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Date: Friday, 25 November 2016

Governance Support
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Torquay
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Dear Member

**POLICY DEVELOPMENT AND DECISION GROUP (JOINT COMMISSIONING TEAM) -
MONDAY, 28 NOVEMBER 2016**

I am now able to enclose, for consideration at the Monday, 28 November 2016 meeting of the Policy Development and Decision Group (Joint Commissioning Team), the following reports that were unavailable when the agenda was printed.

Agenda No	Item	Page
8.	Impact of Public Health England Guidance on Local Suicide Planning	(Pages 76 - 106)
10.	Torbay Children's Safeguarding Board Annual Report	(Pages 107 - 130)

Yours sincerely

Amanda Coote
Clerk

Agenda Item 8



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Meeting: Joint Commissioning Team
Policy Development and Decision Group

Date: 2 November 2016

Wards Affected: All

Report Title: Impact of Public Health England Guidance on Local Suicide Planning (Published October 25th 2016) on Torbay Council

Is the decision a key decision? No

When does the decision need to be implemented? n/a

Executive Lead Contact Details: Caroline Taylor, Director of Adult Social Services, Tor Hill House, Floor 1 South, Torquay, Tel: 01803 208949, email:

caroline.taylor@torbay.gov.uk

Supporting Officer Contact Details: Gerry Cadogan, Public Health Principal

1. Proposal and Introduction

The above guidance provides a local practice resource for suicide prevention. It includes a case study describing the work being undertaken in Torbay, and a Torbay Council Public Health Principal was consulted on early drafts.

The Government's National Strategy for England, *Preventing Suicide in England, a cross-government outcomes strategy to save lives* outlines two principle objectives: to reduce suicide in the general population and to provide better support for those bereaved or affected by suicide.

Following on from the national strategy, Public Health England has produced a document, 'Local Suicide Prevention Planning – a practice resource.

As identified in Appendix 1, the 2015/16 Suicide Audit, the numbers of suicides have been increasing over the years, and the rates for male suicide are amongst the highest in the South West, although recent data release indicates that we are less of an outlier.

The national Suicide Prevention Strategy has two key recommendations:

1. **Building a partnership approach;** Torbay Public Health has been working closely with the CCG, Police, Probation, Prison Services, Fire, private, community and voluntary sector, for a number of years. This relationship has become closer since we have included the Coroner in bringing a regional approach which is including councillors and MPs.
2. **Making sense of local and national data:** The suicide audit attached in Appendix 1 provides context to the suicide issues in the local area. Being a seaside/rural area, with areas of deprivation and rising divorce rates, and levels of debt, provide some, but not all, of the reasons why people choose to take their

forward thinking, people orientated, adaptable - always with integrity.

lives. Torbay Council Suicide Prevention Lead is also involved in Devon wide and South West wide data collection groups. However the trend and nature of suicides in Torbay is unique in that there is a slight increase in older people and many suicides take place at home in contrast to the number of suicides in public places occurring in North Devon.

3. **Developing a Suicide Action Plan and Strategy:** There has been a Torbay and South Devon Action Plan in place since September 2015 (author G.Cadogan). The South Devon aspect of this was agreed by Dr Virginia Pearson (Devon DPH). There has been national recognition given to the prevention work that is occurring with the private and voluntary sector in Torbay (Faculty of Public Health award, national and local BBC TV and radio, invitations to talk and write nationally and internationally). This interest has not been mirrored in Torbay, and so together with the Coroner's support we are leading the work regionally to develop a shared awareness and ownership at the highest level of organisations in Devon and Cornwall. This reflects the aims of the new guidance. An initial meeting occurred at the Coroner's Court and a follow up meeting is being hosted by the Chief Fire Officer at his HQ on January 24th 2017. .

2. Reason for this paper

Progress in relation to the new Public Health England (PHE) guidance: *Local Suicide Prevention Planning-a practice resource*

There are six areas for action identified in the PHE October Guidance:

- 1 **Reduce the risk of suicide in key high risk groups:** Torbay has won national recognition in relation to the work that has been undertaken with men in different settings (barber shops, boxing clubs, pubs, service veterans' groups, and other places where men meet). Good practice in Torbay has been included in the Public Health Guidance itself, and is soon to be published in the Primary Care journal.
- 2 **Tailor approaches to improve mental health in specific groups.** Torbay Public Health and Childrens' Services Childrens' Leads have been undertaking work in schools with young people. Healthwatch Torbay has been supporting Public Health Adult Mental Health lead in undertaking awareness work with the public. This overlaps with work being undertaken in 1 above.
- 3 **Reduce access to the means of suicide.** This is a challenge as most suicides in Torbay and South Devon occur at home. Funding has been obtained from Health Education England to train trainers in delivering Applied Suicide Intervention Skills Training (ASIST) and twelve courses have been undertaken in Torbay/South Devon this year. These raise awareness of the risk factors for suicide in order support family friends and the community in suicide prevention.
- 4 **Provide better information and support to those affected or bereaved by suicide.** There is currently a gap in service provision here in Torbay but ASIST courses and further promotion of Mental Health First Aid courses provides some input to this. We are currently working with the police to develop a proposal to put to the PCC in relation to this.
- 5 **Support the media in delivering sensitive approaches to suicide and suicidal behaviour.** Torbay Communications Team has been very supportive and discussions have been held with the local media but reporting processes, despite guidance and information on sensitive reporting, is dependent on the

journalist and the publication. Torbay continues to work with national colleagues to address this.

- 6 **Support research, data collection and monitoring:** Torbay Public Health is leading the way in terms of the undertaking and reporting of the outcomes of suicide audits since 2009. It is also working with partners such as the police, Network Rail and Devon and Somerset Fire and Rescue Service in developing an overall picture in the Devon and Cornwall area. Submissions have been presented to the Health Select Committee Enquiry into suicide prevention, and invitations to talk at conferences nationally and internationally highlight the work of Torbay in developing data collection processes and undertaking work to address the outcomes.

Conclusion: Torbay Public Health has received national recognition for the good practice in raising awareness and developing community responses to suicide awareness and prevention. This complements the guidance recently produced by PHE in October 2016. There is a requirement for this work to be continued in order to develop on this and embed suicide prevention in local policies and procedures, and in awareness training for staff and Council employees.

Recommendation:

That the report be noted.

Appendices

Appendix 1: Torbay and South Devon Suicide Audit 2015/16

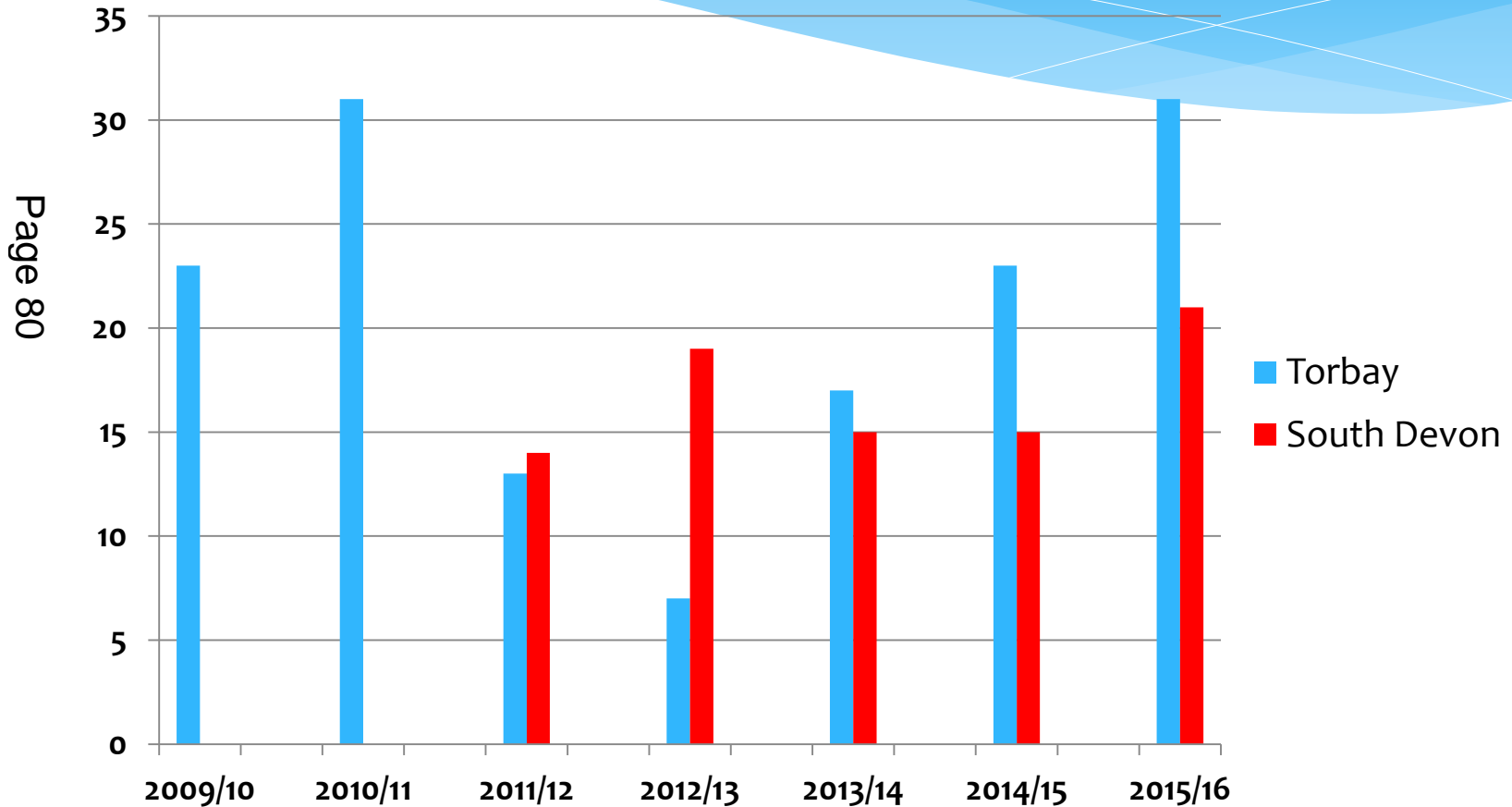


Draft Suicide Audit 2015/16

Torbay and South Devon

Gerry Cadogan
Public Health Principal
Public Health Torbay

TREND IN SUICIDE NUMBERS FOR TORBAY AND SOUTH DEVON

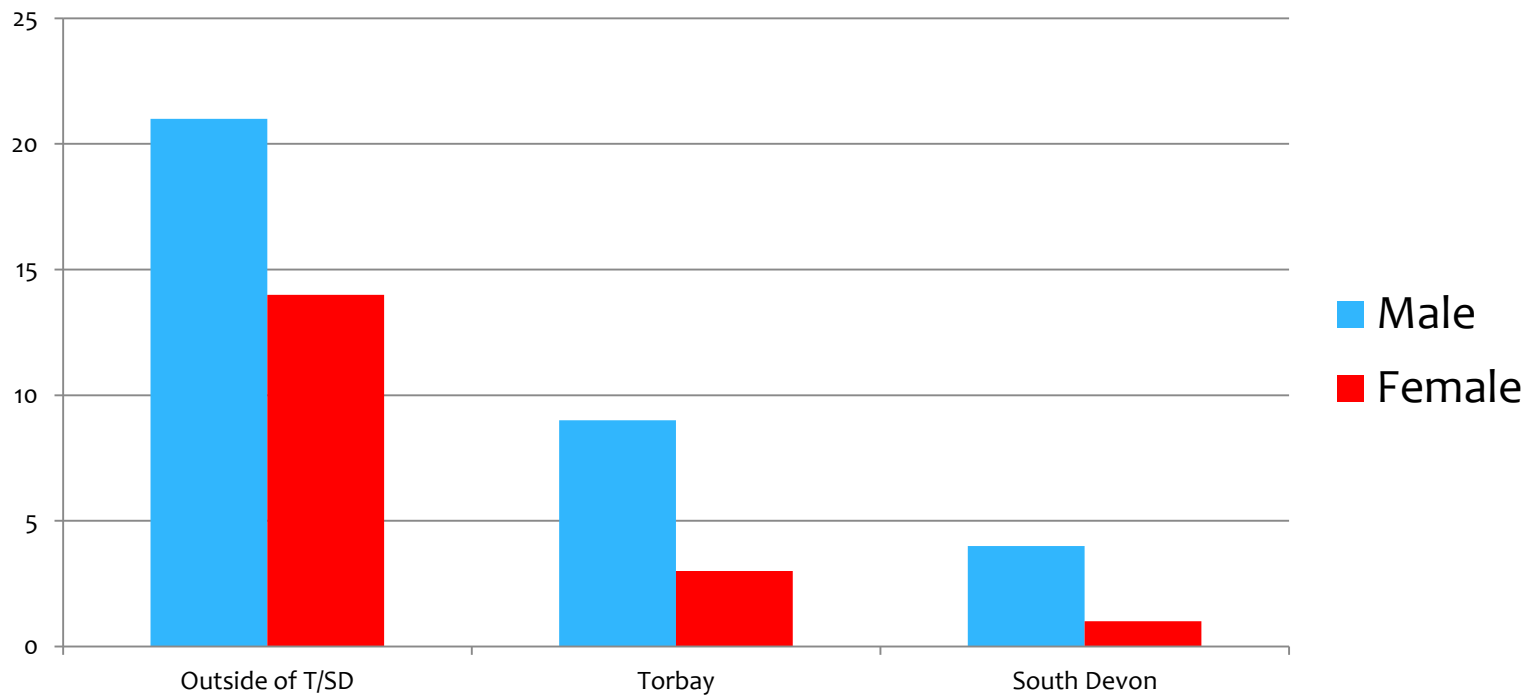


Place of birth 2015/16*

(T/SD: Torbay / South Devon)

