Gateshead Council

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FAMILIES OVERVIEW AND SCRUTINY COMMITTEE AGENDA

Thursday, 8 September 2016 at 1.30 pm in the Bridges Room - Civic Centre

From the Acting Chief Executive, Mike Barker

Item	Business
1	**Apologies for absence**
2	**Minutes of last meeting** (Pages 3 - 10) The Committee is asked to approve as a correct record the minutes of the last meeting held on 16 June 2016
3	**OSC Review of Child Protection - Monitoring Report** (Pages 11 - 14) Report of Interim Strategic Director, Care Wellbeing and Learning
4	**LSCB Annual Report and Plans** (Pages 15 - 76) Report of Interim Strategic Director, Care Wellbeing and Learning
5	**Gateshead Child Health Profile** (Pages 77 - 84) Report of the Director of Public Health
6	**Review of Children's Oral Health in Gateshead - Evidence Gathering** (Pages 85 - 154) Report of the Director of Public Health
7	**Ofsted Inspections and School Data - Progress Update** (Pages 155 - 158) Report of Interim Strategic Director, Care Wellbeing and Learning

Contact: Rosalyn Patterson TEL: (0191) 433 2088
EMAIL: rosalynpatterson@gateshead.gov.uk Date: Wednesday, 31 August 2016

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GATESHEAD METROPOLITAN BOROUGH COUNCIL

FAMILIES OVERVIEW AND SCRUTINY COMMITTEE MEETING

Thursday, 16 June 2016

PRESENT: Councillor B Oliphant (Chair)

Councillors: John Wilkinson, B Clelland, J Graham, E McMaster, S Ronchetti, C Simcox, S Green, M Hall and J Kielty

CO-OPTED MEMBERS: John Wilkinson

F1 APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Hawkins, Mullen, Adams, Kirton, Caffrey, S Craig and McHatton and co-opted members Sasha Ban, Jill Steer and Maveen Pereira.

The Chair welcomed new Councillors on to the Committee.

F2 MINUTES OF LAST MEETING

The minutes of the meeting held on 14 April 2016 were agreed as a correct record.

F3 CONSTITUTION

The Committee agreed the constitution of the Committee and the appointment of the Chair and Vice Chair for the current municipal year.

RESOLVED - That the information be noted.

F4 ROLE AND REMIT

A report was received outlining the remit and terms of reference of the Committee.

RESOLVED - That the remit and terms of reference be noted.

F5 THE COUNCIL PLAN - YEAR END ASSESSMENT OF PERFORMANCE AND DELIVERY 2015-16

The Committee received the end of year performance report, highlighting performance against the strategic outcome indicators and additional indicators that underpins the work of Children's Services.

Overall achievements were outlined, including an increase in the level of engagement in Children's Centres, an improvement in the number of children

achieving a good level of development at age 5 and also the take up of three and four year old places. The Gateshead Youth Offending Team has won a national award for its First World War Art Project. It was also noted that the introduction of the 'MOMO' app (Mind of My Own) has helped young people engage with the service better. It was reported that overall performance for social care remains strong at a time of increased demand.

Areas for improvement were outlined, these include; the attainment gap between disadvantaged and non-disadvantaged pupils at Key Stage 4, the rate of under 18 conceptions, self harm rates and also the rate of permanent exclusions.

In terms of the target for reducing excess weight in primary children in year 6 it was reported that performance is just above the national average, however the rate for Gateshead is on a downward trend and the figures for reception age children are lower than the national average.

Educational attainment at primary school is meeting the target of 82%, with primary schools performing above the national and regional average. It was noted that Gateshead was ranked 44th out of 152 local authorities, with 35% of primary schools in Gateshead being judged as 'outstanding'. Also, GCSE performance remains stable.

The number of young people not in education, training or employment (NEET) is an improving picture, the service is tracking these young people well and the number of young people 'unknown' to the service is decreasing.

In relation to the number of first time entrants to the youth justice system, this currently stands at 47 young people per 100,000. However, there is a data lag so this relates to the period October 2014 – September 2015, this is a 46% reduction from the same period the previous year.

Targets have also been met and are improving in relation to child poverty rates.

The Strategic Outcome Indicator around reducing the number of children subject to a child protection plan has not been met. However, the percentage of children subject to a plan for a second of subsequent time is 11.8%, against a target of 15%, this equates to 40 children out of 338. Performance in terms of placement stability is measured by the percentage of children living continuously in the same placement for two years, performance is currently improving and is well above target. It was noted that the number of children subject to a child protection plan was 273 at the end of the year, this is a 23% increase over the last six months and is above the national average. Work is ongoing to unpick why there has been such an increase in the number of referrals, there is no specific pattern however there has been an increase in large sibling groups.

It was reported that the target has not been met in relation to timeliness of adoptions. There were 25 adoptions over the last year, however a small number of these took a significantly longer time due to sibling groups and complexities of the cases.

There has been some improvement in relation to hospital admissions for self harm although there are still some issues. Hospital admissions are down but are significantly higher than the national picture. There is a lot of work ongoing with the 'Expanding Minds, Improving Lives' project, with Newcastle Council and the Clinical Commissioning Group (CCG), to redesign the Child and Adolescent Mental Health Service (CAMHS), there are strong messages coming from this around early intervention. From this project additional counselling support has been put in place for this year.

It was noted that there is still a gap in GCSE attainment for vulnerable young people, there has been a drop in attainment for those pupils on free school meals and children with special educational needs. Also, attainment for looked after children did not meet the target, however performance was better than last year.

There has been an increase in the number of under 18 conceptions, with Gateshead now the second highest within Tyne and Wear, this was an increase of 16 conceptions. Work is continuing to develop a sexual health strategy for Gateshead.

The rate of permanent exclusions in Gateshead has increased significantly over the last year, there have been 52 over the last year, two of which were from primary schools. The majority of permanent exclusions have been a result of drugs, violence and disruptive behaviour. A task and finish group has been set up by the Local Safeguarding Children's Board (LSCB) to look at this issue in more depth.

At the recent inspection Ofsted raised the issue of care leavers not in education, employment or training. Work is now ongoing across the Council to increase the number of apprenticeships.

Re-offending rates remain steady, at 36.9%, however the service still faces significant issues with young people re-offending.

It was questioned whether the rate of mothers drinking alcohol during pregnancy is monitored, in the same way that smoking is. It was confirmed that the midwifery service do monitor this but it is not reported, although if there were significant issues a referral would be made through the Referral and Assessment Team with the potential of an unborn child protection plan being put in place. It was suggested that this should be reported as there has been increases in babies being born with foetal alcohol syndrome. It was acknowledged that there is still a lot of education work to do around this issue to get the message out around the effect of alcohol in pregnancy. It was confirmed that a case study on alcohol in pregnancy us due to come to this Committee in October 2016.

It was queried why a child would be subject to a child protection plan a second time. It was noted that the first plan may have ended previously and the family has come back into the service, it was confirmed that it is uncommon for a second plan to come in to force within one or two years of the first plan coming to an end. It was noted that a second plan may for example be due to a change in a relationship, this could trigger a reassessment.

The point was made that there has been no improvement in teenage pregnancy

rates. It was confirmed that there has been a decrease since 1998. Although there has been an increase from 2013-14 overall Gateshead is the second lowest in the region for the first quarter. Also, the Family Nurse Partnership is continuing to work with under 19 mothers, this offers an intense service. The point was made that the Council is having little impact in this area and it was suggested that this be looked at in further detail by the Committee.

It was suggested that looked after children's attainment should also be looked at in further detail. It was confirmed that this is being picked up through the Corporate Parenting OSC work programme this year. The point was made that more focus is needed on improving the experience and progress of care leavers, as highlighted by Ofsted. It was acknowledged that there is still a lot of improvement needed in this area, and work is ongoing to develop an action plan for care leavers. It was confirmed that a case study on support for care leavers is due to come back to this Committee in March 2017.

In terms of closing the attainment gap for vulnerable young people at Key Stage 4 it was questioned how one school in Gateshead can have no gap. It was recognised that more sharing of best practice between schools is needed.

It was queried whether the increase in permanent exclusions is occurring in the same school. It was noted that there is a definite increase, however there is no pattern. Outreach work is underway to support schools to deal with behaviour better and ensuring there are better pathways for young people who are excluded.

It was questioned whether it was usual to have care leavers who do not remain in touch with the service. It was confirmed that this is not unusual and it may be the young person's choice not to be involved with the service anymore, however programmes are in place to encourage young people to 'stay put'. It was also questioned whether any care leavers with special educational needs are looked after until the age of 25. It was confirmed that this depends on the level of need, there are a number of support mechanisms in place for young people up to the age of 25. There is an expectation that the service will have a pathway plan to adulthood when a looked after child becomes 16, therefore any special requirements would be supported through their individual pathway plan.

It was questioned what effect there has been on support as a result of Operation Encompass. It was confirmed that from a school perspective this has been very useful, this has enabled the school to be aware of what additional support is necessary.

RESOLVED -

(i) That the Committee considered that the activities undertaken at year end 2015/16 are achieving the desired outcomes in the Council Plan 2015-2020.

(ii) That the Committee agreed that the report be referred to Cabinet on 12 July 2016, with the recommendations from the Families OSC for their consideration.

(iii) That the issue around teenage pregnancy be a focus of the Committee's next performance report in six months time.

F6 CORPORATE STRATEGIC TRACKER AND TARGET INDICATORS 2020

The Committee received a report outlining the proposed service targets for the period up to 2020. It is proposed that the strategic indicators be split into 'tracker' or 'target' indicators; 'target indicators' are those issues where there is direct control by the Council and its partners, targets can be set and improvements measured regularly. For these indicators a fixed 2020 target will be set and progress towards this target will be reported on. 'Tracker indicators' are those targets that the Council and its partners have no direct influence to make changes quickly, these indicators will be tracked and benchmarked and the longer term trend will be monitored. The indicators set for 2020 were highlighted in the report.

It was queried whether, at a time of decreasing resources, this is asking too much of staff. This was noted and it was agreed to be fed back to Chief Executives.

It was suggested that there is confusion over the new measures for exam results. It was noted that there training sessions were being held for schools around this and it would be looked at as to whether this would be rolled out to school Governor training.

RESOLVED -

(i) That the Committee's comments be noted on the proposed 2020 targets set for the corporate strategic indicators and the available benchmarked performance to ensure the Council's performance is continuously improving to contribute to the delivery of Vision 2030 and the Council Plan.

(ii) That the Committee agreed that the report be submitted to Cabinet for approval.

F7 0-19 PUBLIC HEALTH DEVELOPMENTS

The Committee received a presentation on the 0-19 children and young people's Public Health services.

It was noted that the findings from the Joint Strategic Needs Assessment (JSNA) and the Director of Public Health report show that children and young people under 20 make up 22% of the population in Gateshead. Obesity amongst 4-5 year olds is 10.5% and 20.7% for 10-11 year olds, this is above the national average, although locally there has been some improvement. Immunisation rates in Gateshead are above the national average, however hospital admissions as a result of self harm are worse than the national average.

It was reported that public health commissioning responsibilities for children aged 0-5 transferred from the NHS to local authorities in 2015. The main programmes transferred were; Health Visitors 0-5 (Healthy Child Programme), Family Nurse Partnership and School Nursing. The Council has been responsible for commissioning public health services for school-aged children (5-19) since 2013.

The mandated elements for 0-5's are around the five universal checks; antenatal

health promoting visits, new baby review, 6-8 week assessment, 1 year assessment, 2-2 ½ year review. The Council will return data to Public Health England throughout the 18 month mandation period. It was noted that through the mandated elements for 5-19's these interventions are under the Healthy Child Programme and are delivered through the School Nursing team. These elements include; height and weight measurement, hearing screening, visual screening, review vaccination and also reviewing physical, emotional and social development and taking appropriate interventions when needed.

It was acknowledged that the transfer to local authority, offers the potential to join up services across the age spectrum of 0-19 and enables greater integration between public health and children's services. It was also noted that there is more opportunity to remodel early prevention work and align service delivery.

It was reported that there continues to be challenges as there is currently a fragmented commissioning landscape, there are continuing issues with data sharing. In addition, the transfer of the 0-5 service will be reviewed in 18 months and there may not be the capacity to deliver Child Health services.

It was reported that an improvement plan is being implemented, working with the current provider, South Tyneside Foundation Trust, to reduce costs and staffing levels during 2016/17 to make budget savings of £0.459m. A procurement timeline has been established for a new 0-19 service to be in place by April 2018.

RESOLVED - That the Committee agreed to receive future updates as the development of the 0-19 service develops.

F8 REVIEW OF CHILDREN'S ORAL HEALTH IN GATESHEAD - SCOPING REPORT

The Committee received the scoping report for this year's review, which is looking at children's oral health in Gateshead. It was noted that, in the Director of Public Health's Annual Report 2015 and the Joint Strategic Needs Assessment, it was highlighted that poor oral health impacts on children and families' health and wellbeing and is an integral part of overall health in children and young people in Gateshead.

It was reported that oral health remains a local priority, it is related with promoting a healthy diet and appropriate infant feeding practices. Poor oral health can have an impact on self esteem, nutrition and digestion, speech and language. In Gateshead the cost of dental treatment for children is £1.4m. The World Health Organisation has described good oral health as; 'enables an individual to eat, speak and socialise without active disease, discomfort or embarrassment'.

It was noted that poor oral health in children can have a number of effects, including; pain and infection leading to difficulties with eating, speaking and sleeping, missed education and impact on the development of permanent adult teeth. Local authorities have the responsibility to provide or commission oral health promotion and oral health surveys, in order to facilitate the assessment and monitoring of oral health needs and planning provision of dental services.

It was proposed that the review will need to look at the inequality in terms of access to dental care, this is particularly an issue in the east of Gateshead. The review will also look at the prevalence of dental decay in five year olds, the level of hospital admissions for teeth extraction in 0-19 year olds and the approach to sugar reduction in Gateshead. In addition it was proposed that the review will look at commissioning and planning arrangements. The Committee was provided with the proposed timetable for the review, in particular around the evidence gathering sessions and a potential visit to a dental practice.

It was questioned whether there are school dentists in Gateshead. It was noted that there is an oral health team in South Tyneside hospital which goes to schools in Gateshead for the purpose of oral health promotion, however they do not check teeth.

RESOLVED - (i) That the Committee noted the background to the Review and the current issues identified in the Joint Strategic Needs Assessment and Director of Public Health's Annual Report 2014/15.

(ii) That the Committee agreed to the process for the Review.

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FAMILIES
OVERVIEW AND SCRUTINY COMMITTEE
8 September 2016

TITLE OF REPORT: **Monitoring of OSC Review of Child Protection in Gateshead**

REPORT OF: **Sheila Lock, Interim Strategic Director, Care Wellbeing and Learning**

Summary

This is the first monitoring report, providing information on progress that has been made to implement recommendations from the Review of Child Protection in Gateshead undertaken in 2015/16 and agreed at the Overview and Scrutiny Committee on 14th April 2016.

Purpose of report

This report highlights progress on the implementation of the Families Overview and Scrutiny Committee (OSC) review of Child Protection in Gateshead and seeks the Committee's views on progress to date and the future planned approach.

Background

In 2015/16 the Families OSC reviewed how the Council and its partners are supporting Child Protection in Gateshead. The scope and aims of the review were agreed by the Committee at its meeting on 18th June 2015. The review focused on the specific aspects of the system that are concerned with child protection, following the potential steps for a child who becomes subject to a child protection plan.

The key issues that were considered during the 4 evidence gathering sessions were:

- An understanding of the child protection system, the policy context and clarity on roles and responsibilities
- The opportunity for improvement of systems
- The effectiveness of multi-agency working, especially around communication and information sharing.
- The ways in which views of children, young people and their families are used.

Key recommendations from the review were identified as:

i) Additional work is undertaken to further improve the availability of GP reports at ICPCs and RCPCs.

ii) Improve the detail of data provided in relation to school referrals to children's social care. Providing a breakdown by school to facilitate the committee's scrutiny of safeguarding within education.
iii) To review the evidence in light of the latest Ofsted inspection findings published on 11 March 2016
iv) To consider and evaluate the appropriateness of a MASH as part of the redesign of Care, Wellbeing and Learning.

Implementing the review –This progress report provides an update on activity relating to the recommendations agreed by the Families Overview and Scrutiny Committee.

Improve the availability of GP reports at ICPCs and RCPCs

In 2014-15 (financial year) data evidenced that less than a third of conferences had reports provided by GPs (both ICPCs and RCPC's). We undertook an extensive piece of work with health to address concerns including visits to practice and facilitating training workshops in April 2015.

- Between April 2015 and March 2016, we saw a significant improvement in GP reports provided to conference – this figure standing at 70.4%.
- Quarter 1 data for 2016-17 (financial year) shows that this has decreased to 61%. We are meeting with health on a quarterly basis to address any specific concerns (next meeting September) . In addition, we have implemented an additional weekly report to identify any issues with data recording for GP reports (identifies gaps in reports provided from specific practices as well as any inputting issues by senior clerks). This weekly report provides a robust mechanism to immediately identify issues and address them, rather than relying on cumbersome ad-hoc/quarterly data sweeps.
- Regular monitoring of the GP contribution to report writing is taking place jointly with the CCG and Safeguarding Unit.
- All GP Practices are aware of the need to contribute to the child protection process and are developing systems in their own Practices to contribute to this work in a timely manner.

The lack of or late submissions in GP and agencies' reports to conference is an ongoing concern which can result in key pieces of information missing that are crucial to decision making and determining risk. Whilst performance figures have improved and the number of reports provided by GP's to conference has increased this remains a priority area with work ongoing between the CCG and the Local Authority Safeguarding Unit.

i) To improve the detail of data provided in relation to school referrals to children's social care: Providing a breakdown by school to facilitate the committee's scrutiny of safeguarding within education.

- 83 referrals since April had school as the source, but only 15 have school relationships recorded.
- Further development is required in order to provide robust information in this regard.

- The performance team are exploring how to link child level detail held on EMIS (Education Management Information System) which will provide the school detail with Carefirst with a view to providing school level data on a monthly basis.

ii) To review the evidence in light of the latest Ofsted inspection findings published on 11th March 2016

- Following publication of the Ofsted report an action plan has been developed with a number of areas that focus on child protection. These are being taken forward and monitored through regular monthly meetings and scrutinised by the Service Director for Children and Families Social Work.

Inspection recommendation: Improve the quality of all children's plans, including pathway plans to ensure that targets for improvement are clear and that they focus on risk and the most important issues for children, young people and care leavers

- New CP, CiN and LAC plans formatted based on audit and inspection findings
- Targeted training for SWs team mangers and IROs to be developed and rolled out. A series of training workshops have been delivered to ensure staff including IROs and CP Chairs are equipped to write comprehensive and outcome focused plans with clear timescales and contingencies
- Specific audit documentation is being developed to focus on plans taking account of the new planning template in order to provide assurance that the changes are achieving the desired outcome.
- Core group documentation is being revised in light of the new planning framework in order to support core group functionality and monitor progress re the plan

Inspection recommendation: Ensure that children who are subject to child protection processes have access to independent advocacy in order to help share their views and to inform decisions about their lives.

- Dedicated staff members in the Referral and Assessment team provide support to children and young people who are subject to child protection enquiries facilitating their participation in CP processes and ensuring their voice is heard either directly at conference or indirectly through written or drawn submission.
- MOMO being promoted by SWs for children and young people's involvement in CP conferences
- Monitoring use of MOMO and where issues are raised ensure advocacy is offered
- Work is ongoing with NYAS, the commissioned provider for independent advocacy, to enhance the service offer for children and young people who are being supported through the child protection process.

iii) To consider and evaluate the appropriateness of a MASH as part of the redesign of Care, Wellbeing and Learning.

- Service Directors are considering all options for future development in conjunction with support from the Transformation team. The final proposal is yet to be determined.

Summary

Progress is being made against all the recommendations arising from the review. The recommendations are being taken forward within the framework for improvement for Children's Social Care and as such link in to ongoing areas of service development.

Recommendations

Overview and Scrutiny Committee is requested to: -

- Note the progress achieved in the last five months
- Comment on whether the Committee is satisfied with the level of progress to date.

Contact: Ann Day / Elaine Devaney	ext: 3484/ 2704

FAMILIES
OVERVIEW AND SCRUTINY COMMITTEE
8 September 2016

TITLE OF REPORT: Local Safeguarding Children Board Annual Report and Business Plan

REPORT OF: Interim Strategic Director, Care, Wellbeing and Learning

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EXECUTIVE SUMMARY

The Local Safeguarding Children Board (LSCB) has a statutory requirement to publish an annual report on the effectiveness of safeguarding in the local area. The findings of the annual report are then used to determine safeguarding priorities for the LSCB and partner agencies for the following financial year.

The report and priorities are considered each year at OSC to inform the committee of arrangements in place to safeguard children in Gateshead.

Background

1. The Children Act 2004 requires local authorities to have in place a LSCB. The LSCB is the principle mechanism for agreeing how relevant organisations in the local area will cooperate to safeguard and promote the welfare of children in the area and for ensuring the effectiveness of the arrangements. Gateshead has had a LSCB since 2005. It publishes an annual report and business plan which is reviewed and updated annually. The report contains details of the work undertaken by the Board, information of child protection activity and the priorities for the coming year.

2. Gateshead LSCB was independently by Gary Hetherington in 2015-2016 and a recruitment exercise is now underway to appoint a new independent chair in line with statutory requirements. This appointment will strengthen the Board's scrutiny of arrangements and partner agencies in Gateshead.

Performance and activity in 2015-2016

3. The full annual report for 2015-2016 is provided as an appendix to this report. A summary document entitled "how safe are children in Gateshead?" will also be shared with all school councils in Gateshead and other groups of young people.

4. In 2015-2016:

    - The Board made progress against its own priorities of **Leadership**, **Challenge**, and **Learning.** This included hosting a sub-regional conference to raise awareness and strengthen understanding of Child Sexual Exploitation (CSE), strengthening engagement with young people, receiving reports and challenging key areas of practice,

strengthening the Learning & Improvement Framework, developing revised Neglect Guidance and strengthening links with schools.

- The LSCB was subject to an inspection by Ofsted at the same times as Gateshead Council. Whilst the inspection found that the LSCB requires improvement to be good, a number of positives were noted and the Board was found to fulfil its statutory responsibilities.
- The LSCB carried out a detailed inquiry about CSE to scope the scale of the issue locally and reassure the Board that current practice kept children and young people safe. We also arranged for training to be delivered in schools directly to young people and trained over 700 taxi drivers licensed by Gateshead Council to help them to understand their responsibilities to vulnerable passengers and how to spot the signs of CSE
- The Board and partners continued to learn from high profile cases in other areas
- The LSCB Missing, Sexually Exploited and Trafficked Group (MSET) discussed the cases of 43 children and young people who were reported missing from home/care and/or were at risk from CSE. Multi-agency actions were set and diversion plans established to try to reduce the risks
- The Gateshead Local Child Death Review Sub Group was notified of the deaths of nine children in 2015-2016. The sub group reviews the death of every child resident in Gateshead at the time of their death and disseminates any relevant learning. The sub group works closely with similar groups in Sunderland and South Tyneside and feeds into the South of Tyne and Wearside Child Death Overview Panel (CDOP) to review all child deaths in the sub region and establish whether there are any overall lessons to learn. The CDOP provides an annual report to each LSCB
- The LSCB continued to consider ways to strengthen links with local communities and appointed three lay members (jointly with the Safeguarding Adults Board), a representative from the Jewish Community and a representative from the Diversity Forum
- The LSCB continued to offer a number of interactive on-line e-learning modules to complement the existing face-to-face training package. These modules are available to access free of charge and cover areas such as basic child protection, the impact of domestic abuse, self-harm and CSE. Members are welcome to access the modules via the LSCB website to strengthen their knowledge base

5. The annual report also details partner agency performance in relation to safeguarding. In addition to the very positive inspection of Gateshead Council in 2015-2016 a number of other partners were also inspected by the relevant inspectorates. Overall arrangements were judged to be very effective. A number of partner agencies strengthened internal arrangements and also links with other partners to improve information sharing and understanding of risk. Work was also undertaken to receive and support 53 Syrian refugees, 17 of which were children and young people of school age. Partners were able to demonstrate their activity in relation to the LSCB's priorities of **Leadership, Challenge** and **Learning**, for example on health partner set out how named professionals challenged professionals within adult-facing departments to consider the needs of children within the family when an adult attends with a

high risk presentation. Partner agencies were also able to reassure the LSCB via the annual Section 11 audit that suitable arrangements were in place to safeguard children and appropriate consideration was given to statutory requirements.

6. The annual report also contains multi-agency and single agency performance data. Key issues to note include:

    - An increase in the number of children made subject to child protection plans than in previous years (a 5% increase at year end and this has continued to rise into 2016-2017)
    - A large increase (38%) in formal child protection enquiries and also an increase in full child in need assessments. Despite this, compliance with timescales remains high
    - Continuing high numbers of unborn babies subject to formal child protection plans compared to the rest of the country. This was challenged by Ofsted and the Board are satisfied that this is as a result of early referral and multi-agency risk assessments when concerns are identified, whereas other areas wait until much later in the pregnancy before carrying out pre-birth assessments
    - Low re-referral rates to Children's Social Care, which would suggest that families are receiving the correct level of service
    - Higher than expected numbers of children being admitted to hospital for self-harm
    - A large increase in the number of permanent exclusions from our schools

7. Our data reinforces the increasing demands on statutory services. Workloads across the system as a whole continue to increase, often against a backdrop of cuts to budgets and reduced capacity. OSC members will be aware that Early Help services in the borough are being reviewed and the LSCB will scrutinise and challenge these arrangements where necessary. Effective preventative and Early Help services across the system as a whole are vital to keep children and young people safe and to enable them to reach their full potential. Effective early intervention will enable agencies in Gateshead to tackle problems for our children and families before they become more difficult to reverse

Priorities for 2016-2017 and beyond

8. In previous years, the LSCB has produced a combined annual report and business plan; however since 2013-2014 the Board agreed the need for a longer term strategy to set out the strategic direction and key priorities of the LSCB together with an annual action plan. In order to maximise efficiency around the development of priorities, and to reinforce the protocol with the Children's Trust Board, the Board developed three year Business Plan (2014-2017) which emphasises the collective role of the LSCB membership.

9. The 2014-2017 Business Plan focuses on the specific role and remit of the LSCB in ensuring the welfare of children is safeguarded and protected, as set out in *Working Together to Safeguard Children* (2015) and the Children Act 2004. The Business Plan emphasises the role of the LSCB in leading the safeguarding agenda, in challenging the work of partner organisations and in

committing to an approach which learns lessons, embeds good practice and which is continually influenced by the views of children and young people.

10. The Business Plan is based on two strategic outcomes (**protecting vulnerable children** and **preventing harm**) and three strategic business priorities (**leadership, challenge,** and **learning**). The focus will remain on these priorities and outcomes in 2016-2017 with some specific actions for the Board and partners to achieve.

11. The year two (2016-2017) action plan is provided as an appendix to this document.

12. In 2016-2017, in relation to **preventing harm** we will:

- Undertake task and finish work in relation to the increase in the numbers of permanent exclusions in our schools
- Receive the updated "Thresholds/Indicators of Need" document from Children's Social Care and monitor the implementation
- Consider developing a locality risk assessment model to understand where and what the priority need is

13. In relation to **protecting vulnerable children** we will:

- Undertake task and finish work on the issue of self-harm in Gateshead to understand the data and ensure appropriate support is in place for young people who do self-harm
- Receive reports on areas such as CSE and "legal highs" to understand the impact of operational practice
- Continue to lead on the local implementation of the national Child Protection-Information Sharing project (CP-IS)

14. In relation to **leadership** we will do the following:

- Strengthen links with the local community through work with lay members and community representatives
- Receive reports on the re-design of Early Help services and consider the impact on protecting vulnerable children and preventing harm
- Work with other partnerships to strengthen links and improve the visibility of the LSCB
- Carry out specific pieces of work to improve engagement with young people

15. In relation to **challenge** we will:

- Receive and challenge single agency audits of safeguarding practice from our partners
- Develop and implement an Effectiveness Framework
- Receive the outcome of the Families OSC review of child protection and respond as appropriate

16. And, in relation to **learning**, we will:

- Learn from what young people are telling us and use the findings to identify future themes for task and finish work
- Review the learning from the national review of LSCBs and develop an action plan to take forward local areas for development as appropriate
- Continue to review cases where there are lessons to be learned through the Learning and Improvement Sub Group (and Serious Case Review Panel when necessary)
- Review processes to understand the impact of our training offer and maintain a focus on delivering high quality training that meets demand
- Implement and embed the findings and recommendations from inspections/peer reviews as they arise and cascade the learning across partner agencies

17. Families OSC members may be aware that the Government commissioned a national review of LSCBs later in 2015 and this was published in June 2016 (the Wood Report). This report recommends a number of changes to multi-agency strategic safeguarding arrangements and the Government have agreed in principle. However, there currently are no clear indications of timescales or what this will mean in relating and LSCBs and partners are awaiting further information about when legislative changes will take place and what the requirements will be. Information will be shared with key partners and stakeholders as and when possible.

Recommendation

18. It is recommended that the Families OSC note LSCB and partner agency performance for 2015-2016 and note and endorse the proposed priorities. It is also recommended that Families OSC agree to receive updates in relation to any proposed changes to strategic arrangements as a consequence of the Wood Report.

CONTACT: Louise Gill, Extension: 8010

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GATESHEAD
local safeguarding children board

Gateshead LSCB Annual Report

2015-2016

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1. INTRODUCTION AND WELCOME

Gary Hetherington LSCB Independent Chair 2015-2016 and **Councillor Angela Douglas**, Cabinet Member for Children and Young People

Introduction – Councillor Angela Douglas, Cabinet Member for Children and Young People

I am pleased to introduce the Gateshead Local Safeguarding Children Board (LSCB) Annual Report for 2015-2016.

As the Cabinet Member for Children and Young People for Gateshead Council I hold the statutory responsibility, along with Alison Elliott, Director of Children's Services, to ensure that children at risk of harm receive quality services to protect and support them and their families.

The previous twelve months have seen unprecedented challenges for agencies in Gateshead in terms of resources and there is no doubt that these challenges will continue into 2016-2017 and beyond. However, we continue to see excellent practice and commitment from professionals in Gateshead to keep our children safe. As this report will set out, the Local Authority and the LSCB were inspected by Ofsted in the autumn and this inspection found that children are at the heart of good practice in Gateshead and multi-agency practice was judged to be highly effective overall.

The LSCB holds a key and central role in leading and coordinating the work of agencies in Gateshead who work to keep children and young people safe and Ofsted acknowledged the clear strong commitment from key statutory agencies. As part of ongoing development work and a challenge of its own arrangements, the Board had already identified the areas for improvement noted by Ofsted and work has already taken place to address a number of these areas. The LSCB continues to **lead**, **challenge** and **learn** and asks its partners to do the same.

I am confident that the LSCB and its partners will continue to develop in 2016-2017 and continue to strive to improve outcomes for every child in Gateshead, but particularly our most vulnerable. I look forward to being a part of this improvement journey and continuing to support arrangements to safeguard and protect our children over the next 12 months.

Introduction – Alison Elliott, Interim Strategic Director, Care Wellbeing and Learning

This year has seen significant work undertaken by the LSCB within an increasingly challenging environment, not least an Ofsted inspection and the continued austerity across the public sector. The Ofsted judgement of the LSCB, that it requires improvement to be good, reflects the positive contribution of the LSCB to safeguarding children in Gateshead and confirms the areas of improvement that the LSCB had already identified. Partners continue to commit to and participate in the LSCB and it is this partnership that ensures children in Gateshead are safe and supported to thrive.

Next year the LSCB will focus on a number of key strategic areas that reflect the recommendations from Ofsted, but will also focus on specific areas of practice to ensure that the Board has a real positive impact on children's lives.

The Board is grateful for the commitment of three new lay members and as always, is grateful to the Board Business Manager and the Chair for driving forward the agenda and keeping the focus on making a difference to children.

2. EXECUTIVE SUMMARY

As set out in *Working Together to Safeguard Children* (2015), every Local Safeguarding Children Board (LSCB) is required to produce and publish an annual report on the effectiveness of safeguarding in the local area. This report sets out the arrangements to safeguard and promote the welfare of children in Gateshead and provides an assessment of those arrangements. This report also sets out how we discharge our functions as set out in *Working Together to Safeguard Children* (2015).

2015-2016 has been a busy year for us. As well as "business as usual" we were inspected by Ofsted alongside services to safeguard children in Gateshead Council. Whist Ofsted were happy that we were fulfilling our statutory responsibilities and had a clear, strong commitment from our partners, they judged that we require improvement to be "good". They found that a lot of the work that we are doing is done well, and we are moving in the right direction, however there were seven recommendations made to strengthen our performance to make us more effective. We've already started work to address these recommendations and have achieved some of them, for example we now have three active lay members on the Board to strengthen our links with the local community (we share those lay members with the Safeguarding Adults Board to help strengthen our links with them too) and we've strengthened links with the Jewish community and the Health and Wellbeing Board. We're also strengthening our oversight of frontline practice by receiving regular updates on single-agency audits undertaken by our partners.

Throughout 2015-2016 we continued to work towards our priorities of **Leadership, Challenge** and **Learning**, which are part of our three year business plan and help us to ensure that our work impacts on the children of Gateshead by improving outcomes. We arranged a sub-regional event in Gateshead for 500 practitioners and managers to raise awareness and understanding of Child Sexual Exploitation (CSE) and we undertook a detailed inquiry into CSE to ensure that practice is fit for purpose. We also trained 700 taxi drivers so that they could be more aware of vulnerable passengers and CSE in particular. Ultimately, the more people who are aware of how to spot CSE and how to respond, the better the outcomes are for those children at risk. We reviewed our own arrangements to ensure that we were working as effectively as possible and drew on national best practice to support this. We also continued to develop our Learning and Improvement Framework to make sure that the lessons from frontline practice are used to strengthen practice in the future. We also started our programme of "mini-peer reviews" so that we could learn as a Board and single agencies from each other and encourage challenge. This will help us to work together even more effectively to improve outcomes for children in the borough and really make a difference.

Our sub groups also worked hard in 2015-2016. We led on areas like updating procedures, updating the CSE strategy, learning from specific cases, learning from child deaths in the borough and delivering high quality training to frontline professionals.

We received a number of reports in 2015-2016 which allowed us to understand frontline practice and challenge this practice where necessary. This included reports on Novel Psychoactive Substances (also known as "Legal Highs"), the "Dark Web", extremism, high risk adolescents and children convicted of sex offences. By challenging practice we are confident that we have made a positive impact on outcomes for children.

We carried out a "section 11 audit" which told us that on the whole, our LSCB partner agencies and schools are meeting their statutory requirements to keep children and young people safe and have really effective arrangements in place that really make a difference to children's lives. A number of our partners were also inspected in 2015-2016 and the outcomes were, on the whole, really positive. Keeping children safe is at the centre of what many of the agencies in Gateshead do, and generally we do it really well. Inspectors found that our partners are having a positive impact on the lives of children in Gateshead and we're working together to keep them safe.

Our data tells us that we have had:

- A 5.8% increase in the number of children who are subject to child protection plans at year end compared with the previous year
- A slight decrease in the numbers of children subject to child protection plans under the category of neglect
- Continuing high numbers of unborn babies subject to child protection plans and this ensures timely decision making and support for these children
- A sustained decrease in the number of re-referrals to Children's Social Care and our figures are lower than the regional and national averages. This suggests that families are more likely to receive the services they need to keep children safe when they first come to the attention of Children's Social Care
- A 38% increase in the numbers of child protection enquiries (section 47s) completed compared to last year (669 in 2015-2016 compared to 487 last year)
- A 9% increase in Child In Need (CIN) assessments completed (a total figure of 2191 assessments)
- Continuing high numbers of children who are looked after by the local authority and higher than the national average for this indicator
- Higher numbers than expected (for our population size) of children being admitted to hospital for episodes of self-harm and we're going to continue work around this into the future

Our young people tell us that, on the whole, Gateshead is a safe place to live and go to school. The majority of young people that we've spoken to are confident that they would know what to do if they didn't feel safe at home, at school or in the community and they shared that our schools are good at telling them how to keep themselves safe. Some young people reported that they're aware of some areas being less safe than others, e.g. there are certain parks that young people avoid due to older teenagers and adults congregating there and using alcohol and drugs, and they don't always feel safe on buses and metros late at night. We'll be sharing the detail of this with relevant partners to try and make these areas of Gateshead safer or improve the perception of young people.

We will continue to work hard, both as a partnership and single agencies, in 2016-2017 and build on the work we've done over the last 12 months to make sure that we improve outcomes for children in Gateshead. Our vision is that every child should grow up in a loving and secure environment, which is free from abuse, neglect and crime, enabling them to enjoy good health and fulfil their social and educational potential and we are confident that our robust partnership arrangements can support that.

Gateshead LSCB in numbers in 2015-2016

There are **40,100** children living in Gateshead (20% of the total population)	**20.5%** of our children live in poverty (slightly less than last year but higher than the national average)	**8.62%** of school age children are from an ethnic minority **6.2%** of our children speak a language other than English as their first language	**23,848** children attend schools in Gateshead (not including Emmanuel College or the Jewish schools)
4846 children in Gateshead receive free school meals (**22%** of all children, which is an increase)	**68.1** children per 10,000 are currently subject to child protection plans	We've seen a **5.8%** increase in the number of CP plans this year – we're still higher than the national and regional averages	**61.9%** of our child protection plans were due to neglect (**169** cases)
During the course of the year, **66** unborn babies were made subject to child protection plans due to concerns about their pregnant mother or family	Children's Social Care received **8943** "contacts" contacts from people worried about a child in Gateshead	We carried out **669** s47s – an **increase** of **187** from last year **99.7%** were completed within timescale	**85.8** children per 10,000 are currently looked after by Gateshead Council
99.4% of our LAC reviews and **100%** of our Review Child Protection Conferences were held within timescales	**87.8%** of our schools are judged to be good or outstanding	**100%** of schools are now signed up to Operation Encompass – a new project to support children who witness domestic abuse at home	Police shared information with schools via Operation Encompass regarding **1,101** children to ensure that appropriate support was in place
90% of our GPs practices were represented at "level 3" child protection training (28 out of 31 practices)	Over **700** taxi drivers attended training delivered by the LSCB and Police on CSE to help them understand how to keep vulnerable passengers safe	There were **928** episodes where a young person from Gateshead was reported missing from home or care to the police. **71%** of them were "in care"	The cases of **43** young people were discussed at the LSCB's Missing, Sexually Exploited and Trafficked Sub Group (MSET) due to concerns about them
We didn't publish any Serious Case Reviews or initiate any new ones this year. We have looked at a few cases in more detail to try and improve practice though	**1151** practitioners attended a LSCB training event – this is an increase on last year	Gateshead's under 18 conceptions have decreased by **40%** since 1998	Gateshead College delivered a Counter Extremism and Radicalisation tutorial to **1,795** young people and a British Values tutorial to **1,746** young people

3. GATESHEAD AND GATESHEAD LSCB

3.1 The Borough of Gateshead

Geographically, we are the largest of the five Tyne and Wear metropolitan authorities. We cover an area of 55 square miles including a mix of urban, rural and busy commercial areas. Many of our population live in urban areas where there are areas of industrial decline and high levels of deprivation,

Our population is largely of white British origin. However we do have a large orthodox Jewish community of approximately 4,500 people, including just over 1,000 school age children and 1,500 young people in further education (the Jewish further education colleges in Gateshead play host to students from all over the world). 8.62% of our school age children are recorded as being from an ethnic minority group (up from 7.87% last year) and 6.2% of our school age children speak a language other than English as their first language (also an increase from 5.2% last year).

