Herefordshire Council

# Agenda

## Children and young people scrutiny committee

Date: **Tuesday 14 January 2020**

Time: **2.00 pm**

Place: **Committee Room 1 - The Shire Hall, St. Peter's Square, Hereford, HR1 2HX**

Notes: Please note the time, date and venue of the meeting.

For any further information please contact:

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# Agenda for the meeting of the Children and young people scrutiny committee

**Membership**

| | | |
|---|---|---|
| **Chairperson** | **Councillor Carole Gandy** | |
| **Vice-Chairperson** | **Councillor Diana Toynbee** | |
| | **Councillor Paul Andrews** | |
| | **Councillor Kath Hey** | |
| | **Councillor Phillip Howells** | |
| | **Councillor Mike Jones** | |
| | **1 Vacancy - Herefordshire Independents** | |
| **Co-optees** | **Pat Burbidge** | **Education Representative - Archdiocese of Cardiff** |
| | **Andy James** | **Parent Governor Representative – SEND Sector** |
| | **Nicola Kinson** | **Parent Governor Representative – Primary Sector** |

# Agenda

**Pages**

**1. APOLOGIES FOR ABSENCE**

To receive apologies for absence.

**2. NAMED SUBSTITUTES**

To receive details of members nominated to attend the meeting in place of a member of the committee.

**3. DECLARATIONS OF INTEREST**

To receive declarations of interest in respect of Schedule 1, Schedule 2 or Other Interests from members of the committee in respect of items on the agenda.

**4. MINUTES** 5 - 14

To approve and sign the minutes of the meeting on 25 November 2019.

**5. QUESTIONS FROM MEMBERS OF THE PUBLIC**

To receive any written questions from members of the public.
*Deadline for receipt of questions is 5:00pm on Wednesday 8 January. Accepted questions and answers will be published as a supplement prior to the meeting. Please submit questions to: councillorservices@herefordshire.gov.uk.*

**6. QUESTIONS FROM MEMBERS OF THE COUNCIL**

To receive any written questions from members of the council.
*Deadline for receipt of questions is 5:00pm on Wednesday 8 January. Accepted questions and answers will be published as a supplement prior to the meeting. Please submit questions to: councillorservices@herefordshire.gov.uk.*

**7. REVIEW OF BUDGET AND CORPORATE PLAN PROPOSALS FOR 2020/21 RELATING TO THE REMIT OF THE CHILDREN AND YOUNG PEOPLE SCRUTINY COMMITTEE** 15 - 128

To review the budget and corporate plan proposals for 2020/21 relating to the remit of the Children and Young People Scrutiny Committee.

**8. YOUNG CARERS SUPPORT SERVICE** 129 - 154

To review the Young Carers Support Service (YCSS) for Herefordshire against the specification for the service following its implementation in April 2018.

**9. WORK PROGRAMME REVIEW** 155 - 182

To review the attached work programme for 2019/20 and consider the outcomes of the peer on peer abuse in schools spotlight review.

**10. DATE OF NEXT MEETING**

The next meeting of the children and young people scrutiny committee will be held on 16 March 2020.

Herefordshire Council

# Minutes of the meeting of Children and young people scrutiny committee held at Committee Room 1 - The Shire Hall, St. Peter's Square, Hereford, HR1 2HX on Monday 25 November 2019 at 10.15 am

**Present:** **Councillor Carole Gandy (chairperson)**
**Councillor Diana Toynbee (vice-chairperson)**

**Councillors: Graham Andrews, John Hardwick Phillip Howells and Mike Jones**

**Co-optees: Pat Burbidge and Andy James**

**In attendance:** **Councillor David Hitchiner, Councillor Liz Harvey and Councillor Felicity Norman**

**Officers:** **Chris Baird (Director of Children and Families), Andrew Lovegrove (Chief Finance Officer) and Liz Elgar (Assistant Director Safeguarding and Family Support).**

## 21. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Paul Andrews, Councillor Kath Hey and Nicola Kinson.

## 22. NAMED SUBSTITUTES

Councillor Graham Andrews acted as a substitute for Councillor Paul Andrews.

Councillor John Hardwick acted as a substitute for the Herefordshire Independents vacancy on the committee.

## 23. DECLARATIONS OF INTEREST

There were no declarations of interest.

## 24. MINUTES

The minutes of the meeting held on 16 September 2019 were agreed as a correct record and signed by the Chairperson.

## 25. QUESTIONS FROM MEMBERS OF THE PUBLIC (Pages 7 - 10)

The questions and supplementary questions received from members of the public are attached at the appendix.

## 26. QUESTIONS FROM MEMBERS OF THE COUNCIL

There were no questions from members of the Council.

## 27. REVIEW OF BUDGET AND CORPORATE PLAN PROPOSALS FOR 2020/21 RELATING TO THE REMIT OF THE CHILDREN AND YOUNG PEOPLE SCRUTINY COMMITTEE.

The committee considered a report by the Leader of the council which outlined the draft budget and corporate plan proposals for 2020/21. The chief finance officer (CFO) introduced the report and provided the presentation attached to the agenda. The CFO explained the process to be followed in developing the budget which would see it return to the January meeting of the committee and explained the themes contained in the corporate plan. He explained that a proposed pooled budget for social care would cover adults and children and would allow the council to determine where spending should be committed in future to meet pressures. The capital investment priorities in the children and families directorate were outlined.

The director children and families (DCF) explained that the budget was set in the context of the new children and young people's plan and the priorities contained within the plan. Work on the priories from the plan was undertaken with a range of partners who were also looking at financial constraints and issues as well as what more could be done. Within the Council the education, development and skills strategy had been included from the last three year period which contains different areas currently being worked on including early years settings, schools, colleges and other partners; some of this relates directly to the capital budget including the school investment strategy. The safeguarding family support development plan which is a one year plan within the service of the different areas being worked on which prioritised that work which could be done at an earlier stage to prevent children becoming looked after to continue to seek to address the high level of looked after children in Herefordshire. Proposals in the budget included the improvement of practice around social work practice and retention and recruitment. The current pressures consisted on placement costs, corporate contingency was in place to address where there was need for additional spend on children services however a lot of work was undertaken to attempt to keep costs within budget. There were a number of pressures including county lines which the council was working closely with the police and it was an area where the needs of children were having to be met to ensure they were safe. Supported accommodation costs had increased particularly with respect to care leavers; the council had acquired additional duties recently and were responsible for care leavers up to the age of 25. One of the proposals was to develop services to meet need earlier including edge of care to increase support for families and children who need to be cared for outside of the family. The services sought to work with families and carers to return children to the family network as appropriate; work had been ongoing with Staffordshire to learn about practice in edge of care work but cabinet had agreed some funding to support the development of the service.

The cabinet member children and families explained that investment was targeted in those areas where it was required.

The cabinet member finance and corporate services explained that the consultation that had been undertaken had engaged a significant number of consultees to help prioritise investment and determine the priorities in the corporate plan. The budget proposed an uplift in the revenue budget for children and families which was intended to support an aspiration to get to a 'good' Ofsted rating for children's services and to support children. The investment that was planned proposed transformational change to address the level of looked after children however it was important to retain a perspective on the breadth of services provided by children and families including educational attainment.

The Leader explained that the significant issue facing the budget was the number of looked after children and the challenge was to meet more of their needs without the need to come into care.

The committee made those points below in the debate that followed:

- There was support for the areas identified for the planned investments for looked after children, edge of care and improving social care services.
- The level of the increase in the base budget for children and families was queried and how additional pressures would be met if they arose during 2020/21. *The CMF&CS explained the significant increase in the base budget but account needed to be taken of the savings agreed previously and the additional pressures the service was experiencing which meant that how money was being spent in the directorate was shifting. The increase to the base budget was separate to the planned, additional investment. It was acknowledged that individual social cases were not predictable but the financial parameters and pressure for the children and families budget were understood. The CFO concerns the 18/19 base budget was £23.4 million, in 19/20 it was £27 million and for 20/21 it is proposed to be £30.4 million. There was a different approach in the previous year when a contingency arrangement was put in place.*
- It was queried why savings targets were included in the budget if there were such unpredictable pressures. *The DCF explained that savings and efficiencies could still be achieved in certain areas of the service.*
- It was queried when the preventative work funded from the planned investments in the budget would commence. *The DCF explained that the cabinet had made an initial investment in May 2018 to increase early help and family support work as prevention and also to provide more capacity for social work.. Work was also ongoing in respect of the edge of care service and there was engagement with Redbridge Council to look at what more could be done to coordinate early help and the MASH. Work was ongoing with partners to define early help and how work could be undertaken with schools and early years settings to ensure effective coordination.*
- The work that was to be undertaken in respect of dental health was raised; what budget was available and what was planned? *The DCF explained that public health were working with NHS England and seeking to support parents to improve the dental health of children.*
- It was queried how the current situation at the Brookfield school had arisen. *The interim Education and Capital manager explained that the school was the only SEMH school in Hereford and demand for places was high. The nature of the site and setting of the school was constrained which made improvements difficult. It was recognised that investment and improvement was required which the business case set out.*
- The costs associated with care leavers in the report were queried and how many were supported. *The DCF explained that the costs concerned the provision of supported accommodation for care leavers. The number of care leavers currently being supported would be provided after the meeting.*
- It was queried whether the investment planned was sufficient to meet the challenges faced by children's services. *The CMC&F (cabinet member children and families) explained that a realistic approach to meeting challenges was being undertaken with new ways of addressing issues proposed. The CMF&CS explained that investment was targeted to realise improvements in the long term; to divert children from care at an early stage by funded preventative services.*

**RESOLVED: That the committee:**

- **Supports the planned investments for looked after children, edge of care and improving social care services and requests further information is submitted to the committee regarding proposals for these services; and**

- **Asks that a report concerning the dental health initiatives is provided to the committee setting out key performance indicators for the proposals.**

## 28. UPDATE ON REDUCING THE NUMBER OF LOOKED AFTER CHILDREN (LAC)

The committee received a report from the director children and families concerning an update on reducing the number of looked after children (LAC). The Assistant Director Safeguarding & Family Support introduced the report and explained that work to reduce the numbers of LAC included: pursuing special guardianship orders (SGOs) where appropriate; identifying children at risk of becoming looked after at an earlier stage and working with families; seeking to revoke care orders where children were living at home; ensuring that pre-proceedings work was robust; that the alternatives to care panel was sufficiently challenging; the introduction of signs of safety; and ongoing work with other local authority areas to improve processes and systems.

The committee raised those comments below in the debate that followed:

- The outcomes for the 80 children identified in 2017 as potentially suitable for SGOs or reunification was queried. *The ADS&FS explained that during 2017 there was not a tracker to keep a record of the progress of children. A tracker was now in existence which would record the progress of the 49 children currently identified as suitable for SGO or reunification.*
- It was queried whether the review of children that had become looked after between August – October 2019 had included an assessment of early help offered. *The ADS&FS explained that all options were discussed at the alternatives to care panel to attempt to keep children with their families. During pre-proceedings arrangements there was an examination of all work undertaken with children at risk of becoming looked after children.*
- The timescales involved in the provision of early help was queried. *The ADS&FS explained that early help was an approach which had seen the amount of assessments increase steadily. In some settings, such as schools, where a need was identified the provision of early help could be undertaken very quickly.*
- The distinction between edge of care and early help was queried. *The cabinet member for children and families explained the different approaches; edge of care worked with children who were in care or on the cusp of becoming looked after children. Early help was undertaken at a prior stage to work with children and families to divert from care those at risk of becoming looked after children. Members of the committee were encouraged to attend a meeting of the alternative to care panel and the corporate parenting panel and also to visit the MASH.*

**RESOLVED: That the committee:**

- **Recognises the work that has been undertaken and the progress made in implementing systems to reduce the numbers of looked after children; and**

- **Asks that a report is submitted to a meeting in 12 months times which provides a breakdown of the progress made in regard of the 49 children identified for SGOs or reunification.**

## 29. REVIEW OF PERFORMANCE AND PROGRESS AGAINST THE SAFEGUARDING AND FAMILY SUPPORT IMPROVEMENT PLAN 2019 / 2020

The committee received a report from the ADS&FS concerning progress against the safeguarding and family support improvement plan 2019/20. The ADS&FS introduced the report and explained that the challenges presented in the report consisted of the

recruitment of social workers and timeliness of visits. A significant amount of work had been undertaken in the recruitment of social workers which had resulted in the appointment recently of a principal social worker who had made appointments to three posts in the social work academy. The timeliness of visits was judged against a high and aspirational target; social workers often had to prioritise urgent and severe cases which affected timeliness results. The DCF explained that the self-assessments for each of the areas in children and families would be circulated after the meeting.

The committee raised the points below in the debate that followed:

- It was queried whether the risk assessments relating to the potential for child exploitation had been brought up to date. *The ADS&FS confirmed that this work had been completed.*
- The boost in social worker numbers was welcomed but it was noted that the indicator in the report was showing as a downward direction of travel. *The ADS&FS explained that recruitment to some teams had been successful but if remained very difficult to make appointments to teams such as the child protection and court teams.*
- It was queried whether there was concern regarding the 16+ team. *The ADS&FS and DCF explained that a number of staff on the team were leaving but there would be a concerted effort to recruit replacements.*

**RESOLVED: That the committee notes the report and the improvements made since the previous quarter.**

## 30. WORK PROGRAMME REVIEW

The committee considered a report by the democratic services officer which provided the latest version of the work programme 2019/20; an amended scoping document for the peer on peer abuse in schools spotlight review; and the recommendation tracker.

The Chairperson of the committee explained the changes to the work programme as contained in the report. She also explained the amendment to the scoping document which sought to ensure the voice of the child was heard and explained she would read a statement at the spotlight review with the agreement of the author and family.

**RESOLVED: That the committee:**

- **Agrees the updated version of the work programme; and**

- **Approves the amended terms of the reference for the peer on peer abuse in schools spotlight review scoping document subject to the inclusion of reference to a statement to be read aloud if permission was granted.**

## 31. DATE OF NEXT MEETING

The next meeting of the committee was scheduled for 2.00 p.m. on 14 January 2020. The start time for the meeting would be confirmed in due course.

The meeting ended at 12:45 p.m. **Chairperson**

**Supplement – schedule of questions received for meeting of children and young people scrutiny committee – 25 November 2019**

**Agenda item no. 5 - Questions from members of the public**

| Question Number | Questioner | Question | Question to |
|---|---|---|---|
| PQ 1 | Ms Steel, Hereford | At the last CYP scrutiny meeting two public questions were asked in connection with the safety of children in this county. To date, the Council has failed to give a substantive answer to either question.<br><br>The first public question on 16th September was:<br><br>*How long is a reasonable delay between the Council being alerted to possible safeguarding failure, and the Council starting an investigation?*<br><br>The second question referred to a case taken by a child in the county under the Human Rights Act in connection with safeguarding failures after a peer-on-peer sexual assault:<br><br>*Has the Committee seen evidence that the Council undertook a thorough investigation into the 2018 case in order to learn lessons?*<br><br>Why has the committee failed to offer substantive answers to these questions when both are highly relevant to the safety and well-being of children? | Chairperson of Children and Young People Scrutiny Committee |

**Response:**
Thank you for your question.

At the previous meeting of the children and young people scrutiny committee on 16 September the public questions outlined in this question were answered with a statement that the committee would consider the issues raised during its consideration of the scoping document for the peer on peer abuse in schools spotlight review. The committee later approved a scoping document for the peer on peer abuse in schools spotlight review which seeks to investigate policies and procedures at the council to respond to safeguarding concerns over peer on peer abuse in schools but which does not provide for the examination of individual cases. During the spotlight review I will be willing to pose the first question concerning alleged delay to officers. With respect to the question concerning an investigation into a previous case; the commissioned report, appropriately redacted as it refers to the council rather than the school, will be considered as part of the success/effectiveness of policies to address peer on peer abuse in schools.

**Supplementary Question:**
Why have you not initiated an immediate review of all cases of peer on peer sexual assault which have come to the MASH team to ensure that no child is at risk of harm today from the delay in rectifying inadequate and unlawful safeguarding?

**Response from Councillor Norman to supplementary question:**

I would like to take this opportunity to apologise on behalf of the council. No child should be put at risk from physical or emotional harm and when that does happen we strive to have the right approach and support for them. We have investigated our practices in relation to peer on peer abuse and it has become apparent that officers made an error in judgement in recommending the best course of action. There is no doubt that there should be support and advice available for victims, teachers and parents. We as a council play our part in this and are working with others to see what more can be done. There are now clearer procedures and processes in place to improve the way council staff work with children, families, schools and colleges. In the last few years there have been advances in national guidance and we have significantly improved our work alongside partners and schools. As a council we identify the improvement needed and we offer additional support and tools for teachers to help them respond appropriately and continue to discuss and develop our collective approach to the national guidance with schools and colleges.

I will categorically state that, although you can never be sure that there is not a risk of the abuse happening, I am assured that every step that can be taken is being taken and can assure we put out a full recent statement to that effect. I do feel we are doing all that we can and please remember this is not only the Council but all partners with whom we work very closely. We have a number of activities to help to strengthen that safeguarding approach including an extremely successful conference for all safeguarding leads from the schools a couple of weeks ago. We are doing all that we can, I think Chris Baird could add something or something in writing would be more useful where we can very specifically outline our understanding of the issue.

**Response from Chris Baird to supplementary question:**
Every case that is referred into MASH we do work with schools and the families as well as their ongoing safeguarding issues. If there are any concerns about children now then we would like to hear them and we will look into any cases brought to our attention, as well as reflecting on what we are doing with current cases. Not all cases are open to children's social care so part of our work is how we coordinate with schools and others on the ongoing safety of children on a day to day basis.

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| PQ 2 | Ms Liddle | The Spotlight Review on peer-on-peer sexual abuse will not look at historical failures to protect children after they disclose an incident, nor at the failure of the Children's Directorate to learn lessons from safeguarding errors made by Council MASH officers. Does the Children's Scrutiny Committee propose to undertake any scrutiny of how safeguarding errors have continued for over three years despite members of the public repeatedly raising their concerns on this issue? | Chairperson of Children and Young People Scrutiny Committee |

**Response:**
Thank you for your question.

I confirm that the peer on peer abuse in schools spotlight review will not examine historic, individual safeguarding cases. The spotlight review will be provided with detail of the procedures and policies that the council and local schools have in place to respond to and address cases of peer on peer abuse in schools. It will determine whether those procedures and policies are robust and fit for purpose and will seek to make recommendations on any elements it considers inadequate. The children and young people scrutiny committee will consider the outcomes of the spotlight review (including its assessment of current safeguarding arrangements with respect to peer on peer abuse in schools) and determine whether any recommendations should be sent to the executive.

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| PQ 3 | Ms Shore | The anonymity of victims of sexual offences is protected by law. However, so is their right to waive anonymity. At the last CYP scrutiny meeting, the Chair decided that victims of peer on peer sexual abuse would not be invited to give evidence to the upcoming Spotlight Review in order to protect their anonymity. This takes the right to waive anonymity away from victims. The effect renders them powerless, replicating the | Chairperson of Children and Young People |

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| | | loss of control they have already been subjected to in their assault. Learning from empowerment experienced by survivors in the Me Too movement, will the committee respect victims' rights to make their own choices about submitting evidence to the Spotlight Review in person or by representative and make reasonable arrangements for written evidence from them, their family/friends to be submitted - named or anonymously as the victim chooses. | Scrutiny Committee |

**Response:**
Thank you for your question.

This is a sensitive issue and it is one which has been debated and considered at length during the production of the scoping document for the peer on peer abuse in schools spotlight review and in arrangements for the meeting. There is a difficult balance to strike between ensuring that the impact on victims of peer on peer abuse in schools is understood by the spotlight review and that an open forum is provided to allow the public to see scrutiny of an issue which has caused public concern. You are correct that the scoping document for the spotlight review does not contain provision for individual victims of peer on peer abuse to submit statements or address the review in person. Instead the spotlight review seeks to hear about the impact on victims from the children's charities and support groups that will be in attendance at the meeting. I have set out below my thinking as to why the spotlight review has taken this approach and why there is concern over the provision of witness statements, either written or in person:

- As I have stated in response to an earlier question, the spotlight review will not examine individual safeguarding cases but will focus on the safeguarding procedures the council has in place and to determine if the arrangements provide assurance. To receive individual testimony from victims would militate against this purpose and would potentially lead to discussions and debate of individual cases.
- You state that victims of sexual assault have a right to waive their anonymity. I think it important to retain a perspective that the victims of peer on peer abuse in schools will be children. I have never been entirely comfortable with the notion of accepting testimony in a meeting in public from children; be that evidence that is written, provided in person or anonymised. The potential impact on a child of reliving their experiences to provide a statement, of having their case presented in a meeting in public and debated is impossible to quantify. Without appropriate support and guidance, which the council would not be able to guarantee for witnesses, there is the potential for harm. I contend this is also the case for any young person who would have been a child when they were the victims of peer on peer abuse at school. However, I am currently investigating the potential of using a piece of correspondence, concerning the impact of peer on peer abuse in schools, at the spotlight review and I hope to be able to provide more detail on this at the meeting on Monday 25 November or soon after.

The peer on peer abuse in schools spotlight review is to be held in public. If the session had been conducted in private some of the reservations outlined above would be overcome. However, as mentioned, this is a balance we have sought to strike in undertaking the review in public.

I would also encourage any members of the public who wish to outline their experiences to write to me. This is their right and I would consider carefully the information provided. If any correspondence provided permission for onward dissemination at the spotlight review and I felt that it would help provide a level of insight I would consider circulating it. However this will only be possible if informed consent is provided to share the correspondence and that none of the detail would be capable of identifying any individuals.

**Supplementary Question:**
I am very unclear about how the general public out there including victims of sexual abuse will know that is something they can do as they are unaware of scrutiny committees. I'm concerned that whilst it is good that the spotlight review is occurring and that it will look at all aspects of abuse there is a systematic need to look at violence against women and children. I would like as well as the spotlight review I would like there to be a concentration on the

sexual abuse aspect. I accept that they take it seriously but there needs to be some specific action to ensure that there are no children in that position and I don't see that it is clear in the answers provided to the public questions this will happen.

**Response from Councillor Gandy to supplementary question:**
I have taken a decision that I will read out an impact statement, providing I get written agreement from an individual. I am happy to read out impact statement which together with the information we get from the children's society, the rape crisis centre and other voluntary organisations will provide the voice of the child impact upon the individual. I understand concern how to get out to the wider public about the spotlight review and I will talk to officers as to how we achieve that. The spotlight review covers all forms of abuse, including peer on peer sexual abuse which is an area people have raised concerns about but the review will also not shy away from such abuse on social media that has led to suicide.

Herefordshire Council

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| **Meeting:** | **Children and young people scrutiny committee** |
| **Meeting date:** | **Tuesday 14 January 2020** |
| **Title of report:** | **Review of budget and corporate plan proposals for 2020/21 relating to the remit of the Children and Young People Scrutiny Committee** |
| **Report by:** | **Leader of the council** |

## Classification

Open

## Decision type

This is not an executive decision

## Wards affected

(All Wards);

## Purpose and summary

To seek the views of the children and young people scrutiny committee on the budget proposals for 2020/21 and on the draft corporate plan as they relate to the remit of the committee.

The draft proposals have been considered by the committee on 25 November. The committee is now asked to reconsider the children and young people revenue and capital budget proposals following the conclusion of public consultation.

The committee is invited to make recommendations to inform, constructively challenge and support the process for making cabinet proposals to Council regarding the adoption of the budget and associated budget framework items.

## Recommendation(s)

**That:**

**(a) the committee determine any recommendation it wishes to make to Cabinet in relation to the 2020/21 budget and corporate plan proposals specifically affecting**

Further information on the subject of this report is available from
Josie Rushgrove, Tel: 01432 261867, email: jrushgrove@herefordshire.gov.uk

**children and young people.**

## Alternative options

1. There are no alternatives to the recommendations. Cabinet is responsible for developing budget proposals and a draft corporate plan for full Council's consideration and it is a function of this committee to make reports or recommendations to the executive with respect to the discharge of any functions which are the responsibility of the executive. The council's budget and policy framework rules require Cabinet to consult with scrutiny committees on budget proposals.

2. It is open to the committee to recommend alternative spending proposals or strategic priorities; however given the legal requirement to set a balanced budget should additional expenditure be proposed compensatory savings proposals must also be identified.

## Key considerations

3. Every four years, Herefordshire Council develops a corporate plan which sets out the council's ambition and priorities. The revised proposed corporate plan is attached at appendix 1 and sets out three key ambitions:-
    - Economy – support to build on the county's strengths and resources
    - Environment – protect to keep Herefordshire a great place to live
    - Community – ensuring everyone lives well and safely together

4. The proposed corporate plan objectives will set the priorities to ensure the best use of resources and deliver services that make a difference to people of Herefordshire. A delivery plan will follow the adoption of the corporate plan and will identify the key projects planned each year to achieve progress towards the council's priorities. Regular reports monitoring progress against the objectives will then continue to be presented to Cabinet; detailing the latest budget position, as well as performance against delivery of the key activity and achievement of performance measures. The committee is invited to comment on the draft corporate plan priorities specifically in reference to children and young people.

5. Funding and service demand pressures do continue and the new corporate plan will establish the councils focus in supporting and addressing this going forward. This report proposes a balanced budget and includes a 3.9% total increase in council tax, a 3% expected annual pay increase settlement, 200 additional new homes above the assumed growth in new homes (increasing the expected amount of council tax income) and the central government 2019 spending review announcement.

6. The proposed 2020/21 revenue budget is based on an assumed total council tax increase of 3.9%, 1.9% increase in core council tax and a 2% adult social care precept. This increases the band D equivalent charge to £1,573.77 representing an increase of £1.14 per week.

7. The 2020/21 budget proposals include the creation of social care pooled budget of £2.1m, this would cover adults and children and would allow the council to determine where spending should be committed in future to meet pressures.

**2020/21 budget proposals**

8. The budget proposals for children and young people have not changed since the previous scrutiny meeting in November, as shown below:-

| Table 1 | 19/20 revised base £m | Savings £m | Looked after children £m | Edge of care £m | Improving social care services £m | Inflation pressures £m | Total £m |
|---|---|---|---|---|---|---|---|
| Proposed budget - revenue | 27.2 | (0.3) | 1.1 | 1.0 | 1.0 | 0.7 | 30.7 |

9. Overall the revenue budget proposed above shows an increase in the base budget to address revenue budget pressures being experienced now and expectations of the continuing of this pressures. The proposals include funding new initiatives to manage demand pressures through early intervention and improvements in support services.

10. The proposals are set in the context of the children and young people's plan 2019-2024 with the aim that by 2024 Herefordshire children and young people will:-
    - Be safe from harm – the right support at the right time
    - Be amazing – through providing a great start in life
    - Be healthy – help in keeping active and eating healthy
    - Be part of the community – through involvement in decision making effecting the provision of services to children and young people

11. The budget for looked after children is proposed to address the numbers of children requiring this support, this continues to be a budget pressure however the rate of new entrants is coming down. Cost pressures in this area is being seen nationally, the challenge continues to be to meet more of their needs without the need to come into care. The proposed covers an estimated cost. Any costs associated with meeting children's needs further to this will be treated as a corporate risk and budget pressure.

12. The proposed edge of care additional budget will support the provision of an early help edge of care service to support more children staying with their families safely or to return to their families. The safeguarding family support development plan is a one year plan within the service of the different areas being worked on, prioritising work which could be done at an earlier stage to prevent children becoming looked after. By meeting needs earlier through increasing support for families and children who need to be cared for outside of the family, the services sought to work with families and carers to return children to the family network as appropriate.

13. The proposed improving social care services additional budget include the improvement of practice around social work practice and retention and recruitment of social workers. This enhanced service will support work to address children's needs at the right time and with the right services, including supporting children outside of the care system. Specifically the "signs of safety" social work model will be implemented over the next two years, including with partners to provide a strengths based approach with children and families. To be successful this will require resources to implement and embed and also

worker caseloads to be manageable and social workers supported with high quality supervision and training. Steady progress is being made in this area in terms of recruitment and retention but there is more to do.

14. The proposals recommend an increase in the budget associated with services for children and young people to meeting challenges through new ways of addressing issues, targeted to realise improvements in the long term, specifically through diverting children from care at an early stage by funding preventative services. Cost drivers are linked to individual services, by ensuring early help and improved support is provided this in turn will deliver reduced costs and better outcomes.

15. The capital investment budget proposals, shown in table 2 below, are in relation to increasing existing capital investment budgets to support the initiative of driving sustainable school improvement and place availability to meet demand.

| **Scheme** | **Description** | **Current Capital Programme £m** | **Total 21/22 request from capital receipt funding £m** |
|---|---|---|---|
| Brookfield School | Improvement project seeking to achieve higher school buildings compliance, more robust fire evacuation buildings compliance, the release of a council owned split site facility at Symonds Street, the capacity to deliver the full statutory curriculum and improved accommodation. | 2.7 | 1.2 |
| Peterchurch Primary School | A replacement primary school for Peterchurch including all teaching and support spaces, including playground and playing field, necessary for it to function as a full one form entry school. The facility will include for the provision of a nursery and continued use of the swimming pool | 5.5 | 5.3 |
| **Total** | | **8.2** | **6.5** |

## Financing

16. The 2020/21 net budget requirement is financed by retained funding from council tax (£109.8m) and business rates (£36.7m). Assumptions include a 3.9% increase in council tax (1.9% general increase and 2% adult social care precept) and business rate reliefs being funded via a central government grant. Central government funding is included as announced in the provisional funding settlement, the final local government funding settlement is yet to be announced.

17. The provisional settlement announced on 20 December 2019 included £2.2m new home bonus grant income. The overall allocation for each authority is based on the legacy payments for 2017/18 to 2019/20, the ministerial statement announced a Spring 2020 consultation on the future of the scheme, stating that “It is not clear that the New Homes Bonus in its current form is focused on incentivising homes where they are needed most”

and the consultation will “include moving to a new, more targeted approach that rewards local authorities where they are ambitious in delivering the homes we need, and which is aligned with other measures around planning performance”.

18. For this reason it is proposed that this funding is treated as one of funding and is considered for utilisation to fund unforeseen budget pressures in relation to the costs of looked after children. Other consideration include introducing a grant scheme for the Arts, road maintenance or free bus travel.

19. Council tax charges for the last five years are shown in table 3 below:-

**Table 3**

| Council tax band | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 |
|---|---|---|---|---|---|
| A | £850.07 | £883.22 | £917.67 | £962.63 | £1,009.80 |
| B | £991.74 | £1,030.42 | £1,070.61 | £1,123.07 | £1,178.10 |
| C | £1,133.42 | £1,177.63 | £1,223.55 | £1,283.51 | £1,346.40 |
| D | £1,275.10 | £1,324.83 | £1,376.50 | £1,443.95 | £1,514.70 |
| E | £1,558.46 | £1,619.24 | £1,682.39 | £1,764.82 | £1,851.30 |
| F | £1,841.81 | £1,913.64 | £1,988.28 | £2,085.70 | £2,187.90 |
| G | £2,125.17 | £2,208.05 | £2,294.16 | £2,406.58 | £2,524.50 |
| H | £2,550.20 | £2,649.66 | £2,753.00 | £2,887.89 | £3,029.40 |

20. Prudent estimates have been used in providing the council tax and business rates funding assumptions. If additional resource is made available at the final budget setting stage it is proposed to use the additional funding to uplift the centrally held contingency budget.

21. If the final settlement provides additional monies to the draft base budget shown above, unless the use of those funds is specified by government, Cabinet will seek the views of the scrutiny committees as to the best way of deploying the extra funding. In the interim the funding will be allocated to reserves.

**Budget setting timetable**

22. Below is a summary of the 2020/21 budget setting timetable. The committee has already reviewed the proposals at its meeting in November.

| Date | Event | Purpose |
|---|---|---|
| 13 January 2020 | Adults and wellbeing scrutiny committee | To consider adults and wellbeing revenue and capital budget proposals following the conclusion of public consultation and agree any recommendations to be made to Cabinet |
| 14 January 2020 | Children and young people scrutiny committee | To consider children and young people revenue and capital budget proposals following the conclusion of public consultation and agree any recommendations to be made |

| | | |
|---|---|---|
| | | to Cabinet |
| 20 January 2020 | General scrutiny committee | To consider the overall revenue and capital budget proposals following the conclusion of public consultation and agree any recommendations to be made to Cabinet |
| 30 January 2020 | Cabinet | To agree the corporate plan, draft revenue and capital budget 2020/21, treasury management strategy, capital strategy and medium term financial strategy for recommendation to Council |
| 14 February 2020 | Council | Deadline for Members intending to propose an amended motion (as per Section 1 paragraph 4.1.105 and 4.1.106 of Constitution) |
| 14 February 2020 | Council | To agree the council's corporate plan, revenue and capital budget for 2020/21, treasury management strategy, capital strategy and medium term financial strategy |

## Community impact

23. The budget proposals demonstrate how the council is using its financial resources to deliver the priorities within the proposed corporate plan.

24. The council is committed to delivering continued improvement, positive change and outcomes in delivering key priorities as set out in the corporate plan.

25. In accordance with the principles of the code of corporate governance, Herefordshire Council is committed to promoting a positive working culture that accepts, and encourages constructive challenge, and recognises that a culture and structure for scrutiny are key elements for accountable decision making, policy development, and review.

## Equality duty

26. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

A public authority must, in the exercise of its functions, have due regard to the need to -

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

27. Service specific equality impact assessments will be completed for the service specific budget proposals to assess the impact on the protected characteristic as set out in the Equality Act 2010. The duty means that the potential impact of a decision on people with different protected characteristics is always taken into account when these assessments have been completed then we will consider mitigating against any adverse impact identified.

## Resource implications

28. The financial implications are as set out in the report. The ongoing operational costs including, Human Resources, Information Technology and property resource requirements are included in the draft budget and will be detailed in separate governance decision reports as appropriate.

## Legal implications

29. When setting the budget it is important that councillors are aware of the legal requirements and obligations. Councillors are required to act prudently when setting the budget and council tax so that they act in a way that considers local taxpayers. This also covers the impact on future taxpayers.

30. In acting prudently, the council has an obligation to determine whether any planned council increase is excessive (based on a set of principles defined by the Secretary of State, and approved by the House of Commons).

31. To avoid having to hold a referendum, the Council must raise less than the threshold. Alternatively, if an excessive increase in council tax is proposed, the council must hold a local referendum and obtain a 'yes' vote before implementing the increase. The council must also make substitute calculations, based on a non-excessive council tax level. This takes effect if the excessive increase is rejected in the referendum.

32. The Local Government Finance Act 1992 requires a council to set a balanced budget. To do this the council must prepare a budget that covers not only the expenditure but also the funding to meet the proposed budget. The budget has to be fully funded and the income from all sources must meet the expenditure.

33. Best estimates have to be employed so that all anticipated expenditure and resources are identified. If the budget includes unallocated savings or unidentified income then these have to be carefully handled to demonstrate that these do not create a deficit budget. An intention to set a deficit budget is not permitted under local government legislation.

34. The council must decide every year how much they are going to raise from council tax. The decision is based on a budget that sets out estimates of what is planned to be spent on services. Because the level of council tax is set before the year begins and cannot be increased during the year, risks and uncertainties have to be considered, that might force higher spending more on the services than planned. Allowance is made for these risks

by: making prudent allowance in the estimates for services; and ensuring that there are adequate reserves to draw on if the service estimates turn out to be insufficient.

35. The council's budget and policy framework rules require that the chairmen of a scrutiny committee shall take steps to ensure that the relevant committee work programmes include any budget and policy framework plan or strategy, to enable scrutiny members to inform and support the process for making cabinet proposals to Council.

36. Section 106 of the Local Government Finance Act 1992 restricting councillors voting on certain matters where they are in arrears of council tax, does not apply to scrutiny function as the views from scrutiny on the budget are not a recommendation for approval, a resolution or any other type of decision. As a result a s106 check of councillors arrears has not been undertaken.

## Risk management

37. Section 25 of the Local Government Act 2003 requires the S151 officer to report to Council when it is setting the budget and precept (council tax). Council is required to take this report into account when making its budget and precept decision. The report must deal with the robustness of the estimates included in the budget and the adequacy of reserves.

38. The budget has been updated using the best available information; current spending, anticipated pressures and the provisional settlement. This draft will be updated through the budget setting timetable.

39. The most substantial risks have been assessed as part of the budget process and reasonable mitigation has been made. Risks will be monitored through the year and reported to cabinet as part of the budget monitoring process.

40. There are additional risks to delivery of budgets including the delivery of new homes, Brexit, government policy changes following the general election and unplanned pressures. We are maintaining a general fund reserve balance above the minimum requirement and an annual contingency budget to manage these risks.

41. Demand management in social care continues to be a key issue, against a backdrop of a demographic of older people that is rising faster locally than the national average and some specific areas of inequalities amongst families and young people. The budget proposed in this report include risk mitigation measures.

## Consultees

42. Initial public consultation was completed and reported to the meeting on 25 November. At that meeting the committee confirmed their support for the proposed investment in looked after children, edge of care and improving social care services. The committee requested further information be submitted to the committee regarding the proposal for these services, this has been provided in the body of this report.

43. The committee also asked for a report concerning the dental health initiatives is provided to the committee setting out key performance indicators for the proposals. A comprehensive Oral Health Needs Assessment for Herefordshire was published in September 2019 which resulted in 10 key recommend actions. This is attached at Appendix 3. Following this a multi-agency partnership group (Oral Health Improvement

Group) was established in October 2019. The group includes representation from Herefordshire Council, Public Health England, NHS England/Improvement, Healthwatch Herefordshire and the Local Dental Committee. A draft version of an Oral Health Improvement Plan has been shared with this group, in addition to colleagues in the Public Health Team for comments. An update on progress including the final version of the Oral Health Improvement Plan, activities and spend will be shared to committee members as these become available.

44. Further public consultation on the 2020/21 budget and corporate plan 2020-24 has concluded. The consultation ran from 6 November to 4 December. The consultation questionnaire was published on the Herefordshire Council website and residents were invited to complete it online. A printable version was given upon request. The consultation was promoted on the council's social media sites (Twitter and Facebook). In addition to the online survey, there were pop up events held in the market towns and in Hereford City.

45. Attached at appendix 2 is a report on the key points from the analysis of standard responses received to the online consultation questionnaire, an analysis of free text comments and suggestions and trend data when compared to the previous year's consultation. 269 online survey responses were received.

46. On the proposed budget the responses included that 52% of respondents thought that a council tax increase of 4% is about right or too little.

47. 53% did not agree with the allocation of council tax as set out in the proposed till receipt and 21% reported "no opinion", a similar response was received in the previous year. 136 comments were received, below is a table presenting the most popular common themes emerging from the comments:-

| Theme | No. of comments |
|---|---|
| Increase too high /above inflation / not enough money to live on / not value for money / stop wasting money | 38 |
| Too much on admin / IT costs / contractors / waste / councillors and directors pay / interest on borrowing | 26 |
| Not enough on climate change, public spaces / environment / recycling and waste collection | 20 |
| Not enough on public / community / sustainable / rural transport | 17 |
| Not enough roads / road safety and infrastructure / cycle paths / public rights of way | 16 |
| Not enough on libraries / culture / tourism | 10 |

48. Additionally, responses included:-

- In relation to the council tax reduction scheme 63% wanted to keep the council tax discount at 84% or increase it and 52% supported a introducing a minimum award of £5 a week; and

- 75% supported continuing with the current levels of business rate discounts or increasing them.

49. In respect of Herefordshire Council Priorities responses include:-

- Community hubs - 63% of respondents indicated that Herefordshire would benefit to this investment with the most favoured options being ‘health and social care services’(79%), ‘wellbeing help, advice and activities’ (73%) and ‘children's centres’ (71%).
- Community assets - 54% of respondents thought that the council should retain publicly owned land and buildings and manage them on behalf of everyone in the county.
- Affordable housing - 79% of respondents agreed that the council should invest money in developing additional affordable housing stock and retaining it in public ownership.
- Council owned care homes - 81% of respondents supported for investing in council owned care homes or care villages to support vulnerable children, young people and adults with accommodation and care needs.
- Tourism - 65% of respondents thought that it was important for the council to invest to support tourism.
- Core Strategy review - 71% of respondents thought that the council should undertake a fundamental review of the Core Strategy, even though it is a substantial piece of work, investment and will take over three years to complete.
- Maintenance of highways and public spaces - 76% of respondents agreed with the additional funding in public realm.
- Public transport - 16% of respondents indicated that they were regular users of public transport. From a list of options, ‘lack of availability of public transport in my local area’ (56%) and ‘timetables do not match my needs’ (54%) were selected as the most common reasons for not using public transport regularly.
- Planning and investment to address the climate emergency - 64% respondents thought that the council should invest resources to lead a local response to the climate emergency.
- Digital and better use of technology - 72% of respondents supported further investment in technology to enable new and improved ways of delivering services.
- Additional investment - some priority areas for investment were more favoured than others. If we take the overall weighted average for each priority, five areas were noticeably more favoured than the others, with not much difference in support between these five. They were, in order of priority, maintenance of highways and public spaces, planning and investment to address the climate emergency, care homes and accommodation for vulnerable people (children, young people and adults), affordable housing (publicly owned) and public housing.

## Appendices

| | |
|---|---|
| Appendix 1 | Revised draft corporate plan |
| Appendix 2 | Public consultation responses |
| Appendix 3 | Herefordshire Oral Health Needs Assessment (2019) |

## Background papers

None identified

## Glossary

Further information on the subject of this report is available from
Josie Rushgrove, Tel: 01432 261867, email: jrushgrove@herefordshire.gov.uk

| | |
|---|---|
| Adult social care precept | Council tax charge for adult care services |
| Affordable housing | Social rented, affordable rented and intermediate housing |
| Code of corporate Governance | Guidance on the delivery of good governance |
| Community hubs | Local locations for communities to engage |
| Council tax reduction Scheme | Council tax discount for low earners |
| Early help assessments | Questionnaire to determine support requirements |
| Early year's strategy | The councils strategy to provide help for children and families as soon as indications of problems start to emerge |
| Edge of care | Support intended to divert need for conventional care |
| Funding settlement | Central government funding allocations to local councils |
| Healthwatch Herefordshire | Herefordshire's consumer champion for local health and social care |
| NHS England | National Health Service |
| Public Health England | Executive agency of the Department of Health and Social Care |
| S151 officer | Statutory chief financial officer of the council |
| Signs of safety | A widely used framework that aims to reduce the need for children to enter care, through a strengths-based approach |
| Social care pooled budget | Available to address both children's and adults budget pressure |

Herefordshire Council

# *Our ambition for Herefordshire*

"**Respecting the past, shaping our future** - we will help strengthen and encourage vibrant **communities**, create a thriving local **economy** and protect and enhance our **environment**".