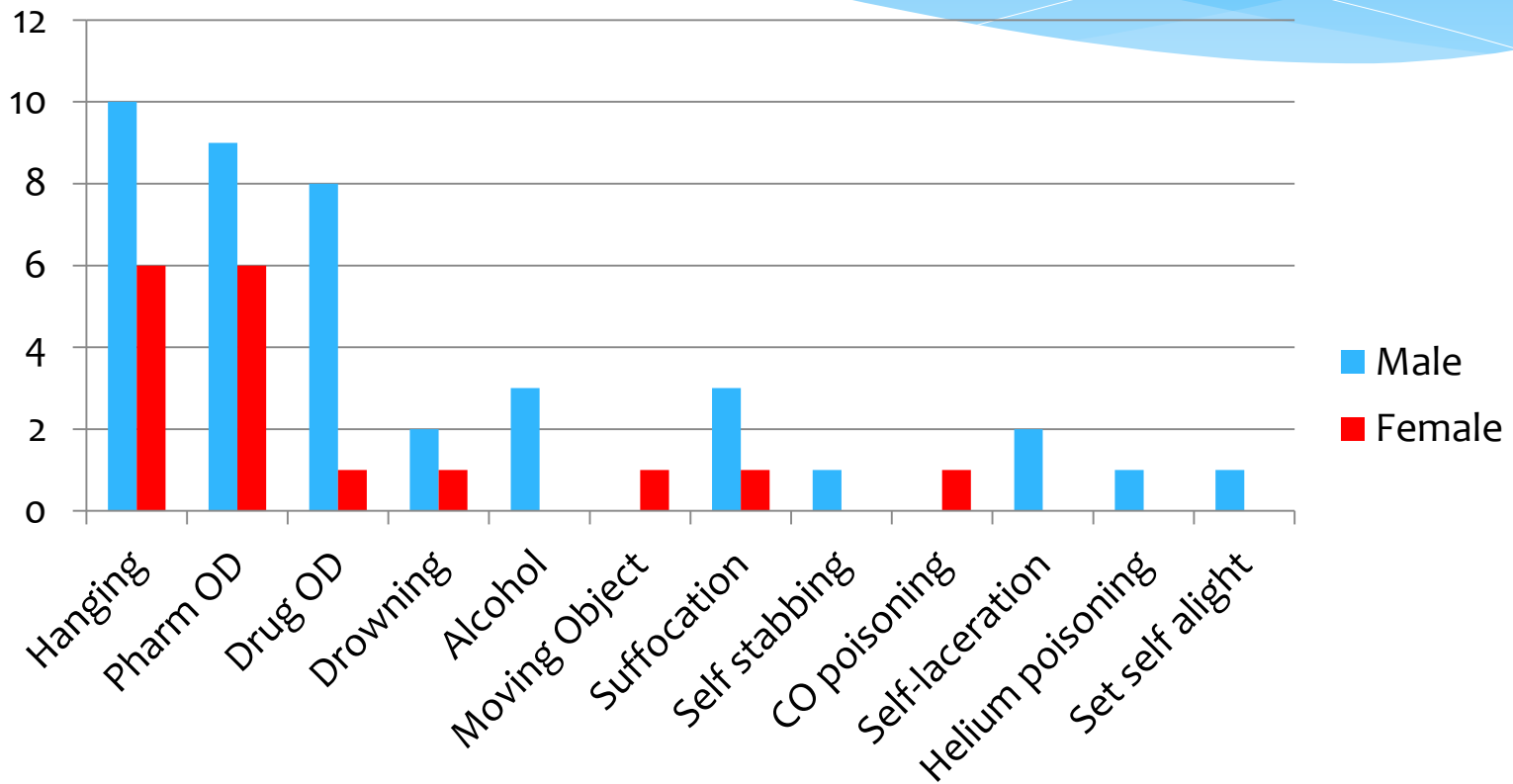
* but lived in T/SD for more than 10 years

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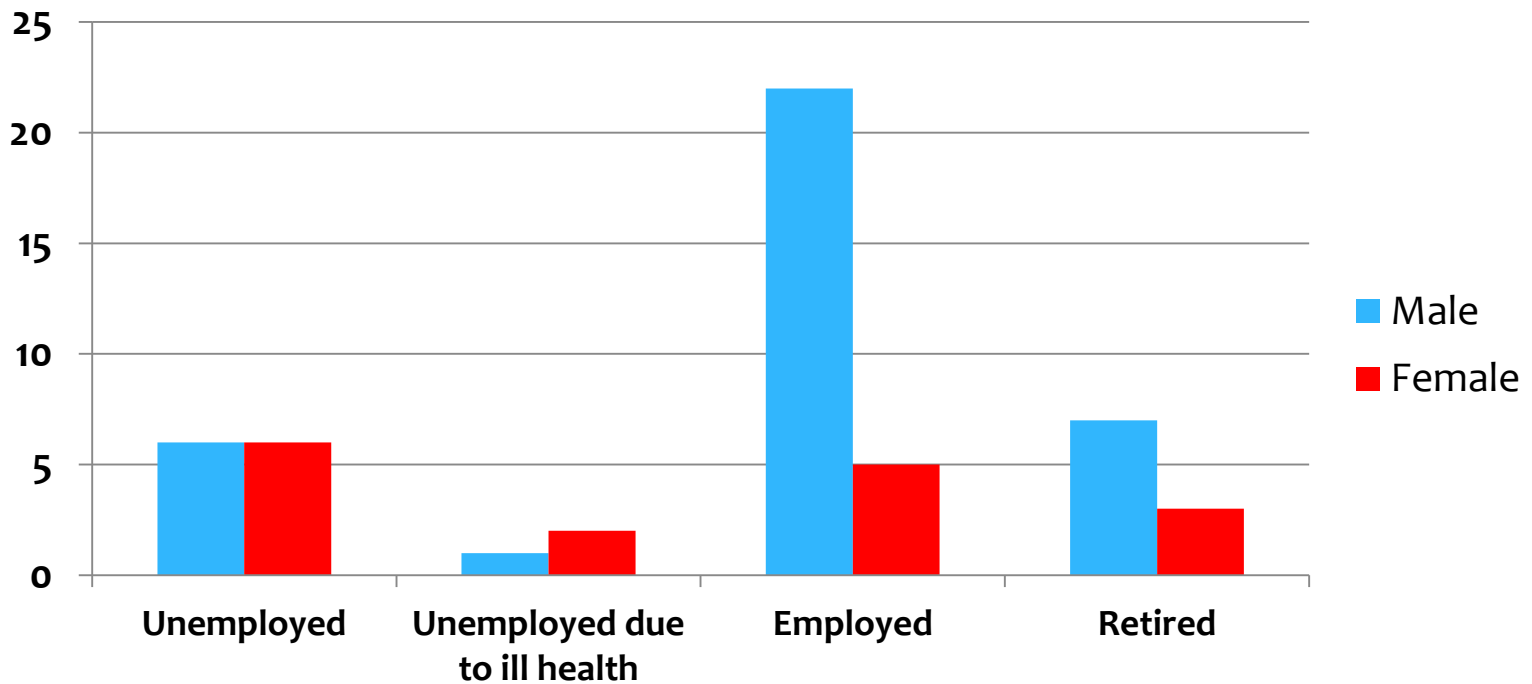
Method of Suicide 2015/16

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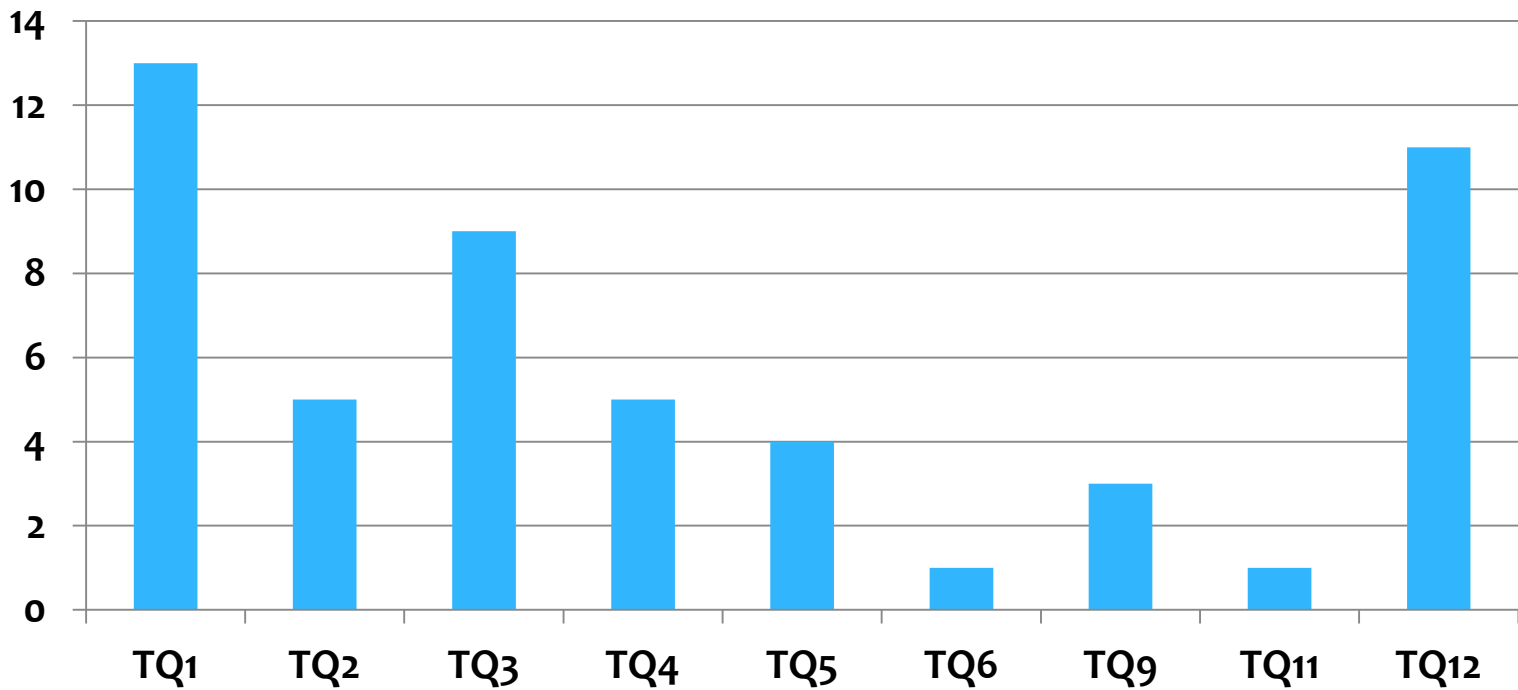
Employment Status 15/16

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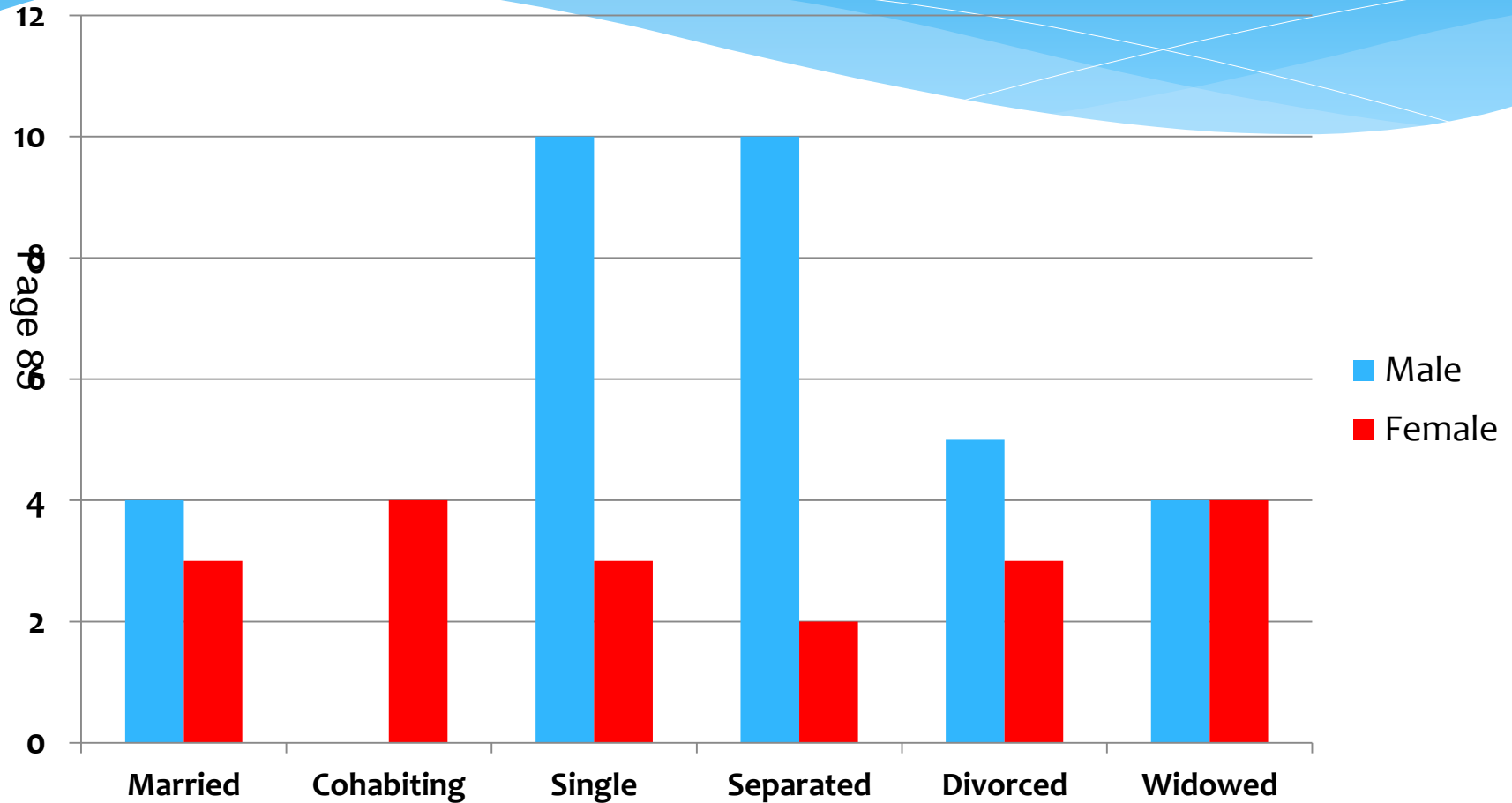


Suicide by Postcode 2015/16

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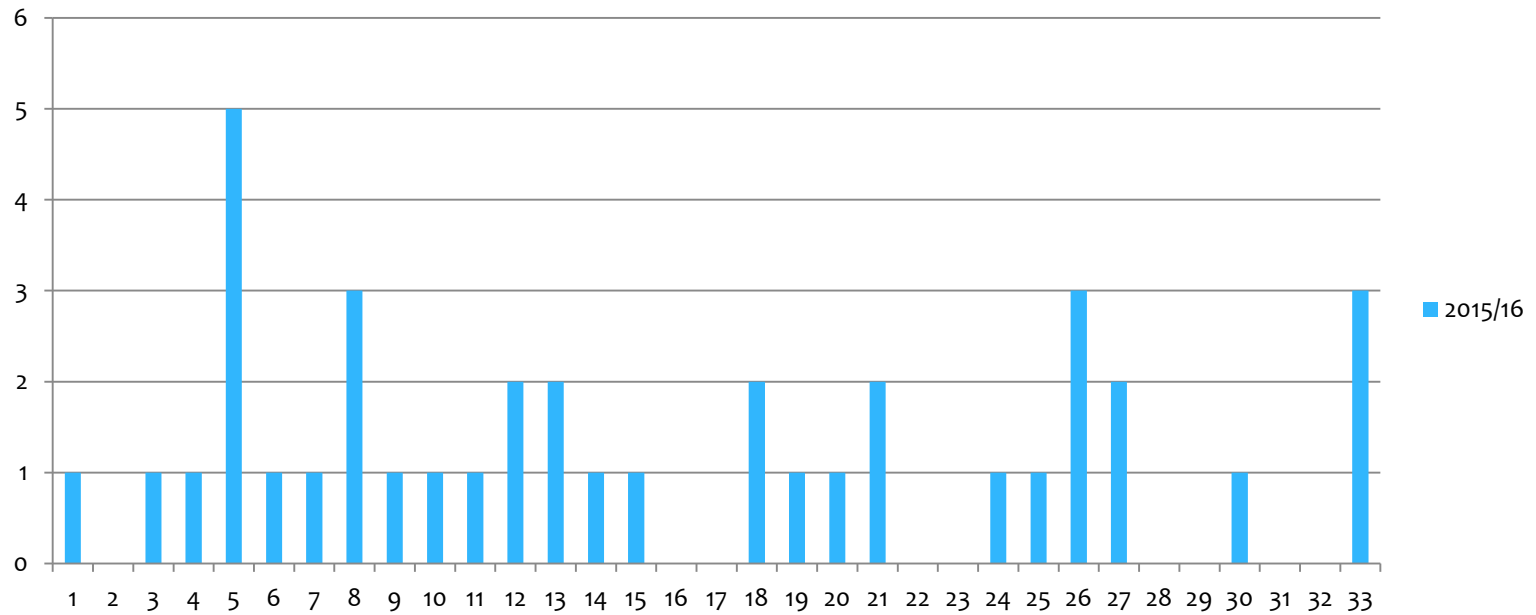
Relationship status 2015/16



