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Children and Young People Scrutiny Committee Agenda

9.30 am Monday, 10 September 2018
Committee Room No. 1 Town Hall
Darlington DL1 5QT

Members of the Public are welcome to attend this Meeting.

1. Introductions/ Attendance at Meeting

2. Declarations of Interest

3. Minutes (Pages 1 - 6)

4. Performance Indicators Quarter 1 2018/19 –
   Report of the Director of Children and Adult Services.
   (Pages 7 - 52)

5. Independent Reviewing Officer Annual Report 2017/18 –
   Report of the Director of Children and Adult Services
   (Pages 53 - 70)

6. Children and Young People Public Health Overview 2018 –
   Report of the Director of Public Health
   (Pages 71 - 148)

7. Designated Officer (DO) Annual Report –
   Report of the Director of Children and Adult Services
   (Pages 149 - 176)

8. Looked After Children Missing from Care who have Autism or Another Disability –
   Report of the Director of Children and Adult Services
   (Pages 177 - 178)

9. Work Programme –
   Report of the Assistant Director Law and Governance (report enclosed)
   (Pages 179 - 190)

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

11. Questions

Luke Swinhoe
Assistant Director Law and Governance

Friday, 31 August 2018

Town Hall
Darlington.

Membership
Councillors C Taylor, L Hughes, Crudass, Crumbie, Mrs Culley, Curry, Kelly, Lister, Mills, Storr and M Wright

Statutory Co-optees
M Frank and P Rickeard

Non Statutory Co-optees
K Chisholm, T Fisher, N Lindsay, M Regan, G Harrison, S Miah and J Woodcock

If you need this information in a different language or format or you have any other queries on this agenda please contact Allison Hill, Democratic Officer, Resources Group, during normal office hours 8.30 a.m. to 4.45 p.m. Mondays to Thursdays and 8.30 a.m. to 4.15 p.m. Fridays email: allison.hill@darlington.gov.uk or telephone 01325 405997

CHILDREN AND YOUNG PEOPLE SCRUTINY COMMITTEE
2 July 2018

PRESENT – Councillor C Taylor (in the Chair); Crudass, Crumbie, Mrs Culley, Curry, L. Hughes, KE Kelly, Mills and Storr. (9)

APOLOGIES – Councillor Lister and Wright; Jane Kochanowski, Assistant Director Children's Services; Sharon Raine, Head of Organisational Planning; Yvonne Coates, Head of Early Intervention and First Contact; Bronwen Smith, Senior Manager Placement; Tim Fisher, Non Statutory Co-opted Member; Maura Regan and Glenis Harrison, Community Representative.

ABSENT – None (0)

STATUTORY CO-OPTEES – None. (0)

NON-STATUTORY CO-OPTEES – Glenis Harrison, Community Representative (1)

OFFICERS IN ATTENDANCE – Miriam Davidson, Director of Public Health; Joanne Stoddart, Head of Assessment, Care Planning and Looked After Children; and Allison Hill, Democratic Officer.

ALSO IN ATTENDANCE – Councillor C Hughes, Cabinet Member with Children and Young People Portfolio; Councillor W Newall, Chair of the Health and Partnerships Scrutiny Committee; and Dr David Landes, Public Health England.

CYP1. DECLARATION OF INTERESTS – There were no declarations of interest reported at the meeting.

CYP2. TIMES OF MEETINGS – RESOLVED – That for the remainder of this Municipal Year the timings of meetings of this Scrutiny Committee be held at 9.30 am.

CYP3. MINUTES – Submitted - The Minutes (previously circulated) of the meeting of this Scrutiny Committee held on 16 April 2018.

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

CYP4. PERFORMANCE INDICATORS QUARTER 4 2017/18 AND PROPOSED INDICATORS FOR 2018/19 – The Director of Children and Adult Services submitted a report (previously circulated) to provide Members with outturn performance data against key performance indicators for 2017/18; to give consideration to the proposed basket of performance indicators for 2018/19; and to note the proposed schedule of performance reporting for 2018/19.

The submitted report highlighted where Children and Young People were performing well and where there was a need to improve.

The submitted report also contained the Children's Social Care Monthly Performance and Quality Assurance Report for Quarter Four.

It was highlighted that 96.7 per cent of contacts had been completed within one working day which exceeded the target of 95 per cent and only 0.6 per cent of contacts were completed in more than three working days; 96 per cent of referrals during quarter four were completed within one working day which was above the target of 90 per cent with 1.8 per cent of referrals taking more than 72 hours to complete which was above the target of 5 per cent; the percentage of assessments completed within 45 working days was 93.3 per cent which has consistently exceeded the target of 90 per cent and higher than statistical neighbours and the England average; 100 per cent of child protection reviews had been completed within timescale; 100 per cent of Looked After Children reviews completed within timescale; 93.4 per cent of Looked After Children statutory visits were completed within timescale and better than the target of 90 per cent and the 2016/17 year end performance at 87 per cent; 100 per cent of all Children in Need, Children Protection and Children in Care had been allocated a Social Worker and had been consistently sustained; and 32.2 per cent of Care Leavers were not in employment, education or training (NEET) which was above the target of 33 per cent and of the 19 Care Leavers currently NEET there were 12 are not available to work due to illness, pregnancy or parenting.

The submitted report also highlighted areas for improvement which included the number of re-referrals within 12 months of a previous referral at 247, which although showing an improvement still remained higher than the local target of 20 per cent; the percentage of children who had been in their current placement for two years or more who had been in care for two and half years or more increased to 65.1 per cent at the end of March 2018 reaching the target of 65 per cent however performance remains behind benchmarks and therefore remains an area for improvement; the percentage of children placed 20 miles or more away from homes has increased to 12 per cent the end of March compared to the 2016/17 year end performance at 7.8 per cent; and at the end of March there were 87.5 percent (140/160) of children with an up to date dental check in the past 12 months although there were an additional 12 children (7.5 per cent) who had refused a dental check this did show an increase on previous year-end performance which was 75.9 per cent.

It was also reported that the 2017/18 basket of indicators had been reviewed by Directors and Assistant Directors for continued relevance and on 4 June 2018 the Monitoring and Co-ordination Group reviewed and agreed the proposed set of indicators for 2018/19 and their allocation to the individual Scrutiny Committees. Since the Monitoring and Co-ordination Group met further review suggests the proposed set is increased to include those additional indicators this Scrutiny Committee received during 2017/18.

Members expressed their concerns at the increase in the number of children who had refused a dental check and the Head of Assessment, Care Planning and Looked After Children advised Members that the numbers related to the older children who were 16/17 years old and officers were looking at different ways to engage with these young people to ensure that they have regular dental and health checks.

RESOLVED – (a) That the performance information relating to Quarter 4 be noted.

(b) That the proposed basket of performance indicators for 2018/19 be approved.

(c) That the proposed schedule for performance reporting for 2019/19 be noted.

CYP5. EARLY INTERVENTIONS FOR LOOKED AFTER CHILDREN MISSING FROM CARE – The Director of Children and Adult Services submitted a report (previously circulated) to provide information regarding children who are Looked After and who experience missing from home episodes following a request by Members at the meeting held on 16 April 2018.

The submitted report outlined some of the reasons children and young people may go missing; the link between children and young people who go missing and exploitation; and Ofsted feedback regarding the management of children and young people who go missing from home and care.

The submitted report also detailed interventions in place to address and reduce missing episodes for children and young people including this authority's procedures for managing children and young people who go missing; placement stability and the duty on the local authority to place a child or young person in the most appropriate placement; and a Secure Order which can be obtained from the Court if all other options for the child or young person have been exhausted.

Members questioned whether information was kept on whether those missing from care had any specific special needs and expressed the importance of having this information as there was evidence to suggest that children on the autistic spectrum were more likely to go missing and also be at risk of sexual exploitation; and that going missing was the first sign that there were problems.

Councillor C Hughes confirmed that every case of missing from care was thoroughly examined by her and the Director of Children and Adults Services and any social aspects were taken into consideration.

RESOLVED – That the report be noted.

CYP6. APPOINTMENT OF CO-OPTED MEMBERS – The Assistant Director Law and Governance submitted a report (previously circulated) to advise Members of the appointment of two non-voting co-opted representatives.

Kate Chisholm, Chair of the Primary School Forum and Head Teacher of Skerne Park Academy and Nick Lindsay, 11-19 Partnership and Head Teacher of Longfield Academy have volunteered to be co-opted Members of this Scrutiny Committee and will be invited to attend all future meetings of this Scrutiny Committee.

RESOLVED – That the appointments be noted.

CYP7. CHILDHOOD OBESITY AND DENTAL HEALTH CARE – The Members of the Joint Review Group, established by this Scrutiny committee to examine Childhood Obesity and Dental Health Care and any associated Mental Health Links submitted a

report to make an interim recommendation in relation to any prospective water fluoridation scheme in Darlington.

The submitted report outlined the investigations of the Joint Review Group in relation to poor dental health outcomes in Darlington with strong links between the highest obesity rates and the poorest dental health being most prevalent in the most deprived areas of the Borough.

It was also reported that dental decay was a significant public health problem in the North East and Darlington had levels of decay in children significantly higher than the average for England.

Joy Warren, Joint Co-ordinator, UK Freedom from Fluoride Alliance; and Alan Hall and Michael Watson, Members of the Public attended the meeting and were given an opportunity by the Chair to speak and express their concerns to the Members by the introduction of a water fluoridation scheme in Darlington.

Dr David Landes, Public Health England also attended the meeting and advised the Members that there was a long history of residents who drink fluoride naturally and that Hartlepool have had fluoridated water since the 1840's and that there was a large body of evidence to show a reduction of dental disease in those areas; and areas which had a water fluoride scheme. He advised that there was also a 59 per cent reduction in general levels of anaesthesia. He also advised Members that a water fluoridation scheme would benefit those in the most deprived areas of the borough.

Glenis Harrison, Community Representative advised the Members that within her Community Centre on a daily basis she sees poor dental health among the parents of young children and felt that there was an issue of parental education for them to be able to take responsibility for the dental health care of their children.

Members agreed that dental decay was a global issue and that an issue authorities needed to examine was to narrow the gap on poor dental health and that water fluoridation could be a way to help.

The Director of Public Health confirmed that the recommendation of the Joint Review Group was to carry out a technical appraisal only and not to make a decision on any potential water fluoridation scheme at this time.

RESOLVED – That this Scrutiny Committee supports the joint work underway to gather information required for consideration about any prospective water fluoridation scheme in Darlington and recommends to Cabinet that it agrees to carry out a technical appraisal for consideration of a water fluoridation scheme in Darlington and/or the Tees Valley.

CYP8. WORK PROGRAMME – The Assistant Director Law and Governance submitted a report (previously circulated) to provide an update on the current work programme for this Scrutiny Committee.

The work programme has been reviewed and revised for the Municipal Year 2018/19 and has been linked to performance indicators from the Performance Management

Framework to provide robust and accurate data for Members to use when considering topics and the work they wish to undertake

With regard to the quad of aims for a review of the Autism Provision at Hurworth School submitted to the Monitoring and Co-Ordination Group, it was agreed that Councillor Mills lead on this Review after the Summer Recess.

RESOLVED – That the current status of the work programme be noted.

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Children's Social Care Monthly Performance & Quality Assurance Report

Quarter 1 2018/19

Children and Young People Scrutiny

Key Performance Indicators

Quarter 1 Performance Summary

Where we are performing well

94.2% of contacts were completed within 24 working hours and 0.5% within 72 hours. The amount of contacts have increase by 290 when compared to Quarter 1 2017/18 which equates to an increase by 19.5% of contacts. This shows that, despite the increase in workloads, the children and young people still receive services quickly and the work flow through the system is efficient.

32 out of 34 children (94.1%) who had a Review Health Assessment due, was completed within the required month at the end of Quarter 1.

98% of Initial Child Protection Conferences (ICPC) were held within 15 working days from the Strategy meeting being held/Section 47 being initiated. This is significantly higher than regional (85.7%), national (77.2%) and our statistical neighbour (87.9%) averages.

100% Child Protection reviews have been completed within the required timescales. This is higher than regional (95%), national (92%) and our statistical neighbour (95%).

100% those children involved with Child Protection and Looked After have an allocated Social Worker.

100% of Looked After reviews were completed within timescales in Quarter 1, this shows continuation of good work from 2017/18 which also saw 100% of reviews completed in timescale at year end.

93.2% of statutory visits of Looked After Children were completed in timescale within Quarter 1, which is better than the target of 90%, and is an improvement from the 2017/18 year end 92.6%.

The stability of Looked After Children placements has seen an improvement compared to Quarter 1 2017/18 with regards to 3 or more placement moves. At the end of this Quarter, 9.6% (22 children) of Looked After Children had 3 or more placement moved within the last 12 months, an improvement of 6.2% when compared to the end of Quarter 1 2017/18 which was 15.8%. This is in line with benchmark data for statistical neighbours (9.5%) and national average (10%).

100% of Return Home Interviews (RHI) were completed in Quarter 1 with 92.5% completed within 72 hours of the child being returned home after the missing episode.

In Quarter 1 the percentage of Care Leavers who were Not in Education, Employment or Training (NEET) was 27.5% (14 Care Leavers aged 19, 20 and 21 out of 51). This positively exceeds the target set at 33.0% and is a reduction of 4.7% of the 2017/18 year end figure. Focus continues to be maintained on decreasing the percentage of Care Leavers who are NEET.

Of the cohort who are in Education, Employment or Training (EET), 2 have started an apprenticeship and working towards NVQ's in their chosen area. School attendance for children in care remains strong at over 95%. There have been no permanent exclusions of Looked After Children.

Where we need to improve

Of the assessments completed in Quarter 1, 83.5% were completed within 45 working days. This is a reduction from the 2017/18 year end performance of 93.3% but this is still higher that the England average of 83%. There has been an increase in the complexity of cases and the number of large sibling groups being referred to Children's Social Care this Quarter, therefore managers have extended timescales for completion of assessments to reflect this. This is supported by the increase in the number of Strategy meetings, Section 47 enquiries and the number of children subject to a Child Protection Plan this Quarter when compared to Quarter 1 in 2017/18. There has also been a significant increase in Court work over Quarter 1 2018/19 which has resulted in additional work to meet Court deadlines and timescales.

The percentage of Looked After Children who have been in their current placement for 2 or more years at the end of Quarter 1 has improved when compared to Quarter 1 2017/18 which was 50.8% and is now 63.1%. However this has still not reached our target of 65%.

5.9% of Care Leavers in unsuitable accommodation.

19 out of 39 (48.7%) dental health checks have been completed at the end of Quarter 1. Progress against this indicator continues to undergo close scrutiny with a tracker in place to ensure robust oversight.

Contacts and Referrals

Quarter 1 Performance Summary

In Quarter 1 the number of contacts into the department was 1,485, when compared to Quarter 1 in 2017/2018, there has been an increase in contacts of 290, which equates to an increase of 19.5% against 2017/18. Considerable work has been done with partners and in particular the police to ensure contacts are more appropriate during this year.

Children's Access Point (CAP) receives all contacts, within Quarter 1 52.5% (1,287) of these received information and advice which is a consistent with Quarter 1 2017/18. The contact outcome of "refer to school attendance support" has increased to 284 (11.6%) compared to 191 (8.8%) in 2017/18. Going forward we will continue to monitor the number of contacts and subsequent outcomes, to assess the impact on the service. However, referrals have been consistent with 12.1% referred to Early Help for assistance, 12.2% referred for Social Care intervention and 11.7% related to already open Early Help workers.

In line with the increase in school attendance support contacts, contacts from education significantly increased, to 34.2% in June. Police continue to be the agency that contact us most frequently regarding young with 36.8% of all contacts in Quarter 1 which is consistent with Quarter 1 in 2017/18 at 35%. Health (including midwifery, GP, Hospital and Health Visitors) have referred 8.1% of the contacts into the department for Quarter 1, which is less than quarter 1 2017/18 at 12.4%. It is of particular note that Health Visitors make the least number of contacts. During 2018/2019 this will be explored further with our health visiting service to understand the low number of contacts.

The timeliness of decision making on contacts remains high with an average of 94.2% completed within 24 working hours at end of Quarter 1 and 0.5% within 72 hours, even with an increase in contacts of 19.5%. This ensures that that children and young people receive services quickly and the work flow through the system is efficient. Dip sampling and auditing activity continues to verify the effectiveness of the front door.

The conversion of contacts to referral is 124.3 per 10,000 for Quarter 1, if this continued at the same trajectory then the end of year figure would be 504.4 per 10,000 this figure is much more in line with statistical neighbours 519.7 per 10,000, yet below most recent national (548.2 per 10,000) and regional (599.6 per 10,000) . The total number of referrals to Social Care during Quarter 1 was 284 which is comparable to last year, this will continue to be monitored through 2018/19 to ensure we remain within statistical neighbour range.

The timeliness of Quarter 1 referrals remains high with all but one month achieving 100% completion within 24 working hours and 0% within 72 hours. This ensures that that children and young people receive services quickly and the work flow through the system is efficient.

The age breakdown for referrals in Quarter 1 shows an increase in those cases been referred for children under 1, which is 14% compared to 8.3 % in Quarter 1 2017/18. Those cases are being reviewed to gain an understanding of why this increase has occurred and will be reported on in Quarter 2.

The rate of re-referrals continues to improve and is on target (20%) with performance at 20.2% as at end of Quarter 1. The continuing review and understanding of trends, has contributed to the improving rate of re-referrals. Re-referrals are in line with regional (20.1%) benchmarks, below national benchmarks (21.9%), yet still slightly above statistical benchmarking (18.5%).

CONTACTS

DEFINITION

Contacts are received through the Children's Access Point (CAP) and are screened against an agreed multi-agency threshold criteria for Social Care. The total number of contacts received by CAP shows how busy CAP are within each month; the number of new contacts shows how many contacts are made on cases which are not currently open to Social Care (a contact can include multiple children); the total number of children in the month (each child can appear more than once) allows us to demonstrate outcomes, as each child may appear more than once they will have different outcomes and different sources, and the distinct number of children (each child is counted only once not matter how many contacts were received) allows us to look at the demography.

PERFORMANCE ANALYSIS

1,485 contacts were received during Quarter 1, This is an increase of 19.5% (290 contacts) when comparing with Quarter 1 2017/18 (1,195).

		CSC 004	CSC 004i	CSC 004k
		Number of contacts received (monthly)	Number of children the contacts were regarding (a child can be counted more than once) (monthly)	Number of individual children contacts were regarding (monthly)
IN MONTH PERFORMANCE	Apr-18	420	701	544
	May-18	450	779	657
	Jun-18	615	970	760
	Jul-18			
	Aug-18			
	Sep-18			
	Oct-18			
	Nov-18			
	Dec-18			
	Jan-19			
	Feb-19			
	Mar-19			
ANNUAL TREND	2015/16			
	2016/17			
	2017/18			
	2018/19 YTD	1485	2450	1961

CONTACTS: TIMELINESS

DEFINITION

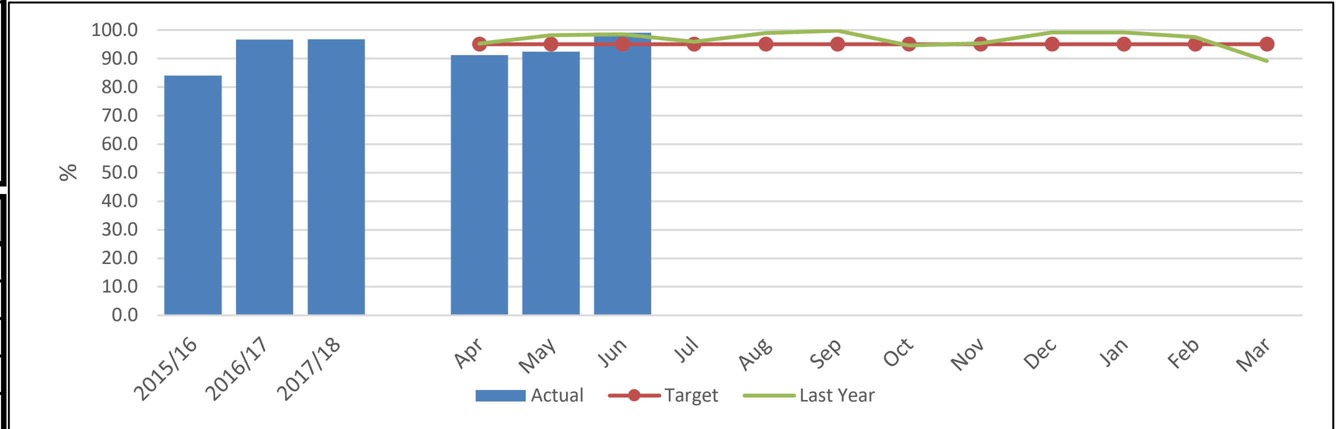
Percentage of contacts completed within 1 working day and over 3 working days within the month. A higher rate of contacts completed within 1 day indicates that assessments are quick and cases are escalated effectively and efficiently without delay and drift.

Performance Analysis

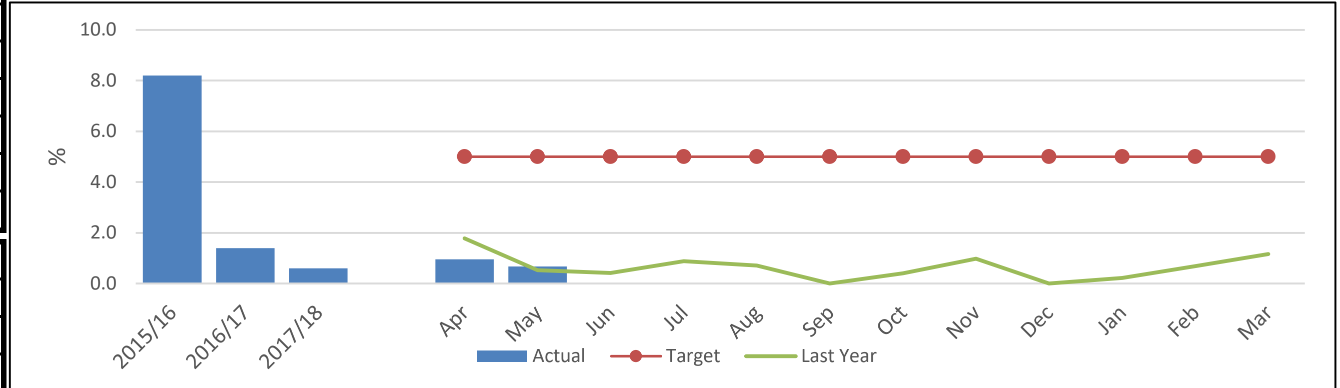
94.2% of contacts were completed within 1 working day, within Quarter 1.
0.5% of contacts had taken more than 3 working days to be completed, within Quarter 1.
Contact timeliness continues to be effective and is showing that, even though there has been an increase in contacts, they are still above target for completions.

		CSC 006	CSC 009
		% of contacts completed within 1 working day within the month	% of contacts completed over 3 working days within the month
IN MONTH PERFORMANCE	Target	95.0	5.0
	Apr-18	91.2	1.0
	May-18	92.4	0.7
	Jun-18	99.0	0.0
	Jul-18		
	Aug-18		
	Sep-18		
	Oct-18		
	Nov-18		
	Dec-18		
	Jan-19		
	Feb-19		
	Mar-19		
Annual Trend	2015/16	84.0	8.2
	2016/17	96.6	1.4
	2017/18	96.7	0.6
	2018/19 YTD	94.2	0.5

CSC 006: % of contacts completed within 1 working day within the month



CSC 009: % of contacts completed over 3 working days within the month

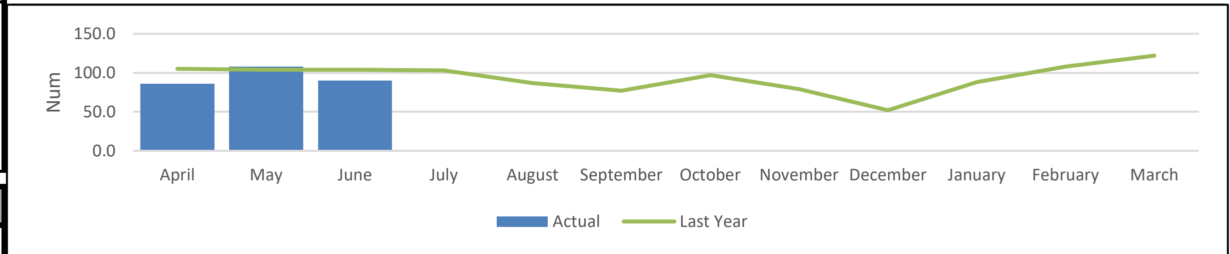


REFERRALS

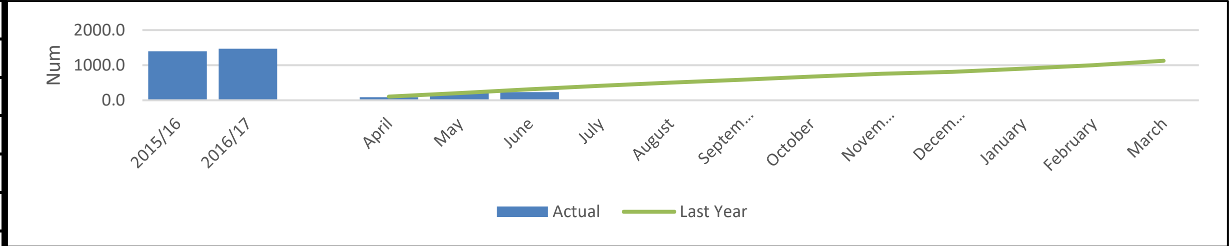
DEFINITION	Monthly number of referrals to Children's Social Care and number of referrals started year to date. A contact will be progressed to a referral if it is considered that an assessment and/or service may be required.
PERFORMANCE ANALYSIS	284 children's referrals were started in Quarter 1 compared to 313 children's referrals in Quarter 1 2017/18.

		CSC 013	CSC 012	CSC 014
		Monthly number of referrals STARTED.	Number of children's referrals STARTED year to date.	Rate of referrals per 10,000 population.
IN MONTH PERFORMANCE	Target	(blank)	(blank)	(blank)
	Apr-18	86	86	38.2
	May-18	108	194	86.2
	Jun-18	90	284	124.3
	Jul-18			
	Aug-18			
	Sep-18			
	Oct-18			
	Nov-18			
	Dec-18			
	Jan-19			
	Feb-19			
	Mar-19			
ANNUAL TREND	2015/16	1398	1398	615.9
	2016/17	1472	1472	650.6
	2017/18	1126	1126	497.6
	2018/19 YTD	284	284	124.3

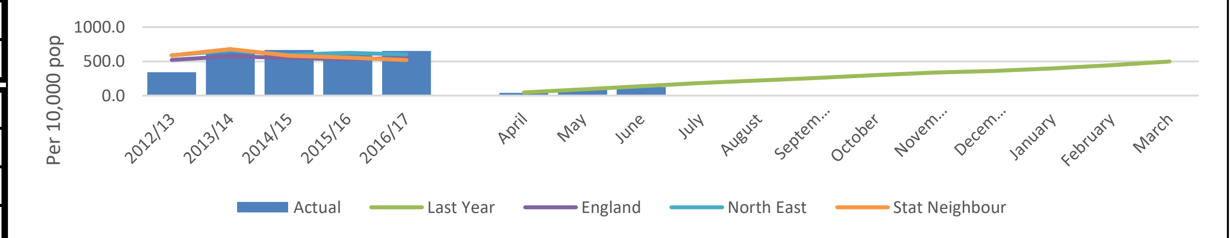
CSC 013: Monthly number of referrals STARTED.



CSC 012: Number of children's referrals STARTED year to date.



CSC 014: Rate of referrals per 10,000 population.



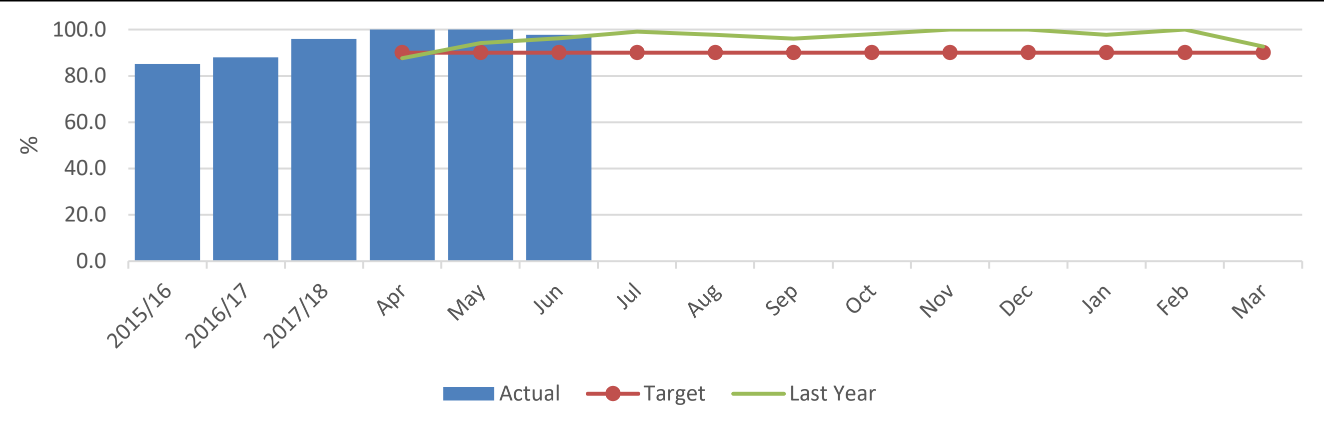
REFERRALS - TIMELINESS

DEFINITION	Percentage of referrals completed within 24 hours and over 72 hours. Referrals completed within 24 hours indicates that decisions regarding the services required are made in a timely manner to minimise drift and delay and to ensure that children are safe.

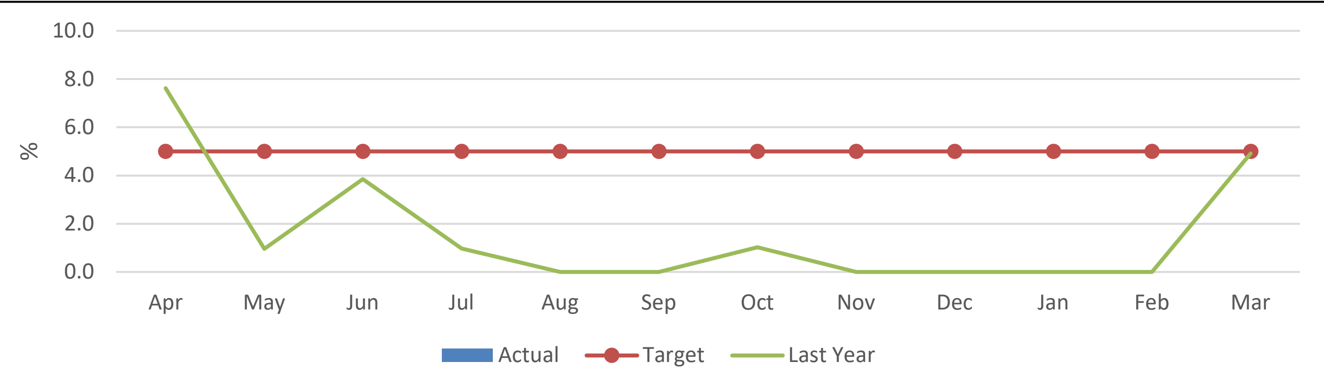
PERFORMANCE ANALYSIS	88 of the 90 referrals were completed within 24 hours. Timeliness has improved compared to this time last year, with no referrals taking longer than 72 hours to complete.

		CSC 022	CSC 026
		Monthly % of referrals completed within 24 hours.	Monthly % of referrals completed in over 72 hours.
IN MONTH PERFORMANCE	Target	90.0	5.0
	Apr-18	100.0	0.0
	May-18	100.0	0.0
	Jun-18	97.8	0.0
	Jul-18		
	Aug-18		
	Sep-18		
	Oct-18		
	Nov-18		
	Dec-18		
	Jan-19		
	Feb-19		
	Mar-19		
ANNUAL TREND	2015/16	85.2	
	2016/17	88.0	4.8
	2017/18	96.0	1.8
	2017/19	99.3	0.0

CSC 022: Monthly % of referrals completed within 24 hours.



CSC 026: Monthly % of referrals completed in over 72 hours.



REFERRALS - RE-REFERRALS

DEFINITION

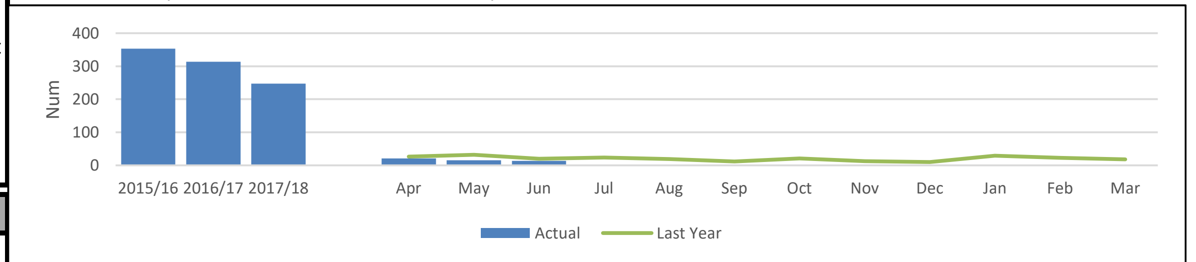
Percentage of re-referrals that are a repeat referral within 12 months of a previous referral.
A re-referral to Children's Social Care could be an indication that the previous referral was inappropriately closed down without addressing the initial concerns or issues.

PERFORMANCE ANALYSIS

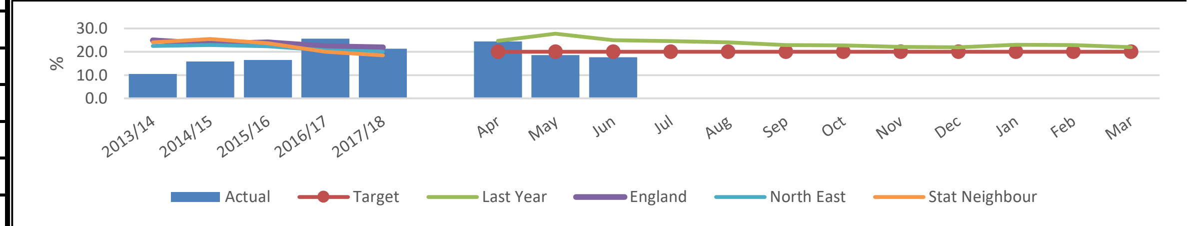
50 re-referrals were received within Quarter 1 which is a reduction of 49% from the re-referrals during 2017/18 in Quarter 1, which was 98.
In Quarter 1, Darlington's current rate of re-referrals within 12 months of a previous referral (20.2) is slightly higher than the target of 20%, and is slightly higher than the most recent regional (20.1%) and statistical (18.5%) benchmarks, but is below recent national benchmark (21.9%).

		CSC 034	CSC 032	
		Monthly number of re-referrals that are repeat within 12 months	% re-referrals that are repeat within 12 months (cumulative)	% re-referrals that are repeat within 12 months (monthly)
IN MONTH PERFORMANCE	Target	(blank)	20.0	
	Apr-18	21	24.4	24.4
	May-18	15	18.6	13.9
	Jun-18	14	17.6	15.6
	Jul-18			
	Aug-18			
	Sep-18			
	Oct-18			
	Nov-18			
	Dec-18			
	Jan-19			
	Feb-19			
	Mar-19			
ANNUAL TREND	2014/15		16.5	
	2015/16	353	25.6	
	2016/17	314	21.4	
	2017/18	247	21.9	
	2018/19 YTD	50	20.2	

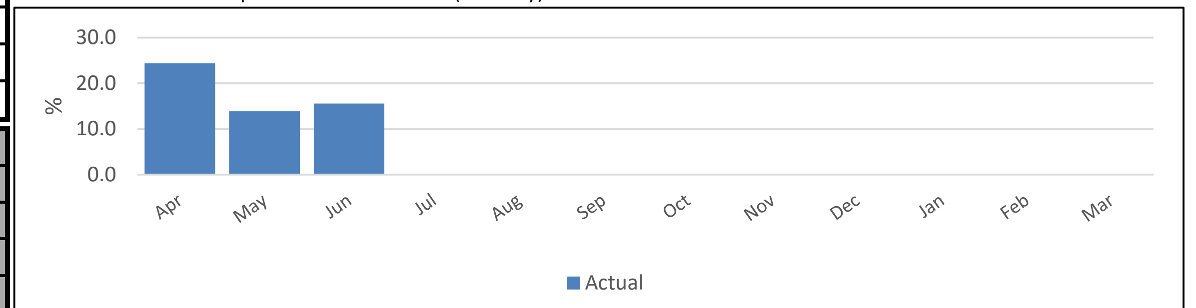
CSC 034: Monthly number of re-referrals that are repeat within 12 months



CSC 032: % re-referrals that are repeat within 12 months (cumulative)



% re-referrals that are repeat within 12 months (monthly)



Early Help

Quarter 1 Performance Summary

Missing

The total number of missing episodes in Quarter 1 is 137 involving 62 young people with no significant differences to the data from previous Quarters.

Most children (88%) have 3 or under missing episodes.

The missing episodes for the Darlington Looked After population is 38% (24 children), children on CiN plans 19% (12 children) and other local authorities' children placed in Darlington 21% (13 children). There were no children with a disability/learning need reported missing in this Quarter.

Significantly in Quarter 1, 25% (15 children) were not known to services when they were reported missing. Of these, the Return Home Interview's (RHI) had resulted in no further action for 7 of the children, the remaining were a referred to social care or early help. This clearly evidences that the RHI has given these young people a voice to explore their risk taking behaviour and appropriate referrals have been made for additional support.

There is a slight but not significant increase in the number of females (55%) who are reported missing.

In this Quarter the number of missing episodes which involved other authorities children placed in Darlington is 14%. This number remains low but has slightly increased and will be monitored by both the local authority, Barnardo's and the ERASE team, and if necessary will be explored with the placing authorities to review if placements are appropriate.

Missing from Home interviews have been completed in over 93% of the cases within 72 hours, 100% have been completed.   Where the coordinator cannot engage the young person, they will then explore the issues with parents, carers, teachers or social workers.

Barnardo's completed an audit of the quality of the RHI and an action plan was agreed to provide the missing coordinator with some training to improve the quality of recording.

All RHI are shared with the ERASE team who analyse these to identify any themes /patterns in relation to associates, locations and known perpetrators.

All cases where children have regular missing episodes are discussed at the Missing and Exploited Group (MEG) and measures are explored to reduce missing episodes.

Early Help

The Early Help data collection for quality and impact remains a work in progress and is a key priority for 2018/19. The recording and reporting on Early Help Assessments is much more robust than previous years and is therefore not appropriate to compare numbers. The current outturn is 261 assessments being active during Quarter 1. The ongoing priority is to continue to develop key reportable data and the final development of the Early Help scorecard. This will allow much deeper analysis than merely reporting on numbers. The number of assessments by external agencies is 84 which is a 32% of the total number of assessments. There has been an increase in activity within the Early Help service, with a number of key developments taken place.

The Early Help Practise Standards have been launched with all staff, ensuring a consistent and robust mechanism of uniformity and expectations of working practise. Managers and Advanced Practitioners are aware of their roles in ensuring standards are adhered to and appropriately challenge areas where standards may drop. All staff have a copy of the standards and are expected to use them as a guide when working with children, families and partners.

The Early Help service now has in place, an observation of practise template which we have developed and is being utilised in a number of areas within the service. This includes 1-1 direct work, group work activity and Team Around the Family (TAF) meetings. This observation template is held on a central drive and has oversight from the Service Manager who will monitor and pick out both areas for improvement and also areas of good practise. Feedback is then shared with all staff during Development meetings alongside team meetings.

A Quality Assessment (QA) template has been developed using the social care model, but with some variance to ensure it fits with expected Early Help (EH) practise standards. Each manager and Advance Practitioner (AP) will complete 2 audits a month totalling 36 each Quarter. There will also be external QA completed by the EH Co-ordinator who will be expected to complete 3 per month. This work has begun and the Service Manager will report findings into the Assistant Directors performance clinic.

The Troubled Families (TF) agenda continues to be a high priority to ensure continuity post 2020. There is an action plan in place and a great emphasis on identification of families via a weekly audit clinic with staff. Cases are scrutinised to ensure identification is tracked. EH managers and AP's also attend the weekly YOS and ASB meetings to share knowledge of cases where there can be joint working.

EARLY HELP ASSESSMENTS

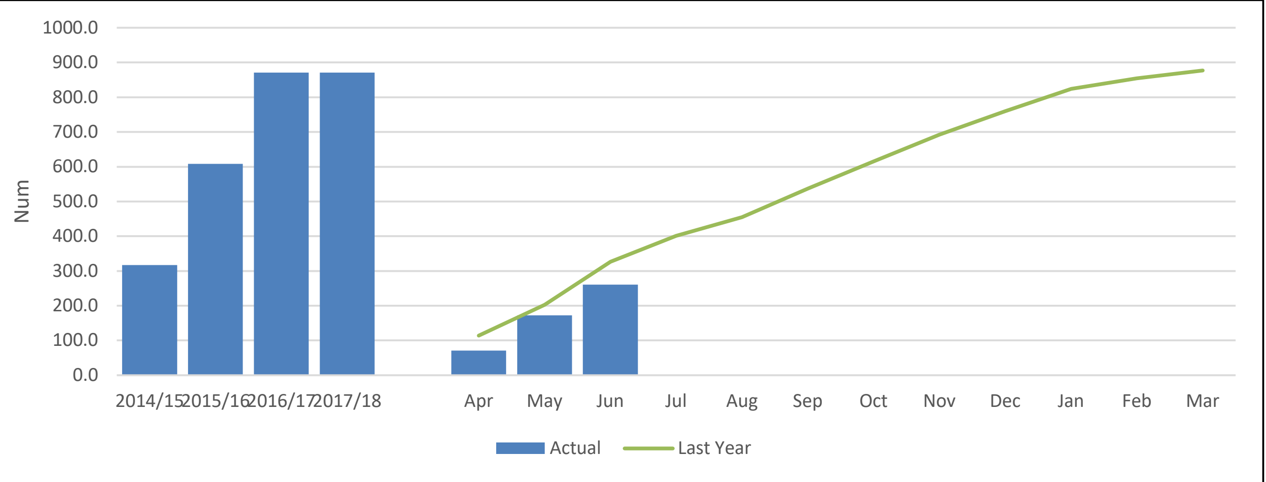
DEFINITION	Number of individual Early Help Assessments recorded year to date.

Performance Analysis

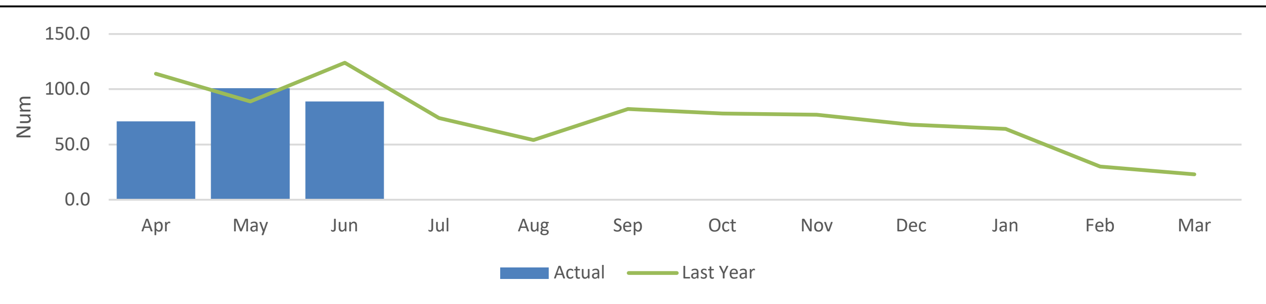
In Quarter 1, 261 Early Help assessments were completed compared to Quarter 1 2017/18 with 327 Early Help assessments completed, this is a reduction of 20% from this time last year.
84 of the 261 Early Help assessments were completed by external agencies, which equates to 32%. This is a positive increase in external agency assessments as during 2017/18 an average of 23% were completed.

		CSC 001	CSC 002
		Number of individual Early Help assessments recorded year to date	Number of individual Early Help assessments recorded per month
IN MONTH PERFORMANCE	Target	(blank)	(blank)
	Apr-18	71	71
	May-18	172	101
	Jun-18	261	89
	Jul-18		
	Aug-18		
	Sep-18		
	Oct-18		
	Nov-18		
	Dec-18		
	Jan-19		
	Feb-19		
	Mar-19		
Annual Trend	2014/15	317	317
	2015/16	608	608
	2016/17	871	871
	2017/18	877	877
	2018/19 YTD	261	261

CSC 001: Number of individual Early Help assessments recorded year to date



CSC 002: Number of individual Early Help assessments recorded per month



MISSING EPISODES

DEFINITION: The number of episodes of children going missing in Darlington, including Looked After Children, Children Looked After by another authority and children who are not currently open to Social Care. The percentage of return home interviews completed within 72 hours.

Performance Analysis

The total number of missing episodes in Quarter 1 is 137 involving 62 children.

Most children (88%) have 3 or less missing episodes.

Missing from Home Interviews have been completed in over 93% of the cases within 72 hours, 100% have been completed.   Where the coordinator cannot engage the young person she explores the issues with parents, carers, teachers or social workers.

		Number of Missing Episodes (children)	Number of missing episodes relating to Children Looked After by Darlington Borough Council (children)	Number of missing episodes relating to Children Looked After by Darlington Borough Council placed more than 20 miles from home (children)	Number of missing episodes relating to other children open to Children's' Services (children)	Number of missing episodes relating to other children open to Early Help (children)	Missing Episodes for Children of Other Authorities (children)	Missing Episodes for Children Not Currently Open to Social Care (children)	% of Return Home interviews completed within 72 hours (excluding CLA OLA)	Missing episodes where a Return Home interview was completed	% Action Plans Completed (cumulative for Quarter)
IN MONTH PERFORMANCE	Apr-18	51 (28)	27 (9)	9 (<5)	5 (<5)	<5 (<5)	8 (6)	10 (9)	93.0%	100%	
	May-18	37(18)	23(10)	<5 (<5)	7 (<5)	<5 (<5)	<5 (<5)	<5 (<5)	93.9%	100%	
	Jun-18	49 (33)	25 (12)	11 (5)	9 (6)	<5 (<5)	8 (8)	<5 (<5)	92.5%	100%	
	Jul-18										
	Aug-18										
	Sep-18										
	Oct-18										
	Nov-18										
	Dec-18										
	Jan-19										
	Feb-19										
	Mar-19										
Annual Trend	2014/15										
	2015/16										
	2016/17										
	2017/18										
	2018/19 YTD	137 (62)	75 (21)						93.1%	100.0	

Assessments

Quarter 1 Performance Summary

As previously detailed, a high percentage of referrals led to an assessment to determine needs and risks, desired outcomes and support required.

During Quarter 1, 315 assessments were completed across all Social Work teams apart from the Looked After Through Care team:

- Children's First Response team – 244 (77.5%)
- Assessment and Safeguarding teams – 62 (19.7%)
- Life Stages 0 – 25 team – 9 (2.8%)

Of the assessments completed in Quarter 1, 83.5% were completed within 45 working days. This is a slight reduction from the 2017/18 year end performance of 93.3%. The following rationale is provided to explain why this has happened:

- The vast majority of assessments that have not been completed within timescale were only over 45 working days by 1 to 2 days. In addition, a number of these could not be completed due to information awaited from other Local Authorities which was critical to informing the assessment
- There has been an increase in the complexity of cases and the number of large sibling groups being referred to Children's Social Care this Quarter. This is supported by the increase in the number of Strategy meetings, Section 47 enquiries and the number of children subject to a Child Protection Plan this Quarter when compared to Quarter 1 in 2017/18.
- There has been a significant increase in Court work over Quarter 1 2018/19. Social Workers have been required to prioritise paperwork for Court to ensure timescales for lodging applications are met to prevent drift and delay. The increase in care proceedings has also meant very short timescales for Social Workers to lodge assessments, evidence and care plans which all have deadlines that cannot be missed.
- There has been a staffing challenge this Quarter as the region had previously introduced a capped rate for all new agency Social Workers appointed. This capped rate was being enforced in July for all those agency social workers already in employment who were being paid more than the new capped rate. The introduction of this cap has resulted in a number of agency Social Workers, who were backfilling maternity leave and sick leave, to move onto other assignments for a higher rate than the capped rate. It has also meant that the pool of agency Social Workers available for appointment has significantly reduced leaving a number of posts not backfilled. This staffing challenge has coincided with the increase in complex cases and court work and has inevitably had an impact on assessment timeliness.

ASSESSMENTS

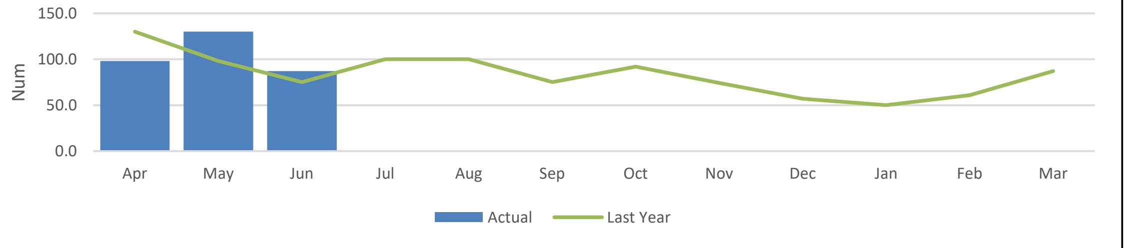
DEFINITION	Monthly and cumulative number of assessments completed.

PERFORMANCE ANALYSIS

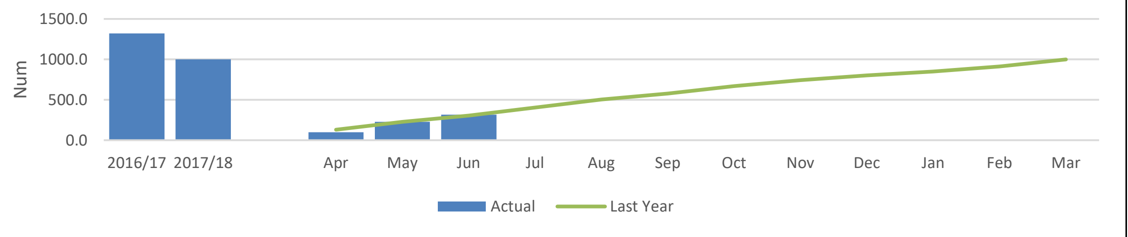
For Quarter 1, 315 Assessments have been completed.
Darlington's current rate of assessments completed is 139.9 per 10,000 population.

		CSC 037	CSC 036	CSC 035
		Monthly number of children & families assessments completed	Number of children & families assessments completed year to date	Rate of Children & Families assessments completed per 10,000 of the 0-17 population.
IN MONTH PERFORMANCE	Target	(blank)	(blank)	(blank)
	Apr-18	98	98	43.5
	May-18	130	228	101.3
	Jun-18	87	315	139.9
	Jul-18			
	Aug-18			
	Sep-18			
	Oct-18			
	Nov-18			
	Dec-18			
	Jan-19			
	Feb-19			
	Mar-19			
ANNUAL TREND	2014/15			
	2015/16		1284	565.6
	2016/17		1321	579.8
	2017/18		999	441.5
	2018/19 YTD	315	315	139.9

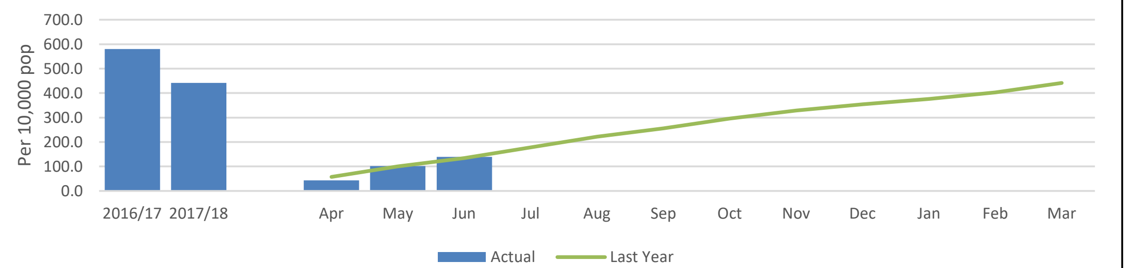
CSC 037: Monthly number of children & families assessments completed



CSC 036: Number of children & families assessments completed year to date



CSC 035: Rate of Children & Families assessments completed per 10,000 of the 0-17 population.



