



Torbay Safeguarding Children Partnership

Annual Report 2025-26

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1. Introduction

Working Together to Safeguard Children 2026 (WT2026) arrangements in respect of statutory safeguarding partners in relation to a local authority area in England are defined under the Children Act 2004 (as amended by the Children and Social Work Act, 2017) as:

- The local authority
- An integrated care board for any area, any part of which falls within the local authority area
- The chief officer of police for an area, any part of which falls within the local authority area

In line with guidance issued within WT2026, the Torbay Safeguarding Children Partnership (TSCP) Lead Safeguarding Partners (LSP) held their initial board meeting on 20/01/25. Subsequent TSCP board meetings have been held at six monthly intervals. In addition to the six monthly TSCP board meetings the LSP's have also met with their Devon, Plymouth and Cornwall counterparts twice yearly in the form of Peninsula board meetings, designed to enhance cross-border procedures, joint working and efficiencies. Within the current reporting period, Peninsula LSP board meetings were held on 03/04/25 and 08/01/26. Although Cornwall LSP's attend these meetings, at present this is in the form of an 'interested party' rather than a formal member of the arrangements. For the reporting period 01/04/25 to 31/03/26 the chair of the TSCP LSP board was Anne-Marie Bond, Chief Executive of Torbay Council, with Donna Manson, Chief Executive of Devon County Council, chairing the Peninsula LSP board.

Throughout the current reporting year, 01/04/25 to 31/03/26, Roy Linden, Nancy Meehan and Penny Smith represented their respective agencies at Delegated Safeguarding Partner (DSP) level. The three DSPs collectively form the statutory element of the TSCP Executive Group, with education providers being represented by Rob Fitsimmons, Headteacher Kings Ash Academy, from March 2026. Roy Linden was chair of the TSCP Executive Group for the reporting period this Annual Report is focused on.

 Roy Linden Policing Commander for South Devon Devon and Cornwall Police	Roy Linden is the Policing Commander for South Devon; an area which extends from Dawlish to Wembury, including Torbay, the South Hams and Teignbridge. Roy is responsible for the overall policing of this area, including responding to incidents, investigation, and neighbourhood policing. Roy joined Devon and Cornwall Police in 2003, and has worked in Patrol, CID, Public Protection and Major Crime, and is an experienced and accredited Senior Investigating Officer and Strategic Firearms Commander. Roy works with partners and commissioners to address key threats to the community and individuals in order to prevent crime and disorder. His aim is to provide a quality local police service by building strong community relationships across the area to keep people safe.
 Penny Smith Chief Nursing Officer NHS Devon Integrated Care Board	Penny Smith is Chief Nursing Officer for the Integrated Care Board in Devon. Penny and the NHS Trust Chief Nursing Officers across Devon are responsible for nursing leadership and professional standards of nurses and allied health professionals employed by the NHS across the county. She has significant experience working in a number of key roles regarding clinical quality, professional leadership, and safeguarding. Penny is also Executive lead for Women's and Children's services. Penny is committed to partnership working across the county to support the health and wellbeing of the whole population of Devon.
 Nancy Meehan Director of Children's Services Torbay Council	Nancy Meehan is the Director of Children's Services for Torbay Council, having previously served as the Deputy Director. Nancy has significant experience, both as a senior manager and consultant for several local authorities across England. Beginning her career in the field of social care in 1989, Nancy has 30 years of post-qualifying social work experience and during this time has successfully led, stabilised, re-designed and launched new services across multiple council departments, always with the intention of improving outcomes for children. Nancy is committed to working in partnership, both with statutory organisations and the voluntary and community sectors, and delivering safe, high-quality services to the children and young people of Torbay.

2. Working Together to Safeguard Children

In April 2017, the Children and Social Work Act received Royal Assent which ended the role of Local Safeguarding Children Boards (LSCB) and all sections of the Children Act 2004 that related to them. To support the updating of local multi-agency safeguarding arrangements the Department for Education (DfE) published revised Working Together to Safeguard Children guidance in July 2018 (WT2018), which set out what organisations and agencies who have functions relating to children must do to safeguard and promote their welfare in England. The major shift within WT2018 was the responsibility for safeguarding children being equally shared between the local authority, health services and the police. The transition period ended in March 2020, and new safeguarding arrangements were fully implemented. For Torbay this meant stepping away from the Torbay Safeguarding Children Board (TSCB) and implementing a new multi-agency safeguarding children partnership, initially via shared arrangements with Plymouth Council, but as a Torbay only partnership, the TSCP, from September 2020.

In December 2023 the DfE published revised Working Together to Safeguard Children 2023 (WT2023) arrangements, which became fully established by December 2024. WT2023 introduced a number of changes, with the most significant for Safeguarding Children Partnership (SCP) structures being the introduction of the role of Lead Safeguarding Partners (LSP), who for the TSCP are the Chief Constable of Devon and Cornwall Police, the Chief Executive of Torbay Council, and the Chief Executive of NHS Devon ICB. LSP's are differentiated from Delegated Safeguarding Partners (DSP) within WT2023 arrangements, with the three TSCP Executive members taking on DSP roles on behalf of their respective organisations.

