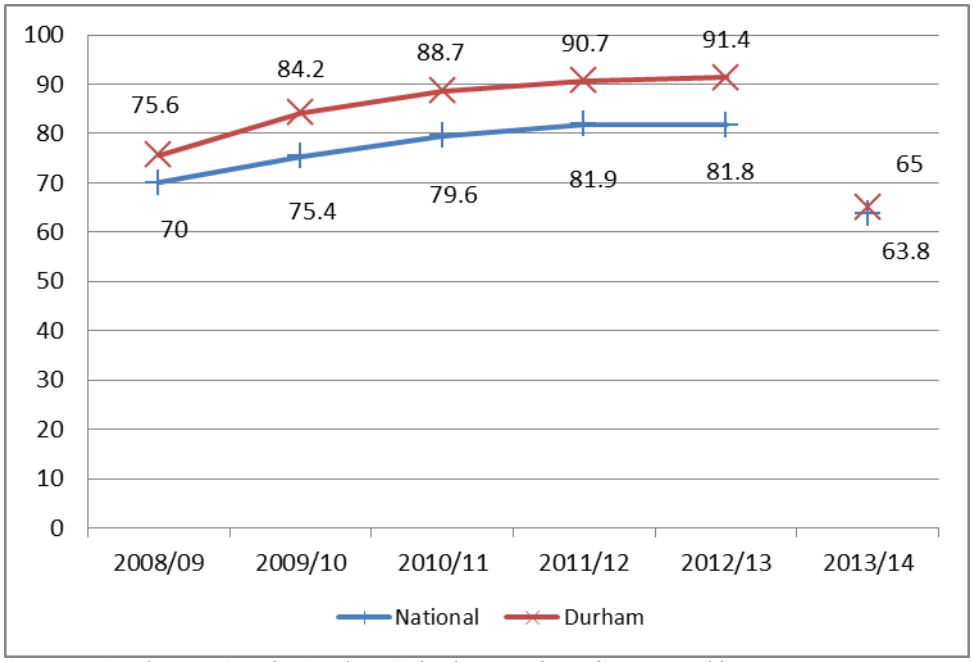
Source: NCER EPAS

Table 25: Percentage of pupils achieving 5 or more A*-C GCSEs including English and Maths

CCG Locality / Constituency	Years				
	2009/10	2010/11	2011/12	2012/13	2013/14
Chester-le-Street	57.2	64.7	70.1	67.8	57.0
Derwentside	60.7	63.2	56.9	58.7	55.7
Durham	60	68.6	67.4	66.6	61.7
Durham Dales	57.7	60.4	65.7	62.3	56.2
Easington	50.5	54	55	63.7	56.7
Sedgefield	51.1	54.6	62.1	57.7	54.8

Source: NCER EPAS

Figure 29: Percentage of pupils achieving 5 or more A*-C GCSEs – 2008/09 to 2013/14 academic year



Source: NCER/KEYPAS and NCER/EPAS databases, DfE performance tables

'A' level achievement

At 'A' Level 53.5% of pupils achieved 2 or more A*-B's, which was better than the national figure of 46.6%, whilst 98.7% of pupils achieved 2 or more A*-E's, which was higher than the national average of 98.0%. (Data relates to pupils at local authority maintained sixth forms and doesn't include further education colleges) (NCER 'National' dataset)

Attainment of looked after children (LAC)

Data for the 2013/14 academic year show that 72% of the children who were looked after for the 12 months to 31st March 2014 reached Level 4 or above in their Key Stage 2 Reading tests. This is three percentage points down from the 2012/13 result. 63% of the cohort were awarded a Level 4 or above in their Key Stage 2 Writing Teacher Assessments, an increase of 8 percentage points on the previous year. 63% of the cohort achieved Level 4 or above in their Key Stage 2 Maths test, which is three percentage points above the previous year's result. 56% of the children achieved Level 4 or above in all three subjects, up from 50% in 2013. Among children who were not looked after, 79% of pupils in Durham achieved these levels in 2014.

The educational attainment of children who are looked after by the local authority is on average significantly lower than all other children. This is similar to the situation nationally.

The percentage of LAC achieving five or more A*-C GCSEs (or equivalent) including C or above in English and Maths GCSEs increased from 4.2% in 2007/08 to 28.0% in 2009/10. Since then the percentage of the cohorts making this achievement has

been between 13% and 17%, and in 2012/13 it was 20%. Among children in County Durham schools who were not looked after, 63.1% made the same achievement. Finalised Key Stage 4 results for LAC in 2013/14 are not available yet.

The percentage of LAC in Durham getting five or more GCSEs at A*-C (or an equivalent) in 2012/13 was 54%. This compares to 91.4% of their peers.

Table 26: Most recent attainment by looked after children at Key Stage 2 and Key Stage 4

Indicator/Description	Figure
Percent achieving Level 4 or above in Reading, Writing and Maths at Key Stage 2 in 2013/14	56%
Percent achieving Level 4 or above in Reading at Key Stage 2 in 2013/14	72%
Percent achieving Level 4 or above in Writing at Key Stage 2 in 2013/14	63%
Percent achieving Level 4 or above in Maths at Key Stage 2 in 2013/14	63%
Percent achieving 5 or more GCSEs at A*-C (or equivalent) incl. English and Maths in 2012/13	20%
Percent achieving 5 or more GCSEs at A*-C (or equivalent) in 2012/13	54%

Source: Department for Education

Children with autism

Children who have autism spectrum disorder have a combination of difficulties with verbal communication, interacting with other children and adults. They often also have a particular focus on specific interests and find it difficult to engage in other subjects. The rate of children who have autism spectrum disorders known to schools in County Durham is 9.9 for every thousand children, as of January 2014. This shows a year-on-year increase since January 2009 and is now higher than the 2012 figures for the North East (8.32) and England (8.17).

Source: Pupil Census

Attainment of Gypsy, Roma and Travellers (GRT) pupils

Pupils from Gypsy, Roma and Traveller (GRT) backgrounds have in the past achieved less well than other students. This is likely to be due to interruptions to school-based education when their families travel.

Results for 2013/14 show that 62% of pupils with GRT heritage achieved Level 4 or above in all of Reading, Writing and Maths at the end of Key Stage 2. This compares to 79% of all pupils in County Durham schools. The figure for GRT pupils in 2012/13 was 60%.

19% of GRT pupils at the end of secondary education achieved at least 5 A*-C GCSEs including English and Maths in 2013/14 compared to 57.6% of all pupils in County Durham. This is up slightly from 16.7% in 2012/13.

The number of pupils known to have GRT heritage in the county is very small. As a result, overall results for the group, and also the gap between their overall results and other pupils', are likely to vary greatly from year to year.

Attainment of children and young people living in the most deprived areas
Key stage 2: in 2014, 73.2% of pupils in Durham who lived in England's most deprived 20% of Super Output Areas (SOA's) achieved Level 4+ in all of Reading, Writing and Maths at KS 2 compared to 82.7% of children living in the other SOAs in Durham. The gap between the two results is 9.5 percentage points, a slight increase from 8 percentage points in the previous year.

Key stage 4: in 2014, 48.7% of pupils living in the most deprived 20% of SOA's achieved 5 or more A*-C GCSE grades including English and Maths compared to 61.7% of children living in other SOAs, which results in a gap of 13 percentage points. This gap should not be compared with that in 2013 due to the changes to policy.

Pupil place planning (PPP)
Pupil place planning (PPP) is a critical aspect of the council's statutory duty to assess the local need for school places to ensure that every child can be provided with a place in a state-funded school in County Durham. Local authorities need to show that they have robust procedures and systems for forecasting pupil numbers and taking account of changes in local circumstances to ensure that there will be the right number of schools in the right places for the number of pupils expected in the future.

The Office for National Statistics (ONS) has produced an overview of key findings from its analysis of pupil numbers using the 2014 School Census information. This represents the national picture and 'broadly' reflects the situation in County Durham:

- Overall pupil numbers (aged up to and including 15) in state-funded schools **began to increase in 2011 and are projected to continue rising, although the** numbers in primary and secondary schools will obviously peak at different stages in the next 15 years.
- Numbers in maintained nursery and state-funded primary schools started increasing in 2010 and are expected to continue rising. Between 2013 and 2017, numbers are projected to increase by 8%.
- State-funded secondary school rolls of pupils aged up to and including 15 have been in decline since 2004 and are expected to decline further until around 2015 when numbers in secondary schools will be about 3% lower than in 2012. Increases in primary pupil numbers will start to flow through at this point and numbers in secondary schools therefore will increase again. By 2018 they are projected to recover to 2013 levels.

Forecasting primary and secondary pupil numbers
Pupil projections are based on relevant data provided from a range of sources:

- Health Authorities (live births).
- Termly School Census (January, October, May each year).
- Primary School patterns of transition to secondary schools.
- Neighbouring Authorities (transfer of information regarding pupil movement across borders and school re-organisation proposals).
- Housing data on new build developments which have received planning. permission and demolition programmes.
- Early Years and Sure Start (nursery / childcare figures).
- Staying on rate at Post-16.

As a result of an increase in the birth rate, it is expected that there will be in the region of 1,220 more primary aged pupils by 2023/24 than there were in 2013/14.

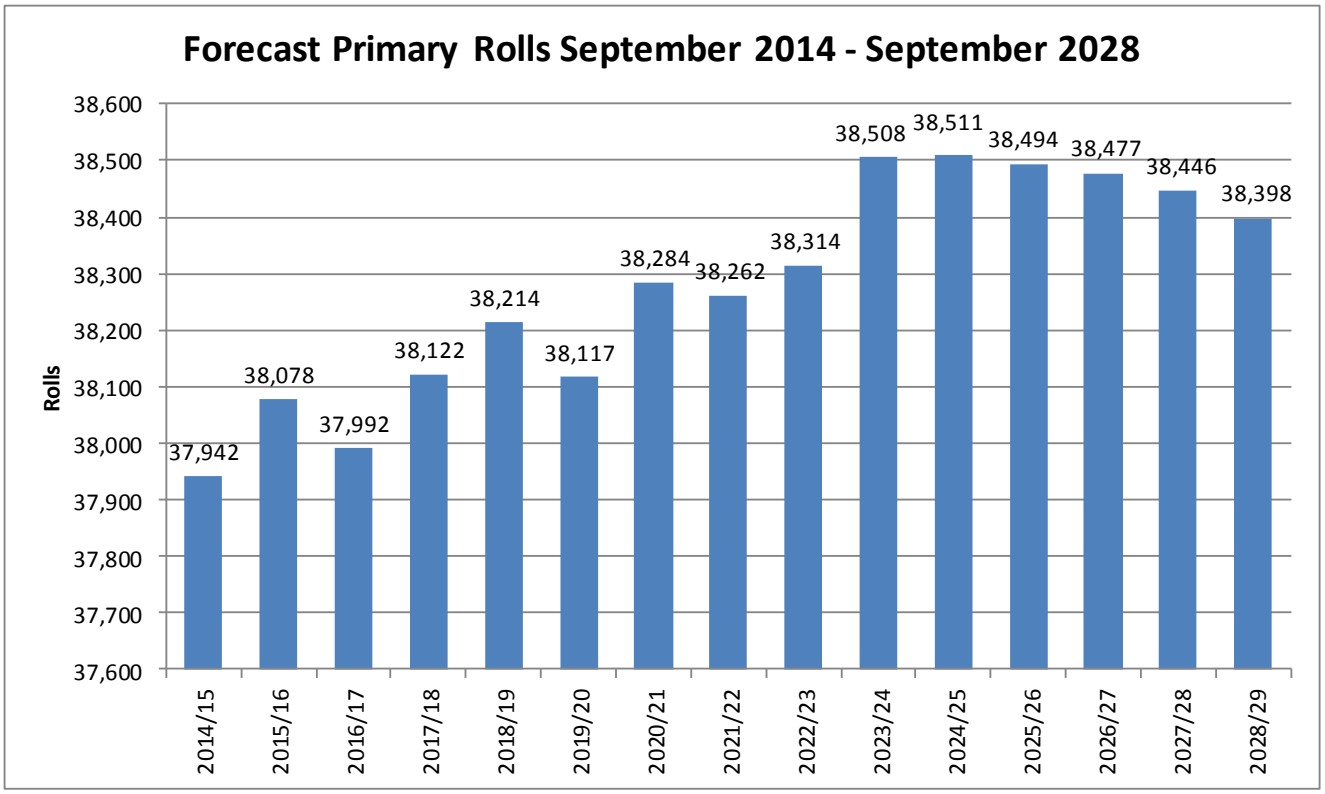
Projected pupil numbers in the primary sector
The total number of primary school places available across all schools in the county is 44,157. Table 27 illustrates the expected number of pupils in County Durham's 223 primary schools from October 2014 to October 2028.

Table 27: Expected number of pupils in primary schools within County Durham from Sept 2015 to Sept 2028

Sept 2014 (actual)	Sept 2015	Sept 2016	Sept 2017	Sept 2018
37,942	38,078	37,992	38,122	38,214
Sept 2019	**Sept 2020**	**Sept 2021**	**Sept 2022**	**Sept 2023**
38,117	38,284	38,262	38,314	38,508
Sept 2024	**Sept 2025**	**Sept 2026**	**Sept 2027**	**Sept 2028**
38,511	38,494	38,477	38,446	38,398

Figure 30 illustrates the expected increase in primary pupil numbers over the next 15 year period.

Figure 30: Forecast primary rolls September 2014 – September 2028



Projected pupil numbers in the 11-16 age range

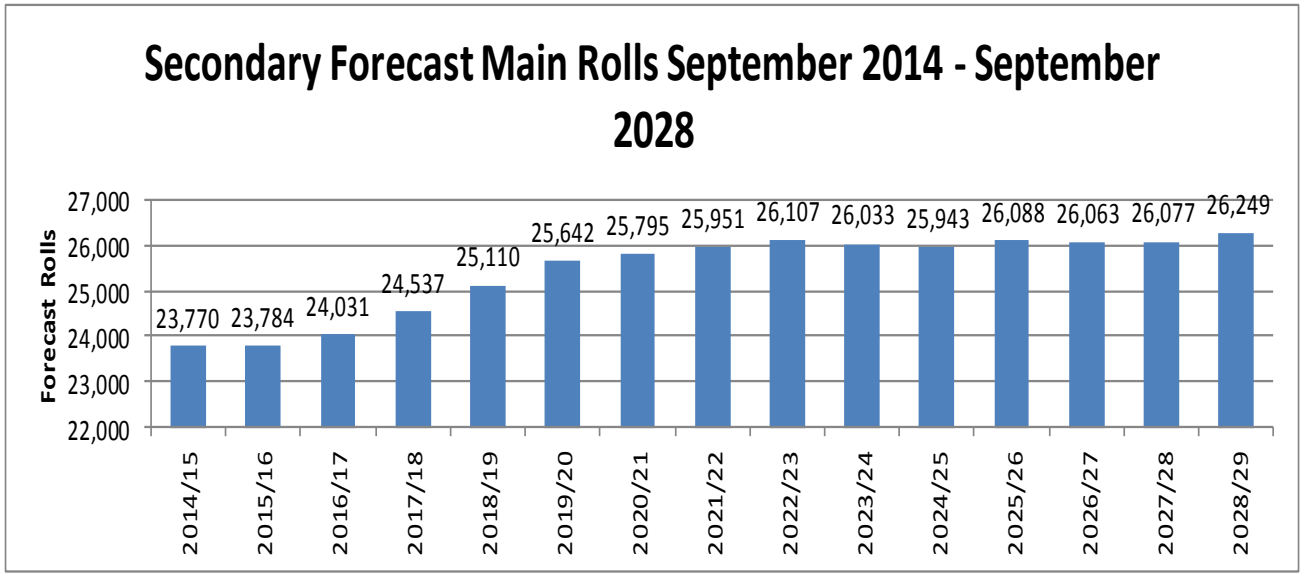
The total number of age 11-16 secondary school places available across all schools in the county is 32,916. Table 28 illustrates the expected number of pupils in County Durham's secondary schools across the 11-16 age range from September 2014 to September 2028.

Table 28: Expected number of pupils in secondary schools within County Durham from September 2014 to September 2028

Sept 2014 (actual)	Sept 2015	Sept 2016	Sept 2017	Sept 2018
23,770	23,784	24,031	24,537	25,110
Sept 2019	**Sept 2020**	**Sept 2021**	**Sept 2022**	**Sept 2023**
25,642	25,795	25,951	26,107	26,033
Sept 2024	**Sept 2025**	**Sept 2026**	**Sept 2027**	**Sept 2028**
25,943	26,088	26,063	26,077	26,249

Numbers are currently in decline and will fall to their lowest point at 2015. From then they will increase to 2028 as illustrated in Figure 31.

Figure 31: Secondary forecast main rolls September 2014 – September 2028



Post-16 pupil place planning

Post-16 numbers are difficult to predict as they are influenced by a number of key factors, including:

- Overall decline in 16 year old cohort (estimated at 5,800 in 2012 which reduces to 5,360 in 2015).
- Increase in proportion of young people achieving 5 A*-C including English and Maths which has an impact on the number of young people choosing to study in school sixth forms.
- The impact of changes in the pattern of post-16 provision, for example, the establishment of new provision in the Durham Community Business College Studio School, the new Apollo Studio Academy (partnership between East Durham College and The Academy at Shotton Hall), 11-18 Academies and ED6 at East Durham College.
- Post-16 transport.
- Broader policy developments, including the introduction of tuition fees.
- Continuing on-going promotion of apprenticeships, traineeships and 16-19 study programmes.
- The number of students from County Durham moving to study in another authority.
- The number of students moving either from other authorities or from the independent sector to study in County Durham's 11-19 maintained schools.

The government is committed to raising the participation age (RPA). From summer 2013, young people were required to continue in education or training until the end of the academic year in which they turn 17. From 2015, they will be required to continue until their 18th birthday. This doesn't necessarily mean staying in school.

Young people will be able to choose how they participate post-16, which could be through: full-time education, such as school, college or otherwise; an apprenticeship; part-time education or training if they are employed, self-employed or volunteering for 20 hours or more a week.

The current participation rate of 16 year olds is 93.8%. The participation rate is a measure of the percentage of 16 year old County Durham residents whom the local authority has recorded as either attending a School Sixth Form, Further Education Provision (College or Work Based Learning Provider), are in an Apprenticeship or have a job with training. 93.8% of all County Durham 16 year olds equates to 5,592 young people. The total number of all 16 year olds recorded in 2014 is 5,954.

The target for 2015 is to increase the percentage of 16 year olds participating to 97%. However as the population data forecast is that the number of 16 year olds will decrease by 2015, this percentage increase will not result in an actual increase in the number of students who will require Post-16 provision.

The population forecast is that the number of 16 year olds in 2015 will have decreased to 5,360. Therefore our target number of 16 year olds participating will be 5,200.

It is also anticipated that learners who are encouraged to participate as a result of RPA are more likely to access provision in Further Education colleges and work-based learning providers.

16-18 year olds not in education, employment or training (NEET)

Engagement in learning impacts on a range of outcomes and research has confirmed that those people who are well educated and achieve high level qualifications generally enjoy better health, live longer, are happier and have greater economic prosperity. They are also better able to adapt to changes in economic circumstances. Barriers to engagement include longer term illness, pregnancy, parenthood and other caring responsibilities. Some groups of young people are placed at greater risk of disengagement including those who offend, those with complex needs, young people in the care of the local authority and those with learning difficulties and disabilities.

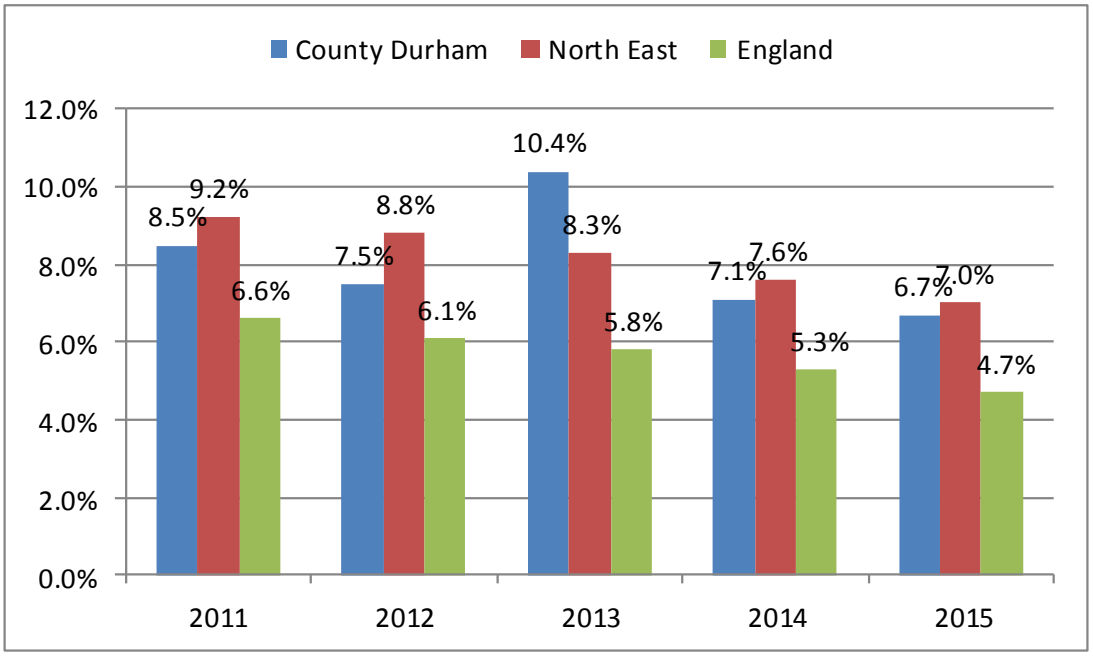
NEETs are defined as 16-18 year olds who are not participating in education, employment or training. Non-participation in education, employment or training between these ages is a major predictor of later unemployment, low income, depression, involvement in crime and poor mental health. Data for NEETs are taken from November-January each year (Figure 32, below), providing a 3-month average of 16 to 18 year olds who are NEET.

County Durham's performance for 16-18 year olds who are not in education, training or employment (NEET) has fallen from 7.1% in 2013/14 to 6.7% in 2014/15; this is lower than the North East (7.0%) but higher than England (4.7%).

County Durham has seen a decrease in the percentage of young people (age 16-18) recorded as Not Known, from 7.5% in 2013/14 to 4.6% in 2014/15. Data for Not Knowns were also taken from the November-January averages each year. As a

result of the Not Known decrease, the number of young people in a “Known” destination has increased, including those recorded as NEET. Personal Advisers in the One Point Service offer impartial Information Advice and Guidance (IAG) support to these young people, to help them secure appropriate learning opportunities.

Figure 32: Percentage of 16-18 year olds who are not in education, employment or training (NI117), 2011 – 2015 (November – January averages)



Source: NCCIS local authority tables 2011 – 2014 (3-month averages November - January)

It also needs to be noted that from 1st April 2011 changes implemented by the Department of Education meant that all 16-18 cohorts are determined by where a client resides. Previously they were determined by where clients were educated (irrelevant of where they resided). In addition, cohorts from 1st April 2011 are calculated on academic age. Previously they were calculated on actual/birth age.

The economic downturn from late 2008 has impacted greatly on the number of opportunities for young people across the county, e.g. those young people who had gained employment (including apprenticeships) but whose employers were not able to sustain their jobs, and on the numbers of young people who were able to secure apprenticeships.

Table 29: 16-18 year olds who are Not in Education, Employment or Training (NEET) by Clinical Commissioning Group Locality / Constituency, 31st March each year

CCG Locality / Constituency	2011	2012	2013	2014	% difference 2011 - 2014
Chester-le-Street	93	77	134	101	**8.6**
Derwentside	187	132	186	232	**24.1**
Durham	153	146	162	110	**-28.1**
Durham Dales	206	188	214	196	**-4.9**
Easington	227	239	387	295	**30.0**
Sedgefield	210	190	309	229	**9.0**
Not Matched / Out Of County	20	15	5	15	**-25.0**
County Durham	**1,096**	**987**	**1,397**	**1,178**	**-15.7**

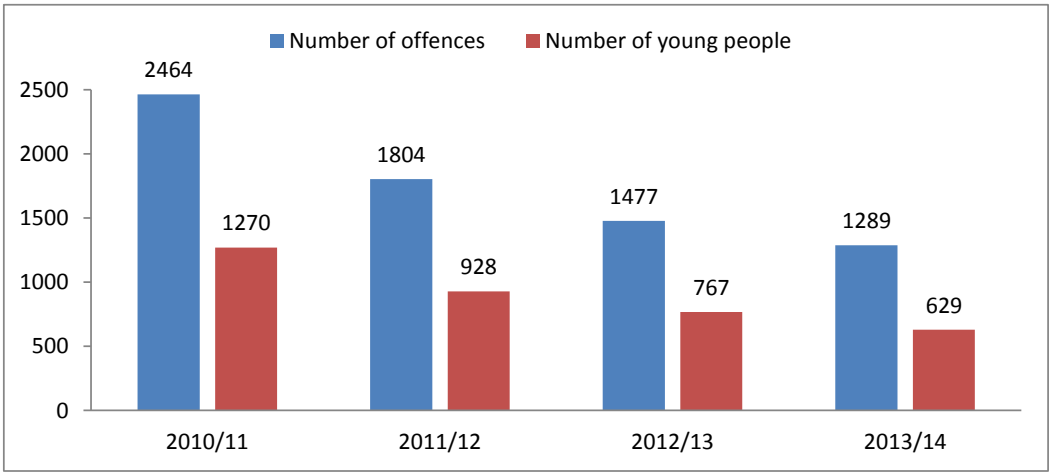
Source: NCCIS MI March 2014

When comparing CCG localities/constituencies within County Durham the number of NEETs is highest in Easington (295) and Derwentside (232). There is a decrease of 15.7% in the number of NEETs in the county in 2014 (1,178) when comparing figures for 2013 (1,397).

Youth offending profile

Since 2010/11 there has been a 47.7% reduction in the number of offences committed (2,464 to 1,289) and a 50.5% reduction over the same period in the number of young people offending (1,270 to 629). Figure 33 shows the year on year reduction in both offences and young people from 2010/11 to 2013/14.

Figure 33: Offending summary 2010/11 to 2013/14



2013/14 saw a total of 1,289 offences committed by 629 young people aged 10-17 (509 male and 120 female) across County Durham, resulting in a Pre Caution Disposal (PCD), pre court/out of court decision or court conviction imposed during the period.

55.5% (715) of all offences were committed by young people aged 16 or over (at the time of offence) with 29.7% (383) committed by 14-15 year olds and 14.8% (191) committed by those aged 10-13 years.

85% (1,096) of all offences were committed by males and 15% (193) by females. This percentage changes slightly when looking at the number of young people offending, with 80.9% (509) being male and 19.1% (120) female.

Males committed more offences on average, with 2.15 offences each, compared with1.6 per female offending.

Crime and location profile

Acquisitive and violent crime remain the top 2 offences, as in the previous 2 years. There was a 23.1% reduction in violent offences (from 329 to 253), compared to a 1.2% reduction in acquisitive crime (from 331 to 327). Only drugs and sex offences saw an increase from the previous year, however the number of such offences remains low, accounting for less than 5% of all offences committed.

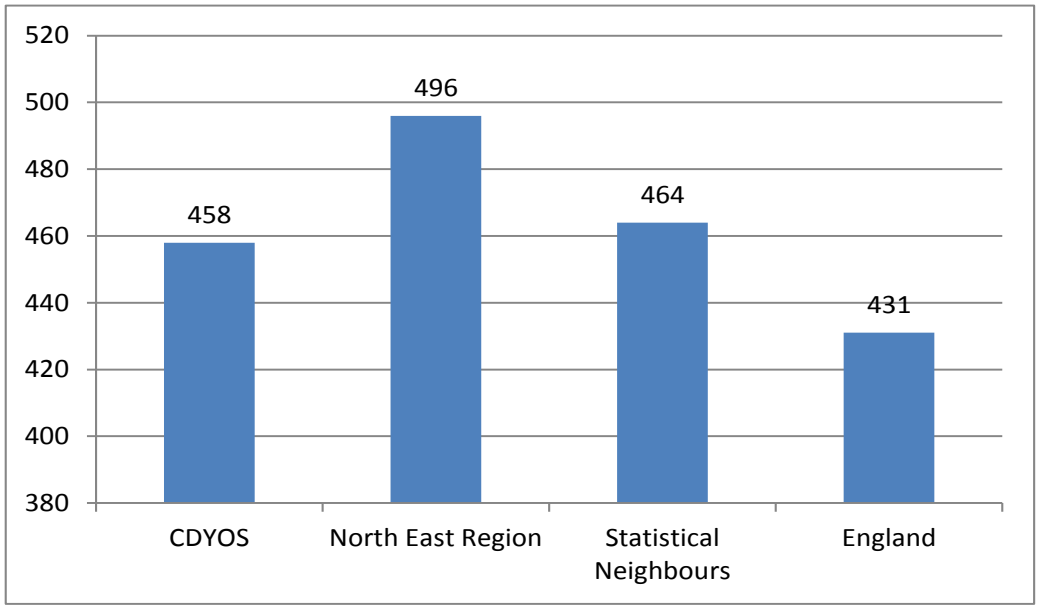
When looking at offences per population, the North area (Consett/Chester-le-Street/ Durham) has a rate of 21.7 offences per 1,000 10-17 year olds, compared to a rate of 38 offences per 1,000 in the South, indicating a much higher offending rate in Sedgefield and Wear/Tees areas. However, all local areas saw a reduction in the number of offences committed compared with the previous year, with the biggest decrease (26.9%) seen in the Chester-le-Street/Durham area.

First time entrants to the youth justice system

The local authority is aiming to create a county where children do not become unnecessarily criminalised, as research suggests that young people who enter the youth justice system experience a range of other negative outcomes and are less likely to achieve.

The latest first time entrants (FTE) information produced nationally using Police National Computer (PNC) data relates to the period April 2013 – March 2014.

Figure 34: FTE Rate per 100,000 10/17 year olds* 2013/14



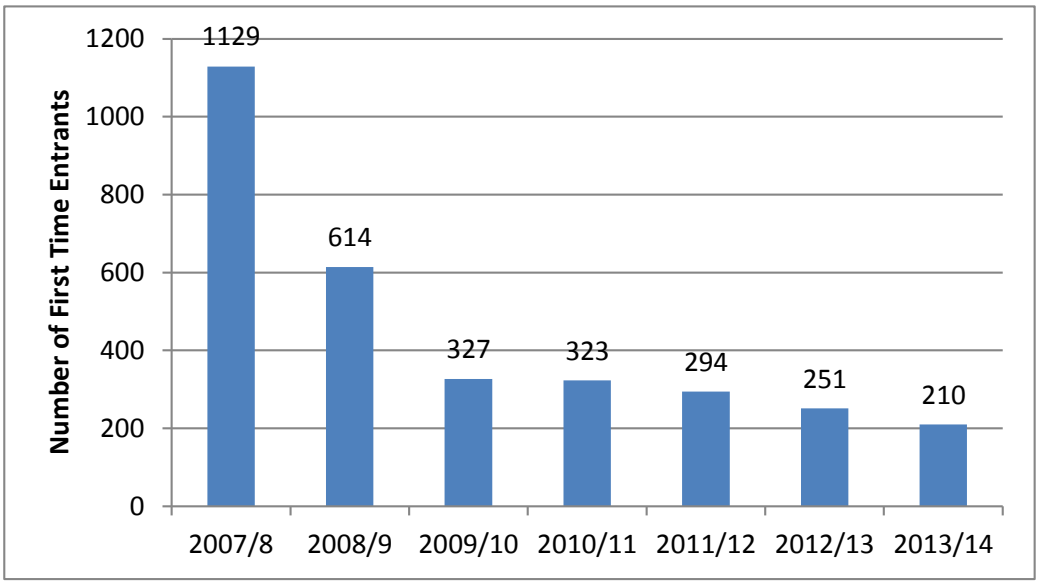
Source: Youth Offending Team Data Summary, YJB Sept 2014 *mid 2013 ONS population estimates (43,857)

The rates (per 100,000) of first time entrants to the youth justice system in 2013/14 were lower in County Durham (458) than the North East (496), but higher than England (431).

The introduction of the integrated pre-court system (2010) and the continued success of the Pre Caution Disposal (formerly the Pre Reprimand Disposal) continue to reduce the number of young people entering the youth justice system.

Figure 35 shows that there has been a continuous reduction, year on year, in first time entrants in County Durham. Over the past 7 years, an 81.4% reduction in FTEs, from 1,129 young people in 2007/08 to 210 in 2013/14, has been achieved.

Figure 35: CDYOS first time entrants 2007/08 to 2013/14



Source: CDYOS local Careworks data

Re-offending

A new national re-offending measure (proven re-offending) was introduced by the Ministry of Justice in 2011/12 which, like the FTE indicator, is calculated from PNC data nationally and includes all young people. The use of PNC data has meant that youth offending teams are unable to verify or reconcile this data with their own data or monitor current re-offending rates. County Durham Youth Offending Service continued to monitor re-offending using the former National Indicator (NI 19) as a proxy measure until April 2014 to allow local performance to be monitored in a more timely manner, but this has now been discontinued. National data are being used from April 2014 to monitor re-offending as this provides regional and national comparisons.

The evidenced success of CDYOS pre-court/out of court systems in diverting young people from the criminal justice system has resulted in a:

- 70.6% reduction in the number of young people in the cohort between 2007/08 and 2011/12 (from 2,145 to 631).
- 67.2% reduction in the number of young people re-offending.
- 62.8% reduction in the number of re-offences.

The latest Ministry of Justice data show that CDYOS has achieved a continuous reduction in proven re-offending from April 2010-September 2013, with the most recent proven rate of re-offending being 37.1%, below the North East average.

Table 30: Proven rate of re-offending (October 2011-September 2012 Cohort)

	Binary Rate (% of cohort re-offending)	% change from previous year
CDYOS	37.1%	-13.5%
Durham PCC Area	36.2%	-16.0%
North East Region	37.6%	-3.7%
England	35.4%	-1.9%

Source: YJB YDS (August 2014)

The success by CDYOS in reducing re-offending was recognised by Her Majesty's Inspectorate of Prisons in August 2014:

'*Over the past 18 months County Durham has achieved a continuing and substantial reduction in proven reoffending by children and young people'.* And *'Case managers knew children and young people well and could accurately and concisely describe why they offended and what needed to be done to reduce reoffending.'*
(HMIP, Short Quality Screening Inspection of CDYOS, August 2014)

Young people in custody
Young people remanded or sentenced to custody experience even greater health needs than those in the community. For example, Youth Justice Board research (2009) found that 80% of young people in custody had used illegal drugs at least once a month and 40 - 49% of young people in custody had been looked after. A study in 2002 identified the placement of a young person in custody itself as a cause of mental health problems, for example, depression and anxiety. All young people in Durham entering custody for the first time are the subject of a multi-agency vulnerability management plan as a result of these concerns.

This situation is exacerbated by the difficulties in coordinating work between community and custody, and back into the community on release. The outcome of this is that many of these health needs can be missed and therefore can go untreated, leading to adverse outcomes and re-offending.

Health needs of young people who offend
In 2013/14, CDYOS worked with 629 young people aged 10-17 who had offended. Analysis was carried out on 188 assessments of young people (148 males, 40 females) receiving either an out of court disposal or court conviction in the period April to June 2014, with the following findings:

- Family and personal relationships: 77% of assessments identified 'family and personal relationships' as a risk to the likelihood of re-offending, with 15% (28/188) identified as a serious risk.
- Education: 58% of assessments identified 'Education, Training and Employment' as a risk to re-offending.
- Lifestyle: 80% of assessments identified 'Lifestyle' as a risk to re-offending, with 15% identified as a serious risk.

- Substance use: 65% of assessments identified 'Substance use' as a risk to re-offending, with 9% identified as a serious risk.
- Physical health: 18% of assessments identified 'Physical Health' as a risk to re-offending. None were identified as a serious risk.
- Emotional and Mental health: 64% of assessments identified 'Emotional and Mental health' as a risk to re-offending, with 9% identified as a serious risk.
- Perception of self and others: 66% of assessments identified this as a risk to re-offending.
- Thinking and Behaviour: 98% of assessments identified this as a risk to re-offending, with 22% as a serious risk.
- Attitude to offending: 85% of assessments identifies this as a risk to re-offending, with 9% identifying it as a serious risk.
- Risk of harm: 20% of young people assessed were identified as being a risk of harm to others; there were gender differences in this however, with only 5% of females and 24% of males presenting as a risk.
- Vulnerability: 32% of young people assessed were considered to have indicators of vulnerability. This could be due to the behaviour of others, their own behaviour or specific events or circumstances; there was little gender difference in terms of vulnerability.
- Looked after Children: 19% have been looked after at some point.
- School Action: 23.4% are/have been on School Action.
- School Action Plus: 30.85% are/have been on School Action Plus.
- SEN Statements: 15.95% are/have had a statement of SEN.
- Permanent School Exclusions: 20.2% were permanently excluded from school at some point and 8 of the 38 (21%) had been permanently excluded twice.

Speech, language and communication needs

National research suggests that 60-90% of young people in the youth justice system have speech, language and communication needs (compared to 10% of the general population). This '*might include an inability… to effectively understand and engage in a legal process, leading to poor presentation in court or during a police or YOT interview.'* (Source: 'Nobody Made the Connection'; Children's Commissioner, 2012).

Since 2013, CDYOS has worked to improve the response to the speech, language and communication needs of young people who offend in County Durham – to support the principal aim to prevent re-offending and reduce first time entrants to the youth justice system. CDYOS has developed and implemented a comprehensive Speech, Language and Communication Needs Strategy for young people who offend in County Durham. This is in 3 phases: Phase 1 (March – September 2014); Phase 2 (October 2014 – March 2015); and Phase 3 (April 2015- March 2016).

Attention problems

Feedback from CDYOS nurses and staff indicates that attention problems are prevalent amongst young people who offend. 18% in a national study of 100 young people in the youth justice system had attention deficit hyperactivity disorder (ADHD) recorded as an issue for them (Source: www.chimat.org.uk).

Learning disabilities
CDYOS nurses and staff indicate that learning disabilities are prevalent amongst young people who offend. National research involving boys in 4 secure children's homes assessed 27% of them as having an IQ less than 70 and 43% between 70-85 (Source: www.chimat.org.uk).

Acquired brain injury was reported in 16% of a sample of young people in contact with the youth justice system (Source: Neuropsychological Rehabilitation 20(6), Williams HW et al 2010). Research shows that 50% of those in custody have some kind of acquired brain injury, but young offenders need different approaches to help reduce re-offending. (Source: Child Brain Injury Trust, 2012. www.childbraininjurytrust.org.uk).

Social vulnerability needs
Significantly high numbers of young people who offend have experienced abuse or neglect as victims, or have been exposed to domestic abuse. 'The proportion of young people in custody who have experienced serious child maltreatment is at least twice that in the population as a whole. Childhood maltreatment is an important risk factor in violent offending.' (Source: www.chimat.org.uk).

The journey of young people who have been looked after by the local authority to custody is well documented nationally. 24% of young men and 49% of young women in a review of young people in Young Offenders Institutions had been looked after in some point in their life. Other sources suggest that between 40 - 49% of all young people in the youth justice system are, or have recently been, looked after. (Source: www.chimat.org.uk).

Of the 200 young people in the 2013 CDYOS re-offending cohort, 54 have been 'looked after' at some time in their lives. This consists of 44 young people in long term care and 10 who have accessed respite services at some point.

36% of young people who CDYOS worked with were assessed as being vulnerable due to a range of factors, including them being a victim of crime.

54% of assessments identified living arrangements as a risk factor for re-offending, with 13.9% of these identifying it as a serious risk to re-offending.

46.2% of all young people who offended aged 16 or over in 2012/13 were not in full time education, training or employment at the end of CDYOS intervention.

Child poverty
Growing up in poverty has a significant impact on children and young people both during their childhood and beyond. Children who are unable to enjoy leisure activities with their peers may find their education suffers, making it difficult for them to achieve their full potential and get the qualifications needed to sustain a well-paid job. This will impact on a child's development, as children from low income families are often excluded from extra curricula activities, e.g. school trips, etc. This in turn limits their potential to earn the money needed to support their own families in later life and so a cycle of poverty is created.

The proportion of children living in poverty in County Durham as of February 2014 is 23%; whilst this is lower than the North East at 24.5%, it continues to be greater than the England average at 20.6%.

Whilst some children thrive despite the poverty they grow up in, for many children growing up in poverty can mean a childhood of insecurity, under-achievement at school and isolation from their peers. Children who grow up in poverty are four times as likely to become poor adults, becoming the parents of the next generation of children living in poverty.

The government has published an evidence-based Child Poverty Strategy 2014/17 which sets out how it will tackle poverty, by:

- Raising the incomes of poor children's families by helping them get into work and making work pay.
- Supporting the living standards of low-income families.
- Raising the educational outcomes of poor children.

The vast majority of children in poverty live in families which claim either income support or income based jobseeker's allowance. In-work poverty, as measured by these data, is much rarer, with only around one in seventy of all children affected compared to over one in five of all children in workless families.

At a local level within County Durham there is a large variation in rates between localities. Of the 320 lower super output areas (LSOAs) within the county, there are six where over half of the children live in poverty.

Woodhouse Close Central continues to be the LSOA with the highest child poverty rate in the county at 58.6%. However it should be noted that child poverty in this area has steadily declined from 65.5% in 2007.

Poverty amongst families with pre-school children tends to be more prevalent. Pre-school poverty rates are higher than overall rates but follow similar trends. Latest data show that in 2011 more than one in four pre-school children in County Durham (26.8%) lived in families with an income less than 60% of the national median, a marginal increase from 2010 and much higher than national comparisons.

Stronger families

Durham County Council and its partners are delivering a programme designed to work with families facing multiple and complex challenges. Known nationally as the Troubled Families Programme, the work is called Stronger Families in County Durham. The programme is a payment by results scheme, whereby some of the funding from the Department of Communities and Local Government (DCLG) will only be paid if we succeed in achieving the targets set. The intention of the programme is to work with a minimum of 1,320 families by March 2015 and as of February 2015, the Stronger Families Programme had worked with **1,695** families and 'turned around' the lives of 1,185 families in County Durham.

These are not new families but families who are known to services, where despite numerous interventions, often over many years, their problems persist and are in many cases intergenerational.

The government's expanded phase 2 national programme will target 400,000 families over a planned 5 year term and will continue to focus on families with multiple high cost problems. However, rather than focusing on a relatively small number of defined national criteria, the expanded programme will be based on a cluster of six headline problems, below which will sit a basket of indicators and referral routes. These headline problems are:

- Parents and children involved in crime and anti-social behaviour.
- Children who have not been attending school regularly.
- Children who need help.
- Adults out of work or at risk of financial exclusion and young people at risk of worklessness.
- Families affected by domestic violence and abuse.
- Parents and children with a range of health problems.

Estimates from the DCLG show that there are 4,330 families in County Durham which have a combination of at least two of the headline problems, which the programme will target and support over the 5 year term.

Referrals of children and young people with mental health needs

Analysis of the number of new referrals to Child and Adolescent Mental Health Services (CAMHS) can provide an indication of mental health need amongst children and young people aged 0-17. These increased by 24% from 2,150 in 2012/13 to 2,667 in 2013/14.

Categories of need can include:

- Severe and enduring distress caused by significant life changes, e.g. bereavement, divorce, parental illness.
- Serious developmental concerns, e.g. attention deficit hyperactivity disorder or autism spectrum disorders.
- Severe and emotional and behavioural difficulties, e.g. depression, obsessive compulsive disorder, eating disorders.
- Trauma associated with abuse or violence.

Estimated need for services at each tier

The Child and Maternal Health Observatory estimates that in County Durham, the number of children and young people who may experience mental health problems appropriate to a response from CAMHS by tier[5] is:

- Tier 1: 15,040
- Tier 2: 7,020
- Tier 3: 1,855
- Tier 4: 80

[5] Tier 1 – Universal services, e.g. GPs etc.
Tier 2 – Targeted services, e.g. primary mental health workers
Tiers 3 & 4 – Specialist services, e.g. child and adolescent psychiatrists, essential tertiary level services such as day units, highly specialised Out Patient teams and In Patient units

Table 31: Child Adolescent Mental Health Service referrals by Clinical Commissioning Group Locality / Constituency – April 2013 to March 2014

CCG Commissioning Locality / Constituency	Number of GP & Other referrals to CAMHs T2 & T3 Services	Population 0-17 ONS 2011 population estimates	Rate per 10,000 population (aged under 18)
Durham	288	15,664	183.9
Chester-le-Street	297	10,586	280.6
Derwentside	646	18,506	349.1
Durham Dales	447	17,578	254.3
Easington	484	19,662	246.2
Sedgefield	505	18,120	278.7
Grand Total	**2,667**	**100,119**	**266.4**

Source: TEWV

The number of new referrals to CAMHS increased by 24% from 2,150 in 2012/13 to 2,667 in 2013/14. However, CAMHS referral rates, as information about children and young people who have reached a critical stage, may not provide a full picture of need.

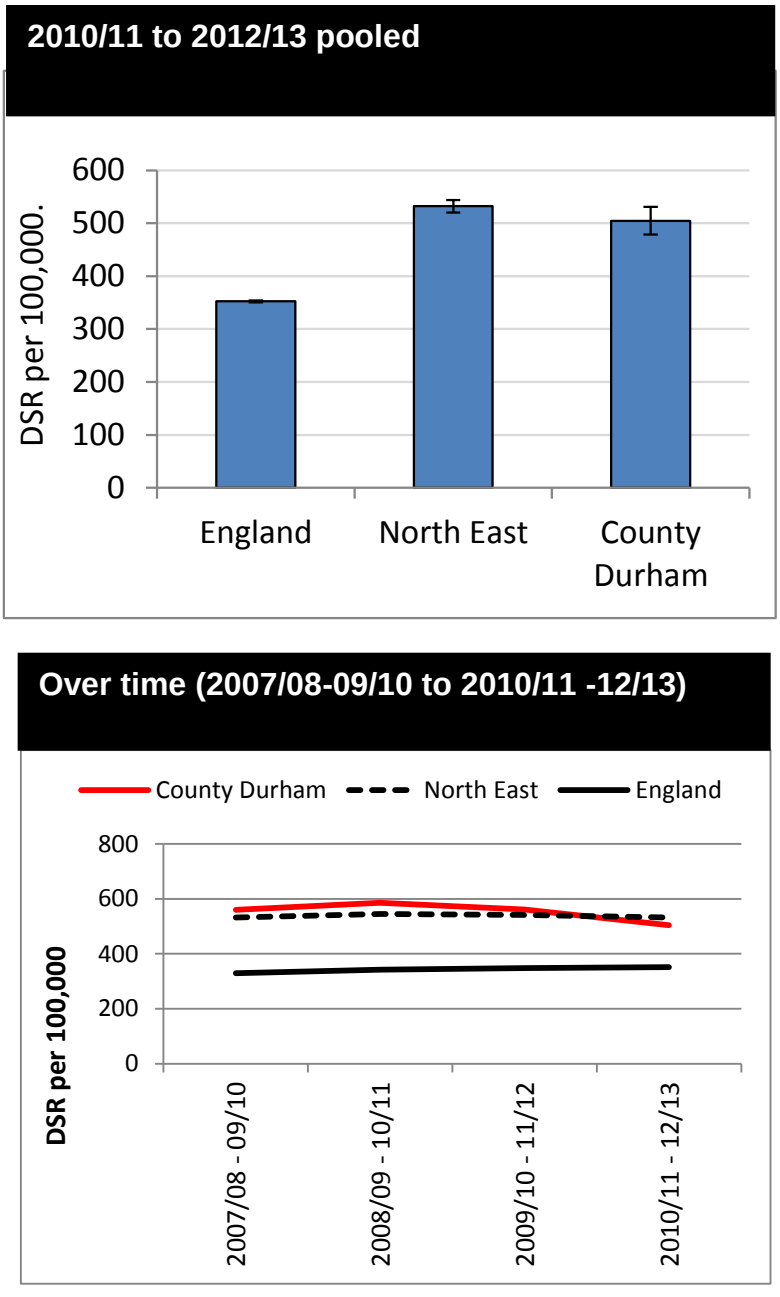
Self-harm (10-24 years)

The term self-harm refers to any act of self-poisoning or self-injury carried out by a person, irrespective of motivation, and commonly involves self-poisoning with medication or self-injury by cutting. Most self-harming behaviour is not lethal and is unlikely to lead to death and most young people and adults who self-harm do not intend to risk their lives.

A wide range of mental health problems are associated with self-harm, including borderline personality disorder, depression, bipolar disorder, schizophrenia, and drug and alcohol-use disorders. Self-harm is common, especially among younger people. People who self-harm have a 50 to 100 fold higher likelihood of dying by suicide in the 12-month period following an episode than people who do not self-harm.

Self-harm does not usually mean an attempt to commit suicide (NSPCC), and self-harming in young people is not uncommon; 10-13% of 5-16 year olds have self-harmed ('No health without mental health' HM Government, February 2011). Levels of hospital admissions for self-harm may not be accurate due to coding issues. In addition, many instances of self-harm may be treated in A&E rather than through admission to hospital and more do not come to the attention of health care services; hospital attendance rates do not reflect the true scale of the problem.

Figure 36: Directly age standardised hospital admission rates per 100,000 as a result of self-harm (10-24 years), 2010/11 - 12/13 and 2006/07-08/09 to 2010/11-12/13, England, North East and County Durham.



Source: Public Health Outcomes Framework, Public Health England

Admissions to hospital as a result of self-harm (aged 10-24) are significantly higher in County Durham (410.5 per 100,000 in 2012/13) than England (346.3), and not significantly different to the North East (479.6).

Over time, self-harm admission rates for those aged 10-24 in County Durham have fallen by around 10%, compared to a 7% reduction nationally. There was no change regionally over the same period.

A local strategy to reduce self-harm and suicide is in place. (A direct comparison of self-harm rates from previous CHIMAT profiles should not be made due to the indicator changing, as previously 0-17 years was the denominator).

Emotional wellbeing of children and young people

Stable families, consistent positive parenting, having friends, access to play, doing well in school, developing self-control, emotional intelligence, self-esteem and confidence are all key to ensuring that children and young people experience good emotional wellbeing, which creates the basis for securing improved outcomes throughout their lives. There are a number of 'risk factors' which can lead to an increased likelihood of a young person experiencing mental health problems. These include:

- Having a learning disability or long-term physical illness.
- Having a parent who has had mental health problems, problems with alcohol or has been in trouble with the law.
- Experiencing the death of someone close to them.
- Having parents who separate or divorce.
- Having been severely bullied or physically or sexually abused.
- Living in poverty or being homeless.
- Experiencing discrimination, perhaps because of their race, sexuality or religion.
- Acting as a carer for a relative, taking on adult responsibilities.
- Having long-standing educational difficulties, or not being in employment, education or training.

'Better Health Outcomes for Children and Young People' 2013 (Department of Health) highlights a need to 'improve the mental health of our children and young people by promoting resilience and mental wellbeing and providing early and effective evidence based treatment for those who need it'. The document also states that it is important to 'support and protect the most vulnerable by focusing on the social determinants of health and providing better support to the groups that have the worst health outcomes.'

The emotional wellbeing of looked after children is reported nationally as part of the Public Health Outcomes Framework (PHOF). This is sourced from the Strengths and Difficulties Questionnaire, based on questions around the following domains: emotional problems; conduct problems; hyperactivity or inattention; friendships and peer groups; positive behaviour and is defined as the average total difficulties score for all looked after children aged between 4 and 16 (inclusive) at the date of their latest assessment, who have been in care for at least 12 months on 31st March.

Prevalence varies by age and sex, with boys more likely (11.4%) to have experienced or be experiencing a mental health problem than girls (7.8%). Children aged 11 to 16 years olds are also more likely (11.5%) than 5 to 10 year olds (7.7%) to experience mental health problems. These prevalence rates of mental health disorders have been further broken down by prevalence of conduct, emotional, hyperkinetic and less common disorders (Green, H. et al, 2004). The following tables show the estimated number of children with conduct, emotional, hyperkinetic, autism and less common disorders in County Durham, by applying these prevalence

rates (the numbers in this table do not add up to the numbers in “any disorder” rows because some children have more than one disorder).

Table 32: Estimated number of children with mental health disorders in County Durham, by age group

Diagnosis	Age (Years)			
	5-10		11-16	
	Estimate (n)	Estimated prevalence (%)	Estimate (n)	Estimated prevalence (%)
Any *	2,443	7.7%	3,207	11.5%
Conduct	1,554	4.9%	1,840	6.6%
Emotional	761	2.4%	1,394	5.0%
Hyperkinetic	508	1.6%	390	1.4%
Less common	412	1.3%	390	1.4%
Autistic Spectrum	317	1.0%	223	0.8%

Estimates based on 'Mental health of children and young people in Great Britain, Green H et al, 2004'. Using Mid-2012 Population Estimates: Single year of age and sex for local authorities in England and Wales.

The exact prevalence of mental and emotional disorders in children and young people in County Durham is not known. However, national evidence suggests:

- Rising prevalence of emotional problems.
- Around 10% of children and young people suffer from a classifiable mental disorder requiring intervention.

Special Educational Needs and Disability (SEND)

Special Educational Needs and Disability (SEND) refers to children and young people who have learning difficulties or disabilities which make it harder for them to learn or access education than most children of the same age. (SEND includes children and young people aged 0-25). Help and assistance will usually be provided to children and young people with SEND in their mainstream early education setting or school, sometimes with the help of outside specialists. Where a child or young person has severe and/or complex learning difficulties, it is sometimes appropriate for him/her to be educated through special schools.

A Special Educational Needs and Disability Strategy has been developed for County Durham in response to the Children and Families Act. This has led to the implementation of Education, Health and Care (EHC) assessments (from birth to 25) and personal budgets for anyone in receipt of an EHC Plan, when requested by the parents or young person. In addition, a Local Offer of services has been launched to support children and young people with special educational needs and their families; as the council has a responsibility to provide advice and guidance for families of children with special educational needs.

The data in Table 33 for academic year 2013/14 show that 92.0% of pupils identified as not having SEN at the start of Key Stage 2 achieved Level 4 or above in Reading, Writing and Maths at the end of KS2, compared to 48.6% identified as having SEN. This results in a gap of 43.4 percentage points. This is slightly narrower than the previous year's gap of 45.4.

The data for 2013/14 also shows that 68.4% of pupils identified as not having SEN achieved 5 A*-C GCSE's grades or equivalent including English and Maths GCSEs, compared to 20.5% of those pupils who did have SEN. This results in a gap of 47.9 percentage points.

This gap can't be compared to the previous year due to the change in policy.

Table 33: Comparison of achievement at Key Stage 2 (where available) and Key Stage 4 for pupils with special educational needs and all other pupils 2005/06 – 2013/14

Year	% Achieving Level 4 or Above in Reading, Writing and Maths at Key Stage 2		% Achieving 5 A*-C GCSEs or Equivalent Including English and Maths	
	Non-SEN	SEN	Non-SEN	SEN
2005/06	n/a	n/a	49.1	8.6
2006/07	n/a	n/a	50.7	8.7
2007/08	n/a	n/a	55.4	9.0
2008/09	n/a	n/a	61.2	13.0
2009/10	n/a	n/a	70.9	20.9
2010/11	n/a	n/a	74.4	19.6
2011/12	88.8	42.3	75.6	24.9
2012/13	91.3	45.9	75.8	24.6
2013/14	92.0	48.6	68.4	20.5

Source: Internal databases, DfE Performance Tables and NCER/EPAS database

Behavioural, emotional and social difficulties (BESD) is an umbrella term to describe a range of complex and chronic difficulties experienced by many children and young people.

The SEN Code of Practice describes BESD as a learning difficulty, where children and young people demonstrate features of emotional and behavioural difficulties such as: being withdrawn or isolated, disruptive and disturbing; being hyperactive and lacking concentration; having immature social skills; or presenting challenging behaviours arising from other complex special needs.

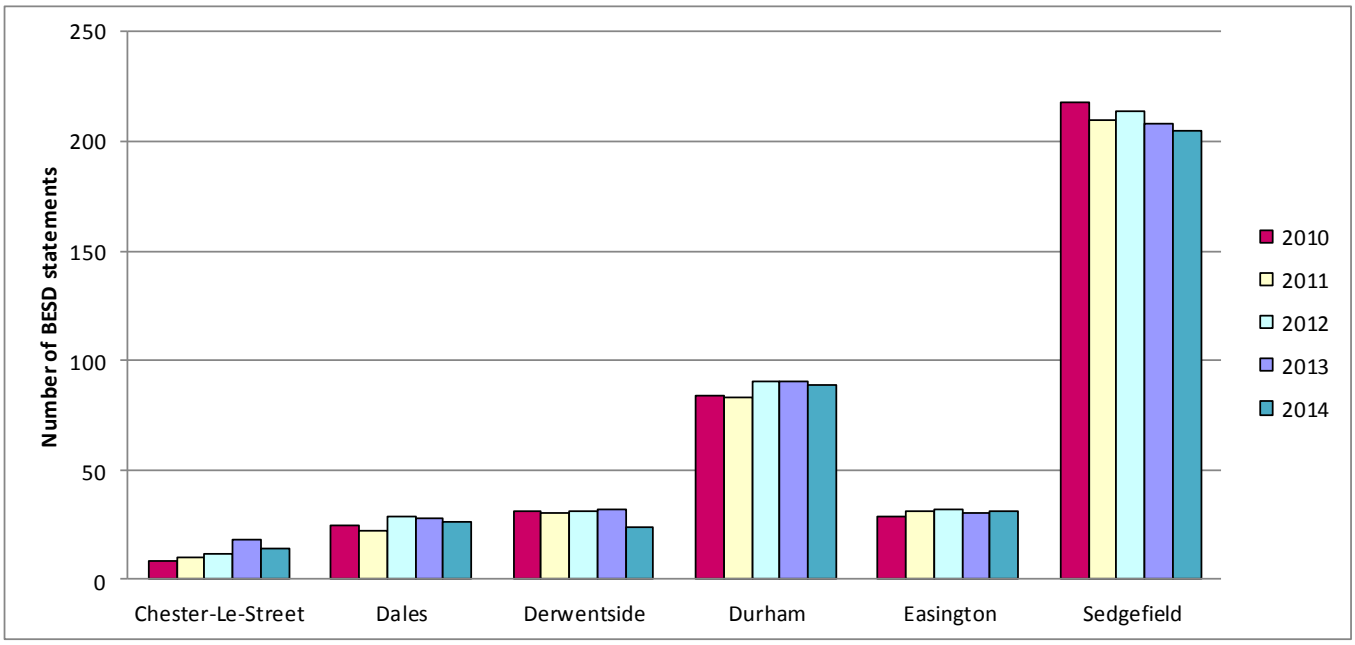
Children and young people whose behavioural difficulties may be less obvious include those who:

- Suffer from anxiety.
- Self-harm.
- Suffer from phobia or depression.

Pupils with BESD cover the full range of ability; however their difficulties are likely to be a barrier to learning. Learning difficulties and behaviour difficulties are often in a two-way relationship with each other. A Statement of Special Educational Needs can be issued to support children in education who display BESD.

- In 2012/13, 376 SEN statements were related to BESD. This is the same figure as 2011/12, and an increase from 2010/11 (355), and 2009/10 (366).
- For the purpose of locality analysis, it must be noted that figures will be inflated due to the number of special schools in some areas. Sedgefield continually has the highest number of SEN statements but from 2009/10 to 2010/11 saw a slight decrease in the number related to BESD (218 to 210); this rose again in 2011/12 (214) but the 2013/14 figure is the lowest yet (205).
- The data for academic year 2013/14 show that 92.0% of pupils identified as not having SEN at the start of Key Stage 2 achieved Level 4 or above in all of reading, writing and maths at Key Stage 2, compared to 48.6% who had SEN. This results in a gap of 43.4 percentage points.
- The data for 2013/14 also show that 68.4% of pupils identified as not having SEN achieved 5 A*-C GCSE's grades or equivalent including English and Maths at Key Stage 4, compared to 20.5% who have SEN. This results in a gap of 47.9 percentage points.
- The rate of children who have autism spectrum disorders known to schools in County Durham was 9.9 per thousand children (January 2014). This shows a year on year increase since January 2009 and is now higher than the 2012 figures for the North East (8.32) and England (8.17).

Figure 37: Special educational needs statements due to behavioural, emotional and social difficulties (BESD) 2009/10 - 2013/14 - County Durham by locality



3. Which groups are most vulnerable and why?

Unborn children
The health risks of smoking in pregnancy are well established, posing risks to both unborn children and mothers. Smoking when pregnant can cause a greater risk of miscarriage and stillbirth and increases infant mortality by approximately 40%. Babies are more likely to be born prematurely and with a low birth weight. Smoking in pregnancy also exhibits a strong social class gradient and contributes to health inequalities among mothers and children.

The earlier in the pregnancy a mother can stop, the better the health outcomes for both her and her baby. Staying smokefree after birth ensures protection for the baby and other siblings from exposure to second-hand smoke. More action is needed to increase referrals of pregnant smokers to the stop smoking service. However, more capacity is needed to support these increased referrals.

Children and young people who are obese
Areas of high deprivation have the highest prevalence of obesity. Deprivation and poverty are key determinants in what families eat. Price is the most important factor leading to purchase of cheaper calorie-dense foods. Families are often aware of what the "healthy choice" would be but cannot afford it and may have difficulties in accessing it. In addition, lower income families spend less on activities and transport.

Teenage parents
Low aspirations and low self-esteem are risk factors for under-16 and under-18 conceptions. The greater the number of indicators a young person (male or female) meets from the list below, the more significant the risk of an unintended conception:

- Young person experiencing deprivation.
- Children of teenage mothers.
- Care leavers and those in care.
- Young people with mental health issues.
- Young offenders.
- Young people who have been sexually abused.
- Young people who misuse alcohol or drugs.
- Young people with low educational attainment.
- Young people disaffected or disengaged from education, including persistent absence.

Children and young people who use alcohol and drugs
Studies suggest that socially excluded groups of young people, such as school truants and pupils excluded, offenders, children in the care of local authorities and those with parents who use drugs/alcohol, tend to report higher rates of substance use than other young people.
Source: The Experience of School Exclusion on Drug Use and Antisocial Behaviour Journal of Youth Studies 10, McCrystal

Children and young people in the child protection system and those who are looked after

Research and data show that there are a number of factors which make children and young people more likely to become a recipient of safeguarding and looked after children services. These include:

- Children whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development (or their health and development will be impaired) without the provision of services, for example, children with a disability.
- Children whose parents have mental ill-health or learning difficulties themselves.
- Children with parents abusing substances.
- Households with children where domestic violence is present.
- Children living in more deprived areas.
- Asylum seeking children and young people.

Young people who offend

The 'ASSET' assessment identifies the extent to which behaviours and attitudes are associated with the likelihood of young people offending. When determining the average scores for factors associated with further offending, the 4 factors most associated with further offending across the county are 'thinking and behaviour', 'lifestyle', 'substance use' and 'family/personal relationships'.

Children and young people who do not achieve as well as their peers

In 2014, 22% of children (5-15 years) across primary, secondary and special schools in County Durham were eligible for free school meals, which is higher than the England average of 17%.

Children identified as qualifying for free school meals are at greater risk of not achieving expected academic outcomes than their peers. The barriers experienced by pupils eligible for free school meals may be many and wide-ranging. Possible influences on their ability to achieve include lack of resources such as tutoring, access to books or the internet and space for private studying.

Children with special educational needs are likely to need high-quality specialised provision in order to achieve fully. They may also have emotional or behavioural problems which could impinge on their ability to access education.

Pupils from traveller backgrounds achieve less well than other students.

Children in poverty

National research tells us "that children's life chances are most heavily predicated on their development in the first five years of life" and that family background, parental education, good parenting and the opportunities for learning and development in those crucial years matter more to children than money, in realising their potential in adult life.

Research by the Centre for Economic and Social Inclusion and the Child Poverty Action Group (CPAG) found that groups more likely to experience poverty include:

- **Lone parents** - children of lone parents are at greater risk of living in poverty than children in couple families. Before housing costs, over a third, 35.0%, (50.0% after housing costs) of children living in lone parent families are poor, compared with less than a fifth, 18.0%, of children in couple families.
- **Large families** - children in large families are at far greater risk of poverty than children from small families: two fifths (40.0%), of children in families with four or more children are poor, compared with under a fifth, (19%), of children in one-child families.
- **Children with disabilities** - disabled children are more likely than their non-disabled peers to live in poverty as a result of lower incomes (because parents need to look after disabled children and so cannot work) and the impact of disability-related additional costs (an impact which is not captured by official figures).
- **Children with disabled parents** - children with disabled parents face a significantly higher risk of living in poverty than those of non-disabled parents. The main reason for this is that disabled parents are much less likely to be in paid work, and also suffer the impact of additional disability-related costs which sap family budgets.
- **Children growing up in social housing** - children living in social housing (either local authority or housing associations) face a high risk of being poor. 49.0% of children in local authority accommodation are poor before housing costs (rising to 58.0% after housing costs). Poor children in social housing are also a large proportion of all poor children. Though the numbers in private rented accommodation are smaller, these children also face a high risk of poverty.
- **Black and minority ethnic children** - children living in households headed by someone from an ethic minority are more likely to be living in a poor household. This is particularly the case for those households headed by someone of Pakistani or Bangladeshi origin, where well over half the children are living in poverty.
- **Asylum seekers** - there is no robust quantitative data on asylum seekers. However the parents in this group are prohibited from working and are only entitled to safety net support at a lower level than the usual income support / jobseekers allowance safety.
- **Gypsy, Roma and Traveller (GRT) children** - there is a severe lack of robust quantitative data on GRT families, including poverty. However, both practice knowledge and other studies show that some have few financial resources.
- **Children leaving care** - young people leaving care are likely to face multiple disadvantages including poverty. Those entering care are also much more likely to have experienced poverty. This is a consequence of their pre-care, in-care, leaving care and after-care 'life course' experiences.

Source: Centre for Economic and Social Inclusion (*Inclusion)* and the Child Poverty Action Group (*CPAG) Child Poverty Toolkit)*

Vulnerable families

Good parenting leads to improved attainment, resilience, healthy lifestyles, confidence and feelings of self-worth. Through the provision of effective universal services such as GP and other community health services, good child care, nursery and school education, play areas, services and so on, most families will flourish.

Some families however, need extra support. Too often cycles of intergenerational disadvantage can become established in families. For example, research shows us that:

- 63.0% of boys with convicted fathers go on to be convicted themselves.
- 61.0% of children in workless homes live in poverty.
- 60.0% of children in lowest reading attainment groups have parents with low literacy.
- Parental alcohol misuse is a factor in over 50.0% of all child protection cases in the UK.

The Marmot Review: Strategic review of health inequalities in England post 2010 states that health inequalities result from social inequalities and that action is needed across all social determinants of health, such as housing, employment and education, to tackle these inequalities. Central to the Marmot Review was the recognition that disadvantage starts before birth and accumulates throughout life. (For further information on the Marmot Review, see Altogether Healthier).