According to the latest data there are more than 40,100 children under 18 living in Gateshead which accounts for approximately 20% of our overall population of 200,500. The latest child poverty data (2013) shows that 20.5% of our children are classed as living in poverty. This is a decrease from the previous figure and may not fully reflect the current economic climate, but is based on average levels of income. Nationally 18% of children are classed as living in poverty, so Gateshead is higher than the national average, however in the North East overall this is 22.2%. This varies from 16.8% in Northumberland to 31.8%% in Middlesbrough. 4846 of our children are in receipt of free school meals (22.3% of the population), which is a slight increase from last year.

Our statutory mainstream school age population in 2015 was 23,848 (not including Emmanuel College and Jewish schools). This is an increase from 23,592 last year and includes 14,674 primary school children, 8,616 attending secondary schools, 469 at special schools and 89 at the Pupil Referral Unit (PRU) – a slight decrease in secondary school numbers but an increase in primary school numbers and a significant increase in numbers at the PRU. Of the 74 schools in Gateshead inspected by Ofsted since January 2012, 87.8% of them have been judged as good or outstanding (a slight increase from 86.5% reported last year).

3.2 Gateshead LSCB

LSCBs are multi-agency statutory partnerships established under Section 13 of the Children Act 2004. More information on the role and function of LSCBs can be found on our website www.gateshead.gov.uk/LSCB

We were established in 2005 (having replaced the Gateshead Area Child Protection Committee) to take responsibility for core inter-agency child protection work in the Borough, whilst also embracing the wider safeguarding duties established in the Children Act 2004.

Our vision is that every child should grow up in a loving and secure environment, which is free from abuse, neglect and crime, enabling them to enjoy good health and fulfil their social and educational potential

Our aim is to build upon and strengthen existing partnerships and to engage with the community. In furthering this vision, the LSCB's core objectives and functions are focused on safeguarding children and young people as set out in *Working Together to Safeguard Children* (2015). Safeguarding is a multi-dimensional and fluid interactive process and, as such, the LSCB formulates its strategies to afford as wide an audience as possible a voice in promoting a safer environment for the children and young people of Gateshead.

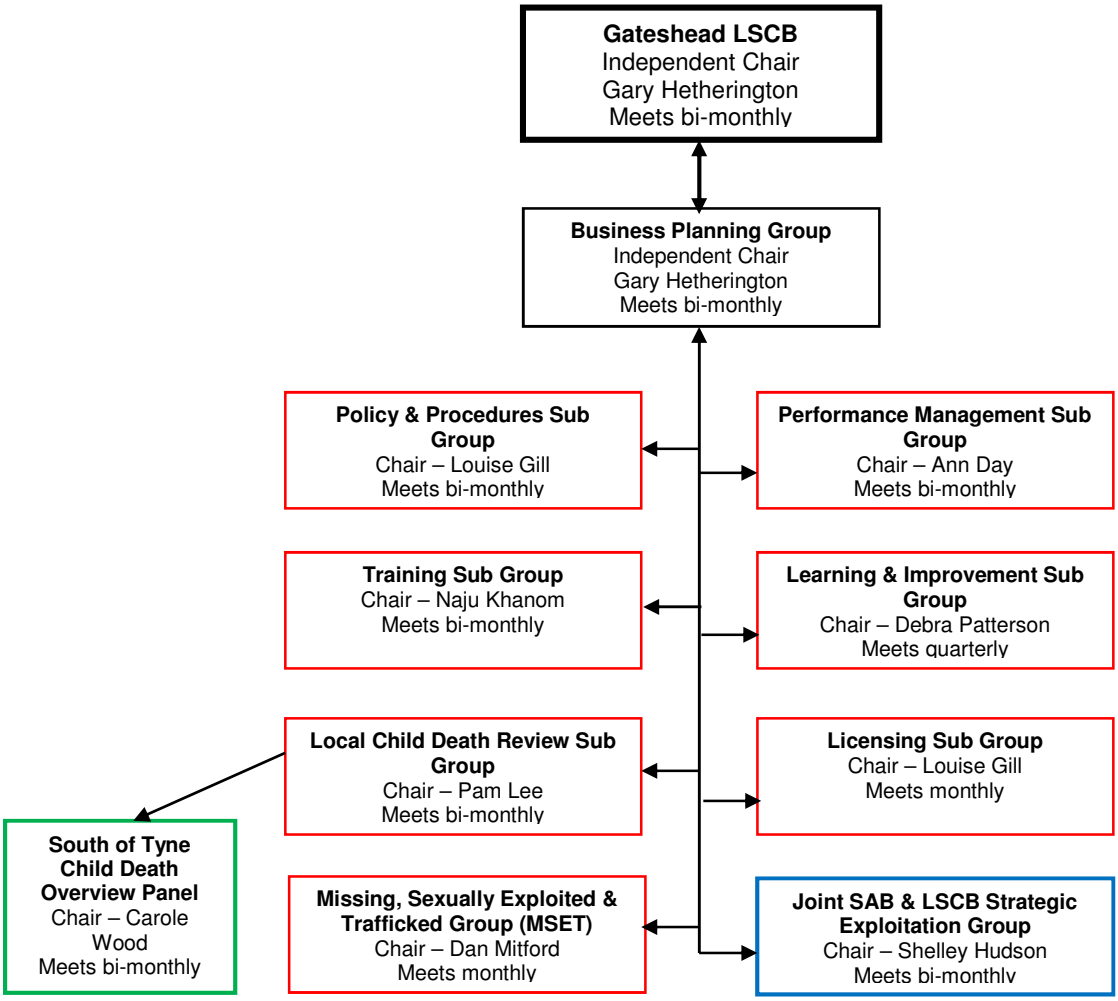
The role of the LSCB is to **lead**, **challenge** and support **learning** and this is reinforced by our own Business Plan. Gateshead LSCB has a three-year approach to facilitate longer term planning and focus business on the specific role and remit of the Board to ensure that the welfare of children is safeguarded and protected, as set out in *Working Together to Safeguard Children* (2015) and the Children Act 2004.

4. STRUCTURE AND MEMBERSHIP

4.1 Structure

Our full Board meets six times a year and is supported by a Business Planning Group and eight sub groups, one of which is shared with the Safeguarding Adults Board. Each sub group has its own Terms of Reference and work plan and is expected to report to the LSCB three times a year and make a contribution to the annual report.

The following diagram outlines our Board and sub group structure as of 31 March 2016:



4.2 Our membership

We review our membership every year to make sure that the right people are at the right meetings. Our Independent Chair also monitors member attendance, contributions and associated issues.

The following table sets out our membership on 31 March 2016:

Membership of the Board	
Independent Chair	Gary Hetherington
LSCB Business Manager	Louise Gill
Lay Member	Rebecca Dixon
	Mike Jones
	Richard Marshall
Organisation	**Representative**
Cafcass	Service Manager
Gateshead College	Director of Student Experience
Gateshead Council	Business Manager – Safer Communities
	Cabinet Member for Children & Young People
	Housing Services Manager
	Interim Strategic Director, Care, Wellbeing & Learning
	MASH Business Manager
	Public Health Programme Lead
	Service Director – Children & Families Support
	Service Director – Children's Commissioning - *vacant post*
	Service Director – Corporate Services and Governance
	Service Director – Learning and Schools
	Service Director – Social Work, Children & Families
	Service Manager – Children's Commissioning
	Service Manager – Early Years & Childcare
	Workforce Development Advisor
Gateshead Health NHS FT (GHNFT)	Designated Doctor – *vacant post in 2015-2016*
	Director of Nursing
Gateshead Safeguarding Adults Board	SAB Business Manager
Jewish Schools representative	Administrator (designated professional)
National Probation Service	Head of National Probation Service South of Tyne
NHS Newcastle Gateshead CCG	Designated Nurse, Safeguarding Children
	Director of Nursing
Northumbria CRC	Director of Offender Management
Northumbria Police	Detective Superintendent – Safeguarding Department
NTW NHS Foundation Trust	Group Medical Director for Specialist Care
Primary School representative	Head Teacher
	Head Teacher
Secondary Schools representative	Head Teacher
Special Schools representative	Head of School,
South Tyneside NHS FT	Director of Nursing and Patient Safety
	Strategic Lead Safer Care
UK Visas and Immigration	Senior Asylum Caseworker

Links are also maintained with NHS England and North East Ambulance Service via the CCG and with Tyne and Wear Fire and Rescue Service

4.3 Our meetings

There are a number of standing agenda items on every LSCB meeting agenda, and these are:

- Members' updates – an opportunity for Board members to provide verbal updates on items impacting on their agencies and partnerships and safeguarding children including organisational change, campaign update, media items and response and inspection updates
- Sub group updates (including regular performance reports and the LSCB data-set)
- Update on Child Sexual Exploitation (CSE)
- Business Manager and Business Planning Group report

From 2016-2017 onwards we will also review single agency audits at every meeting to strengthen our oversight of partner agency frontline practice.

Some of the issues we discussed at our meetings in 2015-2016 included Foetal Alcohol Spectrum Disorder, Children Missing Education, the role of GPs in safeguarding, preventing extremism and NPS ("legal highs"). Appendix 1 of this report contains more detail about our agenda items this year.

We've set our work plan for 2016-2017 and this is monitored at each meeting of the Business Planning Group to make sure we're discussing the most important and relevant issues in terms of keeping children and young people safe in Gateshead.

5. REVIEW OF FINANCES AND RESOURCES

Section 15 of the Children Act 2004 sets out that statutory Board partners may:

- Make payments towards expenditure incurred by, or for the purposes connected with, a LSCB directly, or by contributing to a fund out of which payments may be made
- Provide staff, goods, services, accommodation or other resources for purposes connected with a LSCB.

Cafcass, Gateshead Council, National Probation Service, NHS Newcastle Gateshead CCG, Northumbria CRC and Northumbria Police all made contributions to the LSCB in 2015-2016.

Income (£)	
Cafcass	550
Gateshead Council	66,710*
National Probation Service	250
NHS Newcastle Gateshead CCG	44,023
Northumbria Police	5,000
Northumbria CRC	250
TOTAL	**116,783**

*The contribution from Gateshead Council includes a £11,430 budget held by Organisational Development to manage the LSCB Multi-Agency Training Programme. This was reported separately previously.

There was a decrease from the 2014-2015 budget (£137,404 in total) and this is due to a reduction in the contribution of Gateshead Council.

In total, £110,120 was spent from the LSCB budget in 2015-2016, with an underspend of £6,663. As previously agreed, this underspend will not be carried forward to 2016-2017 and in real terms represents a slightly smaller contribution from Gateshead Council.

In 2015-2016:

- **£81,992** was spent by the LSCB on salaries and on-costs for the LSCB Business Manager and Admin. Officer
- **£16,243** was spent by the LSCB on fees which included £4,000 on the maintenance of the LSCB Inter-Agency Child Protection Procedures, £1,500 to the National Association of Independent Chairs, £500 to the National Working Group (for CSE) and the remainder was payment to the LSCB Independent Chair
- **£11,430** was spent on the LSCB multi-agency child protection training programme for frontline practitioners and **£4,987** was spent on other training

We didn't spend any money on Serious Case Reviews in 2015-2016 and the budget for Child Death Reviews is shared between Gateshead, Sunderland and South Tyneside Councils and not reported on here.

Expenditure (£)	
Salaries and on costs (Business Manager & Admin Assistant)	81,922
Multi-agency training programme	11,430
Chair's fees	10,243
Other LSCB training e.g. CSE conference	4,987
Inter-agency Child Protection Procedures	4,000
Contribution to National Association of Independent Chairs	1,500
Miscellaneous (pool cars, public transport, phone costs etc.)	1,255
Hospitality	801
Printing, stationery, advertising	645
SCR fees	0
TOTAL	**110,120**

Partners have been asked to confirm contributions for 2016-2017.

6. EFFECTIVENESS OF SAFEGUARDING ARRANGMENTS FOR CHILDREN AND YOUNG PEOPLE IN GATESHEAD - REVIEW OF ACTIVITY IN 2015-2016

6.1 Overview and single agency activity

This section of our annual report sets out how effective services are in Gateshead at keeping children and young people safe and what the impact of our work has been in terms of improving outcomes for children and young people. As set out in *Working Together to Safeguard Children* (2015), our objectives are to coordinate and ensure the effectiveness of safeguarding arrangements in the local area. We agreed a new approach for 2014-2017 in a three year Business Plan which was more focused on our specific role and remit in ensuring the welfare of children is safeguarded and protected. Our Business Plan sets out three strategic business priorities: **Leadership**, **Challenge** and **Learning**. Members of the LSCB committed to an approach where the LSCB leads the safeguarding agenda, challenges the work of partner agencies and itself, learns lessons and embeds good practice and is continually influenced by the views of children and young people. We've made progress in

all of these areas to improve safeguarding arrangements and section 6.6 of this report sets out our progress.

Our sub groups have continued to work to their Terms of Reference and work plans and provide regular reports to the Board on their progress. Appendix 5 of this report sets out activity from our sub groups in 2015-2016.

The three priorities of **Leadership**, **Challenge** and **Learning** extend to both the Board's own work and also that of our partner agencies. Our partners have provided examples and evidence of work where **Leadership, Challenge** and **Learning** has taken place and led to changes in practice and will ultimately improve outcomes. By supporting our partners in this areas we can work together to really make a difference for the children and young people of Gateshead. Appendix 2 of this report provides some examples of progress made by our partners in 2015-2016.

There have been a number of operational developments across our partner agencies in the past 12 months to make services more effective at keeping children safe and improving outcomes. For example, a process is now in place between NTW and Children's Social Care to share information in "real time" so that clinicians have access to the most up to date records and the CCG have carried out a pilot to significantly improve GPs' contribution to CP conferences. These two examples show the impact that improved multi-agency working can have as professionals working with these families are more aware of risks and issues and able to put more effective plans in place. Additional examples can also be found in Appendix 2 of this report.

A number of our partner agencies were inspected in the last twelve months including Gateshead Council, Northumbria Police and some health agencies. On the whole, these inspections were very positive and found effective practice in the borough to keep children safe. Inspectors found effective work to keep children and young people safe from CSE, FGM and Honour Based Violence and joined up working between partners was noted. More detail on these inspections is included in Appendix 2 of this report.

The LSCB was inspected at the same time as the local authority and this is covered in section 6.7 of this report. The full report can be found at http://reports.ofsted.gov.uk/local-authorities/gateshead

The following case studies show how our Board partners work within their agencies and together to prioritise safeguarding and improve outcomes for children and young people in the borough and the impact that this can have.

Case study 1:

Family G arrived in Gateshead from the Lebanon as part of the Government's Syrian Vulnerable Person's Resettlement Programme in November 2015. A Refugee Resettlement Officer worked with the family, settling them into their new accommodation, ensuring they had access to health and dentistry as well as information about benefits entitled to them. They also helped them access English courses.

Education Support Workers visited the family and, via an interpreter, explained the education process; gathering information about individual children's education and potential needs, any health issues and generally how they were at school as well as discussing any issues or concerns they might have.

The Education Support Worker then arranged an initial visit to their school(s), facilitating a

meeting with the Head Teacher and staff. Transport was provided. Education Support Service also supported children for the first few weeks into their new school, taking them into school, ensuring they understood bus routes, supporting them in lessons, using iPads to address any language issues. A review meeting was held 6 weeks after they began school to review the process of integration with parents and school. The children have settled well into school and are rapidly improving their English. The family have been welcomed into the school community

Case study 2:
Mr M attended A&E claiming his drink had been spoked and had a 7 year old boy with him who was still wearing his pyjamas at 11am. Mr M was unsteady on his feet and slurring his speech and went to sleep in the waiting room. Meanwhile the child was seen to be wandering unaccompanied round the A&E department by reception staff. Mr M walked out of the department after 10 minutes (without receiving any treatment) and took the child with him and the reception staff reported the incident to the Named Nurse for Safeguarding Children.
Enquiries were made with Children's Social Care and it transpired that Mr M had recently been released from prison for drug related offences and a social worker was already allocated to the case. The family denied that it was their child in A&E so the social worker attended the hospital to view the CCTV footage and positively identified that it was him wandering round the department whilst his father slept.
The child was spoken to alone by the social worker and he indicated that he wanted to live with his grandmother as both his parents were using drugs. Therefore, as s result of the report made by hospital staff the parents signed consent for the child to live with his grandmother and he moved into a significantly safer environment.

6.2 What do young people say about life in Gateshead in 2015-2016?

Understanding the "voice of the child" is a key mechanism for LSCBs to determine how effective services are at keeping children and young people safe and where resources should be directed to improve impact and outcomes. We've done a lot of work this year, both collectively and as single agencies, to find out how safe our young people feel and understand what is important to them.

We had hoped to hold a large engagement event with children and young people, but we didn't manage to set this up before the end of the financial year and this will be completed early in 2016-2017. However, following the Ofsted inspection (see section 6.4.5) we commissioned some smaller pieces of work with specific groups of young people to help us understand their views.

Group of young people	Views
School councils and student leadership teams	We met with school councils, student leadership teams or equivalent groups from a number of schools in Gateshead in late 2015-2016 and further sessions were held after the Easter break in early 2016-2017. A detailed report is being prepared for Board members of the findings of the work. On the whole, young people told us that Gateshead is a fairly safe place to live and go to school. Some of them told us that some areas were "rough" and they didn't like going to certain parks because of older young people and adults drinking alcohol there. Some young people were also aware of areas where people use drugs, either because they'd heard that it happened there or they could smell it on them. There were some schools where young people felt safe on buses but not the Metro and other schools where it was the other way round. Some young people told us that they thought that Gateshead must be a safe place to live as they don't hear much on the news whereas there's a lot on the news about bad things happening in other places. Young people told us that it's important to them for parks to feel safer,

	for buses to feel safer, to hear more about road safety (particularly for cyclists) and fire safety but targeted to older children, to know how to be safer after dark, to know more about what terrorism means for Gateshead and for cyberbullies to be stopped. Almost all of the young people told us that they would know what to do and who to speak to if they didn't feel safe or a friend had a problem. Children from every school apart from one told us that they would speak to someone about a friend, even if the friend told them to keep it a secret, and even if they felt guilty about it, as it would keep them safe. The young people from the other school told us they wouldn't be "a grass" and would sort it out themselves
Young Carers	The bulk of this work was carried out in early 2016-2017, however young people from the group shared that they didn't really feel safe in Gateshead (some because of their neighbours) but they mainly knew what to do if they didn't feel safe at home. They shared worries about the lack of street lighting, stranger danger and road safety
Police Cadets	Overall, these young people said that Gateshead was a safe place to live and they knew what to do if they or a friend didn't feel safe. They shared that the police and local authority should carry out more visits to young people to speak about bullying, cyber bullying and internet safety.

We asked all of our partners as part of the Section 11 audit (see section 6.4.1) whether the voice of the child was used to plan the way that services are delivered and on the whole there was a positive response to this. We also had a discussion at our annual development session on learning from the voice of the child to be more effective. Services for young people's mental and emotional health are currently being redesigned and extensive consultation with young people has taken place through the Expanding Minds Improving Lives (EMIL) project. This included working as "young commissioners" and developing a film of their experiences of mental health services so that professionals can understand their views.

As detailed in section 6.3.1, we held a large conference in Gateshead in October 2015 to raise awareness of CSE. Two groups of young people spoke at the event and received some of the best feedback in the whole programme. The Gateshead Police Cadets told us what they think people need to know about CSE and how they think we should be getting messages to young people. The SCARPA Squad (a group of young people who have previously been involved in CSE or at risk of CSE) also showed us a new film that they've produced using real life stories and told us about how professionals can sometimes get things wrong and how they can make things better, which was really powerful. These presentations highlighted to professionals the terrible impact that CSE can have on a young person's life and gave everyone something to think about in terms of their own practice so that we can improve outcomes in Gateshead in the future.

We've recently started using the MOMO App (Mind Of My Own) in Gateshead and our partners are working hard to promote its use to improve the participation of children and young people in services and make sure their voice is heard. This is an award winning app that helps young people express their views more clearly, get more involved in meetings and make better decisions with their social care team. Ultimately this will help us to keep young people safer. It's too soon for the Board to say in detail about what young people are telling us via MOMO about how safe they feel in Gateshead, but we'll be able to look at that in more depth in the next few months. The early feedback is it's a really easy way to capture

the voice of young people in the child protection system and in care and it was also well received by Ofsted in their recent inspection.

6.3 Thematic activity

6.3.1 Sexual exploitation and missing children

We are required to report on numbers of children have been missing from care each year and how we are addressing the issue. However, we also think it is important to include children who go missing from home in this too. Children who go missing from home/care are at an increased risk of being sexually exploited and regular missing episodes are a risk indicator that a child is at risk of sexual exploitation or being exploited. The MSET is a well-established sub group of the LSCB which reviews individual young people where there are concerns about going missing and/or CSE and/or trafficking to try to reduce the risks and improve outcomes in a multi-agency way

- There were a total of 928 occasions in 2015-2016 where a young person from Gateshead was reported missing to the police (this includes episodes where a child was in the care of Gateshead Council but placed outside of the borough). The 928 episodes included 657 episodes (71%) where a child was reported missing from care, the remaining 271 episodes related to a child being reported missing from their family home or school.
- The total figure of 928 represents an increase from 2014-2015 where there were 864 episodes. There was also an increase in the number of missing from care episodes from 571 to 657 and an increase in the proportion of episodes from 66% to 71%.
- The missing from care episodes have increased significantly year on year for the past few years. The total number of episodes fluctuates each month, as does the proportion of episodes relating to missing from care. For example, in May 2015 there were 116 episodes in total and in January 2016 there were 54 and in May 2015 there were 80 episodes of missing from care and in March 2016 there were 35.
- The actual number of episodes relate to a smaller number of individual young people as there were a number of young people who were reported missing more than once. In fact, there was a small cohort of young people who were reported missing from care on a very regular basis, often together, some months, and this in part explains the large increase in episodes. It should also be noted that there was an increase in the number of episodes lasting over 24 hours, and a number of episodes which lasted significantly longer. Processes are in place to ensure that there is regular oversight of these cases.

Northumbria Police introduced a new “absent” category on 25 January 2016 and all “missing” reports will now be classed as either missing or absent. For the purposes of MSET, cases will be considered regardless of whether they are missing or absent and return interviews will also be offered regardless of the police category.

MSET discussed 43 cases in 2015-2016, which is a decrease from 53 in 2013-2014. The decrease is due in part to the revised MSET referral form which means that cases are referred more appropriately with tangible risks set out for the pre-meeting. Of the 43 cases discussed in 2015-2016, 23 were discussed on more than one occasion and some on almost a monthly basis due to the level of risk and frequency of missing episodes not decreasing. In

summer 2015 a MSET Escalation Procedure was introduced to ensure senior oversight of those cases where MSET members had significant concerns and there was no observed decrease in the level of risk. We used the procedure on two occasions in 2015-2016 to ensure that the risks around the young people in question were fully understood and assessed and all relevant and appropriate actions had been considered.

Ofsted judged that multi-agency arrangements to safeguard vulnerable children who go missing from home, care or education or are at risk of CSE are robust and, as Board, we are satisfied that they contribute towards improving outcomes for young people. The MSET was found to have an impact by providing additional scrutiny of individual cases and has also led to more effective support for children and young people. Intelligence sharing was viewed as effective in relation to potential hotspots and the work of MSET in terms of disruption activity and use of harbouring/abduction notices was found to lead to a reduced risk for those children.

When children return from being missing they are offered “independent return interviews” to assess any risks and determine whether they were harmed. In 2015-2016 there were 379 return interviews requested and of those there were 228 occasions where the young person agreed to be spoken to (an increase from 192 requests and 106 interviews last year). Ofsted found this process to be holistic and robust and resulting in preventative actions and targeted support. It was noted that not all actions arising from assessments or MSET translate into children’s individual plans and Gateshead Council are taking action to strengthen this.

Cases are now “flagged” within Children’s Social Care where there are CSE concerns to allow for additional management oversight and. At the end of 2015-2016 there were 16 cases flagged as being at risk of CSE and there were a total of 14 children who had their cases flagged throughout the year. The impact of this is that practitioners are more aware of who is at risk and what to look out for in order to keep them safer.

We are very clear in Gateshead that safeguarding is everybody’s business and CSE and missing children is one such area where we have reinforced this. The LSCB works collaboratively with others around this, for example in summer 2015 the LSCB Business Manager and police colleagues delivered mandatory CSE and vulnerability training to 700 taxi drivers licenced by Gateshead Council as part of the conditions on retaining their licence. Anecdotally this has led to increased awareness and reporting of vulnerable young people to Northumbria Police by taxi drivers which is evidence that this work had an almost instant impact in terms of keeping children safer. Through the work of the Licensing Sub Group, the LSCB Business Manager has also supported reviews of premises licences where there were risks to children, for example stores selling alcohol and so-called “legal highs” to children and this was seen as a significant strength by Ofsted in their recent inspection.

Strategic work on CSE and missing children was led by the Strategic CSE and Trafficking Sub Group and the group implemented a new CSE Strategy in May 2015 and had in place a delivery plan which was carefully monitored. Ofsted judged that the strategy was consistent with revised guidance and the delivery plan was robust. In March 2016 the sub group merged with a working group of the Safeguarding Adults Board to form the joint LSCB & SAB Strategic Exploitation Group (SAB) and this group will lead strategically on sexual exploitation in both children and adults, missing children, human trafficking and modern

slavery. It will allow for closer strategic and operational links between the Board and more effective transition for vulnerable young people into adult services.

As detailed earlier in the report, in October 2015 we hosted a very successful sub-regional conference in Gateshead for 500 frontline practitioners and managers. The event was opened by Vera Baird (PCC for Northumbria), chaired by Sir Paul Ennals (chair of a number of LSCBs) and closed by Chief Constable Steve Ashman. We had a number of speakers who were nationally and internationally recognised, such as Zoe Loderick (a highly regarded psychotherapist specialising in sexual trauma and CSE), and also presentations from local young people and Northumbria police on an ongoing local CSE operation. Feedback from the event was incredibly positive due the quality of the speakers and the information presented. The event was a key way of the Board raising awareness of CSE and providing practitioners with ways to safeguard and support young people at risk of CSE or being exploited. It also provided us with a key opportunity to **lead, challenge** and support **learning.**

6.3.2 Child deaths

There is a requirement for LSCBs to monitor and oversee the deaths of children resident in their area. Gateshead shares a Child Death Overview Panel (CDOP) with Sunderland and South Tyneside. An annual report is produced by the South of Tyne and Wearside CDOP to report on trends and issues and is published on our website. We aim to learn from all deaths with “modifiable features” to help improve outcomes for children in the future where possible.

The LSCB was notified of the deaths of nine children from Gateshead in 2015-2016. Of these deaths five were of children with known life limiting conditions. There were four unexpected deaths; however some of those children also had medical issues. To date, no identifiable patterns or safeguarding concerns have been noted within these deaths.

The local picture reflects the national findings that the majority of children who die do so due to life limiting medical conditions or as a result issues linked to prematurity. The number of unexpected deaths as a result of external factors remains small.

6.3.3 Private fostering

Children and young people who live with adults who are not members of their immediate family are "privately fostered". This is one of a number of areas that we request an annual update on from the relevant partner agency.

In 2015 the Gateshead Council officer with lead responsibility told us that in 2014-2015 Gateshead Council made three new private fostering notifications to the Department for Education with two new arrangements starting. During the reporting year no arrangements ended. As of October 2015 Gateshead had two children subject to private fostering arrangements (both girls aged 15) and since 2012 the local authority has maintained 100% performance in relation to social work visits every six weeks.

Whilst we challenged whether the actual number of cases was in fact higher than reported, we were assured that Gateshead Council and partners are taking appropriate steps to improve reporting and are appropriately protecting those cases where private fostering arrangements are identified. Private fostering literature was refreshed and re-circulated, however this had little impact on referral numbers. Private fostering was also featured and promoted in Council News and the TV screens in council buildings and social media. A specific question on private fostering is also included in the school transfer forms to help identify arrangements. Board members endorsed the report and agreed that best practice regionally and nationally should be considered in relation to promotional activity.

6.4 Strategic activity

6.4.1 Section 11 audit

Section 11 of the Children Act 2004 places a statutory duty on key organisations to make arrangements to ensure that they have regard to the need to safeguard and promote the welfare of children when discharging their functions. We aim to ask our partner agencies to demonstrate their compliance with this on an annual basis via a Section 11 audit.

In 2016 we asked all Board partner agencies, not just statutory partners, and schools (for the first time) to complete the audit and in total there were over 90 responses, which is the highest number we have ever received. Overall, the results were largely very positive and the majority of agencies reported that standards were met and there were no concerns and evidence was provided to support this. More detail on our Section 11 audit is included in Appendix 3 of this report.

6.4.2 Learning and improvement activity

Whilst we haven't published or initiated any Serious Case Reviews (SCRs) in 2015-2016, we have undertaken a number of pieces of work as part of our Learning and Improvement Framework including submitting a Serious Incident Notification (SIN) regarding a teenage girl who was possibly sexually assaulted whilst missing from care. The criteria for a SCR were not met however we were still able to learn some lessons from the case.

A summary of our learning and improvement activity is provided in Appendix 4 of this report.

It is important for us to be able to evidence and understand the impact of our learning and improvement activity. The Baby T SCR (published October 2014) resulted in a number of

changes in practice that were put in place in 2014-2015 and have continued into 2015-2016. These changes will ultimately lead to improved outcomes for children and young people in Gateshead. For example, processes around checks for section 47 enquires were strengthened and ultimately this means that social workers will have access to more detailed information about a family when assessing the level of risk. Awareness raising sessions delivered following the publication of the SCR have also meant that there is a greater level of understanding around bruising in non-mobile babies across agencies.

It is too soon to analyse the impact of the learning and improvement activity of a number of cases listed in Appendix 4 as much of this is ongoing, and other cases have more specific learning rather than that will impact on multi-agency practice. However we are mindful of the need to evidence the impact of our Learning and Improvement Framework and how it leads to improvement in practice and ultimately improves outcomes for children in the borough.

6.4.3 Progress against Business Plan priorities

The Gateshead LSCB Business Plan for 2014-2017 sets the strategic direction for the Board and reinforces the specific role of the LSCB to **lead, challenge** and support **learning**. The year 2 (2015-2016) action plan identifies specific actions to deliver the strategic outcomes.

The following tables provide a summary of progress:

LEADERSHIP	
Jointly arrange a sub-regional CSE event	This was arranged and took place in October 2016 – the outcome of this event was a better awareness and understanding of CSE across our agencies
Arrange engagements event with young people	The planned carousel event has not taken place however smaller pieces of engagement work have been carried out. The outcome of this is a better understanding for Board members around how safe young people feel and what is important to them
Consider a Youth LSCB structure	This was not achieved however it is linked to the wider work around engagement and will be carried forward to 2016-2017
Review the BPG arrangements	Achieved and also reviewed by Ofsted
Review the operation of the Board	Achieved and also reviewed by Ofsted
Develop a LSCB Communications strategy	Work undertaken with communications leads around this and more effective proposal developed

CHALLENGE	
Conduct the next LSCB inquiry to explore CSE and the effectiveness of the response in Gateshead	This was conducted, although the final report was delayed and carried forward to 2016-2017
Implement a programme of mini-peer reviews to demonstrate effective multi-agency working	The programme was developed and the first review took place. The outcome of this will be a better understanding of multi-agency working in Gateshead and improved practice where challenges are raised
Contribute to the OSC Review of child protection	Some Board members contributed to the Board. Due to delays outside of the LSCB the final report was not received by the end of 2015-2016 and carried forward in the work plan

"Receive reports and monitoring on a number of additional challenges identified e.g. CP conference chairs' reports, GP involvement, police involvement, CAMHS, Novel Psychoactive Substances ("legal highs")	Reports received and challenged by the Board. The outcome of this is a better understanding by Board members of the relevant issue and also improved areas of practice where we made challenges (e.g. GP participation).

LEARNING	
Receive an annual report on the voice of the child and build on the messages. Where necessary use new technology and the outcome of engagement events	Information submitted to the LSCB Development Day including information on the new MOMO app being used by Gateshead Council to gather the voice of young people
Continue to develop the Learning & Improvement Framework	Reviewed by the sub group and also as part of the Ofsted inspection
Explore ways to bring the voice of frontline staff into the LSCB	Included in the mini-peer reviews and also to be taken forward further in 2016-2017. Will also be considered as part of the effectiveness framework
Implement and embed the findings and recommendations from CQC/Ofsted/HMIC inspections as they arise and cascade the learning	Ongoing throughout the year – a number of partners were inspected and mostly with very positive results

PROTECTING VULNERABLE CHILDREN	
Build on the findings of the Neglect Inquiry by developing and implementing new guidance	New guidance developed, however work is still required to implement it (will carry forward to 2016-2017)
Undertake task & finish work on key areas e.g. high-risk adolescents, care leavers, young people convicted of sex offences" -	Reports received and challenged by the Board The outcome of this is a better understanding by Board members of the relevant issue and also hopefully improvements in practice where we made challenges
Lead on the local implementation of the national Child Protection -Information Sharing project" -	CP-IS has been subject to national delays but local arrangements are in progress. This will carry forward to 2016-2017. The outcome of this work will be improved information sharing between agencies and this will ultimately impact on children by making them safer as health practitioners will be able to make more informed decisions about risk

PREVENTING HARM	
Review and update the "Thresholds" document	This was delayed within Children's Social Care, however the existing document was well received by Ofsted
Continue to strengthen links between the LSCB and schools and review the support provided to them	There are now a number of schools represented on the LSBC and links to a number of school-facing partnerships. Work has also been undertaken with school councils and additional training offered to designated teachers. The impact of this is that schools are more aware of the role of the Board and more aware of relevant issues such as CSE which will ultimately help them to keep children safer

Review approaches to extremism, cyber-crime and other forms of exploitation	Reports received and challenged by the Board. The outcome of this is a better understanding by Board members of the relevant issue and also hopefully improvements in practice where we made challenges
Review approaches to other areas of wellbeing in childhood e.g. healthy weight	Work undertaken by Public Health presented to the Board

The action plan for 2016-2017 has been developed and should be read alongside this annual report. Progress against the actions will be reviewed at every meeting of the Board and Business Planning Group.

1.4.5 Ofsted inspection of the LSCB

As previously stated in this report, Gateshead LSCB was subject to a four week inspection in late 2015 alongside the inspection of Gateshead Council under section 15A of the Children Act 2004. The outcome of the inspection was published in March 2016 and Ofsted found that we require improvement to be good.

Inspectors were satisfied that the LSCB fulfils its statutory responsibilities as defined in *Working Together to Safeguard Children* (2015) and there is a clear strong commitment from key statutory agencies. However gaps were noted in membership, activities and monitoring of frontline practice. The report comments that much of the work that the LSCB undertakes it does well and some, very well. During the inspection the lead inspector for the LSCB shared that that the Board was moving towards being good and expressed confidence that steps were being taken to move in this direction. The lead inspector felt that the Board's own self-assessment suggested that improvement was required, but acknowledged that the Board was ambitious and keen to continue to improve and build on previous feedback. It was acknowledged that, although the LSCB requires improvement, the Board is a long way from being inadequate.

Ofsted made seven recommendations to the LSCB, most of which related to areas that we had already identified as part of our ongoing self-assessment:

	RECOMMENDATION
1	Ensure that the LSCB engages more effectively with the community it serves, including learning from the participation and testimony of children and young people, increased engagement with faith and ethnic minority groups, and timely recruitment of lay members
2	Develop appropriate pathways to increase LSCB contribution to and influence on the work of the Health and Wellbeing Board to ensure the experiences of children and young people are given appropriate consideration in all activity
3	Ensure that training is sufficient to meet demand and is informed by a training needs analysis that includes analysis of impact on practice over time and the difference it has made to outcomes for children
4	Ensure that agencies report the outcomes of single-agency auditing activity to the LSCB to increase its oversight of practice
5	Review the multi-agency data set used by the Board to ensure that it meets LSCB priorities and includes all relevant activity that impacts on frontline practice, including workforce information
6	Develop robust mechanisms for measuring the LSCB's effectiveness as part of a performance management framework
7	Ensure that the LSCB annual report provides a clear account of the activity of the LSCB and its strengths and areas for improvement that is easily understood by a lay member

The inspection also noted that attendance at Board meetings is variable, including key decision makers in statutory partner agencies

A number of positive areas were identified by Ofsted:

Two key pieces of work undertaken by the LSCB Business Manager (the sub regional CSE conference and work around licensing) were also identified as good practice by Ofsted in their overarching report.

Following receipt of the draft report, an Ofsted improvement plan was put in place and this is regularly monitored by the Business Planning Group, the full Board and other groups such as Gateshead Council Care Wellbeing and Learning Group Management Team. Progress is being made in all areas and a number of the recommendations were achieved by the end of 2015-2016. The remaining actions will be completed in early 2016-2017.