In March 2026 the DfE published further updated Working Together to Safeguard Children 2026 (WT2026) arrangements that are being incorporated into TSCP working during the reporting period 2026/27. Updates within WT2026 include;

- A reinforced focus on shared responsibility when safeguarding children.
- Clearer expectations and clarification on accountability structures, the reporting of impact, and how partner organisations are inspected.
- Combining targeted Early Help and section 17 support, via the Families First Partnership Programme (FFPP), to create the category of Family Help led by multi-disciplinary teams. The FFPP aims to transform children's social care into a seamless system of support for children, young people, and families.
- Reinforcement of the link between care planning and child protection planning.

- Strengthening of the process for learning from serious child safeguarding incidents.

Click the following links or images below to access the full guidance [Working Together to Safeguard Children 2026](#) and the associated [Summary of Changes](#).



Statutory guidance

Working together to safeguard children 2026: summary of changes

Updated 18 March 2026

3. Governance and Structure

Devon and Cornwall (D+C) Police, NHS Devon Integrated Care Board and Torbay Council are equally responsible for oversight of the TSCP, its activities and outcomes. Under current WT2026 arrangements, ultimate oversight and final decision making within the TSCP rests with the Lead Safeguarding Partners (LSP). The Torbay LSPs have agreed to meet twice yearly, with Peninsula LSP board meetings being held in between Torbay LSP board meetings, also held on a twice-yearly basis. Both the Torbay and Peninsula LSP boards have agreed Terms of Reference and Schemes of Delegation.

Prior to final LSP arrangements being confirmed at the first Torbay LSP board meeting on 20/01/2025, the TSCP Executive Group (DSPs) held responsibility for final oversight of the work of the partnership and agreed multi-agency practice across all areas of children's local safeguarding in Torbay. In line with WT2026 DSPs now defer certain agreed higher-level decisions to LSPs. During the current reporting period the Executive Group continued to meet on a bi-monthly basis, with chairing arrangements being undertaken by the Devon and Cornwall Police Commander for South Devon.

The TSCP Business Group, which has responsibility for maintaining partnership oversight/workflow and enacting operational decisions made by the LSPs and DSPs, sits under the Executive Group. During the current reporting period the chairing of the Business Group was undertaken by the Deputy Director of Safeguarding and Patient Safety for NHS Devon ICB. The current chair is envisaged to remain in this role until March 2027.

In 2025/26 there were four TSCP sub-groups, one long term task and finish group and a short-term project team sitting below the Business Group, with each being established to focus on the core business and priorities of the partnership. The project team are not represented on the structure chart due to the short-term nature of their work finishing updates to the TSCP Levels of Need (Threshold) document that was published in January 2026.

During Spring 2025 the TSCP Learning and Development (L+D) function was merged into the Quality Assurance (QA) Group to better align process and ensure more effective management of capacity/funding. The QA/L+D Group is responsible for managing the partnership's practice oversight and audit activity, including both TSCP multi-agency audits and the implementation of findings from relevant single agency audits. The QA/L+D Group works alongside training leads in

converting audit outcomes into learning, with further future audit activity being designed to ensure learning has become embedded into local safeguarding practice. Due to the L+D function requiring more bespoke time than envisaged, the L+D section of QA Group meetings now has its own dedicated time and attendance list. The TSCP's Independent Scrutineer is a fixed attendee of the QA element of this group.

The Child Safeguarding Practice Review (CSPR) Panel is responsible for oversight of TSCP learning reviews, converting all TSCP learning review recommendations into actions, and ensuring oversight of these actions through to resolution. This is undertaken with the aim of ensuring local multi-agency practice improves in line with that agreed in review reports. The CSPR Panel also reviews regional and national learning and incorporates this into the TSCP where agreed. As per the QA Group, the TSCP's Independent Scrutineer is a fixed attendee of the CSPR Panel.

The Child and Young Persons Exploitation Group (CYPEG) is part of Torbay's multi-agency response to child exploitation and is responsible for Torbay's multi-agency Child Exploitation Strategy. CYPEG is also the TSCP's direct link to local exploitation services. The need for a local Contextual Safeguarding strategy was identified by CYPEG and this led to an agreement for the TSCP to commission a Task and Finish Group to lead on and complete this piece of work. The Contextual Safeguarding Task and Finish Group reports to the TSCP Business Group in line with agreed TSCP process but also shares members with CYPEG to ensure continuity and shared understanding of local safeguarding concerns in respect of exploitation.

The Neglect Group is focused on identifying and understanding causes of local neglect and promoting preventative multi-agency responses. In 2025/26 the Neglect Group maintained oversight of the continuing implementation of Graded Care Profile 2 (GCP2), which is the locally agreed multi-agency tool for assessing neglect in Torbay. The Neglect Group is responsible for the TSCP multi-agency Neglect Strategy.