ASSESSMENTS - TIMELINESS

DEFINITION

Of those assessments completed in a period, the percentage completed within 45 working days. Day zero is the first working day on or after the start date of the referral, or strategy discussion decided to initiate S47 enquiries, or where new information indicates that an assessment should be undertaken. End date is the first working day on or after the recorded date the Team Manager closes the single assessment.

A process indicator as a proxy measure for improved child safety and how quickly services can respond when a child is thought to be at risk of serious harm. Local authorities should investigate and address concerns in a timely and efficient way.

PERFORMANCE ANALYSIS

83.5% of Assessments were completed within 45 working days for Quarter 1 compared to 95.4% for Quarter 1 2017/18.
When compared to benchmarking assessment, timeliness is below statistical neighbours at 86%, but in line with regional 83% and national 83% figures.

		CSC 038	CSC 040	CSC 060	CSC 080	CSC 100
		% C&F Assessments completed within 45 working days (Year to date)	Monthly % C&F Assessments completed within 45 working days	Monthly % C&F Assessments completed within 25 working days	Monthly % C&F Assessments completed within 15 working days	Monthly % C&F Assessments completed within 10 working days
IN MONTH PERFORMANCE	Target	90%	90%	60%	40%	25%
	Apr-18	89.3	89.3	30.6	20.4	13.5
	May-18	85.1	84.6	39.2	26.2	19.2
	Jun-18	83.5	79.3	43.7	27.6	18.4
	Jul-18					
	Aug-18					
	Sep-18					
	Oct-18					
	Nov-18					
	Dec-18					
	Jan-19					
	Feb-19					
	Mar-19					
	2015/16	77.0	77.0	43.0	27.0	21.0
	2016/17	93.0	93.0	58.0	40.0	33.0
	2017/18	93.3	93.6			
	2018/19 YTD	83.5	84.4	37.8	24.7	17.0

Child Protection

Quarter 1 Performance Summary

In Quarter 1 there were a total of 161 strategy discussions that have been held. This is almost double the number of strategy discussions when compared to this period in 2017/18 which was 86.

On average, 54 strategy discussions were held each month in Quarter 1 and involved all Social Work teams apart from the Life Stages team. This is double the average number when compared to Quarter 1 for 2017/18 of 27.

Children's Access Point (CAP) and the Children's First Response Team (FRT) held 64.6% of the strategy discussions in Quarter 1, the Assessment and Safeguarding teams held 34.2%, and the Looked After Through Care Team held 1.2%.

The number of section 47 enquiries started in Quarter 1 was 150. This is again double the number for Quarter 1 in 2017/18 (76).
The outcome of Section 47 enquiries that have been started during Quarter 1 is summarised as follows:

- Continue to single assessment (56.7%)
- Continue to Initial Child Protection Conference (40%)
- No current outcome (2.7%)
- Became Looked After (0.7%)

98% of Initial Child Protection Conferences (ICPC) were held within 15 working days from the Strategy meeting being held/Section 47 being initiated. The remaining 2% relates to 1 case in May that did not meet the timescale. However, performance is still higher than benchmarks:

- North East average – 85.7%
- Statistical Neighbour average – 87.94%
- England average – 77.2%

At the end of Quarter 1, 34 ICPC's had been held, this figure includes transfer-in Conferences. This is higher than Quarter 1 in 2017/18 as the figure at that point was 21.

At the end of Quarter 1, there were 112 children who were the subject of a Child Protection plan compared to only 75 in Quarter 1 the previous year. This equates to a rate of 49.7 per 10,000 of the 0 – 17 population. This brings the figure more in line with benchmarks.

There are no children who have been subject to a Child Protection Plan for longer than 2 years which is a positive. This compares favourably with benchmarks from 2016/17 as the North East average is 3.8%, the Statistical Neighbour average is 3.84% and the England average is 3.4%.

At the end of Quarter 1, the figure for children becoming subject to a Child Protection Plan for a second or subsequent time within 2 years of the previous plan ending was 5.1%. This is lower than the previous year end of 6.5%. All children who fall into this category have their cases analysed by a Head of Service to determine if the Local Authority ended the previous plan in a satisfactory manner, and also to determine whether the presenting issues are similar or different when episodes are compared. A number of the children that are in this cohort have now had their cases escalated into the Letter Before Proceedings (LBP) process, and there are a number where care proceedings have been issued.

All Child Protection cases were allocated to a qualified Social Worker throughout the reporting year. Also, all Child Protection plans were reviewed within timescales throughout the reporting year.

At the end of Quarter 1, 86% (704 out of 819) of statutory Child Protection visits had been undertaken within the internally set visiting frequency of 10 working days. This is an improvement on the previous year of 85.6%. However, it should be noted that in a number of other Local Authorities internally set visiting frequencies for children subject to a Child Protection Plan is 15 working days. If this measure was applied for Quarter 1, this would show that 97% (793 out of 819) visits were undertaken within 15 working days. This is broken down further as follows:

- 4.5% visits were undertaken within 11 working days
- 2% visits were undertaken within 12 working days
- 2% visits were undertaken within 13 working days
- 2% visits were undertaken within 14 working days
- 1% were undertaken within 15 working days.

All statutory visits that are not undertaken within timescales are analysed by the Head of Assessment, Care Planning and LATC and a rationale provided by the relevant Team Manager. However, there are a number (3%) where despite numerous attempts to see the children in the home, visits have been unsuccessful and have exceeded timescales. These cases inevitably result in a legal meeting to determine next steps due to non-engagement. This level of scrutiny will continue to be provided by the Head of Service.

2018/19 has seen an addition to the performance report of care proceedings. Headline data will be provided each month but more detailed information will be provided at the end of each Quarter. Future reporting will also include the number of section 7 and 37 reports that have been requested by the Courts to ensure the whole picture is visible. All matters are referred to as cases and figures provided reflect the number of cases rather than the number of children. For example, one matter may refer to a sibling group of 6 children.

At the end of Quarter 1:

- There were 11 live Public Law Outline (PLO) cases
- 17 sets of care proceedings had been issued. These refer to public law proceedings and not discharges of Care Orders, Placement Orders or adoption
- There were 28 sets of live care proceedings ongoing
- 13 cases were being prepared for care proceedings to be issued. These refer to public law proceedings and not discharges of Care Orders, Placement Orders or adoption
- Live discharge of Care Order cases before the Court
- Live adoption cases before the Court
- There were 8 cases that were being prepared for care proceedings to be issued to discharge Care Orders
- Cases that were being prepared for care proceedings to request Adoption Orders
- CaseS that was being prepared for care proceedings to request a Placement Order
- There were 6 cases being prepared to issue care proceedings regarding inherent jurisdiction

For all cases that are being prepared for issuing care proceedings, the Social Worker has to collate a full Court chronology, a Social Work evidence report, and an initial Court Care Plan. Throughout the care proceedings, further reports and assessments are required from the Social Worker. Towards the end of the proceedings, a final evidence report, updated chronology and final Court Care Plan are also required. Each child needs to have an individual Care Plan as they cannot be consolidated.

At the end of Quarter 1, the average length of public law proceedings was 22 weeks. This performance is good as the timescale set for completion of care proceedings is 26 weeks.

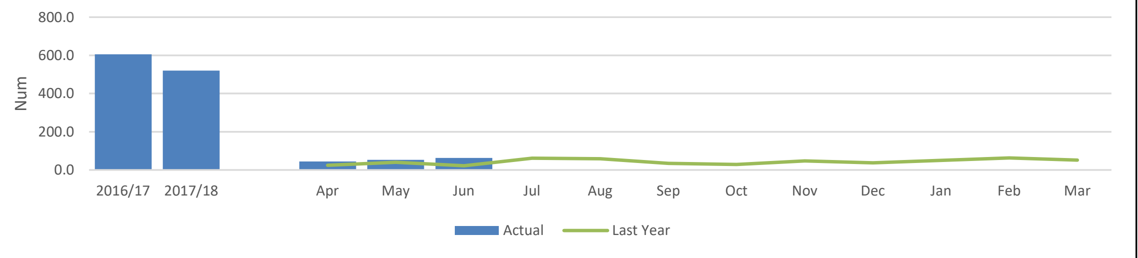
STRATEGY

DEFINITION	The number of strategy discussions started within the month and cumulatively throughout the year.

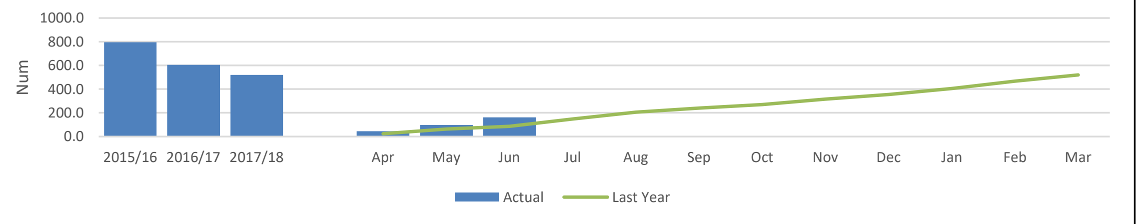
PERFORMANCE ANALYSIS	161 strategy discussions were started during Quarter 1 compared to 86 during Quarter 1 2017/18 giving a 46.6% increase.

		CSC 163	CSC 162	CSC 161
		Monthly number of strategy discussions started (where the child was not already subject to a CPP)	Total number of strategy discussions started (where the child was not already subject to a CPP)	Rate of strategy discussions per 10,000 of the 0-17 population (where the child was not already subject to a CPP)
IN MONTH PERFORMANCE	Target	(blank)	(blank)	(blank)
	Apr-18	45	45	20.0
	May-18	53	98	43.5
	Jun-18	63	161	71.5
	Jul-18			
	Aug-18			
	Sep-18			
	Oct-18			
	Nov-18			
	Dec-18			
	Jan-19			
	Feb-19			
	Mar-19			
ANNUAL TREND	2014/15			322.9
	2015/16	796	796	363.9
	2016/17	605	605	267.4
	2017/18	520	520	229.8
	2018/19 YTD	161	161	71.5

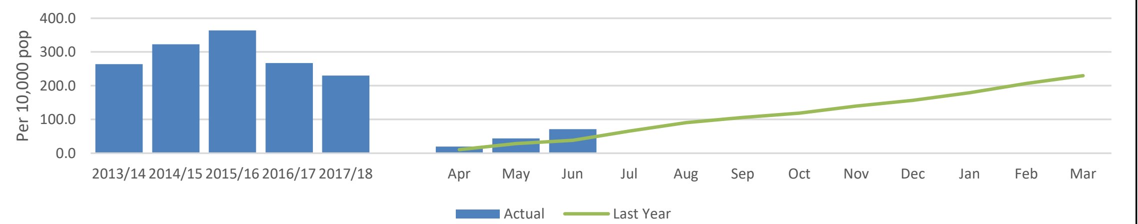
CSC 163: Monthly number of strategy discussions started (where the child was not already subject to a CPP)



CSC 162: Total number of strategy discussions started (where the child was not already subject to a CPP)



CSC 161: Rate of strategy discussions per 10,000 of the 0-17 population (where the child was not already subject to a CPP)



SECTION 47

DEFINITION	Number of Section 47 enquiries started monthly and year to date.

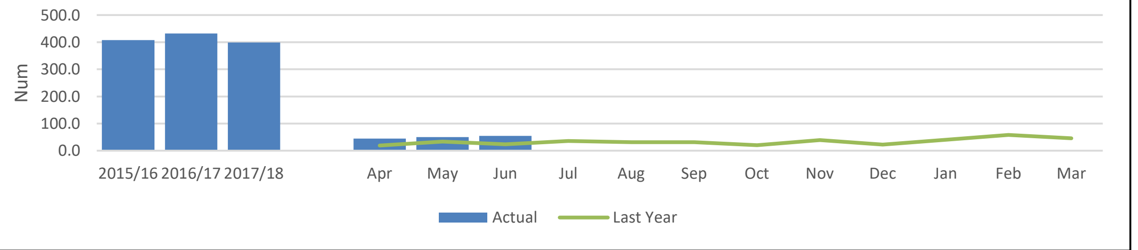
PERFORMANCE ANALYSIS

150 Section 47 enquires were started during Quarter 1 compared to 76 during Q1 2017/18.

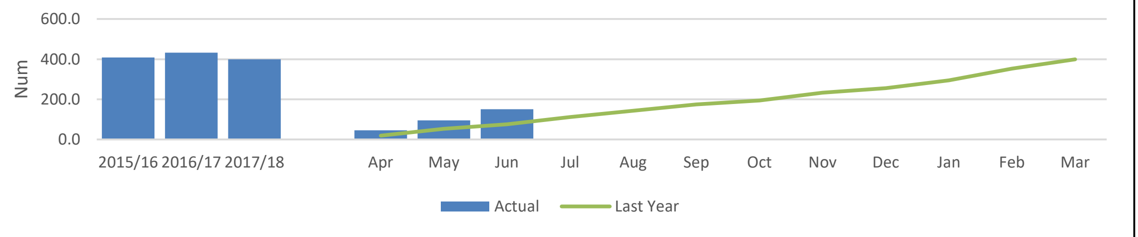
The rate of Section 47 enquiries was 70 per 10,000 population, for Quarter 1.

	CSC 166	CSC 165	CSC 164
	Monthly number of section 47 enquires started (CPP)	Number of section 47 enquires started within the year (CPP)	Rate of section 47 enquiries completed per 10,000 of the 0-17 population (CPP)
IN MONTH PERFORMANCE Target	(blank)	(blank)	(blank)
Apr-18	45	45	17
May-18	50	95	48
Jun-18	55	150	70
Jul-18			
Aug-18			
Sep-18			
Oct-18			
Nov-18			
Dec-18			
Jan-19			
Feb-19			
Mar-19			
ANNUAL TREND 2014/15			138.2
2015/16	408	408	188.6
2016/17	432	432	190.9
2017/18	399	399	172.8
2018/19 YTD	150	150	70

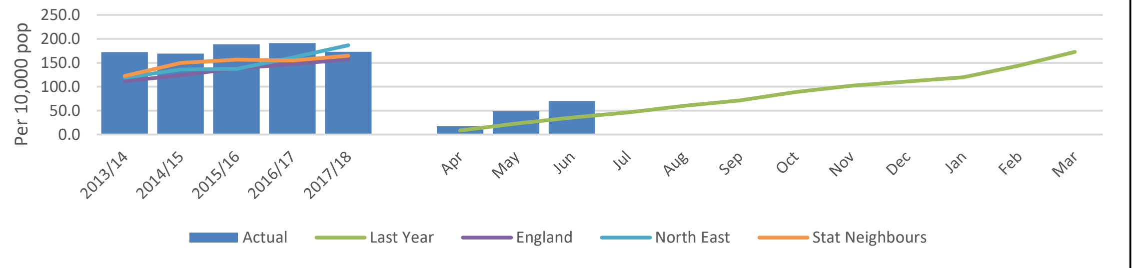
CSC 166: Monthly number of section 47 enquires started (CPP)



CSC 165: Number of section 47 enquires started within the year (CPP)



CSC 164: Rate of section 47 enquiries completed per 10,000 of the 0-17 population (CPP)



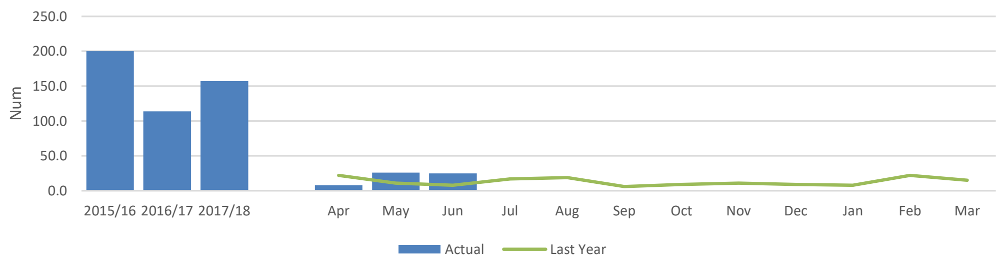
INITIAL CHILD PROTECTION CONFERENCES - CHILDREN

DEFINITION	
	Number of children subject to an Initial Child Protection Conference monthly and year to date (including transfer in conferences).

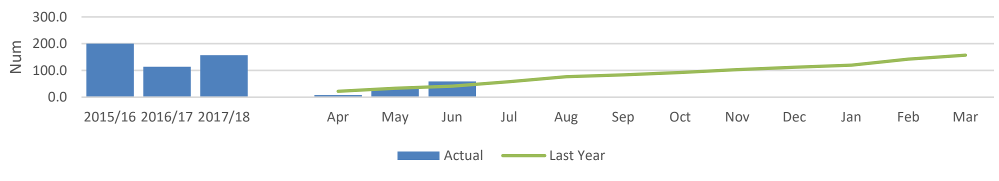
PERFORMANCE ANALYSIS	
	59 children were subject of an ICPC during Quarter 1 compared to 41 children in Quarter 1 2017/18, this is an increase of 18 (30.5%). In June 2018 there were 25 children subject of an ICPC which is a 65% increase compared to 8 children in June 2017.

		CSC 172	CSC 171	CSC 173
		Monthly number of children subject of Initial child protection (CPP) conferences (inc. Transfer in Conferences)	Total number of children subject of an initial child protection (CPP) Conferences (inc. Transfer in Conferences)	Rate of initial child protection (CPP) conferences per 10,000 of the 0-17 population.
IN MONTH PERFORMANCE	Target	(blank)	(blank)	(blank)
	Apr-18	8	8	2.7
	May-18	26	34	9.8
	Jun-18	25	59	15.1
	Jul-18			
	Aug-18			
	Sep-18			
	Oct-18			
	Nov-18			
	Dec-18			
	Jan-19			
	Feb-19			
	Mar-19			
ANNUAL TREND	2014/15			62.6
	2015/16	200	200	88.1
	2016/17	114	114	50.4
	2017/18	157	157	69.4
	2018/19 YTD	59	59	15.1

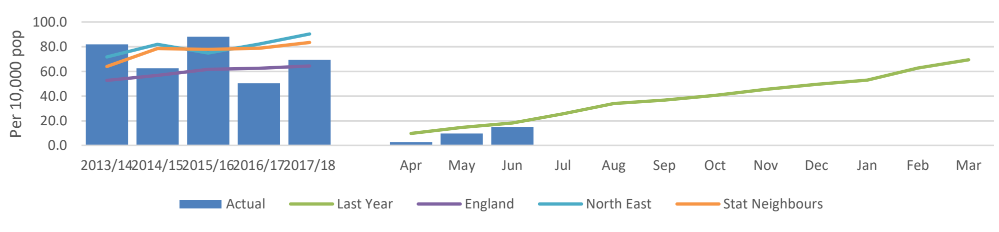
CSC 172: Monthly number of children subject of Initial child protection (CPP) conferences (inc. Transfer in Conferences)



CSC 171: Total number of children subject of an initial child protection (CPP) Conferences (inc. Transfer in Conferences)



CSC 173: Rate of initial child protection (CPP) conferences per 10,000 of the 0-17 population.



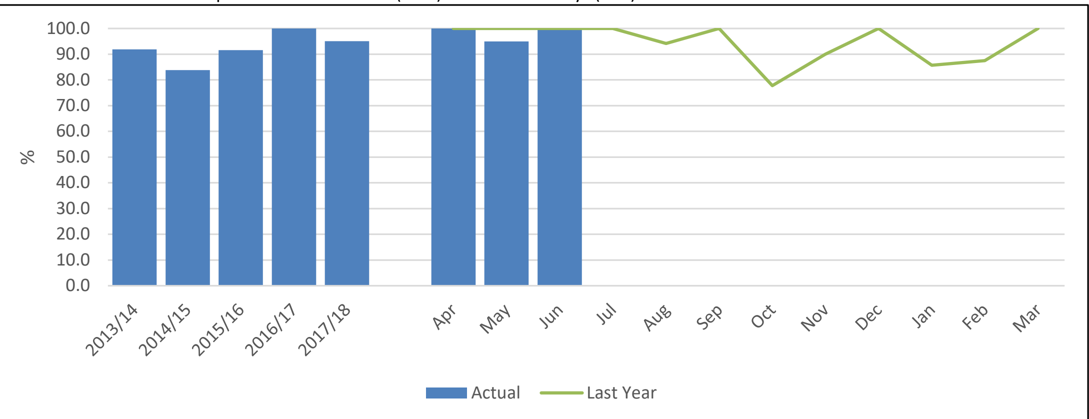
INITIAL CHILD PROTECTION CONFERENCES - TIMELINESS

DEFINITION	Of those ICPCs held within the period (excluding transfer ins), the percentage held within 15 working days of the S47 enquiry. Provides an indication of how quickly the safety of children who are judged to be continuing to, or likely to suffer significant harm is being considered by a multi-agency meeting.

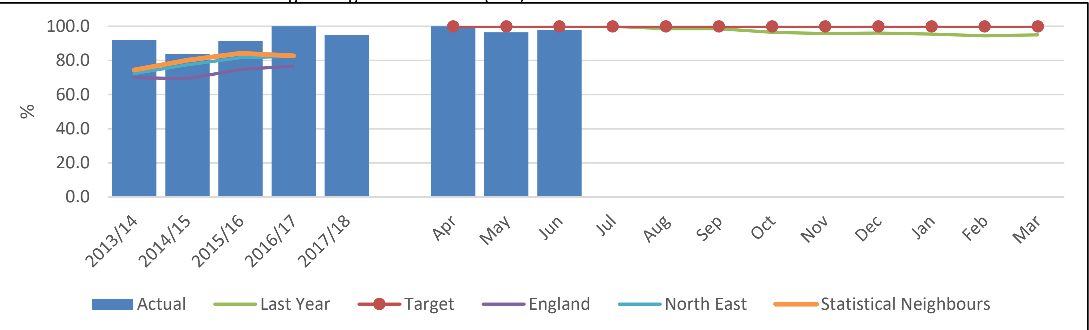
PERFORMANCE ANALYSIS	98% ICPC conference took place within timescale in Quarter 1.

		CSC 178	CSC 176
		Monthly % of cases recorded in the Safeguarding Unit workbook where Child Protection strategy meeting / S47 start to initial child protection conference (ICPC) are within 15 days (CPP). Excludes transfer-in conferences.	% of cases where the initial child protection conference (ICPC) was within 15 days of the initiating strategy discussion / S47 start recorded in the Safeguarding Unit workbook (CPP). This EXCLUDES transfer-in conferences. Year to Date
IN MONTH PERFORMANCE	Target	(blank)	100.0
	Apr-18	100.0	100.0
	May-18	95.0	96.4
	Jun-18	100.0	98.0
	Jul-18		
	Aug-18		
	Sep-18		
	Oct-18		
	Nov-18		
	Dec-18		
	Jan-19		
	Feb-19		
	Mar-19		
ANNUAL TREND	2014/15	83.8	83.8
	2015/16	91.5	91.5
	2016/17	100.0	100.0
	2017/18	95.0	95.0
	2018/19 YTD	98.0	98.0

CSC 178: Monthly % of cases recorded in the Safeguarding Unit workbook where Child Protection strategy meeting / S47 start to initial child protection conference (ICPC) are within 15 days (CPP). Excludes transfer-in conferences.



CSC 176: % of cases where the initial child protection conference (ICPC) was within 15 days of the initiating strategy discussion / S47 start recorded in the Safeguarding Unit workbook (CPP). This EXCLUDES transfer-in conferences. Year to Date



INITIAL CHILD PROTECTION CONFERENCES - CONVERSION TO CHILD PROTECTION PLAN

DEFINITION

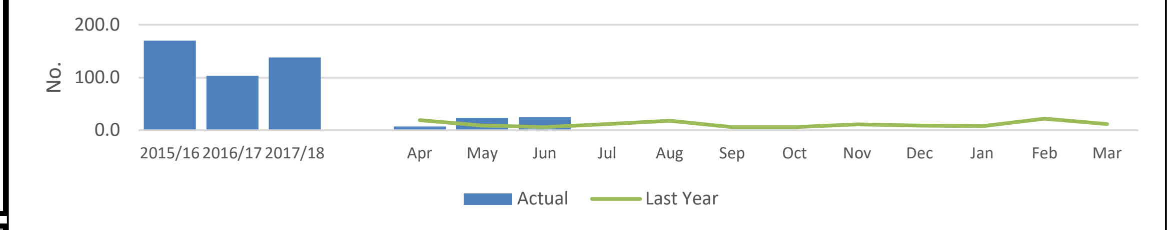
Number and percentage of children becoming subject to a Child Protection Plan following an Initial Child Protection Conference (including transfer ins).

PERFORMANCE ANALYSIS

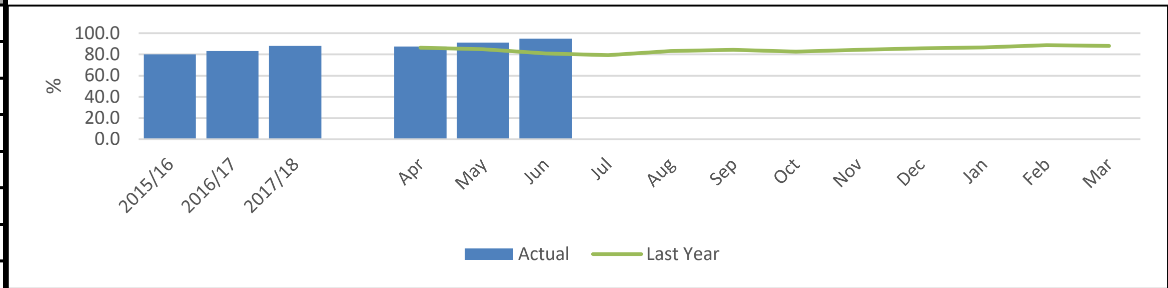
In Quarter 1 2018/19, 56 children have become subject to a Child Protection Plan after an ICPC, this is 60.7% (34) higher compared to Quarter 1 2017/18. This equates to 94.9% of all children conferenced that led to them becoming CP compared to 81% for the same time last year.

		CSC 175	CSC 177	
		Monthly number of children conferenced that led to them becoming CP	Cumulative % children conferenced that led to them becoming CP	Monthly percentage of children conferenced that led to them becoming CP
IN MONTH PERFORMANCE	Target			
	Apr-18	7	87.5	87.5
	May-18	24	91.2	92.3
	Jun-18	25	94.9	100.0
	Jul-18			
	Aug-18			
	Sep-18			
	Oct-18			
	Nov-18			
	Dec-18			
	Jan-19			
	Feb-19			
	Mar-19			
	2015/16	170	80.0	
	2016/17	103	83.3	
	2017/18	138	87.9	
	2018/19 YTD	56	94.9	

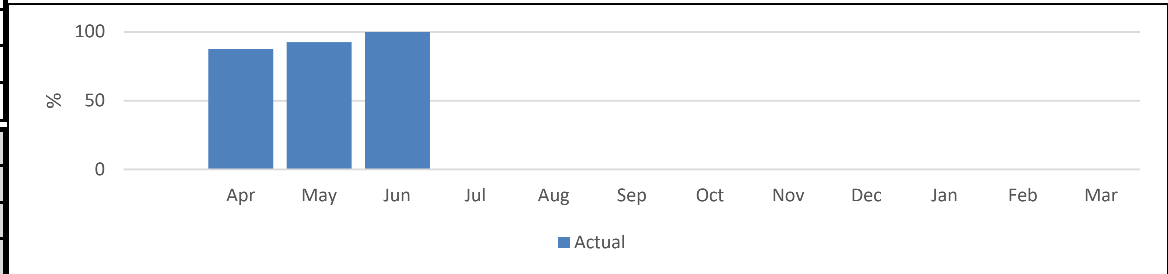
CSC 175: Monthly number of children conferenced that led to them becoming CP



CSC 177: Cumulative % children conferenced that led to them becoming CP



Monthly percentage of children conferenced that led to them becoming CP



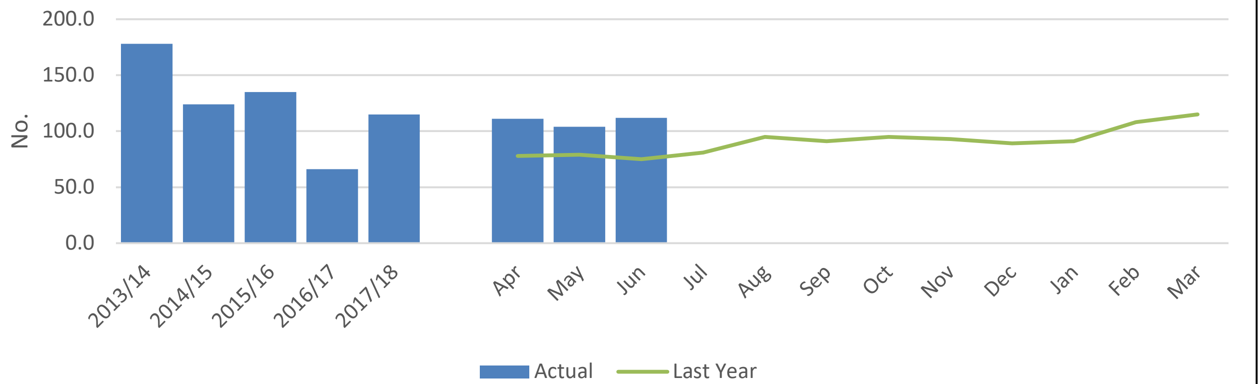
CHILD PROTECTION

DEFINITION	Number of children subject to a Child Protection Plan at the end of the month.

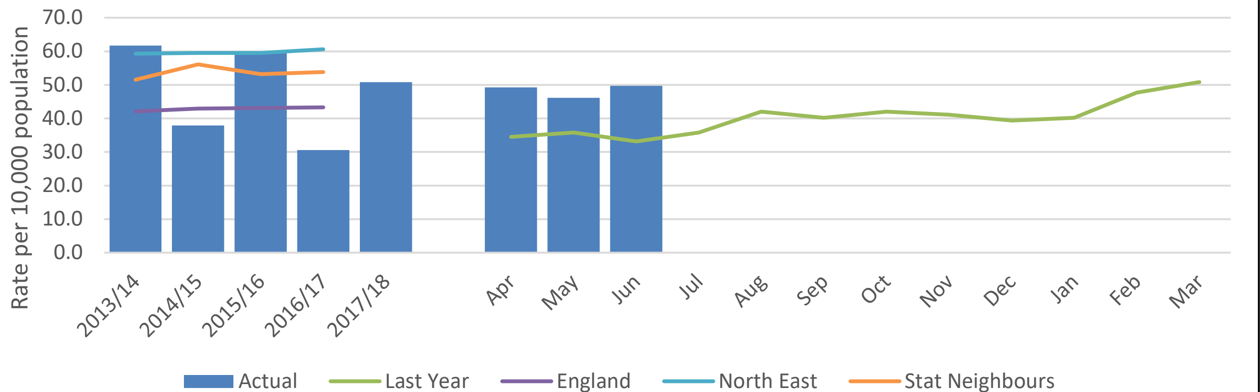
PERFORMANCE ANALYSIS	112 children were subject to a Child Protection Plan compared to 75 children in Quarter 1 2017/18, an increase of 33%.

		CSC 182	CSC 181
		Number of children subject to a child protection plan	Rate of children subject to a Child Protection Plan per 10,000 population
IN MONTH PERFORMANCE	Target		
	Apr-18	111	49.3
	May-18	104	46.2
	Jun-18	112	49.7
	Jul-18		
	Aug-18		
	Sep-18		
	Oct-18		
	Nov-18		
	Dec-18		
	Jan-19		
	Feb-19		
	Mar-19		
ANNUAL TREND	2014/15	124	37.9
	2015/16	135	59.5
	2016/17	66	29.2
	2017/18	115	50.8
	2018/19 YTD	112	49.7

CSC 182: Number of children subject to a child protection plan



CSC 181: Rate of children subject to a Child Protection Plan per 10,000 population

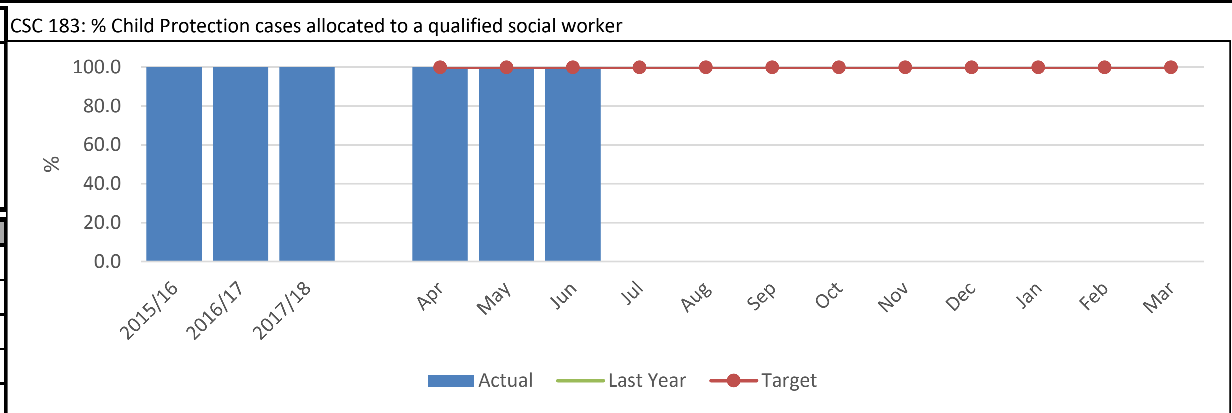


CHILD PROTECTION - ALLOCATION & REVIEWS

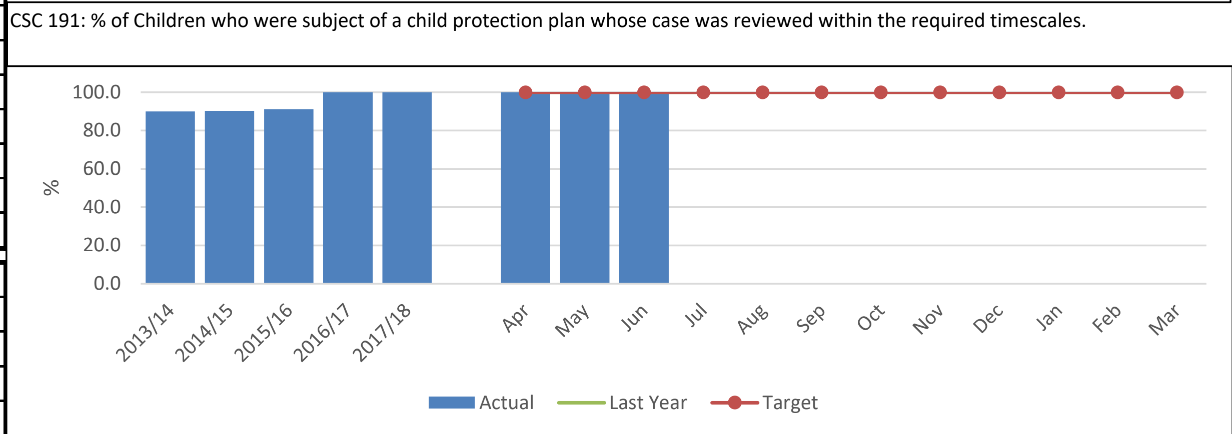
DEFINITION	The percentage of children subject to a Child Protection Plan at the end of the month and who at that date had had a Plan continuously for at least the previous 3 months, whose case was reviewed within the required timescales. Reviews are a key element in delivering Child Protection Plans and effective reviews should ensure the provision of good quality interventions. This indicator is a proxy for the measurement of effectiveness of the interventions provided to children subject to a Child Protection Plan. "Working Together to Safeguard Children" guidance requires that the first review should be within 3 months of the initial child protection conference and thereafter at intervals of no more than 6 months.
PERFORMANCE ANALYSIS	100% of Child Protection Cases were allocated to a qualified social worker. 100% Child Protection reviews have been completed within the required timescales. This is higher than regional 95%, national 92% and statistical neighbours 95%.

		CSC 183	CSC 191
		% Child Protection cases allocated to a qualified social worker	% of Children who were subject of a child protection plan whose case was reviewed within the required timescales.
IN MONTH PERFORMANCE	Target	100.0	100.0
	Apr-18	100.0	100.0
	May-18	100.0	100.0
	Jun-18	100.0	100.0
	Jul-18		
	Aug-18		
	Sep-18		
	Oct-18		
	Nov-18		
	Dec-18		
	Jan-19		
	Feb-19		
	Mar-19		
ANNUAL TREND	2014/15		90.3
	2015/16	100.0	91.2
	2016/17	100.0	100.0
	2017/18	100.0	100.0
	2018/19 YTD	100.0	100.0

CSC 183: % Child Protection cases allocated to a qualified social worker



CSC 191: % of Children who were subject of a child protection plan whose case was reviewed within the required timescales.



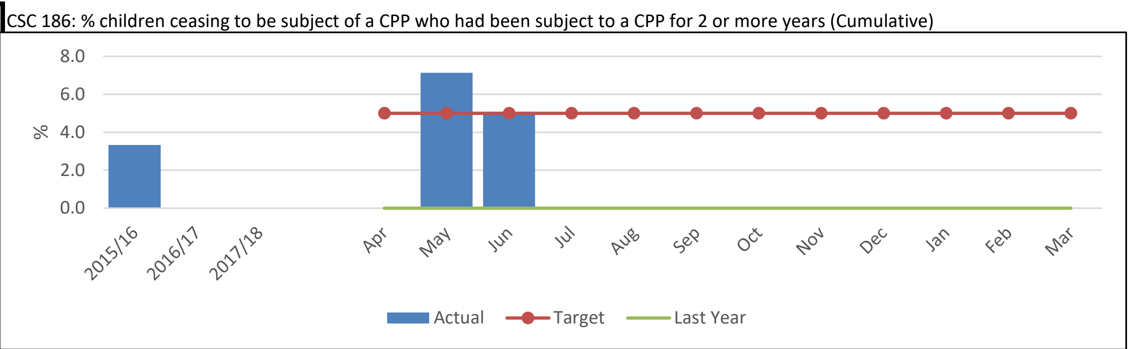
CHILD PROTECTION - TIME PERIODS

DEFINITION	
	Percentage of children ceasing to be subject to a Child Protection Plan who had been subject to a Plan for 2 or more years and percentage of children becoming subject to a Child Protection Plan for the 2nd or subsequent time. These indicators reflect the underlying principle that professionals should be working towards specified outcomes which, if implemented effectively, should lead to all children not needing to be the subject of a Child Protection Plan within a maximum of two years, or becoming subject of a Child Protection Plan for a second or subsequent time.

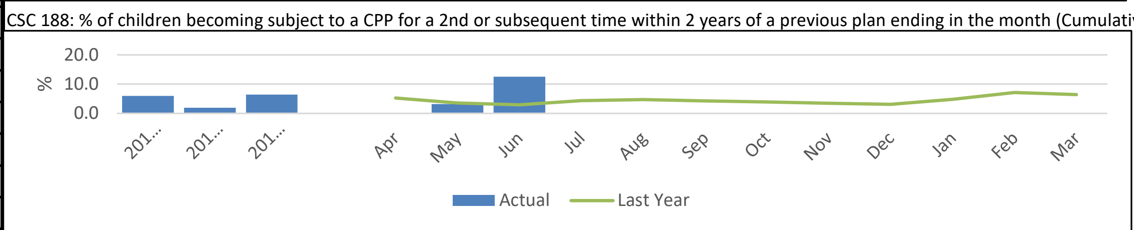
PERFORMANCE ANALYSIS	
	12.5% were subject to a 2nd or more CPP within 2 years of a previous plan ending compared to 2.9% of children in Quarter 1 2017/18. 23.2% were subject to a 2nd or more CPP within no specified period compared to 13.3% of children in Quarter 1 2017/18.

		CSC 186	CSC 188	CSC 189
		% children ceasing to be subject of a CPP who had been subject to a CPP for 2 or more years (Cumulative)	% of children becoming subject to a CPP for a 2nd or subsequent time within 2 years of a previous plan ending in the month (Cumulative)	% of children becoming subject to a CPP for a 2nd or subsequent time ever (Cumulative)
IN MONTH PERFORMANCE	Target	5.0		
	Apr-18	0.0	0.0	0.9
	May-18	7.1	3.2	18.3
	Jun-18	5.1	12.5	23.2
	Jul-18			
	Aug-18			
	Sep-18			
	Oct-18			
	Nov-18			
	Dec-18			
	Jan-19			
	Feb-19			
	Mar-19			
ANNUAL TREND	2014/15	0.6	2.4	
	2015/16	3.3	6.0	14.0
	2016/17	0.0	1.9	10.6
	2017/18	0.0	6.5	19.1
	2018/19 YTD	5.1	12.5	23.2

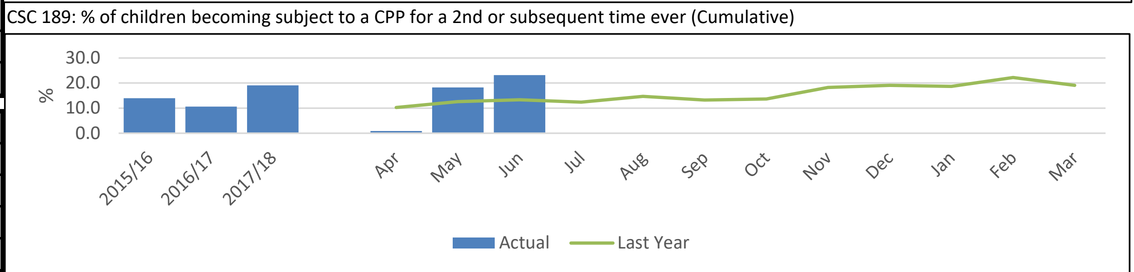
CSC 186: % children ceasing to be subject of a CPP who had been subject to a CPP for 2 or more years (Cumulative)



CSC 188: % of children becoming subject to a CPP for a 2nd or subsequent time within 2 years of a previous plan ending in the month (Cumulati



CSC 189: % of children becoming subject to a CPP for a 2nd or subsequent time ever (Cumulative)



CHILD PROTECTION - STATUTORY VISITS

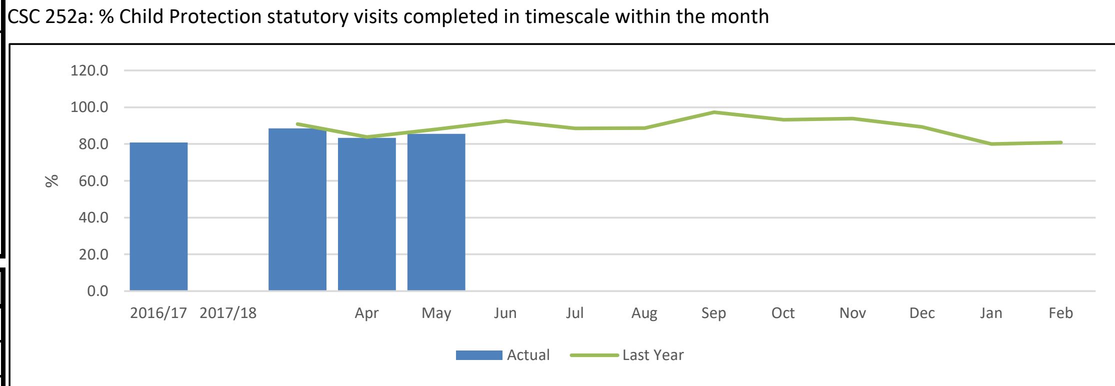
DEFINITION	Percentage of children subject to a Child Protection Plan who had all statutory visits carried out within timescales (10 working days) and percentage of Child Protection statutory visits completed within timescale monthly and year to date.

PERFORMANCE ANALYSIS

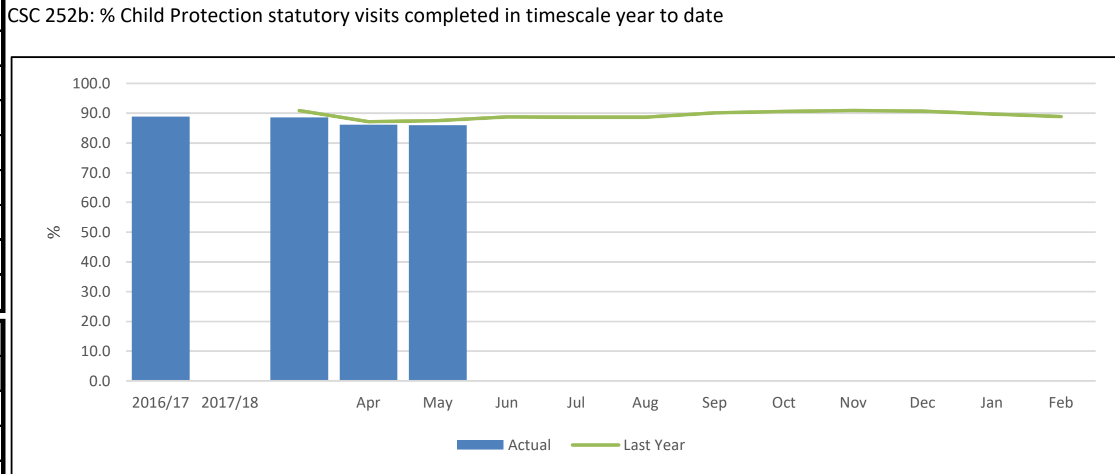
In Quarter 1 2018/19, 704 of the 819 (86%) CP statutory visits were completed within the timescales, compared to 488 of 558 (87.5%) completed CP statutory visits within the timescales in Quarter 1 2017/18.

		CSC 252a	CSC 252b
		% Child Protection statutory visits completed in timescale within the month	% Child Protection statutory visits completed in timescale year to date
IN MONTH PERFORMANCE	Target		
	Apr-18	88.6	88.6
	May-18	83.4	86.1
	Jun-18	85.6	86.0
	Jul-18		
	Aug-18		
	Sep-18		
	Oct-18		
	Nov-18		
	Dec-18		
	Jan-19		
	Feb-19		
	Mar-19		
ANNUAL TREND	2014/15		
	2015/16		
	2016/17	85.6	85.6
	2017/18	80.8	88.9
	2018/19 YTD	85.6	86.0

CSC 252a: % Child Protection statutory visits completed in timescale within the month



CSC 252b: % Child Protection statutory visits completed in timescale year to date



Looked After Children

Quarter 1 Performance Summary

At the end of June, the number of Children in Care was 229 which is higher than previous year ends from 2017/18 to date.

A total of 28 children became looked after during Quarter 1. There were 13 children who were ceased to be looked after in Quarter 1. This demonstrates that in Quarter 1 more children entered care than left care.

100% of Children in Care had an allocated Social Worker. This means the target for this performance has been met.

100% of Children in Care had a Looked After Review completed within timescales. This means the target for this performance has been met.

All children who were subject to a Placement Order but had not yet been adopted have a plan in place to secure their permanence via adoption or a revocation of the Placement Order due to unsuccessful family finding.

In relation to children's participation in their Looked After Review:

- 29 reviews were held for children aged under 4
- 61 reviews had a child who attended and spoke for themselves
- 56 reviews were held where the child did not attend but their views had been sent
- 8 reviews were held where the child did not attend and did not send their views

At the end of Quarter 1, 93% of statutory visits to Children in Care had been carried out in timescale. This is a significant improvement on the 2016/17 year end performance of 86.9%, and is slightly higher than the 2017/18 year end performance of 92.6%. Although this performance is good, there continues to be a focus on analysing the reasons why visits were not carried out in timescales to determine if there are themes arising, and action taken to address these themes if they are apparent.

There continues to be a concerted effort to ensure placement stability improves for children. At the end of June, the percentage of children with 3 or more placement moves in the last 12 months positively reduced to 9.6% which is an improvement on the 2017/18 year end performance of 9.8%. This is in line with the target set of 10%. However, each month in Quarter 1 has seen a steady increase in this percentage as it had been 7.9% in April, and 8.8% in May. This means there has been an actual increase of less than 5 young people who moved into this cohort. It is predicted that performance will positively decrease in July.

The percentage of children who had been in their current placement for 2 years or more who had been in care for 2½ years or more was 63.1% at the end of Quarter 1. This is a reduction from the 2017/18 year end of 65.1%. This means the target of 65% that had been set has been missed.

The placement stability performance has been adversely affected by a number of placement disruptions. All efforts were made to wrap around the placements that disrupted but with little success.

The percentage of children placed 20 miles or more away from home has seen a slight increase to 12.2% at the end of June, when compared to the 2017/18 year-end performance of 12%. This is a concerning increase which will require rigorous monitoring going forward. The cohort represents 27 children and young people whose placements are as follows:

- Placed with a parent at home
- Children are placed with family members/friends (Connected Carers)
- Children are in foster placements
- Young people are in residential placements
- Young people over the age of 16 are in supported accommodation provision

At the end of June there were 100% of Initial Health Review forms returned to Health within 7 working days. Performance for this indicator across Quarter 1 is 100%.

At the end of June, there were 26% of Looked After Children with an up-to-date Review Health Assessment which is on target for Quarter 1. This represents 32 out of 34 children (94.1%) who had a Review Health Assessment due that were completed within the required month at the end of Quarter 1. Progress against this indicator continues to undergo close scrutiny with a tracker in place to ensure robust oversight.

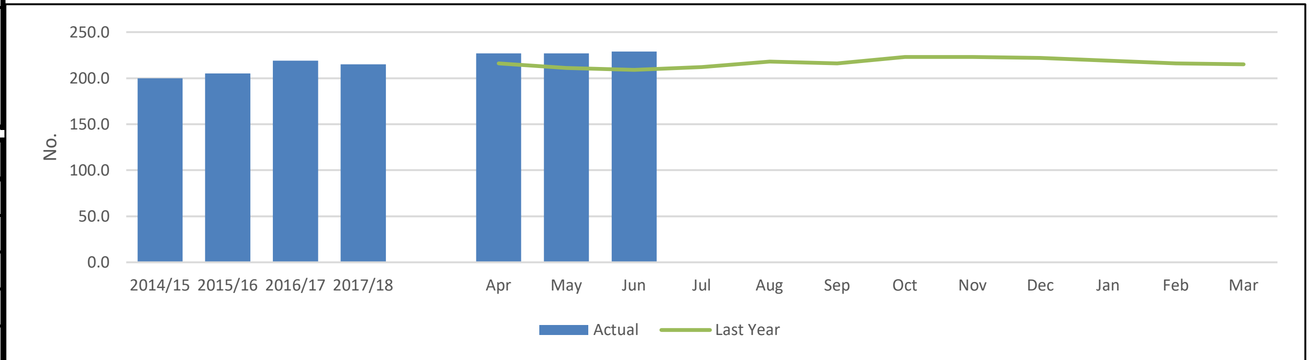
At the end of June, there were 12% of children with an up-to-date dental check in the past 12 months. This represents 19 out of 39 (48.7%) dental health checks that were completed at the end of Quarter 1. Progress against this indicator continues to undergo close scrutiny with a tracker in place to ensure robust oversight.