SUICIDES BY GP PRACTICE 2015/16

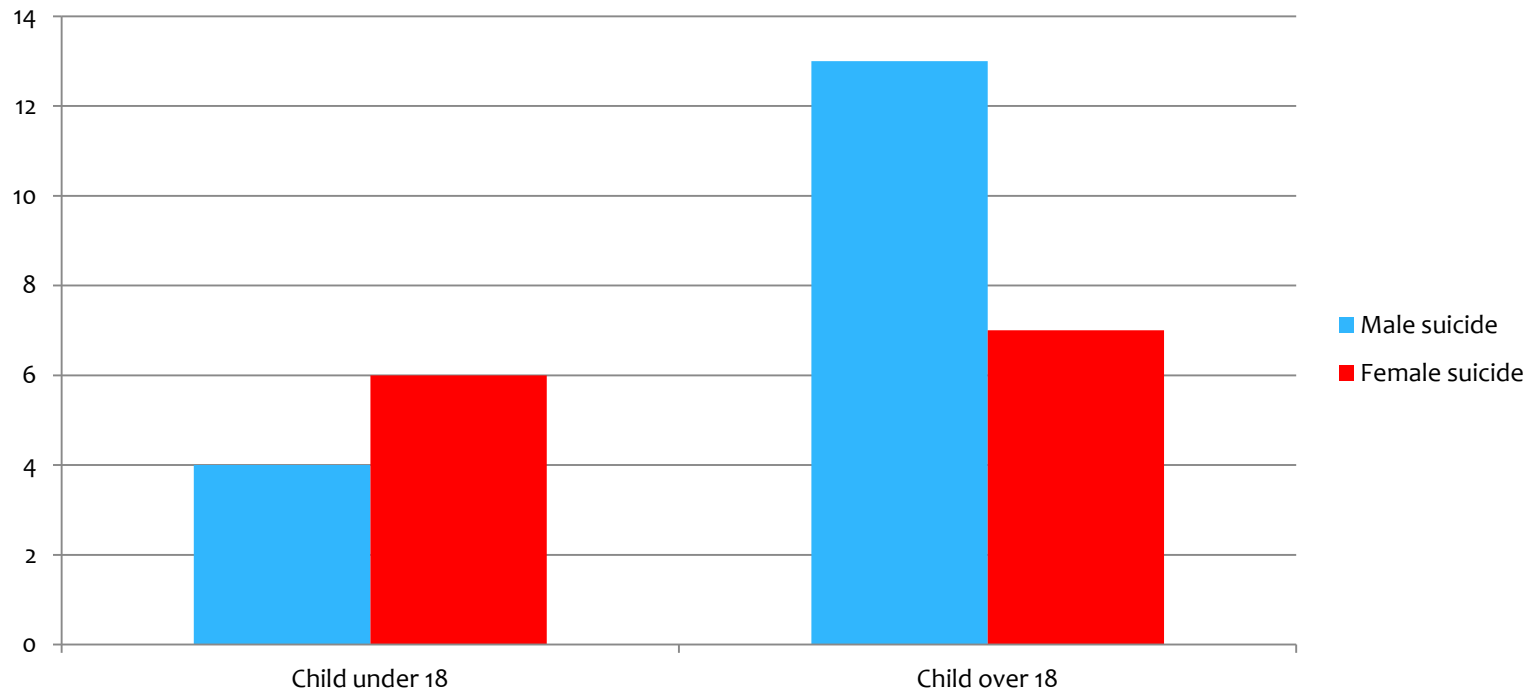
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SUICIDES BY GP PRACTICE 2015/16



Children left behind by Male and Female suicides 2015/16

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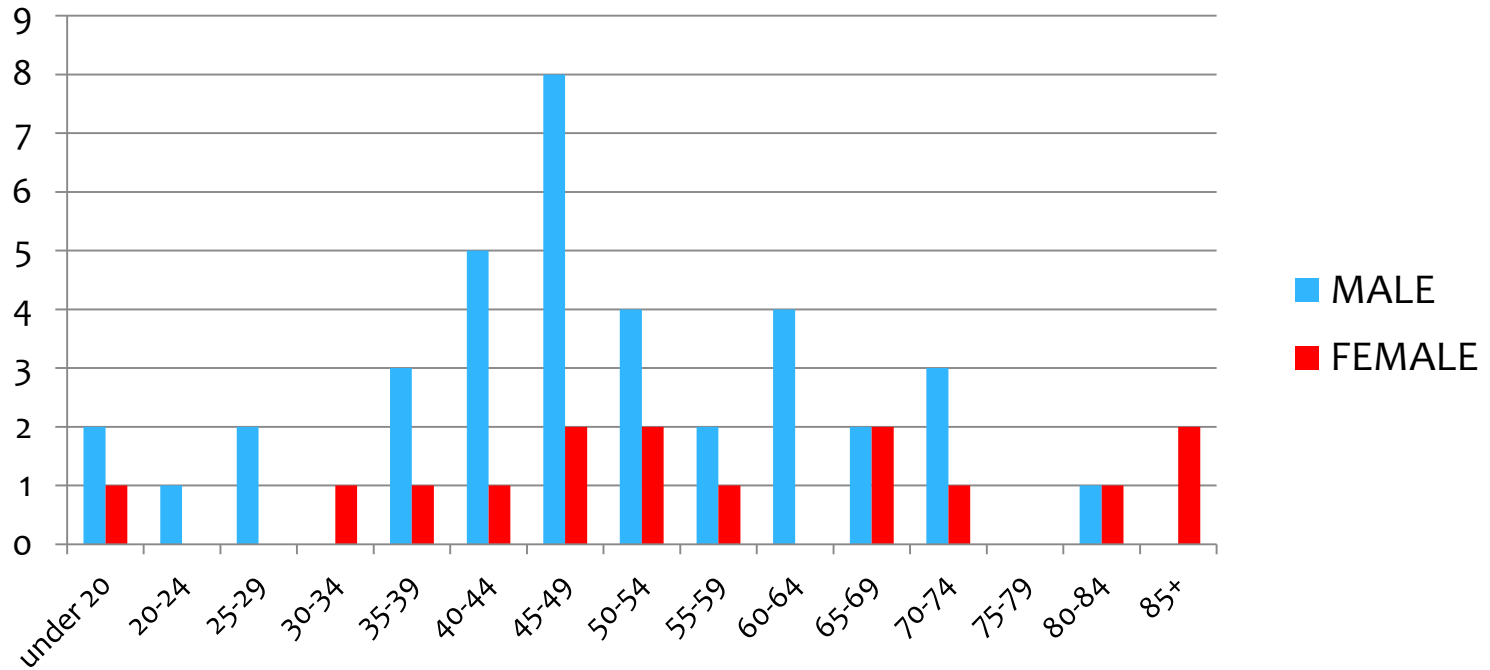


Drugs used in Suicide 2015/16

DRUG	MALE	FEMALE
Citalopram		1
morphine/oxycodone/amitryptilline /nortryptilline	1	
Paracetamol/codeine/co-codamol	1	
co-codamol and amitryptilline	1	
Pramorph	1	
Methadone/amitryptilline/tramadol		1
Legal highs plus asthma drugs		1
Methotrexate and zopiclone		1
oxycodone/amitryptilline		1
amitryptilline and nortryptophan	1	
legal highs and amitryptolline	1	
propranolol and alcohol		1
Amitryptilline ,codeine ,aspirin, alcohol	1	
Codeine linctus	1	

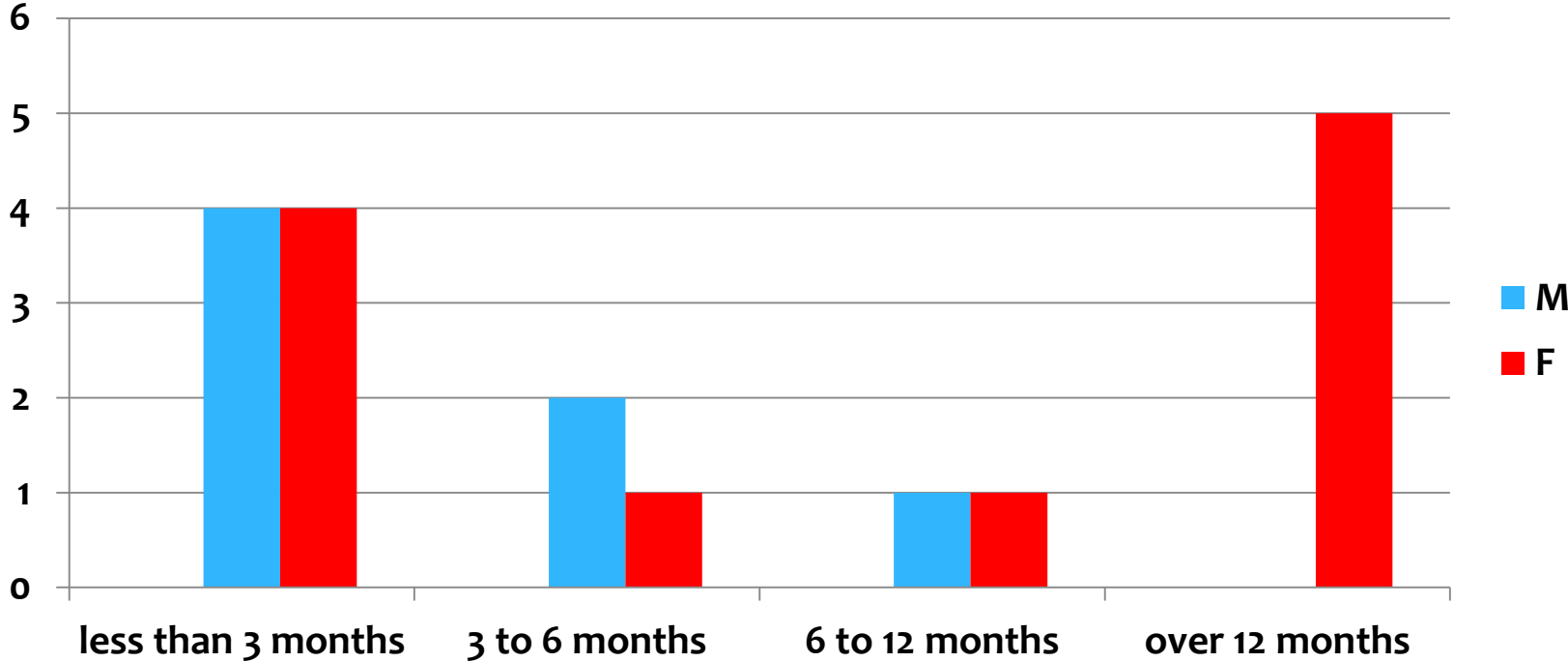
Age Range: Suicides 2015/16

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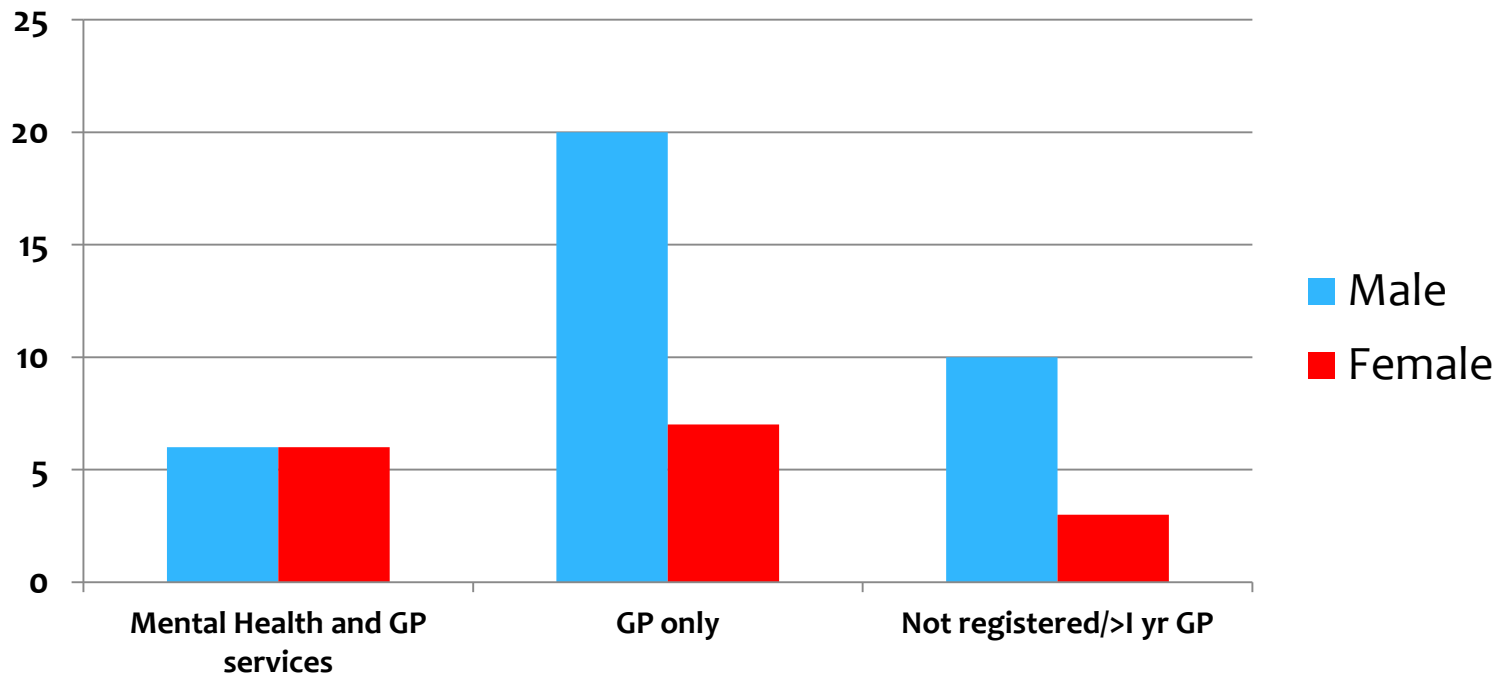
Last Contact with GP (if known) where depression/suicide ideation reported