Three lay members have now been recruited (jointly with the SAB)

Work is being progressed with the Diversity Forum to identify further community representation

A representative from the Jewish community has been identified to strengthen links between the Board and Jewish schools

A formal pathway has been developed between the LSCB and HWB to increase contribution and influence

Single agency auditing has now been built into our workplan to strengthenoversight of frontline practice

National best practice has been explored to develop a performance and effectiveness framework for the LSCB

National best practice has been explored and used to review and strengthen the LSCB dataset

6.5 Data and performance information

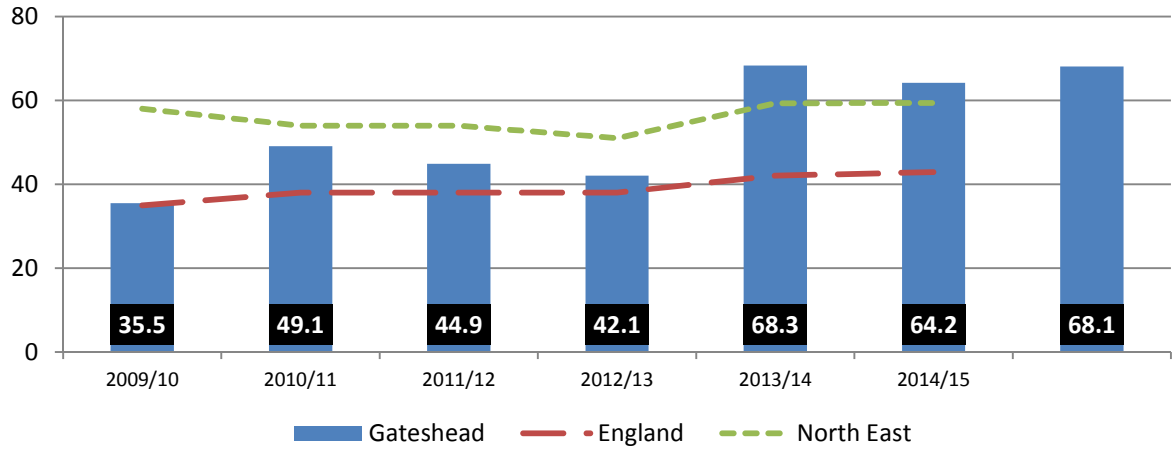
Key performance indicators relating to safeguarding, child protection and early help are monitored by the LSCB Performance Management Sub Group and reported to the Board on a quarterly basis. This enables us to challenge appropriately and satisfy ourselves in relation to the effectiveness of services being delivered in the borough to support children and young people and ensure their safety and wellbeing. In addition, our partner agencies individually monitor their performance indicators and information relating to the welfare of children in Gateshead.

There were 394 Initial Child Protection Conferences (ICPCs) held in 2015-2016 or which 338 (85.7%) resulted in the child being made subject to a CP plan. This indicates that the right cases are going to ICPC and that there is multi-agency agreement on the best way to progress these cases.

The numbers of children becoming the subject of CP plans increased during the year and at the year-end there were 273 children subject to a plan. This represents 68.1 children per 10,000 of the population and therefore we remain higher than the national average (42.9 per 10k), the regional average (59.5 per 10k) and our statistical neighbour average rate (57 per 10k) based on the 2014-2015 CIN Census figures.

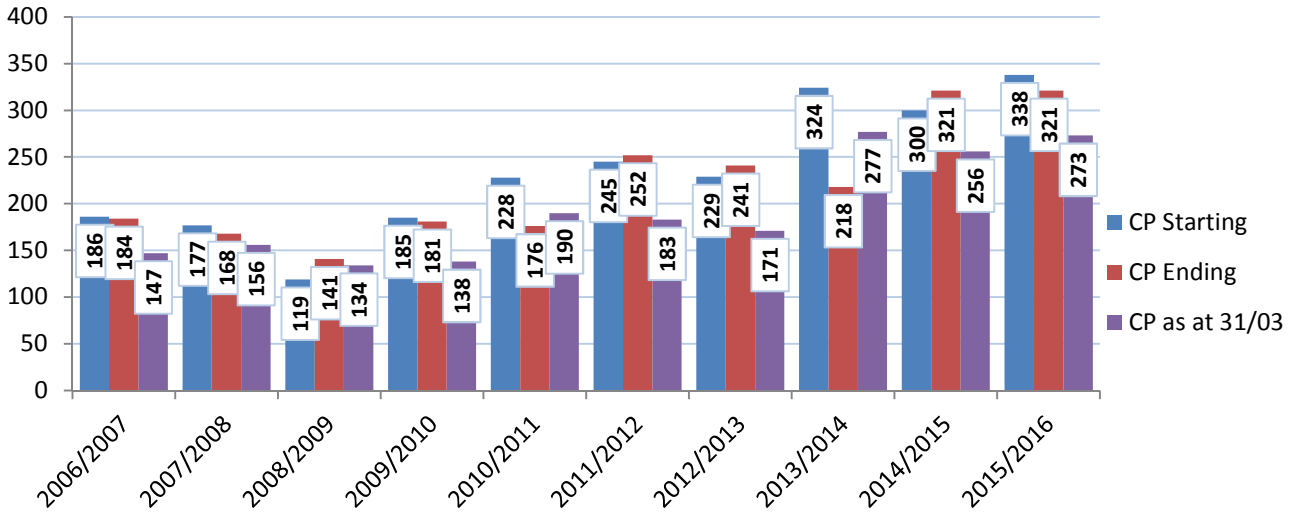
The following graph tracks the changes in our CP plan figures over the past few years and compares them to national and regional averages.

Child Protection Plan numbers per 10,000 at year end



The graph below provides additional trend information in relation to CP plans started, ended and opened as at 31 March 2016. There have been significant rises in child protection numbers over the last 3 years, with this year seeing the largest number of children requiring statutory protection arrangements in 10 years. This increase corresponds with improved practices within Children's Social Care. As a Board we keep a watching brief on the figures and we are reassured that the children who are subject to CP plans have been made so appropriately.

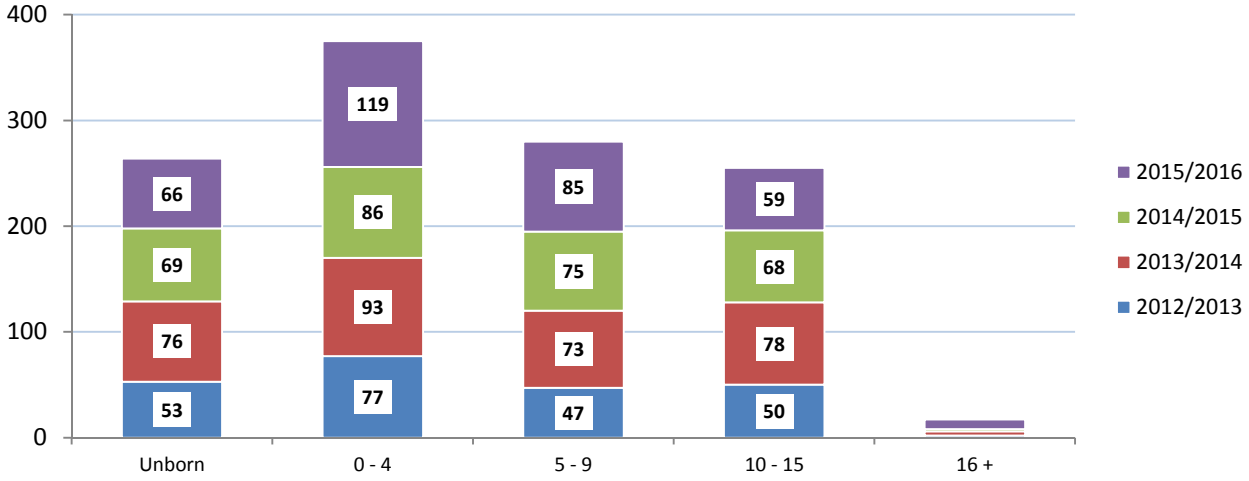
Child Protection Numbers



The following graph shows the significant increase in the proportion of children under the age of 5 who have become subject to a CP plan this year compared with previous years. This is in line with Gateshead's priority of intervening as early as possible in a child's life in order to affect positive change. We continue to have high numbers of unborn children subject to CP plans in Gateshead, with 66 in 2015-2016 (20% of the total). This approach was endorsed by Ofsted who initially queried why these figures were amongst the highest in the country but concluded "*this proactive approach ensures that focused multi-agency work*

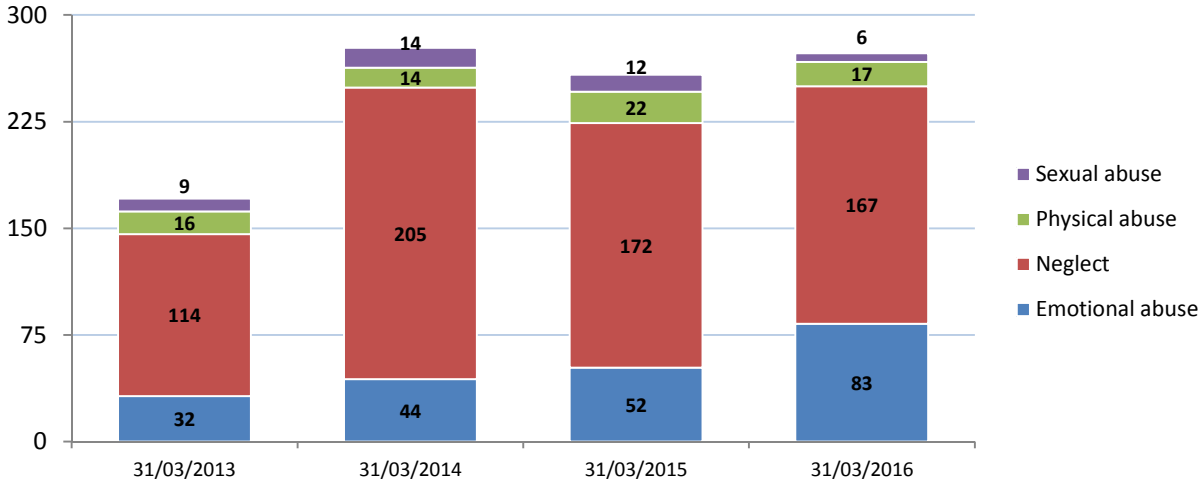
starts as soon as professionals identify concerns. Protective action commences and continues before and immediately after birth".

Age of Children when placed on a Child Protection Plan



We continue to see that neglect remains the most common reason for a child in Gateshead being made subject to a CP plan. At year end 61.9% of all CP plans were under the category of neglect, which is a slight decrease from the end of the previous year when 66.7% of plans were due to neglect. We have also seen some movement in the category of emotional abuse, with an increase from 20.2% of plans at March 2015 to 29.7% of plans at March 2016.

Child Protection Category at Year End

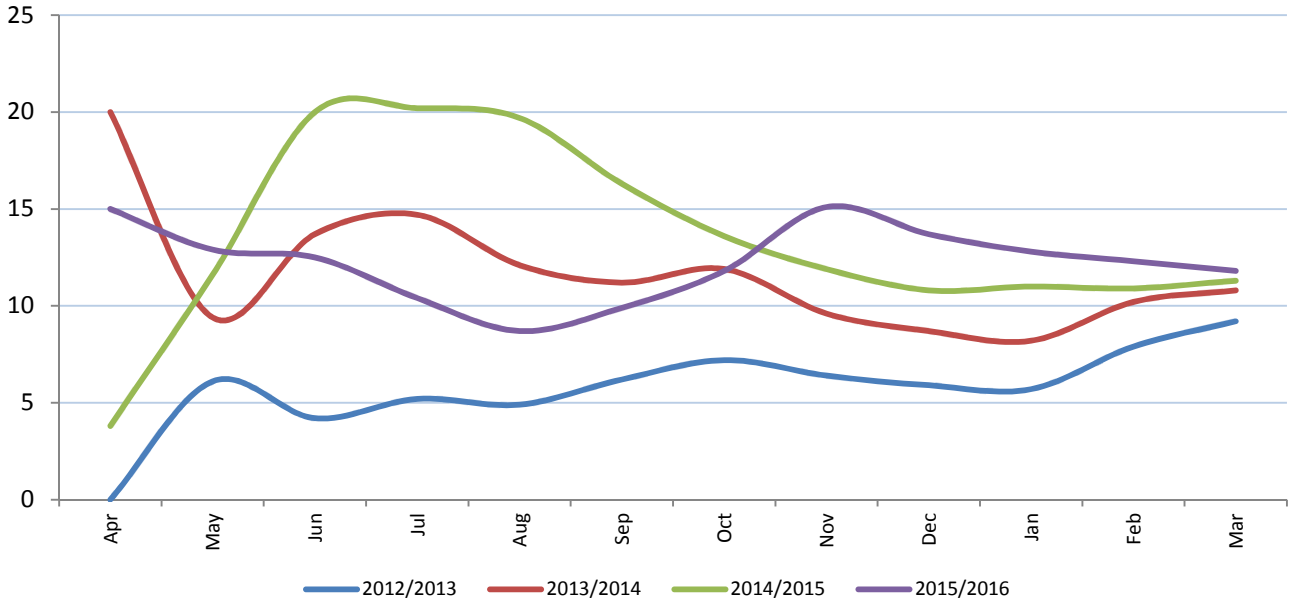


Our social workers visit children who are subject to a CP plan regularly and the service aims to ensure that children are seen at least every 3 weeks, the impact of this is that decisions about a case are made based on current risks and issues. At the end of 2015-2016 there were 273 children subject to a CP plan and of this cohort (excluding unborn babies) 222 had their latest child protection visit held within 3 weeks (87%).

During 2015-2016, 338 children were made subject to CP plans and 40 of them (11.8%) were subject to a CP plan for a second or subsequent time. Six of these children were

subject to a second or subsequent plan within 2 years of their previous plan ending. This is a very slight increase from last year when 34 of 300 (11.4%) children became subject to a CP plan for a second or subsequent time, but compares favourably with national (16.6%), regional (14%) and statistical neighbours (15.7%), based on data from the 2014-2015 CIN Census. Again, these low numbers suggest that there are robust practices in Gateshead and appropriate levels of support.

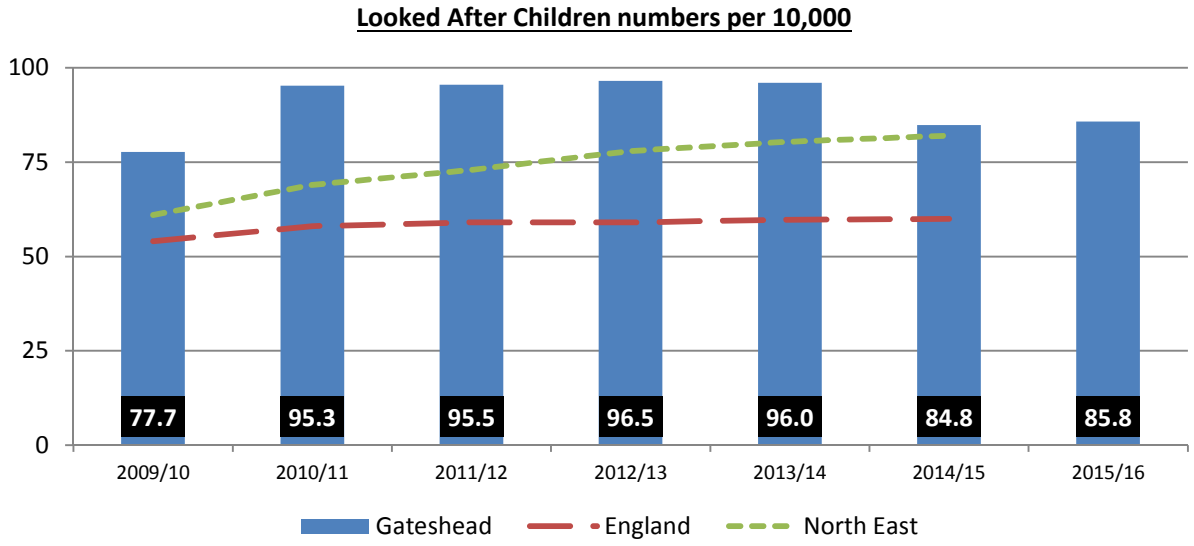
Performance Indicator: % children becoming the subject of Child Protection Plan for a second or subsequent time



Gateshead Council's Referral & Assessment Team received 8,943 "contacts" in 2015-2016, which includes contacts made by statutory partner agencies such as the police, health and education, as well as from members of the public. Of these 8,943 contacts, 2,080 progressed to referrals and 1,937 resulted in comprehensive Child In Need (CIN) assessments. This shows an 18.7% in referrals, although re-referrals remain low at 12.7%. This is lower than our re-referral rate in the previous year (16.2%) and also the England (24%) and North East (22.3%) averages. This suggests that a greater proportion of children and young people who require support are receiving this in a timely way once they come to the attention of Children's Social Care and ultimately this leads to improved outcomes for families.

There were a total of 2,191 CIN assessments completed in 2015-2016 and this includes a number which were not carried out as the result of a referral but were part of ongoing work with a family. 92.9% of CIN assessments (2,031) were completed within required timescales and this continues to represent strong performance in this area. This represents a 9.9% increase on the previous year when there were 1,993 CIN assessments completed and 1,946 (97.6%) within 45 working days. Regionally, 84.9% of CIN assessments are completed within 45 days and nationally this figure stands at 81.5%. Our statistical neighbours average at 80.9% (based on the 2014-2015 CIN Census) and therefore our performance is significantly higher indicates that our families in need are receiving timely support and intervention.

On 31 March 2016 there were 344 children who were looked after by Gateshead Council and this represents 85.8 per 10,000 of our population and is similar to the previous year (340 children, 84.8 per 10k). We continue to have higher numbers of Looked After Children compared with the regional rate of 82 per 10k and our statistical neighbours' rate of 83.3 per 10k. Our figures are also significantly higher than the national rate of 60 per 10k (based on SSDA903 reports for 2014-2015).



In terms of earlier intervention work, in the last 12 months we have seen a significant rise in the number of new Common Assessments being undertaken, rising from 494 in the previous year to 988 in 2015-2016. There are currently 1165 active Teams around the Family (TAFs), which provides a more accurate representation of the multi-agency work being carried out in Gateshead. These figures represent an increase in the number of families being supported through our multi-agency approach to early intervention. The CAF/TAF approach has been increasingly impacted on by our approach through the FamilesGateshead programme (our local version of the Troubled Families programme). A total of 1054 families have been allocated and have started their intervention under phase 2 of the programme.

During 2015-2016 Northumbria Police recorded 4,476 incidents of domestic abuse in Gateshead and 1,948 of these incidents involved children, which is an increase of 91 incidents from the previous year. 1,122 of the incidents involved repeat victims and 1,156 of the victims were classed as high or medium risk at the point of the initial assessment. 76.7% of victims of recorded domestic abuse in Gateshead in 2015-2016 were female.

Operation Encompass is a police-led initiative established to share information with schools in order to support children following a domestic abuse incident. There were 529 separate domestic abuse incidents report from April 2015 to 4 January 2016 of which a total of 1185 children of school age were involved. The average age of the child involved was 9 years and 172 incidents were open or opened to Children's Social Care, of which 132 repeat incidents were recorded. There were 58 incidents which were both repeat incidents and open to Children's Social Care and 73% of incidents involved households where two children reside.

Further follow-up support is also in place for the young people affected and information is fed into TAF meetings. Issues are discussed with the child, where appropriate and more covert actions such as monitoring behaviour, attendance and wellbeing are carried out. 100% of schools in Gateshead are now signed up to Operation Encompass and the success of the initiative has been recognised. Northumbria Police are now looking to roll the model out to other local authority areas in the region. This initiative is an excellent example of the impact that multi-agency work can have on young people as it has led to improved information sharing and improved support for young people where domestic abuse is an issue at home. Previously schools may not have been aware of the incidents and therefore not have been as alert to changes in behaviour or presentation or able to proactively support these young people.

Data in relation to Youth Justice services in Gateshead continues to be positive. The most recent data (October 2014-September 2015) for first time entrants (FTEs) into the system shows a total of 47 FTEs, which is a rate of 276 per 100,000 of 10-17 year olds and is within target. This also shows a reduction in FTEs and this continued reduction is being achieved through the development and expansion of the current YOT Prevention Programme, work with schools, the new Child to Adult Violence programme and also work on pre-pubescent sexualised behaviour that had been identified as a trend in current caseloads. The YOT continues to identify children and young people on the cusp of offending or involved in anti-social behaviour.

The latest hospital data available for “alcohol specific admissions” for under 18s covers the period of 2012-2013 to 2014-2015 and at 54.7 per 100,000 this is a 6.97% reduction from the previous reporting period of 58.8 per 100k. The admission rate has continued on a downward trend over the past four periods of data collection; despite this we still have significantly higher rates than the England rate of 36.6 per 100k. However, in the North East region we have the 4th lowest admission rate and slightly less than the regional average of 60.4 per 100k. The highest admission rate in the North East is Sunderland at 92.9 per 100k, which is also the highest rate in England.

The most recent teenage pregnancy data is available up until the end of 2014 and shows 37.7 under 18 conceptions per 1,000. This data shows a 18.4% increase from the rate in 2013 of 29.3 per 1,000. In real terms this means that from 2013-2014 there was increase 16 under 18 conceptions from 103 in 2013 to 119 in 2014. Our teenage pregnancy rate is now the second highest of the five Tyne and Wear authorities with the lowest being North Tyneside at 22.9 and the highest being Sunderland at 35.3 per 1,000. We are also higher than the overall England rate of 22.8 conceptions per 1,000. The current rate of under 18 conceptions is at the highest level over the last four periods of data collection and this follows a time in 2013 when it was at its lowest since the availability of the data. The data continues to be monitored by our partners who are working together to develop a Sexual Health Strategy to reflect the joint vision for Gateshead in improving sexual health outcomes.

APPENDIX 1 – Our meetings

Meeting	Key agenda items			
May 2015	LSCB Budget	Prevent Duty	Police MFH Co-ordinators	LSCB Business Plan 2015-2016
July 2015	LADO report	IRO annual report	SCU annual safeguarding report	Children's Trust Board annual report
	Families Gateshead Annual Report	SAB Annual Report & Annual Plan	Community Safety Plan	British Transport Police & safeguarding
	CP-IS	OSC review of child protection	MSET escalation process	"The Dark Web"
September 2015	Foetal Alcohol Spectrum Disorder and safeguarding implications	Update on the role of GPs in safeguarding	Cedars Pre-Departure Facility and an overview of the Home Office Returns Process	Savile Inquiry action plan
	Outcome of OSC review of domestic abuse	Revised Neglect Guidance	GP attendance at CP conferences	Update on CSE Inquiry
November 2015	Operation Encompass	CQC inspection update	Report on performance issues with CP conference chairs' reports	Private Fostering annual report
	STFT – revision of safeguarding structures	Mini peer reviews – process and first review	Gateshead Council Budget Consultation	Introduction of the "absent" category
January 2016	CDOP annual report 2014-2015	MAPPA annual report	Elective Home Education Strategy	Business Plan Focus Area – Counter Terrorism and Preventing Extremism
	Business Plan Focus Area – Care leavers	Findings of CQC inspection of STFT	Evidence of positive outcomes and learning between GPs and children and families	Initial findings of the Ofsted inspection of Gateshead Council and LSCB
March 2016	Children Missing Education annual report	Gateshead GP report writer project	Gateshead College – Journey to outstanding	Business Plan Focus Area – homelessness
	Business Plan Focus Area – cyber crime	Business Plan Focus Area – Wellbeing in childhood, healthy weight and healthy schools	Business Plan Focus Area – High risk adolescents (permanent exclusions)	Business Plan Focus Area – NPS ("legal highs")

APPENDIX 2 – Partner agency progress in 2015-2016

Key operational developments
NTW now has process in place with Children's Social Care to has enabled health care records to be updated in "real time" with details of CP plans ensuring any clinicians working with the family are aware of these concerns
Housing Services/The Gateshead Housing Company provide proactive support via the Care Leavers' Accommodation Support Panel. The aim of this work is increase opportunities to succeed. Further work is being done to support young offenders to safeguard and meet their needs
NTW Safeguarding and Public Protection policies have been externally audited and have been given assurance that they are fit for purpose. Senior Managers have received training on learning lessons from Savile and ensured and actions required from recommendations for NHS trusts are completed.
NHS Newcastle Gateshead CCG Safeguarding Team secured funding for a pilot in 2015-2016 to improve GP involvement in the child protection process, particularly CP conferences. The pilot involved seven practices and was a great success and the response rate for GP reports to CP conferences increased from 24% to 71%. There are now plans to roll this work out to more practices
GHNFT has now a Designated Doctor who will start in April 2016. The Named Midwife has also been allocated specific time to undertake safeguarding work. The Trust also appointed another safeguarding administrator to support safeguarding work in Maternity Services generated by the high numbers of unborn babies subject to CP plans. This is evidence of the Trust's commitment to ensuring there are sufficient resources available to the Safeguarding Team to provide a robust service.
Gateshead received 53 Syrian refugees in 2015, 17 of which were children/young people of school age and a further 60 individuals (21 children) will be received in May 2016. Prior to the refugees arriving significant joint work was undertaken to ensure that appropriate arrangements were made and support was in place. The first cohort of children are now attending education and are settling in well, one child (age 13) had never been to school until he moved to Gateshead so the impact of this collaborative work on his life will be huge
The Complex Pupils Meeting is a multi-agency meeting to ensure that managers across agencies are aware of some of our most vulnerable young people who are not accessing full time education and ensure that services are joined up to support them moving towards full time provision. The meetings provide a coordinated approach and recognise that a holistic approach is needed to meet the needs of our most vulnerable children and young people

Progress in relation to the LSCB's priorities:

LEADERSHIP		
Two College staff members requested and received permission from the Home Office to deliver Wrap3 training to other staff	Within the local authority a Service Director and Service Manager commissioned a management review to examine issues of underachieving performance and develop solutions	The LA Performance Clinic is a forum for managers to understand data, performance and QA systems. THe information shared is used by managers to ensure that they lead teams effectively and ensure that children are safeguarded
One health partner made the decision to provide CSE training to all staff in the service over a 12 month period	The Practice Advisory Group play a role in supporting practice improvement and professional development	The service has ensured that training available to the childcare sector is updated to reflect the role of LADO and Prevent
CCG safeguarding staff led the comprehensive action plan and recommendations following the recent CQC inspection – 95% of the actions have been completed	Review of the Safeguarding Service undertaken by one health partner and led to a change of roles and responsibilities to enable a more focused approach	Heath partners were involved in an investigation relating to Jimmy Savile which required strong leadership and close working with DoH, police and witnesses

LA managers at all levels were recognised by Ofsted to be good leaders and worked well with partner agencies, especially with police re CSE	Within social care and education a Complex Pupils multi-agency meeting was developed to improve engagement of complex pupils in education	Development of a multi-agency forum in relation to electively home educated children has led to improved discussion around their needs

CHALLENGE		
A practice development tool has been introduced to improve risk assessment and management. Cases are assessed using the tool and any issues are challenged with practitioners and their managers. This is a means of reflective discussion around judgement and risk	The Performance and QA Framework has been used to improve outcomes for children as performance information was used more effectively to highlight evidence of issues internally and within partner agencies and challenge them	Internal challenge of practice takes place on a daily basis, however a specific example is the review of a case within the service which was presented to the LSCB Learning & Improvement Sub Group and a subsequent review and challenge of practice
The Safeguarding and Public Protection Team routinely challenge operational services within the organisation in respect of attending ICPCs and providing reports	Delivered Counter Extremism tutorials to students aged 16-19 years and challenged their conceptions of radicalisation and extremism	The Safeguarding Policy has been revised and inspectors support schools by reviewing safeguarding arrangements, There has been a change in remit to increase the focus onto the most vulnerable groups of children and young people
Designated staff have challenged the contractual arrangements for safeguarding children to ensure that they are robust	Managers and practitioners regularly challenge other agencies at the MSET	Challenge to staff is evident in a supervision audit and an action plan is in place to improve safeguarding supervision
Named professionals have challenged professionals within adult-facing departments to consider the needs of children in the family when an adult attends with a high risk presentation	Managers within the service have challenged the management of a case by Children's Social Care and escalated issues that were not dealt with initially	Concerns of Trust staff were escalated to managers within another local authority (also covered by the Trust) and a different course of action was then taken

LEARNING		
A recent management review enabled the unit to ensure effectiveness and learn from performance information to ensure statutory requirements are met	Issues raised from a complaint about removing children from their parents in an emergency has led to a change in practice and information provided to parents	The CSE training provided has increased the number of safeguarding concerns raised about children who may be being exploited
Audits of casework demonstrated that the voice of the child was not reflected in recording of support plans etc. This has been addressed in staff team training and via individual supervision	The staff attended the LSCB CSE conference and applied the knowledge to their work. They have also attended other training events e.g. Prevent, DV, SCRs etc. and applied the learning to practice	The learning from SCRs locally and nationally has been implemented and led to improved systems and processes. Best practice has also been shared following CQC inspection of other agencies
There have been several training sessions delivered internally regarding FGM and, as a result, the number of	Learning is demonstrated through supervision and training. The incident reporting system is monitored to	All staff have been trained on "Promoting British Values and Equality & Diversity" to meet the requirements of the Prevent

reported cases has increased considerably	understand safeguarding issues and challenges to frontline staff and this is used to inform training and policy work	Duty

Inspections
Gateshead Council Children's Social Care was inspected by Ofsted in 2015-2016 and services were judged to be "good". This is a key indicator of the effectiveness of safeguarding services in the borough. Ofsted found that "children are at the heart of good practice" in Gateshead. Leaders, managers and workers were judged to be highly effective and very good practice was seen across a number of areas. Children, young people and their families were found to be receiving the right support at the right time and children in need of protection are identified early. Ofsted judged that there is a highly effective multi-agency approach to safeguarding and managing risk across the council and wider partnership and found the response to CSE and missing children particularly strong. Social workers were found to be effectively supervised and therefore able to complete good quality assessments. It was noted, however that plans are not consistently outcome focussed and progress is not always monitored/measured, therefore work is underway to improve this area
In May 2015, STFT received an unannounced CQC inspection of hospital and community services and safeguarding children was identified by inspectors as having good partnership working arrangements, policies and supervision in place to support staff. Inspectors specifically commented upon the joined up working between health visitors and GPs and staff access to the Safeguarding Team. A paper was taken to the LSCB in January 2016
Nine GP practices in Gateshead were inspected by the CCG and eight were rated as "good" for the care of families, children and young people. One practice was rated as "outstanding". Appropriate systems were in place all practices to identify children at risk and immunisation rates were in line with local average. Good examples of joint working with midwives and health visitors. The practice rated as outstanding was seen to have particularly strong relationships with other professionals and also had robust arrangements such as regular safeguarding meetings and a vulnerable child protocol. All of the practices were rated as "good" for the care of vulnerable patients. Practice staff demonstrated that they could recognise signs of abuse in vulnerable adults and children and were aware of their responsibilities and how to raise concerns.
GHNFT was inspected by the CQC in September 2015. The overall rating of the hospital was "good" with services for children and young people also being rated as "good" and maternity and gynaecology services being rated as "outstanding". In terms of providing a safe service the Trust was rated as "good" and rated as "outstanding" for providing a caring service. Inspectors noted that staff within the Emergency and Children's Departments knew how to escalate safeguarding concerns, were able to access appropriate guidance and understood their roles and responsibilities. As a result of robust safeguarding training staff were found to be able to recognise risk factors of FGM and CSE and processes were in place to support inter-agency work and information sharing.
There were two inspections of Northumbria Police by HMIC in 2015-2016. One inspection focussed on vulnerability and the force was judged to be "good". Positive partnership working was identified, particularly around domestic abuse and missing children. The inspection found that the force provides a good response to children who go missing and is well prepared to tackle CSE. The other inspection focused on honour based violence (HBV), FGM and forced marriage and Northumbria was one of only three forces nationally to receive a positive inspection in this area. Northumbria Police is prepared across all areas to protect people from harm from HBV. The force annual assessment for effectiveness found that Northumbria Police is good at keeping people safe. The force was judged to be good in terms of being effective and efficient at keeping people safe and to require improvement in terms of how legitimate the force is at keeping people safe and reducing crime
There have been relatively few Ofsted inspections of schools in the past academic year in Gateshead. Four primary schools were inspected and three were judged to be good or outstanding. Two secondary academies were inspected and received "requires improvement" grades for their overall effectiveness. It should be noted that all three schools judged by Ofsted to require improvement overall received "good" judgements for the personal development, welfare and behaviour aspect of their work. In addition, all schools were judged by inspectors to have effective safeguarding practices.

APPENDIX 3 – Section 11 audit

Section 11 audit

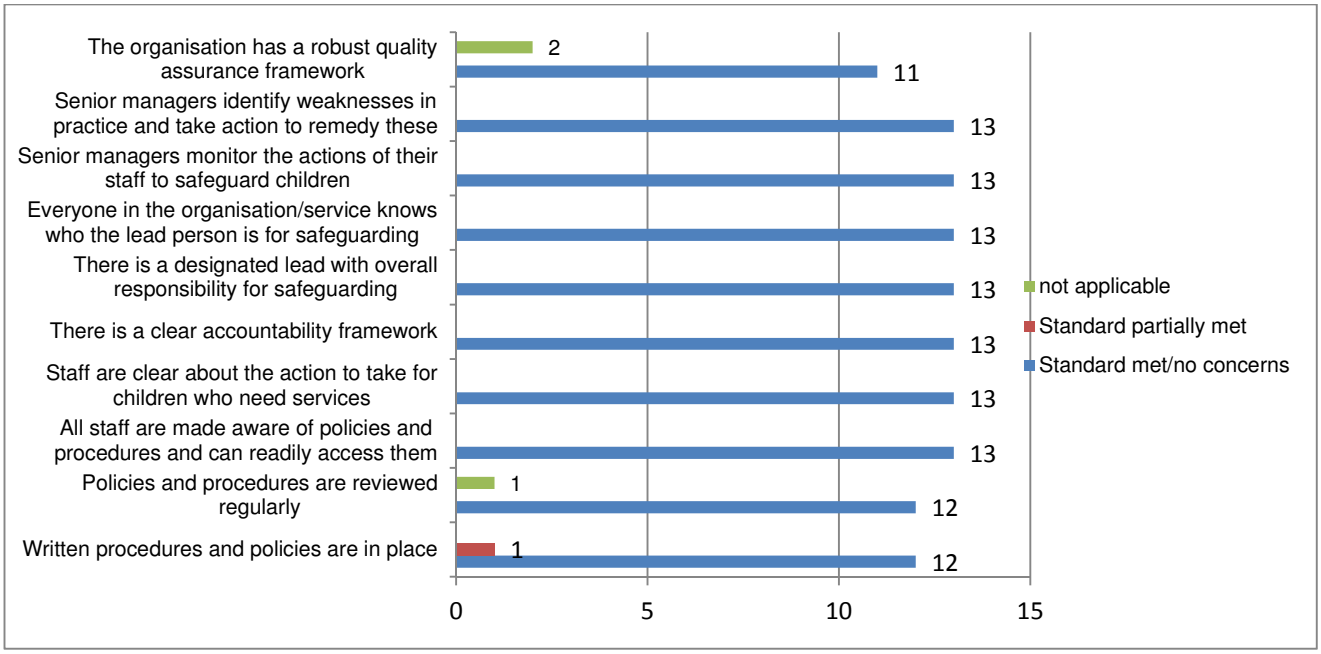
Section 11 of the Children Act 2004 places a statutory duty on key organisations to make arrangements to ensure that they have regard to the need to safeguard and promote the welfare of children when discharging their functions. We aim to ask our partner agencies to demonstrate their compliance with this on an annual basis via a Section 11 audit. In 2016 we asked all Board partner agencies, not just statutory partners, and schools (for the first time) to complete a proforma to demonstrate that they have appropriate arrangements in place including:

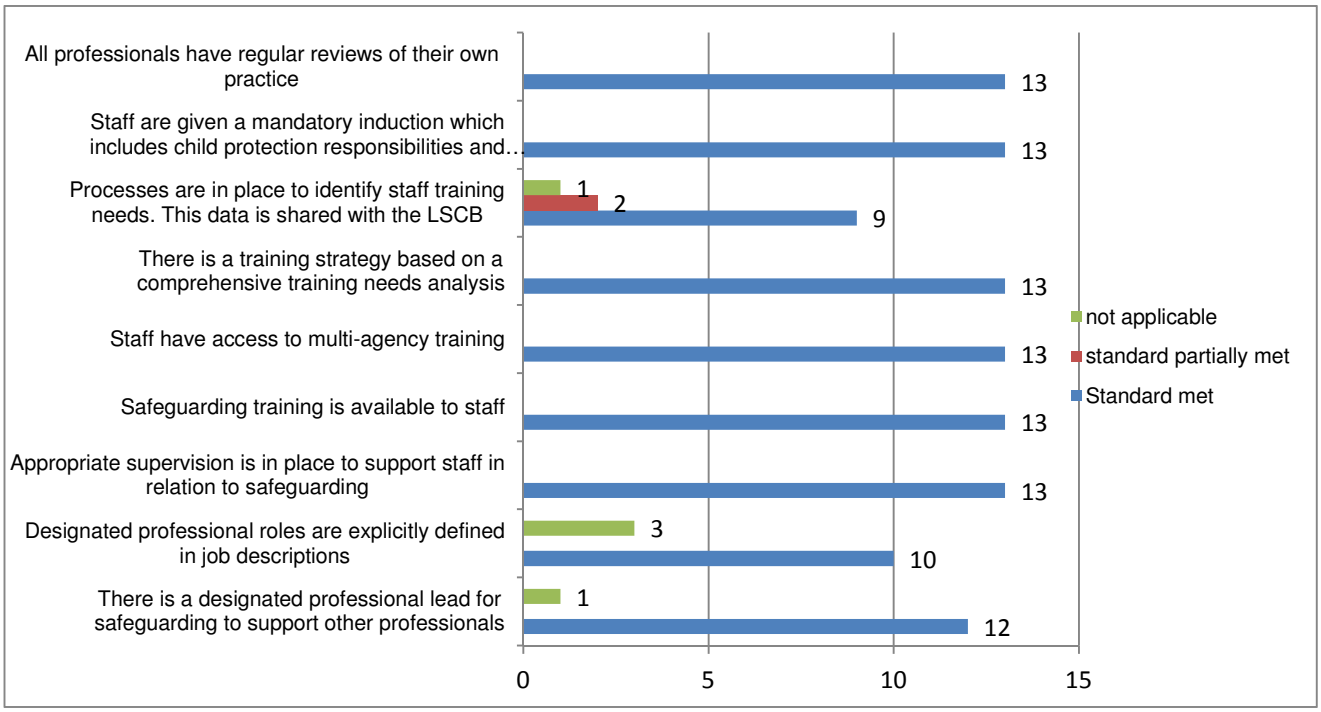
- lines of accountability
- management commitment
- consultation with children and young people
- whistleblowing
- supporting professionals working with children
- safe recruitment
- allegations management

Respondents were asked to state whether each standard was met, partially met, not met or not applicable and provide evidence of their compliance or steps that will be taken to improve this.

In total, there were over 90 responses for the 2016 Section 11 audit, which is the highest number we have ever received (as stated above, this is the first year that schools have contributed and this explains the significant increase in responses). All statutory partners submitted a response to the audit, as did a number of partners not considered statutory under section 11. No response was received from UK Visas and Immigration and Cafcass submitted a generic national response which could not be compared with the responses of other agencies. Board members were satisfied that further action was not necessary in relation to either agency as they are not statutory for the purposes of the Section 11 audit, although it would have been good practice to have responses from all partners.