LOOKED AFTER

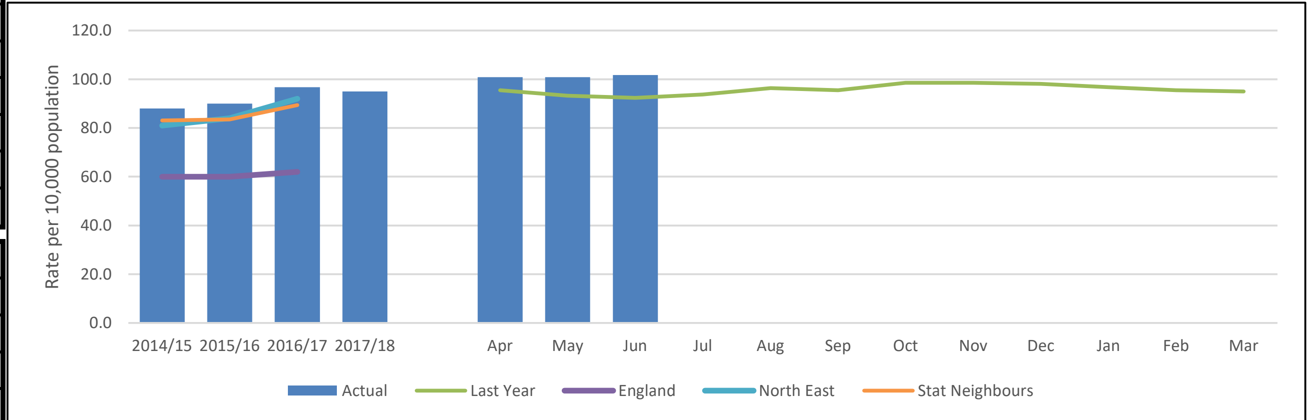
DEFINITION	Number of Looked After Children at the end of each month.
PERFORMANCE ANALYSIS	229 Children were Looked After at the end of Quarter 1 compared to 209 at Quarter 1 2017/18. The rate of Children Looked After is 101.7 per 10,000 population. This is a higher that the national rate (62 per 10,000), regional (92 per 10,000) and statistical (89.4 per 10,000) benchmarks.

		CSC 201	CSC 200
		Total number of Looked After Children	Rate of Looked After Children Per 10,000 population
IN MONTH PERFORMANCE	Target		
	Apr-18	227	100.8
	May-18	227	100.8
	Jun-18	229	101.7
	Jul-18		
	Aug-18		
	Sep-18		
	Oct-18		
	Nov-18		
	Dec-18		
	Jan-19		
	Feb-19		
	Mar-19		
ANNUAL TREND	2014/15	200	88.0
	2015/16	205	90.0
	2016/17	219	96.8
	2017/18	215	95.0
	2018/19 YTD	229	101.7

CSC 201: Total number of Looked After Children



CSC 200: Rate of Looked After Children Per 10,000 population



LOOKED AFTER - ALLOCATION & REVIEWS

DEFINITION

The percentage of Looked After Children cases which should have been reviewed during the year ending 31 March that were reviewed on time during the year and the percentage of Looked After Children cases that were allocated to a qualified social worker at the end of the month.

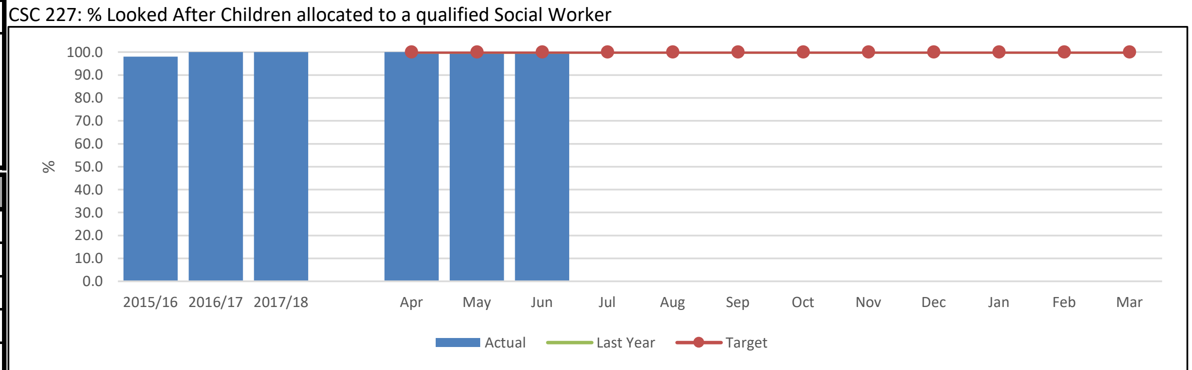
To improve compliance with local authorities' legal requirements under the Review of Children's cases Regulations 1991. The purpose of the review is to consider the plan for the child's welfare, to monitor the progress of the plan and amend it as necessary in light of changed information and circumstances. The statutory intervals are within 20 working days of placement, then within 3 months and 6 monthly thereafter, but reviews may be rescheduled or held inside these intervals if there are significant changes to the child's care plan.

PERFORMANCE ANALYSIS

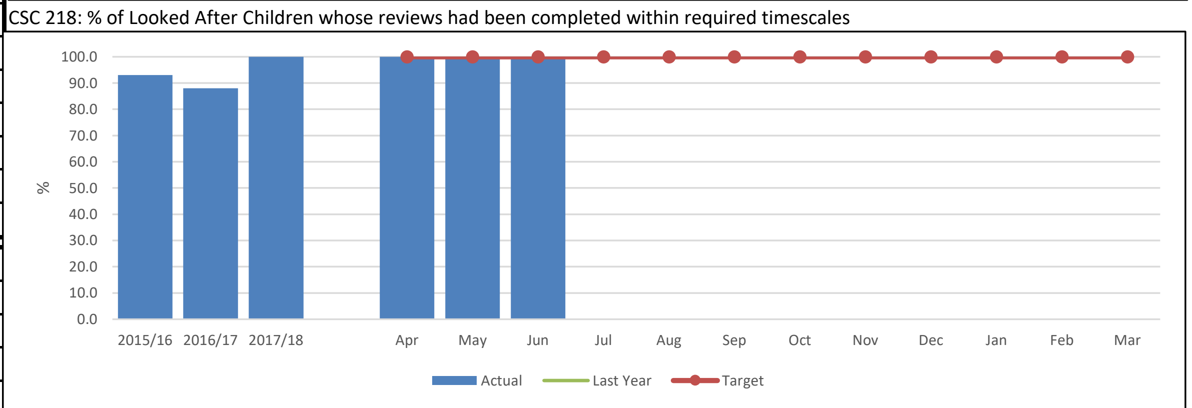
100% of Looked After Children were allocated to a qualified Social worker during Quarter 1.
100% of Looked After reviews had been completed within required timescales during Quarter 1.

		CSC 227	CSC 218
		% Looked After Children allocated to a qualified Social Worker	% of Looked After Children whose reviews had been completed within required timescales
	Target	100.0	100.0
IN MONTH PERFORMANCE	Apr-18	100.0	100.0
	May-18	100.0	100.0
	Jun-18	100.0	100.0
	Jul-18		
	Aug-18		
	Sep-18		
	Oct-18		
	Nov-18		
	Dec-18		
	Jan-19		
	Feb-19		
	Mar-19		
ANNUAL TREND	2014/15		92.3
	2015/16	98.1	93.1
	2016/17	100.0	88.0
	2017/18	100.0	100.0
	2018/19 YTD	100.0	100.0

CSC 227: % Looked After Children allocated to a qualified Social Worker



CSC 218: % of Looked After Children whose reviews had been completed within required timescales



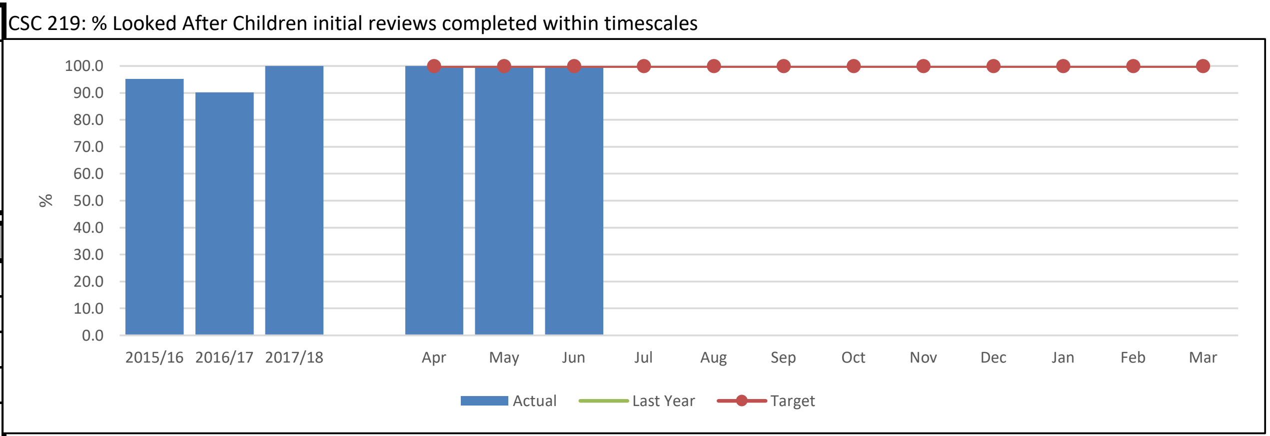
LOOKED AFTER - REVIEWS

DEFINITION	Percentage of the current Looked After Children who had had their initial reviews and all of their subsequent reviews completed within the required timescales.

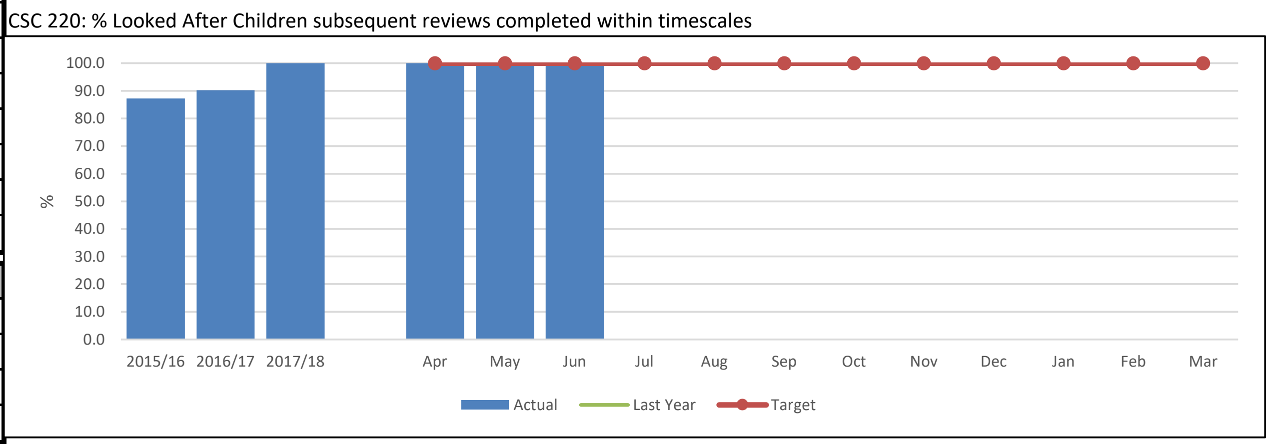
PERFORMANCE ANALYSIS	100% of Looked After reviews had been completed within required timescales during Quarter 1.

		CSC 219	CSC 220
		% Looked After Children initial reviews completed within timescales	% Looked After Children subsequent reviews completed within timescales
IN MONTH PERFORMANCE	Target	100.0	100.0
	Apr-18	100.0	100.0
	May-18	100.0	100.0
	Jun-18	100.0	100.0
	Jul-18		
	Aug-18		
	Sep-18		
	Oct-18		
	Nov-18		
	Dec-18		
	Jan-19		
	Feb-19		
	Mar-19		
ANNUAL TREND	2014/15		
	2015/16	95.2	87.3
	2016/17	90.1	90.2
	2017/18	100.0	100.0
	2018/19 YTD	100.0	100.0

CSC 219: % Looked After Children initial reviews completed within timescales



CSC 220: % Looked After Children subsequent reviews completed within timescales



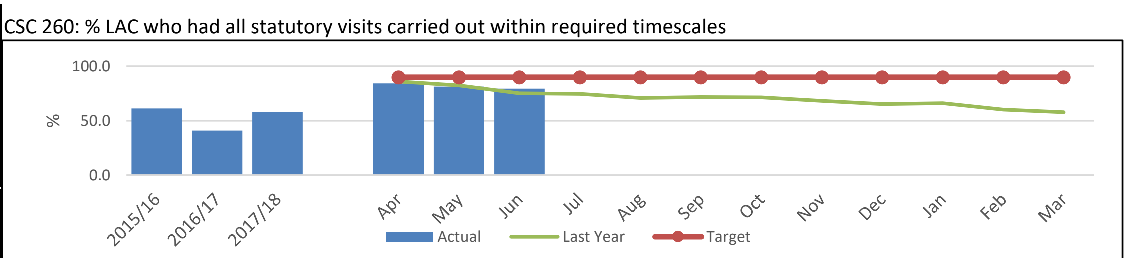
LOOKED AFTER - STATUTORY VISITS

DEFINITION	Percentage of Looked After Children who had all statutory visits completed within required timescales and percentage of Looked After statutory visits completed within timescales each month and year to date.

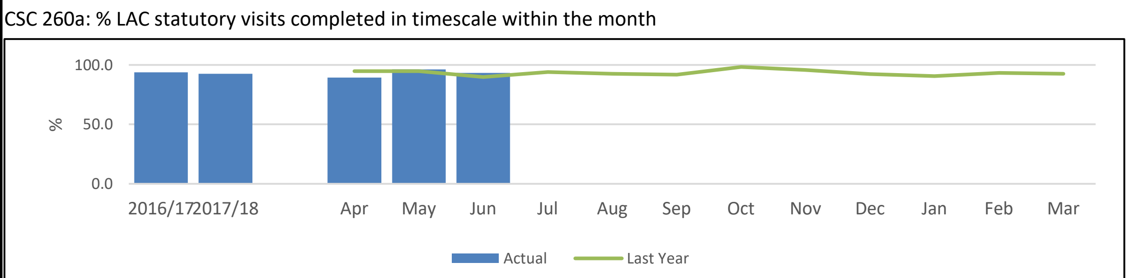
PERFORMANCE ANALYSIS	93% of statutory Looked After visits were completed within the required timescales in Quarter 1 2018/19 which is consistent with Quarter 1 2017/18 at 93.4%.

		CSC 260	CSC 260a	CSC 260b
		% LAC who had all statutory visits carried out within required timescales	% LAC statutory visits completed in timescale within the month	% LAC statutory visits completed in timescale year to date
IN MONTH PERFORMANCE	Target	90.0		
	Apr-18	84.2	89.5	89.5
	May-18	81.3	96.1	92.9
	Jun-18	79.4	93.2	93.0
	Jul-18			
	Aug-18			
	Sep-18			
	Oct-18			
	Nov-18			
	Dec-18			
	Jan-19			
	Feb-19			
	Mar-19			
ANNUAL TREND	2014/15	65.9		
	2015/16	61.3		
	2016/17	41.0	93.8	86.9
	2017/18	57.8	92.6	93.4
	2018/19 YTD	79.4	93.2	93.0

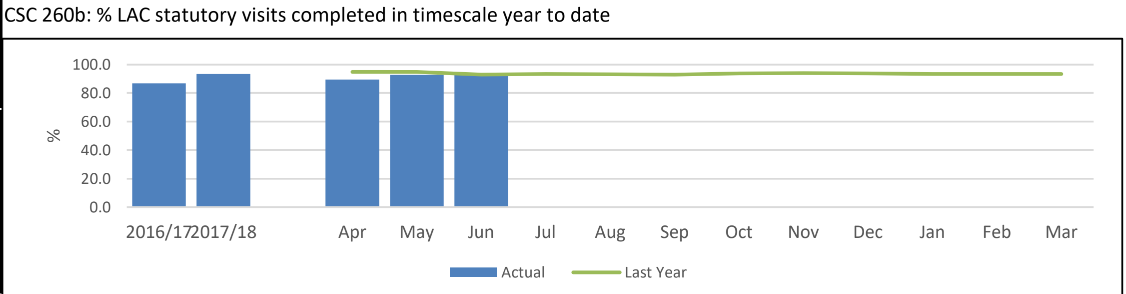
CSC 260: % LAC who had all statutory visits carried out within required timescales



CSC 260a: % LAC statutory visits completed in timescale within the month



CSC 260b: % LAC statutory visits completed in timescale year to date



LOOKED AFTER - PLACEMENTS

DEFINITION

Of those Looked After Children at the point in time (excluding series of short-term placements), the percentage that had 3 or more separate placement in the previous 12 months; who had been in their current placement for 2 or more years. and who were placed more than 20 miles away from their home address.

On the whole stability is associated with better outcomes, placement instability has been highlighted as a key barrier to improving educational outcomes. Proper assessment and an adequate choice of placements to meet the varied needs of different children are essential if appropriate stable placement are to be made. Inappropriate placements often break down and lead to frequent moves. Nevertheless, the circumstances of some individual children will require 3 or more separate placements during a year if they and others are to be kept safe.

PERFORMANCE ANALYSIS

9.6% of children in care in Quarter 1 have had 3 or more placements within the previous 12 months. This is in line with benchmark data for 2016/17 which was for statistical neighbours, 9.5% and national average, 10%.
63.1% of children have been in their current placement continuously for at least 2 years. This is an improvement of 12.3% from Quarter 1 2017/18 which was 50.8%. Benchmarking data for 2016/17 for statistical neighbours is 72% and nationally 68%.
12.2% of children have been placed 20 or more miles away from home in Quarter 1 2018/19.

		CSC 228	CSC 229	CSC 230
		% LAC with 3 or more placements moves during last 12 months	% LAC who have been in their current placement for 2 or more years	% LAC placed 20 miles or more away from home
IN MONTH PERFORMANCE	Target	10	65	10.00
	Apr-18	7.9	67.2	11.0
	May-18	8.8	65.6	11.9
	Jun-18	9.6	63.1	12.2
	Jul-18			
	Aug-18			
	Sep-18			
	Oct-18			
	Nov-18			
	Dec-18			
	Jan-19			
	Feb-19			
	Mar-19			
ANNUAL TREND	2014/15	12.0	70.0	7.0
	2015/16	11.7	57.8	12.8
	2016/17	14.1	52.4	7.8
	2017/18	9.8	65.1	12.0
	2018/19 YTD	9.6	63.1	12.2

CSC 228: % LAC with 3 or more placements moves during last 12 months

CSC 229: % LAC who have been in their current placement for 2 or more years

CSC 230: % LAC placed 20 miles or more away from home

LOOKED AFTER - INITIAL HEALTH ASSESSMENTS

DEFINITION

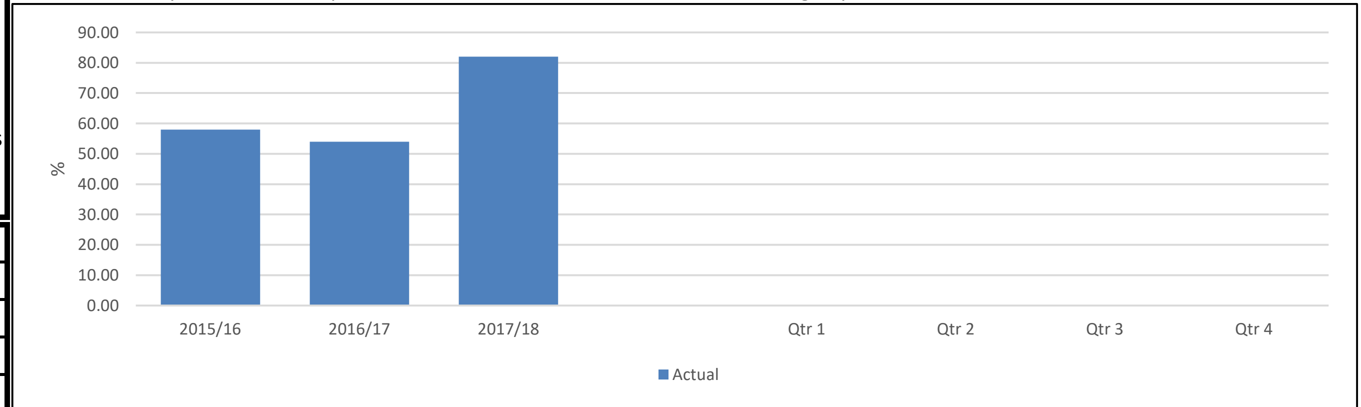
Percentage of Initial Health Assessments completed within 20 working days of a child becoming Looked After year to date, and percentage of IHA forms returned to Health within 7 working days.

PERFORMANCE ANALYSIS

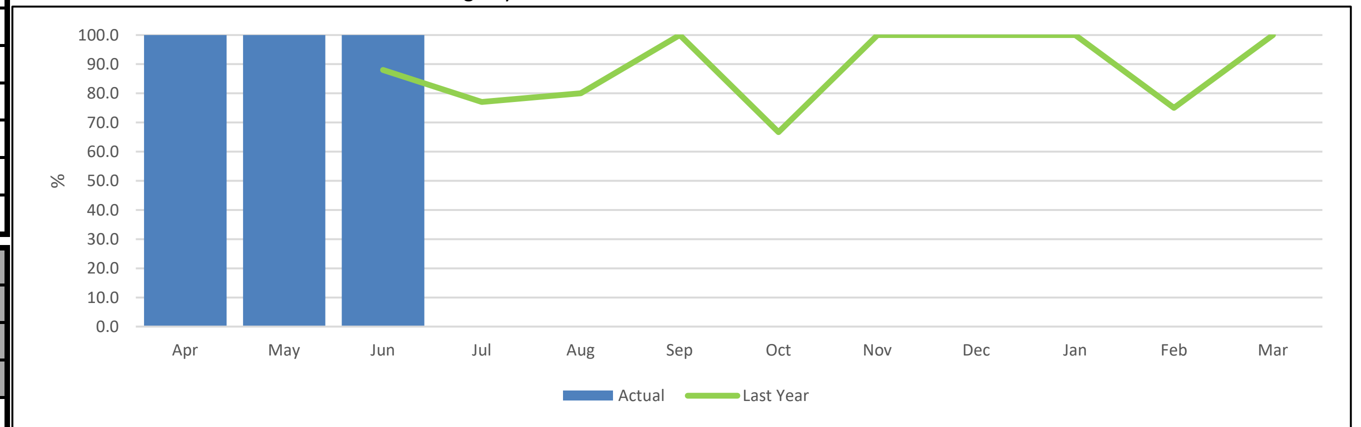
In Quarter 1 2018/19, 100% of IHA forms have been returned to Health within 7 working days.

		CSC 247 % newly LAC with a completed Initial Health Assessment within 20 working days	% IHA forms returned to Health within 7 working days
IN MONTH PERFORMANCE	Apr-18		100.0
	May-18		100.0
	Jun-18	N/A	100.0
	Jul-18		
	Aug-18		
	Sep-18		
	Oct-18		
	Nov-18		
	Dec-18		
	Jan-19		
	Feb-19		
	Mar-19		
ANNUAL TREND	2014/15		
	2015/16	58.0	
	2016/17	54.0	
	2017/18	82.0	
	2018/19 YTD		100.0

CSC 247: % newly LAC with a completed Initial Health Assessment within 20 working days



% IHA forms returned to Health within 7 working days

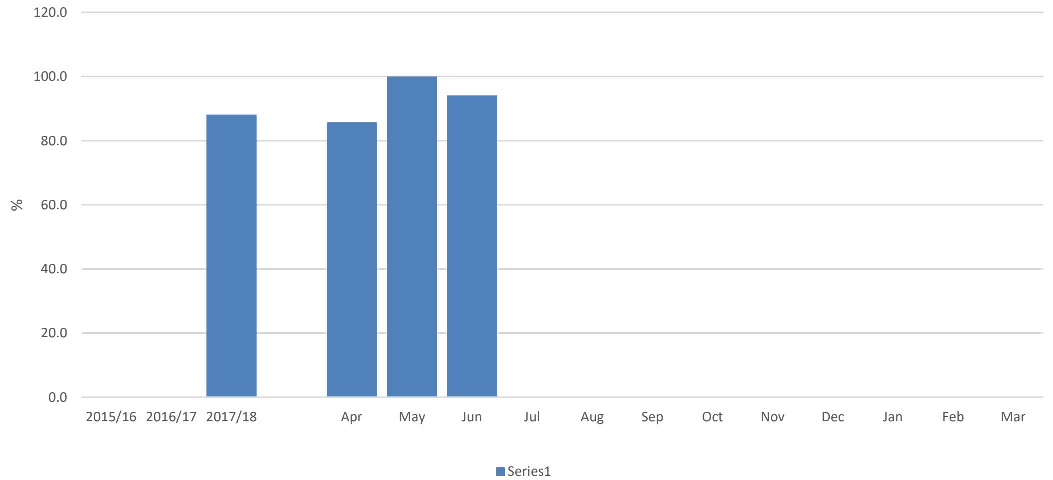


DEFINITION	Of the children in care at 31 March who had been in care continuously for at least 12 months, the percentage who had had their teeth checked by a dentist during the previous 12 months, and the percentage who had had an annual health check during the previous 12 months. Looked After Children share many of the same health risks and problems as their peers, but often to a greater degree. These indicators track the partitcipation of our LAC in health and dental checks as a proxy for monitoring the general health and wellbeing of the children, as well as providing a check on the effectiveness of joint working with Health to secure good health outcomes for LAC.

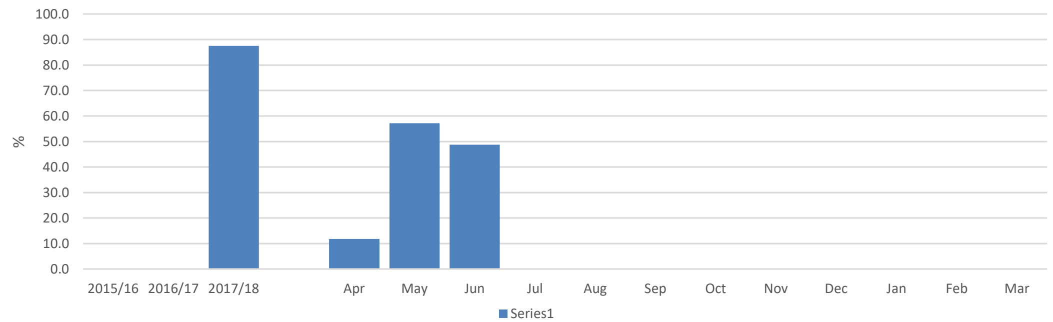
PERFORMANCE ANALYSIS	32 of 34 review health assessments due, were completed by the end of Quarter 1. 19 of 39 dental health check assessments due, were completed by the end of Quarter 1.

		CSC 250b	CSC 251d
		The % of children who have been in care (LAC) for at least 12 months and were due a Review Health Assessment between 1st April and the current reporting date, and have had one.	The % of children who have been in care (LAC) for at least 12 months and were due a Dental Check between 1st April and the current reporting date, and have had on
IN MONTH PERFORMANCE	Target		
	Apr-18	85.7	11.8
	May-18	100.0	57.1
	Jun-18	94.1	48.7
	Jul-18		
	Aug-18		
	Sep-18		
	Oct-18		
	Nov-18		
	Dec-18		
	Jan-19		
	Feb-19		
	Mar-19		
ANNUAL TREND	2014/15	92.6	92.6
	2015/16	57.9	90.2
	2016/17	71.6	75.9
	2017/18	91.3	87.5
	2018/19 YTD	94.1	48.7

CSC 250b: The % of children who have been in care (LAC) for at least 12 months and were due a Review Health Assessment between 1st Apr



CSC 251d: The % of children who have been in care (LAC) for at least 12 months and were due a Dental Check between 1st April and the cur



LOOKED AFTER - HEALTH ASSESSMENTS

DEFINITION

Of the children in care at 31 March who had been in care continuously for at least 12 months, the percentage who had had their teeth checked by a dentist during the previous 12 months, and the percentage who had had an annual health check during the previous 12 months.

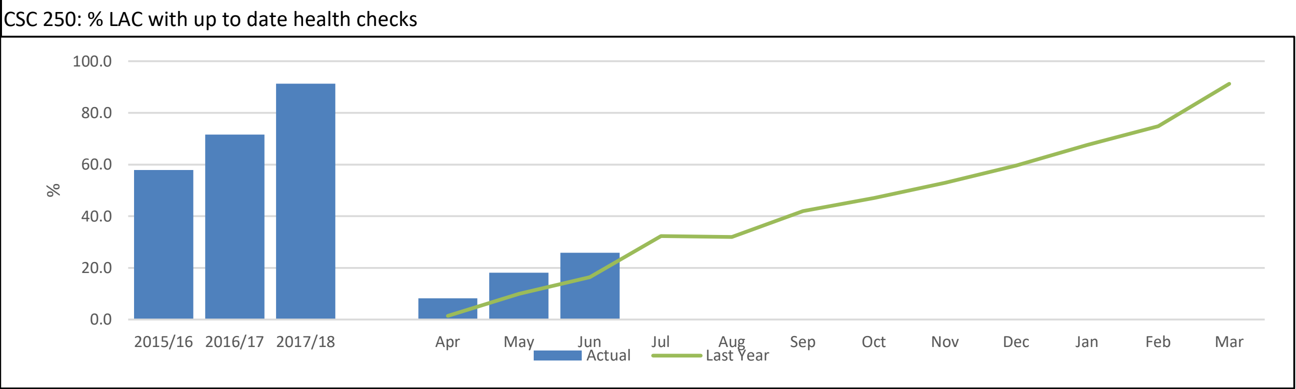
Looked After Children share many of the same health risks and problems as their peers, but often to a greater degree. These indicators track the partitcipation of our LAC in health and dental checks as a proxy for monitoring the general health and wellbeing of the children, as well as providing a check on the effectiveness of joint working with Health to secure good health outcomes for LAC.

PERFORMANCE ANALYSIS

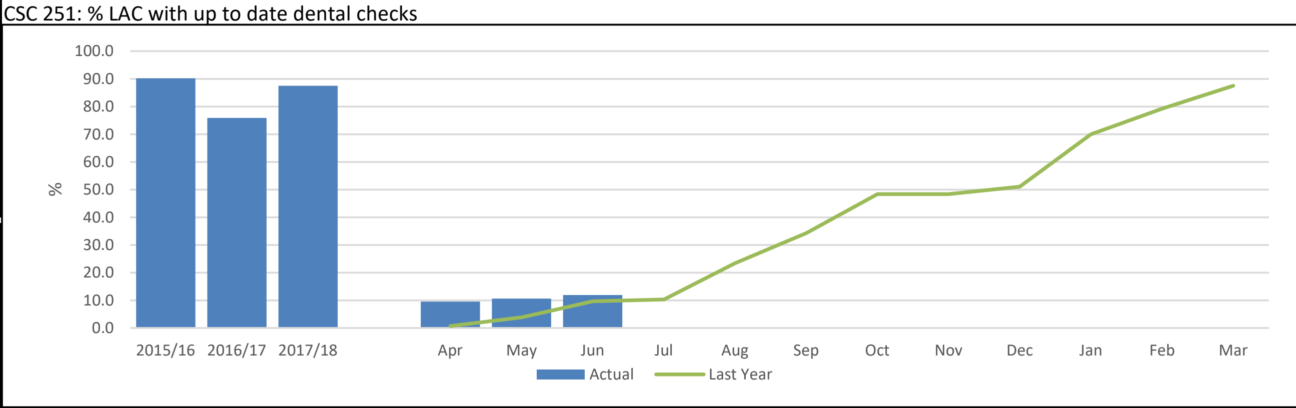
25.8%, Looked After Children (LAC) had completed an up to date health check this is on target for Quarter 1.
12%, Looked After Children (LAC) had completed an up to dental check this is 48% lower than target for Quarter 1.

		CSC 250	CSC 251
		% LAC with up to date health checks	% LAC with up to date dental checks
IN MONTH PERFORMANCE	Target		
	Apr-18	8.2	9.5
	May-18	18.1	10.6
	Jun-18	25.8	12.0
	Jul-18		
	Aug-18		
	Sep-18		
	Oct-18		
	Nov-18		
	Dec-18		
	Jan-19		
	Feb-19		
	Mar-19		
ANNUAL TREND	2014/15	92.6	92.6
	2015/16	57.9	90.2
	2016/17	71.6	75.9
	2017/18	91.3	87.5
	2018/19 YTD	25.8	12.0

CSC 250: % LAC with up to date health checks



CSC 251: % LAC with up to date dental checks



Care Leavers

Quarter 1 Performance Summary

At the end of June, the percentage of Care Leavers in suitable accommodation was 94.1%.

At the end of June, the percentage of Care Leavers who were Not in Education, Employment or Training (NEET) was 27.5% (14 Care Leavers aged 19, 20 and 21 out of 51). This positively exceeds the target set at 33.0% and is a reduction of 4.7% of the 2017/18 year end figure.

Of the 14 Care Leavers who are not in education, employment or training:

- 10 were NEET because of illness or disability or pregnancy
- 4 were NEET because of other circumstances
-

Focus continues to be maintained on decreasing the percentage of Care Leavers who are NEET. There is a monthly NEET Reduction Group where each young person who falls in this cohort are discussed and plans developed in an effort to re-engage them in education, employment or training. There is also a NEET tracker that is maintained to support this performance.

In addition to the monthly NEET Reduction Group, a weekly Job Club has commenced in May 2018 in conjunction with the Morrison's Trust. The focus of the Job Club is to further engage the NEET population in an effort to re-engage them with education, employment or training.

CARE LEAVERS

DEFINITION

The percentage of former care leavers who are eligible for care leavers support who are under the age of 21 who were in suitable accommodation at their most recent contact, and the percentage who were not in employment, education or training at their most recent contact.

This measures accommodation and employment outcomes for young people formerly in care - a key group at risk of social exclusion. It is intended to increase the proportion of former care leavers who are in suitable accommodation and employment, education or training.

PERFORMANCE ANALYSIS

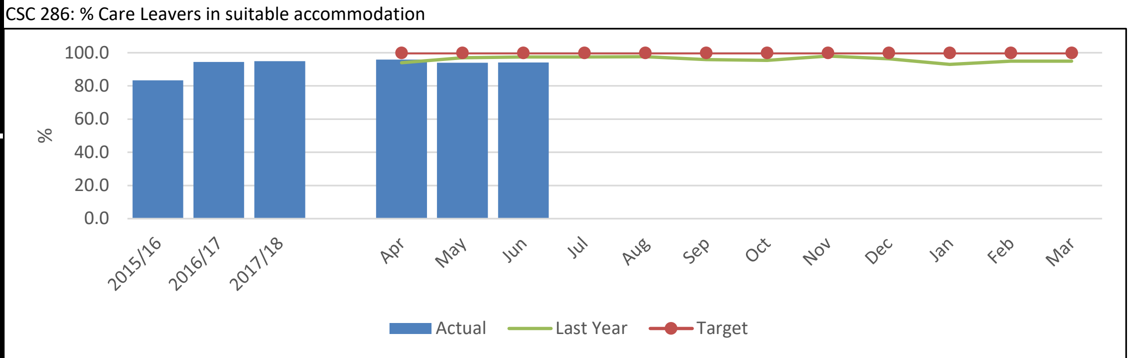
At the end of Quarter 1, the percentage of Care Leavers in suitable accommodation was 94.1%.

At the end of Quarter 1, the percentage of Care Leavers who were Not in Education, Employment or Training (NEET) was 27.5% (14 Care Leavers out of 51). This positively exceeds the target set at 33% and is a reduction of 4.7% of the 2017/18 year end figure.

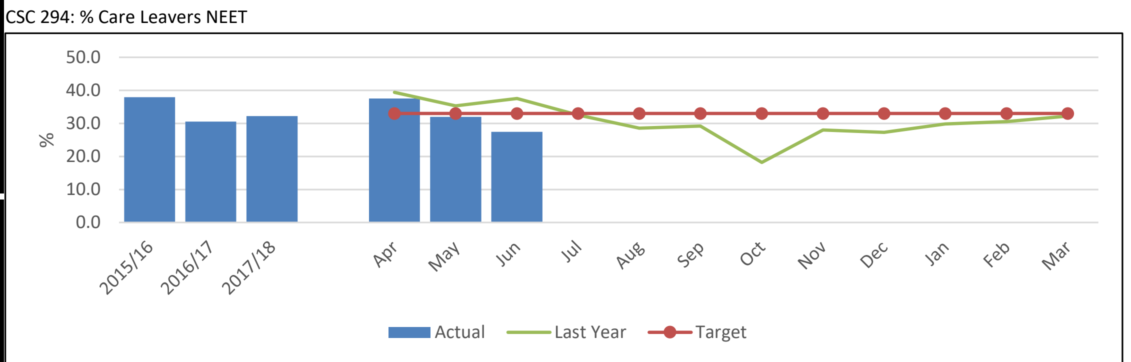
Of the 14 Care Leavers who are not in education, employment or training:
• 10 were NEET because of illness or disability or pregnancy
• 4 were NEET because of other circumstances

		CSC 286	CSC 294
		% Care Leavers in suitable accommodation	% Care Leavers NEET
IN MONTH PERFORMANCE	Target	100.0	33.0
	Apr-18	95.8	37.5
	May-18	94.0	32.0
	Jun-18	94.1	27.5
	Jul-18		
	Aug-18		
	Sep-18		
	Oct-18		
	Nov-18		
	Dec-18		
	Jan-19		
	Feb-19		
	Mar-19		
ANNUAL TREND	2014/15		
	2015/16	100.0	37.9
	2016/17	96.4	30.6
	2017/19	94.9	32.2
	2018/19 YTD	94.1	27.5

CSC 286: % Care Leavers in suitable accommodation



CSC 294: % Care Leavers NEET



AUDITS

DEFINITION	Percentage of audits judged as Outstanding, Good, Requires Improvement, and Inadequate. Audits are undertaken to assess the quality of Social Work and to highlight areas for improvement.

PERFORMANCE ANALYSIS

In Quarter 1, 63.6% of audits carried out were judged as Meets Good and 36.4% Does not yet meet Good.

In June 2018 the new Learning Audit tool was piloted. Audits were undertaken by Team Managers and Independent Reviewing Officers and Audit ratings have been reformed from Outstanding, Good, Requires Improvement, Inadequate to Meets Good and Does not yet meet Good.

		Meets Good		Does not yet meet Good	
		Num	%	Num	%
IN MONTH PERFORMANCE	Target				
	Q4 2017/18	7/22	31.8%	15/22	68.2%
	Q1 2018/19	07/11	63.6%	04/11	36.4%
	Q2 2018/19				
	Q3 2017/18				
ANNUAL TREND	2017/18 YTD	46/115	40.0%	69/115	40.0%
	2018/19 YTD	07/11	63.6%	04/11	36.4%

CHILDREN AND YOUNG PEOPLE SCRUTINY COMMITTEE
10 SEPTEMBER 2018

ITEM NO. ....4...............

PERFORMANCE INDICATORS Q1 2018/19

Purpose of the Report

1. To provide Members with an update on performance against key performance indicators.

Summary

2. This report provides Quarter 1 (April – June) 2018/19 performance information in line with an indicator set agreed by Monitoring and Coordination Group on 2 July 2018, and subsequently by Scrutiny Committee Chairs.

3. It is suggested monitoring focuses on issues and exceptions, and relevant assistant directors will be in attendance at the meeting to respond to queries raised by the committee regarding the performance information contained within this report.

4. Where indicators are reported annually, quarterly updates will not be available.

Where are we performing well?

5. 94.2% of contacts were completed within 24 working hours and 0.5% within 72 hours. The amount of contacts have increase by 290 when compared to Quarter 1 2017/18 which equates to an increase by 19.5% of contacts.

6. 94.1% of children in Quarter 1 had a Review Health Assessment completed.

7. 98% of Initial Child Protection Conferences (ICPC) were held within 15 working days from the Strategy meeting being held/Section 47 being initiated.

8. 100% Child Protection reviews have been completed within the required timescales.

9. 100% those children involved with Child Protection and Looked After have an allocated Social Worker.

10. 100% of Looked After reviews were completed within timescales in Quarter 1,

11. 93.2% of statutory visits of Looked After Children were completed in timescale within Quarter 1, which is above target of 90%.

12. 9.6% of Looked After Children had 3 or more placement moved within the last 12 months, an improvement of 6.2% when compared to the end of Quarter 1 2017/18 which was 15.8%. This is in line with benchmark data for statistical neighbours (9.5%) and national average (10%).

13. 100% of Return Home Interviews (RHI) were completed in Quarter 1 with 92.5% completed within 72 hours of the child being returned home after the missing episode.

14. 27.5% of Care Leavers were not in employment, education or training (NEET) at the end of Quarter 1. This is better than the target of 33% and is a reduction of 4.7% when compared with 2017/18 year end figure.

Where do we need to improve?

15. The Quarter 1 percentage for assessments completed within 45 working days was 83.5%, which is below the target of 90% but above England average (83%).

16. 48.7% dental health checks have been completed at the end of Quarter 1. Progress against this indicator continues to undergo close scrutiny with a tracker in place to ensure robust oversight.

17. The percentage of Looked After Children who have been in their current placement for 2 or more years at the end of Quarter 1 has improved when compared to Quarter 1 2017/18 which was 50.8% and is now 63.1%. However this has still not reached our target of 65%.

Recommendation

18. It is recommended:

    a) That performance information provided in this report is reviewed and noted, and relevant queries raised with the appropriate Assistant Director.

Suzanne Joyner
Director of Children and Adult Services

Background papers

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

Sharon Raine Head of Performance and Transformation : Extension 6091

S17 Crime and Disorder	This report supports the Councils Crime and Disorder responsibilities
Health and Well Being	This report supports performance improvement relating to improving the health and wellbeing of residents
Sustainability	This report supports the Council's sustainability responsibilities
Diversity	This report supports the promotion of diversity
Wards Affected	This reports supports performance improvement across all Wards
Groups Affected	This report supports performance improvement which benefits all groups
Budget and Policy Framework	This report does not represent a change to the budget and policy framework
Key Decision	This is not a key decision
Urgent Decision	This is not an urgent decision
One Darlington: Perfectly Placed	This report contributes to the Sustainable Community Strategy (SCS) by involving Members in the scrutiny of performance relating to the delivery of key outcomes
Efficiency	Scrutiny of performance is integral to optimising outcomes.

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CHILDREN AND YOUNG PEOPLE SCRUTINY
10 SEPTEMBER 2018

ITEM NO. ....5................

INDEPENDENT REVIEWING OFFICER ANNUAL REPORT 2017-18

SUMMARY REPORT

Purpose of the Report

1. The Independent Review Officer (IRO) service is set within the statutory framework of the IRO Handbook (2010), linked to revised Care Planning Regulations and Guidance which were introduced in April 2011. The responsibility of the IRO changed from the management of the Review process to a wider overview of the child's case including regular monitoring and follow-up between Reviews. The IRO has a key role in relation to the improvement of Care Planning for Looked After Children (LAC) and for challenging drift and delay. Further details of the role of the IRO are set out in the attached report.

Summary

2. The Annual IRO report is produced by the Children's Safeguarding Unit (CSU) and provides an overview of the work by the IRO Service in relation to Looked After Children, including the Dispute Resolution Process as required by the statutory guidance. The report also provides an overview of the performance of the unit in a range of responsibilities, activities and functions, including Child Protection, training and advice to professionals. The report also highlighting areas for further development.

3. The statutory requirements for individual services to safeguard and promote the welfare of children are set out in Working Together to Safeguard Children 2015. A guide to inter-agency working to safeguard and promote the welfare of children (March 2015). Working Together stipulates that the chair of a Child Protection Conference needs to be accountable to the Director of Children's Services, and should be a professional, independent of operational and/or line management responsibilities for the case.

Recommendation

4. It is recommended that:-

    (a) Members note the content of this annual report

Suzanne Joyner
Director of Children and Adults Services

Background Papers

Martin Graham : Extension 6703

S17 Crime and Disorder	Nil Impact
Health and Well Being	Nil Impact
Carbon Impact	Nil Impact
Diversity	Nil Impact
Wards Affected	Nil Impact
Groups Affected	Children who are at risk of abuse and neglect and their families will be affected as they will receive statutory intervention which will not always be their choice
Budget and Policy Framework	Nil Impact
Key Decision	No
Urgent Decision	No
One Darlington: Perfectly Placed	Nil Impact
Efficiency	Nil Impact
Impact on Looked After Children and Care Leavers	This report relates to the service delivered to children who are looked after but not care leavers

MAIN REPORT

Role of the Independent Reviewing Officers

5. The Independent Reviewing Officers are committed to achieving the best outcomes for all children and young people in Darlington, particularly the most vulnerable; including, children who are looked after and those subject to Child Protection Plans.

6. The Service has an independent role to ensure that all children, whatever their religious or cultural background, receive the same care and safeguards with regard to abuse and neglect.

7. The service is responsible for the following statutory functions:

    (a) Initial Child Protection Conferences

    (b) Child Protection Review Conferences

(c) Looked After Children Reviews

(d) Annual Foster Carer Reviews

(e) Adoption Reviews:

(f) Disruption Meetings

(g) Reviews of children placed in Secure Accommodation

(h) IROs undertake a range of non-statutory functions including, providing advice and guidance to professionals, facilitating single and multi-agency child protection training and case file audits.

Staffing Levels and Caseloads

8. Responsibility for the operational management, performance and development of the Service lies with the Head of Service for Quality Assurance and Practice Improvement, who reports directly to the Assistant Director, Children's Services.

9. During 2017-18 the IRO team experienced a degree of change with a number of permanent appointments being made: Head of Service (May 2018), 1.0 IRO vacancy appointed to (October 2018), 1.6 Agency IROs converting to permanent posts (October 2018) and recruitment to vacancy covered by agency IRO (February 2018). Currently all substantive posts are permanent appointments.

10. There have been changes in relation to Independent Reviewing Officers with staff leaving and agency appointments made initially to cover vacant posts. Over the last year, the service had a full complement of staff, comprising a mixture of temporary and agency posts. At 31 March 2018 there were 5.4 IRO posts; 5.2 post (96%) were permanent and the additional 0.2 post was agency cover to undertake Annual Foster Carer Reviews.

11. The Independent Reviewing Officers are supported by a full time Business Support Team Leader and 5.0 permanent Business Support Officers (one post is term time only).

12. The Independent Reviewing Officer's handbook (31 March 2010) recommends that caseloads for IROs need to be between 50 and 70 LAC children. Ofsted's; *Independent Reviewing Officers: taking up the challenge?* (June 2013), which looked at 10 local authorities reported IRO average caseloads ranging from 50-112 (with some individual caseloads as high as 120). The average caseload was found to be slightly above 80 cases. More recently a national benchmarking survey (December 2013) placed the average caseload for an IRO between 50 and 95, with the proviso that the size of caseload alone does not indicate the overall workload for each individual IRO as individual roles and responsibilities vary within authorities.

13. The National Children's Bureau; *The Role of the Independent Reviewing Officers (IROs) in England* (March 2014) reported that:

"*Being employed by the local authority usually meant carrying out other duties not specified in the IRO guidance. Having to chair child protection conferences as well as looked after children's reviews was mostly, but not universally, seen as a benefit in providing continuity for children subject to a child protection plan who then become looked after. However, other duties, such as conducting Regulation 33 visits or foster carer reviews, were not always seen as appropriate for IROs. There were concerns that these activities could lead to a conflict of interest and compromise IROs' independence."*

14. The IROs in Darlington do not undertake Regulation 44 Visits (function previously covered by Regulation 33 Visits). This service is provided by NYAS (National Youth Advocacy Service).

15. Annual Foster Carer Reviews are currently being undertaken solely by a part-time agency reviewing officer to ensure independence and avoid any conflict of interest with in-house foster carers.

16. Over the last 12 months, the requirement around the size of caseloads for IROs in Darlington has remained in line with the range determined in statutory guidance. At 31 March 2018 the average caseload was 66 children, however this is a 16% increase from the position the previous year.

17. Manageable caseloads allow IROs to have sufficient time to provide a quality service to each looked after child including, meeting with the child before the review to ensure that their views are clearly understood, consulting with social workers following significant changes, monitoring drift and where appropriate, ensuring that a challenge is made.

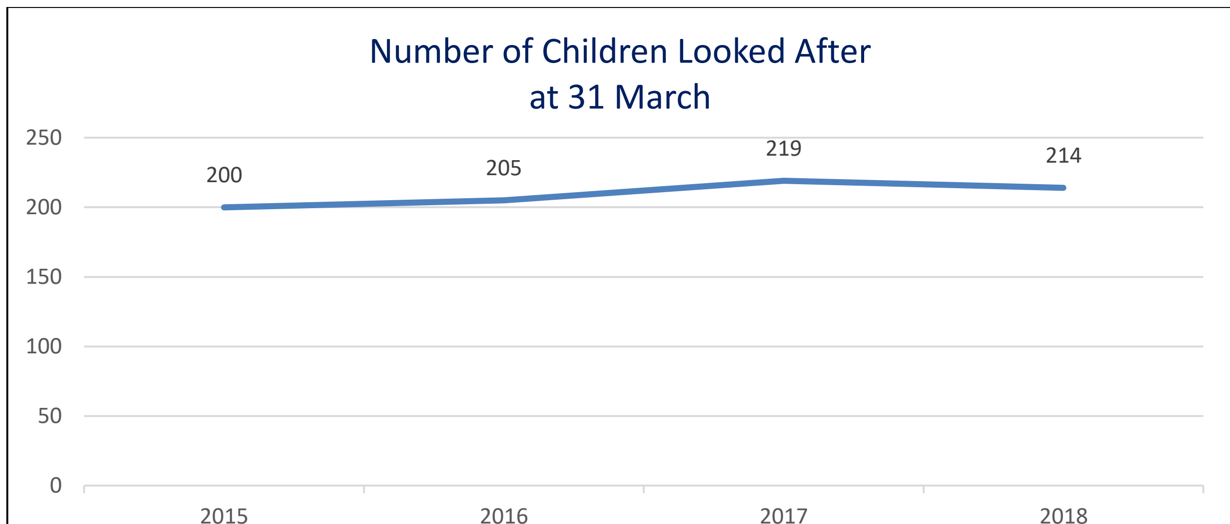
18. In addition to LAC Reviews and Child Protection Conferences, IROs also undertake monthly case file audits and the chairing of, Secure Reviews and Disruption Meetings.

19. There is a statutory requirement in the IRO Handbook to ensure 'sufficient' administrative support to Independent Reviewing Officers in relation to Looked After Reviews. Current responsibilities include the administering and producing a record of Child Protection Conferences, as well as the administrative function in relation to Looked After Children. Regular meetings are held with the Business Support Team leader to agree how the team can best support the Children's Safeguarding Unit.

Looked After Children

20. At the end of March 2018 there were 214 Children Looked After in Darlington, a slight reduction when compared to the previous year (219). This follows the relatively stable position in recent years.

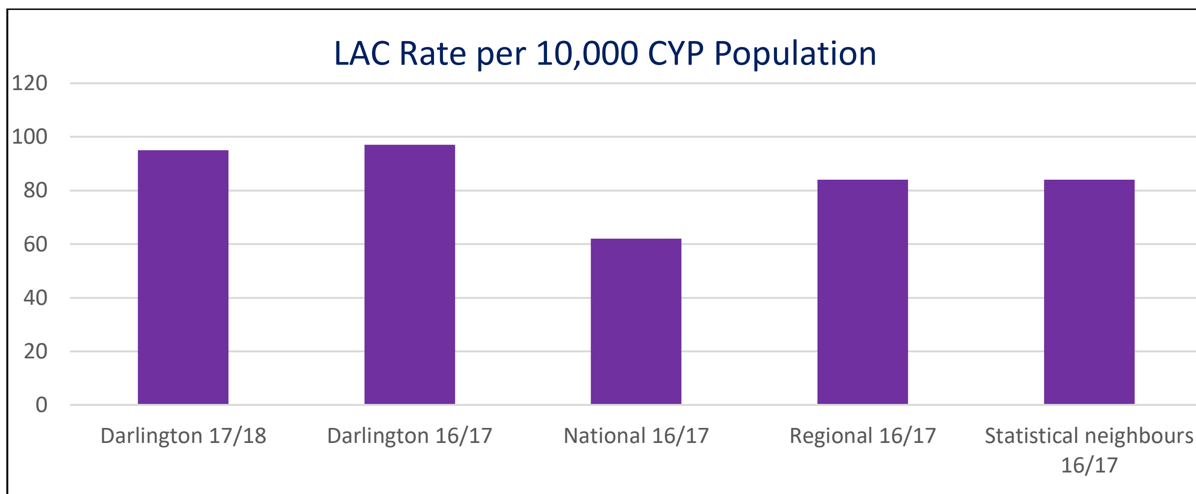
21. The chart below shows the monthly number of Looked After Children (LAC) over the last 4 years.



