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Children and Young People Scrutiny Committee Agenda

DARLINGTON
BOROUGH COUNCIL

9.30 am Monday, 2 September 2019
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. To approve the Minutes of the meeting of this Scrutiny Committee held on 1 July 2019 (Pages 1 - 4)

4. Children and Young People Public Health Overview 2019 –
   Report of the Director of Public Health
   (Pages 5 - 74)

5. Independent Reviewing Officer Annual Report 2018/19 –
   Report of the Director of Children and Adult Services
   (Pages 75 - 92)

6. Designated Officer Annual Report –
   Report of the Director of Children and Adult Services
   (Pages 93 - 114)

7. Work Programme –
   Report of the Managing Director
   (Pages 115 - 164)

8. 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

9. Questions

Luke Swinhoe
Assistant Director Law and Governance

Friday, 23 August 2019

Town Hall
Darlington.

Membership
Councillors Bartch, Mrs Culley, Ali, Bell, C L B Hughes, L Hughes, Lister, Lucas, Preston, Renton and Snedker

Statutory Co-optees
Malcolm Frank and Carly Spence

Non Statutory Co-optees
Maura Regan, Tim Fisher, Nick Lindsay, Glenis Harrison, Janet Woodcock, John Armitage and Helen Tarokh

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

Monday, 1 July 2019

PRESENT – Councillors Bartch (Chair), Mrs Culley, Ali, Bell, C L B Hughes, L Hughes, Lister, Lucas, Preston, Renton and Snedker

STATUTORY CO-OPTEES – Carly Spence

NON-STATUTORY CO-OPTEES – John Armitage

APOLOGIES –Tim Fisher and Glenis Harrison

ABSENT – Malcolm Frank, Maura Regan, Nick Lindsay and Janet Woodcock

ALSO IN ATTENDANCE – Councillor Crudass

OFFICERS IN ATTENDANCE – Jane Kochanowski (Assistant Director of Children's Services), Allison Hill (Democratic Officer), Paul Richardson (Head of Skills and Employability) and Tony Murphy (Head of Education and Inclusion)

CYP39 APPOINTMENT OF CHAIR FOR THE MUNICIPAL YEAR 2019/20

RESOLVED – That Councillor Bartch be appointed Chair of this Children and Young People Scrutiny Committee for the Municipal Year 2019/20.

CYP40 APPOINTMENT OF VICE-CHAIR FOR THE MUNICIPAL YEAR 2019/20

RESOLVED – That Councillor Mrs Culley be appointed Vice-Chair of this Children and Young People Scrutiny Committee for the Municipal Year 2019/20.

CYP41 DECLARATIONS OF INTEREST

RESOLVED - There were no declarations of interest reported at this meeting.

CYP42 TO CONSIDER THE TIMES OF MEETINGS OF THIS COMMITTEE FOR THE MUNICIPAL YEAR 2019/20

RESOLVED - That meetings of this Children and Young People Scrutiny Committee be held at 9.30 a.m. for the remainder of the Municipal Year 2019/20.

CYP43 MINUTES

Submitted – The Minutes (previously circulated) of the meeting of this Scrutiny Committee held on 11 March 2019.

RESOLVED – That the Minutes of the meeting of this Scrutiny Committee held on 11 March 2019 be approved as a correct record.

CYP44 PERFORMANCE INDICATORS QUARTER 4 2018/19

The Director of Children and Adults Services submitted a report (previously circulated) to provide Members with an update on performance against key performance indicators.

The submitted report provided Quarter 4 (January to March 2019) 2018/19 performance information in line with an indicator set agreed by the Monitoring and Co-ordination Group and subsequently by each individual Scrutiny Committee.

The submitted report highlighted where Children and Young People were performing well and where there was a need to improve. It was also highlighted that where indicators are reported annually quarterly updates will not be available.

It was highlighted that 98.2 per cent of referrals are screened and completed within one day which was above the target of 90 per cent; 17.5 per cent of re-referrals were repeated within 12 months which was in an increase on the target of 18 per cent; 100 per cent of children with a Child Protection Plan and 100 per cent of Children Looked After have an allocated social worker; 92.1 per cent who had a dental health assessment due, received their assessment within the required timescale; and 25 per cent of Care Leavers who were not in employment, education or training (NEET) exceeded the target set of 33 per cent.

The areas highlighted for improvement in Quarter 4 was the timeliness of assessments which was slightly below the target of 90 per cent and the reasons for this have been analysed and monitored by the Head of Service; 95.7 per cent of statutory child protection visits were completed within 15 working days with 79.4 per cent completed within 10 working days; and 82.6 per cent statutory looked after children visits were completed within the timeline and all those visits that do not take place within the set days are closely managed; and the rate of looked after children has increased and is currently 110.6 per 10,000 population which was above statistical regional and national benchmarks and this increase was currently being scrutinised to determine if there were any areas that could be strengthened to safety reduce this number.

Members discussed in particular the increase in Section 47 enquiries, which was a significant increase from the previous year and the work being undertaken to reduce the number of enquires; the number of Care Leavers who were NEET and the number of reasons why they were not in education, employment or training; the reduction of timely completion of assessments throughout 2018/19 when compared to the previous year's reporting; the improvements made to the missing from home interviews and what was being done to engage parents in this process to work with the police, health and social care representatives; and clarification on re-referrals which was currently better than the target but remains below statistical numbers, national and north east benchmarks; the current workload situation for social workers; improvement on the percentage of children who had moved placement three or more times; and the improved position regarding Foster Carers.

A Member also questioned if information on referrals made to the Children and Adolescent Mental Health Service (CAMHS) from school and also for Special Education Needs referrals was collated and was advised by the Head of Education

and Inclusion that currently this data is not being collected but he assured Members he would raise this with colleagues in the Clinical Commissioning Group (CCG) and report back to Members of this Scrutiny Committee.

RESOLVED – That the performance information provided for Quarter 4 2018/19 be noted.

CYP45 LEARNING AND SKILLS ANNUAL REPORT 2017/18

The Director of Children and Adults Services submitted a report (previously circulated) to provide Members with an update on the performance of the Learning and Skills Service for the academic year 2017/18.

It was reported that the Learning and Skills Service continues to perform well with a 'Good' Ofsted grade whilst supporting some of the most vulnerable adults, young people and families in Darlington; and have put in place further checks and controls to ensure the service continues to perform at a high level as a result of the shift of provision due to a change in the demographic of the learners.

Members asked about progress since the last Ofsted inspection report and it was pointed out that growing apprenticeship numbers had proven difficult due to the changes to the apprenticeship funding model and the shift from frameworks to standards. However, it was reported by the Head of Skills and Employability that the service had employed an Employer Engagement Officer to address this. Members also asked how the Service could demonstrate the wider impact and it was agreed that some case studies would be shared with the next annual report.

The submitted report also highlighted some challenges to be faced in 2019/20 with the devolution of the Adult Education Budget and ongoing challenges of apprenticeship funding.

General discussion ensued among Members on the provision of apprenticeships and their concerns around the apprenticeship levy; and the impact of the devolution of the Adult Education Budget to the Tees Valley Combined Authority to support the adult learning provision for Tees Valley residents and Members agreed that they would monitor this to see how it affects our learners.

Members also agreed that it would be useful to speak with a representative of the Education and Skills Funding Agency to share data on how the funding for apprenticeships is allocated and be requested to attend a future meeting of this Scrutiny Committee.

RESOLVED – That the annual report be noted.

CYP46 WORK PROGRAMME

The Managing Director 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 2019/20 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.

Discussion ensued on the current work programme and it was suggested to complete a quad of aims to examine the increase in home schooling; and to examine the number of children going from nursery to primary and the 30 hours provision.

It was also agreed to bring forward the current work programme item on Academy Trusts to a future meeting and request the Schools Commissioner attend.

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

CHILDREN AND YOUNG PEOPLE SCRUTINY COMMITTEE
2 SEPTEMBER 2019

CHILDREN AND YOUNG PEOPLE PUBLIC HEALTH OVERVIEW 2019

SUMMARY REPORT

Purpose of the Report

1. To provide Members and partners with an overview of a range of 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 following:

    a. Darlington Children and Young People's Profile 2019 **Appendix 1**
    b. Healthy Lifestyle Survey 2018 **Appendix 2**
    c. Darlington Childhood Healthy Weight Action Plan 2017 – 2022 **Appendix 3**
    d. 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 positive public health messages in relation to children, 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: Ken Ross Public Health Principal Extension 6200

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 2019

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 2019 profile provides a snap shot of child health in Darlington (**Appendix 1**). It enables comparisons over time and against the regional and England averages. The profile was designed to help understand local need and enable services to be planned, in order to improve health and reduce health inequalities.

5. The profile provides an overview of the health and wellbeing of children set out in 32 indicators. The indicators are grouped into five broad domains, namely premature mortality, health protection, wider determinants of ill health, health improvement and prevention of ill health.

6. The profile shows that the health and wellbeing of children is generally worse for Darlington when compared to the England average. 12 of the 32 reported indicators for Darlington are not significantly different when compared to England, 3 are significantly better, 11 are significantly worse. The remaining indicators are not able to be compared nationally.

7. The 11 indicators that are significantly worse than the England average are largely related to the high number of children admitted to hospital for a number of different reasons.

8. There has been one indicator that has shown an improvement since the last profile in 2018 with the number of children recorded as obese aged 10-11 years now statistically similar to the England average. This has reduced from 22.5% in 2016/17 to 21.2% in 2017/18.

9. The profile showed that childhood immunisation rates in Darlington were good with coverage for two year olds in Darlington being above the recommended coverage rate of 90 per cent and overall 88.8 per cent of children in Darlington were up to date with immunisations which was in keeping with the England average.

10. With respect to wider determinants of health the profile also showed that the proportion of 16 to 17 year olds not in education, employment or training in Darlington was statistically significantly better than the national and regional average. The rate of 10 to 17 year olds in Darlington coming into contact with the youth justice system remained similar to the England average and had fallen in Darlington since 2010.

Healthy Lifestyles Survey 2018

11. 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. (**Appendix 2**)

12. 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.

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

14. The headlines from the survey told us that;

    a) The majority of young people have positive emotional attitudes, stating they feel happy in their lives and have strong social networks with friends and family. Around a third of all pupils reported that they do not have someone to confide in.
    b) Just over three quarters of primary aged pupils feel stress, this increases to over 8 in 10 of secondary pupils with homework cited as the main cause of stress for all pupils. Out of school stress is reported as the next greatest cause of stress in all pupils with issues such as body image and bullying being reported.
    c) A third of primary pupils have seen something upsetting or offensive online, this increases to half of secondary pupils.
    d) The majority of all pupils in primary and secondary schools have never tried any form of smoking. Those who tried any form of smoking reported that they were more likely to try a vape than a cigarette, and most only tried it once.
    e) Half of primary pupils and a quarter of secondary pupils have never tried an alcoholic drink.
    f) Nearly all pupils agreed that relationships should be based on respect and affection and the majority could identify unacceptable behaviours in relationships.
    g) The majority of pupils aged 13 to 16 knew where to access sexual health advice, support and treatment.
    h) A significant minority of pupils reported to have been offered illegal drugs and the overwhelming majority have reported to have never tried any kind of drugs.

15. 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 that they know 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

16. The Childhood Healthy Weight Plan 2017-2022 (**Appendix 3**) sets out a whole system approach to tackling childhood obesity and reducing inequalities by recognising the complex relationship between the social, economic and physical environment coupled with individual factors that underpin the development of obesity.

17. Childhood obesity and excess weight are significant health issues for children. Obesity can have serious implications for the physical and mental health of a child which can continue into adulthood with a higher risk of morbidity and premature mortality.

18. The scope and vision of the Darlington Childhood Healthy Weight Plan is to ensure that more children leave primary school aged 10-11 years with a healthy weight.

19. An official launch of the plan and workshop session is planned for September 2019 where all key stakeholders and partners will be invited to take part in shaping the key action plan that will set out how the objectives are to be taken forward.

Darlington Oral Health Plan 2017 - 2022

20. The Childhood Healthy Weight Plan complements the Oral Health Plan 2017 – 2022 (**Appendix 4)** by working to reduces sugar intake. A high sugar diet is a significant risk factor in dental decay and obesity.

21. Tooth decay is a predominantly preventable disease. Over a quarter of children in Darlington aged 5 years old start school with the experience of dental decay.

22. The action plan recommends oral health interventions that support and encourage the use of fluoride. This has been found to be among the most cost-effective in reducing dental decay.

23. A supervised tooth brushing pilot has been commissioned which targets children in nursery and reception class. The pilot programme trains Early Years staff to support children to brush their teeth effectively using fluoride toothpaste, this contributes to strengthening teeth and reducing decay. To date 10 schools and 7 nurseries have participated in this programme.

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Public Health England

Child Health Profile

March 2019

Darlington

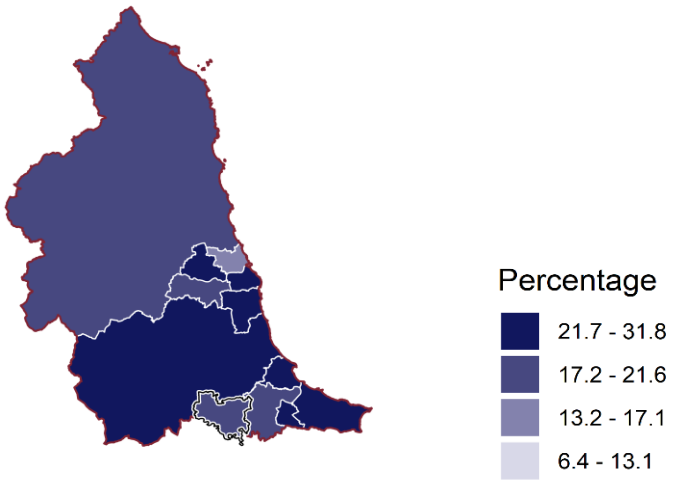
This profile provides a snapshot of child health in this area. It is designed to help local government and health services improve the health and wellbeing of children and tackle health inequalities.

The child population in this area

		Local	Region	England
Live births (2017)		1,137	27,488	646,794
Children aged 0 to 4 years (2017)		6,100 5.7%	146,100 5.5%	3,384,900 6.1%
Children aged 0 to 19 years (2017)		24,700 23.2%	592,800 22.4%	13,169,100 23.7%
Children aged 0 to 19 years in 2027 (projected)		23,800 22.4%	599,800 22.3%	13,904,800 23.7%
School children from minority ethnic groups (2018)		1,879 11.9%	42,598 11.3%	2,544,753 32.3%
School pupils with social, emotional and mental health needs (2018)		500 3.1%	10,707 2.8%	193,657 2.4%
Children living in poverty aged under 16 years (2016)		20.0%	22.6%	17.0%
Life expectancy at birth (2015-2017)	Boys	78.4	77.9	79.6
	Girls	82.3	81.6	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.

Key findings

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

The infant mortality rate is similar to England with an average of 3 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:

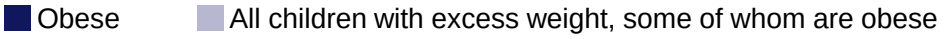
- The teenage pregnancy rate is similar to England, with 44 girls becoming pregnant in a year.
- 16.2% of women smoke while pregnant which is worse than England.
- Breastfeeding initiation data is not available for this area. By 6 to 8 weeks after birth, 31.9% of mothers are still breastfeeding (worse than England).
- The MMR immunisation level does not meet recommended coverage (95%). By age two, 93.0% 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.
- Levels of child obesity are similar to England. 8.6% of children in Reception and 21.2% of children in Year 6 are obese.
- The rate of child inpatient admissions for mental health conditions at 80.1 per 100,000 is similar to England.The rate for self-harm at 521.1 per 100,000 is similar to England.

The level of child poverty is worse than England with 20.0% of children aged under 16 years living in poverty. The rate of family homelessness is better than England.

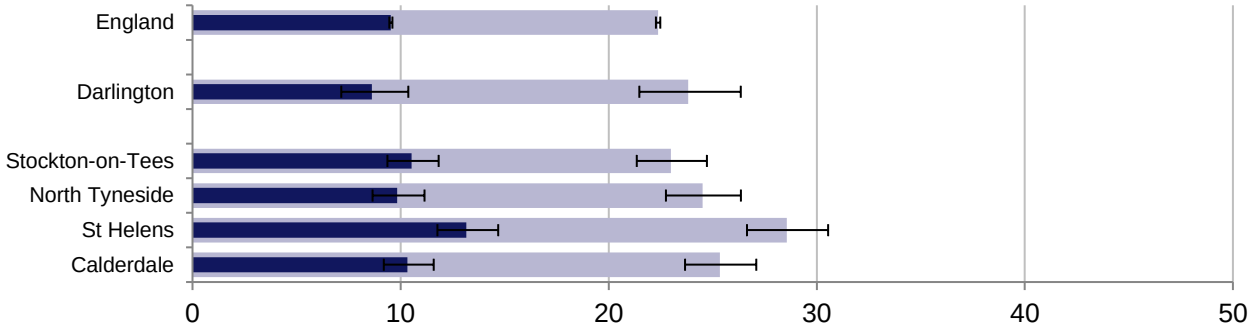
The hospital admission rate for injury in children (aged 0-14) at 155.8 per 10,000 is worse than England, and for young people (aged 15-24) at 189.8 per 10,000 is worse than England.

Childhood obesity

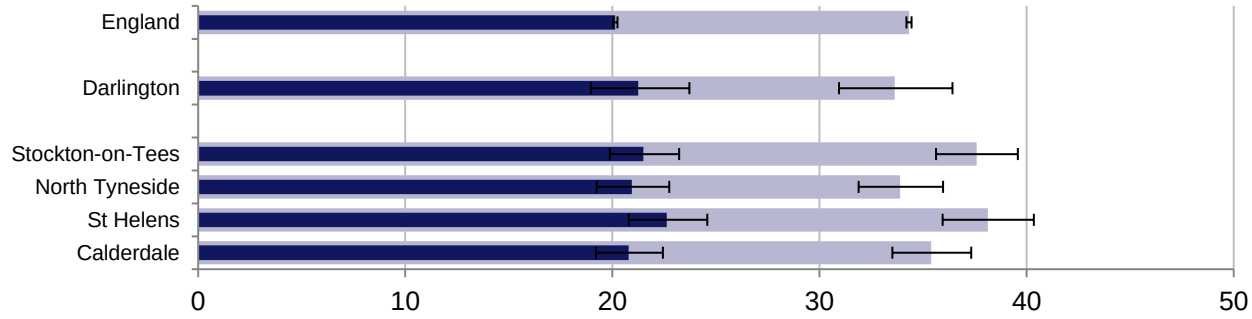
These charts show the percentage of children who have excess weight (obese or overweight) in Reception (aged 4-5 years) and Year 6 (aged 10-11 years). They compare Darlington with its statistical neighbours, and the England average. Compared with the England average, this area has a similar percentage of children in Reception (23.8%) and a similar percentage in Year 6 (33.6%) who have excess weight.



Children aged 4-5 years who have excess weight, 2017/18 (percentage)



Children aged 10-11 years who have excess weight, 2017/18 (percentage)



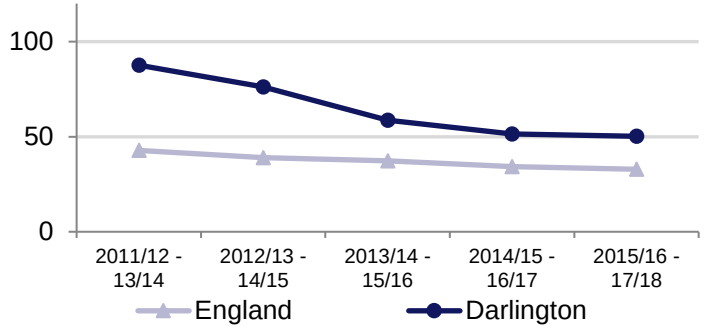
Note: This analysis uses the 85th and 95th centiles of the British 1990 growth reference (UK90) for BMI to classify children as overweight and obese.

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.

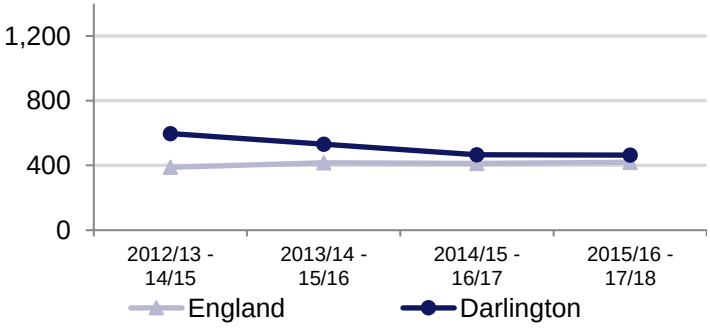
Hospital admissions of children and young people for conditions wholly related to alcohol (rate per 100,000 population aged 0-17 years)



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. The admission rate in the latest pooled period is similar to the England average*. Nationally, levels of self-harm are higher among young women than young men.

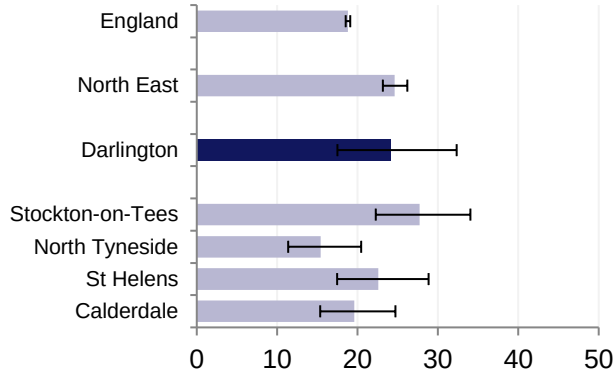
Young people aged 10 to 24 years admitted to hospital as a result of self-harm (rate per 100,000 population aged 10-24 years)



*Information about admissions in the single year 2017/18 can be found on page 4

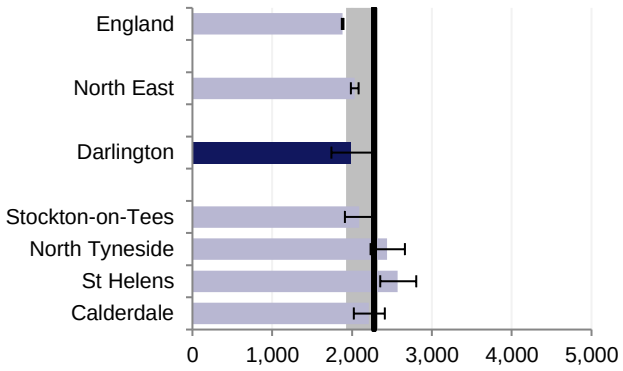
These charts compare Darlington with its statistical neighbours, and the England and regional averages.

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 living 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).

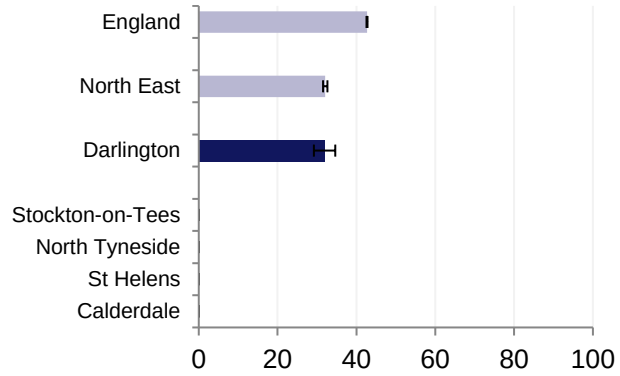
Chlamydia detection, 2017 (rate per 100,000 young people aged 15-24 years)



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 2017, the detection rate in this area was 1,992 which is approaching the minimum recommended rate.