The findings of the audit were shared with Board members as part of the Board development session and the responses from Board partner agencies were analysed in more depth. Overall, the results were largely very positive and the majority of agencies reported that standards were met and there were no concerns. A number of respondents also provided evidence to support this and the remainder were challenged and have since submitted evidence. There were some questions where there were a higher proportion of positive responses than others, for example 92% of Board partners have whistleblowing arrangements in place but only 70% reported that children and young people are listened to and their wishes and feelings are taken into account when developing services. The full results have been presented to Board members via a report and a summary of some areas is provided below:





A detailed analysis of all responses, including schools, was not carried out to the same level of detail as those responses solely from partner agencies due to the sheer numbers involved. As with some partner agencies, some schools submitted responses to indicate that standards were met but did not provide evidence of this and were therefore challenged to provide this and a number of them have done so. There were only six schools in Gateshead who did not respond (five primary schools and one special school). The vast majority of respondents reported that standards were met or partially met which told us that overall LSCB partner agencies and schools in Gateshead have effective arrangements in place to keep children and young people safe and are doing what they are supposed to do. Some schools reported issues which have since been followed up, for example one school reported that they needed additional support from the LADO and therefore the LADO was challenged and asked to contact the school in question.

APPENDIX 4 – Learning & Improvement activity

Case	Details of activity in 2015-2016
Baby T SCR	The Baby T SCR was published in October 2014 and work continued in early 2015-2016 to ensure that all actions were signed off.
Case A	The Learning & Improvement Sub Group received as request from the Designated Doctor for Child Death Reviews to discuss this case as one of the children, an 11 week old baby, died from a suspected "cot death" in late 2014-2015. There were no suspicious circumstances; however there had been previous concerns about the baby's siblings and it was felt that a scoping exercise and more detailed discussion would be beneficial prior to the case being discussed at the Child Death Review Sub Group. Sub group members were satisfied that the baby's death was not linked to any issues in the home or the family circumstances, however it was noted that further discussions were required to ensure that the mother had appropriate support in relation to bereavement and her older children. It was also noted that school had made a referral to Children's Social Care regarding the older children, however the details and intention of the referral were not clear and therefore actions were set to strengthen this.
Case B	We submitted a Serious Incident Notification (SIN) to Ofsted, DfE and the National Panel of Experts in June 2015 when this particular young person made a possible allegation of sexual assault whilst she was missing from care. We reviewed the case and found that it did not meet the criteria for a Serious Case Review, and the National Panel agreed with this. This was a complex case with a number of issues including learning disabilities, sexual abuse and underage sexual activity in the young person's life and also throughout the wider family. The sub group concluded that the young person had not suffered "serious harm" on this occasion and agencies had done their best to safeguard her, however actions were set in relation to working with parents with learning disabilities and Section 20 arrangements. These actions continue to be monitored by the sub group.
Case C	The Learning & Improvement Sub Group received a request to review this case from the Named Doctor at GHNFT to determine if there was any additional learning from this case. The family were non-British nationals and all three children have developmental difficulties and have had periods being subject to child protection plans and being looked after under Section 20. The youngest child sustained possible non-accidental injuries (bruising) whilst in the care of his parents. Following this incident all three children were removed from the family home and care proceedings were issued. Whilst sub group members were happy that the criteria for a SIN notification or a SCR were not met, it was felt that there was some learning in the case. The sub group noted that there were a number of different social workers and health visitors involved in this case and this could have led to inconsistencies. It was also noted that there should have been a tighter framework around legal meetings and tighter decision making processes. It was also noted that there were occasions where a child was noted to have injuries at school but these were not reported until later and work has been undertaken around this. The sub group found that there were no clear processes in place for professionals to escalate multi-agency challenge and therefore this is being progressed further
Case D	The Learning & Improvement Sub Group received a request to review this case from the Named Doctor at GHNFT when one of the children in the family died from medical issues (she had multiple health problems linked to disabilities). Members of the sub group were asked to complete a scoping exercise about the case; however the detailed discussion has been delayed due to an ongoing police investigation. The case will now be reviewed in July 2016 and there is no current evidence that the death was linked to abuse or neglect, however there may still be some learning for agencies

Case E	This case relates to an episode of self-harm by a young person who was subject to a child protection plan. Whilst sub group members were satisfied that this was not a "notifiable incident" we felt that further exploration of the case was required to determine whether there was any additional learning. We decided to use a new methodology known as Critical Incident Collaborative Inquiry (CICI) to learn from those practitioners working directly with the young person to understand what happened. A learning event was held late in March 2016 and a report is currently being prepared for the LSCB. The learning event told us that this was a complex case with issues around domestic abuse, sexualised behaviour, mental health issues and substance misuse. It was agreed that a high level meeting was required to ensure that appropriate services were in place to keep the young person safe and also wider pieces of work were required to strengthen the response to those young people who are vulnerable but also very difficult to manage due to their own behaviour

APPENDIX 5 – Sub group updates

Child Death Review Sub Group (CDRG). Chair – Public Health Consultant (Pam Lee in 2015-2016)

Purpose of the sub group

The purpose of the CDRG is to undertake multi-disciplinary reviews of the deaths of all children who were resident in Gateshead at the time of their death to better understand how and why children die. These findings are used to take action to prevent other deaths, where relevant/appropriate and improve the health and safety of Gateshead's children.

The sub group's remit is determined by the statutory functions of Gateshead LSCB as set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004 and Chapter 5 of *Working Together to Safeguard Children* (2015).

The work of the CDRG feeds into the South of Tyne and Wearside Child Death Overview Panel (CDOP) via the chair and Child Death Review Co-ordinator.

The group collects and collates an agreed minimum data set of information on all child deaths in Gateshead. This data set reflects the national requirements from the DfE and is consistent with the data sets for the two other LSCBs represented on CDOP.

Progress in 2015-2016

During 2015-2016 the group held a development session to assess compliance with guidance and identify areas for improvement. As a result, administration of the group was improved and issues around working with families were raised with CDOP.

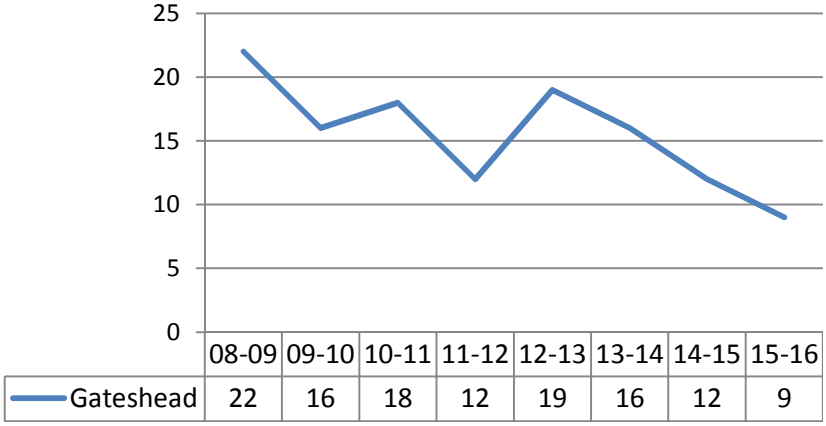
Following the development session, NHS Newcastle Gateshead CCG facilitated a meeting between South of Tyne CDOP and North of Tyne CDOP to learn from each other's processes. A follow-up meeting is planned pending the outcome of the national review of LSCBs and the child death review process.

Training has also been delivered to clinicians involved in child deaths.

Data or management information relevant to the sub group in 2015-2016

The CDRG collects and collates an agreed minimum data set of information on all child deaths in Gateshead. This data set reflects the national requirements from the DfE and is consistent with the data sets for the two other LSCBs represented on CDOP.

The LSCB has been notified of the deaths of nine children who were resident in the borough in 2015-2016. The following chart shows how the number of deaths fluctuates year on year.



	08-09	09-10	10-11	11-12	12-13	13-14	14-15	15-16
Gateshead	22	16	18	12	19	16	12	9

Of these deaths five were of children with known life limiting conditions. There were four unexpected deaths, however some of those children also had medical issues. To date, no identifiable patterns or concerns have been noted within these deaths.

The South of Tyne CDOP met five times in 2015-2016 and completed the reviews of 17 deaths of children who had resided within Gateshead, of these modifiable factors were only identified in one case.

Recent deaths in Gateshead have usually been as a result of:

- Neonatal/perinatal events – prematurity

- Expected deaths with known life limiting conditions

The number of unexpected deaths as a result of external factors remains small. There have been 331 deaths in the SOTW CDOP region since the process began in 2008.

Planned actions for 2016-2017

The workload of the group is determined by local and national events and the group will continue to respond as appropriate.

As stated above, the outcome of the national review of LSCBs may impact on the work of the sub group. This report was due to be published in March 2016 but is now expected in summer or autumn.

Chairing arrangements will also be reviewed in 2016-2017, as will the role of the Designated Doctor for Child Deaths due to the retirement of the existing post holder. Any issues or delays in this area will be escalated to the Board.

Learning & Improvement Sub Group. Chair – Service Director Social Work, Children & Families (Debra Patterson in 2015-2016)

Purpose of the sub group

The sub group has responsibility for monitoring the implementation of the action plans arising from SCRs undertaken by Gateshead LSCB. The group also undertakes Learning Reviews where the criteria for a SCR are not met and makes recommendations for improvement. The group also undertakes Appreciative Enquiries to reflect those cases where multi-agency work has had good outcomes for children and their family.
The sub group also leads on disseminating messages from SCRs, Learning Reviews and Appreciative Enquiries across agencies,

Progress in 2015-2016

As set out in section 6.4.2 of this report, no SCRs were published or initiated in Gateshead in 2015-2016. However, the sub group reviewed a number of cases where it was felt that there were lessons about single-agency and multi-agency practice.

The Learning & Improvement Framework was also reviewed by the group and judged by Ofsted to be "comprehensive" to represent a "proactive response"

Planned actions for 2016-2017

The work of the sub group will be directed by local and national SCRs, Learning Reviews and Appreciative Enquiries.

Licensing Sub Group. Chair – LSCB Business Manager (Louise Gill in 2015-2016)

Purpose of the sub group

The purpose of the Licensing Sub Group is to ensure that the LSCB fulfils its responsibilities as the "Responsible Authority" with regard to the 'protection of children from harm' being one of the objectives of the Licensing Act 2003.

The sub group meets on a monthly basis and considers all applications submitted to Gateshead Council under the Licensing Act 2003 for premises licenses, club premises certificates and Temporary Event Notices (TENS). The group considers each application individually and determines whether there are any implications from a child protection or safeguarding point of view. Other aspects of the licensing process, such as anti-social behaviour, are considered by other responsible authorities.

Gateshead Council is responsible for licensing activities under the Licensing Act 2003. The act requires that local authorities carry out their various licensing functions in order to promote the following four licensing objectives:

- The prevention of crime and disorder
- Public safety
- The prevention of public nuisance
- The protection of children from harm

If any interested party of responsible body, such as the LSCB, is not satisfied that an objective is met then they can raise a representation against an application or request the review of an existing licence. The LSCB Licensing Sub Group focuses specifically on the 4th licensing objective. The applicant (or licensee if the issue relates to an existing licence) will be asked to provide further information and attend a hearing. In the case of new applications, this could lead to an application being refused, or granted with conditions, and in the case of an existing licence this could lead to a licence being revoked or new conditions added.

Progress in 2015-2016

The sub group reviewed 47 applications for new premises licences, variations of existing licences or applications for the review of an existing licence in 2014-2015, this is an increase from 37 applications in 2014-2015. There were no safeguarding concerns with the majority of these applications and reassuringly most new applicants set out robust arrangements to protect children from harm on their premises, however there were some applications to note:

- A premises who had previously had their licence revoked for underage sales applied for a new licence with a different person named however this was withdrawn following objections made by the LSCB and other Responsible Authorities
- The LSCB supported a review application made by another Responsible Authority when a premises was found to be selling alcohol to a 15 year old child volunteer
- The LSCB supported a review application made by another Responsible Authority when a premises was found to be selling tobacco to children
- The LSCB supported a review application made by another Responsible Authority when a premises was found to be selling alcohol to a 14 year old child volunteer and the premises had also been found to have been selling Novel Psychoactive Substances (AKA Legal Highs), drug paraphernalia and "sex articles" (namely unlawful pornography) without an appropriate licence. The premises licence was ultimately revoked by the Licensing Committee due to the concerns raised and an application to transfer the licence to another individual was also refused.

The group also reviewed 195 TENs (an increase from 163 last year) and 71 Street Trading Applications (an increase from 47 last year)

In addition to the standard business of the sub group, the chair wrote and co-delivered training to approximately 700 taxi drivers licensed by Gateshead Council to raise awareness of CSE and their duties as licenced drivers to safeguard young people.

The LSCB Business Manager also utilised links between this group and the MSET to share concerns with the Licensing Authority, for example:

- Information was shared at MSET that young people under 18 were gambling large quantities of cash in the amusement arcade of a shopping centre, so the Licensing Authority arranged for a visit to be undertaken
- Information was shared at MSET that young people were shoplifting wine from a store as it was placed near the door, they were then congregating on wasteland and getting drunk and having sex. The Licensing Authority planned a visit to the store to speak to them about their layout
- Anecdotal information was shared at MSET about a premises in the borough where young people were able to purchase alcohol and were not challenged for ID and investigations were undertaken by the Licensing Authority

The LSCB Business Manager has also been involved in discussions with colleagues from Legal and Public Health about pilot scheme that Gateshead is going to be involved in. Gateshead will become one of eight pilot sites for a national alcohol licensing project in conjunction with Public Health England to assess the practicality of introducing health as a licensing objective (the four licensing objectives are currently prevention of crime and disorder, public safety, prevention of public nuisance and protection of children from harm). Any relevant learning or information from the pilot will be shared with Board members in due course

Planned actions for 2016-2017

- The chair of the sub group will continue to attend the Responsible Authorities Group on a quarterly basis and continue to liaise with other responsible authorities to ensure that due consideration is given to the 4th licensing objective
- The sub group will consider ways in which they can be more proactive in relation to assisting licence holders and applicants to protect children from harm on their premises
- The chair will continue to link the work of the sub group with other partnerships, such as the MSET and Strategic CSE and Trafficking Sub Group, to improve outcomes for vulnerable children and young people

Missing, Sexually Exploited and Trafficked Sub Group (MSET). Chair – Detective Inspector, Protecting Vulnerable People (Dan Mitford in 2015-2016)

Purpose of the sub group

The purpose and remit of the MSET is to safeguard those children and young people in Gateshead who repeatedly go missing and/or are at risk of sexual exploitation and/or exhibit risk taking behaviour and/or where there are concerns about human trafficking. The purpose of the group is to reduce the risks to the young people when missing and to introduce strategies to safeguard them

Progress in 2015-2016

The MSET is now a well-established meeting that has excellent attendance by partner agencies, with National Probation Service now attending following the recent deep dive inspection in South Tyneside (this has strengthened intelligence sharing and disruption). The meeting is chaired by the Detective Inspector from Central PVP CAVA who is supported by the Police Missing from Home Coordinator. The Missing From Home coordinators co-located with the coordinators who cover the whole Northumbria Police area, ensuring intelligence, trends and issues can be shared and fed back into the Operational MSET group. The meeting incorporates a referral form which includes a vulnerability check list (VCL) and scoring matrix for each young person to be discussed at the meeting.

The social worker or other lead professional for each young person is invited to attend the meeting and present the concerns relating to the young person. It is expected that a prevention/diversion plan is prepared in advance of the meeting and then relevant actions are allocated during the meeting to reduce risks associated with sexual exploitation and trafficking and/or reduce missing episodes. For cases of concern, subsequent dates are set for the case to be reviewed at a MSET meeting with the expectation that all actions are completed for the next meeting and an updated VCL submitted when the young person is next discussed. The scoring matrix is reviewed at each meeting with the intention that this risk score reduces over time showing a reduction in risks.

A pre-meet between the sub group chair and LSCB Business Manager takes place prior to the MSET meeting to discuss the top 10 most active children and referrals received from practitioners who are concerned about frequent missing episodes and/or risk of CSE. The agenda for the meeting is then prepared and circulated for agencies to research their involvement.

Members of the MSET continue to monitor the return interview process to ensure consistency in the interviews. Information gathered in the interviews is shared with the police for intelligence sharing via a secure email mailbox.

The joint protocol between Police and the local authority has been reviewed, updated and agreed by partner agencies.

The MSET continues to monitor and evaluate intelligence around sexual exploitation and has close links with Operation Sanctuary, which has recently expanded to include the South of Tyne area.

An escalation process has been developed for cases discussed at MSET where there are consistent high risk concerns for a young person or they are deemed at high risk of CSE. This will allow cases of concern to be forwarded to senior management for review to ensure that no additional actions are required and for guidance as to whether the case should continue to be discussed at MSET.

Data or management information relevant to the sub group in 2015-2016

Data on missing children is also set out in section 6.3.1 of this report.

The cases of 43 young people were discussed at MSET meetings in 2015-2016 and 23 of these young people were discussed on more than one occasion (a number had also been discussed in 2013-2014). This was a decrease in the total number of cases discussed in 2014-2015 where there were 53. This decrease is due in part to the revised MSET referral form which means that cases are referred more appropriately with tangible risks set out for the pre-meeting.

There were a total of 928 occasions in 2015-2016 where a young person from Gateshead was reported missing to the police (this includes episodes where a child was in the care of Gateshead Council but placed outside of the borough). The 928 episodes included 657 episodes (71%) where a child was reported missing from care, the remaining 271 episodes related to a child being reported missing from their family home or school. The total figure of 928 represents an increase from 2014-2015 where there were 864 episodes. There was also an increase in the number of missing from care episodes from 571 to 657 and an increase in the proportion of episodes from 66% to 71%. The missing from care episodes have increased significantly year on year for the past few years.

The number of episodes relate to a smaller number of individual young people as there were a number of young people who were reported missing more than once. In fact, there was a small cohort of young people who

reported missing care on a very regular basis, often together, some months, and this in part explains the large increase in episodes. It should also be noted that there was an increase in the number of episodes lasting over 24 hours, and a number of episodes which lasted significantly longer. Processes are in place to ensure that there is regular oversight of these cases.

Northumbria Police introduced a new "absent" category on 25 January 2016 and all "missing" reports will now be classed as either missing or absent. For the purposes of MSET, cases will be considered regardless of whether they are missing or absent and return interviews will also be offered regardless of the police category.

A breakdown of the episodes reported each month is set out below. More detailed data on where Looked After Children are reported missing from is reported to Gateshead Council Overview and Scrutiny Committee on an annual basis.

Month	Total missing episodes	Missing from care episodes
April	91	77 (85%)
May	116	80 (70%)
June	72	59 (82%)
July	81	63 (78%)
August	76	63 (83%)
September	82	55 (67%)
October	71	47 (66%)
November	76	46 (61%)
December	77	43 (56%)
January	54	40 (74%)
February	65	49 (75%)
March	67	35 (52%)
TOTAL	**928**	**657 (71%)**

Planned actions for 2016-2017

Within the next 12 months:

- The group will continue to review those cases referred into it to support multi-agency ownership of risk and safeguarding. Practitioners will also be encouraged to be more proactive with referrals into the group
- The sub group will continue to strengthen the risk assessment process and scoring matrix so that there is a clear exit and entry point for the MSET
- Regular meetings between Police and the Gateshead Council children's homes managers are to continue to discuss cases of problematic or regular missing persons
- A revised procedure for recording missing and absent episodes for young people by the Police is now in place. Both absent and missing episodes are risk assessed and scrutinised to ensure the appropriate assessment and response is in place. Children's home staff have been spoken to by the Missing from Home Coordinator around the new process and how to challenge any classification and subsequent Police action.

Performance Management Sub Group. Chair – Service Manager Children's Commissioning and Performance (Ann Day in 2015-2016)

Purpose of the sub group

The purpose of the Performance Management Sub Group is to support the LSCB in fulfilling its statutory duty to monitor and evaluate the effectiveness of what is done by the local authority and Board partners, individually and collectively, to safeguard and promote the welfare of children, and advise them on ways to improve.

Continuous performance management is at the core of ensuring the effectiveness and impact of inter-agency safeguarding activity. The sub group supports the LSCB in the monitoring, promotion and planning of high quality practice in line with the inter-agency Performance Management Framework. The framework is used to monitor and analyse a range of quantitative and qualitative information, both via ongoing and set pieces of work. The sub group reports regularly to the Board highlighting any areas of practice that need to be addressed, and identifying areas of good practice.

Progress in 2015-2016

The sub group continued to embed the integrated data set and provide detailed performance information to the full LSCB on a quarterly basis. This regular reporting to the Board includes an overview of performance in relation to safeguarding and early help across all partners.

The performance information provided to the Board has supported the Board's determination of priorities and specific areas for additional scrutiny.

Professional and public awareness of child sexual exploitation (CSE) has grown significantly in recent years the Board therefore wished to scrutinise and determine on a multi-agency basis levels of CSE in Gateshead, develop a clear understanding of CSE, agree a collective approach to data sharing and quality assure the effectiveness of the multi-agency approach.

The sub group led the inquiry reviewing 37 cases and undertaking deep dive audits on 10 of those cases.

The inquiry looked at how children and young people are being identified and protected and sought to understand where there may be lessons to be learned from an audit of practice.
The results were reported to the Board in May 2016.

Data or management information relevant to the sub group in 2015-2016

See section 6.5. of this report

Planned actions for 2016-2017

During 2016-2017 the sub group will continue to provide to develop and enhance performance reporting to the Board. There will be a specific review and remodel the integrated data set in line with Ofsted recommendations and Board priorities.

The sub group will continue to undertake multi-agency audits to quality assure partner agencies collective approaches to Safeguarding and Early Help

Policies and Procedures Sub Group. Chair – LSCB Business Manager (Louise Gill in 2015-2016)

Purpose of the sub group

Gateshead LSCB has a statutory requirement to provide policies and procedures for safeguarding and promoting the welfare of children

> **Regulation 5 of the Local Safeguarding Children Board Regulations 2006** sets out that the functions of the LSCB, in relation to the above objectives under section 14 of the Children Act 2004, are as follows:
>
> 1. (a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:
>
> The action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention

The aims and purpose of the sub group are to:

- Develop policies and procedures for safeguarding and promoting the welfare of children and young people in Gateshead
- Monitor the effectiveness of the procedures in place
- Consider the implications of new policy, legislation, research and guidance in respect of safeguarding and promoting the welfare of children
- To review and accordingly update the Gateshead LSCB Inter-Agency Child Protection Procedures (currently in conjunction with TriX)

Progress during 2015-2016

In line with the current maintenance contract with TriX, two full updates of the LSCB Inter-Agency Child Protection Procedures were made in 2014-2015 to reflect changes to statutory guidance. The sub group also reviewed the arrangement with TriX to determine whether it was the most effective option and we have now entered into a sub-regional agreement with TriX and Sunderland and South Tyneside. This has considerably reduced the cost paid by Gateshead LSCB for the online procedures

The following pieces of work were also completed or are currently ongoing:

- Female Genital Mutilation
- Osman Warnings
- SUDI guidelines
- Templates for child protection conference reports
- Bruising in babies
- Concealed pregnancies

Planned actions for 2015-2016
Work will continue in relation to the following areas: • The new Care Act • Modern Slavery Bill • Parents recording child protection conferences • Use of technology to support attendance at meetings • Breast ironing The sub group will also respond to new areas of business as they emerge and ensure that procedures are compliant with any new guidance. The sub group will also review its own membership to ensure that it is fit for purpose as a number of members have recently changed roles or left organisations.

Strategic CSE and Trafficking Sub Group. Chair – Detective Chief Inspector (Shelley Hudson in 2015-2016

Purpose of the sub group
This is a relatively new sub group of the LSCB that was established in 2014-2015, having previously been a time-limited working group of the Board. The group has since merged with a task and finish group of the Safeguarding Adults Board however to create a joint Strategic Exploitation Group, which will begin reporting to the Board in 2016-2017. The remit of the group was to lead on the development of strategic work in relation to CSE and trafficking. On behalf of the LSCB, the group was tasked with developing, implementing and monitoring the Gateshead LSCB CSE strategy and delivery plan to ensure a coordinated and proactive multi-agency response to CSE and trafficking.
Progress in 2015-2016
The group established and strengthened its Terms of Reference and developed a Delivery Plan which set out key areas of work in relation to safeguarding children at risk of CSE and being exploited. The group finalised the CSE Strategy, which was scrutinised by Ofsted and found to be sound.
Planned actions for 2016-2017
As previously stated, this group has now been disbanded and a new joint LSCB and SAB Strategic Exploitation Group has been formed. The Terms of Reference for the group have been agreed and the work plan is being established

Training Sub Group. Chair – Workforce Development Adviser (Naju Khanom in 2015-2016)

Purpose of the sub group
The purpose of the group is to develop and promote, through training, a shared understanding amongst safeguarding partners around the tasks, processes, principles, roles and responsibilities for safeguarding children and promoting better outcomes. The sub group contributes to identifying training needs and the delivery of the training programme across the workforce and drives forward the programme. The sub group is made up of a variety of professionals from different sectors and services. Training is delivered with a focus on the children and young people's workforce. Training may also be influenced by any new agendas or initiatives. The group also supports, monitors and quality assures single agency training activity by LSCB partner agencies to ensure that minimum standards are reached.
Progress in 2015-2016
The 2015-2016 Children and Adults Safeguarding Training Directory was launched on 1 April 2015 and work took place throughout the year on the 2016-2017 directory in preparation for its launch. Over 70% of the courses in 2015-2016 were delivered "in house" by staff from LSCB partner agencies and the rest were commissioned. The e-learning programme continued to be promoted and strengthened. There was a delay in progressing some of the work of the sub group in 2015-2016 due to changes in personnel however the chair returned from maternity leave part way through the year and good progress was made from

that point.

Data or management information relevant to the sub group in 2015-2016

Multi-agency training is offered to all services and LSBC partner agencies. Records are kept in terms of the attendance a training by individual services and feedback is submitted to the LSCB on a regular basis in relation to attendance, cancellation and demand. This enables future planning.

There were 61 events held in 2015-2016 through the LSCB training directory (an increase from 52 events in the previous year). There were in fact 73 events arranged however 12 events were cancelled due to low numbers or trainer availability.

In total there were 1115 attendees, an increase from 1081 in the previous year. 763 people also accessed the online e-learning. There were 289 unsuccessful applicants who were not offered places at training events (up from 176 in the previous year) and unfortunately there were 151 applicants who were offered places who failed to attend (compared to 164 in the previous year).

Classroom training in 2015-2016:

Course	Attendees	Did not show	Unsuccessful	Cancelled prior to event	% applicants trained
Child Death Reviews	15	4	0	5	63%
CP awareness	250	37	88	64	57%
Child Trafficking	43	1	0	4	90%
Common Assessment Framework	107	17	6	26	64%
Cross cultural awareness	17	1	0	0	81%
Effective CP Conferences	10	3	0	6	50%
Effective Core Groups	0	0	0	0	0%
Fabricated and Induced Illness	56	6	16	4	73%
Female Genital Mutilation	57	4	8	10	70%
Foetal Alcohol Syndrome	24	5	0	3	75%
Information sharing in practice	9	1	0	2	32%
Multi-agency working to safeguard and protect children	48	3	25	19	45%
Neglect	42	9	17	6	50%
Protecting disabled children from Abuse	30	1	0	20	59%
Responding to allegations of abuse against professionals	12	4	5	4	38%
Safeguarding babies	20	2	0	2	83%
Safeguarding children and young people in the digital age	129	15	39	24	62%
Serious Case Reviews	18	5	0	24	32%
The impact of drug use on young people	32	5	23	3	51%
The impact of parental mental health	41	1	10	13	63%
Understanding and responding to child sexual abuse	36	5	12	7	60%
Young people at risk of sexual exploitation	82	17	35	16	51%
Young people who self-harm	73	5	5	20	71%
TOTAL	**1151**	**151**	**289**	**271**	**59%**

Online training in 2015-2016:

Module	Completions	Yet to complete
An introduction to safeguarding children	183	3
Awareness of child abuse and neglect - Core version	159	8
Awareness of child abuse and neglect - Foundation version	56	9
Awareness of child abuse and neglect - young people version	18	0
Awareness of child abuse and neglect core level - Police version	1	1
Awareness of domestic violence and abuse including the impact on children, young people and adults at risk	22	1
Hidden Harm	15	2
Safeguarding and leadership	24	3
Safeguarding children from abuse by sexual exploitation	103	11
Self-harm and suicidal thoughts in children and young people	2	0
Think Safe, Be Safe, Stay Safe	4	0
Female Genital Mutilation: Recognising and Preventing	*176*	*2*
TOTAL	**763**	**40**

Planned actions for 2016-2017

Going forward the Training Sub Group will look at:

- Promoting the directory across organisations and to the people who will benefit from training.
- Encourage registration for the new online booking system.
- Increase training pools.
- Work on implementing Ofsted recommendations
- Work to develop any training areas identified by the LSCB

Gateshead Council has implemented a new HR & Payroll system which includes the ability to book onto training, this system has been extended so those external to Gateshead Council can also use the system to book onto training. Work will continue with this system so that the LSCB can ensure that training meets demands and is effective.

APPENDIX 6 – Glossary

ACPC	Area Child Protection Committee
ARMG	Adolescent Risk Management Group
CAF	Common Assessment Framework
Cafcass	Children and Family Court Advisory Support Service
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CIN	Child In Need
CIN assessment	Child In Need assessment
CP plan	Child protection plan
CQC	Care Quality Commission
CRC	Community Rehabilitation Company
CSE	Child Sexual Exploitation
CCG	Clinical Commissioning Group
DCLG	Department for Communities and Local Government
DfE	Department for Education
DoH	Department of Health
DoLs	Deprivation of Liberty Safeguards
FGM	Female Genital Mutilation
FIT	Family Intervention Team
FT	Foundation Trust (NHS)
FTE	First Time Entrant (to Youth Justice System)
GHNFT	Gateshead Health NHS Foundation Trust
HMIC	Her Majesty's Inspector of Constabulary
ICPC	Initial Child Protection Conference
LAC	Looked After Child
LADO	Local Authority Designated Officer
LSCB	Local Safeguarding Children Board
MARAC	Multi Agency Risk Assessment Conference (for domestic abuse)
MAPPA	Multi Agency Public Protection Arrangements
MASH	Multi Agency Safeguarding Hub
MCA	Mental Capacity Act
MSET	Missing, Sexually Exploited and Trafficked Sub Group (sub group of LSCB)
NICE	National Institute for Health and Care Excellence
NTW	Northumberland, Tyne and Wear NHS Foundation Trust
PRU	Pupil Referral Unit
PVP	Protection of Vulnerable People Department (Police)
QA	Quality Assurance
RCPC	Review Child Protection Conference
SAB	Safeguarding Adults Board
SCR	Serious Case Review
SILP	Significant Incident Learning Process
STFT	South Tyneside NHS Foundation Trust
TAF	Team Around the Family
VAWGS	Violence Against Women and Girls Strategy
VCL	Vulnerability checklist
YOT	Youth Offending Team

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Gateshead LSCB Business Plan 2014-2017

2016-2017 Action Plan

Vision

Our vision is that every child should grow up feeling safe and in a loving, secure environment, free from abuse, neglect and crime, enabling them to enjoy a happy and healthy childhood in which they can fulfil their social and economic potential.

Role of the Business Plan

The Gateshead LSCB Business Plan sets the strategic direction for the LSCB. The Business Plan also reinforces the specific role of the LSCB to **lead, challenge** and support **learning**. The plan identifies specific priorities for action and is clear about roles and accountability.

The Gateshead Approach 2014-2017

Gateshead LSCB agreed a new approach in 2014 and adopted a three year Business Plan to cover the period from 2014-2017. This document provides a focus for Year 3 of the plan, which enables the Board to focus on the specific role and remit of LSCBs in ensuring that the welfare of children is safeguarded and protected, as set out in Working Together (2015) and the Children Act 2004.

The Business Plan emphasises the role of Gateshead LSCB in **leading** the safeguarding agenda, in **challenging** the work of partner organisations, and in committing to an approach which **learns** lessons, embeds good practice and which is continually influenced by the views of children and young people.

The Business Plan can be found at www.gateshead.gov.uk/LSCB

In years one and two we developed and utilised a new "LSCB inquiry" model to undertake task and finish work around the specific areas of neglect and Child Sexual Exploitation (CSE). We have reviewed the use of this model and found that, whilst it provided us with useful results, the bulk of the workload fell onto one or two Board members and it was agreed that we should use a more traditional task and finish group model in year three to encourage greater participation.

Summary of Key Achievements in 2015-2016

A full breakdown of progress in 2015-2016 can be found in the Gateshead LSCB 2015-2016 Annual Report. Highlights are shown in the table below

Area of work	Progress in 2014-2015
Leadership	• A sub-regional CSE event was held in October 2015 for 500 professionals in Gateshead • Work has continued to improve engagement with young people and this has been strengthened following recommendations made by Ofsted following the inspection of the LSCB • The Business Planning Group arrangements and effectiveness were reviewed by the chair and strengthened further following the Ofsted inspection of the LSCB
Challenge	• The second LSCB Inquiry was completed – this focused on CSE • The first mini-peer review took place and evidenced effective multi-agency working • Board members and partners contributed to the Gateshead Council Families Overview and Scrutiny Review of child protection • The Board received reports on a number of areas of challenge including contribution to child protection conferences and the response to the rising problem of Novel Psychoactive Substances aka NPS aka "legal highs"
Learning	• The Learning and Improvement Framework was strengthened and judged to be comprehensive and proactive by Ofsted • The Board and its partners learned from the findings of single agency inspections e.g. HMIC, CQC and Ofsted
Preventing harm	• Revised neglect guidance was developed following the LSCB Neglect Inquiry in 2014-2015 • Task and finish work was undertaken to understand key areas e.g. children convicted of sex offences and high risk adolescents • Work continued in relation to implementing the national Child Protection-Information Sharing Project (CP-IS), despite national delays
Protecting vulnerable children	• Further work took place to strengthen the links between the LSCB and schools, including participation by schools in the annual Section 11 audit • Approaches to extremism, cyber-crime and wellbeing in childhood were reviewed by the Board

As set out in the annual report, the LSCB was subject to an inspection of its effectiveness in 2015-2016 and Ofsted published the outcome of this in March 2016. We have subsequently developed an improvement plan, which we will continue to implement and monitor in 2016-2017.

2015-2016 Action Plan

In Year 3 the focus will continue to be on the three strategic business priorities:

- **Leadership**
- **Challenge**
- **Learning**

The focus will also remain on two strategic outcomes:

- **Protecting vulnerable children**
- **Preventing harm**

We will do the following to deliver our priorities and strategic outcomes and to implement the LSCB Improvement Plan:

In relation to **Leadership** the Board will strengthen links with our local communities through our lay members and community representatives, receive reports on the redesign of Early Help arrangements in Gateshead to ensure that services are fit for purpose and continue to strengthen links with other partnerships such as the Health and Wellbeing Board and Safeguarding Adults Board and develop our visibility and influence to ensure that the importance of safeguarding children is not lost within the wider remit of partnership work in the borough. We will also continue to strengthen our engagement with young people and raise the profile of the Board with them.

In relation to **Challenge** the Board will ask partners to share their single agency audits and account for any areas of development identified, continue to build on the peer review process and receive the outcome of the Gateshead Council Families Overview and Scrutiny Committee's review of child protection services. We will also continue to challenge our own performance through the development of an Effectiveness Framework and develop an updated dataset to enable us to continue to challenge areas of single-agency and multi-agency performance as when necessary.

In relation to **Learning** we will listen to what our young people have told us during our engagement work and act on this, develop an Effectiveness Framework and learn from best practice elsewhere and build on the learning from the Government's national review of LSCBs. We will also continue to learn from practice in Gateshead and other areas via our Learning and Improvement Sub Group and Learning and Improvement Framework and build upon good practice. We will also continue to review processes to understand the impact of our training offer and maintain a focus on delivering high quality training that meets demand.

In relation to **protecting vulnerable children** we will focus on the issue of self-harm and ensure that there are robust processes in place to reduce the incidence of self-harm and to support those young people who do self-harm. We will also continue to maintain a focus on Sexual Exploitation, "legal highs" and other key areas by receiving reports from those agencies leading on operational practice. We will also continue to take a partnership approach to the local implementation of the national Child Protection – Information Sharing project (CP-IS) to ensure that agencies in Gateshead work together to share information to protect vulnerable children. We will also monitor the impact of Team Sanctuary South on some of our most vulnerable children and adults and understand the voice of the survivor in light of recommendations made in other areas such as South Yorkshire.

In relation to **preventing harm** we will review the increase in permanent exclusions in Gateshead to understand the reasons behind this and consider more effective ways of working together to prevent harm to this particular cohort of young people. We will also receive the "Threshold/ indicators of need" document once it has been reviewed by Children's Social Care. We will also consider whether a locality risk assessment model would assist the Board in understanding where and what priority need is.