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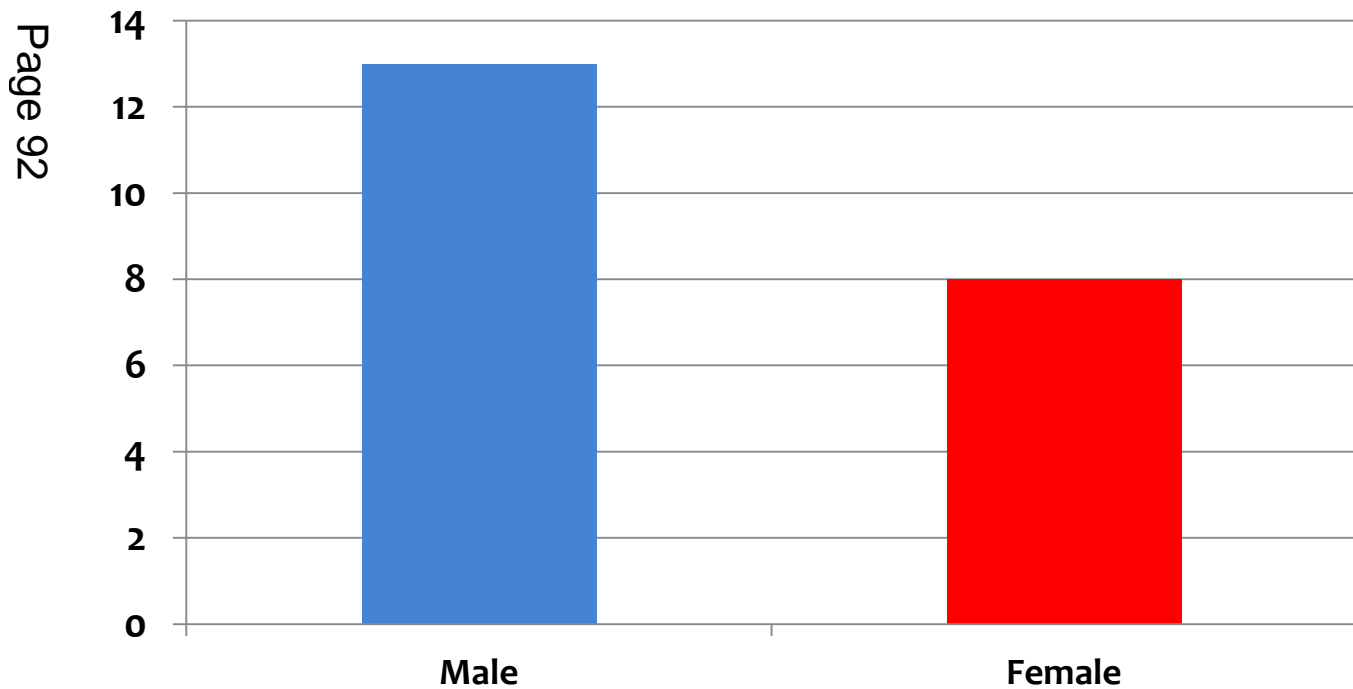


Contact with Mental Health/GP Services

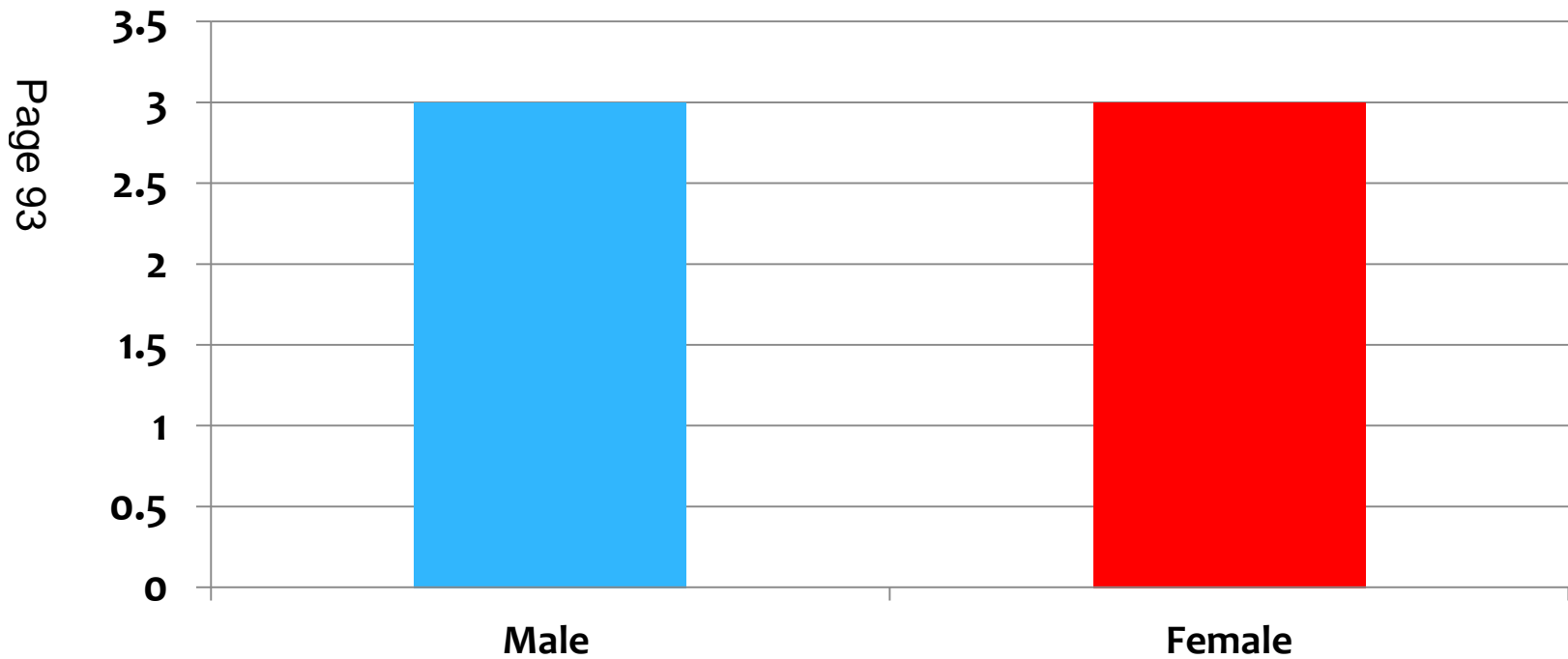
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Previous Suicide attempts/Self-Harm episodes

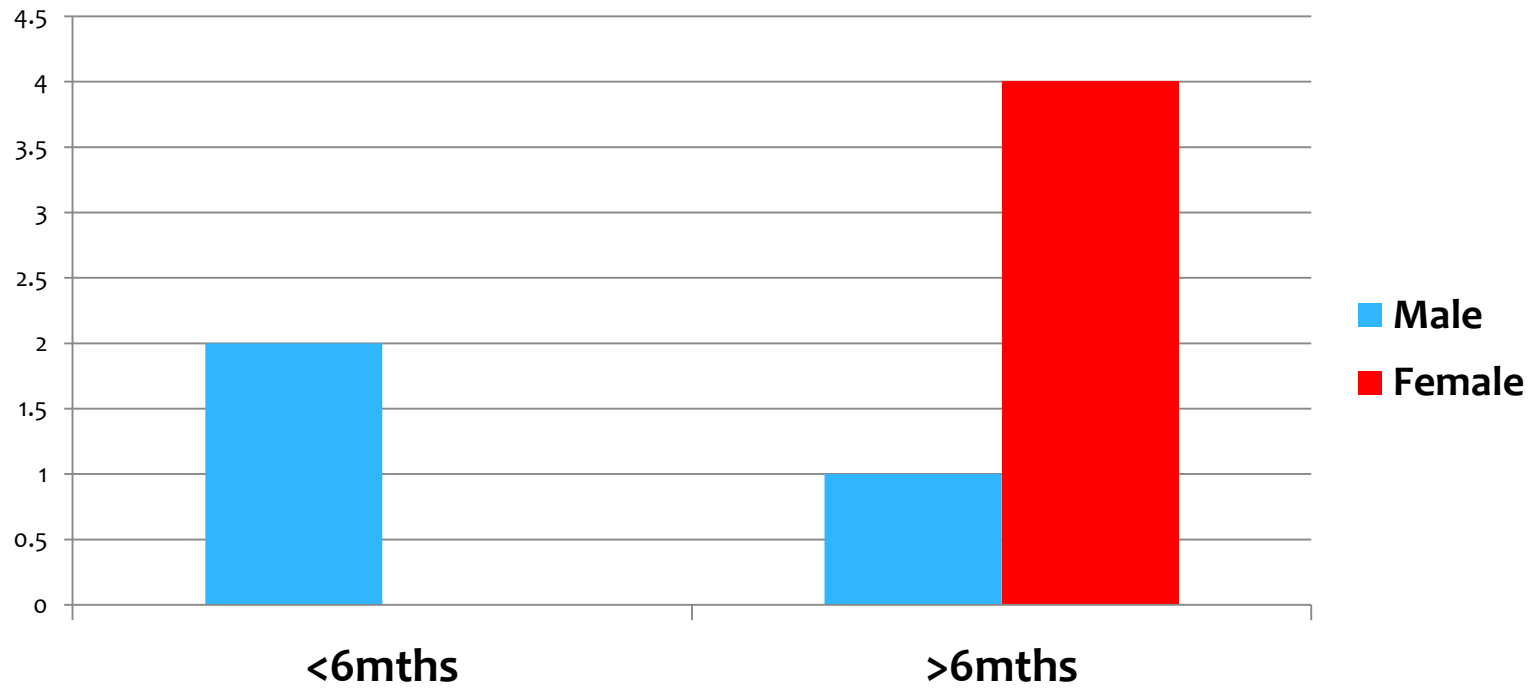


Previous Police Involvement (< 1 year)