22. While comparatively high, the rate of LAC in Darlington has plateaued with relatively small increases in 2016/17 and 2017/18.

Looked After Children rate per 10,000

23. The table below is expressed as the rate per 10,000, which allows benchmarking with other councils (the most recent published data on National and comparator groups of North East authorities and statistical neighbours).



24. At the end of March 2018, 214 children were looked after by Darlington a rate of 95.0% per 10,000, a slight decrease from the outturn figure for 2016/17 of 96.8 per 10,000.

25. Analysis shows that dispute this slight reduction Darlington continues to have a significantly higher rate of Looked After Children [11.5%] than both the Regional and Statistical neighbours average. This can partly be attributed to the legacy from 2016 / 2917 where there was an increase of 39% in relation to the number of Children Looked After.

LAC Demographics

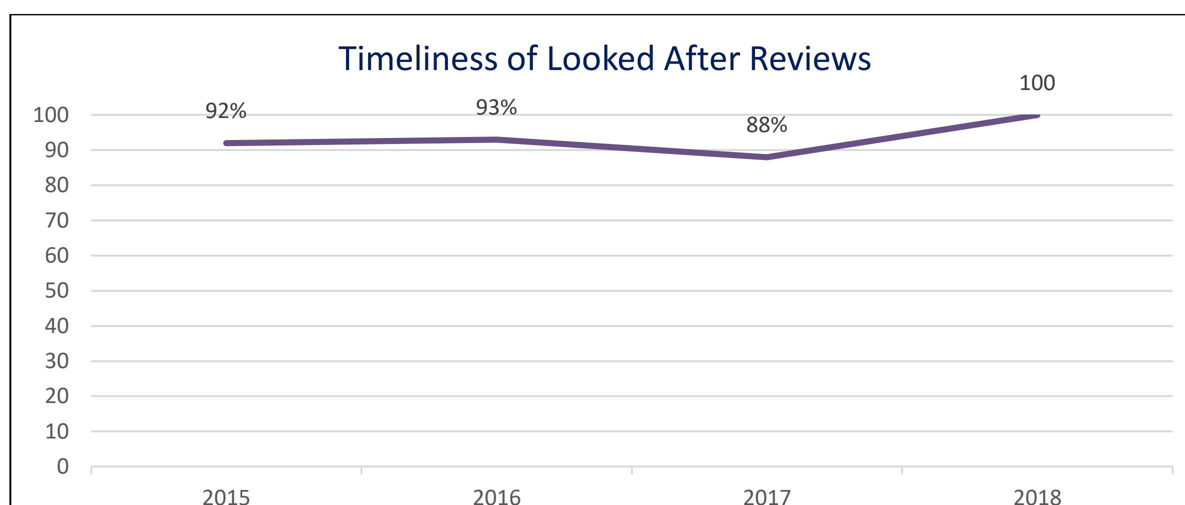
Looked After Children (as of 31st March)	2015		2016		2017		2018	
Under 1	13	7%	16	8%	17	8%	11	5%
1-4	37	19%	36	18%	36	16%	33	15%
5-9	38	19%	44	21%	56	26%	56	26%
10-15	76	38%	69	34%	72	33%	75	35%
16-17	36	18%	40	20%	38	17%	39	18%
Total	200		205		219		214	

26. The age profile of Darlington's Looked After population has remained stable over the last 4 years. The majority of Looked After Children in Darlington are aged between 10 and 15 years which is similar to the distribution nationally.

Ethnicity of Looked After Children as of 31st March	2015		2016		2017		2018	
White	187	94%	192	94%	197	90%	196	92%
Mixed	9	5%	8	4%	13	6%	9	4%
Asian or Asian British	3	2%	3	1%	7	3%	6	3%
Black or Black British	1	1%	2	1%	2	1%	3	1%
Other	0	0	0	0	0	0	0	0
Total	200		205		219		214	

27. The ethnic population of Looked After Children in Darlington has remained stable over the previous 4 years. Although this does not match the national distribution, this is predictable due to the comparative lack of ethnic diversity within the Darlington population as a whole.

Looked After Reviews and Timescales



28. The above chart shows that during 2017-18 performance in relation to the percentage of LAC cases which were reviewed within statutory timescales. For the year to 31st

March 100% (provisional figure) of Looked After Children were reviewed within timescales, an improvement on the figures for the previous 3 years performance.

LAC Participation and contact with IRO

29. Participation applies to children or young people (subject to age and understanding; Care Planning, Placement and Case Review, DCSF March 2010).

30. Participation is based on one of the following methods of participation:

    (a) attending their Review and speaking on their own behalf;

    (b) attending their review but having another person speak for them;

    (c) not attending the review but providing their views in a written form or through another facilitative medium; and /or

    (d) not attending the review but briefing an advocate to represent their views

31. A new performance indicator has been introduced this year in relation to children's participation in their Looked After Review. At the end of this reporting year, 576 individual Looked After Reviews were held.

C&YP Participation in Reviews							
Aged Under 4	**Attended**				**Not attended**		
	Spoke for self	**Advocate**	**Views non verbal**	**No contribution**	**Advocate**	**Views sent**	**No views sent**
128	229	1	5	7	13	146	47
22%	40%	<1%	1%	1%	2%	25%	8%
22%	42%				27%		8%

32. The aim will be to increase the proportion of children and young people over the age of 4 that attend their review meeting, and to reduce the number of meetings where there is no views expressed. It should however be noted that some young people chose not to participate in the process.

33. IROs play a key role in actively seeking the views for children who do not wish to attend their reviews and to see what would assist in getting them there. Independent Reviewing Officers ensure that young people are able to make contact with them if they have any concerns. Once a new admission to care is allocated, the IRO will contact the child, if aged 4 or over and make arrangements to meet them prior to their key LAC review. All contact details are provided at this point.

34. The IRO Handbook recommends the IRO meet with the child/young person within their placement, prior to the Looked After Review meeting or as part of the process. With the reduction in IRO caseloads over the last year this contact with young people between reviews has continued to improve. IROs continue to offer the option of

attending earlier than the review time to meet with the child or young person on the day of the scheduled review if they have not been able to visit them prior or in circumstances where the placement is at a significant distance from Darlington.

35. The expectation with regards to IRO visiting and maintaining contact are set out in the IRO Standards for Looked After Children and their families as well as a pledge specifically aimed at our looked after children. IROs currently record on the Liquid Logic case management system when they visit, have a telephone conversation, or other form communication, with a child or young person.

Permanence Planning and Adoption

36. At the second LAC Review scheduled within 4 months of a child or young person becoming looked after, the Permanence Plan should be agreed. The IRO will then actively monitor the care planning process to minimize any drift or delay. Recent analysis of 4 monthly reviews has shown that all but one child during Q1 had their permanency plan discussed during their 4 monthly review. For 2018/19 performance will now be measured to ensure that all children who are Looked After in Darlington will have a permanency plan at their 4 monthly review.

37. Additional Looked After Children Reviews are required when a child is to be adopted. When a child becomes the subject of a Placement Order an Adoption Review is required within 3 months of the Order being made. For children moving into an adoption placement additional reviews are held within 28 days and at 3 months regardless of when the last looked after review was held. It is therefore possible for individual children to have up to four Looked After Reviews within a twelve month period.

Dispute Resolution Process

38. One of the key functions of the IRO is to resolve problems arising out of the Care Planning process. The Dispute Resolution process reinforces the authority of the IRO and their accountability for decisions made at reviews. IROs will refer to the process when they feel that is appropriate to follow up on recommendations that have not been auctioned or where the implementation of a Care Plan is delayed. IROs will in the first instance use informal negotiation to resolve issues, and only where this is not successful will a formal challenge be made by instigating the Dispute Resolution Process.

39. A revised IRO Dispute Resolution Process was launched in April 2016, bringing greater clarity to the process of challenge by IROs. A monitoring system is in place enabling progress and impact to be tracked and monitored by the Head of Service. IRO challenge is reported regularly at Senior Management Team Meetings.

40. The majority of the challenges in 2017/18 were dealt with at either Social Worker or Team Manager level.

41. Although the ‘IRO footprint’ is now regularly evidenced on children’s records. Work is required to ensure that all staff understand and respond to disputes and challenges in a consistent manner. This will require a review and relaunch of the current

procedure.

Foster Carer Reviews

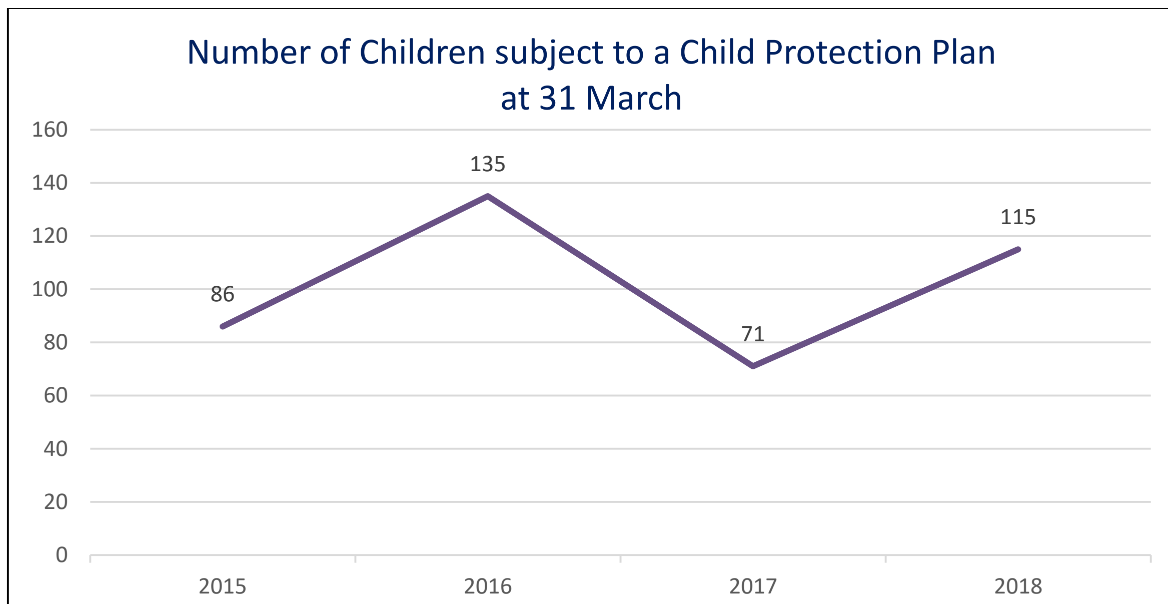
42. Local Authorities are required by Regulation 29 (The Fostering Services Regulations 2001) to review the approval of foster carers at least once a year and the Reviewing & Development Service is responsible for undertaking the annual reviews. The additional part-time agency IRO has been retained. Ofsted during their re-inspection of Services for children in need of help and protection, children looked after and care leavers; commented that it was good practice to have someone other than an IRO undertaking this role due to possible conflicts of interest.

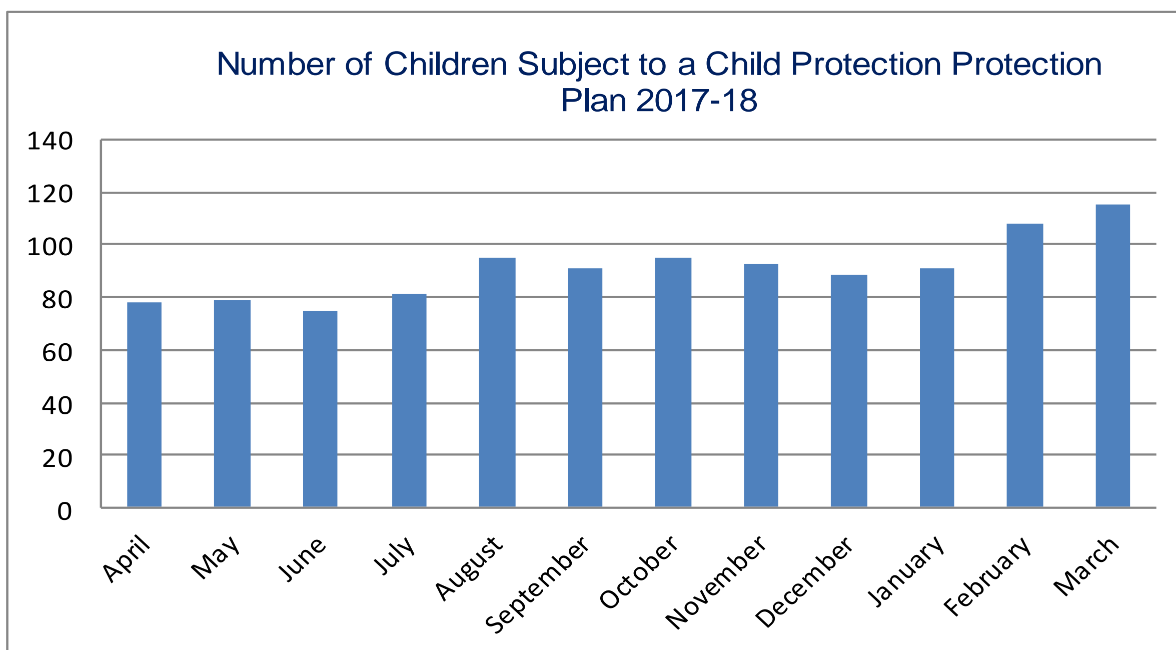
43. Any significant changes to circumstances, or concerns raised at the Annual Review, are referred to the Fostering Panel.

Child Protection Activity

Number of Children subject to Child Protection Plans

44. The chart below shows the number of Children subject to Child Protection Plans (CPP) over the last 4 years.





45. The total number of children with a Child Protection Plan on 31st March 2018 was 115; a rate of 51 per 10,000 children under the age of 18yrs. This is a 62% increase from the figure position at the end of March 2017, when the figure stood at 71 (a rate of 31 per 10,000). It should be noted that that the previous figure had decreased by 47%.

Rate per 10,000 of Children Subject to Child Protection Plans at 31st March National stats table (D1)	**2016/ 17**			**Darlington 2017/18**
	Darlington	**North East**	**England**	
	31	61	43	51

46. The rate of children who were the subject of a Child Protection Plan as of 31 March 2018 is below North East but higher than the England averages of 31st March 2017. Published benchmark data for 2017/18 will be available later in the year.

Number at 31st March	**2014**	**2015**	**2016**	**2017**	**2018**
Darlington National Stats table (D1)	140	86	135	71	115

Child Protection Demographics

47. At the end 2017/18, of the 115 children subject to a Child Protection Plan:

- 2% Unborn, 47% aged under 5 years, 34% aged 5-10 years, 17% aged 11-15 years and 1% aged 16 years+
- 68% Neglect, 23% Emotional Abuse, 4% Physical Abuse, 5% Sexual

Abuse.

Note: percentages may not add up to 100% due to rounding.

48. Nationally the most recent published data for March 2017 was 46% Neglect, 36% Emotional Abuse, 8% Physical Abuse, 4% Sexual Abuse and 6% Multiple-categories (note: multiple-categories should not be used)

49. The proportion of Children subject to Child Protection Plan where the risk is Physical Abuse in Darlington remains is low and potentially masked by the restriction that only one category of abuse is permissible.

50. The proportion of Children subject to Child Protection Plan where the risk is Sexual Abuse remains low, however this is in line with National Statistics and is monitored on a regular basis by the CSU.

51. On the 31st March 2017 there were 71 children subject to Child Protection Plans; over the 12 months to 31st March 2017 this had increased to 115 children. 94 Children had Plans removed and 138 new Plans were made.

CP Plan Activity	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Becoming subject to a CP Plan	124	171	102	138
Ceasing to be the subject of a CP Plan	179	122	166	94
Increase / decrease	-54	+49	-64	+44

52. The table above shows overall activity in relation to Child Protection Plans (numbers becoming subject to or ceasing).

53. 94 children had their Child Protection Plan discontinued in the year 2017/18, a decrease from 166 the previous year. This has been a factor in the number of CP Plans dropping increasing over the year.

54. Over the year, 85 Initial Child Protection Conferences [157 Children], of which 7 were Transfer Conferences [16 children] and 135 Child Protection Review Conferences were held [256 children]. The corresponding figures for the previous year were 72 Initial Child Protection Conference [114 children], 6 Transfer Conferences [6 children] and 194 Child Protection Review Conferences [355 children].

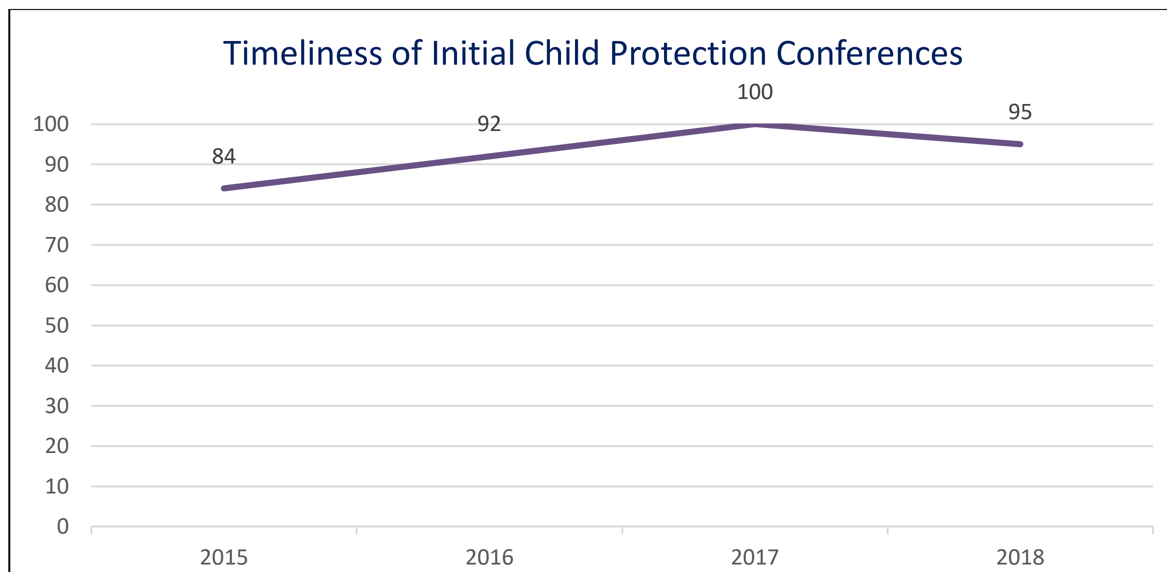
55. The table above shows overall Child Protection Conference activity over the last 4 years. In the last year the number of children who were the subject of an ICPC increased by 38%, from 114 to 157, whilst the number of children subject to a Child Protection Review Conference decreased (due to low numbers of Children subject to Protection Plans at the beginning of the year).

Meeting Activity	2014/15	2015/16	2016/17	2017/18
ICPC	64	103	72	85
Transfer	6	4	6	7
CPRC	168	149	194	135

56. In the year, the proportion of children subject to ICPCs who were not made subject to a Child Protection Plan was 12.1% which is approximately midway between the rates for the previous two years.

57. In Darlington last year at the end of March, there were no children open to Life-stages who are subject to a Child Protection Plan (i.e. Children with Disabilities). This year two children with disabilities were subject to a Child Protection Plan. This information is not currently part of the nationally published data so no comparison is available.

Timeliness of ICPCs

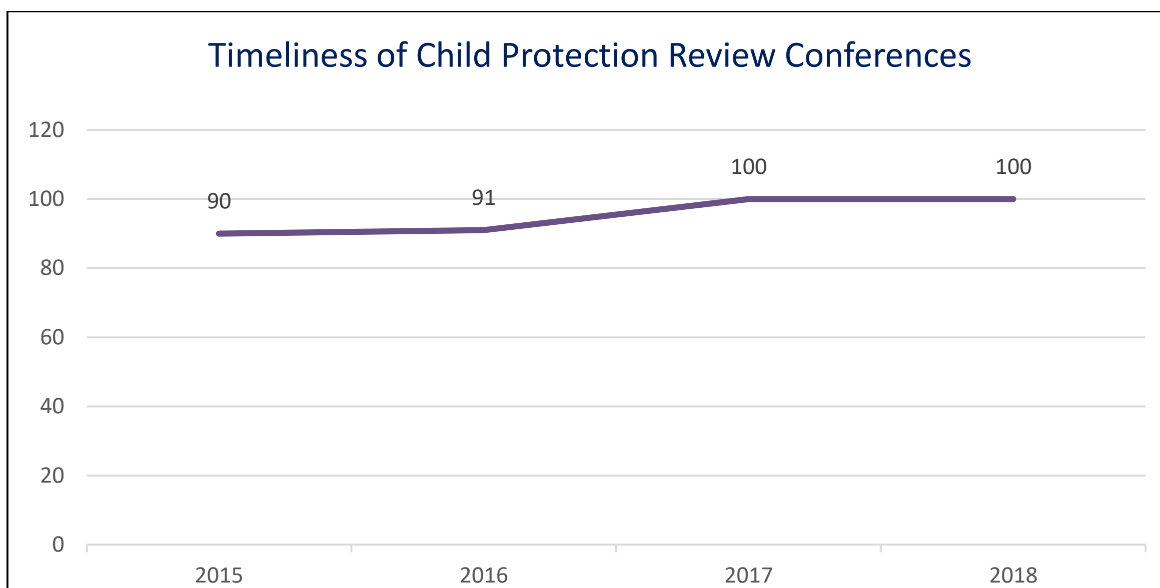


58. The chart above tracks the ICPCs held within the year and records the percentage held within 15 working days of the Section 47 enquiry.

59. For the year to 31st March 2018, 134 (95%) of children were subject to an ICPC (excludes transfer conferences) that was held within the prescribed 15 working days of the Section 47 Enquiry. Although this has been a drop in performance it remains higher than statistical benchmarks; regional [86%], statistical neighbours [88%] and national benchmark of [77%].

Timeliness of CPRCs

60. The Working Together to Safeguard Children guidance requires that the first review should be within 3 months of the initial child protection conference and thereafter at intervals of no more than 6 months.



61. The above chart tracks the percentage of Child Protection cases which were reviewed within statutory timescales in the year. Good performance for this indicator is typified by a higher percentage, ideally 100%. In recent years this has been an area of good performance.

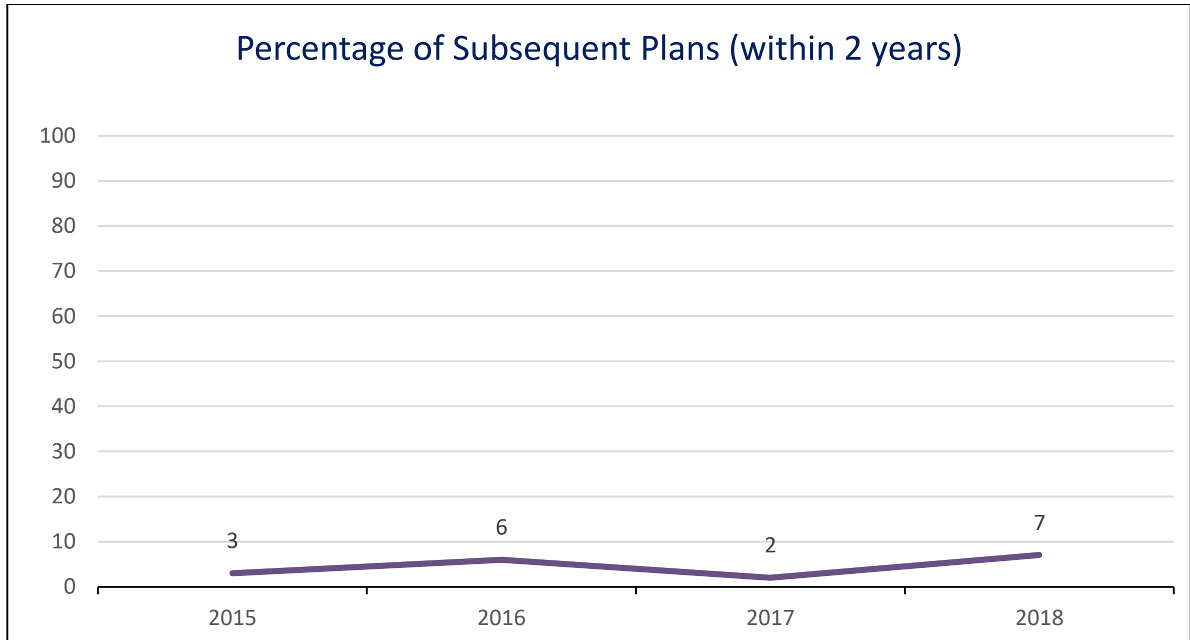
62. For the year to 31st March 2018, all 135 (100%) of Child Protection Review Conferences were held within timescales. Again performance in this area remains higher than regional [95%], national [92%] and statistical neighbours [95%].

Child Protection Review Conferences within timescales	**2016/2017**			**Darlington 2017/18**
	Darlington	North East	England	
	100%	95%	92%	100%

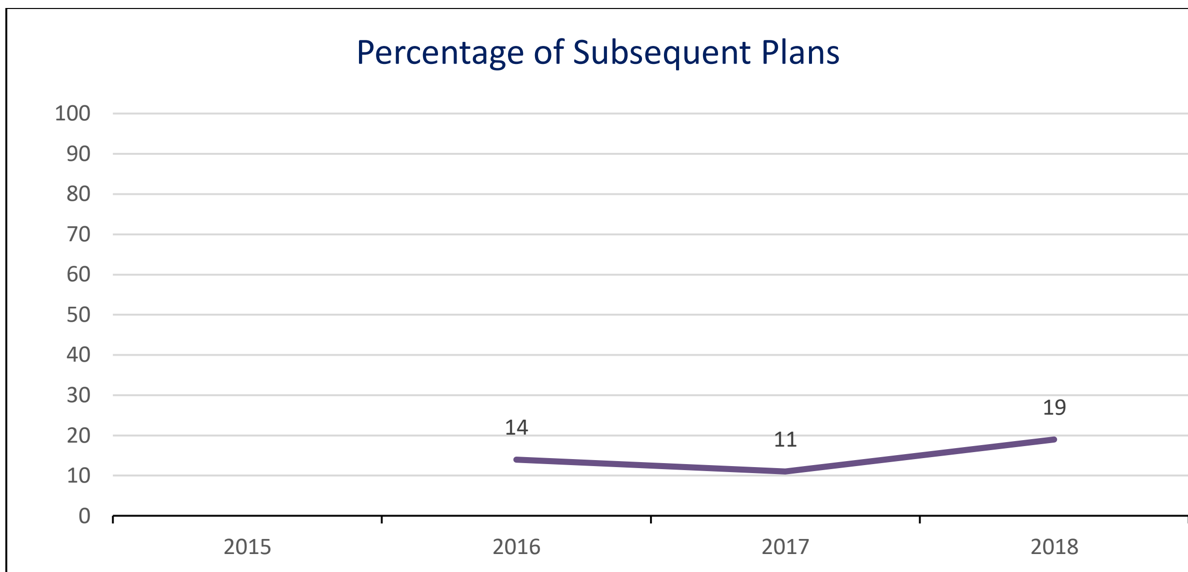
63. Published benchmark data for 2017/18 will be available later in the year.

Second or Subsequent Plans

64. The chart below shows the percentage of children becoming the subject of Child Protection Plans for a second or subsequent time (within 24 months).

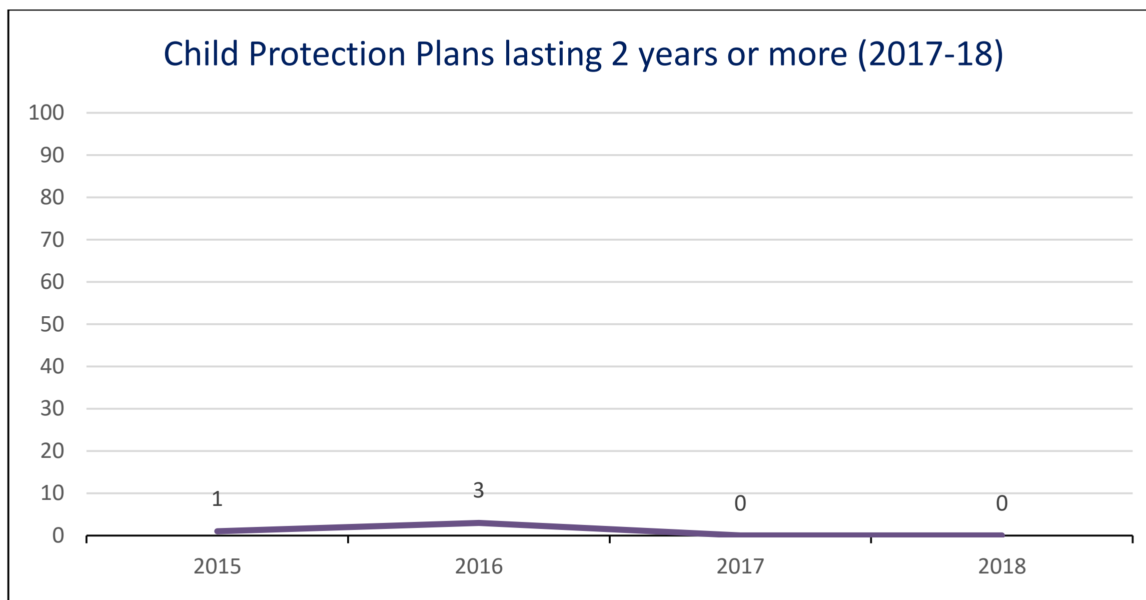


65. This indicator is a proxy for the level and quality of service a child receives. Its purpose is to monitor whether Children's Social Care Services devise and implement a Child Protection Plan which leads to lasting improvement in a child's safety and overall well-being. Good performance for this indicator is typified by a lower figure. However, it is acknowledged that a second or subsequent child protection plan will sometimes be necessary to deal with adverse changes to the child's circumstances.



66. National benchmarked data is based on a second or subsequent plan being agreed at any time after a previous plan. Our rate for 2017-18 was 19%, in-line with the England average of 19%, but higher than the regional average of 14% from the previous year (the most recent published data).

Child Protection Plans lasting 2 years or more



67. The above chart tracks the number of children who had been the subject of a CPP continuously for two years or longer against the number of children ceasing to be the subject of a CPP during the year, expressed as percentage.

68. This indicator reflects the underlying principle that professionals should be working towards specified outcomes which, if implemented effectively, should lead to the majority of children not needing to be the subject of a Child Protection Plan within a two year period, however it is recognised that some children will need CPPs for longer. Good performance is therefore typified by a lower percentage.

69. The period of time that children are subject to a Child Protection Plan is monitored by the Children's Safeguarding Unit Manager with particular attention given to tracking cases where they are:

    (a) Approaching their first Child Protection Review Conference, and
    (b) 15 months after a Child Protection Plan is put in place.

70. This system has ensured that cases are reviewed in a timely manner, and that there is an appropriate level of scrutiny on the plans made for children and young people.

71. The percentage of children ceasing to be the subject of a Child Protection Plan who had been the subject of a Child Protection Plan continuously for two years or longer was 0% during the year to 31st March 2018.

72. The percentage of Child Plans ceasing where the plan had lasted more than 2 years in Darlington is currently below the North East average [1.5%] and England [2.1%] averages at 31st March 2017. Published benchmark data for 2017/18 will be available later in the year.

Family attendance at Conference

73. In the year, out of 91 invitations, family members attended 86 Initial Child Protection Conferences, a total of 95%, in-line with the rate in recent years.

74. In the year, out of 125 invitations, family members attended 114 Child Protection Review Conferences, a total of 91%, again in-line with the rate in recent years. Generally the rate for Child Protection Reviews tends to be lower by a few percentage points.

Year	2014/15	2015/16	2016/17	2017/18
Percentage of ICPCs attended by parents / family	95%	97%	94%	95%
Percentage of CPRCs attended by parent / family	91%	94%	91%	91%

75. Over the year to 31 March 2018, no family members with parental responsibility were excluded from attending child protection conferences.

76. A draft Child Protection Plan is produced at the end of the Initial Child Protection Conference enabling professionals and family members to leave the meeting with a copy.

77. The Unit is committed to promoting independent advocacy for children and young people. The Council has a contract with the National Youth Advocacy Service which provides an independent and confidential service. If the young person is not in attendance the IRO should ensure that there is an agreed action for the Core Group regarding how the advocacy role will be communicated to the child or young person.

Management

Quality Assurance

78. In order to ensure that the effectiveness of the Unit and ability to provide a key Quality Assurance function, it is essential that the Independent Review Team have the relevant skills, knowledge and understanding.

79. The quality and effectiveness of the Children's Safeguarding Unit is ensured through:

    (a) Workload Allocation

    (b) Supervision and Personal Development Review (PDR)

    (c) Team Meetings

    (d) Audit

    (e) Training and Development

    (f) Direct Observation

Workload Allocation

80. All Looked After Children and / or children subject to Child Protection Plans are allocated a designated IRO with the intention that where possible the allocated IRO will remain consistent, until the child is no-longer Looked After or subject to a Child Protection Plan. Recent changes to staff due to the permanent appointments made throughout the year and some staff absence have impacted on this however, there should be an improvement 2018/19 due to the permanent nature of the appointments (i.e. no agency posts).

81. Allocations are monitored regularly and form part of the discussion in monthly supervision sessions.

Supervision and Annual Appraisal

82. Monthly supervision is undertaken with Independent Reviewing Officers that includes:

    (a) Caseloads

    (b) Performance issues (team / individual)

    (c) Relevant Case management discussions

    (d) Disputes

    (e) Training (attended / identified)

    (f) Involvement of young people (visits by IRO / attendance at conference / LAC Reviews)

83. Personal Development Reviews are undertaken in line with corporate arrangements.

Team Meetings

84. Scheduled Team Meetings are held a minimum of a 12 times in year and are augmented with development sessions (normally two in year). Team meetings cover a range of practice issues, updates on local, regional and national developments, sharing of good practice, and learning from reviews and inspections. Additional meetings are held with IROs when necessary. Some sessions focus on the work of the IROs, while others have included the Administration staff who support the IROs.

Audit

85. In 2017/18 all IROs have completed Case File Audits in line monthly quality assurance cycle. Following the Ofsted re-inspection (February March 2018), the Quality Assurance Framework is being revised and IROs will be completing regular Learning Audits in line with the new arrangements.

Training and Development

86. Individual training requirements for IROs are identified through supervision and annual appraisals.

87. IROs attended a bespoke Signs of Safety Training session for IROs in November 2017.

Observation

88. The schedule annual cycle of direct observations of Looked After Reviews was delayed by the Ofsted Inspection. This is currently being undertaken by the IRO line manager.

89. In addition to the above the IRO Unit is open to external scrutiny that has included:

    (a) LSCB Programme of observations

    (b) Ofsted Monitoring visits

Next steps for 2018/19

90. The following are scheduled for action in 2018/19:

    (a) Develop business case for:
    - IRO Manager post
    - Annual Foster Carer Reviewing Officer post

    (b) Review / revise procedures for:
    - Dispute Resolution Process
    - Disruption meetings

    (c) Develop forms within Liquid Logic case management system to support both processes (as above).

    (d) Maintain the permanent appointments within the team and reduce previous reliance on agency staff cover.

    (e) Increase participation and attendance of young people and their families in child protection conferences.

    (f) Promote the take up of Advocacy services for children and young people.

PSHE QUALITY MARK

DARLINGTON BOROUGH COUNCIL

HEALTHY LIFESTYLES SURVEY 2017/18 RESULTS

Thank you to all the 6,340 pupils aged 9-16 from 24 Darlington schools who took part in this year's survey. Below are some of the key findings about the health of Darlington's young people.

EMOTIONAL WELLBEING

The majority of pupils reported that they are generally happy in their lives, have someone they can talk to, and feel supported by their families. ***75%*** *of primary pupils reported feeling stressed, this increases to* ***78%*** *of secondary pupils.* ***Schoolwork*** *was the most frequently chosen cause of stress.*

SMOKING

96% *of primary pupils and* ***73%*** *of secondary pupils have never tried smoking.* ***Over 9 in 10 pupils*** *say smoking is not a good idea for someone their age.* ***Over 4 in 10 pupils*** *report being exposed to second hand smoke, most commonly in their own home.*

THE INTERNET

Pupils have very active online lives with primary and secondary pupils having multiple social media accounts. ***Two thirds of pupils*** *know everyone they are friends with online in person, and most pupils could identify online risks.* ***36%*** *of primary pupils play games that are age - rated 16 or 18.*

PUBERTY AND SEXUAL HEALTH

Nearly 9 in 10 *pupils in school years 9-11 (aged 13 to 16) are not sexually active.*

A third *of primary age pupils are not aware of what changes to expect during puberty.*

DENTAL HEALTH

99% *of primary pupils and* ***98%*** *of secondary pupils have a toothbrush and toothpaste at home.* ***Over 9 in 10 pupils*** *brush their teeth daily or twice a day.* ***Over a quarter*** *of primary pupils have had a tooth removed by the dentist and* ***over 4 in 10*** *have had a tooth filling.*

EXERCISE AND DIET

Primary pupils report being more active than secondary pupils and encouragingly, most say they exercise because they enjoy it.

8 in 10 *primary pupils believe they have a balanced diet, this reduces to* ***66%*** *of secondary pupils.* ***67%*** *of primary pupils and* ***82%*** *of secondary pupils have had an energy drink, despite* ***8 in 10 pupils*** *agreeing they are bad for your health.*

BULLYING

62% *of primary pupils and* ***just over two thirds*** *of secondary pupils have not been bullied in the last year. Verbal bullying in school was the most common form of bullying.* ***96%*** *of primary and secondary pupils agree that young people should never bully others.*

PSHE QUALITY MARK

DARLINGTON BOROUGH COUNCIL

PSHE QUALITY MARK

DARLINGTON BOROUGH COUNCIL

Healthy Lifestyles Survey 2017/18 Executive Summary for the Borough

Methodology

The Healthy Lifestyles Survey (HLS) is undertaken every year with children and young people who are attending primary and secondary schools in Darlington. Each year schools "sign up" to take part in the survey. The survey consists of an anonymous online survey containing questions about experiences, attitudes and behaviours across a range of topics related to health and wellbeing today.

Schools are encouraged to schedule time for pupils to complete the surveys as part of normal lessons during the school day to ensure maximum participation and reduce chances of technical issues. However, for this year one secondary school chose to disseminate the survey to pupils as their homework; this has had an impact on number of completed surveys for that school and therefore may skew some of the data.

The results are used to create several reports:

- Each school receives their own bespoke report related to their school's results
- Data from each Primary school is combined to create a Darlington combined Primary school data report
- Data from each Secondary school is combined to create a Darlington combined Secondary data report
- Key messages and themes from the year are used to create an executive summary for the borough (this summary) and an accompanying powerpoint presentation

The aim of the range of reports above is to provide an insight into the common themes and issues that are affecting children and young people living in Darlington. The Primary combined data report and Secondary combined data report are both published online on the DBC website every year (once sign off has been given) so that the data and findings can be used by others to inform work with young people in Darlington.

The HLS results are also fed back to young people, aiming to inform them about the 'social norms' of their peers and other young people, with respect to the attitudes and behaviours around specific lifestyle choices and risk taking behaviours.

In 2017/18 the Healthy Lifestyles Survey was undertaken by:

- 1,468 Primary aged pupils (9-11 years old) from 16 Primary schools in Darlington
- 4,872 Secondary aged pupils (11-16 years old) from 8 Secondary schools in Darlington

Feedback of Results

The responses by young people to each of the questions in the survey will be different across age groups and between different schools. The responses for each year group in

each individual school are analysed and reported to each school as part of the Team Around the School (TAS) meeting. This enables each school and the multi-agency team of professionals that attend the TAS understand the specific issues that are affecting their pupils, and develop their own action plan for the coming academic year to will prioritise action required to tackle or mitigate the issues that have been identified. It enables staff and teams to plan their work plans in response to the needs of the school population. The individual reports also enable the school to engage with parents, using the evidence from the responses for their year groups to work with parents in addressing any specific issues or problems.

Summary of results-Primary pupils

The results indicate that young people of this age in Darlington largely understand the health information and messages in relation to their health and report that they act on this information and messages through exhibiting positive attitudes and health seeking behaviours. They report negative attitudes to behaviours that have a detrimental effect on their health or the health of others. They report that they understand what positive relationships should look like and the effects of negative behaviours of others such as bullying, on relationships as well as their own health and wellbeing.

The growing influence of social media even in the lives of the younger primary aged children is becoming more apparent from the survey results, with young children having largely unrestricted access to the internet and social media. The responses from these young people indicate that they are using social media as part of developing and maintaining their friendships and relationships, however their responses also show the potential for harm, with many reporting bullying via the internet and others reporting making friends on social media with people that they have never met. The increase in the playing of online games by the majority of pupils in this age group, presents significant new challenges in keeping young people safe.

The survey also shows that on the whole these young people feel happy in their lives and relationships and feel supported by their family and other significant adults; however they report an increasing impact of stress on their lives, largely from activities and pressures relating to school, their studies and their emotions.

Specific responses indicate that young people of this age in Darlington seem to understand the information about health and wellbeing that they receive and are receptive to the health messages around risk taking behaviours such as smoking and consuming alcohol and have negative attitudes towards risk taking behaviours and those in their peer group.

Key Messages-Primary Pupils

- Nearly half of all pupils report that they have been exposed to second hand smoke and the most common location is their own home.
- Around four in ten of pupils have reporting visiting the dentist to have a filling with around a quarter reporting having tooth extracted in the last year.

- A significant proportion of pupils are reporting that they are accessing online games which are not age appropriate.
- The majority of pupils report positive wellbeing, reporting that they feel happy, are supported by family and have someone they can talk to
- A third of pupils are not aware of what changes to expect during puberty or that they are worried or frightened about puberty.
- 97% have not had more than a sip of an alcoholic drink
- 96% have never smoked

Summary of results-Secondary pupils

Overall the responses to the survey indicate that young people attending secondary schools understand the information about health and lifestyles that they receive and are receptive to the health messages, particularly around risk taking behaviours such as smoking, consuming alcohol and engaging in sexual activity. They report negative attitudes towards certain risk taking behaviours that they perceive to be harmful to themselves or others in their peer group as well as negative attitudes towards those who engage in certain perceived risk behaviours. These attitudes do change between different year groups particularly in comparison to younger pupils surveyed. The survey show that young people of this age in Darlington often overestimate the prevalence of some risk taking behaviours in their peer group.

The results indicate that across the year groups (Y7 to Y11) young people report positive attitudes towards relationships and on the whole report that they are happy and supported in their lives at this time. A majority reported that they have experienced bullying in secondary school with a significant minority reporting on-going bullying. The majority of bullying is reported to occur in and around school however cyber bullying is the next most common area. As a group they report significantly negative attitudes towards those who may be bullying others and bullying behaviours.

Young people naturally use the internet and social media as part of their lives with (91%) of those responded reporting using the internet everyday using a range of devices. They report high levels of awareness of the risks and the majority report some protective behaviours online. However, nearly all of those who responded reported having been upset be something they had seen online.

The majority of this age group reported negative attitudes towards smoking, alcohol consumption and taking illegal drugs. Most young people had never or rarely smoked, consumed alcohol, taken drugs or had sex and their responses showed high levels of knowledge and awareness of the information and health messages related to these behaviours.

A minority of this age group reported that they are sexually active, there was evidence that they had low levels of understanding about safe sex and avoiding risk. From the behaviours reported in this group it is likely that they and their peers are greater risk of unintended pregnancy and avoidable sexually transmitted infections.

The large proportion of this age group demonstrated an understanding about a healthy diet and health benefits of physical activity with many reporting positive behaviours in relation to maintaining their own health and wellbeing such as eating a healthy diet and brushing their teeth regularly.

Key Messages-Secondary Pupils

- Nearly 9 out of 10 of those surveyed are not sexually active (in Y9,Y10 and Y11) , only 1 in 8 smoke regularly, only 1 in 10 have tried illegal drugs (in Y9,Y10 and Y11), and around half have ever had a drink of alcohol.
- Over 9 out of 10 of all pupils surveyed, access the internet at least daily, with over 1 in 3 reporting that they do not know all their online friends in person.
- Over a quarter of the young people reported that they had been bullied in the last year.
- More than half report that the media (TV, film, Magazines and reality TV) has had an influence on the choices they make in their relationships.
- Nearly 6 in 10 pupils reported being physically active for 60 minutes a day for four days or more in a week.

The Primary combined data report and Secondary combined data report for 2017/18 and previous years' reports are available on the Darlington Borough Council website; search "Healthy Lifestyles Survey".

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Public Health England

Child Health Profile

June 2018

Darlington

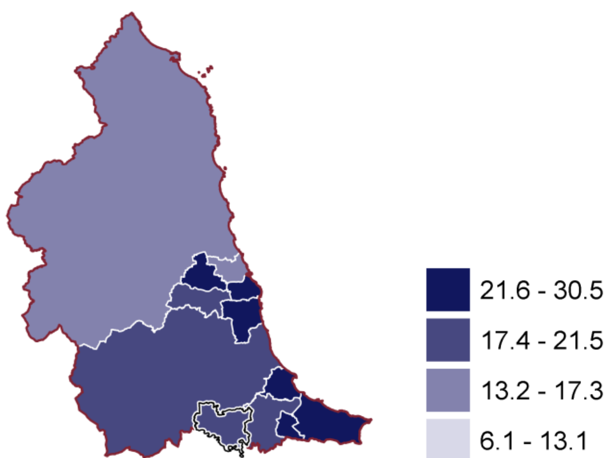
This profile provides a snapshot of child health in this area. It is designed to help local government and health services improve the health and wellbeing of children and tackle health inequalities.

The child population in this area

		Local	Region	England
Live births (2016)		1,154	28,574	663,157
Children aged 0 to 4 years (2016)		6,300 6.0%	148,400 5.6%	3,429,000 6.2%
Children aged 0 to 19 years (2016)		24,800 23.5%	592,200 22.5%	13,107,000 23.7%
Children aged 0 to 19 years in 2026 (projected)		24,400 22.8%	611,400 22.5%	14,065,900 23.8%
School children from minority ethnic groups (2017)		1,506 11.1%	34,058 10.6%	2,132,802 31.0%
School pupils with social, emotional and mental health needs (2017)		487 3.0%	10,364 2.7%	186,793 2.3%
Children living in poverty aged under 16 years (2015)		19.6%	22.0%	16.8%
Life expectancy at birth (2014-2016)	Boys	78.2	77.8	79.5
	Girls	82.1	81.5	83.1

Children living in poverty

Map of the North East, with Darlington outlined, showing the relative levels of children living in poverty.



Map contains Ordnance Survey data.

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Key findings

Overall, comparing local indicators with England averages, the health and wellbeing of children in Darlington is worse than England.

The infant mortality rate is similar to England with an average of 4 infants dying before age 1 each year. Recently there have been 3 child deaths (1-17 year olds) each year on average.

Public health interventions can improve child health at a local level. In this area:

- The teenage pregnancy rate is similar to England, with 44 girls becoming pregnant in a year.
- 16.2% of women smoke while pregnant which is worse than England.
- Breastfeeding initiation data is not available for this area. By 6 to 8 weeks after birth, 34.3% of mothers are still breastfeeding (worse than England).
- The MMR immunisation level meets recommended coverage (95%). By age two, 95.2% of children have had one dose.
- Dental health is similar to England. 26.4% of 5 year olds have one or more decayed, filled or missing teeth.
- 10.6% of children in Reception (similar to England) and 22.5% of children in Year 6 (worse than England) are obese.
- The rate of child inpatient admissions for mental health conditions at 97.7 per 100,000 is similar to England.The rate for self-harm at 472.8 per 100,000 is similar to England.

By age two, 97.9% of children have had Dtap / IPV / Hib immunisation, meeting minimum recommended coverage (95%). Data on immunisations for children in care is not available for this area.

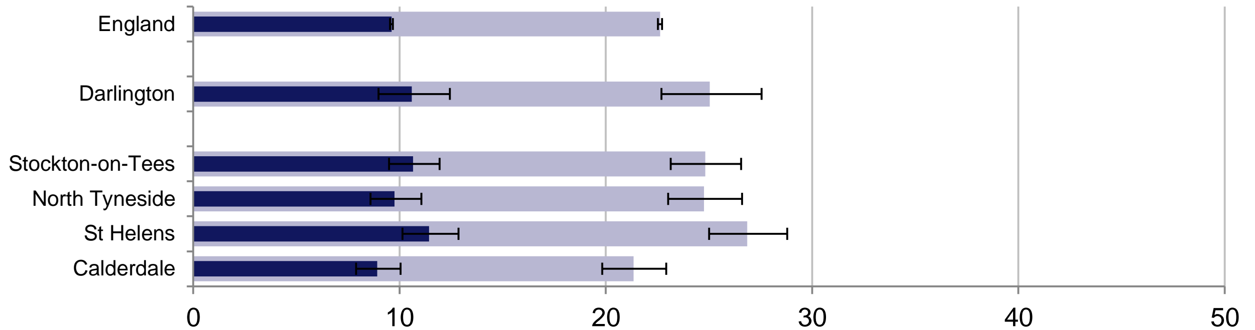
The level of child poverty is worse than England with 19.6% of children aged under 16 years living in poverty. The rate of family homelessness is better than the England average.

Childhood obesity

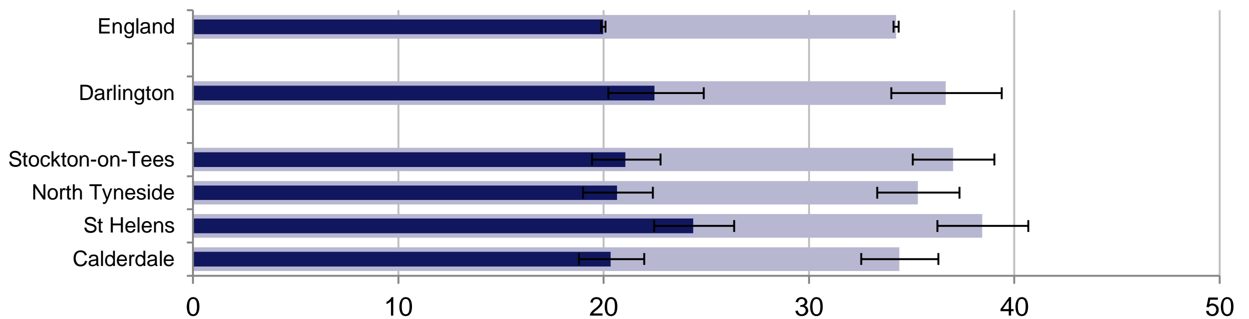
These charts show the percentage of children who have excess weight (obese or overweight) in Reception (aged 4-5 years) and Year 6 (aged 10-11 years). They compare Darlington with its statistical neighbours, and the England average. Compared with the England average, this area has a worse percentage of children in Reception (25.0%) and a similar percentage in Year 6 (36.7%) who have excess weight.