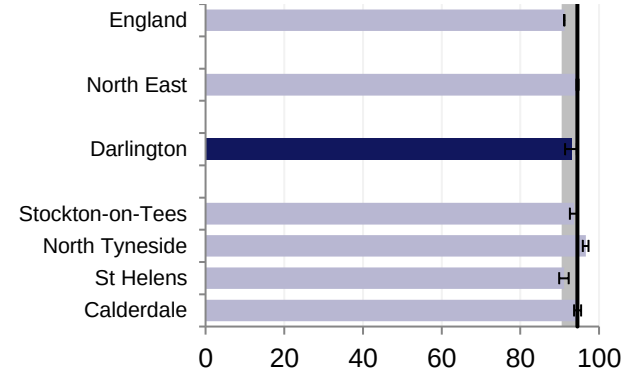
The shaded area from 1,900 shows the range of values approaching the minimum recommended rate of 2,300 (the black line).

Breastfeeding at 6 to 8 weeks, 2017/18 (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, 31.9% of mothers are still breastfeeding (worse than England).

Measles, mumps and rubella (MMR) vaccination coverage by age 2 years, 2017/18 (percentage of eligible children)



Slightly less than 95% (the minimum recommended coverage level) of children have received their first dose of immunisation by the age of two in this area (93.0%). By the age of five, only 92.5% 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).

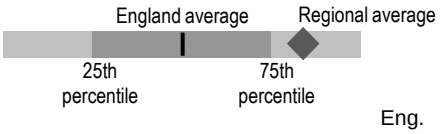
Note: Where data is not available or figures have been suppressed, no bar will appear in the chart for that area.

Darlington Child Health Profile — March 2019

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.

- ↔ No significant change
- ↑↓ Increasing / decreasing and getting better
- ↑↓ Increasing / decreasing and getting worse
- ▪ Trend cannot be calculated

- Not significantly different from the England average
- Significantly better than England average
- Significantly worse than England average
- Significance cannot be tested



	Indicator		Local no. per year*	Local value	Eng. ave.	Eng. worst	Eng. best
Premature mortality	1 Infant mortality	↓	***3***	2.9	3.9	8.1	1.7
	2 Child mortality rate (1-17 years)	▪	***3***	-	11.2	24.3	7.5
Health protection	3 MMR vaccination for one dose (2 years)	↔	1,050	93.0	91.2	75.0	96.9
	4 Dtap / IPV / Hib vaccination (2 years)	↔	1,106	98.0	95.1	83.7	98.5
	5 Children in care immunisations	▪	140	88.8	85.3	5.7	100.0
Wider determinants of ill health	6 Children achieving a good level of development at the end of reception	↑	913	72.6	71.5	63.9	80.5
	7 GCSE attainment: average Attainment 8 score	▪	-	45.5	46.7	39.8	55.8
	8 GCSE attainment: average Attainment 8 score of children in care	▪	-	10.6	19.3	0.0	33.9
	9 16-17 year olds not in education, employment or training	▪	90	4.4	6.0	24.4	1.9
	10 First time entrants to the youth justice system	↓	36	369.2	292.5	687.0	104.4
	11 Children in low income families (under 16 years)	↓	3,940	20.0	17.0	31.8	6.4
	12 Family homelessness	↔	7	0.1	1.7	7.7	0.1
	13 Children in care	↑	215	95	64	185	23
	14 Children killed and seriously injured (KSI) on England's roads	▪	***4***	18.2	17.4	41.7	2.6
Health improvement	15 Low birth weight of term babies	↔	21	2.0	2.8	5.3	1.6
	16 Obese children (4-5 years)	↔	101	8.6	9.5	14.4	4.9
	17 Obese children (10-11 years)	↑	242	21.2	20.1	29.7	11.4
	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 (0-5 years)	▪	***5***	61.3	325.1	1,612.1	10.8
	20 Under 18 conceptions	↓	44	24.1	18.8	36.5	4.6
	21 Teenage mothers	↔	16	1.4	0.7	2.1	0.2
	22 Admission episodes for alcohol-specific conditions - under 18s	↓	***11***	50.2	32.9	106.5	7.4
	23 Hospital admissions due to substance misuse (15-24 years)	▪	***15***	132.0	87.9	329.3	33.1
Prevention of ill health	24 Smoking status at time of delivery	↓	176	16.2	10.8	26.0	2.0
	25 Breastfeeding initiation	▪	-	-	74.5	37.9	96.7
	26 Breastfeeding prevalence at 6-8 weeks after birth	▪	361	31.9	42.7	0.9	81.6
	27 A&E attendances (0-4 years)	↑	7,026	1,150.9	619.0	2,011.3	321.3
	28 Hospital admissions caused by injuries in children (0-14 years)	↔	296	155.8	96.4	203.7	46.5
	29 Hospital admissions caused by injuries in young people (15-24 years)	↔	209	189.8	132.7	284.4	69.0
	30 Hospital admissions for asthma (under 19 years)	↔	72	304.1	186.4	511.7	82.5
	31 Hospital admissions for mental health conditions	↓	18	80.1	84.7	187.6	14.5
	32 Hospital admissions as a result of self-harm (10-24 years)	↓	87	521.1	421.2	1,009.6	116.9

≥95% <90% 90% to 95%

*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), 2015-2017
2 Directly standardised rate per 100,000 children aged 1-17 years, 2015-2017
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2017/18
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2017/18
5 % children in care with up-to-date immunisations, 2018
6 % children achieving a good level of development within Early Years Foundation Stage Profile, 2017/18
7 GCSE attainment: average attainment 8 score, 2017/18
8 GCSE attainment attainment: average attaiment 8 score of children looked after, 2017
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, 2017
10 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2017
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, 2016
12 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2017/18
13 Rate of children looked after at 31 March per 10,000 population aged under 18 years, 2018
14 Crude rate of children aged 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2015-2017
15 Percentage of live-born babies, born at term, weighing less than 2,500 grams, 2017
16 % school children in Reception year classified as obese, 2017/18
17 % school children in Year 6 classified as obese, 2017/18
18 % children aged 5 years with one or more decayed, missing or filled teeth, 2016/17
19 Crude rate per 100,000 (aged 0-5 years) for hospital admissions for dental caries, 2015/16-2017/18
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, 2017/18
22 Hospital admissions for alcohol-specific conditions – under 18 year olds, crude rate per 100,000 population, 2015/16-2017/18
23 Directly standardised rate per 100,000 (aged 15-24 years) for hospital admissions for substance misuse, 2015/16-2017/18
24 % of mothers smoking at time of delivery, 2017/18
25 % of mothers initiating breastfeeding, 2016/17
26 % of mothers breastfeeding at 6-8 weeks, 2017/18
27 Crude rate per 1,000 (aged 0-4 years) of A&E attendances, 2017/18
28 Crude rate per 10,000 (aged 0-14 years) for emergency hospital admissions following injury, 2017/18
29 Crude rate per 10,000 (aged 15-24 years) for emergency hospital admissions following injury, 2017/18
30 Crude rate per 100,000 (aged 0-18 years) for emergency hospital admissions for asthma, 2017/18
31 Crude rate per 100,000 (aged 0-17 years) for hospital admissions for mental health, 2017/18
32 Directly standardised rate per 100,000 (aged 10-24 years) for hospital admissions for self-harm, 2017/18

HEALTHY LIFESTYLES SURVEY 2018/19 RESULTS

Thank you to the 30 schools and 6,560 pupils who took part this year. This survey help us to support and inform Darlington's young people as they grow. Below are some of this year's key findings.

EMOTIONAL WELLBEING: *The majority of young people have positive emotional attitudes, stating they feel happy in their lives and have strong social networks with friends and family.*

Just over three quarters of primary aged pupils feel stress, this increases to 82.5% of secondary pupils with body image a cause of stress for 4 in 10 secondary pupils.

SUBSTANCE USE: *94% of primary pupils and 70% of secondary pupils have never tried any form of smoking. Pupils were more likely to try a vape than a cigarette, and most only tried it once.*

Half of primary pupils and a quarter of secondary pupils have never tried an alcoholic drink.

ONLINE LIVES: *Pupils reported having very active online lives from a young age. Primary pupils were accessing on average five social media sites each, this increases to seven sites for secondary pupils. YouTube, Instagram and Snap Chat were the most popular sites among pupils.*

A third of primary pupils have seen something upsetting or offensive online, this increases to 49% of secondary pupils.

RELATIONSHIPS AND SEXUAL HEALTH: *98% of pupils agreed that relationships should be based on respect and affection and the majority could identify unacceptable behaviours in relationships.*

7 in 10 pupils aged 13 to 16 knew where to access sexual health advice, support and treatment.

EXERCISE AND DIET: *Most pupils had a positive view of physical activity, stating they exercised because the enjoy it and want to keep fit and healthy.*

Younger pupils' diets were most likely to be influenced by parents/carers, with older pupils saying "what tastes nice" was the bigger influence.

SAFETY AND ANTI-SOCIAL BEHAVIOUR:

This year pupils were asked for their behaviours and perceptions in relation to anti-social behaviour (ASB). Just over 2 in 10 primary aged pupils reported taking part in anti-social behaviour, this increases to over a third of secondary aged pupils. 86% of primary aged pupils and 60% of secondary aged pupils would report ASB if they saw an incident.

PSHE QUALITY MARK

DARLINGTON BOROUGH COUNCIL

Healthy Lifestyles Survey 2018/19 Executive Summary

Methodology

The Healthy Lifestyles Survey (HLS) is undertaken every year with children and young people who attend primary and secondary schools in Darlington. The process consists of an anonymous online survey which asks them about their experiences, attitudes and behaviours across a range of topics related to health and wellbeing. 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.

The results of this survey are fed back to schools and teams of professionals via the Team Around the School (TAS) meetings. This enables these schools, and other professionals, to use the responses from the survey to build an understanding of the needs of young people in their year groups and respond with an action plan for the following academic year.

The results from all the schools are collated into two whole borough data reports (one for primary aged pupils and one for secondary aged pupils) providing an insight into the common themes and issues that are affecting children and young people living in Darlington.

The results of the survey paint a picture of the attitudes and beliefs of young people in Darlington. This can help young people and professionals challenge preconceptions and make informed decisions about their own lifestyle choices and risk taking behaviour.

The Healthy Lifestyle Survey for primary schools this year was undertaken by **2,488** young people aged between 9 – 11 years old who were pupils of 23 different primary schools in Darlington. The survey took place from September to October 2018.

The Healthy Lifestyles Survey for secondary school this year was undertaken by **4,072** pupils aged 11- 16 who were pupils of seven different secondary schools in Darlington. The survey took place from November to December 2018.

Summary of results

The results indicate that young people of this age in Darlington largely understand the health information and messages they receive 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.

From the results of this year's surveys, key findings have emerged:

Key findings from the primary survey 2018/19

- Smoking and drinking behaviours, perceptions and attitudes have largely remained similar to previous year.

- Pupils understanding of acceptable behaviours in relationships have improved overall.
- The internet continues to be a large part of primary pupils' lives, especially the use of social media.
- A third of primary pupils have seen something upsetting online this year, in comparison to just over a quarter last year.
- A quarter of primary pupils play games rated 16 or 18.
- The percentage of pupils self-reporting having dental work has marginally decreased since last year, with the exception of tooth/teeth removal which has marginally increased.
- Levels of positive responses to the emotional wellbeing statements have remained similar to previous years.
- Just over three quarters of primary pupils report feeling stressed; homework is the most common reason for school-based stress, with siblings and bullying the most common forms of outside-school stress.

Key findings from the secondary survey 2018/19

- The majority of secondary pupils gave positive responses to the emotional wellbeing statements, although 3 in 10 pupils state they do not have someone to confide in/ talk about their worries to.
- 82.5% of secondary pupils reported feeling stressed; homework was the most common cause of school-based stress, and body image was the most common cause of outside-school stress (4 in 10 pupils).
- Parents/ guardians are the most common influence on diet in younger pupils (Y7 and 8) whereas what tastes nice was the more common influence in older pupils (Y9, 10, 11).
- Secondary pupils have very active online lives, and their online activity is mostly unsupervised by adults.
- Pupils have accounts/are accessing on average seven social media sites, with YouTube, Instagram and Snap Chat the most popular among Darlington pupils.
- 49% of secondary pupils have seen something upsetting online.
- The majority of secondary pupils have positive views on acceptable behaviours in relationships.
- Just over a third of pupils have taken part in anti-social behaviour (ASB); nearly 7 in 10 pupils stated they would know who to report ASB to, yet only 6 in 10 said they would actually report it.

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Darlington
Childhood Healthy Weight Plan

2019 - 2024

DARLINGTON BOROUGH COUNCIL

DARLINGTON | A MOST INGENIOUS TOWN

Contents

To transform the environment so that it supports healthy lifestyles

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 plans will focus on prevention, adopting a partnership approach and will be delivered 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).

Key messages

- The most recent measurements from Darlington (2017/18) 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 21.2%, this figure is more than double the figure at reception age where the percentage is 8.6%.
- 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 is 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 plan is in line with the recommendations outlined in the national government document Childhood Obesity: A Plan for Action (2016) and Childhood Obesity: A Plan for Action: Chapter 2 (2018).

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]

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. In 2018 Chapter 2 was published outlining actions to work across society setting a national ambition; **"to halve childhood obesity and significantly reduce the gap in obesity between children from the most and least deprived areas by 2030".**

- 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.

- 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.

[6] PMcKinsey 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

- 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%. 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]

- 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]

[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) 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

[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 years (Year 6). Prevalence of underweight, healthy weight, overweight, obesity and severe obesity can be examined at local authority level. 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 NCMP measurements from Darlington (2017/18) provide a childhood obesity profile for the town. Levels of obesity at reception age are slightly below the national and regional figures. By Year 6 levels of obesity have risen above the national average whilst remaining slightly below the regional. The figures below provide more detail for both age groups.

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

2017/18	Overweight	Obese (including severe obesity)	Overweight & Obese Combined	Severe obesity
England	12.8%	9.5%	22.4%	2.4%
North East	14.1%	10.9%	25%	2.8%
Darlington	**15.2%**	**8.6%**	**23.8%**	**1.8%**

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

Figure 3: Percentage of overweight and obese children at Reception[18] (ages 10 – 11 years)

2017/18	Overweight	Obese (including severe obesity)	Overweight & Obese Combined	Severe obesity
England	14.2%	20.1%	34.3%	4.2%
North East	14.7%	22.8%	37.5%	5.2%
Darlington	**12.4%**	**21.2%**	**33.6%**	**5.9%**

The percentage of children who are overweight (at reception age) and who are severely obese (in Year 6) are both above the national and regional figures. The percentage of children in reception classified as obese rises from below to above national figures by Year 6 (8.6% in reception to 21.2% in Year 6).

Figure 4: Reception Prevalence of obesity (including severe obesity) Darlington and its nearest CIPFA neighbours[19]

Area ▲▼	Recent Trend	Neighbour Rank	Count ▲▼	Value ▲▼	95% Lower CI	95% Upper CI
England	↑	-	58,196	9.5	9.5	9.6
St. Helens	↑	5	271	13.2	11.8	14.7
Warrington	↑	14	27	11.5	10.2	12.8
North East Lincolnshire	→	2	221	11.4	10.0	12.9
Rotherham	↑	12	360	11.3	10.2	12.4
Wigan	↑	15	399	11.0	10.0	12.1
Doncaster	→	13	388	10.8	9.8	11.8
Stockton-on-Tees	↓	1	252	10.5	9.4	11.8
Calderdale	↑	7	256	10.3	9.2	11.6
Dudley	→	3	389	10.3	9.3	11.3
Telford and Wrekin	-	8	206	10.0	8.8	11.4
Bolton	↑	6	382	10.0	9.1	10.9
Tameside	→	11	286	9.8	8.8	11.0
Plymouth	→	9	264	9.7	8.6	10.8
Derby	→	4	315	9.5	8.5	10.5
Darlington	→	-	101	8.6	7.1	10.4
Bury	→	10	189	8.0	7.0	9.1

Source: NHS Digital, National Child Measurement Programme

Compared with Benchmark: Better Similar Worse Not compared

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

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

Figure 5: Year 6 Prevalence of obesity (including severe obesity) Darlington and its nearest CIPFA neighbours[20]

Area ▲▼	Recent Trend	Neighbour Rank	Count ▲▼	Value ▲▼	95% Lower CI	95% Upper CI
England	⬆	-	116,134	20.1	20.0	20.2
Dudley	⬆	3	878	25.9	24.4	27.4
Derby	⬆	4	726	23.0	21.5	24.5
Rotherham	➡	12	702	22.8	21.3	24.3
St. Helens	➡	5	422	22.6	20.8	24.6
Doncaster	⬆	13	733	21.9	20.6	23.4
Telford and Wrekin	-	8	443	21.5	19.8	23.4
Stockton-on-Tees	➡	1	496	21.5	19.9	23.2
Darlington	⬆	-	242	21.2	19.0	23.7
Tameside 22.9	⬆	11	534	21.2	19.7	
Wigan	⬆	15	727	21.1	19.8	22.5
North East Lincolnshire	⬆	2	388	21.1	19.3	23.0
Bolton	⬆	6	782	20.8	19.5	22.1
Calderdale	⬆	7	503	20.8	19.2	22.4
Bury	⬆	10	458	20.5	18.9	22.2
Warrington	⬆	14	463	19.5	18.0	21.2
Plymouth 20.2	➡	9	464	18.6	17.1	

Source: NHS Digital, National Child Measurement Programme

Compared with Benchmark: Better Similar Worse Not compared

[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 group between 2006/07 and 2016/17. The prevalence varies, there is no strong trend, with figures dipping below and above the national average for both age groups over time.

Figure 6: Trend in obesity prevalence (including severe obesity) in children aged 4-5years (reception) in Darlington between 2006/07 and 2016/17[21]

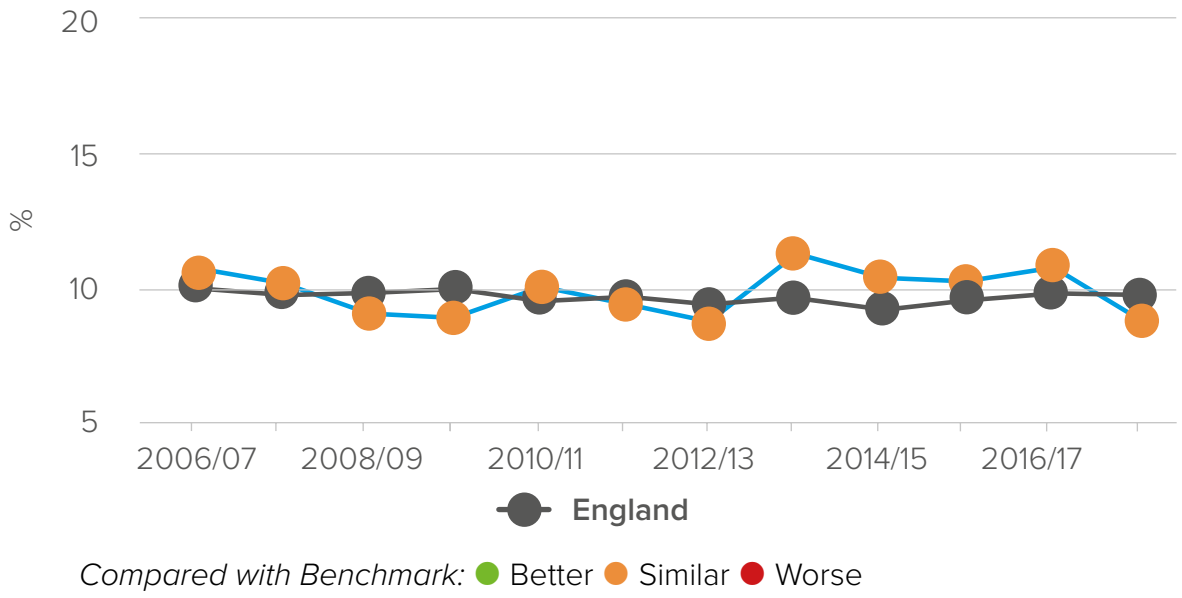
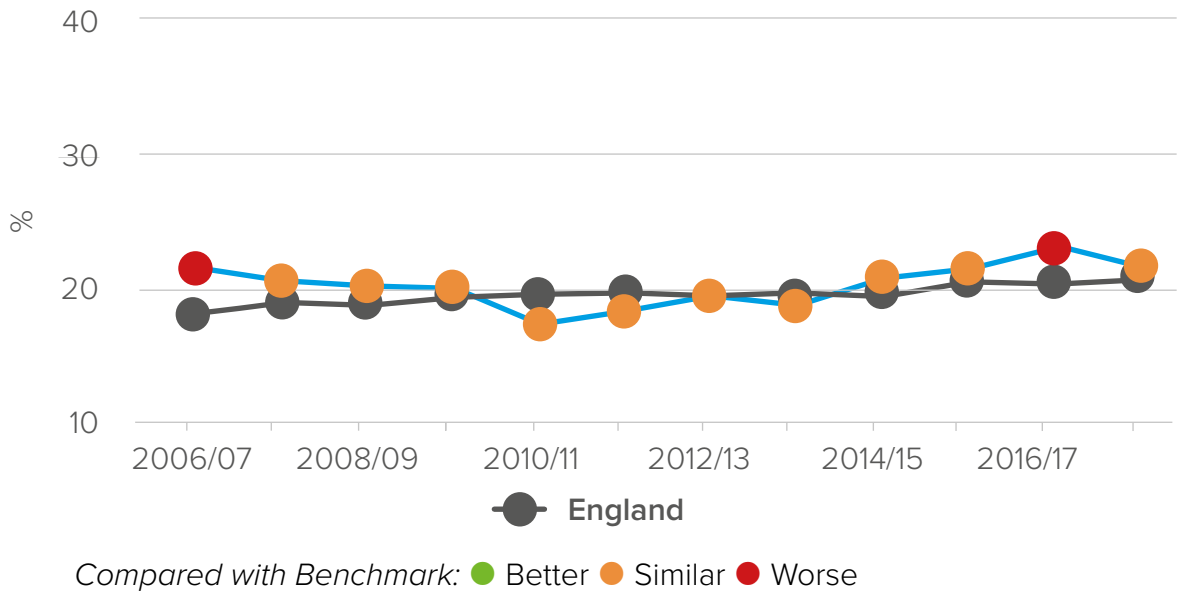


Figure 7: Trend in obesity prevalence (including severe obesity) in children aged 10-11years (Year 6) in Darlington between 2006/07 and 2016/17[22]



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

[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. Prevalence of obesity among children in reception (4-5years) in Darlington is below the national figure and the lowest in the region. There is an increasing trend in Darlington in relation to obesity among children in Year 6, with prevalence above the national average.

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

Area	Recent Trend	Count ▲▼	Value ▲▼	95% Lower CI	95% Upper CI
England	↑	58,196	9.5	9.5	9.6
North East region	↑	3,139	10.9	10.6	11.3
Middlesbrough	↑	259	13.0	11.6	14.6
Hartlepool	→	132	12.2	10.4	14.3
Newcastle-upon-Tyne	→	368	11.8	10.7	13.0
Redcar and Cleveland	→	176	11.6	10.1	13.3
Sunderland	→	327	11.4	10.3	12.7
Country Durham	↑	619	10.9	10.1	11.7
Northumberland	→	329	10.7	9.7	11.9
Stockton-on-Tees	↓	252	10.5	9.4	11.8
South Tyneside	→	169	10.4	9.0	11.9
North Tyneside	→	215	9.8	8.7	11.1
Gateshead	→	192	9.7	8.5	11.1
Darlington	→	101	8.6	7.1	10.4

Source: NHS Digital, National Child Measurement Programme

Compared with Benchmark: Better Similar Worse Not compared

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

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

Area	Recent Trend	Count ▲▼	Value ▲▼	95% Lower CI	95% Upper CI
England	↑	116,134	20.1	20.0	20.2
North East region	↑	6,287	22.8	22.3	23.3
Sunderland	↑	754	25.0	23.5	26.6
Newcastle-upon-Tyne	↑	667	24.6	23.0	26.2
South Tyneside	↑	375	24.2	22.1	26.4
Hartlepool	→	261	24.1	21.6	26.7
Middlesbrough	→	411	23.0	21.1	25.0
Gateshead	→	449	22.9	21.1	24.8
Country Durham d	↑	1,254	22.8	21.7	23.9
Redcar and Cleveland	↑	327	22.3	20.2	24.5
Stockton-on-Tees	→	496	21.5	29.9	23.2
Darlington	↑	242	21.2	19.0	23.7
North Tyneside	→	433	20.9	19.2	22.7
Northumberlan	↑	618	20.7	19.3	22.2

Source: NHS Digital, National Child Measurement Programme

Compared with Benchmark: Better Similar Worse Not compared

Although the previous figures show us that Darlington's prevalence of childhood obesity is slightly below the regional average they do not tell us if this is evenly spread across the town.