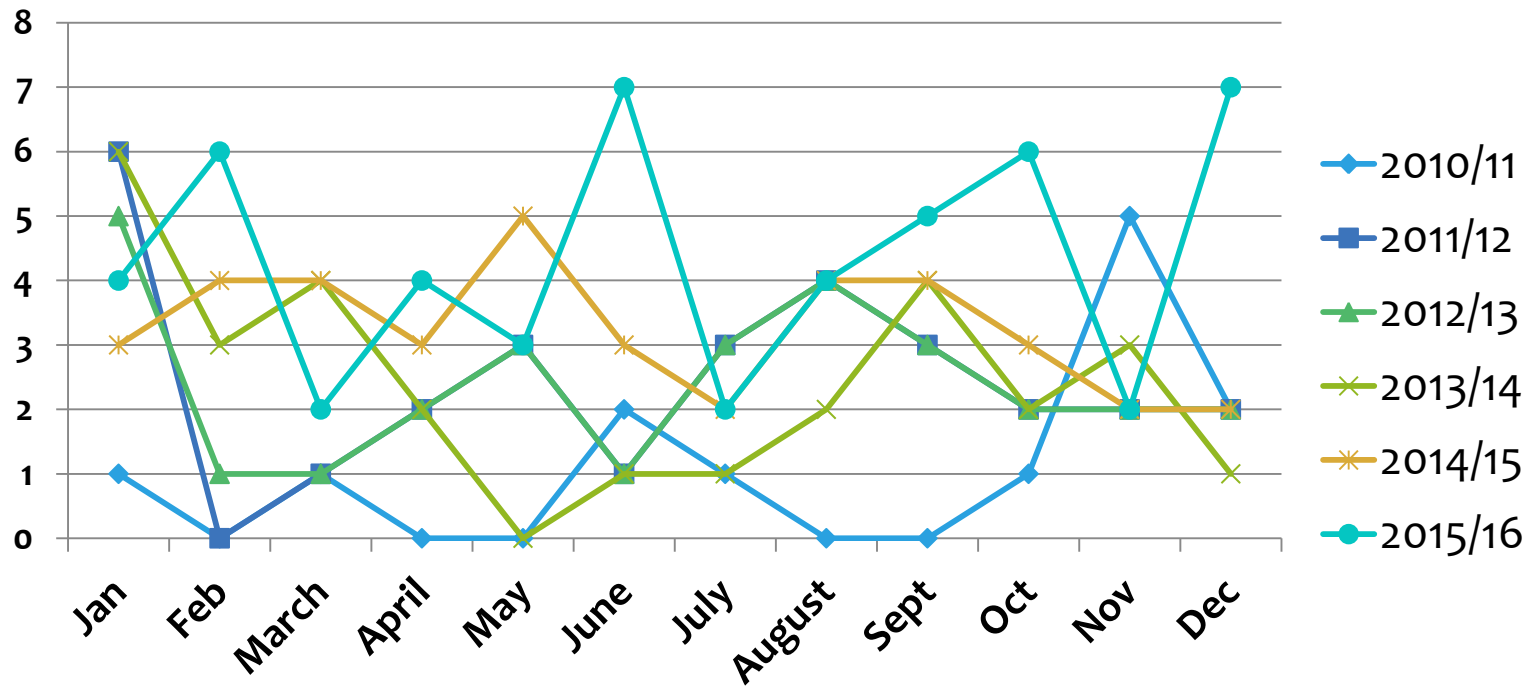
Previous ED contacts prior to death

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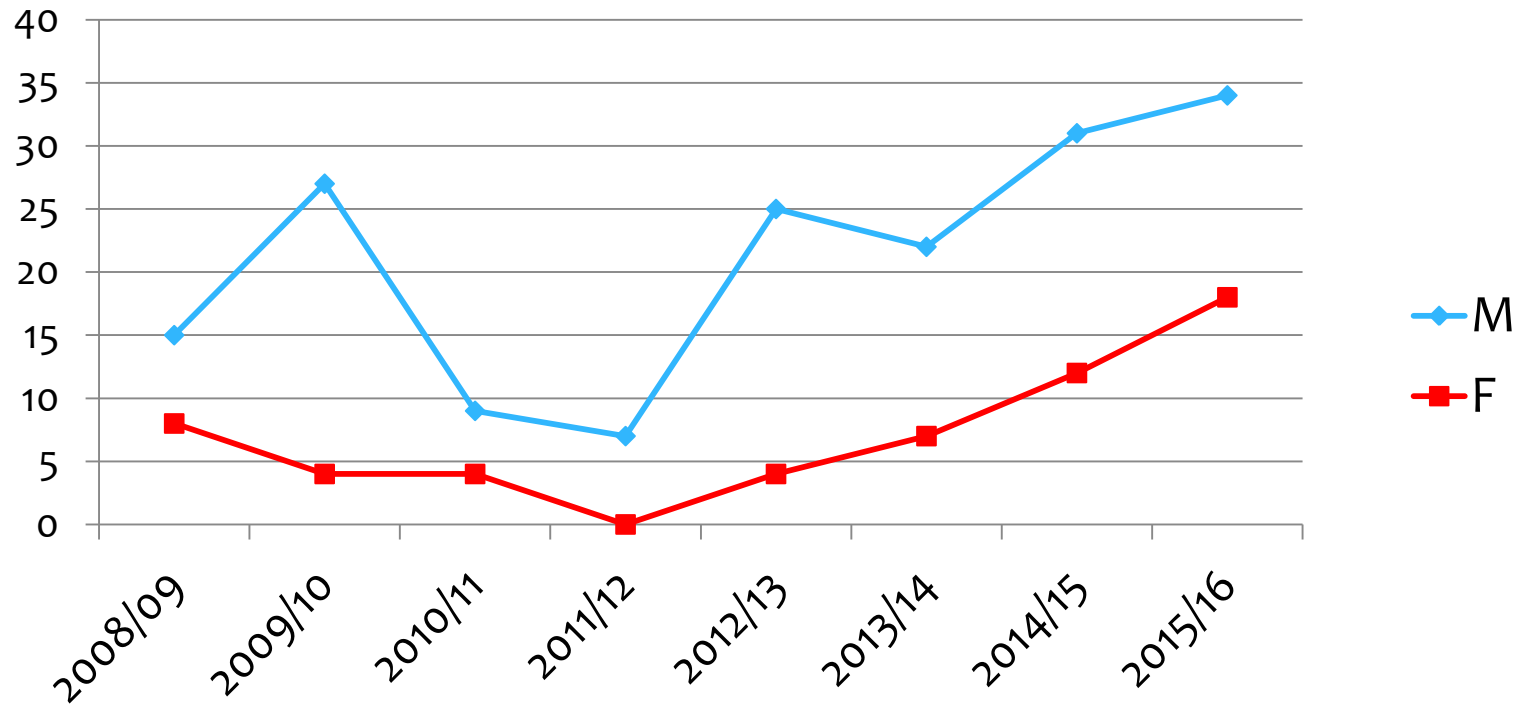
Suicide trends 2011 to 2016

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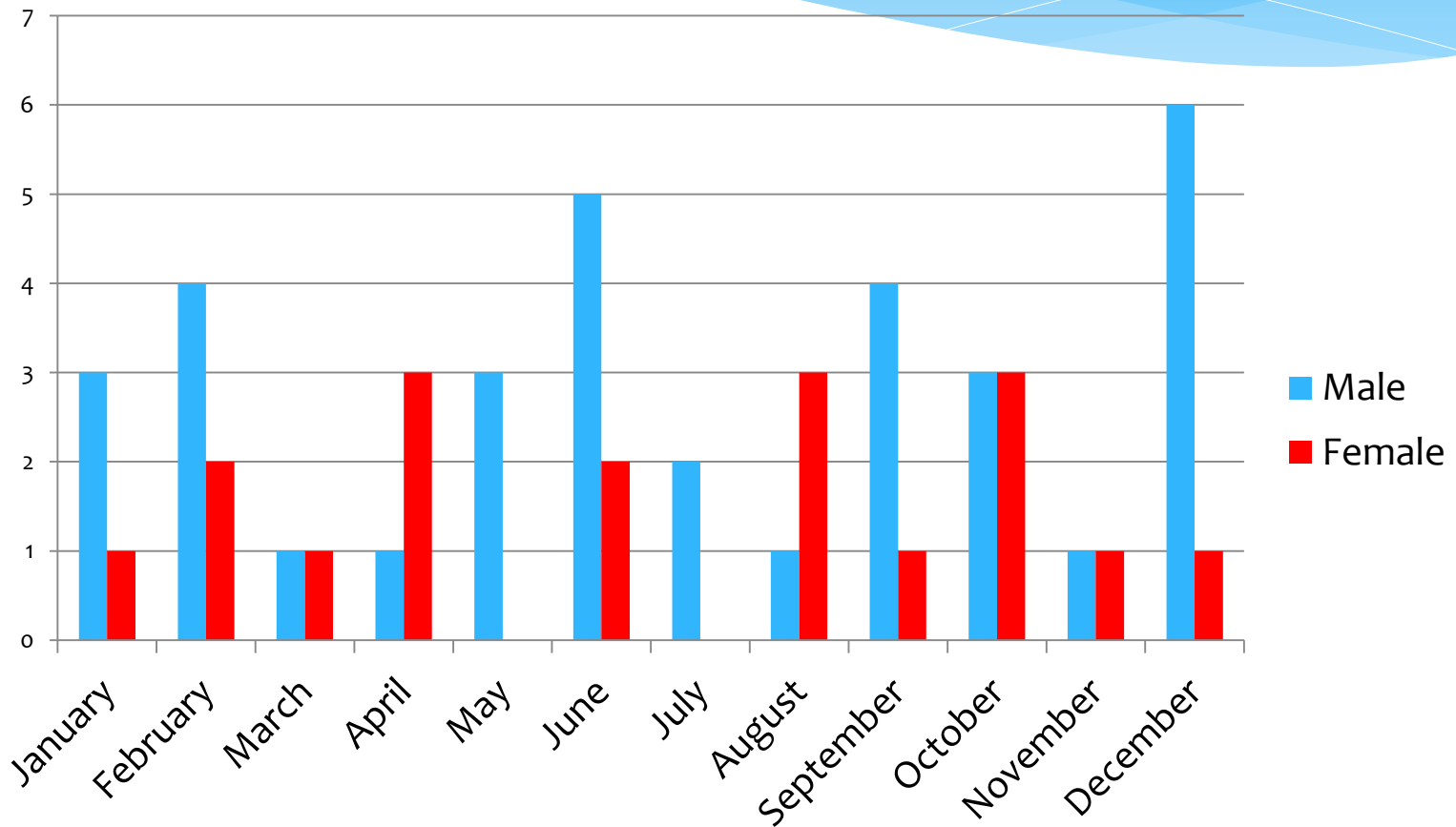
Suicide by Gender from 2008 to 2016

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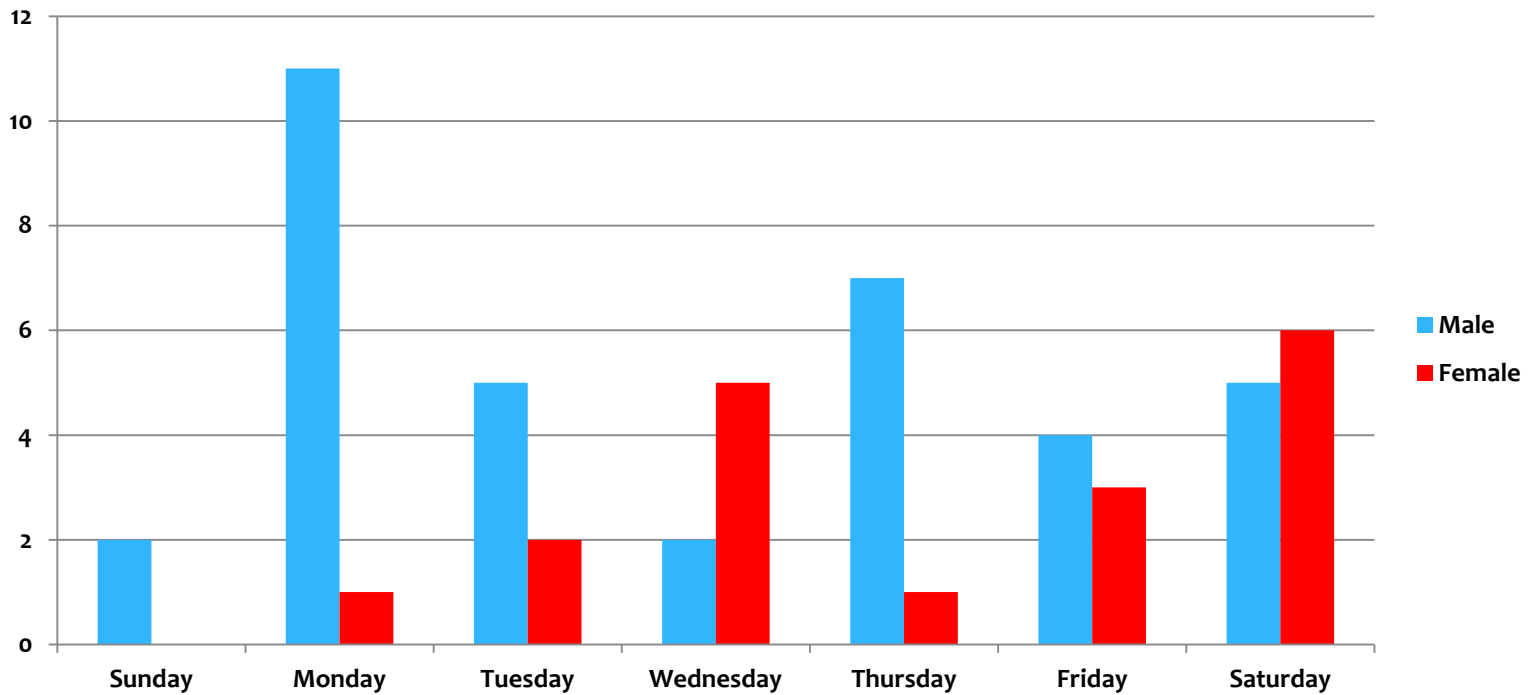
Suicide by month 2015/16

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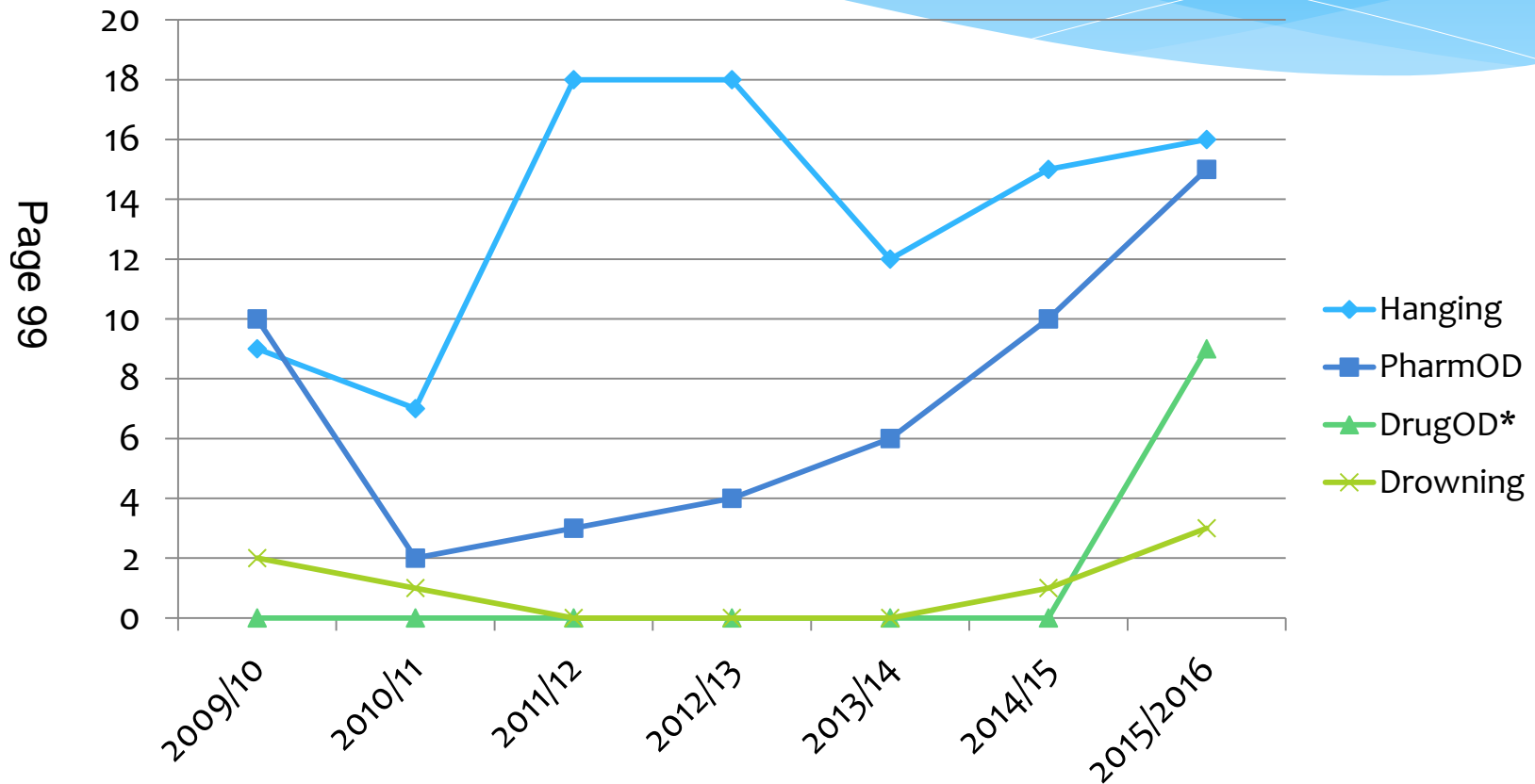
Suicide by Day 2015/16