Obese | All children with excess weight, some of whom are obese

Children aged 4-5 years who have excess weight, 2016/17 (percentage)



Children aged 10-11 years who have excess weight, 2016/17 (percentage)

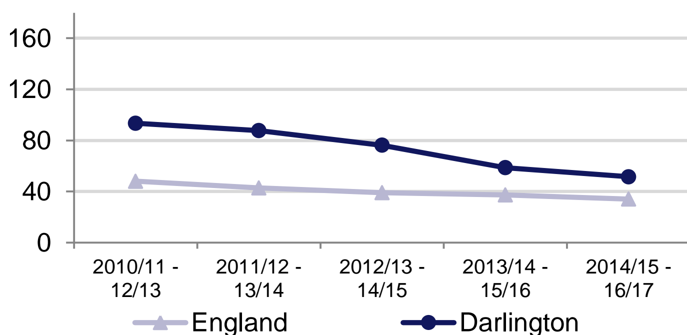


Note: This analysis uses the 85th and 95th centiles of the British 1990 growth reference (UK90) for BMI to classify children as overweight and obese.
I indicates 95% confidence interval.

Young people and alcohol

Nationally, the rate of hospital admissions of children and young people for conditions wholly related to alcohol is decreasing, and this is also the case in Darlington. The admission rate in the latest period is worse than the England average.

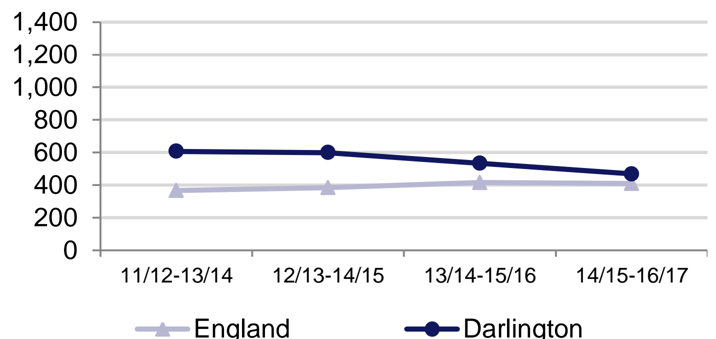
Hospital admissions of children and young people for conditions wholly related to alcohol (rate per 100,000 population aged 0-17 years)



Young people's mental health

Nationally, the rate of young people being admitted to hospital as a result of self-harm is increasing. This is not the case in Darlington where the trend is decreasing. However, the admission rate in the latest pooled period remains higher than the England average*. Nationally, levels of self-harm are higher among young women than young men.

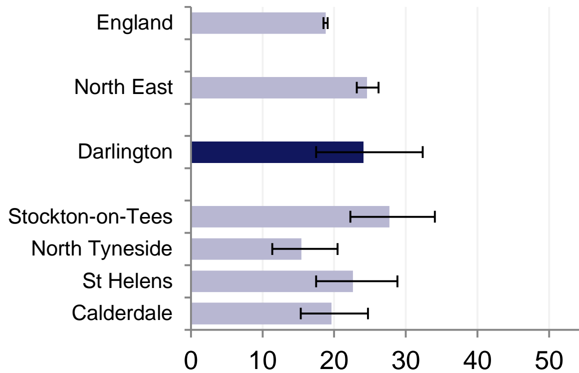
Young people aged 10 to 24 years admitted to hospital as a result of self-harm (rate per 100,000 population aged 10-24 years)



*Information about admissions in the single year 2016/17 can be found on page 4

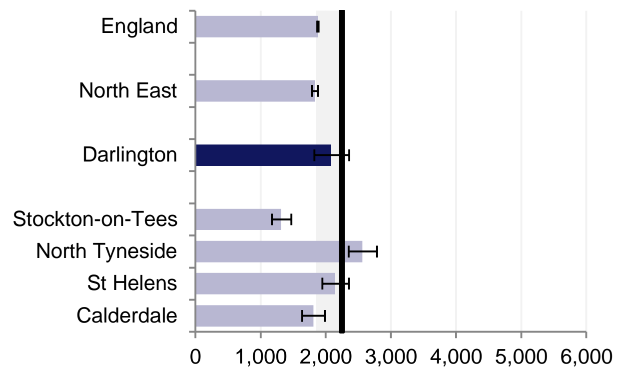
These charts compare Darlington with its statistical neighbours, and the England and regional averages.

Teenage conceptions in girls aged under 18 years, 2016 (rate per 1,000 female population aged 15-17 years)



In 2016, approximately 24 girls aged under 18 conceived for every 1,000 girls aged 15-17 years in this area. This is similar to the regional average (approximately 25 per 1,000). The area has a similar teenage conception rate compared with the England average (approximately 19 per 1,000).

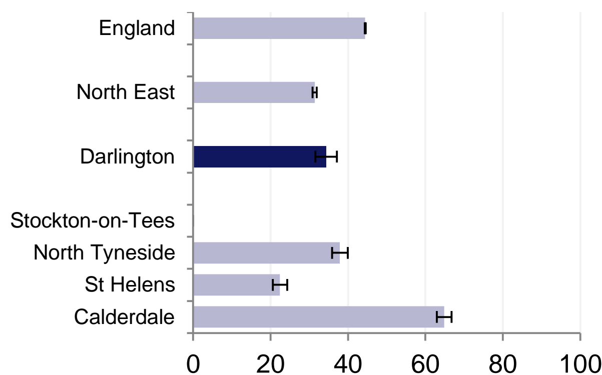
Chlamydia detection, 2016 (rate per 100,000 young people aged 15-24 years)



Chlamydia screening is recommended for all sexually active 15-24 year olds. Increasing detection rates indicates better targeting of screening activity; it is not a measure of prevalence. Areas should work towards a detection rate of at least 2,300 per 100,000 population. In 2016, the detection rate in this area was 2,083 which is approaching the minimum recommended rate.

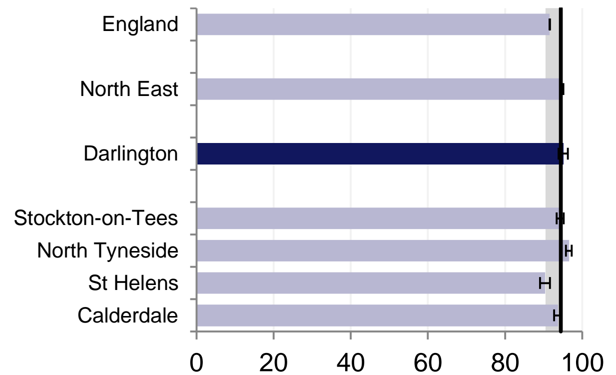
The shaded area from 1,900 shows the range of values approaching the minimum recommended rate of 2,300 (the black line).

Breastfeeding at 6 to 8 weeks, 2016/17 (percentage of infants due 6 to 8 week checks)



Breastfeeding initiation data is not available for this area. By 6 to 8 weeks after birth, 34.3% of mothers are still breastfeeding (worse than England).

Measles, mumps and rubella (MMR) vaccination coverage by age 2 years, 2016/17 (percentage of eligible children)



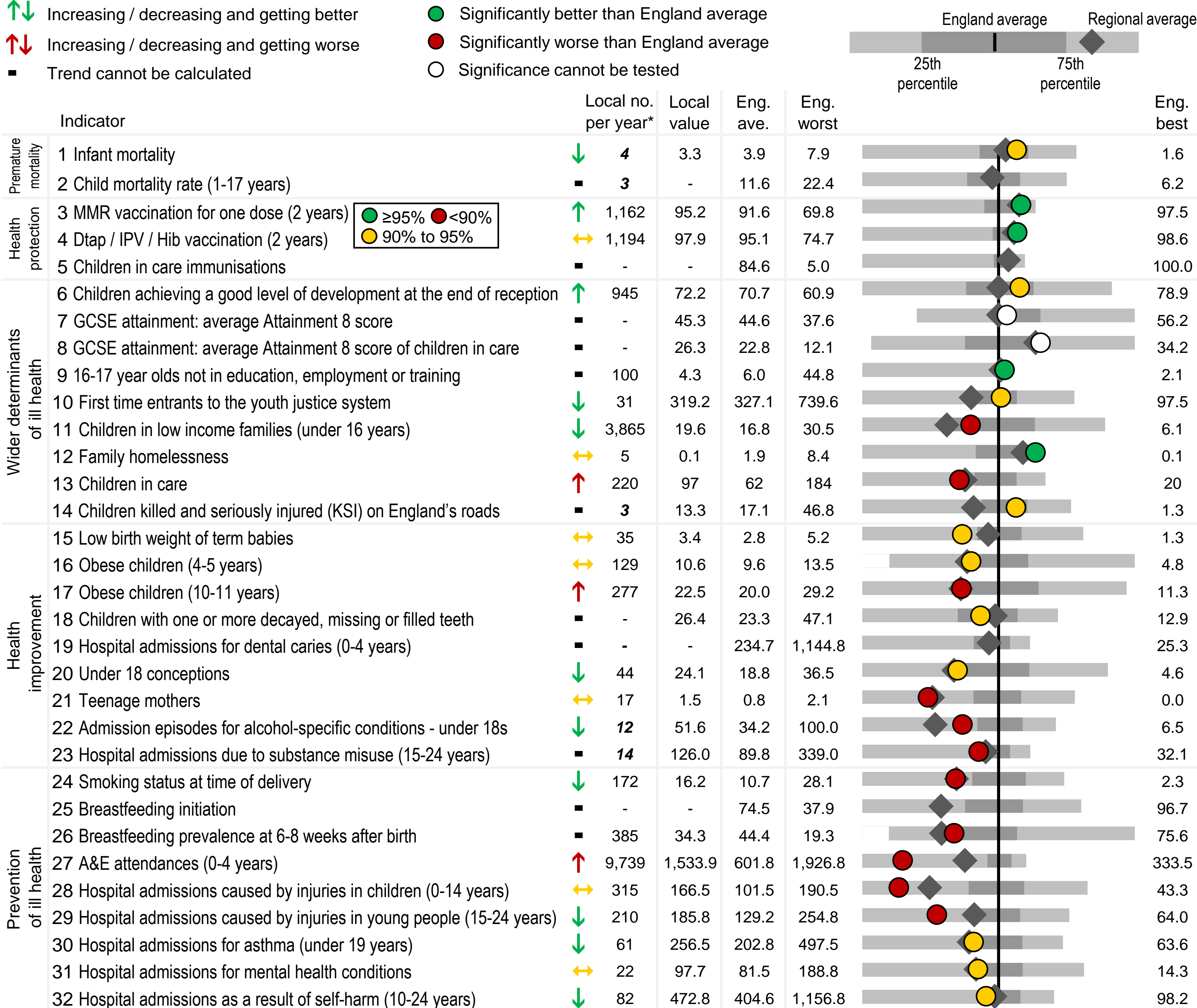
More than 95% (the minimum recommended coverage level) of children have received their first dose of immunisation by the age of two in this area (95.2%). By the age of five, only 92.1% of children have received their second dose of MMR immunisation.

The shaded area from 90% shows the range of values approaching the minimum recommended coverage of 95% (the black line).

Note: Where data is not available or figures have been suppressed, no bar will appear in the chart for that area.

Darlington Child Health Profile June 2018

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average.



	Indicator	Trend	Local no. per year*	Local value	Eng. ave.	Eng. worst	Eng. best
Premature mortality	1 Infant mortality	↓	*4*	3.3	3.9	7.9	1.6
	2 Child mortality rate (1-17 years)	▪	*3*	-	11.6	22.4	6.2
Health protection	3 MMR vaccination for one dose (2 years)	↑	1,162	95.2	91.6	69.8	97.5
	4 Dtap / IPV / Hib vaccination (2 years)	↔	1,194	97.9	95.1	74.7	98.6
	5 Children in care immunisations	▪	-	-	84.6	5.0	100.0
Wider determinants of ill health	6 Children achieving a good level of development at the end of reception	↑	945	72.2	70.7	60.9	78.9
	7 GCSE attainment: average Attainment 8 score	▪	-	45.3	44.6	37.6	56.2
	8 GCSE attainment: average Attainment 8 score of children in care	▪	-	26.3	22.8	12.1	34.2
	9 16-17 year olds not in education, employment or training	▪	100	4.3	6.0	44.8	2.1
	10 First time entrants to the youth justice system	↓	31	319.2	327.1	739.6	97.5
	11 Children in low income families (under 16 years)	↓	3,865	19.6	16.8	30.5	6.1
	12 Family homelessness	↔	5	0.1	1.9	8.4	0.1
	13 Children in care	↑	220	97	62	184	20
	14 Children killed and seriously injured (KSI) on England's roads	▪	*3*	13.3	17.1	46.8	1.3
Health improvement	15 Low birth weight of term babies	↔	35	3.4	2.8	5.2	1.3
	16 Obese children (4-5 years)	↔	129	10.6	9.6	13.5	4.8
	17 Obese children (10-11 years)	↑	277	22.5	20.0	29.2	11.3
	18 Children with one or more decayed, missing or filled teeth	▪	-	26.4	23.3	47.1	12.9
	19 Hospital admissions for dental caries (0-4 years)	▪	-	-	234.7	1,144.8	25.3
	20 Under 18 conceptions	↓	44	24.1	18.8	36.5	4.6
	21 Teenage mothers	↔	17	1.5	0.8	2.1	0.0
	22 Admission episodes for alcohol-specific conditions - under 18s	↓	*12*	51.6	34.2	100.0	6.5
	23 Hospital admissions due to substance misuse (15-24 years)	▪	*14*	126.0	89.8	339.0	32.1
Prevention of ill health	24 Smoking status at time of delivery	↓	172	16.2	10.7	28.1	2.3
	25 Breastfeeding initiation	▪	-	-	74.5	37.9	96.7
	26 Breastfeeding prevalence at 6-8 weeks after birth	▪	385	34.3	44.4	19.3	75.6
	27 A&E attendances (0-4 years)	↑	9,739	1,533.9	601.8	1,926.8	333.5
	28 Hospital admissions caused by injuries in children (0-14 years)	↔	315	166.5	101.5	190.5	43.3
	29 Hospital admissions caused by injuries in young people (15-24 years)	↓	210	185.8	129.2	254.8	64.0
	30 Hospital admissions for asthma (under 19 years)	↓	61	256.5	202.8	497.5	63.6
	31 Hospital admissions for mental health conditions	↔	22	97.7	81.5	188.8	14.3
	32 Hospital admissions as a result of self-harm (10-24 years)	↓	82	472.8	404.6	1,156.8	98.2

*Numbers in italics are calculated by dividing the total number for the three year period by three to give an average figure

Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box

Notes and definitions

1 Mortality rate per 1,000 live births (aged under 1 year), 2014-2016
2 Directly standardised rate per 100,000 children aged 1-17 years, 2014-2016
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2016/17
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2016/17
5 % children in care with up-to-date immunisations, 2017
6 % children achieving a good level of development within Early Years Foundation Stage Profile, 2016/17
7 GCSE attainment: average attainment 8 score, 2016/17
8 GCSE attainment attainment: average attaiment 8 score of children looked after, 2016
9 % not in education, employment or training (NEET) or whose activity is not known as a proportion of total 16-17 year olds known to local authority, 2016
10 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2016
11 % of children aged under 16 years living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2015
12 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2016/17
13 Rate of children looked after at 31 March per 10,000 population aged under 18 years, 2017
14 Crude rate of children aged 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2014-2016
15 Percentage of live-born babies, born at term, weighing less than 2,500 grams, 2016
16 % school children in Reception year classified as obese, 2016/17
17 % school children in Year 6 classified as obese, 2016/17
18 % children aged 5 years with one or more decayed, missing or filled teeth, 2016/17
19 Crude rate per 100,000 (aged 0-4 years) for hospital admissions for dental caries, 2014/15-2016/17
20 Under 18 conception rate per 1,000 females aged 15-17 years, 2016
21 % of delivery episodes where the mother is aged less than 18 years, 2016/17
22 Hospital admissions for alcohol-specific conditions – under 18 year olds, crude rate per 100,000 population, 2014/15-2016/17
23 Directly standardised rate per 100,000 (aged 15-24 years) for hospital admissions for substance misuse, 2014/15-2016/17
24 % of mothers smoking at time of delivery, 2016/17
25 % of mothers initiating breastfeeding, 2016/17
26 % of mothers breastfeeding at 6-8 weeks, 2016/17
27 Crude rate per 1,000 (aged 0-4 years) of A&E attendances, 2016/17
28 Crude rate per 10,000 (aged 0-14 years) for emergency hospital admissions following injury, 2016/17
29 Crude rate per 10,000 (aged 15-24 years) for emergency hospital admissions following injury, 2016/17
30 Crude rate per 100,000 (aged 0-18 years) for emergency hospital admissions for asthma, 2016/17
31 Crude rate per 100,000 (aged 0-17 years) for hospital admissions for mental health, 2016/17
32 Directly standardised rate per 100,000 (aged 10-24 years) for hospital admissions for self-harm, 2016/17

DARLINGTON BOROUGH COUNCIL

Darlington
Childhood Healthy Weight Plan
2017 – 2022
Version 5

DRAFT

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VISION

Darlington is to increase the proportion of children leaving primary school aged 10-11 years (Year 6) with a healthy weight. This will be achieved by developing a whole systems approach to tackling childhood obesity. Darlington will ensure the healthy weight agenda is integrated in other relevant plans; tackling environmental, physical and other determinants which make choosing to eat a healthy balanced diet and having a physically active lifestyle an easier option.

AIM

To increase numbers of children leaving primary school at a healthy weight and reduce inequalities of children and young people in Darlington by identifying priority actions, developing recommendations and implementing plans. These will focus on prevention and a partnership approaches and will have to be within the main envelope of funding.

OBJECTIVES

- To transform the environment so that it supports healthy lifestyles by increasing and maintaining use of green space for play and recreation.
- To transform the environment so that healthier choices are available in the provision of out of home food
- To transform the environment by supporting the public sector to lead by example with Food choices
- Increase making healthier choices easier by providing information and practical support on active travel
- Increase making healthier choices easier by delivering an awareness raising campaign
- To support the services needed to tackle excess weight by increasing breastfeeding rates
- To support the services needed to tackle excess weight by Making Every Contact Count (MECC)

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KEY MESSAGES

- The most recent measurements from Darlington (2016/17) show the rate of childhood obesity in the town sits above the national average at both reception and year 6. It is very slightly below the regional average at reception age but in line with North East regional average in year 6.

- The percentage of children at year 6 who are categorised as obese in Darlington is 22%, this figure is more than double the figure at reception age where the percentage is 10%.

- These rates of childhood obesity have significant consequences for the health of our children during childhood and into adulthood. These include mental health concerns as well as diseases such as diabetes and heart disease.

- In Darlington childhood obesity is not evenly spread it is concentrated in the central urban and eastern wards and has a strong correlation with deprivation levels.

- Although the main causes of obesity are poor diet and low levels of physical activity it has been shown that environmental changes can have the most impact on reducing obesity. An environment that promotes activity in travel and recreation and does not provide easy access to energy dense food can reduce obesity levels.

- This method requires a co-ordinated partnership approach from a wide variety of stakeholders to enable effective and sustainable environmental change. This includes planning and development, environmental health, leisure and culture, and licensing.

- Areas identified as having higher levels of childhood obesity would benefit the most from support to modify the environment to make the healthy choice the easy choice. Mapping to understand the detail of the environments in required including; out of home food provision, exposure to advertising and promotions, healthy food provision and active travel routes.

- Tackling the obesogenic environment will be supported by the promotion of the healthy lifestyle message to reinforce the need for healthy behaviours as a means of prevention and treatment for those with excess weight. This will include complimentary and consistent change for life messages.

- By transforming the environment, making healthier choices easier and supporting services to tackle excess weight we hope to increase the number of children in Darlington leaving primary school at a healthy weight.

- This action plan details specific actions following the recommendations outlined in the national government document Childhood Obesity: A plan for Action 2016.

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INTRODUCTION

- Childhood obesity and excess weight are significant health issues for children. They can have serious implications for the physical and mental health of a child[1]. Obese children are more likely to become obese adults and have a higher risk of morbidity and premature mortality in adulthood[2].

- Obesity and overweight are linked to a wide range of diseases, most notably, diabetes (type 2), asthma, hypertension, cancer, heart disease and stroke[3].

- The effect of obesity on the mental and emotional health of children and young people can also be significant, many children experience bullying linked to their weight[4].

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Figure 1: Obesity Harms Children and Young People[5]

[1] Public Health England, Childhood Obesity: Applying All Our Health (2015)
[2] World Health Organisation Global Strategy on Diet, Physical Activity and Health (2004)
[3] Public Health England, Childhood Obesity: Applying All Our Health (2015)
[4] National Obesity Observatory. Obesity and Mental Health (2011)
[5] Public Health England, Childhood Obesity: Applying All Our Health (2015)

- The impact of obesity is not only on health, the cost to the economy is also great: it was estimated that the NHS in England spent £5.1 billion on overweight and obesity-related ill-health in 2014/15. The total cost to society is estimated to be between £27 billion and £46 billion.[6]

- On 18 August 2016, the government published its childhood obesity plan Childhood Obesity: A Plan for Action. The aim of this document is to significantly reduce England's rate of childhood obesity within the next 10 years by implementing the individual commitments in the plan.

- Poor diet and low levels of physical activity are the primary causal factors to excess weight however the likelihood of children becoming overweight or obese is increased by living in a family where at least one parent or carer is obese[7] There is also strong evidence of a relationship between maternal obesity and the birth of babies above a normal weight range, and the development of childhood and adult obesity, irrespective of environmental and genetic factors[8]

- The amount of sugar that children consume on a daily basis is a major contributing factor to gaining weight. The National Diet and Nutrition Survey found that sugary drinks account for 30% of 4 to 10 year olds' daily sugar intake. Children's consumption of added or processed sugars (non-milk extrinsic sugars) significantly exceeds the maximum recommended level. Their consumption of saturated fat, as part of their daily food energy, significantly exceeds the maximum recommended level of 11% of total food energy[9].

- In July 2015, the Scientific Advisory Committee on Nutrition (SACN) published its Carbohydrates and Health Report. SACN recommended free sugars intake should not exceed 5% of total dietary energy for all ages from 2 years upwards. Free sugars are defined as all sugars added to foods plus those naturally present in fruit juices, syrups and honey. It does not include the sugars naturally present in intact fruit and vegetables or milk and dairy products.

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[6] McKinsey Global Institute Overcoming Obesity: An Initial Economic Analysis. (2014)
[7] Public Health England, (2015) Childhood Obesity: Applying All Our Health
[8] 'Maternal Obesity' noo.org.uk website (December 2015)
[9] Public Health England (2015) Sugar Reduction: the evidence for action

- In October 2015, Public Health England published its sugar reduction evidence package in which it suggested 8 possible actions to reduce population sugar consumption. The report suggested that a structured and universal programme of reformulation to reduce levels of sugar in food and drink would significantly lower sugar intakes, particularly if accompanied by reductions in portion size.

- Sugar reduction is also a key component in the oral health of children and young people. Tooth decay can be a sign of a poor diet, especially excess sugar consumption which can lead to obesity.

- Low levels of physical activity, and increased sedentary behaviours, of children and young people exacerbate the problems of poor diet and nutrition. In England, only 21% of boys and 16% of girls aged 5 to 15 achieve recommended levels of physical activity. As children grow older, the decrease in activity levels is greater for girls than boys: 23% of girls aged 5 to 7 meet the recommended levels of activity, but by ages 13 to 15 only 8% still do[10].

- Areas of socioeconomic disadvantage in England have higher childhood obesity rates than those in lesser deprived areas. At age 5, children from the poorest income groups are twice as likely to be obese compared to their most well-off counterparts; by age 11 they are three times as likely.[11]

- The prevalence of underweight children in the UK is much lower than the prevalence of obesity. The proportion of underweight children in 2016/17 at Year 6 was 1.3%.[12] The causes for this are varied and individual to the child including not consuming enough calories, not absorbing enough calories from food or requiring more calories than normal.[13]

- In most cases of underweight children a paediatrician and dietician will support their individual needs but generally a healthy balanced diet is still recommended. This ensures calories are from healthy food sources and sets habits for life.[14]

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[10] Start Active, Stay Active: A report on physical activity from the four home countries' Chief Medical Officers, July 2011.
[11] Guidance: Childhood Obesity: A Plan for Action (updated 2017) https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action/childhood-obesity-a-plan-for-action#fn:11
[12] NCMP: www.digital.nhs.uk
[13] www.uptodate.com/contents/poor-weight-gain-in-infants-and-children-beyond-the-basics
[14] www.nhs.uk/Livewell/Goodfood/Pages/Underweightolderchild.aspx

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- In some cases the causes of underweight, overweight or obese children can be linked to neglect. This form of neglect is sometimes associated with 'failure to thrive', in which a child fails to develop physically as well as psychologically. However, failure to thrive can occur for other reasons, independent of neglect. Childhood obesity resulting from an unhealthy diet and lack of exercise has been considered as a form of neglect, given its serious long term consequences[15]. There are robust protection laws and reporting mechanisms for professionals working with children in this situation to ensure they are protected and safeguarded.[16]

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[15] Action for Children: Neglect: Research Evidence To Inform Practice
[16] www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/neglect/legislation-policy-and-guidance/

Epidemiological Assessment of Need

The National Childhood Measurement Programme (NCMP) measures children's weight at two age stages: at ages 4 – 5 years (Reception class) and again at ages 10 – 11 year (Year 6). It classifies the results into 4 categories; obese, overweight, healthy weight and underweight. Parents are informed of their child's result via letter and given the opportunity to seek further advice and support if they want to.

Nationally approximately one-fifth of 4 to 5 year olds and a third of 11 year olds are overweight or obese, as well as two-thirds of adults.

The most recent measurements from Darlington (2016/17) show the rate of childhood obesity in the town sits above the national average at both reception and year 6 and is very slightly below the regional average at reception age but in line with North East regional average year 6. Please see tables below for more detailed figures.

Figure 2: Percentage of overweight and obese children at Reception[17] (ages 4 – 5 Years)

2016/17	Overweight	Obese	Overweight & Obese Combined
ENGLAND	13	9.6	22.6
NORTH EAST	13.8	10.7	24.5
DARLINGTON	**14.3**	**10.5**	**24.8**

Figure 3: Percentage of overweight and obese children at Year 6[18] (Ages 10-11 Years)

2016/17	Overweight	Obese	Overweight & Obese Combined
ENGLAND	14.3	20	34.2
NORTH EAST	14.3	22.5	37.3
DARLINGTON	**14**	**22.5**	**36.5**

[17] NCMP: www.digital.nhs.uk/catalogue/PUB30113
[18] NCMP: www.digital.nhs.uk/catalogue/PUB30113

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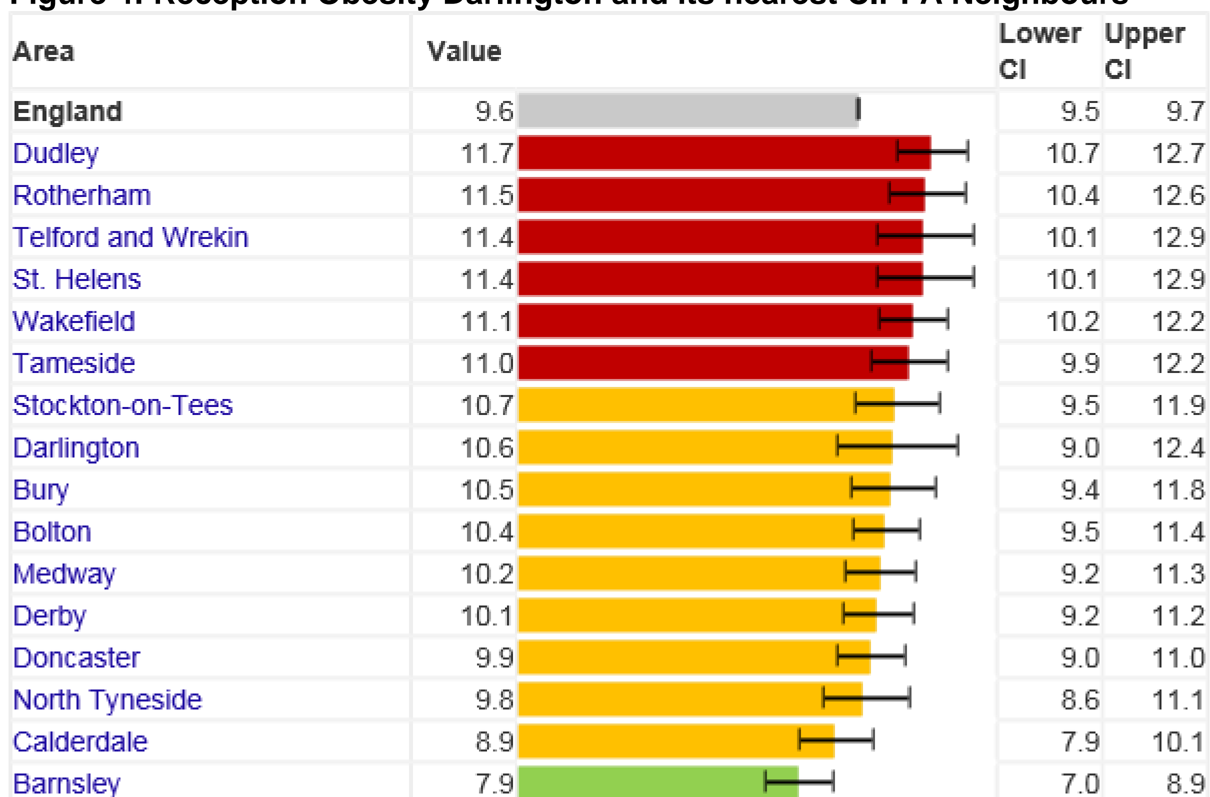
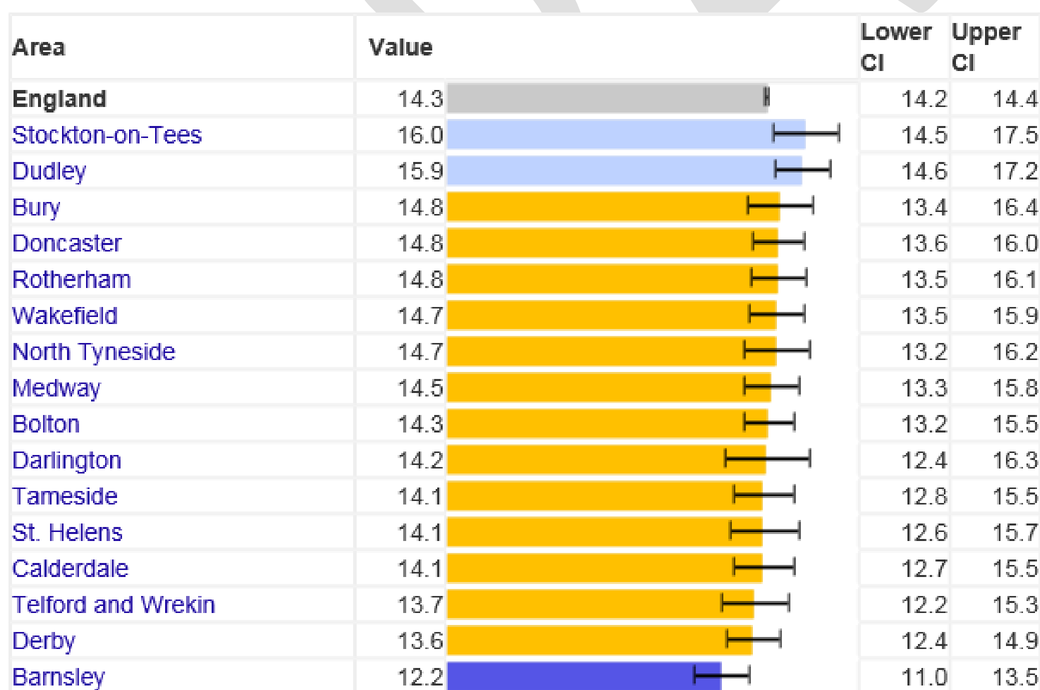
Figure 4: Reception Obesity Darlington and its nearest CIPFA Neighbours[19]



Area	Value	Lower CI	Upper CI
England	9.6	9.5	9.7
Dudley	11.7	10.7	12.7
Rotherham	11.5	10.4	12.6
Telford and Wrekin	11.4	10.1	12.9
St. Helens	11.4	10.1	12.9
Wakefield	11.1	10.2	12.2
Tameside	11.0	9.9	12.2
Stockton-on-Tees	10.7	9.5	11.9
Darlington	10.6	9.0	12.4
Bury	10.5	9.4	11.8
Bolton	10.4	9.5	11.4
Medway	10.2	9.2	11.3
Derby	10.1	9.2	11.2
Doncaster	9.9	9.0	11.0
North Tyneside	9.8	8.6	11.1
Calderdale	8.9	7.9	10.1
Barnsley	7.9	7.0	8.9

Source: NHS Digital, National Child Measurement Programme

Figure 5: Year 6 Obesity Darlington and its nearest CIPFA Neighbours[20]



Area	Value	Lower CI	Upper CI
England	14.3	14.2	14.4
Stockton-on-Tees	16.0	14.5	17.5
Dudley	15.9	14.6	17.2
Bury	14.8	13.4	16.4
Doncaster	14.8	13.6	16.0
Rotherham	14.8	13.5	16.1
Wakefield	14.7	13.5	15.9
North Tyneside	14.7	13.2	16.2
Medway	14.5	13.3	15.8
Bolton	14.3	13.2	15.5
Darlington	14.2	12.4	16.3
Tameside	14.1	12.8	15.5
St. Helens	14.1	12.6	15.7
Calderdale	14.1	12.7	15.5
Telford and Wrekin	13.7	12.2	15.3
Derby	13.6	12.4	14.9
Barnsley	12.2	11.0	13.5

Source: NHS Digital, National Child Measurement Programme

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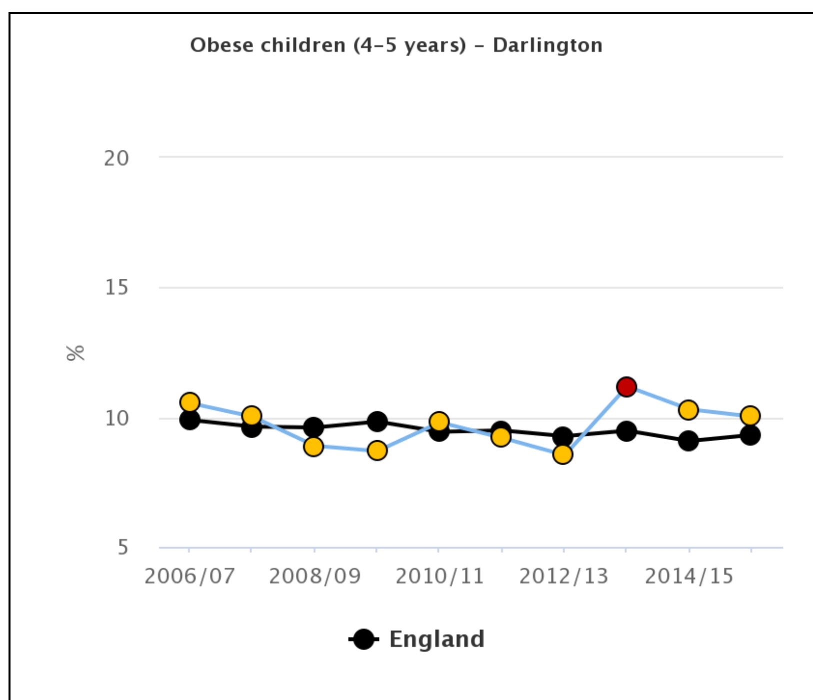
[19] Public health England, Fingertips Tool, NCMP Data www.fingertips.phe.org.uk/profile/national-child-measurement-programme

[20] Public health England, Fingertips Tool, NCMP Data www.fingertips.phe.org.uk/profile/national-child-measurement-programme

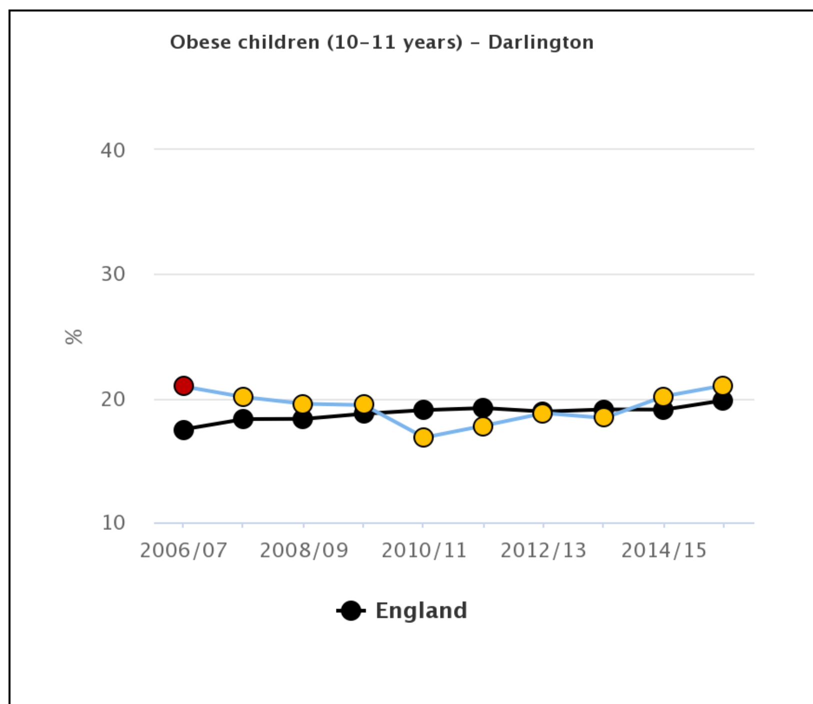
The charts below show us the childhood obesity rates in Darlington, compared to England, at each age range between 2006/07 and 2014/15. We can see that the rates vary, there is no strong trend, with figures dipping below and above the national average for both age ranges over time. However currently both measurements are above the national average.

Figure 6: Trend in obese children aged 4-5 years (reception age) in Darlington 2006/7 to 2014/15[21]



[21]Public health England, Fingertips Tool, NCMP Data www.fingertips.phe.org.uk/profile/national-child-measurement-programme

Figure 7: Trend in obese children aged 10-11 years (Year 6 age) in Darlington 2006/7 to 2014/15[22]



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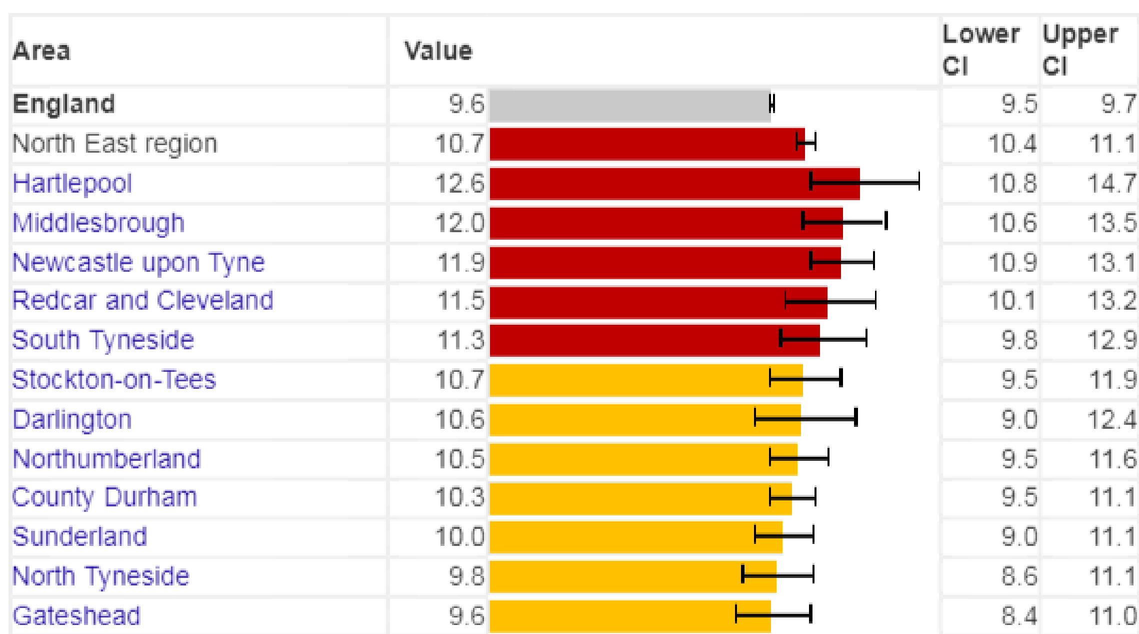
[22]Public health England, Fingertips Tool, NCMP Data www.fingertips.phe.org.uk/profile/national-child-measurement-programme

North East Regional Childhood Obesity

The tables below show obesity prevalence at the two measurement stages across the north east region and broken down by local authority area. Darlington's value is in line with the regional average at both measurement stages.

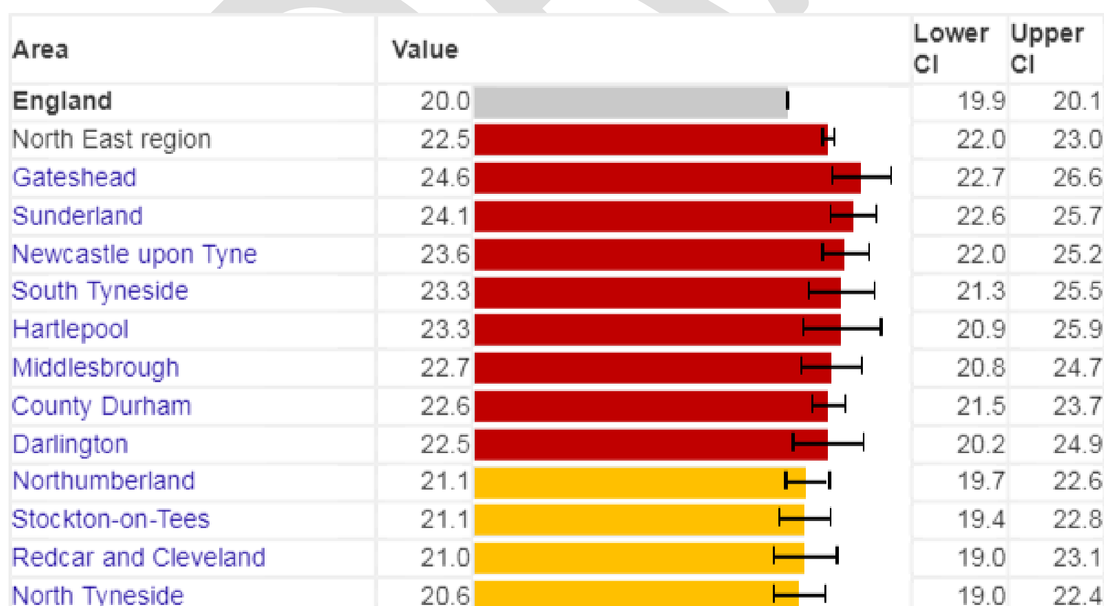
Figure 8: Prevalence of obesity among children in Reception[23]



Area	Value	Lower CI	Upper CI
England	9.6	9.5	9.7
North East region	10.7	10.4	11.1
Hartlepool	12.6	10.8	14.7
Middlesbrough	12.0	10.6	13.5
Newcastle upon Tyne	11.9	10.9	13.1
Redcar and Cleveland	11.5	10.1	13.2
South Tyneside	11.3	9.8	12.9
Stockton-on-Tees	10.7	9.5	11.9
Darlington	10.6	9.0	12.4
Northumberland	10.5	9.5	11.6
County Durham	10.3	9.5	11.1
Sunderland	10.0	9.0	11.1
North Tyneside	9.8	8.6	11.1
Gateshead	9.6	8.4	11.0

Source: NHS Digital, National Child Measurement Programme

Figure 9: Prevalence of obesity children in year 6[24]



Area	Value	Lower CI	Upper CI
England	20.0	19.9	20.1
North East region	22.5	22.0	23.0
Gateshead	24.6	22.7	26.6
Sunderland	24.1	22.6	25.7
Newcastle upon Tyne	23.6	22.0	25.2
South Tyneside	23.3	21.3	25.5
Hartlepool	23.3	20.9	25.9
Middlesbrough	22.7	20.8	24.7
County Durham	22.6	21.5	23.7
Darlington	22.5	20.2	24.9
Northumberland	21.1	19.7	22.6
Stockton-on-Tees	21.1	19.4	22.8
Redcar and Cleveland	21.0	19.0	23.1
North Tyneside	20.6	19.0	22.4

Source: NHS Digital, National Child Measurement Programme

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[23] Public health England, Fingertips Tool, NCMP Data www.fingertips.phe.org.uk/profile/national-child-measurement-programme
[24] Public health England, Fingertips Tool, NCMP Data, www.fingertips.phe.org.uk/profile/national-child-measurement-programme

Although the tables above show us that Darlington's prevalence of childhood obesity is in line with the regional average they do not tell us if this is evenly spread across the town.

The two maps below show the distribution of obesity across Darlington in reception and Year 6. They show that it is not equally distributed across the borough with a concentration in the urban centre and eastern wards.

Figure 10: Distribution of obesity across Darlington in Reception[25]

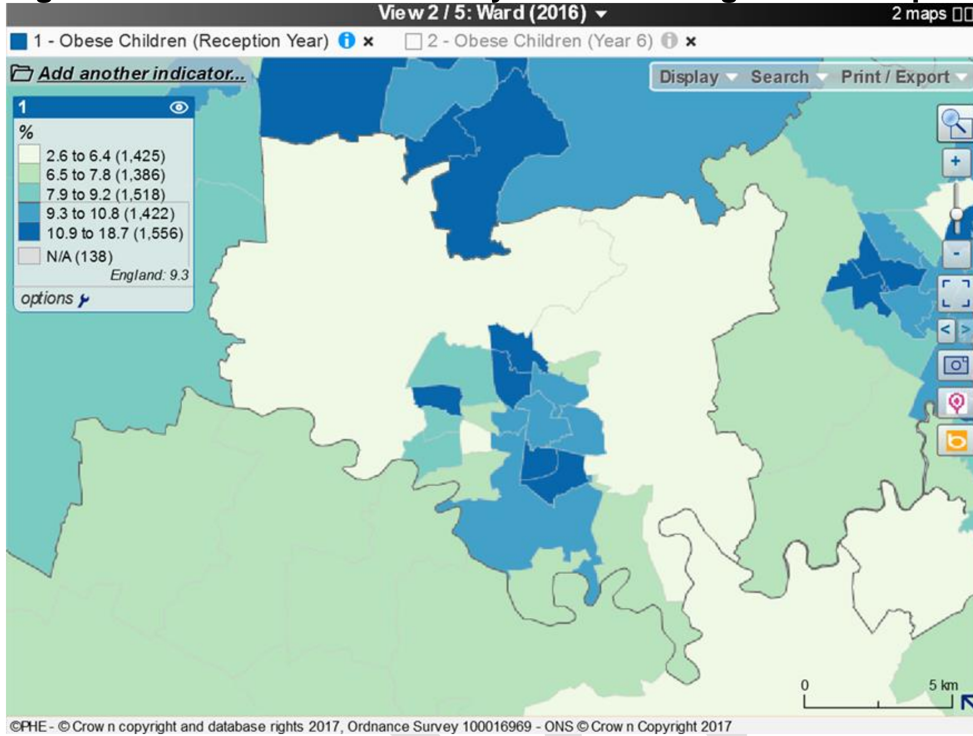
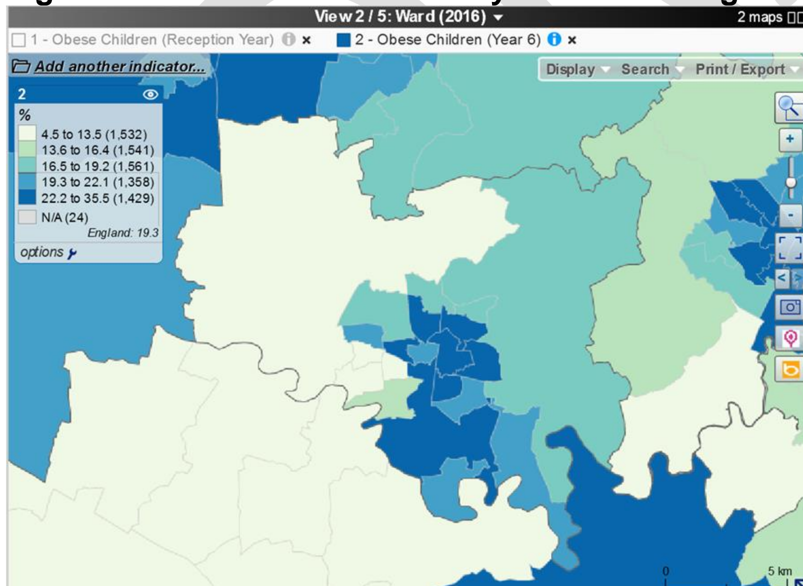


Figure 11: Distribution of obesity across Darlington in Year 6[26]



[25] Public Health England, Local Health Tool, www.localhealth.org.uk
[26] Public Health England, Local Health Tool, www.localhealth.org.uk

This unequal distribution and in particular the apparent link with poverty/deprivation and obesity is supported when the deprivation scores and obesity rates (%) in reception and Year 6 are compared. There is below a definite correlation between deprivation and obesity in primary school children.