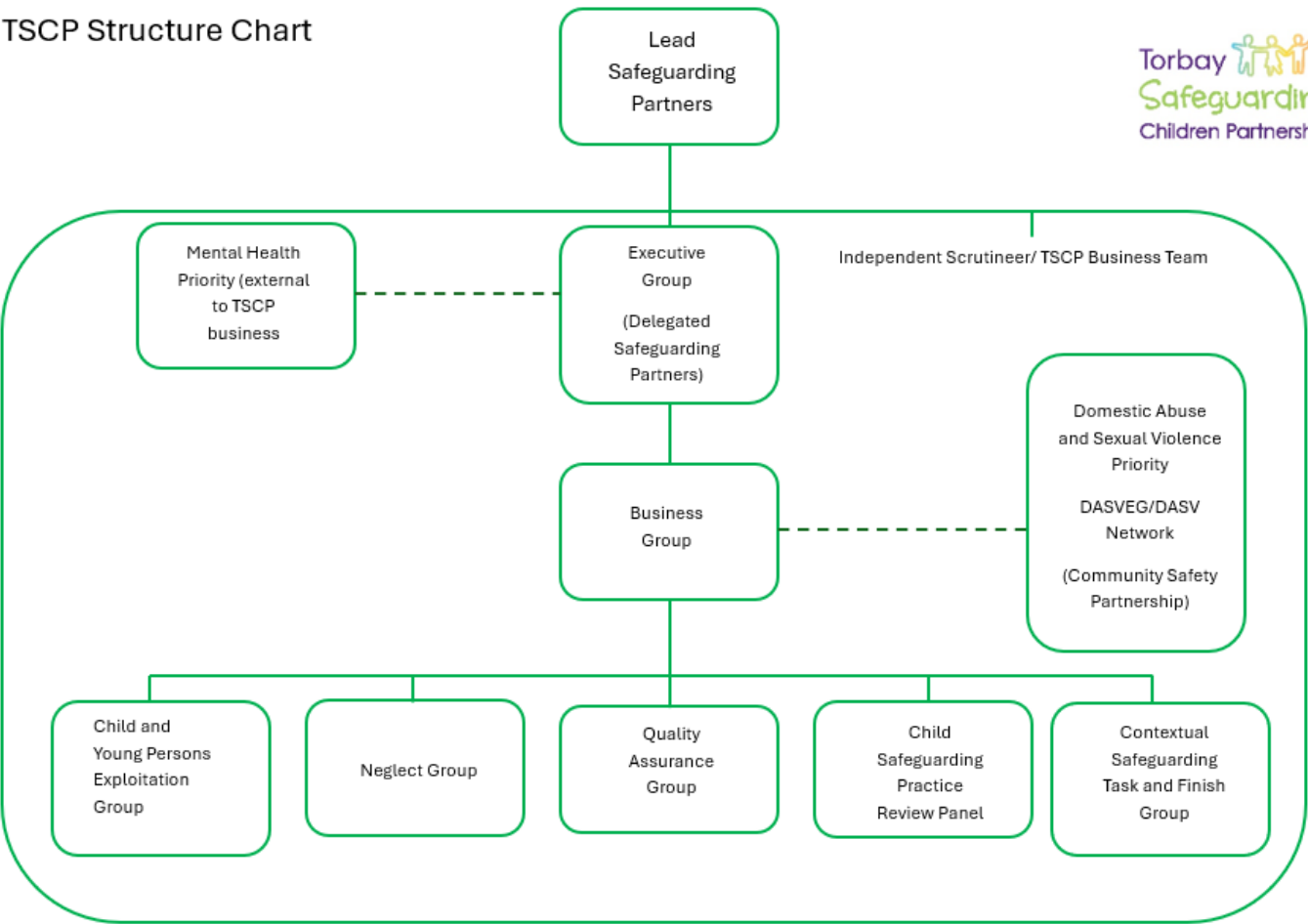
The TSCP's domestic abuse priority continues to be managed via joint arrangements with Safer Torbay, which is the name given to Torbay's Safer Communities Partnership. The domestic abuse lead from Safer Torbay is a fixed attendee of the TSCP Business Group to ensure effective oversight and information exchange. The domestic abuse lead from Safer Torbay also attends TSCP Executive Group meetings by invitation when oversight at a higher level is required.

Children receiving appropriate mental health and emotional wellbeing support, at the correct time,

has been a priority of the TSCP since 2021. During the reporting period 2025/26 significant work was undertaken to improve the local Torbay mental health offer to children and young people. As a result of progress made, the TSCP mental health priority was reviewed and formally ended in April 2026. Assurance on mental health services will continue to be provided to the TSCP when required. This change has provided the opportunity for the TSCP to agree a new priority, which will be based on safeguarding children from sexual abuse within their family environment.

Each TSCP group is chaired by one of the safeguarding partners and is attended by a broad range of agencies, including, where required, the faith, voluntary and community sectors. Attendance expectations are clearly outlined in each group’s Terms of Reference and quoracy is achieved by the attendance of each of the three statutory safeguarding partners, or, for the ICB at sub-group level, an equivalent health professional from the Torbay and South Devon NHS Foundation Trust.

TSCP Structure Chart



4. Area Profile and Context

Torbay's area profile and related context are detailed in the latest version of the [Torbay Joint Strategic Needs Assessment \(JSNA\) 2026/27](#). This document was published in June 2026 and primarily covers the reporting period 2025/26, with some data that is not collated on a yearly basis referring to years before this.