Children and young people with mental health issues
Young people aged 16-18 years old who are not in education, training or employment (NEETs) are more likely to have poor mental health and die an early death. They are also more likely to have a poor diet, smoke, drink alcohol and suffer from mental health problems.

Children and young people with emotional disorders are almost five times more likely to report self-harm or suicide attempts; four and a half times more likely to rate themselves or be rated by their parents as having 'fair/bad health', and over four times more likely to have long periods of time off school.

4. What are people telling us?

In August 2014, a number of engagement events were undertaken by Investing in Children (IIC) to get the views of young people in relation to health and wellbeing. IIC facilitated the following seven groups and ran mini agenda days:

- The Voices Project.
- Stanley One Point.
- Seaham One Point.
- Decisions Group.
- CAMHS.
- Asthma Group.
- Extreme Group.

In total 59 young people took part, ranging in age from 10 to 18 years old. Information was gathered from the young people and the recommendations were as follows:

Achieving and attaining
Young people recommended that more support be offered within schools to help them achieve more. They said that all schools should be disability-friendly and cater

for all their needs. More support should also be available to disruptive pupils other than putting them in exclusion units.

They also recommended that schools offer more careers guidance / advice, as this is lacking and is needed.

Risk-taking behaviour
Smoking, alcohol and drugs are the biggest risks young people take. They all felt that peer pressure has a huge impact on the risks they take. They recommended that first aid training should be available to children and young people, as well as free or cheap activities for them to access as a diversion from taking risks.

A concern was raised by the group regarding young people taking more risks whilst under the influence of alcohol, i.e. having unprotected sex, etc. They recommended that first aid training be offered to young people so that they can deal with any situation.

Obesity
Most of the young people felt that obesity is a problem amongst children however stated that, unless the price of healthy food was reduced, children and young people would always eat unhealthily as it is cheap and convenient. They however recommended that, if free or cheap activities were available throughout the county, children and young people would lead healthier lifestyles.

Sex education
Recommendations were made that sex education should be delivered to young people through trained youth workers, as this would make them feel comfortable and able to open up to them. They raised concerns that in some schools the teachers who deliver the training are not confident, nor have the skills and knowledge to run the sessions.

Crime
The group recommended that more diversionary activities should be on offer by the council to stop young people committing crimes. They also recommended that better relationships between the police and young people be established and that the council promote the positive work of young people to try and tackle barriers within the local communities.

Emotional health and wellbeing
Most of the young people were unaware of where they could go for help with regard to emotional health and wellbeing. They recommended that more services be profiled within the county through schools and youth clubs, etc. They all raised concerns with regards to the number of children and young people they were aware of who self-harm. They said more work needs to be done around this especially within schools, where staff should be trained and services such as CAMHS should do assemblies and drop-ins.

Positive activities
More positive activities should be on offer especially on a weekend and also for children under 13. A lot of the young people did not feel respected for being young

and felt that they were discriminated because of this. They all said the council should be challenging shops and others who discriminate against young people.

Protection from harm
Concerns were raised with regards to feeling safe where they live and the young people felt more could be done, such as: better lighting in villages, clean parks, safe streets, more police and more places to go on an evening and at weekends.

One Point service
More young people need to know about the service, what's on offer and how they can access it. They all felt that more could be done with regards to promotion of One Point and recommended the following: more publicity including posters in schools, school assemblies about One Point, workers visiting youth projects, etc, open days, facebook pages for each hub and a video about the service.

Alcohol
Most of the young people said that alcohol was a problem for young people and suggested that more activities should be on offer on a weekend to divert them from drinking.

Other health issues
Self-harm was raised again and concerns over the length of time it takes to access mental health services. Training for staff was recommended, as well as drop-ins within schools offering support to children and young people.

Emotional wellbeing of children and young people
Emotional and behavioural health of children and young people who are looked after by the local authority is assessed through the use of a Strengths and Difficulties Questionnaire (SDQ). The SDQ is a short behavioural screening questionnaire. It has five sections which cover details of emotional difficulties; conduct problems; hyperactivity or inattention; friendships and peer groups; and also pro-social behaviour.

Conduct problems refer to behavioural problems such as fighting, stealing, lying and cheating. Emotional problems relate to levels of anxiety and depression. Hyperactivity relates to levels of physical hyperactivity, concentration and inattention. Peer problems refer to how well the child gets on with friends and other children and prosocial behaviour is concerned with how kind and considerate a child is to those around them. A total difficulties score tells us the overall level of mental health problems a child has. The score indicates the influence of a child's problems on their own life, and those around them.

Evidence suggests that mental health problems are over four times more likely for looked after children compared to their peers. Carers continue to report that they find it difficult to access appropriate child and adolescent mental health services. The government sees it as critical to address the issue of mental health of children looked after in order to improve both their outcomes and life chances. This data item covers the emotional and behavioural health of children looked after, as recorded by a main carer in the strengths and difficulties questionnaire (SDQ).

Routine SDQ screening is undertaken with all looked after children, with early intervention provided to children identified with some mental health difficulties and prioritisation of children with significant need. The SDQ is useful in identifying mental health strengths and difficulties to inform decision-making, particularly during Looked After Children (LAC) Reviews. The usefulness of SDQ identification of child strengths as a foundation for promoting resilience in looked after children is also recognised.

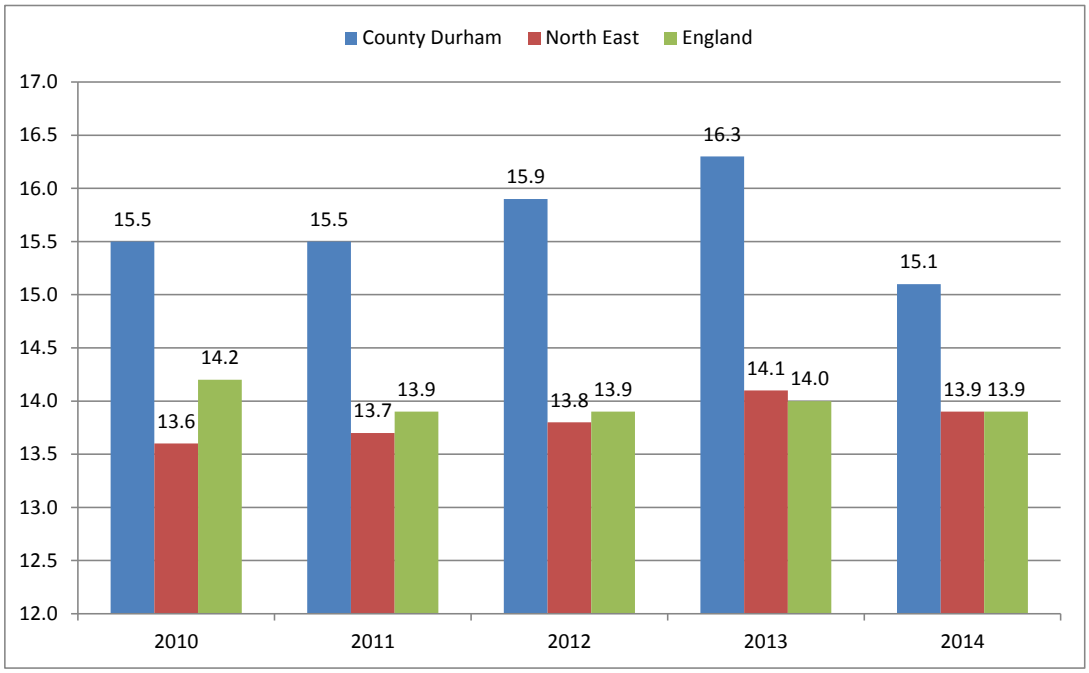
SDQs are required for those children aged 5 to 16 looked after for at least 12 months on the date the data are extracted. As of 31st March 2014, County Durham had 321 children who met this criteria; the analysis is based on the 165 received responses.

Table 34: Strengths and difficulties questionnaire scores by classification

Classification	Score
No difficulties	0 - 13
Few difficulties	14 – 16
Some difficulties	17 – 28
Severe difficulties	29 – 40

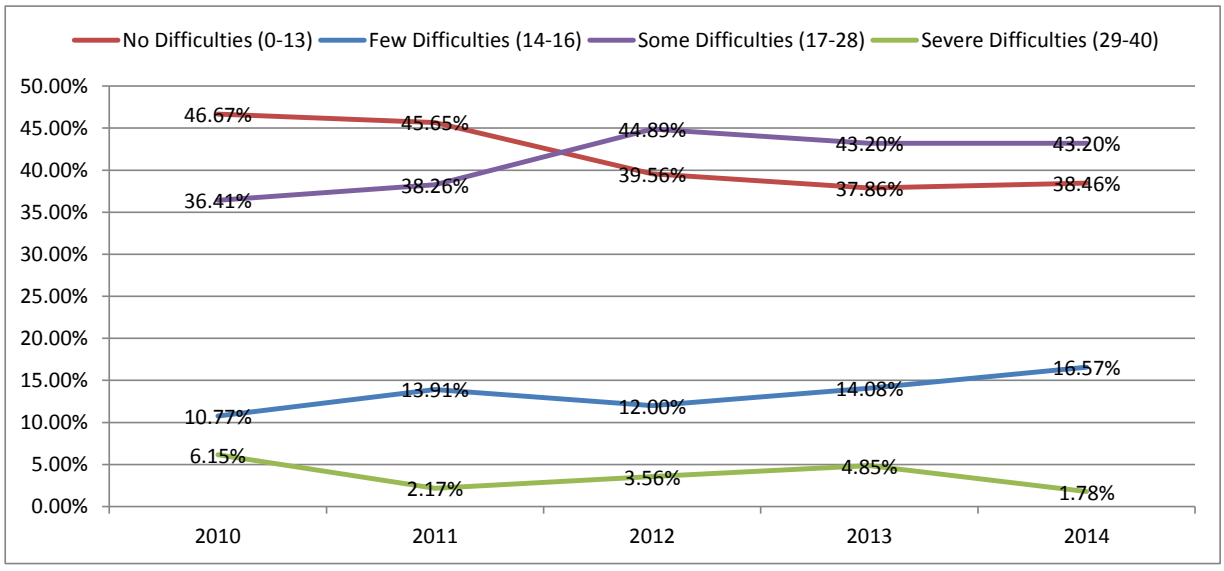
The average total difficulties score for children looked after in County Durham as of 31st March 2014 was 15.1. This was lower than the 2013 score of 16.3.

Figure 38: Strength and Difficulties Questionnaire – Average Child Point Score 2010 – 2014



Source: DfE Children Looked After by Local Authorities in England

Figure 39: County Durham – Strength and Difficulties Questionnaire 2010 - 2014 by Classification



Source: DfE Outcomes for Children Looked After by Local Authorities in England

The proportion of respondents reporting 'some difficulties' (scoring 17-28) has increased from 36.4% in 2009/10 to 43.2% in 2013/14 (Figure 39). This classification has ranked highest in terms of numbers of looked after children for the last three consecutive years.

Of the 169 responses received in 2013/14, 60% were male and 40% female. This is similar to the gender split of the previous year.

Table 35: County Durham looked after children strengths and difficulties questionnaire score classification by gender - 2012/13

	2009/10		2010/11		2011/12		2012/13	
Domain	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Emotional problems	2.95	2.78	2.68	2.48	2.87	3.1	2.65	3.35
Conduct problems	3.99	3.33	3.99	3.14	3.87	3.6	3.64	3.54
Hyperactivity or inattention	6	5.22	6.14	4.81	6.21	5.05	6.18	5.32
Friendships and peer groups	3.74	2.61	3.46	2.92	3.5	3.17	3.56	3.57
Total Difficulties Score	**16.7**	**13.9**	**16.3**	**13.4**	**16.5**	**14.9**	**16.0**	**15.8**
Positive behaviour*	6.28	6.63	5.98	6.94	6.06	6.65	6.23	6.83

*Positive behaviour scores are not included in the total difficulties score
Source**:** County Durham SDQ data / SSDA903 return, 2012/13

Table 36: County Durham looked after children – strengths and difficulties questionnaire score classification by age group

Classification	**Score**	**% of respondents**			
		4-7 years	**8-12 years**	**13-15 years**	**16+ years**
No difficulties	0-13	38.1%	44.9%	30.4%	47.8%
Few difficulties	14-16	12.7%	12.8%	16.1%	17.4%
Some difficulties	17-28	47.6%	35.9%	46.4%	34.8%
Severe difficulties	29+	1.6%	6.4%	7.1%	0.0%
Cause for concern	17+	49.2%	42.3%	53.6%	34.8%

Source**:** County Durham SDQ data / SSDA903 return, 2012/13

More than half of the looked after children in the 13-15 age group displayed 'some' or 'severe' difficulties (53.6%) (Table 36).

5. What are the implications for the future?

Early intervention and prevention

The factors which impact on the lives of children, young people and their families are often complex and multi-faceted. It is essential that families are offered support at the earliest opportunity in order to prevent them from becoming vulnerable and enabling them to maximise their life chances. Failing to provide early intervention and prevention is costly. For example, the cost of a single child in care on average is £25,000 per year for foster care and £125,000 per year for residential care. The costs of crime, anti-social behaviour, domestic violence and other such issues are

felt by individuals, families and communities and ultimately impact on the wellbeing of all.

Integrated services
The complex issues faced by families who are in need of help often cannot be addressed by a single agency but demand a coordinated response. An integrated approach to service delivery is essential in order to support families to promote positive outcomes. The 'One Point' service ensures that there is strong collaboration between agencies. The service brings together children's services professionals from various backgrounds to provide support and where possible intervene early to reduce the need for more specialist services. One Point also works with health and social care services for adults to ensure that the needs of all family members are met.

Stronger families
Analysis shows that issues which affect parents have a significant and detrimental impact on children and young people. These issues include: mental health; domestic violence; substance misuse; and learning difficulties and disabilities. The links between these factors as a *cause* of child poverty, the need for safeguarding services (often manifested as children being neglected) and poorer outcomes are well documented. In order to break the cycle of poverty and the inter-generational need for safeguarding and specialist services, a multi-agency approach to tackle the issues affecting adults / parents is required.

As a high-performing area, County Durham's Stronger Families programme is included in Phase 2 of the government's national troubled families programme. The expanded programme provides an opportunity to further target those families which have multiple and complex needs, with the first 650 families being identified and supported between October 2014 and March 2015.

Cost effective and efficient services
In order to tackle the *causes* of poor outcomes, there needs to be a greater emphasis on commissioning the right services to deliver the greatest impact and benefits to children, young people and families. Reductions in public spending provide a challenge to tackle the complex issues facing families in County Durham. As a result, services must be cost-effective and efficient. Early investment in intervention and prevention services to prevent costly, long term services is required.

6. Key messages

- The proportion of women who start to breastfeed in County Durham (57.4%) is significantly lower than the England average (73.9%) and has been so over time. Breastfeeding initiation in County Durham fell from 59.3% in 2012/13 to 57.4% in 2013/14.
- Breastfeeding prevalence at 6-8 weeks from birth has been rising slowly over time in County Durham. The proportion of women breastfeeding at 6 to 8 weeks in County Durham has risen from 26.9% in 2010/11 to 28.5% in 2013/14. The figure for 2012/13 (28.1%) remains lower than the national average (47.2%).

- The prevalence of excess weight for 10-11 year olds (35.9%) is higher than the England average (33.3%).
- Children's tooth decay at age 5 in County Durham in 2011/12 (0.93%) was not significantly different to England (0.94%) and was lower than the North East (1.02%). However, there are wide variations in the oral health of 5 year old children across areas of the county.
- Physical activity levels for children in County Durham are significantly higher than the English average. 56.7% of children in years 1 – 13 spend at least 3 hours per week on high quality PE and school sport compared to 55.1% nationally (Child Health Profile 2013). Data are no longer available in the 2014 Profile.
- Teenage conception rates (15-17 year olds) in County Durham (33.7 per 1,000) are greater than the England average (27.7 per 1,000) but lower than the North East average (35.5 per 1,000) and have been falling over time.
- For under-16 conceptions (13-15 year olds) the County Durham rate has varied across the years and in 2012 was higher than England, the North East and similar council averages.
- In County Durham 96.1% of those eligible received their first dose of the MMR immunisation by the age of two (2012/13), which was higher than England (92.3%) and the North East (94.1%).
- 93.3% of children in County Durham received their second dose of MMR immunisation by the age of five (2012/2013), which was higher than England (87.7%) but lower than the North East (97.1%).
- County Durham's under-18 alcohol specific hospital admission rate in 2012/13 was 81.5 per 100,000, higher than the regional rate of 72.2. County Durham is ranked 18th worst out of 326 local authorities.
- The most recent County Durham Children's Health Profile (March 2014) identifies that although the rate of admission to hospital for substance abuse (aged 15-24) in Durham has dropped from 105.6 per 100,000 in 2009-12 to 94.6 in 2010-13, it is still above the national rates of 75.2.
- Hospital admission rates for unintentional injuries are significantly higher in County Durham than England but not significantly different to the North East:
- For those aged 0-14, admission rates per 100,000 for 2013/14 were significantly higher in County Durham (168) than England (112), but not significantly different to the North East (147).
- For those aged 15-24, admission rates per 100,000 for 2013/14 were significantly higher in County Durham (202) than England (137), and the North East (173).
- According to provisional data, safeguarding activity for children and young people is projected to decrease for 2014. The total number of children in need as of 31st March each year has increased from 2011 to 2013 (3,931; 3,871; 3,970 respectively), with 2014 projected to see a decrease of 22.3% (3,053) compared to 2011.
- The rate of children in full time looked after care in County Durham is similar to England and lower than the North East. This has improved from March 2012, resulting from the implementation of the county's Looked After Children Reduction Strategy.
- Within County Durham, 32% of initial conferences resulted in a child protection plan due to one of the parental risk factors being alcohol (2013/14).

- During 2013/14, 50.3% of children subject to a child protection plan were aged less than 5 years.
- 56% of County Durham's looked after children who were at the end of primary education achieved the expected levels in reading, writing and maths. Amongst all children in County Durham schools, this figure was 79%.
- In 2013/14, 65% of County Durham's pupils achieved 5 or more GCSEs at A*-C (or the equivalent), compared to 63.8% of pupils nationally.
- At 'A' Level 53.5% of pupils achieved 2 or more A*-B's, which was better than the national figure of 46.6%, whilst 98.7% of pupils achieved 2 or more A*-E's, which was higher than the national average of 98.0%. (Data relates to pupils at local authority maintained sixth forms and doesn't include further education colleges) (NCER 'National' dataset)
- The Department for Education defines 'disadvantaged' children as those who have been eligible for free school meals in the last 6 years and/or have been looked after for 6 months or more. The results for this group of children in County Durham in 2014 show that 38.3% of them achieved 5 or more GCSEs at C or above including English and Maths. This compares favourably to the national rate of 36.5%. In County Durham, 67.5% of children who were not classed as disadvantaged achieved the necessary grades, creating a gap of 29.2 percentage points between disadvantaged children and their peers.
- At the end of their primary school education, 69% of County Durham's disadvantaged children reached Level 4 or above in reading, writing and maths, compared to 67% nationally. In County Durham, 85% of non-disadvantaged children got the required levels, resulting in a gap of 16 percentage points between disadvantaged children and their peers.
- The data for academic year 2013/14 show that 92.0% of pupils identified as not having SEN at the start of Key Stage 2 achieved Level 4 or above in all of reading, writing and maths at Key Stage 2, compared to 48.6% who had SEN. This results in a gap of 43.4 percentage points.
- The data for 2013/14 also show that 68.4% of pupils identified as not having SEN achieved 5 A*-C GCSE's grades or equivalent including English and Maths at Key Stage 4, compared to 20.5% who have SEN. This results in a gap of 47.9 percentage points.
- The rate of children who have autism spectrum disorders known to schools in County Durham was 9.9 per thousand children (January 2014). This shows a year on year increase since January 2009 and is now higher than the 2012 figures for the North East (8.32) and England (8.17).
- County Durham's performance for 16-18 year olds who are not in education, training or employment (NEET) has fallen from 7.1% in 2013/14 to 6.7% in 2014/15; this is lower than the North East (7.0%) but higher than England (4.7%).
- 23% of children aged under 16 years live in poverty compared with the England average of 20.6%.
- County Durham has 4,070 disabled children and young people in receipt of Disability Living Allowance, of which 358 are severely disabled and receive a statutory service from the Children & Young People's Disability Team. (October 2014).
- Hospital admission rates per 100,000 for self-harm in young people aged 10-24 are significantly higher in County Durham (505) than England (352). A local

strategy to reduce self-harm and suicide is in place. (A direct comparison of self-harm rates from previous CHIMAT profiles should not be made due to the indicator changing, as previously 0-17 years was the denominator).

- Around 10% of those aged 5-16 years have a classifiable mental health disorder, which is similar to the national and regional estimate.
- The number of new referrals to Child and Adolescent Mental Health Services (CAMHS) increased by 24% from 2,150 in 2012/13 to 2,667 in 2013/14.
- County Durham continues to have a lower proportion of first time entrants (FTEs) to the Youth Justice System per 100,000 population (479) than the North East (496), but higher than England (431). There continues to be a year on year reduction in the number of FTEs. This is due to the introduction of the integrated pre-court system in 2010 and the continued success of Precaution Disposal (formerly Pre-Reprimand disposal).

Altogether Better for Children & Young People

Summary of Key Indicators

Indicator / measure	Number / %	Performance	Time period	England	Benchmarking
Percentage of children in Reception with height and weight recorded who have excess weight	%	21.9	Academic Year 2012/13	22.2	North East - 24.1
Percentage of children in Year 6 with height and weight recorded who have excess weight	%	35.9	Academic Year 2012/13	33.3	North East – 35.7
Teenage conception rate per 1,000 female population aged 15-17	Number (rate per 1,000)	33.7	2012	27.7	North East – 35.5
Number and rate of children in need referrals received per 10,000 population aged under 18	Number (rate per 10,000)	6,516 (649)	2013/14	657,800 (573.0)	North East – 34,600 (659.8)
Number and rate of children in need per 10,000 population aged under 18	Number (rate per 10,000)	3,038 (303)	31st March 2014	397,600 (346.4)	North East – 23,900 (456.7)
Number and rate of initial assessments completed per 10,000 population aged under 18	Number (rate per 10,000)	4,769 (476)	2013/14	308,520 (269)	North East – 25,490 (487)
Number and rate of core assessments completed per 10,000 population aged under 18	Number (rate per 10,000)	1,213 (121)	2013/14	170,640 (149)	North East – 10,800 (206)
Number and rate of children subject to a child protection plan per 10,000 population aged under 18	Number (rate per 10,000)	453 (45)	31st March 2014	48,300 (42)	North East – 3,100 (59)
Number and rate of children looked after per 10,000 population aged under 18	Number (rate per 10,000)	606 (60)	31st March 2014	68,840 (60)	North East – 4,250 (81)
Percentage of children in the Early Years Foundation Stage achieving a good level of development	%	57	Academic year 2013/14	60	North East – 56
Narrowing the gap between the lowest achieving 20% in the Early Years Foundation Stage Profile and the rest	Percentage points	40.6	Academic year 2013/14	33.9	37.8
Percentage of pupils achieving 5 or more A*-C GCSEs	%	65.0	Academic year 2013/14	63.8	North East - 63.3
Percentage of pupils achieving 5 or more A*-C GCSEs including English and Maths	%	57.6	Academic year 2013/4	53.4	North East – 54.6
LAC reaching Level 4 in Reading at Key Stage 2	%	72	Academic year 2013/14	68	74
LAC reaching Level 4 in Writing at Key Stage 2	%	63	Academic year 2013/14	59	63
LAC achieving Level 4 in Maths at Key Stage 2	%	63	Academic year 2013/14	61	67

Percentage of looked after children achieving 5 or more A*-C GCSEs (or equivalent) including English and Maths	%	20	Academic year 2012/13	15.3	North East – 16.3
The SEN / non SEN gap achieving 5 A*-C GCSEs including English and Maths	Percentage points	47.4	Academic year 2013/14	Comparable data not available	Comparable data not available
Percentage of children with SEND achieving 5 A*-C GCSEs including English and Maths at Key Stage 4	%	20.4	Academic year 2013/14	Comparable data not available	Comparable data not available
Key Stage 2 attainment for Gypsy Roma Traveller (GRT) achieving Level 4 in Reading, Writing and Maths	%	62	Academic year 2013/14	Comparable data not available	Comparable data not available
GRT pupils achieving at least 5 A*-C GCSE grades including English and Maths	%	33.3	Academic year 2013/14	Comparable data not available	Comparable data not available
Gap narrowed between those children in 20% most deprived areas and rest (KS2)	Percentage points	6.9	Academic year 2013/14	Comparable data not available	Comparable data not available
Gap narrowed between those children in 20% most deprived areas and rest (KS4)	Percentage points	12.9	Academic year 2013/14	Comparable data not available	Comparable data not available
First time entrants to the youth justice system aged 10-17 (rate per 100,000 population)	Number (rate per 100,000)	458	2013/14	Comparable data not available	Comparable data not available
Percentage of children in low income families (proportion of children living in poverty) national annual measure)	%	23	February 2014	20.6	North East – 24.5
16-18 year olds who are not in education, employment or training	%	6.7	November 2014 – January 2015	4.7	North East - 7.0
Percentage of 16-18 year olds where activity not known	%	4.6	Nov 2014 to Jan 2015 Average	7.2	North East – 4.1
Percentage of 16-18 year olds in learning	%	81.1	Nov 2013 to Jan 2014 Average	80.8	North East – 82.4
Percentage of young mothers aged 16-19 in education, employment or training	%	23.1	31st March 2014	Comparable data not available	Comparable data not available
Percentage of young people aged 16-19 with learning difficulties and disabilities in education, employment or training	%	78.5	31st March 2014	Comparable data not available	Comparable data not available

KEY

	County Durham is better than England Average
	County Durham is similar to the England Average
	County Durham is worse than England Average

Altogether Healthier

1. Introduction

Health is defined by the World Health Organisation as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity'. It is this broad view of what 'health' means which has shaped plans for health improvement in County Durham. This section attempts to identify the current and future health and wellbeing needs of the local population with regard to the most significant causes of mortality and morbidity locally.

The health and wellbeing of County Durham's population is greatly shaped by a wide variety of social, economic and environmental factors (such as poverty, housing, ethnicity, place of residence, education, and environment). It is clear that improvements in health outcomes cannot be made without action in these wider determinants. Health inequalities are disparities between population groups which are systematically associated with these socio-economic and environmental factors. Such variations in health are avoidable and unjust.

The extensive evidence base on health inequalities demonstrates the need for policy makers to focus actions on the social determinants of health as the most effective way of addressing the issue ('Fair Society, Healthy Lives, The Marmot Review, 2010 and 'Closing the gap in a generation; health equity through action on the social determinants of health', Commission on Social Determinants of Health, World Health Organisation, 2008). The Marmot review states that 'Inequalities in health and wellbeing can be due to many factors including conditions in which people are born, grow, live, work and age'. It is therefore vital to consider the wider determinants which affect health and wellbeing, including poverty, unemployment, housing, environment, transport, education and skills.

2. What are the levels of need?

The health and wellbeing of the people in County Durham has improved significantly over recent years, but remains worse than the England average. Health inequalities remain persistent and pervasive. Levels of deprivation are higher and life expectancy is lower than the England average, and there is also inequality within County Durham for many measures (including life expectancy and premature mortality for example). The links between poor health outcomes and deprivation are well documented.

Health inequalities are affected by socio-economic conditions which exist within County Durham such as lower household income levels, lower educational attainment levels and higher levels of unemployment, which lead to higher rates of benefits claimants suffering from mental health or behavioural disorders. Local priorities for tackling these inequalities include reducing smoking, tackling childhood and adult obesity, promoting breastfeeding, reducing alcohol misuse, reducing teenage conceptions (and promoting good sexual health), promoting positive mental health and reducing early deaths from heart disease and cancer.

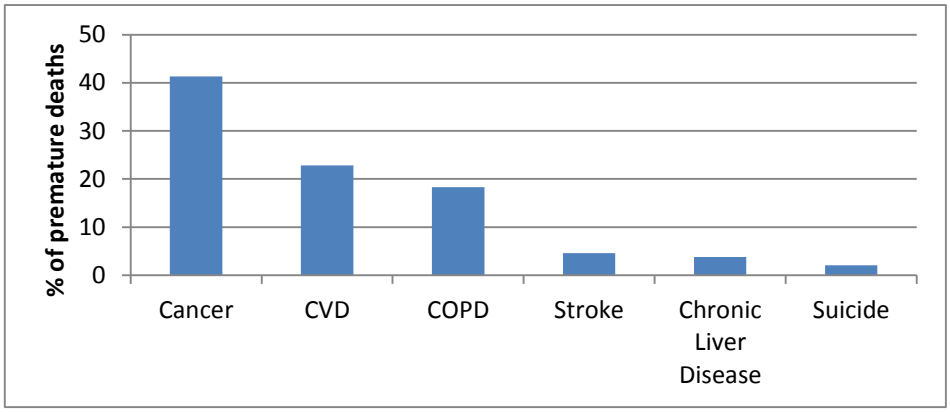
The geography of County Durham also presents several challenges. Those living in rural areas face issues ranging from transport and accessibility of services to the use of local facilities. There are also significant geographical areas of deprivation and disadvantage in our towns and coastal and rural areas, which are often hidden as inequalities but which manifest themselves very differently to those in the more urban areas.

Many of our population suffer from avoidable ill-health or die prematurely from conditions which are entirely preventable. Lifestyle choices remain a key driver to reducing premature deaths but it is clear that social, economic and environmental factors also have a direct impact on health status and can exacerbate existing ill health. The Marmot Review identified a clear social gradient for mortality and morbidity where the poorer are sicker and die earlier. Mortality and morbidity, along with life expectancy and healthy life expectancy are influenced by the conditions in which one is born, lives and dies.

Many people in County Durham continue to engage in unhealthy lifestyle behaviours when compared to England, directly linked to the social, economic and environmental factors outlined above. Smoking prevalence, proportion of mothers smoking during pregnancy, childhood and adult obesity, levels of binge drinking, admissions to hospital for acute intoxication and teenage conception rates are all greater than the England average. Lower than average levels of breastfeeding initiation and participation in physical activity are prevalent, combined with poor diet choices.

In County Durham premature mortality rates for the 'biggest killers' (cancer, heart disease and stroke) are higher than nationally, but have been reducing at a faster rate than England (see the section on premature mortality later in this chapter). In the period 2010-12 cancer accounted for around 41% of all premature deaths in County Durham (Figure 40), cardiovascular disease (CVD) accounted for around 23% and chronic obstructive pulmonary disease (COPD) 18%.

Figure 40: Cause of death as a proportion of all premature, County Durham, 2010-12



Source: Compendium of population health indicators, Health and Social Care Information Service Indicator Portal

Smoking is the biggest single contributor to the shorter life expectancy experienced locally and contributes substantially to the cancer burden. Between 2010 and 2012

cardiovascular disease (CVD) and cancer accounted for 64% of early or premature deaths in County Durham.

An ageing population in County Durham will also present several challenges for health and social care and the wider community (council services, voluntary and private sector and indeed local residents). The number of people with long term chronic conditions requiring health services will increase, as will the number of those requiring additional support to maintain independence in their own homes.

An increasingly older population will see rising prevalence of mental health conditions, dementia, increased levels of disability, sensory and cognitive impairment and long term conditions (LTCs) and will significantly increase the number of people needing to provide care to family members or friends. Population projections suggest that these carers themselves are likely to be older (Projecting Older People Population Information - POPPI) with a significant increase in the proportion of carers aged 65 and over providing unpaid care by 2030.

Dementia presents a significant and urgent challenge to health and social care in County Durham in terms of both numbers of people affected and costs. Projections suggest that the estimated 6,625 people affected in 2014 could almost double to 10,896 by 2030 (POPPI, 2014). Typical of the situation across the country, the observed prevalence in GP surgeries, in other words the number of people registered with dementia, (around 3,000 in County Durham) is around half the expected prevalence. This has implications in terms of lack of treatment, care and unmet need.

County Durham Health Profile 2014
Public Health England's Health Profiles are designed to give a snapshot overview of health for each local authority in England. Produced annually, they aim to help local government and health services make decisions and plans to improve local people's health and reduce health inequalities. The profiles present a set of health indicators which show how the area compares to the national average.

County Durham Health Profile 2014
Public Health England's Health Profiles are designed to give a snapshot overview of health for each local authority in England. Produced annually, they aim to help local government and health services make decisions and plans to improve local people's health and reduce health inequalities. The profiles present a set of health indicators which show how the area compares to the national average.

Of the 32 indicators in the 2014 County Durham Health Profile:

- 19 were significantly worse than England ( table 37).
- 7 were significantly better than England ( table 37).
- 6 were not significantly different to England ( table 37).
- 3 were significantly worse than England and had not improved from the previous reporting period, ( table 38).
- 8 were significantly worse than the England average but had improved from the previous reporting period, ( table 38).
- 16 had shown improvement from the previous profile, ( table 38).
- 4 had got worse from the previous profile, ( table 38).

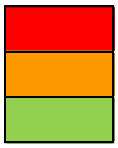
Table 37: Health summary for County Durham, 2014 PHE Health Profile

Indicator	Local Value	England Average
1 Deprivation	**28.8**	20.4
2 Proportion of children in poverty	**23**	20.6
3 Statutory homelessness	**0.1**	2.4
4 GCSE achieved (5A*-C inc. English & Maths)	**63.1**	60.8
5 Violent crime	**6.8**	10.6
6 Long term unemployment	**14.7**	9.9
7 Smoking status at time of delivery	**19.9**	12.7
8 Breastfeeding Initiation	**58.9**	73.9
9 Obese Children (Year 6)	**21**	18.9
10 Alcohol-specific hospital stays (under 18)	**81.5**	44.9
11 Under 18 Conceptions	**33.7**	27.7
12 Smoking prevalence	**22.2**	19.5
13 Percentage of physically active adults	**52.2**	56
14 Obese Adults	**27.4**	23
15 Excess weight in adults	**72.5**	63.8
16 Incidence of malignant melanoma	**15.3**	14.8
17 Hospital stays for self-harm	**269.5**	188
18 Hospital stays for alcohol related harm	**794**	637
19 Drug misuse	**7**	8.6
20 Recorded diabetes	**6.8**	6
21 Incidence of TB	**2.1**	15.1
22 Acute sexually transmitted infections	**645**	804
23 Hip fracture in 65s and over	**636**	568
24 Excess winter deaths	**16.8**	16.5
25 Life expectancy – male	**77.9**	79.2
26 Life expectancy – female	**81.5**	83
28 Infant mortality	**3.9**	4.1
29 Smoking related deaths	**372**	292
29 Suicide rate	**11.3**	8.5
30 Under 75 mortality rate: cardiovascular	**91.3**	81.1
31 Under 75 mortality rate: cancer	**164**	146
32 Killed and seriously injured on roads	**37.5**	40.5

Significantly worse than England

Not significantly different to England

Significantly better than England



Indicator Notes

1 % people in this area living in 20% most deprived areas in England, 2010 **2** % children (under 16) in families receiving means-tested benefits & low income, 2011 **3** Crude rate per 1,000 households, 2012/13 **4** % key stage 4, 2012/13 **5** Recorded violence against the person crimes, crude rate per 1,000 population, 2012/13 **6** Crude rate per 1,000 population aged 16-64, 2013 **7** % of women who smoke at time of delivery, 2012/13 **8** % of all mothers who breastfeed their babies in the first 48hours after delivery, 2012/13 **9** % school children in Year 6 (age 10-11), 2012/13 **10** Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2010/11 to 2012/13 (pooled) **11** Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2012 **12** % adults aged 18 and over, 2012 **13** % adults achieving at least 150 mins physical activity per week, 2012 **14** % adults classified as obese, Active People Survey 2012 **15** % adults classified as overweight or obese, Active People Survey 2012 **16** Directly age standardised rate per 100,000 population, aged under 75, 2009-2011 **17** Directly age sex standardised rate per 100,000 population, 2012/13 **18** The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2012/13 **19** Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2010/11 **20** % people on GP registers with a recorded diagnosis of diabetes 2012/13 **21** Crude rate per 100,000 population, 2010-2012 **22** Crude rate per 100,000 population, 2012 (chlamydia screening coverage may influence rate) **23** Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2012/13 **24** Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.09-31.07.12 **25** At birth, 2010-2012 **26** At birth, 2010-2012 **27** Rate per 1,000 live births, 2010-2012 **28** Directly age standardised rate per 100,000 population aged 35 and over, 2010-2012 **29** Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2010-2012 **30** Directly age standardised rate per 100,000 population aged under 75, 2010-2012 **31** Directly age standardised rate per 100,000 population aged under 75, 2010-2012 **32** Rate per 100,000 population, 2010-2012 ^ "Regional" refers to the former government regions.
More information is available at www.healthprofiles.info Please send any enquiries to healthprofiles@phe.gov.uk

Source: County Durham Health Profile 2014, Public Health England

Table 38: County Durham Health Profile Indicators, 2013 and 2014

No.	Indicator	Rate or %	2014 Health Profile				2013 Health Profile			
			2014 HP		Sig* worse than England?	Period & Source	2013 HP		Sig* worse than England?	Period & Source
			Measure	No.			Measure	No.		
1	Deprivation	%	28.8	148312	Yes	2010	28.8	147519	Yes	ID2010
2	Children in poverty	%	23	20405	Yes	2011	23	20445	Yes	2010
3	Statutory homelessness	CR/1000	0.1	24	No	2012/13	2	425	No	2011/12
4	GCSE achieved (5A*-C inc maths and english)	%	63.1	3450	No	2012/13	62.5	3396	No	2011/12
5	Violent crime	CR/1000	6.8	3504	No	2012/13	9.5	4839	No	2011/12
6	Long term unemplomen t	CR/1000	14.7	4825	Yes	2013	11.6	3834	Yes	2012
7	Smoking at time of delivery	%	19.9	1045	Yes	2012/13	21.3	1216	Yes	2011/12
8	Breast feeding initiation	%	58.9	3098	Yes	2012/13	58.5	3330	Yes	2011/12
9	Obese children (year 6)	%	21	986	Yes	2012/13	22.7	1057	Yes	2011/12
10	Alcohol-specific stays (under 18)	CR/1000	81.5	82	Yes	2010/11-2012/13	122	124	Yes	2007/08-2009/10
11	Teenage conceptions (<18)	CR/1000	33.7	291	Yes	2012	41.4	372	Yes	2009-2011
12	Smoking prevalence	%	22.2	n/a	Yes	2012	No comparison available, new indicator			
13	Physically active adults	% 16+	52.2	n/a	No	2012 (APS)	52.2	n/a	No	2012
14	Obese adults	% 16+	27.4	n/a	No	2012 (APS)	28.6	n/a	Yes	2006-08 (HSE)
15	Excess w eight in adults		72.5	970	Yes	2012 (APS)	No comparison available, new indicator			
16	Incidence of malignant melanoma	DASR/100,000	15.3	82	No	2009-2011	14.4	75	No	2008-2010
17	Hospital stays for self harm	DASR/100,000	269.5	1374	Yes	2012/13	343.1	1625	Yes	2011/12
18	Hospital stays for alcohol related harm	DASR/100,000	794	4069	Yes	2012/13	No comparison available, new indicator			
19	Drug misuse	DASR/100,000	7	2376	No	2010/11	7	2376	No	2010/11
20	Recorded diabetes	%	6.8	29680	Yes	2012/13	6.5	28542	Yes	2011/12
21	Incidence of TB	CR/1000	2.1	4	No	2010-2012	2.6	13	No	2009-2011
22	Acute sexually transmitted infections	CR/100,000	645	3309	No	2012	645	3309	No	2012
23	Hip fractures in 65s and over	DASR/100,000	636	617	Yes	2012/13	471	572	No	2011/12
24	Excess w inter deaths	Ratio	16.8	273	No	01.08.09-31.07.12	18.1	297	No	01.08.08-31.07.11
25	Life expectancy - male	Years	77.9	n/a	Yes	2010-2012	77.5	n/a	Yes	2009-2011
26	Life expectancy - female	Years	81.5	n/a	Yes	2010-2012	81.4	n/a	Yes	2009-2011
27	Infant deaths	DASR/100,000	3.9	23	No	2010-2012	4	23	No	2009-2011
28	Smoking related deaths	DASR/100,000	372	1075	Yes	2010-2012	No comparison available, new indicator			
29	Suicide rate	DASR/100,000	11.3	57	N/A	2010-2012	No comparison available, new indicator			
30	<75 mortality rate: CVD	DASR/100,000	91.3	420	Yes	2010-2012	No comparison available, new indicator			
31	<75 mortality rate: Cancer	DASR/100,000	164	762	Yes	2010-2012	No comparison available, new indicator			
32	Killed & seriously injured on roads	DASR/100,000	37.5	192	No	2010-2012	38.1	195	No	2009-2011

Table 39: County Durham Health Profile indicators which are significantly worse than England

Significantly worse outcomes than England, not improved from the previous profile	Significantly worse outcomes than England, but improved from the previous profile
Long term unemployment	Smoking in pregnancy
People diagnosed with diabetes	Breastfeeding initiation
Hip fractures in people aged 65 and older	Obese Children (Year 6)
	Alcohol-specific hospital stays (under 18)
	Under 18 Conceptions
	Hospital stays for self-harm
	Life expectancy – male
	Life expectancy – female

Source: County Durham Health Profile 2014, Public Health England

IMPROVING LIFE EXPECTANCY

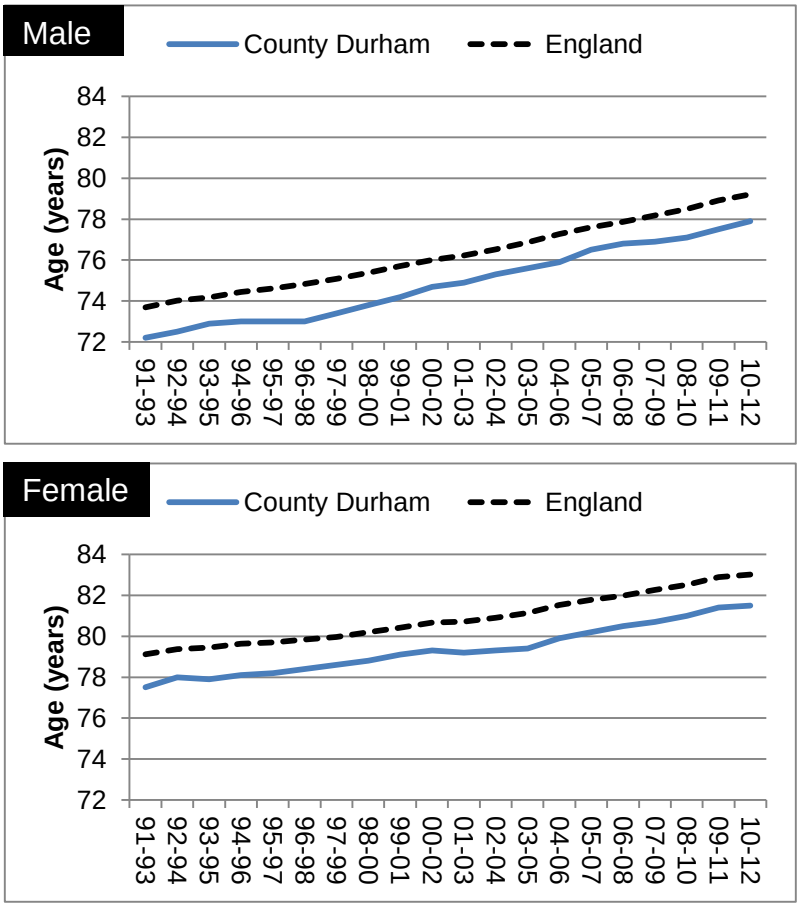
Life expectancy at birth

Life expectancy tells us how long children born today would be expected to live if they experienced the current mortality rates of the area they were born in throughout their lifetime.

Life expectancy at birth in County Durham has been improving over time for both makes and females (Figure 41).

Between 1991-93 and 2010-12, male life expectancy in County Durham increased from 72.2 to 77.9 years. Over the same period, female life expectancy increased from 77.5 to 81.5 years.

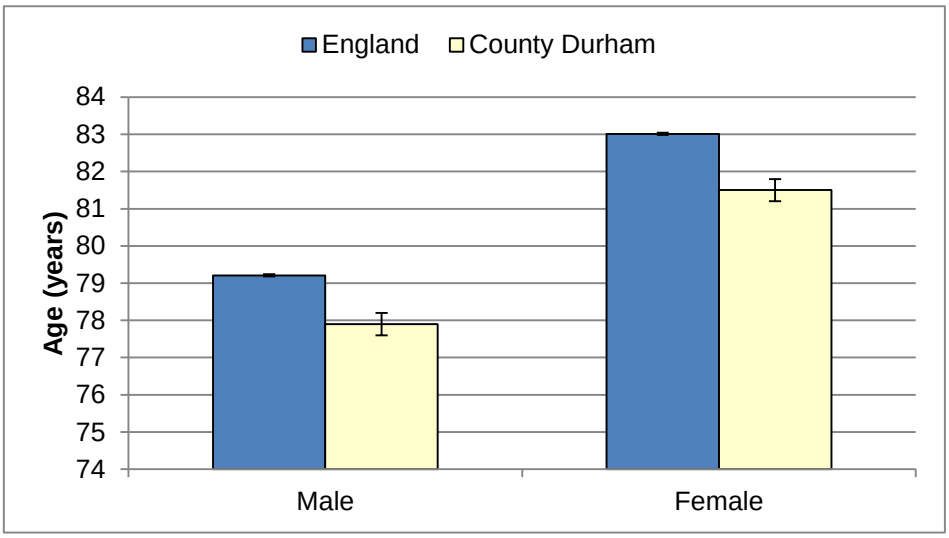
Figure 41: Male and female life expectancy at birth, County Durham and England, 1991-93 to 2010-12



Source: ONS, Life expectancy at birth and at age 65, England and Wales, 1991-1993 to 2010-2012

Life expectancy at birth in County Durham (2010-12) is significantly lower than England for both males and females (Figure 42). Male life expectancy in County Durham is significantly lower than that of females.

Figure 42: Male and female life expectancy at birth with 95% confidence intervals, County Durham and England, 2010-12



	County Durham	England	Gap (years)	Is the difference significant?
Male life expectancy	77.9	79.2	1.3	Yes
Female life expectancy	81.5	83.0	1.5	Yes

Source: ONS, Life expectancy at birth and at age 65, England and Wales, 1991-93 to 2010-12

Absolute health inequality gaps between England and County Durham are simply the difference between the value for England and the value for County Durham for any given indicator. The absolute gap in life expectancy between County Durham and England (i.e. the gap in years between County Durham and England) for both males (1.3 years) and females (1.5 years) has seen little change over this period (Figure 43).

In order to allow comparison between different measures, the relative inequality gap is used. This is calculated by dividing the absolute gap (as described above) by the value in the standard or less deprived area, in this case England. A relative gap closer to 0 indicates less inequality.

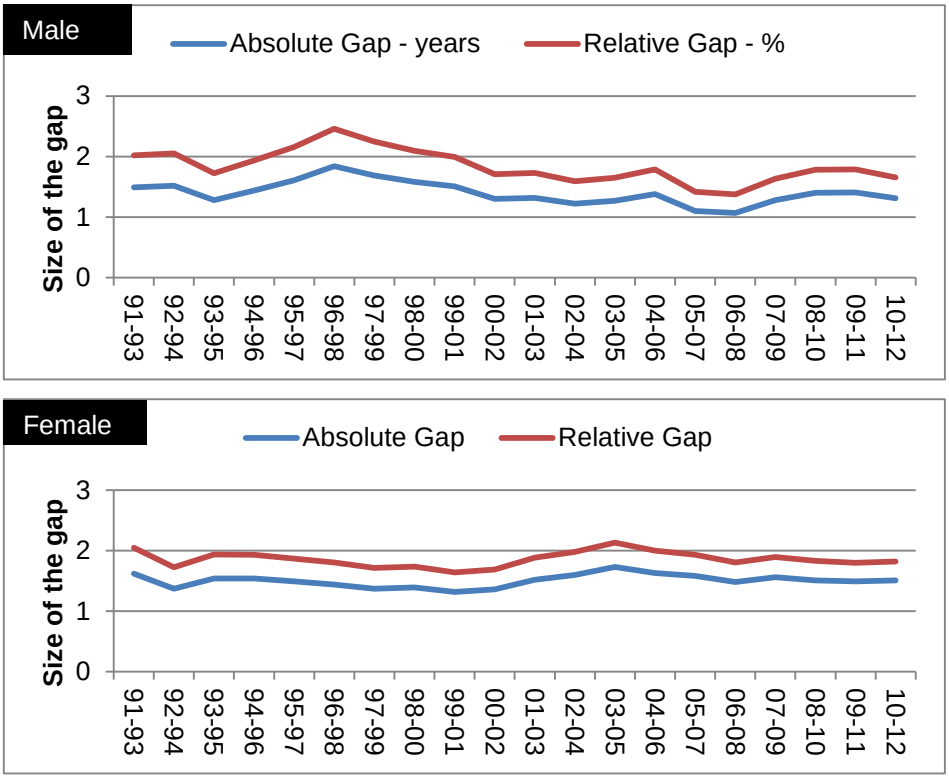
The relative gap between County Durham and England is 1.3% for men and 1.5% for women. This has seen little variation over time, meaning the relative gap between County Durham and England has not closed in terms of life expectancy at birth. Using male life expectancy as an example, the relative gap between County Durham and England is 1.3 (the absolute gap) / 79.2 (life expectancy for England), which expressed as a percentage is 1.7%.

There is inequality in life expectancy within County Durham. The Slope Index of Inequality (Sii) in life expectancy is a single measure representing the size of the gap in life expectancy between the most and least deprived areas (10%) of a population. It provides a consistent measure of health inequalities across populations and takes

into account 'the position of all groups across the [social] gradient simultaneously' (Low and Low, 2004).

Men born in the most affluent areas of County Durham will live 7 years longer than those born in the most deprived areas (Sii=7). The size of this gap has fallen for men from 8.2 years (2009-11). Females born in the most affluent areas of County Durham will live 7.2 years longer than those born in the most deprived areas (Sii=7.2). These gaps have not changed significantly over time in County Durham for either men or women, nor is the difference between the sexes significant.

Figure 43: Absolute and relative gaps in male and female life expectancy at birth, County Durham and England, 1991-93 to 2010-12



Source: Life expectancy at birth (years), 1991-93 to 2010-12, ONS, 2013.

Premature mortality

Premature mortality can be used as an important measure of the overall health of County Durham's population, and as an indicator of inequality between and within areas.

The Public Health Outcomes Framework shows that premature mortality rates for cancer, cardiovascular disease and respiratory disease across the county are significantly worse than England but have been falling over time (Figure 44). Mortality from liver disease is not significantly different to England but has been increasing over time locally and nationally.

Between 2001-03 and 2010-12, the premature mortality rate in County Durham for:

- Cancer has fallen by 14%; this is the same as the national reduction.
- CVD has fallen by 46%, compared to a 41% reduction nationally.
- Liver disease has risen 20%, compared to a 14% rise nationally.
- Respiratory disease has fallen 25%, compared to a 17% reduction nationally.

The cancer health equity audit identified rising incidence of:

- lung cancer in females over time in both CCGs (DDES 22.2% rise:ND 18.7%).
- breast cancer over time in both CCs (DDES 4.9%:ND 10.4%).
- bowel cancer over time in DDES (Male 1%:female 9.1%).

It also identified rising premature mortality from:

- bowel cancer in men in ND only (10.9%).
- lung cancer in women in both CCGs (DDES 14.4%:ND 21.5%).

The health equity audit noted the following:

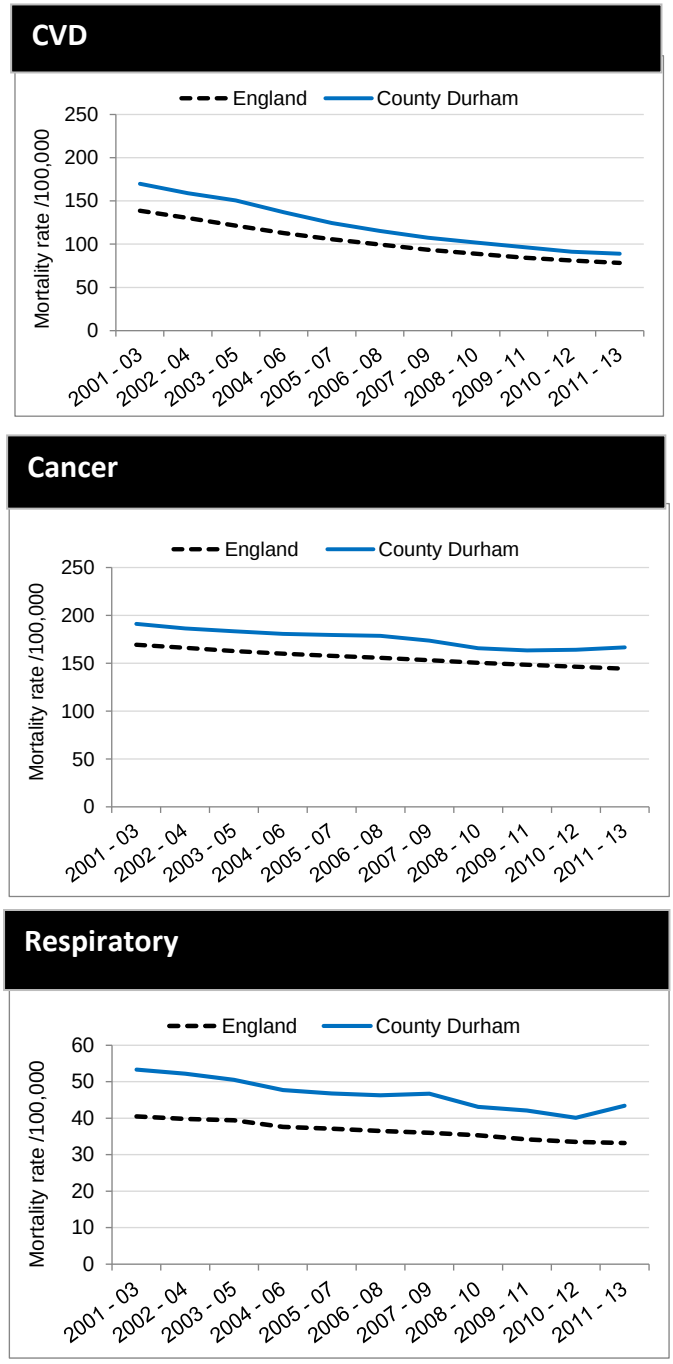
Key areas for action

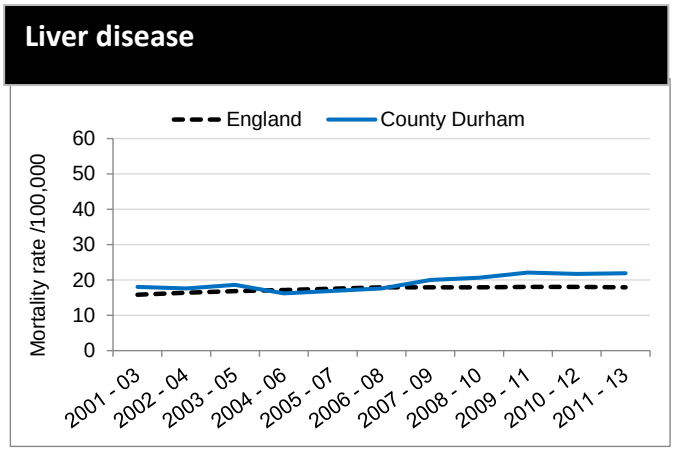
- This health equity profile has identified a range of inequities in cancer across County Durham. However, the headlines for action will focus on those issues that relate to premature deaths from cancer, as the reduction in early deaths from cancer is a priority for Clinical Commisioning Groups.
- Early deaths from cancer are significantly higher than the Engalnd average for both men and women in the DDES area and for women in the North Durham CCG area.
- For both CCG areas, premature mortality rates for cancer are higher in those areas of greatest deprivation.
- Early deaths from lung cancer in females is increasing in both CCG areas and is significantly higher than the England average.
- Early death rates from bowel cancer in males is increasing in North Durham compared with decreases in County Durham and England.
- There is large variation in key cancer outcome measures beween GP practices across County Durham.

Approaches to reducing early deaths from cancer

- There are two main approaches to reducing premature mortality rates from cancer.
- Prevention – reduction in lifestyle factors e.g.: smoking, obesity, alcohol consumption, sun exposure.
- Awareness and earlier diagnosis - finding and treating more cancers earlier (including screening).
- The first of these is very important and is key public health work for CCGs. However it is a medium to long term approach. Cancer prevention approaches take time to result in decreases in mortality rates. The latter is the approach that should result in better cancer survivorship and may produce a faster reduction in cancer mortality rates as outlined in the Cancer Reform Strategy (2007).

Figure 44: Premature (<75 years) mortality rates for selected causes of death, County Durham and England, 2001-03 to 2011-13

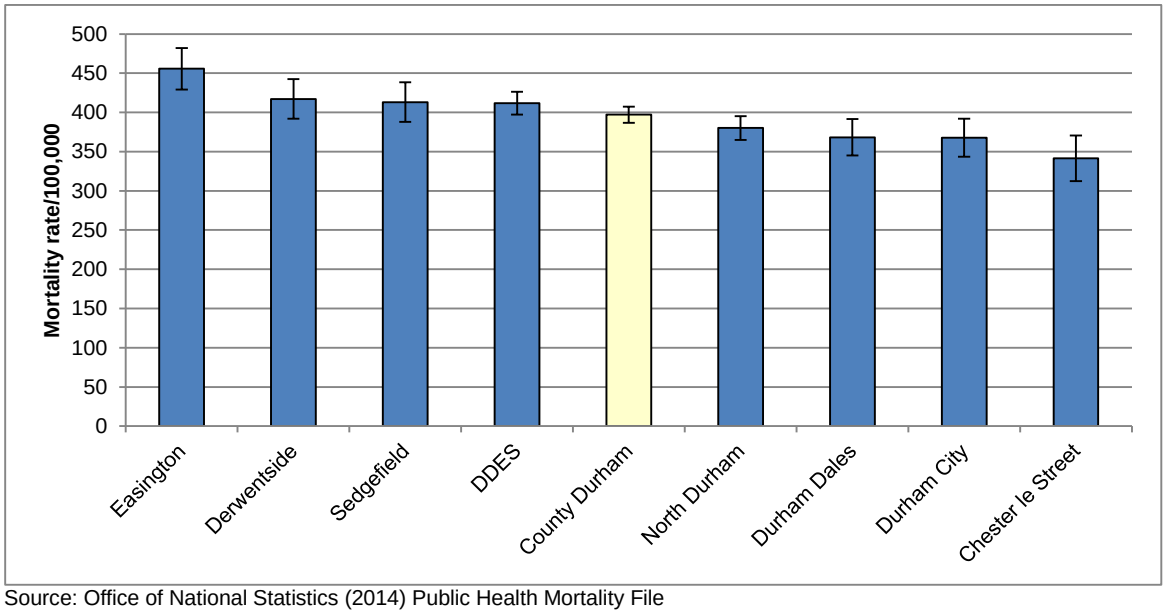




Source: Public Health Outcomes Framework, Public Health England

There is significant variation in premature all-cause mortality within County Durham (Figure 45). The rate in Easington (DDES CCG) is significantly higher than County Durham; the rate in Chester le Street (NDCCG) is significantly lower than County Durham.

Figure 45: Directly age-standardised premature all-cause mortality rates per 100,000 with 95% confidence intervals, County Durham, DDES Clinical Commissioning Group and localities, North Durham Clinical Commissioning Group and constituencies, 2011-13 pooled



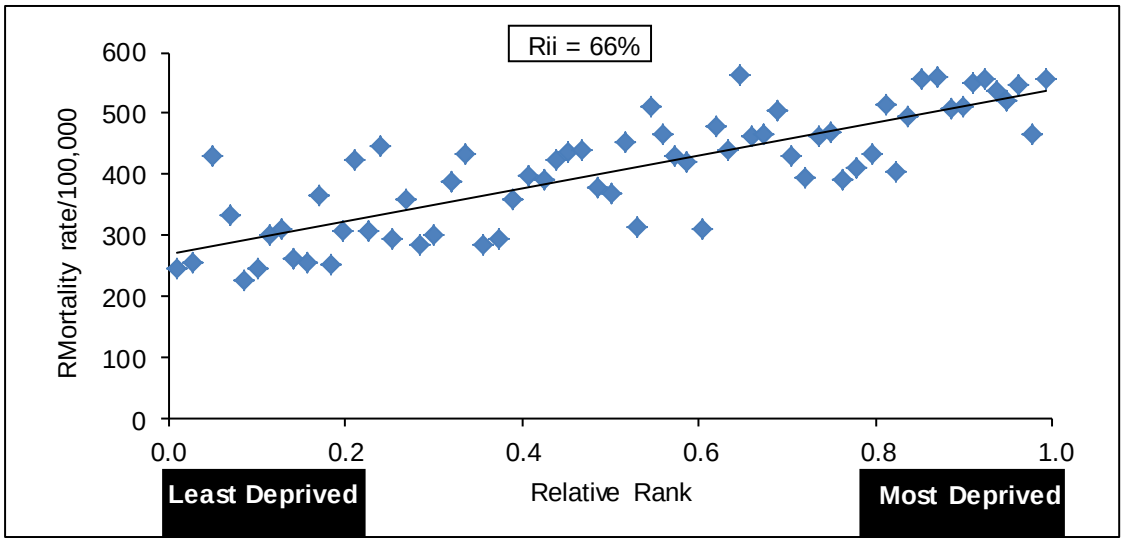
Source: Office of National Statistics (2014) Public Health Mortality File

Measuring the gap in premature mortality

There is significant inequality in premature all-cause mortality within County Durham (Figure 46). The distribution of premature mortality across County Durham is unequal. It is greater in the more deprived wards. The Relative Index of Inequality gap (RII) describes the size of the gap between the least and most deprived MSOAs. Positive (RII) scores indicate higher mortality in the more deprived wards of a given locality. The RII (i.e. the gap between least and most deprived) in County Durham for the period 2011-13 was 66%.

This is smaller than the 70% gap calculated for the period 2007-11, meaning that the size of the gap in all-cause premature mortality between least and most deprived has decreased by 4%.

Figure 46: Measuring the gap in premature all-cause mortality within County Durham, MSOA level all-cause mortality rates per 100,000, 2011-13 pooled

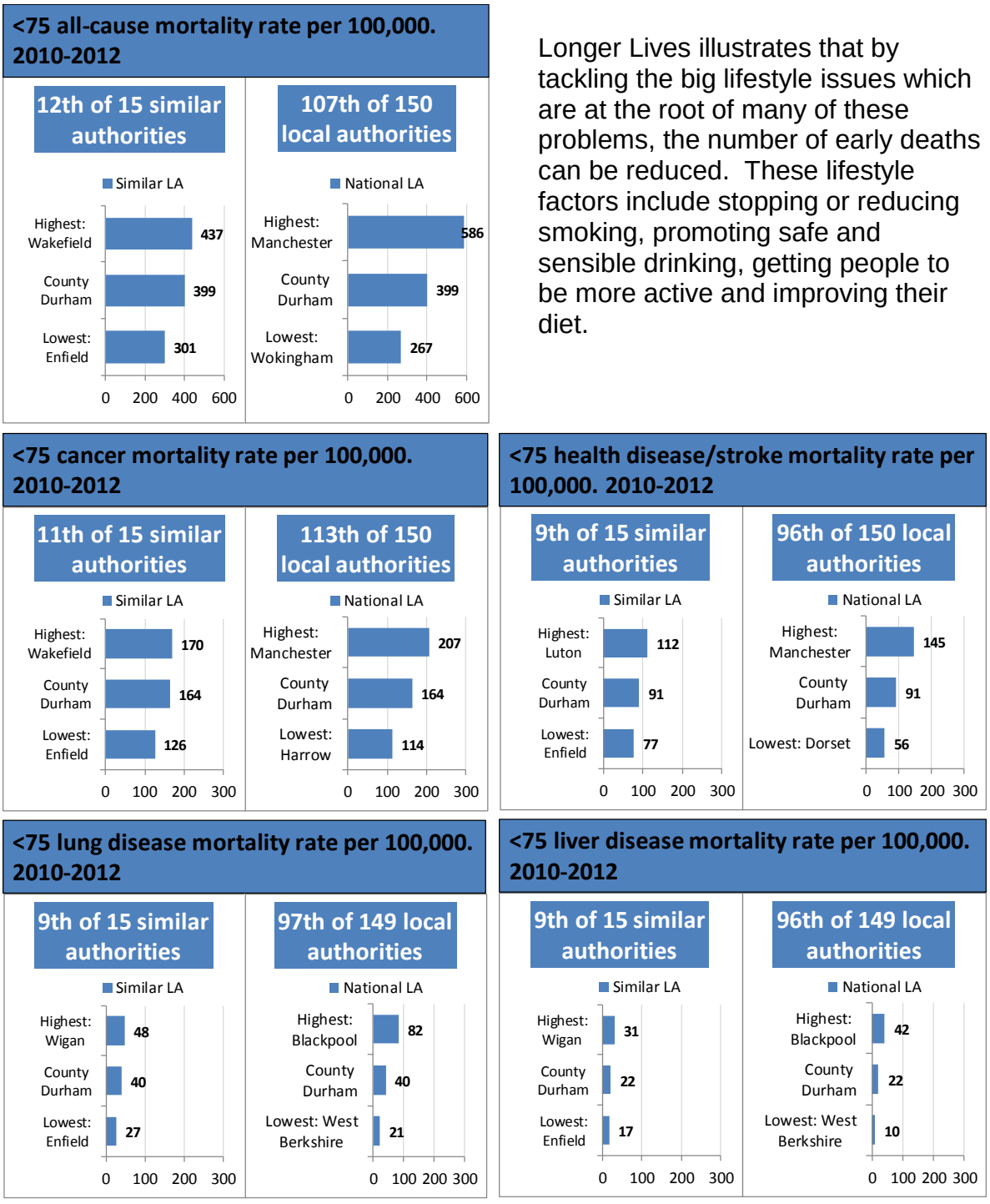


Source: Office of National Statistics (2014) Public Health Mortality File and ID2010, Department of Communities and Local Government

Relative rank - calculated by ranking MSOAs according to ID2010 score and assigning a relative rank, based on a proportion of MSOA population.
Slope Index of Inequality (SII) - The difference between the most and least deprived MSOAs.
Relative Index of Inequality (RII) - The size of the gap between the least and most deprived wards, expressed as a percentage of the average rate over all MSOAs.