Figure 12: Correlation of Obese children at reception age with deprivation score for England Local Authorities[27]

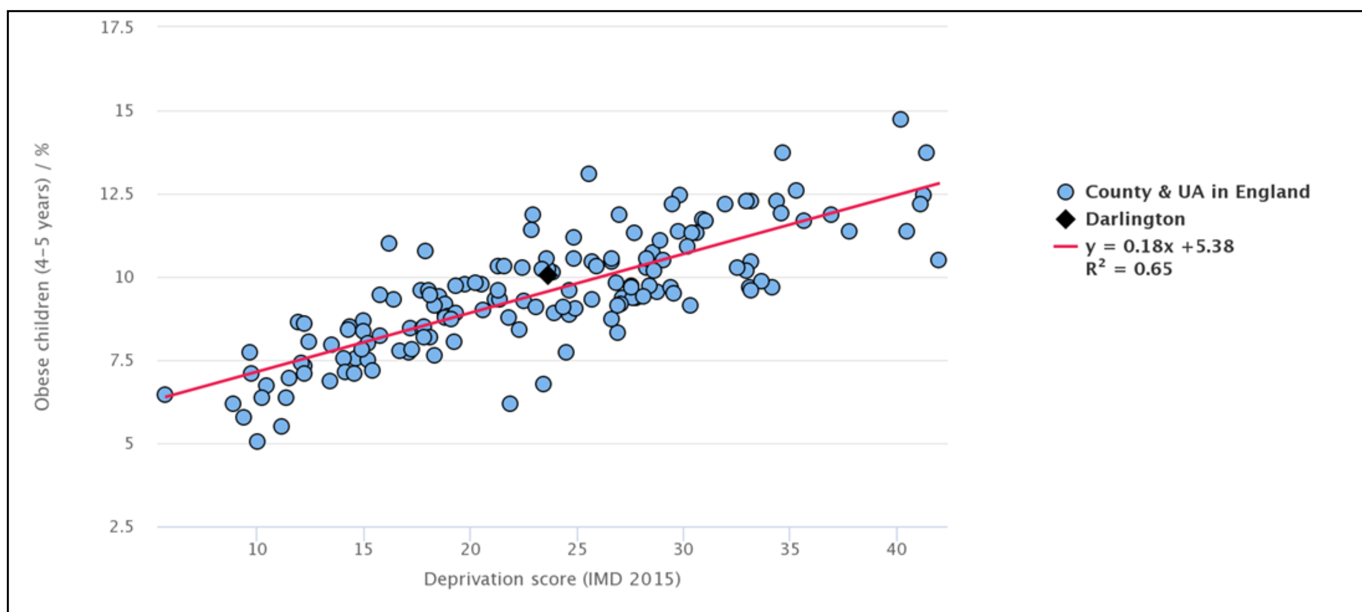
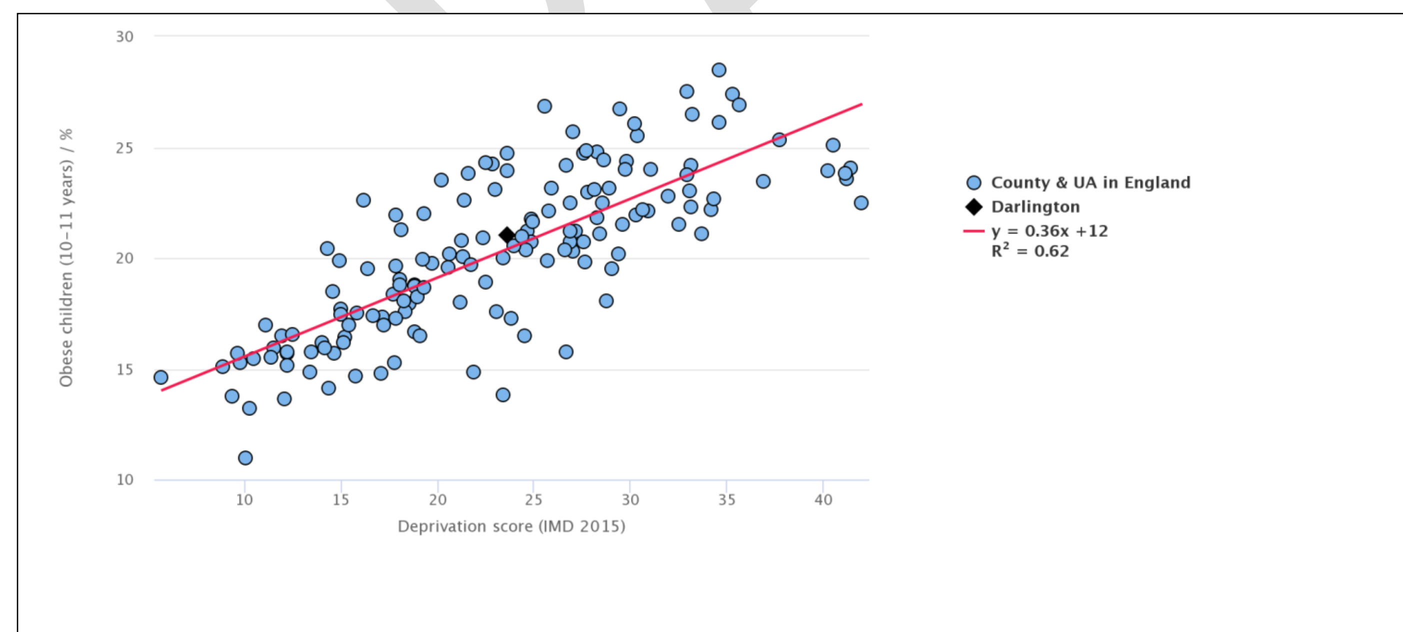


Figure 13: Correlation of Obese children at Year 6 with deprivation score for England Local Authorities[28]



[27] Public Health England, Local Health Tool, www.localhealth.org.uk
[28] Public Health England, Local Health Tool, www.localhealth.org.uk

The English Indices of Deprivation 2015 are based on 37 separate indicators, organised across seven distinct domains of deprivation which are combined, using appropriate weights, to calculate the Index of Multiple Deprivation 2015 (IMD 2015). This is an overall measure of multiple deprivation experienced by people living in an area and is calculated for every Lower layer Super Output Area (LSOA), or neighbourhood, in England. Every such neighbourhood in England is ranked according to its level of deprivation relative to that of other areas.

Figure 14: Correlation of obese Children at Reception age by Darlington Ward compared to IMD 2015 score for Ward[29]

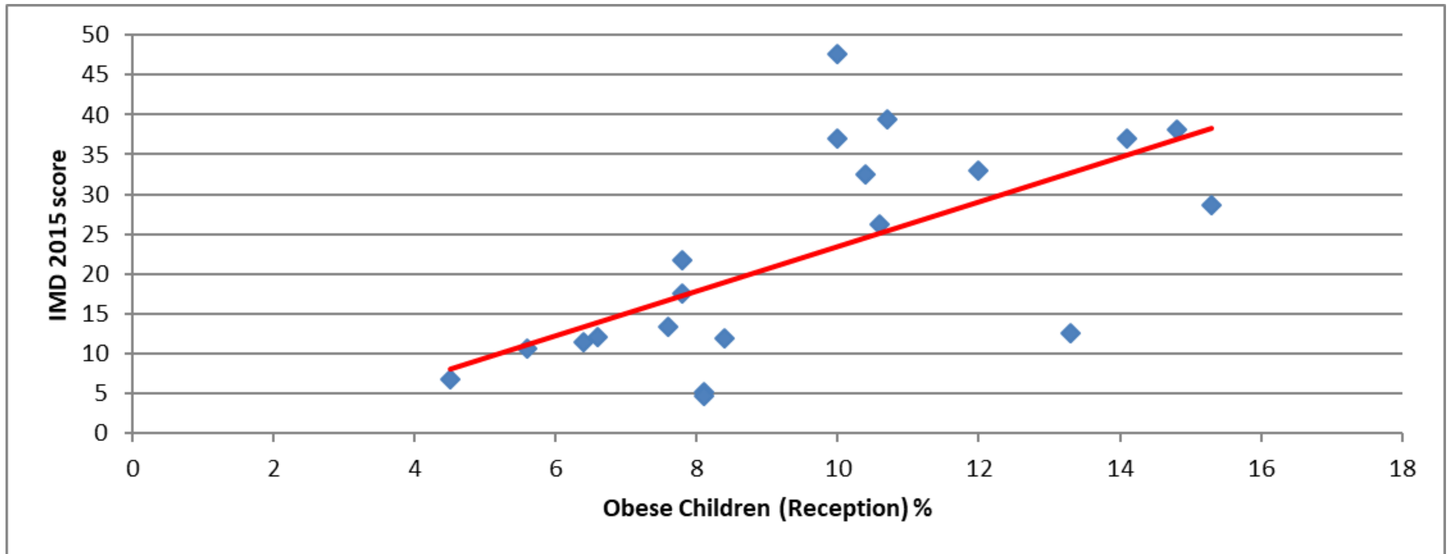
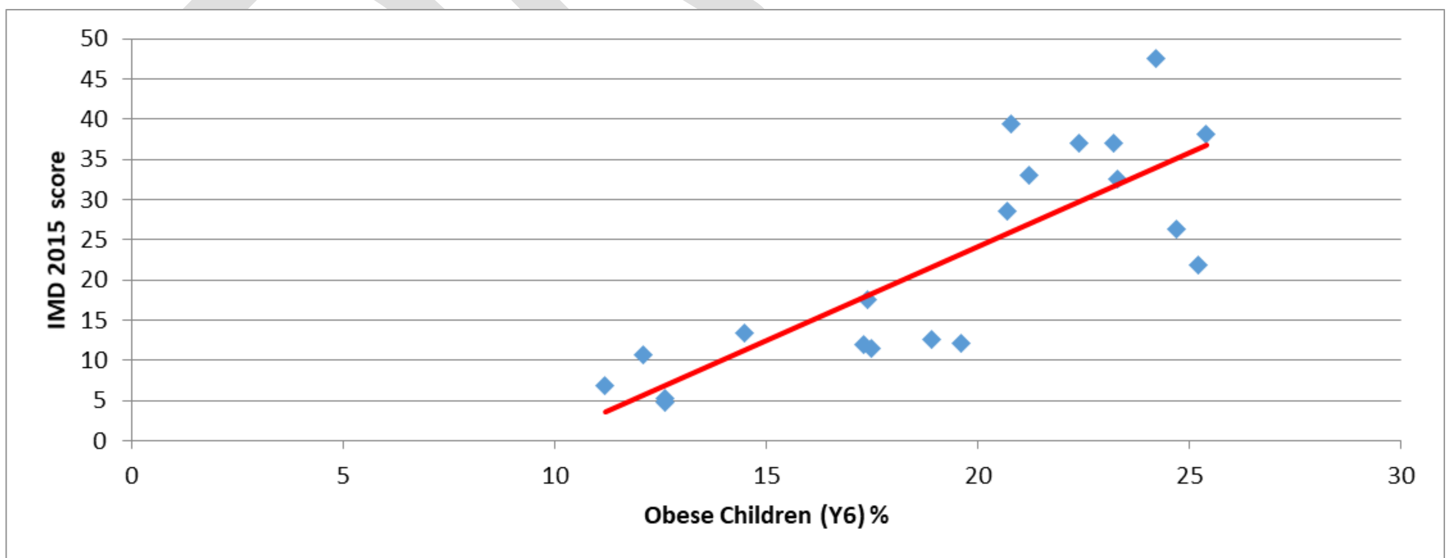


Figure 15: Correlation of obese Children at Year 6 age by Darlington Ward compared to IMD 2015 score for Ward[30]



[29]Public Health England, Local Health Tool, www.localhealth.org.uk
[30]Public Health England, Local Health Tool, www.localhealth.org.uk

Findings from the Healthy Lifestyle Survey in Darlington (primary and secondary schools)

The Primary Healthy Lifestyle Survey 2017/18 took place December 2017 to January 2018 with 16 primary schools in Darlington submitting survey responses. 1,468 number of pupils in year 5 and 6 completing at least one question of the survey. Seven questions in this survey relate to exercise and diet and a further five are related to energy drink consumption. The key findings include:

- 78% (989) of pupils think they achieve the recommended 60 minutes physical activity a day; this is a similar figure to recent years.
- 80% (1019) of pupils included, 'to keep fit and healthy' as one of their reasons for exercising.
- 80% (1012) of pupils stated they eat a balanced diet. However 51% and 35%, respectively, reported that they eat sweets and chocolate and drink fizzy drinks.
- 85% (1079) pupils eat breakfast every day.
- 8% claimed to have energy drinks weekly.

The Secondary healthy Lifestyle Survey 2017/18 surveyed 4872 children from across eight different schools. Among secondary school respondents only 23% (1029) of pupils answered that they achieved 60 minutes of physical activity a day, a big decline from primary school figures. 3001 pupils (65.9%) stated they follow a balanced diet and 2612 pupils (57.3%) eat breakfast every day.

More secondary pupils than primary pupils reported consuming energy drinks. 8% at primary age claimed to have them weekly, this figure rose to 20% by secondary school age. However 80% of respondents at both primary and secondary age recognised that energy drinks were bad for their health.

These results show that children's knowledge on healthy eating is good but practical support to improve physical activity levels at secondary school level would be beneficial.

The information from the survey on diet habits e.g. fizzy drink and sweet consumption also has implications for oral health as well as maintaining a healthy weight due to the high sugar content of these foods. Darlington's oral health plan includes actions to reduce their consumption and therefore reinforces the recommendations in this healthy weight action plan.

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TO TRANSFORM THE ENVIRONMENT SO THAT IT SUPPORTS HEALTHY LIFESTYLES

Understanding and Adapting the Obesogenic Environment

In 2007 the UK government published the Foresight report '*Tackling obesities: future choices*' it remains the most comprehensive investigation into obesity and its causes. It described the complex relations between the social, economic and physical environments and individual factors that underlie the development of obesity.[31]

Obesity is a multi-faceted issue that requires action from individuals and wider society to tackle effectively. A very important action is to adapt the environment so that it does not promote sedentary behaviour or provide easy access to energy-dense food. The aim is to help make the healthy choice the easy choice via environmental modification and action at population and individual levels.

Adapting the environment can include the built environment by planning in recreational green space as well as active travel routes. The government's public health strategy 'Healthy lives, healthy people', states that "health considerations are… Obesity and the environment: increasing physical activity and active travel are an important part of planning policy.'[32]

Reducing the proximity of fast food outlets to schools, colleges, leisure centres and other places where children gather is another recommendation to tackle the obesogenic environment.[33]

The healthy choice is even more difficult to make in deprived areas, which have less disposable income and a higher density of takeaways[34]

This focus on the environment requires what has been described as, 'a whole systems approach' to tackling obesity[35]. In 2015 Public Health England, in partnership with the Local Government Association (LGA) and the ADPH, commissioned Leeds Beckett University (LBU) to deliver this three year 'action research' programme. This approach has effective partnership work at its core.

The diagram below details the variety of different partners the healthy weight agenda and obesogenic environment can relate to. Darlington will seek to transform the environment so that it supports healthy lifestyles and make healthier choices easier by focusing on 3 key areas; out of home food provision, access to green space, and active travel.

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[31] Foresight Report: Tackling Obesity: Future Choices'
[32] Healthy Lives: Healthy People
[33] Measuring Up The Medical Profession's Prescription For The Nation's Obesity Crisis Academy of Medical Royal Colleges' 2013
[34] Public Health England. (2013) Obesity and the environment: fast food outlets
[35] Local Government Association Making obesity everybody's business: A whole systems approach to obesity

Figure 16: Partnership: the Key to Success[36]

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[36] Public Health Matters Blog: Designing a ‘whole systems approach’ to prevent and tackle obesity

Out of Home Food Provision

- The rise in popularity of out-of-home meals has been identified as an important factor contributing to rising levels of obesity.[37] Meals eaten outside of the home tend to be associated with higher intakes of energy, fat and salt.
- One fifth of children eat food from out of home food outlets at least once a week.[38]
- School children make purchases from a variety of food outlets in the school fringe at lunchtime (if there is a no stay on site policy), and during their journeys to and from school. Popular purchases include confectionery, sugar sweetened drinks, and hot food takeaways. Many outlets have price promotions on these items particularly targeted at children and young people.
- Food outlets, including grocers, takeaways and convenience stores, increasingly cluster around schools. However, it is not only the food environment around schools that influences food purchases and consumption patterns, the whole journey environment needs to be considered. This includes advertising in close proximity to schools on bus stops and billboards for example.
- A number of studies, prevalence of and mapping exercises suggest that there is a greater number of hot food takeaways and obesity in deprived areas.
- Information and education are solid foundations for improving diet, however, a growing body of evidence suggests that more structural changes are needed to achieve sustained behavioural change. These could include reducing the price of healthier foods, increasing the availability of healthier options, reducing pack size, and portion control.
- A hot food takeaway "hotspots" heat map produced for Darlington in 2016 shows that takeaways are concentrated in certain areas, sharing the same postcodes. The total number of outlets (from fast food density outlet data) for 2016 in Darlington is 124.
- Further work is planned to understand the food environment in the areas indicated as having high levels of obesity in the local health maps above. This includes the proximity of takeaways to schools along with mapping of grocers and convenience stores.
- Giving consideration to the, 'whole journey' actions to map and restrict advertising of high sugar foods are also detailed in the action plan.
- The Government Buying Standards for Food and Catering Services (GBSF) can be used as a starting point to assess the availability, procurement, price and prominence of healthier ingredients, food products and catering practices.
- The action plan details setting an example by local authority adopting GBSF, and using this good practice to promote the use across the Borough.

[37] Government Office for Science. Tackling obesities: future choices - project report (2nd edition)
[38] Public Health England; Strategies for Encouraging Healthier 'Out of Home' Food Provision

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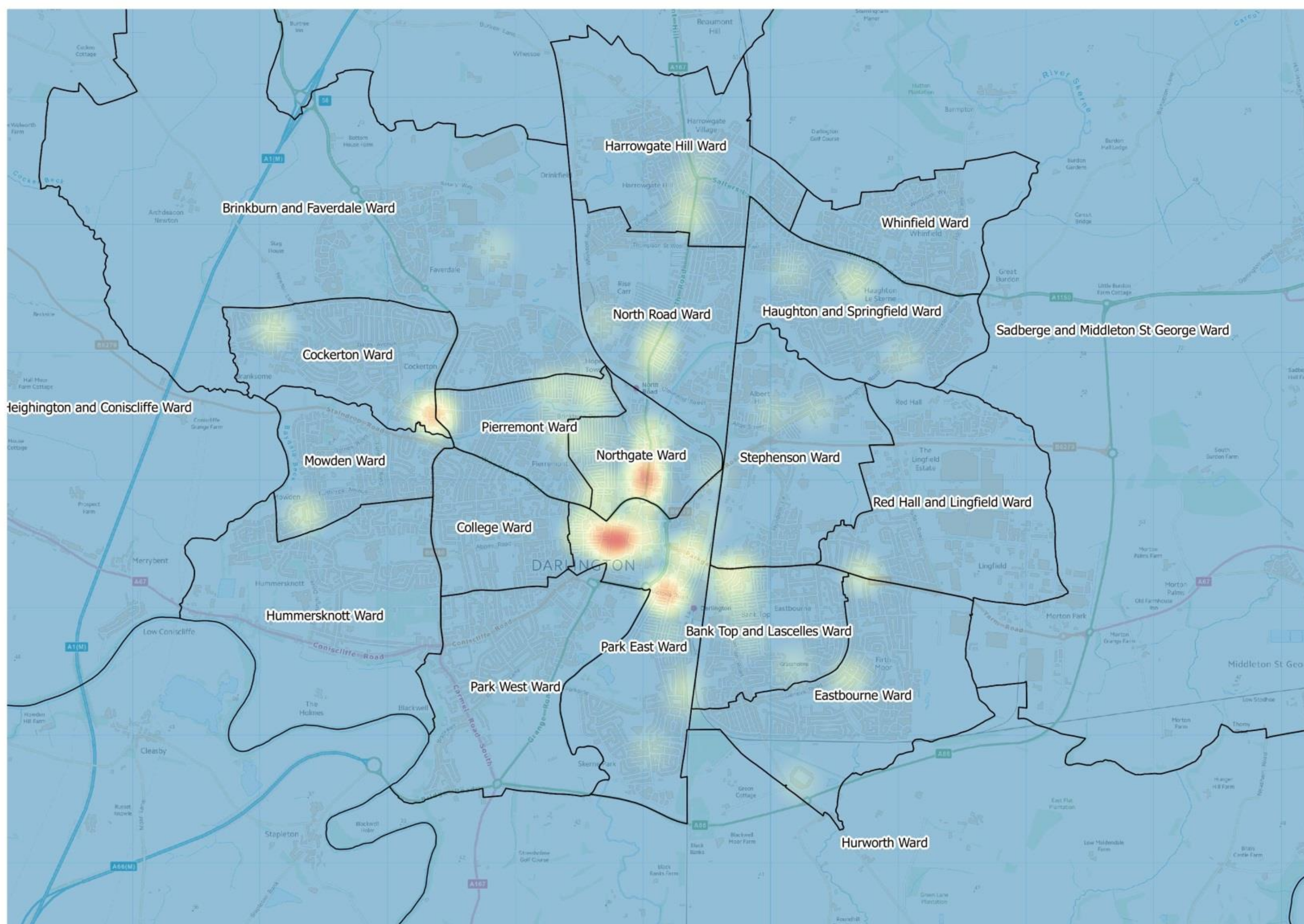
Figure 17: Hot food takeaway "hotspots" heat map[39]



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[39] Created by Public Health Team QGIS

Figure 18: Number of Hot food takeaway outlets by Ward[40]

2015 Ward name	Count of outlet
Bank Top & Lascelles	9
Cockerton	6
Eastbourne	2
Harrowgate Hill	3
Haughton & Springfield	3
Heighington & Coniscliffe	1
Hurworth	1
Mowden	2
North Road	6
Northgate	27
Park East	40
Pierremont	10
Red Hall & Lingfield	4
Sadberge & Middleton St George	4
Stephenson	6

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[40] Created by Public Health Team QGIS

Access to Green Space

- There is substantial evidence that access to good quality green spaces can have benefits to the health and wellbeing of individuals and communities including overweight and obesity levels[41].

- Improving access to green spaces for all social groups can reduce health inequalities due to the unequal access to green space across England.[42] The most deprived areas are less likely to be near green spaces and therefore the people living there will have less opportunity to experience the health benefits of green space compared with people living in less deprived areas.[43] Research shows that there are higher levels of physical activity in areas with more green space.[44]

- Green spaces come in a wide of forms including established parks and woodlands to natural grasslands and wetlands to green corridors such as riverbanks and cycle ways.[45]

- The location of good quality green space and individual's proximity to it are not the only barriers to accessing it. Often people include barriers to using green space such as fear for personal safety, antisocial behaviour, poor maintenance of green spaces, and lack of transport.[46]

- The maintenance of local green spaces is often a local authority responsibility; providing an opportunity to improve and create green space through joint work across different parts of the council and beyond, particularly public health, planning, transport, and parks and leisure.

- The maps below show open green space in Darlington, the action plan aims to support the availability of green space by identifying barriers to accessing it and promoting its use across the borough for play and recreation.

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[41] World Health Organisation Urban Green Spaces and Health
[42] PHE Local Action on Health Inequalities: Improving Access to Green Space
[43] PHE Local Action on Health Inequalities: Improving Access to Green Space
[44] Ellaway A, MacIntyre S, Bonnefoy X. Graffiti, greenery, and obesity in adults: secondary analysis of European cross sectional survey. British Medical Journal. 2005;331(7514):611-2.

[45] Building the foundations: Tackling obesity through planning and development
[46] Public Health England, 2014, Local action on health inequalities: Improving access to green spaces

Figure 15: Open spaces with wards whole borough[47]

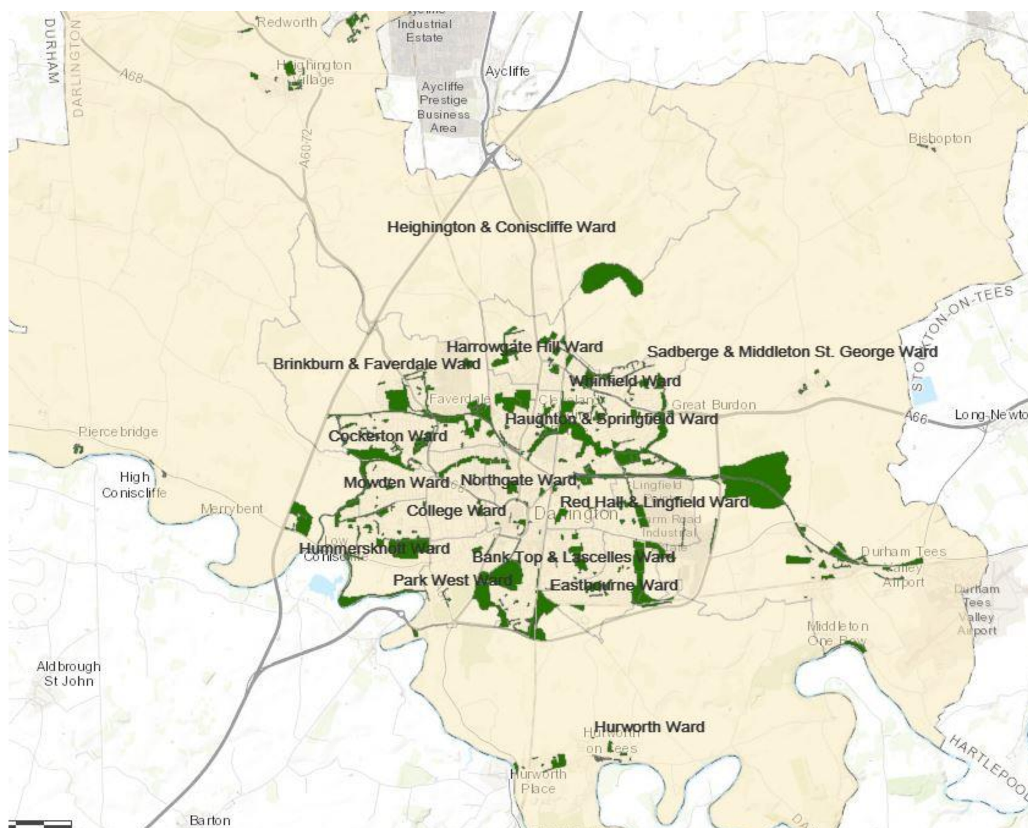
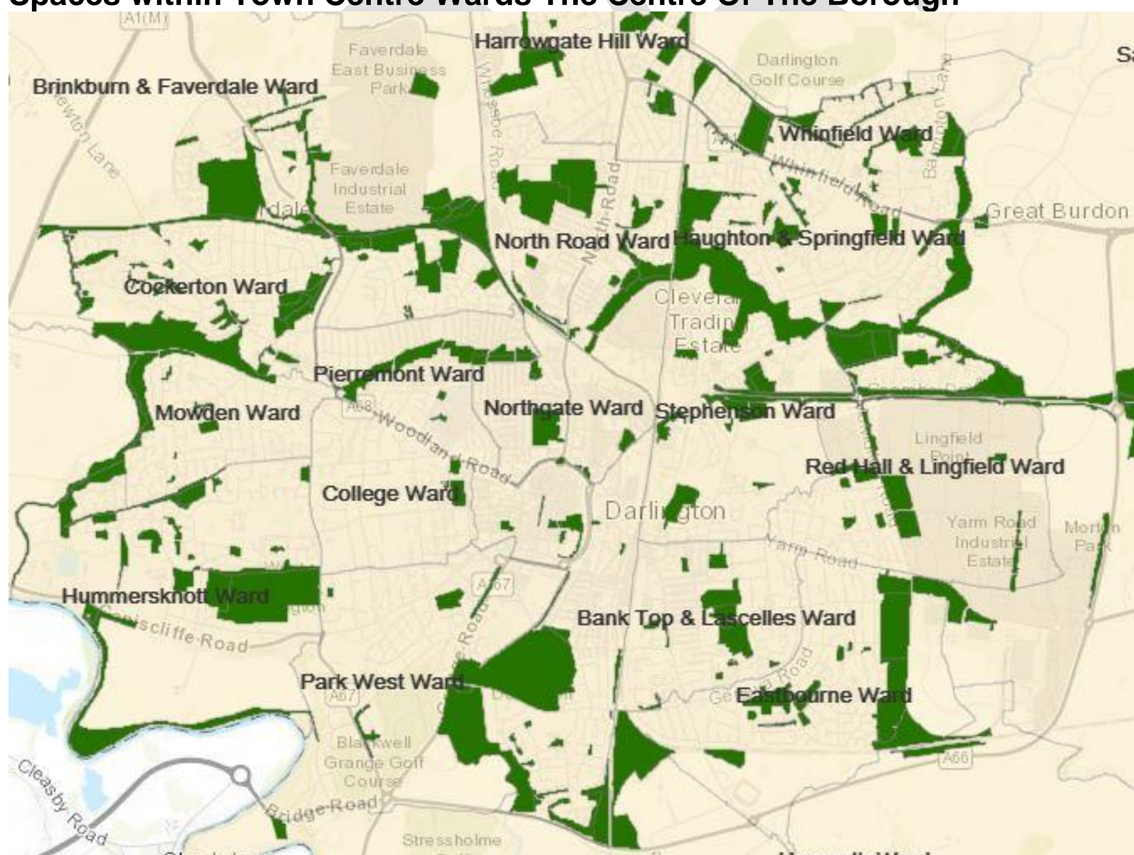


Figure 16: Open Spaces within Town Centre Wards The Centre Of The Borough[48]



47 ArcGIS online

Active Travel

- Darlington's Active Travel Strategy works to supports the health indicators outlined in the Corporate Performance Management Framework to increase physical activity and reduce obesity levels. Darlington's Sport and Physical Activity Strategy 2014-19 has the vision that, 'More Darlington residents are more active more often'.

- Regular physical activity is a key factor helping to prevent obesity and excess weight. The Department of Health recommends that adults complete at least 150 minutes (2.5 hours) of moderate-intensity aerobic activity every week. Children over five should take at least 60 minutes of moderate to vigorous intensity physical activity every day.[49]

- Physical activity that can be incorporated into everyday life, such as brisk walking and cycling, has been found to be as effective for weight loss as supervised exercise programmes.[50] However, over a third of adults report they are not as active as recommended suggesting that the true proportion is even less.[51]

- Creating an environment where people actively choose to walk and cycle as part of everyday life can have a significant impact on public health and may reduce inequalities in health. It is an essential component of a strategic approach to increasing physical activity and may be more cost-effective than other initiatives that promote exercise, sport and active leisure pursuits.[52]

- Practical actions to improve active travel in children included in the plan are mapping to and from school journeys and identifying and overcoming barriers to actively travel. Barriers can range from physical problems like busy roads to safety concerns and confidence issues. *Darlington's Local Transport Plan* supports the healthy weight plan by promoting active travel.

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[48] ArcGIS Online
[49] Healthy people, healthy places briefing Obesity and the environment: increasing physical activity and active travel
[50] Department of Health. Start active, Stay Active: a Report on Physical Activity from the Four Home Countries' Chief Medical Officers. London: Department of Health 2011.
[51] Healthy people, healthy places briefing Obesity and the environment: increasing physical activity and active travel
[52] Cavill N. Increasing walking and cycling: a briefing for directors of public health. 2013. www.noo.org.uk/slide_sets/activity. (updatedMarch 2016)

	Key Areas of Action	Desired Outputs	Expected Outcomes	Timeline	Co-ordinators/ Leads	Funding Position
1a	Develop a communication plan to promote the key actions of strategy	Work with partners to inform public on action plan Work through social media. Use One Darlington as a vehicle to promote positive views across public	Public will support the actions of action plan	April 2018	Public Health Communications Team	Within existing Resource
1b	Undertake a mapping exercise in areas identified as having higher levels of childhood obesity	Understand the, 'journey to school' including proximity of takeaways to schools along with mapping of grocers, convenience stores and advertising	Identify communities, establishments and routes that would benefit most from information and support	September - December 2018	Public Health	
1c	Restrictions on advertising of high sugar foods to children	1. Develop a check list for organisations to follow. 2. Restrict food adverts on bus shelters locally and any advertising space within statutory	Reduced exposure to advertising reducing demand from parents	January – March 2019	Transport and Planning Team Darlington Borough Council Darlington CCG	Within existing Resource

	Key Areas of Action	Desired Outputs	Expected Outcomes	Timeline	Co-ordinators/ Leads	Funding Position
		authority control.			CDDFT NHS Foundation Trust	
1d	Support levy of Sugar Sweetened Beverages	Identified retailers supported with information to stock alternative drinks Reduce sugar consumption within soft drinks	Reduce sugar intake & therefore calories intake Improve oral health in children	January – March 2019	Public Health	Within existing resources
1e	Making healthy options available in the public sector	Local Authority to adopt the GBSF standards Promotion of standards to public organisations.	All statutory body premises will receive standards & be encouraged to adopt.	September 2018	Public Health	Within existing resources
1f	Develop licencing conditions to reduce the number fast food catering establishments local to schools.	Audit through food mapping Approved licence conditions	Prevent further new premises from opening	September - December 2018	Darlington Borough Council Licensing and Planning Department	Within Existing Resource
1g	Support the availability of green space across Darlington for play and recreational use	Support and promote the objectives of the Darlington Green Infrastructure Strategy.		January 2019	Darlington Borough Council Planning Department Healthy New	Within Existing Resource

	Key Areas of Action	Desired Outputs	Expected Outcomes	Timeline	Co-ordinators/ Leads	Funding Position
					Towns Project	

	Key areas of Action	Desired Outputs	Expected Outcomes	Timeline	Co-ordinators /Leads	Funding Position
2a	Using the Change 4 Life Programme of communication and activities to engage and encourage families to make healthier choices.	Consistent, complementary healthy lifestyle promotion campaigns across the town. Maintenance & development of Healthy Darlington brand Promotion of Sugar Smart App and 2 100kcal snack per day message	Consistent messages promoting healthier choices across all media throughout the town.	To commence July 2018 with quarterly review	Communications and Public Heath Team of DBC 0- 19 service Communications Teams of partner organisations Healthwatch	Within existing resources
2b	Deliver an awareness raising campaign	Highlight the benefits of leading a healthy lifestyle in an engaging way to children, young people and families.	Link with Darlington College art students.	Commence in July 2018 with launch of plan in childhood obesity week	Public Health Darlington College DBC Communications	
2c	Develop and support children to enjoy an hour of physical activity every day	Improving the co-ordination of quality sport and physical activity programmes	More children will be physically active School Games	January - July 2019	Move More Team Dolphin Centre	Move More contract Potential Sport

	Key areas of Action	Desired Outputs	Expected Outcomes	Timeline	Co-ordinators /Leads	Funding Position
		for schools Promotion of new interactive tool which will help schools plan for at least 30 min PA/day Walk and cycle to school schemes	School swimming Holiday Programme		DBC Travel Team	England funding
2d	Support the new healthy rating scheme for primary schools	Inform appropriate colleagues of the content and purpose of the scheme	Darlington primary schools will adopt the scheme	September 2018	HDFT Public Health Primary Schools	Within Existing Resource
2e	Making School Food Healthier	All schools to commit to the new School Food Standards (2015)	Awareness of national School Food Plan Maintain and increase breakfast clubs	January 2019	PSHE Lead Schools Public Health	Within Existing Resource
2f	Supporting individuals to make use of nationally regulated information such as Front of Pack labelling.	Use e-learning opportunities. Promotion of Sugar Smart App Incorporate into any	Increased knowledge of individuals Healthier choices made sustainably	September 2019	Developing Darlington	Within existing resources

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	Key areas of Action	Desired Outputs	Expected Outcomes	Timeline	Co-ordinators /Leads	Funding Position
		relevant training				
2g	Supporting Early Settings	Promote government guidelines for early years settings Promote Chief Medical Officers Guidelines for Physical activity in Early Years	Adoption and implementation of settings and guidelines by early years settings. Healthy Start Scheme uptake increase	September 2019		
2h	Ensure all early years services include advice about oral health in information provided on health.	A resource including a list of key messages around oral health according to PHE guidance	Reductions in children tooth decay levels Increased numbers of children accessing NHS dental services	September 2018	Public health Team Early years, DBC 0-19 provider Health Education England	within the existing envelope of funding

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	Key areas of Action	Desired Outputs	Expected Outcomes	Timeline	Co-ordinators/ lead	Funding Position
3a	Enabling early years staff to support families	Early Years staff feel confident discussing nutrition, weight and neglect with children, their families and adults. Consistent healthy weaning advice	Making Every Contact Count resources and training are accessed. Obesity and nutrition modules are accessed by NHS staff via the E-learning for Health platform.	September 2019	Harrogate & District Foundation Trust Public Health	Within Existing resource
3b	Inform on the adoption of the national programme to reduce sugar content of everyday foods by 20%	Letters of expectations to relevant organisations	Reduction of high levels of sugars in foods	January 2019	Public Health England Public Health	Within existing resource
3c	Inform on the national agenda to include saturated fat content of everyday foods.	Letters of expectations to relevant organisations	Reduction of high levels of saturated fat in foods	January 2019	Public Health England Public Health	Within existing resource
3d	Increase rates of Breast Feeding	Consistent breast feeding advice		September 2019	Harrogate & District Foundation Trust NHS Services	Within existing resource

	Key areas of Action	Desired Outputs	Expected Outcomes	Timeline	Co-ordinators/ lead	Funding Position
3e	Improve Maternal Health Ensure access to appropriate physical activity opportunities	Healthy weight Healthy diet Physically active	Brief interventions Low physical impact activities will be available	September 2019		Within existing resource
3f	Ensure frontline health and social care staff working with children and young people give advice on the importance of oral health.	Increased knowledge on oral health among front line professionals working with vulnerable C&YP	Improved oral health for vulnerable groups Increase in access to primary NHS dental services	September 2019	Health Education England Public Health team, DBC PHE Social care	Within existing Resource

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Darlington Oral Health Plan

2017-2022

DARLINGTON
A MOST INGENIOUS TOWN

DARLINGTON BOROUGH COUNCIL

Contents

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Vision

The vision is for the population in Darlington to have good oral health. This will be achieved by integrating oral health in other relevant plans and reducing oral health inequalities. Our focus is on children, young people and older people in residential care homes.

Aim

To improve oral health and reduce inequalities of children, young people and older people in residential and nursing care homes in Darlington by identifying priority actions, developing recommendations and key plans.

Objectives

- Review routinely available epidemiological evidence on dental disease in children and that in older people residing in care in Darlington.
- Support the 0-19 Healthy Children provider to integrate oral health in prevention and early intervention programmes
- Support commissioners in the local authority to incorporate oral health in contracts with care homes.
- To enable and support a Making Every Contact Count (MECC) approach for health and social care staff to make use of opportunities to provide advice on oral health and signposting to dental services when necessary.

1. Key Messages

- Tooth decay is a predominantly preventable disease. A healthy diet and good oral hygiene are the best preventative measures in tackling dental decay.
- There is a significant association between tooth decay and socioeconomic deprivation[1].
- Oral health interventions that support and encourage the use of fluoride have been found to be among the most cost-effective in reducing dental decay.
- The evidence for community water fluoridation sits towards the top of the hierarchy of evidence in terms of quality, design and rigour. The evidence includes a large proportion of systematic and other substantive reviews. The common finding is that levels of tooth decay are lower in fluoridated areas and, for reviews which looked at general health effects, that there is no credible scientific evidence that water fluoridation is harmful to health.
- By the time they start school, more than a third of children have several decayed teeth[2].
- Children who are Looked After (LAC) are entitled to a specific assessment of their oral health and have an action plan to address any deficits and promote their dental health as part of the statutory health assessments for children in care.
- There has been no measurable improvement in prevalence of tooth decay experience in five-year-old children in Darlington over the past few years, a trend not always observed in the region or nationally (proportion % of 5 year old free from dental decay[3]).
- Darlington has a mortality rate of oral cancers (age standardised per 100,000) that is significantly higher than the national, regional and other local authorities in the North East[4]. This is most likely linked to late diagnosis as well as lifestyle behaviours and poverty.
- There is evidence that some older people living in residential and nursing care homes have untreated oral disease and more poorly fitted dentures[5].
- There is strong evidence linking poor oral health and malnutrition to aspiration pneumonia in frail older people[6].
- An ageing population, especially the most vulnerable with dementia residing in care homes poses significant challenges to oral health care provision.
- Local authorities have a statutory requirement to assess their local population's oral health needs and commission oral health improvement programmes to meet that need[7].

1. PHE 2015 (d): Public Health England (PHE). North Yorkshire and Humber oral health needs assessment 2015. Published: September 2015. PHE publications gateway number: 2015317. Available through: www.gov.uk/government/uploads/system/uploads/attachment_data/file/463063/North_Yorks___Humber_oral_health_needs_assessment.pdf
2. Public Health England (PHE). Dental Health Profile in Darlington. July 2017. http://www.nwph.net/dentalhealth/5yearoldprofiles/North%20East/2015/Darlington%20LA%20Dental%20Profile%205yr%202015.pdf
3. Dental epidemiology surveys (NHS Dental Epidemiology Programme for England, Oral Health Survey of 5 year old children 2007/08; 2011/12 & 2014/15).
4. Public Health Profiles: Oral cancer registrations 2013-2015. Public Health England: Available online at https://fingertips.phe.org.uk/search/oral%20health#page/3/gid/1/pat/6/par/E12000001/ati/102/are/E06000047/iid/1206/age/1/sex/4 (accessed 30 October 2017)
5. Moore, D and Davies G.M (2016) A summary of knowledge about the oral health of older people in England and Wales. Community Dental Health, Volume 33, pages 262-266
6. van der Maarel-Wierink CD, Vanobbergen JNO, Bronkhorst EM et al. Risk factors for aspiration pneumonia in frail older people: a systematic literature review. Journal of the American Medical Directors Association, 2011; 12: 344-354.
7. The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012 [Internet]. 2012. Available from: http://www.legislation.gov.uk/uksi/2012/3094/pdfs/uksi_20123094_en.pdf

2. Introduction

Oral disease is an important public health issue because of its impact on the individual and society, the cost of treatment and because it is largely preventable. Poor oral health shares common risk factors with a number of chronic diseases. Socioeconomic deprivation and high levels of sugar consumption are risk factors for both dental decay and obesity. This oral health plan has been developed in parallel to a children and young people healthy weight plan and local action on sugar.

In the last four decades the dental health of adults in England has improved. However, this overall improvement masks huge inequalities in the population. High risk and vulnerable groups include the socioeconomically deprived; institutionalised adults such as those in residential care or prison as well as those with disabilities and mental illness. Such groups still suffer from poor oral health and have variable access to dental care.

The plan focuses on a system wide approach and on an integrated partnership delivery to embed oral health improvement in different programmes and at a strategic level to achieve sustainable improvements. This plan identifies priority actions that are supported by a strong evidence base as described in the Public Health England/ Department of Health guidance "Delivering better oral health: an evidence-based toolkit for prevention"[8], and the National Institute for Health and Care Excellence (NICE) Public Health guidance (PH55) "Oral health: local authorities and partners"[9].

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8. PHE/DH (2017). Delivering better oral health: an evidence-based toolkit for prevention https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/605266/Delivering_better_oral_health.pdf
9. NICE (2014). Oral health: local authorities and partners . https://www.nice.org.uk/guidance/ph55

3. Oral Health in Children

Oral health is essential to general health and quality of life. Dental decay is one of the most common non-communicable childhood diseases, and it is largely preventable. A healthy diet and good oral hygiene are the best preventative measures in tackling dental decay.

Poor oral health can have detrimental consequences on children and young people's physical and psychological wellbeing. The effects of dental diseases on children and young people include school absence, pain, difficulties eating, and impaired nutrition and growth which all have a detrimental impact on a child's quality of life and overall health and wellbeing[10].

Nationally (England), in 2015-2016, extraction of teeth because of tooth decay was the most common reason for hospital admission for children aged 5 to 9 years-old and the sixth most common procedure in hospital for children aged 4 years and under[11]. Usually a general anaesthetic is required for extraction of multiple teeth.

Oral health interventions that support and encourage the use of fluoride have been found to be among the most cost-effective in reducing dental decay.

Examples of such interventions include the use of fluoride toothpaste, the provision of toothbrushes or the use of fluoride varnish.

PHE estimates that after 5 years, the Return on Investment (ROI) for targeted supervised tooth brushing is £3.06 for every £1 spent. After 10 years, this increases to £3.66 for every £1 spent. After 5 years, targeted supervised tooth brushing can result in an extra 2,666 school days gained per 5,000 children[12].

Groups who are at a high risk of dental disease include children and young people from low socio economic groups; Children and young people with special needs, including children and young people with learning difficulties; looked after children and young people; the Gypsy, Roma and traveller population and young offenders[13].

10. https://publichealthmatters.blog.gov.uk/2017/06/19/health-matters-tackling-child-dental-health-issues-at-a-local-level
11. Royal College of Surgeons (2015). Children hospitalised unnecessarily from tooth decay, experts warn – Royal College of Surgeons. https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/children-hospitalised-unnecessarily-from-tooth-decay
12. PHE, 2016. Improving the oral health of children: cost effective commissioning. https://www.gov.uk/government/publications/improving-the-oral-health-of-children-cost-effective-commissioning
13. https://www.gov.uk/government/publications/health-matters-child-dental-health/health-matters-child-dental-health

Health behaviours have been found to account for a modest proportion of the variance in the differences in oral health by socioeconomic position[14]. Focusing solely on individual behaviour change has only short term benefits for oral health. It is therefore essential to focus on the wider determinants of health and on a partnership delivery to achieve sustainable improvements in population oral health[15].

Following the implementation of the Health and Social Care Act 2012, responsibilities for oral health improvement and oral health promotion lie with the Local Authority.

As part of their statutory duties, local authorities have commissioning responsibilities to provide oral health promotion programmes, undertake oral health surveillance and surveys and fund running costs of water fluoridation schemes where these exist. In areas, where there are no schemes of water fluoridation, a local authority should consider the implementation of water fluoridation.

14. Sanders AE, Spencer AJ, Slade GD. Evaluating the role of dental behaviour in oral health inequalities. Community Dental Oral Epidemiology. 2006 Feb;34(1):71-9
15. FDI World Dental Federation. The challenge of oral disease. A call for action. 2nd edition. 2015

4. Oral Health for Older People in

The plan includes oral health for older people in care homes in order to reflect national guidance taking into account the complex oral healthcare needs of older people living in care homes in Darlington. This is timely for the following reasons:

Older people are retaining their natural dentation for longer. Restorations such as multi-unit bridges and implants pose huge challenges for the frail elderly in residential care settings, especially those who cannot self-care and have to rely on others to maintain good oral hygiene and additional dental care for unrestored teeth.

Improved living conditions as well as medical care mean that older people are surviving multiple chronic illnesses and most likely will be on multiple medications. This has implications for oral health care provision as that may create more demand on specialist services as well as the need to take into account the side effects of certain medications when providing dental treatment (e.g. anticoagulant and antiplatelet medications). Additionally, the side effects of certain medications may also compromise oral health; for example causing dry mouth, (e.g. antidepressants and Alzheimer disease medications) or oral candidiasis (e.g. some inhalers for asthma)[16].

Similar to demographic trends observed in other North East local authority areas, Darlington has an increasingly ageing population. Predictions indicate that the 65+ population will increase by 38% by 2035 (from 21,100 in 2017 to 29,100 in 2035)[17].

The percentage increase in the total population aged 65 and over living in a care home with or without nursing in Darlington between 2017 and 2035 is 76.5% (n= 893 in 2017 to n=1,577). This is higher than the percent increase at a regional level (71.6%) but slightly less than that projected nationally in England during the same period (i.e. 78%)[18].

Nursing and residential care homes are expected to provide accommodation to an increasing and significant proportion of over 80 years old frail older people, especially those with dementia, multiple morbidities and highly restricted mobility.

16. Department of Health (2005) Meeting the challenges of oral health for older people: a strategic review. Gerodontology. 22, Supp 1, 3-48.
17. Projecting Older People Population Information (POPPI). Oxford Brookes University: Available at www.poppi.org.uk
18. Ibid (POPPI)

Residential Care

In Darlington, the percentage increase in people aged 65 and over predicted to have dementia between 2017 and 20135 is 68.7% (n= 1459 in 2017 increasing to n=2,461 in 2035[19]. Dementia makes providing oral healthcare quite challenging.

The challenges include the difficulties in communication; lack of capacity to consent and difficulties in maintaining cooperation to allow dental treatment or even tooth brushing. Other challenges include misplacing dentures.

There is evidence that older people living in residential and nursing care homes have more untreated oral disease and more poorly fitted dentures than peers who live elsewhere. A high proportion of older people living in care homes are often dependant on others for their diet, personal care and access to dental treatment. The diet in care homes usually comprises frequent use of sugars[20].

There are no "off-the-shelf" routine data to inform the epidemiological dental needs of the +65 or the vulnerable elderly living in residential and care homes.

19. Ibid (POPPI)
20. https://www.nice.org.uk/improving-oral-health-for-adults-in-care-homes

Appendix 1

Epidemiological Assessment of Need in Children and Young People

A commonly used indicator of tooth decay, the "dmft index", is obtained by calculating the average number of decayed (d), missing due to decay (m) and filled due to decay (f) teeth (t) in a population. In five-year-old children, this score will be for the first (primary) teeth and is recorded as dmft. In 12-year-old children it reports the adult teeth in upper case (DMFT). The average (mean) dmft/DMFT is a measure of the severity of tooth decay experience.

This measure can be used to assess individual oral health or that of a community. A child who has 5 teeth affected by dental disease will have a dmft of 5. A population of 100 children where 50 of them have one tooth affected by dental disease will have a population dmft of 0.5. However, the nature of the index means that a small number of children with a high level of dental disease can result in a misleading level within a community. It is often better to describe oral health need in a community by the proportion of children in a population free from dental disease[21].

The prevalence and severity of oral disease at age five can be used as a proxy indicator for the impact of early year's services and programmes to improve parenting, weaning and feeding of very young children[22].

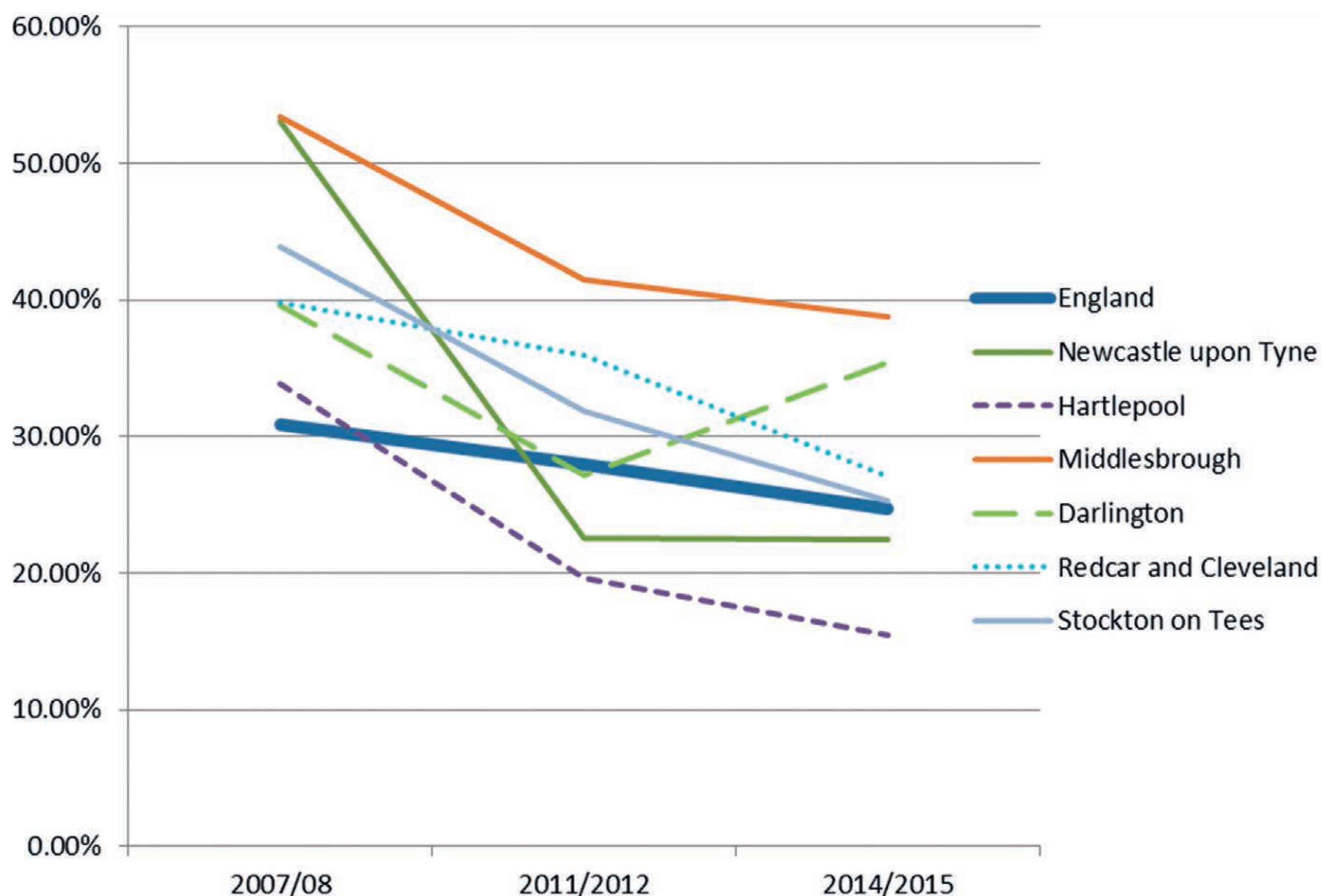
According to the 2015 national dental epidemiological survey of 5 year olds , the proportion of five-year-old children in Darlington who were free from visually obvious dental decay (d3mft = 0) was 64.6% . This was worse than that reported in the North East of England of 72% and that in England of 75.2%.

By the time they start school, more than a third of children in Darlington Borough have several decayed teeth. In 2015, 35.4% of 5 year olds in Darlington experienced dental decay with one or more teeth that were decayed to dentinal level, extracted or filled because of caries (% d3mft > 0). This prevalence is significantly higher than the regional and national prevalence of 28% and 24.7% respectively.