## Environment

**Protect our environment and keep Herefordshire a great place to live**

- Reduce waste and increase reuse, repair and recycling
- Improve and extend active travel options throughout the county
- Contribute to tackling the climate emergency by investing in low carbon projects to further reduce our carbon footprint and reduce running costs
- Ensure the best use of the county's natural resources
- Protect the county's biodiversity, value nature and uphold environmental standards

## Community

**Build communities to ensure everyone lives well and safely together**

- Ensure all children are healthy, safe and inspired to achieve
- Ensure that children in care, and moving on from care, are well supported and make good life choices
- Build our own sustainable and affordable houses and bring empty properties back into use
- Protect and improve the lives of vulnerable people
- Use technology to assist with daily living and keep people at home
- Support communities to help each other through a network of community hubs

## Economy

**Support an economy which builds on the county's strengths and resources**

- Develop environmentally sound infrastructure that attracts investment
- Use council land to create economic opportunities and bring higher paid jobs to the county
- Invest in education and the skills needed by employers
- Enhance digital connectivity for communities and business
- Protect and promote our heritage, culture and natural beauty to increase tourism
- Invest public money locally wherever possible

## Our principles

**Partnership |** We collaborate to maximise our strengths and resources
**Sustainability |** We use resources wisely so Herefordshire is preserved for future generations
**Integrity |** We make decisions based on evidence and work with respect, openness and accountability
**Democracy |** We strengthen local democracy, decision making and service delivery and involve more young people
**Communication |** We listen to and learn from our communities and help people connect through culture, creativity and care

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# Budget 2020/21 and Corporate Plan 2020-24 consultation: key findings

## CONTEXT

The public consultation and engagement about Herefordshire Council's budget for 2020/21 and Corporate Plan for 2020-24 took place in three stages:

1. Informal, qualitative engagement undertaken by Impact Consultancy between September and November informed the priorities to be formally consulted on. Over 1,500 people engaged with this exercise, at a range of events targeted at specific groups of people.

2. The formal, online consultation ran throughout November 2019 (6 November to 4 December). A total of 269 responses were received to the questionnaire, all but three from individuals responding in a personal capacity. About two-thirds were aged 45-64, an over-representation compared to the population (40%).

3. Alongside the online consultation, Impact Consultancy ran six 'pop-up' events in Hereford and each of the market towns. The focus of these events was on the quality of the conversation, rather than the number of consultees. Using three tokens, the 137 people who got involved were asked to 'vote' for their priorities out of the ten areas for additional investment. Probably due to the nature of these events taking place during the working day, the vast majority were older people.

An event with local businesses is planned for early January 2020.

## RESULTS: THE BUDGET

The first section of the online consultation questionnaire asked respondents about their views on the proposed budget and 4% increase to Council Tax, along with questions about discount schemes. The face-to-face engagement did not address these topics.

The main results were that:

- There was an **almost equal split in terms of support for the proposed Council Tax increase**, with just over half thinking a 4% increase was about right (36.9%) or too little (14.6%), compared to just under half (48.5%) thinking it was too much. A similar pattern of responses received to the last year's consultation.

- **A small majority (53%) disagreed with the allocation of Council Tax** as set out in the budget till receipt, whilst only a quarter (26%) agreed and the rest (21%) said they had no opinion. Although the spending allocations that were set out were different to last year, this was a very similar pattern of responses.

  Analysing the comments to this question to understand **why people disagreed** with the allocation of spend, the most common themes seemed to be about the proposed increase in Council Tax. More than one in four of the 136 comments mentioned that the

proposed rise was too high compared to inflation / that it wasn't value for money, whilst one in five negatively referred to the organisational costs of running the council.

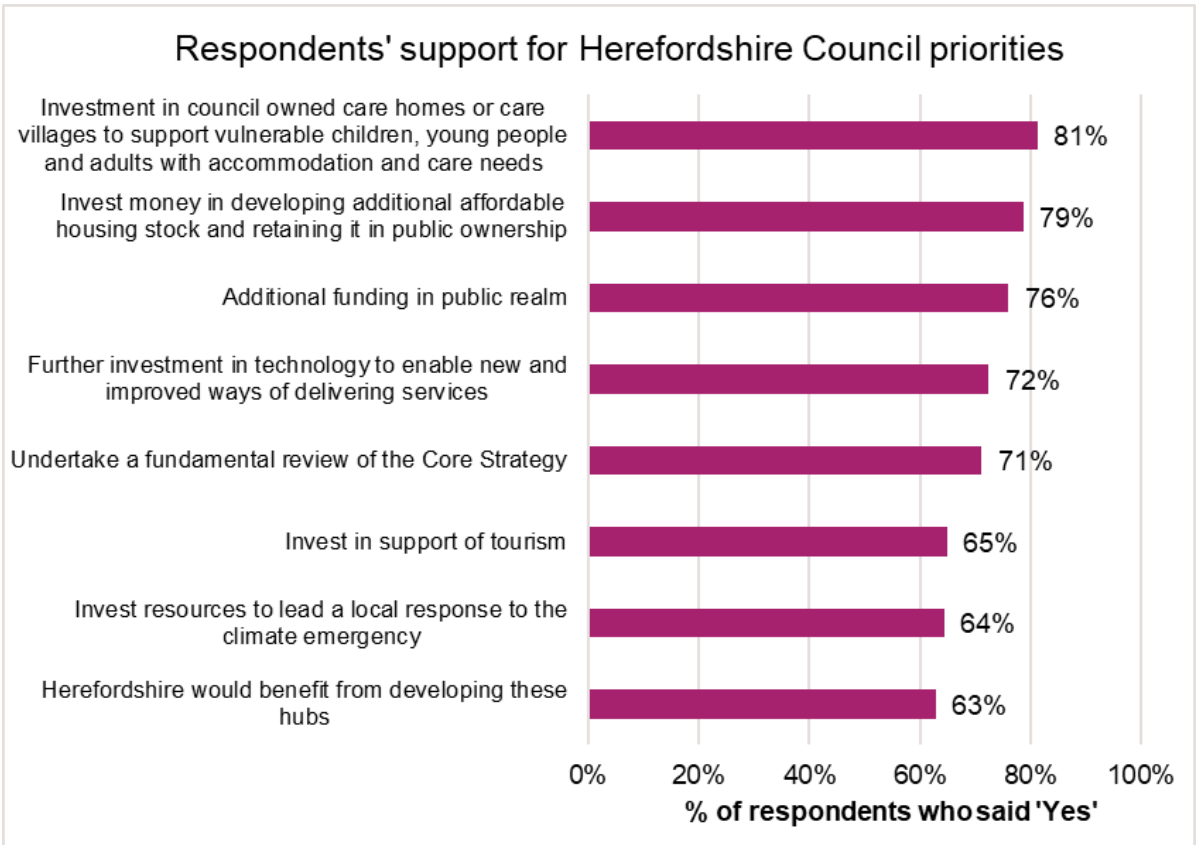
Comments that expressed an opinion about the allocation of spend were mostly saying that not enough was allocated to particular services, rather than too much. Services mentioned most frequently were **related to the environment and place**; not enough on:

- climate change / public spaces / environment / recycling and waste collection (20 comments)
- public / community / sustainable / rural transport (17 comments)
- roads / road safety and infrastructure / cycle paths / public rights of way (16 comments)

## RESULTS: THE PRIORITIES

The next section of the online consultation focused on the areas identified as priorities for additional investment, with respondents first asked for their views about each of the areas (including whether they supported the proposal), before being asked to rank these areas in order of priority.

There was **majority support for all of the areas identified for additional investment**, with as many as four out of five agreeing with additional investment in council-owned care homes or villages (81%) and publicly-owned affordable housing (79%). Even the areas with lower rates of support were supported by almost two out of three respondents: developing community 'super-hubs'; leading a response to the climate emergency; and investing in tourism.



When respondents were asked to **rank the areas in order of importance**, five stood out as being more important than the others (chart below shows the score for each as a weighted average of the ranks):

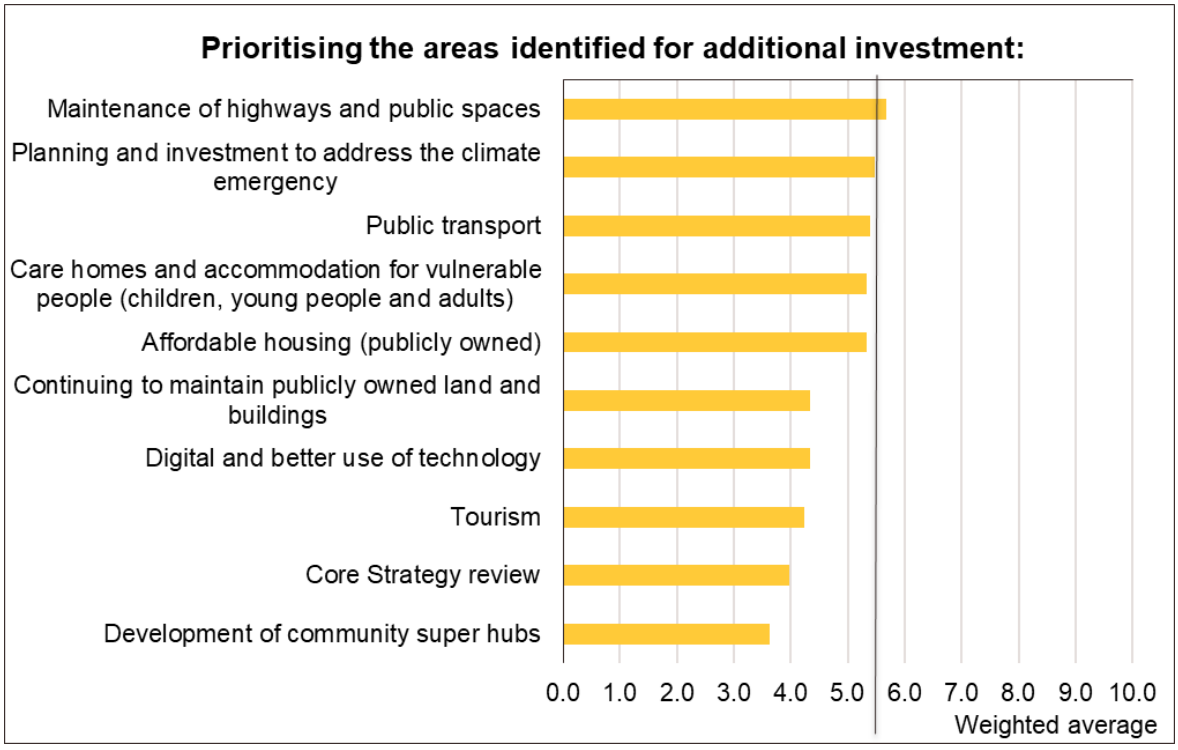
- ✓ Maintenance of highways and public spaces
- ✓ Planning and investment to address the climate emergency
- ✓ Public transport
- ✓ Care homes and accommodation for vulnerable people
- ✓ Affordable housing (publicly owned)

The same five areas were the most favoured in the face-to-face engagement as well.

Uniquely amongst the topics, views on **planning and investment to address the climate emergency** were polarised. 26% ranked it as most important (ten percentage points more than any other option), and it was in the top three for 40%. On the other hand 21% ranked it as *least* important (ten percentage points more than any other option), and it was also in the bottom three for 37% of respondents.

Comments against spending on this area covered themes such as

- it's not a priority / don't care
- should be central government's responsibility
- costly / won't make any difference / not achievable




## THE PRIORITIES: REASONS

The table below summarises the broad themes in the comments about each of the areas identified for additional investment. The right-hand column identifies feedback from the face-to-face engagement that ran alongside the online consultation.

There weren't any areas where the views expressed during the face-to-face engagement were dramatically different to the responses to the online questionnaire.

| Priority area | % agreeing with investment | Comments from online consultation | | Themes from face to face engagement |
|---|---|---|---|---|
| | | In support of | Not in support of | |
| **Developing super-hubs** | 63% | No qualitative questions were asked on this topic.<br><br>Most common response was that if super hubs were to be developed, they should be located in the market towns (69%), followed by larger villages (47%) and the city (43%)<br><br>Overall support for all of the services that could be offered, particularly health and social care (79%); wellbeing help, advice and activities (73%) and children's centres (71%). Other suggestions included legal, financial and housing advice and other information resource. | | Range of public services, nothing very different to the online consultation. |
| **Developing additional affordable housing stock and retaining it in public ownership** | 79% | - build more houses for rent<br>- stop developments with no social or additional affordable houses<br>- additional affordable housing should be good quality, energy efficient and sustainable. | - developers should be made to build more affordable housing that is actually affordable<br>- state should not encourage dependency<br>- tenants should be made to give up larger properties when under occupied<br>- infrastructure cannot support additional housing | Affordable housing was felt to be important, particularly starter homes or making renting more affordable, and also bringing empty properties back into use. |
| **Investment in council owned care homes or care villages to support vulnerable children, young people and adults with accommodation and care needs** | 81% | - if they're built, care homes or care villages must provide value for money<br>- should free up housing for younger people | - very expensive to build and run these so it will not provide value for money<br>- it's central government's or individual families' responsibility to look after vulnerable children, young people and adults | - Priority for old and young people<br>- Quality is key<br>- Not necessarily council-owned, but council should have oversight / control<br>- Also important to enable vulnerable people to stay in their own homes |

| Priority area | % agreeing with investment | Comments from online consultation | | Themes from face to face engagement |
|---|---|---|---|---|
| | | In support of | Not in support of | |
| **Investment in support of tourism** | 65% (very / fairly important) | Respondents insist that investment needed to support tourism. | - private sector should be responsible and will do better<br>- more tourism will create more traffic and will increase pollution (more carbon emissions)<br>- sort out roads first | People suggested investing in tourist information centres as they've been closed.<br>- Not appealing for tourists<br>- Concerns about shops, especially in Hereford city<br>- Not done enough to promote the county and its offerings. |
| **Undertaking a fundamental review of the Core Strategy** | 71% | - current plan needs improvement<br>- new or different priorities required | - nothing wrong with the current plan or smaller scale review better<br>- very expensive so not value for money<br>- take too much time and too disruptive<br>- some believe it will be ignored anyway | Overall very low choice; people did not fully understand the implications.<br>- If it happens it has to be comprehensive and done well<br>- some people felt it was essential if radical changes is to happen in the county, especially climate change and transport |
| **Additional funding in public realm** | 76% | If this is implemented:<br>- ensure that these services are provided properly and value for money<br>- make sure areas are not neglected<br>- avoid contractors/ if use contractors ensure accountability | - this is not a priority<br>- waste of money and not confident that it will improve anything<br>- do not approve of using contractors or the current contractor, they are not value | Some people commented on about there being better contract management including managing overspends, better scrutiny and consequences for not meeting goals. |
| | | 81% supported closer community involvement in setting the BBLP annual plan, involving parish councils or neighbourhood development partnerships. | | |

| Priority area | % agreeing with investment | Comments from online consultation | | Themes from face to face engagement |
|---|---|---|---|---|
| | | In support of | Not in support of | |
| **Invest resources to lead a local response to the climate emergency** | 64% | expressed support and provided suggestions for how to achieve carbon reductions. | - it is not a priority / don't care<br>- should be central government's responsibility<br>- costly /won't make any difference / not achievable | - People want Herefordshire Council to show leadership on this agenda and reflect the climate emergency in their policies and action e.g. building energy efficient housing, having a green public transport plan.<br>- Where they don't have direct influence they need to lobby and educate.<br>- Suggestions for local partnerships / organisations in relation to accessing specialist knowledge/to help plan and advise on this agenda. |
| **Further investment in technology to enable new and improved ways of delivering services** | 72% | Although respondents supported, they are cautious about digital exclusion and suggested to:<br>- keep other formats for elderly who struggle with new technology<br>- develop infrastructure before investing in technology enabled services | - not a priority and it will not provide value for money.<br>- unemployment can go up (threat to jobs) hence negative impact on economy. | Reflects the views made online but very low support:<br>- preferred face to face service delivery especially for elderly.<br>- access to adequate broadband needed to be improved consistently across the county. |
| **Public transport** | No question asked about support for this, the questions asked why they don't use | Only 16% of respondents were regular users; the most common reasons for not using public transport were:<br>- lack of availability of public transport in my local area<br>- timetables do not match my needs | | Similar themes to online<br>- Strong views that public transport is not an option in rural areas<br>- Question of choice: those who can use other methods choose to do so, but it's important because some people rely on it<br>- Poor connectivity and timetabling that doesn't meet needs |
| **Publicly owned land and buildings** | No question was asked about support for this | Majority of respondents (54%) felt that the council should retain and manage assets on behalf of everyone, but no qualitative questions were asked about this topic. | | There weren't any common themes: equal (small) numbers of people saying they should be retained as transferred into community hands |

Herefordshire Council

# Herefordshire Oral Health Needs Assessment

Version - FINAL

Herefordshire Council - Public Health Team

September 2019

## CONTENTS

If you need help to understand this document, or would like it in another format or language, please contact us on 01432 261944 or e-mail researchteam@herefordshire.gov.uk

## ABBREVIATIONS

BAME – Black, Asian and Minority Ethnic
CCG – Clinical Commissioning Group
CDS – Community Dental Service
COHIPB – Child Oral Health Improvement Programme Board
COT – Courses of Treatment
DAC – Dental Access Centre
$D_3MFT/d_3mft$ – Decayed, missing and filled teeth
GDP – General Dental Practitioner
GDS – Community Dental Service
HC – Herefordshire Council
IMD – Index of Multiple Deprivation
JSNA – Joint Strategic Needs Assessment
LAC – Looked After Children
LDC – Local Dental Committee
LGA – Local Government Association
LSOA – Lower Layer Super Output Area
NDEP – National Dental Epidemiology Programme
NHS – National Health Service
NHSE – NHS England
NICE – National Institute of Health and Care Excellence
OHNA – Oral Health Needs Assessment
ONS – Office for National Statistics
PHE – Public Health England
PHOF – Public Health Outcomes Framework
STP – Sustainability and Transformation Partnership
UDA – Unit of Dental Activity
UTLA – Upper Tier Local Authority

## GLOSSARY

**$D_3$mft/$D_3$MFT**

A commonly used indicator of tooth decay and treatment experience in a population - (d), missing due to decay (m) and filled due to decay (f) teeth (t) in a population. In five year old children this score will be for the baby or first teeth or dentition and will be in lower case letters (dmft). In twelve year old children this score reflects the adult or permanent teeth or dentition and will be in upper case letters (DMFT).

**Unit of Dental Activity (UDA)**

Units of Dental Activity (UDAs) are a measure of the amount of work done during NHS dental treatment. More complex dental treatments count for more UDAs than simpler ones. For example, an examination is 1 UDA, fillings are 3 UDAs, and dentures are 12 UDAs.

**Course of Treatment (CoT)**

Dental care is provided to patients as CoT, and reflects –

- An examination of a patient, an assessment of their oral health, and the planning of any treatment to be provided to that patient as a result of that examination and assessment
- The provision of any planned treatment (including any treatment planned at a time other than the time of the initial examination) to that patient

## OVERVIEW

Despite national improvements in oral health over the last few decades, many people across England and Herefordshire experience preventable oral diseases that impact on their everyday life. Oral health is therefore an important public health issue both nationally and locally.

Herefordshire Council and local authorities across England have a clear responsibility for improving the oral health of both children and adults and reducing inequalities in oral health. To inform local priorities and action, national guidance recommends that local authorities undertake an oral health needs assessment.

This document therefore fulfils this requirement, by comprehensively describing the standard of oral health of people living in Herefordshire and providing a detailed overview of current oral health care services locally.

Based on the best available intelligence, this assessment has found that the standard of children's oral health in Herefordshire is poor, and is poorer than both the regional and national picture. For example, just under a third of 5 year olds locally experienced preventable tooth decay in 2016/2017. Significantly this figure has remained broadly unchanged in the last 10 years.

Areas of good practice for preventing and addressing poor oral health in children and adults are evident across Herefordshire. Despite this, local challenges clearly exist in ensuring everyone has equitable access to dental care and preventative interventions for improving oral health.

To address these identified local issues and gaps, this document proposes 10 key recommendations. Each recommendation has been informed by national policy and guidance.

It is envisaged that future action and activity for improving oral health will be led by Herefordshire Council's Public Health Team and undertaken in collaboration with key local and regional organisations e.g. Healthwatch Herefordshire and Public Health England.

## INTRODUCTION

Oral health reflects the 'standard of the oral and related tissues, which enables an individual to eat, speak and socialise without active disease, discomfort or embarrassment' [1 - pg.55]. Good oral health is therefore integral to an individual's overall health, well-being and quality of life [2].

Over the last forty years, the oral health of both children and adults in England has significantly improved [3,4]. Despite this marked inequalities remain and many people continue to experience the negative physical, emotional and social impacts associated with poor oral health and oral disease.

Oral health problems of substantial concern include dental caries (tooth decay), periodontal (gum) disease and oral cancers [5,6]. Importantly, these diseases and almost all oral health problems are either largely preventable or can be treated in their early stages.

The causes of poor oral health and inequalities in oral disease are complex. A broad range of interacting biological, socio-behavioural, psychosocial, societal and political factors contribute to a person's risk of experiencing poor oral health outcomes [3,7,8].

Most oral diseases share modifiable risk factors common to the four leading non-communicable diseases; cardiovascular disease, cancers, respiratory diseases and diabetes [9,10]. These common risk factors include unhealthy diets (high in sugar), tobacco use and alcohol consumption.

Crucially, for both children and adults, poor oral health can cause significant pain and discomfort, making it difficult to eat, drink, communicate and socialise normally [5,11,12]. In addition, poor oral health places a considerable financial burden on individuals and wider society. This is because treating oral diseases is often complex and costly, and those experiencing poor oral health are more likely to be absent from education or employment.

Over the last decade, an increasing national emphasis has been placed on the importance of improving population oral health [8,13,14]. A range of key organisations both within and outside of the social care system, are therefore actively engaged and contributing to this national agenda at a regional and local level e.g. local authorities, Public Health England (PHE), NHS England (NHSE) and the Local Government Association (LGA).

## NATIONAL CONTEXT – ENGLAND

Following the introduction of the Health and Social Care Act 2012, the responsibility for improving population oral health and reducing oral health inequalities in England was conferred to local authorities (unitary and upper tier) [3,4,6,15].

Consequently, since April 2013 and in partnership with PHE, NHSE and Clinical Commissioning Groups (CCGs), local authorities have been required to –

1) Secure the provision of 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
   - Reporting and monitoring of the effects of any local water fluoridation schemes

2) Secure the provision of oral health improvement programmes (to the extent that they consider appropriate in their area)

3) Participate in any oral health survey conducted or commissioned by the Secretary of State

4) Make proposals with regard to water fluoridation schemes, including a duty to conduct public consultations in relation to such proposals and powers to make decisions about such proposals

The commissioning of NHS dental services (including the totality of primary, secondary and unscheduled or urgent dental care), became and remains the responsibility of NHSE as part of the 2012 act. Furthermore, expert and specialist dental public health advice is provided by PHE for both local authorities and NHSE.

## NATIONAL POLICY DRIVERS

A number of national policies and frameworks exist, which drive the agenda and ambition for improving population oral health and reducing oral health inequalities in England –

- The NHS Outcomes Framework [16] and Public Health Outcomes Framework [17] set out the desired health and well-being outcomes for adults and children in England. Both frameworks include indicators related to oral health, enabling regional and local benchmarking and progress to be monitored over time.

- An extensive range of national guidance and toolkits have been published by PHE and the National Institute of Health and Care Excellence (NICE) – See appendix A. Collectively, these present the evidence base of 'what works' for improving oral health at an individual and population level, and provide recommendations for organisations across the system.

- In 2016, PHE in partnership with a range of stakeholders, established the Child Oral Health Improvement Programme Board (COHIPB). The COHIPB action plan (2016-2020), aims to improve the health of all children and reduce the oral health gap for disadvantaged children [18].

- The NHS Long Term Plan (2019), places a major focus on the role and importance of preventing ill-health [19]. The plan includes commitments around improving the oral health of children and increasing NHS support (including dental services) for those with learning disabilities or autism and people living in care homes.

## LOCAL CONTEXT - HEREFORDSHIRE

In 2017, the Joint Strategic Needs Assessment (JSNA) for Herefordshire, reported that the prevalence and severity of oral disease in children (aged 5 years), was worse than both the West Midlands and England position [20]. Consequently, concerns raised about the standard of children's oral health locally, led to Herefordshire Council undertaking the following strategic activity during 2018/2019 (see figure 1 below) –

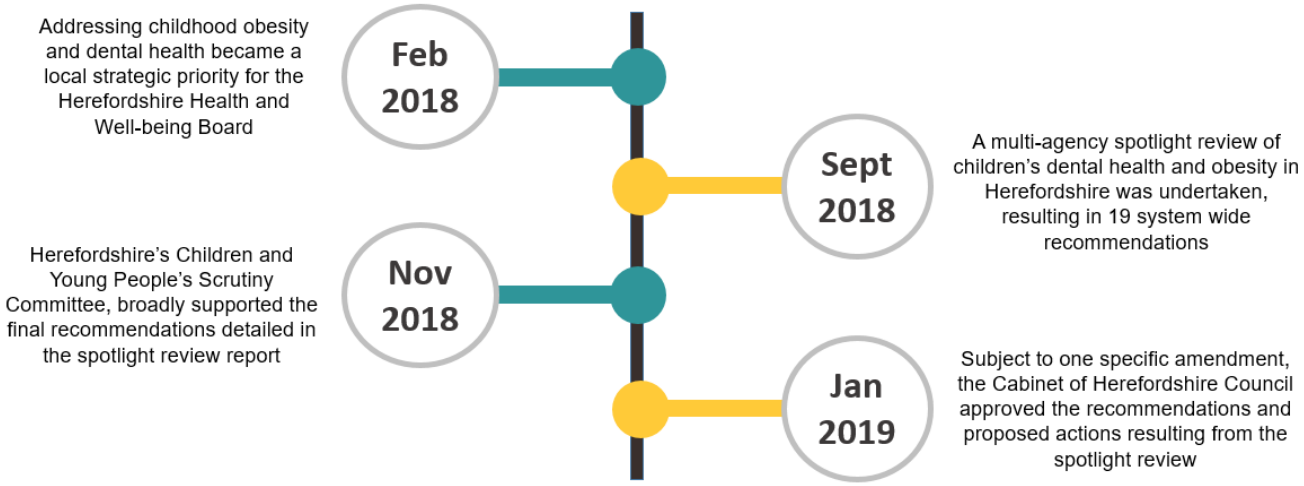



**Figure 1 – Herefordshire strategic activity related to children's oral health (2018/2019)**

One of the recommendations approved by the Cabinet of Herefordshire, was the requirement for a local Oral Health Needs Assessment (OHNA) to be conducted [21]. The Director of Public Health had identified this as a crucial step in determining the local strategic approach for improving oral health.

Given that a local assessment of the population's oral health hadn't previously been undertaken and a local strategic plan was yet to be developed, Cabinet agreed that an OHNA should be completed for Herefordshire.

## ORAL HEALTH NEEDS ASSESSMENT – PURPOSE AND PROCESS

To fulfil the statutory requirement to assess a population's oral health needs and to inform oral health improvement activity, NICE recommend local authorities undertake OHNAs [22].

An OHNA is a cyclical process of –

*"describing the oral health of a population, ascertaining their needs, measuring the capacity of existing services to meet these needs and where gaps exist, identifying new or alternative ways in which such gaps can be prioritised and filled"* (pg18)

In 2014, NICE published guidance to support local authorities to conduct OHNAs, develop a local strategic direction for oral health improvement and deliver effective community based interventions [15].

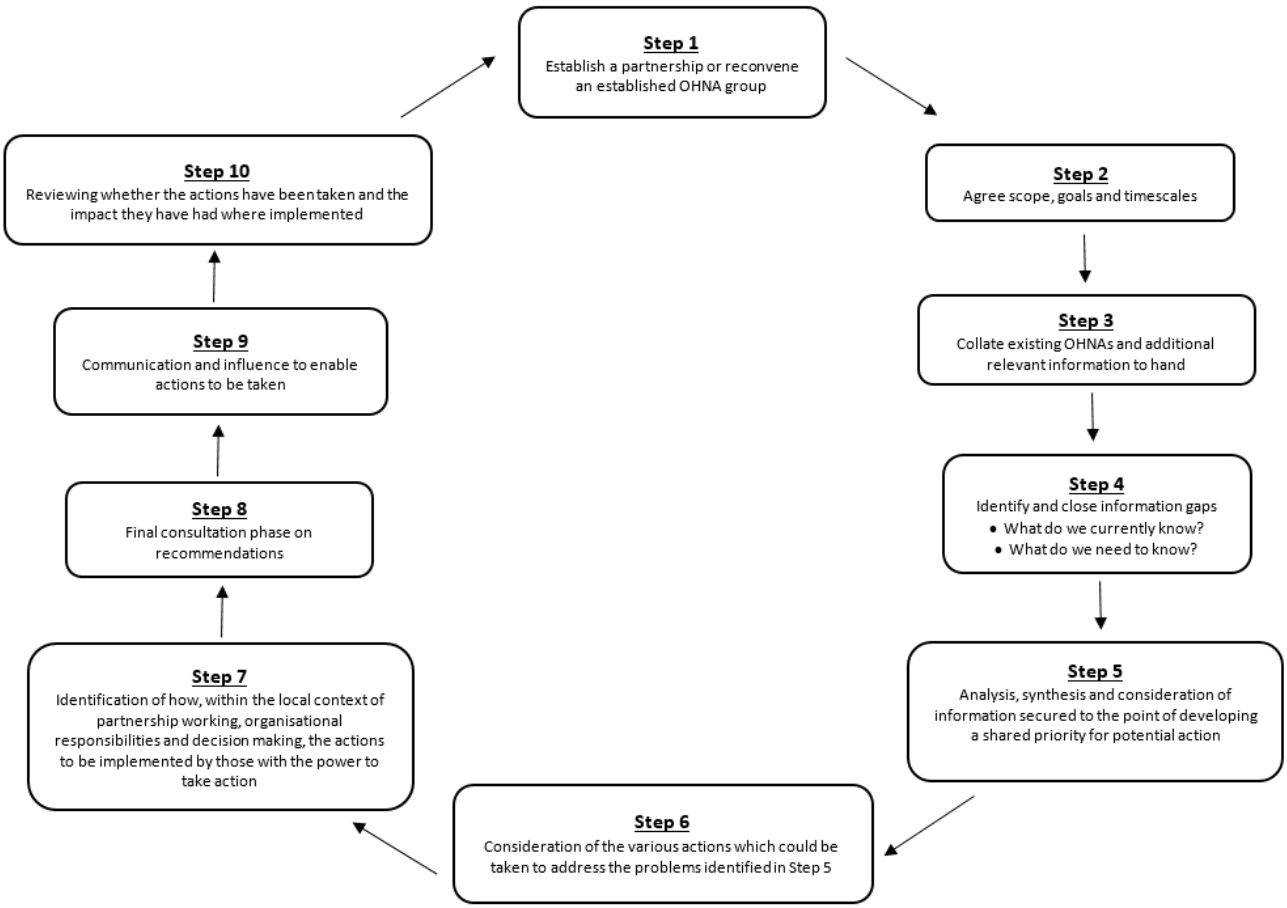



**Figure 2 - 10 steps of conducting an OHNA**

As part of this guidance and to ensure the methods for conducting an OHNA are comprehensive and robust, NICE recommended local authorities adopt the 10 step approach presented in figure 2.

This approach and the example OHNA template included in this guidance, has informed the final Herefordshire OHNA report.

## HEREFORDSHIRE OHNA – AIMS, OBJECTIVES AND SCOPE

The specific aim and objectives of this OHNA were -

**Aim**

In order to inform the local strategic approach to oral health improvement and the reduction of health inequalities in Herefordshire, comprehensively describe the oral health of children and adults and the provision of oral health services across the county.

**Objectives**

The following objectives were developed to achieve the overarching project aim. In relation to the geographical footprint of Herefordshire –

- Describe the oral health needs of both children and adults, reporting on variation according to key socio-demographic and geographic variables
- Describe the provision and access of oral health services and identify any gaps in service
- Describe the provision of oral health improvement programmes, interventions and activities
- Identify opportunities to strengthen the access to and collection of data relevant to oral health
- Make recommendations for the future development of high quality, evidence based and outcome focused oral health care and oral health improvement services

## POPULATION OF INTEREST

The OHNA covered the geographical footprint of the County of Herefordshire (within the West Midlands region). As presented in later chapters, the data included within the OHNA reflects both the resident population of Herefordshire (inclusive of both children and adults) and those accessing oral healthcare services in the county (who may or may not be residing in Herefordshire).

Where possible (based on data availability), the OHNA also considered and described the oral health needs of vulnerable groups within Herefordshire i.e. *"those people whose economic, social, environmental circumstances or lifestyle place them at high risk of poor oral health or make it difficult for them to access oral health services*" (5 - pg 93/94). A description of the vulnerable groups of interest are described in more detail in the following chapter.

## METHODS AND SOURCES OF DATA

The NICE 10 step approach informed the overall methodology employed for conducting Herefordshire's OHNA. The OHNA was conducted as a desk-based exercise and no primary research was undertaken.

To meet the aim and objectives of the OHNA, an extensive range of existing data sources were collected, analysed and reviewed. This included data from –

- Dental Epidemiology Programme (PHE)
- Public Health Outcomes Framework (PHOF)
- NHS Dental Statistics (NHS Digital)
- Office for National Statistics
- Hospital Episode Statistics (NHS Digital)
- GP Patient Survey Dental Statistics (NHSE)

- Understanding Herefordshire (Herefordshire Council and Herefordshire CCG)
- Healthwatch Herefordshire

Furthermore, an extensive range of national policies and guidance underpinned the resultant OHNA findings and recommendations (see Appendix A).

## GOVERNANCE AND ACCOUNTABILITY

The process of completing the OHNA was governed by and accountable to the OHNA Task and Finish Group. Membership of this group included –

- Emma Booth – Specialty Registrar in Public Health, Herefordshire Council (Project lead and main author)
- Chris Nikitik - Intelligence Analyst, Herefordshire Council (Co-author)
- Caryn Cox – Consultant in Public Health, Herefordshire Council (Project supervisor)
- Sophie Hay – Health Improvement Practitioner, Herefordshire Council
- Anna Hunt – Consultant in Dental Public Health, PHE

In addition to the OHNA task and finish group, engagement with the following key stakeholders was crucial in guiding the structure and content of the OHNA –

- NHSE and NHS Improvement (Midlands)
- PHE (West Midlands Centre)
- Herefordshire Local Dental Committee (LDC)
- Wye Valley NHS Trust (Community Dental Services)

Final approval and sign-off for the OHNA was obtained from the Director of Public Health for Herefordshire Council in September 2019.

## REPORT DISSEMINATION

The final local OHNA report will be published on the 'Understanding Herefordshire' website and cascaded to the following key groups and organisations during September 2019 –

- Cabinet of the Herefordshire Council
- Children and Young People Scrutiny Committee – Herefordshire Council
- Herefordshire Council services and teams
- Herefordshire LDC
- Herefordshire CCG
- PHE
- NHSE
- Healthwatch Herefordshire
- Herefordshire and Worcestershire Sustainability and Transformation Partnership (STP)

# ORAL HEALTH AND DISEASE – AN OVERVIEW

Oral health is integral to a person's overall health, well-being and quality of life. The World Health Organization defines oral health as –

*"a state of being free from chronic mouth and facial pain, oral and throat cancer, oral infection and sores, periodontal (gum disease), tooth decay, tooth loss and other diseases and disorders that limit an individual's capacity in biting, chewing, smiling, speaking and psychosocial wellbeing"* [23]

## ORAL DISEASES AND CONDITIONS

This OHNA therefore reports the standard of oral health for both children and adults, in relation to the following oral conditions – tooth decay, gum diseases and oral cancer. Each have been chosen for inclusion within this OHNA, given significant concerns about their prevalence, associated health impacts and the fact they are largely preventable [5,6,15].

Furthermore, national guidance explicitly references the action required by local authorities and key partners to prevent tooth decay, gum diseases and oral cancer [3,4,8,15,24]. Therefore, the OHNA Task and Finish Group agreed that these conditions would be the focus of the OHNA and other aspects of oral health e.g. orthodontics and dental trauma, would not be included within the scope of this OHNA.

For reference, NHSE published a West Midlands Orthodontic Needs Assessment in 2018, which included the population of Herefordshire [25].

*Tooth decay*

- Tooth decay (dental caries) occurs when tooth tissue is demineralised in response to the acids produced when dental plaque bacteria respond to dietary sugars.
- Continued high intake of dietary sugars, inadequate exposure to fluoride and a lack of regular plaque removal, lead to the tooth structures being destroyed.
- Over time this results in cavities and pain, and in the advanced stage, tooth loss and systemic infection.

*Gum diseases*

- Gum (periodontal) diseases comprise a range of oral conditions characterised by inflammation of the gums and loss of the tissues supporting the teeth.
- Caused by an interaction between plaque bacteria and the body's immune system, gum diseases present as bleeding or swollen gums (gingivitis) and pain. As gum diseases progress, chronic inflammation leads to a loss of gum attachment to the tooth and a loosening/loss of teeth (periodontitis).

*Oral cancer*

- Oral cancers include cancers of the lip and all sub-sites of the oral cavity and oropharynx. Oral cancers (especially in their advanced stage) and their associated treatments may cause difficulty in eating, drinking, communicating and affect their facial appearance.

## WHAT CAUSES POOR ORAL HEALTH?

*Wider determinants of oral disease*

Individual behaviours related to oral hygiene and lifestyle are important in determining the risk of poor oral health and oral diseases. For example, inadequate exposure to fluoride and high consumption of sugar increases a person's risk of developing tooth decay and gum disease [4,12].

However, it is widely accepted that individual behaviours are profoundly shaped by the circumstances in which people are born, grow, live, work, and age [26]. The causes of poor oral health are therefore understood to be driven by a complex range of interacting biological, behavioural, psychosocial, environmental and socioeconomic factors [7,26–28] – see figure 3.

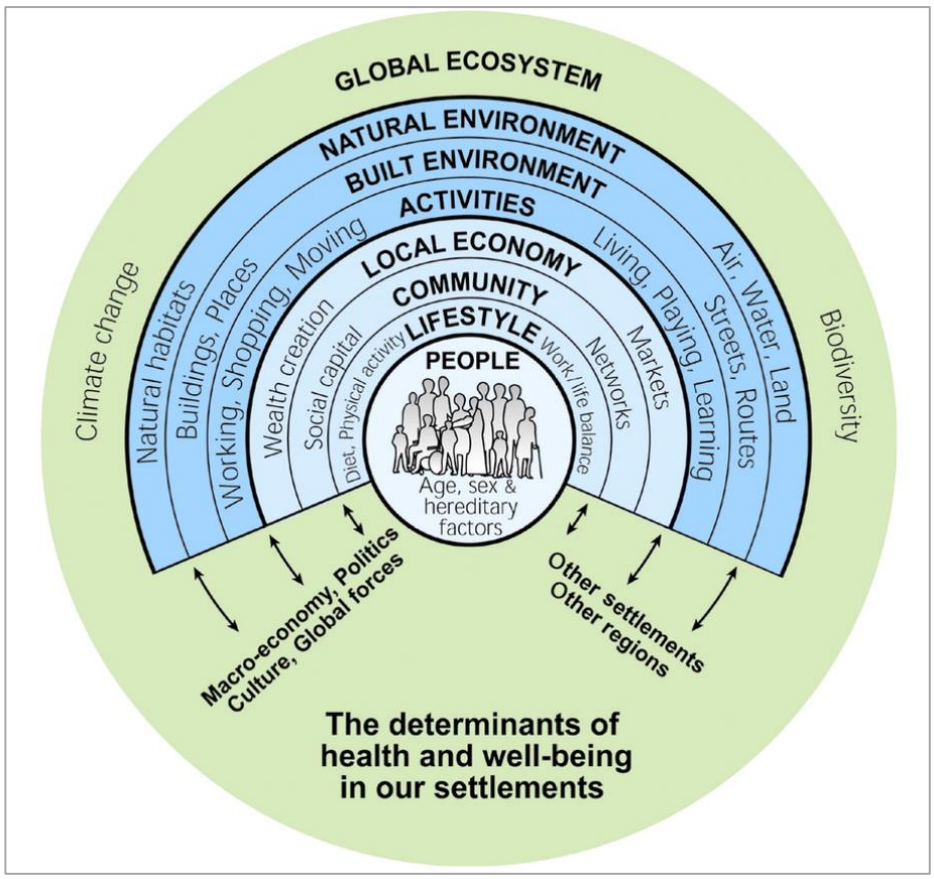



**Figure 3 - The health map [25]**

National policy and guidance on improving oral health [3,8,14,15,24,29], explicitly recognises the relationship between a person's risk of oral diseases and the 'wider determinants' of oral health. The wider determinants represent the background factors or characteristics that may increase someone's likelihood of adopting a particular behaviour or experiencing a specific health outcome.

For example, a person experiencing poverty is more likely to use tobacco, an important and modifiable risk factor for oral cancer [10,30,31].

*Common risk factor approach*

In order to achieve sustainable improvements in oral health, it remains crucial to address both the wider determinants and the modifiable risk factors for oral disease.

Significantly, most oral diseases share risk factors common to the four leading non-communicable diseases in the UK – Cardiovascular disease, cancer, respiratory diseases and diabetes [9]. These common risk factors include unhealthy dietary habits, tobacco use, excess alcohol consumption, poor oral hygiene and stress (see figure 4).

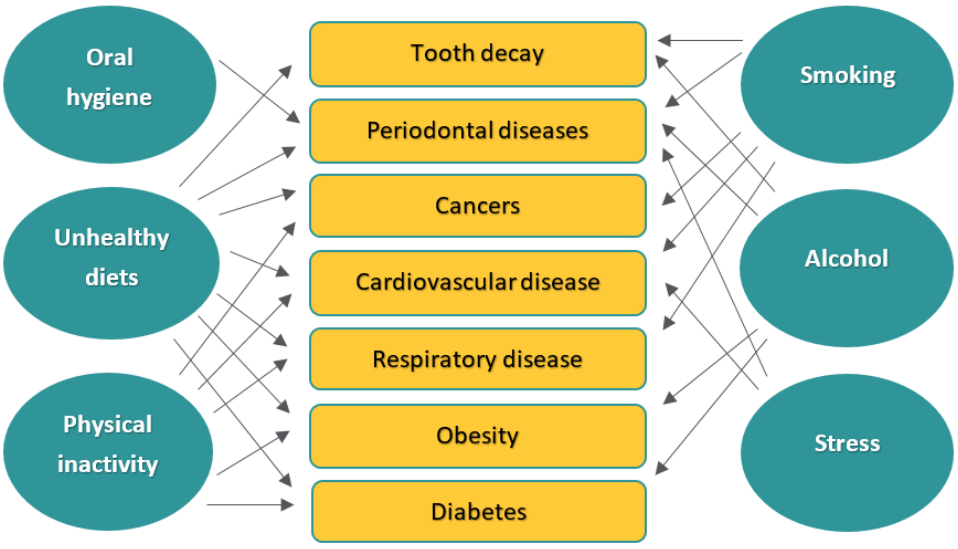



**Figure 4 - Common risk factor approach for oral health (adapted from Watt, 2007[9])**

By adopting a 'common risk factor approach' [10] both the wider determinants and risk factors common to chronic diseases are targeted and modified. This approach is deemed to be more effective and efficient than disease-specific approaches for improving oral health and population health more broadly because –

- Most chronic diseases have multiple risk factors e.g. cancer or cardiovascular disease
- A single risk factor can impact upon multiple diseases e.g. unhealthy dietary habits
- Some risk factors cluster in specific groups of people e.g. those from lower socio-economic backgrounds or particular minority ethnic groups

- Risk factors can interact e.g. relationship between tobacco use and excessive alcohol consumption

Intelligence regarding the incidence and prevalence of common risk factors, helps to understand future oral health needs. Therefore, in addition to the epidemiology of oral diseases, this OHNA also reports the local picture of common risk factors known to impact upon poor oral health i.e. smoking, alcohol use and dietary behaviours.