The key challenges for Torbay highlighted in the current JSNA are;

- There is significant variation in health and wellbeing across the bay. In Torbay's most affluent areas residents can expect to live on average around five years longer than those living in the more deprived communities. There are also significant gaps in healthy life expectancy between the most affluent and deprived areas.
- A consistent pattern of worse health and educational outcomes for those people who live in more deprived areas; Torbay is ranked as the most deprived local authority in the Southwest of England.
- Torbay's economy is ranked among the weakest in England. Average wages are significantly below the regional and national average, with less of the population in full-time employment than the England average.
- Almost 1 in 4 Torbay residents have conditions or illnesses that reduce their ability to carry out day-to-day activities.
- The number of cared for children within the local authority remains significantly higher than the England average. Rates of referrals to children's social care and rates of 'Children in Need' are consistently much higher than the England average. Academic outcomes are significantly worse for these children when compared to children across England as a whole.
- Persistent pupil absenteeism remains at significantly elevated levels post COVID 19, after the rate doubled in 2021/22. This is reflected across England. Rates are much higher among children from Torbay's more deprived areas.
- Compared to the England average, Torbay has far higher levels of need that require support from Adult Social Care in the 18 to 64 population range and higher levels of need requiring support in the 65+ population range. Rates of requests from new clients are higher than the England average in the 18 to 64 and 65+ population.
- The 2021 Census showed that there were 14,900 unpaid carers in Torbay. 5,185 of these

provided 50 hours or more of care. These unpaid carers require support to help deliver this care and to look after their own health and wellbeing. This care is disproportionately provided by women.

- Torbay has an ageing population, with 1 in 3 Torbay residents expected to be 65 and over by the middle of the next decade. This will put increasing demand on health and social care.
- Torbay has lower rates of housing deemed to be energy efficient when compared to the England average.
- Torbay has a consistently higher rate of people owed a duty under the Homelessness Reduction Act (Those who are homeless or threatened with homelessness).
- Torbay has a significantly higher level of hospital admissions for eating disorders than the England average, with a significant rise during 2024/25, largely concentrated among younger females.
- There are consistently high rates of dental extractions among children in Torbay that are performed at a hospital due to dental decay; this is particularly concentrated among Torbay's more deprived communities. Lower levels of Torbay residents have seen an NHS dentist in recent years than the England average.
- Human Papillomaviruses (HPV) vaccination rates for 12- to 13-year-olds in Torbay are significantly lower than the 90% national target (67.7% for 2023/24).
- There are high levels of self-harm hospital admissions, although this is reducing, and suicide in the population of Torbay when compared to the England average. Suicide rates have fallen for the last two years but this is thought to be due to a significant local coroner backlog.
- Torbay has experienced falls in breast and cervical cancer screening rates since COVID 19. Rates of emergency hospital admissions in Torbay for cancer have been significantly higher than the England average for the last three years, even allowing for Torbay's older age profile.
- A general fall in childhood immunisation rates since COVID 19, although rates remain broadly higher than in the rest of England.
- Rates of reported violent and sexual offences have been higher in Torbay than the England average for the last two years.
- There are high levels of vulnerability in the Torbay population, including groups with specialist needs and high levels of mental ill health.
- There are many opportunities for the people of Torbay to be supported to improve their lifestyles. At present approximately 3 out of 10 adults in Torbay are obese and

approximately 1 in 4 reception and over 1 in 3 Year 6 children are overweight or obese. Around 1 in 7 adults in Torbay smoke, Torbay rates are higher than the England average. In Torbay, there are high levels of admissions to hospital related to alcohol use. Torbay also has significantly higher levels of preventable mortality from liver disease.

Better outcomes and improvements in Torbay, highlighted in the current JSNA are;

- An increase in breastfeeding rates at 6 to 8 weeks after birth over the last decade from 40% to 51%.
- Although rates remain high, there was a fall from the 2019 peak in rates of Cared for Children within the local authority and a fall from the 2021 peak in the rate of referrals.
- 93% of people who used Torbay Adult Social Care services during 2024/25 said that those services made them feel safe, this was higher than the England average.
- Consistently higher percentage than the England average of infants receiving a 6-to-8-week review from a health visitor.
- A lower level of unemployment claimants than the England average.
- Affordability of property to buy has improved since 2021, and rents are more affordable than the England average.
- Considerably lower, and falling, level of greenhouse gas emissions per person than the England average.
- Higher screening rates than the England average for chlamydia among Torbay's 15- to 24-year-old female population.
- Over the last decade, Torbay has had a higher proportion of alcohol users that left structured treatment free of alcohol dependence when compared to the England average.
- Increase in the percentage of clients entering drug treatment identified as having a mental health treatment need, who are receiving treatment for their mental health.
- Significant falls over the last decade in the rate of adults having a hospital tooth extraction due to dental decay.
- Although higher than the England average, there was a steady fall over the last decade in the rate of emergency hospital admissions for self-harm (all ages).
- Rates of hospital admissions and under 75 mortalities for strokes have broadly fallen over the last decade.
- Increases in the percentage of household waste sent for reuse, recycling or composting after the decreases recorded during COVID 19.
- Bowel cancer screening rates have increased over the last decade and are consistently

higher than the England average.

- Decrease in under 75 mortalities for lung cancer in males over the last decade.
- Childhood immunisation rates are generally higher in Torbay than the England average.