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

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]

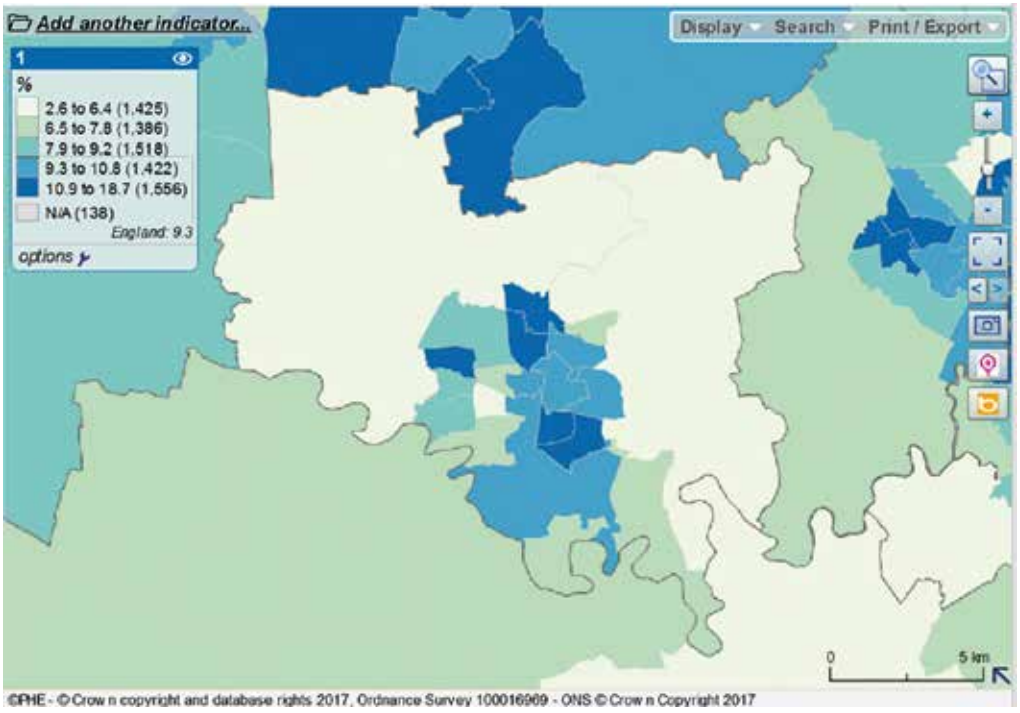
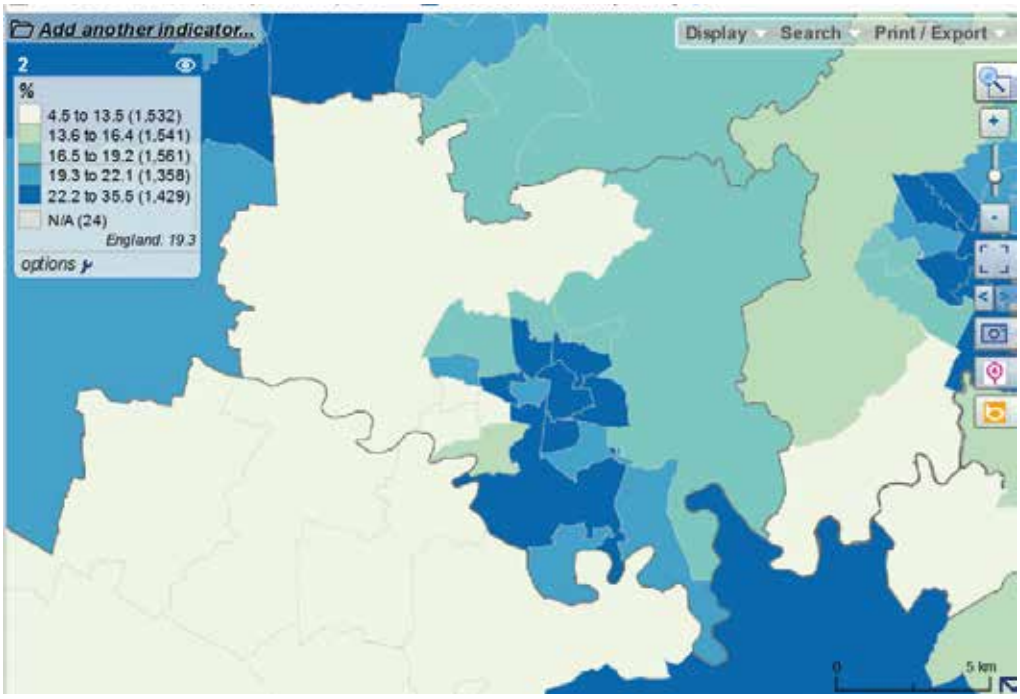


Figure 11: Distribution of obesity across Darlington in Year 6[26]



[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. The figures below show a 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]

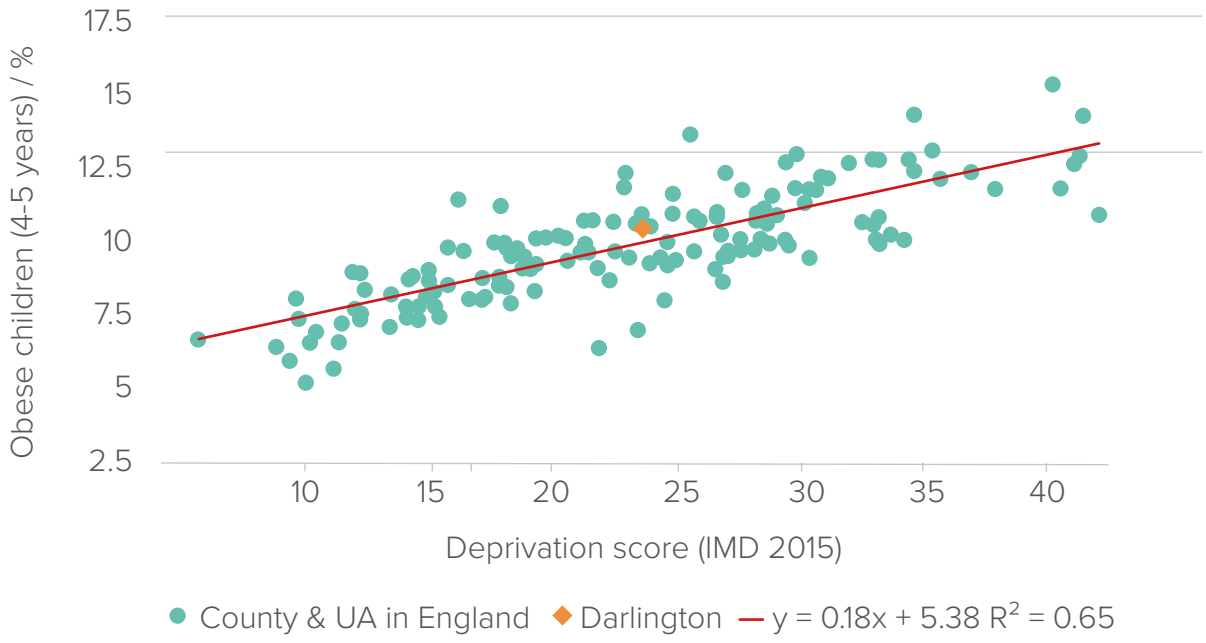
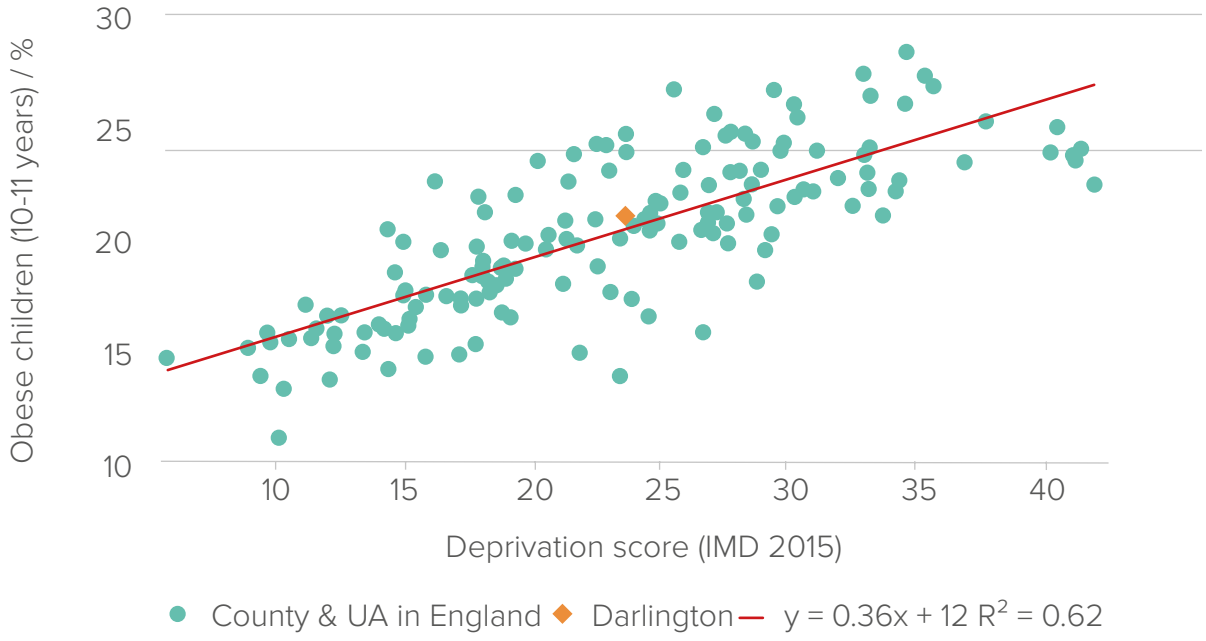


Figure 13: Correlation of obese children at Year 6 with deprivation score for England Local Authorities[28]



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

[26] 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]

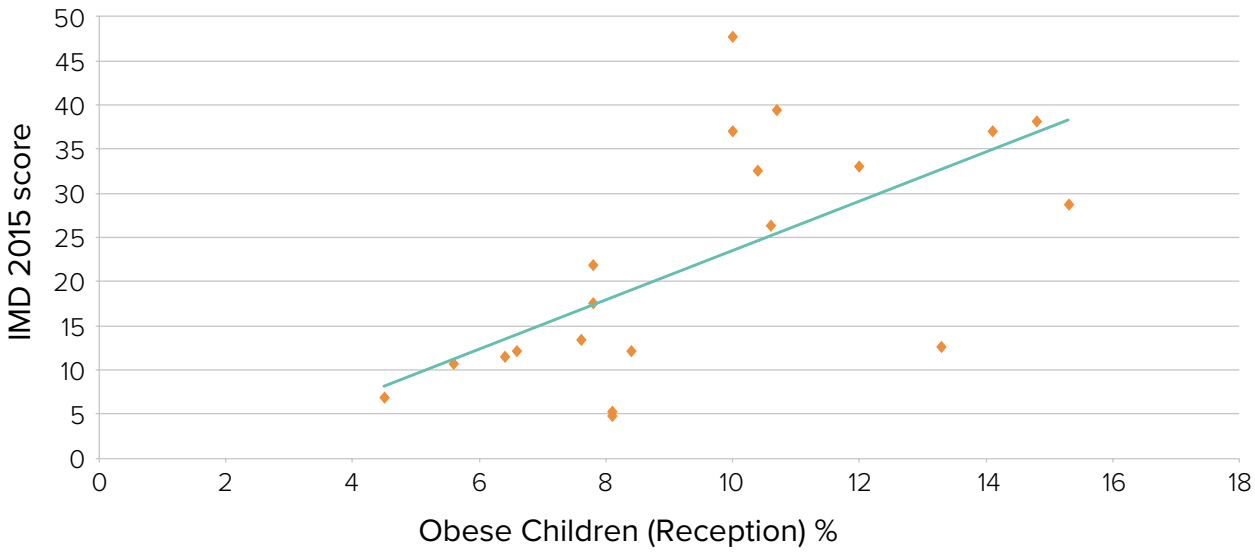
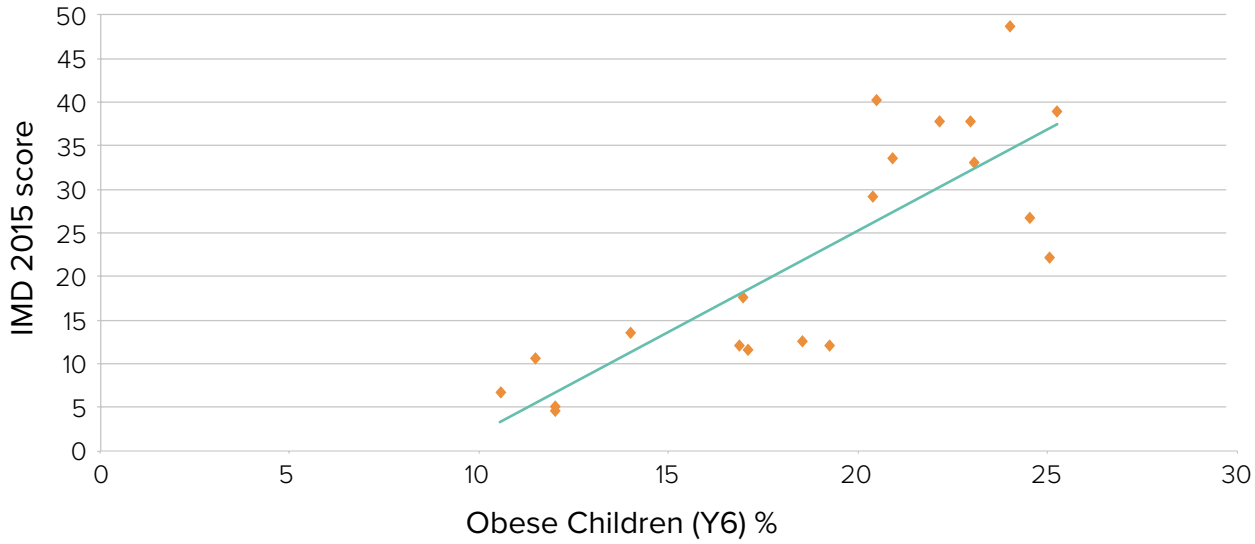


Figure 15: Correlation of obese children at Year 6 age by Darlington Ward compared to IMD 2015 score for Wards[30]



[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

A healthy lifestyle survey has been conducted in primary and secondary schools in Darlington since 2015. The Primary School Healthy Lifestyle Survey 2018/19 took place during September 2018 with 23 primary schools in Darlington submitting survey responses and 2,488 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:

- 79% of pupils included, 'to keep fit and healthy' as one of their reasons for exercising.
- The most popular activity was 'playing sports or games' (74%).
- 79% of pupils stated they eat a balanced diet. However 51% and 35%, respectively, reported that they eat sweets and chocolate and drink fizzy drinks everyday.
- 81% of pupils reported eating breakfast every day.
- 9% claimed to have energy drinks weekly. However 80% recognised that they were not good for health.

The Secondary School Healthy Lifestyle Survey 2018/19 surveyed 4072 children from across seven different schools. The key findings include:

- 63% of pupils included 'to keep fit and healthy' as one of their reasons for exercising.
- The most popular activity was 'walking or running around' (61%).
- 56% of pupils reported eating breakfast everyday.
- 70% of pupils reported that they eat a balanced diet. However, 55% and 41% respectively claimed that they eat sweets and chocolate and fizzy drinks everyday.
- 20% of pupils reported to have energy drinks weekly, however over 80% recognised that they were not good for health.

The results indicate that as children move from primary to secondary education they are less likely to eat breakfast (reduction from 81% to 59%) everyday. The consumption of sweets and chocolate and fizzy drinks slightly increases as they get older.

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 plan.

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]

There is broad consensus that obesity is the result of many factors, activities and determinants and requires action from individuals and wider society. We must support new ways of making the issue everyone's business at a local level. In 2017, Public Health England, the Local Government Association, Association of Directors of Public Health and Leeds Beckett University published a briefing for local authorities *'Making obesity everyone's business. A whole systems approach to obesity'*. [32] A whole systems approach is an ongoing, dynamic and flexible approach that enables stakeholders to come together, share an understanding of the reality of the challenge, consider how the system is operating and where there are the greatest opportunities for change. Stakeholders agree actions and decide as a partnership how to work together to bring about sustainable change. There are many potential stakeholders that can contribute to this agenda.

[31] Foresight Report: Tackling Obesity: Future Choices'

[32] Local Government Association Making obesity everybody's business: A whole systems approach to obesity

Figure 16: Partnership: The Key to Success[33]

A key 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 an important part of planning policy."[34]

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.[35]

The healthy choice is even more difficult to make in deprived areas, which have less disposable income and a higher density of takeaways.[36]

Darlington will seek to transform the environment so that it supports healthy lifestyles and make healthier choices easier by focusing on 3 key areas:

1. Out of home food provision
2 Access to green space
3. Active travel.

[33] Public Health Matters Blog: Designing a 'whole systems approach' to prevent and tackle obesity

[34] Healthy Lives: Healthy People

[35] Measuring Up The Medical Profession's Prescription For The Nation's Obesity Crisis Academy of Medical Royal Colleges' 201

[36] Public Health England. (2013) Obesity and the environment: fast food outlets

Out of Home Food Provision

- Public Health England estimated in 2014 that there are over 50,000 fast food and takeaway outlets, in England. On average, there are more fast food outlets in deprived areas than in more affluent areas.
- The increasing consumption of meals out of the home or takeaways has been identified as an important factor contributing to rising levels of obesity.[37]

Source: PHE, Public Health matters blog: Health Matters: Obesity and the food environment

- 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.

[37] Government Office for Science. Tackling obesities: future choices - project report (2nd edition)

- 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.
- Local councils and food businesses (such as fast food takeaways, restaurants, cafes, mobile food vendors, market stalls, corner shops, convenience stores, leisure centres and children's centres) have great influence over the lives of their local community.
- There are examples of councils working with outlets to create a healthier food environment.

Source: PHE, Public Health matters blog: Health Matters: Obesity and the food environment

- 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 important areas for action.
- 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.

Figure 17: Hot food takeaway "hotspots" heat map[38]

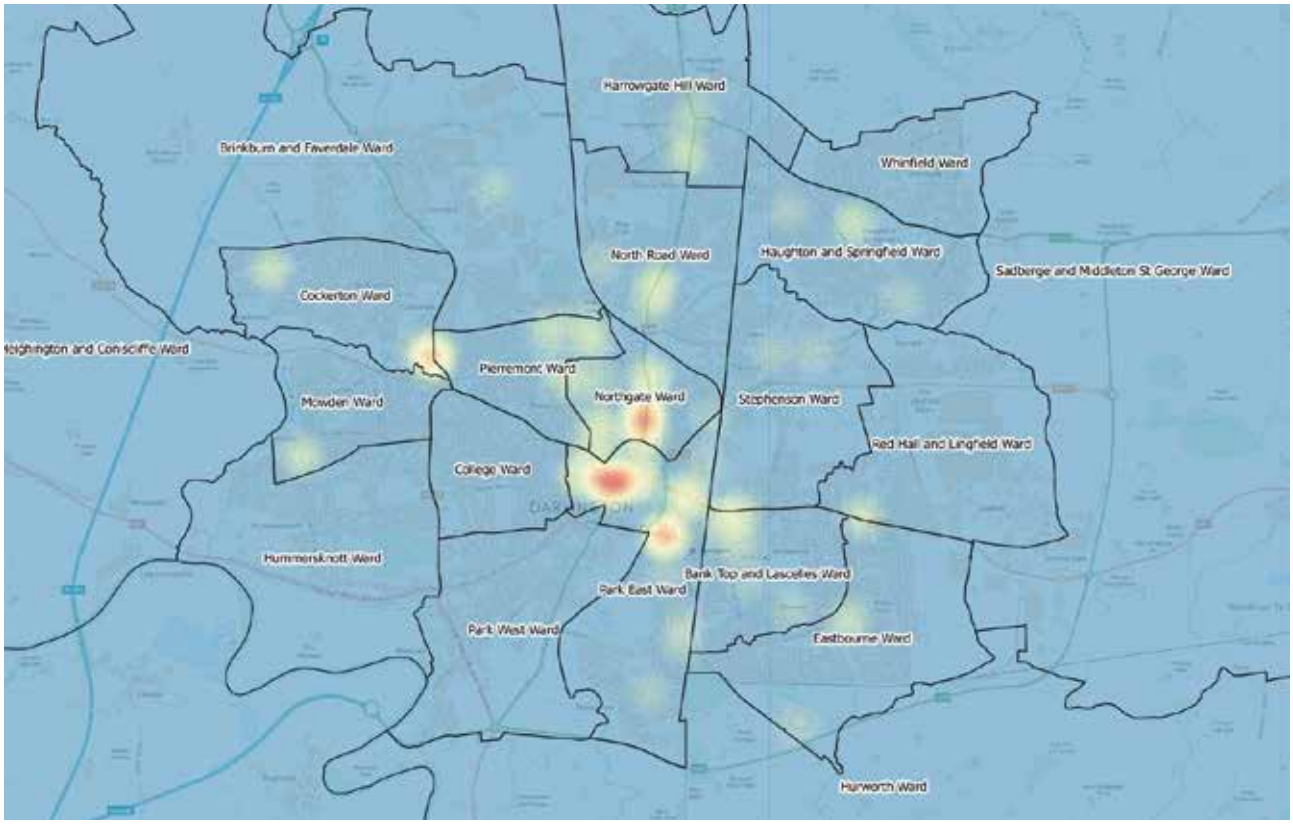


Figure 18: Number of hot food takeaway outlets by ward[39]

2015 Ward Name	Number of Outlets
Bank Top & Lascelles	9
Cockeron	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 Hill & Lingfield	4
Sadberge & Middleton St George	4
Stephenson	6

[38] Created by Public Health Team QGIS

[39] 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.[40]

- Improving access to green spaces for all social groups can reduce health inequalities due to the unequal access to green space across England.[41] 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.[42] Research shows that there are higher levels of physical activity in areas with more green space.[43]

- Green spaces come in a wide of forms including established parks and woodlands, natural grasslands and wetlands and green corridors such as riverbanks and cycle ways.[44]

- 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.[45]

- 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 accompanying this document 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.

[40] World Health Organisation Urban Green Spaces and Health

[41] PHE Local Action on Health Inequalities: Improving Access to Green Space

[42] PHE Local Action on Health Inequalities: Improving Access to Green Space

[43] 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.