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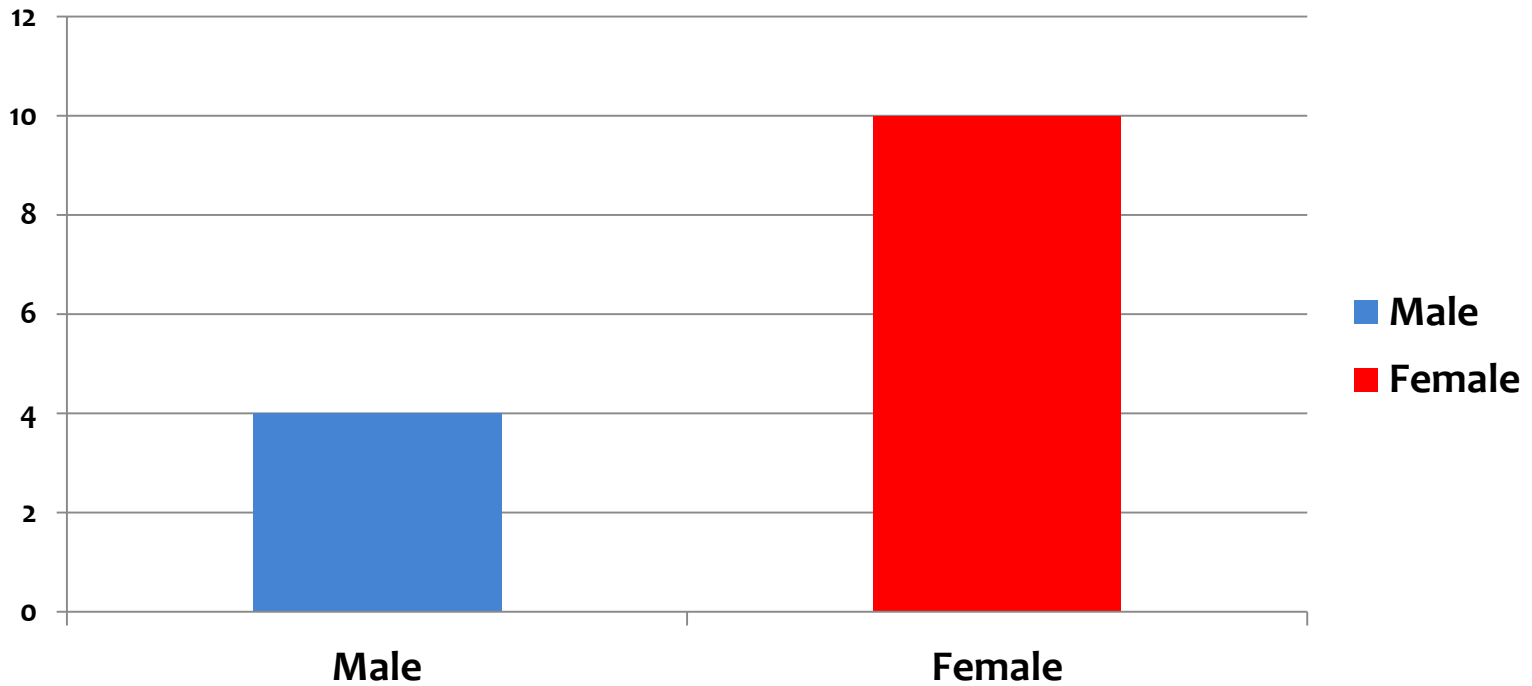
Annual Variations in four most common suicide methods

(* is mainly New Psychoactive Substances)



Suicide Notes/Texts left

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Learning: Some comments from Mental Health Services

- * 'this could have been caused due to her deteriorating physical health issues and her mother's terminal illness'
- * '...had made repetitive statements that she wanted to die.'
- * 'It came to light after W's death that his father had taken his life in exactly the same way a decade earlier'
- * 'DPT staff found out that X was deceased from the local press'
- * 'In the past he has been located on railway lines, on top of tall buildings, and had slashed his wrists'
- * 'Z had recently come off all her medication for depression as she was putting on weight'

Learning: Some Comments from GPs

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- * 'A did not turn up for her appt. No further arrangements were made for follow up'.
- * 'B had recently lost his mother and went through a severe depression'
- * 'Has several physical ailments. C knows the future will be difficult'
- * 'He was anxious about the possibility of moving to a new care home'

Learning: Some Comments from friends/family

- * **‘He came to Torbay for a fresh start but didn’t know anyone’**
- * **‘We tried a number of avenues to get him help’**
- * **‘He became distressed about the number of people coming into the house to clear up’**
- * **‘His partner had left him the day before’**
- * **‘He took his life on what he said was a special day for him and his wife, who had passed’**
- * **‘Both her mental health worker and her GP were on holiday’**
- * **‘His mother had died 3 days previously... he had said he would ‘go mental’ if his mother died’**

Adapted extracts from suicide notes

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- * **'I don't want to go into a home for the elderly'**
- * **'What's the point?'**
- * **'I will only be a burden in later life'**
- * **'Sorry, but I can't stand it any more'**
- * **'I cannot go on living without my....'** (name of ex-wife)
- * **'I cannot go on with my body failing me like this'**
- * **'I have paid all the bills and left my bank details for you for the funeral etc'**

CONCLUSIONS FROM 2015/16 AUDIT-1

- * The suicide numbers in Torbay are the highest since 2010/11, and the highest for South Devon since 2011/12
- * Hanging and drug overdoses respectively are the most common methods of suicide for both men and women
- * 52% of people were employed
- * In Torquay , TQ1 and TQ3 respectively have the highest suicide numbers, with TQ12 being the highest for South Devon
- * Relationship problems/loss are a major risk factor for suicide
- * In overdoses, amitriptyline was used in 50% of cases
- * The highest number of suicides for men was in the 45 to 49 age group, followed by 40 to 44 years

CONCLUSIONS FROM 2015/16 AUDIT-2

- * **More people had contact with their GP than with mental health services before their death**
- * **Previous suicide attempts and incidents of self harm are risk factors for suicide**
- * **The suicide peak in 2015/16 was in May and December**
- * **Monday was the most common day of the week for death**
- * **Whilst hanging is still the most common method, the rate of overdoses is increasing possibly due to the impact of New Psychoactive Substances (NPS)**

TSCB Annual Report

2015-2016 V0.19

November 2016

Keeping children safe is everyone's responsibility

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Foreword by Outgoing Independent Chair



Welcome to the annual report of the Torbay Safeguarding Children Board (TSCB) for 2015-16. This report sets out the activities of the Board in the financial year 2015-16. This report is for all partners of the TSCB as well as informing the work of the Health and Wellbeing Board and providing assurance to the Executive Director of Torbay and the Council's Scrutiny Committee.

The report describes the work of the Board and its sub committees over the last year and notes areas of achievement as well as identifying further areas for improvement and future work. The business plan for the Board for 2016-17 and its identified priorities will draw from the annual report.

In addition the Board has used the recent OFSTED Report to identify priorities for development.

In particular these are focused on agencies having a better understanding of thresholds and how they are used by staff, improving early help and developing coherent strategies in respect to domestic violence and neglect.

Over the last year real progress has been made in improving interagency working in respect to child sexual exploitation and also ensuring there is a better and more holistic focus on safeguarding children through the 'Think Family' Program. It will be important for this work to be consolidated and really embedded in front line practice

The Board will need to be much sharper at understanding what is happening on the ground and providing effective challenge and will pull together a revised data set to help this. In addition work is being done about how we hear the voice of children and young people more consistently in all we do

The reductions in public expenditure and accompanying organisational change put real challenge to building and sustaining effective safeguarding arrangements. It requires organisations to work even closer with one another to achieve this. The Board will be focusing on ensuring that all partners play their part in safeguarding the most vulnerable children and young people.

The Board welcomed a new Independent Chair and Practice Manager this year. Ian Ansell, Independent Chair joined the Board in March 2016 following a lengthy career in Devon and Cornwall Police, followed by more recent experience of senior management within the Probation Service and Police and Crime Commissioners Office. Alex Stuckey, Practice Manager joined us in May 2015 from a previous background working in Probation and more recently, within Devon and Cornwall Police overseeing the MAPPA arrangements for Devon and Cornwall.

David Taylor
Independent Chair

Foreword by Incoming Independent Chair



I was delighted to be appointed as the Independent Chair of the TSCB in March 2016. Having carefully considered the findings and recommendations of the Ofsted Inspection Report (January 2016), where both the Board and Children's Services were graded as inadequate, it is clear that there are a number of key areas where urgent work is required. Structured action plans have been written to ensure that progress is made in 2016/17 and the necessary improvements can be monitored and delivered. For the TSCB this will include:

- work to monitor and evaluate the effectiveness of Early Help
- ensuring that thresholds to access services are understood by all partners
- that the experiences and views of young people in Torbay contribute to the work of the TSCB
- that the services in relation to neglect and domestic abuse are monitored and evaluated to identify where improvements may be necessary

An agreed data framework will be required to inform the work of the TSCB to discharge its statutory duty. It is vital that all Board members collectively commit to making the contributions and improvements that will be integral to taking work in 2016/17 forward to a successful conclusion. A close working relationship with the Children's Services Improvement Board is also essential and Partner's active engagement will be needed. I have been encouraged by the response from all partners to date and am confident that the necessary improvements can be achieved in the forthcoming year.

Ian Ansell
Independent Chair

1 Essential information

Authorship:

Alex Stuckey TSCB Practice Manager, David Taylor Outgoing Independent Chair of the TSCB, Ian Ansell Incoming Independent Chair of the TSCB and Karen Elliott TSCB Practice Manager (covering maternity leave).

Approval Process:

Approved at the TSCB Board Meeting in December 2016

Presented to Torbay Council Policy Development and Decision Group: Joint Commissioning Team on: Monday 28th November 2016

Date of publication: Following final consideration by TSCB in December

This report covers the period 1 April 2015 to 31 March 2016 and reflects the structures that were in place up to the end of March 2016

Contact: tscb@torbay.gov.uk

More information: www.torbay.gov.uk/tscb

Statutory and legislative context for LSCBs

The Torbay Safeguarding Children Board (TSCB) is the key statutory mechanism for agreeing how local organisations cooperate to safeguard and promote the welfare of children within Torbay.

The core objectives of the Board are set out in section 14(1) of the Children Act 2004 as follows:

- to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority; and
- to ensure the effectiveness of what is done by each such person or body for that purpose

Regulation 5 of the Local Safeguarding Children Board Regulations 2006 sets out the functions of the Board in order to fulfil those responsibilities, these include:

- Developing policies and procedures for safeguarding and promoting the welfare of children
- Communicating to local people and organisations the need to safeguard children, raising their awareness of how this can be done and encouraging them to do so
- Monitoring and evaluating the effectiveness of safeguarding work by TSCB members individually and collectively and agreeing ways in which this can improve
- Participating in the planning of services for children and young people in Torbay
- Undertaking Serious Case Reviews and advising Board members on lessons to be learned and actions to be taken
- Implementing an effective and co-ordinated response by Board members to the unexpected death of a child

The full Terms of Reference for the TSCB can be found at www.torbay.gov.uk/tscb

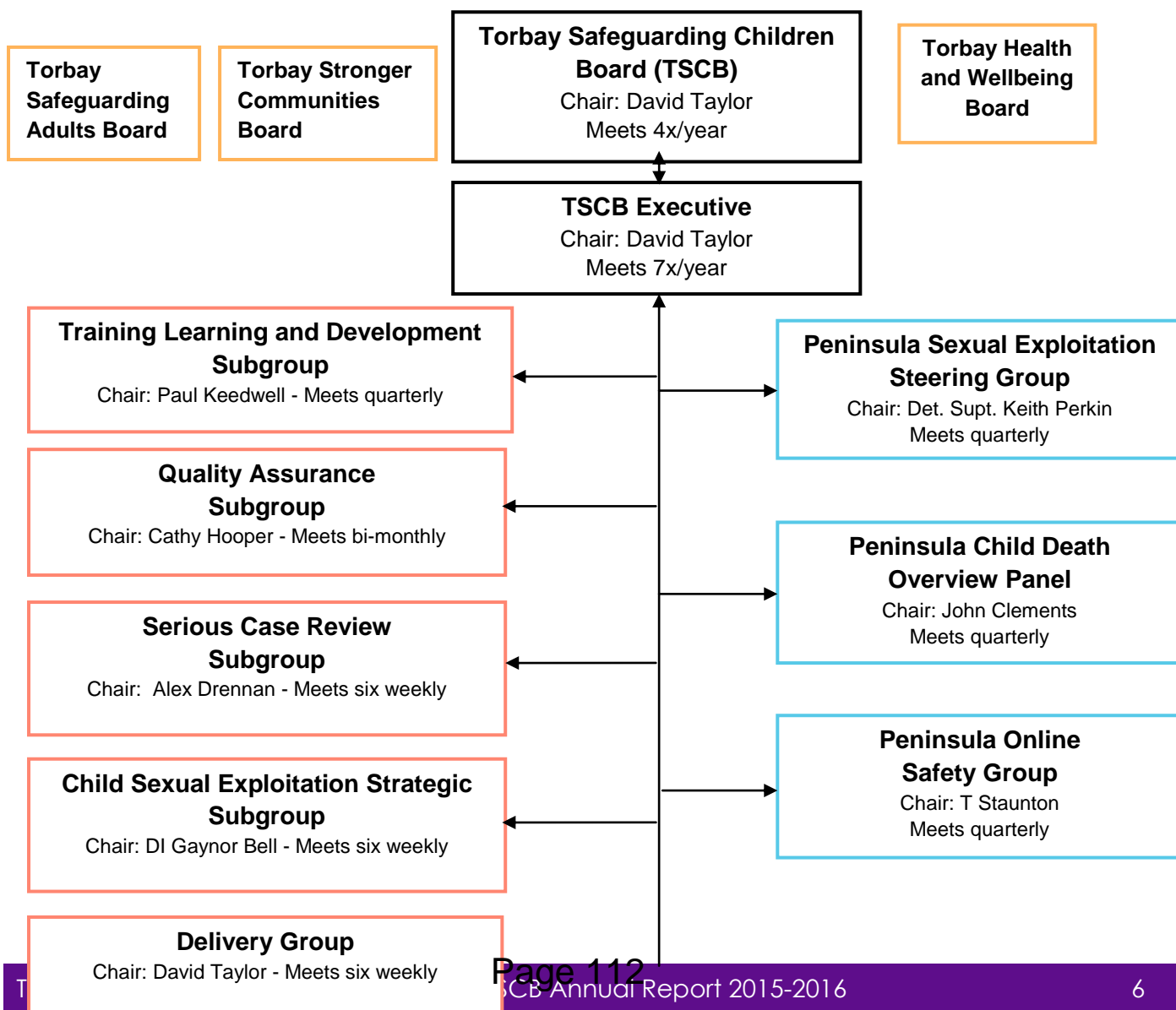
2 Governance and accountability arrangements

The TSCB is required to monitor and evaluate the effectiveness of what is done by the authority and partners individually and collectively to safeguard and promote the welfare of children. The TSCB undertakes this task through its business plan and subgroups.

The full Board continued to meet four times per year and was supported by a smaller Executive which meets six times a year.

The TSCB worked far more closely with the Devon Safeguarding Children Board this year facilitated by having the same Chairperson with the direction of travel leading to the amalgamation of the two Boards. However, the Chief Executive Officer of Torbay Council took the decision to keep the Boards separate and appointed a different Chair for the Torbay Board in March 2016.

The diagram below outlines the structure of the TSCB and its associated subgroups and Peninsula working groups in March 2016.





2.1 TSCB Office

The Board is supported by a small business unit which is responsible for both coordinating the work of the Board and its subgroups and ensuring that the TSCB is supported in making informed decisions. The business unit employs an Independent Chair, Practice Manager and two Coordinators.

2.2 TSCB Financial Statement

Partner agencies contribute to the TSCB budget on an annual basis. There was a reduction in the budget for 2015/16 from the previous year of £451.00 and was set at £123,532.00 this year.