Children in Need or subject of Child Protection Enquiries and Planning

The rate of referrals per 10,000 children in Torbay in 2025/26 was 698. This remains significantly higher than the statistical neighbour (SN) rate of 519, and slightly lower than the England average local authority figure of 715. (Note: all comparisons to SN and England data are compared to the previous year, 2024/25, as more recent data is yet to be published). Although the rate of referrals per 10,000 children has been reducing in Torbay since the first TSCP Annual Report in 2020/21, the pattern of Torbay's referral rate being higher than SN remains a consistent theme and has a known link to local demographics and indices of deprivation. The rationale for the continuing increase in the wider England referral rate will require further investigation.

The proportion of referrals from schools in Torbay increased by two percentage points in 2025/26 to 19%, which is one percentage point below both the SN average and the England figures for 2024/25. The proportion of referrals from Health reduced in 2025/26 by one percentage point to 15%, which is the second consecutive yearly reduction in health referrals to the TSCP and is now in line with the England average, but still remains slightly above the SN average. The proportion of referrals from the Police in 2025/26 decreased by four percentage points to 27%. This rate is now two percentage points below both the SN and England averages for 2024/25. To summarise, in 2025/26 there was an increase in the number of referrals made by schools and a reduction from health and the police. Contact rates and quality of referrals are considered and reviewed via the MASH Strategic Board.

The number of Torbay Children in Need, as per the Department for Education (DfE) definition relating to all children open with any case status, as of 31/03/26 increased to 1264 from the previous year's figure of 1261, recorded on 31/03/25, an increase of below 1% and an increase in the rate per 10,000 children from 493 to 501. SN and England comparator data continues to evidence that Torbay has a consistently higher proportion of Children in Need than many other Local Authority areas, with this being linked to known local deprivation and levels of need. The most recent 2024/25 data comparisons to this year show that Torbay has a Child in Need rate 12% higher than the SN figure of 446 and 51% higher than the England average of 331.

There were 160 children subject to child protection plans in Torbay on 31/03/2026, which is a rate

of 63 per 10,000 children. This is 7% higher than the 2024/25 rate of 59 and 5% below the SN rate of 66 for the previous period. The number of Torbay children subject to child protection plans is 54% higher than the England average of 41 per 10,000 children, a considerable difference that has remained consistent for the last four years. The number of child protection plans starting in Torbay in 2025/26 was 160. This is significantly lower than the previous year when 210 child protection plans began and is the lowest figure for the last four years. The rate of child protection plans starting in Torbay in 2025/26 was 72 per 10,000 children, which is below last year's SN average of 81 but significantly above last year's England average of 51. The number of child protection plans ending in Torbay in 2025/26 was 162, a decrease on the previous four years and slightly higher than the number of plans starting. For comparison, Torbay's rate of child protection plans ending in 2025/26 was 64 per 10,000 children, contrasted to last year's SN rate of 84 and England rate of 51.

At 66%, neglect remained by a significant margin the most common recorded category of abuse for children in receipt of a child protection plan in Torbay on 31/03/2026. Child exploitation is often recorded under the category of neglect, and this may be a factor in the high number of children with neglect recorded as their category of abuse. There is a TSCP workstream focused on contextual safeguarding that has now concluded, with part of that work investigating the potential to create a new category of 'contextual' child protection plan which would be considered restorative for parents/carers and potentially reduce the number of child protection plans under the category of neglect. 'Emotional' was the second most common category of abuse recorded on 31/03/2026 at 21%, with the categories of emotional and multiple abuse continuing to change position in yearly data rankings. The other two categories of abuse, physical and sexual, remain very low in number and are therefore susceptible to the effects of sibling group size impacting on data, although sexual abuse accounted for 4% of child protection plans in 2025/26, an increase on the previous four years.

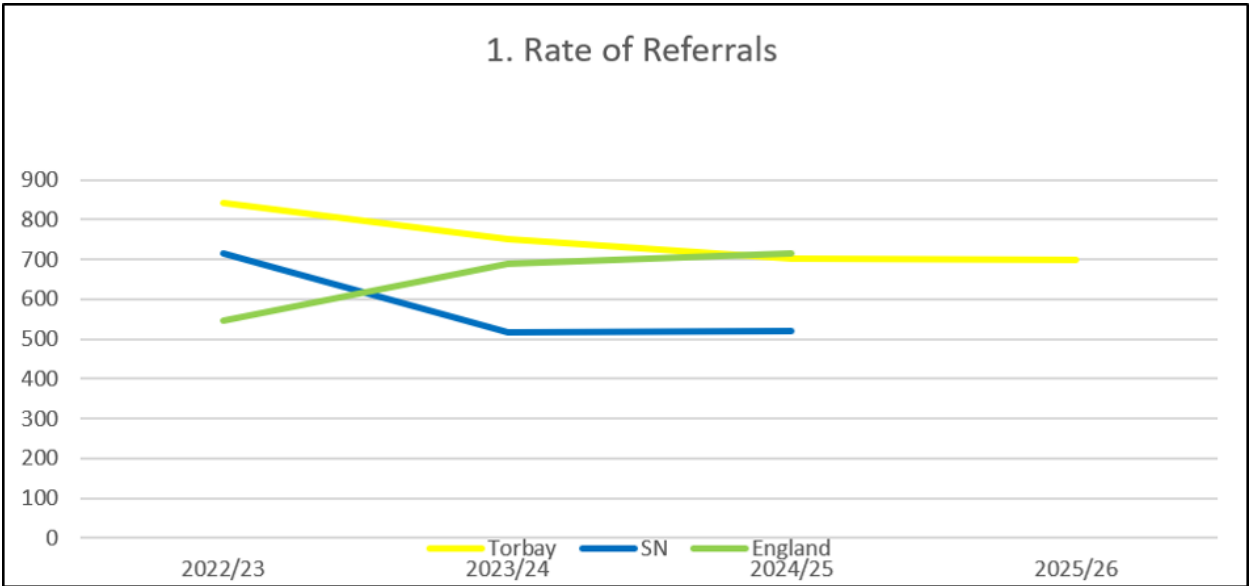
There were 1282 strategy meetings held in Torbay in 2025/26, with 97% of these being quorate. This compares to 2024/25 when a total of 1389 strategy meetings were held, with a quoracy rate of 90%. Strategy meeting quoracy had been declining for each of the three years previously reported, however the rise to 97% in 2025/26 is notable. Data in respect of strategy meeting quoracy is not available for SN and England comparison but is reported on within the TSCP data dashboard to inform local practice.