## WHO IS MOST AT RISK OF POOR ORAL HEALTH?

Despite substantial improvements in oral health in England, marked inequalities remain [7,27,32,33]. Crucially as oral diseases are largely preventable, the existence of inequalities in oral health are considered to avoidable, unfair and unjust [7,34].

Poor oral health and oral diseases disproportionally affect individuals in society who are disadvantaged, vulnerable or socially excluded. For these groups, *"their economic, social or environmental circumstances means they are at greater risk of experiencing poorer oral health or may find it more difficult to access appropriate dental care"* [5 - pg 93/94]. This is inclusive of people who –

*1) Are from a lower socioeconomic group or live in a more deprived area*

Variations in outcomes related to oral health and health more broadly follow a continuum between different socioeconomic groups in society [26]. Those from higher socioeconomic groups experience better oral health than those from the lowest socioeconomic groups who typically experience poorer oral health [7,8].

For instance, a 20.1% difference exists in the prevalence of dental decay between 5 year olds in the most deprived and least deprived communities in England (33.7% and 13.6% respectively) [33].

Deprivation is also a significant driver for the lifestyle behaviours linked to poor oral health, with those in the lowest socioeconomic groups, more likely to smoke, have a diet higher in sugar and less likely to adopt good oral hygiene practices [7,13,30,32].

*2) Are from a Black, Asian and Minority Ethnic group (BAME)*

Within England, the standard of oral health varies according to ethnicity. Those from particular ethnic groups experience a markedly different burden of oral diseases such as tooth decay and oral cancer [6,7].

For example, in 2017, an almost 30% difference in the prevalence of dental decay was identified between Black/Black British children (19.6%) and children from an Eastern Europe background (49.4%) aged 5 [33].

*3) Are older and frail*

Maintaining good oral health can be difficult for those who are older or frail, especially those experiencing multiple long-term conditions and those living in residential care settings [24].

Those who are older or frail may face specific challenges, such as functional or mobility limitations and transport difficulties, which impact on their oral hygiene routine and their ability to access dental care. Both of which leave older people at higher risk of oral diseases and requiring increasingly complex oral healthcare [35,36].

*4) Have learning disabilities*

Children and adults with learning disabilities are likely to have a greater prevalence and severity of oral diseases [6,7]. Furthermore, compared to the general population, individuals with learning disabilities may have greater unmet dental care needs. PHE, recently published guidance [37] detailing the barriers someone with learning disabilities may face in achieving good oral health and accessing quality dental care.

5) *Are, or who have been in care i.e. Looked after children*

Looked after children (LAC) refer to those children under the age of 18 years, being looked after by a local authority. Due to issues associated with poverty, abuse and neglect, LAC tend to have poorer health and well-being than their peers and this is reflected in their standard of oral health [6,38].

LAC typically experience a greater burden of oral disease and are more likely to have unmet dental care needs. As part of the statutory health assessments for LAC, local authorities have a duty of care to identify and address their oral health needs [38].

6) *Are homeless*

People who are homeless are a diverse group comprising of the roofless and those living in temporary accommodation [39]. Limited research exists, which comprehensively evidences the oral health or oral health needs of people who are homeless. Recent studies however have identified that those who are homeless have significantly higher levels of tooth decay, gum disease and tooth loss than the rest of the population.

Furthermore, despite significant challenges in accessing appropriate care, people who are homeless often require more complex dental treatment [3,6,8].

*7) Experience mental health problems*

In 2014, around one in six adults in England met the criteria for having a common mental disorder [40]. Furthermore, 11% of children and young people aged between five and fifteen have a clinically diagnosable a mental health issue [41].

Those experiencing severe or enduring mental health problems are at particular increased risk of poorer oral health compared to the general population. In addition, accessing necessary dental treatment poses specific challenges for both children and adults experiencing mental health problems [42].

*8) Experience issues with substance misuse*

People who misuse drugs or alcohol tend to have poorer oral health. Use of illicit substances and excessive consumption of alcohol, negatively affects oral health by increasing a person's risk of tooth decay, gum disease and oral cancer [6,12,43].

*9) Are from other vulnerable groups*

This is inclusive of Gypsies and Travellers, refugees and asylum seekers, the medically compromised, as well as those with dental anxiety and dental phobia [6,44].

## WHAT ARE THE IMPACTS OF POOR ORAL HEALTH?

As will be detailed later within the OHNA, the prevalence of oral diseases nationally and within Herefordshire, presents a significant public health issue. Poor oral health negatively affects a person's physical, emotional and social well-being and overall quality of life [45].

Oral diseases can cause pain and infection, which may impact upon a child or adults ability to eat, sleep, socialise, learn and work [11,23,34,44] – see figure 5.

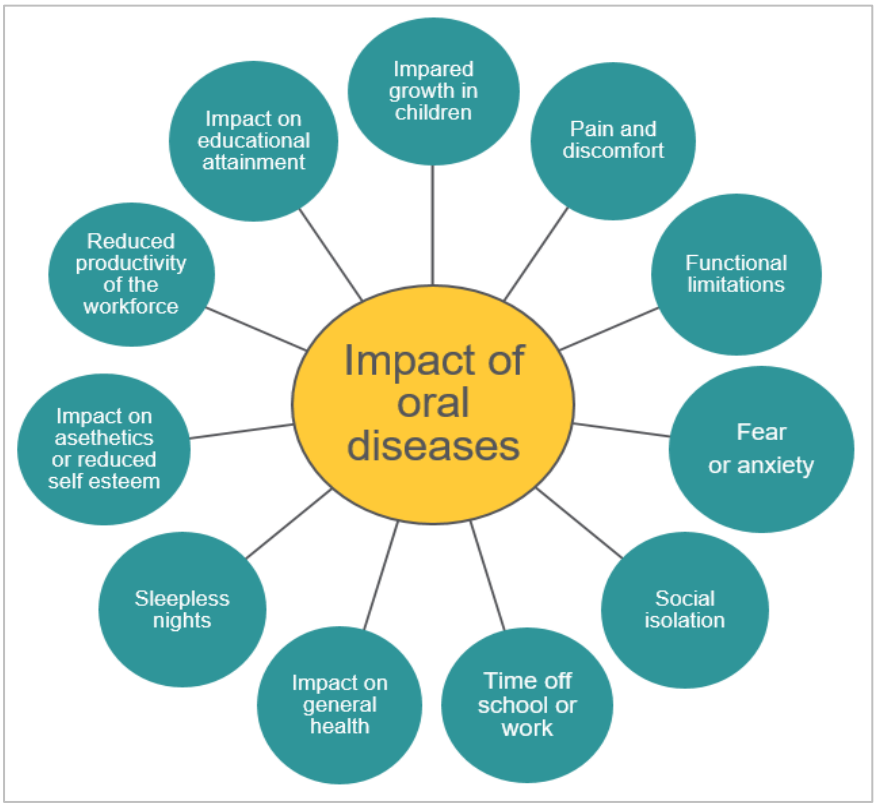



**Figure 5 - Impact of oral diseases [29, 39]**

A substantial negative impact of poor oral health relates to the level of disability in childhood resulting from oral diseases. For children aged 5-9 years in the UK, poor oral health was associated with a greater level of disability, than vision and hearing loss and diabetes mellutis [11,45].

Significantly, the impacts of poor oral health are not limited to the individual or their family, but present consequences to society more broadly. Despite being largely preventable, treating oral disease is costly, given the requirement for highly trained professionals, expensive technology and materials.

The NHS spent approximately £3.4 billion per annum on dental treatment in England during 2014, with an estimated additional £2.3 billion spent in the private sector [45]. Of considerable concern are the costs associated with tooth extractions. During 2015/2016, the NHS spent £50.5 million on tooth extractions for those under 19 years of age, the majority of which were due to preventable tooth decay.

In England, among children under five years of age, there were 9,306 admissions to hospital for tooth extractions in 2015/2016 (with 7,926 specifically identified as being due to tooth decay), at a cost of approximately £7.8 million.

# HEREFORDSHIRE – PLACE AND POPULATION

## PLACE

The County of Herefordshire is located in the West Midlands of England bordering Wales to the west, Shropshire to the north, Worcestershire to the east and Gloucestershire to the south-east (Figure 6). The city of Hereford lies in the middle of the county and other principal locations are the five market towns of Leominster, Ross-on-Wye, Ledbury, Bromyard and Kington.

The county has extensive countryside with remote valleys and rivers and a distinctive heritage. The River Wye divides the county, flowing east from the Welsh border through Hereford city before turning south through the Wye Valley 'Area of Outstanding Natural Beauty'. The Malvern Hills rising to 400m border the east of county, while the south-west is dominated by the western reaches of the Black Mountains with altitudes of more than 600m.

Herefordshire covers 2,180 square kilometres (842 square miles) with 95% of the land area classified as 'rural' and 53% of the population live in these rural areas. Being a predominantly rural county presents opportunities in, for example, tourism and agriculture, but also presents challenges, for example in geographical barriers to services.

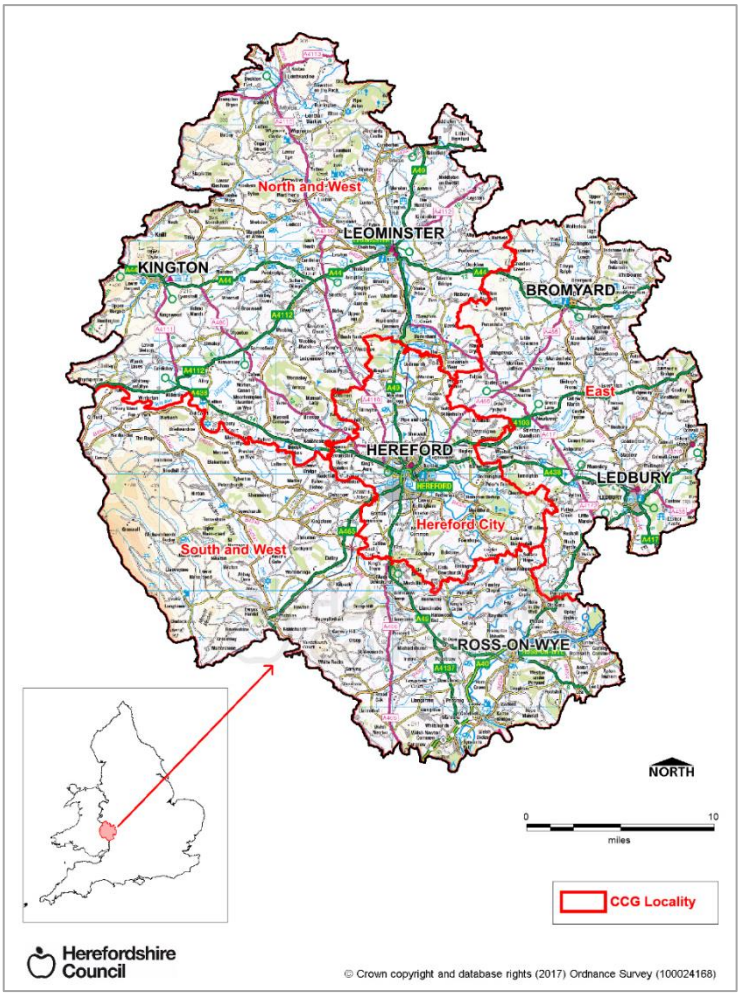



**Figure 6 - Map of the County of Herefordshire**

## POPULATION

This section provides an overview of the total population of Herefordshire using figures produced by the Office for National Statistics (ONS), including information about recent and predicted total population growth and age structure.

Herefordshire is a predominantly rural county and has the fourth lowest population density in England. Between 2001 and 2017 the Herefordshire population increased from 174,900 to 191,000, which represents a 10.9% increase compared to population growth of 12% observed across England and Wales over the same period.

Although Herefordshire has a similar proportion of under-16s (17%) to that across England and Wales (19%), the county has an older age structure with 24% of the population aged 65+ (45,800 people) compared to 18 % nationally.  This includes 6,100 people aged 85+.

Herefordshire is resident to a lower proportion of younger working age adults (from the age of 16 to mid-forties) compared with England & Wales, but has a higher proportion of older working age adults (mid-forties to the age of 64).

If recent (last five years) demographic trends were to continue and nationally determined assumptions about future fertility, mortality and migration were to be realised, the total population of Herefordshire is predicted to increase by 1% from the 2017 figure of 191,000 to 193,000 in 2020, and to 218,800 people by 2030, an increase of 9.2% from 2017 (Table 1).

Between 2017 and 2030 the majority of age groups show predicted increases in numbers, the exceptions being between 45 and 59 where numbers are predicted to fall by 3,000, a proportional decrease of 7.3%.

The greatest increase in numbers are predicted for those aged 75 and over where numbers will increase by 10,500, a proportional rise of over 50%. For those aged under 15 numbers will increase by 12.3% from 30,000 to 33,700.

These changes are reflected in the predicted change in population structure between 2017 and 2030 with there being an evident decrease in the overall proportion represented by those age 45 to 59 falling from 21.6 to 17.5%, a pattern reflected in both males and females (Figure 7).

Conversely, the proportion of the whole population accounted for by those aged 75 and over increases from 10.8 to 14.2%.

**Table 1 - Estimated headline population figures for Herefordshire, mid-2017 to mid-2030**

| Age group | 2017 | 2020 | | 2025 | | 2030 | |
|---|---|---|---|---|---|---|---|
| | | N | % change | N | % change | N | % change |
| 0-4 | 9,500 | 9,600 | 1.1 | 10,300 | 8.4 | 10,800 | 13.7 |
| 5-9 | 10,600 | 10,800 | 1.9 | 10,800 | 1.9 | 11,400 | 7.5 |
| 10-14 | 9,900 | 10,600 | 7.1 | 11,500 | 16.2 | 11,500 | 16.2 |
| 15-19 | 9,700 | 9,100 | -6.2 | 10,200 | 5.2 | 11,000 | 13.4 |
| 20-24 | 8,900 | 9,100 | 2.2 | 9,200 | 3.4 | 10,200 | 14.6 |
| 25-29 | 11,000 | 10,900 | -0.9 | 11,100 | 0.9 | 11,000 | 0 |
| 30-34 | 10,800 | 11,500 | 6.5 | 12,300 | 13.9 | 12,400 | 14.8 |
| 35-39 | 10,600 | 11,100 | 4.7 | 12,600 | 18.9 | 13,300 | 25.5 |
| 40-44 | 10,200 | 10,600 | 3.9 | 12,100 | 18.6 | 13,400 | 31.4 |
| 45-49 | 13,000 | 11,800 | -9.2 | 11,400 | -12.3 | 12,800 | -1.5 |
| 50-54 | 14,500 | 14,100 | -2.8 | 12,600 | -13.1 | 12,100 | -16.6 |
| 55-59 | 13,700 | 14,800 | 8.0 | 14,900 | 8.8 | 13,300 | -2.9 |
| 60-64 | 13,000 | 13,500 | 3.8 | 15,500 | 19.2 | 15,500 | 19.2 |
| 65-69 | 13,100 | 12,700 | -3.1 | 13,800 | 5.3 | 15,600 | 19.1 |
| 70-74 | 12,000 | 13,000 | 8.3 | 12,500 | 4.2 | 13,400 | 11.7 |
| 75-79 | 8,200 | 9,600 | 17.1 | 12,000 | 46.3 | 11,500 | 40.2 |
| 80-84 | 6,300 | 6,700 | 6.3 | 8,200 | 30.2 | 10,300 | 63.5 |
| 85-89 | 3,900 | 4,200 | 7.7 | 4,900 | 25.6 | 6,000 | 53.8 |
| 90+ | 2,200 | 2,300 | 4.5 | 2,700 | 22.7 | 3,300 | 50.0 |
| All ages | 191,100 | 196,000 | 2.6 | 208,600 | 9.2 | 218,800 | 14.5 |

(Data source: ONS 2017 mid-year estimates © Crown copyright)

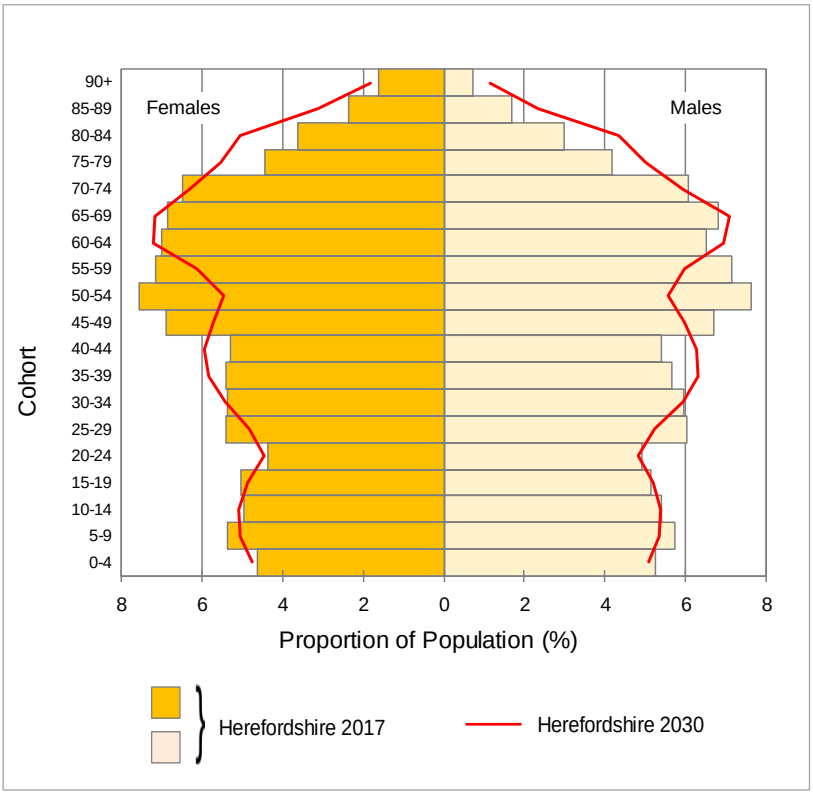



**Figure 7- Estimated resident population of Herefordshire in 2017 and 2013**

(Data source: ONS 2017 mid-year estimates © Crown copyright**)**

The predominantly rural nature of Herefordshire is reflected in the population density across the county with densities of over 5,000 individuals per km$^2$ recorded in some areas of Hereford, while densities of between 1,000 and 5,000 individuals per km$^2$ also evident in the market towns and parts of Hereford; much of the west of the county is resident to low population densities of less than 50 individuals per km$^2$ (Figure 8).

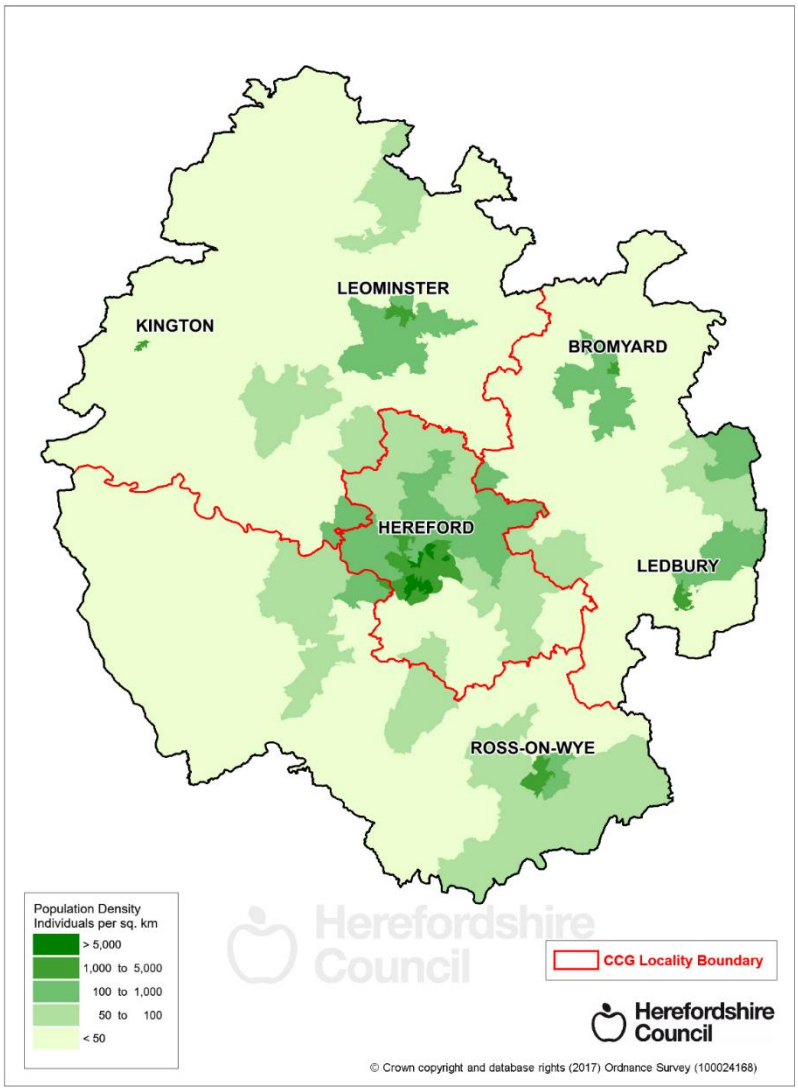



**Figure 8 - Population density across Herefordshire, 2017**

(Data source: ONS 2017 mid-year estimates © Crown copyright)

## ETHNICITY

The 2011 census was the first opportunity to accurately quantify the impact that the expansion of the European Union in 2004 had had on Herefordshire's population, and it remains the only accurate source of information about the characteristics of the population. Estonia, Czech Republic, Hungary, Lithuania, Latvia, Poland, Slovakia and Slovenia joined in 2004; Romania and Bulgaria in 2007.

Experimental estimates in the years between censuses in 2001 and 2011 had indicated that the population of an ethnic origin other than 'white English, Welsh, Scottish, Northern Irish, British' –

known as the ‘Black, Asian and minority ethnic’ (BAME) population – had increased from 2.5 to 5.9%.

However, the 2011 census revealed that migration from Eastern Europe had been significantly under-counted in these estimates (mostly people of ‘white: other’ origin), and that they had also over-estimated the growth in the non-white population. In fact, the non-‘white British’ population in 2011 was 11,600 – more than two-and-a-half times bigger than in 2001 (4,300).

The proportion had increased from 2.5 to 6.3%, although this was still very low in national terms (19.5% across England and Wales as a whole). The ethnicity of the Herefordshire population is summarised in Table 2.

**Table 2 - Ethnicity of Herefordshire population**

| Ethnic Group | Herefordshire | | England |
|---|---|---|---|
| | No. | % | % |
| White: English/Welsh/Scottish/Northern Irish/British | 171,900 | 92.0 | 80.5 |
| White: Irish | 700 | 0.4 | 0.9 |
| White: Gypsy or Irish Traveller | 350 | 0.2 | 0.1 |
| White: Other White | 7,200 | 5.1 | 4.4 |
| Mixed/multiple ethnic groups | 1,250 | 0.8 | 2.2 |
| Asian/Asian British | 1,450 | 1.1 | 7.5 |
| Black/African/Caribbean/Black British | 350 | 0.2 | 3.4 |
| Other ethnic group | 250 | 0.2 | 1 |
| Total not 'White' | 3,300 | 2.3 | 14.1 |

(Data Source: 2011 Census, table KS201. © Crown copyright)

## DEPRIVATION

Based on the Index of Multiple Deprivation, out of 152 upper tier (county or shire council) authorities Herefordshire is the 92nd most deprived and is more deprived than its geographical neighbours – Shropshire (ranked 115th), Worcestershire (ranked 111th) and Gloucestershire (ranked 123th).

Of the 116 ‘Lower Layer Super Output Areas’ (LSOAs) in Herefordshire, Golden Post-Newton Farm is amongst the 10% most deprived across England; a further eight are included within the most deprived 20% in the Country, four of which are in south Hereford and three are in Leominster town.

When considering deprivation in Herefordshire across the county it is evident that a division exists between the east and the west of the county, with the latter comprising a relatively larger number of areas in the 50% most deprived in the county (Figure 9). Hereford city and the surrounding

rural area also have some of the least deprived areas in Herefordshire. Other less deprived areas include LSOAs located within the towns of Bromyard, Ledbury, Leominster and Ross-on-Wye, as well as rural areas between Hereford and Leominster and around Ledbury.

The income deprivation affecting children index is a supplementary index to the overall income domain. It gives the actual proportion of children aged 0-15 living in income deprived families. There are around 4,300 children living in income deprivation across Herefordshire (14% of all children), with the ten most deprived LSOAs in the county each have at least 28% of their under 16s living in income deprivation.

Ridgemoor in Leominster and Golden Post - Newton Farm in south Hereford have the highest proportions of children living in income deprivation with 38 and 34% respectively.

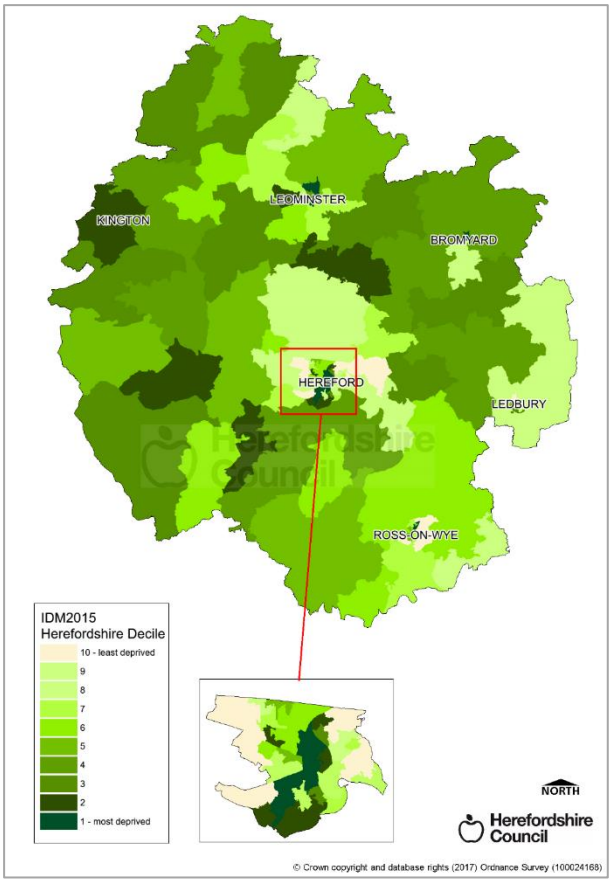



**Figure 9 - Distribution of the IMD 2015 for Herefordshire LSOAs**

(Data Source: ONS, 2015 © Crown copyright).

## LIFE EXPECTANCY

Between 2001-03 and 2015-17 the life expectancy in males and females in Herefordshire have shown a steady increase, although small falls have been evident in subsequent years (Figure 10). For those born in Herefordshire in 2015-17 the average life expectancy is 79.8 years for males and 83.6 years for females. Similar patterns were also evident for England, although throughout

this period both the Herefordshire male and female figures have been higher than those recorded nationally, although in recent years the differences have not been significant.

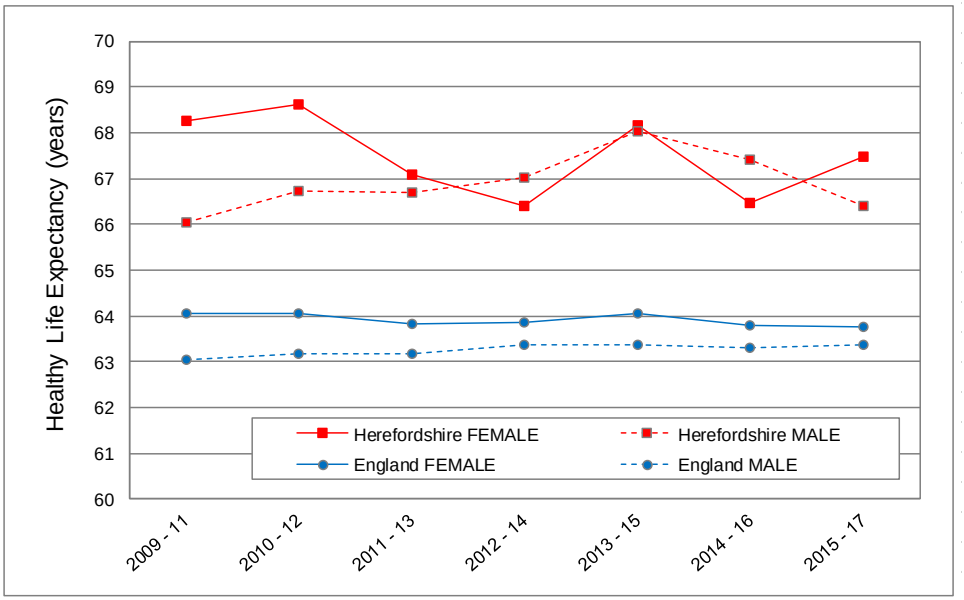



**Figure 10 - Male and female life expectancy at birth in Herefordshire and England.**

(Data source: Public Health Profiles, PHE)

Between 2009-11 and 2015-17 the healthy life expectancy in males and females in Herefordshire have shown some variability, although throughout this period the local figures have been significantly higher than those reported nationally (Figure 11). For those born in Herefordshire in 2015-17 the healthy life expectancy is 66.4 years for males and 67.5 years for females.

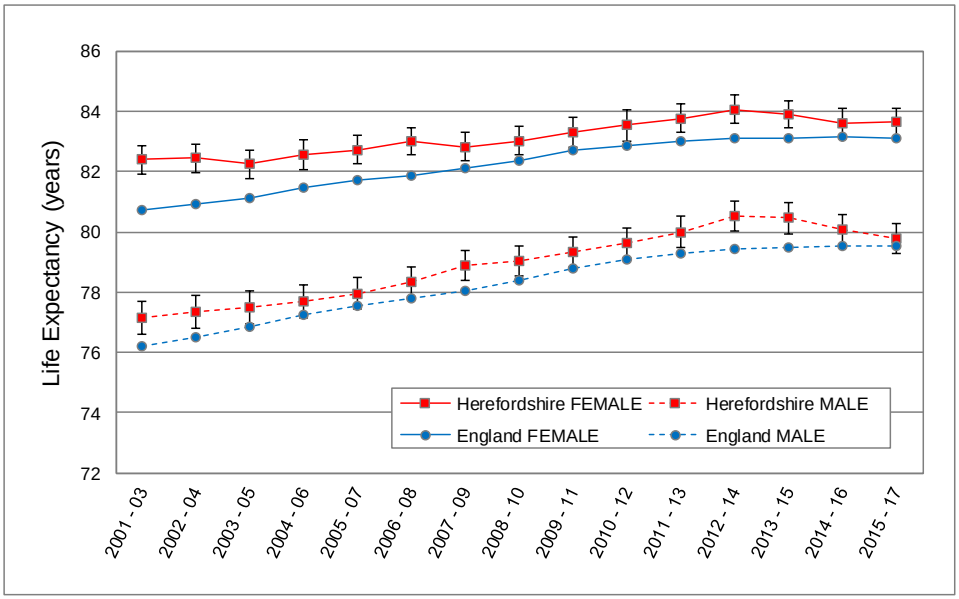



**Figure 11 - Male and female healthy life expectancy in Herefordshire and England.**

(Data source: Public Health Profiles, PHE)

## OVERWEIGHT AND OBESITY - CHILDREN

Between 2007/08 and 2017/18 the proportion of children in reception (4-5 years) who were overweight varied between 20.7% and 24.0% locally, while levels of obesity ranged between 8.0% and 9.8%. In both cases no temporal trends were evident and the local figures were broadly similar to that observed nationally (Figure 12).

Over the same period the proportion of children in year 6 (10-11 years) who were overweight varied between 29.1 and 34.8% locally, while levels of obesity ranged between 15.5 and 19.8%. As with the reception data no temporal trends were evident and the Herefordshire figures were broadly similar to those recorded across England.

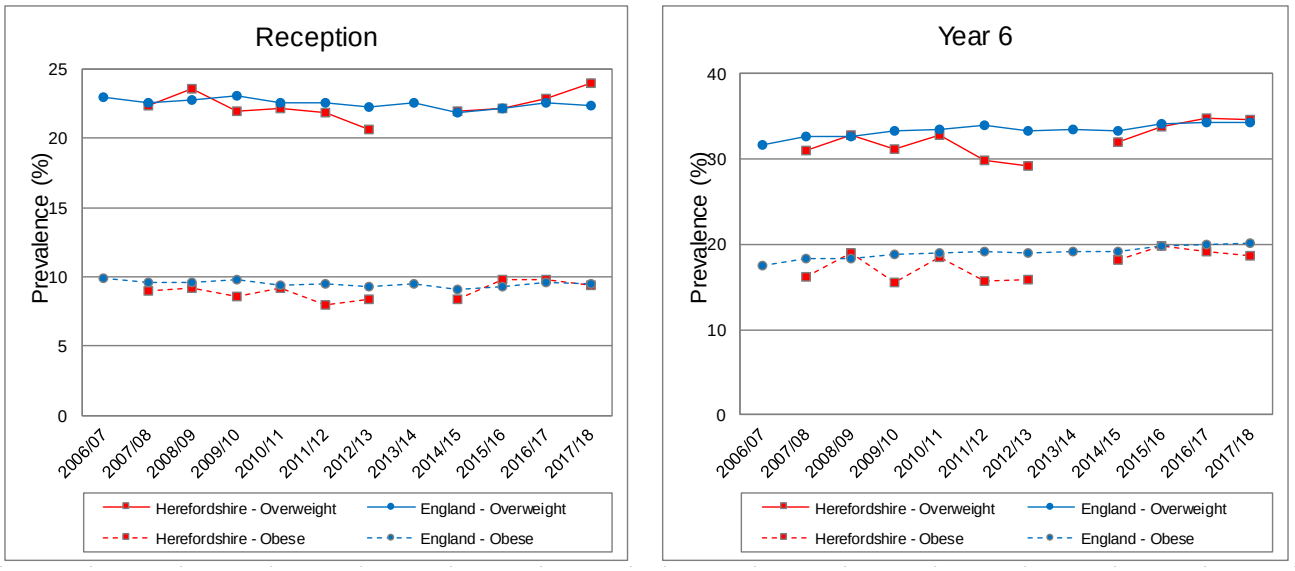



**Figure 12 - Prevalence of overweight and obesity in reception and year 6 children in Herefordshire and England**
(Data source: Public Health Profiles. PHE)

In 2017/18, of 1,841 Herefordshire reception age children measured, 441 (24.0%) were overweight; of this overweight cohort 172 (9.3%) were obese. In 2016/17 a total of 1,757 year 6 children were measured of which 6082 (34.6%) were overweight, 329 (18.7%) were obese. The local overweight and obese prevalence figures for both age groups were similar to those reported for England.

In reception and year 6 the highest prevalence of obesity was evident in the most deprived areas of Herefordshire with prevalence falling with decreasing deprivation, although in both cohorts this pattern is reversed in the least deprived quintile where both figures being higher than the second quintile (Figure 13). However, there are no areas of the county where fewer than 10% of children are obese when they leave primary school.

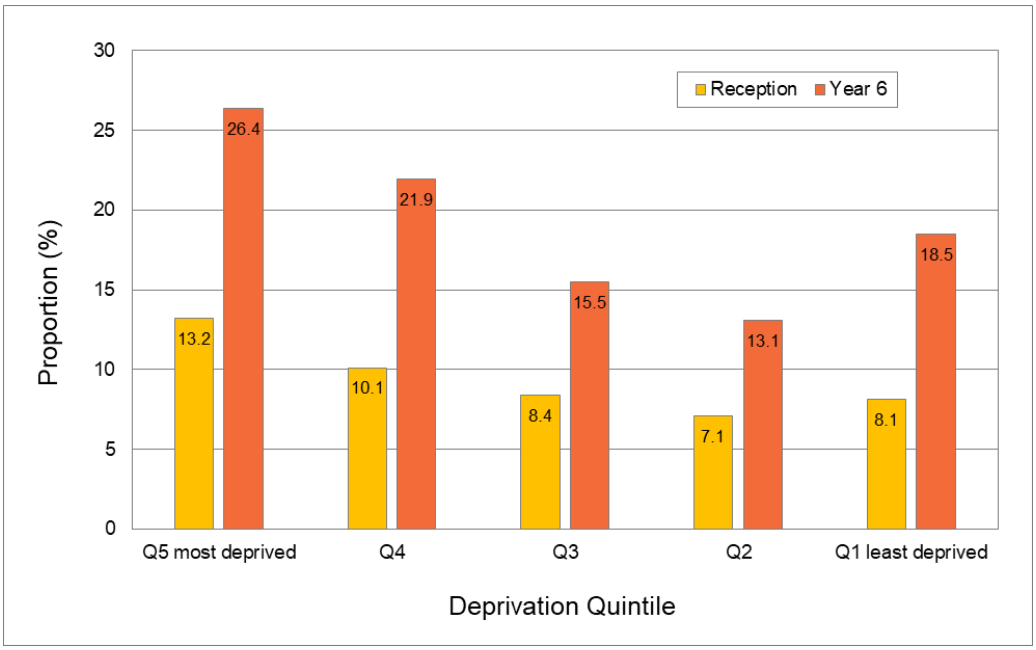



**Figure 13 - Proportion of obese children in reception and year 6 by deprivation in Herefordshire.**
(Data source: National Child Measurement Programme 2017/2018 and IMD 2015)

## OVERWEIGHT AND OBESITY - ADULTS

Since 2015/16 there has been little variability in the prevalence of excess weight or obesity in adults in Herefordshire (Figure 14). In 2017/18 the local prevalence of excess weight was 64.5% which was similar to that recorded for England as a whole (62.0%). The prevalence of obesity in adults in Herefordshire in 2017/18 of 10.2%, was statistically higher than that recorded for England (9.8%).

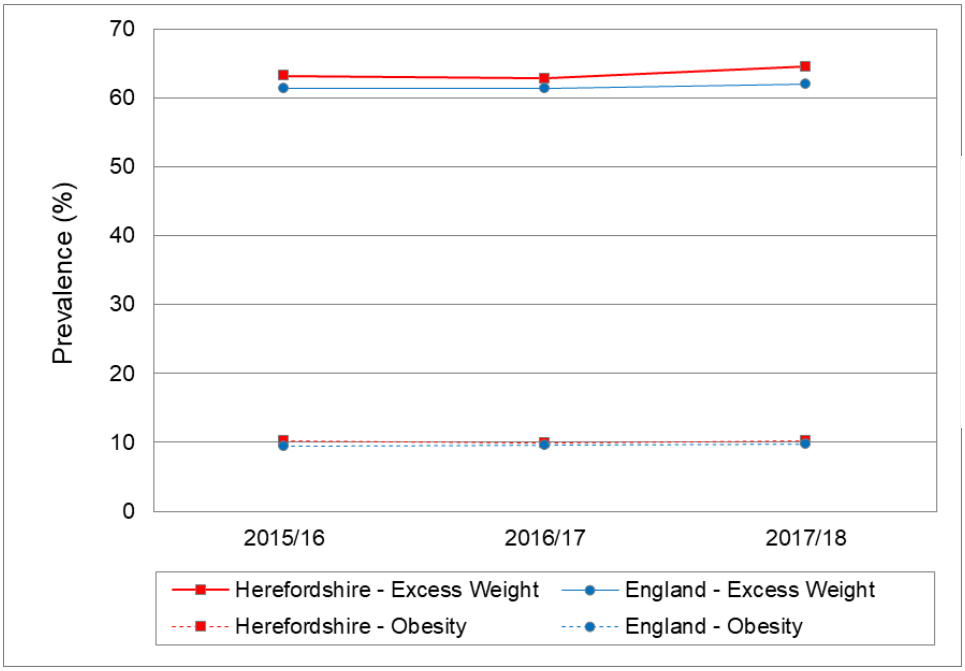



**Figure 14 – Local and national trends in adult overweight and obesity prevalence**

(Data source: Public Health Profiles, PHE)

## HEALTHY EATING - CHILDREN

The government encourages healthy eating through campaigns such as '5 A DAY', which encourages everyone to eat at least five portions of a variety of fruit and vegetables every day. In 2014/15 the What About YOUth (WAY) survey [46] found that 58.3% of 15 year olds in Herefordshire reported eating at least five portions of fruit and vegetables on a daily basis, a figure significantly higher than that for England as a whole.

The Every Child Matters study conducted in 2009 reported that 62% of school children ate "a lot" of fresh fruit and 50% ate "a lot" of vegetables, although 10% reported "never" eating vegetables [47].

## HEALTHY EATING – ADULTS

Between 2015/16 and 2017/18 the proportion of the adult population in Herefordshire reported as consuming at least five portions of a variety of fruit and vegetables every day has varied between 64.8% and 68.5% with this local figure being consistently higher than that reported for England as a whole (Figure 15).

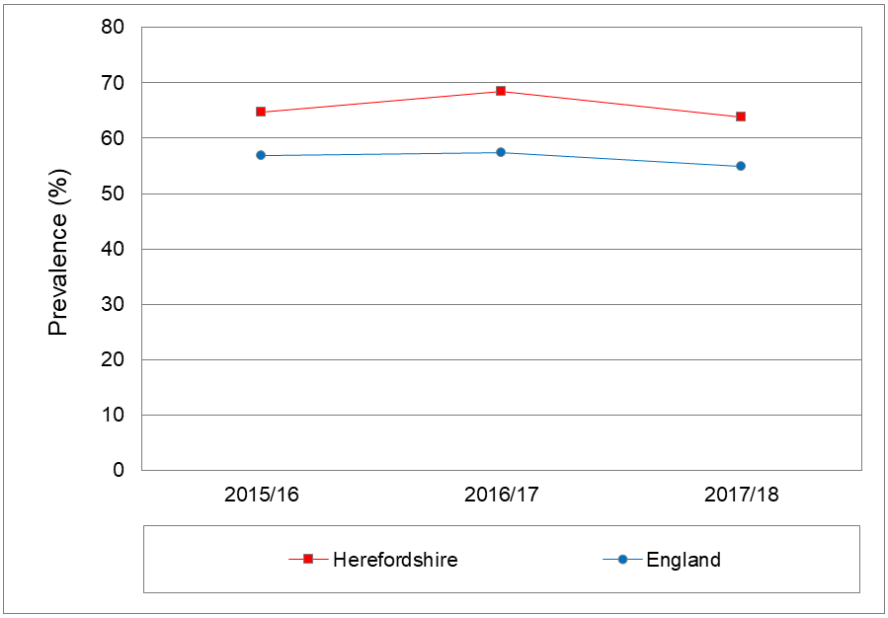



**Figure 15 - Proportion of adults meeting the recommended '5-a-day' on a 'usual day'**
(Data Source: Public Health Profiles, PHE)

## SMOKING – ADULTS

Information on the prevalence of adult smoking has been collected as part of the Integrated Household Survey (IHS) up until 2014 and since 2012 as part of the Annual Population Survey (APS) [31]. Therefore the ONS announced it would no longer produce the IHS. Instead the questions formerly regarded as the IHS core will continue to be asked in the APS.