Although the overall trend for tooth decay in 5 year olds is one of reduction nationally, regionally and in most local areas, this has not been the case for this age group in Darlington. Not only did oral health PHO indicators for 5 year olds in Darlington lag behind those of children their age nationally and regionally, but data from PHE show a worsening trend for Darlington with a larger proportion of 5 year old experiencing dental decay in 2015 (% d3mft > 0 =35.4%) compared to 2012/13 (% d3mft > 0= 29.4%). The comparable trend in England has been one of improvement.

21. Source: Landes D. Five year old Dental Health Survey 2011/12 Locality supplement for Darlington Borough Council
22. PHE, 2015. http://fingertips.phe.org.uk/search/dental#page/6/gid/1/pat/6/par/E12000001/ati/102/are/E06000005/iid/92504/age/34/sex/4

Figure 1: Trend in percentage of 5 year olds with obvious decay experience in Darlington and other Tees Valley Local authorities (% d3mft >0)[23]



The proportion reduction in the prevalence of dental caries in 5 year olds in Darlington (2008 2015) was smaller than that observed in England and the smallest observed among most Tees Valley local authorities (see table 1). Darlington was the only LA in the Tees Valley that experienced an increase in the prevalence of dental caries among 5 year olds between 2012 and 2015.

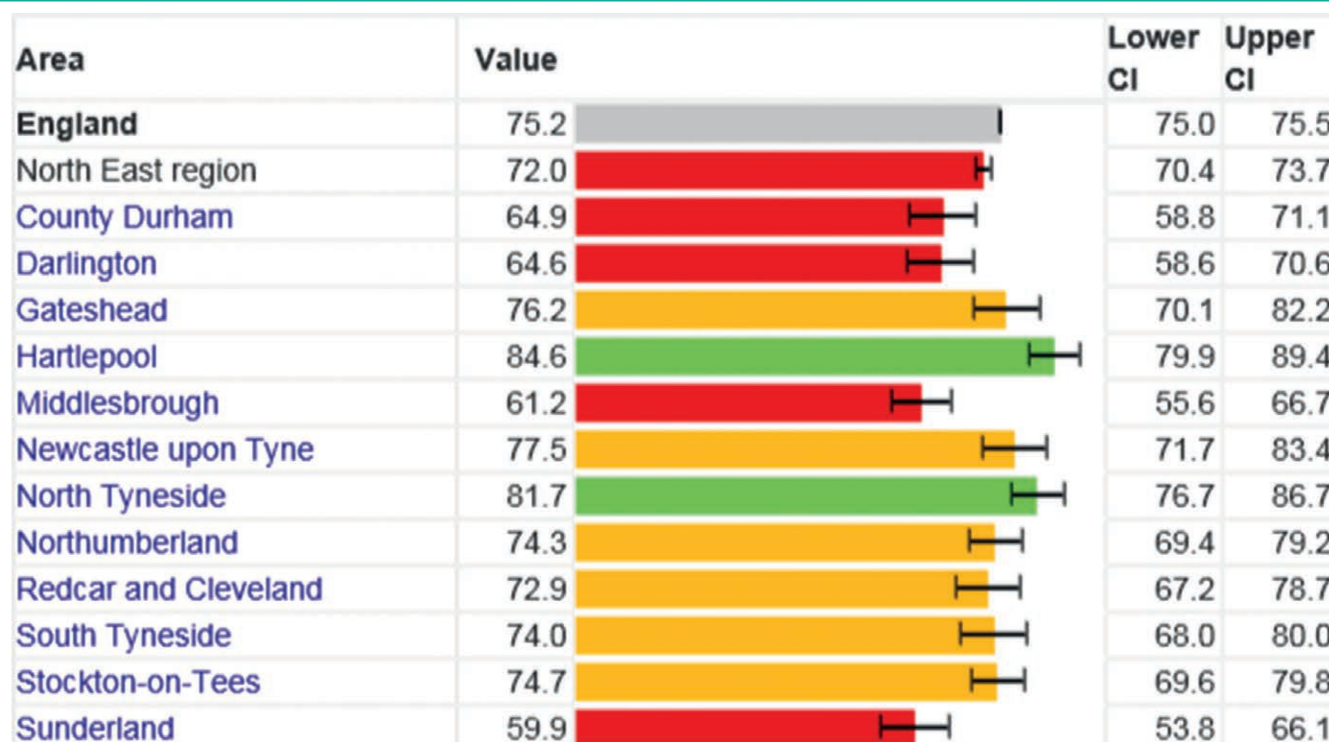
Table 1: Proportion of five year old children with dental decay in Darlington and other Tees Valley local authorities and percentage change between 2012-2015 and 2008 to 2015 (data source: NHS Dental Epidemiology Programme for England, Oral Health Surveys of 5 year old children 2007/08; 2011/12 & 2014/15) [24]

	2008/09	2011/2012	2014/2015	reduction in caries prevalence between 2012- 2015	reduction in caries prevalence between 2008- 2015
England	30.90%	27.90%	24.70%	3.20%	6.20%
Hartlepool	33.80%	19.60%	15.40%	4.20%	18.40%
Middlesbrough	53.40%	41.50%	38.80%	2.70%	14.60%
Darlington	39.60%	27.20%	35.40%	-8.20%	4.20%
Redcar and Cleveland	39.80%	35.90%	27.10%	8.80%	12.70%
Stockton-on-Tees	43.90%	31.90%	25.30%	6.60%	18.60%

23. Dental epidemiology surveys (NHS Dental Epidemiology Programme for England, Oral Health Survey of 5 year old children 2007/08; 2011/12 & 2014/15). (Acknowledgement: source of graph: Dr. Frederike Garb, Oral health needs assessment in Northumberland
24. www.nwph.net/dentalhealth

Variation is evident in the North East (see Figure 2). In 2015, the proportion of five year-old children in Darlington who were free from visually obvious dental decay (d3mft = 0) was better than that reported in Middlesbrough (61.2%) but worse than those reported in other Tees Valley local authorities (74.7% in Stockton on Tees and 72.9% in Redcar and Cleveland) and much worse than that reported in Hartlepool (84.6%). In the latter, exposure to fluoride in naturally fluoridated water is a key factor for the reported lower levels of dental decay.

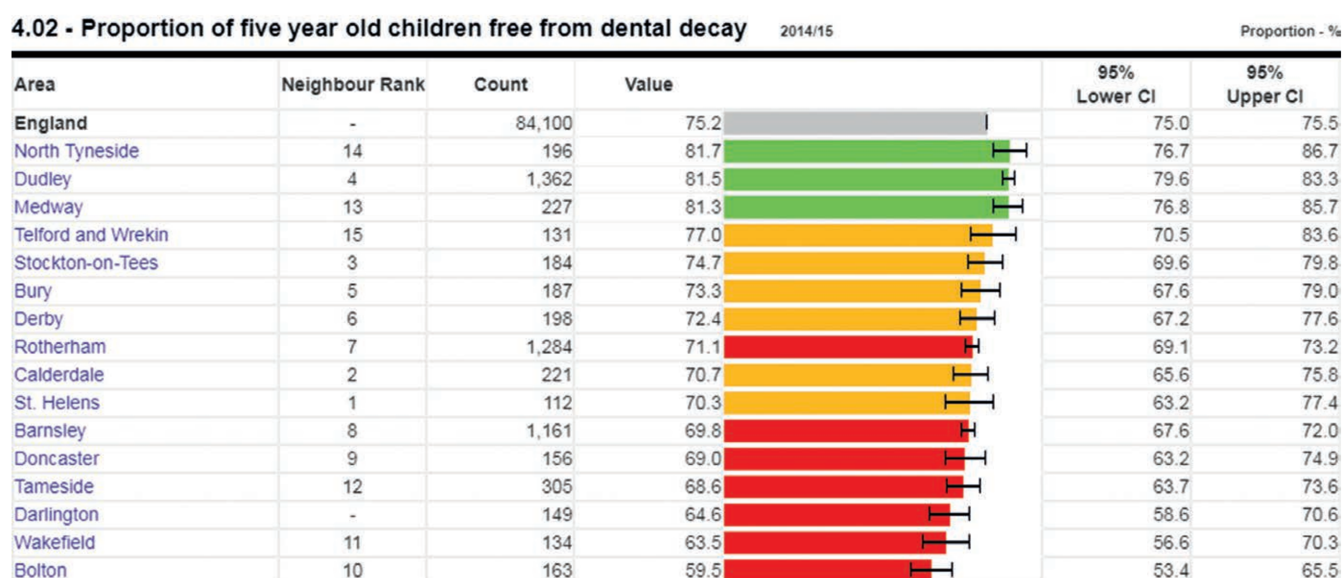
Figure 2: Proportion of five year old children free from dental decay 2014/15 (PHOF indicator 4.02)[25]



Area	Value	Lower CI	Upper CI
England	75.2	75.0	75.5
North East region	72.0	70.4	73.7
County Durham	64.9	58.8	71.1
Darlington	64.6	58.6	70.6
Gateshead	76.2	70.1	82.2
Hartlepool	84.6	79.9	89.4
Middlesbrough	61.2	55.6	66.7
Newcastle upon Tyne	77.5	71.7	83.4
North Tyneside	81.7	76.7	86.7
Northumberland	74.3	69.4	79.2
Redcar and Cleveland	72.9	67.2	78.7
South Tyneside	74.0	68.0	80.0
Stockton-on-Tees	74.7	69.6	79.8
Sunderland	59.9	53.8	66.1

Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children 2015

Figure 3: Proportion of five year old children free from dental decay (2014/15) - CIPFA nearest neighbours



4.02 - Proportion of five year old children free from dental decay 2014/15 Proportion - %

Area	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	-	84,100	75.2	75.0	75.5
North Tyneside	14	196	81.7	76.7	86.7
Dudley	4	1,362	81.5	79.6	83.3
Medway	13	227	81.3	76.8	85.7
Telford and Wrekin	15	131	77.0	70.5	83.6
Stockton-on-Tees	3	184	74.7	69.6	79.8
Bury	5	187	73.3	67.6	79.0
Derby	6	198	72.4	67.2	77.6
Rotherham	7	1,284	71.1	69.1	73.2
Calderdale	2	221	70.7	65.6	75.8
St. Helens	1	112	70.3	63.2	77.4
Barnsley	8	1,161	69.8	67.6	72.0
Doncaster	9	156	69.0	63.2	74.9
Tameside	12	305	68.6	63.7	73.6
Darlington	-	149	64.6	58.6	70.6
Wakefield	11	134	63.5	56.6	70.3
Bolton	10	163	59.5	53.4	65.5

Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children 2015

25. http://fingertips.phe.org.uk/search/dental#page/3/gid/1/pat/6/par/E12000001/ati/101/are/E06000005/iid/92500/age/32/sex/4

Figure 4: Trend in percentage of 5 year olds with obvious decay experience in Darlington and other Tees Valley Local authorities (% d3mft >0)[26]

Area	Value	Lower CI	Upper CI
England	0.84	0.83	0.85
North East region	-	-	-
County Durham	1.06	0.82	1.31
Darlington	1.21	0.90	1.51
Gateshead	0.65	0.45	0.86
Hartlepool	0.40	0.24	0.56
Middlesbrough	1.66	1.32	2.00
Newcastle upon Tyne	0.73	0.46	0.99
North Tyneside	0.54	0.36	0.71
Northumberland	0.74	0.56	0.92
Redcar and Cleveland	1.11	0.78	1.44
South Tyneside	0.70	0.49	0.92
Stockton-on-Tees	0.95	0.69	1.21
Sunderland	1.52	1.17	1.87

Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children 2015

The overall prevalence rates of dental decay in children aged 5 years old reported in Darlington mask inequalities.

The results from the Department of Health in England surveys of the oral health of 5 year old children in state schools in Darlington which were analysed by Dental Public Health in PHE in 2013 showed wide variations in mean DMFT (tooth decay) between children aged 5 years olds living in Darlington wards.

Table 2 gives examples of the average DMFT in various wards in Darlington and the proportion of children with tooth decay.

According to the table, the average dmft in 5 year olds in 2013 in electoral wards in Darlington varied between 0.1 and 2.7. This example is used to demonstrate the socioeconomic patterning of dental decay.

One has to note that these data need to be interpreted with caution because of the small numbers of children seen in each ward and the requirement for positive consent (opt in) may have introduced bias into the data and there have been changes in the boundaries of electoral wards since the original analysis.

26. https://fingertips.phe.org.uk/profile/oral-health/data#page/3/gid/1938133053/pat/6/par/E12000001/ati/101/are/E06000005/iid/92504/age/34/sex/4

Table 2: dmft for 5 year old children in selected electoral wards in Darlington Borough Council (source: PHE, 2013)[27]

Ward name	Children examined	Children selected	Proportion seen	dmft
Cockerton East Ward	38	56	68%	1.7
Cockerton West Ward	25	49	51%	1.9
Eastbourne Ward	53	84	63%	2.2
Harrowgate Hill Ward	50	72	69%	0.5
Haughton West Ward	49	69	71%	1.1
Heighington and Coniscliffe Ward	26	35	74%	0.4
Middleton St. George Ward	32	41	78%	0.6
Northgate Ward	32	57	56%	2.7
North Road Ward	36	69	52%	1.5
Park West Ward	26	36	72%	0.1
Pierremont Ward	26	40	65%	0.8

The percentage of children aged 5 years in Darlington with Sepsis present in 2015 (% Abscess/Sepsis) was 2.1% in Darlington compared to 1.4% in England and 2.2% in the North East[28].

The best oral health indicators seen in children and young people in Darlington are those for three year olds. The proportion of 3-year-old children with no obvious dental decay in 2012-2013 in Darlington was higher than that in England and the north east region and all other Tees Valley LAs, except Hartlepool for reasons mentioned above[29].

In England overall, among the surveyed 3- year olds, 12% had experienced dental decay. The children that had decay on average had 3.07 teeth decayed, missing or filled. The average number of decayed, missing or filled teeth (d3mft) across the whole sample population was 0.36 (PHE 2014)[30]

Figure 5: Proportion of 3-year-old children with no obvious dental decay 2012-2013 (data source: Dental Public Health Epidemiology Programme for England: oral health survey of three-year-old children 2013)[31]

Area	Value	Lower CI	Upper CI
England	88.4	88.1	88.7
North East region	90.0	88.8	91.1
County Durham	93.7	90.6	96.8
Darlington	93.8	90.7	97.0
Gateshead	86.3	81.7	90.8
Hartlepool	95.3	92.5	98.2
Middlesbrough	82.7	78.3	87.2
Newcastle upon Tyne	89.6	85.5	93.6
North Tyneside	96.0	93.2	98.7
Northumberland	90.3	86.4	94.3
Redcar and Cleveland	82.7	77.5	87.9
South Tyneside	94.9	92.0	97.8
Stockton-on-Tees	92.7	88.8	96.5
Sunderland	81.6	76.2	87.0

Source: Dental Public Health Epidemiology Programme for England: oral health survey of three-year-old children 2013

27. Source: Landes D. Five year old Dental Health Survey 2011/12 Locality supplement for Darlington Borough Council (in wards where less than 15 children were examined the data has been suppressed, wards are white).
28. http://www.nwph.net/dentalhealth/5yearProfiles.aspx
29. https://fingertips.phe.org.uk/profile/oral-health/data#page/3/gid/1938133053/pat/6/par/E12000001/ati/101/are/E06000005/iid/92500/age/32/sex/4
30. https://fingertips.phe.org.uk/profile/oral-health/data#page/3/gid/1938133053/pat/6/par/E12000001/ati/101/are/E06000005/iid/92500/age/32/sex/4
31. https://fingertips.phe.org.uk/profile/oral-health/data#page/3/gid/1938133053/pat/6/par/E12000001/ati/101/are/E06000005/iid/92500/age/32/sex/4

The prevalence of tooth decay in 12 year olds in Darlington is 46.8%, significantly higher than the national average. For those 12 year old children with tooth decay, on average, each child had 1.19 teeth affected, significantly higher than the national figure.

Figure 6: Proportion of twelve year olds free from dental decay 2008/09

Area	Value	Lower CI	Upper CI
England	66.4	66.1	66.7
Dudley	72.7	67.6	77.9
Medway	67.8	62.0	73.6
Derby	61.9	57.9	66.0
Telford and Wrekin	61.8	55.7	67.8
Bolton	61.3	56.0	66.6
Wakefield	59.9	54.5	65.3
Tameside	58.6	52.2	64.9
St. Helens	58.1	55.3	60.8
Bury	57.5	51.6	63.3
Barnsley	57.0	51.9	62.1
North Tyneside	56.5	50.6	62.4
Calderdale	55.7	49.6	61.8
Rotherham	55.4	49.5	61.4
Stockton-on-Tees	55.4	49.8	61.0
Darlington	53.2	44.1	62.4
Doncaster	46.0	40.8	51.3

Source: Dental Public Health Epidemiology Programme for England: oral health survey of twelve-year-old children 2009

Figure 7: Average number of decayed, missing or filled teeth (dmft) in twelve year olds DMFT in twelve year olds 2009 CIPFA

Area	Value	Lower CI	Upper CI
England	0.74	0.73	0.75
North East region	-	-	-
County Durham	1.03	0.85	1.21
Darlington	1.19	0.87	1.50
Gateshead	0.64	0.58	0.70
Hartlepool	0.55	0.43	0.67
Middlesbrough	1.10	0.91	1.29
Newcastle upon Tyne	0.82	0.72	0.92
North Tyneside	0.95	0.77	1.12
Northumberland	1.20	0.98	1.42
Redcar and Cleveland	1.17	0.89	1.45
South Tyneside	0.87	0.78	0.96
Stockton-on-Tees	0.96	0.81	1.11
Sunderland	1.10	1.02	1.17

Source: Dental Public Health Epidemiology Programme for England: oral health survey of twelve-year-old children 2009

Appendix 2

Findings on Oral Health from the Healthy Lifestyle Survey in Darlington (Primary and Secondary Schools)

The Primary Healthy Lifestyle Survey 2016/17 took place December 2016 to January 2017 with 15 primary schools in Darlington submitting survey responses. 1,343 number of pupils in year 5 and 6 completed at least part of the survey. Four questions in this survey relate to oral health.

The key findings include

- 38.85% of respondents in years 5 and 6 reported consuming fizzy drinks daily
- Half of respondents eat sweets and chocolate daily
- 544 primary school respondents reported having had a tooth filling and 371 have had teeth removed
- 21% of respondents (n=1,195) reported visiting the dentist once a year, 39% reported visiting the dentist twice a year and 2.7% more than twice a year. 4% of respondents reported never visiting the dentist and 7% of respondents reported visiting a dentist only when they had toothache.
- A little over a third of respondents reported having experienced extraction of a tooth or teeth
- Out of the 1,195 primary school children who answered the question on how often they clean their teeth, 76.15% answered twice a day and a minority of 7% reported brushing their teeth weekly, sometimes or never.

Among secondary school respondents, 1960 of the 4057 pupils answered this question **How often do you go to the dentist?**

The findings show that 48% go to the dentist twice a year. 127 pupils (3%) have never visited the dentist. Also 1922 of 4057 pupils have had a tooth filling (47%), 581 have had a fluoride varnish (14%) and 1570 have had a tooth/teeth taken out (38%). 1356 pupils (33%) have had none of these.

Appendix 3

Epidemiological Assessment of Oral Health Need for Older People in Care Homes in Darlington

- There are no "off-the-shelf" routine data to inform the epidemiological dental needs of the +65 or the vulnerable elderly living in residential and care homes.
- More older people are retaining their natural teeth for longer and hence a larger number of older people in the North East will have a high number of heavily restored teeth
- Proportion of the population aged 65 and older in the North East who were edentulous and surveyed as part of the Adult Dental Health Survey 2009[32].

Table 3: Proportion of the population aged 65 and older in the North East who were edentulous (i.e. without teeth)

Age Band	% edentulous (i.e. without teeth)
65-74	19.7
75-84	44.4
85+	56.3

Oral Cancer

Oral cancer is an umbrella term that includes any cancer of the lip, tongue and rest of the oral cavity, but excludes cancers of the major salivary glands.[33] Oral cancer is not very common in the UK. However, over the last decade in the UK, oral cancer incidence rates have increased by 39%. The incidence is directly proportional to patient age, with half of new diagnoses annually being made in people aged over 65 years of age.

The lifetime risk of developing oral cancer also varies by sex with the risk in men in the UK being double that for women (1 in 75 for men, and 1 in 150 for women).[34] In Darlington the age standardised incidence of oral cancer is not significantly different from the national average (see Figure 9).

Oral cancer registration is viewed as a direct measure of smoking-related harm because a high proportion of these registrations are due to smoking.[35] Hence, interventions that result in a reduction in the prevalence of smoking would reduce the incidence of oral cancer.

32. Adult Dental Health Survey data, 2009. 2011, Health and Social Care Information Centre.
33. BDA 2010: Editors: Speight P, Warnakulasuriya, Ogden G. Early Detection and prevention of oral Cancer: A Management strategy for dental practice. BDA Occasional Paper. November 2010. ISBN 978-1-907923-00-5. (available online through: https://www.bda.org/dentists/policy-campaigns/public-health-science/public-health/Documents/early_detection_of_oral_cancer.pdf
34. Cancer Research UK website. Available online at http://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/oral-cancer/incidence#heading-One
35. PHE. Public Health Profiles. https://fingertips.phe.org.uk/search/oral%20health#page/6/gid/1/pat/6/par/E12000001/ati/102/are/E06000047/iid/1206/age/1/sex/4

The main risk factors associated with the development of oral cancers, are smoking or exposure to the smoke, drinking alcohol which together account for 75% of cases. Research also suggests that lower socio-economic status is a significant risk factor for oral cancer independent of lifestyle behaviours. People in more deprived areas are more likely to have oral cancer and more likely to have poorer outcomes. This is mainly related to irregular attendance at the dentist and hence delayed diagnosis.

Over the last decade in the UK (between 2003-2005 and 2012-2014), oral cancer mortality rates have increased by 20% for males and 19% for females).[36] Five year survival rates are 56%.[37] However, survival rates for oral cancers have been rising over the last two decades. According to figures published by Cancer Research UK, around 40% of those diagnosed with oropharyngeal cancers, 90% of those diagnosed with Lip cancer and 50% of those diagnosed with oral cavity cancer will survive for 5 years or more following diagnosis.[38] Mortality rates from oral cancer in the UK are projected to rise by 38% between 2014 and 2035.

Survival rates are generally closely linked to the stage of the cancer at the time of diagnosis, with higher 5 year survival rates observed at the early stages of diagnosis (stage 0,1 and 2) and lower survival rates observed in late stages (stage 3 and 4) of diagnosis. As seen in Figure 9, Darlington has a mortality rate of oral cancers (age standardised per 100,000) that is significantly higher than the national, regional and other local authorities in the North East. This is most likely linked to late diagnosis.

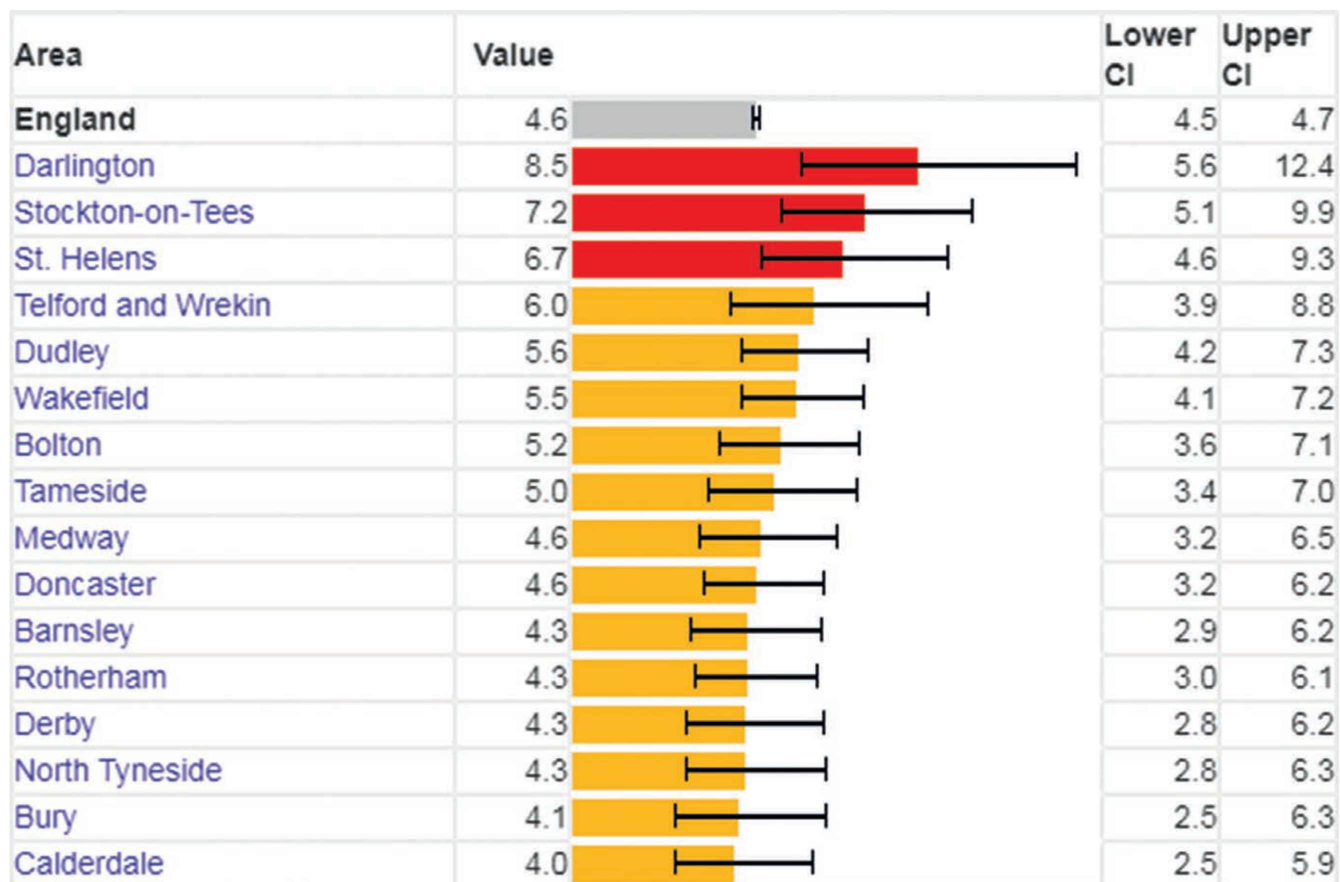
Figure 8: Oral cancer registrations- standardised rate per 100,000 population 2013-2015 (CIPFA)[39]

Area	Value	Lower CI	Upper CI
England	14.5	14.3	14.7
St. Helens	18.5	15.0	22.5
Tameside	18.0	14.8	21.6
Telford and Wrekin	17.9	14.2	22.2
Stockton-on-Tees	17.8	14.5	21.6
Bolton	17.8	14.9	21.0
Wakefield	17.1	14.6	19.9
Bury	17.0	13.7	20.8
Calderdale	16.5	13.4	20.1
Dudley	16.1	13.6	18.9
Darlington	15.6	11.5	20.6
North Tyneside	14.5	11.6	17.8
Rotherham	14.4	11.9	17.3
Doncaster	14.4	12.0	17.1
Derby	14.2	11.5	17.4
Medway	13.6	11.0	16.6
Barnsley	13.0	10.5	16.0

Source: PHE - National Cancer Registration and Analysis Service retrieved from the Cancer Analysis System (CAS)

36. Cancer Research Campaign. Cancer Statistics: Oral – UK. London: CRC, 2000.
37. PHE Health profiles. https://fingertips.phe.org.uk/search/oral%20health#page/6/gid/1/pat/6/par/E12000001/ati/102/are/E06000047/iid/92953/age/1/sex/4
38. http://www.cancerresearchuk.org/about-cancer/type/mouth-cancer/treatment/statistics-and-outlook-for-mouth-cancers
39. Public Health Profiles: Oral cancer registrations 2013-2015. Public Health England: Available online at https://fingertips.phe.org.uk/search/oral%20health#page/3/gid/1/pat/6/par/E12000001/ati/102/are/E06000047/iid/1206/age/1/sex/4 (accessed 30 October 2017)

Figure 9: Oral cancer mortality-directly age standardised per 100,000 population (CIPFA) 2014-16



Area	Value	Lower CI	Upper CI
England	4.6	4.5	4.7
Darlington	8.5	5.6	12.4
Stockton-on-Tees	7.2	5.1	9.9
St. Helens	6.7	4.6	9.3
Telford and Wrekin	6.0	3.9	8.8
Dudley	5.6	4.2	7.3
Wakefield	5.5	4.1	7.2
Bolton	5.2	3.6	7.1
Tameside	5.0	3.4	7.0
Medway	4.6	3.2	6.5
Doncaster	4.6	3.2	6.2
Barnsley	4.3	2.9	6.2
Rotherham	4.3	3.0	6.1
Derby	4.3	2.8	6.2
North Tyneside	4.3	2.8	6.3
Bury	4.1	2.5	6.3
Calderdale	4.0	2.5	5.9

Source: ONS mortality data

Appendix 4

Attendance at NHS Dentists

At a national level in England, the number of children seen by NHS dentist to the period until 31st December 2016 was 6.7 million (that equates to 57.8% of the children population). The parallel figure for adults is 22.2 million of adults nationally seen in the 24 months until 31st of December 2016 (i.e. 51.4% of the adult population in England).

These data reflect the number of patients who are seen 'regularly' but do not include children or adults seen privately which for children in Darlington is thought to be low.

Table 4: Patients seen by an NHS dentist as a percentage of the population, by local authority, in the period ending December 2016[40]

Local Authority	% of child (0-17) population seen in previous 12 months	% of adult (18+) population seen in previous 24 months
South Tyneside	81	83
Middlesbrough	71	68
Stockton-on-Tees	67	58
Newcastle upon Tyne	66	58
Darlington	65	61
Northumberland	63	56
North Tyneside	62	56
Redcar and Cleveland	61	61
Sunderland	56	53
County Durham	54	53
Hartlepool	54	60

40. NHS Digital (2017). NHS Dental Statistics for England - 2016-17, Second Quarterly Report, United Kingdom. Available from: http://www.content.digital.nhs.uk/catalogue/PUB23340

Appendix 5

Oral Health Action plan for Darlington

No	Key Area of Action	Desired Outputs	Expected Outcomes	Milestones	Responsibilities	Funding Position
1. Build healthy public policy						
1a	Develop an evidence based plan of action to improve oral health in Darlington and reduce health inequalities	An oral health action plan endorsed by executive committees in Darlington Borough Council and shared with Health and Well Being Board partners	Improvement of oral health, reduction of dental decay in children and young people in Darlington and integration of oral health in contracts with commissioners	Launch/share plan in April 2018	Public Health Team	Within existing Resource
1b	Integrate and streamline recommendations in the oral health plan with those in the healthy weight action plan for children and young people.	A key focus on sugar reduction as part of an integrated oral health and healthy weight action plan for children and young people in the Borough.	1) Decline in tooth decay levels among five-year-olds 2) Reduction in exposure to sugar in children diet Improved offer of information, advice and support to families, parents, carers with respect to reducing sugar in children's diets. 3) Improved access to information to support professionals in contributing to reducing sugar in children's diets (to measure impact of interventions to reduce exposure to sugar, tackle overweight and obesity and improve oral health).	Long term outcome Information prepared in June 2018	Public Health Team Early Years Practitioners including Health and Early Help, Early Years and Education Providers including: • 0-19 service • Early Years settings • School catering	Within existing Resource

No	Key Area of Action	Desired Outputs	Expected Outcomes	Milestones	Responsibilities	Funding Position
2. Create supportive environments						
2a	Maximise the opportunities in the Healthy Child Programme for the Health Visitors and School Nurses to deliver evidence based interventions to promote oral and dental health at every contact. Support parents to access primary dental care services for routine preventive care and advice for their children. Promote and provide healthy eating through application of existing guidelines and interventions particularly those around sugar reduction.	A resource guide has been developed alongside the oral health plan. It summarises evidence based messages and signpost to services and resources for oral health promotion in early year settings.	Reductions in children tooth decay levels Increased numbers of children accessing NHS dental services	June 2018 Review 2019	0-19 Health Child Service (HDFT) And Early Years partners	Within the existing envelope of funding
2b	Ensure oral health to be part of care plans for older people in care homes and uptake of oral health training by care staff.	A resource including a list of key evidence based messages around oral health promotion for older people in care home	Oral health assessments and mouth care plans for older residents of care homes included as part of contractual responsibilities	May 2018	Commissioners and contract team in adult and social care Care home managers Health Education England	Within the existing envelope of funding

No	Key Area of Action	Desired Outputs	Expected Outcomes	Milestones	Responsibilities	Funding Position
3. Strengthen community action						
3a	Use social marketing methods to promote oral health messages within a range of settings. Promote Smile Week	Develop a range of messages including for dissemination through social media that promote key elements of Oral and Dental Health promotion with communications team	Increased knowledge of parents/carers regarding the appropriate evidence based oral health messages	Work with minimum three community settings	Public Health Communications Team	

No	Key Area of Action	Desired Outputs	Expected Outcomes	Milestones	Responsibilities	Funding Position
4. Develop Personal Skills						
4a	Use the PHE guidance “Delivering better oral health” Early Years settings including advice about oral health in routine contacts and information around health, wellbeing, sugary snacks and drinks, diet, nutrition and parenting.	Key messages based on the PHE guidance Delivering better oral health delivered by early years staff during all contacts, interventions and in information provided in early years settings activities around health, wellbeing, diet, nutrition and parenting	Early Years staff more aware and confident in providing oral health and dental health messages. Improved awareness in parents and families about oral health and dental health. Improved oral health for vulnerable groups Increase in access to primary NHS dental services	May 2018	Public Health England Early Years Settings Early Help Team Public Health Team 0-19 service	Within existing Resource

No	Key Area of Action	Desired Outputs	Expected Outcomes	Milestones	Responsibilities	Funding Position
4b	Provide advice on breastfeeding and infant feeding practices in line with PHE guidance, Delivering better oral health	Midwifery Booking and Post natal information and support by Midwifery and all mandated visits by the Health Visitor as part of the HCP in Darlington	Positive Feedback from parents regarding breastfeeding and infant feeding.	Review June 2018	Public Health Team Midwifery Service CDDFT CCG Commissioners 0-19 service CDDFT Midwifery Services	Within existing Resource
4c	HLS self reported behaviour surveys specific questions regarding knowledge, attitudes and behaviours around dental and oral health to be included in the Healthy Lifestyle Survey for Darlington		Trend information available to inform planning services	December 2018 Review December 2019	Education and Public Health	
4d	Ensure that care home staff access available training on oral health for older people in care homes.	Identify high quality training that is available nationally, regionally and locally. Include requirement for training in Oral Health for older people as part of contractual responsibilities for Care Homes in Darlington.	Increased knowledge and improved practice in care staff in care homes. Increased numbers of Care Staff with evidence of training in Oral Health Promotion relevant to their clients. Oral and dental health included in Care Plans for residents	February 2019	Public Health Team NHS England Local Authority Commissioners CCG commissioners Care Home providers	Within existing Resource

No	Key Area of Action	Desired Outputs	Expected Outcomes	Milestones	Responsibilities	Funding Position
5. Re-orient health care services toward prevention of illness and promotion of health						
5a	Work with dentists and other professional groups who are in contact with individuals from those communities most at risk from oral cancers to increase awareness about the risk factors.	Increased screening, delivery and sign posting of brief advice regarding smoking and alcohol.	Increased uptake of routine dental services in 'at risk' groups and communities. Reduction in high risk behaviours such as smoking and harmful alcohol consumption. Earlier detection and treatment or oral cancers. Long term, improved survival rate in those diagnosed and treated for oral cancer in Darlington	Review December 2019	Public Health Team PHE NHS England Health Education England Local Dental Committee CCG commissioners CDDFT Cancer Services. Primary Care	Within existing Resource

No	Key Area of Action	Desired Outputs	Expected Outcomes	Milestones	Responsibilities	Funding Position
5b	Integrate advice about oral health as part of routine information that is provided about diet, nutrition and parenting as part of health and wellbeing interventions and information that is provided to families and parents by all Early Years staff.	Identify key performance Indicator(s) to be included in the current 0-19 contract and service specifications around the provision of oral and dental health promotion as part of routine contacts during 0-5 years Integrated into Early Years settings assessments particularly new child assessments.	Changes in practice in all early years practitioners and settings Increased awareness of key messages and advice for families and parents around oral and dental health. Measurable improvement in coverage and exposure to this information and advice in parents. Evidence of a sustained reduction in the measure of tooth decay in 5 year old children Reduction in most severe tooth decay/Sepsis due to dental decay in children under 5 years.	June 2018	Public Health Team NHS England 0-19 service Early Years Providers DBC Head of Education (30 hours statutory provision)	Within existing Resource

No	Key Area of Action	Desired Outputs	Expected Outcomes	Milestones	Responsibilities	Funding Position
5c	Increase knowledge about oral health among front line professionals working with vulnerable C&YP and frail older people in care homes in Darlington	Frontline health and social care staff working with vulnerable children and young people as well as frail old people in care homes give consistent and evidence based advice on the importance of oral health.	Increased uptake of training in health and social care professionals Increased number of dental health checks in those children that are Looked After as part of the statutory Health Assessments. Improved oral health for vulnerable groups in future oral health epidemiological survey. Increase in numbers of older people residents are living in care homes who are receive domiciliary dental checks including for those with partial or complete dentures.	June 2018 and June 2019	Health Education England Public Health team, DBC Commissioners PHE Social care Care Home providers Local Dental Committee	Within existing Resource

Acknowledgements

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Dr. David Landes and Dr. Kamini Shah, Consultants in Dental Public Health at Public Health England Dr. Az Hyder, Chair of Burgess-Hyder Dental Group and Chair of the Local Dental Committee; Caroline Gregory, Practice Manager and Oral Health Educator at Burgess-Hyder Dental Group; Rachel Fitzsimons; Health Education England Yvonne Hall, DBC; Jeanette Crompton, DBC; Catherine Shaw, RESH Co-ordinator for DBC; Dr. Frederike Garb; author of the oral health strategy for Northumberland County Council; Dr. Jonathan Lewney, (author of the Oral Health Strategy for Newcastle City Council); Miriam Davidson, Director of Public Health, Ken Ross, Public Health Principal, Rachel Osbaldeston, Public Health Portfolio Lead, Zoe Foster, Analyst in the Public Health Team and Pauline Brown, Administrator, DBC.

For further information please contact public.health@darlington.gov.uk

Darlington

Oral Health Plan

2017-2022

DARLINGTON BOROUGH COUNCIL

ITEM NO. ....6................

CHILDREN AND YOUNG PEOPLE PUBLIC HEALTH OVERVIEW 2018

SUMMARY REPORT

Purpose of the Report

1. To provide Members and partners with an overview of the health promoting activities in relation to children and young people (CYP). The report describes local need and provides some examples of the plans to address the issues.

Summary

2. The report includes information on the Darlington Children and Young People's Profile 2018 **Appendix 1** and the Healthy Lifestyle Survey 2017 **Appendix 2** as means of assessing need. It is followed by information about the Darlington Childhood Healthy Weight Action Plan 2017 – 2022 **Appendix 3** and the Oral Health Plan 2017 – 2022 **Appendix 4**.

Recommendations

3. It is recommended that Members :-

   (a) Note the contents of the report including the activity and actions described.

   (b) Champion the positive Public Health messages in relation children and young people and families.

   (c) Continue the focus on improving outcomes and reducing health inequalities for children and young people in Darlington.

Miriam Davidson
Director of Public Health

Background Papers
No background papers were used in the preparation of this report
Author: Rachel Osbaldeston, Public Health Portfolio Lead Extension 6202

S17 Crime and Disorder	There are no implications arising from this report.
Health and Well Being	The report has recommendations to improve the health and wellbeing of children, young people and families in the borough.
Carbon Impact	There are no implications arising from this report.
Diversity	There are no implications arising from this report.
Wards Affected	All
Groups Affected	This impacts on all children specifically those in disadvantaged wards.
Budget and Policy Framework	There are no implications arising from this report.
Key Decision	No
Urgent Decision	No
One Darlington: Perfectly Placed	The report contributes to the delivery of the objectives of the One Darlington: Perfectly Placed Sustainable Community Strategy in a number of ways through the contribution to the outcome 'better start in life'.
Efficiency	There are no implications arising from this report.
Impact on Looked After Children and Care Leavers	This report impacts on all children across the borough.

MAIN REPORT

Darlington Child Health Profile 2018

4. In order to understand local need and plan services to improve the health and wellbeing of local children and young people the Darlington Child Health Profile is used as a resource. The 2018 profile reflects 2016/17 data (the most recent data) to provide a snap shot of child health in Darlington (Appendix 1). It enables comparisons over time and against the regional and England averages.

5. The profile shows that the health and wellbeing of children in Darlington is varied compared to the England average. 11 of the 32 reported indicators for Darlington are not significantly different when compared to England, 4 are significantly better, 11 are significantly worse. The remaining indicators are not able to be compared nationally.

6. The 11 indicators that are significantly worse than the England average continue to be mainly the high number of children admitted to hospital and is an ongoing priority for all partners.

7. There are some areas of improvement in the 2018 profile compared to previous years; the percentage of children aged 5 years with decayed, missing or filled teeth has decreased from 35.4% in 2017 profile (2015/16 data) to 26.4% (2016/17 data). Darlington is now significantly similar to the England average of 23.3%. However it is worse than one of our CIPFA nearest neighbours, Stockton-On-Tees, which is 20.6%.

8. The profile indicates childhood obesity as an area for improvement; 10.6% of children in Reception, (similar to England) and 22.5% of children in Year 6, (worse than England) are obese. The Darlington Childhood Healthy Weight Plan 2017 – 2022 (Appendix 3) aims to increase the percentage of children leaving primary school at a healthy weight.

Healthy Lifestyles Survey 2017

9. A further method of understanding local need is the Healthy Lifestyles Survey (HLS) which gathers and analyses information from children and young people in Darlington schools about their attitudes and behaviours across a range of health related topics. (A summary report is included as Appendix 2)

10. This information is used to inform strategic planning, service delivery and practice by the local authority, other partners and stakeholders including the NHS, Police, local schools and academies.

11. Schools and academies use this information to inform the curriculum for delivery in the next academic year.

12. The secondary pupils survey 2017 told us that:

    (a) The majority of pupils reported good emotional wellbeing.
    (b) 78% of pupils report feeling stressed, with schoolwork the main cause.
    (c) Pupils lead very active online lives with multiple social media accounts.
    (d) Just over two thirds of pupils have not experienced bullying in the last year.
    (e) Nearly 9 in 10 pupils in Years 9, 10 and 11 report that they are not sexually active.

13. From the primary pupils survey 2017 the headline messages were:

    (a) 96% have never tried smoking.
    (b) 36% play computer games that are age rated 16 or 18.
    (c) Over a quarter of primary pupils have had teeth removed.
    (d) 8 in 10 say they eat a balanced diet and most enjoy exercising.

14. The collective access to the different data sets provides an insight when designing local action plans. It has facilitated the understanding that Darlington has high levels of obesity in Year 6 (10 – 11 Years) age children but that children report an understanding what a healthy diet and exercise are and generally feel that they achieve this. This informed our approach to developing the Childhood Healthy Weight Plan.

Darlington Childhood Healthy Weight Plan 2017 - 2022

15. The Childhood Healthy Weight Plan 2017-2022 (Appendix 3) sets out a whole system approach to tackling childhood obesity and reducing inequalities by ensuring the healthy weight agenda is integrated in other relevant plans.

16. The plan aims to make the healthy choice the easy choice by tackling the environmental and physical barriers to a healthy lifestyle.

17. Although the main causes of obesity are poor diet and low levels of physical activity, environmental changes can have the most impact on reducing obesity.

18. An environment that promotes activity in travel and recreation and does not provide easy access to energy dense food can reduce obesity levels.

19. Tackling environmental issues requires a co-ordinated partnership approach from a wide variety of stakeholders to enable effective and sustainable environmental change. Actions are supported by planning and development, environmental health, licensing, leisure and culture departments.

20. Tackling the obesogenic environment is supported by the promotion of the healthy lifestyle message to reinforce the need for healthy behaviours as a means of prevention and treatment for those with excess weight. This includes a social media a campaign using posters designed by Darlington College students.

21. Transforming the environment, making healthier choices easier and supporting services to tackle excess weight are key actions to increase the number of children in Darlington leaving primary school with a healthy weight.

Darlington Oral Health Plan 2017 - 2022

22. The Childhood Healthy Weight Plan described above tackles sugar reduction and therefore complements the work in the Oral Health Plan 2017 – 2022 (Appendix 4) as a high sugar diet is a significant risk factor in dental decay.

23. Tooth decay is a predominantly preventable disease. A healthy diet and good oral hygiene are preventative measures in tackling dental decay. Over a third of children in Darlington aged 5 years old start school with the experience of dental decay.

24. There is a significant association between tooth decay and socioeconomic deprivation. Oral health interventions that support and encourage the use of fluoride have been found to be among the most cost-effective in reducing dental decay.

25. The plan proposes a ‘whole system approach’ to tackling dental decay, improving oral health and reducing inequalities. The plan is informed by routinely available epidemiological evidence on dental disease and is supported by evidence based guidance.

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CHILDREN AND YOUNG PEOPLE SCRUTINY
10 SEPTEMBER 2018

ITEM NO. ....7...............

DESIGNATED OFFICER ANNUAL REPORT

SUMMARY REPORT

Purpose of the Report

1. The purpose of this report is to update Members of the Children and Young People Scrutiny Committee on the progress and performance of the Designated Officer (DO) service, (previously known as the Local Authority Designated Officer (LADO) April 2017 to March 2018 and to highlight the required actions for April 2018 to March 2019.

Introduction/National Context

2. The framework for the management of allegations of abuse is set out in Working together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (2015) and Keeping Children Safe in Education: statutory guidance for school and colleges on safeguarding children and safer recruitment (2015).

3. In line with the guidance, the Designated Officer function is required to ensure that:

    (a) Advice and guidance is provided to partner agencies and staff.

    (b) Any allegation made against a person who works with children in either a paid or a voluntary capacity is investigated. The DO will facilitate and oversee this process to conclusion. The DO does not investigate. That is the role of the employer or if a criminal allegation, the Police.

    (c) DO meetings are effectively chaired and an agreed outcome of the investigation is established.

    (d) Allegations are appropriately managed by employers to protect not only the welfare of children but also staff.

    (e) Support actions are taken without delay to protect children.

    (f) All learning from DO enquiries is effectively disseminated.

4. All organisations within Darlington are required to have clear policies / procedures in place that outline how and what their organisation should do in the event that an allegation is made against an employee/volunteer who has contact with children.

These policies and procedures should be in line with Darlington Safeguarding Children Boards' procedures.

5. The criterion for a Designated Officer referral is when a person is alleged to have:-

   (a) Behaved in a way that has harmed or may harm a child.
   (b) Has possibly committed a criminal offence against or related to a child.
   (c) Behaved towards a child or children in a way that indicates that he or she would pose a risk of harm if they work regularly or closely with children.

6. The allegation can be in connection with employment / voluntary activity / work placement, regarding individual's own children or related to the community or private life of a partner / member of the family / household member.

Recommendations

7. It is recommended that:

   (a) The contents of the report and the work undertaken during 2017/18 and the priorities of the Designated Officer service for 2018/19 be noted.
   (b) That the annual report be agreed.
   (c) That the report be publicised on the DSCB website;
   (d) To consider how to promote the role of the DO within their own organisation.

Suzanne Joyner
Director of Children and Adult Services

Background Papers

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

Carol Glasper: Extension 6459

Appendix 1 Service Improvements & Developments 2017-2018
Appendix 2 DO Service Priority Plan 2018 / 19
Appendix 3 Definitions of allegation management outcomes
Appendix 4 Case studies
Appendix 5 Definitions of abuse

S17 Crime and Disorder	Nil Impact
Health and Well Being	Nil Impact
Carbon Impact	Nil Impact
Diversity	This report relates to any adult over the age of 18 and where an allegation of abuse and neglect has been made against them
Wards Affected	All wards are affected
Groups Affected	This report relates to any adult over the age of 18 and where an allegation of abuse and neglect has been made against them
Budget and Policy Framework	Nil Impact
Key Decision	No
Urgent Decision	No
One Darlington: Perfectly Placed	Nil Impact
Efficiency	Nil Impact
Impact on Looked After Children and Care Leavers	Nil Impact

MAIN REPORT

Local Arrangements

8. Darlington Borough Council has two Designated Officers 1FTE who are based with the Safeguarding Board's business unit, they also undertake the role of Development Officer supporting the work of the Boards. A key benefit of this arrangement has been the greater flexibility and improved accessibility of agencies to liaise with the DO, as either one or both are available on a daily basis. The post is an independent role within the authority, which ensures the DO remains impartial.

9. Clear arrangements are in place to ensure robust oversight and monitoring of the DO function. This is provided through regular supervision with the Head of Quality Assurance, to ensure that policies are applied consistently and fairly and that all cases are progressed in a timely manner.

10. During 2017/2018 consideration had been given to whether the Designated Officer role should be located within the Safeguarding Board's Business Unit structure. This issue should be resolved in 2018/19.

11. The considerable increase in referrals is due to the way in which notifications to the Designated Officer were recorded during 2017-2018. In previous years, all enquiries which did not meet the DO threshold were recorded as information only and not included in the statistics. This provided only a partial view of the level of work undertaken by the DO.

Cross Boundary Issues

12. Where a child from the Darlington Local Authority area makes an allegation in a setting or placement which is outside the Darlington Borough Council jurisdiction, the lead responsibility for action lies with the local authority for the area where the alleged abuse occurred.

13. In these circumstances, the Designated Officer and, where appropriate, the child's Social Worker, will liaise with the relevant local authority and agree a joint strategy.

14. Checks should be made as to whether there are any other children in the placement. If so, the child's Social Worker and manager must be informed, and the Designated Officer should consult them about the action required.

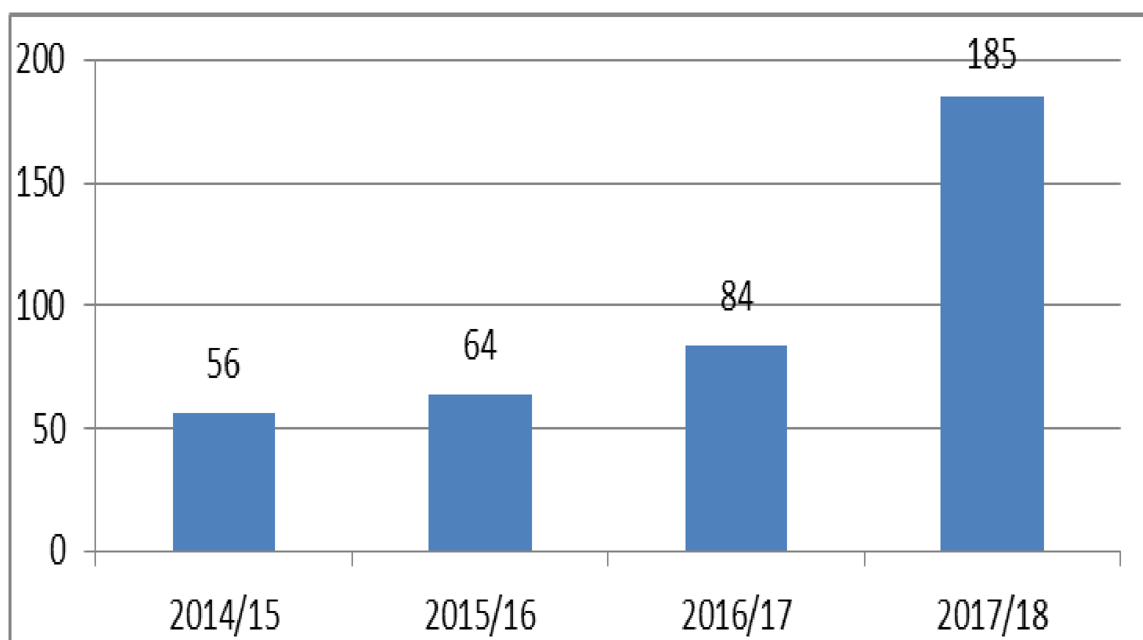
15. Interviews of children from Darlington Local Authority areas will usually be undertaken by their own local children's social care services in conjunction with the police as appropriate.