Year 2 Action Plan

Action	Proposed Lead Officer	Target Date
LEADERSHIP		
Strengthen links with the local community through work with lay members and community representatives	Louise Gill, LSCB Business Manager, to lead with input from Carole Paz-Uceria, SAB Business Manager	Ongoing throughout 2016-2017
Receive reports on the redesign of Early Help services in Gateshead and consider the impact on protecting vulnerable children and preventing harm	Vall Hall, Service Director, Children and Families Support	March 2017
Work with other partnerships to strengthen links and improve the visibility of the LSCB: Receive an annual report from SAB on activity and priorities Receive an annual report from the Community Safety Partnership on activity and priorities Submit an annual report to the SAB Submit an annual report to the HWB	Louise Gill, LSCB Business Manager, to lead with input from Carole Paz-Uceria, SAB Business Manager, and Adam Lindridge, Community Safety Business Manager	Ongoing throughout 2016-2017
Continue to consider a Youth LSCB structure	Independent Chair and Business Planning Group	September 2016
Carry out specific pieces of work to improve engagement with young people	Louise Gill, LSCB Business Manager to coordinate programme with all BPG members involved	Ongoing throughout 2016-2017
CHALLENGE		
Single agency audits to be presented to the LSCB on a regular basis to strengthen the oversight of frontline practice	Louise Gill, LSCB Business Manager to coordinate programme with all Board members involved	Ongoing throughout 2016-2017 in line with the workplan
Develop and implement an Effectiveness Framework	Louise Gill, LSCB Business Manager	July 2016
Receive the outcome of the Families OSC review of child protection and respond as appropriate	Ann Day, Service Manager Children's Commissioning	July 2016
Continue to implement a programme of mini-peer reviews to build on the learning from the 2016 Section 11 audit to demonstrate effective multi-agency working in Gateshead	Louise Gill, LSCB Business Manager to coordinate programme with all Board members involved	Ongoing throughout 2016-2017 in line with the workplan

Continued overleaf

Action	Proposed Lead Officer	Target Date
LEARNING		
Learn from what young people are telling us and Incorporate the findings of the engagement work with school councils to identify themes for task and finish work and reports to the Board where necessary	Louise Gill, LSCB Business Manager to coordinate programme with all Board members involved	Ongoing throughout 2016-2017
Review the learning from the national review of LSCBs and develop an action plan to take forward local areas for development	Louise Gill, LSCB Business Manager	TBC once review published
Continue to review cases where there are lessons to be learned through the Learning and Improvement Sub Group (and Serious Case Review Panel where necessary)	Elaine Devaney, Service Director – Social Work, Children and Families with support of LSCB Business Manager	As required
Review processes to understand the impact of our training offer and maintain a focus on delivering high quality training that meets demand	Naju Khanom, LSCB Workforce Development Officer	Ongoing throughout 2016-2017
Implement and embed the findings and recommendations from inspections/peer reviews as they arise and cascade the learning across partner agencies	For Ofsted inspections of CSC – TBC For HMIC inspections of Police – Lisa Orchard For HMIP inspections of Probation – Karin O'Neill and Martyn Strike For CQC inspections of health agencies – Lead dependant on agency e.g. Maggie Lilburn/Chris Piercy, Hilary Lloyd, Damian Robinson, Kathryn Dimmick For issues arising from Ofsted inspections of schools – Steve Horne/ Jeanne Pratt For issues arising from Ofsted inspection of Gateshead College – John Gray	As required
PROTECTING VULNERABLE CHILDREN		
Undertake task and finish work on the issue of self-harm in Gateshead to understand the data and ensure appropriate support is in place for young people who do self-harm	Kate Jones, Named Nurse, Gateshead Health NHS FT	March 2017
Receive reports on the following areas to understand the impact of operational practice: Sexual exploitation "legal highs" TBC	Louise Gill, LSCB Business Manager to coordinate programme with all Board members involved	Ongoing throughout 2016-2017 in line with the work plan
Continue to lead on the local implementation of the national Child Protection – Information Sharing project (CP-IS)	Ann Day, Service Manager, Children's Commissioning and Kate Jones, named nurse, GNHT	March 2017

Action	Proposed Lead Officer	Target Date
PREVENTING HARM		
Undertake task and finish work in relation to the increase in permanent exclusions and provide a report to enable the Board to understand this increase and areas for development required reduce the numbers of permanent exclusions if appropriate and future strategies to work together to support the young people at risk of permanent exclusion or who have been permanently excluded.	Steve Horne/Jeanne Pratt, EducationGateshead	March 2017
Receive the updated "Threshold/Indicators of Need" document from Children's Social Care and monitor the implementation	Elaine Devaney, Service Director – Social Work, Children and Families and Ann Day, Service Manager, Children's Commissioning	September 2016
Consider developing a locality risk assessment model to understand where and what the priority need is	Business Planning Group	September 2016

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HOW SAFE ARE CHILDREN IN GATESHEAD?

2015 • 2016

THE FACTS SPEAK FOR THEMSELVES

40,100

Children live in Gateshead - that's 20% of Gateshead's population

were recorded as living in poverty (that's nearly enough to fill the seats at Gateshead International Stadium) **8,220**

68.1/10,000

children are subject to Child Protection Plans

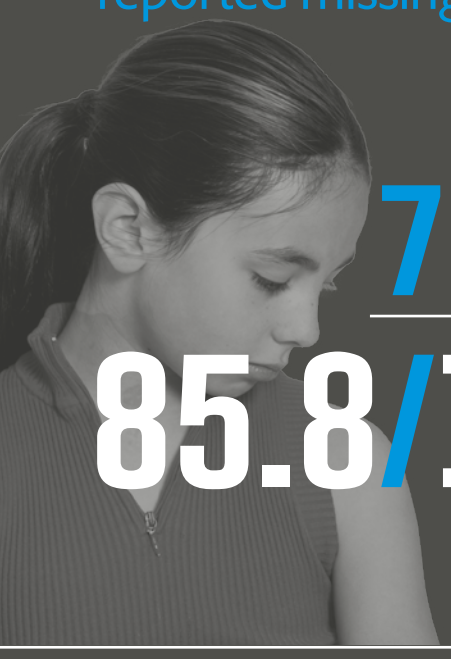
That's 273 children

of which 66 were unborn babies (down by 5 on last year)

REASONS WHY CHILDREN ARE ON CHILD PROTECTION PLANS:

- NEGLECT ..... 169 (down by 5 on last year)
- EMOTIONAL ABUSE..... 83 (up by 29 on last year)
- SEXUAL ABUSE..... 6 (down by 6 on last year)
- PHYSICAL ABUSE..... 17 (up by 3 on last year)

young people were reported missing on **928** occasions



71% of them were 'in care'

85.8/10,000

children in Gateshead are 'looked after' by Gateshead Council

8,943

calls were received from people worried about a child in Gateshead

Under 18 conceptions **DOWN** by 40% since 1998

1,101

children who witnessed domestic abuse were supported via 'Operation Encompass'

THE LOCAL SAFEGUARDING CHILDREN BOARD (LSCB)

AROUND **17** organisations work together on the LSCB to protect children

Gateshead LSCB makes sure that people like the Council, police, local hospitals, schools and GPs work together to keep children and young people safe. When things go wrong, we investigate, learn the lessons and publish what we have found

In 2015-16

- Over 700 taxi drivers received training to keep vulnerable passengers safe
- 1,551 practitioners attended an LSCB training event

23,848 CHILDREN ATTEND SCHOOLS IN GATESHEAD

- 8.62% are from an ethnic minority
- 6.2% don't speak English as their first language

87.8% of our schools are judged to be 'good' or 'outstanding' (**up 1.8%** on last year)

WORRIED ABOUT A CHILD?

IF it's YOU or someone you know who needs help or you have any concerns about a child. **PLEASE CALL ONE OF THE NUMBERS BELOW**

- IF it's an emergency phone the police on 999 or 101
- Contact a social worker on 0191 433 2653 (9am-5pm), 0191 477 0844 (evenings/weekends)

DON'T WANT TO SPEAK TO THE POLICE OR A SOCIAL WORKER?

- Call Childline on 0800 1111 (free)
- OR TALK to your schools 'designated teacher' who has responsibilities for keeping children safe.

For more information on Gateshead LSCB or to see our full annual report:
www.gateshead.gov.uk/lscb

All statistics relate to year 2015-16

Gateshead local safeguarding children board

0812/PS/2016

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FAMILIES
OVERVIEW AND SCRUTINY COMMITTEE
8 September 2016

TITLE OF REPORT: **Child Health Profile for Gateshead 2016**

REPORT OF: **Alice Wiseman, Director of Public Health, Care Wellbeing and Learning**

SUMMARY

The purpose of this report is to provide an overview of the current Child Health Profile published in June 2016. The paper will highlight areas of good and poor performance relating to child health and wellbeing outcomes for Gateshead.

Background

1. The Child Health Profile, produced annually by Public Health England (previously the Department of Health), presents a picture of child health and wellbeing for each Local Authority area. The profile reports on 32 indicators, across 5 health domains as outlined in Appendix 1. The profile can be used by the Local Authority and partners to improve health and wellbeing of children through targeting resources to tackle health inequalities.

2. The data within the profile provides a wide range of information on issues affecting child health, looking at early life and infant mortality, levels of breastfeeding, obesity, teenage conceptions, educational performance and youth crime. The data presented outlines the Gateshead position against the regional average, England Average, worst and best. The traffic light system identifies if Gateshead is significantly worse (red), better (green) or not significantly different (yellow) to the England average.

3. Organisations can use this tool, as part of the Joint Strategic Needs Assessment process, to help understand the needs of their community, enabling the identification of priorities for improving the health and wellbeing of children and young people living in Gateshead.

4. Public Health England's Child and Maternal (ChiMat) Health Intelligence Network website provide and interactive map, online profile and additional health information to create further maps, charts and detailed reports to support child health. A link to the website can be found here: **www.**chimat**.org.uk** .

Current Picture

5. The current profile provides an overview of the local child population in comparison to the region and England. Gateshead is reported to have 22.5% of the total population between the ages of 0-19yrs, and of those 8.5% are from an ethnic minority group.

6. Overall the health and wellbeing of children and young people in Gateshead is generally worse than the England average; however 16 out of the 32 indicators are better or not significantly different to the England average.

Key Findings

7. Key findings from the Child Health Profile 2016 for Gateshead are summarised below:

- The level of **child poverty** in Gateshead is **significantly worse** than the England average with 21.3% of all Children aged 16 years or under living in poverty.

- Children in Gateshead have average levels of **obesity** that are **similar** to the England rate: 9.5% of children aged 4-5 years and 19.9% of children aged 10-11 years are classified as obese. The England Average level of obesity in children aged 4-5 years is 9.1% and 10-11 years olds is 19.1%

- **Immunisation uptake** in Gateshead is **above** the England average and above the required 90% immunisation level.

- The health and wellbeing of children in Gateshead is generally worse than the England average. Infant and **child mortality** rates are **similar** to the England average.

- There has been a decrease in the number of hospital admissions as a result of **self-harm** for young people 10-24. Gateshead is however still **significantly worse** than the England average.

Changes in Performance

8. The profile enables us to monitor improvements or changes in health and wellbeing outcomes through comparison to previous profiles looking for any trends. To provide a brief snapshot of the current improvements or changes within the 2016 profile, comparison has been made between the indicators presented in 2015 profile and the 2014 profile. A summary of the improvements and any changes are presented below. A note of caution is required when comparing the 2015 position with the 2016 position, as the data does not give us a true indication of trend unless looked at with 3 year rolling averages. Further analysis of trend data using at least 3 years data will be presented at committee to support this report.

Indicators showing improvement in 2016

- Reduction in Infant Mortality (aged under 1)
- Reduction in Child Mortality (1-17yrs)
- Increase in Children achieving a good level of development at the end of Reception
- Reduction in First time entrants to the Youth Justice system
- Reduction in Children in Poverty (under 16)
- Reduction in Children in Care
- Reduction in Children killed or seriously injured in road traffic accidents
- Reduction in Low birthweight of term babies
- Reduction in Obese children (4-5yrs)
- Reduction in Obese children (10-11yrs)
- Increase in Breastfeeding prevalence at 6-8 weeks
- Reduction in A&E attendances (0-4yrs)
- Reduction in rate of Hospital admissions caused by injuries in children (0-14yrs)
- Reduction in Hospital admissions caused by injuries in young people (15-24yrs)
- Reduction in Hospital admissions as a result of self-harm (15-24yrs)

Indicators not showing improvement in 2016

- Decrease in MMR vaccination for one dose (2 years)
- Decrease in Dtap/IPV/Hib vaccination (2 years)
- Decrease in Children in care immunisations.

- Increase in 16-18 year olds not in education, employment or training
- No change in the rate of family homelessness
- No change in rate of Under 18 Conceptions
- Increase in Teenage Mothers
- No change in Hospital admissions due to alcohol specific conditions
- Increase in Hospital admissions due to substance misuse (15-24yrs)
- Increase in Smoking status at time of delivery
- Decrease in Breastfeeding initiation
- Increase in hospital admissions due to asthma
- Increase in hospital admissions due to mental health conditions

Changes in the Health Profile Measures

9. The Child Health Profile 2016 for Gateshead released in March 2016 included two new changes and a further change for 2016;

   - Indicator 6 – in 2015 was referred to as new sexually transmitted infections (Inc. Chlamydia). As of 2016 this has been removed as an indicator.

   - Indicator 19 - Hospital admissions for dental caries (1-4yrs) has been newly added for the 2016 profiles

   - Indicator 7 - GCSEs achieved (5 A*-C Inc. English and Maths) is only a single years data due to reforms of the key stage 4 performance measurement data and cannot be compared to earlier data

   - Indicator 20 - (U18 Conceptions) still contains the same value as the previous 2015 profile. The most recent 2014 data release was not in time for the 2016 profile to be updated.

   - Indicator 8 - has not been updated and still does not contain a local value.

Summary

10. The Child Health Profile for 2016 provides an overview of child health and wellbeing for Gateshead showing that many areas of children and young peoples health have shown some improvement compared to the 2015 profile, particularly the improvement of children achieving a good level of development at the end or Reception (Indicator 7) as well as an improvement in the levels of obesity in children aged 10-11 (Indicator 18) an decrease in levels of child obesity in Children aged 4-5yrs (indicator 16).

11. However the Child Health Profile also highlights areas for concern such as an increase in hospital admissions due to mental health conditions (Indicator 13) and an increase in smoking status at time of delivery (Indicator 24).

Recommendations

12. Families Overview and Scrutiny Committee is asked to:

    a. The committee is asked to note the content of the report

    b. Receive future reports which detail specific areas of concern and provide trend analysis showing change over at least 3 years data

Contact: Behnam Khazaeli **Ext:** 0191 433 3036

Public Health England

Child Health Profile
March 2016

Gateshead

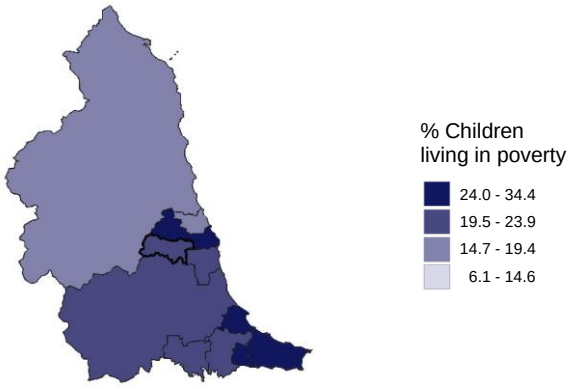
This profile provides a snapshot of child health in this area. It is designed to help the local authority and health services improve the health and wellbeing of children and tackle health inequalities.

The child population in this area

	Local	North East	England
Live births in 2014			
	2,274	28,456	661,496
Children (age 0 to 4 years), 2014			
	11,600 (5.8%)	151,600 (5.8%)	3,431,000 (6.3%)
Children (age 0 to 19 years), 2014			
	45,100 (22.5%)	593,200 (22.7%)	12,907,300 (23.8%)
Children (age 0 to 19 years) in 2025 (projected)			
	45,700 (22.1%)	608,800 (22.5%)	13,865,500 (23.7%)
School children from minority ethnic groups, 2015			
	2,027 (8.5%)	29,842 (9.5%)	1,931,855 (28.9%)
Children living in poverty (age under 16 years), 2013			
	21.3%	23.3%	18.6%
Life expectancy at birth, 2012-2014			
Boys	77.8	78.0	79.5
Girls	81.2	81.7	83.2

Children living in poverty

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



Contains Ordnance Survey data

Data sources: Live births, Office for National Statistics (ONS); population estimates, ONS mid-year estimates; population projections, ONS interim 2012-based subnational population projections; black/ethnic minority maintained school population, Department for Education; children living in poverty, HM Revenue & Customs (HMRC); life expectancy, ONS.

Key findings

Children and young people under the age of 20 years make up 22.5% of the population of Gateshead. 8.5% of school children are from a minority ethnic group.

The health and wellbeing of children in Gateshead is generally worse than the England average. Infant and child mortality rates are similar to the England average.

The level of child poverty is worse than the England average with 21.3% of children aged under 16 years living in poverty. The rate of family homelessness is better than the England average.

Children in Gateshead have average levels of obesity: 9.5% of children aged 4-5 years and 19.9% of children aged 10-11 years are classified as obese.

Local areas should aim to have at least 90% of children immunised in order to give protection both to the individual child and the overall population. The MMR immunisation rate is higher than 90%. The immunisation rate for diphtheria, tetanus, polio, pertussis and Hib in children aged two is higher than 90%.

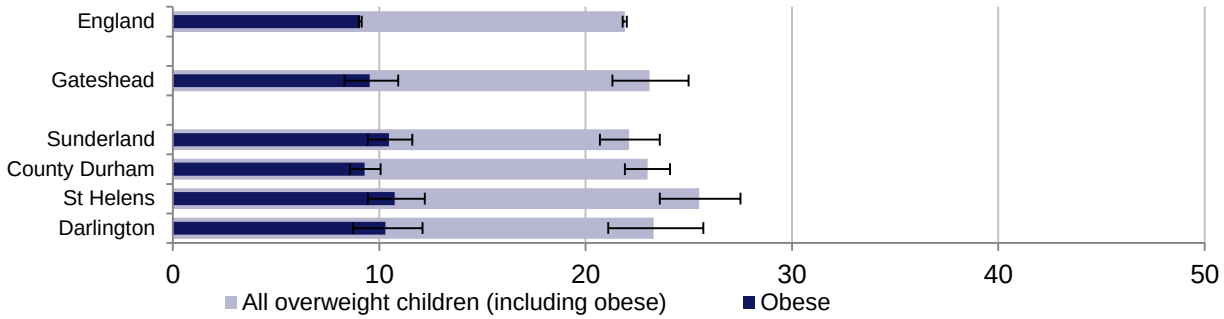
There were 340 children in care at 31 March 2015, which equates to a higher rate than the England average. A higher percentage of children in care are up-to-date with their immunisations compared with the England average for this group of children.

Any enquiries regarding this publication should be sent to info@chimat.org.uk.

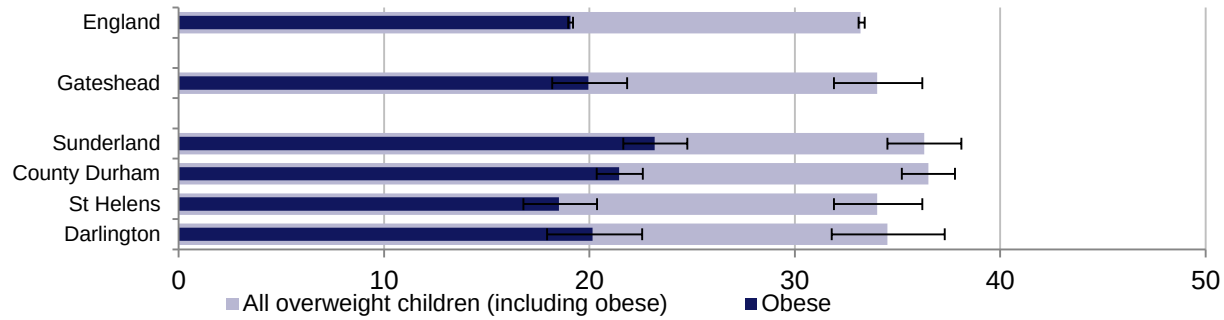
Childhood obesity

These charts show the percentage of children classified as obese or overweight in Reception (aged 4-5 years) and Year 6 (aged 10-11 years) by local authority compared with their statistical neighbours. Compared with the England average, this area has a similar percentage in Reception and a similar percentage in Year 6 classified as obese or overweight.

Children aged 4-5 years classified as obese or overweight, 2014/15 (percentage)



Children aged 10-11 years classified as obese or overweight, 2014/15 (percentage)



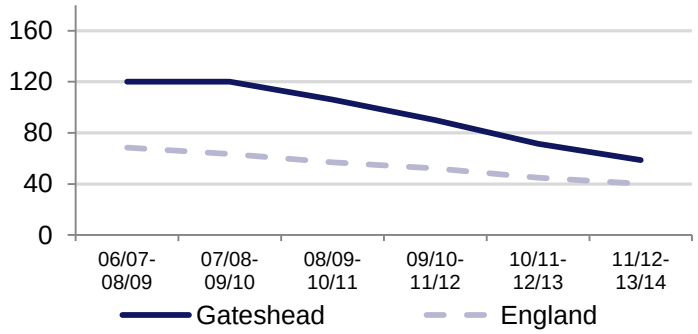
Note: This analysis uses the 85th and 95th centiles of the British 1990 growth reference (UK90) for BMI to classify children as overweight and obese.

I indicates 95% confidence interval. Data source: Public Health Outcomes Framework

Young people and alcohol

In comparison with the 2006/07-2008/09 period, the rate of young people under 18 who are admitted to hospital because they have a condition wholly related to alcohol such as alcohol overdose is lower in the 2011/12-2013/14 period. The admission rate in the 2011/12-2013/14 period is higher than the England average.

Young people aged under 18 admitted to hospital with alcohol specific conditions (rate per 100,000 population aged 0-17 years)

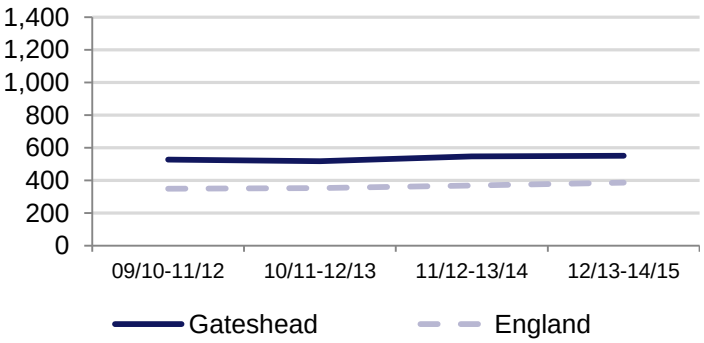


Data source: Public Health England (PHE)

Young people's mental health

In comparison with the 2009/10-2011/12 period, the rate of young people aged 10 to 24 years who are admitted to hospital as a result of self-harm is similar in the 2012/13-2014/15 period. The admission rate in the 2012/13-2014/15 period is higher than the England average*. Nationally, levels of self-harm are higher among young women than young men.

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

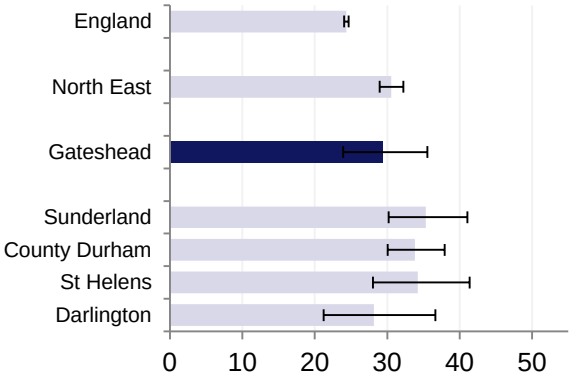


*Information about admissions in the single year 2014/15 can be found on page 4

Data source: Hospital Episode Statistics, Health and Social Care Information Centre

These charts compare Gateshead with its statistical neighbours, the England and regional average and, where available, the European average.

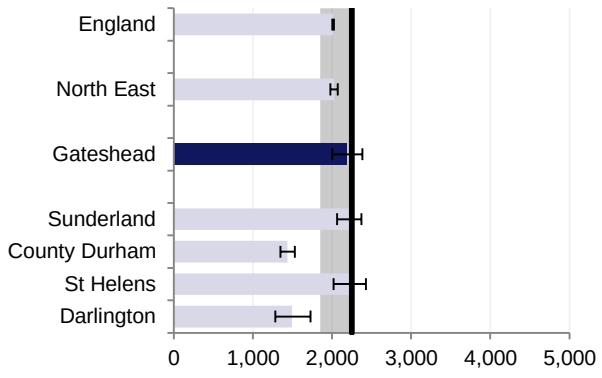
Teenage conceptions in girls aged under 18 years, 2013 (rate per 1,000 female population aged 15-17 years)



In 2013, approximately 29 girls aged under 18 conceived for every 1,000 females aged 15-17 years in this area. This is similar to the regional average. The area has a similar teenage conception rate compared with the England average.

Source: Conceptions in England and Wales, ONS

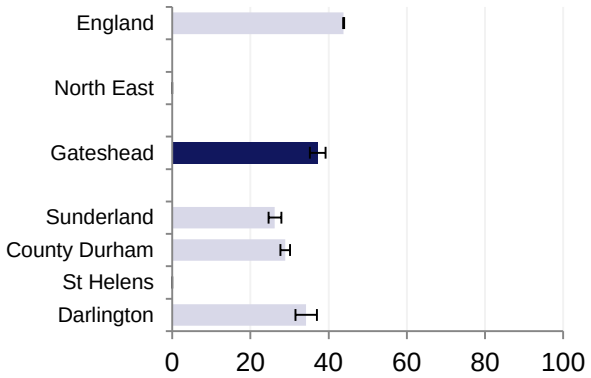
Chlamydia detection, 2014 (rate per 100,000 young people aged 15 - 24 years)



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 2014, the detection rate in this area was 2,186 which is approaching the minimum recommended rate.

Source: Public Health Outcomes Framework. 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, 2014/15 (percentage of infants due 6 to 8 week checks)

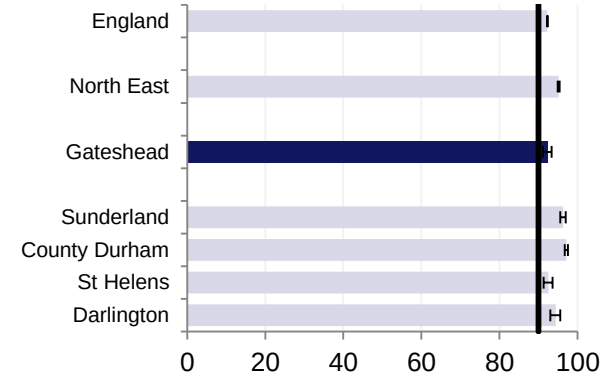


In this area, 37.2% of mothers are still breastfeeding at 6 to 8 weeks. 67.5% of mothers in this area initiate breastfeeding when their baby is born. This area has a lower percentage of babies who have ever been breastfed compared with the European average of 89.1%*.

* European Union 21 average, 2005. Source: Organisation for Economic Co-operation and Development (OECD) Social Policy Division

Source: Public Health Outcomes Framework

Measles, mumps and rubella (MMR) immunisation by age 2 years, 2014/15 (percentage of children age 2 years)



More than 90% (the minimum recommended coverage level, shown as a vertical black line on the chart above) of children have received their first dose of immunisation by the age of two in this area (92.3%). By the age of five, only 89.3% of children have received their second dose of MMR immunisation. In the North East, there were 3 laboratory confirmed cases of measles in young people aged 19 and under in the past year.

Sources: Public Health Outcomes Framework; Public Health England

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

Gateshead Child Health Profile March 2016

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 which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

- Significantly worse than England average
- Significantly better than England average
- Not significantly different
- Regional average

	Indicator	Local no.	Local value	Eng. ave.	Eng. Worst	Eng. Best
Premature mortality	**1** Infant mortality	10	4.5	4.0	7.2	1.6
	2 Child mortality rate (1-17 years)	5	13.0	12.0	19.3	5.0
Health protection	**3** MMR vaccination for one dose (2 years) >=90% <90%	2,074	92.3	92.3	73.8	98.1
	4 Dtap / IPV / Hib vaccination (2 years) >=90% <90%	2,172	96.7	95.7	79.2	99.2
	5 Children in care immunisations	225	95.7	87.8	64.9	100.0
Wider determinants of ill health	**6** Children achieving a good level of development at the end of reception	1,374	63.7	66.3	50.7	77.5
	7 GCSEs achieved (5 A*-C inc. English and maths)	1,095	57.2	57.3	42.0	71.4
	8 GCSEs achieved (5 A*-C inc. English and maths) for children in care	-	-	12.0	8.0	42.9
	9 16-18 year olds not in education, employment or training	460	7.6	4.7	9.0	1.5
	10 First time entrants to the youth justice system	82	463.7	409.1	808.6	132.9
	11 Children in poverty (under 16 years)	7,240	21.3	18.6	34.4	6.1
	12 Family homelessness	112	1.2	1.8	8.9	0.2
	13 Children in care	340	85	60	158	20
	14 Children killed or seriously injured in road traffic accidents	7	18.9	17.9	51.5	5.5
Health improvement	**15** Low birthweight of term babies	69	3.3	2.9	5.8	1.6
	16 Obese children (4-5 years)	188	9.5	9.1	13.6	4.2
	17 Obese children (10-11 years)	369	19.9	19.1	27.8	10.5
	18 Children with one or more decayed, missing or filled teeth	-	25.8	27.9	53.2	12.5
	19 Hospital admissions for dental caries (1-4 years)	40	425.6	322.0	1,406.8	11.7
	20 Under 18 conceptions	103	29.3	24.3	43.9	9.2
	21 Teenage mothers	41	1.9	0.9	2.2	0.2
	22 Hospital admissions due to alcohol specific conditions	23	58.8	40.1	100.0	13.7
	23 Hospital admissions due to substance misuse (15-24 years)	37	160.2	88.8	278.2	24.7
Prevention of ill health	**24** Smoking status at time of delivery	344	15.1	11.4	27.2	2.1
	25 Breastfeeding initiation	1,527	67.5	74.3	47.2	92.9
	26 Breastfeeding prevalence at 6-8 weeks after birth	823	37.2	43.8	19.1	81.5
	27 A&E attendances (0-4 years)	12,576	1,080.4	540.5	1,761.8	263.6
	28 Hospital admissions caused by injuries in children (0-14 years)	474	143.4	109.6	199.7	61.3
	29 Hospital admissions caused by injuries in young people (15-24 years)	423	179.1	131.7	287.1	67.1
	30 Hospital admissions for asthma (under 19 years)	105	245.5	216.1	553.2	73.4
	31 Hospital admissions for mental health conditions	39	97.2	87.4	226.5	28.5
	32 Hospital admissions as a result of self-harm (10-24 years)	179	531.3	398.8	1,388.4	105.2

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

1 Mortality rate per 1,000 live births (age under 1 year), 2012-2014
2 Directly standardised rate per 100,000 children age 1-17 years, 2012-2014
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2014/15
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2014/15
5 % children in care with up-to-date immunisations, 2015
6 % children achieving a good level of development within Early Years Foundation Stage Profile, 2014/15
7 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2014/15
8 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2014 (provisional)
9 % not in education, employment or training as a proportion of total age 16-18 year olds known to local authority, 2014
10 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2014
11 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2013
12 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2014/15
13 Rate of children looked after at 31 March per 10,000 population aged under 18, 2015
14 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2012-2014
15 Percentage of live-born babies, born at term, weighing less than 2,500 grams, 2014
16 % school children in Reception year classified as obese, 2014/15
17 % school children in Year 6 classified as obese, 2014/15
18 % children aged 5 years with one or more decayed, missing or filled teeth, 2011/12
19 Crude rate per 100,000 (age 1-4 years) for hospital admissions for dental caries, 2012/13-2014/15
20 Under 18 conception rate per 1,000 females age 15-17 years, 2013
21 % of delivery episodes where the mother is aged less than 18 years, 2014/15
22 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2011/12-2013/14
23 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2012/13-2014/15
24 % of mothers smoking at time of delivery, 2014/15
25 % of mothers initiating breastfeeding, 2014/15
26 % of mothers breastfeeding at 6-8 weeks, 2014/15
27 Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2014/15
28 Crude rate per 10,000 (age 0-14 years) for emergency hospital admissions following injury, 2014/15
29 Crude rate per 10,000 (age 15-24 years) for emergency hospital admissions following injury, 2014/15
30 Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2014/15
31 Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2014/15
32 Directly standardised rate per 100,000 (age 10-24 years) for emergency hospital admissions for self-harm, 2014/15

FAMILIES
OVERVIEW AND SCRUTINY COMMITTEE
8 September 2016

TITLE OF REPORT: **Review of Children's Oral Health in Gateshead – Evidence Gathering**

REPORT OF: **Alice Wiseman, Director of Public Health, Care Wellbeing and Learning**

SUMMARY

The purpose this report is to provide an overview of the oral health of the child population in Gateshead and their access to dental services.

Introduction

1. The implementation of the health service reforms under the 2012 Health and Social Care Act transferred the responsibilities of accessing the health needs of communities from primary care trusts to local government. This responsibility included advice on ensuring access to services including oral health care services. Local authorities are charged with shaping local services with NHS providers to meet the needs of their population.

2. Additionally local authorities have the responsibility to commission oral health care promotion to meet the needs of the population as they see fit. These duties provide a complex interaction of surveillance, health improvement and scrutiny which will all impact upon the delivery of services for children and families[12].

Current picture oral health of children in Gateshead

3. Public Health England coordinates regular surveys, for various age groups, on children's oral health with occasional surveys for adults. These are carried out according to standardised protocols which allow accurate comparisons to be made between different local authorities to enable benchmarking of the oral health of children[3]. Depending upon the sample size, of 5 year old children, it is possible to identify variations in oral health amongst different parts of the community within a local authority. This is usually reported as variations in the oral health status of children resident in different wards.

4. The last survey of the 5 years old children's' oral health was carried out in 2015[3]. This survey used a small sample which didn't facilitate an understanding of differences between wards in Gateshead and instead only facilitated benchmarking between Gateshead as a whole and other local authorities. However this showed that children aged 5 years old within Gateshead had one of the lowest levels of dental disease when compared to the average for children across the North East.

5. Evidence shows that the main reason for the relatively low levels of dental disease is that Gateshead has been artificially fluoridated since the late 1960s early 70s[4] (funded from the Public Health grant).

6. However, despite low levels of dental disease overall, the last large scale survey of 5 year old children demonstrated significant variations in experience of dental disease between different parts of Gateshead. This has been separately reported to the Director of Public Health. Published in 2013[5] the survey showed that the highest levels of dental disease were in Felling Ward where 47% of children aged 5 years had experienced dental disease while the lowest was in Whickham South and Sunniside with only 9% of children experiencing any dental disease who took part in the survey.

Access to dental services

7. Work undertaken by Public Health England has shown that approximately 70% of children have accessed NHS dental services. This analysis was based upon data from NHS contracted practices irrespective of where a child had accessed to dental services. As such this would have picked up children who are residents of Gateshead but accessed services in areas such as Newcastle, Sunderland, South Tyneside or County Durham. Data was collected over a 12 months period and current NICE guidelines advise that children should be seen at least once every 12 months[6].

8. There are lower levels of access amongst children aged 0-4 which is largely due to the fact that very young children under 6 months old, are unlikely to be taken by their parents to a dentist while those in the 15-19 year age group include some people who have left home and are attending university. There are also issues regarding the levying of patient charges for individuals in the older teenaged years[7] which often is a barrier to accessing dental services. Overall access rates do vary between different areas of the authority, the lowest levels being 35% of a ward population and the highest being 60%.[8]

Orthodontic treatment

9. Orthodontic treatment deals with misaligned (crooked) teeth. It is usually considered that a third of all children will have both a clinical need for orthodontic treatment and will also demand it. Work undertaken in conjunction with NHS England has demonstrated that there is equitable access to orthodontic treatment within the local economy across the three, South of Tyne authorities with no relationship evident between increasing deprivation and lower access to orthodontic treatment[9].

10. The standard measure of need and demand for orthodontic treatment is 33%[10] of 12 year old children. In the SOTW area there were 6,159[11] 12 year old children in 2014. Currently NHS England commissions a full course of orthodontic treatment capacity for approximately 39% of 12 year old children across the South of Tyne area that are in regular contact with dental care. This assumes that services running effectively.

Travel to services

11. The evidence available shows that the majority of residents will access dental services close to where they live with over 50% of Gateshead residents accessing services $2^1/_2$ miles or less travelling distance from their home. Additionally the evidence available shows that people living in the most deprived areas travel the shortest distance to access dental services. This is probably related to their reduced social economic autonomy and while dental treatment may well be free for them they still have to incur travel costs.[12]

Challenges to Oral Health

12. The major challenges facing the oral health of children and families are around the development of dental disease due to a poor diet high in sugars.

13. The council has a range of interventions which can considered to promote good oral health amongst its children and families. This will be synergistic with its broader health improvement programmes to reduce obesity and the likelihood of development of diabetes.

14. Public Health England has produced a set of national guidance to help local authorities consider interventions it might consider promoting to secure further improvements in the oral health of the population, and in particular, targeted in those areas where oral health has been identified as being poor or amongst particular communities where oral health is considered to be poor[13].

15. It should be noted that as the Council currently commissions water fluoridation. As stated, this is one of the most cost and clinically effective interventions any local authority can provide.

Recommendations

16. Families Overview and Scrutiny Committee is asked to:

    a. The committee is asked to note the content of the report and the evidence presented as part of the review of Children's Oral Health in Gateshead.

Contact: Behnam Khazaeli Ext: 0191 433 3036

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Public Health England

Local authorities improving oral health: commissioning better oral health for children and young people

An evidence-informed toolkit for local authorities

About Public Health England

Public Health England's mission is to protect and improve the nation's health and to address inequalities through working with national and local government, the NHS, industry and the voluntary and community sector. PHE is an operationally autonomous executive agency of the Department of Health.

Public Health England
133-155 Waterloo Road
Wellington House
London SE1 8UG
Tel: 020 7654 8000
http://www.gov.uk/phe
@PHE_uk

For queries relating to this document, please contact: Jenny Godson; email: Jenny.Godson@phe.gov.uk

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Foreword

It is well recognised that oral health is an important part of general health and wellbeing. Whilst there have been welcome improvements in the oral health of children in England, significant inequalities remain.

The Health and Social Care Act (2012) conferred the responsibility for health improvement, including oral health improvement to local authorities. This document aims to describe these new responsibilities and to provide support for local authorities in their delivery. It includes information to enable the review and evaluation of current commissions and the integration of evidence-informed programmes within existing programmes for children and young people.

Many general health conditions and oral diseases share common risk factors such as smoking, alcohol misuse and poor diet. Oral diseases are largely preventable; and there is a need to develop interventions to achieve sustained and long-term improvements in oral health and reduce inequalities. To do so, requires partnership action to address the wider determinants of health, ranging from economic and social policy change (creating healthier environments), to the adoption of healthier behaviours by individuals in the population. We recognise that it is fundamentally important to focus also on upstream factors that create inequalities and that cause both poor general and oral health.

Public Health England is pleased to provide this guide, we thank the multidisciplinary steering group and advisers who supported its development.

Kevin Fenton, Director of Health and Wellbeing

Sue Gregory, National Head of Dental Public Health

Public Health England

Executive summary

What responsibilities do local authorities have for improving the oral health of children and young people?

- Local authorities are statutorily required to provide or commission oral health promotion programmes to improve the health of the local population, to an extent that they consider appropriate in their areas. They are also required to provide or commission oral health surveys. The oral health surveys are carried out as part of the Public Health England (PHE) dental public health intelligence programme (formerly known as the national dental epidemiology programme).

Why is children's and young people's oral health important?

- Tooth decay is the most common oral disease affecting children and young people (CYP) in England, yet it is largely preventable. While children's oral health has improved over the past 20 years, almost a third (27.9%) of five-year-olds still had tooth decay in 2012.

- Poor oral health impacts children and families' health and wellbeing. Children who have toothache or who need treatment may have to be absent from school. Parents may also have to take time off work to take their children to the dentist. Oral health is an integral part of overall health; when children are not healthy, this affects their ability to learn, thrive and develop. Good oral health can contribute to school readiness.

- Tooth decay was the most common reason for hospital admissions in children aged five to nine years old in 2012-13. Dental treatment under general anaesthesia (GA), presents a small but real risk of life-threatening complications for children.

- Dental treatment is a significant cost, with the NHS in England **spending £3.4 billion per year on dental care** (with an estimated additional £2.3 billion on private dental care).

Are there oral health inequalities?

- People living in deprived communities consistently have poorer oral health than people living in richer communities. Stark regional differences also exist. For example in 2012, 21.2% of five-year-olds had tooth decay in South East England compared to 34.8% in the North West of England, with even greater inequalities within local authority areas.

What are the policy drivers?