Longer Lives
Longer Lives, launched by Public Health England (PHE), is specifically designed to provide local authorities and the NHS with an insight into the top causes of avoidable early death in their areas such as heart disease, stroke and cancer. It shows how they compare to other areas with a similar social and economic profile. The data presented in Longer Lives are drawn from data published for the Public Health Outcomes Framework and focus on premature death. County Durham is compared against the other 150 local authorities nationally (national LA) and 15 similar local authorities (similar LA). Local authorities in the same socio-economic bracket (identified as similar) are: Brighton & Hove, Camden, Darlington, Enfield, Hammersmith & Fulham, Leeds, Luton, Peterborough, Plymouth, Sheffield, Torbay, Wakefield, Wigan and Wirral.

Figure 47: Premature mortality in County Durham compared to other local authorities



Longer Lives illustrates that by tackling the big lifestyle issues which are at the root of many of these problems, the number of early deaths can be reduced. These lifestyle factors include stopping or reducing smoking, promoting safe and sensible drinking, getting people to be more active and improving their diet.

Source: Longer lives, Public Health England, 2014

Nationally, County Durham is not in the highest decile (10%) of local authorities for any of the selected mortality measures, although early death rates in County Durham are worse than average across a number of areas.

Overall, County Durham ranks 107th out of 150 local authorities for all cause premature deaths. However, mortality rates for these main causes of death have been reducing over time locally and life expectancy has been increasing.

Longer Lives concentrates on early death rather than long term illness, and on physical health rather than mental health. It makes no mention of the conditions in which people are born, grow, live, work or age, which are identified in the Marmot review as the causes of health inequalities.

Healthy life expectancy at birth
Healthy life expectancy at birth is the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health.

The healthy life expectancy for County Durham is significantly worse for both males (58.7) and females (59.4) than for England (63.4 and 64.1 respectively).

Smoking
'Healthy Lives, Healthy People: a Tobacco Control Plan for England' (Department of Health, 2011) recognised smoking to be the primary cause of preventable illness, morbidity and premature death, accounting for 81,400 deaths in England in 2009. The burden of smoking in County Durham is greater than in England. The Tobacco Control Profiles for County Durham (London Health Observatory, 2011, Table 40) show that:

- Smoking attributable deaths (and smoking attributable deaths from heart disease, stroke, lung cancer and COPD) are significantly worse than the England average.
- Smoking attributable hospital admissions are significantly worse than the England average.
- Lung cancer registrations are significantly worse than the England average.
- Smoking at time of delivery is significantly worse than the England average.

Smoking has been identified as the single biggest cause of inequality in death rates between rich and poor in the UK. Death rates from tobacco are two to three times higher among disadvantaged social groups than among the better off (ASH, 2012). Within County Durham it contributes to half the life expectancy gap between more and less deprived wards. As smoking is responsible for half the difference in deaths across socio-economic groups, tobacco control also has a major role to play in reducing health and social inequalities (ASH 2008, Beyond Smoking Kills). Smoking rates are highest among manual workers, in the lower socio-economic groups and certain minority and vulnerable groups (such as Bangladeshi and Pakistani men, those with learning difficulties and those with mental health problems, for example). Estimates suggest that smoking costs the NHS £1.5 billion per year (National Institute for Health and Clinical Guidance) and is the main cause of preventable morbidity and premature death in England.

In County Durham, around 1,100 people a year die from causes related to smoking. County Durham's Tobacco Profile (2013) estimates that 22.7% of adults smoke regularly, rising to 28.9% among people employed in routine and manual

occupations, which equates to around 92,000 smokers age 18+ across County Durham.

Smoking-related death rates per 100,000 (2010-12) were significantly higher in County Durham (372) than England (292) but are falling over time[6]; between 2007/09 and 2010/12, the rate fell by 51.5 per 100,000 (12%).

Estimated local costs of smoking to smokers themselves, to the NHS and society at large, based on national data, include:

- 1,639 years of lost productivity, costing the local economy £28 million.
- 93,822 lost days of productivity every year due to smoking-related sickness, costing around £9m.
- The total annual cost to the NHS in County Durham as a direct result of smoking-related ill health is approximately £21m.
- Passive smoking impacts on the health of non-smokers in County Durham, costing the local healthcare system a further £2m each year.
- Current and ex-smokers who require care in later life as a result of smoking-related illnesses cost an additional £13.1m each year across County Durham. This represents 0.5m in costs to Durham County Council and £5.6m in costs to individuals who self-fund their care.

[6] The smoking-related mortality indicator in PHOF is new and cannot be compared to previous measures.

Table 40: Indicator dataset, County Durham Tobacco Control Profile 2013

Indicator	Period	Co Durham		Region	England			
		Count	Value	Value	Value	Worst	Range	Best
Smoking attributable mortality	2010-12	3,225	372.4	372.8	291.9	473.9		185.8
Smoking attributable deaths from heart disease	2010-12	353	40.2	39.8	34.2	65.2		21.6
Smoking attributable deaths from stroke	2010-12	128	14.6	141.1	11.5	21.7		7.1
Deaths from lung cancer	2010-12	1,255	83.3	87.1	60.9	112.7		63.5
Deaths from chronic obstructive pulmonary disease	2009-11	1,011	71.1	68.8	50.1	97.1		26.1
Lung cancer registrations	2009-11	1,482	102.2	108.7	75.5	144.2		42.1
Oral cancer registrations	2009-11	188	12.5	13.9	12.8	21.1		6.7
Smoking attributable hospital admissions	2010-11	6,748	1,883	2,066	1,420	2,536		808
Cost per capita of smoking attributable hospital admissions	2010-11	13,442, 833	44.4	49.0	36.9	61.7		15.6
Smoking prevalence – routine & manual	2012	-	28.9%	31.0%	29.7%	44.3%		14.2%
Smoking prevalence (Integrated Household Survey)	2013	-	22.7%	22.3%	18.4%	-		-
Smoking status at time of delivery	2012-13	1,045	19.9%	19.7%	12.7%	30.8%		2.3%

Source: Public Health England (2013) Local Tobacco Control Profiles for England

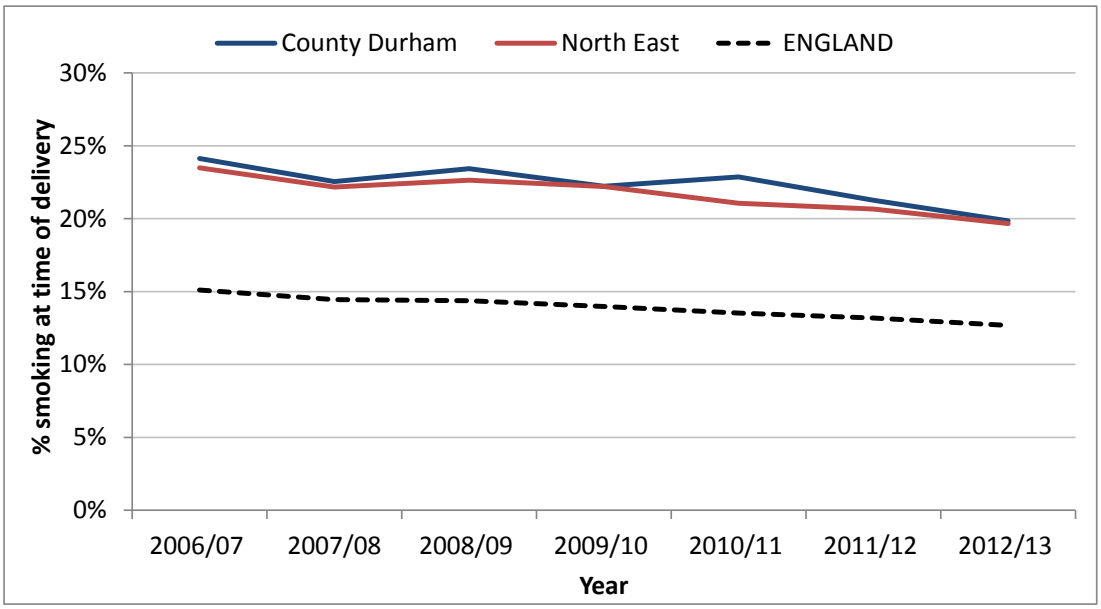
Babies from deprived backgrounds are more likely to be born to mothers who smoke, and to have much greater exposure to second hand smoke in childhood. Smoking remains one of the few modifiable risk factors in pregnancy. It can cause a range of serious health problems, including lower birth weight, pre-term birth, placental complications and perinatal mortality.

Reducing smoking in pregnancy continues to be a major priority in County Durham.

- During 2013/14, 19.9% of mothers were smokers at the time of delivery compared to 20.9% regionally and 12% nationally.

The difference between County Durham and England is statistically significant (Figure 48). The overall trend over time has been downwards locally, regionally and nationally.

Figure 48: Percentage of maternities smoking at delivery – County Durham, North East and England 2006/07 – 2012/13



Source: Statistics on women's smoking status at time of delivery: England. Quarter 4, 2012/13, Health and Social Care Information Centre

Smoking among young people is associated with a range of factors: individual, social, community and societal, which increase young people's risk of becoming smokers. Smoking uptake is linked to socio-economic disadvantage. Young people are most at risk of becoming smokers if they grow up in families and communities where smoking is the norm and where they have access to cigarettes. Children whose parents and/or siblings smoke are more likely to become smokers.

Disadvantaged children, young people and adults are also likely to be exposed to higher levels of second-hand smoke (SHS) than those from more privileged backgrounds. This is due to lower levels of smoking restrictions in the home.

'Smoking, drinking and drug use among young people in England in 2012' (Health & Social Care Information Centre) reported that:

- 22% of school pupils had tried smoking at least once and 3% were regular smokers (smoking at least one cigarette a week).
- Boys and girls are equally likely to smoke.
- Two thirds (67%) of pupils reported that they had been exposed to second-hand smoke in the past year. 55% of pupils said that this had happened in someone else's home, 43% in their own home, 30% in someone else's car and 26% in their family's car.

Estimates by Cancer Research UK suggest that in County Durham:

- 145 children and young people start smoking each month.

- 1,746 children and young people start smoking each year.

Durham County Council's Children and Young People's Survey 2014 shows that:

- 55.5% of children report being exposed to second hand smoke (year 6 only).

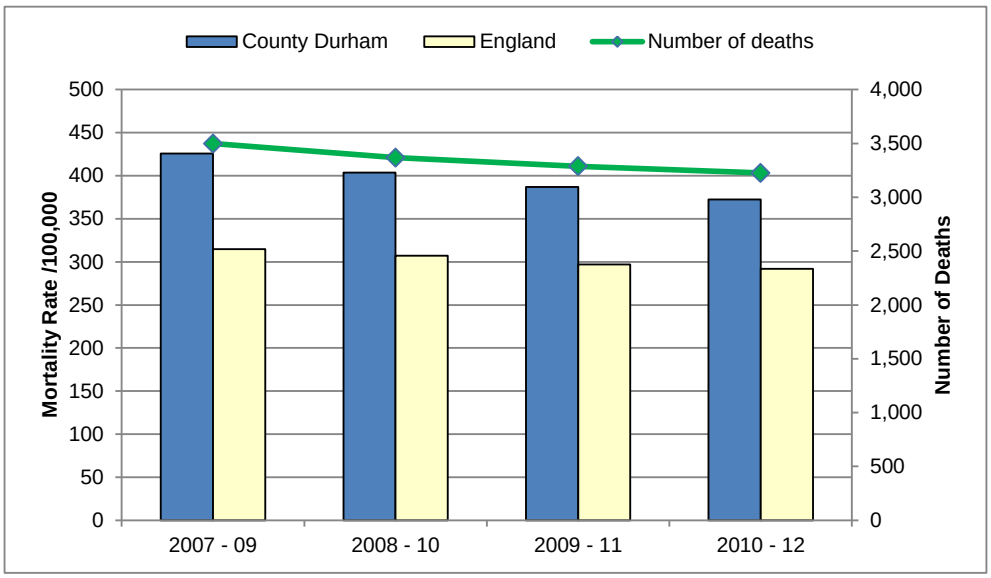
Nationally, around 18% of all adult deaths (aged 35 and over) are estimated to be caused by smoking ('Statistics on Smoking', NHS Information Centre for Health and Social Care). Between 2008 and 2010, 19.9% of all adult deaths in County Durham were smoking related. Around 36% of all deaths due to respiratory diseases and 29% of all cancer deaths were attributable to smoking. 14% of deaths due to circulatory diseases and 5% of deaths due to diseases of the digestive system were attributable to smoking.

In County Durham, 22% of adults are estimated to smoke regularly (Integrated Household Survey). This rises to 28.9% among people employed in routine and manual occupations. This equates to around 92,000 smokers aged 18+ across County Durham.

On average in County Durham around 1,075 people died per year from smoking-related causes in the period 2010-12. Smoking-related death rates are significantly higher in County Durham than England (Figure 49).

Between 2007-09 and 2010-12 smoking related mortality rates in County Durham fell by 12.5%, compared to reductions of 7.2% for England and 9% for the North East.

Figure 49: Smoking related mortality rates per 100,000 and number of smoking related deaths (aged 35+), County Durham and England 2004-06 – 2010-12



Source: County Durham Tobacco Control Profile 2014, Public Health England

Reducing smoking prevalence must be addressed at many levels and tobacco control needs a range of approaches (such as stop smoking services, protecting from the dangers of second hand smoke, media, education and social marketing, restricting tobacco promotion, regulation, and reducing availability). Smokefree

County Durham brings together local partners to deliver on a range of the World Health Organisation's six strands of tobacco control.

Cancer

Cancer remains the single biggest preventable cause of premature death in the UK today. It is responsible for one in five of all deaths in adults aged 35 and over – more than is caused by alcohol, car accidents, suicide, AIDS, murder and illegal drugs combined. The distribution of cancer incidence, prevalence, mortality and survival is not equal. Survival rates from most cancers are significantly better in less deprived areas than more deprived ones (Coleman et al, 1999).

Cancer contributes significantly to the gap in life expectancy between County Durham and England and as such is a priority area for action locally.

The burden of cancer in County Durham is high. 4,600 County Durham residents died from cancer between 2010 and 2012. Of these, almost 50% (2,285) died prematurely (under 75 years). During this period, cancer accounted for almost 40% of all premature deaths in County Durham.

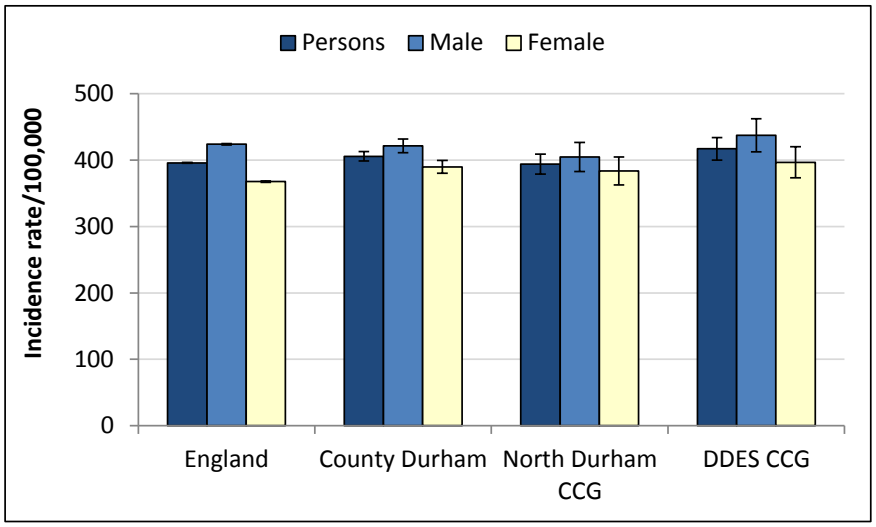
Estimates suggest that over 160 deaths a year (all ages) might be avoided across County Durham if more cancers were diagnosed early. The importance of saving lives through increasing public awareness and encouraging earlier diagnosis has informed local approaches to reducing cancer mortality rates in County Durham.

Cancer Incidence

Cancer incidence is the number of new cases of cancer diagnosed for a given period.

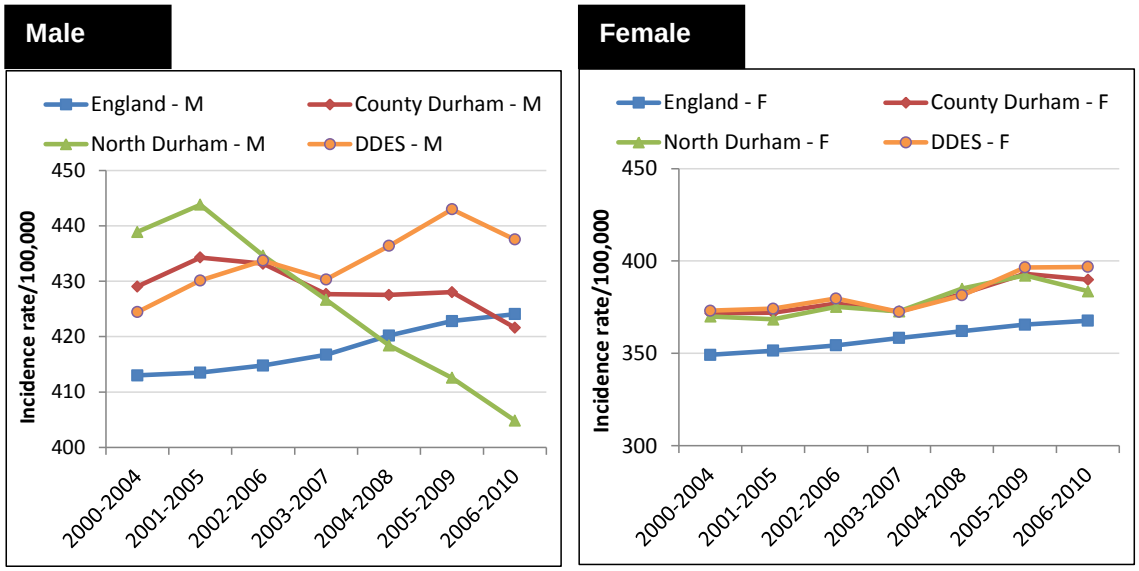
In County Durham (all) cancer incidence is significantly higher in men than women, although this does not show when looking at the CCGs (due to much wider confidence intervals). Male and female incidence in DDES CCG is not significantly different to County Durham or England. Male incidence has increased over time in DDES (+3.1%) and England (+2.7%) compared to decreases in North Durham (-7.8%) and County Durham (-1.7%). Female incidence has increased over time in DDES (+6.4%), England (+5.3%), County Durham (+4.9%) and North Durham (+3.7%).

Figure 50: Cancer incidence per 100,000, with 95% confidence intervals, all cancers, 2006/10 pooled



Source: Public Health England Knowledge and Intelligence Team (Northern & Yorkshire)

Figure 51: Cancer incidence per 100,000, all cancers, 2000-04 to 2006-10



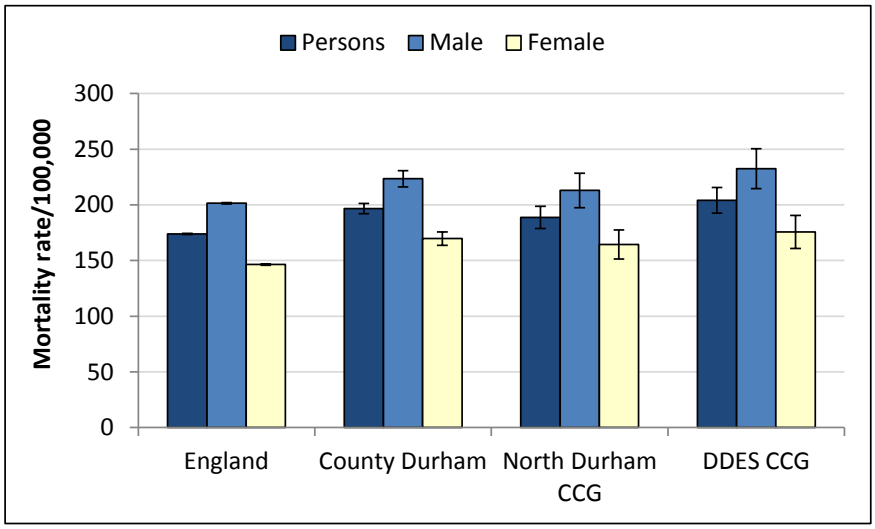
Source: Public Health England Knowledge and Intelligence Team (Northern & Yorkshire)

Cancer mortality

In County Durham (all) cancer mortality is significantly higher in men than women. This is true for both North Durham and DDES CCGs (Figure 52).

Cancer mortality for men and women in DDES CCG is not significantly different to County Durham or England.

Figure 52: Cancer mortality per 100,000, with 95% confidence intervals, all cancers, 2007-11 pooled

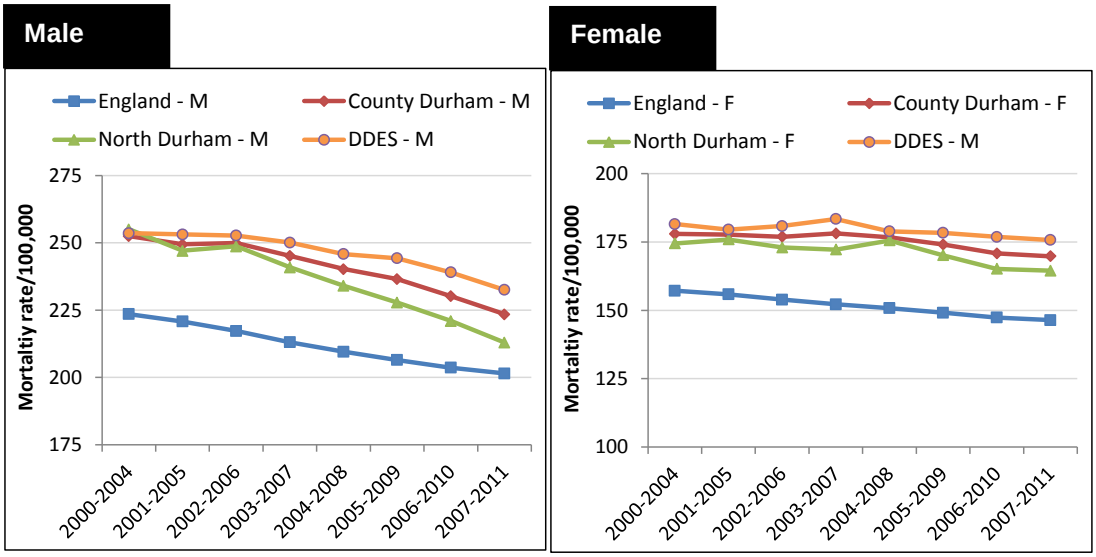


Source: Public Health England Knowledge and Intelligence Team (Northern & Yorkshire)

Male mortality has fallen over time in all areas (Figure 53). DDES experienced a reduction of -8.3%, compared to North Durham (-16.5%), County Durham (-11.5%) and England (-9.9%).

Female mortality has fallen over time in all areas. DDES experienced a reduction of -3.2% over this period, compared to North Durham (-5.7%), County Durham (-4.6%) and England (-6.8%).

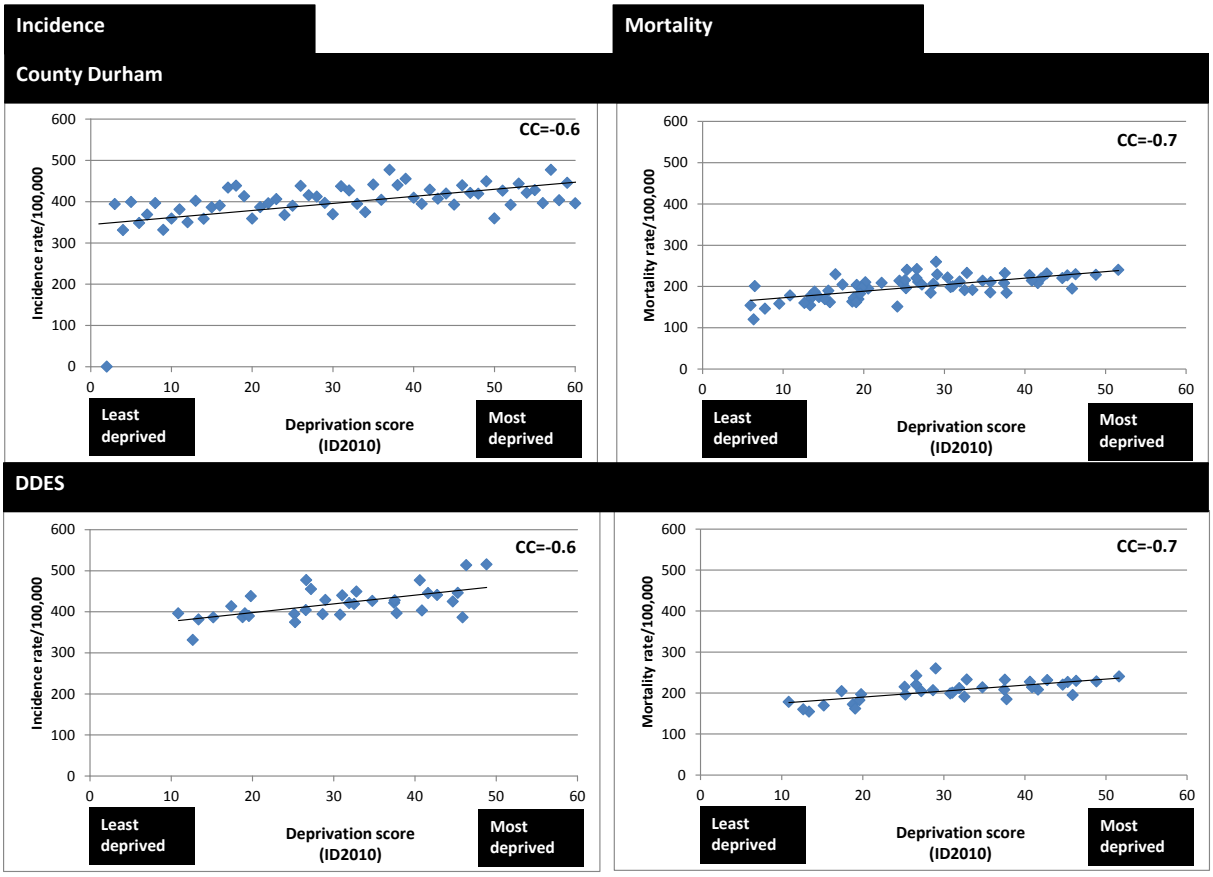
Figure 53: Cancer mortality per 100,000, all cancers, 2000-04 to 2007-11



Source: Public Health England Knowledge and Intelligence Team (Northern & Yorkshire)

The distribution of cancer incidence and mortality across County Durham and DDES CCG is unequal. It is higher in the more deprived areas. For incidence, this relationship is moderate to strong in County Durham and DDES CCG (cc=0.6). The relationship between premature cancer mortality and deprivation is stronger, with a strong correlation in County Durham and DDES CCG (cc=0.7).

Figure 54: All cancer incidence (2006-10 pooled) and mortality (2007-11 pooled) rates by MSOA and deprivation score (ID2010), County Durham and DDES Clinical Commissioning Groups



End of life care

The National End of Life Care Strategy aims for all adults to receive high quality end of life care regardless of age, condition, diagnosis, ethnicity or place of care.

The National End of Life Care Programme 'Information for commissioning end of life care' states that "end of life care helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of

pain and other symptoms and provision of psychological, social, spiritual and practical support."

For County Durham, the End of Life Care vision is: To ensure that people approaching end of life will be able to have a good experience in their preferred place of death, be that hospital, hospice or home.

Annually around 500,000 people die in England; almost two thirds of these are aged over 75 years. Some people receive excellent care at the end of life, many do not. The majority of deaths (58%) occur in NHS hospitals, while 18% occur at home, 17% in care homes, 4% in hospices and 3% elsewhere (End of Life Strategy, DoH, 2008).

One of the fundamental problems is that services are not always joined up and as a result communication between staff and agencies can break down. Research suggests that, given the opportunity and right support, most people would prefer to die at home. In practice, only a minority manage to do so. Many people die in an acute hospital, which is not their preferred place of care (County Durham and Darlington Joint Commissioning Strategy for Palliative and End of Life Care Services). Through better planning around the end of life and by ensuring that the support exists during the last days and hours, we need to make sure that these plans are fulfilled.

The annual incidence of deaths is the single most important indicator of palliative care need in a population, since most palliative care arises in the last year of life (Tebbit, 2004). One indication of success in end of life care is whether or not a person achieves a death in their place of choice. According to research done by Dying Matters, around 70% of people nationally would prefer to die at home or their place of residence.

There are several factors which must be addressed when developing and commissioning services. These include profiles of the service users, demography, health, and the socio-economy of the area.

In County Durham around 5,300 people die each year from all causes, around two thirds of these are aged over 75 years (similar to the national experience). For the period 2008-10 the National End of Life Care profile for County Durham states that:

- 54% (8,474) of all deaths were in hospital.
- 22% (3,511) occurred at home.
- 19% (2,991) occurred in a care home.
- 3% (475) were in a hospice.
- 3% (427) were in other places.

Between 2008 and 2010 in County Durham:

- 29% of all deaths (4,580) were from CVD.
- 29% of all deaths (4,531) were from cancer.
- 28% of all deaths (4,392) were from other causes.
- 15% of all deaths were from respiratory diseases.
- Proportionally there is little variation by locality within County Durham.

Long term conditions (LTC) refers to a group of illnesses which, at present, cannot be cured but can be controlled by medication and other therapies. Once diagnosed with a long term condition, a patient's life is forever altered. However, by supporting patients with a long term condition to manage their condition and their risk factors, the NHS and social care can support the patient to attain better health outcomes and quality of life, slow disease progression and reduce disability.

In early phases of LTC, self-care plays a significant role, as patient and carer education has a significant impact on control. As the condition progresses, increasing amounts of planned care will be needed to support a person's self-care up to and including their end of life care. However, taking such an approach challenges the role LTC plays in the local health economy. Instead of just being a range of conditions which affect people who are the most frequent users of healthcare, it has the potential to be the core principles around which healthcare is commissioned in the future, by focusing attention on the increasing health care needs of an ageing population.

REDUCING HEALTH INEQUALITIES

Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups (WHO, 2013). They can be associated with socio-economic and environmental factors. Often these inequalities are geographical, with health status or outcomes worse in more deprived areas (the social gradient). They can also be experienced by different groups of people. For example, the young, the elderly, veterans or homeless people. Such variations in health are avoidable and unjust (Marmot, 2010).

Fair Society, Healthy Lives, the Marmot Review (2010), states that health inequalities result from social inequalities and that action across all the social determinants of health (e.g. housing, employment and education) should take a 'lifecourse' approach. It set out the key areas to be improved to make a significant impact in reducing health inequalities. It found that the social conditions in which we are born, live, work and age determine variations in health and life expectancy.

Social and economic inequalities in society cause the social and economic differences in health status. The Marmot review outlined how health inequalities are not caused by chance or attributed just to genetic make up, unhealthy behaviour or difficulties accessing health care, and how they accrue across the lifecourse. Marmot also demonstrated a gradient in health outcomes; the lower an individual's social and economic status, the worse their expected health. However, these health inequalities are avoidable and to reduce them is a fundamental issue of social justice, bringing significant benefits to society. The review also presented an evidence base of interventions which could contribute to reducing health inequalities by levelling up the gradient. The central message is that focusing solely on the most disadvantaged in society will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity which is proportionate to the level of disadvantage. This is called proportionate universalism.

The six recommendations from the Marmot review are:

1. Give every child the best start in life.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.

Evidence (such as the Marmot review for example) is very clear that health inequalities are the result of complex interactions caused by a number of factors, which for ease can be described as:

- Inequalities in opportunity – caused by poverty, family circumstances, education, employment, environment, housing – collectively called the wider determinants of health.
- Inequalities in lifestyle choices – caused by smoking, lack of physical activity, poor food choices, drugs misuse, inappropriate alcohol consumption and risky sexual activity.
- Inequalities in access to services for those who are already ill or have accrued risk factors for disease (health inequity).

Such inequalities disproportionately affect disadvantaged groups, with economically deprived and socially vulnerable groups being at higher risk. This can affect various groups and communities including black and minority ethnic groups; disabled people; people with mental health problems or learning difficulties; gay, lesbian and bisexual people; gypsies and travellers; asylum seekers and refugees; and carers.

Men from unskilled, manual occupations are more likely to smoke, drink too much alcohol, suffer from long term conditions (a condition which cannot at present be cured but can be controlled by medication and other therapies). Children from deprived families are less likely to be breastfed, more likely to suffer from asthma, more likely to be obese and more likely to become teenage parents. Migrants, the homeless, drug and alcohol addicts are more likely to suffer from tuberculosis (TB). These inequalities can be partly attributed to disadvantaged groups having significantly more exposure to risk factors, low uptake of preventative programmes, and delayed presentation to health services and subsequently later access to diagnosis, treatment and rehabilitation.

The social determinants of health have been described as ‘the causes of the causes of health inequalities’ (UCL Institute of Health Equity, 2012). These are the conditions in which people are born, grow, live, work and age. What happens within an individual’s social context, during the early years, education, income, skills development, employment and work within communities all impact on their health and length of life.’

Health inequalities exist between County Durham and England. For example:

- Life expectancy for men living in County Durham is 1.3 years less than the England average. For women it is 1.5 years less than the England average (at birth 2010-12).

- Breastfeeding prevalence at 6 to 8 weeks in County Durham has risen from 25.4% in 2008/09 to 28.1% in 2012/13. This remains lower than the national average (47.2%).
- Teenage conception rates are significantly higher than England but have been falling over time. In 2012, teenage conception rates were lower in County Durham (33.7 per 1,000 population of 15-17 year olds) than the North East region (35.5 per 1,000) however this is greater than the national rate (27.7 per 1,000).
- Premature mortality rates from all cardiovascular diseases (2010-12) in County Durham (92.4 per 100,000) are significantly higher than England (81.1 per 100,000).

Health inequalities also exist **within** County Durham. For example:

- The distribution of life expectancy within County Durham is unequal. It is higher in the least deprived middle super output areas (MSOAs[7]). The distribution of life expectancy within County Durham is unequal.
- The distribution of year six obesity prevalence within County Durham (by MSOA) is unequal. It is higher in the more deprived areas.
- The distribution of teenage conceptions within County Durham (2008-10) is unequal. Easington experienced the highest rate within County Durham (52.1 per 1,000). Teesdale had the lowest rate (27 per 1,000).
- The distribution of premature all-cause mortality within County Durham (by MSOA, 2011-13) is unequal. It is higher in the more deprived areas.

The social determinants of health: the Marmot indicators

The Marmot indicators are a new set of indicators of the social determinants of health, health outcomes and social inequality, which broadly correspond to the policy recommendations proposed in Fair Society, Healthy Lives. The 2014 release provides an update on progress to reduce inequalities in health, and against the Institute of Health Equity's 6 key policy recommendations.

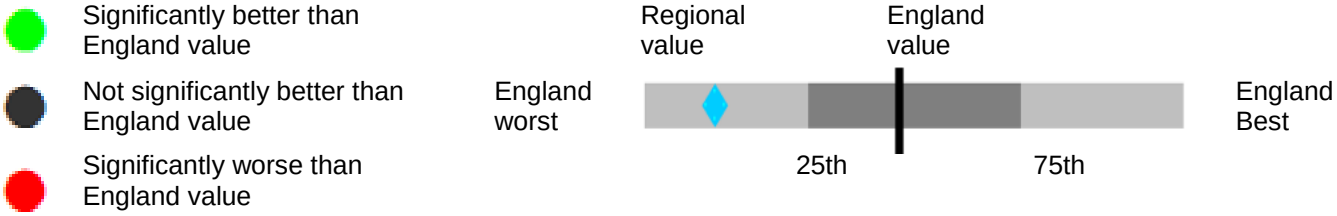
Results for each indicator for County Durham are shown below. On the chart, the value for Durham County Council is shown as a circle, against the range of results for England, shown as a bar.

[7] MSOAs and LSOAs (middle and lower super output areas) are geographic areas used to allow the reporting of small areas statistics. There are 7,193 MSOAs in England and Wales, with an average population of 7,200. An MSOA covers several LSOAs. There are 34,378 LSOAs in England and Wales, with an average population of 1,500. Output Areas (OAs) are the smallest unit for Census data and the table below shows key indicators of the social determinants of health, health outcomes and social inequality which correspond, as closely as is currently possible, to the indicators proposed in Fair Society, Healthy Lives.

Table 41: Marmot indicators for County Durham 2014

Indicator	Period	Local Authority Value	Regional Value	England Value	England Worst	Range	England best
Health outcomes							
Healthy life expectancy at birth – Male (years)	2010-12	58.7	59.5	63.4	52.5		70.0
Healthy life expectancy at birth – Female (years)	2010-12	59.4	60.1	64.1	55.5		71.0
Life expectancy at birth – Male (years)	2010-12	77.9	77.88	79.2	74.0		82.1
Life expectancy at birth – Female (years)	2010-12	81.5	81.6	83.0	79.5		85.9
Inequality in life expectancy at birth – Male (years)	2010-12	7.0	-	-	16.1		3.9
Inequality in life expectancy at birth – Female (years)	2010-12	7.2	-	-	11.4		1.3
People reporting low life satisfaction (%)	2012-13	8.8	7.0	5.8	10.1		3.4
Give every child the best start in life							
Good level of development at age 5 (%)	2012-13	41.9	45	52	27.7		69.0
Good level of development at age 5 with free school meal status (%)	2012-13	26.3	28.7	36.2	17.8		60.0
Enable all children, young people and adults to maximise their capabilities and have control over their lives							
GCSE achieved 5A*-C incl. English & Maths (%)	2012-13	63.1	59.3	60.8	43.7		81.9
GCSE achieved 5A*-C incl. English & Maths free school meal status (%)	2012-13	38.0	34.6	38.1	21.8		76.7
19-24 year olds not in educations, employment or training (%)	2012-13		19.6	16.4			
Create fair employment and good work for all							
Unemployment % (ONS model-based method)	2013	9.1	10.0	7.4	14.4		3.2
Long term claimants of Jobseeker's Allowance (rate per 1,000)	2013	14.7	17.4	9.9	32.6		2.3

Work-related illness (rate per 100,000 population)	2011-12		4630	3640			
Ensure a healthy standard of living for all							
Households not reaching Minimum Income Standard (%)	2011-12		26.3	23.0			
Fuel poverty for high fuel cost households	2012	11.4	11.6	10.4	21.3		4.9
Create and develop healthy and sustainable places and communities							
Utilisation of outdoor space for exercise/health reasons (%)	March 2012 – February 2013	12.4	16.0	15.3	0.5		41.2



The 2014 Marmot indicators show County Durham has significantly worse:

- Male and female healthy life expectancy than England.
- Male and female life expectancy than England.
- Inequality in disability-free life expectancy for males and females than England.
- People reporting low life satisfaction.
- Levels of children achieving a good level of development at age 5 than England.
- Long term claimants of Jobseeker's Allowance.
- Levels of fuel poverty for high fuel cost households.
- Utilisation of outdoor space for exercise/health reasons.

County Durham has significantly better GCSE achievement than England.

The 2012/13 annual report of the Director of Public Health for County Durham focused on reducing health inequalities and what action needed to be taken by a range of organisations, in the short, medium and long term to tackle the persistent and pervasive health inequalities suffered by some of the communities in the county. The report has informed commissioning plans, service developments, the assessment of needs, as well as the future direction of early years' services and the integration of public health across council services.

The annual report had four key messages, which were:

- Continue supporting 'making every contact count' in order to address health inequalities.
- Making smoking history.
- Making use of the change4life campaign in local communities to promote all aspects of health and wellbeing.
- Working at grass roots level within constituencies to encourage the take up of health check opportunities.

Alcohol

Alcohol consumption is a major public health issue in County Durham, with high levels of hazardous, harmful and binge drinking. Nationally it is the second biggest cause of premature death. Alcohol misuse has health and social consequences borne by individuals, their families, and the wider community. Health harms to individuals from drinking can be acute (immediate) or chronic (long term). The main health consequences of alcohol misuse are liver disease, cancers (liver, oral, oesophageal, gastric, colon, breast), hypertension, stroke, acute intoxication and deaths from injuries. Additionally there are psychiatric consequences such as depression and self-harm, as well as impact on the foetus, if pregnant.

County Durham's Alcohol Harm Reduction Strategy aims to reduce the harm caused by alcohol to individuals, families and communities in County Durham while ensuring that people are able to enjoy alcohol responsibly. This harm is evidenced in the Local Alcohol Profiles for England (LAPE, Public Health England). The LAPE puts into a national context 26 separate alcohol statistics around many health issues including mortality, chronic liver disease, alcohol related and alcohol specific hospital admissions and alcohol related crime.

Table 42: LAPE 2014 summary for County Durham

	Indicator	Measure	County Durham	North East	England	National Rank (out of 326)
1	Months of life lost - males	Months	14	14	11.49	269
2	Months of life lost - females	Months	7	7	5.38	289
3	Alcohol-specific mortality - males	DSR per 100,000	17	19	14.57	235
4	Alcohol-specific mortality - females	DSR per 100,000	9	9	6.78	272
5	Mortality from chronic liver disease - males	DSR per 100,000	20	20	15.75	260
6	Mortality from chronic liver disease - females	DSR per 100,000	12	11	8.33	297
7	Alcohol-related mortality - males	DSR per 100,000	68	70	63.20	229
8	Alcohol-related mortality - females	DSR per 100,000	32	31	28.05	255
9	Alcohol-specific hospital admission - under 18s	DSR per 100,000	82	72	44.88	308
10	Alcohol-specific hospital admission - males	DSR per 100,000	616	702	506.95	264
11	Alcohol-specific hospital admission - females	DSR per 100,000	329	342	232.26	292
12	Alcohol-related hospital admission (Broad) - males	DSR per 100,000	2001	2117	1676.33	285
13	Alcohol-related hospital admission (Broad) - females	DSR per 100,000	1042	1065	831.84	298
14	Alcohol-related hospital admission (Narrow) - males	DSR per 100,000	688	735	588.98	279
15	Alcohol-related hospital admission (Narrow) - females	DSR per 100,000	377	388	305.67	294
16	Admission episodes for alcohol-related conditions (Broad)	DSR per 100,000	2478	2678	2031.76	285
17	Admission episodes for alcohol-related conditions (Narrow)	DSR per 100,000	794	856	636.85	295
18	Alcohol-related recorded crime	Crude rate per 1,000	4	4	5.74	75
19	Alcohol-related violent crime	Crude rate per 1,000	3	3	3.93	84
20	Alcohol-related sexual offences	Crude rate per 1,000	0	0	0.12	61
21	Abstainers synthetic estimate	% of drinkers	14	15	16.53	194
22	Lower Risk drinking (% of drinkers only) synthetic estimate	%	74	74	73.25	108
23	Increasing Risk drinking (% of drinkers only) synthetic estimate	%	20	20	20.00	106
24	Higher Risk drinking (% of drinkers only) synthetic estimate	%	7	7	6.75	125
25	Binge drinking (synthetic estimate)	%	32	30	20.10	325
26	Employees in bars	% of all employees	3	3	1.79	251

	Significantly higher than England
	Worst 20% nationally

- 65% (17) of the 26 indicators in the LAPE are significantly higher than England.
- 4% (3) are higher than the regional average (significance has not been tested).
- 38% (10) are lower than the regional average (significance not tested).
- 54% (14) are ranked in the worst 20% of all local authorities nationally.

Table 43: Summary of selected indicators, significance against England and change over time, 2014 County Durham LAPE

	Indicator	Significantly higher than England	Change over time (%)		
			County Durham	North East	England
1	Months of life lost - males	No	+13	-1	-3
2	Months of life lost - females	No	+12	-3	-4
3	Alcohol-specific mortality - males	Yes	+13	-6	-3
4	Alcohol-specific mortality - females	Yes	+7	+9	-3
7	Alcohol-related mortality - males	Yes	-2	-10	-7
8	Alcohol-related mortality - females	Yes	-10	-14	-7
9	Alcohol-specific hospital admission - under 18s	Yes	-37	-35	-34
10	Alcohol-specific hospital admission - males	Yes	+4	+6	+15
11	Alcohol-specific hospital admission - females	Yes	+14	+7	+16
12	Alcohol-related hospital admission (Broad) - males	Yes	+8	+9	+16
13	Alcohol-related hospital admission (Broad) - females	Yes	+12	+10	+18
14	Alcohol-related hospital admission (Narrow) - males	Yes	+1	-1	+4
15	Alcohol-related hospital admission (Narrow) - females	Yes	+5	0	+5
16	Admission episodes for alcohol-related conditions (Broad)	Yes	+13	+15	+23
17	Admission episodes for alcohol-related conditions (Narrow)	Yes	+5	+4	+4

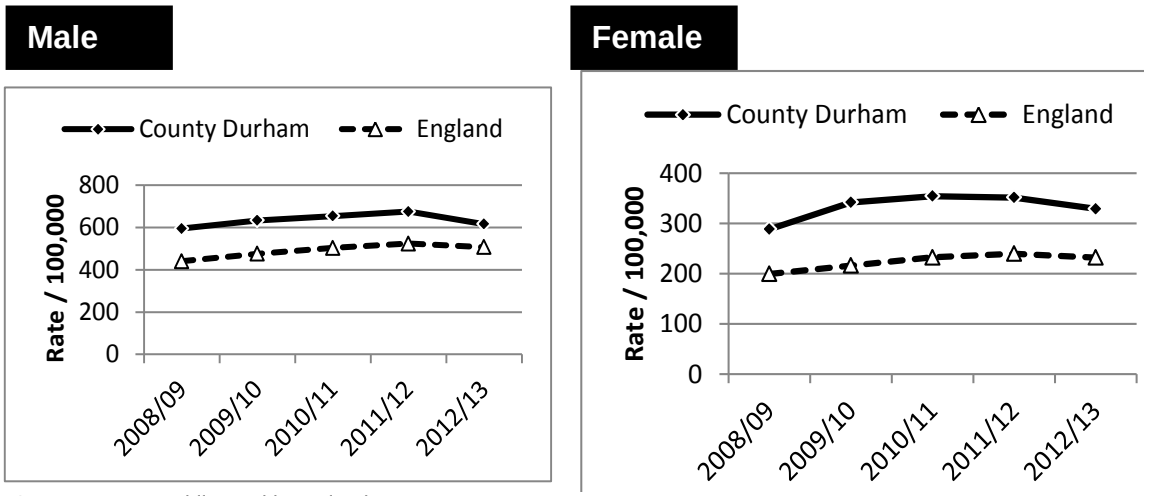
The 2014 LAPE shows that County Durham experiences:

- Significantly higher under-18 alcohol specific admission rates than England. Rates have been falling over time in County Durham, the North East and England. Proportionally this decrease has been greater in County Durham (37%) than the North East (35%) and England (34%).
- Significantly higher alcohol-related admission rates (broad) than England for men and women. Rates have been rising over time for men and women locally (8% men and 12% women), regionally (9% men and 10% women) and nationally (16% men and 18% women).
- Significantly higher alcohol-related admission rates (narrow) than England for men and women. Over time rates have increased locally for men (1%) and women (5%) and nationally for men (4%) and women (5%). Regionally rates have experienced little variation.

The 2014 LAPE for County Durham shows that over time:

- Alcohol-specific hospital admission rates have been increasing over time for men and women both locally and nationally (Figure 55).
    - The increase has been slower in County Durham compared to England. Between 2008/09 and 2012/13 male rates in County Durham increased by 3.6% compared to 15.1% for England. Female rates locally increased by 14.1% over the same period compared to 16.3% nationally.

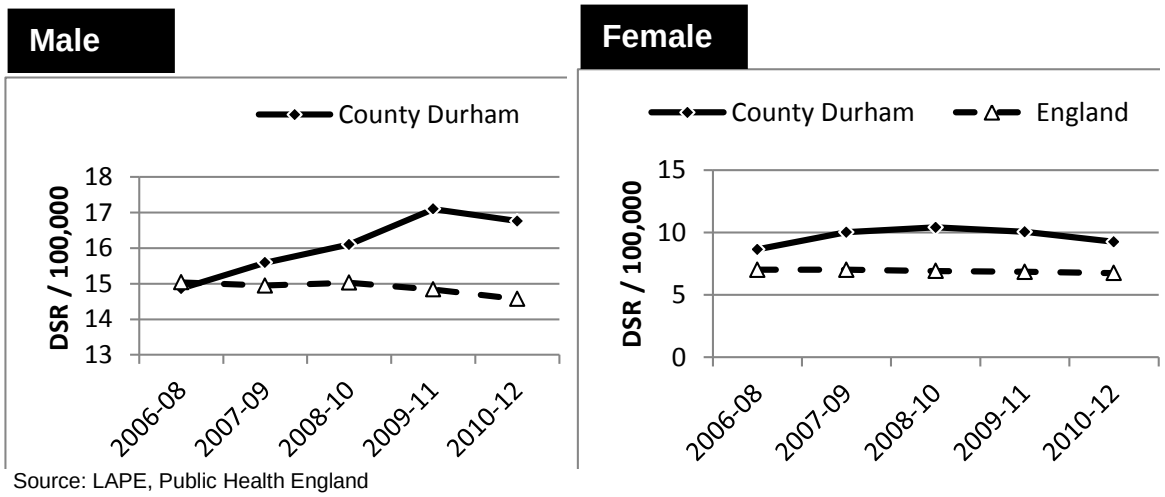
Figure 55: Alcohol-specific hospital admission rate per 100,000, male and female, 2008/09 to 2012/13, England and County Durham



Source: LAPE, Public Health England

Alcohol specific mortality rates in County Durham have been rising over time but reducing nationally (Figure 56). Between 2008/09 and 2012/13 alcohol specific mortality rates increased in County Durham (13% men and 7% women) compared to reductions regionally (-6% men) and nationally (-3% for men and women). Female rates in the North East increased by 9% over the same period.

Figure 56: Alcohol-specific mortality rates per 100,000, male and female, 2006-08 to 2010-12, England and County Durham

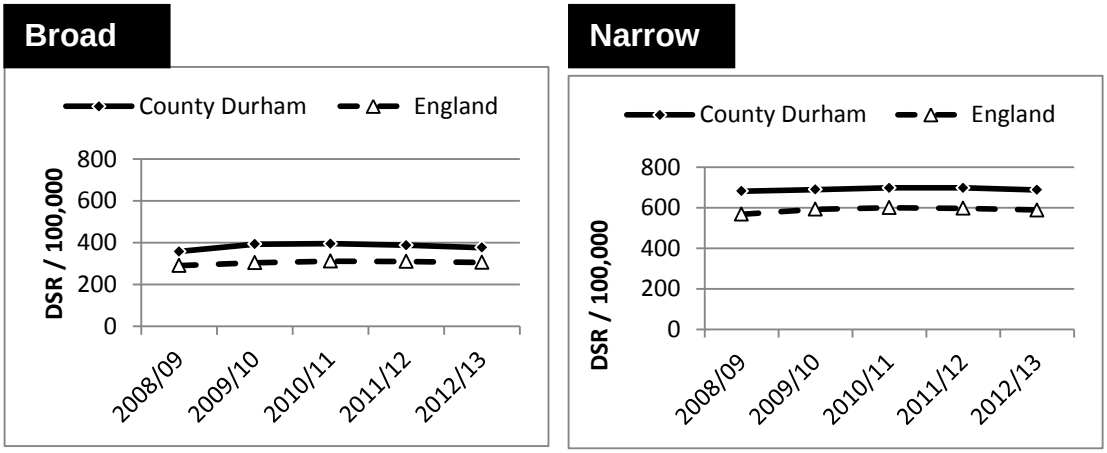


Source: LAPE, Public Health England

Public Health England has made several revisions to the way in which alcohol related hospital admissions (ARHA) are calculated in the 2014 LAPE. A **broad** measure, which is derived by summing the alcohol attributable fraction associated with each admission based on the diagnosis most strongly associated with alcohol out of all diagnoses (both primary and secondary). A **narrow** measure, which is constructed in a similar way but counts only the fraction associated with the diagnosis in the primary position.

To summarise this, the new indicator uses a much narrower search: it looks only for primary or external cause codes which relate to alcohol. These are counted in the same way as before, i.e. by applying attributable fractions.

Figure 57: Alcohol-related hospital admission episode rate per 100,000 (Broad and Narrow), persons, all ages, 2008/09 to 2012/13, England and County Durham

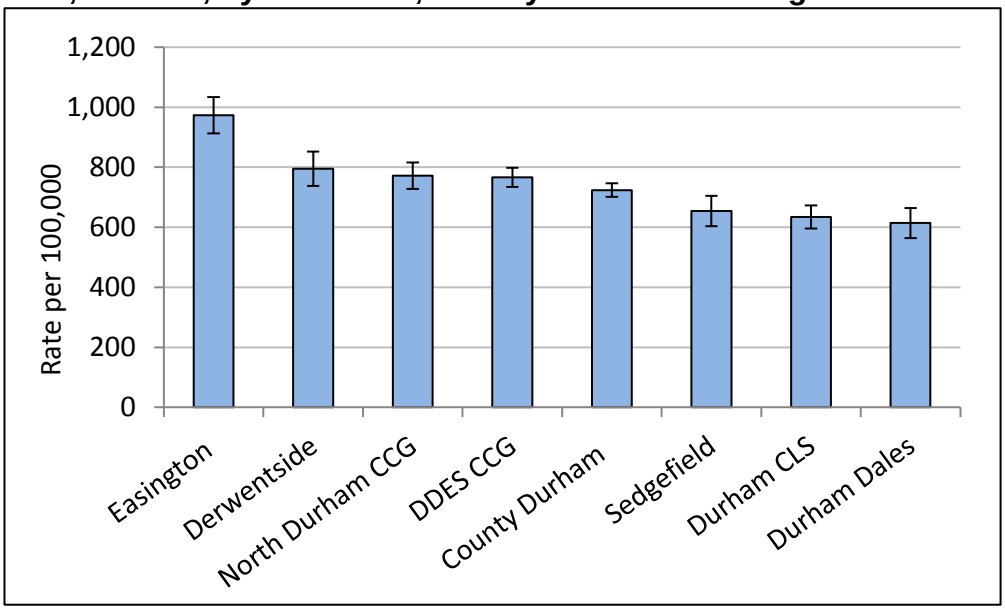


Source: LAPE, Public Health England

Alcohol-related admission rates (broad and narrow) in County Durham are significantly higher than England, and have been rising over time locally (13% broad and 5% narrow), regionally (15% broad and 4% narrow) and nationally (23% broad and 4% narrow).

Local analysis on alcohol-specific admission rates undertaken by Balance (2013) shows significant variation within County Durham by local area (Figure 58). Rates are highest in Easington. There is no statistically significant difference between North Durham CCG, DDES CCG and County Durham.

Figure 58: Alcohol-specific admission rates per 100,000, with 95% confidence intervals, 2011/12, by local area, County Durham and England



Source: Balance 2013

The cost of alcohol-specific admissions to DDES CCG in 2011/12 was around £3.5 million, at a cost per head (aged 15+) of £12.21. This was marginally higher than the County Durham average at £12.

The cost of alcohol-specific admissions to North Durham CCG in 2011/12 was around £3 million, at a cost per head (aged 15+) of £12.36. This was marginally higher than the County Durham average at £12.

Diabetes, physical activity and obesity in adults

Diabetes is a common, life-long health condition and is one of the most significant public health challenges today, affecting both children and adults. It can cause severe difficulties for sufferers and their families and has a significant impact on life expectancy, type 1 reducing it by at least 5 years and type 2 by 5-7 years. Diabetes is the leading cause of blindness in people of working age, the largest single cause of end stage renal failure, and (excluding accidents) the biggest cause of lower limb amputation. It is a chronic and progressive condition for which there is no cure and which causes a heavy burden on health services. Effective control of blood glucose and hypertension can prevent the development and progression of complications. Cost effective treatment close to home is a priority, to reduce unnecessary admissions or attendances to hospital.

Obesity is the excess accumulation of body fat, resulting from the interaction between many factors. It is considered to be a consequence of modern life with the abundance of calorie-rich food and more sedentary lifestyles (Foresight, 2007). Excess weight is a leading cause of type 2 diabetes, heart disease, cancer and maternal obesity. It can lead to complications in childbirth for mother and baby. The costs of obesity to the NHS have been estimated to be over £5 billion (Department of Health, 2011). Being overweight and obese is more common in lower socioeconomic and socially disadvantaged groups, particularly among women.

Physical activity performed on a regular basis can deliver positive physical and mental health benefits. It can reduce the risk of many chronic conditions including obesity, coronary heart disease, stroke, type 2 diabetes, cancer, mental health problems and musculoskeletal conditions (Department of Health, 2011). These benefits can deliver cost savings for health and social care services.

Current recommendations are that adults should achieve at least 150 minutes per week of moderate intensity physical activity, whether in one session or in multiple bouts of at least 10 minutes. The percentage of adults achieving at least 150 minutes of at least moderate intensity physical activity per week is 52.2%. This is lower, but not significantly so, than the England average of 56.0%.

The 2014 County Durham Health Profile (Table 37) shows that:

- The levels of adult obesity (27.4%) are higher than the England average (23.0%). The difference is not statistically significant.
- The levels of excess weight (72.5%) are higher than the England average (63.8%). The difference is statistically significant.
- Levels of physically active adults in County Durham (52.2%) are lower than the England average (56.0%).

- Diabetes prevalence (6.8% is higher than England (6%). This has risen from 4.1% in 2007/08, which places a significant burden on local health care costs.

Being overweight and obese is more common in lower socioeconomic and socially disadvantaged groups, particularly among women. There are over 65,000 adults registered as obese with GPs in County Durham (Quality Outcomes Framework 2012/13). This is 14.5% of the registered population of County Durham.

Poor diet is also a public health issue as it increases the risk of some cancers and cardiovascular disease, both of which are associated with obesity. Fruit and vegetables as part of a balanced diet can help individuals to stay healthy. The 2013 Health Profile showed that the number of healthy eating adults in County Durham (measured as the consumption of five portions of fruit and vegetables per day) was 21.4%. This was less than the English average of 28.7%.

Eye health

There are strong links between sight loss and other health determinants such as an ageing population, social isolation, high levels of social deprivation, high levels of smoking, obesity and chronic diseases such as diabetes, all of which increase the risk of eye disease.

Older people with a limiting health condition or the recent onset of a disability or impairment are particularly vulnerable to social isolation. A decline in physical mobility can impede the ability to get out and about and therefore interact socially. Similarly, a decline in vision and hearing can affect the ability to communicate which can have an isolating effect. Illness, impairment and disease combined with disability in later life have a significant impact on social engagement, thereby influencing and reducing affordable options.

Hearing loss

Hearing loss affects one in six people and as our population ages this number is set to grow. Table 44 shows how the number of people with hearing loss is predicted to rise in County Durham.

Table 44: People predicted to have a moderate or severe, or profound, hearing impairment, projected to 2030

	2014	2015	2020	2025	2030
Total population aged 65 + predicted to have a moderate or severe hearing impairment	41,556	42,512	47,824	55,662	62,213
Total population aged 65 + predicted to have a profound hearing impairment	1,065	1,093	1,241	1,433	1,657
Total population aged 18-64 predicted to have a moderate or severe hearing impairment	13,156	13,168	13,452	13,325	12,607
Total population aged 18-64 predicted to have a profound hearing impairment	119	119	123	123	115

Source: POPPI and PANSI systems

Hearing loss can impact on health, wellbeing and employment and is a contributing factor to anxiety, stress, depression, isolation and dementia, especially in older people.

Only one in three people with hearing loss has hearing aids, leaving four million people in the UK with unaddressed needs.

People with hearing loss have a higher chance of developing dementia as people with normal hearing.

Lesbian, gay, bisexual & transgender (LGBT) Population
LGBT are at higher risk of mental disorder, suicide ideation, substance misuse and deliberate self-harm. 41% of transgender people have reported attempting suicide compared to 1.6% of the general population.

Illicit drug use amongst LGB people is at least 8 times higher than in the general population. Nearly half of LGBT individuals smoke, compared with a quarter of their heterosexual peers.

Around 25% of LGB people indicate a level of alcohol dependency. Men who have sex with men were twice as likely to be dependent on alcohol compared with the rest of the male population, according to a 2008 study.

One in 10 men who have sex with men are living with HIV and 1 in 3 HIV positive men (in major UK cities) have undiagnosed HIV infection. The number of adult men who have sex with men newly diagnosed with HIV each year continues to rise because of increased HIV testing and on-going transmission. It is likely that the HIV epidemic among men who have sex with men is largely due to on-going incidence from men unaware of their infection: of the estimated 41,000 men who have sex with men living with HIV in the UK at the end of 2012, nearly one in five was unaware of his infection.

Compared with the general population, men who have sex with men have worse sexual health, including HIV and sexually transmitted infections. In 2012, about 78% of syphilis, 58% of gonorrhoea and 17% of chlamydia diagnoses were reported among men who have sex with men.

85% of men who have sex with men report not receiving information about same sex relationships at school. Men who have sex with men are twice as likely to be depressed and/or anxious compared to other men.

Health of ex-service personnel
When servicemen and women leave the armed forces, their healthcare is the responsibility of the NHS. All ex-service personnel are entitled to priority access to NHS hospital care for any condition, as long as it is related to their service, whether or not they receive a war pension. They are encouraged to tell their GP about their ex-military status in order to benefit from priority treatment. The needs of the armed forces community members are not identical and will be determined by factors such as their experience before their military service, during their military service and as a civilian, including their transition from military to civilian life.

The ex-service community in the UK is made up of approximately 10.5 million people, of whom just under half were armed forces community members themselves. Over half (52%) of the armed forces community reports having a long term illness or disability, compared with 35% in the general population (Joint Health Overview and Scrutiny Committee of North East Local Authorities report on the regional review of the health needs of the armed forces community).

Nationally available evidence tells us that:

- Some service leavers find it difficult to access services when they are discharged due to the lack of information provided locally. The processes, procedures and criteria which local services often apply also make it difficult for service leavers to prove eligibility.
- There is a lack of awareness and understanding of the unique experiences and challenges of service personnel in civilian professionals and institutions. This has an impact when considering the awareness of health issues of the armed forces community and in particularly the special needs of those who are older or disabled.
- NHS staff and clinicians are not fully aware of the entitlement of the armed forces community to priority access to NHS care when related to their service.
- Homelessness, unemployment and other social exclusion issues exist amongst a small percentage of the armed forces community, who are judged to have particular problems arising from their service.

The North of England Mental Health Development Unit Veteran's Wellbeing Assessment and Liaison Service (VWALS) 12 month evaluation study (October 2013) reported a total of 324 referrals during the initial 12-month pilot period from June 2012 to May 2013. In-depth data were available for analysis relating to 186 referrals. 41% of referrals were self-referrals, 27% came from the NHS and 12% from other statutory agencies. 96% of the referrals were male.

The presenting issues recorded by the VWALS team were wide-ranging. The most common was low mood, 22% of the total recorded concerns, followed by sleep difficulties (11%) and distressing recurring memories or nightmares (8.5%). Non-mental health specific issues including employment, finances and housing each made up 6-7% and suicidal thoughts, plans or significant risk to others made up 5% of the total recorded concerns.

Waiting times for referral to the VWALS ranged from the same day to over one month. The length of time from referral to discharge was also variable and ranged from 0 to 262 days.

Following a report by the North East Joint Health Overview and Scrutiny Committee which examined the health needs of the ex-service community, The Centre for Knowledge, Innovation, Technology and Enterprise (KITE) from Newcastle University carried out research to develop new data sharing and related working practises to improve the understanding of and planning for the numbers, locations and needs of the ex-service community in the North East.

A survey was issued to 58 organisations from the public and voluntary and community sector which provide a range of support and related services to the ex-service community and their families.

41 of the responses received were complete enough to facilitate analysis. In addition, discussions took place with providers and a local authority Armed Forces Forum was observed. The survey included a range of public and third sector providers, local authorities, statutory healthcare, prison and probation services and the Ministry of Defence. 27% of respondents were employed in a service which operates nationally, with the same proportion employed in a regionally operating service. Of the more locality-specific services, areas most represented by survey respondents were the regional centres of Gateshead, Newcastle, Sunderland and North and South Tyneside. The small number of respondents, and the geographical areas they cover, may not accurately reflect issues with service provision in County Durham.

Services delivered by respondents had a diverse range of focus, the most common of which were mental health (44%), general veteran support (44%) and employment/training (9%). Others included housing / homelessness, physical health, drugs and alcohol, criminal justice, finances / debt management and family support.

When asked whether veterans or their families tended to receive any supplementary or additional support from other providers whilst using the respondent's service, two thirds (67%) reported that this was 'often' the case, with the most common additional services reported to be housing services, mental health care and general veteran support – each reported by 78% of respondents.

27% of survey respondents identified one or more information sharing challenges / barriers facing veteran support services in the North East. The issues raised can be grouped under the following five themes (in approximate order of prevalence):

- Identification of the veteran community (and information sharing by the MoD).
- Coordination and awareness / understanding of the provider network.
- Protectionism and the sharing of information in a competitive funding environment.
- Understanding of Data Protection and informed consent.
- Individual organisational barriers and definitions of 'legitimacy'.

Despite the highlighted problems, a number of examples of best practice were also identified in relation to the coordination of regional veterans' services in the North East, which could potentially provide a prototype for emerging networks elsewhere in the UK. These included the North East Veterans Network and their directory of support services (both hosted by Finchale College), the NHS Veterans' Wellbeing, Assessment and Liaison Service (VWALS), and the various local authority Armed Forces Forums held within the region.

A best practice example as a potential resolution to data protection issues was suggested, whereby non-statutory delivery organisations were invited to access local authority training related to safeguarding and data protection.

Reported consequences of the challenges highlighted above included:

- Inability to evidence need and secure funding for new or existing services, or create appropriately targeted services, by not being able to identify veterans.
- Requirement to make complex support decisions based on limited information, sometimes resulting in an over-reliance on self-reported disclosure from the veteran themselves – which can lead to the veteran not accessing the most appropriate form of support.
- Delays in processing applications and providing support.
- Frustration, loss of confidence and / or potential disengagement on the part of the veteran, when faced with having to repeat details of their situation to a number of different organisations.
- The potential for inappropriate referrals and / or duplication of support.
- Loss of staff time and resources when having to repeat assessments / duplicate information already held by other providers.
- Increased resources to and better overall provision in more rural areas – particularly Tees Valley and County Durham – where veterans can be understandably reluctant to travel to the main regional centres to access support, was one specific area of service need identified by respondents.

Offender health

Public Health England data show that offenders are more likely to be dependent on drugs or hazardous drinkers when compared with the general population. Alcohol factors in 47% of violent crime, and drug users are responsible for between a third and half of acquisitive crime. Treatment of alcohol and drug dependence can therefore cut the level of crime offenders commit by about half.

National data identify that female offenders have a history within the care system and a disturbing background of abuse, self-harm, anxiety and depression. Many of them will have problems with drugs and alcohol misuse and nearly two thirds leave behind dependent children when entering prison. The government response to the Justice Committee's Second Report of Session 2013/14 (October 2013) identifies that women offenders have different mental health needs than those of men and are twice as likely to suffer from anxiety and depression and more likely to report symptoms indicative of psychosis.