Between 2010 and 2017 the proportion of adults (aged 18 years and over) in Herefordshire who self-reported as smokers showed a general fall from 19.8 to 12.2%, while over the same period the figures for both England and the West Midlands also fell (Figure 16). With the exception of 2015 the local prevalence was below those recorded nationally and regionally; in 2015 the local figure was higher than both of these figures, although not significantly so.

When considering estimated smoking prevalence and average level of deprivation at each GP practice across Herefordshire it is evident that smoking is more prevalent in the most deprived quartile compared to less deprived quartiles and the lowest smoking prevalence was evident in the least deprived quartile.

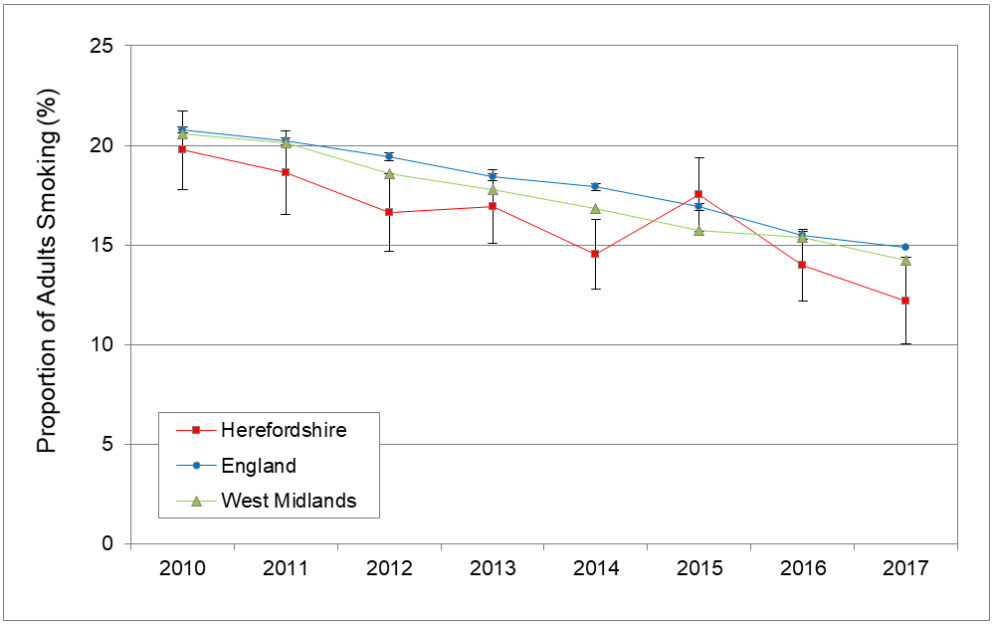



**Figure 16 - Local, regional and national trends in prevalence of self-reported smoking in adults.**
(Data source: PHE Local Tobacco Control Profiles for England)

## ALCOHOL CONSUMPTION– ADULTS

The Herefordshire Health and Well-Being Survey [48] undertaken in 2011 included a section on drinking habits over the previous 12 months and on alcohol intake based on the previous week's consumption.

The findings indicated that 56% of adults reported consuming alcohol on a weekly basis, ranging in frequency from 26% who drank alcohol on average once or twice a week to 11% drinking almost every day (Figure 17). The proportion of males drinking on a weekly basis was 65%, which was significantly higher than the female figure of 46%. Similarly, the proportion of males who drank almost every day (14%) was significantly higher than the female rate of consumption (8%).

Approximately 10% of adults reported that they had not consumed any alcohol over the previous 12 months, while 35% drank less than once a week on average. This data indicates that on average males tend to drink more often than females, a pattern which is evident at all ages,

although for both genders the average frequency of drinking increases with age until 65 years of age after which frequency falls (Figure 18).

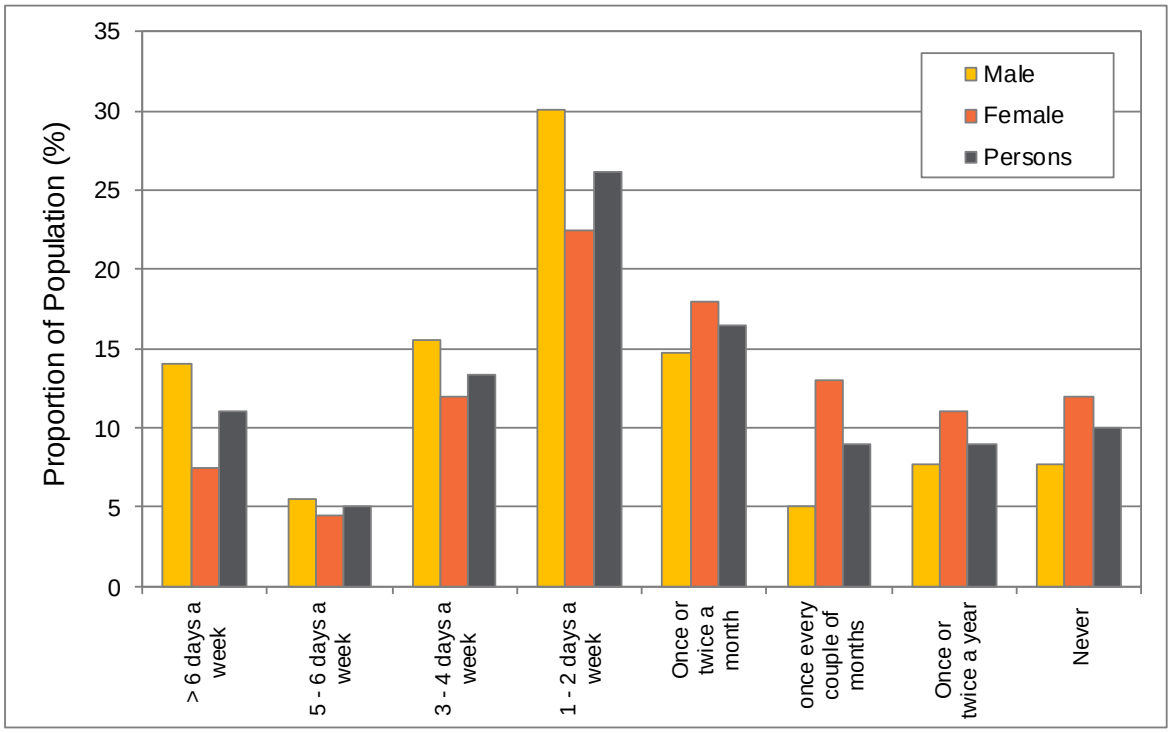



**Figure 17 - Average frequency of alcohol consumption in Herefordshire, 2011.**

(Data source: Herefordshire Health and Well-Being Survey, 2011)

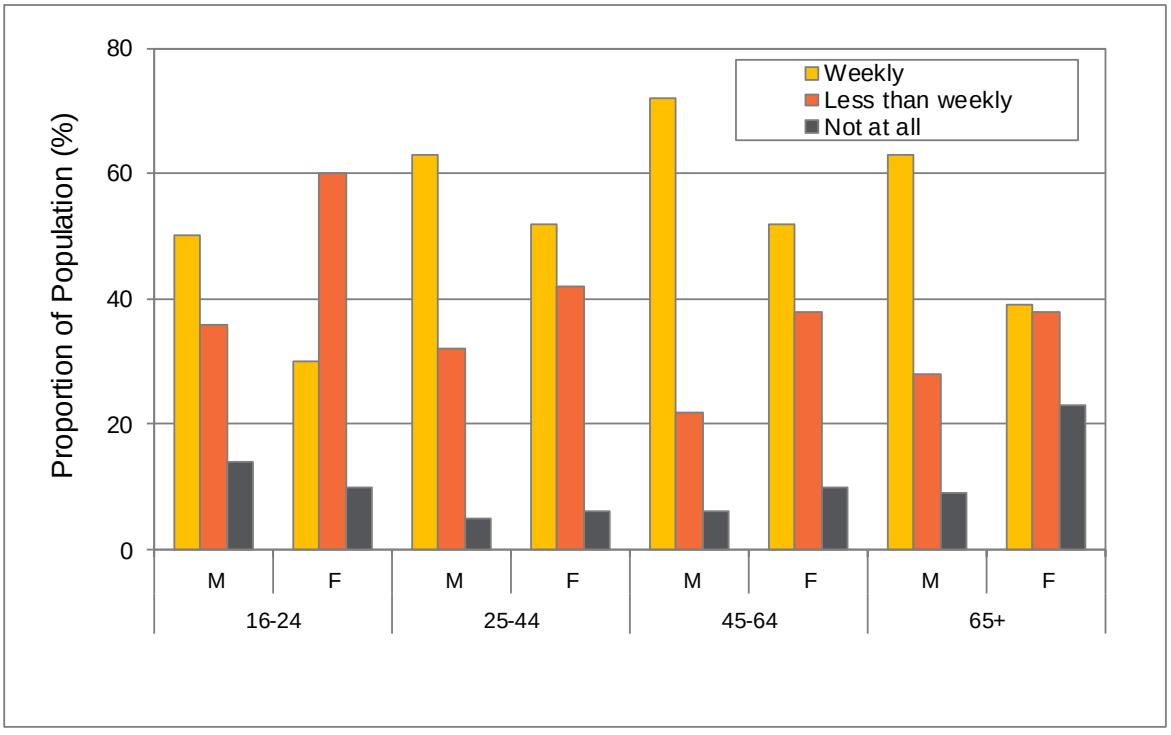



**Figure 18 - Average frequency of alcohol consumption by gender and age in Herefordshire, 2011.**

(Data Source: Herefordshire Health and Well-Being Survey, 2011)

Recommendations from the four Chief Medical Officers in the UK state that in order to keep health risks from alcohol to a low level it is safest not to drink more than 14 units a week on a regular basis [49].

Data for 2001 – 2014 indicate that in Herefordshire 25.9% of adults consumed more than 14 units per week and 21.0% of adults in Herefordshire reported binge drinking on their heaviest drinking day while 14.4% abstained from alcohol.

All three local measures were similar to the majority of figures reported for the ten nearest neighbour authorities. In relation to the level of deprivation across Herefordshire, 45% of adults in the most deprived areas abstain from alcohol, a figure appreciably higher than in less deprived quintiles where the proportions varied between 29 and 32% (Figure 19).

It is interesting to note that the highest proportion of adult binge drinking (22%) was also reported in the most deprived areas. However, a significantly lower proportion of residents in the most deprived areas also reported drinking within guidelines (18%) compared to 26% across the county as a whole. The lowest level of binge drinking in Herefordshire (17%) was recorded in the least deprived areas.

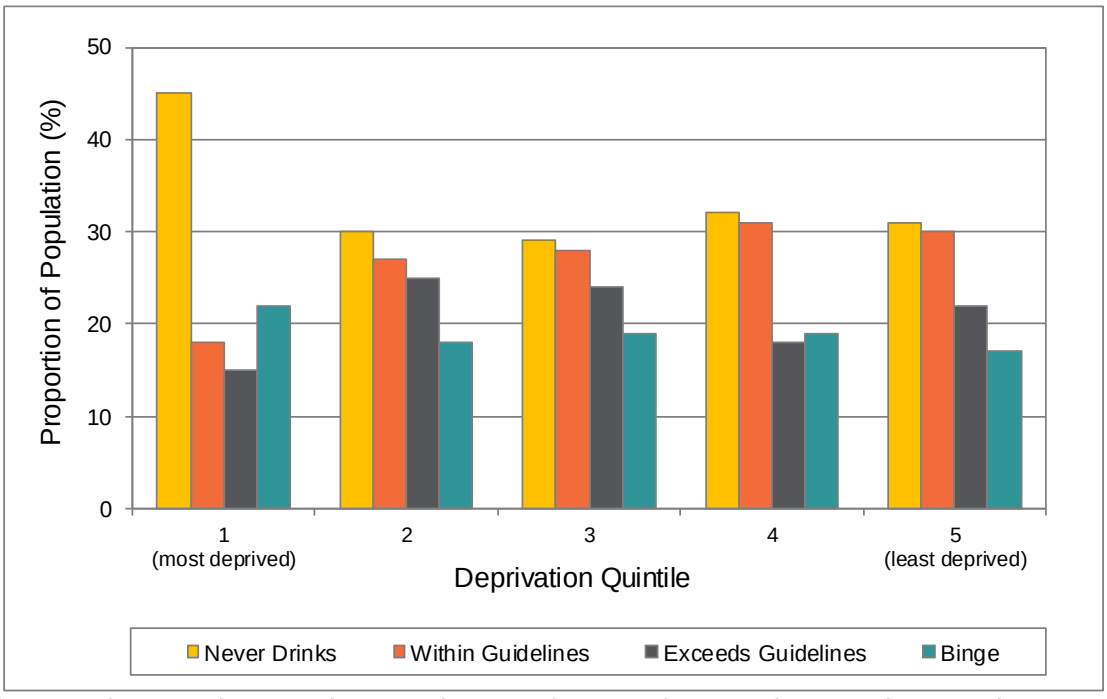



**Figure 19 - Drinking behaviour in relation to consumption guidelines by level of deprivation in Herefordshire, 2011**

(Data Source: Herefordshire Health and Well-Being Survey, 2011)

## POPULATIONS AT RISK

As detailed previously, specific groups in the population are at greater risk of experiencing poorer oral health and some may find it more difficult to access appropriate oral health care. Despite this, there remains a paucity of data related to the oral health experience and overall oral health needs of at risk groups.

Local intelligence does however provide an indication of the numbers and proportion of Herefordshire's population, who belong to specific groups of interest. This information is crucial as it can be used by health and social care professionals to inform the future commissioning and delivery of oral health care services locally.

*Looked after children*

As of the 31st March 2018, there were 313 LAC in Herefordshire [50]. Table 3, presents the rates of children (aged under 18 years), who were looked after by a local authority at a local, regional and national level. Since 2015, the local rate of LAC has increased year on year and remains higher than both the regional and national values.

**Table 3 – Local, regional and national rates of children (aged under 18 years) looked after (per 100,000) as of 31st March 2018 [50]**

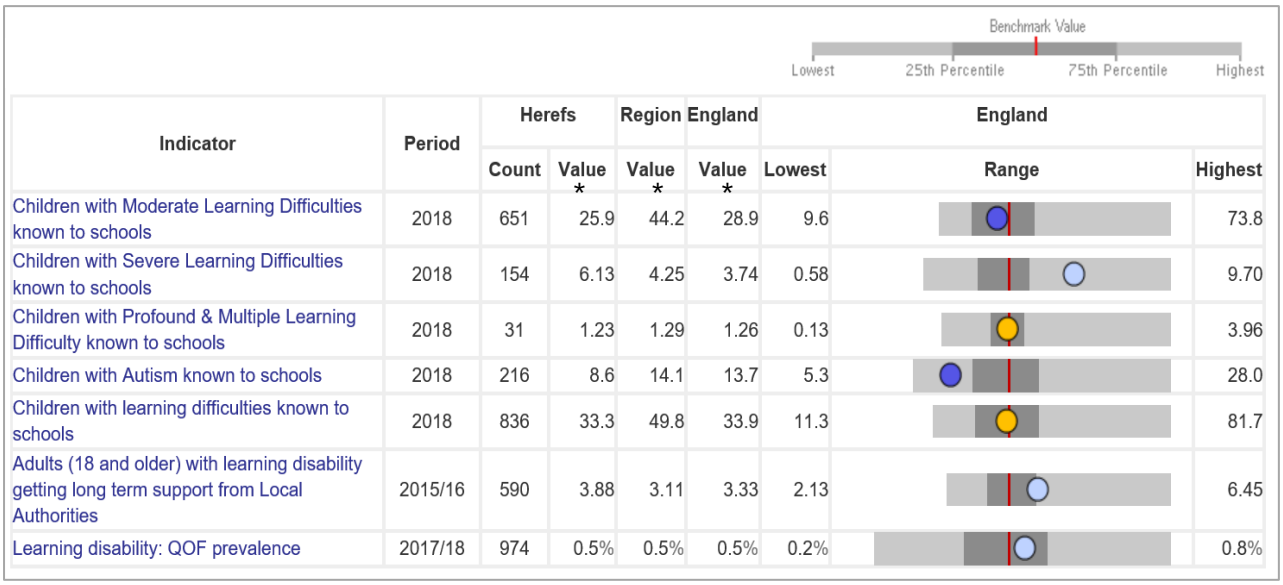
| | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|
| **Herefordshire** | 67 | 75 | 79 | 84 | 87 |
| **West Midlands** | 73 | 74 | 73 | 75 | 78 |
| **England** | 60 | 60 | 60 | 62 | 64 |

*Learning disabilities*

The Public Health Outcomes Framework [17], publishes 'learning disability' profiles for local authorities in England. Each profile includes local data related to children and adults who are known to have a learning difficulty or learning disability and Figure 20 presents the data for Herefordshire.

It is important to note that there are no reliable statistics, which accurately report how many people there are with learning disabilities across the UK. Modelled estimates suggest that GP registers (i.e. QOF prevalence in figure 20), are likely to be an underestimation of the prevalence of learning disabilities.

For example, the true number of people (aged over 14 years) in Herefordshire with a learning disability is estimated to be over 3500 – 2.3% of the population [51,52]. As detailed in Herefordshire's Adult Learning Disabilities Needs Assessment (2018) [52], Herefordshire Council currently provides long-term social care support to around 600 adults with a learning disability.




| Indicator | Period | Herefs | | Region England | England | England | | |
|---|---|---|---|---|---|---|---|---|
| | | Count | Value * | Value * | Value * | Lowest | Range | Highest |
| Children with Moderate Learning Difficulties known to schools | 2018 | 651 | 25.9 | 44.2 | 28.9 | 9.6 | | 73.8 |
| Children with Severe Learning Difficulties known to schools | 2018 | 154 | 6.13 | 4.25 | 3.74 | 0.58 | | 9.70 |
| Children with Profound & Multiple Learning Difficulty known to schools | 2018 | 31 | 1.23 | 1.29 | 1.26 | 0.13 | | 3.96 |
| Children with Autism known to schools | 2018 | 216 | 8.6 | 14.1 | 13.7 | 5.3 | | 28.0 |
| Children with learning difficulties known to schools | 2018 | 836 | 33.3 | 49.8 | 33.9 | 11.3 | | 81.7 |
| Adults (18 and older) with learning disability getting long term support from Local Authorities | 2015/16 | 590 | 3.88 | 3.11 | 3.33 | 2.13 | | 6.45 |
| Learning disability: QOF prevalence | 2017/18 | 974 | 0.5% | 0.5% | 0.5% | 0.2% | | 0.8% |

**Figure 20 - Learning disability population data for Herefordshire** (Data source: PHE Learning Disability Profiles)

***** Unless % is provided, the term 'value' refers to a rate and reflects a value 'per 1000 pupils' (for indicators related to children) and 'per 1000 population' (for the indicator related to adults).

*People who experience mental health problems*

PHE publish intelligence related to mental health at a national, regional and local level [(53)]. This includes data about the prevalence of common mental disorders i.e. depression and severe mental illness i.e. schizophrenia [(54)].

Based on data from GP registers in Herefordshire (2017/2018), PHE reported that for adults (over 18 years), the prevalence of depression was 9.1% (9.9% nationally) and the prevalence of severe mental illness was 0.83% (0.94% nationally). This equates to 13,856 and 1,557 people respectively.

In addition and based on modelled estimates, the local prevalance of mental health disorders in children (aged 5-16 years) during 2015 was 8.9% (2,139 children), lower than both regionally (9.7%) and nationally (9.2%).

As mental health data is obtained from registers of those diagnosed or treated, or from self-reported surveys, it is likely that the true burden of mental health problems is underestimated both locally and nationally.

*People who need adult social care*

There are currently around 1,500 people aged 65 years and over in Herefordshire living in either a local authority or privately funded care home [(55)]. Based on modelling commissioned by Herefordshire Council, the demand for care home places is expected to increase by 3% by 2021

and 5% by 2036 (to 2900). The proportion of people living with dementia in a Herefordshire care home is also expected to rise, from 1200 in 2016 to 2,300 in 2036.

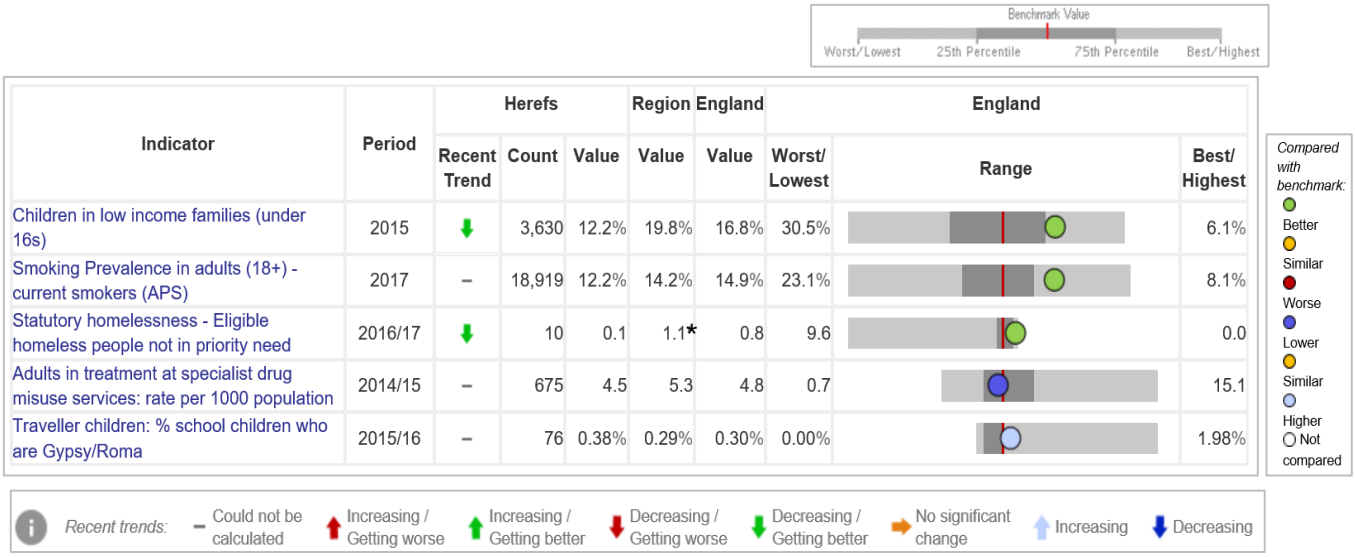
*Asylum seekers and refugees*

Herefordshire has supported the 'Syrian Vulnerable Person's Resettlement Scheme' (SVPRS), with 60 refugees (14 households) being resettled locally between 2016 and 2017 [56]. In addition up to 25 children and young people who are 'unaccompanied asylum seekers' are 'looked after' and supported by Herefordshire Council.

Herefordshire has agreed in principle to re-settle a further 35 refugees through SVPRS and the Vulnerable Children Resettlement Scheme (VCRS) and up to 40 asylum seekers under the General Asylum Dispersal Scheme (GADS).

*Other vulnerable groups*

The Public Health Outcomes Framework, publishes oral health profiles for local authorities in England [17]. Each profile includes local data set related to particular socio-demographic and lifestyle factors that are known to increase a person's risk of poor oral health (see figure 21).




| Indicator | Period | Herefs | | | Region Value | England Value | England | | | Compared with benchmark: |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Recent Trend | Count | Value | | | Worst/ Lowest | Range | Best/ Highest | |
| Children in low income families (under 16s) | 2015 | ↓ | 3,630 | 12.2% | 19.8% | 16.8% | 30.5% | | 6.1% | Better |
| Smoking Prevalence in adults (18+) - current smokers (APS) | 2017 | – | 18,919 | 12.2% | 14.2% | 14.9% | 23.1% | | 8.1% | Similar |
| Statutory homelessness - Eligible homeless people not in priority need | 2016/17 | ↓ | 10 | 0.1 | 1.1* | 0.8 | 9.6 | | 0.0 | Worse |
| Adults in treatment at specialist drug misuse services: rate per 1000 population | 2014/15 | – | 675 | 4.5 | 5.3 | 4.8 | 0.7 | | 15.1 | Lower |
| Traveller children: % school children who are Gypsy/Roma | 2015/16 | – | 76 | 0.38% | 0.29% | 0.30% | 0.00% | | 1.98% | Similar |

Higher
Not compared

Recent trends: – Could not be calculated; ↑ Increasing / Getting worse; ↑ Increasing / Getting better; ↓ Decreasing / Getting worse; ↓ Decreasing / Getting better; → No significant change; ↑ Increasing; ↓ Decreasing

***** Aggregated from all known lower geography values as a crude rate per 1000 estimated total households.

**Figure 21 - Factors impacting on oral health - Oral health profile for Herefordshire** (Data source: PHE Oral Health Profiles)

The data above indicates that aside from adults in treatment for substance misuse services, Herefordshire is broadly better or similar to the regional and national values for the remaining risk factors listed. Despite this, there clearly remains a considerable number of children and adults residing in the county, who may have additional oral health needs compared to the general population.

# HEREFORDSHIRE - EPIDEMIOLOGY OF ORAL DISEASES

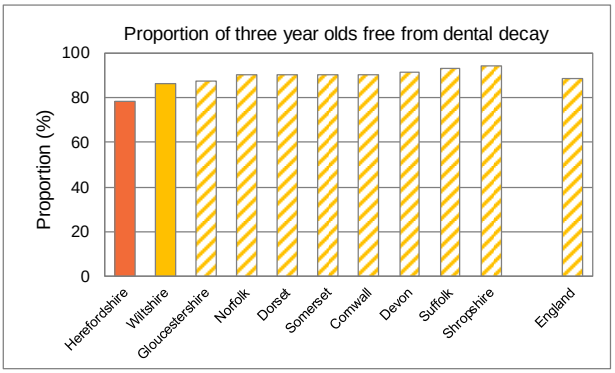
## CHILDREN

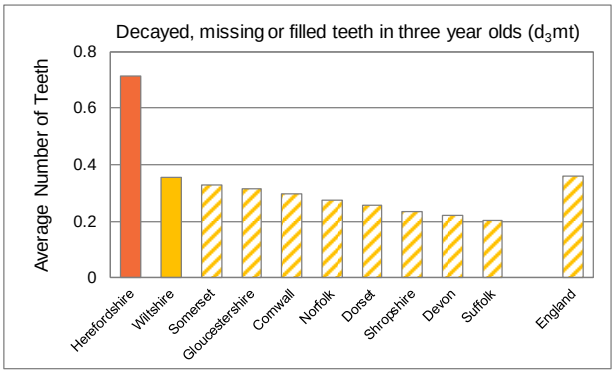
### ORAL HEALTH OF THREE YEAR OLDS

A survey of the oral health of three year olds was undertaken in 2013 as part of the Public Health England (PHE) 'National Dental Epidemiology Programme' (NDEP) [57]. Of the 179 children in Herefordshire who participated, 78.3% were found to be free from dental decay, a figure significantly lower than that reported for England as a whole and for the majority of nearest statistical neighbours (Figure 22).

In Herefordshire there were an average of 0.71 teeth per child affected by decay (decayed, missing or filled teeth – $d_3mt$), a figure twice that recorded nationally and over two and a half times the average for the nearest neighbours (Figure 22). Locally, the number of teeth with obvious, untreated dental decay made up 87% of this figure compared to 89% nationally.

Among those three year olds in Herefordshire with decay experience, the average number of decayed, missing (due to decay) or filled teeth was 3.18, which corresponds to almost one sixth of teeth expected to be present at this age (most children have all 20 primary teeth present by age three). The local figure is similar to that recorded for England (3.08) and is broadly similar to the nearest statistical neighbours (Figure 22).



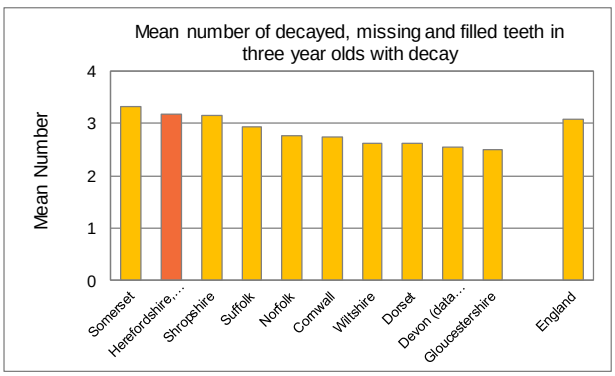




**Figure 22 - Oral health of three year olds, 2013 (shaded bars indicate significantly different from Herefordshire figure).**

(Data Source: NDEP – PHE)

## ORAL HEALTH OF FIVE YEAR OLDS

The proportion of five year olds free from dental decay in Herefordshire has shown some variability with time and the local figure has been consistently lower than that reported for England [33]. The 2016/17 Herefordshire figure of 69.5% was significantly lower than that for England and was lower than the majority of nearest Upper Tier Local Authorities (UTLA) comparators (Figure 23).

The Herefordshire figure was 35th lowest out of 144 UTLAs across England for which data was available.

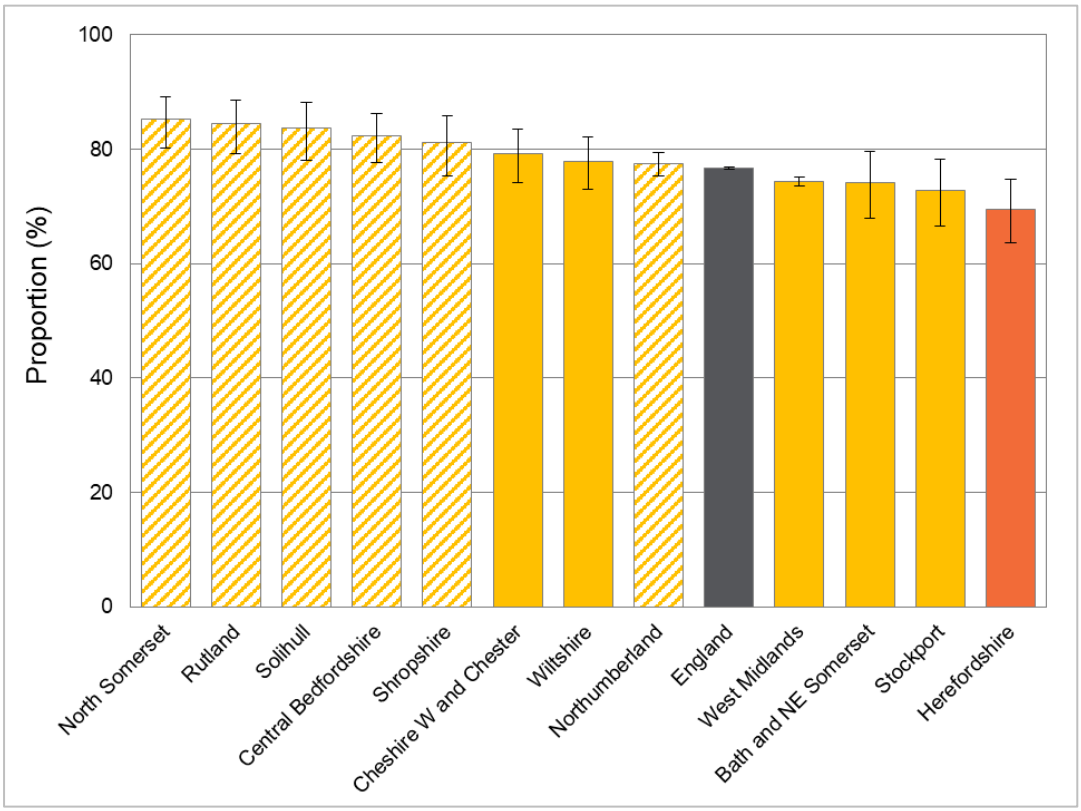



**Figure 23 - Proportion of five year old children free from dental decay, 2016/17 (shaded bars indicate significantly different from Herefordshire figure).** (Data source: NDEP – PHE)

The mean number of decayed, missing or filled teeth in five-year-olds in Herefordshire 2016/17 was 1.08, much higher than nationally (0.78) and regionally (0.82). Herefordshire was also the worst performing authority of its comparator group for this indicator.

The local figure was ranked the 35th highest out of 144 UTLAs across England for which data was available (Figure 24).

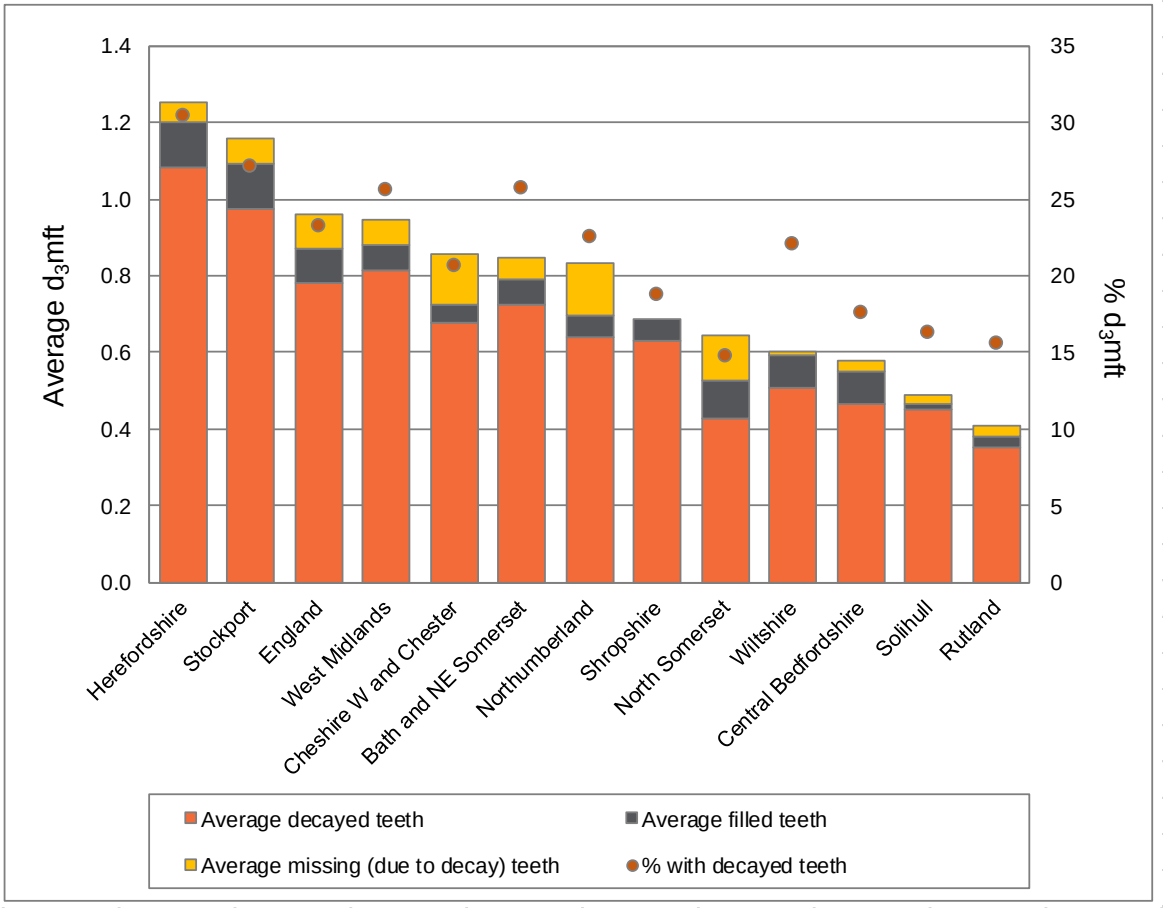



**Figure 24 - The average number of decayed, extracted or filled teeth (d3mft) and the proportion of children affected by dental decay (% d3mft>0) among five-year-old children (Herefordshire, comparator local authorities and England).**
(Data source: NDEP - PHE)

Data from 2017, would indicate at first glance that there has been a considerable local improvement (see figure 25); in 2017, 30% of children in Herefordshire experienced tooth decay compared to 41% in 2015.

However, it is important to note that the differences between the latest local figures and those reported previously are not statistically significant. What can be concluded from the data is:

- There has been no significant change in the local proportion of 5 year old children with experience of tooth decay over the last 10 years.

- 5 year old children in Herefordshire generally have poorer dental health than that reported nationally.

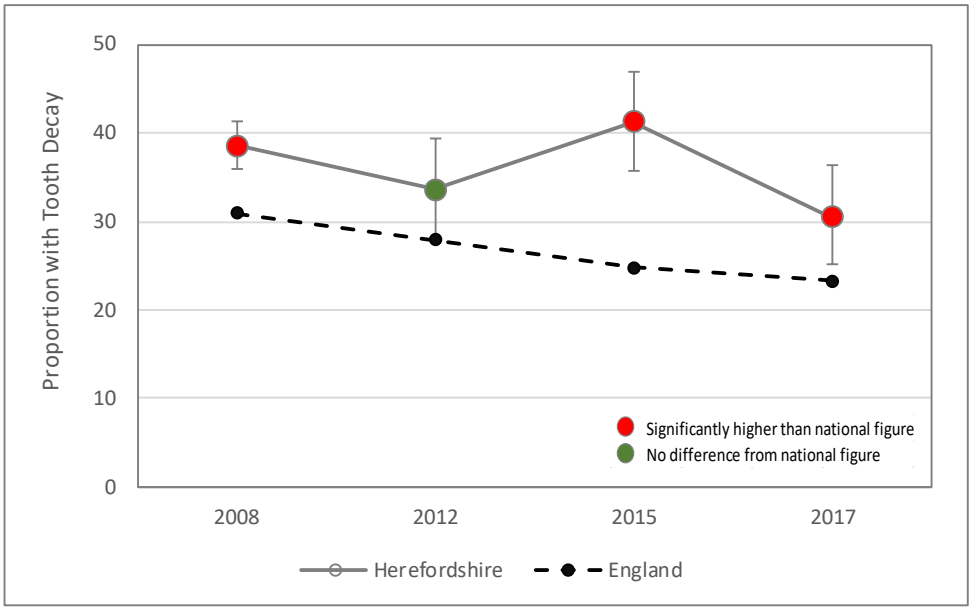



**Figure 25 - Proportion of 5 year old children with tooth decay, 2016/17.**

(Data source: NDEP – PHE)

*Deprivation*

Every child who has teeth is at risk of tooth decay, but the risk increases for those living in the more deprived areas where a range of socioeconomic factors influence children's development. However, in 2016/17, while the lowest level of tooth decay in 5 year old was evident in the least deprived population quintile, there was no strong association between levels of decay and deprivation across the county as a whole (Figure 26).

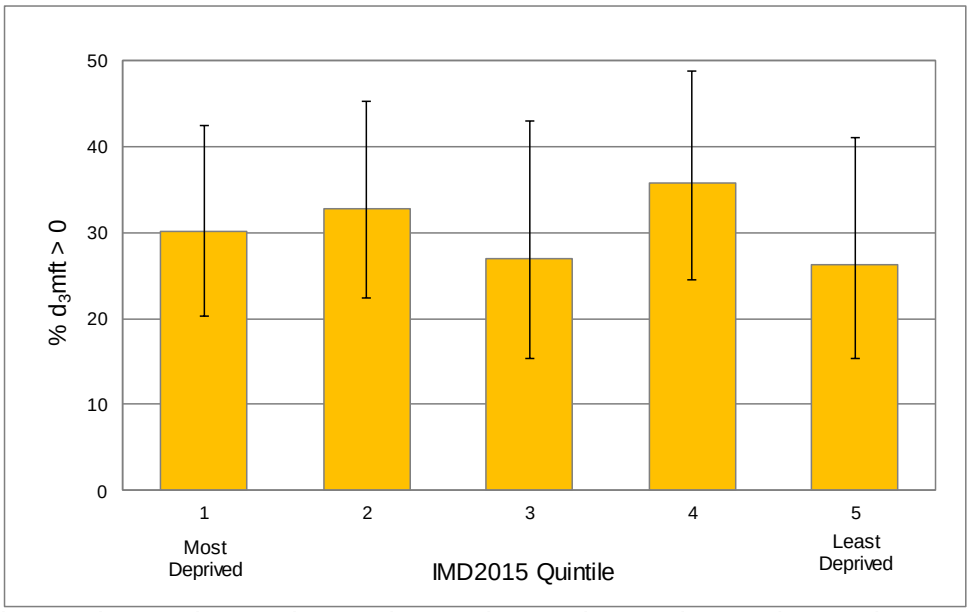



**Figure 26 - Prevalence of decay in 5 year olds in Herefordshire by Index of Multiple Deprivation 2015 quintiles**

(Data source: NDEP – PHE/IMD 2015)

There were however, spatial patterns evident in the levels of tooth decay in Herefordshire, with high levels observed in Hereford (particularly in South West Wye) and also in Leominster (Table 4).

**Table 4 – Tooth decay severity and prevalence in 5 year olds in Herefordshire**

| Area | Average $d_3$mft | % with decay experience | Average $d_3$mft in those with decay experience |
|---|---|---|---|
| **South Wye West** | 1.70 | 40.0 | 4.25 |
| **Leominster** | 1.20 | 43.9 | 2.72 |

*Ethnicity*

As previously described, at a national level there are known associations between oral health and ethnicity, with children from Chinese and Eastern European backgrounds experiencing greater levels of oral disease [33]. Despite this, at a local level, it is currently not possible to determine the standard of oral health in children according to ethnicity.

## ORAL HEALTH OF TWELVE YEAR OLDS

A survey of the oral health of twelve year olds was undertaken in the school year 2008/09 as part of the PHE NDEP [58].

Of the 267 Herefordshire children which participated 55.9% were found to be free from dental decay, a figure significantly lower than that reported for England as a whole and for the majority of nearest statistical neighbours (Figure 27).

In Herefordshire there were an average of 1.05 teeth per child affected by decay (decayed, missing or filled teeth – $D_3$MFT), a figure significantly higher than that recorded nationally and in the majority of nearest neighbours (Figure 27). Locally, the number of teeth with obvious, untreated dentinal decay made up 38% of this figure compared to 44% nationally.

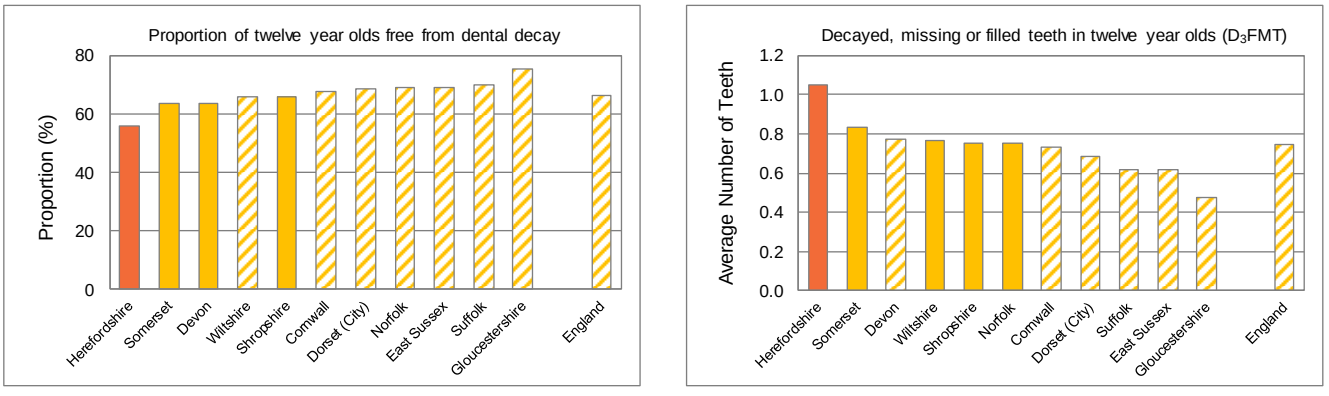



**Figure 27 - Oral health of twelve year olds, 2008/09 (shaded bars indicate significantly different from Herefordshire figure).**
(Data Source: NDEP – PHE)

## LOOKED AFTER CHILDREN

Limited data exists that indicates the current oral health experience of LAC nationally or locally. Data previously published by the Department for Education [59] does however report the number and proportion of LAC who had their teeth checked by a dentist (see table 5). This figure is lower than both the national and regional figure.