- The government made a commitment to oral health and dentistry with a drive to:
  - improve the oral health of the population, particularly children
  - introduce a new NHS primary dental care contract
  - increase access to primary care dental services

- The public health outcomes framework (2013-16) includes “tooth decay in five-year-old children” as an outcome indicator.

- The NHS outcomes framework (2014-15) includes indicators related to patients’ experiences of NHS dental services and access to NHS dental services.

- The Children and Young People’s Health Outcomes Forum report published in 2012 and its 2014 annual report recommended improved integration and greater action to reduce regional variation in child health outcomes.

What can we do to improve oral health outcomes for children and young people and reduce oral health inequalities?

- Put children and young people (CYP) and their families at the heart of commissioning.

- Adopt an integrated approach with partners for oral health improvement (see Table 1.1), including NHS England, Public Health England and Clinical Commissioning Groups. Ensuring all local authority services for CYP have oral health improvement embedded at a strategic and operational level.

- Commission for oral health improvement across the life course, giving every child the best start in life and adopting the principle of proportionate universalism.

- Address the underlying causes of health inequalities and the causes of poor general and oral health though upstream evidence informed actions.

- Use, share and develop information and intelligence.

- Sustain and develop the CYP workforce.

- Support CYP through their families, early years, schools and community settings to maintain good oral health, adopting a place based approach.

- Lead and advocate a clear local vision for oral health improvement and addressing oral health inequalities.

- Provide access to quality local dental services focused on improving oral health.

What does good commissioning look like?

- Commissioning frameworks should ensure that oral health improvement is integrated within existing programmes such as the healthy child programme for 0 to 19-year olds.

- Commissioning specific oral health programmes based on the evidence base and needs of the population.

- Reviewing commissioned oral health programmes to ensure that programmes:
  - meet local needs
  - involve upstream, midstream and downstream interventions that use both targeted and universal approaches
  - consider the totality of evidence of what works
  - engage with partners integrating commissioning across organisations and across bigger footprints as required

Financial considerations

- Local authorities currently use a range of approaches to maximise the value of investment and the evidence of return on investment. Some local authorities may not have used these tools in the context of oral health improvement. These methods include using pooled budgets, collaborative commissioning across organisations and geographies and using cost benefit analysis tools. Local authorities can use these methods in oral health improvement commissioning to maximise value in terms of oral health improvement for spend.

Who is this guidance for?

The document provides guidance to support commissioning of evidence informed oral health improvement programmes for:

- elected members and strategic leaders
- health and wellbeing boards
- directors of public health
- consultants in dental public health and public health
- commissioners in local authorities
- local oral health improvement and oral health promotion teams
- health care providers and children and young people workforce delivering population based oral health improvement programmes

Section 1: Introduction

What is the purpose of this document?

This document aims:

- to support local authorities to commission oral health improvement programmes for children and young people aged up to 19 years
- to enable local authorities to review and evaluate existing oral health improvement programmes and consider future commissioning intentions
- to provide an evidence-informed approach with examples of good practice

What are local authorities' responsibilities for improving the oral health of children and young people?

- The Health and Social Care Act (2012) amended the National Health Service Act (2006) to confer responsibilities on local authorities for health improvement, including oral health improvement, in relation to the people in their areas.
- Local authorities are statutorily required[1] to provide or commission oral health promotion programmes to improve the health of the local population, to the extent that they consider appropriate in their areas.
- They are also required to provide or commission oral health surveys in order to facilitate: the
  - assessment and monitoring of oral health needs,
  - planning and evaluation of oral health promotion programmes
  - planning and evaluation of the arrangements for the provision of dental services, and
  - reporting and monitoring of the effects of any local water fluoridation schemes covering their area
- The oral health surveys are carried out as part of the PHE dental public health intelligence programme.[2] Local authorities are also required to participate in any oral health survey conducted or commissioned by the secretary of state
- Local authorities also have the power to make proposals regarding water fluoridation schemes, a duty to conduct public consultations in relation to such proposals and powers to make decisions about such proposals.[3,4]

- Commissioning arrangements for oral health improvement programmes need to be identified and understood locally because they vary across England. Local authorities still have the lead responsibility for oral health improvement regardless of where the funding may sit since the NHS transition.

Why is children's and young people's oral health important?

- Tooth decay is the most common oral disease affecting children and young people in England, yet it is largely preventable. The dental public health intelligence programme (formerly known as the national dental epidemiology programme) found that while children's oral health has improved over the past 20 years, almost a third (27.9%) of five-year-olds still had tooth decay in 2012.[5] This equates to approximately 177,423 five-year-olds in England who had some experience of tooth decay with 155,801 of five-year olds having one or more untreated decayed tooth.[5,6] Gum (periodontal) disease, traumatic dental injuries and acid erosion are oral diseases that also contribute to poor oral health in children and young people, but are less common.

- Poor oral health can affect children's and young people's ability to sleep, eat, speak, play and socialise with other children.[7] Other impacts include pain, infections, poor diet, and impaired nutrition and growth.[8,9] According to the Global Burden of Disease Study in 2010, five to nine year-old children in the UK experienced the most disability caused by poor oral health.[10] An average of 2.24 hours of children's healthy life was lost for every child aged five-nine years because of poor oral health, exceeding the level of disability associated with vision loss (1.64 hours), hearing loss (1.77 hours) and diabetes mellitus (1.54 hours).[11]

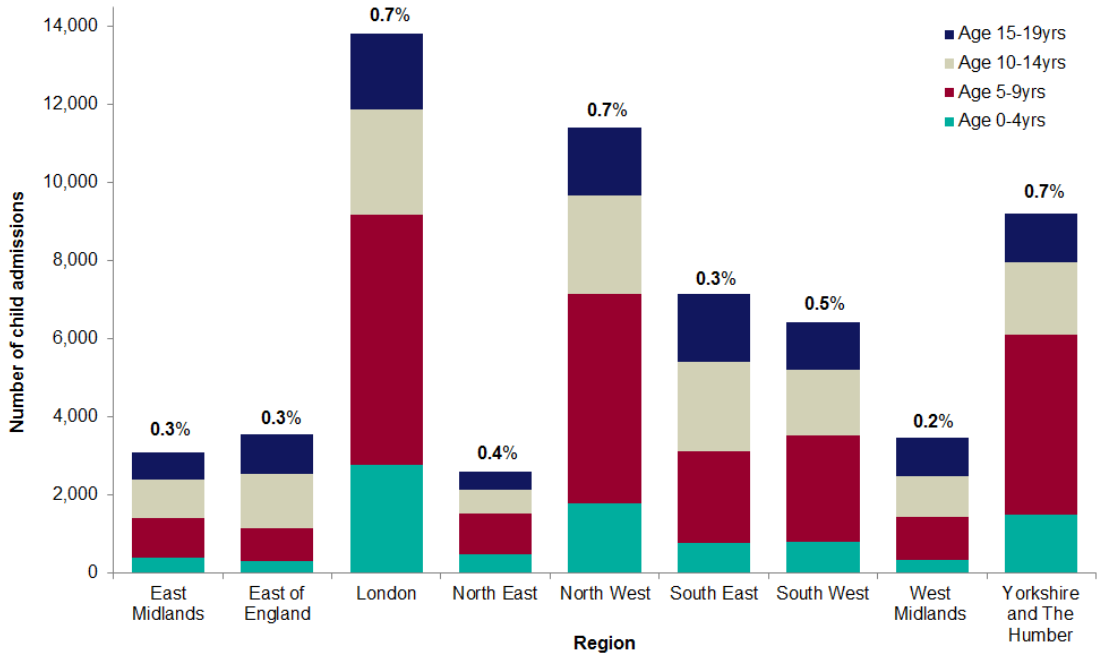
- Poor oral health also has wider impacts at school and for families if a child misses school or when a parent has to take time off work if their child needs dental treatment.[12] Oral health is an integral part of overall health. When children are not healthy, this affects their ability to learn, thrive and develop. Good oral health can contribute to "school readiness". To benefit fully from education, children need to enter school ready to learn, to be healthy and prepared emotionally, behaviourally and socially. School readiness ensures that all children are able to participate fully in all school activities in order to be successful at school. Oral health is therefore an important aspect of overall health status and critical to children's school readiness.

- Poor oral health may be indicative of dental neglect and wider safeguarding issues. Dental neglect is defined as “the persistent failure to meet a child’s basic oral health needs, likely to result in the serious impairment of a child’s oral or general health or development”.[13] Dental teams can contribute to a multi-agency approach to safeguard children and guidance is available to support this role.[14]

- Tooth decay was the most common reason for hospital admissions in children aged five to nine years old in 2012-13.[15] During this period, 60,272 children under 19 years of age were admitted to hospital for tooth extractions with 50% of cases for children nine years or under.[16] Untreated tooth decay can lead to young children needing dental treatment under general anaesthesia (GA), which presents a small but real risk of life-threatening complications for children.[17] Figure 1.1 shows the variation in hospital admissions for dental extractions by region. This variation reflects a combination of differing levels of dental disease, local service provision and data collection but may not capture all dental extractions (eg extractions carried out by community dental services on a sessional basis). This probably means that these figures are an underestimation.

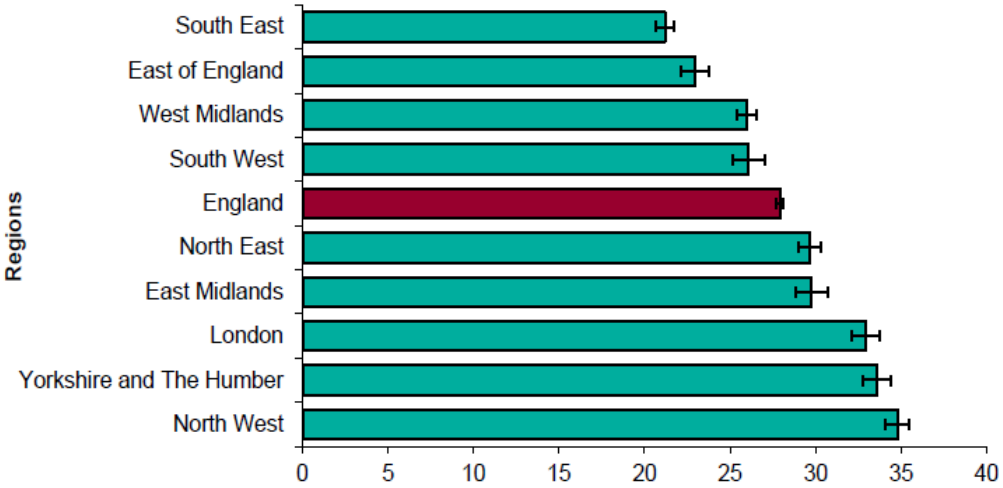
- Tooth extractions under GA are not only potentially avoidable for most children but also costly. The cost of extracting multiple teeth in children in hospitals in 2011-2012 was £673 per child with a total NHS cost of nearly £23 million.[18]

Figure 1.1. Number of children admitted to hospital for extraction of decayed teeth in 2012-13, by region, including the percentage of 0-19 year old children this represents



- People living in deprived communities consistently have poorer oral health than people living in richer communities.[19] These inequalities in oral health run from the top to the bottom of the socioeconomic ladder creating a social gradient. Some vulnerable groups have poorer oral health.[20] Stark regional differences also exist. For example, 21.2% of five-year olds had tooth decay in south-east England compared to 34.8% in north-west England with even greater inequalities within local authorities.[5] (Figure 1.2).

Figure 1.2. Percentage of five-year-old children in England who have had tooth decay in 2012 by region



Source: Public Health England, National Dental Epidemiology Programme for England: oral health survey of five-year-old children 2012. A report on the prevalence and severity of dental decay. 2013.

- The financial impact of dental disease is significant. Although largely preventable, tooth decay remains the most common oral disease affecting children and young people (CYP). Treating oral diseases within the NHS costs £3.4 billion annually in England (in addition to an estimated £2.3 billion for those treated privately).[21]

What is the policy context for oral health improvement in children and young people?

- The government[21,22] made a commitment to oral health and dentistry with a drive to:
  - Improve the oral health of the population, particularly children
  - introduce a new NHS primary dental care contract
  - increase access to NHS primary care dental services

- The public health outcomes framework (2013-16) domain 4 (healthcare public health and preventing premature mortality) includes an indicator related to "tooth decay in five year old children".[23] Local authorities can use this indicator sourced from the Dental Public Health Intelligence Programme to monitor and evaluate children's oral health improvement programmes.

- The Children and Young People's Health Outcomes Forum report published in 2012 and its 2014 annual report recommended improved integration and greater action to reduce regional variation in child health outcomes.[24,25]

- The NHS outcomes framework (2014-15) includes indicators related to patients' experiences of NHS dental services (4aiii) and access to NHS dental services (4.4ii).[26]

What advice and support can local authorities expect from the dental public health workforce?

- The specialist dental public health workforce is now based within PHE centres. They have a key role to support local authorities to deliver their oral health improvement functions.

- Local authorities can expect the specialist dental public health workforce to:
  - work collaboratively to provide oral health input into joint strategic needs assessments (JSNAs) and joint health and wellbeing strategies
  - advocate and lead oral health needs assessments and oral health policy and strategy development
  - review oral health improvement programmes
  - support the commissioning and integration of such programmes within commissioning arrangements for other programmes for children and young people

Are other agencies involved in improving children and young people's oral health?

- Other organisations support local authorities in their lead role commissioning oral health improvement programmes. Table 1.1 shows the organisations and key responsibilities of the agencies working alongside local authorities either indirectly or directly to improve children's and young people's oral health. These organisations can provide opportunities for integrated commissioning and delivering oral health improvement programmes.

- The National Institute for Health and Care Excellence (NICE) will publish the following public health guidance “Oral health: local authority strategies to improve oral health particularly among vulnerable groups” in October 2014. Learning from this guidance will inform subsequent reviews of this guide.

Who are the providers delivering oral health improvement for children and young people?

- A range of providers deliver specific oral health improvement programmes (eg oral health improvement teams, community dental services, general dental practices and third sector providers) and oral health improvement programmes that are integrated within local authority commissioned programmes for children and young people (eg school health and children’s centres). Local authorities have opportunities to integrate oral health improvement within the specification of existing commissions as well as tender for specific oral health improvement programmes.

Table 1.1. Roles and responsibilities of the key organisations Involved with improving oral health in children and young people

	Body	Key Responsibilities
National	NHS England	▪ planning, securing and monitoring primary care community and secondary dental services within a single operating model ▪ developing and negotiating contracts; policies, procedures, guidance and national care pathways ▪ commissioning public health services for children aged 0-5 years (including health visiting, family nurse partnerships within the healthy child programme (HCP) 0-5 years until 2015)
	Public Health England	▪ providing health improvement support for local authorities and NHS England ▪ informing and developing national oral health policies and clinical guidelines ▪ addressing oral health inequalities ▪ ensuring patient safety and governance systems
	Health Education England	▪ providing national leadership for planning and developing the whole healthcare and public health workforce
	National Institute for Health and Care Excellence (NICE)	▪ providing independent advice and guidance to the NHS and social care; developing dental public health guidance
	Health Watch England	▪ representing the rights and views of the public and health and social care users to inform commissioning ▪ identifying public concerns about health and social care services ▪ developing and leading local Health Watch
Regional	NHS England regional reams	▪ providing clinical and professional leadership at the regional level ▪ coordinating and planning dental services on the basis of regional needs ▪ direct commissioning functions and processes ▪ regional director of nursing responsible for supporting and providing assurance on safeguarding children
	PHE regional teams	▪ developing guidance for local authorities ▪ supporting collaborative commissioning of oral health improvement programmes
Local	NHS England area teams	▪ commissioning all NHS dental services - both primary and secondary care ▪ supporting CCGs to assess and assure performance ▪ direct and specialised commissioning ▪ managing and cultivating local partnerships and stakeholder relationships, including representation on local health and wellbeing boards ▪ local area team director of nursing responsible for supporting and providing assurance on safeguarding children
	PHE centres	▪ providing dental public health support to NHS England and local authorities ▪ contributing to joint strategic needs assessments (JSNA), strategy development, oral health needs assessment ▪ supporting local authorities to understand their role in relation to water fluoridation
	Local authorities – public health	▪ jointly statutorily responsible with CCGs for JSNAs assessing local health needs ▪ conducting and/or commissioning oral health surveys to assess and monitor oral health needs ▪ responsible for reducing health inequalities ▪ planning, commissioning and evaluating oral health improvement programmes ▪ leading scrutiny of delivery of NHS dental services to local populations ▪ commissioning surveys to facilitate PHE to monitor and report on the effect of water fluoridation programmes (if water fluoridation programmes affect the local authority area) ▪ lead responsibility for the healthy child programme 5-19 years (and HCP 0-5 years from 2015), the national child measurement programme and the care of vulnerable children and families (ie. looked after children, the troubled families programme) ▪ safeguarding children ▪ commissioning local healthy schools, school food and healthier lifestyle programmes
	Local health watch	▪ providing information and advice to the public about accessing health and social care services and power to enter and view service provision ▪ engaging and collecting public and users' views about access and the quality of services to inform commissioning
	Local dental networks (LDNs)	▪ providing local professional leadership and clinical engagement ▪ supporting the specialist dental public health workforce to plan and design local care pathways, dental services and oral health strategies
	Clinical commissioning groups (CCGs)	▪ GP-led commissioning groups accountable to NHS England for commissioning community health services, children's mental and physical health services, emergency care, maternity services
	Early year providers schools	▪ Department of Health and Department for Education integrated health and education reviews for children aged 2 to 2 ½ by 2015
	Schools	▪ Healthy schools programme ▪ delivering non-statutory personal, social, health and economic (PSHE) education in key stage 1 of the national curriculum

Who is this guidance for?

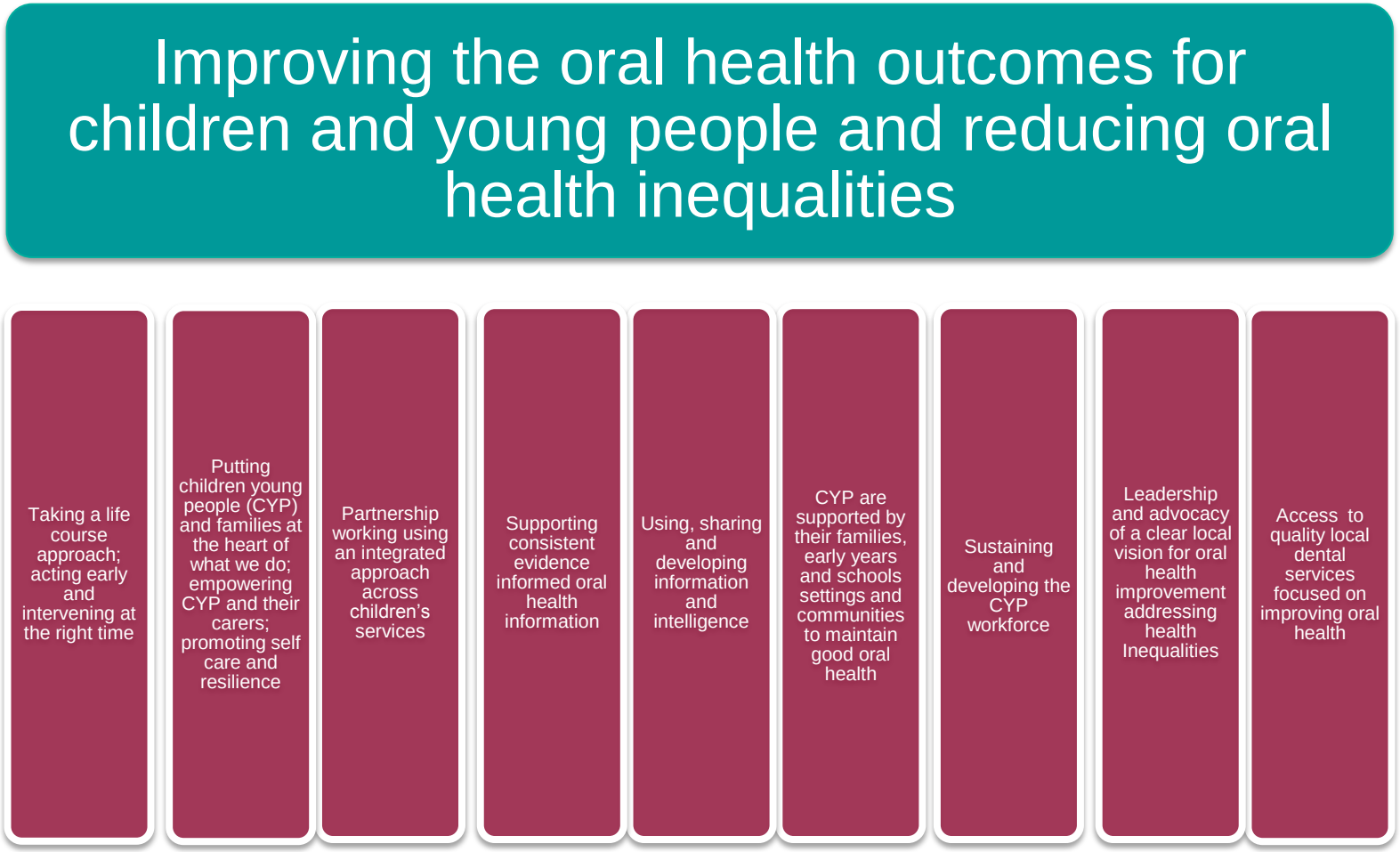
This document provides guidance to support the commissioning of evidence-informed oral health improvement programmes for:

- elected members and strategic leaders
- health and wellbeing boards
- commissioners in local authorities
- directors of public health
- consultants in dental public health and public health
- local oral health improvement and oral health promotion teams
- health care providers and the children's and young people's workforce

What is the ambition underpinning this guide?

Figure 1.3 shows the overarching ambition and the principles for commissioning oral health improvement developed in this guide and further described in section 2.

Figure 1.3. The ambition and principles of commissioning better oral health for children and young people



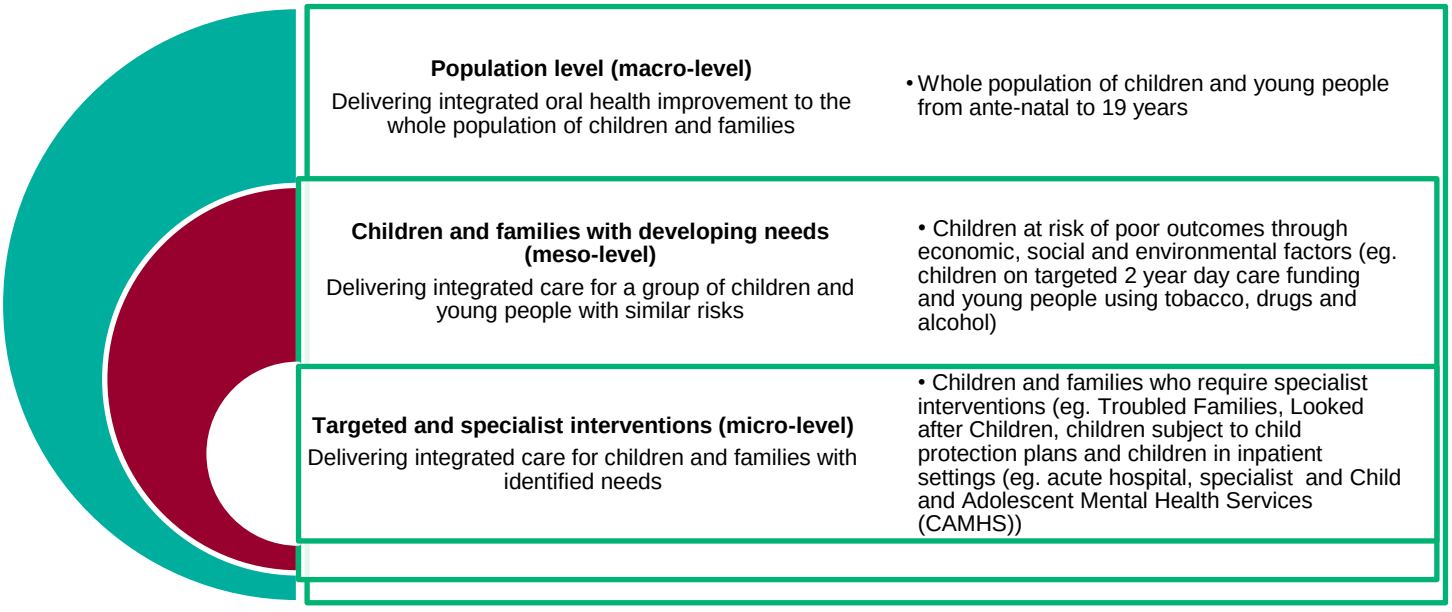
Section 2. Principles of commissioning better oral health for children and young people

Improving the oral health outcomes for children and young people and reducing oral health inequalities

The Marmot Review ('Fair Society, Healthy Lives') recommended the adopting proportionate universalism when developing strategies to improve health and reduce inequalities.[27] This approach recommends actions that are universal, but with a scale and intensity that is proportionate to the level of disadvantage. This approach acknowledges that concentrating solely on the most disadvantaged will not sufficiently reduce health inequalities.

Applying the concept of proportionate universalism to oral health improvement for children means that a combination of universal and targeted activities is needed alongside specialist services. Everyone should receive some support through universal interventions, while children that are particularly vulnerable (eg looked-after children and children from families living in poverty), should receive additional interventions and support. Oral health could be integrated into services at different levels through commissioner collaboration shown in figure 2.1.

Figure 2.1. Service levels at which oral health could be integrated

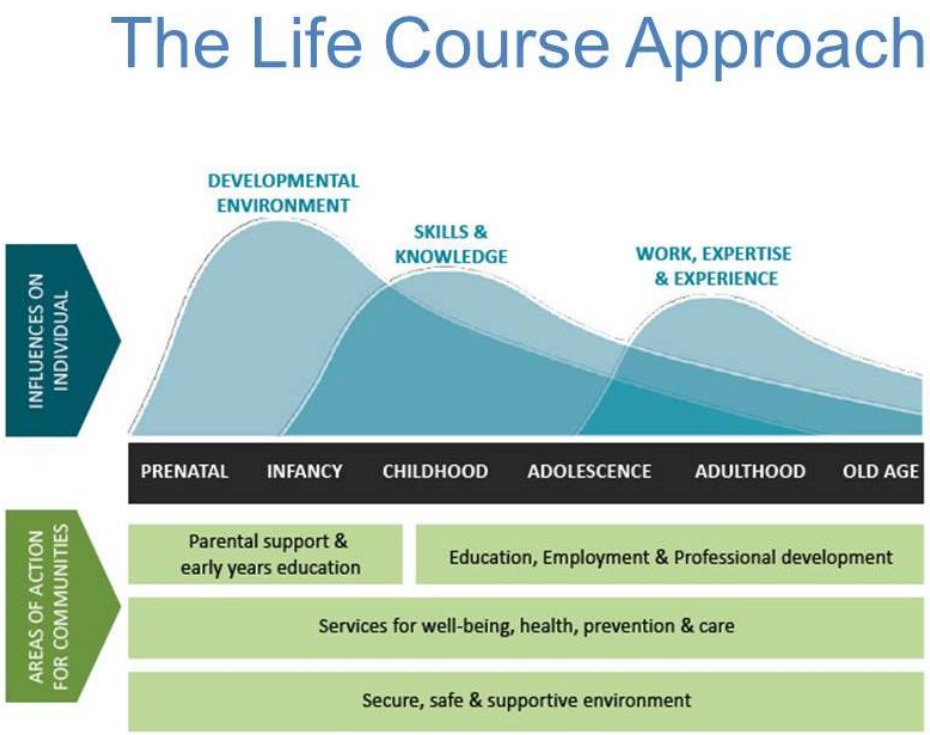


Source: Kings Fund (2011), Integrated Care Summary. Available at URL http://www.kingsfund.org.uk/sites/files/kf/Integrated-care-summary-Sep11.pdf

Taking a life course approach

The Marmot Review[27] and the public health white paper 'Healthy lives, healthy people'[28] highlighted the importance of early life interventions in improving health and reducing avoidable health inequalities across the life course. This life course approach acknowledges that biological and social experiences throughout life have an impact on long-term health and wellbeing. The early years of a child's life are critical to their future life chances because positive and negative effects accumulate throughout the life course (figure 2.2). Adopting the life course approach allows the close links between early disadvantage and poor outcomes throughout life to be broken.[28]

Figure 2.2. Life course stages and entry points for impacting health



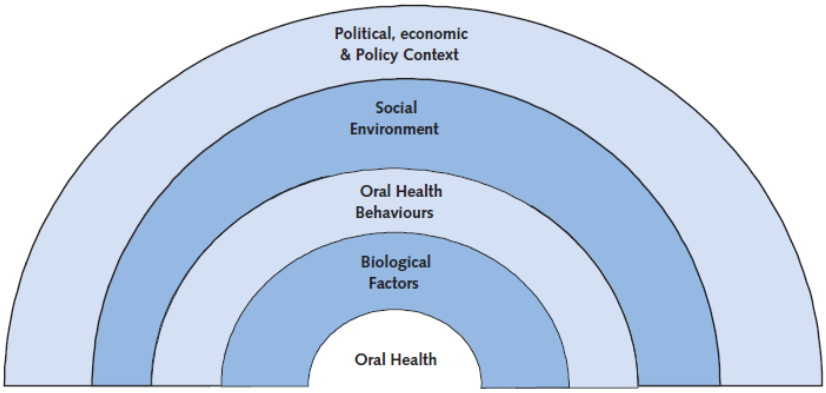
Source: Chief Medical Officer (2011), Annual report: On the state of the public's health. Available at URL https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255237/2901304_CMO_complete_low_res_accessible.pdf

Tackling the underlying causes of oral diseases in children

The traditional view is that oral diseases are caused by individuals engaging in risky behaviours. The importance of these factors at a population level, however, is limited. It is now accepted that the circumstances in which people live and work have a profound effect on their health and wellbeing – including their oral health. The causes of oral diseases, and related inequalities, are therefore mainly social and environmental.[29]

The underlying causes of oral diseases in children range from decisions taken nationally on economic and social policy, to biological factors in individuals (figure 2.3). These causes are common to all health inequalities.

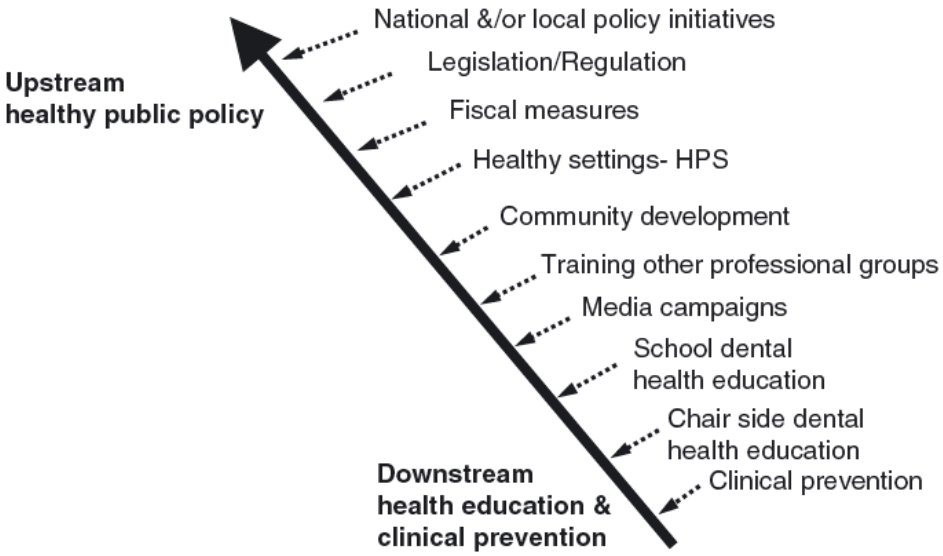
Figure 2.3. The underlying causes of oral diseases



Source: Choosing better oral health: an oral health plan for England. Available at URL webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4123253.pdf

Action is needed to tackle these underlying causes of health inequalities. Creating healthier public policies, supportive environments, strengthening community action, developing personal skills and reorienting health services towards prevention will improve children's oral health. These "upstream" actions should be complemented by specific "downstream" interventions (such as the widespread delivery of fluoride) to effectively prevent oral disease (figure 2.4).

Figure 2.4. Upstream/downstream: options for oral disease prevention



Source: Watt RG. From victim blaming to upstream action: tackling the social determinants of oral health inequalities. Community Dent Oral Epidemiol 2007; 35: 1–11

The common risk factor approach should be adopted wherever possible.[30] This approach is an integrated way of promoting general health by controlling a small number of common risk factors that can potentially impact a large number of chronic diseases.[31] This is more efficient than disease specific approaches.

Putting children, young people and families at the heart of commissioning, empowering communities and building resilience

Services that are co-created with professionals, children, young people, families and wider communities are more likely to produce sustainable improved health outcomes. This asset-based approach puts individuals and communities at the heart of decision-making. It creates empowered, confident, resilient communities who are enabled to take ownership and control of their lives and make decisions that are conducive to good health and wellbeing.

Partnership working using an integrated approach across the commissioning landscape for children and young people

Achieving good oral health for all children needs the support and commitment of a wide range of partners. The shared leadership at local level through health and wellbeing boards and children's trust boards, and the enhanced role for local authorities in health improvement provides multiple opportunities to improve health outcomes using an integrated approach.[28] The most effective way to improve oral health is to embed it in all children's services at strategic and operational levels.

Supporting consistent evidence informed oral health information

This guide provides oral health improvement and practice guidance driven by the best available evidence (Section 3. Commissioning across the life course: what works?). Where available, the evidence also takes into account the cost-effectiveness of interventions.

Using, sharing and developing information and intelligence

Previous legislative flexibilities have enabled joint working between NHS bodies and local government in relation to their health and social care functions. These flexibilities still apply under the Health and Social Care Act 2012.[1] This has the advantage of greater cost effectiveness while also supporting improved experiences for services users.

Integrated commissioning requires commissioners to access information and data held by a number of partners. Key oral health data is held by PHE knowledge and intelligence North West (www.nwph.net/dentalhealth). PHE can provide commissioners with interpretation and local analytical support.

Children and young people are supported by their families, early years, schools settings and communities to maintain good oral health

The inextricable links between people and their environment means that the environments in which children and young people live need to encourage healthier lifestyles if health and wellbeing are to be improved. Actions that could improve oral health through the environment include developing healthier children's centres and preschool settings, safe recreational areas (preventing dental trauma), removing sweets at supermarket checkouts and introducing planning policies that promote healthier food outlets near schools.[31]

Coordinated action to build more healthy public policies would impact a number of public health issues and foster greater equity. Healthy public policy includes legislation, fiscal measures, taxation and organizational change, which in turn promotes safer and healthier goods and services. Examples of healthy public policies that could improve oral health in children include sugar taxation, healthier eating policies in schools and increased access to safe recreational areas for children (which prevent dental trauma). The aim of these upstream activities is to make the healthier choice the easier choice for individuals, organisations and policy makers.

Sustaining and developing the children's and young people's workforce

Implementing 'Making every contact count'[32] gives child care professionals a responsibility to provide brief advice to improve children's overall health and wellbeing. The children's workforce can be supported through training and development to deliver appropriate evidence informed brief advice across the life course. Figure 4.1 provides examples of where oral health may be integrated within currently commissioned programmes. This training may be commissioned by local authorities from oral health promotion providers locally, or by Health Education England (HEE) through local education and training boards (LETBs). This training can be delivered through continuing professional development programmes (CPD) and as part of induction programmes for new staff.

Working together to safeguard children is everyone's responsibility.[33] Paediatricians now acknowledge that dental neglect is an important child protection issue [34]. NICE guidance recommends that providers suspect neglect "if parents or carers have access to but persistently fail to obtain NHS treatment for their child's dental caries (tooth decay)".[35] Signs include visible tooth decay, untreated trauma and multiple hospital admissions for dental care. Using the concept of 'Making every contact count', all staff across healthcare, social care and education should have sufficient knowledge and understanding to recognise signs of poor oral health and neglect and take appropriate action.[32]

Leadership and advocacy of a clear local vision for oral health improvement addressing health inequalities

Local authorities have a lead role championing oral health. Local authorities can develop oral health strategies at a local level to deliver a local vision for improving oral health, alongside general health and wellbeing. Shared leadership of the oral health agenda may help to embed oral health into the wider health and wellbeing agenda for children through integrated commissioning. The leadership and advocacy role of local authorities will increase its impact, particularly if it used to promote upstream actions at a regional or national level. Regulation and/or fiscal policies that influence frequent sugar intake could prevent tooth decay as an upstream intervention. Local authorities can also build and support advocacy for children's oral health improvement by partnering with independent advisory providers.[36]

Access to quality local dental services focused on improving oral health

The scope of health services needs to expand to include a responsibility to improve health outcomes in addition to providing treatment. Improving health by focusing on prevention also improves the cost-effectiveness of services.[37] Intervening early through universal and targeted interventions reduces the need for more specialist services in later years. Local authorities can engage with NHS England in the planning and evaluation of local dental services, influencing the preventive focus of dental services. In particular, local authorities have unique powers around health scrutiny, which enable them to review the planning, provision and operation of health services in their area. This specifically allows local authorities to seek assurance that there is equitable access to dental services for children and young people focused on their needs. Appendix 1 includes ten key questions for the scrutiny of oral health improvement delivery.

The NHS dental contract is currently under review and new models are being piloted. These pilots give dental teams the responsibility for improving the oral health of their practice population. There is also the additional drive to improve the link between dental practices and their communities.

The next section describes how the evidence base for oral health improvement interventions was assessed for a range of interventions targeting different child populations across the life course.

Section 3. Commissioning across the life course: what works?

Introduction

Local authorities can commission a range of different oral health improvement interventions. However, no single “magic bullet” exists. One important consideration in deciding what interventions should be delivered is the evidence base for the intervention. Identifying the best available evidence is important for both clinical practice and public health interventions. However, public health requires a more pluralistic approach to assessing the evidence.[38] While the randomised controlled trial is considered the “gold standard” form of evidence to assess the effectiveness of clinical treatments, a broader range of evidence can be used to assess the evidence base for public health interventions.[39] The nature of the intervention should determine the most appropriate evaluation method.[38]

The review of the evidence in this guide followed the methodological approach adopted by the US Centres for Disease Control (CDC), Community Services Task Force[40] and the Department of Health in Victoria, Australia.[41] The evidence was restricted to relevant published oral health and related systematic and narrative reviews.