There were 552 initial and review Child Protection Conferences held in Torbay in 2025/26, a decrease from 707 in 2024/25. At 93%, conference quoracy in 2025/26 was the highest by a

significant margin over the four-year period that this data has been collated by the TSCP. Data in respect of child protection conference quoracy is not available for SN and England comparison but is reported on within the TSCP data dashboard to inform local practice.

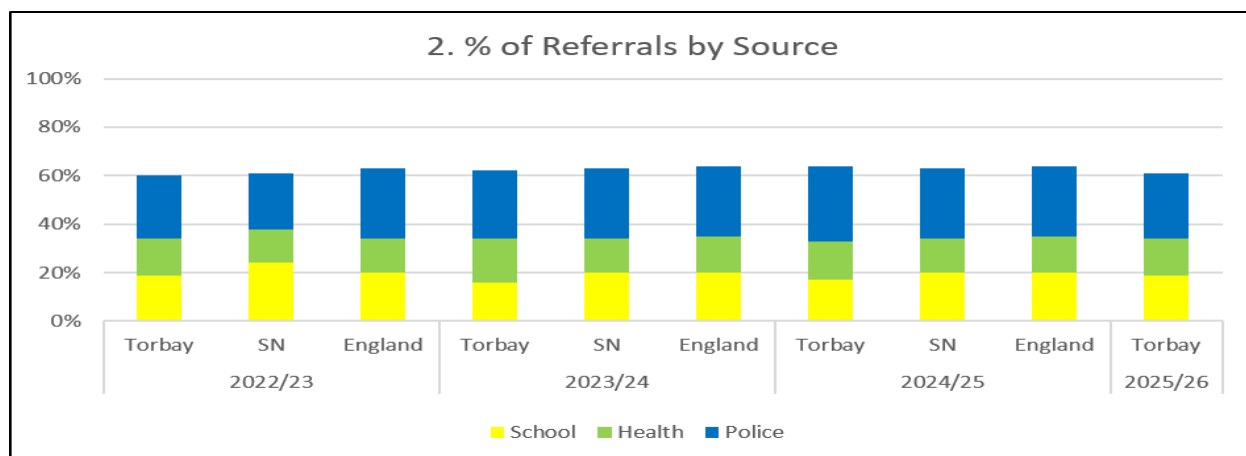
Analysis of the TSCP Annual Report data sets forms part of a wider data system that is undertaken via a joint analytical venture with the Devon SCP. Data analysis continues to develop, with structural links being planned to align with the work of TSCP sub-groups in the Autumn of 2026. All Children in Need/Child Protection data within this report has been provided by the local authority. Police and local health agencies have reviewed their data systems and now provide data to support the TSCP data dashboard. The new improved data system used by the local authority has highlighted some small discrepancies within historic data sets, but these are not reported to be significant enough to have influenced reporting trends. Statistical Neighbour and England data sets have been checked and their accuracies confirmed.

1. Number and Rate of Referrals to Children’s Social Care					
		2022/23	2023/24	2024/25	2025/26
Total number of referrals	Torbay	2126	1899	1774	1762
Rate of referrals per 10,000	Torbay	842	752	702	698
(SN = Statistical Neighbour)	SN	715	518	519	-
	England	545	690	715	-