A study of all prisons in England and Wales housing adult men, published by the National Institute for Health Research in August 2013, established the current availability and degree of integration of health and social care services for older adults.

The mental health needs of older prisoners have been found to vary significantly from those of their younger counterparts in prison. Older prisoners are at a greater risk of becoming isolated within the prison environment and are less likely to have social support, putting them at a greater risk of developing mental health difficulties. It has been established that, within the general prison population, just over one quarter of all self-inflicted deaths occur within one week of prison entry.

Adult male prisoners are 14 times more likely to have two or more mental disorders than men in the general population.

Almost a third of young men in custody felt they had emotional or mental health problems.

More than 70% of the prison population have 2 or more mental health problems.

These offenders are more likely to need support with housing, education or employment to change their lives and prevent future victims.

Offenders have poorer access to treatment and prevention programmes than their peers in the community and often mistrust and are disengaged with the system.

Previous research conducted by the National Institute for Health Research suggested that older prisoners entering prison for the first time experience a number of distressing phenomena, labelled 'entry shock'. Contributing factors included high levels of noise, lack of privacy, indigent facilities, claustrophobic conditions, perplexing rules and regulations and hostility from younger prisoners and uniformed staff. Many older prisoners reported that, in the absence of any support in prison, they were able to recall previous difficult experiences such as induction into the army or a childhood in care and that they used these as an, albeit imperfect, 'blueprint' for how to cope in the prison.

There is an increased risk of suicide among recently released prisoners in England and Wales, with the greatest elevation in risk identified in those aged 50 years and over. Despite these increased needs, older prisoners' resettlement needs are often ignored. It has been suggested that, in spite of evidence to the contrary, this is because they are generally considered to be of lower risk than their younger peers, which is exacerbated by their being less assertive. No studies have been published to date which have followed up older prisoners after their release, to examine the barriers to, and facilitators of, successful community reintegration.

Prior to Transforming Rehabilitation reforms, Durham Tees Valley Probation Trust research included two Health Needs Assessments (HNA) in 2008 and 2011. The aim of the research was to establish the health needs of offenders within the probation setting, with a view to meeting these needs through the development of services based with offender management units.

The 2011 HNA found that offenders need support with four main issues: mental health (depression, stress, anxiety), smoking, dental issues and anger management. In most cases, Health Trainer and/or Health Trainer Champion services within offender management units would be able to provide this support through one-to-one sessions or signposting to outside services.

When broken down by Probation Office area, we are able to see that across County Durham the two main health issues are mental health and stopping smoking. The research shows that across the previous Probation Trust area, concerns regarding mental health increased in 2011, anxiety/stress increasing from 23.1% in 2008 to 30.1% in 2011 and depression increasing from 24.1% in 2008 to 29.9% in 2011.

Current trends indicate that over the next 10 years the number of Registered Sex Offenders over the age of 60 will increase by 123 from the current 44 to 167. This is

on the basis of those offenders currently on the register and does not take into account any new offenders who might join the register during that period. The resources needed to manage an ageing and aged population will change with greater demands being made on services for adults who will become vulnerable due to age. It cannot be assumed that risk will diminish as age increases – many sex offenders become more precise with their offending as they get older. Therefore responses to the problem will need to consider provision for those who continue to pose a high risk of harm.

Smoking prevalence of the general population is approximately 24% compared to approximately 84% for offenders supervised by probation in the community.

Approximately 0.3% of the general population have Hepatitis B compared with approximately 8% of prisoners.

Approximately 0.5% of the general population have Hepatitis C compared with approximately 7% of prisoners.

Approximately 0.2% of the general population have HIV compared with approximately 0.4% of prisoners.

Of the 7 highest causes of preventable deaths, 5 areas are more likely to be experienced by offenders and those in contact with the criminal justice system: smoking, alcohol, suicide, HIV and drug use.

Disease prevalence

Prevalence is a measure of the burden of a disease or health condition in a population at a particular point in time (and is different to incidence, which is a measure of the number of newly diagnosed cases within a particular time period). Prevalence data within the QOF (Quality Outcomes Framework) are collected in the form of practice 'disease registers'.

Disease registers can potentially be used to examine variations in the prevalence of the chronic diseases included in the clinical domains but they should be interpreted with caution. QOF registers do not necessarily equate to prevalence. For example, prevalence figures based on QOF registers may differ from prevalence figures from other sources because of coding or definitional issues.

Year-on-year changes in the size of QOF registers are difficult to interpret for various reasons, including: changes in epidemiological factors (such as an ageing population); improvements in case-finding by practices; changes over time in the definition of the registers.

Practice registered disease prevalence rates may be affected by other factors such as:

- Health care seeking behaviour - people differ in the readiness with which they seek health care when they are not well.
- Access to services - people are more likely to consult for a condition if services are readily accessible.
- Diagnostic practice - it is impossible to completely standardise the methods clinicians use to make diagnoses.

- Data recording - there may be variations in the completeness and accuracy of practice records.

QOF information is not a comprehensive source of data on quality of care in general practice but it is potentially a rich and valuable source of such information, providing the limitations of the data are acknowledged.

Registered disease prevalence in the two CCGs within County Durham is greater than England for many conditions where a national comparison is available (Table 45).

Conditions where prevalence is 20% or more higher than England for both CCG populations are:

- Secondary prevention of coronary heart disease (the definition is 'patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA).
- Heart failure.
- Hypertension.
- Peripheral arterial disease.
- Stroke/TIA.
- COPD.
- Obesity (16+).
- Depression (18+).

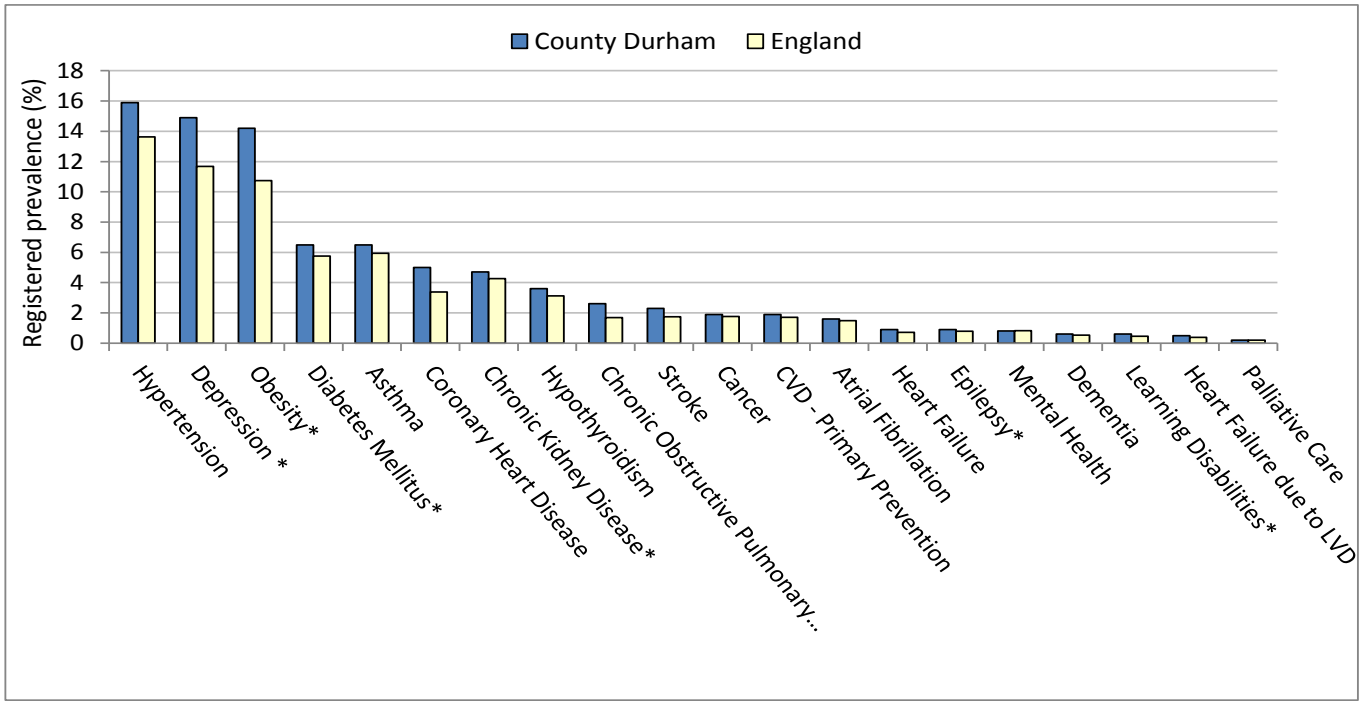
Table 45: Registered disease prevalence in County Durham and England, 2013/14.

Group	Condition	North Durham	DDES	England
Cardiovascular	Atrial fibrillation	**1.6**	**1.8**	1.6
	Secondary prevention of coronary heart disease	**4.5**	**5.3**	3.3
	Cardiovascular disease - primary prevention	**3.5**	**2.7**	2.8
	Heart failure	**0.8**	**1.0**	0.7
	Hypertension	**15.4**	**16.9**	13.7
	Peripheral arterial disease	**0.8**	**1.1**	0.6
	Stroke/TIA	**2.1**	**2.3**	1.7
Respiratory	Asthma	**6.3**	**6.5**	5.9
	Chronic obstructive pulmonary disease	**2.4**	**3.2**	1.8
Lifestyle	Obesity (16+)	**12.5**	**14.6**	9.4
High dependency and long term conditions	Cancer	**2.2**	**2.3**	2.1
	Diabetes mellitus (17+)	**6.5**	**7.2**	6.2
	Hypothyroidism	**3.5**	**4.0**	3.3
	Palliative care	**0.4**	**0.3**	0.3
	Dementia	**0.7**	**0.8**	0.6
Mental health and neurology	Depression (18+)	**7.6**	**7.8**	6.5
	Epilepsy (18+)	**0.8**	**1.0**	0.8
	Learning disability (18+)	**0.5**	**0.7**	0.5
	Mental health	**0.8**	**0.9**	0.9
	Osteoporosis (50+)	**0.5**	**0.5**	0.4
Musculoskeletal	Rheumatoid arthritis (16+)	**0.7**	**0.9**	0.7

20% greater than England

Source: Quality and Outcomes Framework (QOF) 2012/13, Health and Social Care Information Centre.

Figure 59: Registered disease prevalence in County Durham and England as a proportion of list size



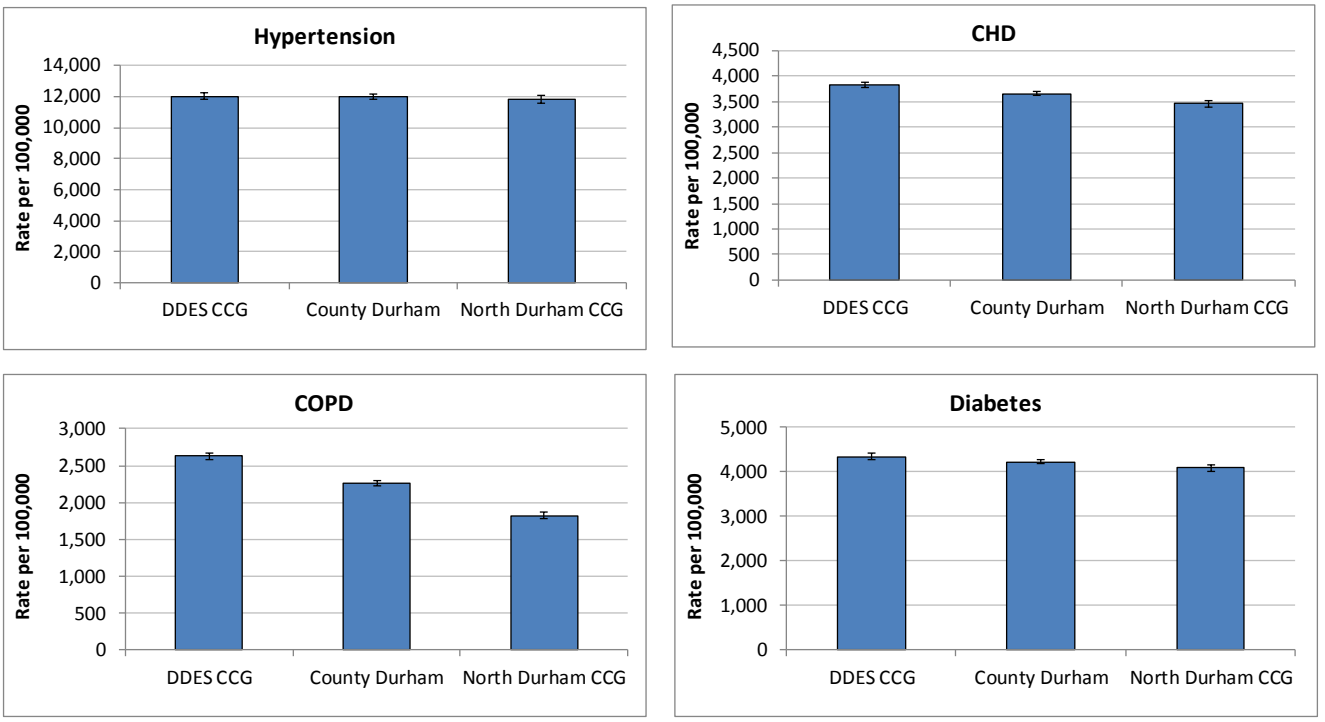
Disease registers are important public health tools.

Spatial analysis of primary care disease register data has an important role for public health and clinical commissioning groups including surveillance, identification of geographic variation in prevalence, planning the provision of health care, monitoring the burden of ill health in the population and monitoring the impact of preventive measures.

Commissioning health and social care services at smaller geographical areas must be based on a sound understanding of the needs and priorities of that local population. The locality 'Population Health Profiles' were designed to assist in the identification of health needs at a local level (CCG, and sub CCG), in order to help inform CCG commissioning decisions.

Figure 60: Selected disease prevalence rates per 100,000, with 95% confidence intervals, by County Durham, DDES Clinical Commissioning Group and North Durham Clinical Commissioning Group, as at September 2011

Spatial analysis of practice disease registers across County Durham shows there is significant variation in registered disease prevalence by CCG in County Durham for:



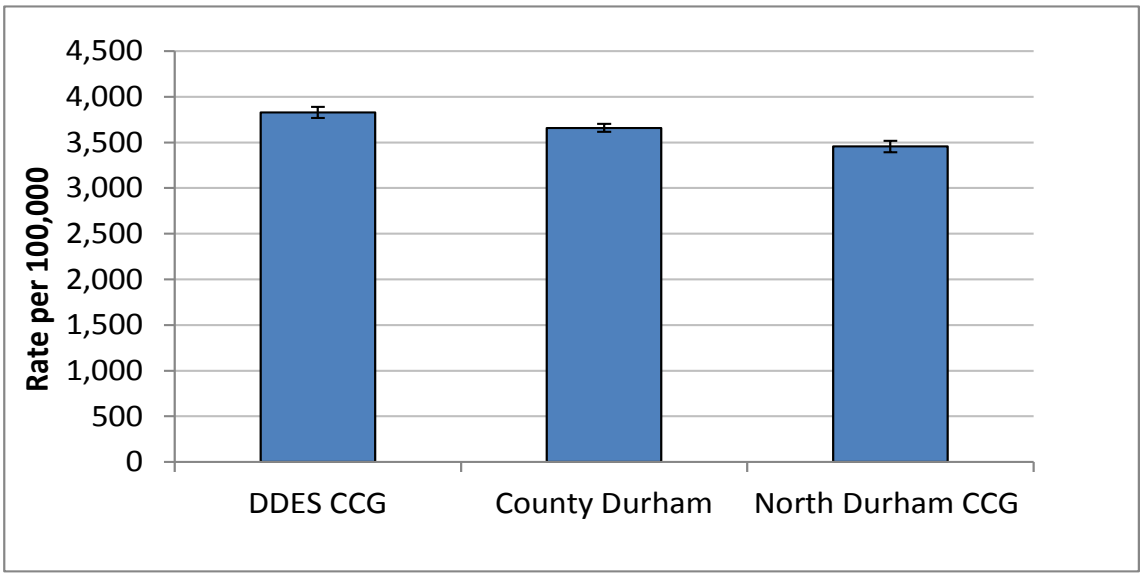
Source: GP practice disease registers

Coronary heart disease (CHD) prevalence

CHD prevalence in County Durham (4.9%) is higher than England (3.3%).

There is also significant variation in prevalence within County Durham. Directly age standardised prevalence rates in DDES CCG (3,830) are significantly higher than for County Durham (3,659) and North Durham CCG (3,455 per 100,000 population). (Figure 61).

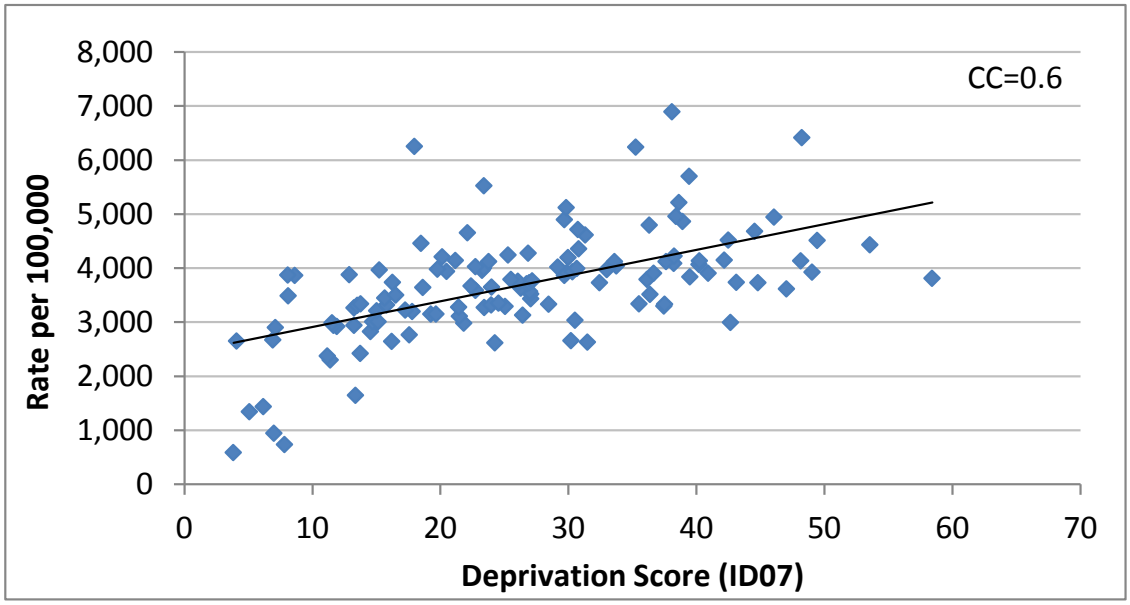
Figure 61: Coronary heart disease prevalence rates per 100,000, with 95% confidence intervals, by Clinical Commissioning Group and County Durham, as at September 2011



Source: County Durham GP practice CHD disease register

The distribution of CHD prevalence in County Durham is unequal. It is higher in the more deprived wards (Figure 62). This relationship is moderate to strong (CC=0.6).

Figure 62: Coronary heart disease prevalence rates per 100,000, as at September 2011, Sedgefield wards, by ID2007 score



Source: County Durham GP practice CHD disease register

Hypertension prevalence

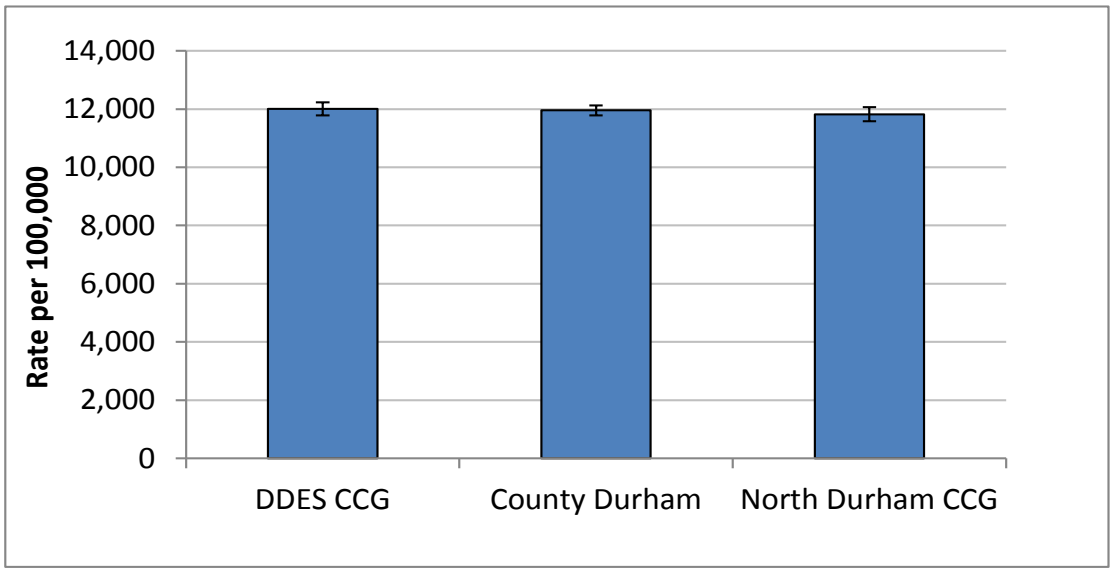
Hypertension prevalence in County Durham (16%) is higher than England (13.7%).

There is significant variation in prevalence within County Durham (12,037) by ward, although directly age standardised prevalence rates between CCGs do not differ

significantly, (11,945 North Durham CCG and 12,123 DDES CCG per 100,000 population) (Figure 63).

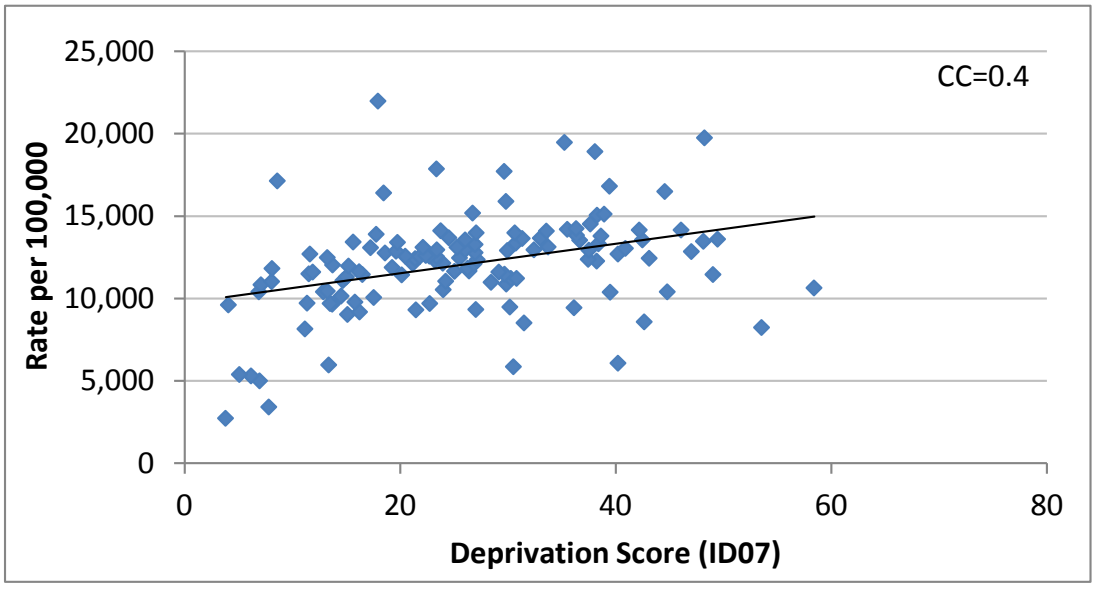
The distribution of hypertension prevalence within County Durham (by MSOA) is unequal. There is significant variation between wards but this has a weak to moderate relationship with deprivation (CC=0.4, figure 64).

Figure 63: Hypertension prevalence rates per 100,000, with 95% confidence intervals, by Clinical Commissioning Group and County Durham, as at September 2011



Source: County Durham GP practice hypertension disease register

Figure 64: Hypertension prevalence rates per 100,000, as at September 2011, Sedgefield wards, by ID2007 score



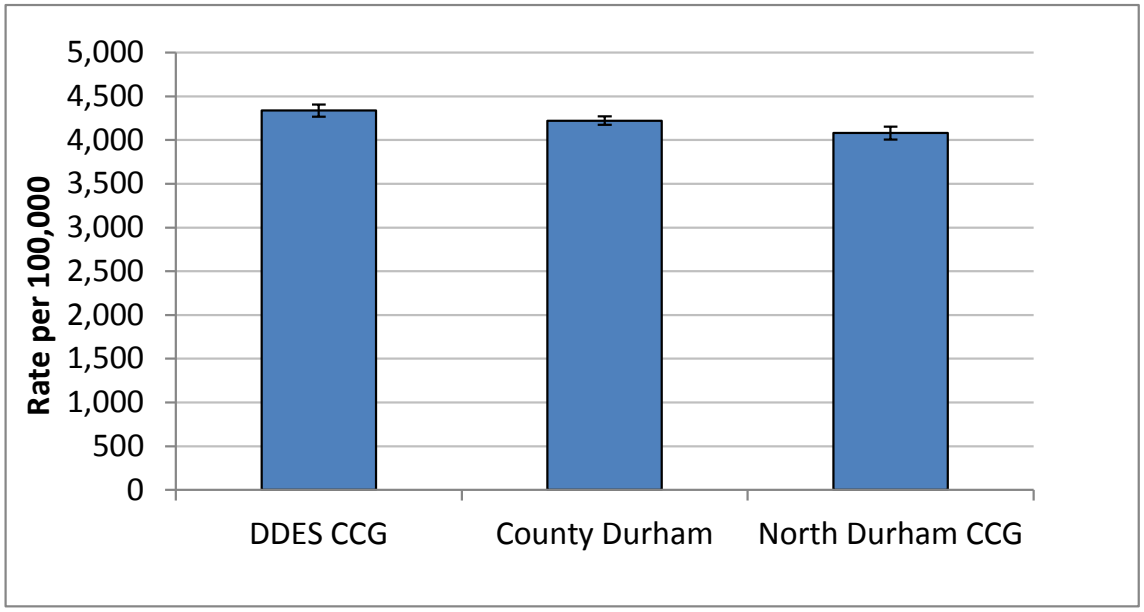
Source: County Durham GP practice hypertension disease register

Diabetes prevalence
Diabetes prevalence in County Durham (6.8%) is higher than England (6%).

There is also significant variation in prevalence within County Durham. Directly age standardised prevalence rates in DDES CCG are significantly higher than for County Durham and North Durham CCG (Figure 65).

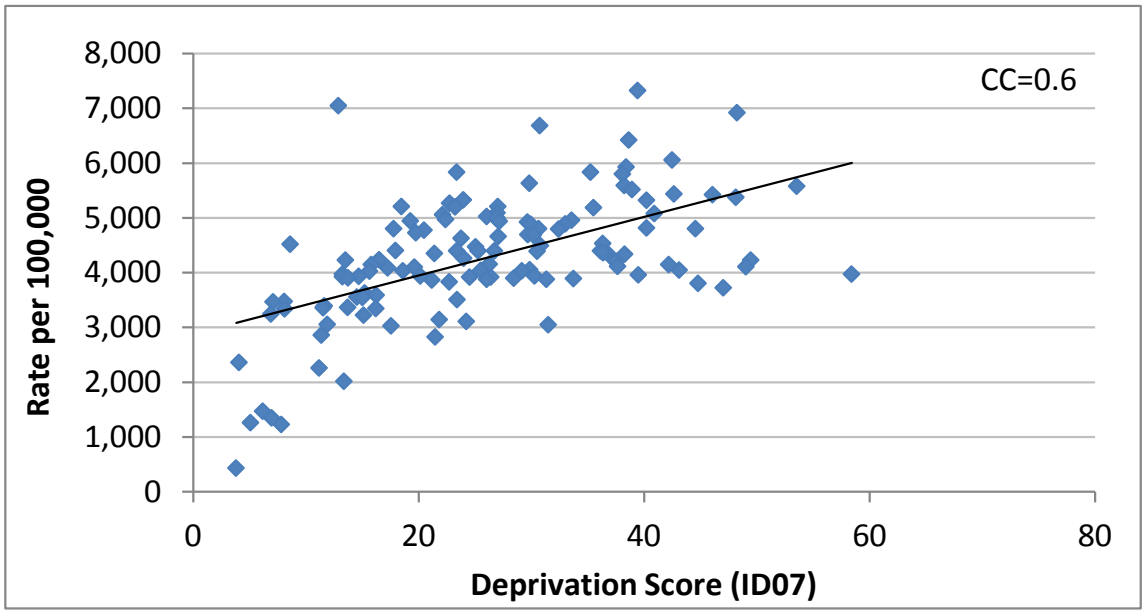
The distribution of diabetes within County Durham (by wards) is unequal. There is significant variation between wards but this is has a weak to moderate relationship with deprivation (CC=0.4, Figure 66).

Figure 65: Diabetes prevalence rates per 100,000, with 95% confidence intervals, by Clinical Commissioning Group and County Durham, as at September 2011



Source: County Durham GP practice diabetes disease register

Figure 66: Diabetes prevalence rates per 100,000, as at September 2011, Sedgefield wards, by ID2007 score



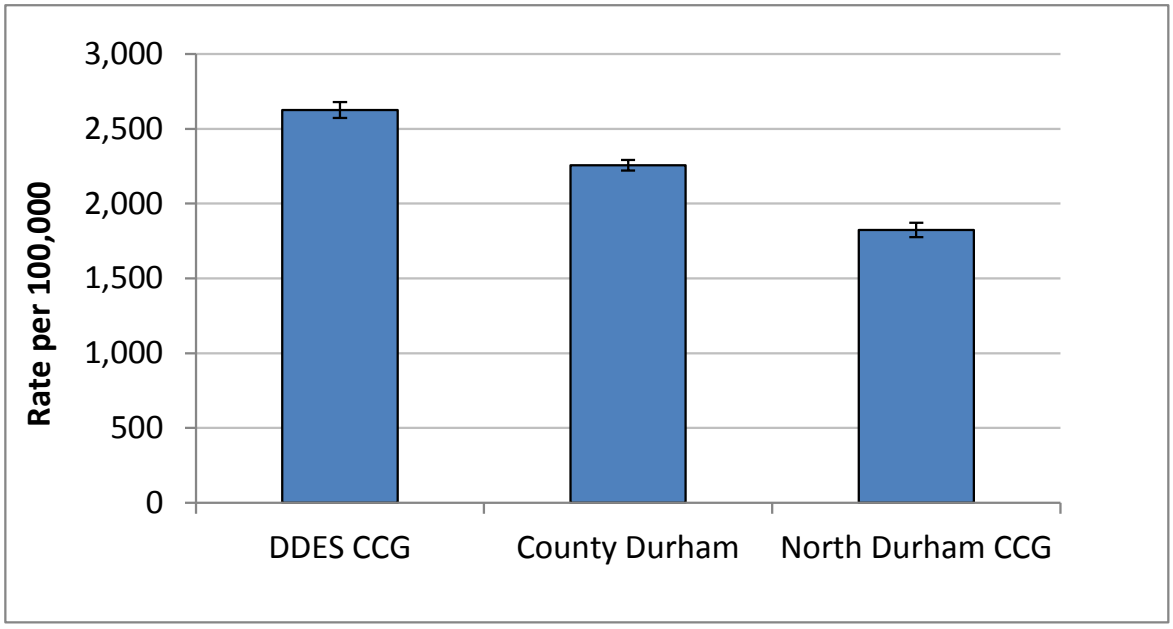
Source: County Durham GP practice diabetes disease register

COPD prevalence

COPD prevalence in County Durham (2.7%) is higher than England (1.7%).

There is also significant variation in prevalence within County Durham. Directly age standardised prevalence rates in DDES CCG are significantly higher than for County Durham and North Durham CCG (Figure 67).

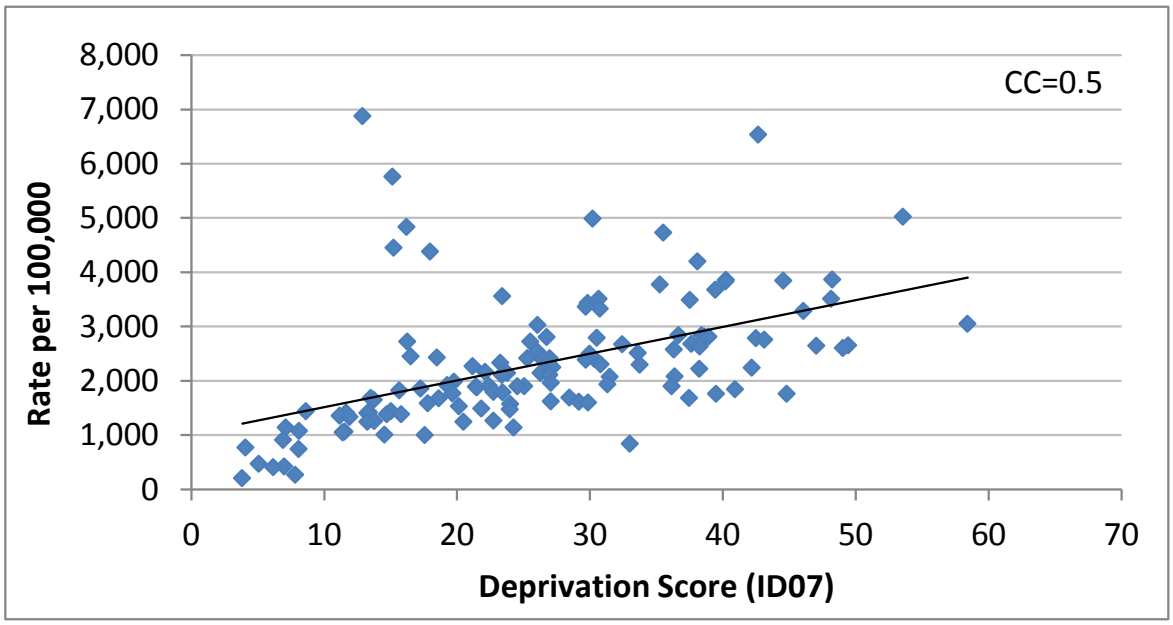
Figure 67: COPD prevalence rates per 100,000, with 95% confidence intervals, by Clinical Commissioning Group and County Durham, as at September 2011



Source: County Durham GP practice COPD disease register

The distribution of COPD within County Durham (by wards) is unequal. There is significant variation between wards and this displays a moderate relationship with deprivation (CC=0.5, Figure 68).

Figure 68: COPD prevalence rates per 100,000, as at September 2011, Sedgefield wards, by ID2007 score



Source: County Durham GP practice COPD disease register

Liver Disease

Risk factors for liver disease include excess alcohol consumption, excess weight, hepatitis B and hepatitis C.

Liver disease is the only major cause of mortality and morbidity which is on the increase in England, in contrast to most EU countries where liver disease death rates are falling.

Alcohol is the most common cause of liver disease in England. Alcoholic liver disease accounts for over a third of liver disease deaths. The more someone drinks above the lower-risk guideline, the higher his/her risk of developing liver disease. The UK is one of the few European countries where alcohol consumption has risen in the last 50 years.

Obesity is an important risk factor for liver disease because of its link to non-alcoholic fatty liver disease (NAFLD), which is the term used to describe accumulation of fat within the liver not caused by alcohol. It is usually seen in people who are overweight or obese. Although the great majority of people with NAFLD never experience any symptoms from the condition, a minority may progress to a more serious form of the disease known as non-alcoholic steatohepatitis, which may ultimately lead to fibrosis and, in a small number of cases, cirrhosis.

In County Durham, between 2010 and 2012, the average number of years of life lost in people aged under 75 from liver disease is 37 per 10,000 persons. This compares to 40 for breast cancer, 20 for stroke and 11 for road traffic accidents.

The rate of alcohol specific hospital admissions in 2012/13 in County Durham is significantly higher than the England average for males and significantly higher than the England average for females.

In County Durham the rate of premature mortality from liver disease between 2010 and 2012 is similar to the England average for males and significantly higher than the England average for females.

An average of 53 people (32 men and 21 women) died each year between 2010 and 2012 in County Durham from alcoholic liver disease (aged less than 75 years).

Between 2001-03 and 2010-12, the average number of people per year who died with an underlying cause of liver disease in County Durham increased from 95 to 141.

Excess winter deaths

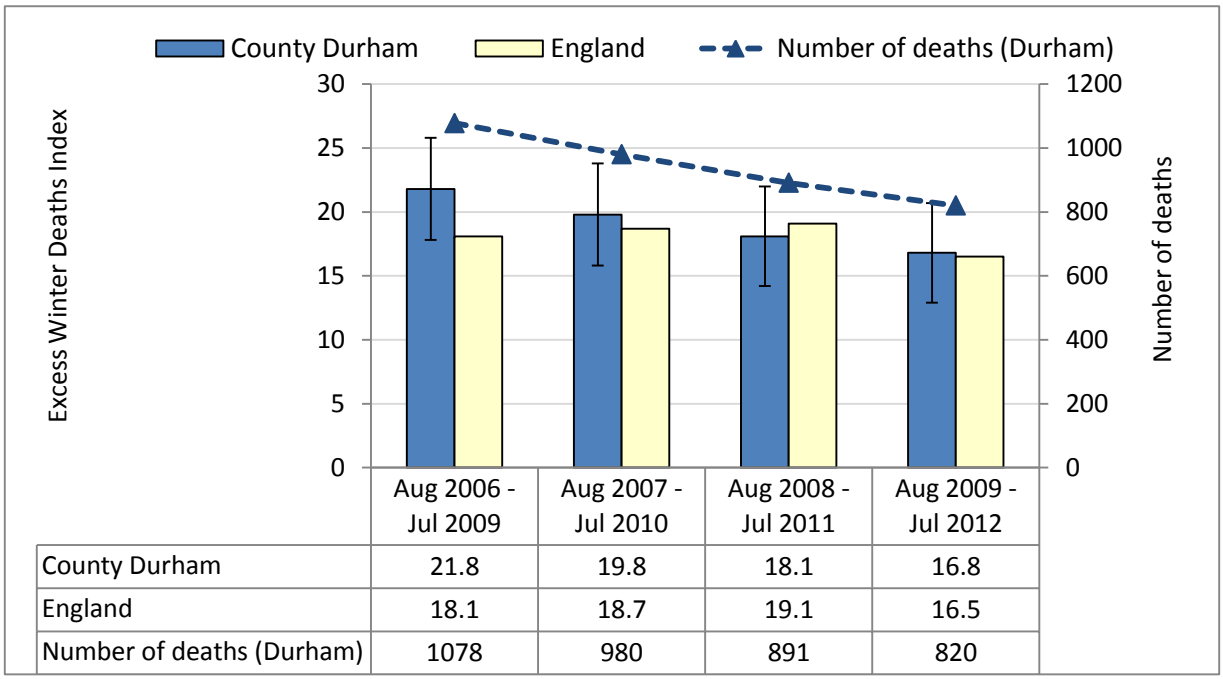
Excess winter deaths (EWD) are a continuous and very important public health issue in the UK, potentially amenable to effective intervention. EWD are greatest in both relative and absolute terms in elderly people and for certain disease groups and are avoidable. They also vary from area to area. EWD are also associated with cold weather but it has been observed that other countries in Europe, especially the colder Scandinavian countries, have relatively fewer excess winter deaths in winter compared to the UK.

The Excess Winter Deaths Index (EWDI) indicates whether or not there are higher than expected deaths in the winter compared to the rest of the year. The EWDI is the excess of deaths in winter (December to March) compared with non-winter months from the preceding August to November and the following April to July, expressed as a percentage.

The EWDI in County Durham has been falling over time. Between 2006-2009 and 2009-2012 the Index fell by almost a quarter (23.9%).

- For ther period 2006-2009 there were a total of 1,078 excess winter deaths at an average of 359 per year.
- Between 2009 and 2012 there was a total of 820 additional deaths, an average of 273 additional deaths each winter than would be expected from the rate of death in the non-winter months. This was not significantly different to the England average.
- For this period, County Durham's EWD Index was 16.8, not significantly different to England (16.5). (Table 46).

Table 46: Excess Winter Deaths Index (EWDI), 3 years, all ages 2006-09 to 2009-12.



	Aug 2006 - Jul 2009	Aug 2007 - Jul 2010	Aug 2008 - Jul 2011	Aug 2009 - Jul 2012
County Durham	21.8	19.8	18.1	16.8
England	18.1	18.7	19.1	16.5
Number of deaths (Durham)	1078	980	891	820

Source: Public Health Outcomes Framework, 2014

Excess winter deaths affect all ages, not just the elderly. However, the EWDI is known to increase with age, with the elderly the most susceptible group to higher death rates in winter. This is true in County Durham (Table 47).

Table 47: Excess Winter Deaths Indices

PHOF Indicator		***Period***	***Number of excess deaths***	***Excess Winter Deaths Index (EWDI)***		
			County Durham		***North East***	***England***
4.15i	*Excess Winter Deaths Index (single year, all ages)*	*Aug 2011- Jul 2012*	*337*	*21*	*11*	*16.1*
4.15ii	*Excess Winter Deaths Index (single year, ages 85+)*	*Aug 2011 – Jul 2012*	*159*	*29.7*	*15.2*	*22.9*
4.15iii	*Excess Winter Deaths index (3 years, all ages)*	*Aug 2009 – Jul 2012*	*820*	*16.8*	*13.7*	*16.5*
4.15iv	*Excess Winter Deaths Index (3 years, ages 85+)*	*Aug 2009 – Jul 2012*	*401*	*25.9*	*19.2*	*22.6*

	Not significantly different to England

Source: Public Health Outcomes Framework, PHE 2014

Excess winter deaths can be attributed to nearly all the main causes of death. However certain conditions are known to be exacerbated during winter months. Previous studies have shown that circulatory and respiratory diseases contribute to most (70%) of the excess winter deaths in England (Table 48).

Table 48: Excess winter deaths by underlying cause of death 2002-09

Condition	EWD Index	Average EWDs
Coronary heart disease	13.8	37.9
All circulatory diseases	19	105.3
Stroke	27	41.4
Chronic lower respiratory disease	52.5	54.4
All respiratory diseases	57.6	126.4
All causes	52.5	54.4

	Significantly different from England
	Not significantly different from England

Source: Excess Winter Deaths in England, West Midlands Public Health Observatory, 2013

Mental health and wellbeing

Positive mental health is central to all other health-related choices. Mental wellbeing is key to understanding the impact of inequalities in health and other outcomes (Friedli, 2009). Relative deprivation and social injustice erode mental wellbeing.

Poor mental health is not uncommon. Mental illness affects a high proportion of the population and is closely related to inequalities. Estimates suggest that one in four adults will experience mental health problems at any one time. For some, mental health problems are treated and never return; however, for others, the problems last for many years, especially if not appropriately treated.

One in ten children aged between 5 and 16 years has a mental health problem and many continue to have mental health problems into adulthood.

Half of those with lifetime mental health problems first experience symptoms by the age of 14, and three-quarters before their mid-20s. Almost half of all adults will experience at least one episode of depression during their lifetime. One in ten new mothers experiences postnatal depression.

Poor mental health has a range of significant impacts. 20% of the total burden of disease in the UK can be attributed to poor mental health (including suicide). This compares with 17% for cardiovascular diseases and 16% for cancer. This burden is due to the fact that poor mental health is not uncommon.

There are over 4,600 people in County Durham registered with GPs with a diagnosis of mental illness (Quality Outcomes Framework 2012/13). This prevalence is

predicted to increase significantly over the coming years due to a variety of factors, including an ageing population and the challenging economic climate.

There are over 29,400 people in County Durham registered with GPs with a diagnosis of depression (Quality Outcomes Framework 2012/13).

Levels of mental ill health are projected to increase. By 2026, the number of people in England who experience a mental illness is projected to increase by 14%, from 8.65 million in 2007 to 9.88 million. However, this does not take account of the current economic climate which may increase prevalence.

Those at higher risk of suffering from poor mental health include:

- More deprived populations.
- Those with poor educational attainment.
- The unemployed.
- Older people.
- Those with long term conditions, e.g. coronary heart disease.
- People with learning disabilities.

Poor mental health can impact on anybody at any time. Quantifying the level of need in the population is complex and can be difficult due to the lack of quality data around mental health, and the fact that a significant proportion will be unreported.

It is well recognised that social and health inequalities can both result in and be caused by poor mental health. Many of the acknowledged risk factors for mental illness are linked to deprivation. Measures of deprivation can help to identify geographical areas where the need for mental health services is likely to be greatest. County Durham has some of the most deprived areas in the country.

Claimants of incapacity benefit with mental or behavioural problems per 1,000 working age population can be used as a proxy measure of levels of severe mental illness in the community, and a direct measure of socio-economic disadvantage in those ‘not in work’ because of mental illness.

Rates of incapacity claimants (per 1,000 working age population) in County Durham in 2007 (42.6) and 2008 (37.1) were significantly higher than England over the same period, (27.7 and 27.6 per 1,000 population).

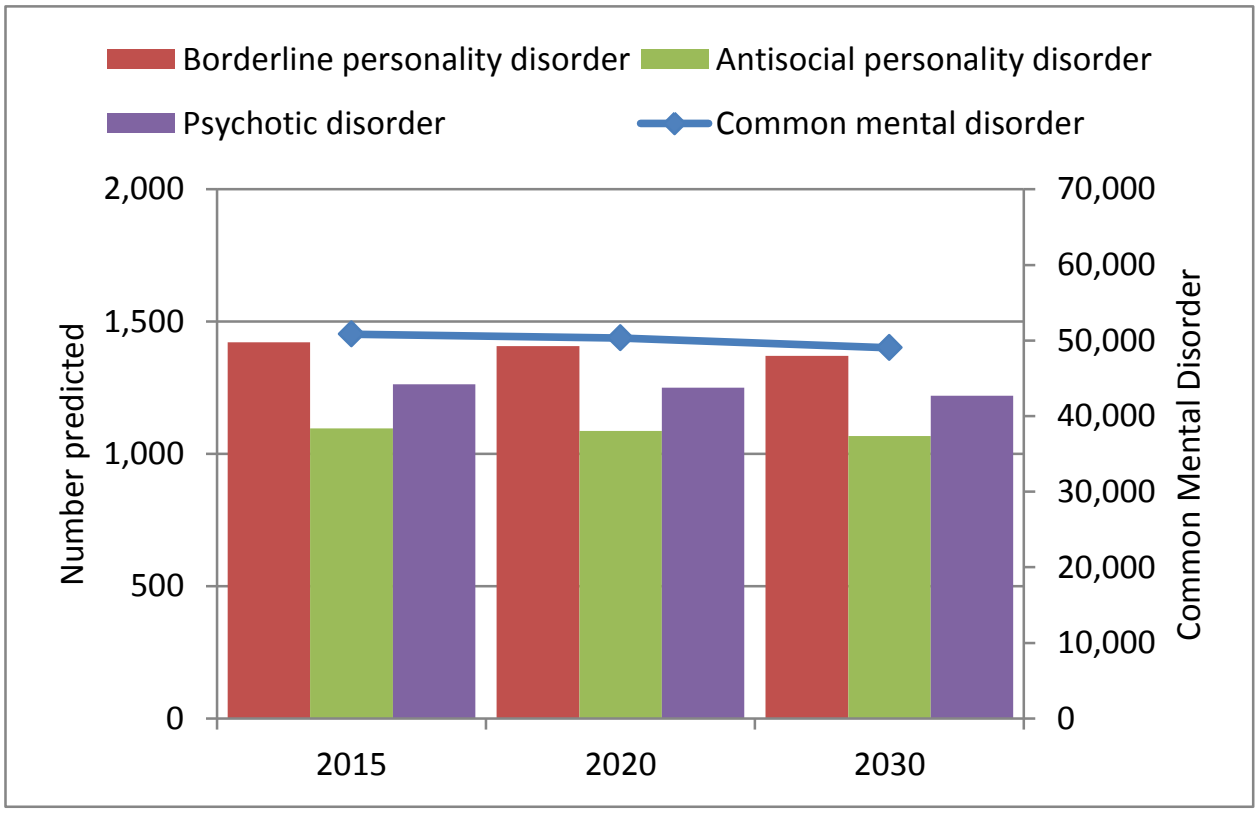
Worklessness is a much wider indicator than unemployment and is generally associated with poor physical and mental health. From February 2013, the definition of worklessness has been changed from those people of working age who claim out of work benefits to the statistical group used by the Office for National Statistics to describe people fit for work but not in employment. This group includes: Job Seeker Allowance Claimants, Employment Support Allowance and Incapacity Benefit Claimants, Lone Parents and people claiming other income related benefits.

As of February 2013, there were 51,010 persons (15.4%) workless in the county. This shows a decrease from the previous year of 2% and shows a decline of 4.8% from the May 2010 figure of 16.2.

Projected mental health needs

Projecting Adult Needs and Service Information (PANSI) and Projecting Older People Population Information (POPPI) are web-based tools which predict need and services across a number of care groups up until 2030 for a specified area. The calculations around prevalence and service need are based on nationally accepted research.

Figure 69: Mental Health Needs projected to 2030 - County Durham

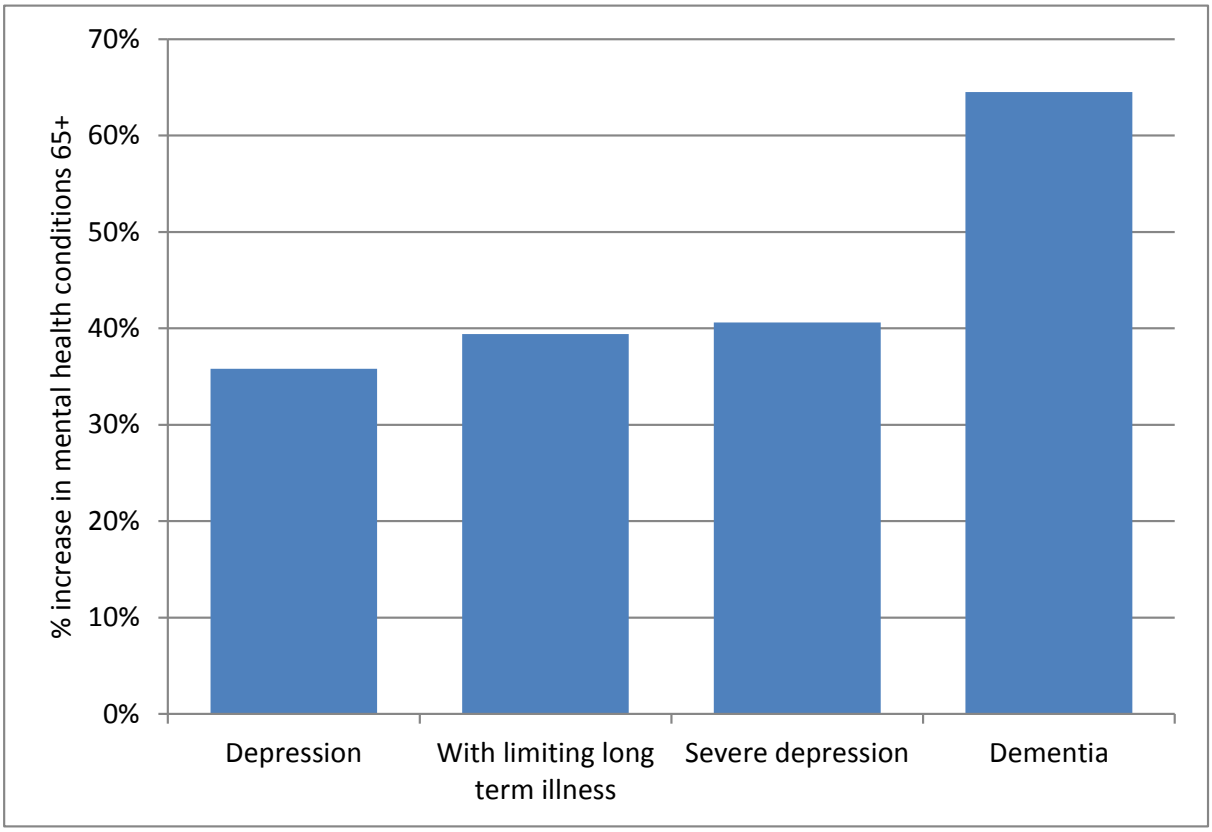


Source: Projecting Adult Needs and Service Information System (PANSI) 2014

PANSI (2014) predicts (Figure 69) that in County Durham the number of people predicted to have:

- A common mental disorder will fall from 50,894 in 2014 to 49,046 (3.6%).
- A borderline personality disorder will fall from 1,424 to 1,371 (3.7%).
- An anti-social personality disorder will fall from 1,098 to 1,067 (2.8%).
- A psychotic disorder will fall from 1,265 to 1,219 (3.6%).

Figure 70: Percentage increase in people aged 65+ predicted to have a mental health problem projected to 2030 - County Durham



Source: Projecting Older People Population Information Systems (POPPI) 2014

POPPI (2014) forecasts (Figure 70) that in County Durham the number of people predicted to have:

- Depression will rise from 8,763 to 11,897 (35.8%).
- Limiting long term illness will rise from 59,573 to 83,049 (39.4%).
- Severe depression will rise from 2,759 to 3,879 (40.6%).
- Dementia will rise from 6,625 to 10,896 (64.5%).

The *Adult Psychiatric Morbidity Survey* (APMS) provides data on the prevalence of both treated and untreated psychiatric disorder in the English adult population (aged 16 and over). It is one of the main sources of information on the number of people with psychoses.

The 2007 APMS estimates (Table 49) that in England:

- 23% (almost one in four people) had at least one psychiatric disorder.
- 16.7% have considered suicide.
- 15.1% have a neurotic disorder.
- 7.2% had two or more disorders.
- 0.9% have a personality disorder.
- 0.5% have a psychotic disorder.

Table 49: Estimated adults in County Durham with various mental health disorders

Mental Disorder	National Prevalence (%)	Estimated County Durham population affected (based on national prevalence)	Population age range (16+ = 424,400)
At least one psychiatric disorder	23%	89,792	16+
Have considered suicide	16.7%	65,197	16+
Neurotic disorder	15.1%	58,950	16+
Two or more disorders	7.2%	28,109	16+
Personality disorder	0.9%	3,147	16-74
Psychotic disorder	0.5%	1,749	16-74

Source: Local estimates derived from APMS 2007

Applying national prevalence rates from APMS 2007 for common mental disorders (CMD) surveyed by age group to the County Durham population (mid-2009 estimates, ONS) local estimates (Table 50) suggest that:

- Over 68,500 in County Durham people will have any CMD.
- The greatest burden of CMD is seen in the 35-44 age band (around 14,500 people with any CMD).

It should be noted that these are estimated numbers of those likely to be affected by these disorders in County Durham, based on national prevalence reported in the APMS.

Table 50: Common mental disorders (CMD) - estimated number of people in County Durham by age

Persons	16-24	25-34	35-44	45-54	55-64	65-74	75+	All
Mixed anxiety and depressive disorder	7,073	6,012	6,082	8,126	5,286	3,081	2,383	38,238
Generalised anxiety disorder	2,464	2,344	3,768	4,392	2,750	1,584	1,068	18,579
Depressive episode	1,513	1,226	2,061	2,722	1,239	498	597	10,029
All phobias	1,017	1,090	1,499	1,055	876	148	98	6,222
Obsessive compulsive disorder	1,582	837	778	836	369	148	171	4,693
Panic disorder	769	896	958	688	671	257	196	4,681
Any CMD	12,122	10,507	12,269	14,400	9,447	5,130	4,016	68,775

Source**:** Local estimates derived from APMS 2007

Community mental health profiles (CHMP)

The 2013 CMHP present a range of mental health information for local authorities in England. The CMHP are designed to give an overview of mental health risks, prevalence and services at a local, regional and national level using an interactive mapping tool. The data should be used to inform commissioners of health and social care services in their decision-making, leading to the improvement of mental health and mental health services.

The individual local authority profiles comprise 31 mental health indicators covering the following themes:

- Wider determinants of health.
- Risk factors.
- Levels of mental health and illness.
- Treatment.
- Outcomes.

The wider determinants of health (Table 51)
Significantly better than England:

- Episodes of violent crime (2010/11).

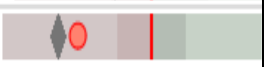
Significantly worse than England:

- The percentage of 16-18 year olds not in employment, education or training (2011).
- The percentage of the relevant population living in the 20% most deprived areas in England (2010).
- The rate of working age adults who are unemployed (per 100,000) (2010/11).
- The rate of hospital admissions (per 1,000) for alcohol attributable conditions (2011/12).

Not significantly different to England:

- The rate of people (aged 18-75) in drug treatment (per 1,000) (2011/12).

Table 51: Wider Determinants of Health – CMHP 2013

Wider Determinants of Health		Local Value	England Average	England Worst	England Range	England Best
1	Percentage of 16-18 year olds not in employment, education or training, 2011	7.5	6.2	11.2		1.9
2	Episodes of violent crime, rate per 1,000 population, 2010/11	10.3	14.6	34.5		6.3
3	Percentage of the relevant population living in the 20% most deprived areas in England, 2010	28.6	19.8	83.0		0.3
4	Working age adults who are unemployed, rate per 1,000 population, 2010/11	62.2	59.4	106.2		8.3
5	Rate of hospital admissions for alcohol attributable conditions, per 1,000 population, 2011/12	30.6	23.0	38.6		11.4
6	Numbers of people (aged 18-75) in drug treatment, rate per 1,000 population, 2011/12	5.3	5.2	0.8		18.4

Key

Regional average
Not significantly different to England
Significance Not Tested
England Average

Where perceived polarity:
Significantly worse than England
Significantly better than England

Where no perceived polarity:
Significantly lower than England
Significantly higher than England

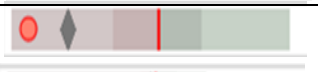
Risk factors (Table 52)
Significantly better than England:

- Statutory homeless households (per 1,000) (2010/11).
- First time entrants into the youth justice system (aged 10-17 years), (2001-2011).
- The percentage of adults (16+) participating in the recommended level of physical activity (2009/10 to 2011/12).

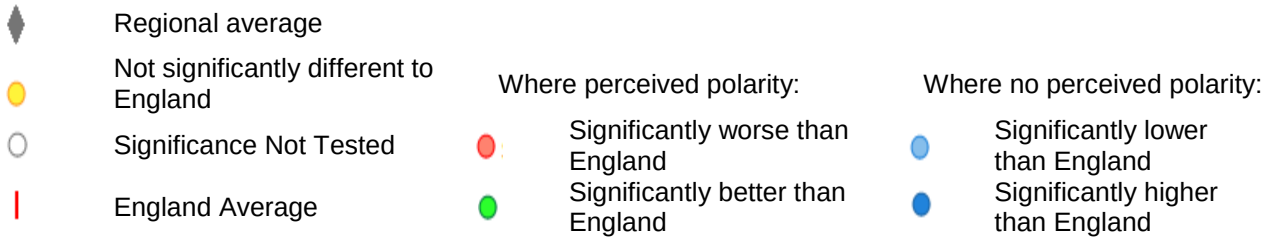
Indicators significantly worse than England:

- The percentage of the population with a limiting long term illness (2001).

Table 52: Risk Factors – CMHP 2013

	Risk factors	Local Value	England Average	England Worst	England Range	England Best
7	Statutory homeless households, rate per 1,000 households, all ages, 2010/11	1.76	2.03	10.36		0.13
8	Percentage of the population with a limiting long term illness, 2001	23.5	16.9	24.4		10.2
9	First time entrants into the youth justice system 10 to 17 year olds, 2001 to 2011	680	876	2,436		343
10	Percentage of adults (16+) participating in recommended level of physical activity, 2009/10 to 2011/12	12.8	11.2	5.7		17.3

Key



Levels of mental health and illness (Table 53)
Significantly better than England:

- The ratio of recorded to expected prevalence of dementia (2010/11).

Significantly worse than England:

- The percentage of adults (18+) with dementia (2011/12).
- The percentage of adults (18+) with depression (2011/12).

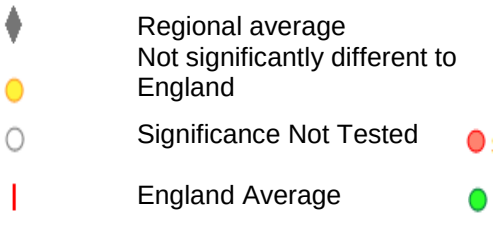
Significantly higher than England

- The percentage of adults (18+) with learning disabilities (2011/12).

Table 53: Levels of mental health and illness – CMHP 2013

Levels of Mental Health and Illness		Local Value	England Average	England Worst	England Range	England Best
11	Percentage of adults (18+) with dementia, 2011/12	0.62	0.53	0.95		0.21
12	Ratio of recorded to expect prevalence of dementia, 2010/11	0.48	0.42	0.27		0.69
13	Percentage of adults (18+) with depression, 2011/12	14.87	11.68	20.29		4.75
14	Percentage of adults (18+) with learning disabilities, 2011/12	0.57	0.45	0.21		0.77

Key



Treatment (Table 54)

Significantly better than England:

- Hospital admissions for schizophrenia, schizotypal and delusional disorders (2009/10 to 2011/12), rate per 100,000.

Significantly worse than England:

- Hospital admissions for mental health (2009/10 to 2011/12), rate per 100,000.
- Hospital admissions for unipolar depressive disorders (2009/10 to 2011/12), rate per 100,000.
- Hospital admissions for Alzheimer's and other related dementia (2009/10 to 2011/12), rate per 100,000.
- Percentage of referrals entering treatment from Improving Access to Psychological Therapies (2011/12).

Not significantly different to England:

- The allocated average spend for mental health per head (2011/12).

Significantly lower than England:

- Contacts with mental health services (2010/11), rate per 1,000.

Significantly higher than England:

- People using adult and elderly NHS secondary mental health services (2010/11), rate per 1,000.
- People on a Care Programme Approach (2010/11), rate per 1,000.
- In-year bed days for mental health (2010/11), rate per 1,000.
- Contacts with Community Psychiatric Nurse (2010/11), rate per 1,000

Table 54: Treatment – CMHP 2013

Treatment		Local Value	England Average	England Worst	England Range	England Best
15	Directly standardised rate for hospital admissions for mental health, 2009/10 to 2011/12	297	243	1,257		99
16	Directly standardised rate for hospital admissions for unipolar depressive disorders, 2009/10 to 2011/12	37.0	32.1	84.8		4.7
17	Directly standardised rate for hospital admissions for Alzheimer's and other related dementia, 2009/10 to 2011/12	149	80	226		5
18	Directly standardised rate for hospital admissions for schizophrenia, schizotypal and delusional disorders, 2009/10 to 2011/12	40	57	233		5
19	Allocated average spend for mental health per head, 2011/12	206	183	147		257
20	Numbers of people using adult & elderly NHS secondary mental health services, rate per 1,000 population, 2010/11	3.2	2.5	0.0		9.6
21	Percentage of referrals entering treatment from Improving Access to Psychological Therapies, 2011/12	53.8	60.1	28.9		99.7
22	Numbers of people on a Care Programme Approach, rate per 1,000 population, 2010/11	9.8	6.4	0.3		17.1
23	In-year bed days for mental health, rate per 1,000 population, 2010/11	296	193	72		489
24	Number of contacts with Community Psychiatric Nurse, rate per 1,000 population, 2010/11	182	169	3		584
25	Number of total contacts with mental health services, rate per 1,000 population, 2010/11	261	313	31		823

Key

Regional average

Not significantly different to England

Significance Not Tested

England Average

Where perceived polarity:

Significantly worse than England

Significantly better than England

Where no perceived polarity:

Significantly lower than England

Significantly higher than England

Outcomes (Table 55)

Significantly better than England:

- People with mental illness and or disability in settled accommodation (2011/12).

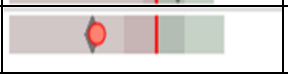
Not significantly different to England:

- Recovery rate for Improving Access to Psychological Therapies (IAPT) (2011/12).
- Excess under 75 mortality rate in adults with serious mental illness (2010/11).

Significantly worse than England:

- Emergency hospital admissions for self-harm (2011/12), directly age standardised rate per 100,000.
- Mortality ratio for suicide and undetermined injury (2010/11), indirectly standardised mortality ratio[8].
- Hospital admissions caused by unintentional and deliberate injuries in <18s (2009/10), crude rate per 100,000).

Table 55: Outcomes – CMHP 2013

	Outcomes	Local Value	England Average	England Worst	England Range	England Best
26	People with mental illness and or disability in settled accommodation, 2011/12	77.7	66.8	1.3		92.8
27	Directly standardised rate for emergency hospital admissions for self-harm, 2011/12	343	207	543		52
28	Indirectly standardised mortality rate for suicide and undetermined injury, 2010/11	145	100	174		29
29	Hospital admissions caused by unintentional and deliberate injuries in <18s, 2009/10	184	123	217		68
30	Improving Access to Psychological Therapies - Recovery Rate, 2011/12	41.2	43.8	9.9		65.3
31	Excess under 75 mortality rate in adults with serious mental illness, 2010/11	1,064	921	1,863		210

Key

Regional average

Not significantly different to England

Significance Not Tested

England Average

Where perceived polarity:

Significantly worse than England

Significantly better than England

Where no perceived polarity:

Significantly lower than England

Significantly higher than England

[8] * Ratios can only be compared to the reference population, in this case England.

Suicide
Reliable, timely and accurate suicide statistics are essential to inform an effective Public Mental Health Strategy for County Durham. To facilitate this, a systematic suicide audit programme has been in place locally since 2002.

Demographically, 81% of those who took their own life between 2005 and 2012 were male, with a peak age of 40-49. 62% were divorced and 32% lived alone. Hanging was identified as the most common method used. A significant number of suicides were found to have diagnosed mental health problems (58.9%). Furthermore, 30% were recorded as alcohol dependent, 13% were recorded as users of illicit drugs, and 39.2% had a history of self-harm. For the period 2011/13, the suicide rate per 100,000 in County Durham (13.4) was significantly higher than England (8.8). Between 2001 and 2003, and 2011 and 2013, suicide mortality rates in County Durham have seen no significant variation

Triggers for suicide are complex and may be a combination of factors. Through the County Durham Suicide Audit some key factors were identified: 26% experienced a relationship or family breakdown, 17% were recently bereaved and 12% were in financial difficulty.

National statistics show that men aged 35-54 years are now the group with the highest suicide rate. Understanding and addressing the factors associated with suicide in men, or working to limit their negative impact, will help to reduce population suicide risks. Key factors include depression, alcohol or drug abuse, unemployment, family and relationship problems, social isolation and low self-esteem.

Action on alcohol and drugs, the response to the recent economic uncertainty, efforts to reduce suicide and self-harm among people in contact with the criminal justice system and treating depression in primary care will all play a part in reducing suicide risk among men.