[44] Building the foundations: Tackling obesity through planning and development

[45] Public Health England, 2014, Local action on health inequalities: Improving access to green spaces

Figure 19: Open spaces with wards whole Borough[46]

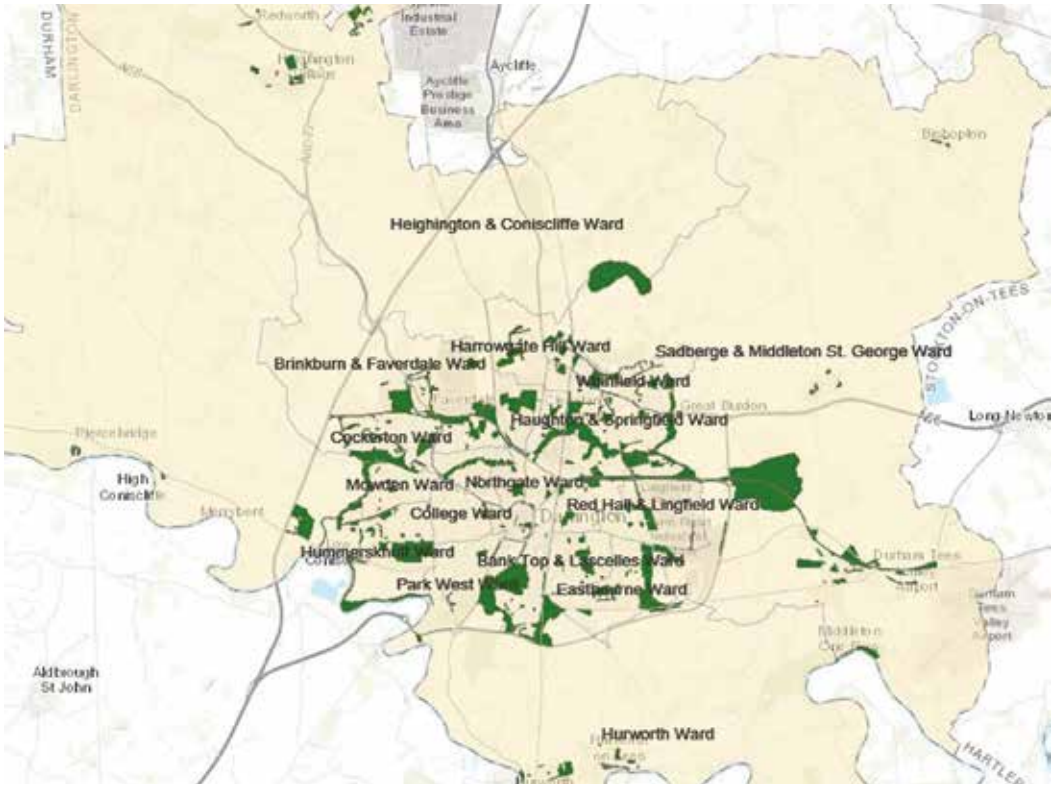
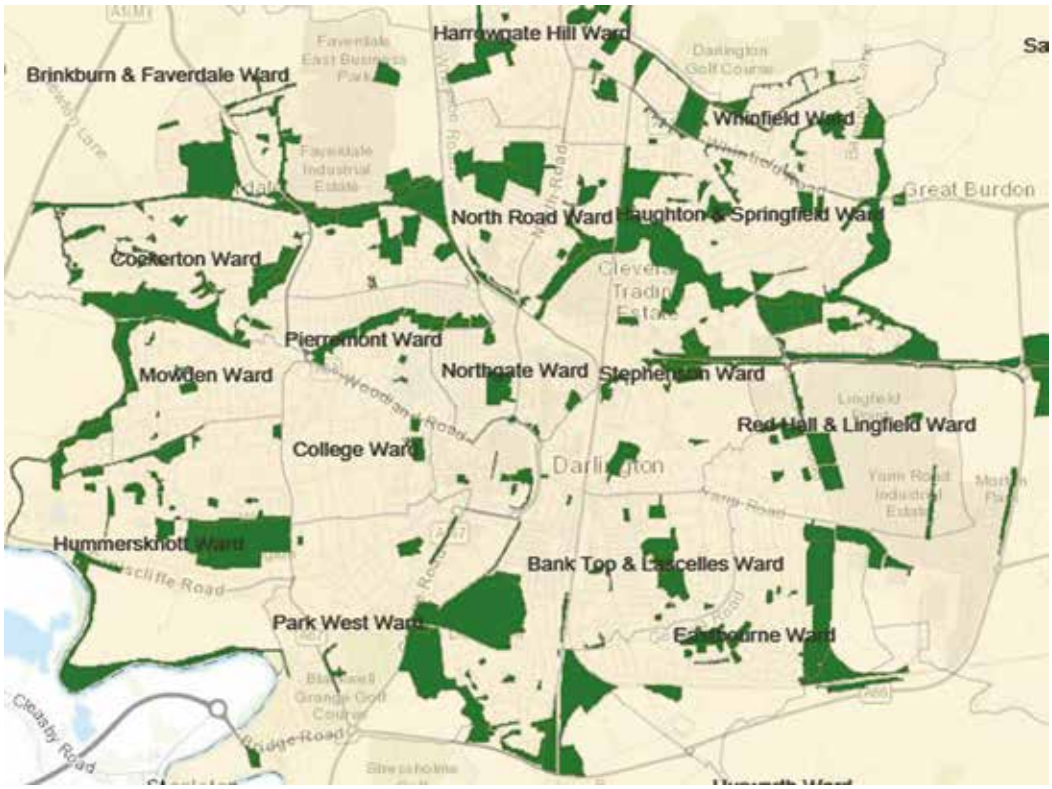


Figure 20: Open Spaces within Town Centre Wards, The Centre Of The Borough[47]



[46] ArcGIS online

[47] ArcGIS Online

Active Travel

- Darlington's Active Travel Strategy works to support 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.[48]

- 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.[49] However, over a third of adults report they are not as active as recommended suggesting that the true proportion is even less.[50]

- 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.[51]

- Practical actions to improve active travel in children include mapping to and from school journeys and identifying and overcoming barriers to active 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.

[48] Healthy people, healthy places briefing Obesity and the environment: increasing physical activity and active travel

[49] 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.

[50] Healthy people, healthy places briefing Obesity and the environment: increasing physical activity and active travel

[51] Cavill N. Increasing walking and cycling: a briefing for directors of public health. 2013. www.noo.org.uk/slide_sets/activity. (updatedMarch 2016)

Darlington Oral Health Plan 2017-2022

DARLINGTON | A MOST INGENIOUS TOWN

DARLINGTON BOROUGH COUNCIL

Contents

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].

Councillor Andrew Scott
Health and Partnership Portfolio Lead

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].

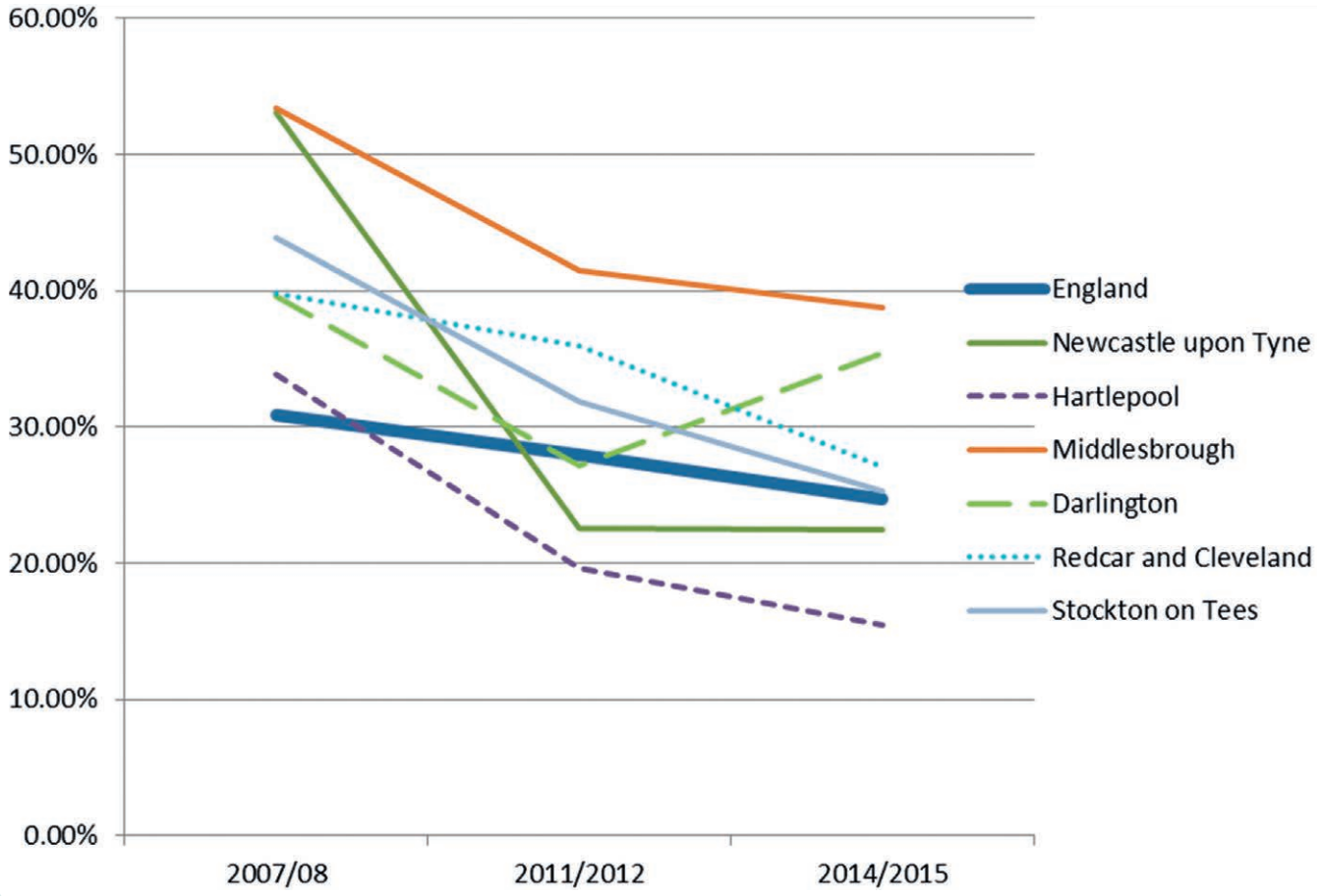
According to the 2015 national dental epidemiological survey of 5 year olds , the proportion of five-year-old children in Darlington who were free from visually obvious dental decay (d3mft = 0) was 64.6% . This was worse than that reported in the North East of England of 72% and that in England of 75.2%.

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]

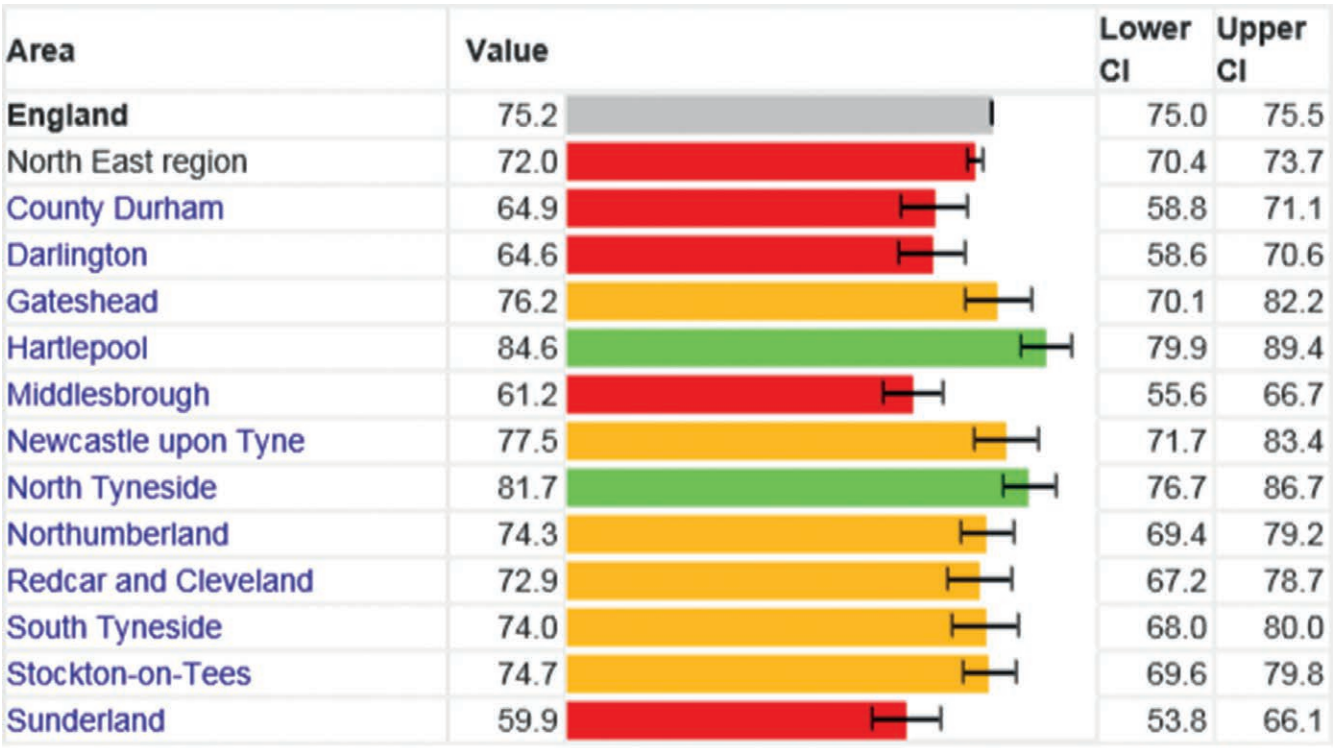
	2008/09	2011/2012	2014/2015	reduction in caries prevalence between 2012- 2015	reduction in caries prevalence between 2008- 2015
England	30.90%	27.90%	24.70%	3.20%	6.20%
Hartlepool	33.80%	19.60%	15.40%	4.20%	18.40%
Middlesbrough	53.40%	41.50%	38.80%	2.70%	14.60%
Darlington	39.60%	27.20%	35.40%	-8.20%	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]

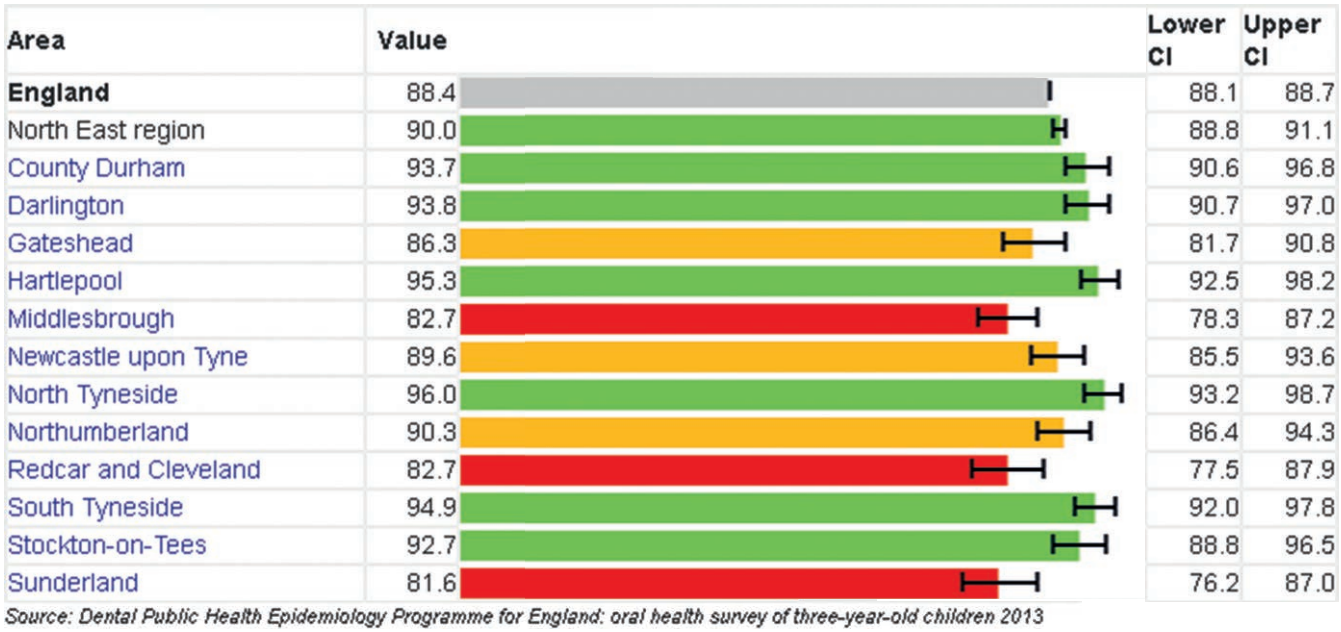
Ward name	Children examined	Children selected	Proportion seen	dmft
Cockerton East Ward	38	56	68%	1.7
Cockerton West Ward	25	49	51%	1.9
Eastbourne Ward	53	84	63%	2.2
Harrowgate Hill Ward	50	72	69%	0.5
Haughton West Ward	49	69	71%	1.1
Heighington and Coniscliffe Ward	26	35	74%	0.4
Middleton St. George 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]



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

Report Author: Dr. Balsam Ahmad, Speciality Registrar in Public Health, Public Health Team, Darlington Borough Council

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

Darlington Oral Health Plan 2017-2022

DARLINGTON BOROUGH COUNCIL

CHILDREN AND YOUNG PEOPLE SCRUTINY COMMITTEE
2 September 2019

INDEPENDENT REVIEWING OFFICER ANNUAL REPORT 2018-19

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, A guide to inter-agency working to safeguard and promote the welfare of children (July 2018). 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 Members note the content of this annual report

Suzanne Joyner
Director of Children and Adults Services

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

8. IROs undertake a range of non-statutory functions including, providing advice and guidance to professionals, facilitating single and multi-agency child protection training, are members of formal panels, management meetings and undertake case learning audits.

Staffing Levels and Caseloads

9. 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.

10. During 2018-19 the IRO team has been stable and all substantive posts are currently permanent appointments. At 31 March 2019 there were 5.4 IRO posts; 5.2 post (96%) are permanent and the additional 0.2 post is 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 (2010) recommends that caseloads for IROs need to be between 50 and 70 LAC children. Ofsted's; *Independent Reviewing Officers: taking up the challenge?* (2013) found that the average caseload was slightly above 80 cases and a national benchmarking survey (2013) placed the average caseload for an IRO between 50 and 95.

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. 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.

15. Over the last 12 months, the requirement around the size of caseloads for IROs in Darlington has increased from an average of 66 children to 71 children which at the upper limit of the statutory guidance. This represents an increase in caseloads of 7.6%.

16. This figure does not include additional work undertaken by IROs:

    - one IRO is a member of the Children's Placement Service Panel (14 Panels held annually)
    - another provides Multi-agency Child Protection training sessions (12 sessions in year).

17. When caseloads are manageable it allows 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.

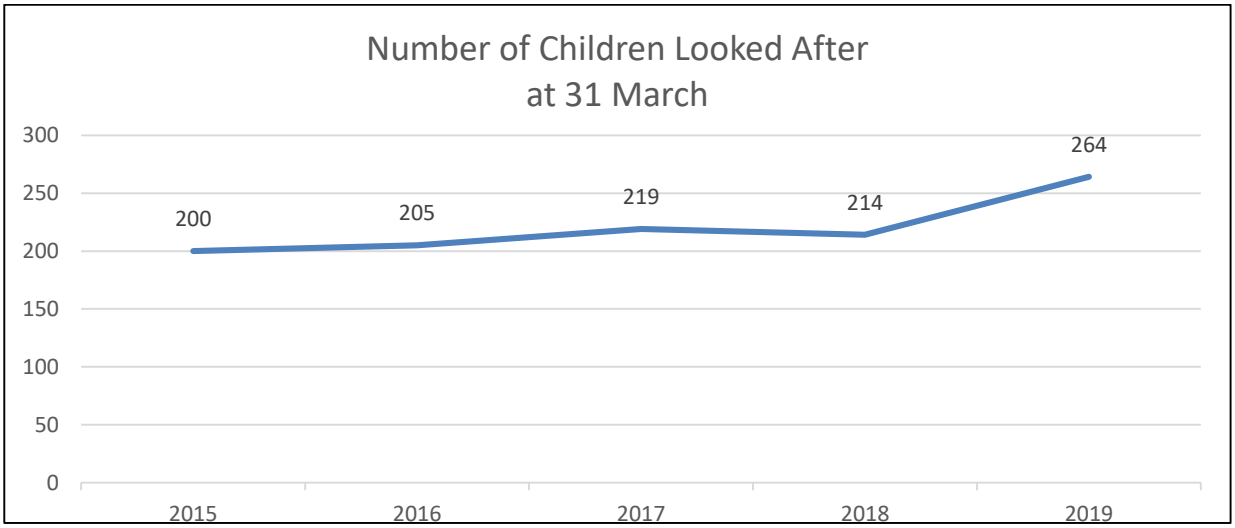
18. In addition to LAC Reviews and Child Protection Conferences, IROs also undertake monthly case file audits and the chairing of, Secure Reviews and Disruption Meetings.

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 2019 there were 264 Children Looked After in Darlington, a significant increase when compared to the previous year (214). This follows the relatively stable position that has been in place since 2016.

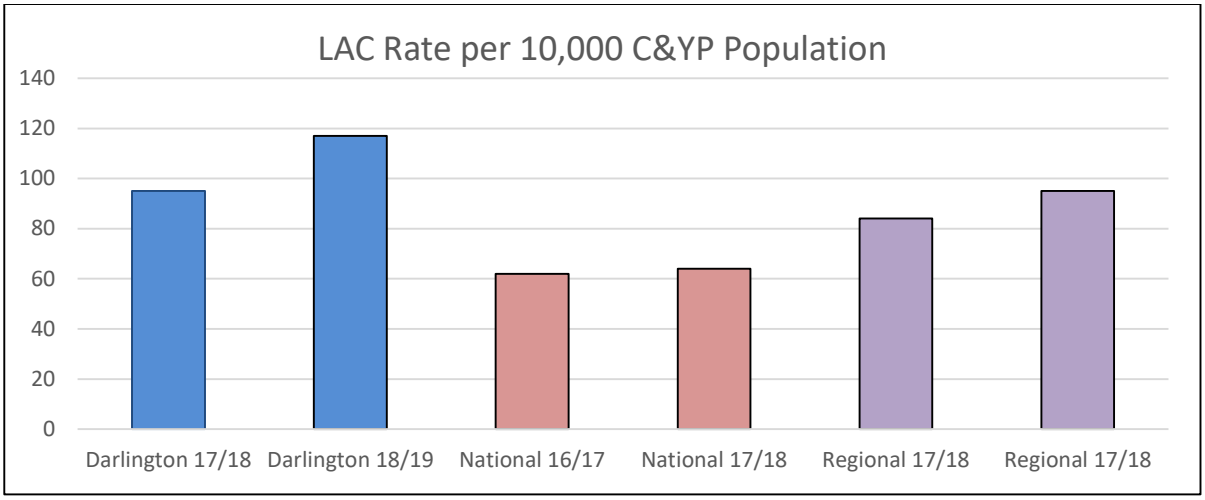
23. The chart below shows the monthly number of Looked After Children (LAC) over the last 5 years.



24. The rate is Darlington has remained comparatively high it plateaued with only small increases though 2016 to 2018, however there has been a significant increase in numbers over the last 12 month period.

Looked After Children rate per 10,000

25. 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).



26. At the end of March 2019, 264 children were looked after by Darlington a rate of 117.2 per 10,000, a significant increase from the outturn figure for 2017/18 of 95.0 per 10,000.

27. Analysis shows that Darlington continues to have a significantly higher rate of Looked After Children than both the Regional and Statistical neighbours' average. It should be noted the most recent published data is as of 31 March 2018 and there has been a national increase in Children Looked After over the year. The comparator figures for 31 March 2019 will be published in the autumn.