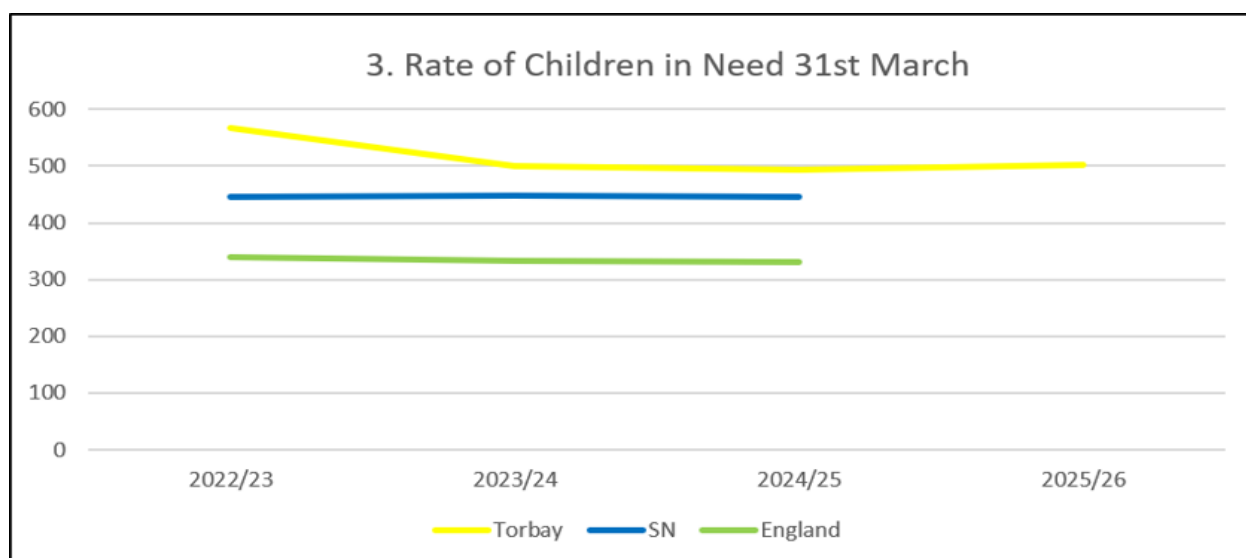
2. Referrals to Children's Social Care by Source

	2022/23			2023/24			2024/25			2025/26
	Torbay	SN	England	Torbay	SN	England	Torbay	SN	England	Torbay
School	19%	24%	20%	16%	20%	20%	17%	20%	20%	19%
Health	15%	14%	14%	18%	14%	15%	16%	14%	15%	15%
Police	26%	23%	29%	28%	29%	29%	31%	29%	29%	27%

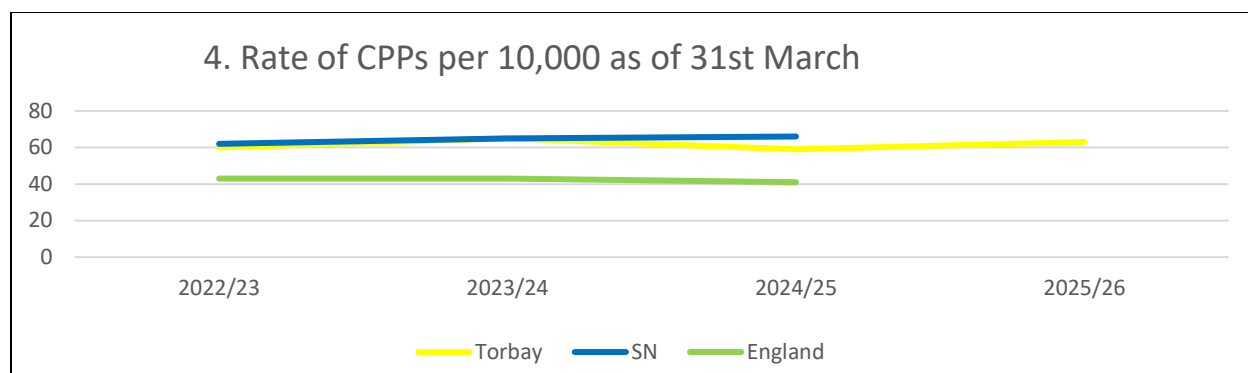


3. Number and Rate of Children in Need as of 31st March

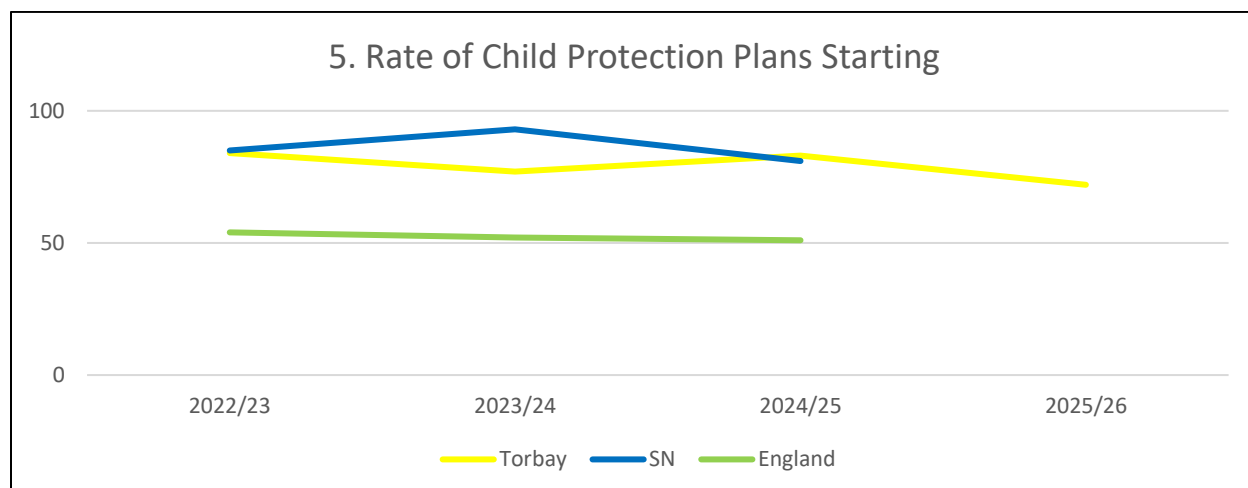
		2022/23	2023/24	2024/25	2025/26
Number of Children in Need	Torbay	1453	1275	1261	1264
Rate of Children in Need per 10,000	Torbay	568	499	493	501
	SN	445	448	446	-
	England	339	333	331	-