Defining the scope of oral health improvement interventions to include in the review

This review focused on children and young people aged 0 to 19 years of age. Evidence was sought for population-based interventions aimed at improving knowledge, behaviour or oral health status. The review considered interventions, which could be implemented within a community-based programme (eg school-based fluoride varnish programmes) but not individual dental clinic-based interventions (eg fluoride varnish applications applied during regular dental appointments). The evidence for individual dental practice based interventions is covered in the publication ‘Delivering better oral health: an evidence-based toolkit’.[42]

Identifying relevant systematic and narrative reviews

English language data sources were searched for systematic reviews and narrative reviews of interventions that promoted oral health. Sources included MEDLINE, Cochrane Database of Systematic Reviews, Centre for Reviews and Dissemination, peer networks and reference lists of reviewed articles. Systematic reviews describing broader public health outcomes were also included where there was no literature related to specific oral health outcomes (eg social marketing interventions and fiscal policies to promote oral health).

Using a multifactorial approach to assess the evidence for oral health improvement

Interventions were classified and assessed using a range of key public health criteria to inform the **final recommendation based on the totality of evidence**. Each intervention was first classified as a downstream, midstream or upstream intervention based on figure 2.4 and mapped to a target population or life course stage (ie. preschool, school children and young people). The effectiveness of each intervention was then assessed based on the criteria used by Haby and Bowen[41] and Rogers[43] shown in table 3.1.

Table 3.1. Effectiveness of Oral Health Improvement Programmes

Strength of evaluation and research evidence	Description
Strong evidence of effectiveness	One systematic review or meta-analysis of comparative studies; or several good quality randomised controlled trials or comparative studies
Sufficient evidence of effectiveness	One randomised controlled trial; one comparative study of high quality; or several comparative studies of lower quality
Some evidence of effectiveness	Impact evaluation (internal or external) with pre and post-testing; or indirect, parallel or modelling evidence with sound theoretical rationale and program logic for the intervention
Weak evidence of effectiveness	Impact evaluation conducted, but limited by pre or post-testing only; or only indirect, parallel or modelling evidence of effectiveness
Inconclusive evidence of effectiveness	No position could be reached because existing research/evaluations give conflicting results; or available studies were of poor quality
No evidence of effectiveness	No position could be reached because no evidence of impact/outcome was available at present. (This is not the same as evidence of ineffectiveness – see below)
Evidence of ineffectiveness	Good evaluations (high quality comparative studies) show no effect or a negative effect

The review process also took contextual factors and pragmatic considerations into account alongside the more traditional evidence of effectiveness to provide some indication of the feasibility of implementation rather than just the effectiveness of the intervention. An assessment of the likely impact on reducing oral health inequalities was made, based on public health principles of intervention design and whether the intervention focused on the underlying determinants of inequalities. The impact on inequalities was classified as encouraging, uncertain, or unlikely.

Cost and resource implications were considered as the balance between the costs of the intervention (ie. set up and ongoing costs) versus intervention reach, intervention uptake and retention and the sustainability of outcomes. The cost/resource implications categories were good use of resources, uncertain or costly. Implementation issues included resource and personnel requirements, potential disruption to partners, acceptability of the intervention to key stakeholders, self-sustaining outcomes achieved and political support required. Implementation issues were categorised as deliverable, uncertain or major challenges in delivery. Some interventions that were difficult to categorise fell into two categories. For example, under “implementation issues,” an intervention listed as “uncertain/major challenges” indicated that it was difficult to judge the deliverability but that there could be major challenges in delivery.

Making final recommendations about oral health improvement programmes based on the totality of the evidence

Combining the findings from the four assessment criteria (strength of the evidence, impact on reducing inequalities, cost/resource implications and implementation issues) produced a final overall recommendation for each intervention. The overall recommendations for oral health improvement interventions (shown in table 3.2) were recommended, emerging, limited value or discouraged. Ineffective interventions were not assessed in terms of impact on inequalities, cost or implementation.

Table 3.2. Summary of the final overall recommendation

Overall recommendation	Strength of evaluation and research evidence	Impact on reducing inequalities	Cost/resource considerations	Implementation Issues
Recommended	Strong/sufficient/some evidence	Encouraging	Good/ uncertain	Deliverable
Emerging	Weak/inconclusive/ no evidence	Encouraging/uncertain	Good/ uncertain	Deliverable
Limited value	Strong/some/sufficient/ weak/inconclusive/ no evidence	Uncertain/unlikely	Uncertain/ costly	Uncertain/ major challenges
Discouraged	Ineffective	Not applicable	Not applicable	Not applicable

Table 3.3 provides a summary of the interventions and the recommendations made for oral health improvement programmes assessed in this guide. **The overall recommendation for each intervention should be considered in the context of the totality of evidence and the explanatory narrative presented in table 3.4.**

Table 3.3. Summary of the oral health improvement programme's overall recommendations

Nature of intervention	Intervention classification	Target population	Strength of evaluation and research evidence	Impact on inequalities	Cost/resource considerations	Implementation issues	Overall recommendation
SUPPORTING CONSISTENT EVIDENCE INFORMED ORAL HEALTH INFORMATION							
Oral health training for the wider professional workforce (eg. health, education)	Midstream	Preschool, school children, young people	Some evidence of effectiveness	Encouraging/ uncertain	Good	Deliverable	Recommended
Integration of oral health into targeted home visits by health/social care workers	Downstream	Preschool, school children	Sufficient evidence of effectiveness	Encouraging	Good	Deliverable	Recommended
Social marketing programmes to promote oral health and uptake of dental services by children	Midstream	Preschool, school children, young people	Inconclusive evidence of effectiveness	Uncertain/ encouraging	Uncertain/costly	Uncertain/major challenges	Limited value
Person-centred (one-to-one) counselling based on motivational interviewing outside of dental practice settings	Downstream	Preschool, school children (via parents), young people	Inconclusive evidence of effectiveness	Uncertain	Costly	Uncertain	Limited value
One off dental health education by dental workforce targeting the general population	Downstream	Preschool, school children	Evidence of ineffectiveness	Not applicable	Not applicable	Not applicable	Discouraged

Table 3.3. Summary of the oral health improvement programme's overall recommendations (continued)

Nature of intervention	Intervention classification	Target population	Strength of evaluation and research evidence	Impact on inequalities	Cost/resource considerations	Implementation issues	Overall recommendation
COMMUNITY-BASED PREVENTIVE SERVICES							
Targeted community-based fluoride varnish programmes	Downstream	Preschool, school children	Strong evidence of effectiveness	Encouraging/ uncertain	Uncertain/costly	Deliverable/ uncertain	Recommended
Targeted provision of toothbrushes and tooth paste (ie. postal or through health visitors)	Downstream	Preschool, school children	Some evidence of effectiveness	Encouraging	Good use of resources	Deliverable	Recommended
Targeted community-based fissure sealant programmes	Downstream	Preschool, school children	Sufficient evidence of effectiveness	Uncertain	Costly	Uncertain/major challenges	Limited value
Targeted community-based fluoride mouth rinse programmes	Downstream	School children	Sufficient evidence of effectiveness	Uncertain	Uncertain	Deliverable/ uncertain	Limited value
Facilitating access to dental services	Downstream	Preschool, school children	Weak/inconclusive	Uncertain / unlikely	Uncertain	Uncertain/major challenges	Limited value
Using mouth guards in contact sports	Midstream	School children	Some evidence of effectiveness	Uncertain	Uncertain	Uncertain	Limited value
SUPPORTIVE ENVIRONMENTS							
Supervised tooth brushing in targeted childhood settings	Midstream	Preschool, school children	Strong/sufficient evidence of effectiveness	Encouraging/ uncertain	Good/uncertain	Deliverable/ uncertain	Recommended
Healthy food and drink policies in childhood settings	Midstream/ Upstream	Preschool, school children, young people	Some evidence of effectiveness	Encouraging	Good	Deliverable	Recommended

Table 3.3. Summary of the oral health improvement programme's overall recommendations

Nature of intervention	Intervention classification	Target population	Strength of evaluation and research evidence	Impact on inequalities	Cost/resource considerations	Implementation issues	Overall recommendation
SUPPORTIVE ENVIRONMENTS							
Fluoridation of public water supplies	Upstream	Preschool, school children, young people (whole population)	Strong evidence of effectiveness	Encouraging/ uncertain	Good/uncertain	Deliverable	Recommended
Provision of fluoridated milk in school settings	Midstream/ downstream	Preschool, school children	Inconclusive	Uncertain	Uncertain	Uncertain/ major challenge	Limited value
COMMUNITY ACTION							
Targeted peer (lay) support groups/peer oral health workers	Midstream	Preschool, children, young people	Sufficient evidence of effectiveness	Encouraging	Good	Deliverable/ uncertain	Recommended
School or community food co-operatives	Midstream	Preschool, school children, young people	Weak evidence of effectiveness	Encouraging	Good	Deliverable/ uncertain	Emerging
HEALTHY PUBLIC POLICY							
Influencing local and national government policies	Upstream	Preschool, school children, young people	Some evidence of effectiveness	Encouraging/ uncertain	Good	Deliverable/ uncertain	Recommended
Fiscal policies to promote oral health	Upstream	Preschool, school children, young people	Some evidence of effectiveness	Uncertain	Good	Deliverable/ uncertain	Emerging
Infant feeding policies to promote breastfeeding and appropriate complementary feeding practices	Midstream/ upstream	Preschool	No evidence of effectiveness	Encouraging/ uncertain	Good	Deliverable	Emerging

Table 3.4. Additional information about oral health improvement programmes

Nature of intervention	Publications reviewed	Further information
SUPPORTING CONSISTENT EVIDENCE INFORMED ORAL HEALTH INFORMATION		
Oral health training for the wider professional workforce (health, education, others)	Rogers, 2011 [43] Sprod et al., 1996 [44]	Definition: Oral health training for the wider health, social care and education workforce - based on capacity building (ie. increasing knowledge and skills of others) to support oral health improvement in their daily role. More strategic means of health education - ensuring oral health messages are appropriate and consistent across the board Examples of interventions: training health visitors and teachers to provide oral health education and pharmacists to deliver oral health advice, supporting the wider public health workforce and decision makers (ie. councillors, Directors of Public Health) Key points ▪ Evidence is limited to impact evaluation studies. Lack of randomised controlled trials ▪ Good in terms of cost as it is building capacity among those already delivering services rather than establishing new services. ▪ Could be linked in to an 'accreditation of settings' scheme
Integration of oral health into targeted home visits by health/ social care workers	Rogers, 2011 [43]	Definition: Integration of oral health into targeted home visits by health/social care workers based on building the capacity of health /social care workers to provide oral health support during their visits Examples of interventions: Integrating key oral health messages into the family nurse partnership programme which supports new mothers, integrating key oral health messages into support provided as part of the troubled families programme Key points ▪ Targeted at vulnerable families at higher risk of oral disease ▪ Based on integration of oral health component into existing support programmes, rather than establishing specific oral health home visits ▪ Regular update training required for health workers carrying out home visits
Social marketing programmes to promote oral health and uptake of dental services among children	Gordon et al., 2006 [45], Stead et al., 2006 [46], Janssen et al., 2013 [47]	Definition: Using commercial marketing techniques to influence target audiences and promote healthier behaviours Examples of interventions: Media campaigns to promote the importance of good oral health and raising awareness of the availability of NHS dental services – based on extensive consumer research (focus groups etc.), segmentation and targeting of specific population groups Key points ▪ Evidence weak/inconclusive, particularly on the long term impact. Studies largely based on nutritional interventions, physical activity and substance abuse programmes ▪ Costly if extensive consumer research is carried out. Some suggestion that online interventions cost less and have greater reach ▪ Sustainability of impact likely to be an issue ▪ Intervention has the potential to address inequalities by specific targeting of population groups with accurate segmentation of the population ▪ See notes on "facilitated access to dental services" for further information about increasing uptake of services

Table 3.4. Additional information about oral health improvement programmes

Nature of intervention	Publications reviewed	Further Information
SUPPORTING CONSISTENT EVIDENCE INFORMED ORAL HEALTH INFORMATION		
Person-centred (one-to-one) counselling based on motivational interviewing outside of dental practice settings	Rogers, 2011 [43], Yevlahova and Satur, 2009 [48], Gao et al., 2013 [49]	Definition: One-to-one counselling exploring barriers to change and supporting individual behaviour change. This does not refer to individual 'brief intervention' support provided by dental staff during routine dental appointments Examples of interventions: Motivational interviewing programmes to prevent early childhood caries: new mothers invited to a 30 minute individual session with a trained counsellor with two follow-up phone calls from the counsellor in a six-month period. Key points ▪ Very intensive if done thoroughly ▪ Requires considerable compliance. Questionable effect on inequalities ▪ Can be difficult to deliver. Requires significant specialised training ▪ One to one intervention is relatively costly ▪ Effectiveness demonstrated for a range of health-related lifestyle issues (eg. substance abuse, poor adherence to medication regimes). Inconclusive evidence in relation to oral health
One off dental health education by dental workforce targeting the general population	Rogers, 2011 [43], Watt and Marinho 2005 [50], Sprod et al., 1996 [44], Kay and Locker, 1996 [51]	Definition: One off dental health education by dental workforce targeting the general population Examples of interventions: Annual visits to a school by a dentist (eg. 'puppet show' type sessions demonstrating tooth brushing), direct provision of oral health education to new mothers (by dental workforce), health fairs Key points ▪ Only short term changes in health literacy and/or behaviours are likely to be achieved - improvements are unlikely to be sustained in the longer term ▪ Limited effects on clinical outcomes – possible short term improvement in plaque levels ▪ Costly as reliant on dental workforce to deliver
COMMUNITY-BASED PREVENTIVE SERVICES		
Targeted community-based fluoride varnish programme	Marinho et al., 2013 [52], NHMRC, 2007 [53], Rogers, 2011 [43]	Definition: Application of fluoride varnish to children's teeth carried out by dental personnel outside dental practices Examples of interventions: Fluoride varnish programmes in schools/early years' settings Key points ▪ Strong evidence of effectiveness of fluoride varnish in preventing tooth decay ▪ Studies have evaluated fluoride varnish intervention in community and clinical settings ▪ Positive impact on inequalities depends on appropriate targeting of high-risk populations, high rates of consent, compliance and retention. Successful delivery depends on engaging with parents, schools and early years' settings, ensuring the inclusion of wider oral health improvement messages and supportive environments ▪ Good links with dental practices are needed to ensure that dental practices are informed if their patients have received fluoride varnish ▪ High cost due to need for clinical personnel. Use of skill mix may help to reduce costs (eg. using dental nurses rather than dentists) ▪ Must be sustained to be effective. Evidence base relates to children within two year programmes with at least twice yearly applications ▪ Clinical governance requirements are considerable and careful planning is needed ▪ As fluoride varnish contains alcohol, the religious beliefs of families should be considered for those taking part in the programme

Table 3.4. Additional information about oral health improvement programmes

Nature of intervention	Publications reviewed	Further Information
COMMUNITY-BASED PREVENTIVE SERVICES		
Targeted provision of toothbrushes and toothpaste (postal, or through health visitors)	Rogers, 2011 [43]	Definition: Targeted and timely provision of free toothbrushes and toothpaste (ie. postal delivery or via health visitors) Examples of interventions: Toothbrushes and toothpaste handed out by health visitors at regular child development checks as part of the Brushing for life programme. Postal provision of toothbrushes and toothpaste to children in targeted areas Key points ▪ Timely provision of oral health resources encourages parents to adopt good oral health practices and start tooth brushing as soon as the first teeth erupt ▪ Postal delivery is likely to minimize uptake issues making the impact on inequalities more favourable ▪ Sustainability important – limited benefit of one off provision. Engaging with health visitors important to ensure support for programme and consistency of messages
Targeted community-based fissure sealant programmes	Ahovuo-Saloranta et al., 2013 [54], NHMRC, 2007 [53], Rogers, 2011 [43]	Definition: Application of fissure sealants to children's teeth – carried out by dental personnel, outside the dental setting. Examples of interventions: Fissure sealant programmes in schools /early years' settings Key points ▪ Evidence of effectiveness in preventing or controlling tooth decay, particularly in high risk children ▪ Most studies evaluate intensive interventions within clinical environments; relatively few studies have evaluated community based programmes ▪ Many studies were carried out when disease levels were higher. Relative effectiveness may be less marked now ▪ Positive impact on inequalities depends on appropriate targeting of high risk populations, high rates of consent, compliance and retention ▪ Successful delivery depends on engaging with parents, schools and early years' settings ▪ Good links with dental practices are needed to ensure that dental practices are informed if their patients receive fissure sealants. ▪ High cost due to need for clinical personnel ▪ More disruptive for settings than a fluoride varnish programme because the application of fissure sealants is more involved, more time-consuming and requires more equipment ▪ Fissure sealants can last for several years in contrast to fluoride varnish applications which are most effective if applied at least twice-yearly ▪ Must be sustained to be effective ▪ Clinical governance requirements are considerable and careful planning is needed

Table 3.4. Additional information about oral health improvement programmes

Nature of intervention	Publications reviewed	Further Information
COMMUNITY-BASED PREVENTIVE SERVICES		
Targeted community-based fluoride mouth rinse programmes	Marinho et al., 2003 [55], NHMRC, 2007 [53], Rogers, 2011 [43]	Definition: Regular use of fluoride mouth rinse in community settings (either daily or weekly rinsing depending on concentration of mouth rinses) Examples of interventions: School fluoride mouth rinse programmes Key points: ▪ Evidence of effectiveness in preventing tooth decay ▪ Effectiveness of mouth rinses more limited compared to other fluoride vehicles, depends on fluoride concentration of mouth rinse and regular use ▪ Positive impact on inequalities depends on appropriate targeting of high risk populations, high consent rate and compliance ▪ Correct usage of mouth rinse important (children are advised to spit mouth rinse out and not rinse afterwards) ▪ Not suitable for children under eight due to risk of swallowing ▪ Correct storage of mouth rinse important; mouth rinses containing alcohol need to be stored securely. The religious beliefs of families should be also considered for children taking part in the programme ▪ Lower costs than fluoride varnish or fissure sealant programmes as clinical personnel not needed. Teaching staff could supervise regular school mouth rinsing programmes but require training and standard protocols ▪ Effect limited because programmes are restricted to term times
Facilitating access to dental services	Rogers, 2011 [43]	Definition: Coordinated efforts to identify population groups with low attendance rates, contacting them and arranging dental appointments with appropriate dental services, moves beyond simple signposting to services Examples of interventions: Early years parents contacted, encouraged to attend a dental appointment and appointments arranged at local dental practices Key points: ▪ While ensuring good access to dental services is important, access to services alone is not enough to improve oral health. Broader social determinants of health need to be also tackled. Important to ensure that dental services are delivering appropriate and high quality care ▪ Ensuring service capacity is vital since ethical issues arise if services are not available to meet the demand. Services must be appropriate for the targeted population group. For example, if a scheme is set up to increase access to services for children with special needs, it is important to consider whether there are any training needs for the dental workforce ▪ Requires close collaboration with NHS England who commission NHS dental services. The reformed dental contract currently being piloted aims to encourage dental services to adopt a more preventive approach to care ▪ Facilitated access schemes can increase inequalities unless appropriately targeted because uptake may not increase for people who are in need of care ▪ Monitoring and evaluation of facilitated access programmes can be difficult and costly ▪ Limited value without reorientation of healthcare services towards a more preventive approach
Using mouth guards in contact sports	Schiff et al., 2010 [56], Knapik et al., 2007 [57], Rogers, 2011 [43]	Definition: Using mouth guards in contact sports to reduce the risk of injuries Key points ▪ Evidence that use of mouth guards during contact sports decreases the risk of mouth and facial injuries. Clear individual benefits but limited value as a population measure. Limited impact if delivered without additional complementary action to create safe environments ▪ Requires close collaboration with NHS England who commission NHS dental services ▪ Uncertain impact on inequalities since higher uptake more likely in more affluent population groups ▪ Relatively costly in the short term but may avoid high costs of complex restorative dental treatment in the longer term

Table 3.4. Additional information about oral health improvement programmes

Nature of intervention	Publications reviewed	Further Information
SUPPORTIVE ENVIRONMENTS		
Supervised tooth brushing in targeted childhood settings	Marinho et al., 2003[58], NHMRC, 2007[53], Rogers, 2011[43], Sprod et al., 1996[44]	Definition: Supervised tooth brushing programmes established in targeted childhood settings Key points: ▪ Effectiveness and benefit of fluoride toothpaste firmly established. Evidence based on two year programmes ▪ School/early years' settings-based programmes effective for preventing tooth decay but not improving periodontal (gum) health ▪ Targeting is important. programmes are more likely to be effective in areas with high tooth decay rates and less effective when children are already brushing their teeth at least twice a day with fluoridated toothpaste ▪ Positive impact on inequalities depends on appropriate targeting of high risk populations, high consent rates, compliance and retention ▪ Successful implementation depends on engaging with parents, schools and early years' settings ▪ Requires teacher supervision which can be time-consuming; alternative is using older peers or parent supervisors ▪ Staff will require ongoing support in terms of training, cross infection control and consent issues ▪ Integration of tooth brushing into the daily routine should help to ensure sustainability of the programme. Links to the home environment may increase the chances of sustained impacts
Healthy food and drink policies in childhood settings	Rogers, 2011[43]	Definition: Introduction of healthier food and drink policies in childhood settings to create a health promoting environment Examples of interventions: Nutritional standards in school canteens, school policies on snack, celebration and reward foods, providing drinking water in schools and early years' settings Key points ▪ Potential for wider public health benefits in addition to oral health ▪ Integrated, multi-component, whole school approach (eg. with links to curriculum activities) more likely to be successful than single stranded interventions. Programmes could be linked to an 'accreditation of settings' scheme ▪ Active involvement of parents and link with home environment important ▪ Encouraging impact on inequalities by creating a more health promoting environment ▪ Potentially easy to sustain once established
Fluoridation of public water supplies	NHS Centre for Reviews and Dissemination[59], Medical Research Council [60], NHMRC, 2007[53], Truman et al., 2002 [61]	Definition: Fluoride occurs naturally in water at varying concentrations. Fluoridating the water supply increases the level of fluoride to the optimum concentration for dental health Key points ▪ Water fluoridation is associated with reductions in levels of dental decay. Evidence of effectiveness based on systematic reviews ▪ No randomised controlled trials conducted because of methodological difficulties ▪ Universal approach targeted at geographic areas rather than specific population groups. Likely to require collaboration between neighbouring local authorities. Feasibility studies necessary to determine deliverability ▪ Uncertain evidence about impact on health inequalities. However ,this intervention is not affected by selective compliance ▪ Costs include public consultation costs, initial set-up costs, running costs, capital costs, monitoring costs ▪ Cost effectiveness depends on water supply system complexity and baseline levels of disease. Sustainable once established ▪ Public and political support fundamental. Requires significant planning and lead-in time

Table 3.4. Additional information about oral health improvement programmes

Nature of intervention	Publications reviewed	Further Information
SUPPORTIVE ENVIRONMENTS		
Provision of fluoridated milk in school settings	Yeung et al., 2007[62], NHMRC, 2007[53], Cagetti, 2012[63]	Definition: Providing fluoridated milk to children at school Key points: ▪ Inconclusive evidence about the effectiveness of fluoridated milk in preventing tooth decay ▪ Implementation issues include access difficulties because only a limited number of dairies supply fluoridated milk, (non-fluoridated milk must also be made available), storage issues, consent issues, compliance (and quantity consumed) difficult to monitor, funding difficulties related to funding being devolved from local authorities to schools ▪ Positive impact on inequalities depends on appropriate targeting of high risk populations, high rates of consent and compliance ▪ Limited effect because implementation restricted to term times ▪ Uncertain costs. May not be cost-effective if there are considerable implementation issues and implementation is poor ▪ Costs of amending an existing school milk scheme will be considerably lower than the cost required to establish a new scheme ▪ Programme success requires strong school support
COMMUNITY ACTION		
Targeted peer (lay) support groups/ peer oral health workers	NICE, 2008[64], Ford et al., 2013[65], Rogers, 2011[43]	Definition: Layperson of similar background/culture trained to support a local community group with particular health issues Examples of interventions: Peer-led programmes within an ethnic minority community helping to improve oral health knowledge and supporting individuals to adopt healthier behaviours Key points: ▪ Extensive evidence supporting peer (lay) support in wider public health programmes (eg. breastfeeding, infant feeding, smoking cessation); limited evidence for using peer support for oral health programmes ▪ Implementation can be difficult if staff/volunteer turnover is high ▪ Costs for training staff/volunteers and providing ongoing support ▪ Peer-led programmes within ethnic minority groups may help to overcome cultural barriers and tackle health inequalities ▪ Interventions which improve social support may be of greater benefit to more disadvantaged groups
School or community food co-operatives	Popay et al., 2007[66], McGlone et al., 1999[67]	Definition: Food is purchased by a co-operative to enable the local community to access fresh fruit and vegetables at reduced prices, closer to home Examples of interventions: Communities or schools join together to purchase healthier foods at more affordable prices. Key points ▪ Sustainability and success often largely depends on funding and level of community support ▪ Potential wider public health benefits in addition to oral health impacts ▪ Some suggestions that community engagement initiatives may have a positive impact on social cohesion and community empowerment ▪ Support and training needed for those involved

Table 3.4. Additional information about oral health improvement programmes

Nature of intervention	Publications reviewed	Further Information
HEALTHY PUBLIC POLICY		
Influencing local and national government policy	NICE, 2010[68], Rogers, 2011[43]	Definition: Influencing local and national government policy in order to improve oral and general health Examples of interventions: Local public health input into planning decisions (eg. to restrict food take-away outlets near schools), establishing safe play areas. National policies advocating tighter controls on advertising, promoting and labeling of sugary food and drink, promoting plain packaging for cigarettes, minimum pricing for alcohol Key points ▪ Based on the concept of health advocacy ▪ Combination of actions to gain political commitment, policy support, social acceptance and structural change in order to improve health ▪ Difficult to evaluate using traditional evidence-based methodologies ▪ Progress with tobacco control provides an example of best practice
Fiscal policy to promote oral health	Jha et al 2014[69] Bellew, 2008[70], NICE 2010[71]	Definition: Introducing fiscal policies which promote oral health Examples of interventions: local policies - affordable healthier food/drinks in public settings (eg. libraries, or leisure centres); national policies - minimum unit pricing for alcohol, increased taxation on tobacco Key points ▪ Little evidence on use of fiscal policy specifically for oral health improvement measures but some evidence on the effectiveness of enhancing access to and increasing availability of healthier foods ▪ Strong evidence demonstrating effectiveness of increased tobacco taxation/prices in reducing tobacco consumption ▪ Uncertain Impact on inequalities. Raising the price of unhealthy foods can increase health inequalities but subsidising healthier choices to make them more affordable could reduce inequalities ▪ Successful implementation at a local level requires community engagement and support
Infant feeding policies to promote breastfeeding and appropriate complementary feeding practices	NICE, 2008[64], Rogers, 2011[43]	Definition: Wide ranging intervention based on concept of creating environments which support breastfeeding and appropriate infant feeding Examples of interventions: Creating baby-friendly settings, encouraging appropriate weaning practices, Bottle-to-cup programmes to encourage parents to wean babies off bottles from six months Key points ▪ Strong evidence on the impact of breastfeeding on general health but not specifically on oral health ▪ Should be integrated into wider public health programmes

Section 4. Supporting commissioners – what does this mean for commissioning?

Introduction

This section aims to support local authorities to develop and review local oral health improvement commissioning frameworks for children and young people (CYP), identifying local oral health needs, currently commissioned services and their costs and reviewing these in the light of the totality of the evidence presented in section 3. This will enable local authorities to develop frameworks, which maximise oral health improvement outcomes, while ensuring that financial considerations make the most of the value of the investment. Financial considerations may include using pooled budgets, collaborative commissioning and cost benefit analysis tools.

Whilst acknowledging that local authorities may be starting from different positions and engagement and work may already be in progress within existing frameworks, identifying local needs and population characteristics is an essential first step. NICE are currently developing public health guidance for local authorities, which will include recommendations about oral health needs assessments. They have commissioned a review (as part of this process) of what methods and sources of information would help local authorities to identify oral health needs.[72] PHE is in the process of developing tailored oral health reports for local authorities. These reports could guide their decision-making about designing and targeting oral health improvement programmes. In addition, table 4.1 provides sources of information that could support assessing the oral health needs of local populations.

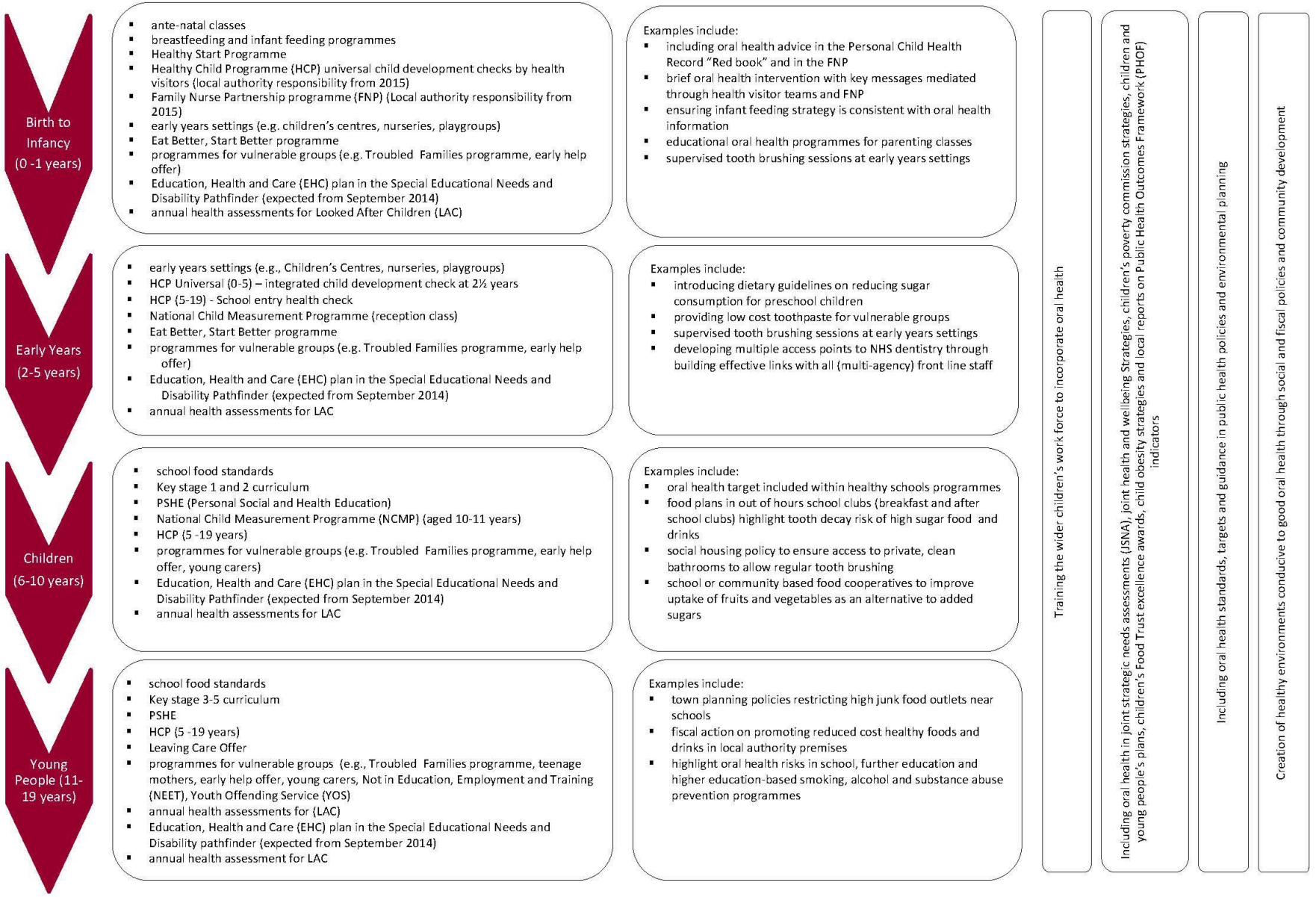
Table 4.1. Sources of information for assessing local oral health needs

Information	Sources	Link to sources
Local children's oral health survey	Dental Public Health Intelligence Programme	www.nwph.net/dentalhealth
National Children's Dental Health Surveys	Health and Social Care Information Centre (HSIC)	www.hscic.gov.uk/article/3740/Dental-Health-Survey-of-Children-and-Young-People
Local data on children's dental attendance	Health and Social Care Information Centre	www.hscic.gov.uk/searchcatalogue?topics=0%2f Primary+care+services&sort=Most+recent&size=10&page=1#top
Admission of children to hospital for tooth extractions data	Dental Public health Intelligence Programme	www.nwph.net/dentalhealth/extractions.aspx
Local joint strategic needs assessments (JSNA)	Local authorities sources	
Deprivation statistics (eg., Index or Multiple Deprivation 2010)	Department for Communities and Local Government	data.gov.uk/dataset/index-of-multiple-deprivation
Targeted 2 year old take up and reach data	Department for Education	
Early Years Foundation Stage Profiles	Department for Education	www.gov.uk/government/publications/early-years-foundation-stage-profile-results-2012-to-2013
Integrated 2 to 2½ year check performance	Implemented from 2015	
Children and Young People's Health Benchmarking Tool	Public Health England	fingertips.phe.org.uk/profile/cyphof/data

Figure 4.1 Opportunities to integrate oral health improvement into health programmes and public policies

Examples of what local authorities could do to integrate oral health improvement into health programmes and public policies

Suggested cross-cutting strategic approaches for integrating oral health improvement



Integration and adding value

There are real opportunities for commissioners to add value to their existing programmes with little additional costs by integrating oral health improvement into existing programmes for CYP. Integrated and often cost-neutral or low-cost approaches involve training the CYP workforce to deliver oral health interventions, although some interventions may require local contract variations. Figure 4.1 provides examples of where local authorities could consider integrating oral health improvement activities across the CYP life course.

Developing frameworks to maximise oral health benefits and outcomes from oral health improvement interventions

In addition to integrating oral health improvement within existing CYP policies and programmes, local authorities could also include specific oral health commissioning detailed in table 3.3 within their frameworks.

A good practice approach would be to commission a range of upstream, midstream and downstream interventions based on the local oral health needs of the population. Some of these programmes may involve a universal approach whilst others may be targeted to areas of identified oral health inequalities following the Marmot principles of “proportionate universalism” (See Section 5. Making commissioning choices – what does good look like?).

Local authorities may want to commission “emerging” oral health improvement interventions, particularly interventions strategically aligned with wider public health and wellbeing strategies (eg. infant feeding and fiscal policies). Interventions classified as “emerging” are often interventions that have inconclusive or little evidence to support their effectiveness, although the intervention looks promising in terms of impacts on inequalities, deliverability and cost. Local authorities who want to commission emerging interventions may also consider establishing research collaborations with dental public health specialists in academic institutions to collate local evidence and pilot programmes to address implementation issues.

In relation to interventions classified as “limited value”, depending upon local circumstances, local authorities may still want to commission these programmes, particularly if the programmes are already operating, have no or low costs and have wider health benefits (ie. the general health benefit of milk). Another example would be integrated commissioning with NHS England related to facilitating access to primary care dental services. These access programmes may be of limited value in terms of improving oral health unless the services have a preventive focus. The Department of Health dental contract reform programme is currently piloting elements of a new dental contract with a preventive focus and the delivery of improved oral health outcomes.

Monitoring and evaluation

Figure 4.2 shows an outcomes triangle illustrating how local authorities could assess oral health improvement programmes at different outcome levels. Some overarching strategic outcomes (such as reducing tooth decay in five year-olds) are long-term outcomes, which may take two-three years to demonstrate improvements. Intermediate outcomes (ie. improving health visitors' knowledge of oral health) could be evaluated in the short term.

Financial considerations

There are a range of financial approaches and techniques that could maximise the value of the investment and the evidence of the return on investment. Many local authorities will routinely utilise these tools but may not have applied them in the context of oral health improvement.

These include**:**

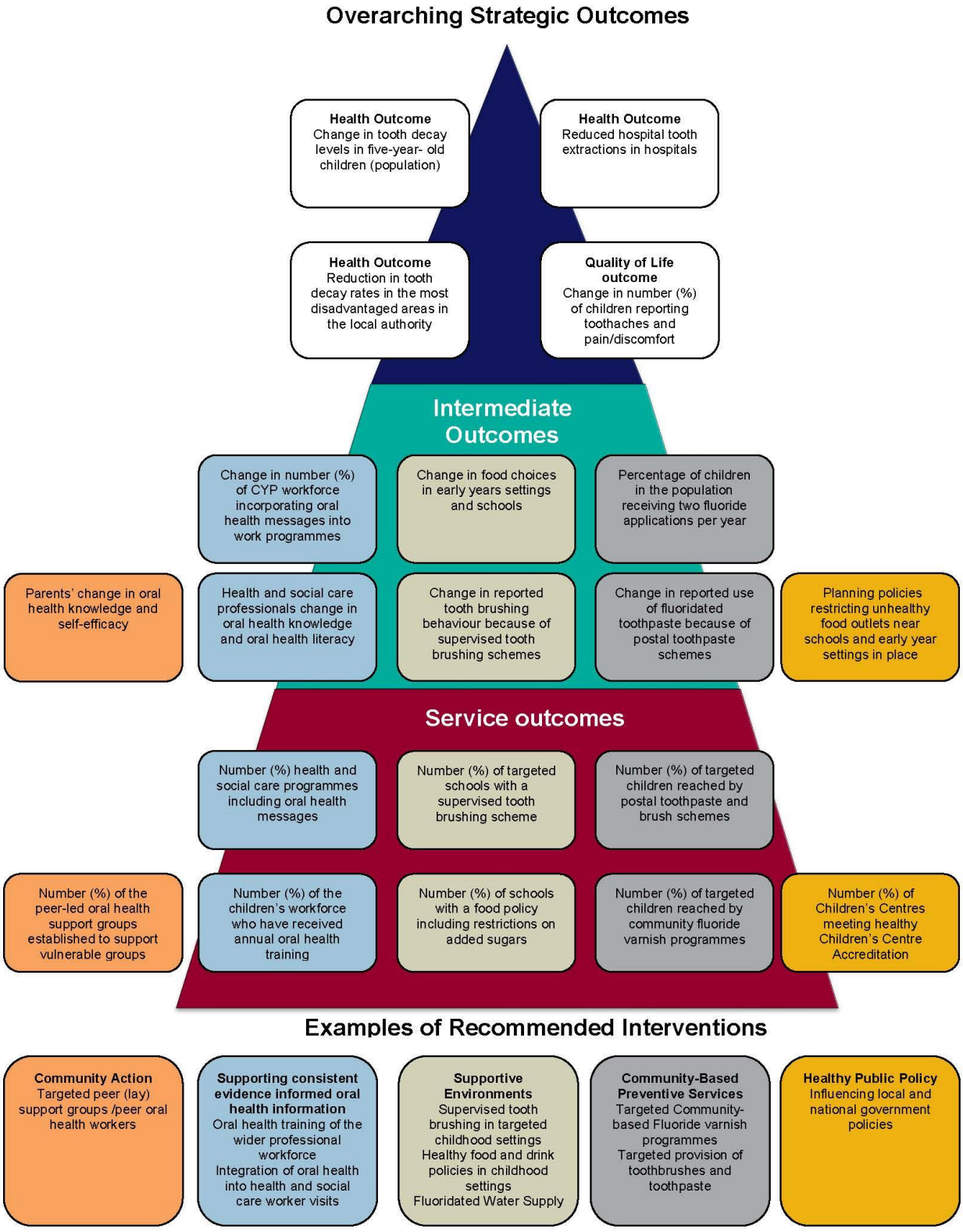
- Pooled budgets

A number of legislations make provision for the pooling of budgets, including the National Health Service Act 2006. Pooled budgets are in place across many local authorities for specialist services where both the cost and the volume of recipients can be high. In some cases, a pool may not be the most efficient process for smaller levels of investment, where the unit costs are lower to administrate. In these situations, a partnership agreement (under Regulations and Section 75 of the 2006 National Health Service Act)[73] can be a vehicle to align resources across the local authority, the NHS, schools and other commissioners.