**Table 5 - Number and proportion of LAC who had their teeth checked by a dentist (as of 31 March 2016) [59]**

| | Number of LAC (looked after for at least 12 months) | Number of LAC who had their teeth checked by a dentist | Proportion of LAC who had their teeth checked by a dentist (%) |
|---|---|---|---|
| **Herefordshire** | 205 | 145 | 70.7 |
| **West Midlands** | 6,860 | 5,620 | 81.9 |
| **England** | 48,490 | 40,770 | 84.1 |

## HOSPITAL ADMISSIONS

In Herefordshire (during 2017/18) there was a total of 104 hospital admissions in individuals aged under 19 for which diseases of the oral cavity, salivary glands and jaws (ICD10 K00-K14) were the primary diagnosis [60].

Of the 104 hospital admissions recorded, 97 were for elective admissions, of which 44 were for impacted teeth i.e. a tooth has been blocked from breaking through the gum. Dentofacial anomalies and dental caries accounted for 14 and 10 admissions respectively. Overall, 60 out of the 104 admissions resulted in the extraction of one or more teeth, with all but seven being in individuals aged 10 or over.

Currently robust data is not available to ascertain whether the numbers of children undergoing dental extractions under general anaesthesia in Herefordshire is higher than regional or national rates.

## ADULTS

### ADULT DENTAL HEALTH SURVEY

The Adult Dental Health Survey is completed every 10 years with data available at a regional level [61]. The results of the last survey, which was undertaken in 2009, are discussed below.

Across the West Midlands, 91% of adults were dentate (i.e. had teeth), compared to 94% in England as a whole. The average number of natural teeth of dentate adults in the West Midlands was 25.1 while the figure nationally was 25.7; a functional amount of teeth is assessed as being 21.

Across the West Midlands 9% of adults were classed as periodontally (i.e. gum) healthy compared to a figure of 17% reported for England. Regionally, a further 32% of adults were periodontally healthy but had calculus, while 59% had loss of attachment and/or bleeding; the corresponding figures for England were 33% and 50%. Only 4% of adults in the West Midlands were classed as having excellent oral health compared to 10% nationally.

In the West Midlands, 39% of dentate adults had carious teeth (crowns and roots) compared to the national figure of 30% across England.

Around one in seven dentate adults in the West Midlands reported never or hardly ever feeling dental pain in the last 12 months, a figure similar to that reported nationally. Similarly, the proportion of dentate adults regionally reporting feeling pain fairly or very often (7%) was broadly similar to that reported across England (8%).

### ORAL HEALTH SURVEY OF MILDLY DEPENDENT OLDER PEOPLE

As part of PHE's NDEP, standard examinations and questionnaires of a random sample of older people (aged 65 and above) living in supported housing were undertaken in the year September 2015 to August 2016 [35].

Of those assessed in Herefordshire 14.5% were endentulous (i.e. had none of their own teeth), a figure appreciably lower than those report for England (27.0%) or the West Midlands (54.8%). While 17% of those assessed in Herefordshire had not seen a dentist within the last two years, the figure for England was twice this (34.0%); the proportion for the West Midlands was 41.4%.

Of those dentate individuals in Herefordshire 5.1% reported feeling oral pain on the day of examination compared to 9.5% and 8.5% reported across England and the West Midlands respectively.

While 3.2% across England and 2.8% in the West Midlands were considered to be in urgent need of dental care none of those assessed in Herefordshire were in such need.

The proportion of dentate individuals in Herefordshire with an open pulp, ulceration, fistula or an abscess was 1.7 compared to 7.8 per cent nationally and 4.2% regionally. Locally, 80% of dentate individuals had visible plaque and 63% had visible calculus, with both figures being higher than those reported nationally and regionally.

Of those individuals in Herefordshire with partial dentures 6.9% were in need of replacement compared to 13.0% across England and 8.8% in the West Midlands. The local figure for individuals in need of replacement of full dentures was 15.8%, while the national and regional proportions with a similar need were 14.8% and 11.8% respectively.

Overall, the study found that nationally poorer oral health tended to be recorded in the more deprived areas.

## ORAL CANCER

Between 2001-03 and 2014-16 the incidence of oral cancer in Herefordshire has shown a general rise which is mirrored in the incidence rate (Figure 28); a similar pattern is evident across England as a whole. In 2014-16 the local incidence rate was 14.0 per 100,000, a figure similar to that observed nationally and in nearest statistical neighbours (Figure 29)

Over this period the number of deaths Herefordshire related to oral cancer over any given three years showed some variability ranging between 10 and 23. Similarly, the local oral cancer mortality rate has shown some variability with no consistent pattern evident, although since 2009-11 the rate has shown a general increase (Figure 28). In 2015-17 the local mortality rate was 14.0 per 100,000, a figure similar to that observed nationally and in nearest statistical neighbours (Figure 29).

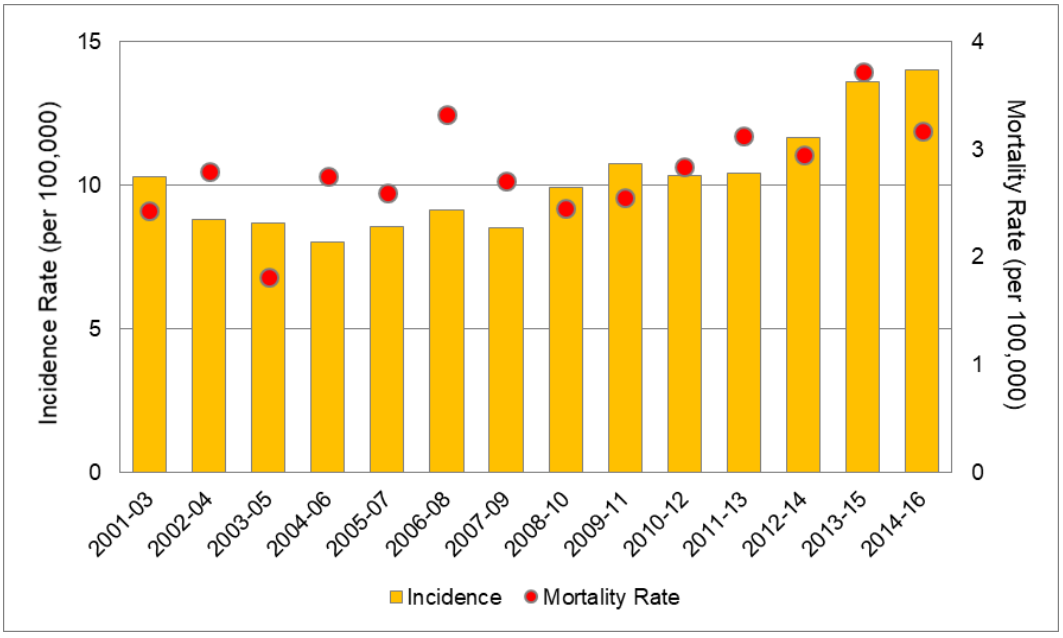
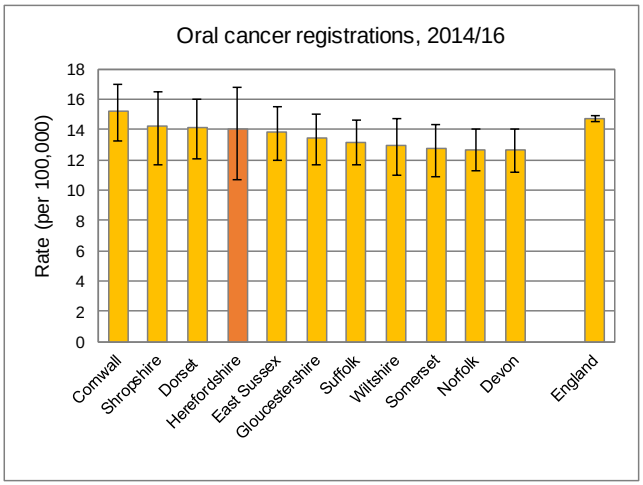



**Figure 28 - Oral cancer incidence and mortality rates in Herefordshire.** (Data Source: NCRAS)



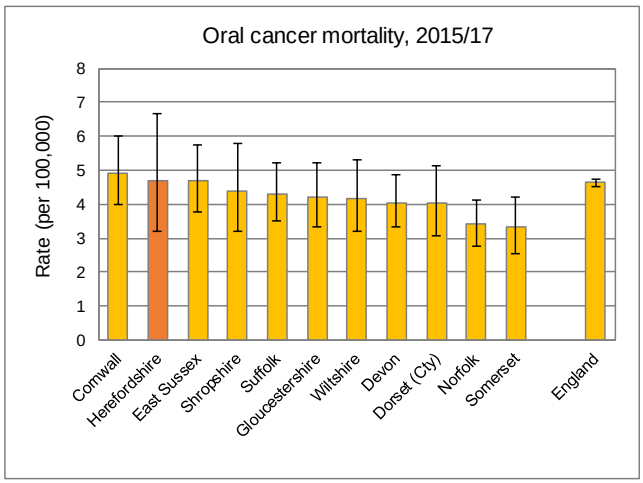




**Figure 29 - Oral cancer incidence and mortality rates in Herefordshire.** (Data Source: NCRAS)

## HOSPITAL ADMISSIONS

The most common primary diagnosis associate with the 557 elective admissions in adults was dental caries which accounted for 175 cases, while 91 admissions were related to “other” disorders of teeth and supporting structures and 83 were associated with “other” diseases of lip and oral mucosa [60].

More specialist dental services can be provided in Primary and/or Secondary care and are accessed by referral from a primary care general dental practitioner. They are not discussed in this needs assessment as they fall outside the agreed scope.

# HEREFORDSHIRE - ORAL HEALTHCARE SERVICES

## PROVISION OF ORAL HEALTHCARE SERVICES

In England, a range of key organisations commission, deliver and support the provision of oral healthcare services (see figure 30). The specific roles and responsibilities of each of these organisations listed in figure 30, were defined by Public Health England in 2014 (see Appendix B).

In relation to NHS dental services, NHS England has the statutory responsibility for securing provision, which meet the needs of a local population. NHS dental services in Herefordshire, comprises primary care, which is inclusive of general dental services, together with unplanned (urgent) dental care and services provided by the Community Dental Service.

Furthermore, and as displayed in figure 30, NHS England also commission secondary dental services for delivery within hospital settings i.e. specialist orthodontic services.

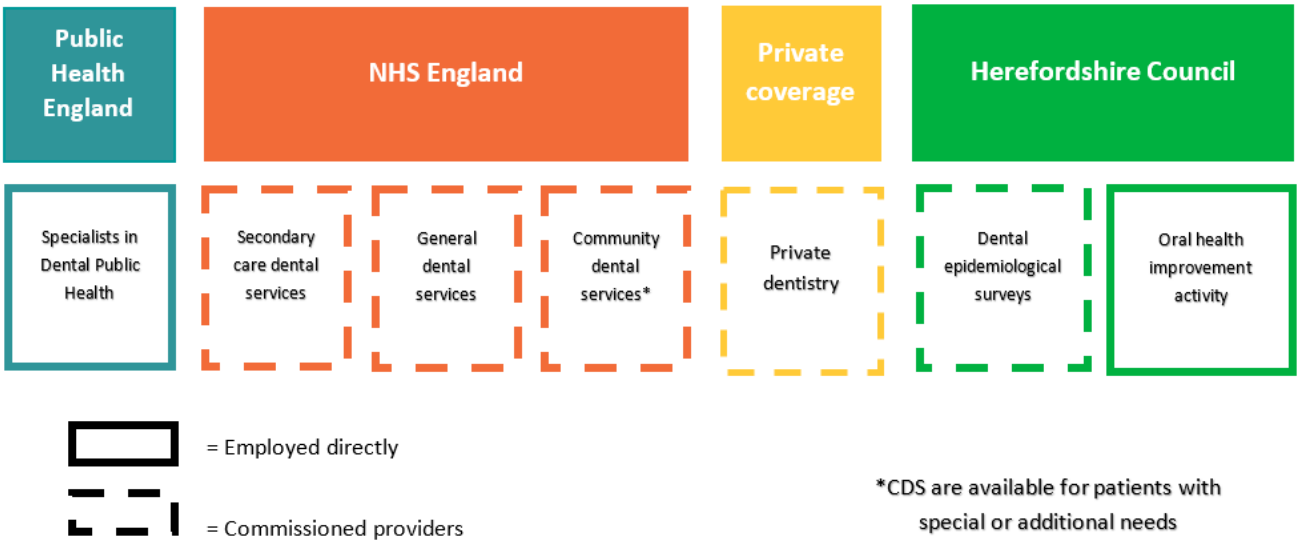



**Figure 30 - Organisation of oral healthcare services**

## PRIMARY CARE DENTAL SERVICES

NHS dental services in England are provided predominantly within primary care. The majority of primary care dental services are non-specialist in nature and are provided by General Dental Practitioners (General Dental Services or GDS) or Community Dentists (Community Dental Services or CDS). Both types of service provision are described and discussed within this chapter of the OHNA. Primary care specialist services e.g. orthodontics fall outside of the scope of this OHNA.

## GENERAL DENTAL SERVICES

Nationally and within Herefordshire, most NHS GDS are delivered by general dental practitioners (GDPs) – i.e. high street dentists [62–64]. Dentists providing GDS for the NHS, are not employed by the NHS, but are independent providers commissioned for their services.

Access to NHS primary care dentistry is commissioned for anyone who seeks it, regardless of where they live. In contrast to general practice registration, patients can choose any geographical area to access NHS dental services in England. For example, those in employment may choose to access an NHS dental provider close to where they work rather than where they live.

Since April 2006, patients are no longer registered to a dental practice and are only 'attached' to a dental practice when they are in active treatment [62,64]. Practices providing NHS GDS hold a notional list of patients who regularly attend their practice. Maintaining a patient list, enables dental practices to manage their capacity for providing dental care to both regular patients and new patients.

Whilst NHS dental services are recognised to be demand led, as part of the current NHS dental contract, NHS England are expected to target services towards those whose oral health is poor or who are at high risk of disease.

*Current NHS dental contract*

Since 2006, payments for NHS GDS are based on a contracted number of 'Units of Dental Activity' (UDAs) performed each year [63,65]. Each individual dental practice has a separate contract with NHS England, which outlines the number of UDAs they will be paid to deliver every year and the cost associated/contract value.

The number of UDAs contracted per area or per dental practice, is decided by NHS England based on their assessment of local population need. Practices are expected to deliver the contract value with a 4% tolerance for underperformance and over-performance is not remunerated [62,63].

The contract held between a dental practice and the NHS does not limit the amount of private practice it is able to perform.

In England, children under the age of 18 years of age are eligible for free dental care in any NHS environment. However, unless exempt from paying NHS dental charges [66], adults contribute towards the costs of NHS dental treatment in primary care. As displayed in table 6, the cost of the contribution is determined by the treatment band [67].

**Table 6 - NHS patient dental charges (aged 18 years+)***

| Course of treatment | Cost |
|---|---|
| Band 1 | £22.70 |
| Band 1 urgent | £22.70 |
| Band 2 | £62.10 |
| Band 3 | £269.30 |

* As of May 2019

*National Contract Reform*

In England, new NHS dental contract prototypes for GDS are being tested. This includes piloting a new remuneration system, which blends activity and capitation (i.e. patient registration) [65]. The pilot prototype scheme aims to increase the focus within GDS to preventive dental care by aligning both financial and clinical drivers. Two dental practices in Herefordshire are currently testing the new prototype dental contract (one within Hereford and one within Leominster).

## AVAILABILITY OF SERVICES

Based on information from NHS England, as of May 2019, there are 17 contracts providing NHS GDS within Herefordshire (8 of which are based within Hereford City centre).

This number is subject to annual variation, given that existing dental general practices close and new ones open. Figure 31 overleaf, presents the geographical distribution of NHS GDS providers in Herefordshire.

During 2017/2018, there were 103 Dentists delivering NHS activity in Herefordshire. At 54 Dentists per 100,000 population, this was a 9.6% increase from 2016/2017 and higher than both the regional and national rates (43 and 44 per 100,000 respectively).

*Dental access survey*

The NHS website [64,68] provides information about general dental practices within a specific geographical area, including confirmation about whether a practice is taking on new patients. Whilst it is the responsibility of individual practices to keep the NHS website updated with this information, guidance from both NHS England and the Herefordshire Local Dental Committee, indicated this may not always the case.

Consequently, in May 2019, a local dental access survey was undertaken. Each of the 17 contracted providers delivering NHS GDS services in Herefordshire were contacted via telephone and asked if they were currently accepting new NHS patients.

Of the 17 practices, 6 reported they were currently accepting new child NHS patients, of which 3 were also accepting adults. Therefore as of May 2019, a total of 11 practices were not accepting new child NHS patients and 14 were not accepting either new child or adult NHS patients.

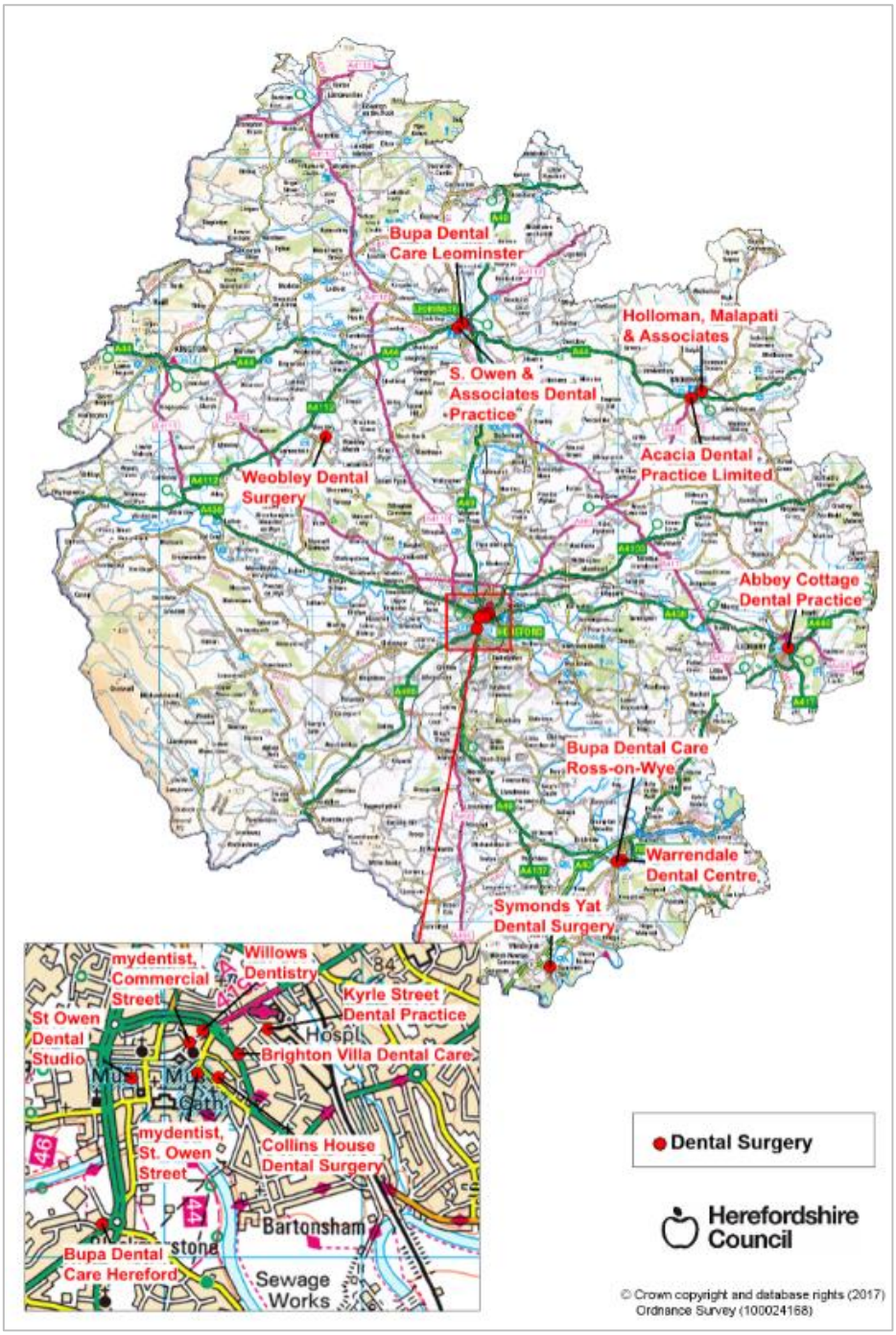



**Figure 31 - Geographical distribution of NHS GDS providers in Herefordshire (as of May 2019)**

## ACCESS TO GENERAL DENTAL SERVICES

Access to GDS rates reflect the widespread availability of NHS dental care. Access rates are measured by the proportion of the resident population who were seen by an NHS dentist in the 12 months prior (for children) or 24 months prior (for adults).

This metric is based upon NICE guidance, which recommends specific interval lengths between dental examinations, based on a patient's oral health and other factors such as age and lifestyle risk factors i.e. smoking [(69)].

A total of 21,084 children (aged 0-17 years) were seen by an NHS dentist in Herefordshire, in the 12 months prior to the 31st of December 2018 (see figure 32). This is 58.7% of all children in Herefordshire (aged 0-17 years) and is approximately the same proportion as that identified nationally for the same age group over the same period (58.6%).

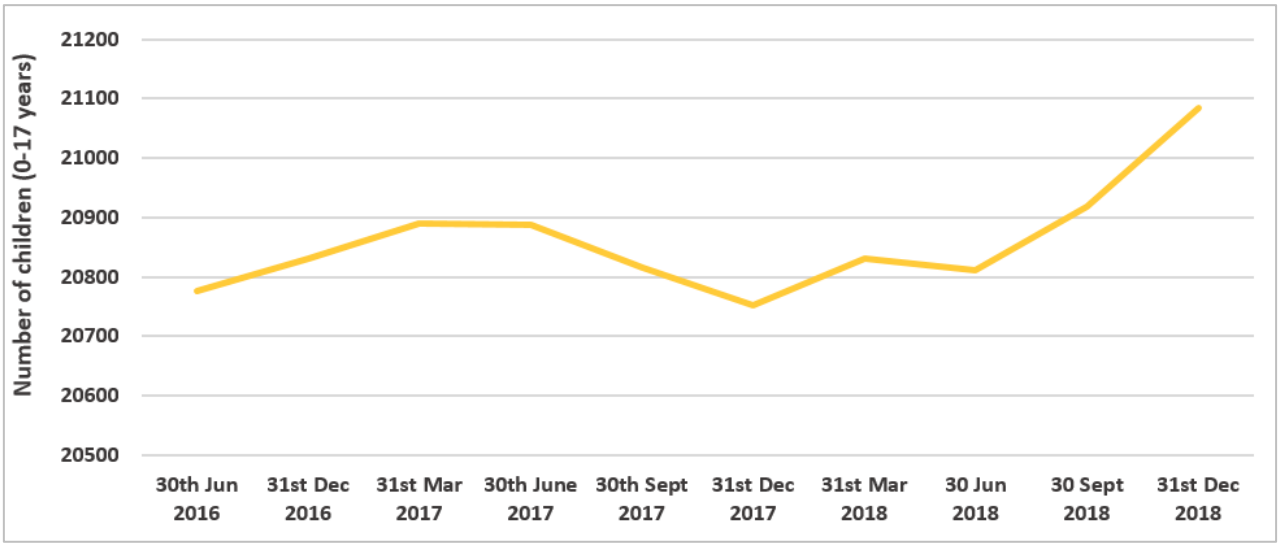



**Figure 32 - Number of children in Herefordshire, seen by an NHS Dentist in the 12 months prior to 31st December 2018** (Data source: NHS Digital)

As of the 31st of December 2018, 43.1% of children aged 0-5 years in Herefordshire were seen by an NHS dentist (compared to 38.9% in England) – see figure 33.

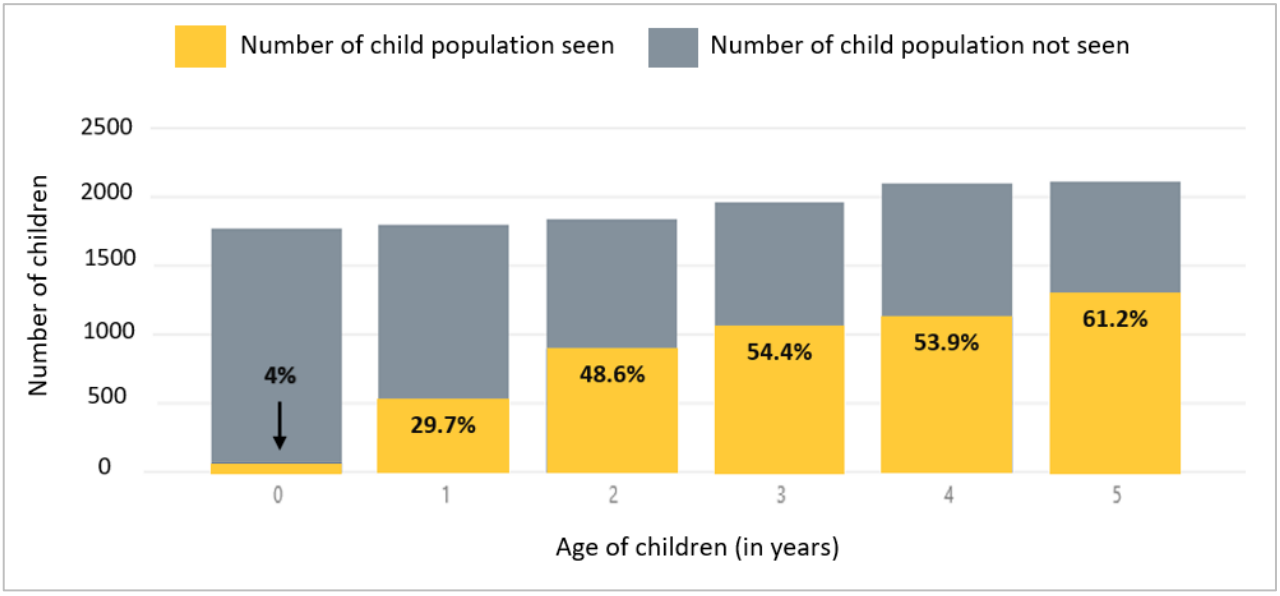



**Figure 33 - Number and proportion of children (aged 0-5 years) in Herefordshire, seen by an NHS Dentist in the 12 months prior to 31st December 2018** (Data source: NHS Digital)

A total of 74,592 adults were seen by an NHS dentist in Herefordshire, in the 12 months prior to the 31st of December 2018 (see figure 34). This is 48.1% of all adults in Herefordshire and is marginally lower than the national proportion over the same period (50.4%).

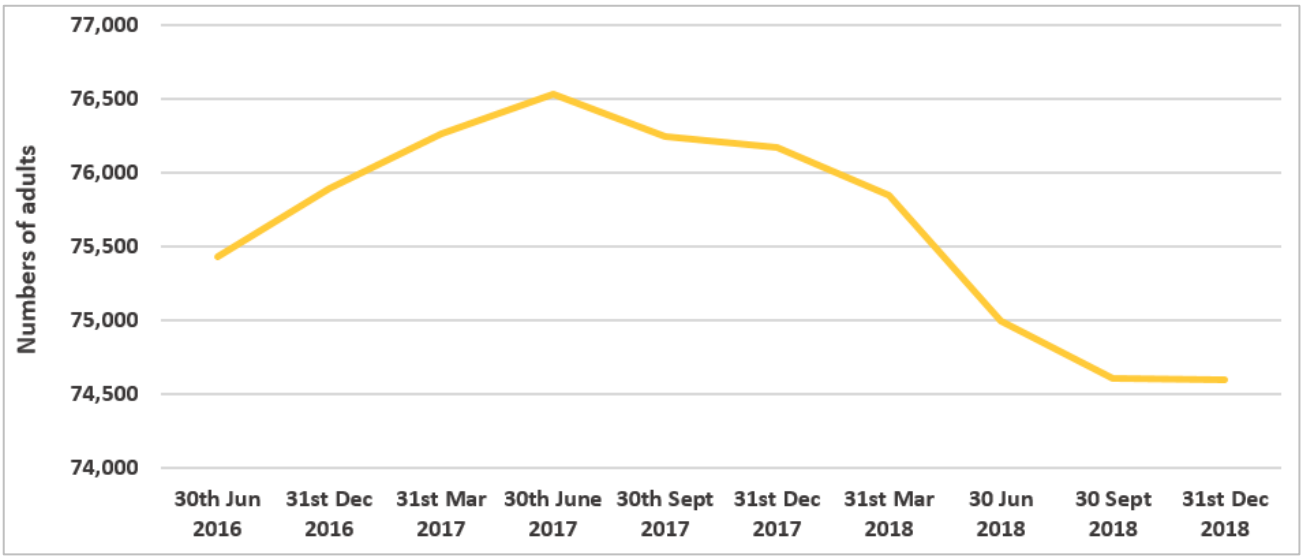



**Figure 34 – Number of adults in Herefordshire, seen by an NHS Dentist in the 12 months prior to 31st December 2018**
**(**Data source: NHS Digital)

It is important to note that NHS dental access data does not reflect the number of children and adults who were seen within private dental practice or who may have used hospital dental services exclusively.

This information is not included within NHS primary dental care data sets and therefore the reported dental access rates within Herefordshire may be higher than shown in figures 32, 33 and 34 above.

## DENTAL SERVICE USAGE

Between 1st October 2017 and 30th September 2018, there were 127,755 Courses of Treatment (CoT) delivered within NHS GDS in Herefordshire. Dental care is provided to patients as CoT, and reflects -

- An examination of a patient, an assessment of their oral health, and the planning of any treatment to be provided to that patient as a result of that examination and assessment

- The provision of any planned treatment (including any treatment planned at a time other than the time of the initial examination) to that patient.

Each COT delivered within GDS is allocated a treatment banding and a fixed number of UDAs per band [62,63,65,70]:

- **Band 1**: includes an examination, diagnosis and advice. If necessary, it also includes x-rays, a scale and polish, application of fluoride varnish or fissure sealants, prevention advice and planning for further treatment (1 UDA)

- **Band 1 urgent**: includes urgent care such as removal of the tooth pulp, removal of up to two teeth, dressing of a tooth and one permanent tooth filling (1.2 UDAs)

- **Band 2**: includes all treatment covered by Band 1, plus additional treatment, such as fillings, root canal treatment, gum treatments and removal of teeth (3 UDAs)

- **Band 3**: includes all treatment covered by Bands 1 and 2, plus more complex procedures, such as crowns, dentures and bridges (12 UDAs)

For every CoT conducted, contracted providers submit a standard form i.e. 'FP17' to NHS Business Services Authority in order to receive payment. Each FP17 details the specific treatment the patient has received according to the relevant banding and therefore the associated UDAs [62,63,70].

Figure 35, presents the proportion of CoT delivered in Herefordshire during 2017/2018 according to each treatment band. As displayed in figure 35, band 1 treatments constitute the majority of COTs between 2017/2018.

Between 1st October 2017 and 30th September 2018, there were 228,180 UDAs delivered within GDS in Herefordshire. As described previously, UDAs are the currency in which GDS providers are remunerated for their NHS dental activity.

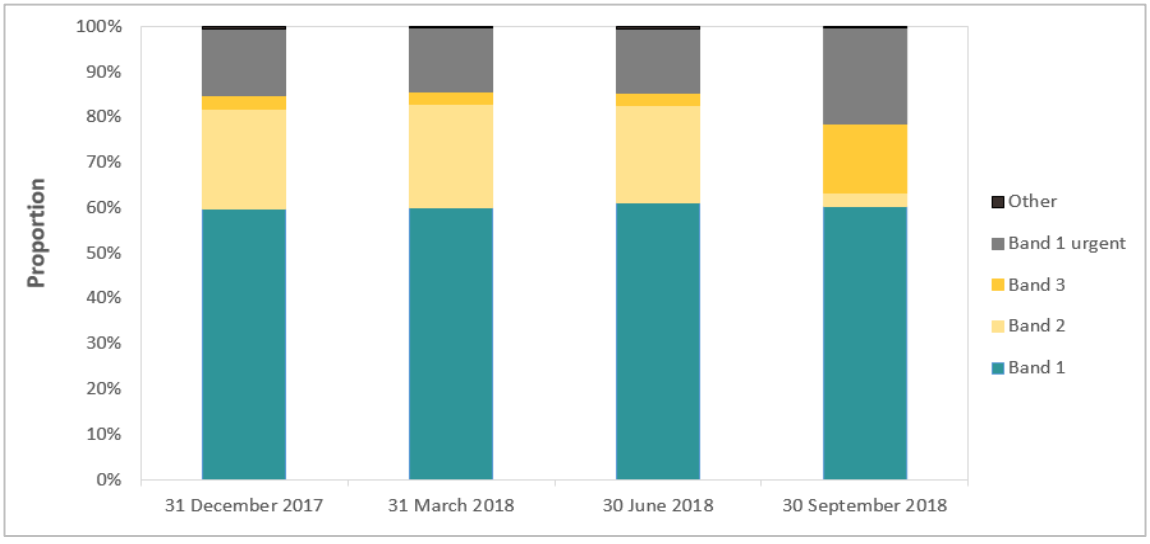


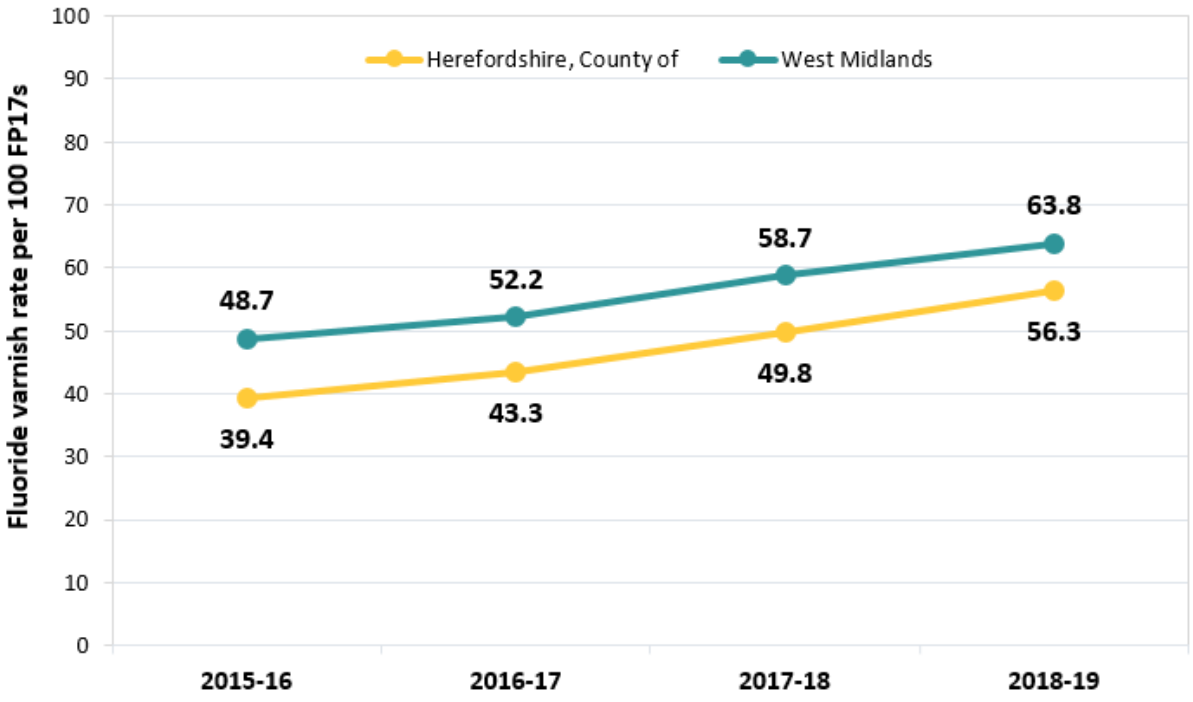

**Figure 35 - Proportion of CoT delivered in Herefordshire according to each treatment band during 2017/2018.**
(Data source: NHS Digital)

*Fluoride varnish application*

Evidence clearly demonstrates that application of fluoride varnish by a trained professional, reduces tooth decay in both children and adults (delivering better, 2017). Consequently, national guidance recommends the application of fluoride varnish every six months for all children between 3-16 years old and more frequently for all children (0-16 years) at higher risk of tooth decay i.e. those likely to develop caries or those with special needs [4]. For adults with a higher risk of tooth decay, it is recommended that fluoride varnish is applied twice a year.

As displayed in figure 36, the rate of fluoride varnish applications in children (aged 3-16 years) accessing NHS GDS in Herefordshire has increased since 2015/2016. Despite this, there remains a significant proportion within this age group who appear to have not received this intervention within NHS GDS in Herefordshire (43.7%).

Furthermore, based on submitted FP17s the rates of fluoride varnish applications in Herefordshire for this age group, appear to be consistently lower than the regional* average rate as reported by NHS Business Services Authority [71].




* 'West Midlands' - Inclusive of Birmingham, Coventry, Solihull, Warwickshire, Worcestershire, Herefordshire, Sandwell, Dudley, Warwickshire, Walsall and Wolverhampton.

**Figure 36 - Fluoride varnish applications for 3-16 year olds resident in Herefordshire and the West Midlands.**
(Data source: NHS Digital)

## COMMUNITY DENTAL SERVICES

Across England and Herefordshire, community dental services (CDS), form an integral role in the delivery of primary dental care provision. Commissioned CDS providers deliver specialist and additional services for those with special care needs and/or those experiencing difficulties in accessing GDS. This may include –

- Children and adults with learning disabilities
- Children with complex and extensive dental treatment needs
- Children and adults experiencing mental health issues
- Frail older people who cannot receive care in general dental practice
- Children and adults who are severely physically and/or medically compromised
- Children and adults with severe dental anxiety
- Looked after children or children with identified safeguarding concerns
- People who are homeless
- People who are currently experiencing issues with substance misuse

In Herefordshire, the Wye Valley NHS Trust is commissioned to deliver CDS across the county. As of May 2019, local CDS provision in Herefordshire included –

- Advanced mandatory services – Provided on referral due to high level of facilities, experience or expertise required i.e. minor oral surgery
- Domiciliary services – Provided 'outreach' e.g. within a patients home or a care setting
- Sedation services – Including inhalation and intravenous sedation and general anaesthetic
- Urgent (i.e. unplanned) primary dental care

CDS in Herefordshire are delivered from seven dental clinics (i.e. Dental Access Centres - DACs) and within the County Hospital (e.g. for oral surgical procedures). Figure 37 overleaf, presents the geographical distribution of DACs within Herefordshire.

## URGENT DENTAL CARE SERVICES

Urgent dental care is provided for patients who do not or are unable to access treatment from GDS but have an urgent need for treatment either in or out of hours.

Patients who require treatment urgently do not have to be registered or listed with a specific general dental practice in order to access appropriate dental care.

In Herefordshire, some NHS GDS providers offer urgent dental care within hours. The commissioned CDS provider offers urgent dental care both within and out of hours.

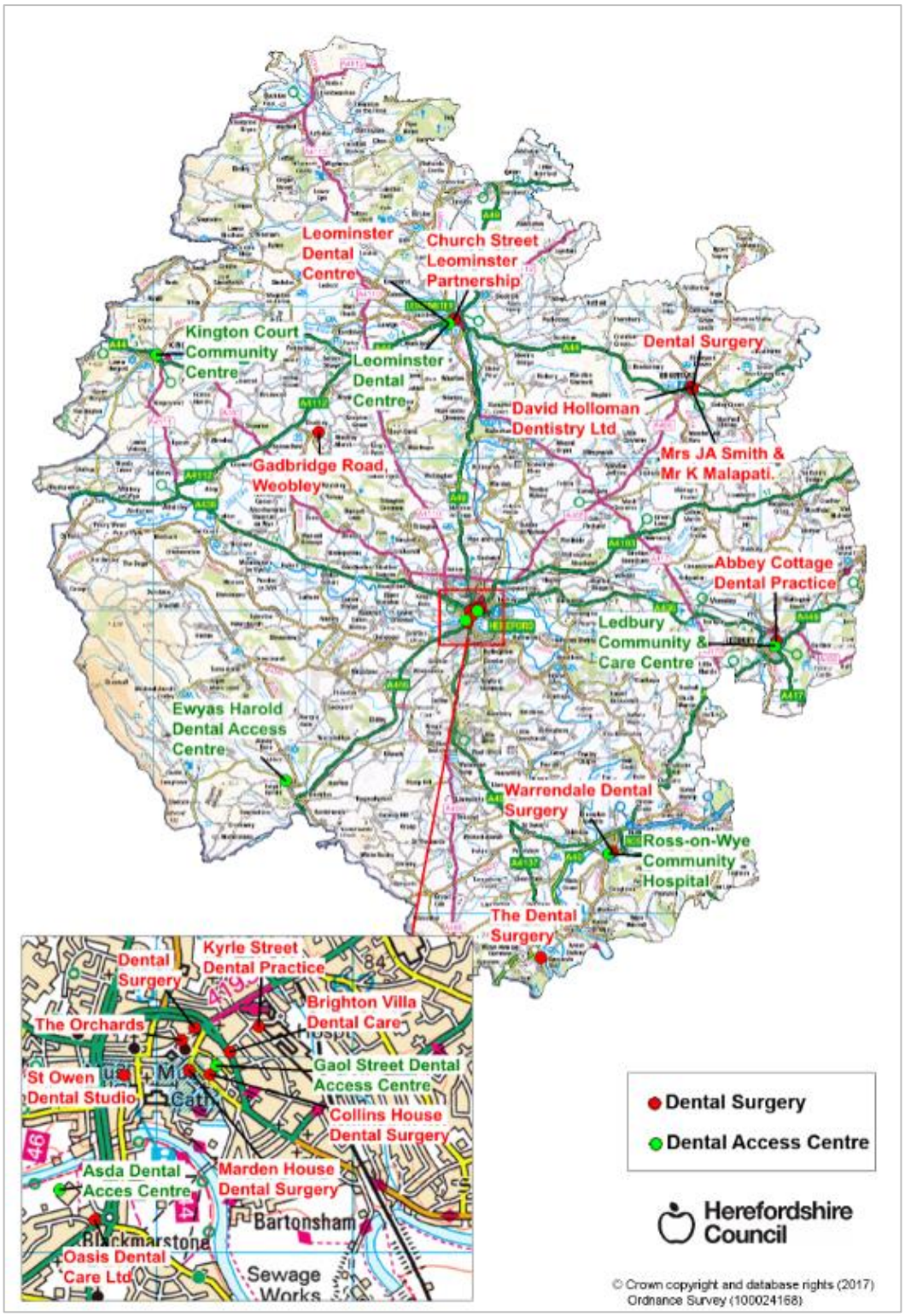



**Figure 37 – Geographical distribution of NHS GDS providers and DACs in Herefordshire (as of May 2019)**

## SECONDARY CARE DENTAL SERVICES

Secondary care dental services are predominantly delivered within hospital settings and include oral surgery, orthodontics, oral medicine, oral and maxillofacial surgery and restorative dentistry. Secondary care dental services are primarily accessed via referrals from primary dental care (either NHS or private providers), with some referrals from primary medical care. Services delivered within secondary care are free from patient charges.