LAC Demographics

Age Looked After Children (as of 31st March)	2015	2016	2017	2018	2019	
Under 1	7%	8%	8%	5%	20	8%
1-4	19%	18%	16%	15%	42	16%
5-9	19%	21%	26%	26%	68	26%
10-15	38%	34%	33%	35%	103	39%
16-17	18%	20%	17%	18%	31	12%
Total	200	205	219	214	264	

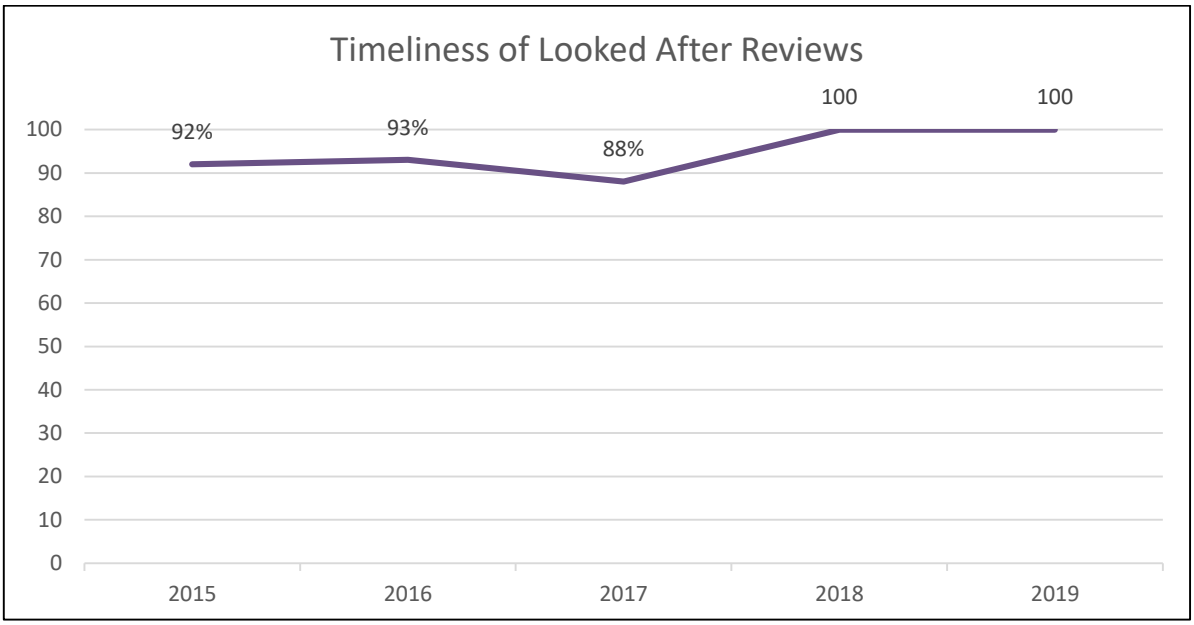
28. The age profile of Darlington's Looked After population has remained stable over the last 4 years. The majority of Looked After Children in Darlington are aged between 10 and 15 years which is similar to the distribution nationally.

Ethnicity of Looked After Children (as of 31st March)	2015	2016	2017	2018	2019	
White	94%	94%	90%	92%	239	91%
Mixed	5%	4%	6%	4%	14	5%
Asian or Asian British	2%	1%	3%	3%	8	3%
Black or Black British	1%	1%	1%	1%	3	1%
Other	0%	0%	0%	0%	0	0%
Total	200	205	219	214	264	

29. 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



30. The above chart shows that during 2018-19 performance in relation to the percentage of LAC cases which were reviewed within statutory timescales was 100%, an improvement on the figures for the previous 4 years performance.

LAC Participation and contact with IRO

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

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

- attending their Review and speaking on their own behalf;
- attending their review but having another person speak for them;
- not attending the review but providing their views in a written form or through another facilitative medium; and /or
- not attending the review but briefing an advocate to represent their views

33. Children's participation in their Looked After Review looks at those children over the age of 4 years who participate in their statutory review through attending or other form of contribution (via advocate, written submission etc.). At the end of this reporting year, 712 individual Looked After Reviews were held, a 24% increase on the 576 held the previous year.

Aged Under 4	C&YP Participation in Reviews (over the age of 4 years)	
	Participated	Did not Participate
169	485 (90%)	54 (10%)

34. 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.

35. 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 LAC review. All contact details are provided at the time of allocation.

36. 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.

37. 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

38. 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.in 2018/19 all children had their permanency plan discussed at their 4 month review.

39. 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

40. 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.

41. The IRO Dispute Resolution Process was revised in September 2018. Monitoring the progress of disputes raised shows that the majority of the challenges in 2018/19 were resolved either directly with the Social Worker or their Team Manager.

42. There is increased evidence of the 'IRO footprint' being evidenced on children's records. The letter form Ofsted following the Focused Visit in February 2019 stated:

- Independent reviewing officers (IROs) have become more effective since the last inspection (February / March 2018). They appropriately challenge Social Workers and Team Managers to help progress plans and reduce delay for children.

Foster Carer Reviews

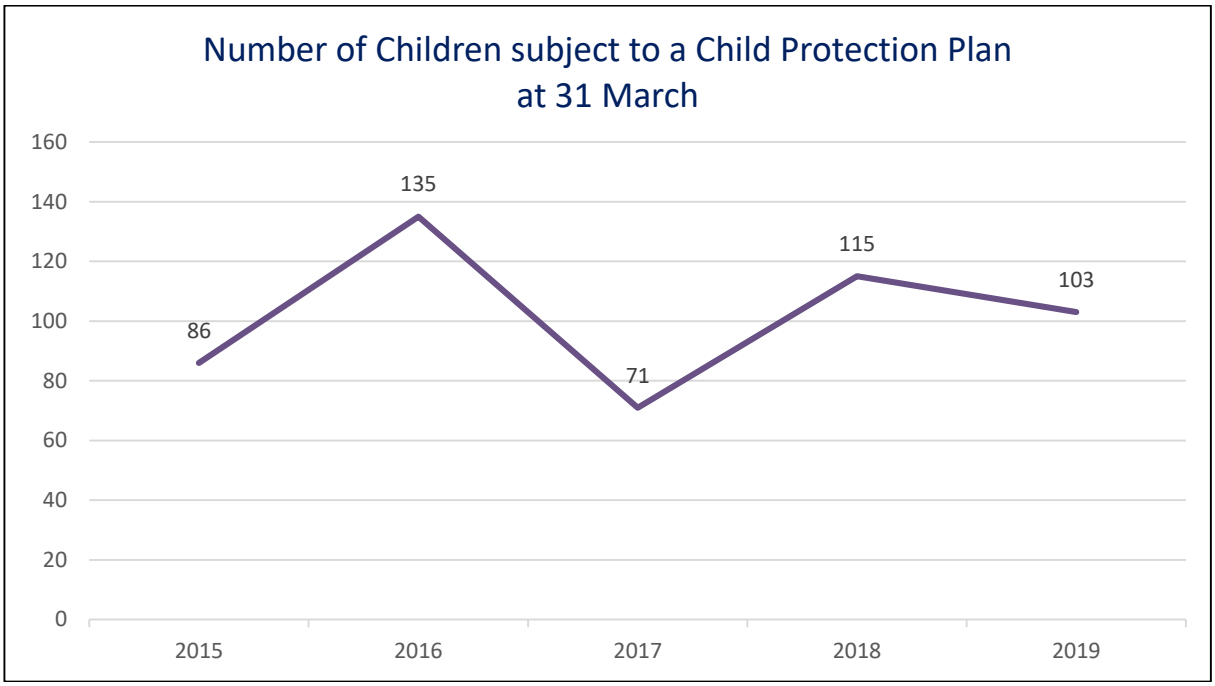
43. Local Authorities are required by Regulation 29 (The Fostering Services Regulations 2001) to review the approval of foster carers at least once a year and the Reviewing & Development Service is responsible for undertaking the annual reviews. The additional part-time agency IRO has been retained. 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.

44. Any significant changes to circumstances, or concerns raised at the Annual Review, are referred to the Children's Placement Service Panel.

Child Protection Activity

45. Number of Children subject to Child Protection Plans

The chart below shows the number of Children subject to Child Protection Plans (CPP) over the last 5 years.



46. The total number of children with a Child Protection Plan on 31st March 2019 was 103; a rate of 45.7 per 10,000 children under the age of 18yrs. This is a decrease from the figure position at the end of March 2018, when the figure stood at 115 (a rate of 51 per 10,000).

Rate per 10,000 of Children Subject to Child Protection Plans at 31st March National stats table (D1)	2017/ 18			2018/19
	Darlington	North East	England	Darlington
	51.2	65.7	45.3	45.7

47. The rate of children who were the subject of a Child Protection Plan as of 31 March 2019 is below North East and inline England averages of 31st March 2018. Published benchmark data for 2018/19 will be available later in the year.

Number at 31st March	2014	2015	2016	2017	2018	2019
Darlington National Stats table (D1)	140	86	135	71	115	103

Child Protection Demographics

48. At the end 2018/19, of the 103 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.

49. Nationally the most recent published data for March 2018 was:

    - 48% Neglect, 38% Emotional Abuse, 6% Physical Abuse, 4% Sexual Abuse and 5% Multiple-categories (note: multiple-categories should not be used).

50. The proportion of Children subject to Child Protection Plan where the risk is Physical Abuse or Sexual Abuse are broadly in line with the national position. The interpretation of the impact of emotional harm in cases of neglect may inflating the percentage of cases categorised as being at risk from Emotional Abuse.

51. On the 31st March 2018 there were 115 children subject to Child Protection Plans; over the 12 months to 31st March 2019 this had decreased to 103 children. 192 Children had Plans removed and 180 new Plans were made.

CP Plan Activity	2014/15	2015/16	2016/17	2017/18	2018/19
Becoming subject to a CP Plan	124	171	102	138	180
Ceasing to be the subject of a CP	179	122	166	94	192
Increase / decrease	-54	+49	- 64	+44	-12

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

53. There were 180 new Child Protection Plans made and 192 children had their Plans discontinued in the year 2018/19, which is a relatively stable position when compared to the larger fluctuations seen in previous years.

54. Over the year, 114 Initial Child Protection Conferences, of which 19 were Transfer Conferences [a combined total of 210 children] and 191 Child Protection Review Conferences were held [375 children].

55. The corresponding figures for the previous year were 85 Initial Child Protection Conferences [157 children], 7 Transfer Conferences [combined total of 173 children] and 135 Child Protection Review Conferences [256 children].

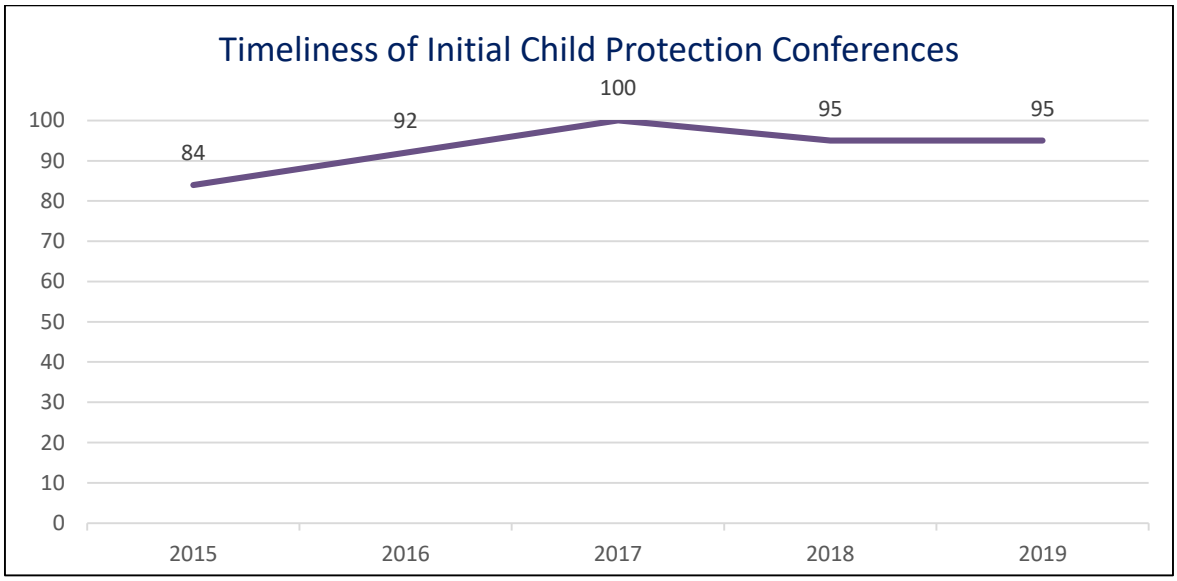
56. The table above shows overall Child Protection Conference activity over the last 5 years. In the last year the number of children who were the subject of an ICPC increased by 34%, from 157 to 210, correspondingly the number of children subject to a Child Protection Review Conference also increased [by 46%].

Meeting Activity	2014/15	2015/16	2016/17	2017/18	2018/19
ICPC	64	103	72	85	14
Transfer	6	4	6	7	19
CPRC	168	149	194	135	135

57. In the year, the proportion of children subject to ICPCs who were not made subject to a Child Protection Plan was 14.3% similar level to the previous year [12.1%].

58. In Darlington 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 was the same position over the year April 2018 – March 2019; no child with a disability was 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

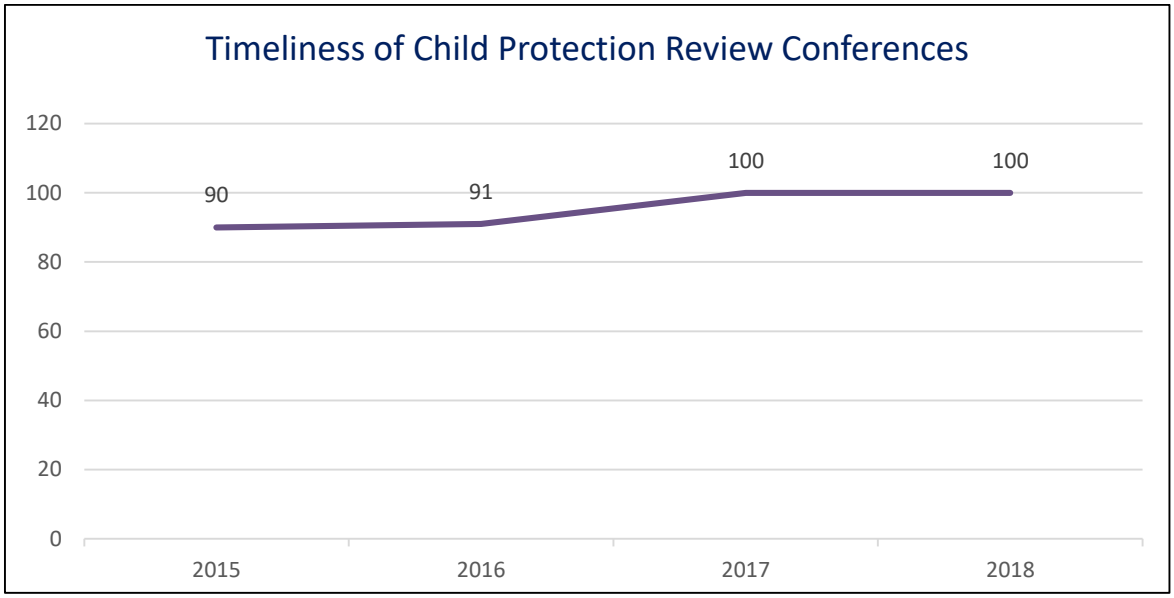


59. The chart above tracks the ICPCs held within the year and records the percentage that are held within 15 working days of the Section 47 enquiry.

60. For the year to 31st March 2019, 134 (95.4%) of children were subject to an ICPC (excludes transfer conferences) that was held within the prescribed 15 working days of the Section 47 Enquiry. This is at the same level as the previous year and remains higher than statistical benchmarks; regional [83%], statistical neighbours [86%] and national benchmark of [77%].

Timeliness of CPRCs

61. 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.



62. 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.

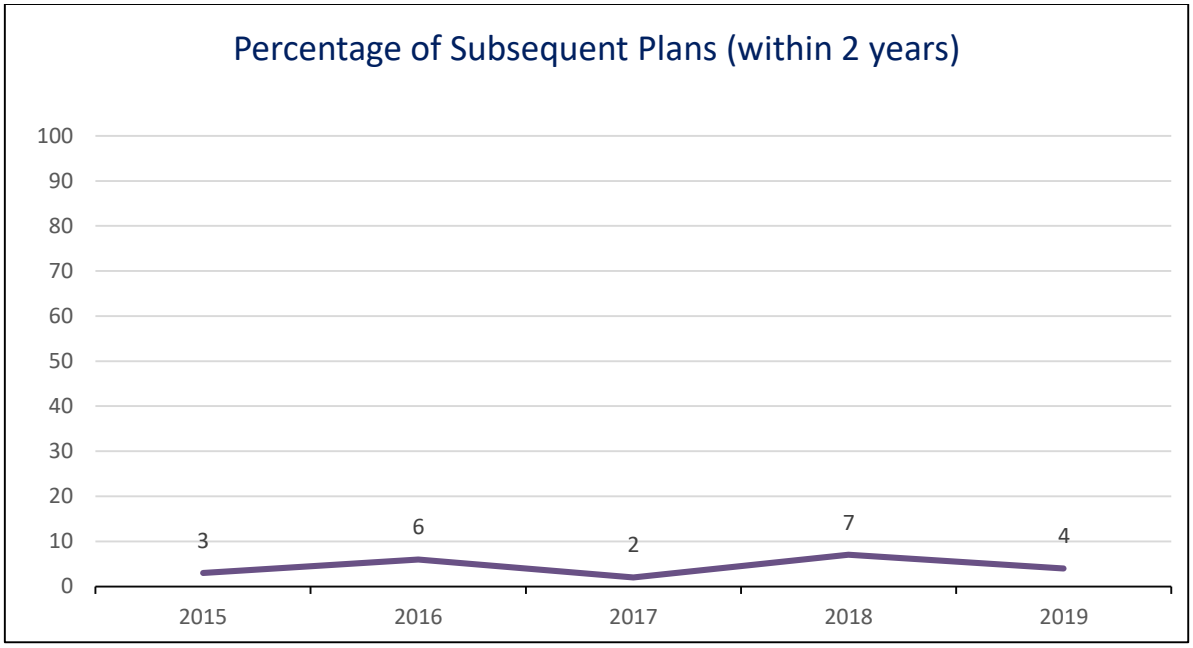
63. For the year to 31st March 2018, all but one of the 191 of Child Protection Review Conferences were held within timescales [99.9%], a slight drop. Again performance in this area remains higher than regional [92%], national [91%] and statistical neighbours [95%].

	2017/2018			2018/19
Child Protection Review Conferences within timescales	Darlington	North East	England	Darlington
	100%	92%	91%	99.9%

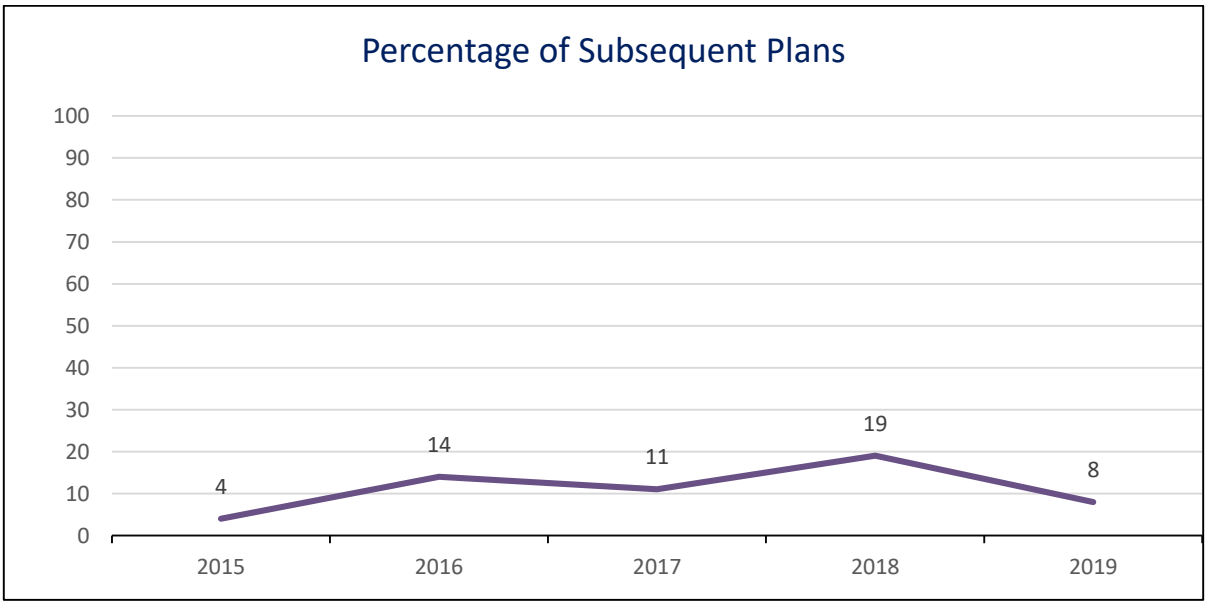
64. Published benchmark data for 2018/19 will be available later in the year.

Second or Subsequent Plans

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

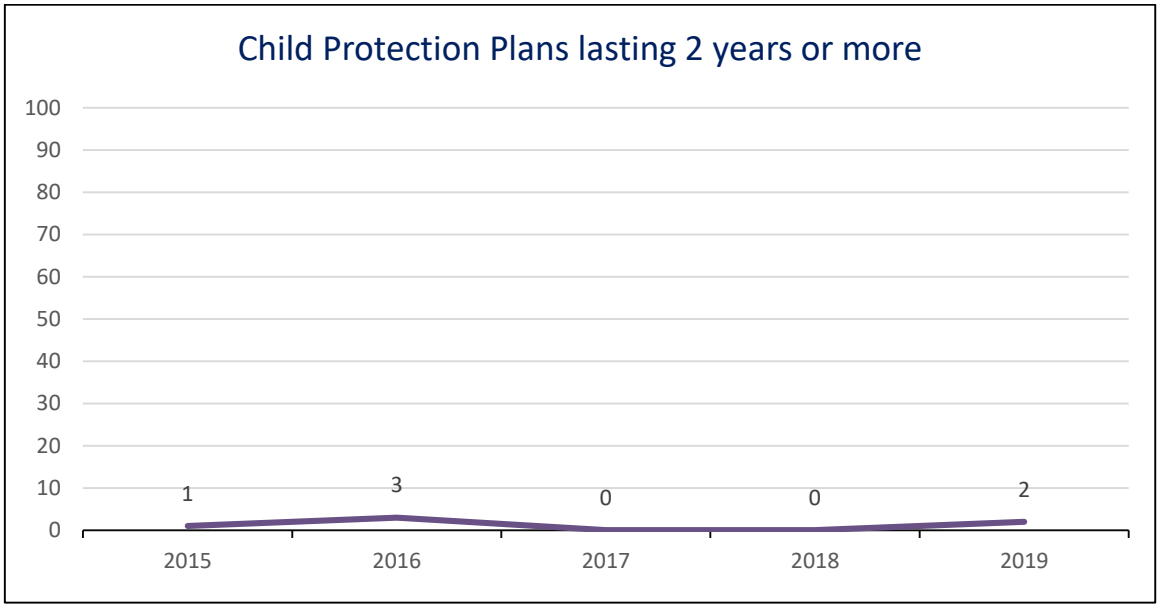


66. This indicator is a proxy for the level and quality of service a child receives. Its purpose is to monitor whether Children's Social Care Services devise and implement a Child Protection Plan which leads to lasting improvement in a child's safety and overall well-being. Good performance for this 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.



67. National benchmarked data is based on a second or subsequent plan being agreed at any time after a previous plan. Our rate for 2018-19 was 7.8%, this is an improvement on the previous year and continues to better than both the England average of 20.2% and the regional average which is 20.3% (most recent published data).

Child Protection Plans lasting 2 years or more



68. 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.

69. 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.

70. 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:

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

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 1.6% during the year to 31st March 2019.

72. The percentage of Child Plans ceasing where the plan had lasted more than 2 years in Darlington is currently below both the North East average [2.2%] and England [3.4%] averages at 31st March 2018. Published benchmark data for 2018/19 will be available later in the year.

Family attendance at Conference

73. In the year, out of 95 invitations, parents attended 89 Initial Child Protection Conferences, a total of 94%, in-line with the rate in recent years.

74. In the year, out of 191 invitations, family members attended 173 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	2018/19
Percentage of ICPCs attended by parent	95%	97%	94%	95%	94
Percentage of CPRCs attended by parent	91%	94%	91%	91%	91%

75. Over the year to 31st March 2019, 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:

- Workload Allocation
- Supervision and Personal Development Review (PDR)
- Team Meetings
- Audit
- Training and Development
- 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. The team has been permanent staffed over the covered by this period of this report, with no staff changes requiring temporary cover. This is positive position when compared to previous years.