16. Where the referral relates to a child from another local authority, temporarily placed in an establishment located within the Darlington Local Authority area, the Designated Officer should liaise with the child's home authority about the roles and responsibilities in carrying out this procedure.

Referrals

17. In 2017-18, the Designated Officer service received a total of 185 enquiries, of which, 42 were determined to meet the DO threshold for an Initial Evaluation Meeting. This equates to 22.7% of all referrals. The remaining 143 enquiries did not meet the threshold for referral or strategy however, advice support and guidance was offered. During 2017-2018 all enquiries were recorded as a referral in order that the DO workload could be evaluated.

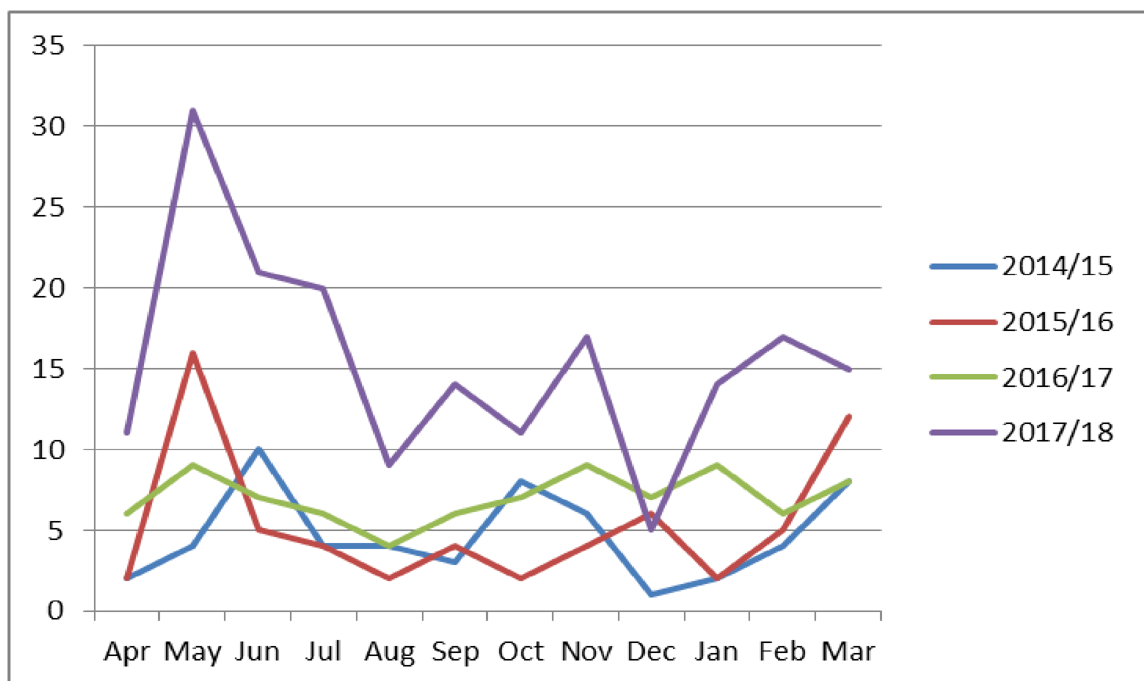
Chart 1 Number of referrals 2014 – 2018



18. Initial Evaluation Meetings take place when it is clear that information sharing would be beneficial between agencies involved e.g. Human Resources, Police, and Children's Services. This can be after a strategy meeting held by Children's Services or be a standalone meeting. In some circumstances it is appropriate to share information over the phone without the need for convening an Initial Evaluation meeting.

19. The figures in Chart 2 show that through May to July 2017, the referral rate increased. There were other smaller increases in November 2017 and February 2018. It should be noted that there had been DO briefings in May 2017 and October 2017, which may account for an increase in late May and November.

Chart 2 Annual Comparisons 2014-2018 Referrals by Month



20. As in previous years there was a downward trend in the rate of enquiries during some school holidays, evidenced in the months of August 2017, December 2017. However there is an anomaly in February 2018 when there was an unusual spike in referrals not previously seen. There were seventeen referrals in February 2018. There were nine referrals from a school setting but two related to issues within a staff member's private life and were for information only. The other were from a variety of other settings. There were Management Allegation briefings in February 2018 which may account for the rise in the referral rate.

Chart 3 Annual Comparison by Quarter 2014-2018

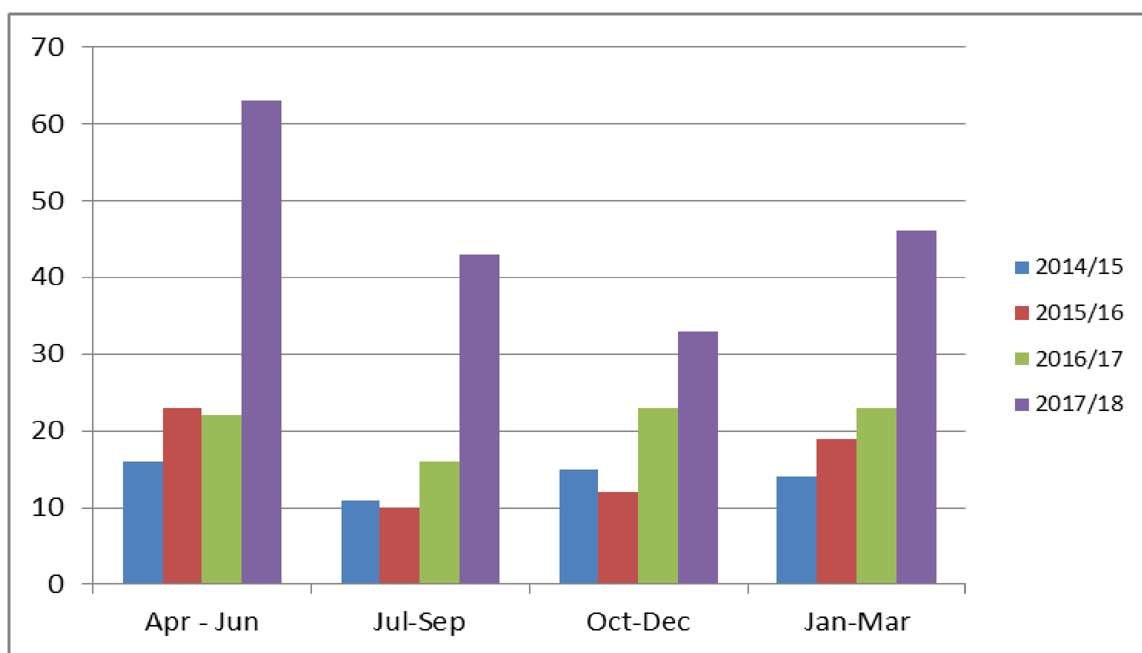


Table 3 Annual Comparisons 2014-2018 Referrals by Month

	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	TOTAL
2014/15	16	11	15	14	56
2015/16	23	10	12	19	64
2016/17	22	16	23	23	84
2017/18	63	43	33	46	**185**

Area of Concern

21. Of the 184 referrals accepted in 2017/18, the main category for referral was allegation of physical abuse. In 2017/18, 77 of accepted referrals were made under the category of physical abuse accounting for 42% of cases. This figure correlates with the presenting referrals from education, often involving physical restraints being used within educational settings i.e. Team Teach which is an approved management model for dealing with children and young people who are posing a risk to themselves or others.

22. As can be seen from chart 4 below, there has been an increase in referrals of allegations of sexual abuse from 7 in 2016/17 to 24 during 2017/18. The number of allegations re sexual abuse represents 13% of all cases referred. How Safe are our children 2016, reported that all parts of the UK have seen a national rise of child protection referrals for the category of sexual abuse. This increase is in line with the national rise and is suggestive of how professionals in Darlington are more aware of the incidents of sexual abuse, due to the ongoing face to face safeguarding training

provided by the Local Authority to multi-agency groups.

23. Although there has been an increase in referrals with regards to allegations of neglect, rising from no referrals in 2016/17 to 14 in 2017/18, the percentage of Neglect referrals remained at 8% of all referrals to DO. There is no clear reason for this rise but it may be due to a difference or better understanding of the term 'neglect'.

24. There has been an increase in the number of referrals with regards to allegations of emotional abuse, rising from 4 referrals in 2016/17 to 12 in 2017/18, however the proportion of referrals received is similar to the previous year. Emotional abuse referrals represent 7% of all referrals to DO.

25. Conduct accounted for 58 (31%) of the referrals in 2017-18. The use of conduct as an area of concern is not included in Working Together 2015, but is still widely used by Designated Officers. There is an on-going discussion regionally as to which Local Authorities are still using this category. The outcome and recommendations will be considered at the national quarterly DO meeting. The majority of referrals received relating to conduct, were in relation to physical interventions with young people.

26. The overall trend within the DO service is that a number of referrals continue to be of a complex nature and this often requires more than one strategy meeting. DO referrals predominately involve a Human Resources representative from the referring employer and Police involvement.

Chart 4 Allegations by Category 2017-2018

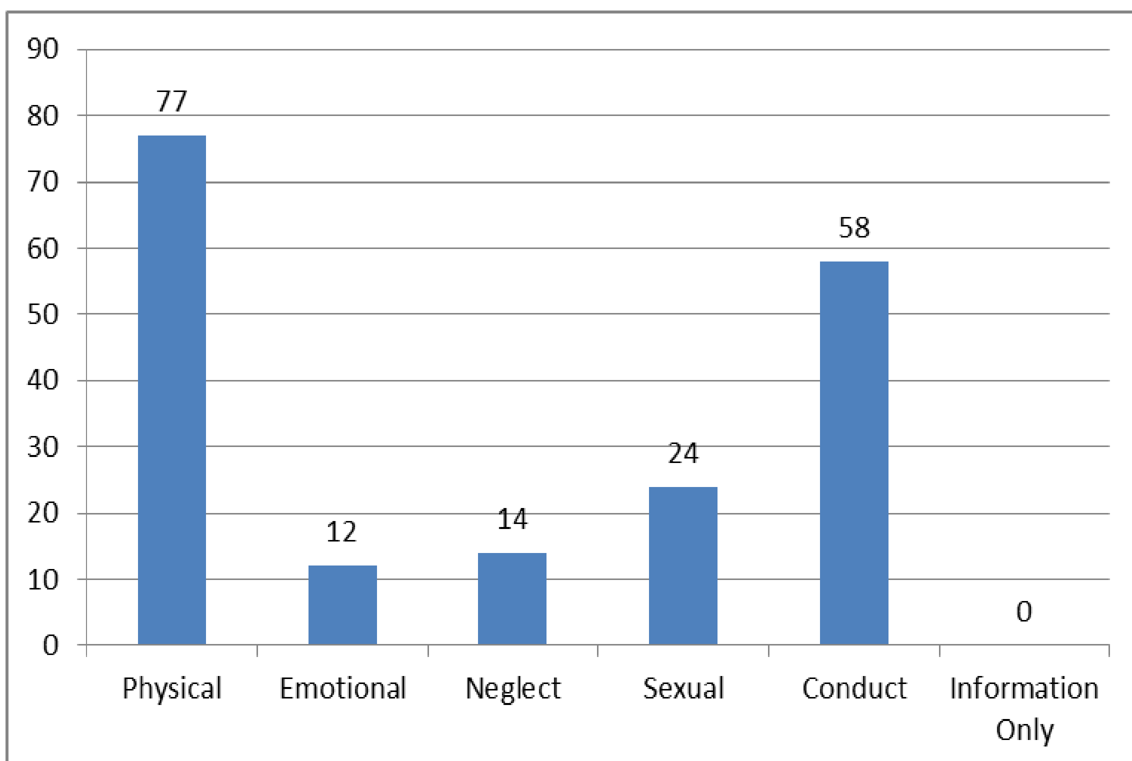


Table Allegations by Category comparison with last year

	Physical	Emotional	Neglect	Sexual	Conduct	Info only
2016/17	49%	5%	8%	0%	36%	2%
2017/18	42%	7%	8%	13%	31%	0%

Note: percentages may not add up to 100% due to rounding

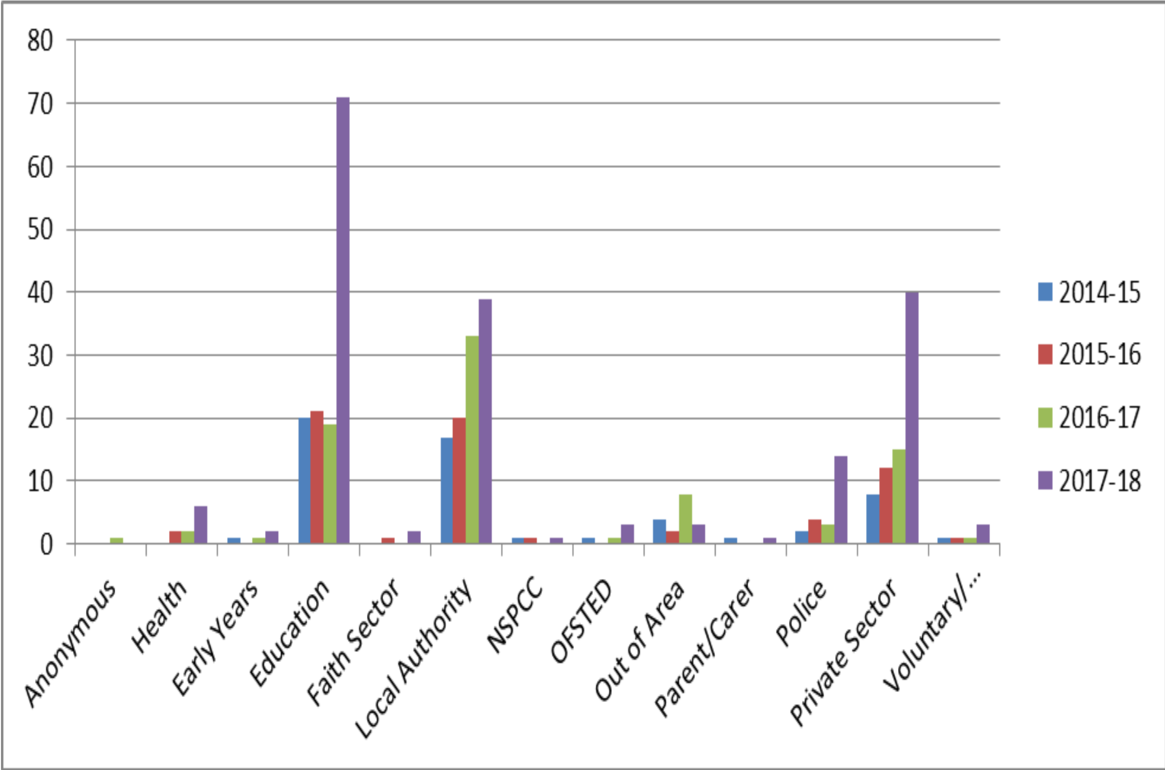
Source of Referrals by Profession / employment setting

27. As can be seen in Chart 5 Education settings in 2017/18 are the largest referring group, accounting for 71of 185 referrals. This therefore accounts for 38% of all referrals in 2017/18 when grouping all Educational settings together. At the point of writing this report, education is not broken down into settings other than early years being a standalone provision. A task for 2018/19 will be to separate the education referrals into the following categories; - primary, secondary, further education and special educational. A separate category will also be for schools attached to residential units. It would seem that most educational allegations arise from restraint or physical intervention by staff.

28. The Designated Officer continues to liaise with the North East Ecumenical Safeguarding Group, to ensure that interaction and engagement between the faiths continues to share an understanding of the safeguarding roles and responsibilities within each church and the cross border issues faced as well as to raise awareness of the DO role. It was agreed a booklet will be developed explaining the

safeguarding roles within each of the churches, along with the relevant safeguarding contact details. It is anticipated this will be on an annual basis to continue the engagement and increase awareness.

Chart 5 –Source of referrals



29. Referrals have continued to be received from a wide range of professions/settings. In this reporting year the 'other' category has seen an increase in its diversity and referral numbers to the DO Service. This would support a view that the active work undertaken by the DO Service with regards to the role of the DO, has led to an increased awareness within the different profession / settings. The referrals were received from a wide range of agencies these included; Child-minders; Scout Leaders; Police.

Allegations by Staff Group

30. Charts 6 and 6a illustrates the number of referrals made for the types of staffing groups across various settings. Some staffing groups are illustrated together for example; Local Authority Social Work and Residential staff. However there are on-going discussions on whether roles should be further distinguished to give a truer picture of the type of staff group allegations are being made against.

31. As would be expected, the largest number of allegations by staffing groups is that of education with 86 referrals being made which is 36% of all allegations.

32. The number of referrals regarding Independent Fostering Carers, saw an annual increase from 5 referrals in 2016/17 to 9 referrals for 2017/18. This is a rise in referrals for the second year in a row. There have been 4 referrals relating to Darlington Borough Council Foster Carers.

33. The Charts shows that referrals are made across a wide range of roles and settings, whether paid staff or volunteers as outlined in the national guidelines.

Chart 6 Allegations by staffing group 2014-2018

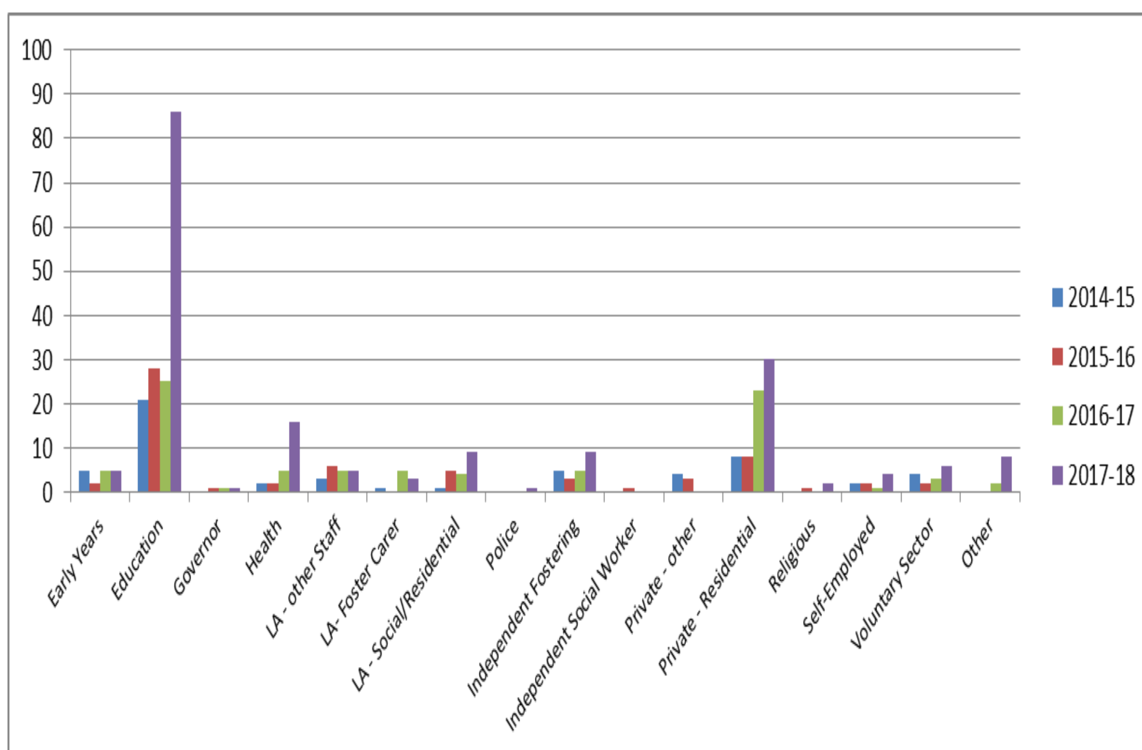
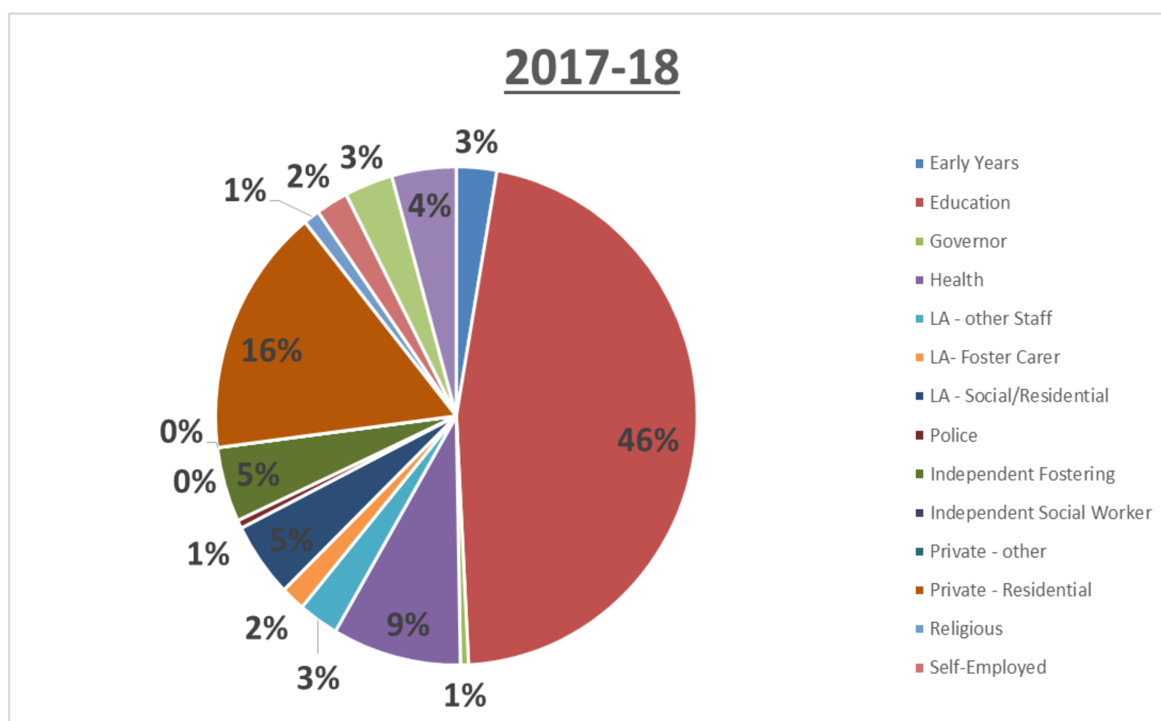


Chart 6a Allegations by staff groups 2017-2018



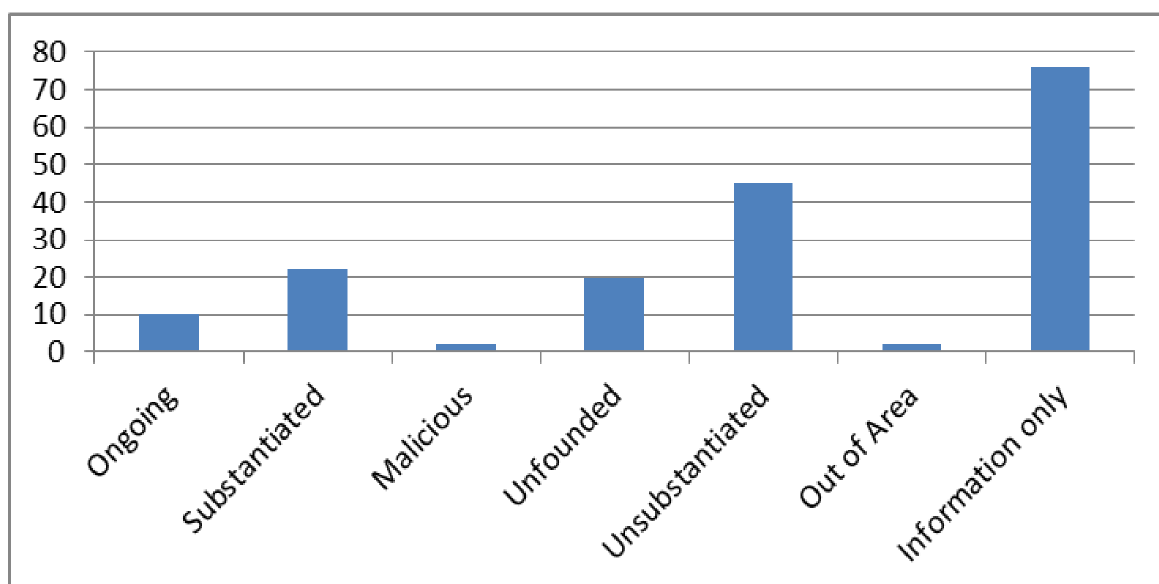
Outcomes of cases

34. In relation to the 21 (11%) cases where the allegations were substantiated, with action being taken against all of the staff in question. This led to 2 staff requiring additional training to effectively fulfil the duties of their post, 5 staff being dismissed, 2 resignations, 1 resignation with an agreed settlement; 5 disciplinary, 1 foster carer being de-registered and 5 staff being re-instated.

35. There were 49 (26%) unsubstantiated outcomes, leading to 2 dismissals; 3 receiving Management advice and further training ; 8 re-instated; 2 resigned; 34 no further action.

36. There were 21 (11%) cases unsubstantiated. 2 (1%) cases were recorded as out of area; 18 (10%) were ongoing and 76 (41%) were recorded as for information only.

Chart 8 Outcome of cases 2017-2018



Performance

37. The Designated Officer Service continues to work to the professional standards as set out in Working Together. The performance of the DO is measured and monitored through supervision between the Head of Quality Assurance & Practice Improvement and the DO.

38. The number of DO enquiries progressing to referral and Strategy leading to an Initial Evaluation meeting was 42 (23%).

39. Working Together 2010 set out expectations that:

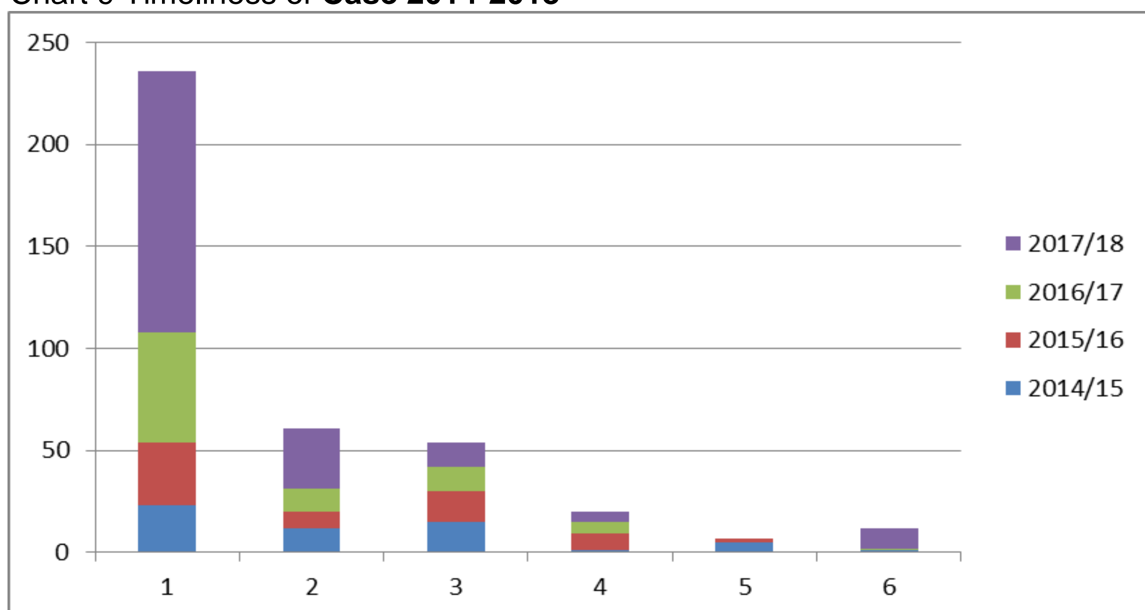
    (a) 80% of LADO cases are resolved within one month
    (b) 90% within three months

40. The number of Designated Officer cases resolved within 1 month as at end March 2018 was 128 which is 69% of total cases. This is an increase from 64% in 2016/17. However this is still below the accepted resolution of 80%. This is due to the complexity of cases including, on-going Police investigations and internal investigations where the alleged perpetrator may have declared themselves unfit for work and therefore, disciplinary action was delayed. . The total number of cases closed within 3 month is 160 which is just over 85%; less than 5% away from the expected total of 90%. Again this is due to on-going Police or internal investigations. There were 5 cases open longer than 6 month. There are 10 cases still active at the time of writing this report.

41. The Designated Officer Service in its attempt to seek a timely resolution to any referral, tracks all open cases on a 4 weekly basis to ensure that updates on

outcomes of investigations are received and to enable cases to be closed in a timely manner.

Chart 9 Timeliness of **Case 2014-2018**



Freedom of Information Requests

42. During 2017/18 the DO service has continued to take the lead on freedom of information requests with regards to allegations made about adults working with children. During the time frame of the annual report there were a total of 4 requests, 2 of which were from unknown applicants and 2 from the media. The requests were for information re non recent sexual abuse of looked after children; allegations of a sexual nature against staff in a looked after child's care home; allegations of sexual abuse within a boarding school setting and allegations of a sexual nature against staff within social services.

Service Improvements & Developments 2017/18

43. See Appendix 1.

DO Service Priorities and Plan 2018/19

44. In 2018/19 the Designated Officer plans to continue to promote awareness of the service across a range of professions, to ensure that appropriate referrals are submitted and to break down any barriers to agencies seeking the advice and support of the DO Service.

45. The Service also wants to improve the quality of the performance information gathered and to maximise the efficiency of the service through the use of

electronic recording systems.

46. The Service will have an active role in the development of Liquid Logic to ensure that Darlington Children's Services can improve data matching where appropriate.

47. The DO Service aims to be crucial to frontline practice to safeguard children in Darlington.

48. In 2018/19 the DO service has identified 9 key priorities (Appendix 1) which are pivotal to the on-going development of the service.

Service Improvements & Developments 2017/18

A number of actions were identified for development of the DO function during 2017-2018 which would further improve the performance of the service. The progress against these actions is highlighted below.

	Action	Lead	Timescale	Update
1	DO will continue to raise awareness of the DO role via a range of media throughout the coming year	DO	March 2018	All relevant information re DO has been posted on the Local Safeguarding Children's Board and will be updated regularly
2	DO will continue to engage with the Safeguarding Multi Agency Trainer and Safeguarding Education Officer in relation to continual roll out of designated training	DO	March 2018	The DO continues to engage and provide training as evidenced throughout the annual report.
3	DO to continue to forge links with faith settings in addition to Christian organisations across Darlington and the North East	DO	On-going	The DO has attempted to engage with faith organisations outside of the Christian faith but despite invitations to briefings the uptake has been negligible.
4	DO to liaise with Police in relation to any historical allegations that may come as a result of the Independent Enquiry into Child Sexual Abuse.	DO	On-going	The DO has an agreed strategy in place referring any notifications of historical sexual abuse from the Independent Enquiry into Child Sexual Abuse.

5	The DO will continue to maintain accurate records of referrals, decision making and outcomes; monitor date and identify any themes that emerge and feed these themes into training	DO	On-going	Records are reviewed monthly to ensure that they are accurate and up to date. Cases are discussed in monthly supervision with the Line Manager.
6	DO will remain informed of local. Reginal and national practice and any legislative changes which may affect recording of allegations and the gathering of performance data.	DO	On-going	The DO attends quarterly regional DO meetings. The DO to attend annual DO conference which unfortunately was cancelled in March 2018 due to inclement weather conditions. It was held in May 2018 but Darlington DO unable to attend as only appointed the week of the Conference All information from Conference was shared via email.
7	DO will continue to develop recording practice with system developments for future reports	DO and Line Manager	On-going	Liquid Logic will be the preferred recording tool. The DO will engage with staff developing Liquid Logic to include recording and collection of data from the DO service. This will feed into the performance indicators and ensure more accurate recording.
8	To develop a safer recruitment guidance to offer further support and guidance to settings	DO and HR	Completed	The Safe Recruitment guidance is available on Darlington Borough Council's Recruitment and Selection Policy.
9	The DO will provide feedback on National DO standards and seek approval from DSCB and legal Services	DO	On-going	The National Standards are not yet completed.

10	The DO will review and up-date the procedure for Managing Allegations and concerns against staff, carers or volunteers and seek approval via the DSCB Practice and Development and Procedures sub-group.	DO	On-going	
11	To review and up-date the Guidance for staff facing an allegation	DO	Completed	This has been completed but will be kept under review.
12	The DO will undertake planned training events with Designated Safeguarding Leads within Education settings; foster carers; residential providers' both local and private.	DO	On-going	The DO continues to liaise with the Trainer. There has been 9 DO briefings held during 2017/18 and include 2 bespoke packages for individual providers.

DO Service Priority Plan 2018 / 19

Priority 1. To ensure the induction of a newly appointed DO is successful and the appointee is retained

Action	Planned outcome	Lead	Timescale
Permanent DO to be enlisted onto the appropriate induction courses	The DO will have completed the induction courses and successfully completes their probationary period.	Head of Service	December 2018

Priority 2: To ensure that all publicity information with regards to the DO has the most up to date contact details and name of the DO

Action	Planned Outcome	Lead	Timescale
Details of DO to be uploaded onto Darlington's website and DSCB information will be easily accessible and relevant referrals made to the relevant services. Should a new DO be appointed a letter giving details to be sent out to all partner agencies.; DSCB to be updated with DO's Name; email to be sent to all agencies on DO database to advise them of name and contact details of DO.	Websites and literature to have the name and contact details of the DO. All agencies will have correct details of DO. DO information will be easily accessible and relevant referrals made.	DO	On appointment of DO

Priority 3: To raise the profile of the DO Service

Action	Planned Outcome	Lead	Timescale
Training to continue to be offered via the annual briefing sessions. Bespoke training events to be offered for organisations where a training need has been identified.	To seek to continue to improve employer's awareness across the Local Authority, of their duty of care by offering bespoke training which should lead to an increase in appropriate referrals from a broader range of organisations	DO	To March 2019

Priority 4: DO database/recording to be integrated within Liquid Logic

Action	Planned Outcome	Lead	Timescale
DO to work with IT service to ensure that DO recording systems are transferred to Liquid Logic.	For the DO service will be electronic and solely use Liquid Logic. For all performance indicators to be available on Liquid Logic which will feed figures into the DO Annual report.	DO and Business Management	To March 2019

Priority 5: To develop and approve with northern partners a regional DO referral form

Action	Planned Outcome	Lead	Timescale
DO to attend quarterly regional DO meetings and have an input into the regional referral form.	Regional data sharing will be undertaken**.** New Regional referral form to be used in the North East until the national referral form has been agreed.	DO	Regional meeting 02.10.2018

Priority 6: To continue to participate and strengthen Darlington's role at regional and national events

Action	Planned Outcome	Lead	Timescale
DO to attend all pre-agreed regional DO meetings to ensure that Darlington's views and opinions are represented. DO to attend National Annual DO Conference	To be a lead organisation in the area of practice development	DO	March 2019

Priority 7: To review the DO minute template

Action	Planned Outcome	Lead	Timescale
Review recent DO strategy meetings on an agreed audit form which will be used to inform and support changes to DO recording	Review recent DO strategy meetings on an agreed audit form which will be used to inform and support changes to DO recording	DO	December 2018

Priority 8: To provide bespoke training for professionals in relation to DO role and improve quality of referrals.

Action	Planned outcome	Lead	Timescale
Training to be offered to raise professionals' awareness of the DO role.	Referrals will be timely and appropriate	DO and Safeguarding training co-ordinator	To March 2019

Priority 9: To continue to forge links with faith settings across Darlington and the North East in addition to Christian organisations

Action	Planned Outcome	Lead	Timescale
To review the ways in which DO has engaged with faith organisations other than those of Christian organisations e.g. through Community Police Liaison Officers.	To improve relationships with faith groups other than Christian and offer a high level of support and advice to these other groups.	DO	December 2018

Appendix 3

Definitions of allegation management outcomes

The Department for Education requires the following definitions be used when determining the outcome of allegation investigations:

Substantiated: there is sufficient identifiable evidence to prove the allegation.

False: there is sufficient evidence to disprove the allegation.

Malicious: there is clear evidence to prove there has been a deliberate act to deceive and the allegation is entirely false.

Unfounded: there is no evidence or proper basis which supports the allegation being made. It might also indicate that the person making the allegation misinterpreted the incident or was mistaken in what they saw. Alternatively, they may not have been aware of all of the circumstances.

Unsubstantiated: this is not the same as a false allegation. It means that there is insufficient evidence to prove or disprove the allegation. The term, therefore, does not imply guilt or innocence.

Appendix 4

Case Study 1 - physical abuse

Background

A staff member within an educational setting was alleged to have bruised a young person whilst restraining them by the use of Team Teach. This was following an altercation where the young person was being verbally and physically abusive to the staff member and refused to adhere to an instruction to leave the classroom.

Intervention

A DO meeting was held due to criteria:

- Behaved in a way that has harmed or may harm a child
- Has possibly committed a criminal offence against or related to a child

A DO Initial Evaluation meeting was arranged and the following invited:

- Police
- Operation's Manager for School
- Team Leader from School
- Young person's Social Workers from the host Local Authority.

DO advice offered:

- Staff member to be removed from the Team Teach rota. The reason for this was that the school had a duty of care not only to the young person but also to the Staff member.
- School were to consider whether the staff member was being targeted by pupils or whether their tolerance was less than other staff and they failed to de-escalate situations and used Team Teach inappropriately.

Outcome

Police decided to take no further action. Due to sickness of Police investigator and holidays of witnesses, this process took 4 month.

The staff member was relieved from Team Teach intervention for a period of 6 months. The outcomes were reviewed and a follow up phone call was made by DO to ensure the staff member had been removed from Team Teach rota.

Case unsubstantiated.

Case Study 2 - neglect

Background

Young person had earlier attended a hospital appointment at a local walk in centre, where they requested to go in alone due to being supported by a member of staff of opposite gender. The young person continued their day, however some time later they disclosed that earlier during the medical appointment they had been given a number of

tablets and that they had taken them all. The young person was then taken to Darlington Memorial Hospital to be assessed. The concern raised was who at the medical appointment had prescribed the tablets. Within the medical records it showed in detail that the young person had a history of self-harming behaviour and was known to have attempted numerous overdoses and also displayed other self-injurious behaviours.

Intervention

A DO meeting was held due to criteria that a member of Hospital staff:

- Behaved in a way that has harmed or may have harmed a child.
- Has possibly committed a criminal offence against or related to a child.

A DO Initial Evaluation meeting was arranged and the following invited:

- Young person's Social Worker
- Young person's and their support worker
- representative from the Hospital's H.R. department
- Police.

Outcome

The Hospital Trust were to conduct a root-cause analysis reporting the outcome of this to the DO and the young person's Social Worker. A management discussion was to take place with the employee. Ofsted were advised of the recommendations from the meeting and the outcome of the root cause investigation.

DO contacted SW following root cause analysis and management discussion agreed how the case should be finalised.

Case substantiated leading to a disciplinary hearing.

Case Study 3 - sexual abuse

Background

A sports referee allegedly sent an inappropriate snap chat picture of themselves to a 16 year old boy, who was a member of a sports club and then asked the youth 'to show him his body'. The matter was reported to police by the club welfare officer

Intervention

A DO meeting was convened due to the following criteria:

- Behaved in a way that has harmed or may have harmed a child.
- Possibly committed a criminal act against or related to a child.

A DO Initial Evaluation meeting was arranged and the following invited:

- DO
- Police
- representative from the sports club

The purpose of the meeting was to discuss the allegations and actions to be taken to safeguard children. The action plan agreed was that the alleged perpetrator was suspended immediately from the Club.

Outcome

A DO Initial evaluation was held.

Police took no further action due to lack of evidence.
Case unsubstantiated; however the Sports Club continued with an internal investigation resulting in the alleged perpetrator being dismissed.

Definitions of Abuse – from Working Together 2015
Emotional Abuse

The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meets the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Physical Abuse

A form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

Sexual Abuse

Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse Sexual abuse can take place online, and technology can be used to facilitate offline abuse. Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Neglect

The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

a. Provide adequate food, clothing and shelter (including exclusion from home or abandonment);
b. Protect a child from physical and emotional harm or danger;
c. Ensure adequate supervision (including the use of inadequate care- givers);

d. Ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs.

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CHILDREN AND YOUNG PEOPLE SCRUTINY COMMITTEE
10 SEPTEMBER 2018

ITEM NO. ......8.................

LOOKED AFTER CHILDREN MISSING FROM CARE WHO HAVE AUTISM OR ANOTHER DISABILITY.

SUMMARY REPORT

Purpose of the Report

1. To provide Members with information regarding the number of those children who are Looked After with autism or another disability, who experience missing from home episodes.

Summary

2. At the Children and Young People Scrutiny Committee held on 16 April 2018, Members requested a report be submitted to the Committee being held on 2 July 2018 which addressed the interventions in place for children who are looked after and who experience missing episodes, and the reasons why these children go missing. This report was submitted, however Members requested further detail to inform of the number of these children who have autism or another disability.

Recommendation

3. It is recommended that :-

   (a) Members acknowledge and note the contents of this report.

Suzanne Joyner
Director of Children and Adult Services

Background Papers

There were no background papers used in relation to this report.

Joanne Stoddart x 6286

S17 Crime and Disorder	Nil impact
Health and Well Being	Nil impact
Carbon Impact	Nil impact
Diversity	Nil impact
Wards Affected	Nil impact
Groups Affected	Nil impact
Budget and Policy Framework	Nil impact
Key Decision	No
Urgent Decision	No
One Darlington: Perfectly Placed	Nil impact
Efficiency	Nil impact
Impact on Looked After Children and Care Leavers	Whilst this report is in relation to Looked After Children, it is for information only and therefore there is no impact on this group or Care Leavers

MAIN REPORT

4. **Looked After Children Missing from Home who have Autism or Another Disability.**

   There were no children or young people missing from home with a recorded disability including autism throughout the reporting year of 2017/18.

   There has been one missing episode for one young person with autism in the current reporting year of 2018/19. This young person left his foster placement in the early evening and was located and returned home within the hour.

CHILDREN AND YOUNG PEOPLE SCRUTINY WORK PROGRAMME

Topic	Timescale	Lead Officer	SCS Outcome	Darlington Conditions	Link to PMF (metrics)	Scrutiny's Role
Performance Management and Regulation	Q1 10 September 2018 Q2 10 December 2018 Q3 11 March 2019 Q4 June/July 2019	Sharon Raine	Children with the best start in life A safe and caring community Enough support for people when needed More people healthy and independent	Build strong communities Spend every pound wisely	Agreed set of indicators	To receive quarterly monitoring reports and undertake any further detailed work into particular outcomes if necessary
Public Health Children and Young People Overview **Healthy Lifestyles Survey**	30 October 2017 10 September 2018	Rachel Osbaldeston Ken Ross/Rachel Osbaldeston	Children with the best start in life A safe and caring community Enough support for people when needed More people healthy and independent	Build strong communities	PBH 009 PBH 013c PBH 016 PBH 018 PBH 020 PBH 021 PBH 054	Combined health update of Children and Young People in Darlington (incorporating Healthy Lifestyles Survey 2016/17/Darlington Child Health Profiles 2017/Health Visitors Service and Healthy Weight Action Plan

Topic	Timescale	Lead Officer	SCS Outcome	Darlington Conditions	Link to PMF (metrics)	Scrutiny's Role
2017/18/Childrens Healthy Weight Plan						
Recording practices for statutory visits for Child Protection Cases	27 June 2016 Continual monitoring	Jane Kochanowski	Children with the best start in life A safe and caring community Enough support for people when needed	Build strong communities	CSC 252	To examine recording practices
Extension of Funding to 21 for Children in Foster Care	9 January 2017 19 February 2018 11 March 2019	Jane Kochanowski	Children with the best start in life A safe and caring community Enough support for people when needed More people healthy and independent	Build strong communities		Annual monitoring – a duty on Local Authorities to facilitate, monitor and support staying put arrangements
2016 Childcare Sufficiency Assessment and Action Plan	7 November 2016 30 October 2017	Christine Shields	Children with the best start in life A safe and caring community	Build strong communities		To provide an annual report to elected Members on how the authority meets its

Topic	Timescale	Lead Officer	SCS Outcome	Darlington Conditions	Link to PMF (metrics)	Scrutiny's Role
2017 Childcare Sufficiency Review **2018/19 Childcare Sufficiency Review**	10 December 2018	Nicola Davies	Enough support for people when needed			duty to secure sufficient childcare places.
Stability of Places for Looked After Children	27 June 2016 (deferred) 18 December 2017 10 December 2018	Bronwen Smith Joanne Stoddart Joanne Stoddart	Children with the best start in life Enough support for people when needed	Build strong communities	CSC 228 CSC 229	To monitor annually the stability of places for Looked After Children.
Educational Landscape	10 April 2017 29 October 2018	Steve Nyakatawa Tony Murphy	Children with the best start in life	Build strong communities	CSC 044 Basket of LAIT KS1, KS2, GCSE & A Level indicators. Local Authority Interactive Tool (LAIT) academic year 2014/15/ Ofsted Sept 2014/ Department for Education (DFE) performance data.	To examine school improvement including the decline in performance for maths and English and what action is being taking to address this.
Services for Families with children with disabilities 0-3 years Review Group	Meetings of review group held between 2	Kevin Kelly/Yvonne Coates	Children with the best start in life	Build strong communities		Scrutiny Members to report back on the 'Deep dive' examination of the

Topic	Timescale	Lead Officer	SCS Outcome	Darlington Conditions	Link to PMF (metrics)	Scrutiny's Role
	November and 27 February 2017. Final Report to Scrutiny 10 Apr 2017. Review of the service after six months (30 October 2017)		Enough support for people when needed			service for families with children with disabilities 0-3 years old to test the effectiveness of the service and consult with stakeholders. Following the recommendation of the Review Group to review the service after 6 months and meet again with professionals, families and stakeholders.
Annual Report of the Local Safeguarding Children Board	7 November 2016 19 February 2018 29 October 2018	Emma Chawner Amanda Hugill/ Simon Hart, Independent Chair		Build strong communities	LSB Annual Report	Annual monitoring
IRO Annual Report	4 September 2017 10 September 2018	Jane Kochanowski	Children with the best start in life		CSC201	To examine the Annual Report of the Independent Reviewing Officer for Looked After Children

Topic	Timescale	Lead Officer	SCS Outcome	Darlington Conditions	Link to PMF (metrics)	Scrutiny's Role
LAC Missing from Care – Reasons and Interventions	10 September 2018 10 September 2018	Yvonne Coates	Children with the best start in life Enough support for people when needed		CSC246	To examine the reasons why children in care go missing and the interventions in place to avoid. To invite the Police Liaison Officer to attend Scrutiny to discuss Update information regarding Missing Episodes following the report to the meeting in September
Local Authority Designated Officer Annual Report (LADO)	10 September 2018	Martin Graham				To examine the Annual Report and assure Members that allegations made against staff who work with children are reported and how they are actioned
Children and Young People Plan 2017-22	29 October 2018	Christine Shields	Children with the best start in life			Half yearly update to Members.

JOINT REVIEW WITH HEALTH AND PARTNERSHIPS SCRUTINY:						
Topic	**Timescale**	**Lead Officer**	**SCS Outcome**	**Darlington Conditions**	**Link to PMF (metrics)**	**Scrutiny's Role**
Childhood Obesity/ Oral Health/Mental Health Links	November 2017 – February 2018 Scoping meeting held on 27 November 2017 2nd Meeting held on 31 January 2018		Children with the best start in life Enough support for people when needed More People Healthy and Independent	Build strong communities		To investigate the high incidence of childhood obesity in Darlington and the associated links to poor dental health; and whether the desire to promote good 'self image' has an impact on mental health issues in young people.

ARCHIVED ITEMS

Early Help Service	7 November 2016 9 January 2017 19 June 2017	Jane Kochanowski	Children with the best start in life Enough support for people when needed	Build strong communities	CSC001 CSC022 CSC038	To receive regular reports on the progress towards aligning all Early Help Services into one single service in line with MTFP target.
Youth Unemployment	30 October 2017	Paul Richardson	Enough support for people when needed			To examine youth unemployment in Darlington
SEND Inclusion Strategy	4 September 2017 30 October 2017	Christine Shields/ Helen Ellison	Children with the best start in life More people healthy and independent Enough support for people when needed	Build strong communities		To consult with Scrutiny on the draft Strategy prior to Cabinet approval
Workforce Sufficiency, Skills, Recruitment and Retention	12 September 2016	Yvonne Coates/Paige Thomason/Corina Dias)	Children with the best start in life	Build strong communities		To examine social work caseloads, workforce recruitment and

	30 October 2017		A safe and caring community Enough support for people when needed			retention and pressures on social workers
Children and Young People's Plan 2017/22	10 April 2017 (draft plan) 4 September 2017	Christine Shields/Rosie Banks	Children with the best start in life Enough support for people when needed			To consult with Scrutiny prior to consideration by Cabinet
Sustainability and Transformation Plan (Maternity Services)	19 June 2017	CCG	Children with the best start in life More people healthy and independent			To challenge the CCG on the impact to children and young people in Darlington of the STP (maternity services and services for forces families)

CHILDREN AND YOUNG PEOPLE SCRUTINY COMMITTEE
10 SEPTEMBER 2018

ITEM NO. ....9...........

WORK PROGRAMME

SUMMARY REPORT

Purpose of the Report

1. To consider the draft work programme for this Scrutiny Committee for the Municipal Year 2018/19.

Summary

2. The proposed work programme has been reviewed and revised for the Municipal Year 2018/19 and Members are requested to consider the attached draft programme.

Recommendation

3. Members' views are requested.

Luke Swinhoe
Assistant Director Law and Governance

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

Author: Allison Hill Extension 5997

S17 Crime and Disorder	This report has no implications for Crime and Disorder
Health and Well Being	This report has no direct implications to the Health and Well Being of residents of Darlington.
Carbon Impact	There are no issues which this report needs to address.
Diversity	There are no issues relating to diversity which this report needs to address
Wards Affected	The impact of the report on any individual Ward is considered to be minimal.
Groups Affected	The impact of the report on any individual Group is considered to be minimal.
Budget and Policy Framework	This report does not represent a change to the budget and policy framework.
Key Decision	This is not a key decision.
Urgent Decision	This is not an urgent decision
One Darlington: Perfectly Placed	The report contributes to the Sustainable Community Strategy in a number of ways through the involvement of Members in contributing to the delivery of the eight outcomes.
Efficiency	The Work Programmes are integral to scrutinising and monitoring services efficiently (and effectively), however this report does not identify specific efficiency savings.
Impact on Looked After Children and Care Leavers	This report has no impact on Looked After Children or Care Leavers.

MAIN REPORT

Information and Analysis

1. The format of the proposed work programme has been reviewed to enable Members of this Scrutiny Committee to provide a rigorous and informed challenge to the areas for discussion. **Appendix 1**

2. Each topic has been reviewed to link it to the outcomes and the conditions in the Sustainable Community Strategy – One Darlington Perfectly Placed:-

SCS Outcomes:	Three Conditions:
a) Children with the best start in life	a) Build strong communities
b) More businesses more jobs	
c) A safe and caring community	b) Grow the economy
d) More people caring for our environment	
e) More people active and involved	c) Spend every pound wisely
f) Enough support for people when needed	
g) More people healthy and independent	
h) A place designed to thrive	

3. In addition, each topic has been linked to performance indicators from the Performance Management Framework (PMF) to provide robust and accurate data for Members to use when considering topics and the work they wish to undertake. There are some topics where appropriate PMF indicators have not yet been identified however; these can be added as the work programme for each topic is developed.

4. The topics have been grouped into two sections as follows:

   a) Overarching e.g. Performance Management
   b) Children and Young People

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