The following hospitals are commissioned to provide secondary care services for children and adults who are resident within Herefordshire. The type, nature and complexity of a patient's oral and general health needs will determine which services are accessed in each setting.

- County Hospital in Hereford (Wye Valley NHS Trust)
- Birmingham Dental Hospital (Birmingham Community Healthcare NHS Foundation Trust)
- Birmingham Children's Hospital (Birmingham Women's and Children's NHS Foundation Trust)
- Bristol Dental Hospital (University Hospitals Bristol NHS Foundation Trust)

## PATIENT AND PUBLIC VIEWS

*Healthwatch Herefordshire survey (April 2018)*

Between 2017 and 2018, Healthwatch Herefordshire engaged with and consulted over 500 residents and professionals about their views and experiences of dental health in Herefordshire.

Findings from the published report in 2018 [72], indicated that that –

- Parents who were registered with a dentist tended to register their child at the same practice at about one years old.
- Parents who were not themselves registered with a dentist experienced no issues registering their child despite it being difficult to register themselves.
- Amongst parents of young children who had not as yet been registered with a dentist, approximately 50% were unsure as to what age their child should start to see a dentist
- A small number of parents thought that milk teeth were not that important.
- Approximately 5% of people did not know NHS dental care for children was free.
- Some parents from Eastern European countries, were unaware of how to find and register with a dentist.
- In rural areas, transport was identified as a barrier to accessing dental care as many parents reported not having access to a car. Furthermore, public transport was deemed to be expensive and commonly infrequent.

*GP Patient Survey (August 2018)*

The GP Patient Survey is an independent annual survey run by Ipsos MORI on behalf of NHS England [73]. The survey includes questions about a patient's experience of NHS dentistry.

Between January and March 2018, a total of 2,797 adults within Herefordshire completed the GP Patient Survey. Of the responses received, 94% people reported being successful in getting an NHS dental appointment within the last two years (compared to 93% nationally).

Of those reportedly not attempting to obtain an NHS dental appointment within the previous two years, 52% of respondents in Herefordshire (39% nationally), attributed this to either preferring private dental care (29%) or staying with a dentist when they moved from NHS provision to private practice (23%).

Finally, when asked about their overall experience of NHS dental services, respondents reported it was either very good (54%) or fairly good (33%). Both figures of which were comparable to the national picture (52% and 33% respectively).

# IMPROVING POPULATION ORAL HEALTH

As previously described poor oral health and oral diseases, including those within the scope of this OHNA are largely preventable. Common risk factors exist, which affect a person's risk of developing oral diseases and a range of other non-communicable diseases. Furthermore, these common risk factors are understood to be driven by complex and interrelating economic, social and environmental determinants.

Addressing both the risk factors and wider determinants of poor oral health, is of fundamental importance for local authorities and key partners, who are tasked with improving oral health and reducing oral health inequalities at a population level [8,14,15,24].

## NATIONAL GUIDANCE

To support local authorities to fulfil their specific role and responsibilities regarding oral health improvement, PHE, NICE and the LGA have published an extensive array of evidence-informed guidance and toolkits (see Appendix A).

Each of these national documents advocate for local authorities to –

- Identify, target and modify both the common risk factors and the wider determinants of oral diseases
- Adopt a population level needs based approach, whilst targeting action towards those groups at greater risk of poor oral health
- Prioritise the role of prevention, across the life course and within key settings i.e. families, schools, community and oral healthcare services
- Commission and/or deliver a range of evidence-informed oral health improvement programmes, that are co-created by professionals, families and wider-communities
- Ensure fair and equitable access to high quality dental care, which emphasises the importance of prevention
- Work in partnership with key partners for oral health improvement, including PHE, NHSE and CCGs

## APPROACHES TO PREVENTION - UPSTREAM VERSUS DOWNSTREAM

A clear and consistent theme within national guidance is the requirement for local authorities and other key partners, to target interventions towards the prevention of poor oral health and oral diseases [3,4,8]. Whilst equitable access to high quality dental care forms an important part of improving a person's oral health, in isolation this will not achieve sustainable reductions in the burden of poor oral health and associated inequalities at a population level [7,13,32].

Approaches and options for preventing poor oral health and oral diseases can be understood as representing a continuum, from downstream interventions to upstream interventions [74].

Downstream interventions primarily aim to address the common risk factors or individual behaviours known to affect a person's risk of oral diseases. In contrast upstream interventions, aim to address the underlying causes of these common risk factors i.e. the wider determinants (see figure 38).

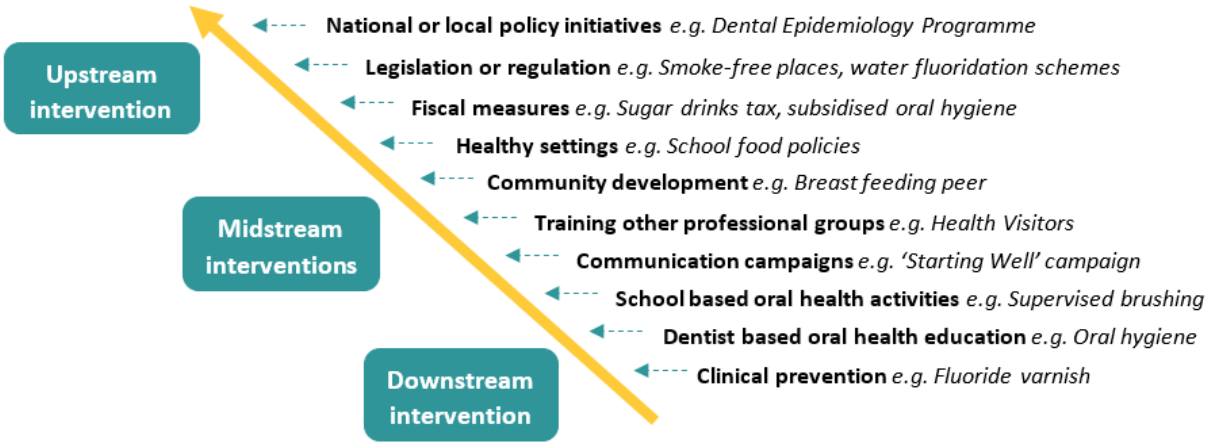



**Figure 38 - Options for oral disease prevention (adapted from Watt, 2007 [67])**

In fulfilling their statutory responsibilities, local authorities are expected to assess the local oral health needs of their population and then advocate for, influence and where relevant provide evidence-informed interventions across this continuum (presented in figure 38).

By ensuring upstream, midstream and downstream interventions are incorporated into a population level approach to prevention, the common risk factors and wider determinants for both oral diseases and other non-communicable conditions are simultaneously addressed. Evidence suggests the adoption of this approach reduces the overall burden of preventable ill-health and premature mortality within a population [5,23,45,75].

*Proportional universalism*

As discussed previously, there exists a social gradient in the experience of oral health and health outcomes more broadly [26,76]. With increasing disadvantage, vulnerability and social exclusion comes a greater prevalence and severity of oral diseases.

However, as everyone experiences some degree of inequality within a population, focusing solely on the most disadvantaged will not sufficiently reduce health inequalities across the social gradient [26,34].

Consequently, action to improve everyone's oral health needs to be universal, yet targeted with a scale and intensity that is proportionate to the level of inequality an individual, family or community faces. For example, whilst preventative dental care should be available for all children, 'Looked after children' and those experiencing poverty may require additional support i.e. through targeted fluoride varnish applications.

## ORAL HEALTH IMPROVEMENT – WHAT WORKS?

A wealth of evidence now exists that proposes which interventions and action will improve the oral health of individuals and communities – See Appendix A. Since 2014, PHE have published a range of national toolkits, to reflect and summarise this evidence base [4,15,24,77].

Each toolkit makes evidence-informed recommendations regarding the local commissioning or provision of downstream, midstream and upstream interventions. The recommendations of 'what works' are relevant for primary care dental teams, local authorities and organisations who specifically engage with children, young people and older adults.

### WHAT WORKS AT AN INDIVIDUAL LEVEL?

Primary care dental teams play an integral role in the prevention of oral diseases and the overall improvement of their patient's oral health. In recognition of this, in 2017, PHE published the 3rd edition of 'Delivering better oral health: an evidence-based toolkit for prevention' [4].

This provided dental professionals with clear guidance on which evidence-informed interventions should be delivered at an individual level. Key recommendations focused on providing patients with –

- Advice about oral hygiene practices across the life course e.g. twice daily exposure to appropriate levels of fluoride
- Tailored support and signposting in order to facilitate lifestyle behaviour changes e.g. reducing sugar consumption and stopping smoking
- Prevention focused dental care, including specific interventions known to prevent development or worsening of oral diseases i.e. application of fluoride varnish

Whilst NHS England (NHSE) are responsible for the commissioning of NHS primary care provision, local authorities can play a crucial role in advocating for dental professionals to adopt an preventive focus to individual care.

Furthermore, local authorities have a responsibility to seek assurance from NHSE and PHE that based on local need, their residents have equitable access to high quality and evidence-informed NHS dental services [3,14].

Outside of primary dental care, a number of downstream interventions i.e. delivered at an individual level, are promoted by PHE [15,24,77] as being effective for improving the oral health of children, young people and older vulnerable adults (e.g. those within care settings) –

*Children and young people (0-19 years)*

- The integration of oral health into targeted home visits by health and social care workers
- Targeted fluoride varnish programmes delivered outside of dental practices, for those who are deemed to be at greater risk of poor oral health
- Targeted provision of toothbrushes and tooth paste i.e. through health visiting services^

*Vulnerable older people*

- Appropriate oral hygiene promotion^, including daily exposure to higher fluoride toothpastes and powders (i.e. 2,800 to 5,000 ppm)
- Routine denture identification marking, to ensure lost dentures are returned to the correct person
- Targeted fluoride varnish applications in care homes and community settings

^ = *As of May 2019, a local mapping exercise has indicated that whilst not systematically adopted or delivered across Herefordshire, there is some evidence that the intervention is being provided locally*

## WHAT WORKS AT A COMMUNITY LEVEL?

Individual interventions are an important component of local approaches to preventing poor oral health. However in order to achieve a sustainable improvement in population oral health and a reduction in inequalities, local authorities are required to commission or deliver interventions targeted at community settings and wider environments [3].

To inform this process, PHE published two evidence-informed toolkits for local authorities (one focusing on children and young people [15] and the other older vulnerable adults [24]. Each details the effectiveness of mid and upstream interventions for improving oral health in these specific groups.

Interventions deemed to be 'recommended' (R) or 'emerging' (E) and therefore of potential interest for local authorities included –

*Children and young people (0-19 years) –*

- Supervised tooth brushing in targeted childhood settings i.e. early years and schools (R)
- Healthy food and drink policies in childhood settings i.e. early years and schools^ (R)
- Targeted peer (lay) support groups and peer oral health workers (R)
- School or community food co-operatives (E)

- Fiscal policies to promote oral health (E)

Vulnerable older adults –

- Protocols for improving oral care in care settings (R)
- Outreach programmes & interventions to independently living older people (E)
- Assessment and multidisciplinary integrated preventive approach (including oral health) in primary care for independently living older people (E)

For children, young people and vulnerable older adults –

- Oral health training for the wider professional workforce e.g. health visitors, care home staff^ (R)
- Fluoridation of public water supplies* (R)
- Interventions and policies promoting breastfeeding, complementary feeding practices and wider dietary change across community settings for children and adults^ (E)

* Water fluoridation is the controlled adjustment of a fluoride compound to a public water supply in order to bring the fluoride concentration up to a level which effectively prevents tooth decay [77]. Deemed to be both safe and effective in improving oral health and reducing health inequalities, around 6 million people in England (approximately 10% of the population) currently receive water where fluoride has been artificially added [78].

## RETURN ON INVESTMENT

In 2016, PHE published a rapid evidence review and return on investment (ROI) tool regarding the clinical and cost-effectiveness of the following evidence-based interventions for reducing tooth decay in 0-5 year olds [29] –

- Targeted supervised tooth brushing
- Targeted provision of fluoride varnish
- Targeted provision of toothbrushes and paste by post
- Targeted provision of toothbrushes and paste by post and by health visitors
- Community water fluoridation

The ROI tool was designed to support local authorities, who are making decisions about the commissioning and delivery of oral health improvement programmes for pre-school children in their area.

Based on a typical oral health profile and indicative costs, the infographic overleaf (figure 39) illustrates the 5 and 10 year ROI associated with each intervention included [29].

This includes monetised savings to the local authority and the NHS including the reduction in fillings provided in NHS primary care and tariff costs for dental extractions in NHS secondary care, the reduction in days missed at work for parents/carers accompanying children to the dentist and/or hospital. In addition the 'number of days saved at school' are generated although not monetised in the ROI.

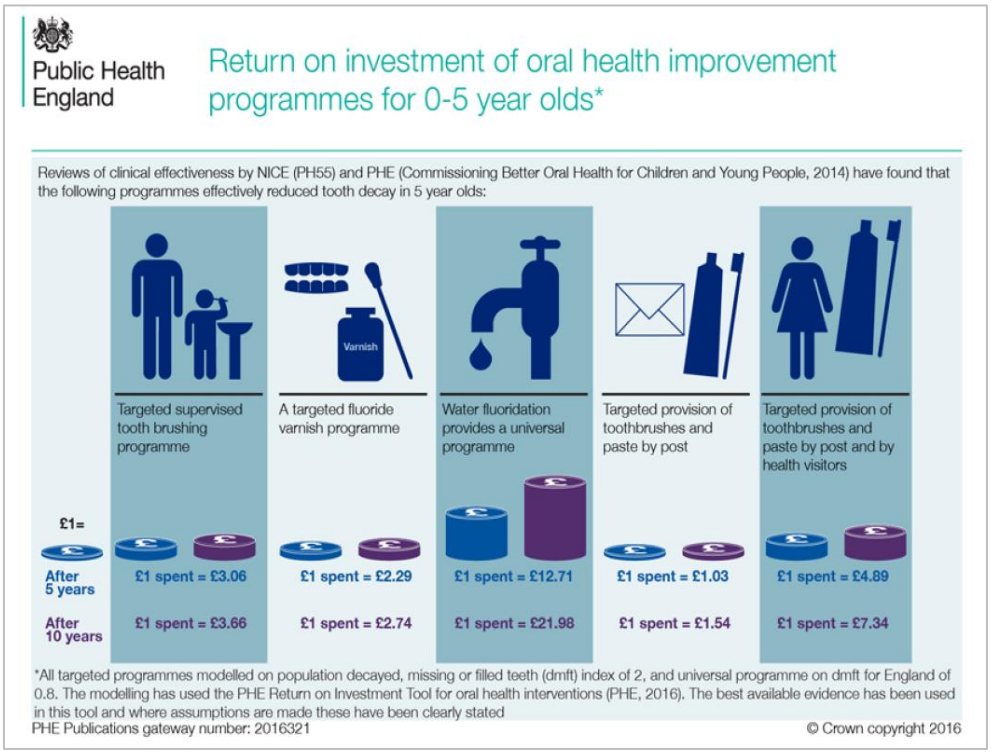



**Figure 39 - Return on investment of oral health improvement programmes for 0-5 year olds**

## NICE GUIDANCE – LOCAL AUDIT AND MAPPING

As a unitary local authority, Herefordshire Council (HC) are the organisation statutorily required to commission or provide oral health improvement programmes for the population of Herefordshire. In addition to evidence reviews and toolkits available from PHE, NICE developed national guidance to inform the approach adopted by local authorities and key partners for improving oral health [8].

Table 7, details the 21 recommendations contained within this national guidance, and maps the current provision or activity in Herefordshire against each (as of May 2019). Recommendations to address any identified gaps are discussed in the next chapter.

**Table 7 - Local audit against NICE guidance [8]**

| NICE recommendations | What's happening in Herefordshire? | Gaps against NICE recommendations |
|---|---|---|
| 1. Ensure oral health is a key health and wellbeing priority | Oral health is a core component of Herefordshire's Joint Strategic Needs Assessment (JSNA) and Child Integrated Needs Assessment (CHINA).<br><br>Improving the dental health of children and young people is a strategic priority for Herefordshire's Health and Well-being Board and identified in the Director of Public Health's annual report 2018. | The strategic responsibility for oral health improvement and reducing health inequalities is not led or overseen by a multi-agency group. |
| 2. Carry out an oral health needs assessment (OHNA) | A final draft of the OHNA for Herefordshire was completed in June 2019 and the final report will be shared widely with partners throughout September 2019. | No formal plans exist for ensuring the OHNA forms part of a cyclical planning process. |
| 3. Use a range of data sources to inform the oral health needs assessment | The recent OHNA, was informed by epidemiological and socio-demographic data, which was obtained at a national, regional and local level. PHE and NHS England supported the process of data collection and analysis. | N/A |
| 4. Develop an oral health strategy | None identified | A local oral health strategy and/or action plan has not been developed, although is planned to be following the completion of the OHNA. |
| 5. Ensure public service environments promote oral health | Areas and examples of good practice exist across Herefordshire i.e. promotion of breastfeeding; provision of healthy food and drink choices in some early years settings, schools and care settings. | A system-wide or consistent approach does not exist, which ensures all public service environments in Herefordshire promote oral health and healthier eating e.g. within leisure centres, nurseries, community centres, health and social care settings. |

| NICE recommendations | What's happening in Herefordshire? | Gaps against NICE recommendations |
|---|---|---|
| | HC Public Health Team are having initial discussions about engaging with public service environments to become 'health promoting'. Furthermore, 'levers' to influence planning decisions regarding fast food, are being reviewed. | |
| 6. Include information and advice on oral health in all local health and wellbeing policies | Areas and examples of good practice exist across Herefordshire i.e. provision of information and advice in maternity and public health nursing services, schools and care settings.<br><br>HC Public Health Team are having initial discussions with key services and settings about including oral health in local policies i.e. care homes. | A system-wide or consistent approach does not exist, which encourages all commissioners and providers of public services in Herefordshire to include information and advice on oral health. |
| 7. Ensure frontline health and social care staff can give advice on the importance of oral health | Advice according to 'Delivering better oral health (PHE)', is delivered on an ad-hoc basis to various frontline services (by the HC Public Health Team).<br><br>Making Every Contact Count (MECC), is delivered to some frontline staff within public services and includes topics on oral health and healthy eating. | A requirement for front line staff to receive oral health training is currently not detailed within all specifications of relevant public services in Herefordshire. |
| 8. Incorporate oral health promotion in existing services for all children, young people and adults at high risk of poor oral health | Oral health promotion is currently embedded within Public Health Nursing Services and Children's Centres. In addition, examples of good practice exist is some adult care settings i.e. provision of appropriate oral hygiene advice. | A requirement for oral health promotion to be incorporated into all existing services is currently not met. Variation in provision is evident across children's services and health and social care services. |

| NICE recommendations | What's happening in Herefordshire? | Gaps against NICE recommendations |
|---|---|---|
| 9. Commission training for health and social care staff working with children, young people and adults at high risk of poor oral health | None identified | Regular training (focused on oral or wider public health) is not routinely commissioned or provided for health and social care staff. |
| 10. Promote oral health in the workplace | Limited ad-hoc oral health promotion advice may be offered in some public sector organisations in Herefordshire i.e. through occupational health and human resource services. | The promotion of oral health as per 'Delivering better oral health' (PHE)[4] is not delivered systematically and routinely across all public sector organisations in Herefordshire. |
| 11. Commission tailored oral health promotion services for adults at high risk of poor oral health | None identified | Herefordshire Council do not commission or facilitate the provision of tailored oral health promotion services or interventions for specific at-risk groups i.e. outreach services for people who are homeless, Traveller communities, or those who have sought asylum locally. |
| 12. Include oral health promotion in specifications for all early years services | Oral health promotion is included in the contract specification for the Herefordshire Public Health Nursing Service (contract commenced 2018) and is monitored by strategic targets. | A requirement for all contract specifications for early years services to promote oral health and train staff is currently not met within Herefordshire. |
| 13. Ensure all early years services provide oral health information and advice | Areas and examples of good practice exist across Herefordshire i.e. provision of information about oral health and healthier eating within maternity and public health nursing services, Children's Centres, schools and care settings. | The provision of oral health information and advice as per 'Delivering better oral health' (PHE)[4] is not delivered systematically and routinely across all early years services. |
| 14. Ensure early years services provide additional tailored information and advice for groups at high risk of poor oral health | Areas and examples of good practice exist across Herefordshire i.e. In 2019, Public Health Nursing Service provided free tooth brush packs to families in groups at high risk of poor oral health. | The provision of additional tailored information and advice is not delivered systematically and routinely across all early years services. |

| NICE recommendations | What's happening in Herefordshire? | Gaps against NICE recommendations |
|---|---|---|
| 15. Consider supervised tooth brushing schemes for nurseries in areas where children are at high risk of poor oral health | None identified | Currently Herefordshire Council do not commission or facilitate the provision of supervised tooth brushing schemes i.e. in early years settings or schools. |
| 16. Consider fluoride varnish programmes for nurseries in areas where children are at high risk of poor oral health | None identified | Currently Herefordshire Council do not commission or facilitate the provision of supervised tooth brushing schemes i.e. in early years settings or schools. |
| 17. Raise awareness of the importance of oral health, as part of a 'whole-school' approach in all primary schools | Areas and examples of good practice exist across primary schools in Herefordshire i.e. implementation of the 'School Food Plan', availability of plain drinking water and provision of healthier food choices. | Local evidence is not available, which determines the proportion of primary schools in Herefordshire who adopt a 'whole school' approach to oral health or implement national guidance and policies for improving oral health of children. |
| 18. Introduce specific schemes to improve and protect oral health in primary schools in areas where children are at high risk of poor oral health | None identified | Local evidence is not available, which determines the existence of specific schemes and interventions (i.e. staff training, adapted oral health advice, tooth brushing schemes being delivered in primary schools. |
| 19. Consider supervised tooth brushing schemes for primary schools in areas where children are at high risk of poor oral health | None identified | Currently Herefordshire Council do not commission or facilitate the provision of supervised tooth brushing schemes i.e. in early years settings or schools. |

| NICE recommendations | What's happening in Herefordshire? | Gaps against NICE recommendations |
|---|---|---|
| 20. Consider fluoride varnish programmes for primary schools in areas where children are at high risk of poor oral health | None identified | Currently Herefordshire Council do not commission or facilitate the provision of community-based fluoride varnish programmes i.e. in early years settings or schools. |
| 21. Promote a 'whole school' approach to oral health in all secondary schools | Areas and examples of good practice exist across primary and secondary schools in Herefordshire i.e. implementation of the 'School Food Plan', availability of plain drinking water and provision of healthier food choices. | Local evidence is not available, to determine the proportion of secondary schools in Herefordshire who adopt a 'whole school' approach to oral health or implement national guidance and policies for improving oral health of children and young people. |

# CONCLUSIONS AND RECOMMENDATIONS

Based on the intelligence and information available, this OHNA has comprehensively described the standard of oral health of people living in Herefordshire. In addition, this OHNA has also presented a detailed overview of current oral health care services locally, in relation to their availability, accessibility and activity.

Where possible, the local picture in Herefordshire has been benchmarked against regional and national positions, in order to provide a comparative understanding of oral health needs and experiences locally.

## CHALLENGES AND GAPS

Findings from this OHNA, indicate that a number of challenges and gaps exist in relation to the oral health of Herefordshire's population.

### PLACE AND POPULATION

- Herefordshire has one of the highest proportions of people over the age of 65 years. As older adults are more likely to require complex oral health care, in the future this may increase the level of need and demand for appropriate dental services.

- Over half of all residents in Herefordshire live in rural communities. Although the local population-dentist ratio is higher than both nationally and regionally, approximately half of dental provision is in Hereford city. This may create challenges for rural communities, who require dental care but experience barriers to transport or access more broadly.

- A concerning proportion of children and adults in Herefordshire are overweight or obese. Furthermore, a significant number of people smoke and/or consume alcohol excessively. The prevalence and unequal distribution of these risk factors locally are an important consideration for addressing poor oral health in Herefordshire.

### STANDARD OF ORAL HEALTH

- Children in Herefordshire have significantly poorer oral health than reported nationally and generally poorer oral health than reported by our geographical and statistical neighbours. This finding is consistent across all survey results for 3 year olds, 5 year olds and 12 year olds.

- For children aged 5 years, there has been no significant change in the standard of oral health locally over the last 10 years.

- In the last ten years the incidence and mortality rate of oral cancer in Herefordshire has generally increased (a trend reflected nationally).

*Gaps in knowledge*

- Small sample sizes and limited data, mean it is not possible to confirm the true prevalence and severity of oral diseases experienced in Herefordshire. In addition, reliable conclusions cannot be drawn about the extent of oral health inequalities locally e.g. related to deprivation or ethnicity.

- Whilst the numbers of people within particular at-risk groups can be estimated, local information is lacking about the burden of oral diseases experienced within these groups i.e. Looked after children, older adults in care, people who are homeless.

## ORAL HEALTHCARE SERVICES

- A larger proportion of children in Herefordshire have been seen by an NHS dentist than reported nationally, however a significant number of children under 5 years have not accessed NHS dental services (especially those under 2 years).

- Results from the local dental access survey (May 2019) indicate that it may currently be difficult for both children and adults to obtain routine NHS dental care within Herefordshire.

- A large proportion of children and young people in Herefordshire appear to not be receiving fluoride varnish applications within NHS dental care.

- Approximately a third of 'Looked after children' in Herefordshire have not had their teeth checked by a dentist. Without more recent data, it is not known if this remains a current challenge.

*Gaps in knowledge*

- A lack of local data at a granular level, means it is not possible to determine the current equity of access to NHS dental care according to different demographics i.e. deprivation, age, sex, ethnicity or geography.

- It is not known whether there is reasonable and equitable access to local dental services that meet the needs of at-risk groups i.e. in relation to domiciliary care, outreach or specialist primary care services.

## ORAL HEALTH IMPROVEMENT

As detailed in Table 7 (pg. 59), a number of gaps exist between NICE recommended practice for local authorities and the current approach to oral health improvement locally.

- Whilst improving oral health (particularly in children), is a local strategic priority, there remains a lack of strategic direction and designated resources to achieve positive outcomes at a population level

- There is limited co-ordination and consistency in the delivery of oral health improvement activities and messages across community settings (i.e. children's services, educational settings, care homes).

*Gaps in knowledge*

- Insufficient local data means it is not possible to evidence the extent of oral health inequalities in Herefordshire. Due to this, at the current time, the need for fluoridation of local public water supplies is not able to be determined.

- It is not known to what extent the dental workforce are engaged with Making Everyone Contact Count (MECC).

## RECOMMENDATIONS

To address the challenges and gaps identified in this OHNA and improve the oral health of Herefordshire's population, 10 key recommendations are proposed (see table 8 below). Each recommendation is based on the findings from the OHNA and is extensively informed by national guidance (see Appendix A).

As per their statutory obligation, Herefordshire Council are expected to have overarching responsibility and accountability for the recommendations listed. However, ensuring the recommendations are actioned, will require engagement with and input from the following key multi-agency partners across the system –

- PHE
- NHS
- Herefordshire LDC
- Herefordshire and Worcestershire STP
- Healthwatch Herefordshire

| Table 8 - Herefordshire OHNA - 10 key recommendations | | |
|---|---|---|
| **Recommendation Number** | **Recommendation** | **By when? (Suggested owners)** |
| 1 | Establish a multi-agency steering group to lead the strategic direction for improving oral health and reducing oral health inequalities in Herefordshire. Ensure key partners are represented in the group's membership. | By October 2019 (Herefordshire Council – Public Health Team) |
| 2 | Based on the findings from the OHNA, develop a clear local vision and a high-level action plan for improving oral health and reducing oral health inequalities in Herefordshire. | By November 2019 (Herefordshire Council - in conjunction with multi-agency steering group) |
| 3 | Bridge the gaps in the current local approach to oral health improvement identified through the audit against the NICE guidance and the review of PHE guidance. | Ongoing (Herefordshire Council - Public Health Team, in conjunction with multi-agency steering group) |
| 4 | In accordance with PHE evidence-informed toolkits, scope and investigate the commissioning and provision of programmes with a known return on investment –<br>• Targeted community fluoride varnish (for children and older vulnerable adults)<br>• Targeted supervised tooth brushing<br>• Targeted provision of toothbrushes and toothpaste by post and/or health visitors | By December 2019 (Herefordshire Council - Public Health Team, in conjunction with multi-agency steering group) |
| 5 | In line with 'Delivering Better Oral Health' (PHE, 2017), promote the role and value of primary prevention within NHS primary dental care across Herefordshire. This is inclusive of –<br>• Increasing the delivery of preventive interventions i.e. fluoride varnish applications<br>• Encouraging parents/carers of infants (< 2 years) to access NHS dental care<br>• Embedding Making Every Contact Count within dental care settings | Ongoing (NHS England and Public Health England in conjunction with the local dental committee and Herefordshire Council) |

| | | |
|---|---|---|
| | • Ensuring dentists and oral health professionals are able to refer patients to community based health promotion activities i.e. for weight management, smoking cessation. | |
| 6 | Engage with and support key community settings (especially those commissioned or provided by the local authority) to develop local policies for improving oral health that reflect NICE guidance i.e. care settings, children and young people's settings, general practices and hospitals. | Ongoing (Herefordshire Council - Public Health Team, in conjunction with multi-agency steering group) |
| 7 | Ensure continued local participation in the PHE Dental Public Health Epidemiology Programme and identify opportunities to increase both sample sizes and consent rates of local dental surveys | Ongoing (Public Health England in conjunction with Herefordshire Council) |
| 8 | Explore the feasibility of undertaking a health equity audit of access to dental services in Herefordshire, specifically related to 'at-risk groups' (e.g. Looked after children, vulnerable older adults, people who are homeless or refugees, those with a learning disability). | By December 2019 (Herefordshire Council - Public Health Team, in conjunction with NHS England) |
| 9 | Seek opportunities to influence the common risk factors and wider determinants for poor oral health, obesity and other key public health issues i.e. smoking, high-risk drinking. For example through encouraging public service settings to be 'health promoting' and influencing local relevant planning decisions. | Ongoing (Herefordshire Council - Public Health Team, in conjunction with multi-agency steering group) |
| 10 | Based on a Cabinet approved recommendation (Jan 2019), investigate the case for commissioning a feasibility study into water fluoridation. This should be considered in the context of local needs and the range of oral health improvement programmes currently commissioned/provided. | By December 2019 (Herefordshire Council - Public Health Team, in conjunction with multi-agency steering group) |

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# Appendices

Appendix A – Key national guidance on oral health

| Organisation | Guidance/toolkit title | Year of publication |
|---|---|---|
| Public Health England | • Local authorities improving oral health: commissioning better oral health for children and young people | 2014 |
| | • Improving the oral health of children: cost effective commissioning | 2016 |
| | • Delivering better oral health: an evidence-based toolkit for prevention | 2017 |
| | • Child oral health: applying All Our Health | 2018 |
| | • Oral health improvement programmes commissioned by local authorities | 2018 |
| | • Commissioning better oral health for vulnerable older people | 2018 |
| | • Oral care and people with learning disabilities | 2019 |
| | • Adult oral health: applying All Our Health | 2019 |
| National Institute of Health and Care Excellence | • Oral health: local authorities and partners, PH55 | 2014 |
| | • Oral health promotion: general dental practice, NG30 | 2015 |
| | • Oral health for adults in care homes, NG48 | 2016 |
| | • Oral health promotion in the community, QS139 | 2016 |
| | • Oral health in care homes and hospitals, QS151 | 2017 |
| Local Government Association | • Tackling poor oral health in children | 2016 |

Appendix B – Roles and responsibilities of the key organisations involved with improving oral health (15 - pg.15)

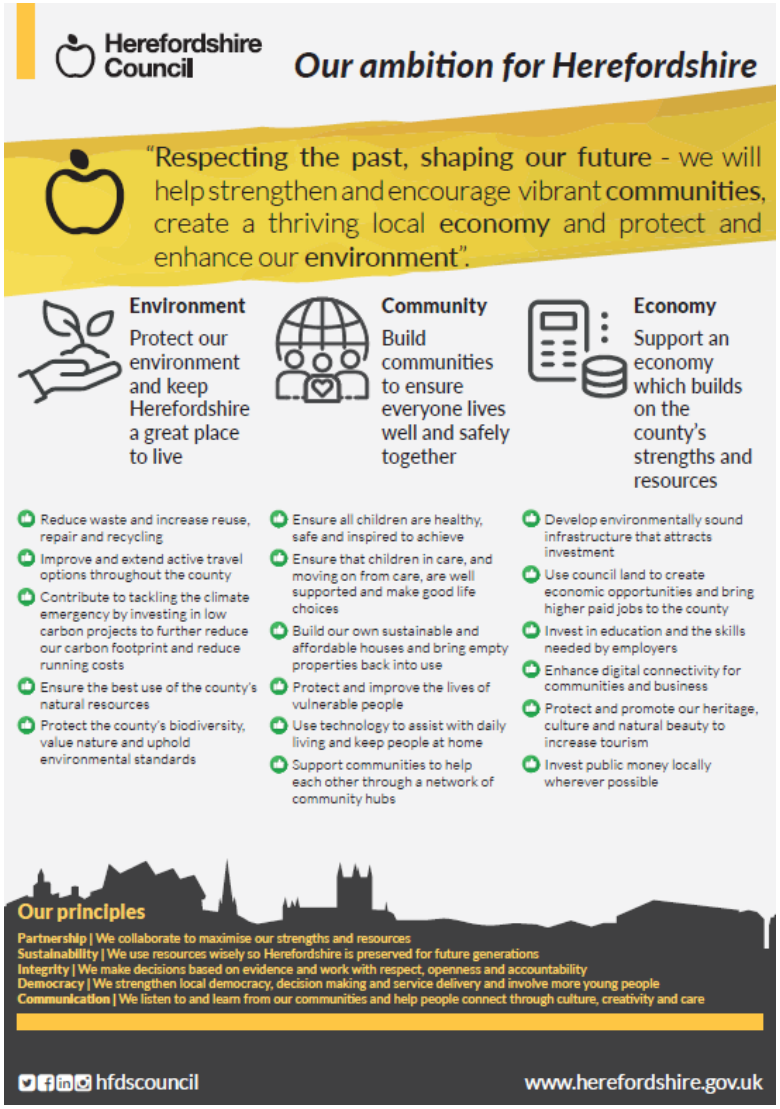
| | Body | Key Responsibilities |
|---|---|---|
| National | NHS England | ▪ planning, securing and monitoring primary care community and secondary dental services within a single operating model<br>▪ developing and negotiating contracts; policies, procedures, guidance and national care pathways<br>▪ 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<br>▪ informing and developing national oral health policies and clinical guidelines<br>▪ addressing oral health inequalities<br>▪ 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<br>▪ identifying public concerns about health and social care services<br>▪ developing and leading local Health Watch |
| Regional | NHS England regional reams | ▪ providing clinical and professional leadership at the regional level<br>▪ coordinating and planning dental services on the basis of regional needs<br>▪ direct commissioning functions and processes<br>▪ regional director of nursing responsible for supporting and providing assurance on safeguarding children |
| | PHE regional teams | ▪ developing guidance for local authorities<br>▪ supporting collaborative commissioning of oral health improvement programmes |
| Local | NHS England area teams | ▪ commissioning all NHS dental services - both primary and secondary care<br>▪ supporting CCGs to assess and assure performance<br>▪ direct and specialised commissioning<br>▪ managing and cultivating local partnerships and stakeholder relationships, including representation on local health and wellbeing boards<br>▪ 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<br>▪ contributing to joint strategic needs assessments (JSNA), strategy development, oral health needs assessment<br>▪ 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<br>▪ conducting and/or commissioning oral health surveys to assess and monitor oral health needs<br>▪ responsible for reducing health inequalities<br>▪ planning, commissioning and evaluating oral health improvement programmes<br>▪ leading scrutiny of delivery of NHS dental services to local populations<br>▪ 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)<br>▪ 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)<br>▪ safeguarding children<br>▪ 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<br>▪ 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<br>▪ 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<br>▪ delivering non-statutory personal, social, health and economic (PSHE) education in key stage 1 of the national curriculum |

# Budget 20/21 and corporate priorities (2020 -2024)

Children and Young People Scrutiny committee

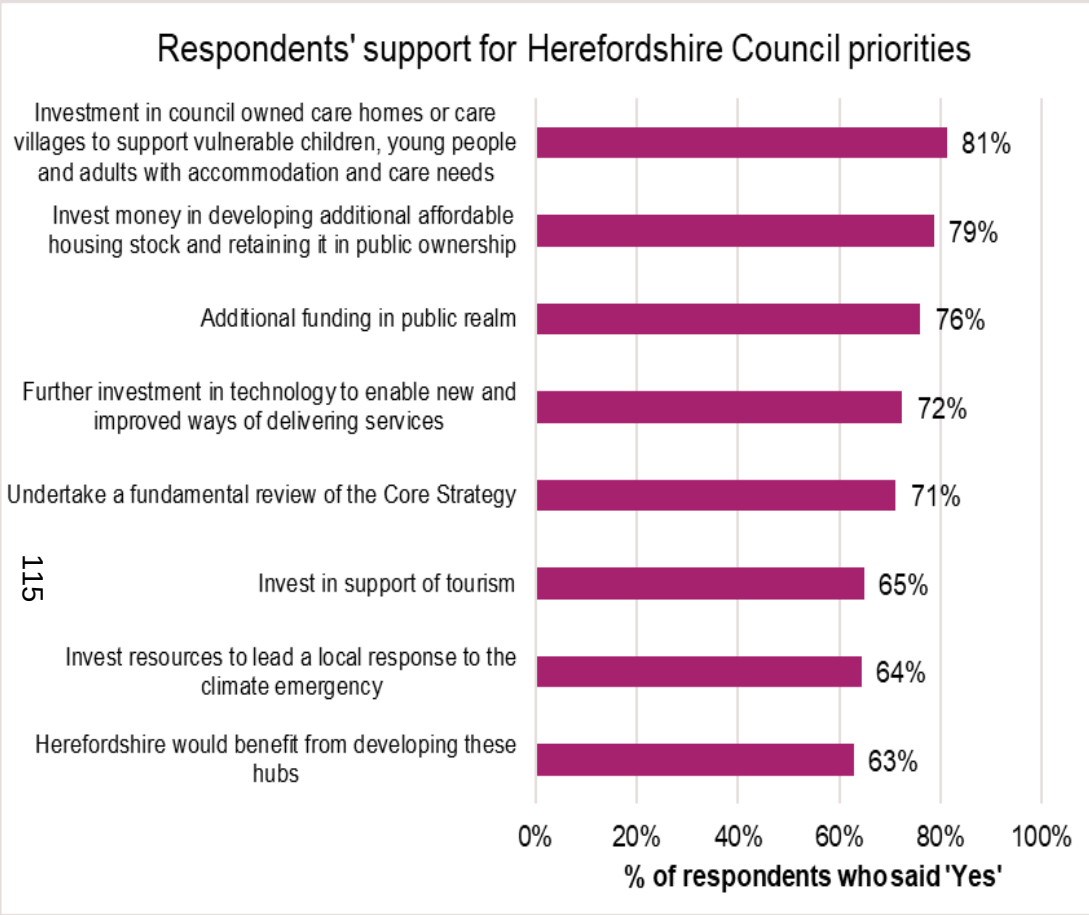
*14th January 2020*

# Corporate plan




- Updated "1 page plan" developed to set out the ambitions of the council and the principle ways of working
- Key ambitions remain as stated in November
- Changes reflect conclusion of consultation

# Feedback from consultation on proposals - priorities




There was majority support for all of the areas identified for additional investment, with as many as four out of five agreeing with additional investment in council-owned care homes or villages (81%) and publicly-owned affordable housing (79%).

# Feedback from consultation on proposals - budget

- 4% council tax increase; 51.5% was about right or too little

- A small majority (53%) disagreed with the allocation of Council Tax as set out in the budget till receipt
- Comments that expressed an opinion about the allocation of spend were mostly saying that not enough was allocated to particular services, rather than too much. Services mentioned most frequently were related to the environment and place.

# Net Revenue Budget 2020/21 – following provisional settlement

| | £k |
|---|---|
| Council Tax assumed 3.9% | 109,780 |
| Business rates | 36,726 |
| Revenue Support Grant | 635 |
| Rural services delivery grant | 5,101 |
| Adult social care grant | 4,875 |
| **Total net budget** | **157,117** |

# The Base Net Budget requirement

| Directorate | Base at November scrutiny £k | Legal services £k | PWLB interest £k | Base Budget £k |
|---|---|---|---|---|
| Adults and Communities | 56,282 | | | 56,282 |
| Social care pool | 2,054 | | | 2,054 |
| Children and families | 30,699 | | | 30,699 |
| Economy and Place | 28,955 | | | 28,955 |
| Corporate Services | 15,803 | 700 | | 16,303 |
| **Total Directorate** | **133,793** | **700** | | **134,493** |
| Central | 22,306 | | 318 | 22,624 |
| **Total Net Budget** | **156,099** | **700** | **318** | **157,117** |

# 2020/21 Assumptions

- 3.9% increase in Council Tax ( 1.9% general, 2% Adults Social Care) Band D = £1,573.77 increase of £1.14 per week;
- Improved better care fund (ibcf) £6.6m (£5.4m Adults and £1.2m new schemes);
- Public Health grant of £9.2m, ring fence to continue;
- Provisional settlement shared, consultation open until 17 January, final settlement will follow

# Children and young people – no change from November

| | 19/20 revised base £m | Savings £m | Looked after children £m | Edge of care £m | Improving social care services £m | Inflation pressures £m | Total £m |
|---|---|---|---|---|---|---|---|
| Proposed revenue budget | 27.2 | (0.3) | 1.1 | 1.0 | 1.0 | 0.7 | 30.7 |

The provisional settlement announced on 20 December 2019 included £2.2m new home bonus grant income.

One off funding considered for utilisation to fund unforeseen budget pressures in relation to the costs of looked after children.