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:

- Caseloads
- Performance issues (team / individual)
- Relevant case discussions
- IRO Disputes
- Training (attended / needs identified)
- Involvement of young people (visits by IRO / attendance at conference / LAC Reviews)

83. Annual 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 2018/19 all IROs have completed Learning Audits in line monthly quality assurance cycle. Following the Ofsted re-inspection (February and March 2018), the Quality Assurance Framework was revised and IROs haven been integral to the Learning Audits programme in line with the new arrangements which has included involving the case holder in the audit process.

Training and Development

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

87. Bespoke Disruption Meeting Training for IROs in has been commissioned and will held (sub-regionally) in May 2019.

Observations

88. The Children's Safeguarding Unit is open to external scrutiny. During 2018/19 this has included a programme of observations by the Local Safeguarding Children Board. Five Observations were completed by Board Members form October 2018 – January 2019.

89. A programme of direct observations of Looked After Reviews is scheduled to be undertaken by the IRO line manager.

Next steps for 2019/20

90. The following are scheduled for action in 2019/20

a) Create:
- an IRO Manager post.

b) Review:
- arrangements for the completion of Annual Foster Carer Reviews.
- The team structure to ensure there are sufficient numbers of IROs to fulfil statutory functions and reduce previous reliance on agency staff cover.

c) Embed:
- adopted procedures for the IRO Dispute Resolution Process, and Disruption meetings

d) Promote:

- the participation and attendance of young people and their families in child protection conferences.
- the take up of Advocacy services for children and young people.

CHILDREN AND YOUNG PEOPLE SCRUTINY
2 SEPTEMBER 2019

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, April 2018 to March 2019 and to highlight the required actions for April 2019 to March 2020.

Summary

2. In line with the national guidance, the Designated Officer function is to ensure that:

   (a) Advice and guidance is provided to partner agencies and staff where an allegation is made against a person who works with children (paid or voluntary capacity).
   (b) The Designated Officer will facilitate and oversee this process. The Designated Officer does not investigate. That is the role of the employer or if a criminal allegation, the Police.
   (c) 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 is effectively disseminated.

4. All organisations working with children in Darlington are required to policies and procedures in place 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.

6. The allegation can be in connection with:
   (a) Employment
   (b) voluntary activity
   (c) Work placement
   (d) The individual's own children
   (e) Related to the community or private life of a partner, member of the family or other household member.

Recommendations

7. It is recommended that:

(a) The contents of the report and the work undertaken during 2018/19 and the priorities of the Designated Officer service for 2019/20 be noted.
(b) That the annual report be agreed.
(c) That the report be publicised on the Darlington Safeguarding Partnership website;
(d) To consider how to promote the role of the Designated Officer 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

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

Designated Officer Annual Report 2018-19

Managing allegations and concerns against staff, carers or volunteers

Contents

Appendices

Designated Officer Annual Report 2018-19

Managing allegations and concerns against staff, carers or volunteers

1.0 Purpose of report

1.1 The purpose of this report is to update the Darlington Safeguarding Board and partners on the progress and performance of the Designated Officer (DO), (previously known as the Local Authority Designated Officer LADO) April 2018 to March 2019 and to highlight the required actions for April 2019 to March 2020.

2.0 Introduction / National Context

2.1 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 (July 2018) and Keeping Children Safe in Education: statutory guidance for schools and colleges (September 2018).

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

- Advice and guidance is provided to partner agencies and staff.
- Any allegation made against a person who works with children in either a paid or a voluntary capacity is investigated. The Designated Officer will facilitate and oversee this process to conclusion. The Designated Officer does not investigate. That is the role of the employer or if a criminal allegation, the Police.
- Designated Officer meetings are effectively chaired and an agreed outcome of the investigation is established.
- Allegations are appropriately managed by employers to protect not only the welfare of children but also staff.
- Support actions are taken without delay to protect children.
- All learning from Designated Officer referrals is effectively disseminated.

2.3 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.

2.4 The criterion for a Designated Officer referral is when a person is alleged to have:

- Behaved in a way that has harmed or may harm a child.

- Has possibly committed a criminal offence against or related to a child.
- 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.

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.

3.0 Local Arrangements

3.1 Darlington Borough Council has one Designated Officer who is based with the Safeguarding Boards Business Unit. A Development Officer within the Safeguarding Board deputises for the Designated Officer in her absence. A key benefit of this arrangement has been the greater flexibility and improved accessibility of agencies to liaise with the Designated Officer, as either one or both are available on a daily basis. The post is an independent role within the authority, which ensures the Designated Officer remains impartial.

3.2 Clear arrangements are in place to ensure robust oversight and monitoring of the Designated Officer function. This has been 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.

3.3 During 2018/19 consideration has been given to whether the Designated Officer role should be located within the Safeguarding Boards Business Unit structure. This issue will by further discussed by Management after the new Darlington Safeguarding Partnership procedure comes into force in July 2019.

4.0 Cross boundary issues

4.1 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.

4.2 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.

4.3 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.

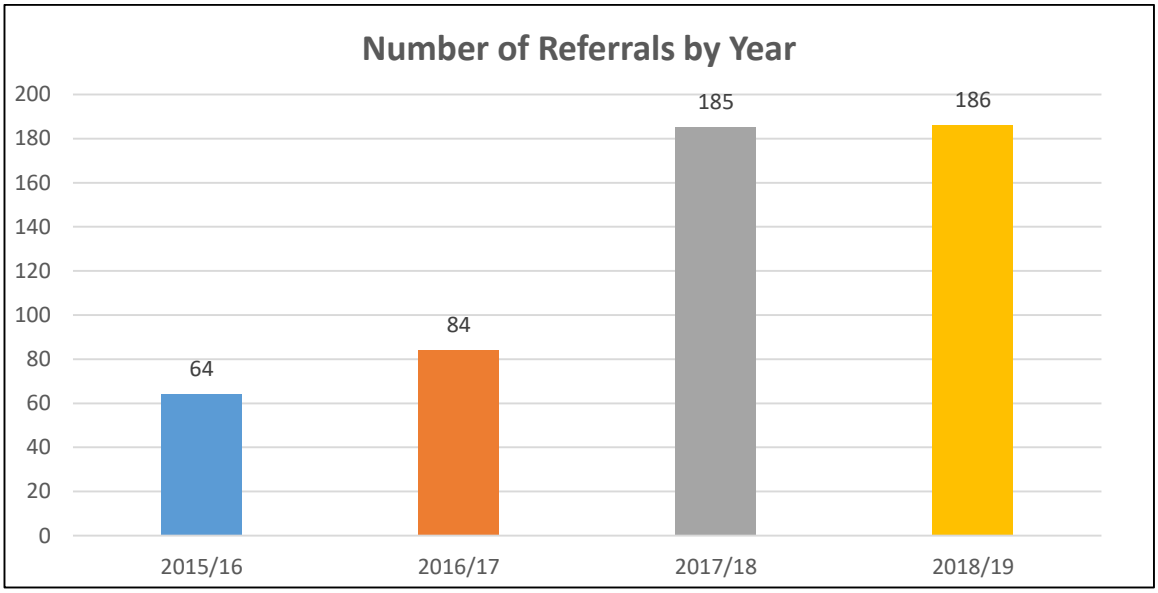
4.4 Interviews of children from Darlington Local Authority areas will usually be undertaken by their own local children's social care services in conjunction with the police as appropriate.

4.5 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.

5.0 Referrals

5.1 In 2018-2019, the Designated Officer service received a total of 186 referrals, of which 31 were determined to meet the Designated Officer threshold for an Initial Evaluation Meeting, this is 17% of all referrals. The remaining 153 referrals did not meet this threshold.

Chart 1

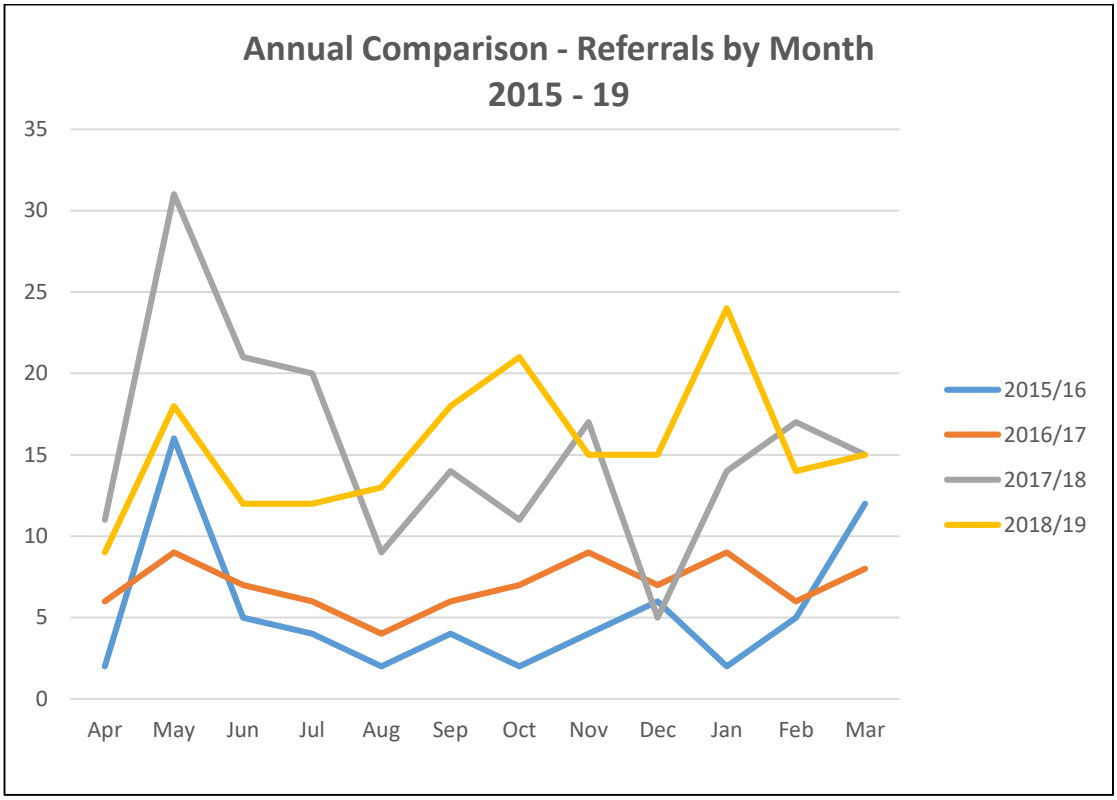


5.2 Initial Evaluation Meetings take place when it is clear that information sharing would be beneficial between agencies involved e.g. Designated Safeguarding leads within the referring organisation, Human Resources, Police, and Children's Services. This can be after a strategy meeting held by Children's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

5.3 The figures in Chart 2 show that through May to June 2018 the referral rate decreased from 63 to 40. This follows the pattern seen in previous years.

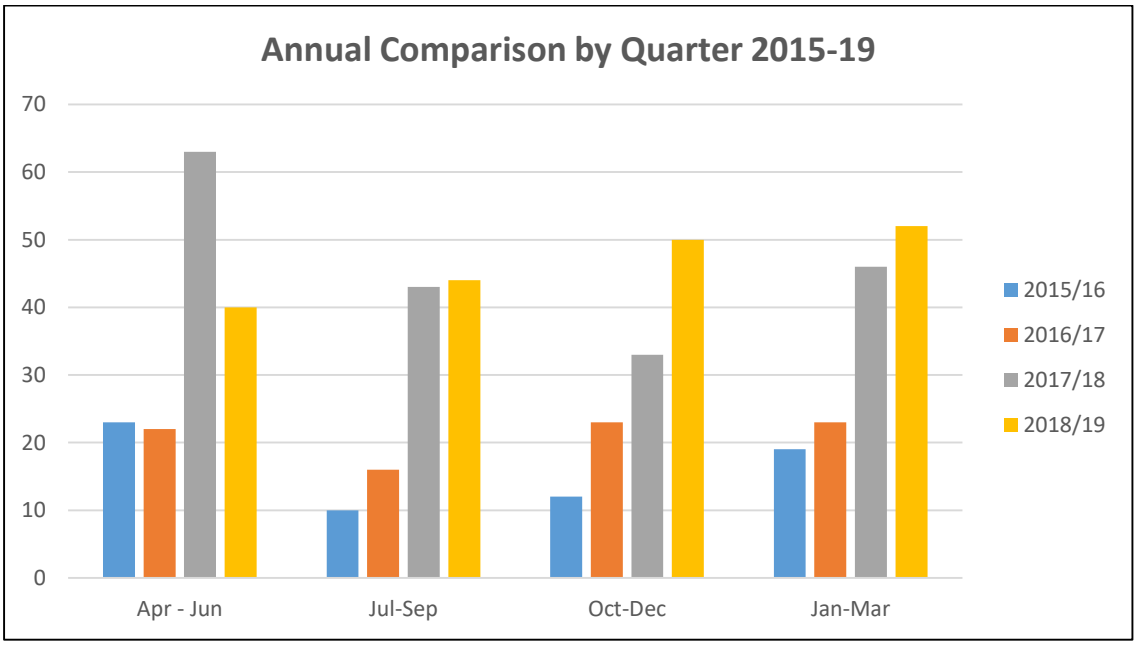
There was a significant increase in referrals during the October to December period, from 33 to 50. This may be as a result of Designated Officer briefings which were undertaken with individual organisations. The DO undertook bespoke briefings for a number of organisations namely, ARQ (a LGBT voluntary group), Marchbank School, Beaumont Hill School, Witherslack group, ADL School, and a number of Team meetings within Darlington's Children's Services as well as four multi agency briefings during 2018-19.

Chart 2



5.4 Often there can be an increase in the number of referrals prior to school holiday periods; this was seen in August and December 2018.There were 13 referrals in August, an increase of 4 and 15 in December which was a significant increase from 5 the previous year.

Chart 3



6.0 Area of Concern

6.1 Of the 186 referrals accepted in 2018/19 the main category for referral was allegation of physical abuse. In 2018/19, 90 (48%) of accepted referrals were in relation to physical abuse. 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. One school which has an intake of pupils who have been excluded from mainstream schooling because of challenging behaviour, made 26 referrals to the DO accounting for 29% of all educational referrals. 24 of the referrals were due to allegations of assault during physical interventions.

6.2 As can be seen from chart 4 below, there has been an increase in referrals of allegations of sexual abuse from 24 during 2017/18, to 32. This is an increase for the second year running. This represents 17% 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 safeguarding training provided by the Local Authority to multi-agency groups. The Local Authority and Local Safeguarding Children Board provide a wide range of safeguarding training for professionals and includes both adult and children's safeguarding.

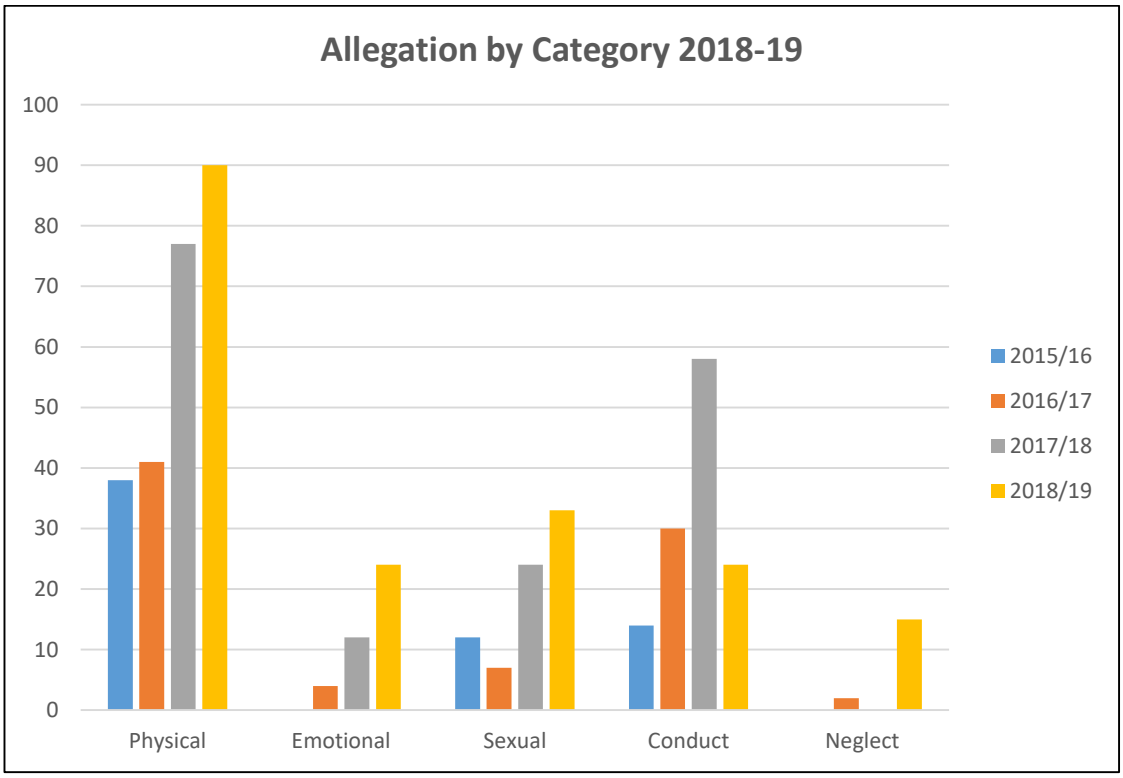
6.3 There was a significant rise in in the number of referrals under the category of neglect from none in 2016 /17 to 14 in 2017/18. There were 16 referrals in 2018/19 representing 9% of all cases.

6.4 There has also been an increase in the number of referrals with regards to allegations of emotional abuse, rising from 12 referrals in 2017/18 to 24 in 2018/19. Emotional abuse referrals represent 13% of all referrals to Designated Officer. The reason for this may be due to a better understanding of the term emotional harm from training provided.

6.5 The one area where there was a decrease in referrals was Conduct which accounted for 24 (13%) of the referrals in 2018/19. This is a significant fall from 58 conduct issues during 2017/18. The use of conduct as an area of concern is not included in Working Together but is widely used by Designated Officers as some referrals do not fit neatly into the four categories of physical, sexual, emotional and neglect. There has been on-going discussion regionally as to which Local Authorities are still using this category. The outcome and recommendations have been considered at the national quarterly Designated Officer meeting and a decision made that it was the responsibility of the individual Local Authorities whether the term conduct is used. The majority of referrals received relating to conduct were in relation to physical interventions with young people.

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

Chart 4

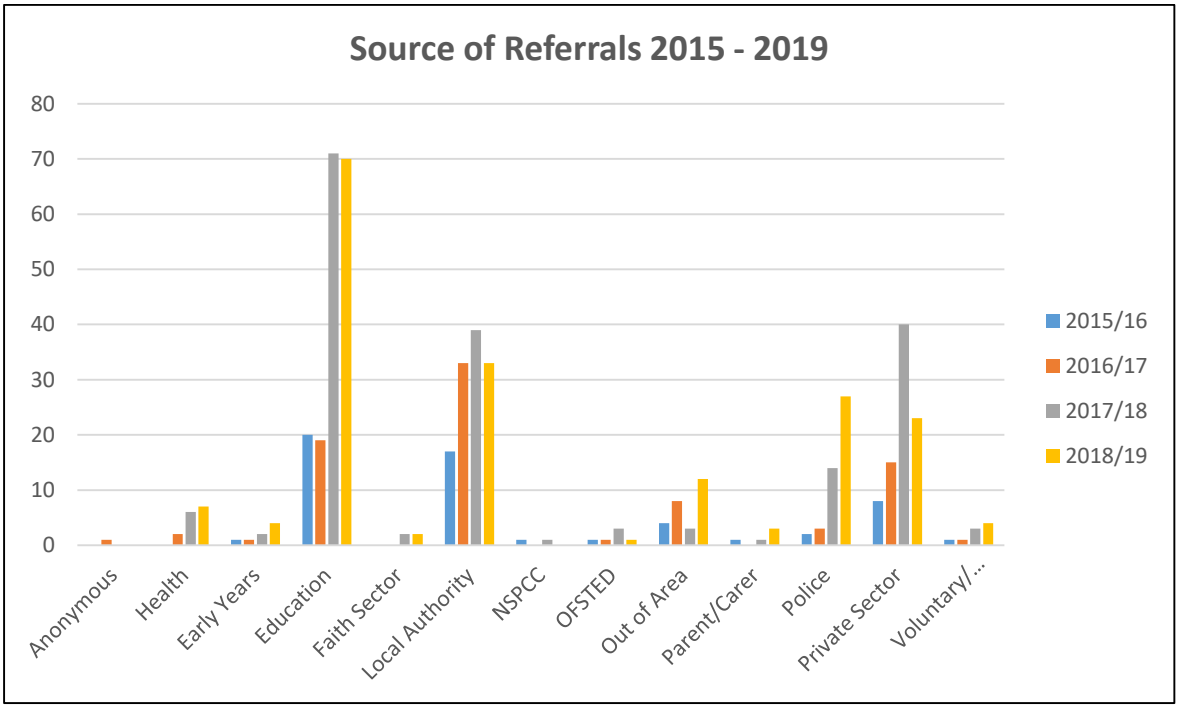


7.0 Source of Referrals by Profession / employment setting

7.1 As can be seen in Chart 5 Education settings in 2018/19 continue to be the largest referring group, accounting for 70 (38%) of the 186 referrals made. The majority of referrals from school were as a result of restraints. Referrals from Early Years is a standalone referral with 7 referrals during 2018/19.

7.2. 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 Designated Officer role. The North East Ecumenical Board have revised their schedule of quarterly meetings and will include an invite to all North East Designated Officers.

Chart 5

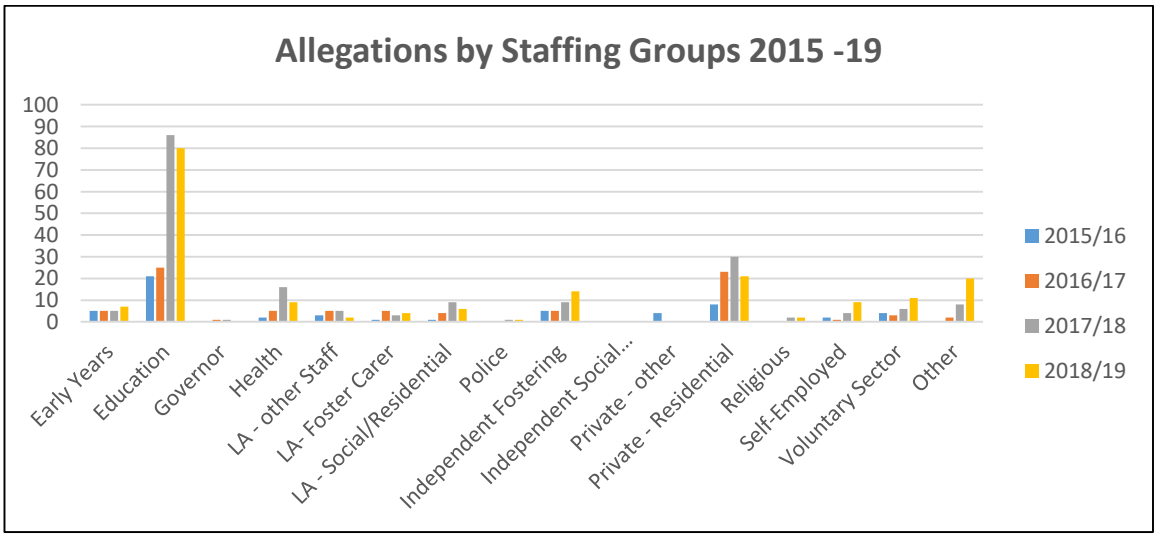


7.3 Referrals have continued to be received from a wide range of professions / Settings.

8.0 Allegations by staff group

8.1 The Chart 6 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



8.2 As would be expected the largest number of allegations by staffing groups is that of education where 80 referrals were made which is 43% of all allegations.