'Preventing suicide in England: One year on', the first annual report on the cross-government outcomes strategy to save lives, highlights a number of actions which local services can implement to prevent suicides:

- Implement NICE guidelines on self-harm to improve the experiences and outcomes for people who self-harm, in particular ensuring that people who present to emergency departments following self-harm receive a psychosocial assessment.
- Training for staff in general hospitals is important to address negative attitudes and lack of knowledge. Training of psychiatric staff in psychosocial assessment and in effective brief psychological interventions may also be needed.
- Local public health teams can track local trends and provide surveillance, to inform decisions about local authority and NHS resources needed for mental health promotion, prevention, and early intervention and to deal with the assessment and management of self-harm.
- The National Confidential Inquiry, July 2013, called on services to do more for patients facing debt, housing problems and unemployment.

- Debt can cause, and be caused by, mental health problems. The need for close working between specialist services, primary care, and credit counselling agencies is recognised, and a number of resources are available to help local services support people with debt and mental health problems
- GPs can make a big difference to overall suicide rates. People can recover more quickly from depression if it is identified early and responded to promptly, using evidence-based treatment.
- Community outreach programmes into traditional male environments can also be powerful in engaging with men.
- Developing a local suicide prevention action plan as part of local health and wellbeing work with clinical commissioning groups and other partners.
- Local Directors of public health leading a data monitoring / surveillance function. Have local forums in place to monitor suicide trends, respond to incidents, and deliver the suicide prevention strategy locally.
- Engaging with local media regarding suicide reporting.
- Working with transport and other partners in health and wellbeing boards on mapping hot spots and taking appropriate actions.
- Working on local priorities to improve mental health. This might include: addressing stigma and social isolation in older people; workplace health promotion and support with local business; working with police on mental health literacy; addressing issues relevant to the local population, e.g. increasing awareness and support for young Asian women in arranged marriages.

Learning disabilities

The term learning disability encompasses a very broad range of functioning, including:

- A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence).
- A reduced ability to cope independently (impaired social functioning) which started before adulthood, with a lasting effect on development.

Learning disabilities can affect the way a person learns new things in any area of life, the way they understand information and how they communicate. Adults with learning disabilities are a very diverse and vulnerable population with differing needs, often experiencing health inequalities, social exclusion and stigmatisation. People with a learning disability have lower life expectancy than the general population and are more likely to have undiagnosed long term conditions and musculoskeletal problems (Disability Rights Commission. Equal Treatment: Closing the Gap; 2006). They are also more likely to have sensory and physical disabilities as well as mental health problems, which tend to increase in severity as they grow older (Emerson E, Hatton, C. Estimating Future Need for Adults Social Care for People with Learning Disabilities in England. Centre for Disability Research, Lancaster University; 2008).

A learning disability can be mild, moderate or severe. Some people with a mild learning disability can talk easily and look after themselves, but take a little longer than usual to learn new skills. Others may not be able to communicate at all and may have more than one disability.

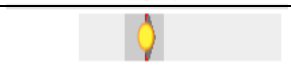
In County Durham in 2012/13, there were 2,567 adults on GP learning disability registers (2012/13 QOF).

The 2013 Public Health England Learning Disabilities profile presents a range of learning disability information for local authorities in England. These profiles are designed to give an overview of learning disability prevalence and services (health and social care) at a local, regional and national level. The data should be used to inform commissioners of health and social care services in their decision-making, leading to the improvement of learning disability services.

The individual local authority profiles comprise 26 learning disability indicators covering the following themes:

- Population.
- Health.
- Accommodation and social care.
- Coordination and local planning.

Table 56: Population with learning disabilities, County Durham

Population		Local value	England Average	England Lowest	England Range	England Highest
1	Adults with learning disability known to GPs	5.74	4.54	2.08		7.66
2	Adults (18 to 64) with learning disability known to Local Authorities	5.11	4.27	2.36		8.63
3	Children with autistic spectrum known to schools	8.07	8.17	2.36		19.71
4	Children with moderate learning difficulties known to schools	25.10	19.65	6.50		51.36
5	Children with severe learning difficulties known to schools	4.85	3.65	1.09		7.53
6	Children with profound and multiple learning difficulties known to schools	1.21	1.23	0.00		4.02
7	Children with learning difficulties known to schools	31.16	24.53	9.57		58.31

Key

Regional average

Not significantly different to England

Significance Not Tested

England Average

Where perceived polarity:

Significantly worse than England

Significantly better than England

Where no perceived polarity:

Significantly lower than England

Significantly higher than England

Source: 2013 County Durham LD Profile, Public Health England

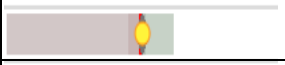
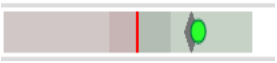
Not significantly different to England

- Children with autistic spectrum disorder known to schools.
- Children with profound and multiple LD known to schools.

Significantly worse than England

- Adults with a LD known to GPs.
- Adults with LD known to Durham County Council.
- Children with LD known to schools.
- Children with moderate LD known to schools.
- Children with severe LD known to schools.

Table 57: Health indicators for learning disabilities, County Durham

	Health	Local value	England Average	England Worst	England Range	England Best
8	Proportion of eligible adults with a learning disability having a GP health check	33.97	52.73	13.37		100.00
9	Median age at death	57.00	56.00	1.00		69.50
10	Emergency hospital admissions as % of total	56.83	49.96	75.27		12.59
12	Admission rate for non-psychiatric ambulatory care sensitive conditions in people with LD	20.07	23.27	89.59		5.57
13	Identifying people with learning disability in general hospital statistics	36.85	27.12	5.75		45.40

Key

Regional average

Not significantly different to England

Significance Not Tested

England Average

Where perceived polarity:

Significantly worse than England

Significantly better than England

Where no perceived polarity:

Significantly lower than England

Significantly higher than England

Source: 2013 County Durham LD Profile, Public Health England

Significantly better than England

- Identifying people with LD in general hospital statistics.

Not significantly different to England

- Median age at death.
- Admission rate for non-psychiatric ambulatory care sensitive conditions.

Significantly worse than England

- Proportion of eligible adults with a learning disability having a GP health check.
- Emergency hospital admissions as a % of total.

Table 58: Accommodation, social care, coordination and local planning indicators for learning disabilities, County Durham

Accommodation & social care		Local value	England Average	England Worst	England Best
16	Living in settled accommodation	86.1	74.8	47.6	94.4
17	Living in non-settled accommodation	13.9	21.7	42.0	1.6
18	Accommodation status unknown to LA	0.0	3.5	36.1	0.00
19	Accommodation severely unsatisfactory	0.00	0.13	1.85	0.00
20	Adults (age 18-64) using day services	681.96	347.20	38.83	681.96
21	Adults(age 18-64) receiving community services	1,064.22	749.71	438.46	1,064.22
22	Adults with learning disability in employment	2.7	6.8	0.0	23.8
23	Adults (age 18-64) receiving direct payments	22.13	0.00	6.35	98.33
24	Gross current expenditure for residential personal social services per 1,000 people known to LAs with LD	20.37	21.52	5.07	43.03
25	Rates of safeguarding referral for abuse of vulnerable person	120	120.5	0.00	805
Coordination and local planning					
26	Comparison of LA and QOF prevalence estimates	12.31	6.16	0.42	88.84

Source: 2013 County Durham LD Profile, Public Health England and 2013-14 ASC-CAR and SAR return data in NASCIS

Better than England

- Living in settled accommodation.

Significantly higher than England

- Adults using day services.
- Adults receiving community services.
- Comparison of LA and QOF prevalence estimates.

Significantly worse than England

- Adults with learning disabilities in paid employment.

Social isolation

Social isolation and loneliness is a significant and growing public health challenge for County Durham's population. It affects many people living in County Durham and has a significant negative effect on health and wellbeing across the lifecourse. Anybody can be affected by social isolation or loneliness. It can 'affect any person, living in any community'. It is costly to local health and care services and can increase the chances of premature death.

The Marmot Review 'Fair Society, Healthy Lives' (2010) makes the case for tackling social isolation clear by noting that "individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely. It was also clear that health inequalities result from social inequalities and that action is needed across all the social determinants of health (e.g. housing,

employment and education) taking a 'lifecourse' approach. It is recognised that what happens within an individual's social context, during the early years, education, income, skills development, employment and work within communities all impact on their health and length of life."

People with stronger social networks are more likely to be healthier and happier. Those with weaker social networks can become isolated and, as a result, more likely to experience poor physical and mental health and increase the burden on local health and care services. Earlier interventions could help prevent some of the negative effects of social isolation from accumulating further and impacting on health and wellbeing as people get older.

The links between isolation and loneliness and poor physical and mental health are strong. Effects can include depression, decreased immunity and longer recovery from illness, poor nutrition, increased anxiety, fatigue, social stigma, and ultimately increased morbidity and (premature) mortality. Recent studies suggest that isolation can:

- Have a more negative effect on wellbeing than physical inactivity, obesity or smoking 15 cigarettes a day.
- Increase an older person's chances of premature death by 14%.
- Increase the likelihood of admission into residential or nursing care.

'Healthy lives, healthy people: our strategy for public health in England' sets out a range of local approaches to improve physical and mental health, recognising that the community and environment in which we live can also strongly influence both population and individual mental health and wellbeing. Approaches of particular importance include:

- Reducing isolation, support during times of difficulty, and increasing social networks and opportunities for community engagement.
- Providing easy access to continued learning.
- Improving support for informal carers.
- Warm homes initiatives.
- Promotion of physical activity and physical health.

Older people are particularly vulnerable due to factors such as bereavement, reduced mobility, sensory impairment or limited income. However, other groups along the lifecourse are at risk including new, young or lone parents; carers (both young and old); women experiencing domestic abuse; lesbian, gay, bisexual or transgender young people; the long term unemployed; people with autism or a learning disability; those with a physical disability or long term condition; black minority ethnic and recent migrant communities; those experiencing poverty and deprivation; the young; the homeless; and those with substance misuse problems.

Risk factors for isolation and loneliness can be categorised into four distinct areas, as shown in Table 59.

Table 59: Risk factors for isolation and loneliness

Personal circumstance	Health and disability	Life changes	Wider determinants
Age Gender Ethnicity Sexuality Living alone Low income In care	Cognitive impairment Sensory impairment Mobility Chronic illness Incontinence / hygiene issues Malnutrition Drug and alcohol misuse	Young / lone parenthood Moving house Retirement Becoming a carer Bereavement Hospitalisation Recently stopped driving	Transport Rurality Crime / fear of crime Housing Built environment Natural environment Digital exclusion Availability of toilets Availability of parks / play areas

Further exploration of social isolation is provided in the Annual Report of the Director of Public Health County Durham 2013/14.

It is difficult to quantify the level of people suffering from, or being at risk of, social isolation or loneliness. However, estimates suggest that in County Durham around:

- 22,000 people aged 18-64 years are socially isolated (7%).
- 19,400 people aged 65+ are lonely (20%), with over 10,600 (11%) experiencing intense loneliness.
- Around 23% of all dependent young people in County Durham, and 29% of the overall population are classified as income deprived. The relationship between poverty and social isolation can be described as cyclical as each is driven by, and drives, the other.

ENABLING ADULTS WITH SOCIAL CARE NEEDS TO LIVE INDEPENDENTLY

Durham County Council continues to meet the requirements of the government's care and support agenda by working with a range of partners to develop new ways of working, to help people live as independently as possible. Fairness, equity and independence are at the heart of adult social care in County Durham.

Durham County Council provides a flexible service, with the primary aim of helping service users to help themselves, and prioritises the health and wellbeing of all residents to support their independence and quality of life.

The provision of adult social care is governed by legislation which means that all local authorities with adult social care responsibilities have a statutory duty to provide an assessment. The assessment process uses eligibility criteria to determine the level of substantial and critical need of individuals. Durham County Council offers advice and information on social care services to everyone but focuses on people identified through eligibility criteria as having 'critical' and 'substantial' needs. The following provides an explanation of the eligibility criteria at each level of need:

- **Substantial** – risk to the service user in carrying out daily living tasks is greatly increased, i.e. inability to carry out a 'majority of' rather than several

tasks. The risk of abuse or neglect is also included in this level, as is reduced choice and control over the immediate environment.
- **Critical** – if life is or could be threatened; if there are significant health problems and the possibility of serious abuse or neglect.

The Care Act 2014 established a new legal framework, putting wellbeing of individuals at the heart of care and support services. The Act marks the biggest transformation to care and support law in over sixty years, and replaces more than a dozen pieces of legislation with a single modern law. From April 2015, there will be a national minimum eligibility threshold for all local authorities in England. Although local authorities will continue to have freedom to meet other needs, they will not be able to restrict eligibility below the threshold of substantial need.

Over the past year, adult care services in County Durham have undergone a transformation to ensure that services are delivered to promote people's independence wherever possible and to promote a 'self-help' culture, where fewer people are dependent on statutory services.

As part of Durham's transformation programme more people are being dealt with at the point of contact, therefore reducing the need for statutory social care services. In 2013/14, 71.6% of contacts with Social Care Direct were resolved or redirected, an increase of 4.3% from 2012/13 (67.3%).

Between 2010/11 and 2013/14, the top "critical needs" for older people, service users with a learning disability, substance misuse or mental health problem and service users with physical disability/sensory support needs were:

- Personal care.
- Health.
- Falls.
- Personal safety.
- Carers issues.

In 2011 a new reablement service became operational which gives people over 18 years of age the opportunity, motivation and confidence to relearn / regain some of the skills they may have lost as a consequence of poor health, disability, impairment or accident and helps people to stay independent in their own homes for as long as possible. Between 1st April 2013 and 31st March 2014 there were 1,450 referrals to the reablement service, an increase of 7.3% from the previous year (1,351).

The following provides information on the needs of service users and carers who access social care services in County Durham. As there is variation across the service user groups, their needs have been looked at in individual sections, i.e. older people, adults with a learning disability, adults with autism, physical disability / sensory support, carers, substance misuse, adults with mental health needs.

N.B. - Where low numbers exist in tables (i.e. less than 6) a notional figure of 3 has been used and the total amended accordingly.

OLDER PEOPLE (aged 65 years and over)

Referrals and assessments

Referrals for older people in County Durham continue to decrease from 2010/11 (7.8%). However, the number of older people in County Durham who have received a social care assessment has increased by 7.1% from 2010/11. In 2013/14, Easington CCG Locality has the highest rate of referrals (141.0) and assessments (125.8) per 1,000 population.

Table 60: Number of older people referred by Clinical Commissioning Group Locality / Constituency 2010/11 – 2013/14 (includes safeguarding referrals)

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11 – 2013/14	Population 65+ - ONS 2012 population estimates	Referrals 2013/14 per 1,000 population 65+
Chester-le-Street	1,350	1,184	1,289	1156	-14.4	10,733	107.7
Derwentside	2,222	2,135	2,094	1979	10.9	17,106	115.7
Durham	1,768	1,817	1,718	1865	5.5	16,266	114.7
Durham Dales	2,300	2,296	2,280	2107	-8.4	18,352	114.8
Easington	2,576	2,603	2,612	2435	-5.5	17,266	141.0
Sedgefield	2,378	2,304	2,242	2064	-13.2	16,858	122.4
County Durham	**12,594**	**12,339**	**12,235**	**11,606**	**-7.8**	**96,581**	**124.8**

Source: SSID 2014

Table 61: Number of older people who have received an assessment by Clinical Commissioning Group Locality / Constituency 2010/11-2013/14

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11 – 2013/14	Population 65+ - ONS 2012 population estimates	Assessments 2013/14 per 1,000 population 65+
Chester-le-Street	1,350	1,184	1,289	1156	-14.4	10,733	107.7
Derwentside	1,705	1,810	1,925	1872	9.8	17,106	109.4
Durham	1,293	1,435	1,484	1646	27.3	16,266	101.2
Durham Dales	1,825	1,886	1,945	1857	1.8	18,352	101.2
Easington	2,063	2,156	2,248	2172	5.3	17,266	125.8
Sedgefield	1,857	1,967	1,922	1826	-1.7	16,858	108.3
County Durham	**9,728**	**10,226**	**10,613**	**10,419**	**7.1**	**96,581**	**124.8**

Source: SSID 2014

Table 62 shows that hospital discharge referrals for older people have fluctuated between 2010/11 and 2013/14. In 2014, figures indicate that 89.4% of older people were still at home 91 days after discharge from hospital. This is higher than both the North East figure (87.2%) and England (81.9%).

Of those clients assessed or reviewed during the year:-

- 44.3% (7,760) of older people feel they need daily support with most, if not all things around the house.
- 33.8% (7,292) of older people feel they need support most of the time to stay safe.
- 14.3% (3,007) of older people need daily support to maintain relationships.

Table 62: Number of older people with a hospital discharge referral by Clinical Commissioning Group Locality / Constituency 2010/11 – 2013/14

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11-2013/14	Population 65+ - ONS 2012 population estimates
Chester-le-Street	398	380	427	390	-2.0	10,733
Derwentside	674	663	708	606	-10.1	17,106
Durham	615	615	637	695	13.0	16,266
Durham Dales	662	738	734	664	0.3	18,352
Easington	848	837	952	917	8.1	17,266
Sedgefield	781	790	813	745	-4.6	16,858
County Durham	**3,978**	**4,023**	**4,271**	**4,017**	**1.0**	**96,581**

Source: SSID 2014

Intermediate Care Plus

Intermediate Care Plus, either residential or non-residential, is a range of time-limited health and social care services which may be available to promote faster recovery from illness, avoid unnecessary admission to hospital, support timely discharge from hospital and avoid premature long term admission to a care home.

When comparing 2010/11 to 2013/14, the number of older people receiving Intermediate Care Plus funded by Durham County Council increased by 4.7% from 2,105 to 2,203.

Between 1st April 2013 and 31st March 2014, there were 1,450 referrals to the reablement service, an increase of 7.3% on the previous year (1,351). 62.3% of those referred completed the period without the need for ongoing care. 21.5% received a reduced care package. 83.8% of people completing reablement achieved their goals. There were 985 service users who received reablement as part of their intermediate care package. In 2013/14, 91% of people referred to the Reablement Service were older people.

Table 63: Number of older people receiving Intermediate Care Plus by Clinical Commissioning Group Locality / Constituency 2010/11 – 2013/14

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11 – 2013/14	Population 65+ - ONS 2012 population estimates	Intermediate care 2013/14 per 1,000 population 65+
Chester-le-Street	184	143	170	199	8.2	10,733	18.5
Derwentside	267	300	265	258	-3.4	17,106	15.1
Durham	257	341	272	341	32.7	16,266	21.0
Durham Dales	218	288	222	242	11.0	18,352	13.2
Easington	964	950	879	866	-10.2	17,266	50.2
Sedgefield	215	219	286	297	38.1	16,858	17.6
County Durham	**2,105**	**2,241**	**2,094**	**2,203**	**4.7**	**96,581**	**22.8**

Source: SSID 2014

Direct payments and personal budgets

Self directed support is about making social care services more personalised and giving service users more choice and control over their own care and support arrangements; giving service users independence and flexibility over who provides their care and support and how and when it is delivered.

Direct payments for older people increased in the 4 year period 2010-2014 across the CCG Localities / Constituencies, with an overall increase of 54.3% when comparing figures for 2010/11 (403) to 2013/14 (622). However, between 2011/12 and 2013/14, numbers have fallen from 711 to 622.

In 2013/14 in County Durham 7,931 older people were in receipt of personal budgets, this is an increase of 20.8% when comparing 2010/11 figures (6,566).

Table 64 – Number of older people in receipt of direct payments by Clinical Commissioning Group Locality / Constituency 2010/11 - 2013/14

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11-2013/14	Population 65+ - ONS 2012 population estimates	Direct payments 2013/14 per 1,000 population 65+
Chester-le-Street	34	44	49	51	50	10,733	4.8
Derwentside	100	213	207	168	68	17,106	9.8
Durham	50	118	115	120	140	16,266	7.4
Durham Dales	100	157	146	132	32	18,352	7.2
Easington	34	42	52	48	41.2	17,266	2.8
Sedgefield	85	137	139	103	21.2	16,858	6.1
County Durham	**403**	**711**	**708**	**622**	**54.3**	**96,581**	**6.4**

Source: SSID 2014

Table 65: Number of older people in receipt of personal budgets by Clinical Commissioning Group Locality / Constituency 2010/11 – 2013/14

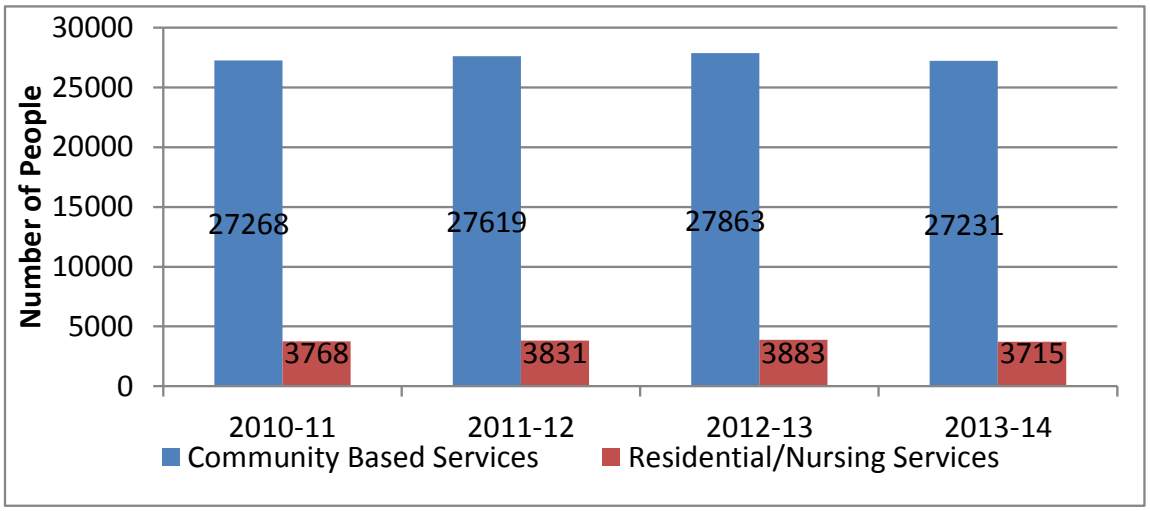
Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11 – 2013/14	Population 65+ - ONS 2012 population estimates	Personal budgets 2013/14 per 1,000 population 65+
Chester-le-Street	669	785	855	837	25.1	10,733	77.98
Derwentside	1,216	1,519	1,529	1402	15.3	17,106	81.96
Durham	997	1,241	1,277	1293	29.7	16,266	79.49
Durham Dales	1,357	1,395	1,509	1373	1.2	18,352	74.81
Easington	1,137	1,439	1,441	1562	37.4	17,266	90.47
Sedgefield	1,190	1,505	1,676	1464	23.0	16,858	86.84
County Durham	**6,566**	**7,884**	**8,287**	**7931**	**20.8**	**96,581**	**82.12**

Source: SSID 2014

Community based services / residential and nursing services

Figure 71 shows that 27,231 older people in County Durham were accessing community based services in 2013/14, a decrease of 0.1% when compared to 2010/11 (27,268) although there was a small rise in numbers in 2011/12 and 2012/13. The number receiving residential/nursing services decreased from 3,768 in 2010/11 to 3,715 in 2013/14, although there was a small rise in numbers in 2011/12 and 2012/13.

Figure 71: Number of older people in receipt of community based services / residential and nursing services 2010/11 – 2013/14



Source: SSID 2014

Community based services includes small items of equipment. Residential care includes short stay / respite.

Self funders

The quarterly survey of care homes carried out by commissioners has highlighted that approximately 16-17% of beds are occupied by people who fund their own care, and this has remained constant since 2009.

Community services

Older people are provided with a range of services in the community to help them maintain their independence and remain in their own homes, including home care and day care.

Home care

Between 2010/11 and 2013/14, the number of older people who received a home care service during the year has decreased from 6,717 to 5,793 (13.8%). In 2013/14, 45.3% of older people who received a home care service were aged 85 years and over.

Home care provision for older people of 10 hours or more per week decreased from 1,443 as of 31st March 2011 to 1,328 as of 31st March 2014 (8%). Non-intensive home care provision decreased from 2,037 in 2010/11 to 1,884 in 2013/14 (7.5%).

Table 66: Number of older people in receipt of intensive home care (10 hours + per week) by Clinical Commissioning Group Locality / Constituency as at 31st March each year 2010/11 – 2013/14

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11 – 2013/14	Population 65+ - ONS 2012 population estimates	Intensive home care 2013/14 per 1,000 population 65+
Chester-le-Street	151	153	151	119	-21.2	10,733	11.09
Derwentside	263	223	204	203	-22.8	17,106	11.87
Durham	199	202	204	212	6.5	16,266	13.03
Durham Dales	297	326	292	278	-6.4	18,352	15.15
Easington	234	271	266	223	-4.7	17,266	12.92
Sedgefield	299	343	335	293	-2	16,858	17.38
County Durham	**1,443**	**1,518**	**1,452**	**1,328**	**-8**	**96,581**	**13.75**

Source: SSID 2014

Table 67: Number of older people in receipt of non-intensive home care by Clinical Commissioning Group Locality / Constituency as at 31st March each year 2010/11 – 2013/14

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11 – 2013/14	Population 65+ - ONS 2012 population estimates	Non-intensive home care 2013/14 per 1,000 population 65+
Chester-le-Street	258	212	192	181	-29.8	10,733	16.86
Derwentside	307	256	271	253	-17.6	17,106	14.79
Durham	319	319	282	298	-6.6	16,266	18.32
Durham Dales	427	346	325	372	-12.9	18,352	20.27
Easington	371	360	388	380	2.4	17,266	22.01
Sedgefield	355	342	381	400	12.7	16,858	23.73
County Durham	**2,037**	**1,835**	**1,839**	**1,884**	**-7.5**	**96,581**	**19.51**

Source: SSID 2014

Day care

The number of older people receiving day care decreased by 50.0% when comparing 2010/11 (2,233) figures with 2013/14 (1,117) and a 17.7% decrease when comparing 2012/13 (1,357) and 2013/14 (1,117) figures. This is due in part to the introduction of day care charges and charging for transport costs, as well as the consistent application of eligibility criteria. Message refers to older people

Although the number of service users in receipt of day care reduced by 13.3% when comparing 2012/13 to 2013/14, Durham County Council is still above national and regional averages in terms of day care provision.

Table 68 - Number of older people in receipt of day care by Clinical Commissioning Group Locality / Constituency 2010/11-2013/14

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11-2013/14	Population 65+ - ONS 2012 population estimates	Day care 2013/14 per 1,000 population 65+
Chester-le-Street	331	272	171	137	-58.6	10,733	12.76
Derwentside	380	334	252	196	-48.4	17,106	11.46
Durham	347	310	225	191	-45.0	16,266	11.74
Durham Dales	373	308	206	176	-52.8	18,352	9.59
Easington	398	360	216	189	-52.5	17,266	10.95
Sedgefield	404	376	287	228	-43.6	16,858	13.52
County Durham	**2,233**	**1,960**	**1,357**	**1,117**	**-50.0**	**96,581**	**11.57**

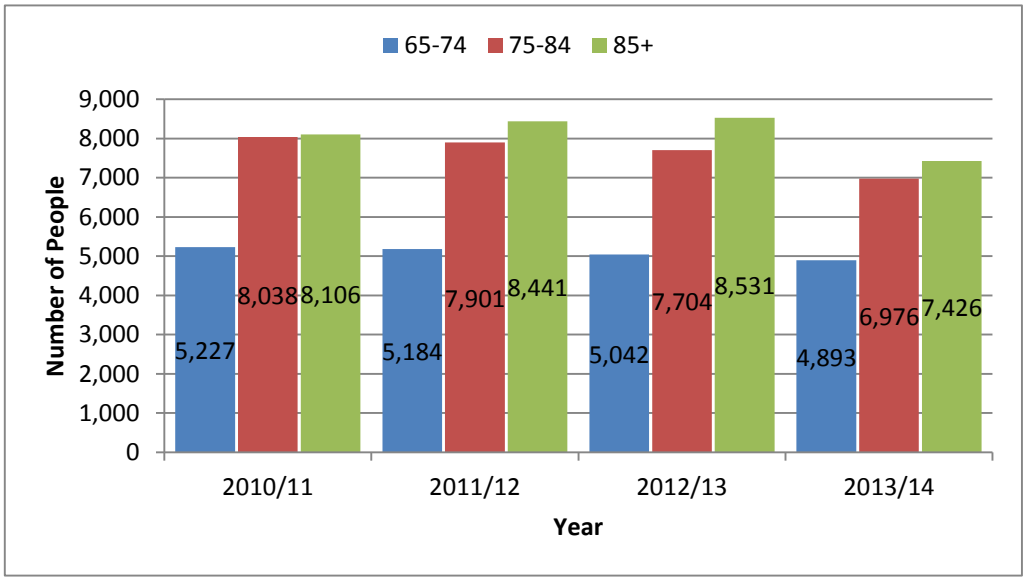
Source: SSID 2014

Community equipment

In County Durham in 2013/14, 19,295 older people were in receipt of community equipment (Figure 72). Bathing equipment represents the most issued items of community equipment to older people during 2013/14**.**

'Falls detector' has consistently been the item of telecare equipment most issued to older people when comparing 2009/10 to 2013/14 information.

Figure 72: Number of older people in receipt of community equipment as at 31st March each year 2010/11 - 2013/14 by age group



Source: SSID 2014

Residential and nursing care

As people are supported in their own homes for longer, the average age of permanent admission for older people into residential care continues to show a steady increase from 85.5 years in 2010/11 to 86.63 years in 2013/14 and the length of stay has risen over the last two years, following a steady decline prior to this. This can be attributed to people living longer in old age and improvements in medical care.

The rate of permanent admissions to residential or nursing care for clients aged 65+ has reduced from 907 per 100,000 population during 2011/12 to 736 per 100,000 during 2013/14.

Table 69: Average age at permanent admission 2004/05 – 2013/14

Year of permanent admission	Nursing	Residential
2004/05	83.02	84.36
2005/06	83.51	84.75
2006/07	83.83	84.92
2007/08	83.44	84.93
2008/09	84.34	84.76
2009/10	84.31	85.15
2010/11	83.90	85.50
2011/12	85.17	85.45
2012/13	83.40	86.30
2013/14	84.3	86.63

Source: SSID 2014

Table 70: Older people residential and nursing care - average 2007/08 – 2013/14

Year	Average days	
	Residential	Nursing
2007/08	637	324
2008/09	631	273
2009/10	528	280
2010/11	547	180
2011/12	491	235
2012/13	521	257
2013/14	609	271

Source: SSID 2014

As shown in table 71, the number of older people resident in care homes is predicted to rise by 66.4% by 2030:

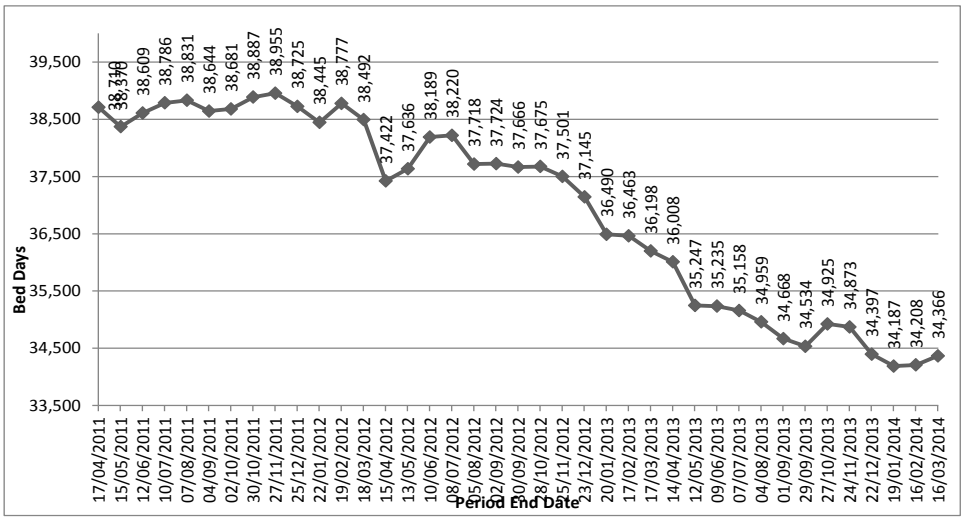
Table 71: People aged 65 and over living in a care home with or without nursing by local authority / non-local authority, by age, projected to 2030

	2014	2015	2020	2025	2030
Total population aged 65 and over living in a care home with or without nursing	3,549	3,645	4,247	5,087	5,905

Source: POPPI

The demand for residential care continues to decrease (Figure 73) when comparing April 2011 to March 2014, with the number of residential bed days commissioned each four week period for older people decreasing from 38,710 in April 2011 to 34,366 (11.2%) in March 2014.

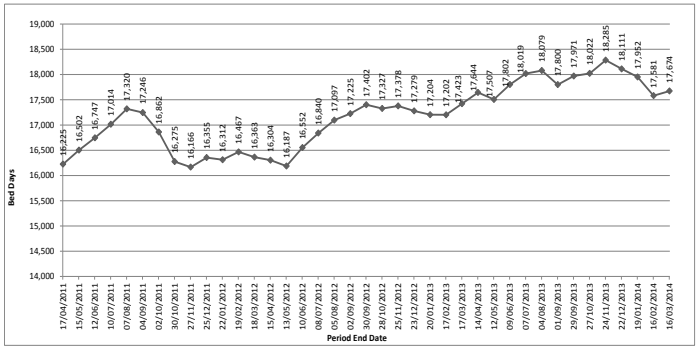
Figure 73: Bed days commissioned each period – older people residential from April 2011 to March 2014 (excludes full fee payers & self funders and dementia residential)



Source: SSID 2014

Figure 74 highlights an upward trend in nursing bed days commissioned for older people from mid May 2012 onwards. Decreasing from 17,320 to 16,187 (6.5%) in May 2012, there is an increase in nursing bed days until it reaches its highest point of 18,285 in November 2013. When comparing four week periods between April 2011 and March 2014, there has been an increase of 8.9%.

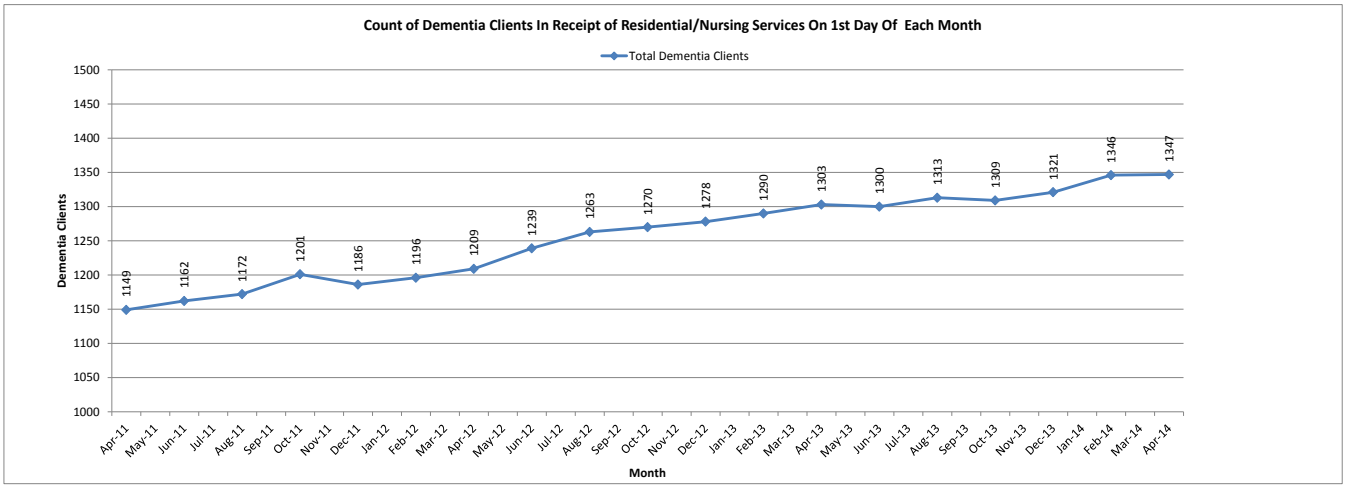
Figure 74: Bed days commissioned each period – older people nursing care from April 2011 to March 2014 (excludes full fee payers & self funders)



Source: SSID 2014

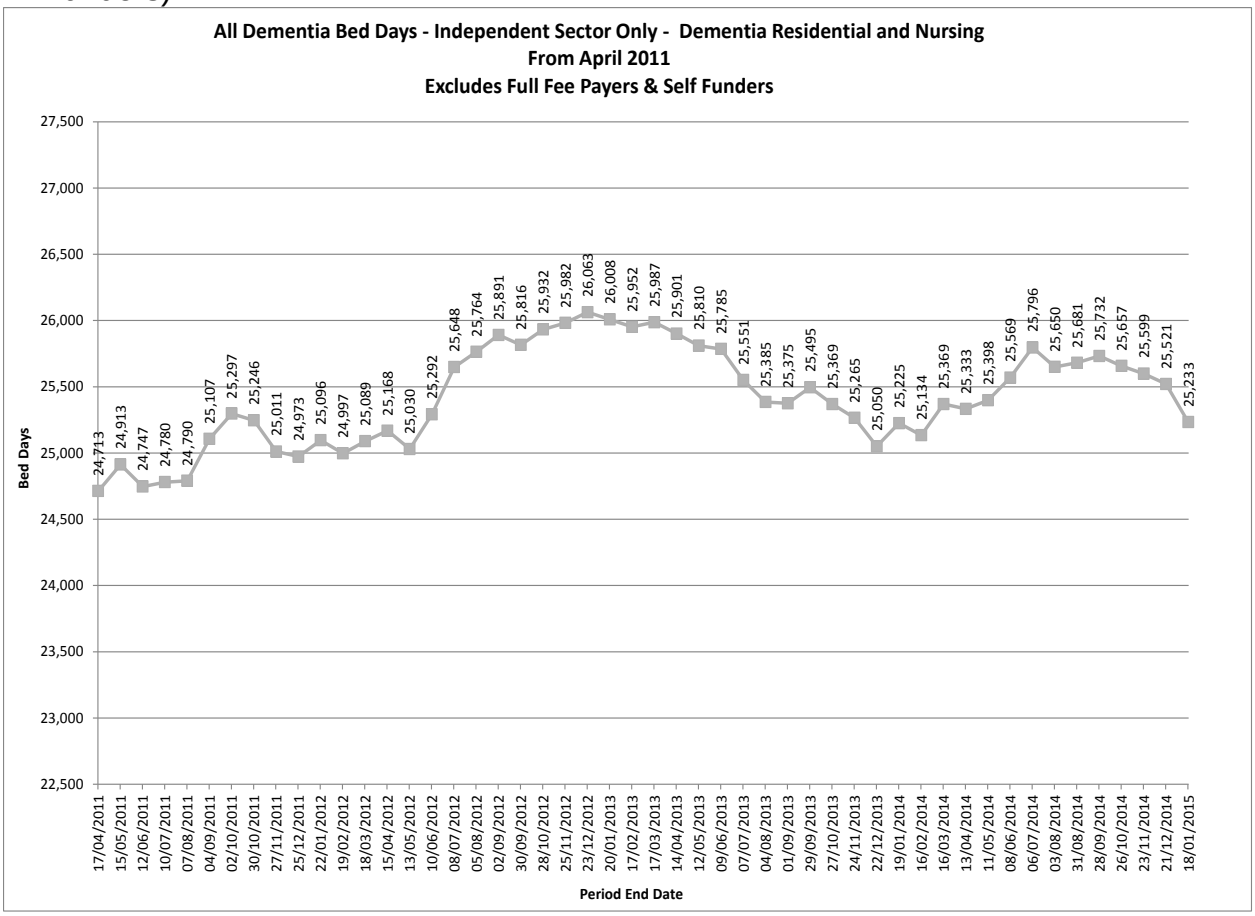
- The number of clients with dementia accessing residential / nursing services rose from 1,149 in April 2011 to 1,347 in April 2014, a rise of 198 clients (17.2% increase).

Figure 75: Clients with dementia accessing residential/nursing services.



Source: SSID 2014

Figure 76: Bed days commissioned each period – older people dementia residential care from April 2010 to March 2014 (excludes full fee payers & self funders)



Ethnicity of older people in receipt of social care services – 2013/14
In 2013/14, 99.8% of older people in receipt of social care services were from a white British background. The remaining 0.2% were from a white/other background and other minority ethnic groups.

ADULTS WITH A LEARNING DISABILITY

A person with a learning disability is defined as someone with "the presence of a significantly reduced ability to understand new or complex information, and to learn new skills, as well as a reduced ability to cope independently" (Valuing People Strategy document 2001).

In October 2014 there were 2,214 people with a learning disability in County Durham known to adult social care, which consists of any open social care cases where the service user has a recorded learning disability. However, baseline estimates from PANSI and POPPI predict that by 2020 there will be 7,599 people aged 18-64 and 2,389 people aged 65+ and over in County Durham with a learning disability.

The numbers of entrants to the service are not increasing, but due to increased life expectancy service users are living longer and therefore remaining in the service for longer.

Referrals and assessments
There has been an increase in the number of referrals (14.5%) for adults with a learning disability when comparing 2010/11 figures to 2013/14 figures. There has been a decrease in the number of assessments (-21.6%) between 2010/11 and 2013/14; this decrease can be linked to changes in the way safeguarding referrals are recorded (see Altogether Safer section).

Table 72: Number of adults with a learning disability referred by Clinical Commissioning Group Locality / Constituency 2010/11 – 2013/14 (includes safeguarding referrals)

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11 – 2013/14	Population 18-64 – ONS 2012 population estimates	Referrals 2013/14 per 1,000 population 18-64
Chester-le-Street	35	41	46	49	40	32,984	1.49
Derwentside	112	118	110	96	-14.3	56,288	1.71
Durham	65	98	97	128	96.9	62,972	2.03
Durham Dales	126	185	112	107	-15.1	54,197	1.97
Easington	115	132	96	123	7	58,122	2.12
Sedgefield	98	145	102	128	30.6	52,965	2.42
County Durham	**551**	**719**	**563**	**631**	**14.5**	**317,528**	**1.99**

Source: SSID 2014

Of those clients assessed or reviewed during the year :

- 38.7% (619) of adults with a learning disability feel they always need someone with them to make them feel safe.
- 33.5% (536) of adults with a learning disability feel they need support most of the time to stay safe.
- 48.2% (770) of adults with a learning disability feel they need daily support with most, if not all, things around their home.
- 27% of adults with a learning disability (438) feel they need daily support to maintain their relationships.

Table 73: Number of Adults with a Learning Disability assessed by Clinical Commissioning Group Locality / Constituency 2010/11 – 2013/14

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2013/14	Population 18-64 – ONS 2012 population estimates	Assessments 2013/14 per 1,000 population 18-64
Chester-le-Street	38	43	28	29	-23.7	32,984	0.88
Derwentside	132	89	96	75	-43.2	56,288	1.33
Durham	69	68	92	86	24.6	62,972	1.37
Durham Dales	85	90	89	75	-11.8	54,197	1.38
Easington	105	90	79	75	-28.6	58,122	1.29
Sedgefield	108	104	102	81	-25	52,965	1.53
County Durham	**537**	**484**	**486**	**421**	**-21.6**	**317,528**	**1.33**

Source: SSID 2014

Direct payments / personal budgets

In 2013/14 in County Durham 1,509 adults with a learning disability were in receipt of personal budgets (which includes 392 in receipt of direct payments); this was an increase of 50.1% from the year of implementation (2010/11).

Table 74: Number of adults with a learning disability in receipt of direct payments 2010/11 – 2013/14

CCG Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11 – 2013/14	Population 18-64 – ONS 2012 population estimates	Direct payments 2010/11 – 2013/14 per 1,000 population 18-64
Chester-le-Street	35	40	37	36	2.9	32,984	1.09
Derwentside	61	80	79	77	26.2	56,288	1.37
Durham	40	67	76	94	135	62,972	1.49
Durham Dales	52	64	62	63	21.1	54,197	1.16
Easington	54	61	62	59	9.3	58,122	1.02
Sedgefield	71	73	75	63	-11.3	52,965	1.19
County Durham	**313**	**385**	**391**	392	25.2	**317,528**	**1.23**

Source: SSID 2014

Table 75 - Number of adults with a learning disability in receipt of personal budgets by Clinical Commissioning Group Locality / Constituency 2010/11 – 2013/14

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11 – 2013/14	Population 18-64 – ONS 2012 population estimates	Personal budgets 2013/14 per 1,000 population 18-64
Chester-le-Street	106	125	116	129	21.7	32,984	3.91
Derwentside	182	255	231	240	31.9	56,288	4.26
Durham	176	319	256	331	88.1	62,972	5.26
Durham Dales	152	218	220	267	75.7	54,197	4.93
Easington	225	281	256	287	27.6	58,122	4.94
Sedgefield	164	250	221	255	55.5	52,965	4.81
County Durham	**1,005**	**1,348**	**1,300**	**1,509**	**50.1**	**317,528**	**4.75**

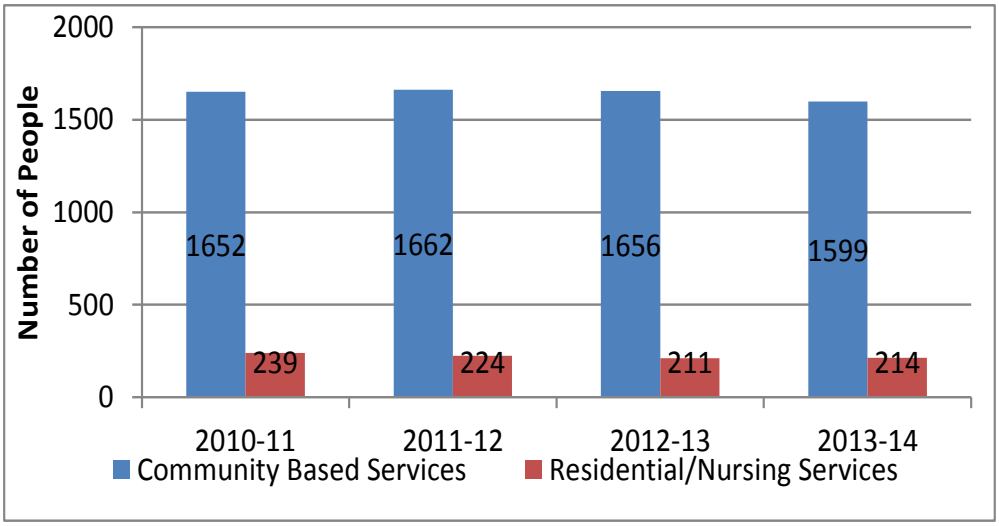
Source: SSID 2014

Community based services / residential and nursing services

Community based services includes small items of equipment. Residential care includes short stay / respite.

Figure 77 shows that the number of adults with a learning disability accessing community based services has decreased by 3.2% when looking at the figures for 2010/11 (1,652) to 2013/14 (1,599). There has been a decrease of 10.5% in residential services over the same four year period (from 239 to 214).

Figure 77: Number of adults with a learning disability in receipt of community based / residential / nursing services 2010/11 – 2013/14



Source: SSID 2014

Settled accommodation

Over half (805) of all adults with a learning disability in 2013/14 in settled accommodation live in mainstream housing with their family and/or friends, with a greater number of males (459) than females (346) living in this type of accommodation. Over the same time period, there were 240 people in unsettled accommodation.

Table 76: Settled accommodation for adults with a learning disability 2009/10 - 2013/14

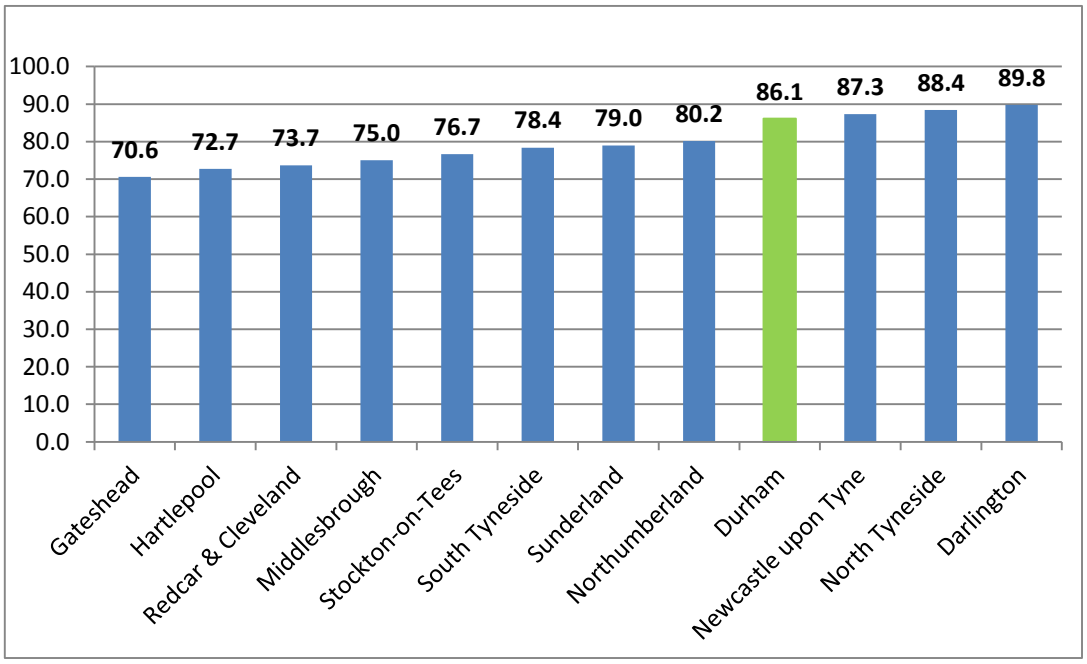
Accommodation detail	Year				Total % difference 2010/11-2013/14
	2010/11	2011/12	2012/13	2013/14	
Settled mainstream housing with family/ friends	740	774	823	805	8.8%
Supported accommodation/supported lodgings	315	349	383	425	34.9%
Tenant - local authority/arms length management organisation	91	87	98	87	-4.4%
Tenant - private landlord	83	96	127	109	31.3%
Adult placement scheme	49	50	36	38	-22.4%
Owner occupier / shared ownership scheme	15	14	13	13	-13.3%
Sheltered housing / extra care sheltered housing	6	6	3	5	-16.7%
Approved premises for Probation	0	0	0	3	n/a
Mobile Accommodation for G.R.T. community.	0	3	0	3	n/a

Source: AS-CAR 13-14

Where low numbers exist in tables, a notional figure of 3 has been included and the total amended accordingly.

County Durham is the fourth highest authority in the North East region supporting adults with a learning disability to maintain their independence.

Figure 78: Percentage of adults with a learning disability known to Durham County Council who are living in their own home or with their family across North East local authorities 2013/14



Source: National Adult Social Care Intelligence Service (NASCIS) 2013/14. The data for the above graph is restricted data. This data is available as management information ONLY and must not be re-used externally.

Community services

Adults with a learning disability are provided with a range of services in the community to help them maintain their independence and remain in their own homes, including home care and day care.

The number of people with a learning disability in receipt of a service in County Durham has remained static between 2011/12 (1,794) and 2012/13 (1,797), however expenditure has increased by 4.9%.

Home care

In 2013/14, a total of 612 adults with a learning disability received a home care service during the year.

In 2013/14, there were 354 adults with a learning disability in receipt of intensive home care services (10+ hours per week) and 192 in receipt of non-intensive home care; this is a decrease of 3.5% and an increase of 40.1% respectively.

Table 77: Number of adults with a learning disability in receipt of intensive home care (10 hours + per week) by Clinical Commissioning Group Locality / Constituency as at 31st March 2013/14

Clinical Commissioning Group Locality / Constituency	2011/12	2012/13	2013/14	% Difference 2011/12 – 2013/14	Population 18-64 – ONS 2012 population estimates	Intensive home care 2013/14 per 1,000 population 18-64
Chester-le-Street	31	25	27	-12.9	32,984	0.82
Derwentside	48	50	43	-10.4	56,288	0.76
Durham	58	70	68	17.2	62,972	1.08
Durham Dales	81	79	78	-3.7	54,197	1.44
Easington	66	64	60	-9.1	58,122	1.03
Sedgefield	83	89	78	-6.0	52,965	1.47
County Durham	**367**	**377**	**354**	**-3.5**	**317,528**	**1.11**

Source: SSID 2014

Table 78: Number of adults with a learning disability in receipt of non-intensive home care by Clinical Commissioning Group Locality / Constituency as at 31st March 2013/14

Clinical Commissioning Group Locality / Constituency	2011/12	2012/13	2013/14	% Difference 2013/14	Population 18-64 – ONS 2012 population estimates	Non-intensive home care 2013/14 per 1,000 population 18-64
Chester-le-Street	12	14	14	16.7	32,984	0.42
Derwentside	44	47	51	15.9	56,288	0.91
Durham	19	26	38	100	62,972	0.60
Durham Dales	22	27	36	63.6	54,197	0.66
Easington	19	20	21	10.5	58,122	0.36
Sedgefield	21	30	32	52.4	52,965	0.60
County Durham	**137**	**164**	**192**	**40.1**	**317,528**	**0.60**

Source: SSID 2014

Day care

In 2013/14, 1,043 adults with a learning disability were in receipt of day care; this was a decrease of 4% from 2012/13 (1,087).

Table 79: Number of adults with a learning disability in receipt of day care by Clinical Commissioning Group Locality / Constituency 2012/13-2013/14

Clinical Commissioning Group Locality / Constituency	2012/13	2013/14	% difference 2012/13 – 2013/14	Population 18-64 – ONS 2012 population estimates	Referrals 2013/14 per 1,000 population 18-64
Chester-le-Street	94	84	-10.6	32,984	2.55
Derwentside	185	163	-11.9	56,288	2.90
Durham	203	235	15.8	62,972	3.73
Durham Dales	187	180	-3.7	54,197	3.32
Easington	220	204	-7.3	58,122	3.51
Sedgefield	198	177	-10.6	52,965	3.34
County Durham	**1,087**	**1,043**	**-4.0**	**317,528**	**3.28**

Source: SSID 2014

Community equipment

There is a 1.7% increase in the number of adults with a learning disability accessing community equipment when comparing 2010/11 figures (301) with 2013/14 (306), with moving and handling equipment being the most popular item issued.

Table 80: Number of adults with a learning disability in receipt of community equipment by Clinical Commissioning Group Locality / Constituency as at 31st March each year 2010/11 – 2013/14

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11 – 2013/14	Population 18-64 – ONS 2012 population estimates	Community equipment 2013/14 per 1,000 population 18-64
Chester-le-Street	25	24	22	22	-12	32,984	0.7
Derwentside	56	56	53	49	-12.5	56,288	0.9
Durham	33	46	55	64	93.9	62,972	1.0
Durham Dales	52	52	55	52	0.0	54,197	1.0
Easington	58	61	64	57	-1.7	58,122	1.0
Sedgefield	77	84	75	62	-19.5	52,965	1.2
County Durham	**301**	**323**	**324**	**306**	**1.7**	**317,528**	**1.0**

Source: SSID 2014

ADULTS WITH AUTISM

The National Autism Strategy 2010 states 'Autism is sometimes described as a "hidden disability", not only because it has no physical signs, but also because adults with autism are some of the most excluded, and least visible, people in the UK'. The government's vision is that 'all adults with autism are able to live fulfilling and rewarding lives within a society that accepts and understands them'.

There are over half a million people in the UK with autism – around 1 in 100. Together with their families they make up over two million people whose lives are touched by autism every single day.

In 2013/14 there were 293 adults with autism aged 18-64 years accessing social care services in County Durham, a 3.2% increase on 2012/13 figures (284), of which 77.8% are male. The top 4 services provided to adults with autism in 2013/14 are day care, supported living, transport, direct payments (home care).

Information from PANSI suggests that by 2020 in County Durham, there will be 3,104 people (18-64) predicted to have Autism Spectrum Disorder.

Table 81: Number of adults with autism aged 18-64 years by Clinical Commissioning Group Locality / Constituency 2012/13 – 2013/14

Clinical Commissioning Group Locality / Constituency	2012/13			2013/14			% Difference 2012/13 – 2013/14
	Female	Male	Total	Female	Male	Total	
Chester-le-Street	3	19	24	6	21	27	12.5
Derwentside	3	30	32	3	30	33	3.1
Durham	14	48	62	14	48	62	0
Durham Dales	6	25	31	10	27	37	19.4
Easington	19	58	77	19	59	78	1.3
Sedgefield	16	42	58	13	43	56	– 3.4
County Durham	**61**	**222**	**284**	**65**	**228**	**293**	**3.2**

Source: SSID 2014

Where low numbers exist in tables, a notional figure of 3 has been included and the total amended accordingly.

Ethnicity of adults with a learning disability in receipt of social care services – 2013/14

In 2013/14, 99.3% of adults with a learning disability were from a white British background. The remaining 0.7% were from a white/other background and other minority ethnic groups.

The Learning Disability Census

The Learning Disability Census provides a national, individual record-level snapshot of inpatients with learning disabilities, autism spectrum disorder and/or behaviour that challenges, and the services they receive. The Census includes service users who were inpatients in NHS and independent services at midnight on 30 September 2013.

Data in the Learning Disability Census 2013 shows that:

- Around three in four service users (74.6%) were male and one in four (25.4%) were female. Most service users (92.1%) were adults of working age (18-64).
- Six in ten service users (60.0%) had been inpatients for a year or more and around one in six (17.6%) had been inpatients for five years or more.
- Just under one in five inpatients (18.2%) were staying in wards located 100km or more (as the crow flies) from their residential postcode. Substantial regional inequalities were found in the distances travelled for inpatient care – more than half of service users in the South West (52.6%) were inpatients in wards located 100km or more from their postcode of residence, compared with 8.8% of service users resident in the North East.
- Most service users (76.3%) were inpatients in wards predominantly providing services for people with learning disabilities.
- Maintaining contacts with family, friends, advocates and commissioners helps ensure that inpatient stays remain suitable for service users' needs. Overall, providers could not supply a valid residential postcode for 28.0% of inpatients.

PHYSICAL DISABILITY / SENSORY SUPPORT

The Disability Discrimination Act 1995 defines disability as an impairment which has a substantial long term effect on a person's ability to carry out normal day-to-day activities.

Physical disabilities may be congenital or acquired at any age, be temporary, long term or fluctuating. People with physical disabilities may often have unique and multi-dimensional requirements requiring tailored services.

Sensory impairment encompasses visual (including blind and partially sighted), hearing (including those who are profoundly deaf, deafened and hard of hearing), and dual sensory impairment (deaf/blindness). As with physical disabilities, sensory impairments may be congenital or acquired at any age.

The information below provides a breakdown of the number of adults with physical disability/sensory support needs registered with Durham County Council as of June 2014. It should be noted that these registers are voluntary and therefore will be an under-estimation.

- The Blind / Partially Sighted Register identifies an increase of 1.4% when comparing figures for 2012/13 (3,388) with 2013/14 (3,437).
- The number of people on the Deaf / Hard of Hearing Register have remained consistent over the same time period, when comparing figures for 2012/13 (2,362) with 2013/14 (2,396).
- The number of people on the Physical Disability Register have increased slightly (1.4%) from 26,523 in 2012/13 to 26,902 in 2013/14.

Referrals and assessments

The following information provides an analysis of the social care needs of adults with physical disability/sensory support needs in County Durham.

The number of adults referred for a social care assessment with physical disability / sensory support needs decreased from 2,978 in 2010/11 to 2,904 in 2013/14. However the number of assessments (re-assessments) is static over the four year trend period. DDES CCG Locality had the greatest percentage of referrals (61.7%) and assessments (63.8%) during 2013/14.

Table 82 - Number of adults with physical disability / sensory support needs referred for a social care assessment by Clinical Commissioning Group Locality / Constituency 2010/11 – 2013/14 (including safeguarding referrals)

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11-2013/14	Population 18-64 – ONS 2012 population estimates	Referrals 2012/13 per 1,000 population 18-64
Chester-le-Street	278	237	246	249	-10.4	32,984	7.55
Derwentside	493	485	503	497	0.8	56,288	8.83
Durham	362	384	313	366	1.1	62,972	5.81
Durham Dales	557	538	550	507	-9.0	54,197	9.35
Easington	699	736	725	719	2.9	58,122	12.37
Sedgefield	589	637	589	566	-3.9	52,965	10.69
County Durham	**2,978**	**3,017**	**2,926**	**2,904**	**-2.5**	**317,528**	**9.15**

Source: SSID 2014

Table 83: Number of adults with physical disability / sensory support needs who have received an assessment by Clinical Commissioning Group Locality / Constituency 2010/11-2013/14

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11 – 2013/14	Population 18-64 – ONS 2012 population estimates	Assessments 2013/14 per 1,000 population 18-64
Chester-le-Street	159	143	180	149	-6.3	32,984	4.52
Derwentside	321	352	357	351	9.3	56,288	6.24
Durham	225	229	223	248	10.2	62,972	3.94
Durham Dales	402	359	424	389	-3.2	54,197	7.18
Easington	531	518	543	543	2.3	58,122	9.34
Sedgefield	410	459	414	389	-5.1	52,965	7.34
County Durham	**2,048**	**2,060**	**2,141**	**2,069**	**1**	**317,528**	**6.52**

Source: SSID 2014

Of those clients assessed or reviewed during the year:-

- 19.1% (138) of adults with physical disability/sensory support needs feel they need support every night with the assistance of one person.
- 36.2% (261) of adults with physical disability/sensory support needs feel they need support most of the time to stay safe.
- 28.4% (205) of adults with physical disability/sensory support need daily support with most, if not all things around the home.

Direct payments / personal budgets

Following the introduction of personal budgets in April 2010, 1,012 adults with physical disability / sensory support needs in County Durham in 2013/14 were in receipt of personal budgets, including 361 in receipt of direct payments; this is an increase of 10.4% over the four year trend period for 2010/11 (327) to 2013/14 (361).

Table 84: Number of adults with physical disability / sensory support needs in receipt of direct payments by Clinical Commissioning Group Locality / Constituency 2010/11-2013/14

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11-2013/14	Population 18-64 – ONS 2012 population estimates	Direct payments 2013/14 per 1,000 population 18-64
Chester-le-Street	37	37	43	41	10.8	32,984	1.24
Derwentside	62	59	53	53	-14.5	56,288	0.94
Durham	54	62	65	67	24	62,972	1.06
Durham Dales	64	63	62	72	12.5	54,197	1.33
Easington	47	46	60	56	19.1	58,122	0.96
Sedgefield	63	80	78	72	14.3	52,965	1.36
County Durham	**327**	**347**	**361**	**361**	**10.4**	**317,528**	**1.14**

Source: SSID 2014

Table 85: Number of adults with physical disability / sensory support needs in receipt of a personal budget by Clinical Commissioning Group Locality / Constituency 2010/11 –2013/14

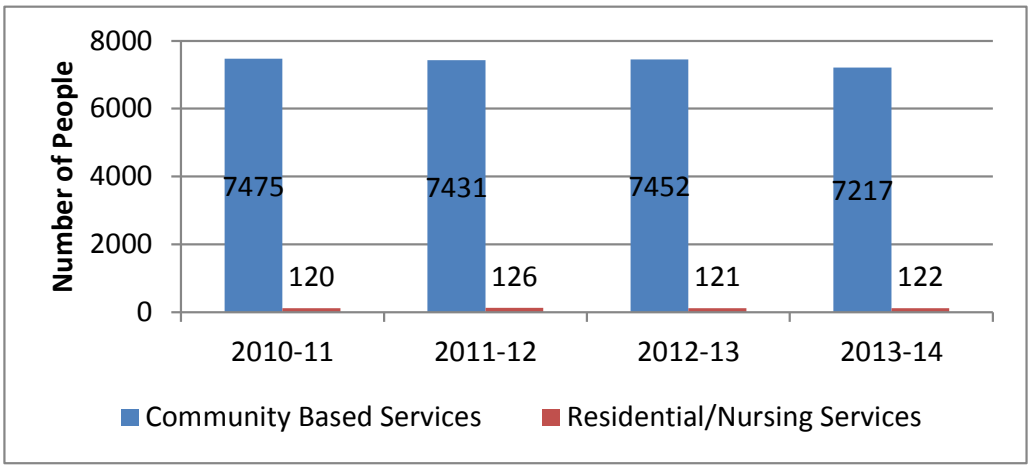
Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11 – 2013/14	Population 18-64 – ONS 2012 population estimates	Personal budgets 2013/14 per 1,000 population 18-64
Chester-le-Street	106	100	114	115	8.5	32,984	3.49
Derwentside	149	148	166	152	2	56,288	2.70
Durham	133	148	149	170	27.8	62,972	2.70
Durham Dales	204	155	182	179	-12.3	54,197	3.30
Easington	189	174	189	209	10.6	58,122	3.60
Sedgefield	179	201	207	187	4.5	52,965	3.53
County Durham	**960**	**926**	**1,007**	**1,012**	**5.4**	**317,528**	**3.19**

Source: SSID 2014

Community based services / residential and nursing services

Figure 79 shows the number of adults with physical disability / sensory support needs receiving community based or residential / nursing services. When comparing figures for 2010/11-2013/14, community based services decreased from 7,475 to 7,217 (3.5%), but has fluctuated over the period. Residential / nursing provision increased by (1.6%) from 120 in 2010/11 to 122 in 2013/14.

Figure 79: Number of adults with physical disability / sensory support needs in receipt of community based services / residential / nursing care 2010/11 – 2013/14



Source: SSID 2014

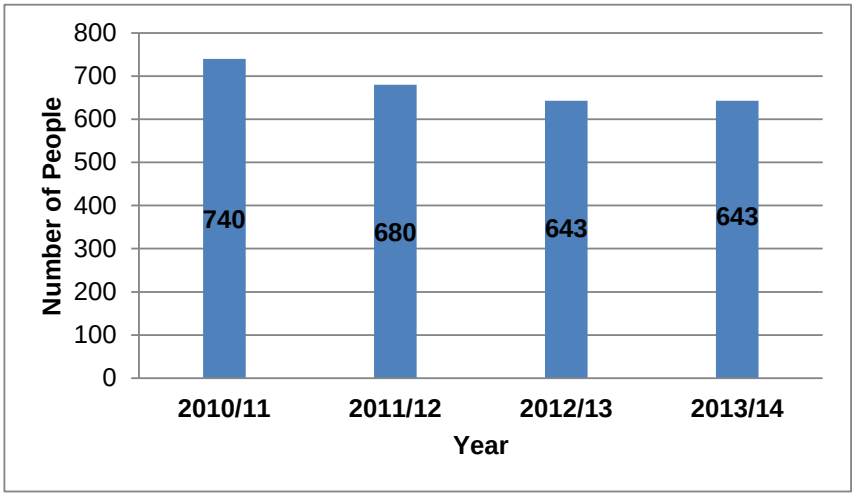
Community services

Adults with physical disability / sensory support needs are provided with a range of services in the community to help them maintain their independence and remain in their own homes, including home care and day care.

Home care

Figure 80 shows the downward trend in the number of adults with physical disability / sensory support needs between 2010/11 and 2013/14, who have received a home care service, decreasing from 740 to 643 (13.1%).