Expenditure type	Outrun £
Staffing	£76,537.81
Independent Chair	£20,750.00
TSCB Annual Conference (joint with Devon)	£803.01
Best Practice Forums	£1,241.00
Meetings	£1,735.02
Subgroup activity	£3,377.10
Child Protection Procedures	£3,075.76
Child Death Overview Panel	£9,651.36
SCR costs (Training event)	£2,817.94
Total	£119,989.00
Contribution from TSCB Partners	£123,532.00
Under spend carried forward to 16/17	£3,543.00

Each year partner agencies are asked to complete a training needs analysis which determines how many multi-agency training courses are required. The costs associated with Training in 2015-16 came to £55,772.09. Partners contribute to the costs based on the number of places they purchase.

Trainers	£40,547.48
Venues	£6,316.51
Refreshments	£312.55
Admin and Management	£8,595.55
Total	£55, 772.09

2.3 Board Meetings

The Board agenda offers opportunities for information sharing and discussion, but also encourages questioning and challenge. Four meetings have taken place this year with a range of areas having been addressed. Appendix 1 sets out Board Membership.

The June Board meeting looked at the findings from the Child Sexual Exploitation case audit and the Board's priorities for the coming year.

September's meeting was a joint event with Devon and Torbay Adult and Children Safeguarding Boards and focused on 'Think Family' and the findings of the multi-agency case audit undertaken by the Quality Assurance Subgroup.

January's meeting focused on the findings of the recent OFSTED inspection.

The March meeting looked at Early Help including findings from the multi-agency case audit undertaken by the Quality Assurance Subgroup.

A summary of all Torbay Safeguarding Children Board meetings can be found on the TSCB website. <http://www.torbaysafeguarding.ork.uk>

Unfortunately this year 2015/16, a consistent record of attendance was not collated for the 3 meetings and the event in September. This has now been addressed and attendees will be recorded for all future meetings and events going forward.

2.4 Partnership and accountability arrangements

The TSCB has an Independent Chair who is directly accountable to the Chief Executive Officer of Torbay Council and works closely with the Director of Children's Services. The Lead Member for children's services is the councillor elected locally with responsibility for making sure that the local authority fulfils its legal responsibilities to safeguard children and young people. The Lead Member contributes to the TSCB as a participating observer and is not part of the decision making process.

The TSCB have 2 Lay Members on the Board who should play an important role challenging, supporting and holding partners to account in the way that they meet their safeguarding duties. They also serve to develop stronger public engagement and awareness of children's safeguarding issues.

Designated Health Professionals sit on the Board and subgroups and take a strategic and professional lead on all aspects of health service contributions to safeguarding children.

The Health and Wellbeing Board provides a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. Health and wellbeing Board members will collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way. A Protocol has been drafted to address the relationship with this board and the TSCB but it is currently unsigned.

The Police and Crime Commissioner's role is to hold the Chief Constable to account in relation to policing priorities. A representative of the Commissioner's office sits on the Board.

Torbay does not have a Children's Trust arrangement to develop and promote integrated front line delivery of services to safeguard children unlike many other local authorities.

3 Local background and context

Torbay is located within the South West region of England. It consists of 24 square miles of land spanning the towns of Torquay, Paignton and Brixham, which together occupy an east-facing natural harbour by the English Channel.

Torbay is highly populated with some 146,000 people across its 24 square miles. Torbay's position as a seaside community continues to prove popular as a retirement destination with the number of over 65's residing in the area being 7% higher than the England average.

Approximately 25,100 children and young people under the age of 18 years old live in Torbay which is just under 20% of the total population in the area. Approximately 21.6% of Torbay's children are living in poverty. 18.6% of primary school children are entitled to free school meals (national average is 15.6) and 12% of secondary school children (national average is 13.9%)

18.1% of children come from minority ethnic groups, which is much lower than the national average of 28.6%. The majority of the children in Torbay are recorded as 'any other white background'

5.1% of children in primary schools have English as an additional language which is lower than the national average of 19.4%. For secondary school children it is slightly lower at 4.1% where the national average is 15%

There are pockets of severe deprivation and inequalities within Torbay. These pockets tend to be communities that experience poorer outcomes such as poorer educational attainment, poorer socioeconomic status, lower earnings and the lowest life expectancy.

Torbay has been identified in the Marmot Review report – 'Fair Society, Healthy Lives' as an area on the edge of poverty. That is where a downturn could force thousands into poverty. The report suggests parts of the UK that are most vulnerable if the economy worsen, Torbay is ranked as highest nationally, with 37% of households (22,600) identified as being at risk of falling into poverty.

The Report on Children's Wellbeing carried out by the Children's Society in 2015 highlights a number of issues in relation to children's wellbeing in Torbay. Survey questionnaires were carried out and face to face consultations were undertaken with children and young people in the Torbay area. The report highlighted that 'Healthy Relationships' and 'Safety' are particularly problematic in the Torbay Area compared to elsewhere in the country. Although numbers in the focus groups were quite small, the researchers were concerned that there were strong recurrent themes and the particular issues were:

- Girls approached by older men leering and making offensive sexualised comments.
- Girls feel under scrutiny about their appearance. Secondary school girls are subjected to negative comments being made about their appearance by boys.
- Young people with learning difficulties are concerned about safety when out and about in Torbay
- Frightening behaviour such as drunks is very visible for young people in Torbay

Domestic Abuse rates in Torbay are very high 431 per 10K; highest rates across the Devon and Cornwall Police Force area. The number of recorded crimes on under 18 year olds is also high. The rate of sexual offences across age ranges in Torbay is double the national average and is the highest in the Peninsula. The Children's Society also comment that there is no counselling service for young people who have been sexually assaulted and access to Mental Health Services for children is poor in Torbay.

When children and young people are subjected to witnessing domestic abuse at home and in the community, it is more likely that they are then unable to maintain healthy relationships, have low self esteem and become the victims of domestic abuse themselves which perpetuates the cycle.

Early Help in Torbay is underdeveloped; partners are confused about their role in this and there is no coordinated overview of the Early Help provision in Torbay with any evaluation of its impact. There is a disproportionate distribution of agencies adopting the role of lead professional with Children's Services responsible for about 59%. This means that children young people and their families may not be able to access the right support at an early stage. This will form part of the Board's plan of work for next year.

In addition Torbay is an outlier in a number of other national and statistical neighbour indicators. Children's Services has the ninth highest number of care proceedings being filed. Nearly twice the number of section 47 investigations undertaken compared to our statistical neighbours. Just over 100 children per 10K of the population are looked after which is disproportionate for the size of Torbay. The number of young people in a CAMHS Tier 4 provision is high.

The number of pupils with SEN statements is the highest in the country at just over 4% with the national average being 2.8% and high numbers of children subject to Child Protection Plans.

Domestic abuse is a significant feature in Torbay as detailed above and this alone accounts for around 40% of cases held across all levels of thresholds of the child's journey.

Children's Services in Torbay recorded 1988 referrals which was just over 4.5% less than last year.

Year	Total number of referrals	Torbay per 10K	Statistical neighbour per 10k	National average per 10k
13/14	2748	1104	715	573
14/15	2134	851	644	548
15/16	1988	789	771	532

The above table show a year on year reduction. The slight decrease in referrals this year may be related to the introduction of the Multi Agency Safeguarding Hub (MASH) and the ongoing work with key partners, particularly the police, over the consistent application of thresholds especially in respect of police notifications regarding vulnerability (ViSTs).

Referrals from all other sources have remained reasonably consistent over the last 24 months. Despite this small decrease, Torbay's referrals are still 25% higher than that seen amongst

comparable authorities. OFSTED (2015) also highlighted thresholds as an area of concern for the Board, noting the impact this has on drift and delay throughout the system when trying to manage high levels of inappropriate referrals.

Further work around understanding thresholds of intervention for Children's Services and the Child's Journey document will form part of the plan of work for the TSCB for 16/17.

The levels of referral are indicative of the levels of demand within the community and the ability and readiness of the public and partners to identify children about whom they are concerned. Contacts from Schools, Health and members of the public all rose by about 30% in 2013/14 compared to the previous year.

Private Fostering is where parents make their own arrangements for the care of their children who are under 16 years old to live away from home with someone other than a parent or close relative. The local authority must be notified of these arrangements if they last for more than 28 days or more. For the year ending 31 March 2016, notifications were received in respect of **236** Private Fostering arrangements which is a 3% increase on last year. This high number is in relation to the number of language schools based in the Torbay area. The number of notifications in relation to local young people was broadly the same as last year.

Approximately 94% of all privately fostered young people in Torbay were from overseas and most came to this country in order to study and improve their English with most of the host families recruited by the various schools and organisations are white British. This year **52%** were seen within statutory timescales representing a considerable improvement on the previous year which was 26%. The number of statutory visits completed on time was 80% this year compared to 8.75% in the previous year.

4 Board Priorities

Following the appointment of the new Practice Manager, the June 2015 Board meeting was used to determine the Board's 5 priorities for 2015/16 which were as follows:

Priority 1 - Safeguarding children and young people with disabilities

The aim was to ensure that disabled children and young people are protected from abuse and neglect in all areas of their lives.

Due to a delay in setting the priorities for 2015-16, there has been a delay in arranging an audit of cases in this area – this is however now scheduled to take place in June 2016. The case audit, alongside the recommendations in the NSPCC report 'We have the right to be safe', will give an overview of the quality of services being provided to children with disabilities and will inform additional training needs and practice guidance for the children's workforce.

Priority 2 - Improving the emotional wellbeing of children and young people in Torbay

The aim was to develop a framework of supportive intervention that aids the recovery of children and young people from all forms of abuse and neglect.

The CAMHS Service is currently undergoing a redesign process to review how it provides services to children and young people with a focus on provision of emergency and out of hours care.

An Education subgroup was set up in June 2015 because there was a need for a forum for dialogue with schools that linked with Designated Teachers. It also provided a feedback mechanism from schools to the TSCB. This Subgroup reviewed the 'Healthwatch Torbay – We're Doing Something About Bullying' Report in November 2015 with bullying being a high priority within their work.

All 175/157 audits which were sent out to all schools to self assess their safeguarding arrangements were returned with only 1 exception which will be followed up next year. A review of the process, reporting and identifying areas and themes for improvement will form part of the Board's work plan for next year. This will include Language schools being part of this process going forward.

The Board supported a task and finish group led by the Assistant Director of Children's Services to review existing provision around domestic abuse for children and young people. This work led to the development of a multi-disciplinary delivery plan focussed on children and young people with the Domestic Abuse and Sexual Violence Steering Group overseeing the implementation of this plan.

It was identified that the plan addressed support for mothers affected by domestic abuse with the provision of the Freedom Project but did not address complimentary intervention for their children. One of the actions was to look at the delay in the setting up of this provision which was later resolved and the Children's Programme was finally set up.

The Public Health team led on a 6 month secondment to complete a needs analysis of Domestic Abuse and Sexual Violence in Torbay. This work (with a prevention/early identification emphasis) includes a review of the literature relating to the needs of children and young people, as well as other characteristics that put people at increased risk of experiencing or perpetrating this type of abuse. The report has not yet been published.

The SWIFT team, at the same time, completed an in-depth analysis of current domestic abuse demand focussing particularly around families and has produced a business case to appoint a social investor and commission specialist services in 2017 by looking at a social impact bond option.

The Campaign in November 2015 focussed on healthy relationships for young people which was successful. An increased activity on the website was observed which could suggest people looking for information to support others.

There is however a lack of a coordinated response to Domestic Abuse across services and organisations and this will be an area of work to focus on next year for the Board including the monitoring and evaluation of domestic abuse services in Torbay.

WRAP training has also been rolled out across Torbay schools and a joint protocol has been agreed between the Adult Safeguarding Board, TSCB and the Community Safety Partnership.

The Children's Society has secured funding to roll out Teen Triple P parenting by delivering programmes for free for parents to self refer and will be running a media campaign to advertise it next year.

Priority 3 – 'Think Family'

The aim in partnership with the Safeguarding Adults Board, Health and Wellbeing Board and Community Safety Partnership was to embed a culture of 'Think Family' across both adult and children's services.

The TSCB published C42 Serious Case Review in 2014, which underpinned the 'Think Family' approach. Throughout 2015 and 2016, this approach has been promoted across all strands of the Board's work. A protocol has been developed which all partners have signed up to. A focus on 'Think Family' now cuts across all case audits. A joint case audit was undertaken this year with the Adult Safeguarding Board to embed this focus. A 'Think Family' Conference was held to share good practice from within individual agencies, such as Devon Partnership Trust and the Police following whole service reviews around safeguarding. This conference was held in collaboration with the adult and children's Boards from both Devon and Torbay.

Priority 4 - Engagement with the voluntary and community sector including the faith sector

The aim was for children and young people to be able to participate safely in community and faith activities.

There has been some progress in this area this year. This has culminated in the setting up of a specific reference group to the Training and Development Subgroup which includes members from across the voluntary and faith sector. The group have agreed terms of reference and a work plan which focuses on supporting voluntary and community groups to increase their safeguarding awareness and enhance their current practice through self assessment, training, safer recruitment, improved links with the LADO role and website development.

Priority 5 – Embedding the SoS (Signs of Safety) Approach

The aim was for Children and Young People to be directly involved in the planning of services to safeguard them.

The Board has supported the implementation of the Signs of Safety approach across Children's safeguarding this year. This is a nationally recognised, researched and an Ofsted recommended approach, which supports the 'Think Family' focus and improves family engagement in their own planning to address safeguarding concerns. Staff from the across the partnership have received briefings and training on the SoS approach. Templates have been improved adopting a SoS approach for reports and documents to be used within the child protection process.

5 Ofsted Inspection

Ofsted carried out the Inspection of services for children in need of help and protection, children looked after and care leavers from 12 October 2015 to 5 November 2015 with the report being published on 5 January 2016.

Ofsted judged Children's Services in Torbay to be inadequate and as a result a Children's Improvement Board has been set up to plan and monitor improvements. This needs to be a multi agency Board and the Chair of the TSCB will sit on this Board. Hampshire County Council has been identified as Torbay's improvement partners. Senior managers from Hampshire under the leadership of the Director of Hampshire Children's Services will be working with Torbay senior managers offering support and challenge to promote improvement. Hampshire will be reporting to the DfE improvement Team on progress and any barriers to improvement on a monthly basis.

There were some strengths that were recognised and beginnings of improvements but many weaknesses were identified; some of which are included below:

- Leaders and managers in Torbay have been ineffective in prioritising, challenging and improving the quality of practice, in particular children who are in need of help and protection.
- Leaders have lost focus on core tasks of ensuring good-quality frontline services to children and families.
- Performance information is not reliable and therefore cannot be used to enable effective scrutiny of activity.
- Quality assurance processes are not fully embedded, audit activity is limited and findings have not been used effectively to improve practice.
- Weakness in social work practice.
- Children and families do not receive a timely response to their needs
- Thresholds are not well understood or applied.
- Children and families experience delay in gaining access to help and protection at referral
- Delays are not challenged by managers of child protection conference chairs.
- Poor assessments
- Child's voice is not always heard.