8.3 During 2018/19, of the 80 education referrals, 34 (43%) were regarding employees from Primary schools; 37 (46%) from secondary schools; 6 (8%) from further education; 2 (3%) from residential establishments with attached education provision and 1 from education but school which was out of area (1%). Fifty-one (64%) of education referrals were under the category of physical abuse.

8.3 The number of referrals regarding Independent Fostering Carers is stable with 9 referrals being referred during 2018/19. There have been 4 referrals relating to Darlington Borough Council Foster Carers during the recording period.

8.4 The Designated Officer has undertaken briefing sessions with staff from within Darlington Borough Council which includes the Fostering Team, the Assessment Teams and the Life Stages Team (0-25).

8.5 The Designated Officer continues works closely with the service Manager for the Fostering Team following a decision in 2018 that all referrals about foster carers (i.e. including Independent Fostering Agencies) would be shared with the Service Manager. This would enable the Service Manager to keep a close check on those agencies whose standards of care fall below what is expected of an accredited provider of services. When appropriate this information is shared with the Commissioning Team.

9.0 Outcomes of cases

9.1 In relation to the 26 cases where the allegations were substantiated, action being taken against all of the staff in question. This led to 8 staff being dismissed (31%), 4 resignations (15%), 2 referrals to the Disclosure and Barring Service (8%), 1 resulted in no further action (4%) and 11 staff re-instated (42%).

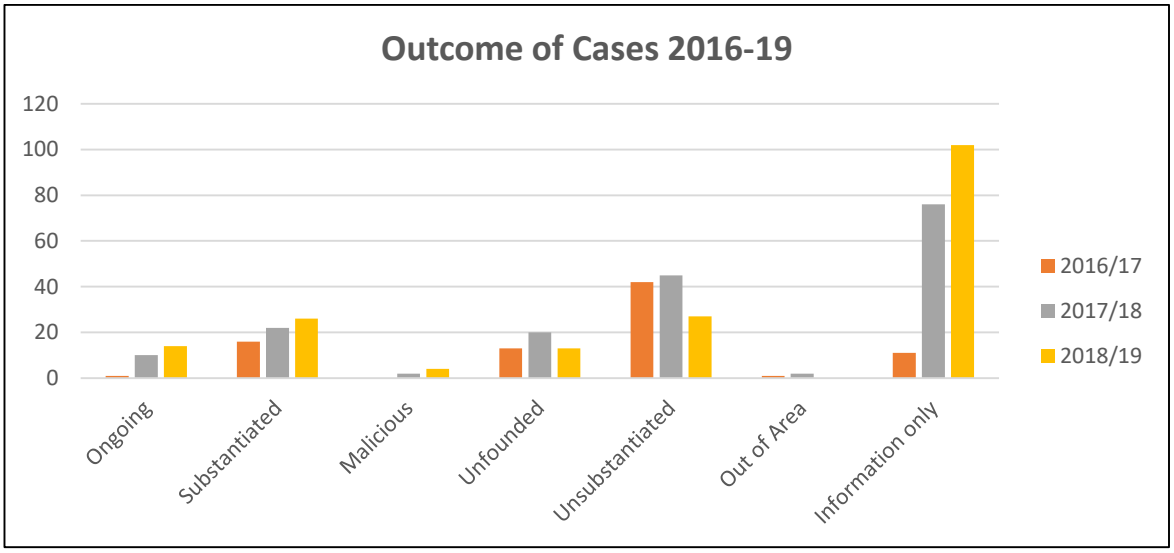
9.2 There were 27 unsubstantiated outcomes, leading to 1 resignation (4%); 23 staff were re-instated (85%) and 3 resulted in no further action (11%).

9.3 There were 13 cases unfounded, where 9 staff were re-instated (69%) and 4 were where no further action was taken (31%). Overall 4 cases were deemed to be malicious; all 4 were re-instated, 2 of which were following disciplinary investigations.

9.4 Over the year, 102 cases which were recorded as for information only and 14 cases remain open; these are either on-going Police investigations or complex internal investigations.

9.4 The category of out of area has been included in information only.

Chart 8



10.0 Performance

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

10.2 The number of Designated Officer referrals that progressed through to an Initial Evaluation meeting was 31 (17%).

Local targets are set in line with an earlier version of Working Together (2010) that:

- 80% of Designated Officer cases are resolved within one month
- 90% within three months

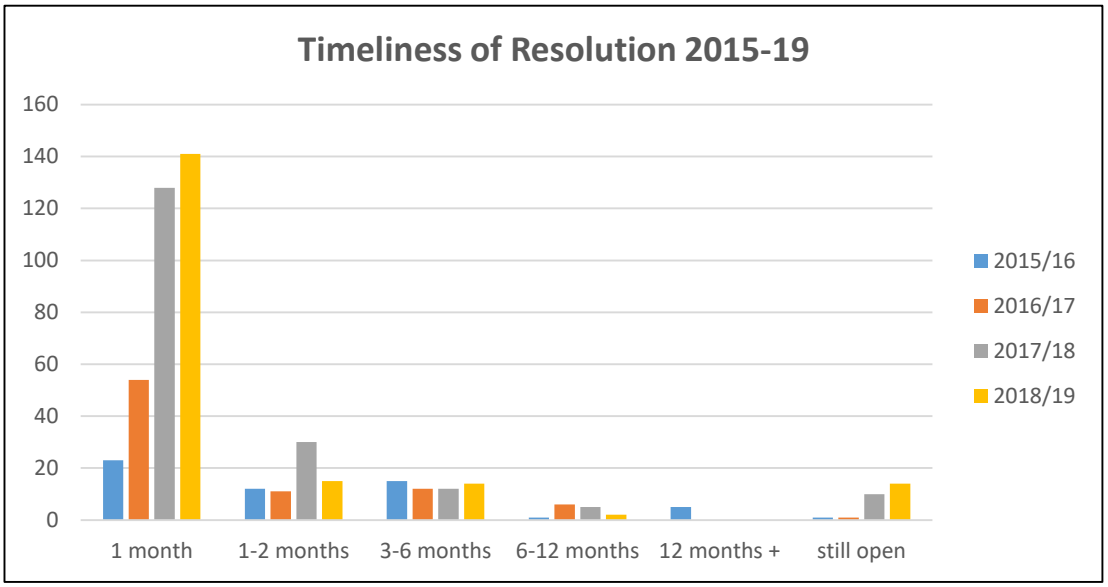
10.3 Allegations are resolved in a timely manner with 139 (75%) of total cases being resolved in one month, this is a 6% improvement on the previous year. Resolutions timescales can be impeded by the complexity of cases involving ongoing criminal investigations and internal investigations where the employee has declared themselves unfit for work therefore delaying disciplinary action.

10.4 84% of cases were resolved within 3 months and 91% within 6 months. There were a further 2% that concluded after 6 months. The remaining cases were ongoing and not finalised at the end of this reporting period, this is predominantly involving ongoing complex cases and criminal or internal investigations. At the time of writing the report 8% of cases were still active.

10.5 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. However it must be noted once Police are involved or a case is referred to an employer for disciplinary procedures to be followed, the

Designated Officer is reliant on external process which impact on resolution timescales.

Chart 9



11.0 Freedom of Information Requests

11.1 During 2018/19 the Designated Officer service has continued to take the lead with regards to Freedom of Information Requests with regards to allegations made about adults working with children. Over the year total of 4 requests were received, 2 from members of the public and 2 from the media.

12.0 Service Improvements & Developments 2018/19

12.1 See Appendix 1.

13.0 DO Service Priorities and Plan 2019/20

13.1 In 2019/20 the Designated Officer Service plans to continue to promote awareness of the service across a range of professions to ensure that appropriate referrals are coming in and to break down any barriers to agencies seeking the advice and support of the Designated Officer Service. There are a number of briefings arranged for all of Darlington Borough Council's children's residential workers for June 2019. There are multi-agency briefings to be held in April and September 2019. A number of schools have asked for bespoke packages to be provided for their individual establishments.

13.2 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.

13.3 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.

13.4 The Designated Officer Service aims to be crucial to frontline practice to safeguard children in Darlington.

13.5 In 2019/20 the Designated Officer service has identified 8 key priorities (Appendix 2) which are pivotal to the on-going development of the service.

14.0 Recommendations

14.1 To note the contents of the report and the work undertaken during 2018/2019 and to acknowledge the priorities of the Designated Officer service for 2019/2020.

14.2 To share the Annual report with Darlington Safeguarding Partnership and Members who will be asked to:

- Agree this annual report;
- Agree its publication on the Darlington Safeguarding partnership website;
- To consider how they will continue to promote the role of the DO within their own organisation.

15.0 References

- Working Together to Safeguard Children July 2018
- Keeping Children Safe in Education September 2018
- Guidance for Staff facing an allegation 2014
- Guidance for Safer Working Practice October 2015 – Safer Recruitment Consortium

16.0 Author

Carol Glasper
Designated Officer (Designated Officer)
Safeguarding Boards Business Unit
Date: 31 July 2019

Appendix 1

Service Improvements & Developments 2018/19

A number of actions were identified for development of the Designated Officer function during 2018-2019 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 2019	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 2019	This is on-going.
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 limited.
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	DO	On-going	The DO attends quarterly regional DO meetings. The DO to attend annual DO conference. The National DO Conference was planned for 10 May 2019 which was later than anticipated

	gathering of performance data.			due to difficulties with Conference venue. DO for Darlington attended the Conference. All information from Conference to be shared via email.
7	DO will continue to develop recording practice with system developments for future reports	DO and Line Manager	On-going	This has been picked up as priority for 2019/20
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. There is an on-going discussion as to whether a National Guidance will be appropriate for such a wide diversity of Local Authorities.
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	Completed	Completed
11	To review and up-date the Guidance for staff facing an allegation	DO	Completed	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 Safeguarding Trainer. There has been 4 multi-agency DO briefings held during 2018-19. There has been bespoke packages delivered for a range of organisations including Darlington Children's Services Fostering Team, ARQ voluntary project and 4 individual packages for schools.

Appendix 2

DO Service Priority Plan 2019/20

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 appointment of a permanent DO has been delayed due to the re-organisation of Darlington Safeguarding Partnership.	The DO will have completed the induction courses and successfully completes their probationary period.	Head of Service	Revised date : January 2020

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 Darlington Safeguarding Partnership (DSP) information will be easily accessible and relevant referrals made to the relevant services. When a new DO is appointed a letter giving details to be sent out to all partner agencies.; DSP 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 (see above)

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 2020

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 2020

s) Lead Time

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 02.10.2019 and every subsequent 3 month

Action Success measure(s) Lead Time

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	On-going

Priority 7: To review the DO minute template

Action	Planned Outcome	Lead	Timescale
Review the format of DO initial evaluation meetings template for inclusion in Liquid Logic. [See Action 4 above]	Review recent DO strategy meetings on an agreed audit form which will be used to inform and support changes to DO recording	DO	September 2019

Priority 8: To provide bespoke training for professionals and volunteers in relation to DO role and improve quality of referrals.

Action	Planned outcome	Lead	Timescale
Training to be offered to raise professionals' and volunteer's awareness of the DO role.	Referrals will be timely and appropriate	DO and Safeguarding training co-ordinator	To March 2020

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

Definitions of Abuse – from Working Together 2018

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
2 SEPTEMBER 2019

WORK PROGRAMME

SUMMARY REPORT

Purpose of the Report

1. To consider the work programme items scheduled to be considered by this Scrutiny Committee during the 2019/20 Municipal Year and to consider any additional areas which Members would like to suggest should be included.

Summary

2. Members are requested to consider the attached draft work programme (**Appendix 1**) for the remainder of the Municipal Year which has been prepared based on Officers recommendations and recommendations previously agreed by this Scrutiny Committee in the last Municipal Year.

3. Once the work programme has been approved by this Scrutiny Committee, any additional areas of work which Members wish to add to the agreed work programme will require the completion of a quad of aims in accordance with the previously approved procedure (**Appendix 2**).

Recommendations

4. Members are requested to consider and approve the attached draft work programme as the agreed work programme for the Municipal year 2019/20 and consider any additional items which they might wish to include.

Paul Wildsmith
Managing Director

Background Papers

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

Author: Allison Hill

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

5. 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.

6. Each topic links 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	c) Spend every pound wisely
e) More people active and involved	
f) Enough support for people when needed	
g) More people healthy and independent	
h) A place designed to thrive	

7. In addition, each topic links 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.

Forward Plan and Additional Items

8. Once the Work Programme has been agreed by this Scrutiny Committee, any Member seeking to add a new item to the work programme will need to complete a quad of aims. A revised process for adding an item to a previously approved work programme, has been agreed by the Monitoring and Co-ordination Group.

9. A copy of the Forward Plan has been attached at **Appendix 3** for information.

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APPENDIX 1

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 28 October 2019 Q2 16 December 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
Children and Young People Public Health Overview 2019	**On the agenda for this meeting**	Ken Ross	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	Annual monitoring - Children and Young People's Profile 2018, Healthy Lifestyle Survey 2017, Childhood Healthy Weight Action Plan 2017-2022 and Oral Health Plan 2017-2022

Topic	Timescale	Lead Officer	SCS Outcome	Darlington Conditions	Link to PMF (metrics)	Scrutiny's Role
IRO Annual Report	**On the agenda for this meeting**	Martin Graham	Children with the best start in life		CSC201	To examine the Annual Report of the Independent Reviewing Officer for Looked After Children
Local Designated Officer Annual Report	**On the agenda for this meeting**	Amanda Hugill Carol Glasper				To examine the Annual Report and assure Members that allegations made against staff who work with children are reported and how they are actioned
Annual Report of the Darlington Safeguarding Partnership	28 October 2019	Amanda Hugill		Build strong communities	LSB Annual Report	Annual monitoring
Children and Young People Plan 2017-22	28 October 2019	Christine Shields	Children with the best start in life			Annual update to Members.
2019/20 Childcare Sufficiency Review	16 December 2019	Nicola Davies/ Tony Murphy	Children with the best start in life A safe and caring community Enough support for people when needed	Build strong communities		To provide an annual report to elected Members on how the authority meets its duty to secure sufficient childcare places.

Topic	Timescale	Lead Officer	SCS Outcome	Darlington Conditions	Link to PMF (metrics)	Scrutiny's Role
Childhood Healthy Weight Plan	3 February 2020	Miriam Davidson	Children with the best start in life			To examine the effectiveness of the Plan on childhood obesity and mental health issues in children and young people
Looked After Children Missing From Care	3 February 2020	Chris Bell	Enough support for people when needed			To further examine the reasons why children in care go missing and the interventions in place to avoid including partnerships working.
Extension of Funding to 21 for Children in Foster Care	30 March 2020	Bronwen Smith	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

Topic	Timescale	Lead Officer	SCS Outcome	Darlington Conditions	Link to PMF (metrics)	Scrutiny's Role
Learning and Skills Service Annual Report	June/Jul 2020	Paul Richardson	Enough support for people when needed			Annual Report to demonstrate challenge
Autism Provision at Hurworth School Review Group	TBA					To review the arrangements between this Council and Hurworth School in providing the resourced Autism provision and attached Outreach Support Service for Darlington. Quad of aims April 2018
Private Children's Homes and Planning Guidance	TBA					To monitor the number of private children's homes in the borough.
Academy Trusts	TBA					To examine safeguarding measures and health and safety training in place within the boroughs Academies and

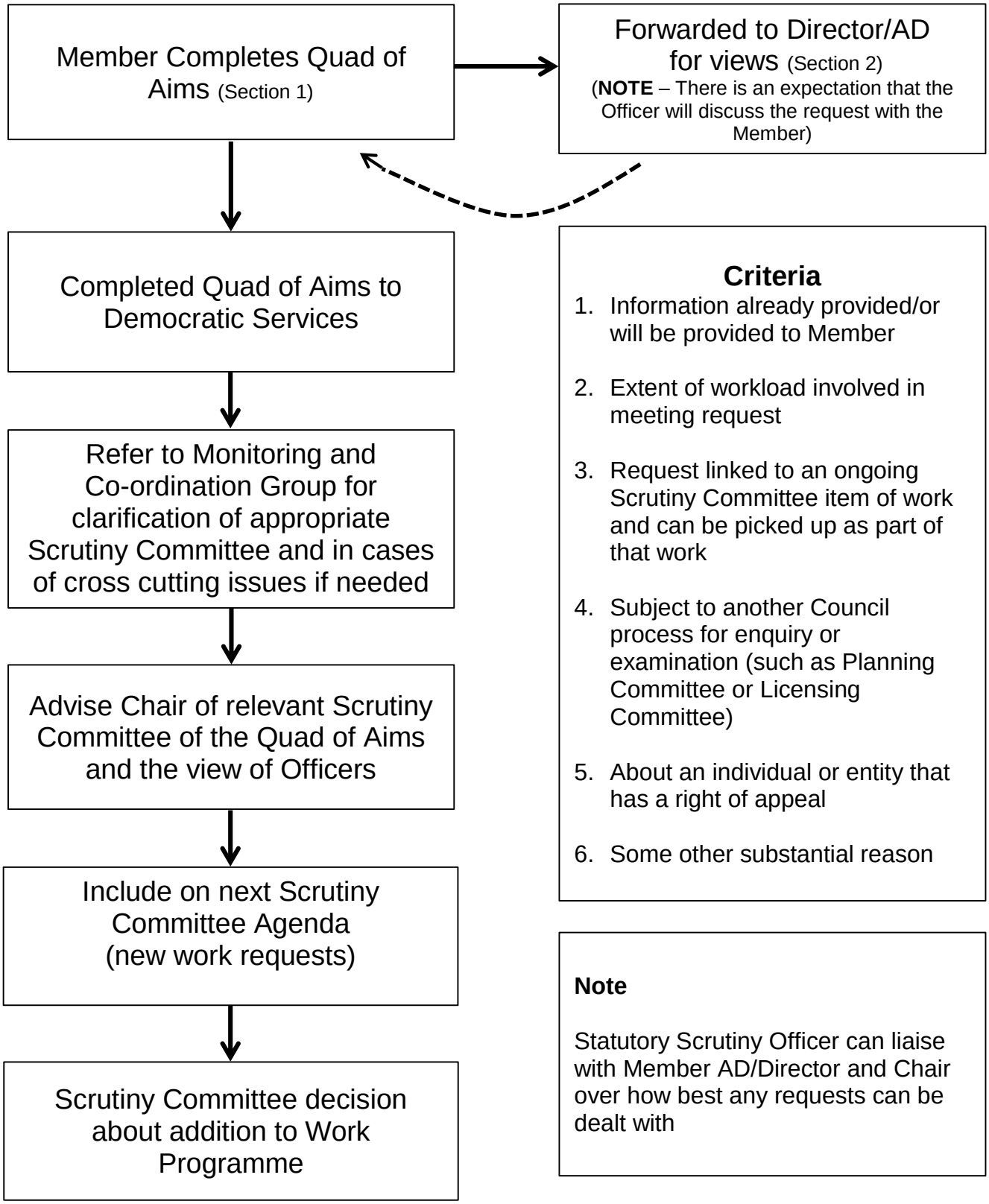
Topic	Timescale	Lead Officer	SCS Outcome	Darlington Conditions	Link to PMF (metrics)	Scrutiny's Role
						attainment within Academy Trusts.
JOINT REVIEW WITH HEALTH AND PARTNERSHIPS SCRUTINY:						
Topic	**Timescale**	**Lead Officer**	**SCS Outcome**	**Darlington Conditions**	**Link to PMF (metrics)**	**Scrutiny's Role**
Childhood Obesity/ Oral Health/Mental Health Links	Review suspended – Members to examine childhood obesity and mental health links by monitoring the effectiveness of the Childhood Healthy Weight Plan at a future date. Interim Report to Cabinet on 11 September 2018 on Oral Health.		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

LAC Missing from Care – Reasons and Interventions	10 September 2018	Joanne Stoddart	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
Educational Landscape	Archived on 3 Oct 2018	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.
Stability of Places for Looked After Children	10 December 2018	Joanne Stoddart	Children with the best start in life	Build strong communities	CSC 228 CSC 229	To monitor annually the stability of places

			Enough support for people when needed			for Looked After Children. To be monitored via the regular performance reports in future
Children Services Accessibility Strategy	10 December 2018					To give Scrutiny Members the opportunity to consider the Strategy prior to Cabinet.
SEND High Needs Review: **Strategy and Funding** **Home to School Transport**	 29 October 2018 10 Dec 2018 29 October 2018	Tony Murphy	Children with the best start in life More People healthy and independent Enough support for people when needed			To give Scrutiny Members the opportunity to consider 3 of the 4 core elements of the Review. Members to carry out a T/F Review on the proposals.
SEND Strategy and Funding Consultation Review Group	10 December 2018		Children with the best start in life			To give a Scrutiny response to the consultation on the SEND Strategy and Funding and SEND Travel Assistance Policy

PROCESS FOR ADDING AN ITEM TO SCRUTINY COMMITTEE'S PREVIOUSLY APPROVED WORK PROGRAMME



PLEASE RETURN TO DEMOCRATIC SERVICES

QUAD OF AIMS (MEMBERS' REQUEST FOR ITEM TO BE CONSIDERED BY SCRUTINY)

SECTION 1 TO BE COMPLETED BY MEMBERS

NOTE – This document should only be completed if there is a clearly defined and significant outcome from any potential further work. This document should **not** be completed as a request for or understanding of information.

REASON FOR REQUEST?	**RESOURCE (WHAT OFFICER SUPPORT WOULD YOU REQUIRE?)**
PROCESS (HOW CAN SCRUTINY ACHIEVE THE ANTICIPATED OUTCOME?)	**HOW WILL THE OUTCOME MAKE A DIFFERENCE?**

Signed Councillor …… **Date …….**

SECTION 2 TO BE COMPLETED BY DIRECTORS/ASSISTANT DIRECTORS
(NOTE – There is an expectation that Officers will discuss the request with the Member)

1. (a) Is the information available elsewhere? Yes …….. No ……..

   If yes, please indicate where the information can be found (attach if possible and return with this document to Democratic Services)

   ……

   (b) Have you already provided the information to the Member or will you shortly be doing so?

   ……

2. If the request is included in the Scrutiny Committee work programme what are the likely workload implications for you/your staff?

   ……

3. Can the request be included in an ongoing Scrutiny Committee item of work and picked up as part of that?

   ……

4. Is there another Council process for enquiry or examination about the matter currently underway?

   ……

5. Has the individual or entity some other right of appeal?

   ……

6. Is there any substantial reason (other than the above) why you feel it should not be included on the work programme?

   ……

Criteria

1. Information already provided/or will be provided to Member
2. Extent of workload involved in meeting request
3. Request linked to an ongoing Scrutiny Committee item of work and can be picked up as part of that work
4. Subject to another Council process for enquiry or examination (such as Planning Committee or Licensing Committee)
5. About an individual or entity that has a right of appeal
6. Some other substantial reason

PLEASE RETURN TO DEMOCRATIC SERVICES

Signed …… Position …….. Date ……

PLEASE RETURN TO DEMOCRATIC SERVICES

FORWARD PLAN
FOR THE PERIOD: 7 AUGUST 2019 - 31 DECEMBER 2019

What is a Forward Plan?

The Forward Plan is a list of all of the decisions, which are due to be taken by Cabinet, including key decisions taken by Cabinet a Member of the Cabinet or a designated Officer in accordance with the Local Authorities (Executive Arrangements) (Access to Information) (England) Regulation 2012. It also gives notice of the decisions that are likely to be taken in private. These decisions need to be published on the Forward Plan at least 28 clear days before the decision is to be taken. The Plan is updated on an ad hoc basis, but at least once a month. It can be accessed on the Council website www.darlington.gov.uk.

What is a Key Decision?

A key decision in the Council's constitution is defined as to:

1. result in the Borough Council incurring expenditure which is, or the making of savings which are, significant having regard to the budget for the service or function to which the decision relates; or

2. be significant in terms of its effects on communities living or working in an area comprising one or more wards in the Borough.

What are the reasons that a report can be held in private?