# Childrens capital request – increases to current schemes

| Scheme | Description | Current Capital Programme £m | Total 21/22 £m | Capital receipt funding £m | Total Request £m |
|---|---|---|---|---|---|
| Brookfield School | Improvement project seeking to achieve higher school buildings compliance, more robust fire evacuation buildings compliance, the release of a council owned split site facility at Symonds Street, the capacity to deliver the full statutory curriculum and improved accommodation. | 2.7 | 1.2 | 1.2 | 1.2 |
| Peterchurch Primary School | A replacement primary school for Peterchurch including all teaching and support spaces, including playground and playing field, necessary for it to function as a full one form entry school. The facility will include for the provision of a nursery and continued use of the swimming pool | 5.5 | 5.3 | 5.3 | 5.3 |
| **Total** | | **8.2** | **6.5** | **6.5** | **6.5** |

# Children and young people

## National

91% of LAs spent more than planned for in 2017/18; 93% predicted for 2018/19

LAC numbers – increased by 10% in four years nationally to 2018

CP numbers – 2018 biggest increase nationally in last four years; numbers have increased by 84% in last decade

LGA – by 2020 there will be a £2billion funding gap in children's services due to rising demand

2018 – spend on children's services the fastest growing area of council spend in the country; spend on looked after children growing at a faster rate than the overall rate (9% in one year vs 6.7% overall)

Recent DfE figures note that the number of unborn recorded within total number of children in need nationally has almost trebled in last eight years



## Herefordshire

1 in 5 living in poverty; increase in vulnerable children; increase in children with special educational needs, increase in fixed term exclusions

CP numbers varied significantly over number of years but higher rate than nationally over last four years

LAC numbers – far higher than statistical neighbours, rate of new entrants is coming down but still relatively high

Early Help – from 500 early help assessments in 2018 to 1,200 in 2019

Contextual Safeguarding – child exploitation, county lines

Unaccompanied Asylum Seeking Children

Section 20s conversion

Herefordshire Children and Young People's Partnership

# Giving children and young people a great start in life

## Herefordshire's Children and Young People's Plan 2019 - 2024

By 2024 Herefordshire children and young people will:

### Be SAFE FROM HARM

**Be safe with others**
We will increase our early help and social care support; we will work together to make clear decisions so you receive the right support at the right time

You will live with supportive families and have a better understanding of healthy and positive relationships

**Feel safer**
You will know how to keep safe where you live so that you are confident when you go out

### Be AMAZING!

**Have a great start in life**
We will support you to have a great start in life and to overcome barriers to your achievement

**Be better prepared for adulthood**
You will receive quality guidance on careers to help you make informed choices.

**Have better chances of success**
You will have more opportunities to develop the skills you will need for the world of work

### Be HEALTHY

**Lead a healthier lifestyle**
You will have good information and support to help you keep active and eat healthily

**Have healthier teeth**
You and your family will receive clear advice about the importance of good dental health.

**Be confident to talk about mental health**
You will have better support to meet your emotional and mental health needs

### Be PART OF THE COMMUNITY

**Live in a happier community**
With your help, we will tackle discrimination and ensure everyone feels valued in our community

**Be more influential**
We will work with you so that you are involved in decision making in our community and to deliver the Children and Young People's Plan

**This plan is owned by all agencies, working alongside children, young people, families and communities across Herefordshire to provide the right support at the right time**

# Herefordshire Council Education, Development and Skills Strategy 2018-21

**Vision**

**Keeping children and young people safe and giving them a great start in life**

**Core purpose**

**Safety and well-being**
All children and young people are protected from harm, both physical and mental

**High standards**
All children and young people can access high-quality provision and achieve their potential

**Equity**
Access to education and training is fair. All vulnerable children and young people receive extra support to overcome barriers to their achievement

**Successful transition to adult life**
Young people embark on their chosen career path at 19+ with the qualifications, skills and character to contribute to the local, regional and national economy

## Priorities

### 1 Drive sustainable school improvement
- Support schools' improvement in teaching and learning and leadership practice, under the direction of the Herefordshire School Improvement Partnership (HSIP)*
- Work collaboratively with NLEs (national leaders in education), teaching schools and HSIP both on plans to recruit and retain suitable staff and to ensure there is high quality professional development which meets identified areas of need
- Align council statutory functions and IT systems so that schools and settings can access the support they need to be set up for success
- Learn from best practice nationally and get the most out of national initiatives for Herefordshire

### 2 Strengthen leadership
- Support governors and external agencies such as DfE, RSC's office and Ofsted to prevent under-performance and to help all schools and settings improve

### 3 Embed clear accountability
- Provide leaders, especially governors, with clear information to help them to hold schools and settings to account
- Develop existing risk assessment procedures to include post - 16 so that there is a clear understanding of performance across all phases

### 4 Support and protect vulnerable children
- Champion fair access to education and training for vulnerable children and young people and challenge and support practice
- Improve existing partnership working with multi-agencies so that there is a joined up approach to support for children and young people, particularly around their mental health and on issues such as county lines
- Review our strategy to improve SEN and disabilities provision
- Work with external partners, such as the Home Office to protect children and young people from radicalisation

### 5 Develop the early years strategy
- Create an approach that supports the autonomy of early years settings and providers, particularly around workforce development

### 6 Deliver Herefordshire's Schools Capital Investment Strategy
- Deliver 249 new places at primary and 816 at secondary to meet demand
- Complete improvements to the school estate, including builds at Marlbrook, Brookfield, Peterchurch and the 16-19 SEN free school

### 7 Focus on the 16-19 education and skills agenda
- Develop provision in technical level qualifications so that outcomes match those at A-level
- Adapt NEETs strategy so that the number of young people in education or employment with training is well above national average
- Champion employability by working with schools, employers and FE providers on a county careers strategy which complements a broad, empowering, creative curriculum
- Link to the Marches Skills strategy and create new opportunities for young people in Herefordshire through, for example, apprenticeships and NMiTE

## Principles

**Children and young people first**

**High expectation for every child**

**Supported autonomy for schools and settings**

**Top quartile performance**

**Impact measure:** is the strategy leading to improvements in outcomes for children and young people?

DfE - Department for Education, RSC - Regional Schools Commissioner, NMiTE - New Model in Technology and Engineering

* see HSIP delivery model

hfdscouncil

herefordshire.gov.uk

# Safeguarding and Family Support Development Plan 2019/20

**Vision**

**Keeping children and young people safe and giving them a great start in life**

**Goals**

**Resilient families**

Strengthening families through our 'early help' and 'edge of care' offers

**Children and young people first**

Ensuring the child's voice is heard. Taking direct action when children are at risk of significant harm

**High quality service and practice**

Exploring all opportunities to support children and young people to remain outside of the care system

**Positive futures**

Achieving permanency for children at the earliest point possible. Ensuring looked after children and care leavers receive support which will help them effectively transition into adulthood

**Priorities**

**1. Strengthen leadership**

- Enable the workforce to take responsibility and manage risks appropriately
- Ensure there is a clear and shared understanding of thresholds across partner agencies so that children are referred appropriately to the MASH
- Develop practice that is integrated, inter-disciplinary and cross-agency
- Ensure sound decision-making so LAC placements are stable and residential care placements and community foster placements are explored, where appropriate
- Raise awareness of emerging issues for the county such as county lines, sexual exploitation and radicalisation
- Develop an 'edge of care' service which is clearly understood by all partner agencies
- Commission services to meet Herefordshire's safeguarding profile

**Impact measure:**

Is the Safeguarding and Family Support Development Plan leading to improvements in outcomes for children and young people?

**2. Improve the quality of social work practice**

- Support social work practice through the 'Signs of Safety' social work model so there are rapid improvements in:
  - Consistent application of thresholds throughout the system
  - Quality and consistency of case recording
  - Quality and timeliness of assessments
  - Helping children understand their journey through life story work
  - How graded care training is used actively in neglect cases
  - Quality and timeliness of case and worker supervision
  - Decision making particularly around the initiation of strategy and section 47 enquiries
- Develop a robust Independent Reviewing Officer (IRO) service
- Develop a whole service performance system
- Empower staff to deliver our objectives

**3. Retain and attract high quality social care staff**

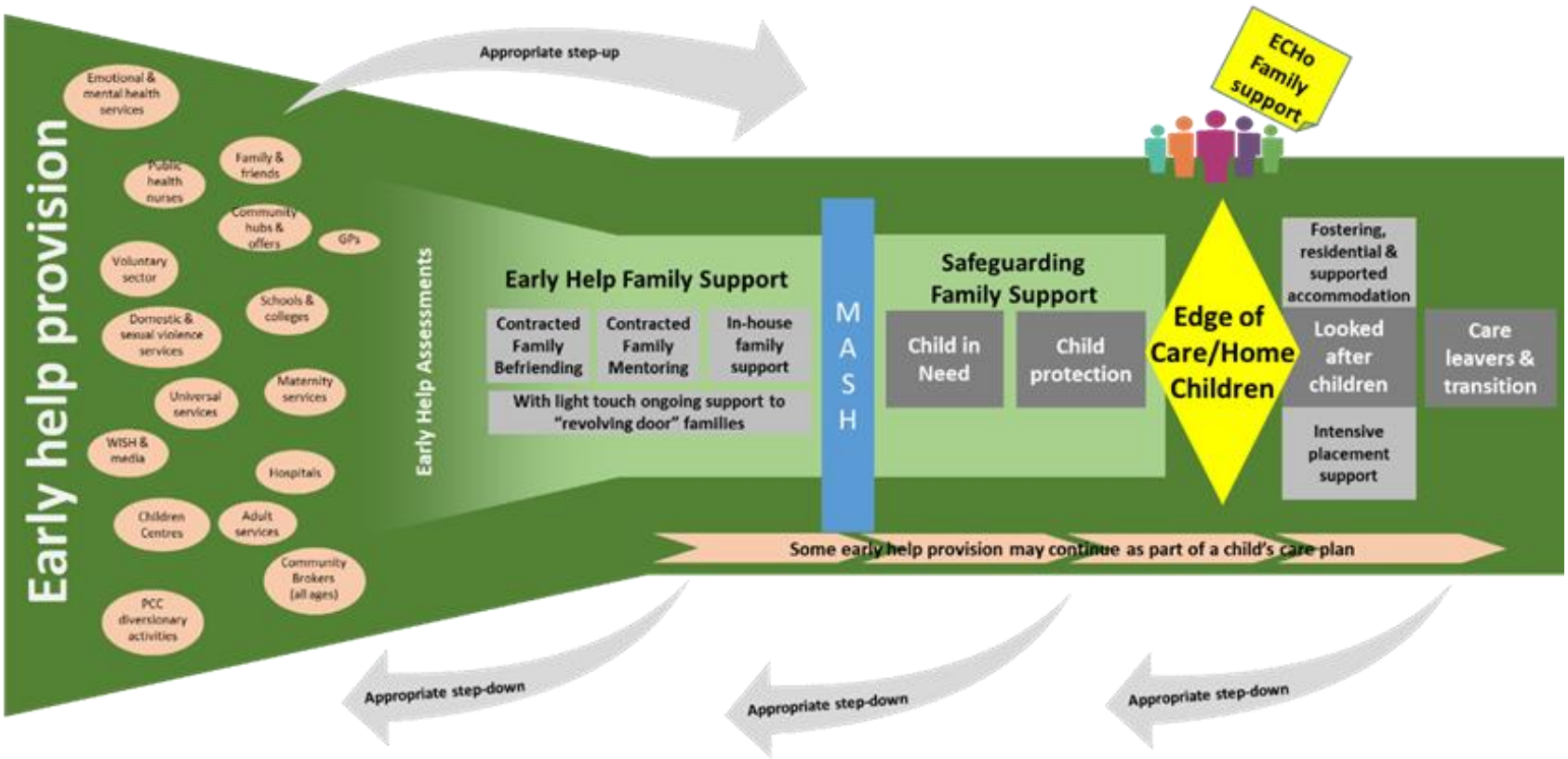
- Develop career pathways for social workers and high quality recruitment and retention packages
- Develop comprehensive offer to recruitment and progression of ASYE's
- Ensure worker caseloads are acceptable
- Ensure the right case in right place
- Undertake regular case and worker supervision
- Embed a high quality training programme
- Review and implement proposals for recognition and reward for 'hard to fill' roles
- Ensure effective and regular communication and engagement with staff and partners
- Develop the culture to deliver better outcomes for children, young people and their families

**4. Governance, performance and accountability**

- Ensure management oversight and grip through proactive scrutiny and challenge which prevents drift and delay in our work to support children
- Embed a performance improvement culture
- Improve performance data and IT systems so leaders are better able to be held and hold others to account

**To inspire, support and challenge each other to enable all children and young people to thrive** **#buildingbetterfutures**

# Edge of Care investment



# Oral health needs assessment

**Table 8 - Herefordshire OHNA - 10 key recommendations**

| Recommendation Number | Recommendation | By when? (Suggested owners) |
|---|---|---|
| 1 | Establish a multi-agency steering group to lead the strategic direction for improving oral health and reducing oral health inequalities in Herefordshire. Ensure key partners are represented in the group's membership. | By October 2019 (Herefordshire Council – Public Health Team) |
| 2 | Based on the findings from the OHNA, develop a clear local vision and a high-level action plan for improving oral health and reducing oral health inequalities in Herefordshire. | By November 2019 (Herefordshire Council - in conjunction with multi-agency steering group) |
| 3 | Bridge the gaps in the current local approach to oral health improvement identified through the audit against the NICE guidance and the review of PHE guidance. | Ongoing (Herefordshire Council - Public Health Team, in conjunction with multi-agency steering group) |
| 4 | In accordance with PHE evidence-informed toolkits, scope and investigate the commissioning and provision of programmes with a known return on investment –<br>• Targeted community fluoride varnish (for children and older vulnerable adults)<br>• Targeted supervised tooth brushing<br>• Targeted provision of toothbrushes and toothpaste by post and/or health visitors | By December 2019 (Herefordshire Council - Public Health Team, in conjunction with multi-agency steering group) |
| 5 | In line with 'Delivering Better Oral Health' (PHE, 2017), promote the role and value of primary prevention within NHS primary dental care across Herefordshire. This is inclusive of –<br>• Increasing the delivery of preventive interventions i.e. fluoride varnish applications<br>• Encouraging parents/carers of infants (< 2 years) to access NHS dental care<br>• Embedding Making Every Contact Count within dental care settings | Ongoing (NHS England and Public Health England in conjunction with the local dental committee and Herefordshire Council) |

# Oral health needs assessment

| | | |
|---|---|---|
| | • Ensuring dentists and oral health professionals are able to refer patients to community based health promotion activities i.e. for weight management, smoking cessation. | |
| 6 | Engage with and support key community settings (especially those commissioned or provided by the local authority) to develop local policies for improving oral health that reflect NICE guidance i.e. care settings, children and young people's settings, general practices and hospitals. | Ongoing (Herefordshire Council - Public Health Team, in conjunction with multi-agency steering group) |
| 7 | Ensure continued local participation in the PHE Dental Public Health Epidemiology Programme and identify opportunities to increase both sample sizes and consent rates of local dental surveys | Ongoing (Public Health England in conjunction with Herefordshire Council) |
| 8 | Explore the feasibility of undertaking a health equity audit of access to dental services in Herefordshire, specifically related to 'at-risk groups' (e.g. Looked after children, vulnerable older adults, people who are homeless or refugees, those with a learning disability). | By December 2019 (Herefordshire Council - Public Health Team, in conjunction with NHS England) |
| 9 | Seek opportunities to influence the common risk factors and wider determinants for poor oral health, obesity and other key public health issues i.e. smoking, high-risk drinking. For example through encouraging public service settings to be 'health promoting' and influencing local relevant planning decisions. | Ongoing (Herefordshire Council - Public Health Team, in conjunction with multi-agency steering group) |
| 10 | Based on a Cabinet approved recommendation (Jan 2019), investigate the case for commissioning a feasibility study into water fluoridation. This should be considered in the context of local needs and the range of oral health improvement programmes currently commissioned/provided. | By December 2019 (Herefordshire Council - Public Health Team, in conjunction with multi-agency steering group) |

Herefordshire Council

| | |
|---|---|
| **Meeting:** | **Children and young people scrutiny committee** |
| **Meeting date:** | **Tuesday 14 January 2020** |
| **Title of report:** | **Young Carers Support Service** |
| **Report by:** | **Director for Children and Families** |

## Classification

Open

## Decision type

This is not an executive decision

## Wards affected

(All Wards);

## Purpose and summary

To review the Young Carers Support Service (YCSS) for Herefordshire against the specification for the service following its implementation in April 2018.

The council has a statutory duty regarding young carers written in the Children Act 1989, the Children Act 2004, the Children and Families Act 2014 and the Young Carers (Needs Assessment) Regulations 2015. This includes identifying, assessing the needs of the young carer and their family and providing the required support.

The council's corporate plan includes a commitment to enabling people to live safe, healthy and independent lives. Many vulnerable people are dependent upon carers in order to do so. The young carers' service seeks to support that contribution and help to ensure that young carers themselves are safe, healthy and enabled to fulfil their aspirations. It promotes identification of young carers by universal services and focuses on connecting young carers to their community and other sources of support.

To allow scrutiny to review the performance and progress of the new service and make any recommendations to the executive to drive any improvements forward.

The specification for the YCSS has derived from the Joint Carers Strategy 2017- 2021 which was produced jointly by Herefordshire Council and Herefordshire Clinical Commissioning Group in consulatation with carers and young carers.

Further information on the subject of this report is available from
Nicola Turvey, Tel: 01432383237, email: nturvey@herefordshire.gov.uk

The YCSS has 4 objectives:

1. Offer and carry out early help assessments which satisfy statutory requirements. Meeting this objective. All young carers who have requested a statutory assessment have had one.
2. Offer and carry out transitions assessments which satisfy statutory requirements. Meeting this objective. All young carers who are transitioning and requested a transition assessment have had one.
3. Enable young carers to access a range of community and universal services. Meeting this objective for those young carers who are being or have been supported.
4. Enable young carers to access a range of digital resources.

Meeting this objective.

## Recommendation(s)

**That:**

**(a) The children and young people's scrutiny committee review the information within the report and make any recommendations to the executive and the Herefordshire Clinical Commissioning Group as necessary to improve the service.**

## Alternative options

1. There are no alternative options as this report is to provide an overview of the Young Carers Service following its implementation.

## Key considerations

2. The 2011 census reported that there were c1,270 young people aged up to 24 providing unpaid care in Herefordshire. Of that group, just over 400 were aged under 15. No estimate is available of how these numbers may have changed since 2011, but it is reasonable to expect that there may be around 400-700 young carers aged 18 currently in Herefordshire. Of the 2011 census cohort, the amount of care provided could vary as follows:

| **2011 Census – Unpaid Carers** | **Age 0 to 15** | | **Age 16 to 24** | |
|---|---|---|---|---|
| Provides unpaid care: Total | 406 | | 863 | |
| Provides 1 to 19 hours unpaid care a week | 337 | 83% | 650 | 75% |
| Provides 20 to 49 hours unpaid care a week | 45 | 11% | 118 | 14% |
| Provides 50 or more hours unpaid care a week | 24 | 6% | 95 | 11% |

3. The Joint Carers Strategy 2017 – 2021 and associated commissioning intentions were approved by Cabinet in 20 July 2017. That decision noted that a panel or focus group of carers, including young carers, would contribute to the final design of new services to be commissioned and participate in the procurement process. That work concluded that a service for Young Carers should be commissioned separately from the wider carers provision. There were numerous challenges to commissioning a service delivered by an independent provider for Young Carers and it was proposed and agreed that the council's Early Help Family Support team would provide this service. The specification for the service is appendix A.

4. There had been an intention to undertake pre-decision scrutiny on the decision before it went to Cabinet in March 2018. Unfortunately due to the pressing timescales it was agreed that the committee would not undertake pre-decision scrutiny on the decision and instead review progress with the implementation of the new service a year after its introduction. This was confirmed at the cabinet meeting on 15th March 2018 that approved the provision of a young carers service. Due to visit by Ofsted at the beginning of 2019 and the local elections in May 2019 it has not been possible to schedule a report to the committee until now.

5. The children and young people scrutiny committee have responsibility for the scrutiny of services in Herefordshire for children and young people. The committee seeks to scrutinise the implementation of the young carers service, following its introduction in March 2018, to ensure that the service is meeting its objectives and providing effective support, care and guidance for young carers in Herefordshire.

6. On 1st April 2018 the in house Early Help Family Support took on the statutory obligations under the Young Carers (Needs Assessments) Regulations 2015 to assess the needs of young carers and their family holistically to enable young carers to lead fulfilled lives and to access opportunities available to other children by overcoming any barriers. The service is named Young Carers Support Service (YCSS) and consists of two full time family support workers managed within the Early Help Family Support Team, the holistic family assessment used is the Early Help Assessment (EHA). The service is countywide and young people are seen in locations and environments where they feel most comfortable.

7. The services focuses on four main objectives:

    - Young carer assessments following a whole family approach resulting in a tailor made multiagency package of support with an outcome focused action plan.
    - Transition assessments for young carers
    - Wide ranging networking and signposting to offer diverse opportunities
    - Increasing the availability of online/digital opportunities and support

8. The YCSS started by promoting the new service through the council website and WISH (Wellbeing, Information & Signposting for Herefordshire) explaining what a young carer is, how the service can provide support and how to make a referral. It developed three different presentations to target different audiences: primary school children, secondary school children and professionals. The service is also being promoted through the council communications 'Spotlight on children' and the Children Wellbeing bulletin. Posters have been produced for schools, doctor's surgeries and other community buildings - appendix B. It also attends Carer Forums and the Carer & Networking Events 2019 run by 2gether and Cares4trust in June 2019.

9. Objective 1: To offer and carry out early help assessments (EHA) which satisfy statutory requirements. 83 statutory family assessments have been requested and completed using the EHA. This assessment takes a whole family approach by identifying all the family's needs and putting together a tailor made package of support with an outcome focused support plan for all the family. Of the 36 closed cases 26 achieved positive outcomes, 4 were referred to statutory social care services (families received the right support at the right time) and the 6 other cases closed for various reasons e.g. moved out of county, did not want the support and on assessment there was not a young carer in the

family. The appendices C & D are examples of young carer cases. The majority of families do not view the children as young carers and the children have grown up in a caring role and do not know any different. There are a range of needs identified in young carer's family assessments however the most frequent areas include the health needs of the parent/guardian and the emotional needs of the child.

10. Objective 2: 9 young carer transitional assessments have been requested and completed. All young carers who have been transitioning to an adult carer role have been supported to make this as smooth as possible.

11. Objective 3: Enable young carers to access a range of community and universal services. Part of the work with young carers and their families is to support them to access activities and services of interest to them including young carer groups. Families are supported to complete application forms, transport is discussed and the workers often accompany a young carer to a group to start with.

12. Objective 4: Enable young carers to access a range of digital resources. Digital technology is regularly used in working with young carers e.g. the NSPCC website for keep safe work, the 'Think you Know' website about keeping children safe online and the 'Bullying UK' website. The 'Wellbeing Information Signposting Hub' (WISH) is also used to access information and activities for the family. Digital technology is being used to promote the service through the council website using different adverts in rotation and young carers are also involved in an innovative way of promoting the service by making animation clips from photographs and audio clips of young carers.

13. The council communication team advised on social media options. It was agreed that the safest form of social media contact was via a closed Facebook page with YCSS having administrative rights and membership being private. This was set up but then it was realised that as Facebook is only legally available for children of 13 or over, this method did not cover all of the young carer age group. The site was removed. After discussion with young carers, their preferred method of contact is through text messaging. This has proved to be very successful but will be reviewed on an annual basis. The team are currently exploring the use of WhatsApp as an additional way of communicating with young carers. Contact with young carers continues once all the actions have been carried out on the family plan and changes have been made. The case is closed but 'light' contact remains and further support is available if required

14. All 96 schools have been contacted via email explaining the new service and offering an age appropriate presentation. Primary schools have been very receptive to accepting the offer of a presentation to their pupils. These have been well received and children have identified themselves as young carers. Secondary schools have also engaged. There has been good engagement from Hereford Sixth Form College and a presentation was given there on Young Carers awareness day..

15. The average age of a young carer in Herefordshire is 14 which is in line with the national average age of a young carer. The youngest young carer registered is aged 5 years, this is an exception.

## Community impact

16. In accordance with the adopted code of governance, Herefordshire Council achieves its intended outcomes by providing a mixture of legal, regulatory and practical interventions. Determining, the right mix of these is an important strategic choice to make sure

outcomes are achieved. The council needs robust decision-making mechanisms to ensure our outcomes can be achieved in a way that provides the best use of resources whilst still enabling efficient and effective operations and recognises that a culture and structure for scrutiny are key elements for accountable decision making, policy development and review.

17. The council's corporate plan includes a commitment to enabling people to live safe, healthy and independent lives. Many vulnerable people are dependent upon carers in order to do so. The young carers' service seeks to support that contribution and help to ensure that young carers themselves are safe, healthy and enabled to fulfil their aspirations. It promotes identification of young carers by universal services and focuses on connecting young carers to their community and other sources of support.

18. Enabling young carers to sustain their caring role while balancing their own needs was a key theme during engagement with young carers. Many young carers stated that they felt constrained by their caring role and unable to access the same educational or social opportunities as their peers, demonstrating inequity. Measuring the impact of such early constraints is difficult but there is recognition that this impacts young carers in many ways, including emotionally and mentally. Herefordshire's health and wellbeing strategy identifies mental health and children as key priorities. Therefore, early identification of young carers and connecting them to sources of support are essential to promoting good physical, emotional and mental health. The majority of young cares have been identified with emotional needs and supported with this or to access specialist services.

19. The Carers strategy is aligned to both Herefordshire Council's Corporate Plan and Herefordshire Clinical Commissioning Group's Five Year Strategic Plan. Both plans emphasise the importance of active prevention by changing the way services are delivered and keeping people well within their communities. Seamless and innovative ways of working, and the use of improved technology and resources within Herefordshire, will help us continue our collaborative work to support young carers and keep them and their family's well.

20. The vision has been developed with carers as a means of articulating that carers are unique but with similar aspirations, although some are more specific to certain groups of carers. For example, young carers are likely to have different aspirations to older carers. The vision has informed six priorities:

    - Information, advice and signposting
    - Identifying carers
    - Carers' knowledge, skills and employment
    - Access to universal services
    - Networking and mutual support
    - Assessment and support – this also fits with the Council's Health and Wellbeing Strategy and Adults Wellbeing Plan

    Services provided to the cared for person need to be focused on maintaining the independence of both themselves and their carer, whilst bolstering their strengths by:

    - Facilitating access to the community

- Meeting any unmet needs to ensure the cared for person and the carer can have fulfilled lives within their communities where possible

- Enabling young carers to lead lives of their own and access opportunities available to other children

## Equality duty

21. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:
A public authority must, in the exercise of its functions, have due regard to the need to -

    (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

    (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

    (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

22. The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services.

23. Age and disability are protected characteristics under the Equality Act, although being a carer is not. National research shows that young carers are 1.5 times more likely than their peers to have a special educational need or a disability, yet there is no strong evidence that young carers are more likely than their peers to come into contact with support agencies, despite government recognition that this needs to happen. Additionally, young carers are less likely than their peers to achieve their full potential in education. The new service for young carers will work with strategic partners to address this.

24. The Equality Impact Assessment has been reviewed and updated with the current service data. There is no new national data since the Census in 2011 see above.

## Resource implications

25. The service has a budget of £65k per annum. This money pays for two full time Young Carer Support workers, management oversight and additional costs which include travel and subsistence, transporting young people to appointments and refreshments for young carers.

26. A Young Carers Grant scheme was developed this year to provide opportunities for young carers in Herefordshire to take part in groups and activities that provide a break from their caring responsibilities. £20,000 was made available and, with assistance of two young carers in evaluating the bids, grants were awarded to Carerstrust4all on 1 May 2019. The service has been working alongside the inhouse service to identify young carers across the county, particularly in more rural parts of the county to ensure support developed meets local need.

## Legal implications

27. There are no specific legal implications with regard to the recommendations of the report. The statutory duties are outlined in the report.

## Risk management

28. The council has a statutory duty regarding young carers written in the Children Act 1989, the Children Act 2004, the Children and Families Act 2014 and the Young Carers (Needs Assessment) Regulations 2015 therefore not delivering the service will mean the council is noncompliant with its duty.

29. In summary, the council is obliged to do what it can to identify young carers and complete an assessment of their needs using a whole family approach. The assessment and subsequent support package is voluntary and would include supporting and enabling carers to balance their caring role with their own aspirations which is aligned to the council's wider strategic approach to prevention, promoting health and wellbeing and enabling those with health or social care needs to stay within their community for as long as possible.

30. There is a risk that referrals to the service will be higher than capacity this is being mitigated by other Early Help Family Support Workers carrying out this work as part of their role and responsibilities.

## Consultee

Service users complete a service evaluation form at the end of the intervention and this helps support the development of the service.

Young carers are asked if their support worker explained to them why they were working with their family.

Response: 100% of young carers said their support worker explained to them why they were working with them and their family.

Young carers are asked how they would like us to get in touch in the future, the responses are below:

75% of young carers said they would like us to get in touch in the future by text.

25% of young carers said they would like us to get in touch in the future by email.

50% of young carers said they would like us to get in touch in the future by phone.

0% of young carers said they would like us to get in touch in the future by other (e.g. social media), letter or not at all.

Young carers are asked if their support worker understood their situation and are asked to rate this between ‘good’, ‘okay’ and ‘not good.

Response:

75% of young carers said that they felt the support worker did understand their situation and rated the support as ‘good.

25% of young carers rated the support as ‘okay’.

Young carers are asked who else has helped them since YCSS has been working with their family.

Response: 75% of young carers ticked ‘clubs’.

Young Carers are asked ‘Is there anything else that YCSS could do better to help your family?

The only comment received is ‘No because you have been amazing’.

## Appendices

Appendix A – Young Carers Service Specification

Appendix B – Poster offering Support to Young Carers

Appendix C – Young Carer case study

Appendix D – Young Carer case study

## Background papers

None identified.

## Please include a glossary of terms, abbreviations and acronyms used in this report.

EHA = Early Help Assessment

YCSS = Young Carers Support Service

NSPCC = National Society for the Prevention of Cruelty to Children

WISH = Wellbeing Information Signposting Hub

Herefordshire Council

# Young carers service summary specification

## Overview

Herefordshire Council is redesigning service for carers in Herefordshire to meet statutory obligations under the Care Act and to respond to the implementation of the carers strategy. Delivering a young carer specific service that considers the whole family will enable the needs of young carers to be assessed holistically and enable them to overcome the barriers they face in achieving their aspirations.

The approach of the young carers service will complement and reflect the wider health and social care agenda, working within the context of universal services. The Children and Young People's Plan 2015 - 2018 sets out the vision for "all children and young people in Herefordshire to have the best start in life and grow up healthy, happy and safe within supportive family environments. We want them to have the best possible health, education and opportunities."

This specification sets out the context and principles which form the basis of the proposed service, along with a strategic framework and details of the delivery model. The service will be commissioned and monitored by the Adults and Wellbeing Commissioning Team.

## Service period

1st April 2018 – 31st March 2020

## Budget

£65,000 per annum

## Principles

The service will respect the young carer's right to choice; uphold their rights, privacy, dignity and independence.

The service specification is informed by the following guiding principles. In fulfilling the contract and delivering the service, the provider will ensure that these principles are observed in principle and practice.

## Clarity of Purpose

The young carers service will have clearly stated aims and objectives and be able to demonstrate how it meets the stated principles, linked to the priorities within Herefordshire's carers strategy. The carers service will ensure that young carers, providers and funding agencies have information on the scope and limitations of the role of the service.

## Empowerment

The young carers service will support self-determination and empowerment through its work. The degree of involvement and style of delivery will be in accordance with the wishes of the people who use the service. The provider will support and enable young carers to participate in the management and delivery of the service in a variety of ways.

## Competent and skilled workforce

The service will ensure all staff and volunteers are; competent, prepared, trained, supported and provided with opportunities to develop their skills and experience.

## Confidentiality

The service shall (and shall ensure that all its staff) comply with all requirements under the Data Protection Act 1998 (DPA) and duly observe all obligations under the DPA and the General Data Protection Regulations once in force.

## Safeguarding

The service will ensure that all staff and volunteers have been trained to comply with, support and implement the West Midlands Adult Safeguarding policy and procedures, which can be found on the council's website.

The service will ensure that it employs staff who promote the wellbeing and welfare of adults and children, are subject to a satisfactory enhanced DBS check and receive appropriate training on adult safeguarding, with a specific focus on the role of the carer in preventing, recognising and reporting abuse.

## PEOPLE values

The service shall be underpinned by Herefordshire Council's PEOPLE values:

- People: Treating people fairly, with compassion, respect and dignity
- Excellence: Striving for excellence, and the appropriate quality of service, care and life in Herefordshire
- Openness: Being open, transparent and accountable
- Partnership: Working in partnership and with all our diverse communities

- Listening: Actively listening to, understanding and taking into account people's views and needs
- Environment: Protecting and promoting our outstanding natural environment and heritage for the benefit of all

## Context

The provision of the young carers service shall be anchored to the implementation of Herefordshire's carers strategy. The strategy outlines the specific national and local aspirations and challenges faced by all carers. It seeks to mitigate the challenges carers face by changing the way that universal services are provided and enabling carers to support each other, recognising their strengths and promoting their independence. The strategy acknowledges the high numbers of carers, many of whom do not identify that they are carers, and the current context of significantly changing public services.

The service will connect and work with a variety of other services, including but not limited to other young carer services, other carer services, young people services and the community.

The service will contribute to the whole system changes that are require to enable young carers to meet their needs and aspirations. The service will need to enable young carers and positively change their experiences in accessing wider services, working within the context of the strategy.

## Legislation

The service must comply with all current legislation. This includes, but is not limited to the Care Act 2014, the Children and Families Act 2014 and the Childrens Act 1989.

## Aims

- To identify young carer needs.
- Help enable young carers to lead fulfilled lives and access opportunities available to other children by overcoming barriers.
- Ensure young carers have access to appropriate information and support to enable them to maintain their own wellbeing whilst providing care to someone else.
- Ensure compliance with statutory responsibilities to young carers.

## Overview of Delivery Model

The service will complete statutory young carer assessments and support young carers to maintain their wellbeing and achieve their aspirations, using a whole family approach.

The service will adopt a variety of approaches to communicate with and engage young carers as individuals and a collective. The service will also engage with community assets and other services to help young carers achieve their individual goals and ambitions.

The young carers service will be expected to have an active presence in the carers strategy action group, take a lead role in making the voice of young carers heard and support universal services to understand how they can best meet the needs of young carers in Herefordshire.

**Service Availability**

The service is required to accept and action all contacts and be available between the hours of 09.00 and 17.00, Monday to Friday (excluding Public Holidays) but direct provision must be at whatever times are agreed between the individual using the service and the service provider, which may include early morning or evening work. Individual meetings with people will be expected to be in a setting which complies with lone worker policy and procedures.

**Objectives and Outcomes**

Objective 1:

Offer and carry out early help assessments which satisfy statutory requirements.

Outcomes:

- All young carer assessments are considered in the context of the whole family
- Young carers are supported to create and apply an outcome focused support plan that identifies ways in which they can overcome the barriers to achieving their aspirations, access opportunities and achieve their potential, using a strengths based approach.
- Once identified outcomes are met and the case is closed, young carers are able to maintain contact through social media, with an offer of reassessment at any time.

Objective 2:

Offer and carry out transitions assessments which satisfy statutory requirements.

Outcomes:

- All young carers who are transitioning to an adult carer role are made aware of and encouraged to sign up to carers register
- Young carers understand the changing demands on them as a carer as they transition into adulthood

Objective 3:

Enable young carer to access a range of community and universal services.

Outcomes:

- Advocate on behalf of young carers and facilitate their inclusion in the development of community based services to enable young carers to access and engage with these services.
- Network with services who can meet the needs of young carers, e.g. schools, G.P.'s and other universal services, for example work with identified carers champions in schools to provide up to date information and learning.
- Connect young carers to other services that can assist them to fulfil their aspirations, including other carer specific services.

Objective 4:

Enable young carers to access a range of digital resources.

Outcomes:

- Support young carers to access digital technology and safe web based support (where appropriate) to meet identified needs.
- Encourage the active involvement of young carers in the design and development of resources, for example on the WISH site.

**Outcome measures**

Young carers will identify that –

- When my needs have been considered they have taken into account all of my family.
- My support plan identifies my strengths, what my aspirations are and ways that I can overcome any barriers to achieving my aspirations.
- I feel able to get another assessment if I need one.
- I know what services are in my community and I am able to access the ones that interest me.
- The services I access, such as my school and doctor, are aware of the specific needs I may have as a young carer.
- I know what carers services are available and how to access these if I wish.
- I feel able to use the internet and digital technology to help me in my caring role, keeping me well and achieving my aspirations.
- I have been encouraged to be involved in developing information and advice resources for carers, for example information on the WISH site.
- If I choose to continue caring as I transition into adulthood I understand what the changing demands will be on me as a carer.

- I understand what the opportunities for education and employment are and any considerations I may need to take into account if I choose to continue in my caring role.

**Output measures**

The young carers service will be expected to demonstrate activity in relation to:

- Numbers of young people accessing young carer services; to include type of referrer and age of young person.
- Numbers of young carers signposted for information or advice without an assessment.
- Numbers of young carers assessed.
- Number of crisis incidents.
- Number of safeguarding concerns raised.

**Review arrangements**

The service will provide evidence of meeting quarterly outcome and output measures, in a format to be agreed with AWB commissioning.

Method of gathering outcome measures:

Feedback demonstrating user satisfaction, comments and complaints

- Case studies demonstrating user experience and how any comments and complaints are acted upon.
- Case studies demonstrating how young carers have been supported to overcome challenges and improved access their community offer.
- Evidence of a variety of media and approaches that engage young carers and other providers.
- User satisfaction survey.

6 monthly review meetings will be held with AWB commissioning.

## Methodological statement (to be completed by CWB)

| Input | Indicator | Data source | Review method/ frequency |
|---|---|---|---|
| Staff volumes and sufficiency | Staffing structure indicating number of staff, brief description of roles/responsibilities and hours dedicated to contract. | | |
| Staff qualifications/skills/training | For each role:<br>• Entry level qualifications<br>• Mandatory training requirements<br>• Role specific training<br>• DBS certificates | | |
| Management capacity and infrastructure | Management accountability arrangements.<br>Supervisory arrangements. | | |
| Organisational culture | Evidence of training and development opportunities for staff.<br>Process for dealing with compliments, comments and complaints.<br>Methods for user participation and feedback.<br>Equality and diversity policy. | | |

Herefordshire Council

# A YOUNG CARER

**Young carers have a lot of extra responsibilities, because they live with someone who is experiencing illness, disability or addiction.**
**Does this describe you or someone you know?**
**if so please contact us**


Donna Smith or Tim Williams, our early help support workers are happy to help. They will talk you through the process and make the arrangements to contact your family and set up a home visit and assessment:

**Donna Smith**
**Phone:** 01432 383074, or **mobile:** 07792 881 722 or **email:** Donna.Smith@herefordshire.gov.uk
**Tim Williams**
**Phone:** 01432 383 529 or **mobile:** 07792 881 512 or **email:** Timothy.Williams@herefordshire.gov.uk

Appendix A

# Case Study for a Young Carer

## BACK GROUND HISTORY OF THE CASE

- The Young Person (YP) lives with her mother who has an aggressive form of Multiple Sclerosis (MS) and is in a wheelchair. Mother uses a frame to help her walk upstairs but she is very stiff and she has recently been assessed by the MS Team at Hereford Hospital as having MS to a severity of 7-8 out of 10.
- Mother has completed a week's course of Lemtrada treatment in Birmingham in June 2018 and is due to have this again in June 2019.
- Social care completed an assessment on 20th March 2018, following a MARF being received from Brookfield School with concerns around home conditions, mothers deteriorating MS and the child's presentation at school. The case is now closed to social care.
- The social worker referred the Young Person to the Young Carers Support Service (YCSS).
- The YP has Social, Emotional, and Mental Health (SEMH) difficulties and has an Education, Health & Care Plan (EHCP). She helps her mother by fetching drinks, wheeling mother next door to see her sister and other basic household tasks.
- Mother started to have carers attend the property 3 times per day following an adult social care assessment in March 2018 and this has taken some of the pressure away from the Young Person however, she still worries about her mother while she is at school/out with friends.
- Mother also has the support of the MS Nurse, a friend takes her shopping on a weekly basis and her grandmother attends daily to clean the house.

## IDENTIFIED NEEDS OF THE FAMILY

- Early Help Assessment (EHA) completed with the family
- The YP was attending primary school when FSW first became involved. There was concern that she would have to move from a specialist school to a mainstream school due to the specialist school only having males on role and it was deemed that she wouldn't cope well and given a place at the Specialist Secondary school, Brookfield.
- Mother has a lot of debt for different things e.g. non-payment of a TV License & Council Tax. This was spiraling further out of control each month. Some companies were wanting to take mother to court.
- Mother had put a claim in for Personal Independence Payment (PIP) but was waiting for a response.
- Wishes and feelings work to be completed with the Young Person- due to her mother's increasing disability.
- Referral to HOPE for Young person to socialise with other young people in a similar situation.

- Family didn't have a working cooker or washing machine.
- The YP started to self-harm at home and sometimes at school.
- The YP's general mental health due to her not eating at school or drinking or using the toilet.
- Mother had no way to get out of the flat if there was a fire and didn't want the fire brigade to attend for a safety talk.
- Road safety work due to YP being involved in a road traffic accident
- Internet safety due to YP's age and who she is associating with.
- A day in the life of a Young Carer work to be completed.
- Personal hygiene sessions with YP due to concerns about her presentation at school.
- Work with the carers around what the family need support with.
- Mother to gain more insight into parenting a teenager and how she can do this with her disability.

## WORK COMPLETED WITH THE FAMILY, OUTCOMES ACHIEVED & IMPACT

- Liaising with school, special education needs team and partner agencies to support YP remaining in Brookfield School for her secondary education.
- Addressing debt within the family home- contacting all organisations where Mum had debt and setting up a debt recovery plan with monthly payments being automatically collected from Mum's bank account. Mum then didn't have to worry about missing a payment.
- Supporting Mum to access with completing all paperwork linked to her PIP.
- FSW completed 1-1 sessions with the YP around self-harm and offered strategies to try and not self-harm e.g. a journal, drawing or using the NSPCC strategy of drawing a butterfly on your arm and the aim for that day is to keep the butterfly alive and not kill it by cutting.
- FSW took the YP to the GP on two occasions and this has proved helpful and the young person is slowly opening up about things at home and how she is worried about her mother. GP has stated that as long as YP is eating/drinking/toileting at home then there is no reason to refer to other agencies.
- Supported Mum to access the monthly MS Society lunch.
- FSW has completed a Day in the Life of this YP and been able to grasp a further understanding of the child's lived experiences and her worries.
- FSW has completed a number of sessions with Young Person around personal hygiene. Young Person is aware that she needs to shower daily, wash her hair every other day and put deodorant on after a shower. Young Person also now knows that she needs to change her clothes on a daily basis.
- FSW and YP also looked at a book together about what is happening to her young body e.g. periods, physical changes in her body, developing different feelings for boys/girls etc.
- Wishes and feelings work completed with the YP and showed that she was extremely worried about her mother being at home alone and also of her mother dying.
- FSW, Mother, YP and other family members have had discussions around a plan for when Mother dies. The plan is for the YP to reside with her Aunty.
- Referral to HOPE YP decided she didn't want to attend a group setting but wanted 1-1 support.
- FSW was able to find a charity that was generous enough to give the family some money towards a cooker and washing machine. This has helped the family enormously.
- FSW has organized an Occupational Health Therapist to complete an assessment of Mum to see if she was entitled to a stair lift. She was and this was fitted on 20th February 2019.
- FSW tested all smoke alarms within the house when a fire safety session occurred in Jan 2019.
- During the EHA meeting in December 2018 it was decided by school that there wanted to make a CDC referral, mother agreed and FSW made a referral for support with her sleeping.
- Internet safety work has been completed with both YP and mother using the CEOP resources online.
- Road safety work has been completed due to YP being injured in a road traffic accident.
- FSW supported Mum to create a list of the household chores she needed help to completed daily, weekly and monthly. It was a good activity where mother felt empowered to get the support she needs.
- FSW has completed a number of sessions around the Triple P parenting strategies with Mum and she is trying to implement these as best as she can.