- Collaborative commissioning

Collaborating across a bigger geographical footprint is increasingly recognised as an efficient way to manage the market of provision. This involves aligning commissioning intentions across local authorities, and agreeing single processes to commission and procure. One example is where a number of local authorities are all commissioning supervised tooth brushing programmes from a single community provider. Commissioning the programme through a single contract model with one co-ordinating commissioner, with a number of associates to the contract, could reduce costs by sharing management costs and utilising economies of scale in purchasing equipment. It could also result in better coverage for children and young people living along local authority borders.

Figure 4.2: Examples of possible outcomes measures that local authorities could use to evaluate and monitor oral health improvement programmes for Children and Young People (CYP)



Collaboration can extend between NHS bodies and other organisations. Table 1.1 outlines the range of commissioning responsibilities for children and family services, shared across NHS England, PHE and clinical commissioning groups. A local authority may want to initiate an oral health improvement programme delivered by health visitors (currently commissioned through the healthy child programme by NHS England) through the overarching contract. Similarly, they may want to run an oral health campaign and engage providers through the NHS England dental contract.

There are numerous examples of local authorities commissioning in this way, often using framework contracts to do so. A framework agreement is an agreement with suppliers that sets out the terms and conditions under which specific purchases can be made throughout the life of that agreement. They are used for generic goods and services across the public sector and in children's services; services such as residential children's homes are purchased through them. A framework agreement will generally allow more flexibility around the goods or services contracted for, both in terms of volume and the detail of the relevant services. A "multi-supplier" framework allows commissioners to select from a number of suppliers for its requirements, helping to ensure that each purchase represents best value and targets commissioners' local needs. Public sector organisations such as local authorities and NHS England, can use a framework agreement set up by another partner so long as it is stipulated in advance. A framework agreement particularly lends itself to the purchase of equipment, for example, toothbrushes or fluoride toothpaste.

- Cost benefit analysis tools

The government has set out a challenging public service reform programme, which includes improving the transparency of services and making better use of public money. Using finance models that provide intelligence is increasingly important as local authorities implement wide-ranging austerity measures whilst attempting to evidence effective use of public resources. Cost benefit analysis approaches provide a framework for structuring financial evidence. While it may not be possible to identify a quantifiable outcome for all interventions, the logic proposed can be partially applied with available data.

One example of a cost analysis model used in an oral health improvement programme, compared the cost of providing the national nursery tooth brushing programme in Scotland with the estimated NHS expected cost savings that might be associated with an improvement in the oral health of five-year-old children.[74] The cost benefit analysis of these types of schemes depends on baseline tooth decay levels. Greater expected benefits are associated with a higher baseline decay level. The expected savings in England would be realised within NHS England who commission all dental services. Assuming it is possible to quantify the cost savings from any reduction in the cost of treating tooth decay in children, the identification and redirecting of such funding would

depend on current contractual and commissioning arrangements. This illustrates the importance of aligning priorities, collaborative commissioning and pooled budgets. Improved oral health outcomes are achievable in the long term, but require sustained investment and collaborative working to allow the benefits to be realised.

Local authorities can obtain other examples of cost benefit analysis approaches and toolkits from the following sites:

New Economy: neweconomymanchester.com/stories/1778-cost_benefit_analysis

Early Intervention Foundation: www.eif.org.uk/publications/making-an-early-intervention-business-case-checklist-and-recommendations-for-cost-benefit-analysis/

Section 5. Making commissioning choices – what does good look like?

Introduction

This section draws on the information from the previous sections to support the process that local authorities may adopt to review and develop their commissioning framework for oral health improvement. Ensuring the maximum benefit in terms of oral health improvement outcomes, while considering financial issues, makes the most value for the investment.

This section provides exemplars describing two fictitious local authorities with contrasting circumstances. Suggested actions show how local authorities could integrate oral health improvement activities within existing services for children and young people and construct their commissioning frameworks by selecting specific “recommended” or “emerging” oral health improvement interventions from the interventions listed in table 3.3.

The child population in local authority A had generally good oral health. However, there were some socially deprived areas where children were at a higher risk of dental disease. The approach in this circumstance focussed on delivering oral health improvement interventions through universal integrated programmes (with low additional cost) within existing CYP services, supplemented by specific oral health improvement programmes targeting those areas with high levels of dental disease. This illustrates how a local authority could commission services based on the concept of “proportionate universalism” described on page 18. The second local authority (local authority B) had generally poor oral health and in addition, areas where children were at a very high risk of poor oral health. These exemplars are also illustrated using brief ‘real world’ case studies from across England.

Other examples of oral health improvement programmes from across the UK are the Childsmile programme in Scotland (www.child-smile.org.uk/) and the Designed to smile programme in Wales (www.designedtosmile.co.uk/home.html).

Illustrative example of local authority A with high levels of disease in localised areas

Upper tier local authority A has a large geographical footprint with seven lower tier local authorities. The local authority commissioned and collected oral health data for five-year olds as part of the PHE dental public health intelligence programme in 2012. The director of public health discussed the findings with their named consultant in dental public health in PHE. The findings showed that marked inequalities existed at the lower tier level but the overall percentage of children who had dental decay experience was only marginally higher than the national average. The director of public health and the health and wellbeing board (HWB) were both highly committed to improving outcomes for all children including those from vulnerable groups. A recent, wide-ranging engagement exercise identified children's health issues (including children's oral health and obesity) as key priorities for the borough. This was reflected in all health and wellbeing policies within the district.

Local authority A considered its commissioning intentions for the next year. It chose to commission universal interventions for children in all areas of the borough (integrated within existing CYP services) alongside additional targeted population programmes for children living in lower tier areas with higher levels of tooth decay. Oral health improvement programmes were commissioned to address the need for children from vulnerable groups to receive targeted services. Programmes also utilised every child contact to share important general and dental health related health messages. Oral health messages were integrated into existing programmes (such as the healthy child programme and the family nurse partnership) at very little extra cost. Local authority A made a long-term investment in oral health, and included a range of outcomes, recognising that it could take some time to demonstrate tangible improvements in oral health. It also developed an evaluation plan incorporating interim outcome measures (figure 4.2). The HWB included in its joint health and wellbeing strategy an action point to ensure that council facilities provided environments that promoted good oral health. The local authority also considered commissioning local oral health surveys for specific age groups in the future to monitor the oral health of children over time. The strategy also intended to influence relevant departments to amend their policies and advise on mechanisms by which they might be enacted.

Table 5.1 shows the specific actions taken by local authority A to commission tailored oral health improvement programmes for its population.

Table 5.1. Actions taken by local authority A to commission oral health improvement interventions for children and young people

Actions	Description	Level of intervention	Principles
Universal action: influencing national and local policy	▪ Planning department considered general and dental health when presented with applications from shops and food outlets wishing to open near to schools (case study 1) ▪ Pricing policies were adopted locally to facilitate healthier food and drink choices with collaboration across several local authorities to influence national implementation (case study 2) ▪ Schools and their governors (via healthy schools workers) established policies creating environments that promoted oral health (eg. by making water freely available, offering a selection of foods and drinks that support a healthier diet, including those in vending machines) (case study 3) ▪ An accreditation scheme was created in recognised settings that achieved a health promoting environment (case study 4) ▪ The local authority, head teachers and school governors identified opportunities in the curriculum to teach children about the importance of and how to maintain good oral health ▪ All CYP service specifications included a requirement for services to promote oral health and develop settings that did so	Upstream	Healthy public policy
Universal action: oral health training for the wider professional workforce	▪ The local authority commissioned training programmes to ensure that all personnel in the children and young people workforce could access training covering the key oral health messages and how to communicate the key messages to parents at the appropriate developmental stage (case study 5) ▪ The training was updated as part of their continuing professional development (CPD) and became integrated into the induction programmes for new starters ▪ The local authority and partner commissioners ensured that all service specifications for CYP included a requirement to promote oral health	Midstream	Supporting consistent evidence informed oral health information
Universal action: integration of oral health into the healthy child programme	▪ Health visitor service specifications included oral health improvement as part of the healthy child programme ▪ Health visitors received training about how to advise parents of young children about starting to brush when the first teeth erupt, also providing a family a pack to support this activity (Programme – Brushing for life) delivered within the healthy child programme (case study 6) ▪ Health visitors included advice about healthier feeding and weaning of babies ▪ Health and social care workers included tooth brushing advice as part of their supportive care to targeted high risk families as part of the family nurse partnership ▪ This action aimed to initiate twice daily tooth brushing with one occasion occurring as part of a bedtime routine, integrating tooth brushing within home activities to also increase parenting skills, self-efficacy and confidence	Midstream	Supporting consistent evidence informed oral health information
Targeted action: a**pplication of fluoride varnish in community settings**	▪ Preventive advice given and fluoride varnish applied in targeted children's centres, nurseries and crèches in areas with high tooth decay (case study 7) ▪ Clinical teams (including a dental care professional with additional skills in prevention) were commissioned to carry out fluoride varnish applications and provide oral health improvement advice and support for families ▪ Specification ensured that the programme ran for a two year cohort with children having two applications per year over two years ▪ Performance monitoring incudes number (%) consenting, number of children in the scheme, number of applications and number of children having two applications per year	Downstream	Community-based preventive services

Illustrative example of local authority B with high levels of disease in all areas, and very high levels in areas of social deprivation

Local authority B was concerned about the high levels of tooth decay among their five-year-olds, which was significantly higher than the national average for England as reported by the dental public health intelligence programme in 2012. The director of public health consulted their named consultant in dental public health in PHE and requested further analysis of the data. This revealed that there were also inequalities within the district, with a large proportion of the five-year-olds having very high levels of oral disease. The tooth decay experience of five-year-olds was significantly higher than in other parts of the country and there were large inequalities across the district. The health and wellbeing board (HWB) was concerned about this, realising that the high tooth decay level among five-year olds was indicative of poor infant feeding practices. Oral health improvement among young children was prioritised. A named individual from the public health department was assigned to address the issue. A comprehensive oral health needs assessment had been carried out (with relevant sections included in the JSNA). An oral health strategy for the district was developed and highlighted within the HWB strategy. The oral health lead established a group to take forward the strategy action plan and secured funding for the agreed plan.

The action group considered all the interventions that could be applied universally. Oral health should be integrated with general health activities. Many existing services could take action to improve self-care home activities among families and change child care environments to reduce the risk factors for tooth decay. This was facilitated by greater integration and partnership working. There was no public water fluoridation scheme and local research showed that few parents adopted a twice-daily tooth brushing habit using fluoridated toothpaste for their children. The action group considered water fluoridation as a universal option within the action plan but recognised that the process of initiating a new scheme would require a long lead-in time. The group felt that it was also necessary to consider other options to improve oral health in the interim. Local authority B decided to commission several population-based interventions to increase the availability of fluorides in the population in addition to targeted interventions. Actions were adopted across the life course starting in the early years and continued throughout child development.

Table 5.2 shows the specific actions taken by local authority B to commission tailored oral health improvement programmes for their population.

Table 5.2. Actions taken by local authority B to commission oral health improvement interventions for children and young people

Action	Description	Level of intervention	Principles
Universal action: influencing national and local policy	▪ Planning department considered general and dental health when presented with applications from shops and food outlets wishing to open near to schools (case study 1) ▪ Pricing policies were adopted locally to facilitate healthier food and drink choices with collaboration across several local authorities to influence national implementation (case study 2) ▪ Schools and their governors (via healthy schools workers) established policies creating environments that promoted oral health (eg. by making water freely available, offering a selection of foods and drinks that support a healthier diet, including those in vending machines) (case study 3) ▪ An accreditation scheme was created in recognised settings that achieved a health promoting environment (case study 4) ▪ The local authority, head teachers and school governors identified opportunities in the curriculum to teach children about the importance of and how to maintain good oral health ▪ All CYP service specifications included a requirement for services to promote oral health and develop settings that did so	Upstream	Healthy public policy
Universal action: oral health training for the wider professional workforce	▪ The local authority commissioned training programmes to ensure that all personnel in the children and young people workforce could access training covering the key oral health messages and how to communicate the key messages to parents at the appropriate developmental stage (case study 5) ▪ The training was updated as part of their continuing professional development (CPD) and became integrated into the induction programmes for new starters ▪ The local authority and partner commissioners ensured that all service specifications for CYP include a requirement to promote oral health	Midstream	Supporting consistent evidence informed oral health information
Universal action: infant feeding policies to promote breastfeeding and appropriate complementary feeding practices	▪ An update of the existing local authority infant feeding policy was required and would be relevant for improving oral health, also as a key resource and influencer for other interventions ▪ The extended feeding policy covered all areas relevant to healthier feeding and weaning of babies, serving to improve both general and dental health (case study 8) ▪ A wide range of stakeholders helped to deliver the policy covering breastfeeding, baby led weaning onto solid foods, safe bottle use and transfer to drinking from a cup	Mid and upstream	Healthy public policy
Universal action: supervised tooth brushing in all childhood settings	▪ The local authority commissioned a universal supervised brushing scheme for all preschool sites rather than a targeted programme (case study 9) ▪ The service specification delivered the scheme in reception and year one, with each child cohort group therefore brushing for two years	Midstream	Supportive environments
Universal action: **re-orientating dental services so that CYP attend primary care dental care services that focus on prevention and oral health improvement**	▪ Collaborative commissioning with partners in NHS England working to promote general dental practices to adopt a more pro-active preventive approach to care ▪ The current flexibility in the dental contract enabling this also aligns with the national contract reform programme which seeks to emphasise preventive activity ▪ The local authority established a scheme to encourage attendance by pre-school children to preventively orientated practices by mobilising all relevant services in contact with young children (case study 10) ▪ General dental practice teams were given updates on the correct preventive messages and supplied with toothpaste and toothbrush packs, funded by the local authority ▪ The programme also reinforced the importance of tooth brushing as the last action before sleep and no eating or drinking in the last hour before bed	Downstream	Community-based preventive services

Table 5.2. Actions taken by local authority B to commission oral health improvement interventions for children and young people

Action	Description	Level of intervention	Principles
Universal action: water fluoridation	▪ The local authority agreed to work with the local water company and PHE colleagues to consider the feasibility of establishing a local water fluoridation scheme ▪ The local authority followed the guidance as laid out in the national statutory framework with regard to water fluoridation [3]	Upstream	Supportive environments
Universal action: integration of oral health into the healthy child programme	▪ Health visitor service specification included oral health improvement as part of the healthy child programme ▪ Health visitors received training about how to advise parents of young children about starting to brush when the first teeth erupt, also providing a family pack to support this activity ('Brushing for life') delivered within the healthy child programme (case study 6) ▪ Health visitors included advice about healthier feeding and weaning of babies ▪ Health and social care workers included tooth brushing advice as part of their supportive care to high risk targeted families as part of the family nurse partnership ▪ This action aimed to initiate a twice-daily tooth brushing habit as part of a bedtime routine, integrating tooth brushing within home activities to increase parenting skills, self-efficacy and confidence	Midstream	Supporting consistent evidence informed oral health information
Targeted action: **application of fluoride varnish in community settings**	▪ Preventive advice given and fluoride varnish applied in targeted children's centres, nurseries and crèches in areas with high tooth decay (case study 7) ▪ Clinical teams (including a dental care professional with additional skills in prevention) were commissioned to carry out fluoride varnish applications and provide oral health improvement advice and support for families ▪ Specification ensured that the programme ran for a two year cohort with children having two applications per year over two years ▪ Performance monitoring incudes number (%) consenting, number of children in the scheme, number of applications and number of children having two applications per year	Downstream	Community-based preventive services

Case studies

Case study 1. The role of local planning on the food environment

Local authorities have recently begun to use the legal and planning systems to regulate the growth of fast food restaurants near schools. Improving the quality of the local school food environment near schools can potentially influence food purchasing habits and children's future diets. However, planning restrictions on hot food takeaways is only part of the solution; it does not limit the sale of high sugar food and drinks that children can still purchase from shops near schools.

A number of local authorities have drawn up supplementary planning documents (SPDs) to restrict new fast food premises from opening near schools including St Helens, Barking and Dagenham, Tower Hamlets, Newham, Hillingdon, Waltham Forest and Sandwell.

St Helens Council implemented a wide-ranging policy restrictions including only granting planning approval "within identified centres, or beyond a 400 metre exclusion zone around any primary or secondary school and sixth form college either within or outside local education authority control".

Birmingham City Council adopted a planning policy to restrict and manage the number of hot food takeaways in the city. The policy stated that no more than 10% of units within a local shopping centre, or parade, should comprise hot food takeaways. Planning applications exceeding this percentage were normally refused. At the time the policy was adopted, 33 of Birmingham's 73 local centres already exceeded that figure, thereby placing an immediate cap on any future growth in those centres. Between March 2012 and December 2013, the city council received 36 applications for hot food takeaways; of these, 21 were approved and 15 refused. Six of the 15 applicants appealed. The city council won all six appeals demonstrating that the policy is robust and has the support of the Planning Inspectorate.

Alongside planning policies, there were other measures available, implemented by environmental health or licensing teams to help local authorities regulate the sale of fast food. For example, Hillingdon Borough Council passed a resolution banning ice cream vans from the vicinity of schools and nurseries. One of the reasons cited for the ban was that ice cream trading near schools contradicted dietary recommendations and the aims of the Healthy Hillingdon Schools scheme.

What does good look like

- Joint working between council members and officers to address a public health issue
- Implementation of planning policy as part of a wider obesity or healthier eating strategy
- Widespread public consultation before implementation of the policy especially involvement of schools
- Regular monitoring in place
- Robust process important to ensure the support of the planning inspectorate

Case study 2. A collaborative approach across local authorities in the North West to influence national policy

Blackpool's public health department started a debate on policy measures to tackle the obesity epidemic seen in the North West and across the country. It considered government policies to influence the reduction in levels of obesity and improve oral health. It was clear from the evidence base that policies targeted at reducing both sugar and fat consumption were more likely to reduce levels of obesity based on a common risk factor approach. Similarly, a curb on high fat, sugar and salt product advertising to children would also help to reduce childhood obesity levels. Working jointly across the North West, the region's directors of public health decided to commission a collaborative programme to lobby government for:

- A sugar sweetened beverage tax
- A ban on marketing and advertising to children and young people
- The implementation of 20 mph zones in built up areas to provide a safe environment and encourage physical activity

What does good look like?

- Collaborative working on key issues to achieve greater influence
- Action based on evidence of outcomes that maximise impact
- Sustained over a long time period to allow impact to be measured

Case study 3. Healthier eating school policies and schemes in primary schools

Twenty three primary schools with higher than the national average uptake of free schools meals in eight local authorities in South West England and South Wales introduced a fruit tuck scheme as part of a cluster randomised control trial in 2008. The scheme offered children in participating schools a choice of fruit (priced at 15 pence each); no sweets, crisps or sugary snacks were provided. The scheme was evaluated after one year, comparing 23 participating schools with 20 non-participating schools (control schools). Children in participating fruit schemes schools received an estimated 70,000 pieces of fruit during the school year. Children in participating schools were more likely than children in non-participating schools to report eating fruit as a snack in schools. The research team also assessed children's reported food intake using a computerised 24-hour recall questionnaire. Children attending schools that had both a fruit scheme and a school policy restricting foods brought into school (ie. no food or "fruit only" policy) had higher fruit intakes than children attending schools with just a fruit scheme This emphasised the impact of school food policies, providing supportive environments to supplement low cost healthier food schemes.

What does good look like?

- Subsidised fruit schemes reinforced by school food policies restricting the types of food brought into school
- Schools policies should follow national guidelines incorporating healthier eating messages tackling general and dental health (ie. tooth decay and childhood obesity)
- Policies should also support out of school (home) eating practices by involving and engaging parents

Case study drafted from research publications by Moore and Tapper 2008 and Moore et al 2011[75,76]

Case study 4. Accreditation scheme for early years settings promoting good oral health in Bradford

The 'First steps to healthy teeth' dental health award was instigated by the Bradford District Care Trust Salaried Dental Service. It aimed to recognise and reward early years settings that demonstrated and promoted the oral health of young children. This award scheme was developed for all early years settings promoting good oral health with preschool children, particularly focussing on healthier eating as recommended by the Caroline Walker Trust Guidelines 'Eating well for under 5's in child care' and for those over one, the national voluntary food and drink guidelines for early years settings in England – a practical guide developed by the Children's Food Trust. The award was supported by principles set out in the early years foundation stage, which required early years practitioners to have a holistic view of each child and to understand that a child's dietary and physical needs underpin their ability to develop. The award schemes had three levels: bronze, silver and gold. Eligible early years settings completed an application. Settings that received a gold level award had an oral health/nutrition policy that included all the award criteria.

The award was supported by the Bradford Early Years Child Care and Play Service, Day Nursery Association, Pre-school Learning Alliance, Child Minding Network, Bradford under Fives Association, and Bradford and Airedale Dietetic Service.

What does good look like?

- Award standards developed in line with national children's guidelines and with stakeholder groups
- Integrated approach to oral and general health
- Early establishment of good dietary practices contributing to giving every child the best start in life

Case study 5. Training the children and young peoples and voluntary sector workforce to support oral health improvement.

Children in Lancashire and Cumbria have poorer dental health compared to children in other parts of England. The Smile4Life programme was developed in partnership with local authorities to address this problem. The programme aimed to reduce tooth decay in children, laying a solid foundation for their good oral health throughout life. The approach focussed on sustained behaviour change, supported across the health and social care systems in Lancashire and Cumbria, with interventions informed by 'Delivering better oral health'. Smile4Life was designed to support everyone who had a role in the development of children and young people.

Four key areas for action provided the framework for implementing the programme. These related to facilitating healthier diets, regular and appropriate tooth brushing, adopting healthier lifestyles and regular access to dental services. Community staff throughout the programme, developed policies, implemented actions, carried out procedures, and exhibited behaviours, aligned to the four key areas for action. These actions were unique to their setting and sensitive to their local community's needs. Staff submitted evidence to demonstrate their activities in a standardised workbook that included policy documents, photographs of interactive displays or sessions, and reports. This evidence contributed to awards, which recognised the settings' achievements in each of the key areas, and formed part of the programme evaluation. Each council recorded and reported the achievement awards as part of the performance monitoring system.

An important programme enabler was equipping the wider workforce to effectively and consistently support programme delivery. This involved a cascade training approach involving the children and young people', and voluntary sector workforce in children's centres and other early year's settings. Experienced NHS oral health promoters initially trained nominated oral health champions using a standardised training package and web-based resources. The oral health champions then shared and helped to deliver evidence-based oral and general health messages within their workplaces. An e-learning tool is under development to support this process.

Dental nurses have been trained to promote oral health and apply fluoride varnish in Cumbria's substantial number of rural communities. Dental nurses have to complete an assessment of their clinical skills and a verbal examination.

What does good look like?

- Training and supporting oral health champions to implement the programme
- Support from commissioners of early years settings
- Demonstrable partnership working across health and social care sectors
- Providing awards recognising successful implementation
- Ongoing monitoring to ensure maintenance of standards

Case study 6. 'Building brighter smiles' in Bradford – commissioning oral health improvement programmes across the life course.

The oral health of five-year olds in Bradford and Airedale is poor, with significant inequalities throughout the district. Oral health improvement programmes in this district were focused on the oral health of young children and followed Marmot principles to tackle inequalities reflecting national and local priorities. 'Building brighter smiles' (BBS) incorporated a series of evidence-based programmes, which adopted a life course approach based on the principles of "proportionate universalism". These programmes had population-wide and targeted elements and included breast feeding advice, partnership working with health visitors, community-based fluoride varnish applications, a dental health award programme promoting a healthy diet in pre-school settings and toothpaste and brushing programmes in schools and mosques. Supervised brushing was offered to nursery and reception classes in schools where 25% plus of pupils were eligible for free school meals. Children's teeth were brushed once a day over a two year period. All classes within special schools were included in the programme. Free toothpaste and toothbrushes were provided as part of the programme and during the main school holidays. Training and regular updates in evidence based oral health practice to professionals working with children, young people, elderly and special need clients was embedded within BBS, to communicate consistent oral health and general health messages so ensure widespread impact. Training was integral to the health visitor led 'Brushing for life' programme where health visitors distributed fluoride toothpaste, toothbrushes. They also gave evidence-based oral health advice to support parents of young families. The intervention was incorporated within the healthy child programme service specification.

Dental practices in Bradford were supported to re-orientate their services towards prevention through the Health promoting dental practices award (HPDPA). Thirty-five dental practices participated in the HPDPA programme. Primary care dental practices were encouraged to deliver evidence based prevention and promote regular attendance for fluoride varnish application. BBS was underpinned by embedding oral health improvement into local strategies, policies and guidance. This included incorporation into early years, service specifications; oral health included as a priority in the health and wellbeing action plan and input into 'Every baby matters' infant nutrition policies and guidelines. Work continued and included embedding oral health into integrated child pathways utilising the strength of universal services to deliver oral health prevention and early intervention, developing partnerships with children's centres and engaging with partners.

What does good look like?

- Overarching strategy: life course approach and "proportionate universalism"
- Integrate into local health pathways meeting local needs
- Multidisciplinary approach to issues such as consent maximising the success of fluoride varnish programme
- Using different members of the dental team including dentists, dental nurses, dental therapist and hygienists (skill mix)
- Monitoring and reviewing performance and outcomes

Case study 7. A community-based fluoride varnish programme in Liverpool

Young children in Picton, Liverpool have high levels of dental disease and poor access to health services. Levels of deprivation are high and there is a significant proportion of the local population from black and minority ethnic (BME) groups, who often face significant barriers to accessing care.

A locally commissioned programme provided evidence based preventive care and promoted increased dental attendance for children at the children's centre. A dental therapist from the local dental practice offered fluoride varnish applications on two afternoons a week to children aged two-four years who were attending groups and activities within the centre. This introduced dental care to children at an early age.

The initial activity was supported by an oral health improvement officer whose role was to raise awareness about the programme among families accessing the centre. They also ensured that wider oral health messages around dental care were delivered to families.

The success of the pilot was assessed based on a number of parameters:

- number of new, early child contacts made at the children's centre
- number of varnish applications undertaken
- number of new child attendances at the local dental practice
- feedback from service users, education centres, dental staff and health promotion officers

The practice reported a high attendance rate for appointments. Feedback from practice and centre staff confirmed that this model reached a high number of families of young children and represented a non-threatening introduction to dental care for local families.

What does good look like?

- A broad approach giving families advice about home care, not just limited to the application of varnish. Parents should be present to hear the advice, discuss as required and provide valid consent
- Programmes should be sustained over the long-term supported by the evidence of effectiveness related to children have four applications per year in a two-year programme
- Appropriate range of dental health professionals (skill mix) trained to give oral health advice and to apply fluoride varnish (eg. primary care commissioning guidelines: the use of fluoride varnish by dental nurses to control caries: www.pcc-cic.org.uk/sites/default/files/articles/attachments/the_use_of_fluoride_varnish.pdf)
- Targeting age groups and social groups that are likely to be at greater risk of tooth decay to maximise benefit
- Clinical conditions which optimise successful applications of fluoride varnish in community settings (eg. good light, reclining chair, good infection control procedures)
- Encouragement and assistance to attend a dental practice with good links to practices

Case study 8. Implementing a healthy baby feeding policy

A broad stakeholder group in Manchester developed a baby feeding and weaning policy. Prolonged bottle use containing high sugar drinks was of particular concern in this local area, increasing the risk of tooth decay in young children. This concern led to the widespread support and agreement to establish an infant feeding policy. The policy development team consisted of health visitors, paediatricians, speech and language therapists and oral health improvement practitioners. They worked together on a commissioned programme to launch the policy, which alongside the guidance for the healthy feeding and weaning of babies encouraged parents to discard feeding bottles at the appropriate developmental stage.

This programme aimed to tackle the culturally embedded custom of prolonged bottle-feeding particularly at night, by encouraging parents to stop using a baby feeding bottle by the time their child was 12-months old. Parents were also encouraged to change to water or milk as the drink of choice between meals.

The oral health improvement team launched and co-ordinated the programme and purchased and distributed suitable trainer cups to project partners. Health visitors and nursery nurses provided cups to the parents of children aged eight to 12 months onwards at a range of events and venues attended by young children. These staff and other health and social care workers talked to parents about discarding the bottle and the dangers of long-term bottle use, especially at night. A leaflet reinforcing advice about safe drinks and the risks of leaving a baby with a bottle at night was given out with the cups.

The programme was evaluated and showed that parents who had received trainer cups and proactive messages from healthcare workers in the test areas had better knowledge about bottle feeding and better reported home care habits changing from bottles and cups.

What does good look like?

- The multidisciplinary development of the policy facilitated the implementation of the commissioned programme
- Consistent evidence-informed advice from all health, education or social care partners
- Provision of free flow trainer cups, not no-spill cups, at no cost to family
- Support given to families to make gradual changes if necessary

Case study 9. Tees daily supervised tooth brushing programme in schools

A scheme ran in Teesside aimed at improving the oral health of young children by providing materials for supervised tooth brushing in schools**.** The oral health improvement team (working with the consultant in dental public health) operationalised and coordinated the project. They gained school cooperation, informed parents, ordered, stored, distributed and replenished supplies of toothpaste, toothbrushes and toothbrush holders. They also trained school staff. Schools were targeted based on the results of the nationally co-ordinated dental epidemiology programme (now the PHE dental public health intelligence programme) survey of five-year-old children in 2005-06, which involved a large sample of children. Schools in the two most deprived quintiles (ie. those with the highest disease levels), were targeted for the intervention and invited to take part. Nursery and reception children in 58 schools joined the programme and school staff supervised tooth brushing on a daily basis. The NHS originally funded the programme. Local authority public health departments have provided the funds for resources (ie. toothbrushes, toothpaste and toothbrush racks) to run the school programme since 2013.

PHE dental public health intelligence programme data in 2012 was used to analyse changes in tooth decay levels. The data showed a reduction in tooth decay levels in brushing schools compared to schools not participating in the scheme.

What does good look like?

- Endorsement of the project by local authority commissioned and managed services to maximise co-operation
- Dedicated personnel to recruit schools, communicate with parents, train staff, deliver and replenish equipment and troubleshoot
- Provision of correctly designed toothbrush storage and labelling systems and toothpaste of the correct concentration of fluoride
- An effective reminder system to reinforce the message about twice daily brushing at home with the option of providing toothpaste and brushes for holiday periods
- Inbuilt robust evaluation processes to measure improvements in oral health

Case study 10. Re-orientating dental services to encourage prevention and dental attendance through collaborative commissioning

The first task of the Greater Manchester local dental network (LDN) focused on improving the oral health of preschool children in the “Baby teeth DO matter” project. General dental practitioners worked with commissioners from NHS England to agree a contract variation that encouraged NHS practices to attract non-attending preschool children to attend for check-ups, pro-active preventive advice and treatment where needed. The LDN programme provided promotional materials, which delivered key dental health messages and emphasised the importance of bedtime brushing before sleep and no eating and drinking in the last hour before bed.

General dental practice teams were given updates about the key preventive messages and supplied participating families with toothpaste and toothbrush packs at no cost to them. These packs were given to families with two to five-year old children, whose parents reported they had not attended a dentist before.

Local clinical leads encouraged practices to participate, working together to identify young children who had no local dentist to encourage attendance. The scheme was facilitated and supported by oral health improvement teams. Libraries, medical practices, children’s centres, nurseries and nursery classes at schools displayed posters and distributed the contact details of participating practices. Whole families who had not previously attended a dental practice visited participating practices and received preventive advice and free toothpaste. Children received fluoride varnish applications when possible.

What does good look like?

- Dental practice teams should be trained in the key dental health messages and apply the guidance from the evidence informed toolkit for prevention ‘Delivering better oral health’
- Involvement by oral health improvement teams
- Support from the local authority so that services that are provided or commissioned by them support the publicity drive and promote the scheme
- Collaborative commissioning in partnership between NHS England area teams and local authorities

Appendix 1. Ten key questions to ask - improving the oral health of children and young people

Local authorities' public health role

Key questions to ask when assessing local oral health improvement delivery

1. What are the oral health needs of children and young people (CYP) in your local area?
    - Do you have information and intelligence regarding the oral health of CYP and the services that are available, benchmarking to similar authorities and local neighbours?
    - Does this identify vulnerable groups and those most affected?
    - Does it identify inequalities within the district?

2. Is oral health included in a joint strategic needs assessment (JSNA) and the health and wellbeing (HWB) strategy and is this underpinned by more detailed oral health needs assessments and strategic documents?

3. Do you have a local oral health strategy in place to address oral health issues? Is there an integrated approach to oral health improvement across children's services and the children's workforce?

4. Are commissioned programmes appropriate to local needs and informed by the information and intelligence locally?

5. Are the oral health improvement programmes that you commission supported by the best available evidence?

6. Are your oral health improvement programmes monitored and evaluated and what are the outcomes, outputs and impact? These may be short, medium and long-term outcomes, and include both quantitative and qualitative measures.

7. Do you have an identified lead or established leadership and advocacy for oral health improvement and commissioning? Are there mechanisms in place to oversee accountability, delivery and engagement with partners?

8. Are the children's workforce supported through training and development to deliver for oral health improvement locally?

9. What engagement processes do you have to collect the views of CYP and have their views influence decision-making?

10. Is there reasonable and equitable access to local dental services and are these focused on prevention and the needs of CYP?

Acknowledgements

Steering group members

Jenny Godson (Chair), regional consultant in dental public Health, lead for oral health improvement, PHE

Vanessa Muirhead (Collator), NIHR academic clinical lecturer/specialty registrar in dental public health, Queen Mary University of London

Amanda Crosse, consultant in dental public health, Anglia and Essex Centre, PHE

Claire Robertson, consultant in dental public health, London Centre, PHE

Debbie Manger, clinical director, adult services and specialist in special care dentistry, Northamptonshire Healthcare NHS Foundation Trust

Eustace de Sousa, deputy director, children, young people and families, PHE

Gill Davies, specialist in dental public health, Greater Manchester Centre and the Dental Observatory, PHE

Jasmine Murphy, consultant in public health (children and young people, sexual health, dental public health), Leicester City Council

Jenny Oliver, consultant in dental public health, Thames Valley Centre, PHE

Jill Colbert, head of service, commissioning, children, families and wellbeing, Trafford Council

Karen Badgery, service manager, children's commissioning, London Borough of Tower Hamlets

Liz Gaulton, director of public health, St Helens Council

Lorna MacPherson, professor of dental public health, director of dental research, University of Glasgow Dental School

Mandy Murdoch, senior public health strategist, public health for Camden and Islington

Mary Tomson, consultant in dental public health, West Midland Centre, PHE

Maria Morgan, senior lecturer in dental public health, Cardiff University School of Dentistry

Melanie Catleugh, consultant in dental public health, Cumbria and Lancashire Centre, PHE

Pauline Watts, professional officer for health visiting with the Department of Health

Richard Watt, professor and chair of dental public health, University College London

Sandra Anglin, assistant head of public health commissioning, NHS England

Semina Makhani, consultant in dental public health, East Midlands Centre, PHE

Shalin Mehra, general dental practitioner, Northampton

Sharon Fryer, children and families partnership director, Knowsley Council

Sharon Walker, chair, National Oral Health Promotion Group

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FAMILIES
OVERVIEW AND SCRUTINY COMMITTEE
8 September 2016

TITLE OF REPORT: **Analysis of School Inspection Spring and Summer Terms 2016**

REPORT OF: **Sheila Lock, Interim Strategic Director, Care, Wellbeing and Learning**

Summary

This report details the position of Gateshead schools in relation to Ofsted Inspection findings for the spring and summer terms 2016.

Background

In this version of the school inspection framework each school is given an overall **effectiveness grade** based upon four areas**;**

- effectiveness of leadership and management
- quality of teaching, learning and assessment
- personal development, behaviour and welfare
- outcomes for pupils.

September 2015 has seen the introduction of a significantly different approach to school inspection. Essentially, "outstanding" schools are largely exempt, "good" schools receive a one day inspection and "requires improvement" schools a two day inspection. HMI, alone, having been inspecting good schools.

Ofsted use the following grading system

1 = Outstanding
2 = Good
3 = Requires Improvement
4 = Inadequate

Schools identified as "requires improvement" will usually be re-inspected within two years, and often before. Schools that are judged as requires improvement with a leadership management grade of requires improvement will receive regular monitoring visits from HMI.

Full copies of all inspection reports can be found at www.ofsted.gov.uk.

Outcomes

Over the autumn term 7 schools were inspected:

4 primary schools
1 Pupil Referral Unit
2 Secondary Schools

2 schools was judged to be outstanding
1 school was judged to be good
3 schools were judged to require improvement
1 school was judged to be inadequate

3 schools improved their overall effectiveness grade from the previous inspection
2 schools received the same grade as in the previous inspection
2 schools received a lower overall effectiveness grade from the previous inspection.

Primary/Nursery Schools

School	Previous Inspection	Present Inspection
Brandling Primary School	good	Outstanding
Roman Road Primary School	good	Outstanding
Washingwell Primary School	Requires Improvement	Good
St Wilfrid's Catholic Primary	Requires Improvement	Requires Improvement

Secondary Schools

School	Previous Inspection	Present Inspection
Whickham School	good	Requires Improvement
Joseph Swan Academy	Requires Improvement	Requires Improvement
Millway (PRU)	requires improvement	Inadequate

The Pupil Referral Unit (Millway)

The ofsted findings were extremely disappointing and the full judgements were;

Overall Effectiveness – Inadequate
Leadership and Management – Requires Improvement
Teaching – Requires Improvement
Behaviour/Personal Development – Inadequate
Outcomes – Requires Improvement

Whickham School and Joseph Swan Academy

Both schools received an identical grade profiles

Overall Effectiveness – Requires Improvement
Leadership and Management – Good
Teaching – Requires Improvement
Behaviour/Personal Development – Good
Outcomes – Requires Improvement
Sixth Form - Good

Recommendations

OSC is asked to consider the position of schools in relation to ofsted inspections.

Contact: Steve Horne	Extension: 8612

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