The TSCB was also judged to be inadequate and Ofsted made the following recommendations for the TSCB:

- Produce an effective multiagency performance data set and report, and an up-to-date annual report that provides a rigorous and transparent assessment of the performance and effectiveness of local services that provide help for children and young people (paragraphs 140, 143, 158 of the Inspection report)
- Monitor and evaluate the effectiveness of early help services (paragraph 144 of the Inspection report)

- Ensure that partners monitor the application of thresholds for intervention consistently and robustly across Torbay (paragraph 152 of the Inspection report)
- Ensure that mechanisms to gather the experiences and views of young people and families in Torbay regarding safeguarding practice are introduced and that learning from this contributes effectively to the development of the work of the TSCB (paragraph 155 of the Inspection report)
- Strengthen the monitoring and evaluation of services in relation to domestic abuse and neglect so that it is clear where improvements are needed (paragraph 156 of the Ofsted Inspection report)

The January 2016 Board meeting saw a presentation of the Ofsted findings for both Children's Services and the TSCB looking at the recommendations and future planning. It was agreed at this meeting that a Performance Management Subgroup would be set up to address the issue of a Board data set. Further planning to address the other Ofsted recommendations has taken place throughout the year.

6 Allegations against people that work with children

Local authorities in England should identify designated officers (LADO) to be involved in the management and oversight of individual cases of allegations of abuse made against those who work with children as set out in the Allegations against People who Work with Children Procedure. Their role is to give advice and guidance to employers and voluntary organisations; liaise with the Police and other agencies, and monitor the progress of cases to ensure that they are dealt with as quickly as possible consistent with a thorough and fair process.

In 2015-16 there were 164 referrals made to the LADO which is an increase from last year when there were 112. Of these 164, only 47 met the LADO threshold. The referrals come from a variety of sources but the largest majority of these are from Children's Services and schools. The settings subject to allegations included foster carers, schools and community organisations as well as others.

There was an increase of physical and sexual abuse allegations compared to last year. This year there was a small number of emotional abuse allegations which did not feature last year.

We are still awaiting the LADO report when further detailed analysis of the data can take place.

7 Work with the Board updates

The Board has had a review of the subgroups and reporting processes this year. This has resulted in the re-commissioning of a Torbay stand alone Serious Case Review subgroup which has enabled sharper focus on Torbay specific issues. Additionally, the Education Subgroup has been reinstated, along with a Voluntary and Community (including Faith) sector reference group. This group will be focusing on improving the links between the Board and this sector and supporting development of Safeguarding practice across the voluntary and community sector.

Although it was intended that reporting processes would require each subgroup to review progress against work plans quarterly and to identify priorities for the following quarter keeping them focused on achieving outcomes, was never fully implemented.

The Board has worked closely with other Boards this year on a number of projects. This has included developing a joint PREVENT protocol with the Adult Safeguarding Board and Safer Communities Partnership, and supporting the rollout of WRAP training to the children's workforce.

The Board also presented a joint adult and children conference with colleagues from Devon to promote the 'Think Family' approach alongside sharing learning from the case audits and serious case reviews.

Local task and finish work is in progress to develop a neglect screening tool alongside promoting the Graded Care Profile as an assessment tool.

The Board has also supported other local work with partners on Modern Slavery and Child Sexual Exploitation.

This year, the Board have worked with colleagues from other local and regional Boards to re-commission the South West Child Protection Procedures and the Child Death Overview Panel. The Board have responded to feedback from practitioners and from service reviews to inform the contracts for these areas of work to ensure they are fit for purpose.

7.1 Child Sexual Exploitation (CSE) Strategic Subgroup

The CSE Subgroup is responsible for supporting strategic delivery of the multi agency response to children and young people involved in or at risk of sexual exploitation.

Key achievements this year include:

- The development of a local problem profile
- The development of a CSE Data Set
- The introduction of Missing Monday Meetings to identify and safeguard children who go missing or are absent
- The introduction of a risk indicator toolkit
- Introduction of a dedicated Local Authority CSE Rep (highlighted as a strength by Ofsted)

- Implementation of the CSE Strategy across partner agencies, with partners reporting positive progression and a more effective response on the ground.

A virtual team of multi professional CSE Champions has been developed which includes: Health, Police, YMCA, IYSS, ARC, Torquay Academy, Single Assessment Team, Disability Service, PCSO, and CAMHS

Raising awareness of CSE continues to be a key priority and a range of activities have taken place this year including:

- Incorporating CSE and Missing into the TSCB online safeguarding training
- Training for designated safeguarding leads in schools
- A presentation delivered to the local authority's licensing forum

A series of activities to support the national CSE awareness day on the 18 March 2015 involved representatives from Police, Children's Services, Health, Checkpoint, Torbay Council, Schools and the YMCA working together to ensure that key messages were delivered throughout Torbay.

- Stands were set up in Torquay, Paignton and Brixham town centre where staff from agencies engaged with in excess of 600 members of the public offering advice and raising awareness in relation to Child Sexual Exploitation
- Twitter feeds, face book entries, what's app and thunderclap were sent out during the day
- 115 hand pledges were completed
- Leaflets and posters were handed to local stores, cafes, churches, swimming centres, sea scouts, scouts, rugby clubs, community groups, homeless shelters and security guards
- A presentation was delivered to 600 parents at Torquay Boy's Grammar
- Posters and stickers were delivered to local schools for children with additional needs
- Internal messages were sent to schools, children's services, health and police
- Posters were displayed in Torbay Hospital, Torquay Police Station, Paignton Police Station and Torbay Council
- The YMCA engaged with young people in 1-2-1 sessions using hands to decorate a large display. 20 hands were completed with paint to highlight CSE
- Assemblies were held in a local school on a daily basis throughout the week with each pastoral group completing a hand board with pledges by young people and staff
- Approx 5000 stickers were issued over the week



CSE training has continued to be very well attended with 119 members of the children and young people’s workforce attending training through the TSCB. The following are quotes from delegates:

“I have used the experience through a case where CSE was prevalent and as a result held greater understanding of the pressure my service user was under”

“This course was one of the most informative courses I have attended. The trainers were fantastic and really helpful”

“The course was informative and thought provoking. It emphasised the genuine risk faced by vulnerable youths”

“Thank you for the session - not an easy topic to spend a day working on but it was a very helpful session following which I feel better informed and better able to look at what we can do in this context as a school”

7.2 Quality Assurance Subgroup (QASG)

The Quality Assurance Subgroup is responsible for monitoring and assuring the quality of all aspects of safeguarding work undertaken by all partner agencies of the TSCB by:

- Overseeing an annual programme of individual case audits (including both Section 11 and Section 157/175), ensuring policies and procedures are embedded across the safeguarding system
- Report against the QASG Action Plan to the Executive Board through the Chair’s report, escalating risks and outstanding actions where appropriate
- Identify cross-organisational risks and ensure those that cannot be resolved at lower level are escalated to the Executive Board
- Ensure learning from audits (including Section 11) is disseminated across all agencies and subgroups and embedded in practice

Agencies represented on the group are: Health (commissioning and provider), Education, CRC, Police, Voluntary sector and Torbay Council.

Four Multi agency case audits were undertaken in 2015/16, focusing on Child Sexual Exploitation, Toxic Trio ('Think Family'), Child Sexual Abuse, and Early Help. A review of all partner agencies Section 11 returns has been undertaken.

These audits have identified areas of good practice:

- Evidence of the 'Think Family' approach being considered, partnership working with adult facing services
- Improved compliance with supervision standards
- Evidence of improved practice in capturing the voice and experience of children and young people
- Evidence of professional challenge
- Evidence that professionals are proactive in taking steps to safeguard children

Areas of improvement identified were:

- Continued practice of Strategy meetings being held without appropriate agencies being invited or represented
- Evidence that professionals struggle to identify the appropriate pathway to safeguard children, for example one audit saw three similar cases being managed three different ways
- a continued theme that the analysis and synthesis of historical information, and how that impacts on ability of adults to parent and engage with services was not always evident within assessment and subsequent interventions

Learning from multi agency case audits is distributed through the TSCB Meetings and the Best Practice Forums. The underpinning process requires review. It has been identified by the Board that practice does not appear to be improving outcomes for children and young people, despite findings identified.

In response to this a task and finish group was identified to review its' Section 11 process. The previous year in October 2014 the audit was collated as a Peninsula from partner agencies. No audit was carried out this year. An event was organised for agencies to present their audit findings of the previous year focusing on their key achievements and identifying specific areas for improvement in April 2016. The Section 11 Audit process requires further refining to ensure greater compliance by partners and a clearer method to follow up where improvements have been highlighted as necessary.

This is part of the work plan of the Quality Assurance Subgroup for the year going forward and the process by which Section 11 submissions are submitted will be reviewed during 16/17 to improve quality and compliance.

7.3 Performance Management Information - data

The lack of a data set to inform the Board was highlighted by Ofsted as an issue. Work commenced at the end of this year (2015/16) to develop an agreed data set for the TSCB which will require further commitment and contribution from all partners next year. It is of crucial importance that partners contribute to the provision of meaningful data set so that good analysis and evaluation can take place to identify where improvements are required, hold partners to account and monitor progress.

7.4 Serious Case Review (SCR) Subgroup

At the beginning of April 2015 the SCR subgroup was a joint sub group with Devon. The joint subgroup had run for 6 months before it was decided in June 2015 that the format was not working and that the subgroup needed to revert back to individual LSCB subgroups. The reformed Torbay SCR subgroup commenced its first meeting in July 2015.

The purpose of the subgroup was set out to screen all referrals that come in to determine whether they meet the threshold for a Serious Case Review in line with Chapter 4 of Working Together 2015. Its purpose was also to oversee any subsequent recommendations and actions from SCRs or Management Reviews. The full terms of reference have been completed and can be accessed via the TSCB.

There have been no SCRs in 2015/16 although two referrals were received for consideration by the subgroup. Neither referral met the criteria however it was agreed that a management review would be undertaken for one of them. This review is not yet concluded.

The actions relating to Serious Case Reviews C40 and C42 published in November 2014 were finally completed this year (2015/16) except for one.

This outstanding action relates to the Rapid Response Team and is subject to ongoing discussion.

The Child Death Overview Panel (CDOP) representative for Torbay now sits on the SCR subgroup to improve joined up working.

In August 2015 the Peninsula SCR toolkit was reviewed and updated following the publication of 'Working together to safeguard children March 2015'.

One Health Management review took place last year (2014/15) overseen by this group with two actions outstanding. One Health Management Review took place this year (2015/16) with all actions having been completed.

7.5 Training Subgroup

This year (2015/16) 95 safeguarding children training courses were available to the children and young people's workforce in Torbay which was an increase of 56 more courses than last year. This equated to 1,962 practitioners working with children attending training.

This increase is due to the introduction of 22 Early Help training courses, 23 WRAP training courses (Workshops to Raise Awareness of 'Prevent') and 2 WRAP Train the Trainer courses. WRAP training on the whole has been delivered by Safer Communities staff and Designated Safeguarding Leads within schools. Early Help training has been delivered by volunteers from partner agencies within Torbay. WRAP is an interactive facilitated workshop centred on a package of video content. The workshop provides an introduction to 'Prevent' which is part of the government counter-terrorism strategy aimed at supporting vulnerable people.

The focus has remained on introducing Signs of Safety and across 2015/16 13 events have been offered. Children's Services and Torbay and South Devon NHS Foundation Trust staff have also access the 5 day practice leads course.

The Training subgroup has continued to use the online evaluations for the courses; this includes the initial evaluation and an impact evaluation. Courses are also observed by members of the Training, Learning and Development Subgroup.

The Workforce Development Officer for Children's Services has worked with the contracted training providers to review the evaluations and implement changes accordingly. This has meant quick but effective changes have been made within the course designs; where what has worked well has been kept and other areas improved.

The data on course evaluations is fed back to the Training, Learning and Development Sub group on a termly basis with Subgroup members also undertaking observations of the courses.

The data below shows the take up of the main partner agency places purchased in advance

Agency	2013/14	2014/15	2015/16
Torbay and Southern Devon Health and Care NHS	78%	121%	105%
Children's Services	71%	84%	72%
South Devon Healthcare Foundation Trust	43%	43%	100%
Devon and Cornwall Police		23%	82%

The Trust has increased their compliance in training and in accessing the number of places purchased. Devon and Cornwall Police have also improved in terms of the percentage of places accessed that have been purchased in advance.

Best Practice Forums share learning from the multi-agency case audits, local and national serious case reviews and current issues affecting children and young people. The forums have been well attended by frontline professionals from both adult and children's services – this year a total of 128 members of staff have attended three Best Practice Forums on the following subjects

- Fragility of Babies and looked after children - this focused on C40 SCR.
- Domestic Abuse – joint event with Torbay Safeguarding Adults Board and included multi agency contributions.

- PREVENT – led by Devon and Cornwall Police and Community Safety of Torbay Council which included a table top discussion on Supervision and a briefing on the Social Work Innovation Fund Torbay (SWIFT).
- Toxic Trio and Signs of Safety.

7.6 Child Death Overview Panel (CDOP)

In the South West Peninsula the four LSCBs: Devon, Torbay, Plymouth and Cornwall and the Isles of Scilly have come together to form a singular Peninsula CDOP. The South West Peninsula CDOP and the Child Death Enquiries Office at the University of Bristol together administer the functions of the Peninsula CDOP.

During 2015/16, there has continued to be a steady decline in child deaths in line with the national trend. In 2015/16, there were 75 deaths of children (aged 0-18 years) notified to the SW Peninsula CDOP office.

Child Deaths	Number	Percentage
Torbay	7	9
Devon	28	37
Plymouth	11	15
Cornwall & Isles of Scilly	27	36
Non resident	2	3
Total	75	100

Age	Number	Percentage
<28 days old	42	56
28 days to 1 year old	8	11
1 - 4 years old	7	9
5 - 9 years old	7	9
10 - 14 years old	6	8
15 -17 years old	5	7

The 2015 OFSTED inspection in Devon challenged the effectiveness of the current CDOP arrangements commenting that the number of modifiable deaths was relatively low in comparison to the rest of England and that the Rapid Response Service was not meeting its statutory requirements because it has only convened a rapid response meeting in half of unexpected deaths. CDOP have challenged this. A review of rapid response has been undertaken by clinical commissioning groups and will be reported on in next year's report.

8 Going forward - 2016 to 2017

There is clearly a significant amount of work to do to make the improvements identified by Ofsted. It is critical that Partners are able to work far more collaboratively in Torbay to make the necessary changes in services and the way that we work together to improve services for children and young people. We need to be able to measure and monitor services, challenge each other and hold each other to account to ensure improvements are sustained.

We need to know that what we do really does impact positively on our children's futures and we can only do that together.

The TSCB will need to agree a robust Business Plan for next year and the priorities agreed will have to be driven by the Ofsted Inspection report paying particular attention to the following:

- Board Data Set
- Child's Voice
- Early Help
- Thresholds
- Domestic Abuse Services
- Neglect

Appendix 1: TSCB Membership as at March 2016