## ACTIVITIES

The sessions with the family have been active sessions where we have attended meetings at school and all been in the car or FSW has taken the Young Person out for the morning and gone for a walk in Hereford and a coffee or been to look at different Christmas Lights within the local area at Christmas time.

Sessions with the Young Person have included making slime and completing games online around internet safety or supporting her with different topics at school.

Please see Young Persons statement attached for her views on having a FSW and the impact it has made on her and her mother's lives.

# Case Study for two Young Carers

## BACK GROUND HISTORY OF THE CASE

- Family of three who live in a small two bedroom property which does not meet mothers needs for her mobility condition.
- They were originally a family of four however, the eldest son was killed whilst serving in the British Army in Afghanistan. Due to this sudden and tragic death, the mother has a lot of mental health issues. As a family of four, they lived in a three bedroom house, due to mother's loss of earnings and the issues to do with her son's will, they had to sell their home and move in with the maternal Grandmother (MGM). The relationship between MGM and her daughter had been very difficult before the family moved in. MGM made the family homeless. Coming to Herefordshire Council as registered homeless they were given a property that could house them but didn't meet their specific needs.
- Mother's health is very poor and deteriorating. She has Fibromyalgia and Hyper mobility syndrome (Ehlers-Danlos) which is a soft tissue disorder and was diagnosed 20yrs ago with this - both conditions affect her mobility greatly. She now has Osteo Arthritis in her joints. She has subloxation where her joint pops and this tears soft tissue. She also has Oedema in her legs – where her legs fill with fluid. The best way to alleviate some of the discomfort is through elevation of legs helps this. She has a hiatus hernia and has liver issues.
- The family were referred to YCSS via Hereford Young Carers and the school where the boys attend. The referral stated that both boys look after their mother a lot at home due to her physical and mental health conditions. The boys were cleaning the home, doing the laundry, looking after the pets and cooking the family meals.
- Due to the family bringing most of their belongings from MGM's property to a much smaller home, the house was very full of clutter and many bags of excess clothes and household items. A large portion of these bags were put into the double bedroom and filled the room floor to ceiling, only allowing the door to be opened a fraction to get in. As mother finds it hard to get up and down the stairs she slept in the lounge and the boys shared a single room with bunk beds. The dining room table was also full of clutter so the family could not eat their meals together.

## INTERVENTION DELIVERED

- At the start of the intervention was to focus most of the FSW visits to support mother and sons to remove old items from the house which were not needed, grown out of or broken to make room for one of the sons to move into the double room.

- FSW supported mother to request a Fire Safety Check from the Fire Brigade to check the home and whether it was suitable for the family to live in.
- FSW spent a lot of time speaking with the boys 1:1 and building a rapport with them. Both have aspirations for future life to succeed in different fields of study, however both also felt they needed to remain at home to look after their Mum. FSW encouraged the boys with their aspiration and explained that as their mother's care needs became more personal then a professional carer would be needed.
- FSW ensured there was good communication with school as the eldest son felt the school were aware but unsympathetic to his role as a young carer – for example though knowing his duties at home, as he was in top set for all subjects there was an increased workload and amount of homework and he felt the school pushed him to keep at this top level.
- As mother had a lot of worries and concerns about life whether it was to do with her health, her sons' education, the memories of her eldest son, her housing issues and worries about the future, FSW would spend on average an hour just letting mother talk and help guide her to some outcomes or different points of view. Due to her mental and physical conditions she had a weight problem which she wanted to address so the FSW supported her to access the Healthy Lifestyles Trainer Service.
- Mother encouraged to look to move to more suitable accommodation. She had become low regarding the hope of going to a new place that she had long stopped looking and felt worried that though she had been told she was on a waiting list for a purpose built property, that if she moved somewhere else then she'd lose her place. FSW met with the Hospital Discharge Officer, the Housing Development Officer and the Housing Officer – Fortis Living to give mother clear communications regarding her housing status, where to look for new properties, when she can apply and importantly that she is still on the list for the purpose built property.

**OUTCOMES ACHIEVED**

- The double bedroom is now clear of clutter and the boys have their own bedrooms. This has meant they are getting along better and able to have better bedtime routines. Removing a lot of the clutter has allowed all the family to appreciate what they do have and to understand what they can take and will need to buy for the next property they move to.
- At time of writing case study, family are still waiting for Fire Brigade to book fire safety check.
- Both boys have been clear that they have felt the support invaluable in being able to talk with someone about their problems and how they felt about caring for their mother. Both have said they have a better understanding of their role as young carers and, through the conversations about routines and their tasks, they feel they are able to manage their time better. This better time management has enabled them to ensure they have some down time and has meant one can focus on learning the guitar and practice using music making software.
- Both boys are feeling better about school. School have helped the eldest son to drop French as an after school activity which has relived some of the pressure. The older of the two brothers is in year 11 and feeling more ready for his exams and relaxed about being able to study at home.
- They didn't have a public responsibility at the last Remembrance service at school as they said they wouldn't like to, but still sat holding their older brother's medals on the front row.

- Mother is still attending sessions with her Healthy Lifestyles Trainer and has decided to change the food the family eat to improve all of their health and wellbeing. Mother has ensured she is talking with her friends more about her feelings and is ready to call on her local support network of friends when needed.
- Though they are still living in a two bedroom property, mother is very enthusiastic about regularly searching for a more suitable property knowing that the family will remain on the list to have a purpose built property. The FSW has been in contact with the Housing development officer who has confirmed that there is a new build in Bromyard that will be ready in March which the family can bid on. The FSW has also supported mother to look on Rightmove for private rentals.
- The dining room table is now clean and the family can eat meals together.
- The FSW has spoken to the boys about activities. One likes to be in his bedroom playing computer and the other brother prefers to take part in after school clubs, be with his friends and walking the dog.
- A referral was made to for bereavement counselling to Phoenix but only limited support of one appointment was given. Another bereavement counselling service CRUISE is currently being explored.
- The FSW has supported the family with putting curtains poles up in the bedrooms and putting shelves up in the shed to store tins of paint that were originally housed on the stairs causing a danger and fire risk.

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Herefordshire Council

| | |
|---|---|
| **Meeting:** | **Children and young people scrutiny committee** |
| **Meeting date:** | **Tuesday 14 January 2020** |
| **Title of report:** | **Work programme 2019 - 2020** |
| **Report by:** | **Democratic Services Officer** |

## Classification

Open

## Decision type

This is not an executive decision

## Wards affected

(All Wards);

## Purpose and summary

To review the committee's work programme 2019/20 and agree the recommendations arising from the peer on peer spotlight review which took place on 16 December 2019.

The attached work programme was agreed at the meeting of the committee on 25 November 2019. Since this meeting a new item has been added to the meeting on 16 March 2020; to undertaken pre-decision scrutiny on the decision on a framework for young people's accommodation. Two items have been moved from the current meeting to the 16 March 2020 meeting: Review of performance and progress against the Safeguarding and Family Support improvement plan 2019/20; and Child Exploitation task and finish group – outcomes and recommendations.

## Recommendation(s)

**That the committee:**

**(a) reviews and agrees the 2019/20 work programme at appendix a and determines any additional items of business or topics for inclusion in the work programme;**

**(b) agrees the recommendations (appendix b) arising from the peer on peer abuse in schools spotlight review for submission to the executive; and**

**(c) notes the recommendation tracker in appendix c.**

Further information on the subject of this report is available from
Matthew Evans, Tel: 01432 383690, email: Matthew.Evans@herefordshire.gov.uk

## Alternative options

1. It is for the committee to determine its work programme to reflect the priorities facing Herefordshire. The committee needs to be selective and ensure that the work programme is focused, realistic and deliverable within existing resources. The committee needs to develop a manageable work programme to ensure that scrutiny is focused, effective and produces clear outcomes. Topics selected on the work programme should reflect issues of current importance facing children's services at Herefordshire council.

## Key considerations

### Work Programme

2. The work programme needs to focus on the key issues of concern and be manageable allowing for urgent items or matters that have been called-in. Should committee members become aware of any issue they think should be considered by the committee they are invited to discuss the matter with the chairperson, vice chairperson and the statutory scrutiny officer. The current version of the work programme is attached at appendix a.

3. Since the last meeting of the committee on 25 November a new item to the meeting on 16 March has been added; to undertaken pre-decision scrutiny on the decision on a framework for young people's accommodation. Two items have been moved from the current meeting to the 16 March meeting: Review of performance and progress against the Safeguarding and Family Support improvement plan 2019/20; and Child Exploitation task and finish group – outcomes and recommendations.

### Constitutional Matters

### Task and Finish Groups

4. A scrutiny committee may appoint a task and finish group for any scrutiny activity within the committee's agreed work programme. A committee may determine to undertake a task and finish activity itself as a spotlight review where such an activity may be undertaken in a single session; the procedure rules relating to task and finish groups will apply in these circumstances but the review is likely to be attended by all members of the committee and chaired by the chairperson.

5. The scrutiny committee will approve the scope of the activity to be undertaken by a task and finish group, the membership, chairperson, timeframe, desired outcomes and what will not be included in the work. A task and finish group will be composed of a least 2 members of the committee, other councillors and may include, as appropriate, co-opted people with specialist knowledge or expertise to support the task. The committee will appoint the chairperson of a task and finish group.

6. The committee is asked to determine matters relating to the convening of a task and finish group including the scope of the review to be undertaken, the chairperson, membership, timeframe, desired outcomes, what will not be included in the review and whether to co-opt any non-voting members to the group. Such co-optees could consist of individuals with valuable skills and experience that would assist a task and finish group to undertake a review (see below).

7. The peer on peer abuse in schools spotlight review took place on 16 December. The outcomes and recommendations from the spotlight review are attached at appendix b which the committee is asked to agree for submission to the executive.

### Co-option

8. A scrutiny committee may co-opt a maximum of two non-voting people as and when required, for example for a particular meeting or to join a task and finish group. Any such co-optees will be agreed by the committee having reference to the agreed workplan and/or task and finish group membership.

9. The Committee is asked to consider whether it wishes to exercise this power in respect of any matters in the work programme.

### Tracking of recommendations made by the committee

10. A schedule of recommendations in the current administrative council term is appended to this report as appendix c.

### Forward plan

11. The constitution states that scrutiny committees should consider the forward plan as the chief source of information regarding forthcoming key decisions. Forthcoming key decisions are available publically under the forthcoming decisions link on the council's website, as below:

http://councillors.herefordshire.gov.uk/mgDelegatedDecisions.aspx?&RP=0&K=0&DM=0&HD=0&DS=1&Next=true&H=1&META=mgforthcomingdecisions&V=1

### Suggestions for scrutiny from members of the public

12. Suggestions for scrutiny are invited from members of the public through the council's website, accessible through the link below. There have been no suggestions for scrutiny received from members of the public since the previous meeting of the committee.

https://www.herefordshire.gov.uk/info/200148/your_council/61/get_involved/4,

## Community impact

13. In accordance with the adopted code of corporate governance, Herefordshire Council is committed to promoting a positive working culture that accepts, and encourages constructive challenge, and recognises that a culture and structure for scrutiny are key elements for accountable decision making, policy development and review. Topics selected for scrutiny should have regard to what matters to residents.

## Equality duty

14. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

    A public authority must, in the exercise of its functions, have due regard to the need to -

    (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

    (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

15. The outcomes of the peer on peer abuse in schools spotlight review is attached to this report in appendix b. The committee is asked to agree the recommendations for onward submission to the executive. The response of the executive to the recommendations will need to give due regard to the council's public sector equality duty.

## Resource implications

16. The costs of the work of the committee will have to be met within existing resources. It should be noted the costs of running scrutiny can be subject to an assessment to support appropriate processes.

17. The councillors' allowance scheme contains provision for co-opted and other non-elected members to claim travel, subsistence and dependant carer's allowances on the same basis as members of the council. If the committee agrees that co-optees should be included in the membership of the spotlight review they will be entitled to claim allowances.

## Legal implications

18. The council is required to deliver a scrutiny function. The development of a work programme which is focused and reflects those priorities facing Herefordshire will assist the committee and the council to deliver a scrutiny function.

19. The Scrutiny Rules in Part 4 Section 5 of the Council's constitution provide for the setting of a work programme, the reporting of recommendations to the executive and the establishment of task and finish groups, as below.

20. Paragraph 4.5.28 of the constitution explains that the scrutiny committee is responsible for setting its own work programme. In setting its work programme a scrutiny committee shall have regard to the resources (including officer time) available.

21. Under section 4.5.10 of the constitution a scrutiny committee may appoint a task and finish group for any scrutiny activity within the committee's agreed work programme. A committee may determine to undertake a task and finish activity itself as a spotlight review where such an activity may be undertaken in a single session; the procedure rules relating to task and finish groups will apply in these circumstances. The relevant scrutiny committee will approve the scope of the activity to be undertaken, the membership, chairperson, timeframe, desired outcomes and what will not be included in the work. It will be a matter for the task and finish group to determine lines of questioning, witnesses (from the council or wider community) and evidence requirements.

22. Under section 4.5.19 of the constitution task and finish groups will report their findings/outcomes/recommendations to the relevant scrutiny committee who will decide if the findings/outcomes/recommendations should be reported to the cabinet or elsewhere.

## Risk management

23.

| Risk / opportunity | Mitigation |
|---|---|

| | |
|---|---|
| There is a reputational risk to the council if the scrutiny function does not operate effectively. | The arrangements for the development of the work programme should help mitigate this risk. |

## Consultees

24. The work programme is reviewed at every committee meeting and during business planning meetings between the Chairperson, Vice Chairperson and the Statutory Scrutiny Officer. The work programme attached at appendix a has been discussed at a work programming session of the scrutiny committees on 6 June 2019 and was agreed by the committee at its last meeting on 25 November 2019.

## Appendices

| | | |
|---|---|---|
| Appendix a | – | Work Programme 2019/20 |
| Appendix b | – | Amended scoping document for peer on peer abuse in schools spotlight review |
| Appendix c | – | recommendation tracker |

## Background papers

None identified.

**Children and Young People Scrutiny Committee**

**14 January 2020**

**Work Programme 2019/20**

| Meeting date: 15 July 2019– **1.00 p.m.** | | Despatch: 5 July | |
|---|---|---|---|
| Item | Description | Report Author | Form of Scrutiny* |
| Corporate Parenting Strategy – annual report | To consider the updated action plan to the corporate parenting strategy and receive a performance report against the objectives. | Gill Cox | Performance review |
| Adoption Service and Fostering Service annual reports | To receive the annual reports from the adoption and fostering services and consider the outcomes and recommendations. To make recommendations to the cabinet member on the operation of the services during 2019/20. | Gill Cox | Performance review |
| Work Programme 2019/20 | To agree the schedule of business for the children and young people scrutiny committee for 2019/20. | Matthew Evans | |
| **Briefing notes** | Update on the Herefordshire Children and Young People Mental Health and Emotional Wellbeing Transformation Plan 2015 – 2020 - CCG<br><br>New Safeguarding Monitoring Arrangements – To receive details of proposed safeguarding monitoring arrangements (replacing the HSCB in Herefordshire under new legislative provisions.<br><br>Outcome of internal audit review of section 20 arrangements and processes. | CCG<br><br>Liz Elgar<br><br>Internal Audit | |

| | | | |
|---|---|---|---|
| Meeting date: 16 September 2019 – **10.15 a.m.** | | Despatch: 6 September | |
| Accommodation based support service for care leavers | To undertake pre-decision scrutiny of the cabinet decision for an accommodation based support service for care leavers with complex needs. | Amy Whiles/Ewen Archibald | Pre-decision call-in |
| Youth Justice Plan | To endorse the Youth Justice Plan 2019/20 for approval by full Council and consider whether there are any comments the committee would wish to make that would inform the production of the Plan for 2020/21. | Keith Barham | Pre-decision call in of Policy Framework Item |
| **Briefing notes** | Multiagency panel relating to looked after children mental health services.<br><br>Introduction of the care leavers' covenant.<br><br>Supported housing for young people project referral levels. | Gill Cox<br><br>Gill Cox<br><br>Gill Cox | |
| Meeting date: 25 November 2019 – **10.15 a.m.** | | Despatch: 15 November | |
| Update on reducing the number of looked after children (LAC) | Updates concerning efforts to reduce the number of looked after children (LAC). | Liz Elgar | Performance Review |
| Budget and Medium Term Financial Strategy (MTFS) | To seek the views of the committee on the draft medium term financial strategy (MTFS) 2017-21 and the budget proposals for 2020-21 relating to Children and Families. | Andrew Lovegrove, Josie Rushgrove | Pre-decision call-in/Policy review and development |
| Review of performance and progress against the Safeguarding and Family Support improvement plan 2019/20 | To review progress against the improvement plan produced in response to the Ofsted Inspection of Local Authority Children's Services (ILACS) inspection judgement of June 2018 and the subsequent Safeguarding and Family Support division improvement plan 2019 / 2020. | Liz Elgar | Performance Review |
| Meeting date: 14 January 2020 – **2.00 p.m.** | | Despatch: 6 January | |

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|---|---|---|---|
| Budget, Medium Term Financial Strategy (MTFS) and Corporate Plan | To seek the views of the committee on the draft medium term financial strategy (MTFS) 2017-21, the budget proposals for 2020-21 relating to Children and Families and the corporate plan. | Andrew Lovegrove, Josie Rushgrove | Pre-decision call-in/Policy review and development |
| Young Carers Service | To consider an update report on progress with the implementation of the young carers service. | Nicky Turvey | Performance review |
| Peer on peer abuse in schools spotlight review – outcomes and recommendations | To receive the outcomes and recommendations of the peer on peer abuse in schools spotlight review. | | Policy review and development |
| Meeting date: 16 March 2020 – **10.15 a.m.** | | Despatch: 6 March | |
| School Examination Performance | To consider school performance of summer 2018 and make recommendations to cabinet on how the effectiveness of the school improvement framework and strategy could be enhanced. | | Performance review |
| Decision on framework for young people's accommodation | To conduct pre-decision scrutiny on developing proposals for a local contract framework for purchasing accommodation based services for care leavers and other vulnerable young people ahead of an intended key decision for in March/April 2020. | | Pre-decision call-in |
| Review of performance and progress against the Safeguarding and Family Support improvement plan 2019/20 | To review progress against the improvement plan produced in response to the Ofsted Inspection of Local Authority Children's Services (ILACS) inspection judgement of June 2018 and the subsequent Safeguarding and Family Support division improvement plan 2019 / 2020.<br><br>To include an update on work with West Mercia Police regarding referrals to the Multi-agency safeguarding hub. | Liz Elgar | Performance Review |
| Child Exploitation task and finish group – outcomes and recommendations | To receive the outcomes and recommendations of the child exploitation task and finish group. | | Policy review and development |

**Business to allocate in 2019/20** – Early Help Strategy – policy review and development item
– Elective Home Education (EHE) – Spotlight Review
– Speech and Language Therapy – task and finish group

***** *Pre-decision call-in, Performance review, Policy review and development*

[redacted]

# Spotlight Review Report

**Spotlight review concerning peer on peer abuse in schools**

**December 2019**

**Spotlight review concerning peer on peer abuse in schools**

Chairperson's Foreword

The children and young people scrutiny committee agreed that a spotlight review focusing on peer on peer abuse in schools was added to the committee's work programme for 2019/20.

We would like to place on record our thanks to all who contributed. The attendance at the spotlight review from a range of local partner organisation was excellent and I am grateful for the time and effort of the council's officers and all our local partners. I commend the quality of the presentations which provided a comprehensible and concise overview of some very complex areas. The quality of the presentations and the involvement of all those in attendance in the lively and constructive discussions allowed for a number of recommendations to emerge from the day.

I must also thank all those members of the council and the children and young people scrutiny committee who attended and contributed to the day including:

Cllr Paul Andrews, Cllr Christy Bolderson, Mr Pat Burbidge, Cllr John Hardwick, Cllr Kath Hey, Cllr Philip Howells, Mr Andy James, Cllr Peter Jinman, Cllr Mike Jones, Cllr Jeremy Milln and Cllr Diana Toynbee

Councillor Carole Gandy, December 2019
Chairperson of the Spotlight Review

1 Executive Summary

1.1 At its meeting on 15 July 2019 the children and young people scrutiny committee requested the convening of a spotlight review concerning peer on peer abuse in schools as part of the setting of its work programme priorities. The committee agreed to undertake this review due to reports of increasing levels of peer on peer abuse and public concern at schools in Herefordshire. At the following meeting on 16 September a scoping document for the spotlight review was presented. The committee proposed some amendments with final agreement given to the scoping document (attached as the appendix) at its meeting on the 25 November.

1.2 A number of partners and local agencies were invited to participate in the spotlight review and the following bodies and organisations were represented: Herefordshire Council; Public Health; West Mercia Police; Primary and Secondary schools in Herefordshire; West Mercia Rape & Sexual Abuse Support Centre (WMRSASC); The Children's Society; and Herefordshire Clinical Commissioning Group.

1.3 Presentations were provided are as follows (slides for the presentations are contained through the weblink below):

- Herefordshire Council presentation
- Public Health presentation
- WMRSASC

1.4 The full recording of the spotlight review and all presentations can be accessed through the webpage below:

http://councillors.herefordshire.gov.uk/ieListDocuments.aspx?CId=1087&MId=7561&Ver=4
,

1.5 The outcomes and recommendations from the spotlight review can be condensed into ten topics. The recommendations focus on:

1. School policies
2. DfE guidance
3. Herefordshire Council review of historic cases
4. Data collection of incidence of peer on peer abuse cases and national reporting
5. CLD Trust positive relationships training
6. Risk Assessments
7. Resource Pool for schools
8. Family support workers
9. Future meetings of the spotlight review
10. Council Policies

2. Composition of the Spotlight Review

2.1 All members of the children and young people scrutiny committee and any other member of the council expressing an interest. At the spotlight review 12 members of the council and co-optees of the children and young people scrutiny committee attended to contribute to discussions and the consideration of recommendations.

3 Context

Why did we set up the group?

3.1 The spotlight review was convened in order to:

- To receive data on the incidence of peer on peer abuse in Herefordshire schools;
- To learn of statutory guidance relating to peer on peer abuse and child protection policies in schools;
- To consider policies in place at schools to address peer on peer abuse and assess their effectiveness;
- To look at the role of the Council, the Police and voluntary/charitable organisations to assist schools, pupils and their parents
- To consider potential future initiatives and projects; and
- To inform a report to the children's scrutiny committee with potential recommendations relating to peer on peer abuse in schools.

What were we looking at?

3.2 A range of local partner organisations were invited to the review and they were asked to present evidence and detail of work with respect to peer on peer abuse in schools.

Who did we speak to?

3.3 The spotlight review engaged the following organisations in the discussions:

| **Organisation** | **Invitee** |
|---|---|
| Children and Families, Safeguarding and Education, Herefordshire Council | – Chris Baird, Director Children and Families<br>– Liz Elgar, Assistant Director Safeguarding and Family Support Children and Families<br>– Ceri Morgan<br>– Alison Naylor, Head of Learning and Achievement |
| Public Health | – Karen Wright, Director of Public Health |
| West Mercia Police | – DCI Jon Roberts, Herefordshire Local Policing Area |
| Secondary and Primary Schools | – Sian Alderton, Aylestone School<br>– Julie Rees, Ledbury Primary School<br>– Diana Pearce, St Francis Xavier RC Primary School<br>– Trixie Clarke/Serena Croad, John Kyrle High School<br>– Martin Henton/Pete Gibbins, Bishop of Hereford Bluecoat School |
| West Mercia Rape and Sexual Abuse Support Centre | – Jocelyn Anderson, CEO, WMRSASC<br>– Anna Coombs |
| The Children's Society | – Lucy Belcher, Service Manager – North, Prevention Programme, The Children's Society |
| Herefordshire Clinical Commissioning Group | – Rebecca Haywood-Tibbetts, Named Professional for Safeguarding |

What did we ask?

3.4 In order to undertake the review the lines of questioning below were proposed:

- What is peer on peer abuse and what are the different forms;

- What are the latest statistics for the incidence of peer on peer abuse in Herefordshire schools;
- What statutory guidance exists regarding the incorporation of peer on peer abuse in schools' child protection polices;
- What work does the Council undertake with Herefordshire schools to introduce peer on peer abuse policies;
- What preventative work is being undertaken to address peer on peer abuse;
- Are those policies that have been introduced in schools effective in addressing peer on peer abuse;
- Where a case of peer on peer abuse cannot be resolved at school how is it escalated or what is the course of action followed;
- How the police deal with incidents of peer on peer abuse and how they work with local schools;
- How other agencies including therapy and voluntary/charitable services assist schools, pupils and their parents?

## 4. Summary of our findings

1. School policies
2. DfE guidance
3. Herefordshire Council review of historic cases
4. Data collection of incidence of peer on peer abuse cases and national reporting
5. CLD Trust positive relationships training
6. Risk Assessments
7. Resource Pool for schools
8. Family support workers
9. Future meetings of the spotlight review
10. Council Policies

### 4.1 School Policies

The spotlight review heard that a number of schools had chosen to implement a separate policy to address peer on peer abuse in schools. The numbers of schools which had chosen to implement a separate policy was not available but it was hoped that in 2020 when a review of safeguarding policies had been completed all schools would introduce a separate policy. The spotlight review felt that in order to ensure consistency across Herefordshire, all schools should be encouraged to establish a separate policy regarding peer on peer abuse.

It was further felt that peer on peer abuse policies at schools in Herefordshire contain provision for children inside and outside of the criminal justice system and children under the age of criminal responsibility.

### 4.2 DfE guidance

The spotlight review questioned the guidance from the DfE concerning the separation of victim and perpetrator and whether it was felt to be adequate. The difficulty of ensuring there was no contact between victim and perpetrator was raised and the guidance concerning the potential return to a school of a perpetrator who had been convicted of a criminal offence. It was confirmed that the separation of victim and perpetrator did present a challenge but schools employed methods such as staggered start times and establishing safe areas at break times.

It was queried whether guidance should be amended to state that a perpetrator should be suspended or removed from a school if they were convicted or currently under investigation. It was explained that such guidance would require a change to exclusion rules however it was confirmed that if a pupil was convicted of rape or a serious sexual assault it was likely they would have breached school disciplinary policy and would be excluded from school.

The spotlight review heard that Keeping Children Safe in Education 2019 had assisted to provide better guidance regarding peer on peer abuse in schools and demonstrated that the issue was receiving prominence nationally. In producing a school policy for peer on peer abuse in schools the importance of learning from best practice was highlighted whilst retaining a focus on the contextual elements of each school.

The spotlight review felt that guidance from the DfE could be clarified to include greater detail regarding the separation of perpetrator and victim and that exclusion policies at schools should state explicitly the types of peer-on-peer abuse that could result in an exclusion. It was also felt that the likely consequences of committing peer on peer abuse should be outlined in schools disciplinary policies.

4.3 Herefordshire Council review of historic cases

The spotlight review requested details of the review of cases of peer on peer abuse referred to the multi-agency safeguarding hub (MASH) between 2017 and 2018 and when it was likely that the review would be concluded. It was explained that a systematic review would be taking place into how cases had been handled in the past and one outcome would concern if there was any need to change current processes. The review would be concluded by late February 2020 and there would be a report to the children and young people scrutiny committee. It was requested that the outcomes be presented to members of the spotlight review.
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4.4 Data collection of incidence of peer on peer abuse cases and national reporting

The spotlight review considered the data relating to the incidence of peer on peer abuse that was compiled from the multi-agency referral forms (MARF) submitted to the MASH. It was queried what reporting of ‘lower level’ peer on peer abuse incidents took place and how this data was compiled. It was explained that schools did not have to report lower level incidents therefore such statistics were not collected.

There was concern that without reporting of the full range of peer on peer incidents it was not possible to gain an accurate perspective of the scale of the issue. There was further concern that there were no national statistics regarding such a serious issue in schools and it was felt the DfE should be lobbied to establish a reporting method and data set for peer on peer abuse cases nationally.

The spotlight review felt that the council should work to compile the data in Herefordshire that was available and then analyse this data to determine where gaps existed. This would assist the development of a dataset relating to peer on peer abuse in schools in Herefordshire.

4.5 CLD Trust positive relationships training

The spotlight review referred to the CLD Trust (counselling/learning/development) and the valuable work they undertook in schools to promote healthy relationships between pupils. Ambassadors from the Trust visited schools to provide training on positive relationships and the spotlight review felt that schools should be encouraged to utilise this training. The promotion of positive relationships between pupils would complement efforts to address the incidence of peer on peer abuse cases in schools.
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4.6 Risk assessments

The spotlight review learned from the police that the CPS advice in cases of sexual abuse, where children are the suspects, is that they should be subject to a risk assessment to assist CPS decision-making in the case. This risk assessment was undertaken by children services in other area of the West Midlands but this was not advocated in Herefordshire because it was not a statutory responsibility for council and it was costly and time consuming. In Herefordshire it was explained that there was no route to obtaining the risk assessment prior to conviction. The CPS have demanded the AIM 2 risk assessment (a national level risk assessment for children at risk of sexually offending) which the youth offending service were trained to provide but not funded to undertake at the pre conviction stage.

The spotlight review learned that the West Mercia Rape and Sexual Abuse Support Centre had undertaken training to complete AIM 2 risk assessments. It was explained that the programme would shortly be updated to AIM 3.

The spotlight review felt that the provision and resourcing of the risk assessment required clarification and relevant partners should work together to achieve this.

4.7 Resource Pool for schools

The spotlight review heard from schools about the difficulties involved in addressing complex cases of peer on peer abuse that involved the police. It was explained that the role of schools was to educate and ensure the safety of pupils and during cases of peer on peer abuse it was important schools did not prejudice the work of the police. It was explained that access to advice from the council, health partners and the police was welcomed by schools. The spotlight review recognised the complex issues that potentially surrounded cases of peer on peer abuse in schools and suggested that consideration be given to establishing a pool of specialist resources that schools could access when addressing complex cases of peer on peer abuse.

4.8. Family support workers

The spotlight review heard from schools that the work undertaken by the family support team in schools with pupils was highly regarding and provided a valuable contribution to early help and preventative work. The spotlight review felt that the work of family support workers with schools should be assessed and whether there was provision in the service to make additional resources available to support this work.

4.9 Future meetings of the spotlight review

The spotlight review was minded to suggest further meetings of the spotlight review took place in due course to: consider responses to the recommendations raised; review new data that was available; assess the introduction of peer on peer abuse policies at schools; and consider the outcomes of the review into historic cases of peer on peer abuse and the lessons learned.

4.10 Council Policies

As a consequence of the prominence of the issue the spotlight review considered that Peer to peer abuse should be linked in to all relevant council policies.

5 Summary of Recommendations

From our findings, the spotlight review would like to make the following **12 recommendations** to the executive and ask that they are given appropriate consideration:

5.1 School Policies

**i) That the executive promotes to all schools in Herefordshire the implementation of distinct, stand-alone peer on peer abuse child safeguarding policies;**

**ii) That the executive works with all schools in Herefordshire to ensure that exclusion policies explicitly state the forms of peer on peer abuse that will result in permanent exclusion;**

**iii) That the executive works with all schools in Herefordshire to ensure that peer on peer abuse policies contain provision for children inside and outside of the criminal justice system and children under the age of criminal responsibility;**

5.2 DfE guidance

**iv) That the children and young people scrutiny committee writes to the department for education (DfE) to outline the comments of witnesses at the spotlight review concerning existing peer on peer abuse guidance for schools. In particular, correspondence should highlight the requirement for specific guidance for schools to develop their own peer on peer abuse policies. .**

5.3 Herefordshire Council review of historic cases

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**v) That the executive provides the outcome of the current review (including lessons learned) into cases of peer to peer abuse referred to the Multi Agency Safeguarding Hub (MASH) to the spotlight review and the children and young people scrutiny committee;**

5.4 Data collection of incidence of peer on peer abuse cases and national reporting

**vi) That the children and young people scrutiny committee write to the DfE to encourage the establishment of a national database on peer on peer abuse cases including data on:**

- **level 4 referrals to MASHs and convictions relating to rape, assault, assault by penetration and sexual assault; and**

- **'lower level' of seriousness cases to allow for information to be compiled on the scale and diversity of peer on peer abuse cases.**

5.5 CLD Trust positive relationships training

**vii) That the executive encourages all schools to invite the CLD Trust ambassadors to provide training on positive relationships between peers;**

5.6 Risk assessments

**viii) That the executive works with the Crown Prosecution Service and the West Mercia Youth Justice Board to clarify responsibility for the production of risk assessments for children attending court in peer on peer abuse cases and considers a suitable provider for risk assessments in future;**

5.7 Resource Pool for schools

**ix) That the executive considers the establishment of a pool of resources for schools to access to address complex cases of peer on peer abuse.**

5.8. Family support workers

**x) That the executive considers what extra resources can be committed to the work of family support workers with schools.**

5.9 Future meetings of the spotlight review

**xi) That the children and young people scrutiny committee agree further meetings of the spotlight review to consider a greater level of data to provide a more informed understanding of the scale and complexity of peer on peer abuse in Herefordshire.**

5.10 Council Policies

**xii) That the executive gives consideration to how to include reference to peer on peer abuse in relevant council policy (e.g. the children and young people plan);**

**Children and Young People Scrutiny Committee** Appendix

**Peer on Peer Abuse in schools Spotlight Review – Scoping Document**

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|---|---|
| Title of review | Peer on Peer Abuse in schools Spotlight Review |
| Scope | |
| Reason for review | The work programme of the children and young people scrutiny committee has identified the issue of peer on peer abuse to be considered at a spotlight review. Department for Education statutory advice[1] defines peer on peer abuse as consisting of (but not limited to):<br><br>• Bullying (including cyberbullying);<br>• Physical abuse such as hitting, kicking, shaking, biting, hair pulling, or otherwise causing physical harm;<br>• Sexual violence and sexual harassment;<br>• Sexting (also known as youth produced sexual imagery); and<br>• Initiation/hazing type violence and rituals.<br><br>There is a concern regarding reports of increasing levels of peer on peer abuse and this spotlight review will consider available data regarding the incidence of peer on peer abuse in all Herefordshire schools including primary, secondary and post-16 settings. The review will also assess the incorporation of peer on peer abuse into child protection policies. |
| Links to the corporate plan | The review contributes to the following objectives contained in the Herefordshire corporate plan and other key plans and strategies:<br><br>• Keep children and young people safe and give then a great start in life; and<br>• Secure better services, quality of life and value for money. |
| Summary of the review and terms of reference | Summary:<br><br>The review will receive data on the incidence of peer on peer abuse in Herefordshire schools. It will learn of statutory guidance relating to peer on peer abuse and child protection policies in schools. It will consider policies in place at schools to address peer on peer abuse and assess their effectiveness. It will look at the role of the Council, the Police and voluntary/charitable organisations to assist schools, pupils and their parents.<br><br>The review will ensure that a focus is retained on the experience of children and young people; to understand how work undertaken by stakeholders supports them, educates them, prevents incidents from occurring and seeks to change behaviour if it has occurred. |
| | Terms of Reference:<br><br>The spotlight review will: |

[1] Statutory Guidance for Schools and Colleges, September 2018

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|---|---|
| | • Receive a definition of and understand the nature of peer on peer abuse and consider latest statistics concerning its incidence in Herefordshire schools;<br>• Develop an understanding of recent statutory guidance and the requirement for schools to ensure that child protection policies include procedures to address peer on peer abuse.<br>• Examine selected child protection policies in place at Herefordshire schools to ensure that they take account of statutory guidance and contain procedures to hear the voice of the child.<br>• Receive evidence from teachers and school professionals on the challenge posed by peer on peer abuse and the introduction of polices designed to meet the challenge.<br>• Engage teachers and school professionals to assess the success/effectiveness of policies to address peer on peer abuse in Herefordshire schools.<br>• Develop an understanding of the role of the Council to: provide advice to schools on the production of peer on peer abuse policies; undertake preventative work; and raise awareness.<br>• Engage with West Mercia Police to understand how incidents of peer on peer abuse are dealt with and how the Force works with schools.<br>• Understand how other agencies such as therapy services and voluntary/charitable services assist schools, children and their parents. Witnesses for these sectors will be asked to present the voice of the child.<br>• To look at examples of best practice from other local authority areas and possible implementation in Herefordshire.<br><br>Membership:<br><br>- All members of the children and young people scrutiny committee<br>- Councillor Peter Jinman<br>- Councillor Jeremy Milln<br>- Councillor Christy Bolderson |
| What will NOT be included | • The examination of any individual cases concerning peer on peer abuse. |
| Potential outcomes | • An understanding of the current statistics and data in respect of peer on peer abuse;<br>• Assurance that the advice schools are receiving is compliant with statutory guidance; and<br>• Assurance that the Council is working with schools and local agencies to support the introduction of effective policies to address peer on peer abuse. |
| Key Questions | To consider:<br>• What is peer on peer abuse and what are the different forms;<br>• What are the latest statistics for the incidence of peer on peer abuse in Herefordshire schools;<br>• What statutory guidance exists regarding the incorporation of peer on peer abuse in schools' child protection polices; |

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|---|---|
| | • What work does the Council undertake with Herefordshire schools to introduce peer on peer abuse policies;<br>• What preventative work is being undertaken to address peer on peer abuse;<br>• Are those policies that have been introduced in schools effective in addressing peer on peer abuse;<br>• Where a case of peer on peer abuse cannot be resolved at school how is it escalated or what is the course of action followed;<br>• How the police deal with incidents of peer on peer abuse and how they work with local schools;<br>• How other agencies including therapy and voluntary/charitable services assist schools, pupils and their parents? |
| Cabinet Member(s) | Cabinet member children and families<br>Cabinet member housing, regulatory services and community safety |
| Key stakeholders / Consultees | Internal – Education (Children's and Families)<br><br>External – Schools in Herefordshire<br>– Herefordshire pupils and parents of children at schools in Herefordshire – through governing bodies<br>– West Mercia Police<br>– Therapy services |
| Potential witnesses | • Council officers in Education department at Herefordshire Council.<br>• Teachers and governing body representatives from schools in Herefordshire.<br>• Therapy services<br>• Voluntary/Charitable organisations<br>• CLD Trust – strong young minds<br>• Action for Change – c/o bhbs<br><br><u>Voice of the Child</u> – as part of the review: charities in attendance; the WMRSASC; student initiated work will be invited and asked to represent the voice of the child. |
| Research Required | • Trends and statistics relating to peer on peer abuse in Herefordshire;<br>• <u>Statutory guidance – child protection policies in schools</u>; and<br>• Peer on peer abuse policies for schools. |
| Potential Visits | |
| Publicity Requirements | Following the conclusion of the spotlight review, report back to the children and young people scrutiny committee. |

| Outline Timetable: | |
|---|---|
| *Activity* | *Timescale* |
| Confirm approach, Terms of Reference, programme of consultation/research/provisional witnesses/meeting dates | Committee meeting – 16 September2019 |
| Spotlight Review | Autumn 2019 |
| Present final report to Children and Young People Scrutiny Committee | 25 November 2019 or 20 January 2020 |

| Spotlight review members – All Members of children and young people scrutiny committee | |
|---|---|
| Chair | Councillor Diana Toynbee |
| Support Members | |
| Co-optees | Education co-optees on children and young people scrutiny committee |
| Support Officers | J Coleman<br>M Evans |

Appendix

**Schedule of Children and Young People Scrutiny Committee recommendations made and actions in response**

| Meeting | item | Recommendations | Action | Status |
|---|---|---|---|---|
| 15 July 2019 | Corporate Parenting Annual Update – 2018/2019 | RESOLVED: That:<br>• A briefing note is provided concerning the multiagency panel relating to looked after children mental health services;<br>• A briefing note is provided on the introduction of the care leavers covenant;<br>• A response is provided to the question relating to the implications of the national funding changes on A Levels undertaken by looked after children;<br>• A letter is sent to Herefordshire clinical commissioning group to seek clarification regarding the resourcing of the looked after children health team; and<br>• A briefing note is provided on SHYPP referral levels. | • Circulated on 3 October 2019<br>• Circulated on 3 October 2019<br>• Response circulated on 31 July 2019<br>• Letter sent to CCG on 31 July 2019<br>• Circulated on 3 October 2019 | Completed |
| | Fostering and adoption service annual reports 2018/19 | RESOLVED: That:<br>• The achievements in the adoption annual report and the compliments in the fostering report are recognised and the officers working in those | | Completed |

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| | | teams and carers of the council's looked after children are commended;<br>• A briefing note on proposals to increase the retention of foster carers and details of the training provided be provided;<br>• A letter is sent to the Wye Valley Trust (WVT) to request details of the provision of occupational therapists in Herefordshire; and<br>• A session is organised to look at case samples of how appropriate forms of care are determined for looked after children. | • Foster carers training programme circulated on 31 July.<br>• Letter sent to WVT on 31 July.<br>• Included in safeguarding training delivered to members of the Council. | |
| 16 September 2019 | Accommodation based support service for care leavers | RESOLVED: That the committee:<br>• supports the introduction of the accommodation based support service for care leavers;<br>• supports an ongoing review of the service to determine its effectiveness and possible replication in future; and<br>• requests that a site visit to the facility is arranged once completed. | Approved at cabinet on 26 September | Completed |
| | Youth Justice Plan 2019-2020 | RESOLVED: That the committee:<br>• Endorses the Youth Justice Plan for presentation to full Council; and<br>• Asks that an addendum is added to the report, in forthcoming years, providing up-to-date statistics. | Approved at full Council on 11 October | Completed |

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| 25 November 2019 | Review of budget and corporate plan proposals for 2020/21 relating to the remit of the children and young people scrutiny committee | RESOLVED: That the committee:<br>• Supports the planned investments for looked after children, edge of care and improving social care services and requests further information is submitted to the committee regarding proposals for these services; and<br>• Asks that a report concerning the dental health initiatives is provided to the committee setting out key performance indicators for the proposals. | | Completed |
| | Update on reducing the number of looked after children | RESOLVED: That the committee:<br>• Recognises the work that has been undertaken and the progress made in implementing systems to reduce the numbers of looked after children; and<br>• Asks that a report is submitted to a meeting in 12 months times which provides a breakdown of the progress made in regard of the 49 children identified for SGOs or reunification. | | Completed |
| | Review of performance and progress against the safeguarding and family support improvement plan | RESOLVED: That the committee notes the report and the improvements made since the previous quarter. | | Completed |

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|---|---|---|---|---|
| | 2019 / 2020 | | | |