Figure 80: Number of adults with physical disability / sensory support needs receiving a home care service during the year 2010/11 – 2013/14



Source: SSID 2014

The number of adults with physical disability / sensory support needs in receipt of intensive home care of 10 hours or more per week decreased from 176 in 2010/11 to 171 in 2013/14. Non-intensive home care has increased by 15.2% over the same period.

Table 86: Number of adults with physical disability / sensory support needs in receipt of intensive home care (10 hours + per week) by Clinical Commissioning Group Locality / Constituency as at 31st March each year – 2010/11 - 2013/14

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11 - 2013/14	Population 18-64 – ONS 2012 population estimates	Intensive home care 2013/14 per 1,000 population 18-64
Chester-le-Street	23	30	27	25	8.7	32,984	0.76
Derwentside	24	21	20	19	-20.8	56,288	0.34
Durham	15	23	15	26	73.3	62,972	0.41
Durham Dales	31	30	26	30	-3.2	54,197	0.55
Easington	41	45	38	33	-19.5	58,122	0.57
Sedgefield	42	46	43	38	-9.5	52,965	0.72
County Durham	**176**	**195**	**169**	**171**	**-2.8**	**317,528**	**0.54**

Source: SSID 2014

Table 87: Number of adults with physical disability / sensory support needs in receipt of non-intensive home care by Clinical Commissioning Group Locality / Constituency as at 31st March each year 2010/11 - 2013/14

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11 - 2013/14	Population 18-64 – ONS 2012 population estimates	Non-intensive home care 2013/14 per 1,000 population 18-64
Chester-le-Street	30	22	30	30	0.0	32,984	0.91
Derwentside	32	29	23	36	12.5	56,288	0.64
Durham	31	36	36	37	19.4	62,972	0.59
Durham Dales	35	45	52	45	28.6	54,197	0.83
Easington	46	47	57	63	37.0	58,122	1.08
Sedgefield	50	48	45	47	-6.0	52,965	0.89
County Durham	**224**	**227**	**243**	**258**	**15.2**	**317,528**	**0.81**

Source: SSID 2014

Day care

Day care provision for adults with physical disability / sensory support needs aged 18-64 years decreased by 38.9% when comparing 2010/11 and 2013/14, from 316 to 193.

Table 88: Number of adults with physical disability / sensory support needs in receipt of day care by Clinical Commissioning Group Locality / Constituency 2010/11 – 2013/14

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11— 2013/14	Population 18-64 – ONS 2012 population estimates	Day care 2013/14 per 1,000 population 18-64
Chester-le-Street	32	31	21	15	-53.1	32,984	0.45
Derwentside	52	40	28	20	-61.5	56,288	0.36
Durham	50	39	30	35	-28.8	62,972	0.56
Durham Dales	55	55	46	40	-28.8	54,197	0.74
Easington	64	56	53	47	-26.6	58,122	0.81
Sedgefield	63	57	40	36	-42.9	52,965	0.68
County Durham	**316**	**278**	**218**	**193**	**-38.9**	**317,528**	**0.61**

Source: SSID 2014

Community equipment

The number of adults with physical disability / sensory support needs provided with community equipment increased steadily between 2010/11 (5,095) and 2012/13 (5,994), but fell in 2013/14 (5,851).

The number of items of telecare equipment issued to adults with physical disability/sensory support needs increased from 186 in 2012/13 to 242 in 2013/14 (30.1%). 'Fall detector' continues to be the most popular item provided throughout this period.

Telehealth

The Department of Health's headline findings from the Whole System Demonstrator programme showed that Telehealth can reduce A&E visits, hospital admissions and mortality rates.

Since 2012, Telehealth pilot projects across County Durham and Darlington have explored how technology can be used to enhance patient services, including monitoring of vital signs such as blood pressure, oxygen saturation, weight or temperature for people with long term conditions, remote monitoring of weight and appetite for patients who have been prescribed nutritional supplements, and automated follow up telephone calls following the discharge of patients who have had surgery.

The success of these services was acknowledged in shortlistings for the Health Service Journal award in 2014 and feedback from patients suggested that they found telehealth services supportive and reassuring. Areas for additional use of telehealth are being explored further, particularly in relation to falls and therapy services, and extending services across County Durham and Darlington.

Ethnicity of adults with physical disability / sensory support needs in receipt of social care services – 2013/14
In 2013/14, 99.5% of adults with physical disability / sensory support needs were from a white British background. The remaining 0.5% were from white/other background and other minority ethnic groups.

CARERS

The introduction of the Care Act 2014 means that, for the first time, carers are recognised in the law in the same way as those they care for. The Act gives local authorities a responsibility to assess a carer's needs for support, where the carer *appears* to have such needs. This replaces the previous law, which stated that the carer must be providing "a substantial amount of care on a regular basis" in order to qualify for an assessment. This means that more carers are able to have an assessment, comparable to the right of the people they care for.

The Care Act relates mostly to adult carers – people over 18 who are caring for another adult, because young carers (aged under 18) and adults who care for disabled children can be assessed and supported under children's law. However, the regulations under the Act mean that there are rules about looking at family circumstances when assessing an adult's need for care, which means, for example, making sure that the position of a young carer within a family would not be overlooked. The Act also has rules about working with young carers, or adult carers of disabled children, to plan an effective and timely move to adult care and support.

The definition of a carer is someone who: *"spends a significant proportion of their life providing unpaid support to family and potentially friends"* according to the Department of Health publication 'Carers at the Heart of 21st Century, Families and Communities' (2008). The document also highlights that people who provide unpaid care are twice as likely to be in poor health themselves, and need to be supported both in their own right and in their role as carers.

Within the above definition there are three types of carers:

1. **Adult carers** - adults caring for adults over the age of 18, including parents caring for their adult children.
2. **Parent carers** - parents caring for a child or young person under the age of 18 who has a disability.
3. **Young carers** – children or young people under the age of 18 who are caring for either another child, young person or an adult.

Referrals and assessments
Following a review of carers on their respective databases, the number of carers registered with the locality carers centres in County Durham increased from 6,459 in 2009/10 to 10,368 in 2013/14 (60.5%). Those with physical disability, sensory support needs and long term conditions continue to account for the largest percentage of service users cared for: 42.0% in 2013/14.

The majority of carers receive an assessment (or re-assessment) with the service user they care for. There was a steady increase in the number of carer assessments carried out jointly with the service user from 4,767 in 2010/11 to 5,372 in 2012/13 (12.7%), however this decreased to 4,948 in 2013/14. Carers assessed in their own

right increased by 52.6% between 2011/12 (209) and 2013/14 (319) and by 16.8% over the four year period (from 273 to 319).

County Durham shows the highest increase in joint assessments (15.9%) from 838 to 971.

The Projecting Older People Population Information (POPPI) System, which provides projections based on population increases, suggests that within County Durham the future local carer profile of older people who are carers will be as follows:

- The number of carers aged 65 and over providing unpaid care is set to increase by 30.6% by 2030 (from 14,911 in 2014 to 19,481 in 2030).
- By 2030, the number of carers aged 65 years and over providing care between:
- 1-19 hours per week is set to increase by 25.9% (from 5,729 to 7,214).
- 20-49 hours per week is set to increase by 30.1% (from 2,094 to 2,725).
- 50 or more hours per week is set to increase by 34.6% (from 7,087 to 9,541).

Table 89: Number of carers assessed jointly by Clinical Commissioning Group Locality / Constituency 2010/11 – 2013/14

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11 – 2013/14
Chester-le-Street	570	587	630	546	-4.2
Derwentside	757	859	893	755	-0.3
Durham	838	1,005	989	971	15.9
Durham Dales	803	828	854	761	-5.2
Easington	854	967	879	902	5.6
Sedgefield	945	1,081	1,127	1,013	7.2
County Durham	**4,767**	**5,327**	**5,372**	**4,948**	**3.8**

Source: SSID 2014

Table 90: Number of carers assessed in their own right by Clinical Commissioning Group Locality / Constituency 2010/11 – 2013/14

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11 – 2013/14
Chester-le-Street	23	15	10	23	0
Derwentside	37	29	48	66	78.4
Durham	48	37	36	44	-8.3
Durham Dales	49	34	61	87	77.6
Easington	56	32	30	49	-12.5
Sedgefield	60	62	27	50	-16.7
County Durham	**273**	**209**	**212**	**319**	**16.8**

Source: SSID 2014

Carers receiving a service
The number of carers receiving a service (including information and advice) increased by 5% from 5,040 in 2010/11 to 5,267 in 2013/14.

In 2013/14, 65.5% of carers receiving a service were aged 18-64 years. The number of older carers aged 65 years and over receiving a service increased by 2.1% from 1,778 in 2010/11 to 1,815 in 2013/14. The number of older carers aged 75 years and over receiving a service (such as sitting service or respite break, including information and advice) increased by 3% from 853 in 2010/11 to 875 in 2013/14.

Table 91: Number of carers receiving a service (including information and advice) by age group 2010/11 – 2013/14

Age of carer	2010/11	2011/12	2012/13	2013/14	% difference 2010/11 – 2013/14
< 18	16	3	6	2	-88
18-64	3,246	3,467	3,580	3450	6
65-74	925	1,065	1,029	940	2
75 and over	853	1,002	969	875	3
Total	**5,040**	**5,537**	**5,584**	**5,267**	**5**
Older Carers (65+)	**1,778**	**2,067**	**1,998**	**1,815**	**2**

Source: SSID 2014
Where low numbers exist in tables, a notional figure of 3 has been included and the total amended accordingly

POPPI estimates show that the number of older people aged 65 and over providing unpaid care is expected to increase by 30.6% from 14,911 in 2014 to 19,481 in 2030.

Direct payments
The number of carers receiving direct payments decreased by 46.6% across the county when comparing figures for 2010/11 and 2013/14 (from 131 to 70).

Table 92: Number of carers in receipt of direct payments by Clinical Commissioning Group Locality / Constituency 2010/11 – 2013/14

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11 – 2013/14
Chester-le-Street	8	10	10	4	-50.0
Derwentside	33	30	19	16	-51.5
Durham	19	16	13	10	-47.4
Durham Dales	20	23	20	11	-45.0
Easington	10	25	25	12	20
Sedgefield	41	39	35	17	-58.5
County Durham	**131**	**143**	**122**	**70**	**-46.6**

Source: SSID 2014

Provision of care

Census returns show that carers in County Durham are providing an increasing amount of care. The number of carers aged over 16 providing between 1 and 19 hours of unpaid care a week decreased by 1.9 % between 2001 and 2011 whilst there was a 17.2% increase in those providing 20-49 hours of unpaid care a week, and a 17.6% increase in those providing more than 50 hours of unpaid care a week.

Table 93: Number of people aged 16+ providing unpaid care in County Durham

Area	Carer providing 1-19 hours unpaid care per week	Carer providing 20 to 49 hours unpaid care per week	Carer providing 50 or more hours unpaid care per week	Total number carers providing unpaid care per week
North Durham CCG	**16,145**	**3,630**	**6,900**	**26,675**
Derwentside CCL	6,060	1,504	2,987	10,551
Chester le Street CCL	3,830	858	1,576	6,264
Durham CCL	6,255	1,268	2,337	9,860
DDES CCG	**17,356**	**5,077**	**9,893**	**32,326**
Durham Dales CCL	5,949	1,495	2,946	10,390
East Durham CCL	5,724	1,947	3,842	11,513
Sedgefield CCL	5,683	1,635	3,105	10,423
County Durham	**33,501**	**8,707**	**16,793**	**59,001**

Source: Census 2011

SUBSTANCE MISUSE

Durham County Council works in partnership to reduce the harm caused by alcohol and drugs; protect communities; and address the preventative, treatment and control elements of substance misuse. This work is coordinated through the public health team. (Also see section on alcohol and substance misuse harm reduction in the Altogether Safer section and section on substance misuse in the Altogether Healthier section).

The County Durham Health Profile 2014 shows the estimated number of drug misusers in 2010/11 was 7.0 per 1,000 population aged 15-64 years in County Durham; this is significantly better than the England average (8.6).

The following information provides an analysis of the health and social care needs of adults with drug and alcohol needs in County Durham.

Referrals and assessments (including health and social care)
The total number of adults in County Durham referred with drug and alcohol needs during 2013/14 was 3,592; 59.6% in relation to alcohol and 40.4% in relation to drugs.

There has been a reduction in the number of people being referred and assessed for drug and alcohol needs when comparing the figures for 2010/11 and 2012/13. Referrals and assessments for those with drug needs reduced by 10.3% and 6.7% respectively, alcohol referrals and assessments reducing by 36.5% and 11.4% respectively. During 2012/13 the highest number of referrals for alcohol needs was recorded in Derwentside (300), whilst the highest number of referrals (319) and assessments (218) for people with drug needs was recorded in Easington.

Over half of all referrals and assessments for drug and alcohol needs in County Durham were for males.

Although the number of people being referred and assessed for drug and alcohol needs is reducing, information from North East & Cumbria Regional Analysis for sector led improvement identified that rates for County Durham hospital admissions for substance misuse in 15-24 year olds was 105.6 for 2009-12, per 100,000 population. The national rate was 69.4 and Stockton (60.4) was the best in the region.

When people start treatment for drug or alcohol misuse, it is recorded if they have a child / children living with them. However, this information is not updated throughout a client's treatment journey, which could last for several years, so if living arrangements change (such as children being taken into care or returned from care, or a client having a child) this is not recorded.

The data in Table 94 relates to the number of people in treatment in County Durham who reported living with a child / children at the start of the treatment journey.

Table 94: People in treatment in County Durham who reported living with a child / children

County Durham	2009/10	2010/11	2011/12	2012/13
Drugs	165 (30%)	152 (19%)	175 (23%)	140 (20%)
Alcohol	N/A	N/A	254 (20%)	222 (20%)

Note: The figure in () is the number of people in treatment in County Durham who reported living with a child / children at the start of the treatment journey in that year, as a percentage of the total number of new presentations to treatment in that year.

Ethnicity of adults with substance misuse needs in receipt of social care services 2013/14

In 2013/14, 99% of adults with substance misuse needs were from a white British background. The remaining 1% were from other minority ethnic groups.

ADULTS WITH MENTAL HEALTH NEEDS

The World Health Organisation defines mental health as being "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity".

Mental illness is usually categorised as:

- Severe and enduring mental illness (SMI) - this includes schizophrenia and bipolar disorder.
- Common mental disorder (CMD) - this includes a range of conditions such as depression / anxiety and obsessive compulsive disorder.

'New Horizons: A shared vision for mental health' (Department of Health, 2009) suggested that:

- At any one time, just over 20.0% of working-age women and 17.0% of working-age men are affected by depression or anxiety; approximately 5.0% of men and 3.0% of women can be assessed as having a personality disorder and over 0.4% have a psychotic disorder such as schizophrenia or bipolar affective disorders.
- Mental illness accounts for 20.0% of disability-adjusted life years, far more than cardiovascular disease (16.2%) and cancer (15.6%). By 2030, that figure is set to rise to 31.0%.
- Half of those with common mental health problems are limited by their condition and around a fifth are disabled by it.
- Over half of all adults with mental health problems will have begun to develop them by the time they were 14.

The World Health Organisation predicts that by 2020 depression will be the second leading cause of disability worldwide.

Mental health problems are associated with loss of social and economic functioning leading to a cycle of disadvantage. People with a severe mental illness:

- Are 3 times more likely to be in debt.
- Have the lowest employment rate for any group of disabled people (4.0% for people with schizophrenia).

Life expectancy is on average 10 years lower for people with mental health problems due to poor physical health. People with a severe mental illness are:

- 5 times as likely to suffer from diabetes.
- 4 times as likely to die from cardiovascular or respiratory disease.
- 8 times as likely to suffer from Hepatitis C.
- 15 times as likely to be HIV positive.

Improvements in the level of social networks can have a significant impact on mental wellbeing and have been shown to increase life expectancy as much as stopping smoking.

Referrals and assessments

Referrals for adults with mental health needs are made to Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV), which leads on the provision of mental health services in County Durham in partnership with Durham County Council (adult social care). Referrals are made to the integrated community adult mental health teams.

The number of adults referred and assessed with mental health needs increased year on year across County Durham, by 23.4% for referrals and by 22.9% for assessments when comparing 2010/11 figures with 2013/14. Sedgefield CCG locality was identified as having the highest rate of referrals and assessments per 1,000 population at 13.2 and 9.2 respectively.

Table 95: Number of adults referred with mental health needs across Clinical Commissioning Group Localities 2010/11 – 2013/14 (includes safeguarding referrals)

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11 – 2013/14	Population 18-64 – ONS 2012 population estimates	Referrals 2013/14 per 1,000 population 18-64
Chester-le-Street	275	351	326	402	46.2	32,984	12.19
Derwentside	559	639	603	620	10.9	56,288	11.01
Durham	467	557	587	498	6.6	62,972	7.91
Durham Dales	236	278	310	416	76.3	54,197	7.68
Easington	573	727	712	263	-54.1	58,122	4.52
Sedgefield	245	277	360	707	188.6	52,965	13.35
County Durham	**2,355**	**2,829**	**2,898**	**2,906**	**23.4**	**317,528**	**9.15**

Source: Tees, Esk & Wear Valleys NHS Trust (TEWV) 2014/

Table 96: Number of adults assessed with mental health needs across Clinical Commissioning Group Localities 2010/11 – 2013/14 (includes safeguarding referrals)

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2013/14	Population 18-64 – ONS 2012 population estimates	Assessments 2013/14 per 1,000 population 18-64
Chester-le-Street	200	281	287	273	36.5	32,984	8.28
Derwentside	422	510	511	386	-8.5	56,288	6.86
Durham	405	492	446	396	-2.2	62,972	6.29
Durham Dales	201	218	267	303	50.7	54,197	5.59
Easington	448	552	591	498	11.2	58,122	8.57
Sedgefield	235	223	321	492	109.4	52,965	9.29
County Durham	**1,911**	**2,276**	**2,423**	**2,348**	**22.9**	**317,528**	**7.39**

Source**:** Tees, Esk & Wear Valleys NHS Foundation Trust (TEWV) 2014/

Adult mental health professional assessments

Approved mental health professional (AMHP) assessments are carried out in relation to those people requiring a mental health assessment under the Mental Health Act 1983. To be detained under the Mental Health Act 1983, individuals need to be assessed as suffering from a recognised mental disorder of a nature or degree which warrants detention in hospital on the grounds of health or risk to themselves or others.

As shown in Table 97, the number of referrals for AMHP assessments for adults with mental health needs remained relatively static between 2011/12 and 2013/14.

Table 97: AMHP assessments for adults with mental health needs across Clinical Commissioning Group Localities 2010/11 – 2013/14

Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11 – 2013/14	Population 18-64 – ONS 2012 population estimates	AMHP assessments 2013/14 per 1,000 population 18-64
Chester-le-Street	38	42	44	55	44.7	32,984	1.67
Derwentside	79	78	96	80	1.3	56,288	1.42
Durham	85	113	99	98	15.3	62,972	1.56
Durham Dales	87	98	106	110	26.4	54,197	2.03
Easington	87	86	89	81	-6.9	58,122	1.39
Sedgefield	101	118	90	104	3.0	52,965	1.96
County Durham	**477**	**535**	**524**	**528**	**10.7**	**317,528**	**1.66**

Source: SSID 2014

Direct payments and personal budgets

In 2013/14, 74 adults with mental health needs were in receipt of direct payments

The number of adults with mental health needs in receipt of a personal budget increased by 116.4% from 61 in 2010/11 to 132 in 2013/14.

Table 98: Number of adults with mental health needs in receipt of a personal budget by Clinical Commissioning Group Locality / Constituency 2010/11 - 2013/14

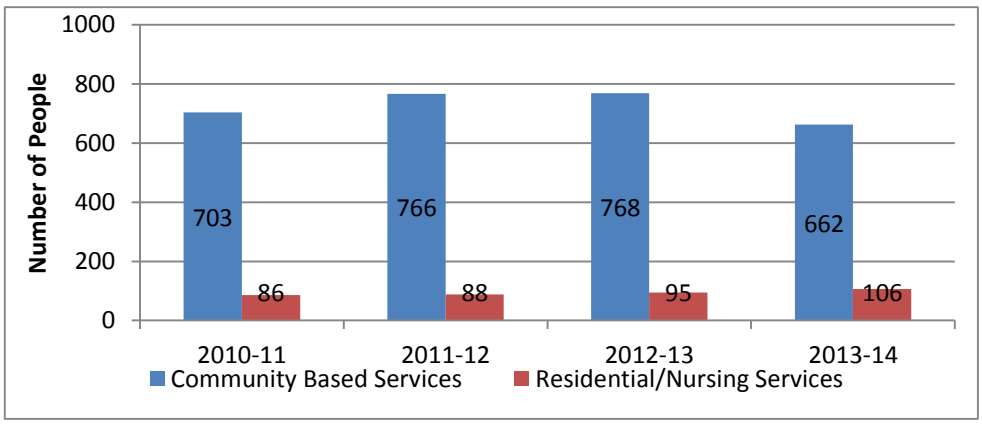
Clinical Commissioning Group Locality / Constituency	2010/11	2011/12	2012/13	2013/14	% difference 2010/11 – 2013/14	Population 18-64 – ONS 2012 population estimates	Personal budgets 2013/14 per 1,000 population 18-64
Chester-le-Street	3	12	15	20	566.7	32,984	0.61
Derwentside	8	22	19	16	100	56,288	0.28
Durham	11	37	19	18	63.6	62,972	0.29
Durham Dales	12	23	43	40	233.3	54,197	0.74
Easington	15	25	28	18	20	58,122	0.31
Sedgefield	9	29	26	20	122.2	52,965	0.38
County Durham	**61**	**148**	**150**	**132**	**116.4**	**317,528**	**0.42**

Source: SSID 2014

Community based services / residential and nursing services

Figure 81 shows that the number of adults with mental health needs helped to live at home and receiving services in the community decreased from 703 in 2010/11 to 662 in 2013/14 (5.8%) but has fluctuated over the four year period. Over the same time period, residential / nursing care has increased from 86 to 106 (23.3%).

Figure 81: Adults with mental health needs in receipt of community based / residential and nursing services 2010/11 – 2013/14



Source: SSID 2014

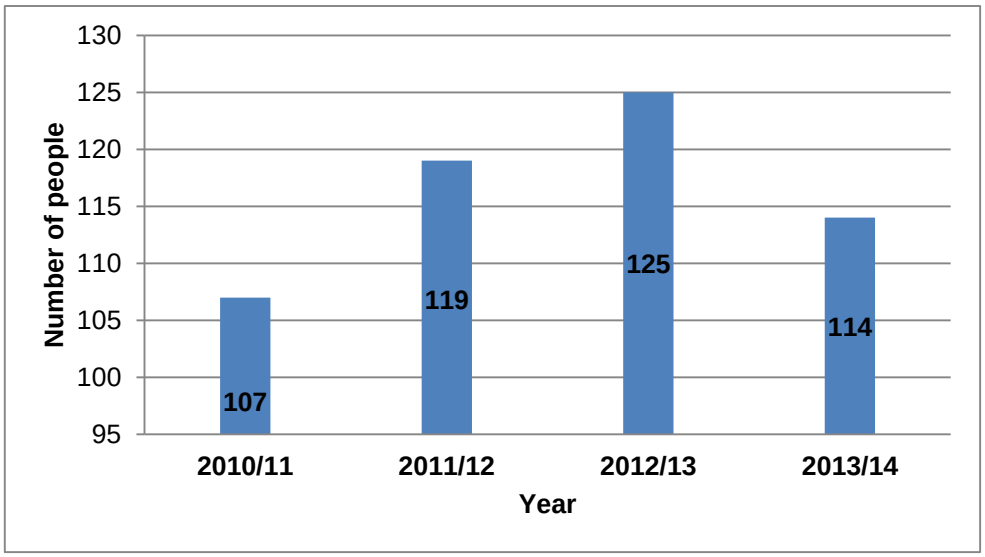
Community services
Adults with mental health needs are provided with a range of services in the community to help them maintain their independence and remain in their own homes, including home care and day care.

Home care and day care
Figure 82 shows that the number of adults with mental health needs who have received a home care service during the year has increased steadily from 107 in 2010/11 to 125 in 2012/13, but then fallen to 114 in 2013/14 (a change of 6.5% between 2010/11 and 2013/14).

In County Durham, 98 adults with mental health needs were receiving home care services, with 65 people receiving 10 hours or more per week.

In 2013/14, 304 adults with mental health needs were provided with day care, this is a decrease of 23.4% on the previous year's figures.

Figure 82: Number of adults with mental health needs receiving a home care service during the year 2010/11 – 2013/14



Source: SSID 2014

Ethnicity of adults with mental health needs in receipt of social care services – 2013/14
In 2013/14, 98.8% of adults with mental health needs were from a white British background. The remaining 1.2% were from white/other background and other minority ethnic groups.

3. Which groups are most vulnerable and why?

Some people are more vulnerable to poor health than others. Proportionate universalism has already been discussed within this document (The Marmot Review, *Fair Society, Healthy Lives)* and describes how just focusing on the most disadvantaged will not reduce health inequalities sufficiently. Actions must be universal but with a scale and intensity proportionate to the level of disadvantage.

This means that more vulnerable populations will require targeted support in addition to the services available to everyone, in order to achieve improved health outcomes.

Deprived communities
Socially deprived communities currently bear the greatest burden of ill health and disease in County Durham. This is generally accounted for by lifestyle behaviours which are causal factors for many of the main causes of morbidity and premature mortality (smoking, obesity, alcohol). Reasons for this unequal distribution include socioeconomic factors, such as higher rates of unemployment, poor educational attainment, poorer quality housing, as well as lifestyle factors such as higher rates of smoking, higher rates of excessive drinking and poor diet.

Mortality rates for the 'big killers' in County Durham including CVD and cancer are unevenly distributed and are higher in the more deprived areas. COPD, obesity, diabetes, teenage conceptions, poor oral health are all unevenly distributed along the social gradient.

Smoking prevalence varies between population groups and its distribution within communities is unequal. It is more common in areas of greater deprivation.

Substance misuse is strongly associated with poverty and deprivation. The Advisory Council for the Misuse of Drugs report 'Drug Misuse and the Environment' has shown that the greater the level of deprivation in an area, the increased prevalence of substance misuse. Similarly, poor housing, or lack of access to affordable housing, is another contributory factor in drug misuse. Other important factors include educational disadvantage, criminal involvement, unemployment and low income.

Problems such as drug dependency, drug-related deaths, infections, crime and mental illness cluster together in areas which are particularly socially deprived. In County Durham the legacy of the loss of ready employment, especially male employment through mining and other industries, has left many communities vulnerable to the effects of substance misuse.

Older people
The number of older people is increasing nationally and locally due to improvements in health and social care.

Many long term conditions (LTCs) including cardiovascular disease (CVD), osteoarthritis, chronic obstructive pulmonary disease (COPD), diabetes, dementia and cancer tend to have a later onset, and so are likely to increase in prevalence as our population ages. Across the country as a whole, it is estimated that more than three quarters of people aged 75 years and older have one or more long term conditions, with more than a quarter having three or more. It is therefore reasonable to suggest that significant changes in the way services are provided will need to occur in order to ensure that the health and wellbeing needs of County Durham are met.

It is widely accepted that the stresses of living in poverty are particularly harmful to a number of vulnerable groups including older people. Income deprivation affecting

older people is defined as those adults aged 60 or over living in pension credit (guarantee) households as a proportion of all those 60 or over. Income deprivation for older people is a significant issue in County Durham where levels are greater than the England average. 35% of County Durham's LSOAs are in the worst 30% nationally for income deprivation affecting older people (ID2010).

Hospital admission as a result of a fall is predicted to increase by over 50% by 2030 in County Durham (POPPI 2014). When older people suffer from an accident or fall, it can significantly influence their physical and mental ability to recuperate and rehabilitate to their optimum health and social capacity.

A significant rise in the older population and in related mental health problems is predicted in the next 10-15 years. The effect of an ageing population will include an increase in the numbers of people living with dementia, their health and social care needs and the needs of their carers.

People with learning disabilities

Learning disabilities can lead to various health and wellbeing problems. The importance of poverty, poor housing, unemployment and social isolation as factors leading to poorer health are well known. People with learning disabilities are more likely to experience some or all of these factors.

People with learning disabilities experience lower life expectancy than within the general population and people with learning disability are more likely to have undiagnosed long term conditions. Research also shows that:

- People with learning disabilities take less exercise than the general population.
- Their diet is often unbalanced, with an insufficient intake of fruit and vegetables.
- People with learning disabilities can also find it hard to understand the consequences of lifestyle on their health and as a result are more likely to be either underweight or obese than the general population.
- Young people with mild learning disabilities have higher rates of smoking than their peers which can consequently lead to poor health.
- Large numbers of people with learning disability are unwaged; nationally evidence shows that they are more excluded from the workplace than any other group of disabled people.
- Coronary heart disease (CHD) is the second most common cause of death in people with learning disabilities.

People with autism

In March 2010 the government published 'Towards Fulfilling and Rewarding Lives: A Strategy for Adults with Autism in England'. The strategy highlights the lack of understanding of adults with autism, the barriers they face in trying to find employment and access services, and the need for partner agencies to ensure that all services respond to people with autism in an appropriate way.

Older people with learning disabilities
As the population aged 65 years and over grows and adults with learning disability live longer, the number of people in the population with learning disabilities will also increase. As they grow older, their carers will also age and will therefore be more likely to need services themselves.

There is evidence that dementia affects adults with a learning disability more than it affects other people (13% of people aged 50 and over, and 22% of people aged 65 years and over). Approximately 20% of adults with a learning disability have Down's syndrome and the predicted incidence rate of dementia is even higher.

POPPI estimates show that the number of older people aged 65 and over predicted to have autism spectrum disorders is expected to increase by 41.9% from 87,942 in 2014 to 124,822 in 2030.

People with physical disability / sensory support needs
For people with sensory loss, communication has particular and unique problems and specialist skills and equipment are often required to facilitate appropriate access to health and social care. Provision of specialist information is needed for people with sensory loss in a variety of different formats.

Children with physical disabilities / sensory support needs
Children with physical disability / sensory support needs require support services through the transition from children's services to adult services.

Carers aged 18-25
A needs assessment of carers aged between 18 and 25 was commissioned by Durham County Council and NHS County Durham and Darlington and carried out by Barefoot Research and Evaluation. Findings from the report published in September 2010 stated that:

- Young adult carers are a hidden group because they do not present themselves for services.
- Young adult carers respond to proactive, energetic and persistent outreach.
- Young adult carers commonly suffer from social isolation, an absence of friends and feel that they have no independence.
- Many carers are unable to secure employment because of their caring role and must rely on state benefits to survive.
- Caring can often affect the health of carers, particularly their mental health.

Research undertaken recently by Teeside University (2014) with the project in County Durham working with young adult carers identified over 550 young people over the 3 years of the project, around 200 of whom received intensive levels of support.

Young adult carers valued the reliability and practicality of the service, and appreciated their central place in determining the nature of interventions offered.

The project helped young people to contain and manage their caring role, to feel better about themselves and their life options, and to develop plans for the future.

The project equipped young adult carers in Durham to realise their potential.

Older carers
'As long as they need me: Supporting Older Carers in County Durham', published in February 2011 is a report of a study carried out by Age UK (County Durham) on behalf of Durham County Council to support the Joint Commissioning Strategy for Carers 2009-13. The study set out to explore the experiences, needs and aspirations of carers aged over 65 years in County Durham and identified a number of gaps in services and opportunities for improvement.

Some of the key findings were that:

- There is a stigma attached to asking for help when the caring role is associated with mental ill-health, dementia, alcohol or drug misuse.
- The information and support needs of older carers change as they get older.
- Gaps in services include a need for practical help around the home and help with finding and having access to gardeners, mobile hairdressers, decorators and cleaners.

Carers who are in / taking up employment
The national carers strategy (*Carers at the Heart of 21st Century Families and Communities 2008)* placed a large emphasis on supporting carers in gaining and maintaining employment. If a carer needs replacement care in order to gain or maintain employment, this should be considered as part of the assessment process and appropriate replacement care may be arranged, linked to assessed need. Jobcentre Plus provides funding for replacement care for carers attending approved employment related activities.

Young carers
Young carers are particularly likely to remain hidden. Systems are in place in County Durham to ensure that the needs of young carers, where identified, are included in social care assessments of adults, in order to recognise and protect young carers from inappropriate levels of caring.

Within County Durham, there are estimated to be 1,458 young carers, 26% of whom reside in the North Durham locality (Carers Joint Commissioning Strategy 2009-13).

Recently published Census results for 2011, shows that there are 4,201 young carers in County Durham between the ages of 0 – 24, which represents 3% of the 0 – 24 population.

People with learning disabilities and mental health needs
'How People with Learning Disabilities Die' (Learning Disabilities Observatory, 2011) makes several statements about the relationship between cause of death for people with learning disabilities and mental health. In terms of the relationship between mental health conditions and learning disabilities, the report states that there are several conditions more commonly associated with people with learning disabilities. The relationships include Down's syndrome and unspecified dementia, Down's syndrome and Alzheimer's disease and learning disability with no specified condition, and schizophrenia.

'Health Inequalities and People with Learning Disabilities in the UK: Improving Health and Lives ' (Learning Disabilities Observatory, 2011) states that the prevalence of psychiatric disorders is 36% among children with learning disabilities, compared to 8% among children without learning disabilities. Challenging behaviours (aggression, destruction, self-injury and others) are shown by 10%-15% of people with learning disabilities, with prevalence peaking between ages 20 and 49. The report also states that anxiety and depression are particularly common amongst people with Down's syndrome and that adults with a learning disability who have Attention Deficit Hyperactivity Disorder (ADHD) have been shown to be more severely affected by mental health problems and less likely to improve over time than other people with ADHD.

People with substance misuse and mental health needs

Mental health problems are often linked with other contributing factors such as substance misuse. In the Department of Health's "Dual Diagnosis Good Practice Guide" it states that *"substance misuse is usual rather than exceptional amongst people with severe mental health problems*". It should be noted, however, that the above report relates only to people with severe mental health problems and not those with more common mental health problems like anxiety and depression.

Dual needs is the term used when people have concurring mental health and substance misue problems. In County Durham in 2013/14, 266 individuals (16%) accessing community alcohol services had reported dual needs, while 271 individuals (13.7%) accessing the community drugs service had reported dual needs.

People with dementia

Dementia presents a significant and urgent challenge to health and social care in County Durham in terms of both numbers of people affected and costs. It is a clinical syndrome characterised by a widespread loss of mental function, including memory loss, language impairment, disorientation, change in personality, self-neglect and behaviour which is out of character. One of the main causes of disability in later life, it has a huge impact on capacity for independent living.

The effect of an ageing population will include an increase in the numbers of people living with dementia, their health and social care needs and the needs of their carers. Dementia affects 5% of those aged 65 years and over and 20% of the over 80 year olds (Alzheimer's Society 2007).

Nationally, dementia is the main cause of mental health admissions to hospital amongst older people, accounting for 41% of all mental health admissions (21% unspecified dementia, 14% vascular dementia and 5% Alzheimer's Disease, APHO, 2008).

The national hospital admissions rate for dementia amongst 75-79 year olds is approximately 200 per 100,000 rising to around 600 per 100,000 at 85 and over. It is estimated that after the age of 60 the prevalence of dementia doubles every five years so that about 22% aged 85 and over and 30% of those aged over 95 are affected.

Local QOF data (2012/13) indicates:

- A prevalence of 0.6% for dementia in County Durham, marginally higher than England.
- Around 3,470 people in County Durham are on GP dementia registers. This is around half the number predicted to have dementia (by POPPI, 2014).
- This prevalence is predicted to increase in County Durham between 2014 and 2030. The population aged 60 and over with dementia in County Durham is predicted to rise from 6,625 in 2014 to 10,896 by 2030, an increase of almost 4,300 cases (64.5%). Typical of the situation across the country, the observed prevalence in GP surgeries (around 3,000 in County Durham) is around half the expected prevalence. This has implications in terms of lack of treatment and care.

This increase supports the estimated prediction that the numbers of people with dementia in England is set to double in the next 30 years (Prime Minister's Challenge on Dementia).

Admissions of people with dementia

Admissions of people with dementia very often come with other conditions which require treatment, or are a factor which may influence the person with dementia's care or recovery. An analysis of data from April 2013-February 2014 showed that very few patients are admitted to acute hospitals with a primary diagnosis of dementia (2.2%), however 32% of admissions was deemed of sufficient importance to causation / care that dementia is one of the first three recorded diagnoses. 66% of admissions had dementia coded as one of the five most relevant diagnoses recorded.

This means, two thirds of all people admitted to acute hospitals who have dementia, will usually have the dementia recorded as a secondary condition. Where dementia is given as one of the first few recorded diagnoses, this should represent dementia being a significant contributor to causing admission or having a significant impact on the patient's care.

Readmission of people with dementia to non-mental health providers

Taking necessary steps to reduce the readmission of patients with dementia is a key focus. As explained above, many admissions to non-mental health providers concern a co-morbidity of dementia with other conditions requiring treatment, or where dementia is a factor which may influence the patient's care or recovery. This presents a challenge for not only the community and acute providers, but for local services in taking steps to avoid unnecessary readmission to hospitals within 30 days and 90 days.

An analysis of data covering patients registered with a member practice of Durham Dales, Easington and Sedgefield Clinical Commissioning Group, North Durham Clinical Commissioning Group and Darlington Clinical Commissioning Group and unregistered patients within their boundaries shows an average 12% patients with dementia are readmitted to non-mental health providers within 30 days of discharge from a prior admission, and 20% within 90 days of discharge from a prior admission.

Table 99: Admissions within 30 days of discharge from a prior admission - May 2013 to February 2014

CCG / Point of Delivery	Admission within 30 days of discharge from prior admission	Admission NOT within 30 days of discharge from prior admission	Admission with readmissions status not known	Total	% of dementia related admissions in month that are 30 day readmissions
Darlington	43	364	2	409	10.5
Acute	43	343	2	388	11.1
Community Hospital		21		21	0.0
DDES	147	1123	7	1277	11.5
Acute	142	1061	6	1209	11.7
Community Hospital	5	62	1	68	7.4
North Durham	135	872	4	1011	13.4
Acute	122	778	4	904	13.5
Community Hospital	13	94		107	12.1
County Durham and Darlington	325	2359	13	2697	12.1

Table 100: Admissions within 90 days of discharge from a prior admission - May 2013 to February 2014

CCG / Point of Delivery	Admission within 90 days of discharge from prior admission	Admission NOT within 90 days of discharge from prior admission	Admission with readmissions status not known	Total	% of dementia related admissions in month that are 90 day readmissions
Darlington	72	335	2	409	17.6
Acute	72	314	2	388	18.6
Community Hospital		21		21	0.0
DDES	248	1022	7	1277	19.4
Acute	239	964	6	1209	19.8
Community Hospital	9	58	1	68	13.2
North Durham	229	778	4	1011	22.7
Acute	205	695	4	904	22.7
Community Hospital	24	83		107	22.4
County Durham and Darlington	549	2135	7	2697	20.4

The NHS Choices website states that regular physical activity can reduce depression by up to 30% and reduce dementia by up to 30%. Mental Health Foundation 2013 studies show that adults participating in daily physical activity have a 20-30% lower

risk for dementia. Physical activity also seems to reduce the likelihood of experiencing cognitive decline in people who do not go on to develop dementia.

Young onset dementia

The Alzheimer's Society (2002), estimates that there are about 18,500 younger people with dementia in the UK, suggesting that young onset dementia may occur in 1 in 1,400 people between the ages of 40 and 65. However the Society states that this is likely to be an underestimate and the true figure could be up to three times higher.

Figures in Table 101 are based on Local Authority mid-2006 estimates, using age range 40-64 to estimate prevalence rates against Alzheimer's Society suggested prevalence rates for this age range.

Table 101: Estimated prevalence of young onset dementia

Area	Population aged 40-64 years	Prevalence based on 1:1,400
County Durham	171,500	123

There are currently 203 patients younger than 65 who are open to services within County Durham and Darlington Mental Health Service for Older People. This particular group requires support from dedicated consultant sessions, dedicated and specialised psychological services, nursing and IT staff with skills in assessment and the management of young onset dementia.

Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) provides aspects of this service in County Durham and Darlington.

In South Durham and Darlington, whilst dedicated resources are in place, there remains a gap in provision for neuropsychology. Whilst patients receive a range of required interventions, the full complement of recommended interventions needs to be expanded.

In North Durham, there is currently no dedicated resource and limited specialist interventions, and patients with suspected young onset dementia are seen within community teams by generic staff. Activity information shows considerably lower numbers than in South Durham and Darlington where there is a dedicated resource. The current number of patients seen by the teams is also significantly lower than prevalence figures would suggest. It is recognised that the support offered to people with young onset dementia could benefit from being connected to other services for rare conditions, such as Huntington's disease which has some symptoms of dementia. It is also recognised that staff providing young onset dementia services would benefit from having access to a single point of information to enable them to support the person with dementia and their carers at the earliest opportunity.

Plans are in place to expand the range of support. It is understood from past experience that when a dedicated resource has been put into place, an increase in referral rates from GPs follows, as has been the case in South Durham and

Darlington. This is largely owed to the fact that young onset dementia is recognised as a gap by GPs and other service providers.

Young people with dementia

There are sometimes significant age-related barriers for younger people trying to get access to dementia services. Where services are open to younger users, these may not be appropriate to their needs. Younger people often feel that they are made to 'fit in' to a service, rather than the service fitting their needs.

'Health Inequalities and People with Learning Disabilities in the UK' (Learning Disabilities Observatory, 2011) highlights that people with Down's syndrome are at particularly high risk of developing dementia, with the age of onset being 30-40 years younger than that for the general population.

Migrants

While the vast majority of migrants enjoy good health, there are some key challenges facing services and some migrant groups. There is also a statutory requirement that their needs should be taken into account when planning services and on economic and public health grounds.

The physical health needs of migrants are affected by the background levels of diseases, health behaviours and health services in countries of origin, as well as the reason for migration. Economic and educational migrants tend to be drawn from healthier and wealthier populations in any country, whereas those arriving as asylum seekers or refugees may have experienced deprivation, disease and disaster, often arriving in the UK with greater and more immediate health needs. Currently data provide only limited information on the physical health needs of migrants in County Durham. This is due both to a failure to capture and a failure to record the migrant status and/or country of origin of individual patients.

Vaccine-preventable diseases represent a specific challenge. Many migrants come from countries where childhood vaccination programmes are poorly administered or differ from UK programmes, and have different experiences of endemic diseases. One of the most pressing issues for primary health care clinicians concerns non-UK schedules of immunisation for new registrations who are migrants. Finally, health behaviours, such as smoking, differ across countries and migrants import such behaviours.

Mental health needs is a key issue among migrants. However, it is important to recognise that different migrant groups have very different experiences of mental health issues. Asylum seekers and refugees are often fleeing persecution, violence, disaster, or disease and therefore have a greater risk of serious mental health problems. The nature of their journey to the UK and the conditions they experience on arrival can exacerbate the risk even further. Women and children among such groups are particularly vulnerable.

Although all migrants could be at risk of vulnerability, this is dependent on many factors including the circumstances which makes them a migrant, their circumstances in their country of origin, their experiences related to their journey to the UK as well as their experiences on arrival. Although most migrants may enjoy

good health and not require specific health and social care support or interventions, there will be certain groups within migrant populations who will be more vulnerable and should be identified and targeted with appropriate support and interventions.

Some of these more vulnerable sub-groups include:

- Women and children – women and children have specific needs with relation to health, education, housing, etc. They may be at greater risk of social isolation, having poor English skills and at greater risk of exploitation.
- Those with poor English skills – at risk of social isolation and will have significant barriers to access services.
- Asylum seekers – they may have been subject to, or in fear of, persecution in their country of origin. This might have been in the form of physical abuse and they may have had traumatic experiences before reaching the UK. Under the terms of the 1951 Geneva Convention, these individuals are only granted refugee status once this fear has been proven. These individuals may be living in constant fear of being returned to their country of origin at any time.
- Irregular immigrants – due to their 'illegal' status they are much less likely to be registered or access services, particularly routine services and may present late in crisis situations. Irregular immigrants may also have had traumatic experiences related to their journeys to the UK and may be at greater risk of exploitation.

Gypsy, Roma and Travellers

In County Durham the Gypsy, Roma and Travellers (GRT) community forms the largest single ethnic minority grouping in the area. However, due to a number of reasons, it has been historically difficult to both identify and engage with this community which has resulted in a poor understanding of their health and their health needs.

Analysis from the GRT Health Needs Assessment for County Durham and Darlington 2011 suggests that the health of gypsies and travellers deteriorates more rapidly in older age than the rest of the population. GRT appear over four times more likely to die between the ages of 55 and 74 years than the population as a whole.

Although often based on responses from small numbers of people, the findings of recent local Health Needs Assessments (HNAs) carried out in various parts of the country have tended to confirm that GRT suffer worse health than the general public in several respects:

- GRT face a range of inequalities in terms of employment opportunities, housing options, the criminal justice system, educational attainment, ill health and access to social care. Indeed there is much national evidence to suggest that they fare worse than other socially deprived and ethnic minority groups across all of these areas.
- Most GRT live in houses; managing sites and providing services there should represent only one element of a programme for working with the whole community.
- Around two thirds of GRT may be living in the private housing sector and one third in social housing but it is quite possible that people from a travelling

background make up a much more significant proportion of the community than is currently recognised.
- More research is also needed to establish whether GRT in permanent housing fare better or worse than those living on sites, and whether more should be done to increase the wellbeing of the majority living in housing, by finding ways of meeting their cultural needs.
- Evidence provided for the assessment suggests that literacy and school attainment generally are problems; they appear likely to be assessed as much less school-ready than other children.
- The health of GRT appears to deteriorate more rapidly in older age than the rest of the population.
- There appears to be a very distinct pattern of mortality, with GRT over four times more likely to die between the ages of 55 and 74 than the population as a whole.
- This pattern of increased mortality and relatively rapid deterioration in old age, but combined with a comparatively strong sense of wellbeing earlier in life, clearly presents a unique health promotion challenge which is being addressed in County Durham.
- Suicide rates are almost 7 times higher among GRT men compared with men in the general population.

4. What are people telling us?

The Assessment and Review Survey 2013/14 is sent to a random sample of service users in receipt of social care services who have had an assessment or review in the previous month. Results of the survey show that:

Older people
- 94.3% (390) of respondents reported that the help and support they received help them to have a better quality of life.
- 92.0% (390) of respondents reported that they were extremely, very or quite satisfied with the help and support they received.

Learning disability
- 97.4% (111) of respondents were very or fairly happy with the way staff help them.
- 97.4% (112) of respondents reported that the help and support they received help them to have a better quality of life.

Physical disability / sensory support
- 94.1% (80) of respondents reported that the help and support they received help them to have a better quality of life.
- 95.5% (84) of respondents reported that they were extremely, very or quite satisfied with the help and support they received.

Carers
Information from the 2012/13 DoH Carers Survey highlights that:
- 79.2% (209 of 390) of carers stated they felt always or usually involved or consulted.

- 84% (389 of 463) of carers were extremely, very or fairly satisfied with the help and support that they, and the person they cared for, had received in the last 12 months. This is higher than the England rate of 72.8%.
- 52% (252 of 485) of carers stated that they have as much social contact as they want with people they like. This is higher than the England result of 41.2%.
- 52.6% (250 of 475) of carers feel they have encouragement and support in their caring role. This is higher than the England result of 43.3%.
- When asked about their health, carers in County Durham responded that they had the following: Physical impairment or disability – 20.1%, Sight or hearing loss – 19%, A mental health problem or illness – 6.1%, A learning disability or difficulty – 2.0%, a long standing illness – 24.7%, other – 12.2%.

Reablement
Results from the Reablement Survey 2012/13 of users of the reablement service show that:

- 96.7% perceive their quality of life has improved.
- 96.1% perceive their confidence has improved.
- 97.6% are satisfied with the reablement service they received.

Local CAS Survey Programme

- 93.9% of adult social care users who responded to the local CAS survey programme between April and December 2014 reported that they have control over their daily lives.
- 94.1% of adult social care users who responded to the local CAS survey programme between April and December 2014 reported that they were 'extremely','very' or 'quite' satisfied with the care and support services they receive.
- Between April and December 2014, 92.7% of service users reported that the help and support they receive has made their quality of life better.
- 93.9% of adult social care users who responded to the local CAS survey programme between April and December 2014 reported that the care and support services they received helped them to feel safe and secure.

5. What are the implications for the future?

The negative effect of poverty and social, economic and environmental factors on the health and wellbeing of County Durham's population is a recurrent theme throughout this section. We know that health inequalities are affected by socio-economic conditions which exist within County Durham, such as lower household income levels, lower educational attainment levels and higher levels of unemployment, which lead to higher rates of benefits claimants suffering from mental health or behavioural disorders. This, combined with the current economic climate and imminent changes to welfare benefits, poses a significant and direct challenge. It is clear that improvements in health outcomes cannot be made without action in these wider determinants.

The distribution of lifestyle behaviour related to health (smoking, poor diet, harmful levels of alcohol consumption, lack of exercise) reflects the pattern of deprivation

within the county. A higher proportion of these deprived populations continues to smoke, drink alcohol excessively, has a poor diet and exercises less. These persistent and pervasive levels of deprivation suggest that demands on health and social care services will remain high.

An increasingly older population will present several challenges for both health and social care. These will include: rising prevalence of mental health conditions, dementia, increased levels of disability and long term conditions (LTCs) and will significantly increase the number of people needing to provide care to family members or friends. Population projections suggest that these carers themselves are likely to be older, with a significant increase in the proportion of carers aged 75 and over providing unpaid care. This increasingly ageing population, combined with limited resources and the changing face of NHS and social care provision, may present a significant challenge.

Projections for people with dementia suggest that the estimated 6,625 people affected in 2014 could almost double to 10,896 by 2030 (POPPI, 2014). Typical of the situation across the country, the observed prevalence in GP surgeries (around 3,000 in County Durham) is around half the expected prevalence. This has implications in terms of lack of treatment and care.

Obesity poses a major health challenge and risk to future health and wellbeing and life expectancy in County Durham. Obesity increases the risk of heart disease, stroke, diabetes, hypertension and some cancers and can reduce life expectancy on average by nine years through premature death. It can also lead to social and psychological problems, for example depression and low self-esteem.

Diabetes is the condition which will increase most as the prevalence of obesity increases, and the number of people diagnosed with diabetes has been rising over time. Prevalence of type 2 diabetes is increasing locally (and nationally) to a considerable extent; this is because of the ageing population and increases in the prevalence of risk factors, in particular obesity.

Reducing health inequalities through delivering improved health outcomes requires health improvement and prevention programmes working across life course pathways, with citizens, communities and partners. It is essential to give a greater emphasis to prevention and early intervention and self-care, to support continued independent living.

It is vital to increase health improvement services in order to enable people not to develop LTCs, and for those with LTCs to remain healthier for longer.

Joint Commissioning Strategies are in place for a number of service user groups and, as part of the integration and transformation agenda in adult care services, both the council and NHS partners are working to provide and commission services which provide care closer to home, ensuring that people are supported to maintain their independence in their own home for as long as possible.

Requirements under the military covenant to improve mental health services and support for the armed forces community will need to be met.

There will be increasing demands for community equipment, as service users get older and continue to live independently in their own home. More choice and control will be required for service users to purchase their own care services through direct payments and personal budgets. Interventions such as reablement will also help delay or prevent the need for on-going support and care, when age and health related needs are rising.

6. Key messages

The health and wellbeing of County Durham's population is greatly shaped by a wide variety of social, economic and environmental factors (such as poverty, housing, ethnicity, worklessness, place of residence, education, environment). It is clear that improvements in health outcomes cannot be made without action in these wider determinants.

Health inequalities are affected by socio-economic conditions which exist within County Durham such as lower household income levels, lower educational attainment levels and higher levels of unemployment, which lead to higher rates of benefits claimants suffering from mental health or behavioural disorders. Local priorities for tackling these inequalities include reducing smoking, tackling childhood and adult obesity, promoting breastfeeding, reducing alcohol misuse, reducing teenage conceptions (and promoting good sexual health), promoting positive mental health and reducing early deaths from heart disease and cancer.

By tackling the big lifestyle issues which are at the root of many of these problems, the number of early deaths can be reduced. These lifestyle factors include stopping or reducing smoking, promoting safe and sensible drinking, getting people to be more active and improving their diet.

- Life expectancy at birth in County Durham has been improving over time for both males and females, although not as fast as England. The absolute gap is increasing for both males and females.
- In County Durham, males born in the most affluent areas will live 7 years longer than those born in the most deprived areas. Females born in the most affluent areas will live 7.2 years longer than those born in the most deprived areas.
- The healthy life expectancy for County Durham is significantly worse for both males (58.7) and females (59.4) than for England (63.4 and 64.1 respectively).
- There is a need to identify those who are, or who are at risk of becoming, socially isolated. There is a role for communities and individuals to support isolated people at a local level, and to build resilience and social capital in their communities.
- County Durham supports 86% of adults with a learning disability within settled accommodation. This compares favourably to both the England average of 74.8% and the North East average of 80.8%.
- In 2013/14 there were 293 adults with autism aged 18-64 years in County Durham, a 3% increase on 2012/13.

- Information from PANSI suggests that by 2020 in County Durham, there will be 3,104 people (18-64) predicted to have Autism Spectrum Disorder.
- The number of people who will be living with sight loss in County Durham is set to increase over the coming decade. Current estimates suggest that over 8,300 people in County Durham have moderate or severe visual impairment.
- 3,437 people are registered as blind / visually impaired with Durham County Council (as of July 2014).
- Estimates suggest that by 2020 the number of people aged 75+ in County Durham with a registerable eye condition will rise to 3,379 (from 2,746 in 2012).
- Within 20 years of diagnosis, most people with Type 1 diabetes and almost two thirds of those with Type 2 diabetes will have some degree of retinopathy. Current prevalence is around 7% in County Durham.
- Estimated local costs of smoking to smokers themselves, to the NHS and society at large based on national data include:
    - 1,639 years of lost productivity, costing the local economy £28 million.
    - 93,822 lost days of productivity every year due to smoking-related sickness, costing around £9m.
    - The total annual cost to the NHS in County Durham as a direct result of smoking-related ill health is approximately £21m.
    - Passive smoking impacts on the health of non-smokers in County Durham, costing the local healthcare system a further £2m each year.
    - Current and ex-smokers who require care in later life as a result of smoking-related illnesses cost society an additional £13.1m each year across County Durham. This represents £0.5m in costs to the local authority and £5.6m in costs to individuals who self-fund their care.
- During 2013/14, 19.9% of mothers were smokers at the time of delivery compared to 20.9% regionally and 12% nationally.
- Smoking-related death rates per 100,000 (2010-12) were significantly higher in County Durham (372) than England (292). Annually around 1,100 people die in County Durham from causes related to smoking.
- Smoking related death rates have been falling over time in County Durham[9], between 2007/09 and 2010/12 the rate fell by 51.5 per 100,000 (12%).
- County Durham's Tobacco Profile (2013) estimates that 22.7% of adults smoke regularly, rising to 28.9% among people employed in routine and manual occupations, which equates to around 92,000 smokers age 18+ across County Durham.
- There were almost 30,000 people aged 18+ in County Durham with recorded diabetes (2013).
- Diabetes is the condition which is set to increase the most as prevalence of excess weight increases. Diabetes prevalence in County Durham has been increasing over time. Between 2006/07 and 2013/14 prevalence rose from 3.9% to 6.9%, (Quality Outcomes Framework, Department of Health), placing a significant burden on local health care. It should be stressed however that rising prevalence is not necessarily a bad thing, as it means less undiagnosed diabetes in the population and more people with the condition being in receipt of appropriate management. There were 29,680 people aged 17+ on practice

[9] The Smoking related mortality indicator in PHOF is new and cannot be compared to previous measures.

diabetes registers in 2013/14, with PHE estimating a further 2,700 being undiagnosed.

- Adult obesity in County Durham (27.4%) is not significantly different from England (23%) or the North East (25.9%).
- Excess weight in County Durham (72.5%) is significantly higher than England (63.8%) but not significantly different to the North East (68%).
- Being overweight and obese is more common in lower socioeconomic and socially disadvantaged groups, particularly among women.
- The 2014 Local Alcohol Profile shows that County Durham experiences:
    - Significantly higher under 18 alcohol specific admission rates than England. Rates have been falling over time in County Durham, the North East and England. Proportionally this decrease has been greater in County Durham 37% than the North East (35%) and England (34%).
    - Significantly higher alcohol-related admission rates (broad[2)] than England for men and women. Rates have been rising over time for men and women locally (8% men and 12% women), regionally (9% men and 10% women) and nationally (16% men and 18% women)
    - Significantly higher alcohol-related admission rates ($narrow_2$) than England for men and women. Over time rates have increased locally for men (1%) and women (5%) and nationally for men (4%) and women (5%). Regionally rates have experienced little variation.
- Recorded prevalence of many long term conditions is greater in County Durham than England (CHD, hypertension, COPD, diabetes).
- Although disease prevalence in County Durham is higher that England we know that there are considerable gaps between the number of people known to health services compared to the expected numbers with long term conditions including circulatory diseases (heart disease, stroke, high blood pressure), respiratory diseases (chronic obstructive pulmonary disease (COPD) and asthma) and diabetes. This suggests that there is a high number of people with undiagnosed disease in our communities, often referred to as ‘the missing thousands’.
- There are 4,604 people in County Durham registered with GPs with a diagnosis of mental illness (Quality Outcomes Framework 2012/13). This is around 0.9% of the registered population of County Durham, the same as England. This prevalence is predicted to increase significantly over the coming years due to a variety of factors including an ageing population and the challenging economic climate.
- For the period 2011/13, the suicide rate per 100,000 in County Durham (13.4) was significantly higher than England (8.8). Between 2001 and 2003, and 2011 and 2013 suicide mortality rates in County Durham have seen no significant variation.
- The number of assessments carried out under the Mental Health Act 1983 for adults with mental health needs has remained relatively static over the last 3 years with 535 in 2011/12 ,524 in 2012/13 and 528 in 2013/14.
- In County Durham in 2013/14, 266 individuals (16%) accessing community alcohol services had reported dual needs, while 271 individuals (13.7%) accessing the community drugs service had reported dual-needs. (Dual

needs is the term used when people have concurring mental health and substance misuse problems).

- Durham Tees Valley Probation Trust research includes two Health Needs Assessments (HNA) in 2008 and 2011. The 2011 HNA found that offenders need support with four main issues:
    - mental health (depression, stress, anxiety)
    - smoking
    - dental issues
    - anger management.
- The research shows that across the Probation Trust area, concerns regarding mental health increased in 2011, anxiety/stress increasing from 23.1% in 2008 to 30.1% in 2011 and depression increasing from 24.1% in 2008 to 29.9% in 2011.
- The armed forces community in the UK is made up of approximately 10.5 million people. Over half (52%) of the armed forces community report having a long-term illness or disability, compared with 35% in the general population (Joint Health Overview and Scrutiny Committee of North East Local Authorities report on the regional review of the health needs of the armed forces community).
- The presenting issues recorded in October 2013 by the Veteran's Wellbeing Assessment and Liaison Service (VWALS) team were wide-ranging. The most common was low mood, which made up 22% of the total recorded concerns, followed by sleep difficulties (11%) and distressing recurring memories or nightmares (8.5%). Non-mental health specific issues including employment, finances and housing each made up 6-7% and suicidal thoughts, plans or significant risk to others made up 5% of the total recorded concerns.
- Although the provision of residential care is decreasing in County Durham; there is 6.4% more people per 100,000 population supported in residential care when compared to the North East. When comparing April 2011 to March 2014, with the number of residential bed days commissioned each four week period for older people, there is a decrease from 38,710 to 34,366 (11.2%)
- As people are supported in their own homes for longer, the average age of permanent admission for older people into residential care continues to show a steady increase from 85.5 years in 2010/11 to 86.63 years in 2013/14. From 2010/11 to 2013/14 the length of stay in residential care has risen which reflects the fact that people are living longer.
- In 2014, figures indicate that 89.4% of older people were still at home 91 days after discharge from hospital. This is higher than both the North East figure (87.2%) and England (81.9%).
- In County Durham, between 1st April 2013 and 31st March 2014, there were 1,450 referrals to the reablement service, an increase of 7.3% on the previous year (1,351).
- POPPI estimates that in County Durham the future local carer profile of older people who are carers will be as follows:
    - By 2030, the number of carers aged 65 years and over providing care between:
        - 1-19 hours per week is set to increase by 25.9% (from 5,729 to 7,214)
        - 20-49 hours per week is set to increase by 30.1% (from 2,094 to 2,725)

    - 50 or more hours per week is set to increase by 34.6% (from 7,087 to 9,541).
- Nationally and regionally there has been a reduction in the number of carers receiving a service; however, in County Durham, there is an increase of 2% from 5,040 in 2010/11 to 5,267 in 2013/14.
- In County Durham, overall satisfaction of people who use services for their care and support increased from 64.3% in 2012/13 to 67.10%. This is above the England average (64.9%).
- Annually around 500,000 people die in England, almost two thirds of these are aged over 75 years. Some people receive excellent care at the end of life, many do not. The majority of deaths (58%) occur in NHS hospitals, while 18% occur at home, 17% in care homes, 4% in hospices and 3% elsewhere.
- In County Durham, around 5,300 people die each year from all causes; around two thirds of these are aged over 75 years (similar to the national experience). The 2012 National End of Life Care profile for County Durham states that for the period 2008-2010:
    - 54% of all deaths were in hospital
    - 22% occurred at home
    - 19% occurred in a care home
    - 3% were in a hospice
    - 3% were in other places.
    - 29% of all deaths were from CVD
    - 29% of all deaths were from cancer
    - 28% of all deaths were from other causes
    - 15% of all deaths were from respiratory diseases.
- For the period 2013/14 in County Durham:
    - 96% of people who stated their preferred place of death achieved it in the North Durham Clinical Commissioning Group area.
    - 83% of people who stated their preferred place of death achieved it in the Durham Dales, Easington and Sedgefield Clinical Commissioning Group area.

Altogether Healthier

Summary of Key Indicators

Indicator / Measure	Number / %	Performance	Time Period	England	Benchmarking
All age all cause mortality	Directly age standardised rate per 100,000	**596.2**	2012	523.9	592.8 (North East SHA)
Premature (under 75) all cause mortality	Directly age standardised rate per 100,000	**294.6**	2012	256.4	298.3 (North East SHA)
Premature (under 75) cancer mortality	Directly age standardised rate per 100,000	**122.1**	2012	105.3	123.6 (North East SHA)
Premature (under 75) CVD mortality	Directly age standardised rate per 100,000	**59.3**	2012	56.0	64.7 (North East SHA)
Mortality from COPD (all ages)	Directly age standardised rate per 100,000	**38.1**	2012	26.6	37.0 (North East SHA)
Four week smoking quitters	Rate per 100,000 population (16years +)	**1,165**	2012/13	868	1,169 (North East SHA)
Smoking at time of delivery	% of maternities smoking at delivery	**19.9**	2012/13	12.7	19.7
Deaths at home (from all causes)	% of all deaths	**23.4**	2010-12 (pooled)	21.6	22.1
Cervical cancer screening	% of total eligible population screened	**77.7**	2013	73.9	75.9 (North East)
Adults in contact with secondary mental health services living independently with or without support	Percentage	**90.2%**	2013/14	60.9%	58.7% Statistical Neighbour, 41.5% N.East
Adults in contact with secondary mental health services in employment	Percentage	**10.9%**	2013/14	7.1%	6.0% Statistical Neighbour, 6.8% N.East
Percentage of people who use adult social care services stating they are 'extremely' or 'very happy' with their care and support	Percentage	**67.1%**	2013/14	64.9%	65.4% Statistical Neighbour, 67.6% N.East
The % of people reporting that the way I'm helped and treated makes me think and feel better about myself	Percentage	**61.7%**	2013/14	60.3%	60.1% N.East
Social care service users offered self-directed support	Percentage	**60.1%**	2013/14	62.1%	54.7% Statistical

Indicator / Measure	Number / %	Performance	Time Period	England	Benchmarking
(direct payments and individual budgets)					Neighbour, 60.6% N.East
Proportion of older people who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Percentage	**89.4%**	2013/14	81.9%	85.3 Statistical Neighbour, 87.2% N.East
Proportion of adults with learning disabilities who live in their own home or with their family	Percentage	**86.1%**	2013/14	74.8%	81.9% Statistical Neighbour, 80.8% N.East
Number of carers (all service user types) receiving a specific carers service as a percentage of service users receiving community based services	Percentage	34.0%	2013/14	33.5%	31.9% N East
Overall satisfaction of carers with social services, expressed as a percentage,	Percentage	**47.9%**	2012/13 (No carer survey 2013/14)	42.7%	46.1% Statistical Neighbour,48.9 % N.East
Adults with learning disabilities in employment	Percentage	2.7%	2013/14	6.8%	5.0% Statistical Neighbour, 5.5% N.East

KEY

	County Durham is better than England Average
	County Durham is similar to the England Average
	County Durham is worse than England Average

Altogether Safer

1. Introduction

Crime and disorder has both direct and indirect effects on health and there is a strong correlation between poor health and high levels of crime.

A number of strategies have been developed both by the Safe Durham Partnership and nationally since the JSNA 2011 and information contained within these has been included in the summary below.

As well as confirming the Safe Durham Partnership's long term priorities, the Safe Durham Partnership Plan 2014-17 outlines the strategic key areas for improvement which the partnership will focus on over the period of the plan. These are:

- Reduce anti-social behaviour
- Protect vulnerable people from harm
- Reduce re-offending
- Alcohol and substance misuse harm reduction
- Embed the Think Family approach
- Counter terrorism and prevention of violent extremism
- Road casualty reduction

The Safe Durham Partnership Strategic Assessment 2014 monitors progress against the Safe Durham Partnership Plan and identifies shifts in the risk and threats to the communities of County Durham in terms of crime and disorder.

Safeguarding adults is a key priority for Durham County Council. All adults should be able to live free from fear and harm and have their rights and choices respected. The Safeguarding Adults Board operates a zero tolerance approach to all forms of abuse and is committed, with other partners, to preventing the abuse of adults and responding promptly with other partners when abuse is suspected.

2. What are the levels of need?

Anti-social behaviour
The Strategic Assessment 2014 identifies that within County Durham incidents of ASB recorded by the police were as follows:

- 45,249 in 2010/11
- 33,718 in 2011/12
- 25,496 in 2012/13
- 24,234 in 2013/14.

The highest number of incidents and the highest rates of ASB are found in the areas of Easington and Sedgefield.

Since the end of 2010/11, the number of police reported ASB incidents across the county has reduced from 45,249 to 24,234 – a fall of 46%.

The Safe Durham Partnership Strategic Assessment 2014 identifies that County Durham experienced a reduction of 4.9% in police recorded ASB in 2013/14. Other force areas across the country have also seen continuous reductions in ASB.