Whilst the majority of the Executive decisions listed in this Forward Plan will be open to the public and media organisations to attend, there will inevitably be some decisions to be considered that contains, for example, confidential, commercially or personal information.

The Forward Plan is a formal notice under the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 that some of the decisions listed in this Forward Plan will be held in private because the report will contain exempt information under Schedule 12A of the Local Government Act 1972 (set out below) and that the public interest in withholding the information outweighs the public interest in disclosing it.

1. Information relating to any individual
2. Information which is likely to reveal the identity of an individual
3. Information relating to the financial or business affairs of any particular person (including the authority holding that information)
4 Information relating to any consultations or negotiations, or contemplated consultations or negotiations, in connection with any labour relations matter arising between the authority or a Minister of the Crown and employees of, or office holders under the authority
5. Information in respect of which a claim to legal professional privilege could be maintained in legal proceedings
6. Information which reveals that the authority proposes:–
   (a) to give under any enactment a notice under or by virtue of which requirements are imposed on a person; or

(b) to make an order or direction under any enactment

7. Information relating to any action taken or to be taken in connection with the prevention, investigation or prosecution of crime.

Who takes Key Decisions?

Under the Council's constitution, key decisions are taken by Cabinet.

Are only Key Decisions listed in the Forward Plan?

The Council only has a statutory obligation to publish key decisions and decisions that are to be heard at a private meeting, however, all decisions to be taken by Cabinet are included on the plan to give Scrutiny Committees and the public an early indication of decisions to be made.

What does the Forward Plan tell me?

The Plan gives information about:

- What decisions are coming up
- What key decisions are coming up
- When those decisions are likely to be made
- Which decisions will be held in private
- Who will make those decisions
- The relevant Scrutiny Committee that the decision relates to
- What consultation will be undertaken
- Whether the decision will be an open or closed report (and the reason why) (public and press are not allowed to access closed reports and will not be able to stay in the Cabinet meeting when a closed report is being considered)
- Who you can contact for further information

How to make representations

Members of the public have a right to make representations to the Council, including whether they think that any items we are proposing to consider in private should be dealt with in public. The Council will consider any representations before a decision is taken.

Anyone who wishes to make representations to the decision maker about a particular matter should do so in writing, at least a week before it is due to be considered, either by letter or email to Lynne Wood using the contact details set out below.

How and who do I contact?

Each entry in the Plan indicates the names of all the relevant people to contact about that particular item.

For general information about the decision-making process and for copies of any documents outlined in the Forward Plan please contact Lynne Wood, Elections Manager, Democratic Services, Resources Group, Town Hall, Feethams, Darlington, DL1 5QT. Tel: 01325 405803. Email: lynne.wood@darlington.gov.uk.

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Darlington Crematorium Refurbishment	Cabinet 8 Oct 2019	21
Rail Heritage Quarter	Cabinet 8 Oct 2019	22
Joint Venture Proposal with Esh Homes	Cabinet 8 Oct 2019	23
Housing Allocation Policy	Cabinet 8 Oct 2019	24
Library Service Update	Cabinet 5 Nov 2019	25
Council Tax Empty Property Premium	Council 5 Dec 2019 Cabinet 5 Nov 2019	26
Council Tax Support - Scheme Approval 2019.20	Council 5 Dec 2019 Cabinet 5 Nov 2019	27
Revenue Budget Monitoring - Quarter 2	Cabinet 5 Nov 2019	28
Project Position Statement and Capital Programme Monitoring - Quarter 2	Cabinet 5 Nov 2019	29
Darlington Borough Local Plan 2016/36 - Proposed Submission	Council date to be agreed Cabinet date to be agreed	30
Faverdale Masterplan Report	Council date to be agreed Cabinet date to be agreed	31
Skerningham Masterplan Report	Council date to be agreed Cabinet date to be agreed	32
Proposed Sale of Land at High Faverdale	Cabinet date to be agreed	33

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Haughton Children's Centre

Brief Description
To consider the proposed lease arrangement of the Haughton Children's Centre to the Education Village Academy Trust to provide Special Educational Needs and Disabilities (SEND) placements at Beaumont Hill Academy.

Decision Type
Key

Decision Status
For Determination

Urgent Decision
Yes

Anticipated Restriction
Open

Decision Maker
Cabinet

Date of Decision
10 Sep 2019

Relevant Scrutiny Committee
Children and Young People Scrutiny Committee

Relevant Cabinet Member(s)
Children and Young People Portfolio

Contact Officer/Report Author
Tony Murphy, Head of Education and Inclusion
Tony.Murphy@darlington.gov.uk

Department
Childrens and Adults

Wards Affected
Haughton and Springfield

Consultation Process
Meetings and communications.

Document to be submitted
Report

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
In2 Project

Brief Description
To support young people in their transition from Yr6 primary school to Yr7/8 secondary school from some of the deprived Wards within the Borough

Decision Type
Non-Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker
Cabinet

Date of Decision
10 Sep 2019

Relevant Scrutiny Committee

Relevant Cabinet Member(s)
Economy and Regeneration Portfolio

Contact Officer/Report Author
Ian Thompson, Assistant Director Community Services
Ian.Thompson@darlington.gov.uk

Department
Economic Growth and Neighbourhood Services

Wards Affected
Bank Top and Lascelles; Eastbourne; Harrowgate Hill; North Road; Northgate; Stephenson

Consultation Process
Meetings and communications

Document to be submitted
Report

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Treasury Management Annual Report and Outturn Prudential Indicators 2018/19

Brief Description
Report providing information on the regulation and management of the Council's borrowing, investments and cash-flow and requesting approval of the Prudential Indicators.

Decision Type
Non-Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker
Cabinet

Date of Decision
10 Sep 2019

Relevant Scrutiny Committee
Efficiency and Resources Scrutiny Committee

Relevant Cabinet Member(s)
Efficiency and Resources Portfolio

Contact Officer/Report Author
Peter Carrick, Finance Manager Central/Treasury Management
peter.carrick@darlington.gov.uk

Department
Resources

Wards Affected
All Wards

Consultation Process
None

Document to be submitted
Report

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Replacement of Dog Control Orders with Public Space Protection Orders

Brief Description
To request approval to commence consultation with the public regarding converting the existing Dog Control Orders into Public Space Protection Orders.

Decision Type
Non-Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker
Cabinet

Date of Decision
10 Sep 2019

Relevant Scrutiny Committee
Place Scrutiny Committee

Relevant Cabinet Member(s)
Economy and Regeneration Portfolio

Contact Officer/Report Author
Ian Thompson, Assistant Director Community Services
Ian.Thompson@darlington.gov.uk

Department
Economic Growth and Neighbourhood Services

Wards Affected
All Wards

Consultation Process
8 week public consultation - Police, Crime and Victime Commissioner and Police will also be consulted

Document to be submitted
Report

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Release of Capital Allocation in the Medium Term Financial Plan

Brief Description
Release of capital for the Town Hall Toilet Refurbishment in Block D and Access Points in Customer Contact Centre.

Decision Type
Non-Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker
Cabinet

Date of Decision
10 Sep 2019

Relevant Scrutiny Committee
Efficiency and Resources Scrutiny Committee

Relevant Cabinet Member(s)
Efficiency and Resources Portfolio

Contact Officer/Report Author
Kelvin McDade
kelvin.mcdade@dalington.gov.uk

Department
Economic Growth and Neighbourhood Services

Wards Affected
Park East

Consultation Process
Internal communication

Document to be submitted
Report

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Regulatory Investigatory Powers Act (RIPA)

Brief Description
To inform and update Members about issues relevant to the use of the Regulation of Investigatory Powers Act 2000 and developments and recent developments

Decision Type
Non-Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker
Cabinet

Date of Decision
10 Sep 2019

Relevant Scrutiny Committee
Efficiency and Resources Scrutiny Committee

Relevant Cabinet Member(s)
Efficiency and Resources Portfolio

Contact Officer/Report Author
Amy Wennington, Principal Lawyer (Litigation)
amy.wennington@darlington.gov.uk

Department
Resources

Wards Affected
All Wards

Consultation Process
None

Document to be submitted
Report

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Public Spaces Protection Order (PSPO) Monitoring Report

Brief Description
To update Members on the actions taken with regard to the recently introduced PSPO for the town centre.

Decision Type
Non-Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker
Cabinet

Date of Decision
10 Sep 2019

Relevant Scrutiny Committee
Place Scrutiny Committee

Relevant Cabinet Member(s)
Community Safety Portfolio

Contact Officer/Report Author
Ian Thompson, Assistant Director Community Services
Ian.Thompson@darlington.gov.uk

Department
Economic Growth and Neighbourhood Services

Wards Affected
College; Northgate; Park East; Park West

Consultation Process
None

Document to be submitted
Report

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Annual Review of the Investment Fund

Brief Description
To provide an update on the schemes and projects agreed by Cabinet to be being funded from the £50m investment fund.

Decision Type
Non-Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker
Cabinet

Date of Decision
10 Sep 2019

Relevant Scrutiny Committee
Efficiency and Resources Scrutiny Committee

Relevant Cabinet Member(s)
Efficiency and Resources Portfolio

Contact Officer/Report Author
Elizabeth Davison, Assistant Director Resources
elizabeth.davison@darlington.gov.uk

Department
Resources

Wards Affected
All Wards

Consultation Process
None

Document to be submitted
Report

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Review of Complaints to the Ombudsman

Brief Description
To provide Members with an update of the outcome of cases which have been determined by the Local Government, Social Care Ombudsman (LGSCO) and the Housing Ombudsman (HO)

Decision Type
Non-Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker
Cabinet

Date of Decision
10 Sep 2019

Relevant Scrutiny Committee
Efficiency and Resources Scrutiny Committee

Relevant Cabinet Member(s)
Leader of the Council

Contact Officer/Report Author
Lee Downey, Complaints and Information Governance Manager
lee.downey@darlington.gov.uk

Department
Resources

Wards Affected
All Wards

Consultation Process
None

Document to be submitted
Report

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Complaints, Compliments and Comments Annual Reports 2017/18

Brief Description
To consider the annual complaints, compliments and comments annual reports for Adult Social Care, Children's Social Care, Corporate, Housing and Public Health.

Decision Type
Non-Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker
Cabinet

Date of Decision
10 Sep 2019

Relevant Scrutiny Committee
Adults and Housing Scrutiny Committee, Children and Young People Scrutiny Committee, Efficiency and Resources Scrutiny Committee, Health and Partnerships Scrutiny Committee, Place Scrutiny Committee

Relevant Cabinet Member(s)
Efficiency and Resources Portfolio

Contact Officer/Report Author
Lee Downey, Complaints and Information Governance Manager
lee.downey@darlington.gov.uk

Department
Resources

Wards Affected
All Wards

Consultation Process
None

Document to be submitted
Report and complaints reports.

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Special Education Needs & Disability Capital Project Release of Funds

Brief Description
Request for authorisation for the release of Capital Funds for two new Special Educational Needs and Disability Units.

Decision Type
Non-Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker
Cabinet

Date of Decision
10 Sep 2019

Relevant Scrutiny Committee
Children and Young People Scrutiny Committee

Relevant Cabinet Member(s)
Children and Young People Portfolio

Contact Officer/Report Author
Paul Richardson, Head of Skills and Employability
paul.richardson@darlington.gov.uk

Department
Childrens and Adults

Wards Affected
All Wards

Consultation Process
Follow up from consultation on SEND Strategy

Document to be submitted
Report

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Sale of Four Riggs Car Park, off Bondgate, Darlington

Brief Description
To seek Cabinet approval for the sale of land at Four Riggs Car Park.

Decision Type
Non-Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Fully exempt 3 Information relating to the financial or business affairs of any particular person (including the authority holding that information)

Decision Maker
Cabinet

Date of Decision
10 Sep 2019

Relevant Scrutiny Committee
Efficiency and Resources Scrutiny Committee

Relevant Cabinet Member(s)
Efficiency and Resources Portfolio

Contact Officer/Report Author
Richard Adamson, Estates Officer
Richard.Adamson@darlington.gov.uk

Department
Economic Growth and Neighbourhood Services

Wards Affected
Northgate

Consultation Process
Internal communication.
External consultation as part of normal planning process.

Document to be submitted
Report

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Schedule of Transactions

Brief Description
To consider the Schedule of Transactions and seek approval of the terms negotiated. (NOTE - this report is included on the agenda for each meeting of Cabinet but there are not always transactions to consider)

Decision Type
Non-Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Fully exempt 3 Information relating to the financial or business affairs of any particular person (including the authority holding that information)

Decision Maker
Cabinet

Date of Decision
10 Sep 2019

Relevant Scrutiny Committee
Efficiency and Resources Scrutiny Committee

Relevant Cabinet Member(s)
Efficiency and Resources Portfolio

Contact Officer/Report Author
Guy Metcalfe, Head of Service for Asset Management and Investment
Guy.Metcalfe@darlington.gov.uk

Department
Economic Growth and Neighbourhood Services

Wards Affected
All Wards

Consultation Process
None

Document to be submitted
Report and Schedule of Transactions.

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Fairer, Richer Darlington

Brief Description
Tackling poverty and inequalities in Darlington by supporting local wealth creation that benefits all residents.

Decision Type
Non-Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker
Cabinet

Date of Decision
8 Oct 2019

Relevant Scrutiny Committee
Efficiency and Resources Scrutiny Committee

Relevant Cabinet Member(s)
Efficiency and Resources Portfolio

Contact Officer/Report Author
Seth Pearson, Partnership Director
seth.pearson@darlington.gov.uk

Department
Resources

Wards Affected
All Wards

Consultation Process
Methods

Document to be submitted
Report

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Permit System to Manage and Co-ordinate Roadworks

Brief Description
An update on work to develop a permit scheme for roadworks coordination that Councils across the country are being required to consider by the Department for Transport.

Decision Type
Non-Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker
Cabinet

Date of Decision
8 Oct 2019

Relevant Scrutiny Committee
Place Scrutiny Committee

Relevant Cabinet Member(s)
Leisure and Local Environment Portfolio

Contact Officer/Report Author
Dave Winstanley, Assistant Director Capital Projects, Transport and Highways Planning
dave.winstanley@darlington.gov.uk

Department
Economic Growth and Neighbourhood Services

Wards Affected
All Wards

Consultation Process
Meetings and correspondence.

Document to be submitted
Cabinet Report

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Tees Valley Joint Waste Management Contract

Brief Description
To approve the outline business case for Waste Management post 2025 and the associated inter-authority agreement.

Decision Type
Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker
Cabinet

Date of Decision
8 Oct 2019

Relevant Scrutiny Committee
Place Scrutiny Committee

Relevant Cabinet Member(s)
Leisure and Local Environment Portfolio

Contact Officer/Report Author
Ian Thompson, Assistant Director Community Services
Ian.Thompson@darlington.gov.uk

Department
Economic Growth and Neighbourhood Services

Wards Affected
All Wards

Consultation Process
N/A

Document to be submitted
Report

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Darlington Crematorium Refurbishment

Brief Description
To present the options to Members to consider regarding refurbishment of the existing Crematorium in West Cemetery.

Decision Type
Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker
Cabinet

Date of Decision
8 Oct 2019

Relevant Scrutiny Committee
Place Scrutiny Committee

Relevant Cabinet Member(s)
Leisure and Local Environment Portfolio

Contact Officer/Report Author
Ian Thompson, Assistant Director Community Services
Ian.Thompson@darlington.gov.uk

Department
Economic Growth and Neighbourhood Services

Wards Affected
All Wards

Consultation Process
Meetings and survey.

Document to be submitted
Cabinet Report

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Rail Heritage Quarter

Brief Description
To present the outcome of work to date on the Rail Heritage Quarter, timeline for implementation and funding strategy.

Decision Type
Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker
Cabinet

Date of Decision
8 Oct 2019

Relevant Scrutiny Committee
Place Scrutiny Committee

Relevant Cabinet Member(s)
Leisure and Local Environment Portfolio

Contact Officer/Report Author
Ian Thompson, Assistant Director Community Services
Ian.Thompson@darlington.gov.uk

Department
Economic Growth and Neighbourhood Services

Wards Affected
All Wards

Consultation Process
Various

Document to be submitted
Report and Master Planning Documents.

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Joint Venture Proposal with Esh Homes

Brief Description
Proposal for New Sites outside the Darlington Boundaries.

Decision Type
Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker
Cabinet

Date of Decision
8 Oct 2019

Relevant Scrutiny Committee
Efficiency and Resources Scrutiny Committee

Relevant Cabinet Member(s)
Efficiency and Resources Portfolio

Contact Officer/Report Author
Elizabeth Davison, Assistant Director Resources
elizabeth.davison@darlington.gov.uk

Department
Resources

Wards Affected
All Wards

Consultation Process
None

Document to be submitted
Report

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Housing Allocation Policy

Brief Description
Changes are being made to the Tees Valley Allocation Policy to both reflect the legislative requirements around the Homeless Reduction Act 2017 and ensure the policy is clear and transparent for applicants.

Decision Type
Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker
Cabinet

Date of Decision
8 Oct 2019

Relevant Scrutiny Committee
Adults and Housing Scrutiny Committee

Relevant Cabinet Member(s)
Housing, Health and Partnerships Portfolio

Contact Officer/Report Author
Janette McMain
Janette.McMain@darlington.gov.uk

Department
Economic Growth and Neighbourhood Services

Wards Affected
All Wards

Consultation Process
Public consultation has been undertaken via a press release and survey around the Common Allocations Policy, with website links to the survey on the Compass and DBC's websites. The survey has been widely circulated to staff in Housing and Housing Providers/Housing related providers asking they encourage their staff and customers to complete the survey.

Document to be submitted
Report and Housing Allocation Policy.

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Library Service Update

Brief Description
To present proposals to Members for the refurbishment of Crown Street Library and proposed service.

Decision Type
Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker
Cabinet

Date of Decision
5 Nov 2019

Relevant Scrutiny Committee
Place Scrutiny Committee

Relevant Cabinet Member(s)
Leisure and Local Environment Portfolio

Contact Officer/Report Author
Ian Thompson, Assistant Director Community Services
Ian.Thompson@darlington.gov.uk

Department
Economic Growth and Neighbourhood Services

Wards Affected
All Wards

Consultation Process
Meetings / discussions.

Document to be submitted
Cabinet Report and Library Plan

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Council Tax Empty Property Premium

Brief Description
To consider and approve changes to the Council Tax Empty Property Premium from April 2020.

Decision Type
Non-Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker	Date of Decision
Cabinet	5 Nov 2019
Council	5 Dec 2019

Relevant Scrutiny Committee
Efficiency and Resources Scrutiny Committee

Relevant Cabinet Member(s)
Efficiency and Resources Portfolio

Contact Officer/Report Author
Anthony Sandys, Head of Housing and Revenues
anthony.sandys@darlington.gov.uk

Department
Resources

Wards Affected
All Wards

Consultation Process
Letter and e-mail.

Document to be submitted
Report

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Council Tax Support - Scheme Approval 2019.20

Brief Description
To consider and approve a draft Council Tax Support Scheme.

Decision Type
Non-Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker	Date of Decision
Cabinet	5 Nov 2019
Council	5 Dec 2019

Relevant Scrutiny Committee
Efficiency and Resources Scrutiny Committee

Relevant Cabinet Member(s)
Efficiency and Resources Portfolio

Contact Officer/Report Author
Anthony Sandys, Head of Housing and Revenues
anthony.sandys@darlington.gov.uk

Department
Resources

Wards Affected
All Wards

Consultation Process
None

Document to be submitted
Report and Council Tax Support Scheme.

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Revenue Budget Monitoring - Quarter 2

Brief Description
To provide an up to date forecast of the revenue budget outturn as part of the Council's continuous financial management process.

Decision Type
Non-Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker
Cabinet

Date of Decision
5 Nov 2019

Relevant Scrutiny Committee
Efficiency and Resources Scrutiny Committee

Relevant Cabinet Member(s)
Efficiency and Resources Portfolio

Contact Officer/Report Author
Peter Carrick, Finance Manager Central/Treasury Management
peter.carrick@darlington.gov.uk

Department
Resources

Wards Affected
All Wards

Consultation Process
None

Document to be submitted
Report

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Project Position Statement and Capital Programme Monitoring - Quarter 2

Brief Description
To provide information on the delivery of the Council's Capital Programme, the financial outturn position, financing of Capital expenditure and an update on the current status of all construction projects currently being undertaken.

Decision Type
Non-Key

Decision Status
For Determination

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker
Cabinet

Date of Decision
5 Nov 2019

Relevant Scrutiny Committee
Efficiency and Resources Scrutiny Committee

Relevant Cabinet Member(s)
Efficiency and Resources Portfolio

Contact Officer/Report Author
Peter Carrick, Finance Manager Central/Treasury Management, Brian Robson, Head of Capital Projects
peter.carrick@darlington.gov.uk, brian.robson@darlington.gov.uk

Department
Resources

Wards Affected
All Wards

Consultation Process
None

Document to be submitted
Report

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Items Due for Consideration with no agreed Cabinet date

Title
Darlington Borough Local Plan 2016/36 - Proposed Submission

Brief Description
To agree the final draft of the Local Plan to advertise for representations and ultimately submit for examination.

Decision Type
Non-Key

Decision Status
Item Deferred

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker **Date of Decision**
Cabinet

Council
Relevant Scrutiny Committee
Place Scrutiny Committee

Relevant Cabinet Member(s)
Economy and Regeneration Portfolio

Contact Officer/Report Author
David Hand, Head of Service for Planning Policy, Economic Strategy and Environment
David.Hand@darlington.gov.uk

Department
Economic Growth and Neighbourhood Services

Wards Affected
All Wards

Consultation Process
Legal duty to seek representations prior to submission to Government for examination. Email and Letter and use of the Council's consultation portal.

Document to be submitted
Report and draft Local Plan

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Faverdale Masterplan Report

Brief Description
Approval of supporting documents for Local Plan Submission Draft.

Decision Type
Key

Decision Status
Item Deferred

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker **Date of Decision**
Cabinet

Council
Relevant Scrutiny Committee
Place Scrutiny Committee

Relevant Cabinet Member(s)
Economy and Regeneration Portfolio

Contact Officer/Report Author
David Nelson, Planning Officer
David.Nelson@darlington.gov.uk

Department
Economic Growth and Neighbourhood Services

Wards Affected
Harrowgate Hill

Consultation Process
Document to be made available on the Council's website.

Document to be submitted
Report and Masterplan Documents for Faverdale.

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Skerningham Masterplan Report

Brief Description
Approval of supporting document for Local Plan Submission Draft

Decision Type
Key

Decision Status
Item Deferred

Urgent Decision
No

Anticipated Restriction
Open

Decision Maker **Date of Decision**
Cabinet

Council
Relevant Scrutiny Committee
Place Scrutiny Committee

Relevant Cabinet Member(s)
Economy and Regeneration Portfolio

Contact Officer/Report Author
David Nelson, Planning Officer
David.Nelson@darlington.gov.uk

Department
Economic Growth and Neighbourhood Services

Wards Affected
Harrowgate Hill; Haughton and Springfield; Sadberge and Middleton St. George; Whinfield

Consultation Process
Document to be made available on the Council's website

Document to be submitted
Report and Masterplan Document for Skerningham.

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN

Title
Proposed Sale of Land at High Faverdale

Brief Description
To seek Cabinet approval of a proposed sale of land at High Faverdale.

Decision Type
Key

Decision Status
Item Deferred

Urgent Decision
No

Anticipated Restriction
Part exempt 3 Information relating to the financial or business affairs of any particular person (including the authority holding that information)

Decision Maker **Date of Decision**
Cabinet

Relevant Scrutiny Committee
Efficiency and Resources Scrutiny Committee

Relevant Cabinet Member(s)
Efficiency and Resources Portfolio

Contact Officer/Report Author
Guy Metcalfe, Head of Service for Asset Management and Investment
Guy.Metcalfe@darlington.gov.uk

Department
Economic Growth and Neighbourhood Services

Wards Affected
Brinkburn and Faverdale

Consultation Process
None.

Document to be submitted
Cabinet Report.

DARLINGTON BOROUGH COUNCIL
FORWARD PLAN