The November 2010 Residents Survey in County Durham reported feelings of safety to be very high: 97% of people felt very/fairly safe in their local area during the day and 81% felt safe in the evening/night. 10% of residents felt unsafe in their local area at night. 71% of respondents felt that the police and the council were good/very good at dealing with crime, with just 12% feeling they were poor/very poor. However, this survey omits reference to ASB.

The Strategic Assessment 2014 highlights results from the Police Survey which shows that, by December 2014, 57.3% of respondents said that they were confident that the council and police are dealing with crime and ASB.

Council recording of ASB shows that the number of requests for services in relation to ASB recorded in 2010/11 was 19,351. In 2011/12 the number of service requests increased to 21,945, in 2012/13 that number decreased to 18,279 and in 2013/14 it reached 20,696.

The reasoning behind the disparity between public perception / confidence and levels of crime and ASB is not always clear. This is compounded by the fact that different local surveys can provide conflicting results. There are generic measures of best practice which can be adopted in terms of increasing positive perception and confidence in services. These are represented in the Safe Durham Partnership Communications Plan, Media Protocol and minimum standards of service for dealing with ASB, although there are no quality-based data to identify performance against best practice or standards of service.

PROTECT VULNERABLE PEOPLE FROM HARM
(Also see reducing serious and violent crime section for additional information.)

Domestic abuse
Levels of domestic abuse related incidents reported to the police have seen a continuous but small increase, with 10,209 incidents in 2009/10, 10,425 in 2010/11, 10,865 in 2011/12, 11,084 in 2012/13 and 11,550 in 2013/14.

The number of adults accessing outreach support from domestic abuse services in 2013/14 was 1,332.

Due to changes to police recording methods, it is no longer possible to provide data on the number of domestic violence related serious assaults and attempted murders. However, Table 102 shows domestic abuse related serious violence during 2013/14.

Peterlee has the highest rate of domestic abuse related serious violence.

Table 102: Domestic abuse related serious violence by Clinical Commissioning Group Locality / Constituency 2013/14

Locality	2013/14	Rate per 1,000	Population Estimates
Chester le Street	154	2.8	54,116
Dales	242	2.7	90,017
Derwentside	254	2.8	91,720
Durham	186	2	94,280
Sedgefield	246	2.8	87,750
Easington	323	3.4	95,111
County Total	**1405**	**2.7**	**512,994**

Source: Durham Constabulary

Table 103 shows the percentage of domestic violence victims, who are repeat victims, being managed through the Multi-Agency Risk Assessment Conferences (MARAC). County Durham tracks consistently below the England and North East comparators.

Table 103: Repeat incidents of domestic violence (referrals to MARAC)

Year	County Durham	England	North East
2010/11	8%	22%	26.8%
2012/13	12.6%	24%	27%
2013/14	8.9%	24%	27%

Distraction burglary

County Durham recorded 23 distraction crimes for the period 2010/11. The most common modus operandi (MO) utilised were water board, gas and social care / council. Information provided by 'Operation Strongbow' highlights that the North East continues to be the highest performing region, with a 36% detection rate for 2010/11, which is a 6.0% improvement from 2009/10; the national average is 19%. In 2013/14 the number of distraction burglaries halved to a total of 12 and a detection rate of 47%.

Shoplifting

There is some evidence to suggest that the reason non-professional shoplifters are offending is due to difficult economic times.

The May 2014 Safe Durham Partnership Performance Escalation report provided additional potential links with welfare reform. In 2013/14, 13,959 people (9,411 adults and 4,548 children) received food provisions from food banks operating within the County Durham Food Bank group, more than double the number in 2012/13 (6,003). This follows a rising trend in the demand for food bank support. The

reasons for people accessing food banks indicates that this is predominantly linked to benefit delays (38%), benefit changes (21.6%) and low income (16.3%). Food banks have been most utilised by single people without dependants (50%) of all those accessing the service in this period, single parents (16%), families (15.2%) and couples (14.4%).

'Theft offences' is a high volume category and accounted for 11,727 recorded offences in 2013/14; a 7.3% rise against 2012/13.

Shoplifting increased by 8% in 2013/14. 2014/15 projections for theft offences show reductions for the majority of individual theft categories, however shoplifting is forecast to increase by 22.1% in 2014/15. This is deemed to be significant.

The Durham Constabulary Force area shows a rate of shoplifting (5 per 1,000 population) below that of the national average. Darlington is included in this rate. However, Darlington has a rate (10 per 1,000 population) twice that of County Durham.

Durham Constabulary has carried out analysis of shoplifting for the period of January to June 2013 and 2014. The following represents a summary:

Retailer Perceptions (35 stores):

- 54% of stores perceived a change in shoplifting over the last 6 months, 51% cited an increase in shoplifting levels.
- Current economic climate was cited most frequently as cause of change.
- Food (24) was cited most frequently as item(s) stolen, followed by alcohol (7). Within the food category meat was identified most frequently (8).

Offender Profile:

- Under 17 age group has seen a 9% increase in offending levels - with females seeing the biggest increase – 5% of this age category in 2013 to 17% in 2014.
- The 18-24 age category has seen a 7% decrease in offending levels.
- 25-34 year olds represent the largest proportion of offenders, however proportions are decreasing, 33% in 2013 and 42% in 2014.
- Males within the 35-44 age category have seen an increase of 9% offending levels.
- Females within the 45-54 age category have seen an increase of 5% in offending.
- In 2013 top ten offenders accounted for 6.3% (76) of all crimes in 2014 the figure was 10.7% (136). This point is further illustrated that the number of offences committed by 'top' offender had increased from 10 in to 2013 to 19 in 2014.
- Proportion of offenders with only one crime was 41% in 2013 and 42% in 2014.

Location:

- 3 of top ten stores were not part of the Shop Watch.
- All top ten offenders between Jan-Jun 2014 offended in the locality where they live.

Property:

- Between 2013 and 2014 the top 5 categories of items stolen were; food, alcohol, toiletries and clothing. The proportion of food stolen had increased by 5% whilst alcohol had reduced by 5%.

Hate crime
A Hate Crime Problem Profile has been developed and an action plan has been produced based on the findings.

The profile identifies the following issues:

- It is difficult to accurately measure the amount of hate crime which occurs in County Durham due to under-reporting.
- Hate crimes range from verbal abuse to serious violence.
- Hate crime cannot be solved in isolation, there needs to be two strands to all work that is done: one directly focused on hate crime (encourage reporting, support victims and target offenders); with a second strand aimed at developing community cohesion (providing education, awareness, and encouraging understanding to all members of the wider community).
- A negative experience with police (either experienced personally or known to have happened to other members of the community) has a big impact on whether or not someone will report a hate crime.

Serious and violent crime
Victims of rape and sexual violence are diverse but the most vulnerable in our society are overrepresented and these include children and young people. Perpetrators can repeatedly abuse and rape the same victim and/or commit rape or other sexual assaults against different victims. Stranger rapes are very rare. Sexual Violence remains often unreported therefore it is difficult to accurately identify the scale of the problem in County Durham.

A joint Sexual Violence Strategy for County Durham and Darlington 2011-14 is in place and is currently being refreshed. A rape profile was carried out in order to inform the development of the strategy. The profile identified the following:

- In just over half of all reported rapes, the victim was a young person under the age of 16 years. 21% of these were under the age of 13 and their relationship with the offender was most commonly that of a family member or an acquaintance.
- 31% of victims were aged between 13 and 15 years old. Over a third (36%) of the victims were in a consensual relationship with the offender; of the remainder, the most common relationship was that of acquaintance.
- The vast majority (71%) of male victims were under the age of 13 at the time of crime.
- The majority of child abuse rapes were historic when reported, 21% were acute (i.e. happened within the last 72 hours).
- Rape causes severe and long lasting harm to survivors including physical injury, sexually transmitted infections and unwanted pregnancy. Long term consequences can include post-traumatic stress disorder, anxiety and panic attacks, depression, social phobia, substance misuse, eating disorders, self-harm and suicide.
- It causes harm to society. The overall cost to society nationally is estimated at more than £8 billion each year.
- Victims do not always get the support they need. It is estimated that around 90% of people who suffer rape do not tell anyone about it.
- Where victims do try to access support, it is not always available.

- It is an important and dangerous element of domestic abuse (links to domestic abuse section). Rape is associated with the most severe cases of domestic abuse and is a risk factor for domestic homicide.
- It is difficult to assess with any accuracy the levels of sexual violence within the county due to under-reporting.

Locally, the profile highlights that within County Durham and Darlington there are an average of 120 rapes and 300 other instances of sexual violence recorded each year, which suggests significant under-reporting. Therefore it is difficult to assess with any accuracy the level of sexual violence within the county.

The Sexual Violence Strategy also highlights that research into alcohol and sexual violence indicates a strong association between alcohol use - both drinking in the event and long term drinking patterns - and sexual violence. Many perpetrators are drinking when they attack their victim or have alcohol abuse problems. Alcohol-related sexual assaults are more likely to occur between people who do not know each other well, and more likely to occur in bars and at parties than at either person's home. There is often both offender and victim drinking in incidents of sexual violence and the presence of alcohol has implications for the severity of sexual violence outcomes.

A review of the rape profile carried out in 2012 by Durham Constabulary reiterated the findings of the initial profile, that victims of rape and sexual violence are diverse but the most vulnerable in our society are over-represented, including children and those trapped in a cycle of abusive relationships. Perpetrators can repeatedly abuse and rape the same victim and/or commit rape or other sexual assaults against different victim(s). Stranger rapes are very rare, with the majority of victims knowing their offender.

Teenage partner violence

Research conducted by the NSPCC in 2011 clearly shows that violence in young people's intimate relationships should be viewed as a significant child-welfare problem. The research found that:

- Girls, compared to boys, reported greater incidence rates for all forms of violence. Girls also experienced violence more frequently and described a greater level of negative impacts on their welfare.
- Younger participants (aged 13 to 15 years old) were as likely as older adolescents (aged 16 and over) to experience particular forms of violence.
- The majority of young people either told a friend about the violence or told no-one. Only a minority informed an adult.
- Associated factors, both for experiencing and instigating teenage partner violence, included previous experiences of child maltreatment, domestic violence in the family and aggressive peer networks.
- For girls, having an older partner, and especially a "much older" partner, was associated with the highest levels of victimisation.

'Violence Against the Person' (VAP)

VAP increased by 17% in 2013/14 in County Durham compared with the previous year. This incorporates historical offences which occurred in the Consett area.

However, even when Consett is removed from the figures, the increase still stands at 9%.

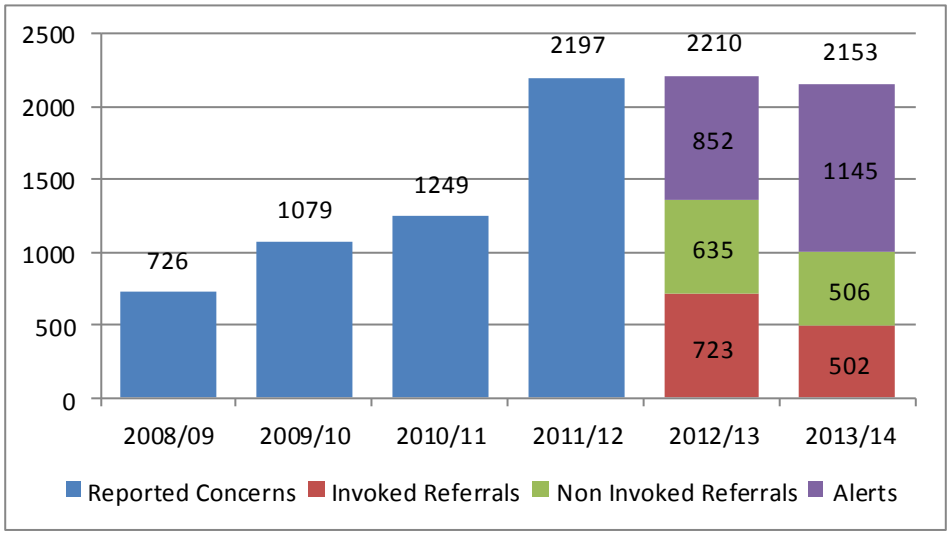
Safeguarding vulnerable adults from harm

In April 2012, County Durham introduced a new alert threshold which has enabled lower level concerns to be addressed by a single agency response, such as care coordination. This does not require a multi-agency response and avoids the need to invoke safeguarding procedures. This may account, in part, for the reduction in the rate of referrals previously recorded.

Referrals

Figure 83, demonstrates that a level of stability has been reached in the reporting of safeguarding concerns, with 2,153 reported concerns in 2013/14.

Figure 83: Adult safeguarding reported concerns – 2008/14



Source: SSID 2014

The initial increase can be attributed to an increase in awareness in the voluntary and independent sectors. This was influenced by a comprehensive training package being provided by the County Durham Safeguarding Adults Board and a number of high profile cases such as Winterbourne View and the Mid-Staffordshire NHS Foundation Trust inquiry. The referral rate has stabilised during 2013/14 and it is hoped that this will be more representative of safeguarding activity.

Table 104: Adult safeguarding referrals by service user group 2009/10 –2013/14

Service User Group	2009/10	2010/11	2011/12	2012/13	2013/14	Difference from 2009/10
Older Person	675	792	1342	1397	1345	99.2%
Learning Disabilities	267	275	542	458	444	66.2%
Mental Health	32	79	136	154	209	553.1%
Disabled Person	99	100	143	136	116	17.1%
Not Stated (Alerts)	0	0	0	41	24	-
Drug and Alcohol	6	3	34	24	8	33.3%
Total	**1079**	**1249**	**2197**	**2210**	**2153***	**99.5%**

Source: SSID 2014
Where low numbers exist in tables a notional figure of 3 has been included and the total amended accordingly.
** Includes 7 service users in other categories.*

The number of safeguarding adults referrals for older people has levelled out in recent years and when compared to figures for 2010, referrals have increased by 99.2%

The majority of safeguarding referrals for alleged abuse refer to incidents which have occurred in care homes and at the service user's home address. Neglect or Acts of Omission was the most common type of alleged abuse in 2013/14.

Of all invoked cases, 87% resulted in follow-up action for the victim including reassessment, increased monitoring, applications to the court of protection and referral to advocacy or counselling; and 81% of alleged perpetrators required further intervention, including disciplinary action, criminal prosecution, action by the Care Quality Commission, or counselling or training.

REDUCE RE-OFFENDING

Reducing re-offending remains a strategic priority for the Safe Durham Partnership. This is in response to the national estimate that 10% of the active offender population are responsible for half of all crime.

A Reducing Re-offending Strategy 2014-17 has been developed and its aim is clear: reduce crime by reducing re-offending rates. The strategic objectives outlined in the Reducing Re-offending Strategy are:

- Prevent inter-generational offending.
- Prevent repeat offending.

To manage the most prolific offenders in County Durham, the Safe Durham Partnership has put in place an Integrated Offender Management team across the county. This is split into three delivery hubs: North Durham, Easington and South Durham.

Within County Durham, the impact and influence of Integrated Offender Management (IOM) on the offender cohort is clear and performance in this area is strong. 2011/12 showed a 61% reduction in the cohorts offending and 2012/13 continued this trend with a 58% reduction. In 2013/14 there was a 65% reduction in the cohorts offending.

The proportion of offenders who are still offending while being part of the IOM cohort was 23% at the end of 2013/14. Figures for 2013/14 also show that 50% of IOM offenders reoffended within 1 year of being released from prison.

ALCOHOL AND SUBSTANCE MISUSE HARM REDUCTION

Alcohol

Research carried out during the production of the County Durham and Darlington Alcohol Health Needs Assessment in 2011 found that underage drinking, violence caused by alcohol, and people being drunk and rowdy in public are the leading social issues locally.

Alcohol misuse is strongly linked to crime and anti-social behaviour and performance data for 2013/14 show that:

- 34.8% of violent crimes are alcohol related.
- 38.6% of all domestic violence incidents reported to the police are alcohol related.

Research carried out by BALANCE (the North East Alcohol Office) in December 2011 highlights that within County Durham nearly all residents questioned associated ASB, assaults and violence and domestic abuse with alcohol. This research also shows that, compared to the region, the County Durham population is more likely than the regional average to associate domestic abuse and alcohol.

The Local Alcohol Profiles for England (2014 update) indicate a downward trend in alcohol related crime rates in County Durham. Alcohol related crime has fallen from 4.6 per thousand population during 2009/10 to 3.58 in 2012/13. The rate is significantly better than England (5.4) and lower than the North East (4).

Figures provided by Durham Constabulary identify that 11.7% of all crime committed in 2013/14 was alcohol-related; an increase of 3.1% on the previous year. It should be noted that there has been a push for compliance with the alcohol qualifier which will account for some of the increase in alcohol related crime.

(See 'Altogether Healthier' section for further information on alcohol.)

Drugs

The government published a drugs strategy in December 2010, 'Reducing demand, restricting supply, building recovery: supporting people to live a drug free life'. Previous activity has been focused on increasing the number of people able to access and receive drug treatment, either in the community or in custody. The 2010 strategy emphasises not taking drugs in the first place and reducing the time a person remains on them.

The three main aims of the strategy are:

- Reducing demand, including breaking the cycle of inter-generational dependency, by supporting vulnerable people.
- Restricting supply by focusing on the international trade in drugs, supply routes into prisons and the role agencies within a community safety partnership can have when they work together.
- Building recovery in communities, including getting people through recovery, to continue their lives drug free in order to reduce the impact on themselves and their communities.

In terms of implications within the crime and disorder agenda for County Durham, there is a need to ensure that appropriate substance misuse education is delivered to the correct level. Confidence in the courts in the treatment system needs to be maintained so that drug rehabilitation requirements are seen as an effective option to custody. Shared outcomes for individuals between health and criminal justice agencies are to be agreed. In order to restrict supply, work is taking place at a national level and, at a local level, integrated enforcement activity involving the Safe Durham Partnership, the public and service users is important.

The 2014-17 County Durham Drug Strategy is now in place and its delivery plan is currently being implemented.

(See 'Altogether Healthier' section for further information on drugs.)

Embed the Think Family approach

Think Family is an approach which requires all agencies to consider the needs of the whole family when working with individual members of it. It encourages a broader view of need than that normally adopted. To 'Think Family' is to understand that children's problems do not sit in isolation from their parents, and that parents' problems impact on their children. This approach ensures that all family members are able to get the support they need, at the right time, to help their children achieve good outcomes. All agencies are encouraged to 'Think Family' and to coordinate their efforts. This means making sure that families receive co-ordinated, multi-agency, solution focused support.

A small number of families require a disproportionate amount of support. In the case of families facing multiple challenges, they often receive services from several separate agencies in response to a range of needs. Think Family focuses specifically on the needs of these families.

For many families their complex needs can result in offending behaviour or victimisation and so it is important that Think Family is embedded and integrated into the service models used by the Safe Durham Partnership. Equally, this approach can have a significant impact on crime and disorder outcomes and presents an opportunity to improve performance.

The 'Think Family' approach is intrinsically linked to the Stronger Families Programme in County Durham (this programme is known nationally as 'The Troubled Families' Programme.) These are not new families but families who have been known to services, often for many years, and despite numerous interventions their

problems persist, and are in many cases intergenerational, leading to cycles of disadvantage for such families.

COUNTER TERRORISM AND THE PREVENTION OF VIOLENT EXTREMISM

The government's CONTEST Strategy has four strands:

- Pursue – to stop terrorist attacks (remit of police and security services).
- Prepare – where we cannot stop an attack, to mitigate its impact.
- Protect – to strengthen our overall protection against terrorist attacks.
- Prevent – to stop people becoming or supporting terrorists.

Within County Durham, the main focus is on the Prevent objectives:

- Respond to the ideological challenge of terrorism and the threat we face from those who promote it.
- Prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support.
- Work with sectors and institutions where there are risks of radicalisation which we need to address.

Recent national and international events have led to the government increasing the national threat level to 'severe'. The Counter Terrorism and Security Bill places local authorities at the heart of 'Prevent', the government's strategy for preventing people being drawn into terrorism and so, together with partner organisations, the council need to build on existing work to respond to this emerging issue.

CASUALTY REDUCTION

The North East Regional Road Safety Resource produced the report 'Reported Road Casualties in North East England 2013'. This identifies that within County Durham the casualty rate per billion vehicle miles during 2013 for those killed has increased by 20% since 2012. This is the fourth consecutive increase since 2009. The rate for those seriously injured has decreased by 1% since 2012. Both have a higher rate than that of the region.

Table 105: Casualty rate per billion vehicle miles 2012/13

Casualty rate per billion vehicle miles	NE region 2012	NE region 2013	NE region % change from 2012	County Durham 2012	County Durham 2013	County Durham % change from 2012
Killed	6.8	6.7	-1%	10.1	12.1	20%
Seriously injured	73.9	63.6	-14%	73.1	72	-1%
Slightly injured	604.1	548.8	-9%	565.3	489.1	-13%
All casualties	684.7	619	-10%	648.5	573.3	-12%

Source: North East Regional Road Safety Resource 2013

Within County Durham, pedestrians killed or seriously injured has increased from 52 during 2012 to 53 during 2013.

Children (0-15 years) killed or seriously injured fell from 24 in 2011 to 19 in 2012. This number returned to 24 in 2013. County Durham has a higher rate of child

casualties than most other English local authorities but this is offset by higher levels of vehicle traffic.

3. Which groups are most vulnerable and why?

Reduce anti-social behaviour
Although all areas have seen a decrease in recorded incidents of ASB reported to the police, Sedgefield, the Dales and Easington have the highest rates per 1,000 population.

Protect vulnerable people from harm

Domestic abuse
Potentially 54,000 female and 34,350 males, including approximately 5,302 LGBT people 16 years and above, will experience domestic violence in County Durham, based on research which indicates that one in four women and one in six men will be a victim of domestic abuse. This ratio suggests a level of parity; however, what these figures conceal is the fact that 47% of males experience a single incident, with an average of seven incidents per victim, compared with 28% of female victims experiencing a single incident, with an average of 20 incidents per victim (Walby and Allen 2004). Women victims of male perpetrators are more likely to be repeatedly abused, or murdered.

The County Durham Domestic Abuse Strategy 2012-15 was published in December 2012. It identifies the following as priority groups:

- Women, especially those aged 40 and over.
- Lesbian, Gay, Bisexual and Transgender (LGBT).
- Black, Minority, Ethnic and Refugee (BMER).
- Gypsies and Travellers.
- Children and young people as victims, witnesses and perpetrators.
- Parents and carers.
- Those with disabilities.

The population within County Durham from BMER groups is low, however it needs to be recognised that language and communication skills can create barriers to individuals' confidence and ability to disclose abuse. Cultural beliefs or concerns such as pressure to stay from family members, bringing shame on the family, or abuse being viewed as accepted behaviour are extremely important and need to be understood, especially if we want to encourage all communities to be able to disclose any type of abuse that they may be suffering. Other issues relevant to the domestic abuse agenda include Female Genital Mutilation, forced marriage and so called 'honour' based violence.

Hate crime
In terms of vulnerable groups, the Safe Durham Partnership Hate Crime Problem Profile 2009 identifies the following:

- All strands of hate crime are occurring across County Durham, with hate crime becoming a part of daily life for many people who are disabled, Black Minority Ethnic (BME) or Lesbian Gay Bisexual Transgender (LGBT).

- We need to understand where our vulnerable communities are.
- The majority of repeat victims (who report hate crime to the police) are shops and takeaway establishments. However the few homes which have been identified as repeat victims show a long history of verbal abuse, harassment and criminal damage by people towards them because of their race or sexuality.
- Young people are also more likely to report a hate crime, with 68% of those reporting aged under 35. Only 10% of victims reporting a hate crime were aged over 45. Males are also more likely to report.
- The majority of offenders are young white British. Over three quarters of repeat offenders are male.

The National Hate Crime Action Plan (Home Office, 2012) highlights that under-reporting is a significant issue amongst new migrant communities; Gypsy, Irish travellers and Roma communities; transgender victims; and disabled victims. The Equality and Human Rights Commission report 'Hidden in Plain Sight' (2011), highlights that nationally, disability related harassment is a common problem experienced by those with disabilities but many incidents go unreported.

Reduce re-offending
The Safe Durham Partnership refreshed the Integrated Offender Management (IOM) cohort for the period 2012/13.

- The majority of offenders were male, with ages spread from 18 to approximately 33 years of age.
- The cohort of 195 offenders was responsible for 889 offences in 2012/13. The main offences being shop theft, drugs, and vehicle crime.
- Of the 195 offenders, only 2 were assessed as not having an issue with substance misuse. Heroin was the most frequently problematic drug abused.
- 69% of the cohort had accommodation issues linked to their re-offending.
- At the end of 2012/13, only 1 of the cohort was in legitimate employment.
- 78 of the 195 offenders had children. 35 had no contact with their children, 31 had contact and 12 lived with their children.
- 37 of the 195 cohort were female. There were 58 prolific and priority offenders (1 female), 42 with a drug rehabilitation requirement (9 female) and 95 high crime causers (27 women).

Alcohol and substance misuse harm reduction
The County Durham and Darlington Alcohol Health Needs Assessment 2011 showed the following additional information:

Alcohol misuse is also associated with worklessness, relationship breakdown, poor parenting and, in the most serious cases, child abuse and alcohol is reported as a factor in approximately one-third of domestic violence incidents.

Alcohol related crimes also feature in those sectors with more deprived localities.

The rape profile for County Durham and Darlington shows that alcohol related rapes are more likely to be acute and committed on a Saturday. Alcohol was a factor in 28% of these cases.

Surveys suggest that between 30% and 60% of child protection cases involve alcohol. Within County Durham, 25% of children on the at risk register became the subject of an initial child protection plan as a result of parental alcohol misuse (June 2013).

13.8% of initial child protection conferences (June 2013) had substance misuse recorded as the main parental risk factor.

Embed the Think Family Approach

The Think Family approach supports children, young people and their families who are facing multiple and complex challenges, including:

- Parents and children involved in crime or anti-social behaviour.
- Children who have not been attending school regularly.
- Children who need help – either identified as 'in need' or subject to a Child Protection Plan.
- Adults out of work or at risk of financial exclusion, or young people at risk of worklessness.
- Families affected by domestic violence and abuse.
- Parents and children with a range of health problems.

Counter terrorism and the prevention of violent extremism

Objective 3 of the new Prevent strategy is underpinned by new research and understanding about the risks of becoming susceptible to terrorist propagandists. Sympathy for terrorism is highest among young people.

Nationally, most Channel[10] referrals, and 10% of all terrorist convictions, fall within the age range 15 -19. Most terrorist offences are committed by those under 30 and some people, supportive of terrorist groups and ideologies, have sought or gained positions in schools. National research should not be interpreted to mean that schools within County Durham are at particular risk or imply any causation, however agencies needs to be aware of the general risk and act in a proportionate manner.

Broader research highlights particular sectors and institutions as key areas where the risk of radicalisation needs to be addressed. The key sectors are: schools and children; youth offenders and youth justice; higher and further education; prisons and probation; health; and the internet. Key members of staff, particularly within the schools and children sector, need to be aware of the signs displayed by those vulnerable to radicalisation and understand what to do when their suspicions are alerted. This work is progressing. However, the strategy stresses the importance of ensuring this work is proportionate to the risk.

[10] 'Channel: Supporting individuals vulnerable to recruitment by violent extremists' was published as a guide for local authorities in March 2010 by the Home Office and the Association of Chief Police Officers as part of the Government's Prevent Strategy.

The health sector continues to progress awareness training for its staff and the North East Ambulance Service is to be provided with guidance and support in raising awareness of its staff.

Road casualty reduction
The North East Regional Road Safety Resource report 2013 highlights that the number of all road casualties within County Durham has decreased by 11%. The number of all road casualties killed or seriously injured has increased by 2%. The number of people killed or seriously injured has increased in 2013 compared to 2012 and these include pedal cyclists (up from 10 to 15), children 0-15 years (from 19 to 24) and occupants of vehicles driven by a young driver 17-24 years (from 14 to 19). The number of occupants of vehicles driven by an older driver aged 70 or more years has reduced from 15 to 7.

4. What are people telling us?

In terms of public perception of anti-social behaviour, data from the Police Perception Survey for the end of the period 2013/14 identify that residents of Easington, Sedgefield and Derwentside have a higher perception of anti-social behaviour than the county average.

Table 106: Perception of anti-social behaviour by Clinical Commissioning Group Locality / Constituency 2013/14

Locality	Total Respondents	Number that perceive a high level of ASB	% 2013/14 (August-March)
Chester le Street	152	46	30.3%
Dales	524	149	28.4%
Derwentside	366	115	31.4%
Durham	218	41	18.8%
Sedgefield	248	80	32.3%
Easington	262	108	41.2%
County Total	**1770**	**539**	**30.5%**

Source: Durham Constabulary 2014

High levels of perception are linked with areas of deprivation. Due to changes in the structure of the Police Confidence Survey, we are unable to show historic trends. The County Durham Residents Survey has not been renewed since 2010/11 therefore the findings presented in this JSNA are the most recent available.

In 2012, the Victims' Services Advocate was commissioned by the Victims' Commissioner to look at which services are available and what victims need from local services. The report found that within County Durham, victims of domestic abuse felt that they were not always taken seriously, especially if there were no signs

of physical abuse. The first response was also considered to be the most important in terms of influencing outcomes relating to engagement with criminal justice processes, referrals for holistic needs assessment and subsequent development of appropriate pathways of support.

The Hate Crime Problem Profile identified that a negative experience with police (either experienced personally or known to have happened to other members of the community) has a big impact on whether or not someone will report a hate crime.

The 2013 Safe Durham Partnership Strategic Assessment identified offender mental health as a key issue across the whole of the criminal justice system.

The Police Confidence Survey 2013/14 shows that 45.5% of people perceive people drinking and causing nuisance in public spaces to be a problem. Due to changes in the survey this figure is not comparable to previous surveys.

Table 107: Perceptions of people drinking and causing nuisance in public spaces by Clinical Commissioning Group Area 2013/14

Locality	Total Respondents	Number that perceive people drinking and causing nuisance	% 2013/14 (August-March)
Chester le Street	169	99	58.6%
Dales	602	241	40.0%
Derwentside	420	187	44.5%
Durham	243	90	37.0%
Sedgefield	289	154	53.3%
Easington	313	156	49.8%
County Total	**2036**	**927**	**45.5%**

Source: Durham Constabulary 2014

More recent perception data from the Police Confidence Survey shows that 47.1% of people in County Durham perceive drug use / drug dealing and abuse as a problem. Table 108 breaks this down by CCG area. Easington, Sedgefield and Chester le Street all have a higher perception of this as a problem. Due to changes in the structure of the perception survey we are not able to compare this data with previous years.

Table 108: Perceptions of drug dealing and abuse by Clinical Commissioning Group area 2013/14

Locality	Total Respondents	Number that perceive drug dealing and abuse	% 2013/14 (August-March)
Chester le Street	164	87	53.0%
Dales	593	263	44.4%
Derwentside	407	189	46.4%
Durham	236	74	31.4%
Sedgefield	280	148	52.9%
Easington	309	176	57.0%
County Total	**1989**	**937**	**47.1%**

Source: Durham Constabulary 2014

5. What are the implications for the future?

There is a need to build capacity within communities in order to create greater independence. For example, through the use of restorative approaches and neighbourhood watch and drug recovery volunteer peer programmes, such as the Ambassador and Smart programme.

Public confidence and perceptions of anti-social behaviour are a key focus for the future.

Embedding the Think Family approach within the priorities of the Safe Durham Partnership is a focus. This approach will have a significant impact on community safety outcomes and embedding Think Family into priorities for all partner organisations should be a key response.

The first Police and Crime Commissioner for County Durham and Darlington was elected in 2012; this has enabled greater opportunities for joint working and commissioning of services.

The Law Commission consultation on Hate Crime creates a greater focus on all strands of hate crime such as disability, which has positive implications for the equality and diversity agenda.

A greater focus on proxy provision of alcohol is required and all agencies will need to raise awareness of the risk factors of alcohol consumption by young people.

A countywide Domestic Abuse Service is now operational and work is taking place to implement a domestic abuse and sexual violence delivery plan. The impact of this means that we have better measures in place, which may identify an increased need for resources in this area.

All agencies will need to monitor issues of domestic extremism as a result of recent local, regional and national incidents.

6. Key messages

- As of February 2015, County Durham's Stronger Families programme has identified and worked with 1,695 families. 1,185 of these families have been 'turned around' through the Stronger Families programme.
- National research has highlighted Teenage Partner Violence as an emerging issue.
- The number of hate motivated incidents reported to the police has increased from 222 in 2012/13 to 282 in 2013/14.
- Under-reporting of hate crime is a significant issue amongst new migrant communities; Gypsy, Irish travellers and Roma communities; transgender victims; disabled victims.
- Local Domestic Homicide data have highlighted that women aged 40+ are at risk of experiencing domestic abuse which either goes unreported or is not recognised by professionals.
- Safeguarding reported concerns (Alerts and Referrals) have levelled out across 2011/12 (2,197), 2012/13 (2,210) and 2013/14 (2,153).
- The majority of safeguarding referrals for alleged abuse refer to incidents which have occurred in care homes and at the service user's home address. Neglect or Acts of Omission was the most common type of alleged abuse in 2013/14. (For example, failure to provide for medical, social or educational needs. Withholding necessities such as food, drink and warmth, and a lack of protection from hazards.)
- The percentage of referrals in which safeguarding procedures are invoked (those which require multi-disciplinary investigations) decreased by 7% in 2012/13 to 33% and again by 10% in 2013/14 to 23%.
- Of all invoked cases, 87% resulted in follow-up action for the victim including reassessment, increased monitoring, applications to the court of protection and referral to advocacy or counselling; and 81% of alleged perpetrators required further intervention, including disciplinary action, criminal prosecution, action by the Care Quality Commission, or counselling or training.
- The Safe Durham Partnership profile of the 2012/13 Integrated Offender Management (IOM) cohort showed that all but two of the 195 adult offenders being managed through the IOM programme had issues with substance misuse.
- All but one was unemployed; 78 of the 195 offenders had children, 35 had no contact with their children, 31 had contact and 12 lived with their children.
- 11.7% of all crime committed in 2013/14 was alcohol-related, compared to 8.7% in 2012/13. A drive to improve recording will have influenced this increase.
- 45.5% of residents within County Durham perceive drinking as a problem.
- 47.1% of residents within County Durham perceive drug dealing and abuse as a problem.
- National research highlights particular sectors and institutions as key areas where the risk of radicalisation needs to be addressed. The key sectors are:
  - Schools and children.
  - Youth offenders and youth justice.

- Higher and further education.
- Prisons and probation.
- Health.
- The internet.

Altogether Safer

Summary of Key Indicators

Indicator / measure	Number / %	Performance	Time period	England	Benchmarking
Repeat incidents of domestic violence (referrals to MARAC)	%	8.9	2013/14	24	27
Percentage of adult safeguarding investigations completed within 28 days	%	79	2013/14	Comparable data not available	Comparable data not available
Proportion of people who use services who say that those services have made them feel safe and secure	%	72.6 (National Survey)	2013/14	79.2	North East – 79.3
Percentage change in detected crimes for offenders in the Integrated Offender Management (IOM) cohort	%	65	2013/14	Comparable data not available	Comparable data not available
First time entrants to the youth justice system aged 10-17	Number	210	2013/14	Comparable data not available	Comparable data not available
Percentage of successful completions of those in alcohol treatment	%	36	January to December 2013	36	Comparable data not available
Percentage successful completions of those in drug treatment – opiates	%	8	July 2012 to July 2013	8	Comparable data not available
Percentage of successful completions of those in drug treatment – non-opiates	%	36.9	July 2012 to July 2013	40	Comparable data not available
Building resilience to terrorism	Level	Level 4	2013/14	Comparable data not available	Comparable data not available
Recorded level of victim based crimes	Number	22,401 (43.6 per 1,000 pop)	2013/14	54.2 per 1,000 pop	55.8 per 1,000 pop Durham CSP MSG
Dealing with concerns of ASB and crime issues by the local council and police	%	57.3% (January – Dec13)	2013/14	Comparable data not available	59.2% Durham Force MSG
Overall crime rate (per 1,000 population)	Rate per 1,000	49.1	2013/14	61.1 per 1,000 pop	Comparable data not available
Perceptions of ASB	%	30.5% (Aug13 –Mar14	2013/14	Comparable data not available	Comparable data not available
Number of serious or major crimes	Number	840	2013/14	Comparable data not available	Comparable data not available
Number of police reported incidents of anti-social behaviour (ASB)	Number	24,234	2013/14	Comparable data not available	Comparable data not available

Number of reported crimes categorised as stealing	Number	11,727	2013/14	Comparable data not available	Comparable data not available
Proportion of offenders who re-offend in a 12-month period	%	29.2% (January 11–Dec11)	2013/14	26.8%	Comparable data not available
Percentage of alcohol related ASB incidents	%	15	2013/14	Comparable data not available	Comparable data not available
Percentage of alcohol related violent crime	%	34.8	2013/14	Comparable data not available	Comparable data not available
Number of hate incidents	Number	282	2013/14	Comparable data not available	Comparable data not available

KEY

	County Durham is better than England Average
	County Durham is similar to the England Average
	County Durham is worse than England Average

Altogether Wealthier

1. Introduction

County Durham is extremely diverse in terms of labour markets, skill levels, transport connectivity, housing, socioeconomic characteristics and landscape. The county is home to a wide range of businesses from micro rural businesses to large multinationals, from small scale engineering to large scale manufacturing, business services and leading research engines. County Durham offers businesses and residents a range of options and these must be sustained and developed to serve the diversity which exists.

Globalised market forces continue to pose threats and opportunities for our economy, particularly in our manufacturing sector, which accounts for over 15% of the resident employment and contributes 20% of the county's GVA. It is crucial that businesses can access appropriate high quality workspace which meets their business needs and creates the right environment for business development. Despite sustained efforts to attract inward investment and to support the creation of new jobs and businesses, the gap in economic performance between County Durham and the regional and national economies has widened during the last decade.

Deprivation is one of the key determinants of inequality within the county. Industrial restructuring, the housing market and accessibility and health may be the underlying causes of area deprivation, and the impacts of these trends have already been felt within the county. The level of economic dependence on the coal mining industry was high and led to a dispersed settlement pattern within the county. This dispersed and isolated settlement pattern has compounded the isolation of these communities and aggravated the problem of accessing those jobs which are available. Despite improving economic circumstances (and in particular, employment growth) and attempts to regenerate areas, geographic concentrations of deprivation persist.

Much of the housing in our deprived areas is older terraced stock and has over time suffered market fragility, presenting further inequalities. Average house prices are low relative to the regional and national averages; the dwelling stock suffers from high turnover and private absentee landlords do not provide effective management services. Poor quality housing is often associated with poor health and can amplify the spiral of decline within an area and precipitate outward migration.

The performance of the economy gives a good indication of both levels of employment and prosperity in the general population. In particular, levels of employment provide an indication of the health of the working age population.

A review of evidence-based research over a substantial time period has served to demonstrate that unemployment and worklessness play a significant role in increasing poverty, social isolation and loss of self-esteem; and decreasing psychological wellbeing, physical health and mental health.

Two studies have demonstrated the strong association between worklessness and poor health.[11] There is strong evidence that unemployment is generally harmful to health, including:

- Higher mortality.
- Poorer general health, long-standing illness, limiting longstanding illness.
- Poorer mental health, psychological distress, minor psychological/psychiatric morbidity.
- Higher medical consultation, medication consumption and hospital admission rates.

Tackling worklessness remains one of the fundamental priorities and challenges within County Durham. As with most former mining areas, ex-miners themselves were the largest group of incapacity benefit claimants.

2. What are the levels of need?

Housing – an introduction

The relationship between housing and health is a complicated one which involves multiple factors. Nevertheless it is clear that good housing is a pre-condition for good health. We know that unsuitable or poor quality housing and an absence of housing support can have as much impact on health and wellbeing as illness does. Housing can contribute to health and wellbeing through:

- Promoting independence.
- Preventing accidents, emergencies and admissions to hospital.
- Providing care and support in the right accommodation and in the right places.

The home is the place we grow up and grow old in. It is a hub around which care, family and community support and social relationships are built. County Durham needs to have the right balance of safe, healthy and appropriate housing in the right locations to meet its population's needs.

Housing's influence on health can be seen within the context of:

- The condition and suitability of the home.
- The operation of the housing market.
- The place of housing within neighbourhoods and communities.

The 2014 Care Act seeks to place much greater emphasis on preventing, delaying and reducing people's care and support needs through greater understanding of how needs impact on wellbeing. It is now recognised through this legislation how wellbeing is influenced by housing circumstances.

Housing conditions

It has been suggested that living in sub-standard housing can lead to an increased risk of cardiovascular and respiratory disease, along with anxiety and depression.[12]

[11] Is Work Good for Your Health and Well-Being? Waddell, G. and Burdon, A. K. (2006) London, The Stationery Office; Worklessness and Health – What Do We Know About the Causal Relationship? Evidence Review. Mclean, C, Carmona, C, Francis, S, Wohlgemuth, C. and Mulvihill, C. (March, 2005), NHS – Health Development Agency.

[12] National Institute for Health and Clinical Excellence Housing and Public Health: a review of reviews of interventions for improving health. Evidence Briefing. Taske, L. Taylor, L. Mulvihill, C. Doyle, N. With Goodrich, J. And Killovan, A. (December 2005); Housing and Health, Houses of Parliament, PostNote Number 37, January 2011.

Housing quality is poorest in the private rented sector, a sector which has grown considerably in County Durham over the last ten years. The private rented sector now accounts for around 12.6% of all households across the county.[13]

The exact relationship between poor housing and health is complex and difficult to assess. Housing-related hazards which increase the risk of illness include damp, mould, excess cold and structural defects which increase the risk of an accident (such as poor lighting or lack of stair handrails). The strength of the evidence linking such factors to ill health varies. Studies using population data suggest that the strongest links are for:

- Accidents – 45% of accidents occur in the home and accidents are in the top 10 causes of death for all ages.
- Cold – cold homes are linked to increased risk of cardiovascular, respiratory and rheumatoid diseases, as well as hypothermia and poorer mental health. There was an estimated 31,100 excess winter deaths attributable to all causes in England and Wales in 2012/13.

The elderly are particularly at risk of health problems relating to accidents and excess cold in the home. Elderly people who have retired may also be financially vulnerable:

- The elderly are more likely to suffer injuries during an accident. Adaptations play a role in preventing accidents and maintaining independent living.
- The elderly are also more likely to suffer ill health in a cold home. Some may have a cold home because of the expense of heating but fuel poverty is closely related to the energy efficiency of a house, as well as to income and fuel prices.

Overall, the building research establishment (BRE) has calculated that poor housing costs the NHS at least £600 million per year.[14]

Regulatory framework

The government's White Paper 'Healthy Lives Healthy People' (2010) includes a number of priorities relating to housing, including:

- Fuel poverty.
- Hospital admissions for fall injuries in persons aged over 65.
- Mortality from cardiovascular diseases.
- Excess winter deaths.

The Audit Commission's 'Building Better Lives' report (2009) recommends that improving the condition of housing stock can improve public health and children's education. The report confirms that every £1 spent on housing support for vulnerable people can save £2 in reduced health service costs.

Fuel poverty

Fuel poverty arises from households' inability to afford the energy required to power and heat their home to a satisfactory standard. This standard is defined as satisfactory where domestic temperatures of 21^{o}C in the primary living area (living

[13] Census 2011 - Tenure
[14] Housing: English House Condition Survey

room) and 18°C in the secondary living area (other occupied rooms) are attained. This regime is one which is necessary for good health.

Table 109: The effect on comfort and health of different living room temperatures

Indoor temperature effect	Living room (°C)
Comfortable temperature for all, including older people, in living rooms.	**21**
Minimum temperature with no health risk, although older and sedentary people may feel cold.	**18**
Resistance to respiratory diseases may be diminished.	**<16**
Exposure to temperatures between 9°C and 12°C for more than two hours causes core body temperature to drop, blood pressure to rise and increased risk of cardiovascular disease.	**9-12**
Significant increase in the risk of hypothermia.	**5**

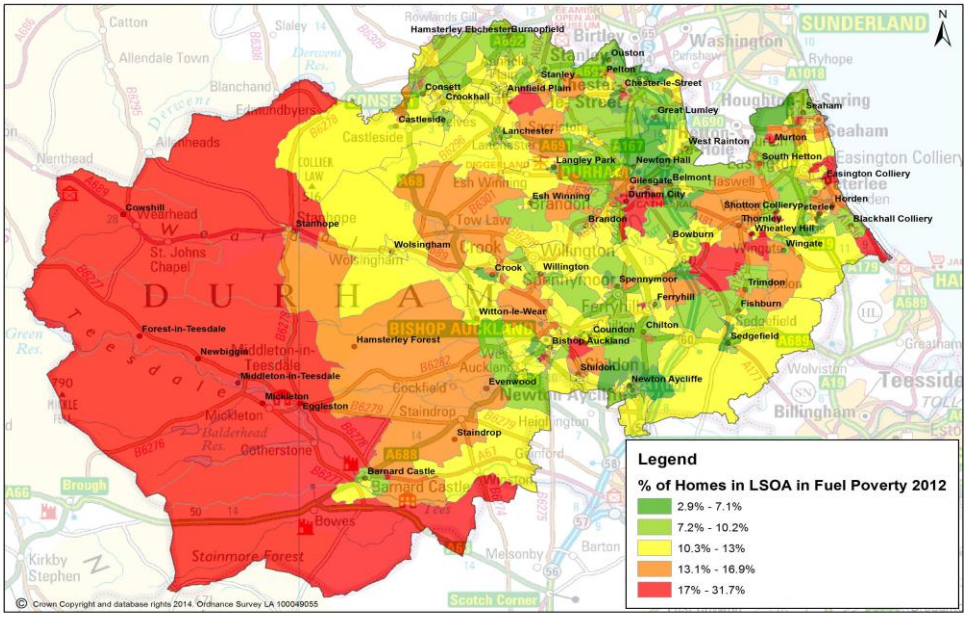
Source: Vivienne Press (2003) Fuel poverty and health toolkit.

In the context of the recent economic downturn and significant rises in energy costs, living in a cold home can present particular risks to health. In 2012, 11.4% of households in County Durham suffered fuel poverty.[15]

A household is said to be in fuel poverty if:

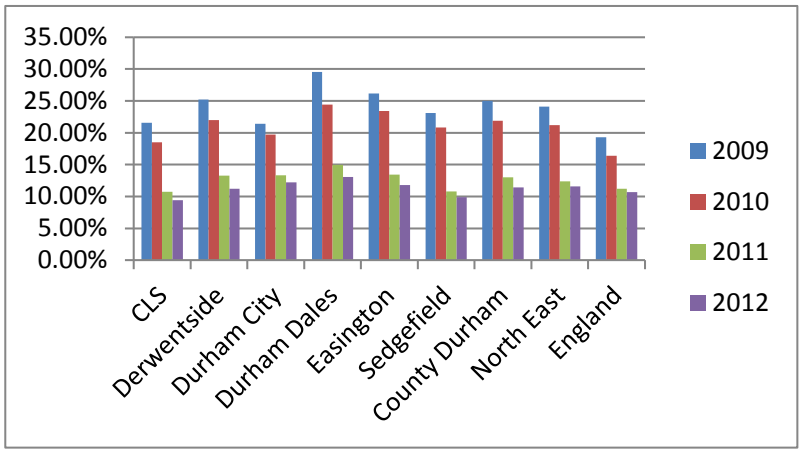
- They have required fuel costs that are above average (the national median level).
- Were they to spend that amount they would be left with a residual income below the official poverty line.

Map 3: Percentage of homes in LSOA in fuel poverty 2012



[15] ONS – Fuel Poverty Sub-Regional Statistics

Figure 84: Percentage of households in Fuel Poverty by locality, 2009-12



Source: https://www.gov.uk/government/statistical-data-sets/fuel-poverty-2010-sub-regional-data

The localities of the Durham Dales and Durham City have the highest percentage of households in fuel poverty, with 13.05% and 12.22% respectively.

In 2014 the government dropped the Boardman 10% definition of fuel poverty in favour of an all new 'Low Income High Cost' (LIHC) indicator to measure national levels of fuel poverty. As a consequence of this change, the overall numbers of households classified to be in fuel poverty have reduced. But this is not to be viewed as fuel poverty being on the decrease, in fact according to the national fuel poverty charity (NEA) it is expected that under the new definition the level and depth of fuel poverty could show an annual increase.

Under the government's new Low Incomes High Costs (LIHC) definition of fuel poverty, in 2011 fuel poverty affected 2.4 million households in England. This is compared to 3.2 million under the previous 10% definition over the same period.

Between 2000 and 2010, the decent homes programme aimed to address the problems of fuel poverty and refurbish all social sector homes to a minimum standard. However, private rented sector homes housing people on benefits were not supported under this programme.

Cold homes and ill health

Poor housing has an important detrimental effect on health, as occupiers spend more time in their homes than anywhere else. Poor housing and low income can worsen existing ill health problems including heart problems, respiratory problems and strokes. Being chronically cold or malnourished makes people more vulnerable to sickness and 44% of households have one or more persons with a limiting long term illness[16]. Energy and food bills have continued to rise.

[16] Source: Krishnan Bhaskaran et al (2010) Short term effects of temperature on risk of myocardial infarction in England and Wales: time series regression analysis of the Myocardial Ischaemia National Audit Project (MINAP) registry. BMJ;341:c4540. http://www.bmj.com/content/341/bmj.c4540

Recent trends have seen a steep increase in the cost of all fuels. National Energy Action (NEA) estimates that for every 1% increase in energy prices a further 10,000 households fall into fuel poverty. Between January 2003 and February 2011 gas prices increased by 137% and electricity by 115%, meaning householders now pay on average 126% more for their combined fuel bill and the average annual fuel bill is now £1,342[17].

Tackling fuel poverty and preventing excess winter deaths are increasingly important. Historically, County Durham has had a higher than average rate of excess winter deaths with those aged 85 or over at the greatest risk.

There were an estimated 31,000 Excess Winter Deaths in England during the winter of 2012/13. This represents an increase of 29% compared to the winter of 2011/12.[18]

The Joint Health and Wellbeing Strategy has a strategic aim to 'Reduce health inequalities and early deaths' with an action to 'Reduce excess winter deaths' through the integration and roll out of interventions to address the impact of fuel poverty on excess mortality and morbidity.

The greatest risks to health in housing are related to cold and damp (including moulds and fungus), which affect and exacerbate respiratory conditions. Indoor air quality, dust mites and other allergens, house type and overcrowding represent further examples of risk factors. Other less direct risks include neighbourhood effects such as a broad range of anti-social behaviour, which can have a negative impact on mental wellbeing.

Some research highlights differences in health between those living in particular housing tenures. Housing conditions in homes which are owned tend to be better than in homes which are rented, especially in relation to problems of condensation, lack of adequate heating and damp, with proportions in the rented sector around twice as high.

There are large numbers of homeowners living in poverty, which can contribute towards negative health outcomes; therefore, the relationship between tenure type and poverty needs rethinking. Housing problems are a component of the multiple disadvantages which combine to affect - and be affected by – health and wellbeing.

The County Durham Health Impact Assessment (CDHIA) establishes that improvements to housing conditions can produce health benefits and significant reductions in long term NHS costs.

The County Durham Affordable Warmth Strategy will tackle fuel poverty to deliver economic and health and wellbeing benefits to many households. There is an opportunity to maximise reductions in levels of fuel poverty and cold related illness

17 Ofgem Fact Sheet number 98

[18] Source: Office of National Statistics. Excess Winter Mortality in England and Wales, 2012/13 (Provisional) and 2011/12 (http://www.ons.gov.uk/ons/rel/subnational-health2/excess-winter-mortality-in-england-and-wales/2012-13--provisional--and-2011-12--final-/stb-ewm-12-13.html)

by combining national funding under the government's Green Deal and Energy Company Obligation with Public Health and NHS funding.

County Durham Affordable Warmth Strategy
Durham County Council is committed to tackling the plight of fuel poverty faced by many of its households. The Housing Strategy and Affordable Warmth Strategy (AWS) have been designed to consider the main issues affecting the diverse communities of County Durham by identifying current barriers and solutions to affordable warmth. Key aims and objectives have been developed in the AWS to assist with the alleviation of fuel poverty and reductions in excess winter deaths, ensuring that the benefits of energy efficiency measures are brought to the attention of all households.

The County Durham Energy and Fuel Poverty Partnership oversees delivery of the AWS to ensure joint working between relevant council services i.e. housing, public health, etc. and external partner organisations.

County Durham Health Impact Assessment
The County Durham Health Impact Assessment (CDHIA) uses a recognised method of assessing the health impacts of cold and damp housing using Housing Health and Safety Rating (HHSR) Category 1 hazards. The quantitative information provided by the CDHIA on the impact on health of private sector housing provides evidence on costs, savings and benefits of improving housing in the private sector and the costs to health of not doing so. This has allowed the production of a health cost benefit analysis showing the costs of rectifying cold related ill health housing hazards and the resultant savings to the NHS and society as a whole.

Table 110: Category 1 hazards

Hazard Type	Numbers of hazards				Estimated Medical Interventions
	Private Dwellings	Owner Occupier	Private Rented	Lowest 20% IMD	
Damp and mould	1,396	1,237	159	193	689
Excess cold	8,506	6,131	2,375	1,171	47
Falling on levels surfaces	5,954	5,126	828	784	331
Falling on stairs	7,558	6,506	1,051	995	236
Falling between levels	1,152	992	160	152	115

Quality adjusted life years
The HIA also allows for measuring the levels of wellbeing in terms of Quality Adjusted Life Years (QALYs) lost and QALYs saved through carrying out different housing improvement scenarios. Estimating the cost of improvements can also allow an Incremental Cost Effectiveness Ratio (ICER) expressed as '£ per QALY' allowing further consideration of the cost effectiveness of interventions.

Costs to the NHS
The CDHIA produces costs based on real estimates of incidents occurring as a result of HHSR Cat 1 Hazards and first year of NHS treatment costs.

Table 111: Class of harm outcome

Hazard	Class of harm outcome			
	Class 1	Class 2	Class 3	Class 4
Damp and mould	n/a	Type 1 allergy (£1,998)	Severe re asthma (£1,120)	Mild asthma (£180)
Excess cold	Heart attack, care, death (£19,851)	Heart attack (£22,295)	Respiratory condition (£519)	Pneumonia (£84)
Falls on stairs	Quadriplegic (£52,246)	Femur fracture (£25,424)	Wrist fracture (£745)	Treated cut or bruise (£67)

A study published in the British Medical Journal found that a 1^{o}C reduction in the daily mean temperature nationwide is associated with around 200 additional heart attacks over a 29 day period. An increase in strokes and respiratory disease occurs after 5 and 12 days respectively.

Excess winter deaths amongst those residing in the warmest homes are around 20% lower than the number of EWDs occurring amongst those occupying the coldest homes and can result in heart attacks on average, 2 days after a cold snap.[19]

Warm and Healthy Homes Programme
The current project addresses exposure to both excess winter deaths and decreased hospital admissions for those residents in County Durham who have a health condition relating to living in a cold damp home. This is achieved by installing domestic energy efficiency measures and maximising incomes resulting in warmer homes, enabling people to manage fuel debt and assisting in reducing cold related illnesses. The installation of these measures also aims to enhance the condition of private sector housing stock across County Durham.

The project is managed by Durham County Council's Housing Regeneration Service, providing a countywide training and referral process for front line health

[19] BMJ (2010) Short term effects of temperature on risk of myocardial infarction in England and Wales: time series regression analysis of the Myocardial Ischaemia National Audit Project (MINAP) registry. 341: c3823.(http://www.bmj.com/content/341/bmj.c3823)

and social care practitioners. Energy conservation measures, i.e. new central heating, wall and loft insulation are delivered by Warm Up North, a consortium of eight North East local authorities including Durham County Council in partnership with British Gas.

This programme assists patients / clients with an underlying health condition related to living in a cold damp home by installing domestic energy efficiency measures. The programme will develop clearer links with the two Clinical Commissioning Groups (CCG's) across County Durham in order to make them aware of the impact the programme can have on their patients, reducing hospital admission and re-admission rates and improving life quality.

The correlation between health and warmer homes is quantified in terms of quality of life / wellbeing and the potential savings resulting from pro-active / targeting and prevention resulting from the County Durham Health Impact Assessment. The programme represents good practice and value for money. Delivery is capable of being scaled up using the targeting mechanisms included within the CDHIA and Durham County Council housing stock condition model.

Changes to housing benefit mean that working-age tenants whose property is larger than their needs have to pay more of their rent if alternative accommodation cannot be sourced. In some cases this leads to lower incomes, with some tenants slipping into arrears.

Housing market

The housing market in Durham is described in the Strategic Housing Market Assessment (SHMA 2013). It assesses both supply and demand for different types of housing across different needs groups. It has determined the amount of affordable housing we require across the county and forms the basis of evidence which has been used to create the draft Local Plan.

Affordable housing

The SHMA 2013 has identified a shortfall of affordable housing supply of around 674 units. Affordable housing meets the needs of those households who are unable to secure housing in the open market and is primarily affordable rented accommodation, although low cost home ownership also falls within the definition. The level of need varies across the county (see table below)

Table 112: Annual affordable housing requirements by delivery area, property size and designation (general needs/older person) 2013/14 to 2017/18

Delivery area	General		Older Person	TOTAL
	Smaller 1/2 Bed	3+Bed		
North Durham	97	29	68	194
Central Durham	46	20	52	119
East Durham	61	4	72	137
The Dales and South Durham	80	16	129	225
Total	**284**	**69**	**321**	**674**

Social housing

Durham County Council currently owns 19,000 council homes across County Durham. Homes within the Durham City area (6,000) are directly managed by Durham City Homes. The other areas are managed by Arms Length Management Organisations (ALMOs). These homes will be transferred to a new housing group 'County Durham Homes' in April 2015.

The majority of homes managed by social housing providers meet the decent homes standard. However, every year further works are carried out to meet this standard.

Numbers on the social housing waiting list stood at 11,302 in March 2014. This is a decrease of 2,166 (16.1%) since March 2013.

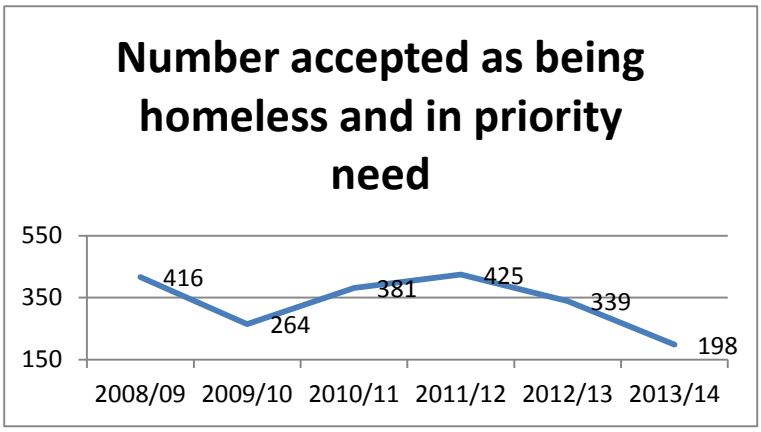
It should be noted that rents charged by social housing providers are eligible for housing benefit (HB) (subject to means testing of the applicant). Since April 2013 the HB entitlement has been reduced, should the household be deemed to be under-occupying the house by one or more bedrooms. This has led to rent arrears; stress and pressures on family life (especially where children have to share small bedrooms).

Homelessness

Homeless people have some of the poorest health in our communities and require greater levels of access to health services compared to the general population. People who have access to secure and sustainable housing are more likely to be healthy, safe, and in employment.

The number of people, in County Durham, accepted as being homeless and in priority need has decreased for the second consecutive year in a row and is the lowest it has been since 2008/09 at 198 people. This is 0.87 people per 1,000 household and is far below the average for England of 2.32 people per 1,000 households.

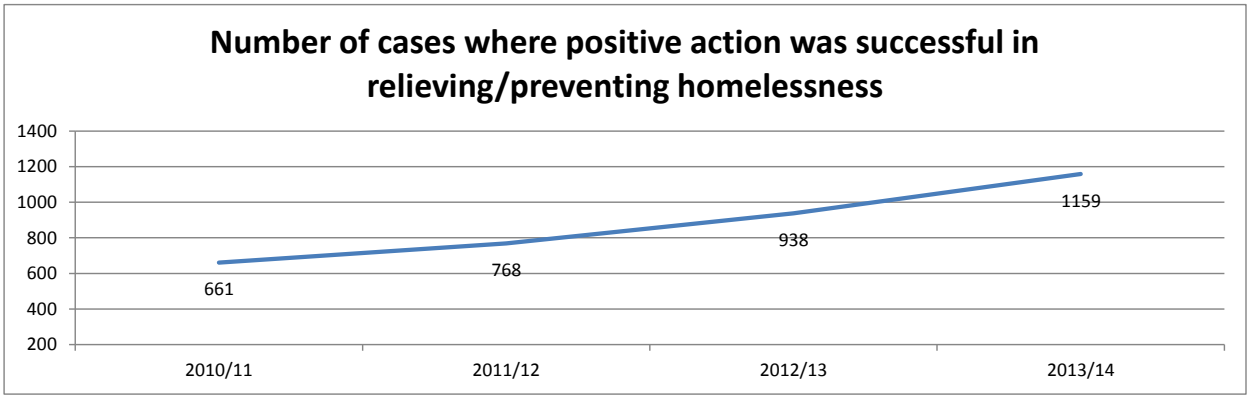
Figure 85: Applicant Households for which decisions were taken during the quarter



In 2013/14, the number of cases where positive action was successful in preventing / relieving homelessness increased by 221 cases. This continues the trend of increasing prevention, with cases having almost doubled in the last 4 years. This support to relieve homelessness cases will no doubt have a knock-on effect in improving the health of the people involved, through relieving stress and anxiety to living in a home which meets acceptable standards.

Nevertheless, in order to continue the efforts to alleviate and prevent homelessness, there needs to be further increases in affordable housing supply and better standards in the private rented sector to prevent evictions and enhance security of tenure.

Figure 86: Total cases where positive action was successful in preventing / relieving homelessness



During the period 2013/14, violent relationship breakdown was one of the 3 main reasons for people presenting to the Housing Solutions Service as homeless, behind financial hardship and housing options advice.

Table 113 shows the change in the number of people presenting to Housing Solutions as homeless, due to fleeing domestic abuse.

Table 113: Housing Solutions enquiries for violent relationship breakdown

Enquiry Type	2011/12	2012/13	2013/14	% change between 2011/12 and 2013/14
Relationship breakdown - Violent	423	431	457	8.0%

Of the actions taken by Housing Solutions officers to prevent homelessness in 2013/14, enabling clients to remain in their own home, the most successful prevention tool was the Remain Safe Scheme. This scheme offers free security measures to enable victims of domestic abuse to feel safe and remain in their home; in 2013/14, it prevented 283 households from becoming homeless.

Older persons

The ageing population means that there is an increasing number of older people (and people with disabilities) living in properties which are unsuitable for their needs or who require support to continue to live independently (and avoid the need for costly care).

The SHMA 2013 (see above) has highlighted that a significant amount of unmet need is accounted for by older persons. The study found that a significant number (over 40%) of persons aged 55 or over are seeking to move into more appropriate accommodation. It was also found that around 50% who wanted to move felt they could not do so – many for reasons of affordability or suitability of alternative housing. This is bound to impact on health needs.

Additional housing in the form of bungalows, extra care housing and other forms of specialised housing are vital if we are to meet this growing need.

A particular focus should be on the needs of those living with dementia to ensure that they can continue to live in the community with appropriate care and support.

Specialised housing

New specialised housing represents less than 10% of overall new affordable housing provision in the county. Alongside specialised housing for older persons there are a wide range of needs groups which could benefit from this type of provision ranging from those with learning difficulties; mental health needs; physical disabilities and other chronic health needs. In addition, vulnerable groups disadvantaged in the housing market are also in need of specialist housing if only on a temporary basis. This group includes ex-offenders; young people at risk of homelessness; people leaving the armed forces; and women at risk of domestic violence.

National Planning Policy Framework

The National Planning Policy Framework (NPPF) outlines the high-level objectives of a Local Plan[20]:

[20] CLG (2012) National Planning Policy Framework, Ministerial Foreword

"The purpose of planning is to help achieve sustainable development. Sustainable means ensuring that better lives for ourselves don't mean worse lives for future generations.

Development means growth. We must accommodate the new ways by which we will earn our living in a competitive world. We must house a rising population, which is living longer and wants to make new choices. We must respond to the changes that new technologies offer us. Our lives, and the places in which we live them, can be better, but they will certainly be worse if things stagnate."

There is a clear need to create a balance of these elements but the government has made it clear that Local Plans must support economic growth.

County Durham Plan

The County Durham Plan was submitted to the Planning Inspectorate and was subject to a formal examination in public in Autumn 2014. The Planning Inspector's interim report from Stage 1 of the examination has been received. We will be considering the planning inspector's interim report and establishing next steps in the development of the plan.

The County Durham Plan aligns with Council Plan ambitions in making the 'Altogether Wealthier' the highest of its five thematic priorities[21]. The ambition underpinning the vision of an Altogether Wealthier Durham is to focus on creating a vibrant economy and putting regeneration and economic development at the heart of all plans. The Council Plan recognises that a coordinated approach is needed to achieve this ambition, with public and private sector organisations and residents working together. The ambition also focuses on Durham City as a driver for growth, and the need to capitalise on the untapped potential of the county's economic assets.

The County Durham Plan recognises the importance of the employment rate as the key driver for stimulating economic growth in the county. Increasing levels of disposable income and the number of businesses should also begin to reduce deprivation in some localities. It recognises that the employment rate needs to return to 73% over the period to 2030, through business growth, inward investment and business creation in order to return the economy to pre-recession levels. The County Durham Plan also highlights the need to continue to invest in skills development, supporting our residents to access jobs, and support vulnerable residents, to improve quality of life alongside economic prosperity. It contains prospects to provide at least 31,400 net new dwellings across the county over a period to 2030.

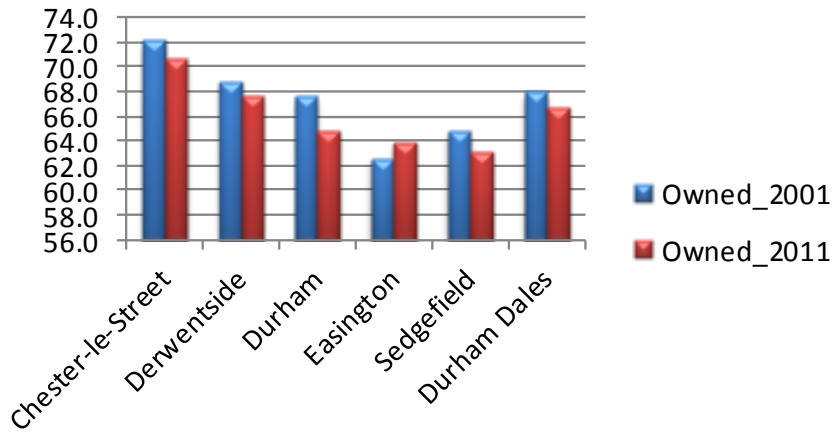
Spatial planning is an enabler, so that how places are planned affects us all adversely or well. 'Good spatial planning helps improve the liveability of areas'[22]. The National Planning Policy Framework recognises the role spatial planning has in promoting health (DCLG, 2012).

[21] The five thematic priorities of the Council Plan are Altogether Wealthier, Altogether Better for Children and Young People, Altogether Healthier, Altogether Safer, Altogether Greener

[22] Barton H (2009). Land use planning and health and well-being. Land Use Policy, vol. 26, S 115-S123 accessed at www.apho.org.uk/resource/item.aspx?RID=122156

Exploratory work carried out by the National Institute for Health and Care Excellence[23] suggests that the benefits of undertaking high quality, comprehensive spatial planning outweighs the costs by a significant margin. Two interventions, walking and cycling infrastructure and retrofitting homes with insulation had significant outcomes which outweighed costs by 60:1 for walking, 168:1 for cycling and 50:1 for insulating homes.

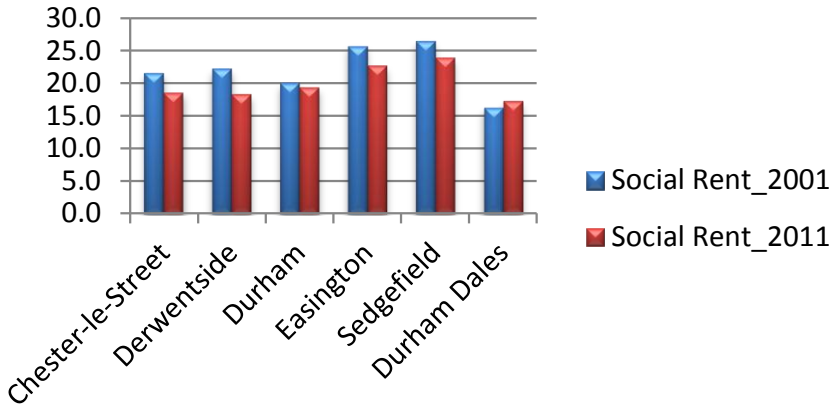
Figure 87: Census 2001/11 – Tenure: Owned



Tenure

Home ownership figures have shown a decrease from 2001 to 2011 across all CCG localities, except for Easington where there has been a slight increase from 62.6% in 2001 to 63.9% in 2011. Durham City had a 2.9% decrease in home ownership over the 10 year period, and showed the biggest decline in ownership across all localities.

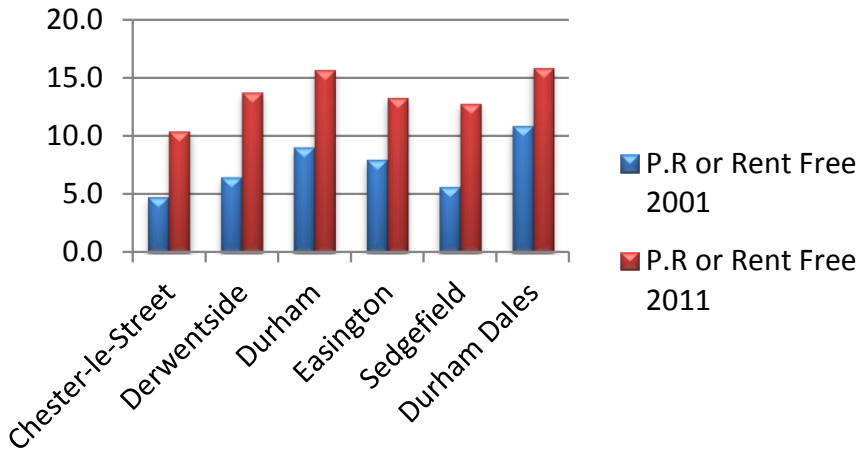
Figure 88: Census 2001-11 – Tenure: Social Rented



[23] National Institute for Health and Care Excellence (2013). Spatial Planning for Health: Programme of evidence review work. www.nice.org.uk/guidance/index.jsp?action=folder&o=53883

Most areas showed slight decreases in the number of properties which are social rented between 2001 and 2011. However the Durham Dales had an increase of 0.9%.

Figure 89: Census 2001-11 - Tenure: Private rented or living rent free



The private rented / living rent free sector showed the biggest changes out of all tenure types over the 10 year period, with all areas showing an increase in private rented / living rent free households. Derwentside had the biggest overall increase, from 6.5% in 2001 to 13.8% in 2011 (7.3% increase).

The impact of welfare reforms in the private rented sector is arguably more acute, where 12,600 households are affected. These changes started in 2010 and were some of the earliest of the government's welfare reforms and in County Durham will save £13m per year from 2013 onwards. Specifically, these changes lower the amount of benefit payable to tenants, thereby lowering tenants' income. In some cases this leads to accumulating arrears and potentially eviction.

Lifetime Neighbourhoods

The accessibility of the local neighbourhood is important particularly as we get older. For people to remain independent in their homes they need access to shops, transport and other services. Poor access exacerbates social exclusion which has an impact on health and social care services. The County Durham Plan offers opportunities to improve neighbourhoods.

Role of Housing Providers

Housing providers can offer services which enhance community development and resilience through 'added value' work, ranging from employment initiatives through to community play schemes. This focus on enhancing wellbeing in communities can help to promote independence for individuals.

Local growing and short food supply chains

Short food supply chains (SFSC's) have potential to contribute to more sustainable food systems, rural development and healthier communities[24]. Marmot (2010)[25] argues that one of six policy objectives is about 'creating and developing healthy and sustainable places and communities'. As part of the recommendations he argues that improving the food environment in local areas across the social gradient is one way to prioritise policies and interventions which reduce health inequalities and mitigate climate change:

- Provides opportunities to create employment not just in growing food but in the supply chain and an outlet for the products.
- Creating learning opportunities to assist people build their knowledge and skills in food production related jobs.
- Sustainability. Reduced carbon from lower food miles, reduced waste.
- Building community resilience.

Access to affordable, safe and nutritious food is essential to health and wellbeing of individuals. Food sourced locally is often fresher and more nutrient rich as there is less need for preservatives due to the shorter duration of transportation and storage which will help reduce damage and spoilage.

SFSC's lead to an increased knowledge of food by consumers and therefore the adoption of a healthier diet. This is the case with a range of social groups but in particular school children.

Whilst the direct links between health and locally sourced food are hard to demonstrate, it can be said that fruit and vegetables which have been harvested locally are fresher and therefore higher in vitamins. Grass fed meat is healthier than meat fed on a diet of concentrates. It is also easier to find out what is in your food when it is sourced locally.

Community growing provides benefits to the individual for mental health and wellbeing, levels of physical activity and improved access to healthy food. There are also wider environmental and social benefits from engaging local groups in food growing as well as the aesthetic improvement to the public realm. The personal, environmental and economic benefits of community-food growing include:

- Mental and physical health benefits, from eating more fresh food and being physically active outdoors.
- Community cohesion, because food growing sites can bring diverse groups of people together around a common interest.
- The potential for economic development, through learning new skills and exploring commercial options for dealing with surplus produce and the provision of social services.

[24]WWW,22/07/2014,http://www.foodlinkscommunity.net/fileadmin/documents_organicresearch/foodlinks/CoPs/evidence-document-sfsc-cop.pdf

[25] The Marmot Review (2010). Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010, Institute of Health Equity, London.

- Education – improved educational outcomes have been achieved at schools which grow and eat healthy food and have incorporated food growing into the curriculum.[26]

In recent times, Durham County Council has made strides in attempting to facilitate short supply chains and local growing by signing the Sustainable Local Food Strategy[27] and Food Charter[28].

Durham University has made excellent progress in sourcing locally. For example, its milk and yogurt come from Embleton Hall Dairies (nr Wingate), its pork from Houghall College, and fruit and vegetables are sourced locally via a wholesale intermediary.

DCC has procured all its eggs and milk from local suppliers. In addition, Taylor Shaw were successful when the school meals contract was procured and now provide meals to most of the primary schools in the county. They have been awarded a Bronze level Food for Life Catering award.

Individual consumers can purchase local food from Farm Shops, Farmers Markets, and a small number of Box Schemes. Some independent retailers (butchers, greengrocers) also sell local produce. Durham Local Food Network has over 400 members.

The economy

Productivity and gross value added (GVA)

County Durham has historically suffered from a low wage economy and continues to fall behind its peer group authorities when comparisons of productivity are made. Productivity in the county remains sluggish and is constrained by the relatively large number of persons of working age in the county on state benefits and low earnings.

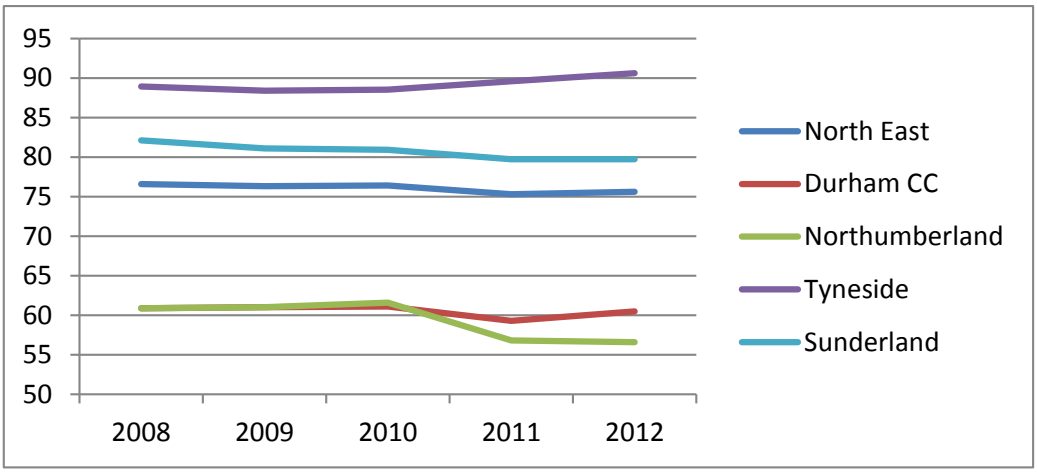
GVA is a commonly used indicator for the overall state of the economy. In County Durham, the level of GVA (which in basic terms is the value of goods produced in the area) has been falling relative to the national average for a number of years. This indicator sets the county against the national average. Higher levels of GVA are generally associated with high levels of employment and high levels of knowledge-based private sector businesses. The lower than average value in County Durham is attributed to low productivity through higher than average numbers of benefit claimants, in particular, out of work benefits, and also from the types of businesses located in the county (predominantly lower value industries and a large number of public sector jobs). Daily net outward commuting from the county to more highly remunerated employment in the surrounding conurbations also has the effect of lowering the per capita GVA figure; but this is generally small when compared to the other factors listed above.

[26] www, 24/07/2014,Planning sustainable cities for community food growing, http://www.sustainweb.org/publications/?id=295
[27] www, 24/07/2014, http://fooddurham.net/wp-content/uploads/2014/03/SLFS-2014.pdf
[28] www, 24/07/2014, http://fooddurham.net/

This reflects the issue regarding the economic scale and specialisation within the county and the relatively limited development of higher value added economic activity and investment. County Durham's GVA is amongst the lowest in the country and persistently hovers around 61% of the national average, placing it sixth lowest of all Nomenclature of Units for Territorial Statistics (NUTS) areas; by this we mean that the types of jobs located here are not generating high levels of business productivity (profit, in simple terms) compared to the rest of the North East and to the rest of the UK.

Low value added activity reflected in the shift away from manufacturing toward public and private services has a high weighting on the county's productivity. The current business base is dominated by important service and public sectors like the university, NHS and civil service which do not have their full value captured by the overall GVA statistic. Net outward commuting from the county also artificially deflates its GVA to some extent. This is reflected in County Durham's residence-based GDP figure (67% of the EU28 average in 2010) which is slightly higher than its workplace based GVA indicator at 61% of the UK average.

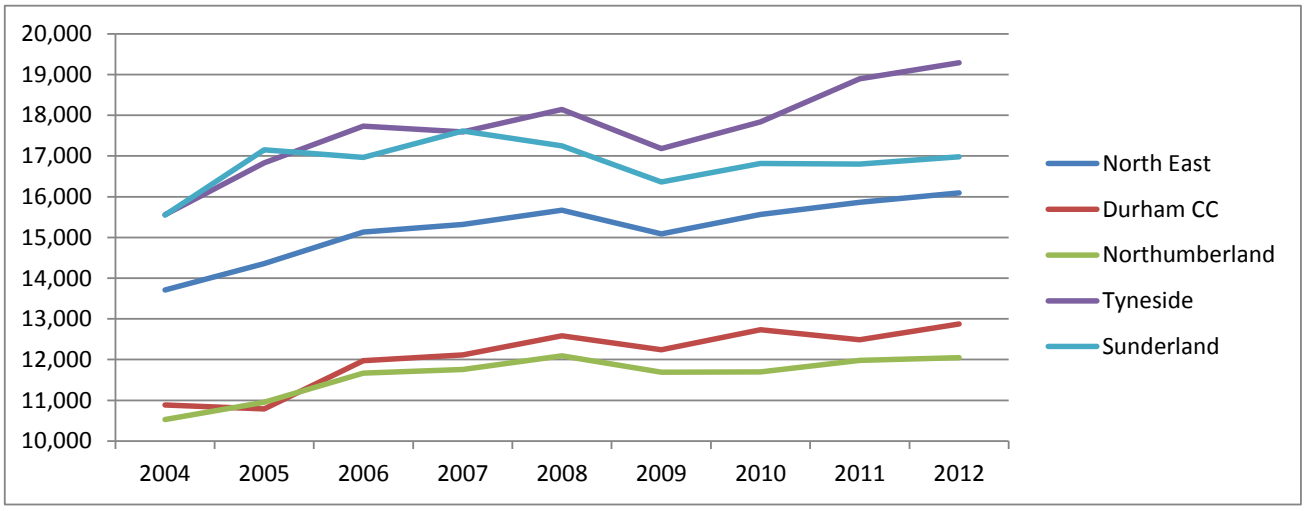
Figure 90: Gross Value Added per head index (UK=100) – 2008-12 North East and North East LEP Area



Source: ONS Regional Accounts

Current GVA (2012) for the county is £12,875 per capita and £16,091 for the North East. By comparison, the corresponding UK figure is £21,674.

Figure 91: Gross Value Added per head (£'000) 2004-12 – North East and North East LEP Area



Source: ONS Regional Accounts

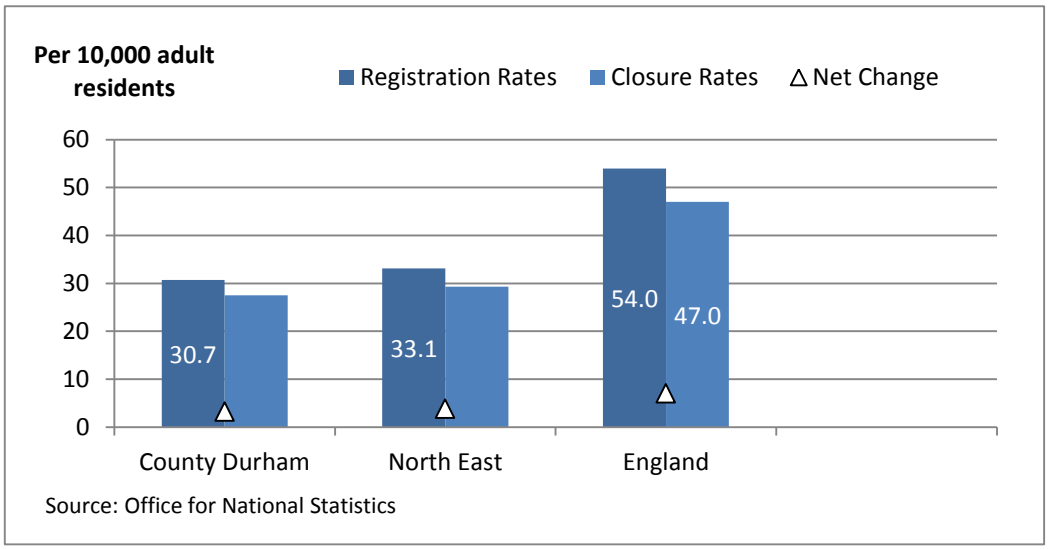
Business start and death rates

County Durham has far fewer business registrations per capita than the national average. Business registrations are an indicator of new jobs and particularly entrepreneurialism. Depending on the VAT threshold (£81,000 2014/15), not all new businesses are recorded within the context of Inter-Departmental Business Register (IDBR) data. However, this measure enables direct comparison with the business formation rate in the rest of the country. IDBR data include both VAT and/or PAYE registered businesses. Growth in new business registrations (and/or a reduction in de-registrations) is a sign of a developing economy.

There were 14,785 VAT and/or PAYE registered businesses in County Durham (IDBR, March 2013), representing 19.6% of all businesses in the North East (75,375). In line with the national trend, almost two thirds of businesses are owner managed or micro employing up to 4 people.

Whilst business survival rates in County Durham are on a par with, and in some years better than, those for the North East and England, the number of registrations during 2011 at 30.7 per 10,000 resident adult population is below the North East at 33.1, and well below England at 54.0.

Figure 92: Business registrations and closures per 10,000 resident adult population (2011)



BankSearch[29] data provide a more current perspective on business start-up trends in County Durham as well as on a comparative basis. The data include all businesses which start trading at the point of opening a business bank account. There were 9.4% fewer business start-ups in County Durham during 2013 (2,720) compared with 2012 (3,002).

This growth rate ranked County Durham at 123 out of the 326 English data districts.

8.6% fewer businesses started in the North Eastern Local Enterprise Partnership (LEP) area during 2013 compared with 2012. This growth rate ranked the North Eastern LEP 7th out of the 39 LEPs nationally.

In all parts of the North Eastern LEP area (County Durham, Northumberland, Gateshead, Newcastle upon Tyne, North Tyneside, South Tyneside and Sunderland) the start-up trend increased to a peak in 2010; since then there has been a moderate decline in all areas. This is an anticipated trend during a period of recession when start-up activity might be expected to rise initially and, subsequently, taper off.

On an annual basis, County Durham has around a 24-27% share of regional start-up activity (relative to a 20% share of population and working age population of the North Eastern LEP area total).

[29] BankSearch Information Consultancy Ltd. is a leading software house and information consultancy specialising in the financial and public sectors.

Table 114: The number of start-ups in County Durham and the wider North Eastern LEP area

Year	County Durham – number of start-ups	County Durham year on year % change	North Eastern LEP – number of start-ups	North Eastern LEP year on year % change	County Durham share of NE LEP total start ups
2008	3,125	N/A	11,550	N/A	27%
2009	3,116	-0.3%	11,646	0.8%	26.7%
2010	3,469	11.3%	12,929	11.0%	26.8%
2011	3,217	-7.2%	12,421	-3.9%	25.9%
2012	3,002	-6.7%	12,243	-1.4%	24.5%
2013	2,720	-9.39%	11,190	-8.6%	24.3%

The rate of decline in start-up activity has been more marked in County Durham (post 2010) relative to the wider North Eastern LEP area.

Growth in the number of start-ups across the English regions has fallen. During 2013, the North West (-6.1%), North East (-6.7%) and the West Midlands (-9.3%) saw the strongest 'growth' compared to 2012. The South West (-12.2%), South East (-12.6%) and Yorkshire and the Humber (-12.9%) have had the weakest 'growth.'

Two thirds of start-ups in County Durham are in recreational, personal and community service / real estate, professional services / wholesale and retail trade activities.

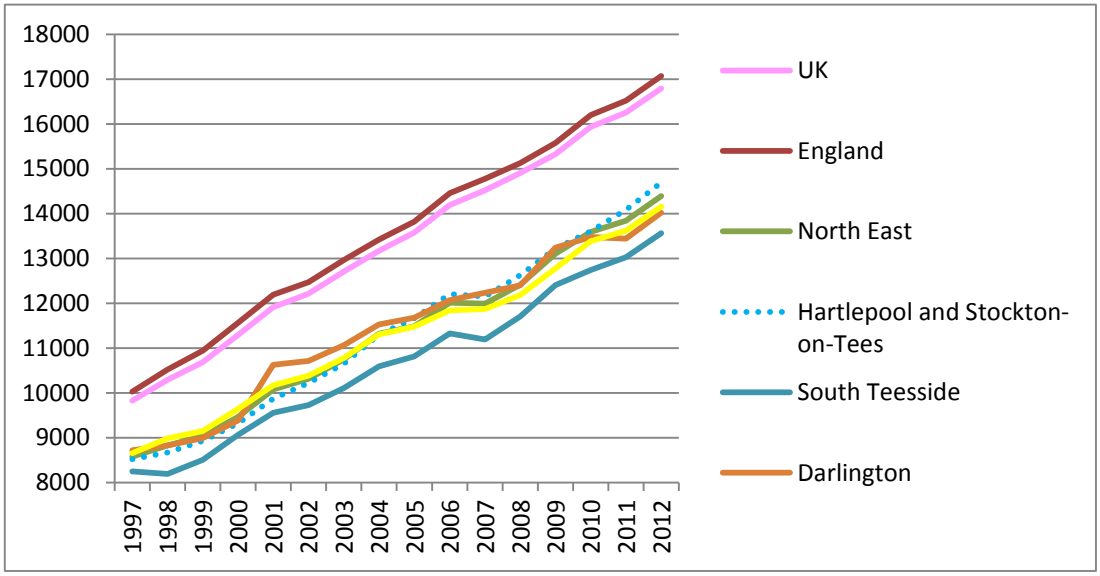
The intensity of start-up activity is spatially polarised – highest in and around Durham City, lowest in East Durham. During 2013 there were wide variations in the range of start-up activity – highest in Barnard Castle West (75), Barnard Castle East (60) and Delves Lane and Consett South (60) and, lowest in Belmont (25), Deneside (17) and Easington (27).

Whilst the creation of businesses and returning to employment increases the likelihood of improved health, almost threefold, and doubles the quality of life[30], losing your job and being unemployed can have detrimental impacts on one's health. One in seven men develop clinical depression within six months of losing their job, while prolonged unemployment increases the incidence of psychological problems from 16-34 per cent with major impacts on an individual's spouse[31].

In County Durham the number of business deaths has been on a steady decline over the last 3 years, with 1,170 businesses ceasing trading in 2011. This is a decrease of 75 businesses from 2010, when 1,245 businesses ceased trading. With the improving economy and less businesses ceasing trading, this can only have a positive impact on health and wellbeing.

[30] Carlier et al, 2013
[31] Royal College of Psychiatrists, 2013; Paul & Moser, 2009, Marcus, 2012

Figure 93: Gross disposable income



Source: Regional Accounts, ONS

Although disposable income increased in monetary terms during the recession period, if we look at the rate of growth in disposable income, it slowed across almost all regions between 2008/09. The North East and the West Midlands were the only regions where growth in disposable income increased during this period, although at 0.2 and 0.4% respectively.

Factors affecting this slow-down in the rate of growth of disposable income include unusually low interest rates for savings, a reduction in numbers of people in employment, a fall in house prices, as well as minimal increases in wages. All of this can have a detrimental impact on health, in particular on psychological wellbeing.

Employment

The relationship between employment, the economy and health status is not straightforward.

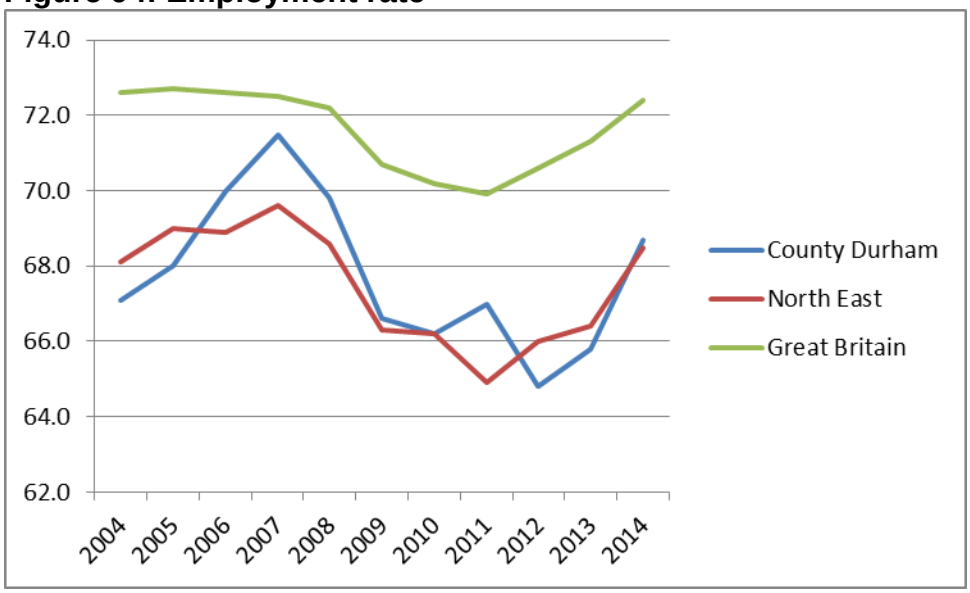
Evidence has been found to show a relationship between unemployment and poor health.[32] The evidence suggests a strong association between unemployment and poor mental health. The complex relationship though is less clear, in part confounded by other variables such as educational attainment, the environment and economic circumstances.

Employment is often a reflection of the health status of individuals, but also of the probability of being in work with a given health status[33]. Studies indicate that work is generally good for physical and mental health and wellbeing, whereas worklessness is associated with poorer physical and mental health. One of the leading causes of worklessness and sickness absence in the UK is poor mental health. Those with poor mental health have employment rates of between 16-35 per cent[34].

[32] Carl Mclean, Chris Carmona, Simon Francis,
Clare Wohlgemuth and Caroline Mulvihill - Worklessness and health –What do we know about the causal relationship? – March 2005.
[33] Working for a Healthier Tomorrow, 2008
[34] London Mental Health and Employment Partnership, 2012

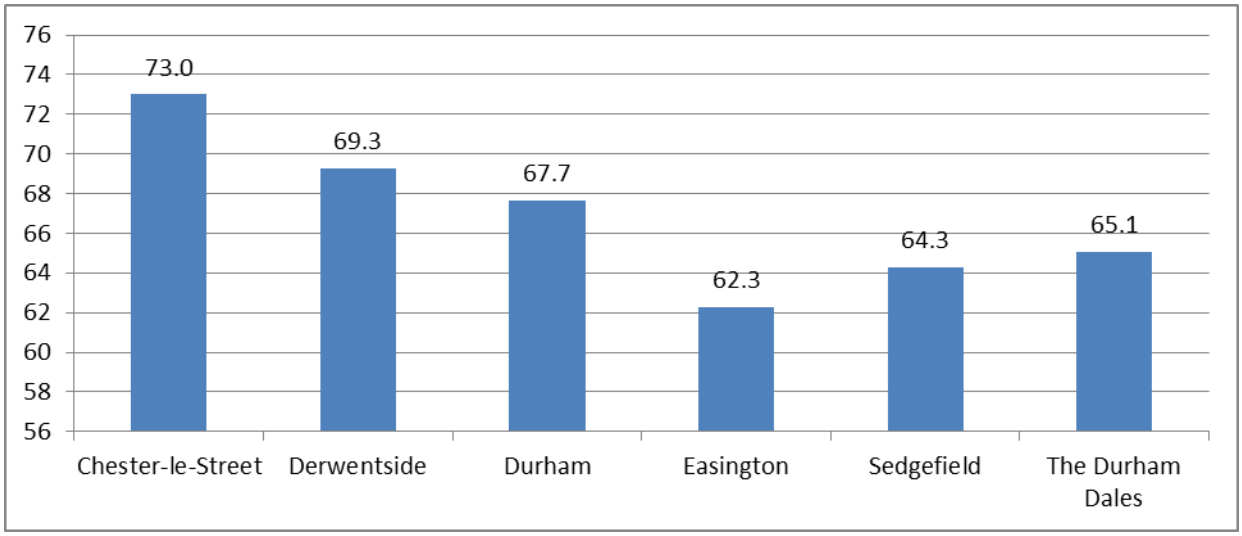
The employment rate in the county was relatively high up to 2006/07 at 71.2%. However, with the onset of the recession the employment rate fell to a low of 64.5% in 2010. The employment rate has risen slightly since then and was 67.9% at September 2014. This is below the national average of 72.2% and the North East rate of 68.1%

Figure 94: Employment rate



Over the last 6 years, the CCG locality of Chester-le-Street has had the highest average employment rate of 73%. This is due to the fact that this area is in the north of the county and people commute to more highly remunerated employment opportunities in Newcastle and Sunderland.

Figure 95: Average employment rate over last 6 years, by Clinical Commissioning Group Locality / Constituency



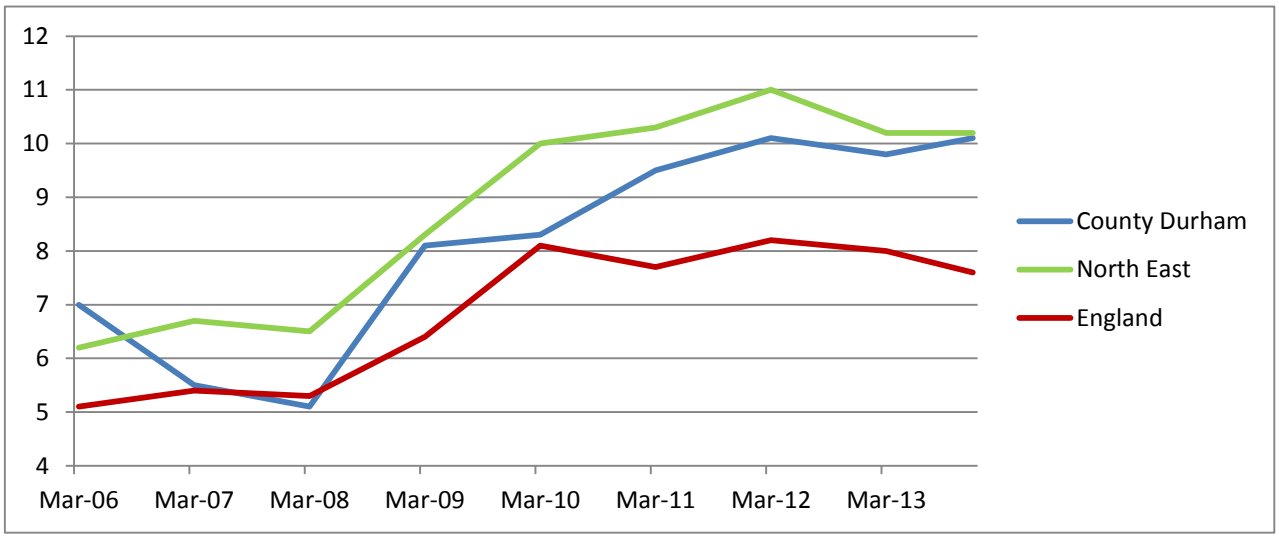
The county's commuting ratio is 1.157 [35]. The commuting ratio is the ratio between the number of workers in County Durham (resident working age population) and the number of jobs available within the county. A value of 1.157 indicates that there are more resident workers in County Durham than jobs and, therefore, that a proportion of workers are commuting outside of the county to employment opportunities in adjacent areas. On average the daily net outflow is in the order of 30,961 (Census, 2011).

The employment rate could be increased by continuing the trend of recent decades through which the county's residents have accessed employment in Tyne and Wear as well as the Tees Valley. The Easington CCG locality showed the lowest average employment rate of 62.3%. The ambition is for all parts of County Durham to have the same employment rate.

The unemployment rate has shown a steady increase since 2006/07. County Durham had remained below the regional average for this period, however in March 2009 it reached 8.1%, 0.2 % less than the North East rate with unemployment at 8.3 %. This is the closest unemployment has been to the regional figure over the last 8 years, however the figure remains high when compared to the national figure of 6.4%.

Since then the unemployment rate for County Durham peaked in March 2012 at 10.1% and despite a slight dip in March 2013, 9.8%, is back up to 10.1% (December 2013).

Figure 96: Unemployment rate



The incidence of long term unemployment amongst young people has grown significantly over the last few years and 1,275 young people (aged 18-24) have now been claiming JSA for more than 6 months, representing a rate of 12.4%. This represents around 40% of all JSA claimants aged 18-24 and is a concerning development in terms of its impact on self-esteem.

[35] Census 2011, Travel to Work Data

The increasing unemployment rate can have a detrimental effect on health. The effects of unemployment on health are well documented. One recent study by a researcher at Harvard School of Public Health found that in the year and a half after losing their jobs, laid-off workers were twice at risk of developing high blood pressure, diabetes or heart disease[36].

High unemployment also raises stress levels amongst the unemployed and employed. A study in Michigan found that those who were worried about their jobs were significantly more likely to develop depression or suffer anxiety attacks or both. They were more likely to suffer from depression and poor health than those who lost their jobs and got a new one.[37]

Child poverty

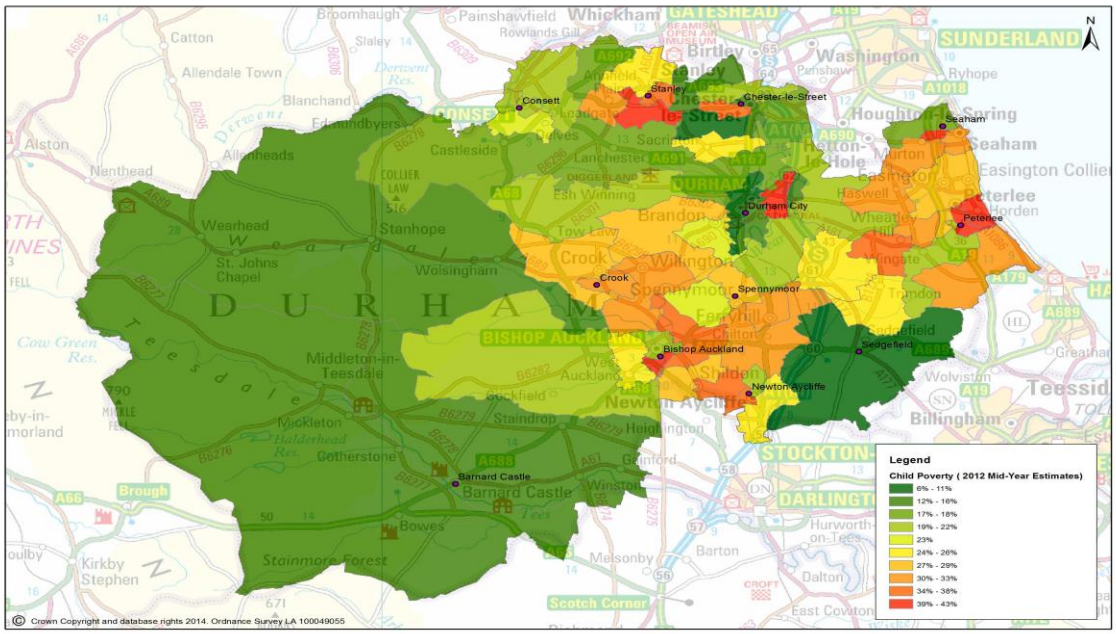
Long term unemployment can lead to child poverty amongst disadvantaged families. Children from disadvantaged families are more likely to be born underweight and weigh, on average, 200g less than the babies in the richest families.

Children living in poorer families are also two and a half times as likely to suffer from chronic illness as toddlers and twice as likely to have cerebral palsy. They are also over three times as likely to suffer from mental health disorders as those in well-off families.[38]

23% of children aged under 16 years live in poverty compared with the England average of 20.6%.

21% of children are from workless households; this is higher than both the North East and England.

Map 4: Child poverty in County Durham, 2012 mid–year estimates by wards



[36] David Futrelle – Is high unemployment making us all sick?

[37] Burgard, Sarah, Lucie Kalousova, and Kristin Seefeldt. 2012. "Perceived Job Insecurity and Health: The Michigan Recession and Recovery Study." PSC Research Report No. 12-750. January 2012.

[38] Campaign to end child poverty, http://www.endchildpoverty.org.uk/

Wards of Horden, Gilesgate and Woodhouse all have child poverty above the 40% mark.

Average weekly earnings

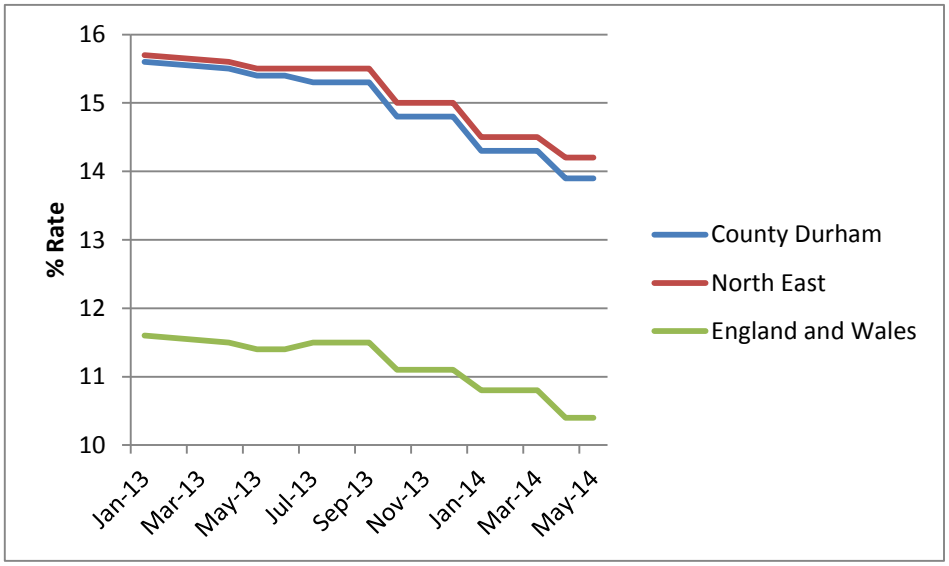
The average weekly earnings for full time workers in County Durham, 2013, was £466.4. This has risen by £8 since 2012, but unlike last year is now below the regional average for the North East which stands at £472. The national average is higher at £518. The average weekly earnings for County Durham have continued to rise annually, with 2012 showing the highest annual increase in the last 5 years, with a 4.3% increase. 2013 showed a smaller increase of 1.8%.

Worklessness

Worklessness is a much wider indicator than unemployment, and is generally associated with poor physical and mental health. From February 2013 the definition of worklessness has been changed from those people of working age who claim out of work benefits to the statistical group used by the Office for National Statistics to describe people fit for work but not in employment. This group includes: Job Seeker Allowance Claimants, ESA and Incapacity Benefit Claimants, Lone Parents and people claiming other income related benefits.

As of May 2014, the number of people in worklessness fell to 45,650 (13.9%). This shows a decrease from the previous year of 0.4%, and confirmed a declining trend over the past one and a half years.

Figure 97: Worklessness

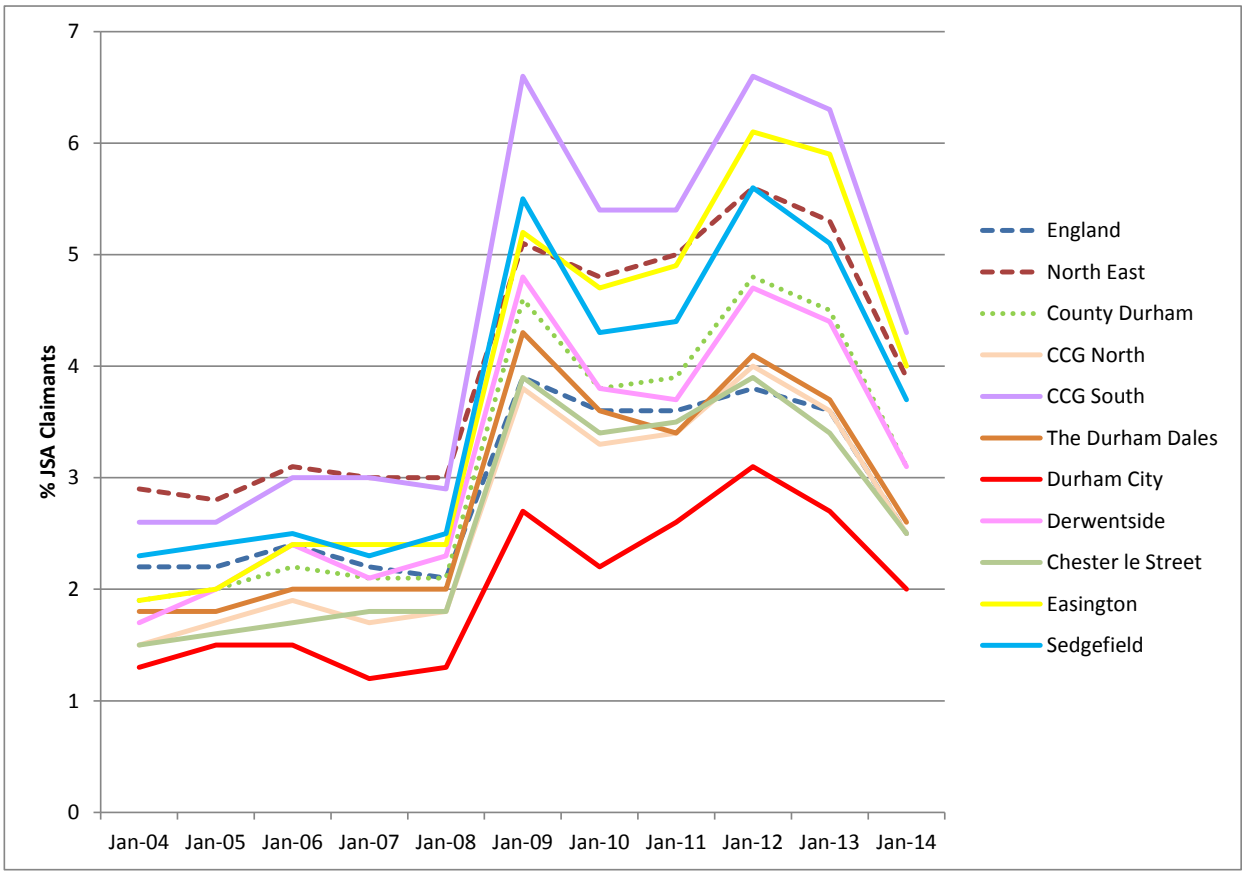


Job seekers allowance claimants

The number of people claiming Job Seekers Allowance (JSA) in the county had been steadily falling for 11 years until June 2004, where it remained relatively constant at around the 2% mark until the onset of the current economic recession in 2008.

The total JSA claimants in May 2014 was 10,276, 3.1% of the working age population. This is below the regional rate of 3.9 but still above the national average of 2.5. The total JSA claimants has shown a decline over the last 2 years from the high point of 15,545, 4.7%, in June 2012 which was the highest the total has been for County Durham in the last 10 years.

Figure 98: Job seekers allowance count



Welfare rights cases

Durham County Council's Welfare Rights Service helps people with questions and problems on a wide range of social security benefit and tax credit issues.

This includes providing information on benefit entitlement and how to claim, checking that people are receiving the correct amount of benefit, advising how benefits are affected if circumstances change, giving advice on how to appeal against a decision on a claim and in some circumstances, advocating at an appeal or other dispute, or representing at a tribunal hearing.

Table 114 shows that people with mental health problems and people with a physical disability, frailty or sensory impairment are most likely to request assistance with benefits.

Table 115: New welfare rights cases for quarter 1 of 2014/15 - by client type and age

Client Type	<16	16-17	18-64	65+	Not recorded	Total
Carer	1	0	10	3	0	14
Learning disability	4	4	31	1	0	40
Mental health	2	0	110	1	1	114
Physical disability, frailty or sensory impairment	2	1	267	203	5	478
Substance misuse	0	0	1	1	0	2
Vulnerable person	0	0	3	1	0	4
Other	0	0	49	7	1	57
Total	9	5	471	217	7	709

NB The total is less than the total number of all new cases opened by the service (723) as this table omits clients for whom Client Type was not recorded - 14 (1.94%) of all cases

Use of foodbanks

People in monetary crisis can access food from the County Durham foodbank after being issued with a foodbank voucher by a referral organisation, such as:

- Citizens Advice Bureaux
- Jobcentre Plus
- One Point or Sure Start
- Housing charities
- Other local charities
- Drug and alcohol services
- Durham County Council social care and health services
- Health visitors
- The Probation Service.

Vouchers can be exchanged for food from one of fourteen distribution centres situated across the county. For those people unable to access a distribution centre, pre-packed Emergency Food Boxes are held by partner agencies to distribute as they visit clients in need.

Since it started in late 2011 the foodbank in County Durham has grown rapidly both in its coverage of the county and the numbers fed. In the first 12 months 3,209 people were fed. In 2013 the figure was 11,684 (an increase of 264%) and the numbers continue to rise.

As of August 2014, food was provided for 3 days to around 1,300 people each month, representing approximately 800 distinct individuals, as the average number of times someone visits the foodbank is 1.6.

Individuals accessing foodbanks are offered money advice and signposted to other support services which can offer help with other difficulties impacting on their health and wellbeing.

Skills / qualifications data

The number of people with higher level qualifications (NVQ 3 and NVQ4 or higher) in 2013 has risen slightly from 2012 at 47.6% and 45.8% respectively. The number of people with no qualifications has shown a decrease of 2.2% from 2012. 11.3% of people in County Durham have no qualifications, which is above both the regional and national rates of 10.7% and 9.1% respectively. County Durham is also below the regional and national rates for the number of people holding NVQ Level 1-4 qualifications.

Easington has the highest level of people with no qualifications at 15.4%. Durham City shows the highest number of people with Level 4 qualifications or higher at 32.3%.

The proportion of young people in the county passing 5 GCSEs including Maths and English at Key Stage 4 was 62.6% in 2012/13. This has risen from 40.4% in 2005/06. The 2012/13 percentage is above both the North East (58.8%) and England (59.2%) averages. This places County Durham inside the top third of local authority areas in England.

Figure 99: Qualifications – County Durham, North East and England, January - December 2013

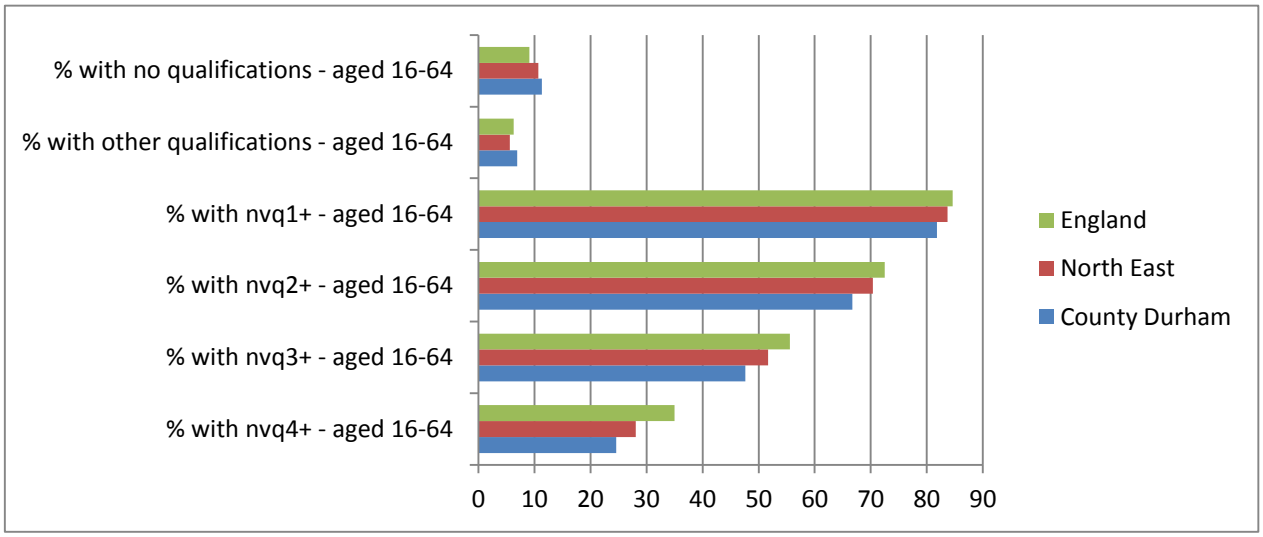
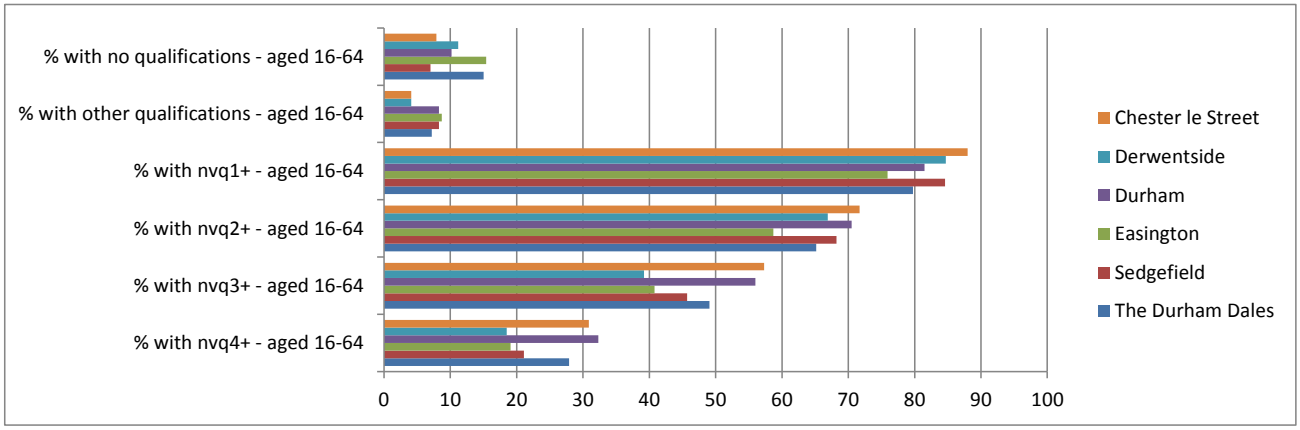


Figure 100: Qualifications by County Durham area. January - December 13



3. Which groups are most vulnerable and why?

Many health-related issues are worse for people living in poverty. These include the unemployed and people living in poor quality housing.

People living in poverty are likely to experience fewer life chances, shortened life expectancy, poorer health and fewer opportunities to lead a flourishing life. They are less likely to benefit from education to the same degree as others; are less likely to be in professional, managerial and skilled jobs; and are more likely to live in poor housing and in neighbourhoods where crime is more prevalent and where community safety is threatened.

All of these conditions and circumstances can have an adverse effect on physical and mental health and wellbeing.

4. What are people telling us?

The 2012 Household Survey conducted as part of the Strategic Housing Market Assessment (SHMA 2013) asked respondents how satisfied or dissatisfied they were with the quality of their accommodation. Overall 89% of respondents expressed satisfaction (54% were very satisfied and 35% were satisfied); 6.9% were neither satisfied nor dissatisfied; a total of 4.1% of residents expressed degrees of dissatisfaction, of which 0.9% was very dissatisfied.

Data indicate that households in East Durham (7.3%) and Central Durham (4.2%) were more likely to express dissatisfaction. Levels of dissatisfaction exceeded 10% amongst unfurnished private renters (11.1%).

5. What are the implications for the future?

Unemployment and worklessness play a significant role in increasing poverty and social isolation for individuals. In the coming years the county needs to increase economic activity and tackle the worklessness problem. This can be addressed by looking at:

- Capitalising on economic assets to stimulate investment and growth.
- Tackling our worklessness problem by supporting suitable job creation, especially for workers with a limiting health condition.
- Addressing the skills balance in the labour market and the types of jobs located in the county.
- Improving long term sustainability of employment within the county.
- The relationship between economic growth and the housing market.

A **Regeneration Framework** has been produced for each of the 12 main towns across County Durham. A number of key projects taken from the frameworks are planned for delivery over the next three years, including physical regeneration improvements in Peterlee, Seaham, Crook, Consett, Stanley, Spennymoor and Shildon town centres.

The County Durham Plan will seek to guide the future development of place to improve the lives of its existing and future residents. The principal aim is to achieve and maintain an employment rate at around 73% (currently at 66.2%) by 2030.

The main threat to the county's economy over the last few years has stemmed from the recession in the UK. However, in 2014, some degree of recovery in the UK economy has occurred, but while there is light at the end of the tunnel there are still risks to take into account such as the Eurozone and the wider global economic environment.

6. Key messages

- The employment rate in County Durham has started to increase. The proportion of 16-64 residents in employment in the year to September 2014 increased to 67.9% which is 2.5 percentage points higher than the same period to September 2013. This is the equivalent of an extra 7,200 residents in work.
- In the context of the recent economic downturn and rising energy costs, living in a cold home can present particular risks to health. It is estimated that 25,079 households in County Durham experienced fuel poverty in 2012, which is 11.4% of all households with a significantly higher percentage in rural off gas communities. This is just below the regional average (11.6%) but higher than the national average (10.7%). Fuel poverty figures have declined as a consequence of the new national fuel poverty indicator; this is not to be viewed as fuel poverty being on the decrease. In fact according to the national fuel poverty charity (NEA) it is expected that under the new definition the level and depth of fuel poverty could show an annual increase.
- Homelessness – Number of people accepted as being homeless and in priority need. This fell for the 2nd year in a row and is now half of what it was in 2011/12, at 198. The number of cases of prevention increased by 221. This continues a trend of increasing prevention, with cases almost doubled in the last year. This could also explain the decrease in accepted homelessness cases.
- Long term unemployment amongst young people has grown significantly over the last few years and 1,275 young people (aged 18-24) have now been claiming JSA for more than 6 months, representing a rate of 12.4%.

- By May 2014, there were some 45,650 persons (13.9%) workless in the county - a decrease from the previous year of 0.4%. This confirms a declining trend over the past one and half years.
- 23% of children aged under 16 years live in poverty compared with the England average of 20.6%.
- The total number of Job Seekers Allowance (JSA) Claimants in May 2014 was 10,276, 3.1% of the working age population. This is below the regional rate of 3.9% but still above the national average of 2.5%. The total number of JSA claimants has shown a decline over the last 2 years from the high point of 15,545, (4.7%), in June 2012 which was the highest the total has been for County Durham in the last 10 years.
- The number of people with higher level qualifications (NVQ 3 and NVQ4 or higher) in 2013 has risen slightly from 2012 at 47.6% and 45.8% respectively. The number of people with no qualifications is at 11.3%; this is a decrease of 2.2% but is above both the regional and national rates of 10.7% and 9.1% respectively.
- The proportion of young people in the county passing 5 or more GCSEs at C or above including Maths and English at Key Stage 4 was 57.6% in 2013/14. This percentage is above both the North East (54.6%) and England (56.6%).

Altogether Greener

1. Introduction

The environment in which people live can have direct and indirect impacts on their health and wellbeing, and it can be harnessed to improve physical and mental wellbeing. The County Durham Environment Partnership has four primary objectives, all of which contribute towards improving the wellbeing of communities in the county:

1. Engender pride in our communities to deliver a cleaner, more attractive and sustainable environment.

2. Support the work of the Local Nature Partnerships in order to maximise the value and benefits of Durham's natural environment.

3. Mitigate the impact of and adapt to climate change.

4. Promote green infrastructure sustainable design and Durham's built heritage.

2. What are the levels of need?

Using the built and natural environment to increase physical activity
Over the last few decades, technological advancements combined with increased affordability have changed our lives dramatically - not only at home where it is commonplace to have a wide range of labour saving devices and access to a car, but also in our workplaces where the number of 'active' jobs is falling. As a result of these changes, there has been a rise in physical inactivity.

Lack of physical activity has a negative impact on health; it is a key contributor to the obesity epidemic, increases the risk of cardiovascular disease, Type 2 diabetes and some cancers. Research within the UK suggests that increasing access to parks and open spaces could reduce NHS costs of treating obesity by more than £2 billion *(Groundwork 2011).*

The Department of Health's Living Well for Longer report states that:

'Physical inactivity in the UK is a contributor to around 17% of premature deaths. The decline in regular physical activity in the last 50 years is well documented, although it is only in the last 5-10 years that we have had adequate data to describe the problem. This decline appears to be evident in most, if not all, areas of people's lives.'
(Department of Health, Living Well for Longer, April 2014)

In County Durham, 28.2% of the adult population, compared to 25.6% nationally, meets the government's target to participate in at least 30 minutes sport and active recreation of at least moderate intensity (including recreational walking and cycling) on at least 3 days a week *(Active People Survey 8, Sport England, April 2014).* This figure falls to 13.8% in those aged 55 and over.

Research has shown that a well-designed built environment with access to the natural environment can provide effective and relatively inexpensive opportunities for communities to increase their levels of physical activity. Improvements to cycling and walking routes, the availability of parks and open spaces and safe areas for children to play are examples of the contribution the environment can make in this area. The wide range of natural landscapes within County Durham, from the North Pennines AONB across to the Durham Heritage Coast, provide excellent opportunities to be active in natural settings.

As well as providing a means to increase physical activity, there is evidence that access to the natural environment can help people recover from illness and that it can prevent illness by reducing stress levels. Time spent in gardens and natural settings, and allotment and community gardening in particular, have been shown to have physical and mental wellbeing benefits.

Access to green space can also reduce mental health admissions, resulting in additional savings to the NHS. Similar independent studies in the Netherlands, Canada and Japan all showed that every 10 per cent increase in exposure to green space translated into a reduction of five years in age in terms of expected health problems.

The natural environment provides the population of County Durham with the chance to take part in voluntary work, with associated mental and physical health benefits as a result of physical activity and social interaction within a natural setting. There are 380 active members of the Durham Voluntary Countryside Rangers Service, with many more involved through other channels such as schools, colleges and corporate groups.

Mitigating and adapting to the impact of climate change

The reality of climate change is now generally accepted and although it may bring some localised benefits, such as fewer winter deaths in temperate climates and increased food production in certain areas, the overall health effects are likely to be overwhelmingly negative (*UK Climate Change Risk Assessment: Government Report, Defra 2012*).

In recent years, County Durham has experienced a higher frequency of extreme weather events and it is predicted that there will be an increase in the occurrences of major flooding as well as hotter summers. These effects will present a threat to health and wellbeing and plans are being developed to mitigate against the unavoidable impacts climate change will bring. These will also ensure that our communities are able to interpret these headline warnings, understand the likely impacts on them and prepare appropriately.

3. Which groups are most vulnerable and why?

Using the built and natural environment to increase physical activity
Physical environments which promote good health can be helpful in reducing socio-economic health inequalities. Living in an area with green spaces significantly reduces the effects of income-related health inequality. In greener areas, all-cause mortality rates are only 43% higher for deprived groups, compared to 93 percent higher in less green areas *(Mitchell R, Popham F. Effect of exposure to natural environment on health inequalities: an observational population study. Lancet 2008).*

However, access to green space is unequally distributed with people from more deprived areas having less access. Children in deprived areas are nine times less likely to have access to green space and places to play *(National Children's Bureau 2013*).

Mitigating and adapting to the impact of climate change
There is a direct link between extremely high temperatures and deaths from cardiovascular and respiratory disease. (During the 2003 European summer heatwave, more than 70,000 excess deaths were recorded). The elderly and those with pre-existing respiratory conditions, such as asthma, are more susceptible to extremely high temperatures. High temperatures increase air pollutants (ozone, pollen, allergens) which can trigger asthma attacks.

Floods contaminate freshwater supplies and heighten the risk of water-borne diseases. They also cause drowning and physical injuries, damage homes and disrupt health services. Long term environmental damage, involving air, water and changes to the eco-system, could be a greater risk.

We also need to consider the sources of pollution both in terms of the contribution we make to this and when addressing the quality of air, water and land. Air pollution, caused by road, rail, air and sea traffic, can be a potent contributor to several respiratory diseases, cardiovascular disease and cancer.

4. What are people telling us?

Using the built and natural environment to increase physical activity
Access to the natural environment is consistently ranked as important to our communities, giving them the opportunity to socialise, exercise and enjoy nature.

Users of the Durham Voluntary Countryside Rangers Service have provided feedback that they would like to see more guided walks provided at the service and through channels such as the Walk 4 Life scheme.

Mitigating and adapting to the impact of climate change
Having questioned 668 people, the County Durham Residents Survey 2010 identified that 54% were concerned about climate change and 34% were not concerned.

When considering variations in the level to which residents are not concerned about climate change, the Residents Survey identified that this is higher amongst those who live in Easington (42%) and Bishop Auckland and Shildon (39%), yet lowest amongst residents of Teesdale (25%) and Great Aycliffe and Middridge (25%). The following demographic groups are also most likely not to be concerned about climate change: those aged 16-24 (47%), 25-34 (37%) and 75+ (37%), private renters (40%), those living in the top 10% most deprived areas (43%), and those living in town and fringe locations (37%). In addition, residents of the Eastern Neighbourhood Services Area are the most likely not to be concerned about climate change (38%).

5. What are the implications for the future?

It is now recognised that walking and cycling are effective ways of boosting levels of physical activity for most of the population, but that there is a need for further investment in green infrastructure to support this *(BMA, Healthy Transport = Healthy Lives, 2012)*. Future development programmes will, like the Locomotion Way which links Shildon, the Locomotion Museum and Aycliffe Business Park, need to incorporate the infrastructure to support sustainable transport. Locomotion Way is half the length of the road route and is one of a number of cycling and walking improvements.

The county's extensive network of railway paths, which link many communities directly to the natural environment, and connect to the National Cycle Network, will continue to provide the opportunity for people to commute to work, education and services. Durham's Heritage Coastal Footpath, and our coastal bathing waters, will provide further means of using our natural environment to be active.

The incorporation of Sustainable Urban Drainage Schemes (SUDS) aims to reduce surface water flooding and improve water quality at a local level, both of which would have a positive impact on wellbeing.

Resilient and healthy ecosystems across our rural and urban landscapes all play a crucial role in absorbing and storing carbon, and thus helping to protect us from climate change.

6. Key messages

- Encouraging more physical activity is central to improving the health and wellbeing of the population and reducing overall health care costs.
- Parks, open spaces and the natural environment in general are vital, cost-effective resources which allow a range of physical activities to be carried out to increase a person's health and wellbeing.
- There will be an increased frequency of extreme weather which can have a negative effect on people's health. Plans are being developed to help people understand the likely impacts and prepare appropriately.

Abbreviations / Glossary of Terms

A&E	Accident and Emergency
AAP	Area Action Partnership
ADHD	Attention deficit hyperactivity disorder
AF	Atrial Fibrillation
ADHD	Attention Deficit Hyperactivity Disorder
AIDS	Acquired Immune Deficiency Syndrome
AIM	Assessment, Intervention and Moving on
AMHP	Approved Mental Health Professional
APHO	Association of Public Health Observatories
ASB	Anti-Social Behaviour
ASCOF	Adult Social Care Outcomes Framework
ASH	Action on Smoking and Health
ASSET	Youth Justice Board Assessment Tool
BESD	Behavioural, Emotional and Social Difficulties
BME	Black and Minority Ethnic
BMJ	British Medical Journal
BRE	Building Research Establishment
CAF	Common Assessment Framework
cc	correlation co-efficient
CCG	Clinical Commissioning Group
CCL	Clinical Commissioning Locality
CDYOS	County Durham Youth Offending Service
CHD	Coronary Heart Disease
CMD	Common Mental Disorder
CMHP	Community Mental Health Profiles
Co	County
COPD	Chronic Obstructive Pulmonary Disease
CPAG	Child Poverty Action Group
CSP	Community Safety Partnership
CVD	Cardiovascular Disease
DACT	Drug & Alcohol Commissioning Team
DCC	Durham County Council
DCLG	Department for Communities and Local Government
DDES	Durham Dales, Easington and Sedgefield (Clinical Commissioning Group)
DfE	Department for Education (formerly DCSF – Department for Children, Schools & Families
DoH	Department of Health
EPAS	Educational Planning and Assessment System
ESA	Employment Support Allowance
EWDI	Excess Winter Deaths Index
EYFS	Early Years Foundation Stage
FTE	First Time Entrant (to Youth Justice System)
GADD	Gay Advice Darlington and Durham
GCSE	General Certificate of Secondary Education
GP	General Practitioner
GRT	Gypsy, Roma and Travellers

GVA	Gross value added
HHSRS	Housing Health and Safety Rating System
HIV	Human Immunodeficiency Virus
HM	Her Majesty's
HMIP	Her Majesty's Inspectorate of Prisons
HNA	Health Needs Assessment
IAG	Independent Advisory Group
ICPC	Initial Child Protection Conference
ID	Index of Deprivation
IDBR	Inter-Departmental Business Register
IIC	Investing in Children
IMD	Index of Multiple Deprivation
IOM	Integrated Offender Management
IYSS	Integrated Youth Support Service
JSA	Job Seekers Allowance
JSNA	Joint Strategic Needs Assessment
KS	Key Stage
LA	Local Authority
LAC	Looked After Children
LAPE	Local Alcohol Profiles for England
LCB	Local Children's Board
LD	Learning Disability
LEP	Local Enterprise Partnership
LLTI	Limiting Long Term Illness
LSCB	Local Safeguarding Children's Board
LSD	Lysergic Acid Diethylamide
LSOA	Lower Super Output Area
LTC	Long term condition
LVD	Left Ventricular Dysfunction
MO	Modus Operandii
MoD	Ministry of Defence
MSG	Most Similar Group
MSOA	Middle Super Output Area
N/A	Not applicable
NCCIS	National Client Caseload Information System
NCER	National Consortium for Examination Results
NCMP	National Child Measurement Programme
NE	North East
NEA	National Energy Action
NEET	Not in Education, Employment or Training
NHS	National Health Service
NI	National Indicator
NICE	National Institute for Health and Clinical Excellence
NSPCC	National Society for the Prevention of Cruelty to Children
NVQ	National Vocational Qualification
ONS	Office for National Statistics
PANSI	Projecting Adult Needs and Service Information
PAYE	Pay As You Earn
PHOF	Public Health Outcomes Framework

PND	Penalty Notices for Disorder
POPPI	Projecting Older People Population Information
PPP	Pupil Place Planning
QOF	Quality Outcomes Framework
RII	Relative Index of Inequality
SCS	Sustainable Community Strategy
SDQ	Strengths and Difficulties Questionnaire
SDSQ	Self Directed Support Questionnaire
SEN	Special Educational Needs
SEND	Special Educational Needs and Disability
SFR	Statistical First Release
SHA	Strategic Health Authority
SHMA	Strategic Housing Market Assessments
SHS	Second hand smoke
SII	Slope Index of Inequality
SMI	Severe and enduring mental illness
SMR	Standard mortality rate
SSID	Social Services Information Database
TB	Tuberculosis
TEWV	Tees, Esk & Wear Valley NHS Foundation Trust
TIA	Transient ischaemic attacks
UK	United Kingdom
WHO	World Health Organisation
YJB	Youth Justice Board
YOS	Youth Offending Service

Please ask us if you would like this document summarised in another language or format.

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