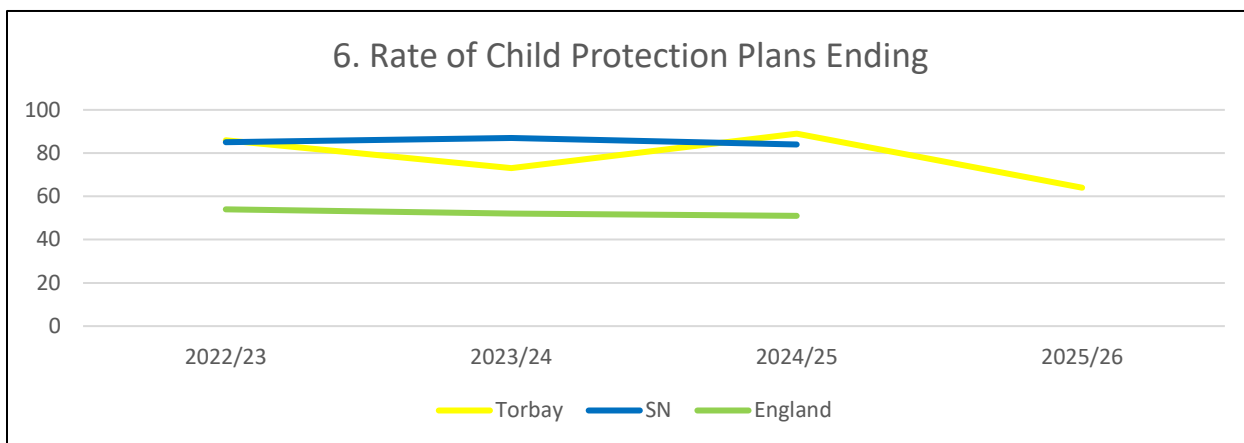
4. Number and Rate of Child Protection Plans as of 31 st March					
		2022/23	2023/24	2024/25	2025/26
Number of CP plans	Torbay	152	163	149	160
Rate of CP plans per 10,000	Torbay	60	65	59	63
	SN	62	65	66	-
	England	43	43	41	-



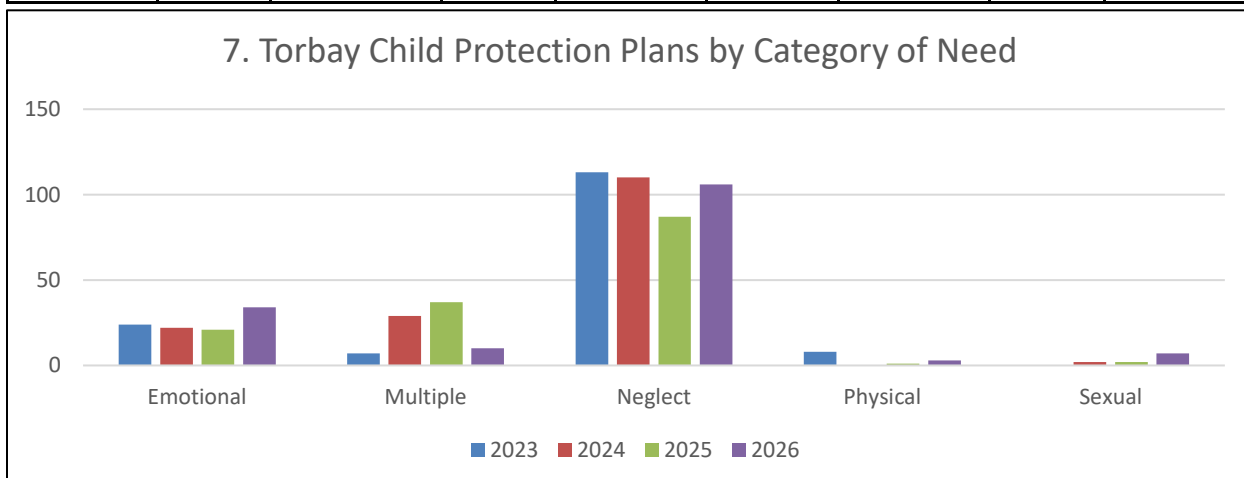
5. Number and Rate of Child Protection Plans Starting					
		2022/23	2023/24	2024/25	2025/26
Number of CP plans starting	Torbay	213	194	210	160
Rate of CP plans starting per 10,000	Torbay	84	77	83	72
	SN	85	93	81	-
	England	54	52	51	-



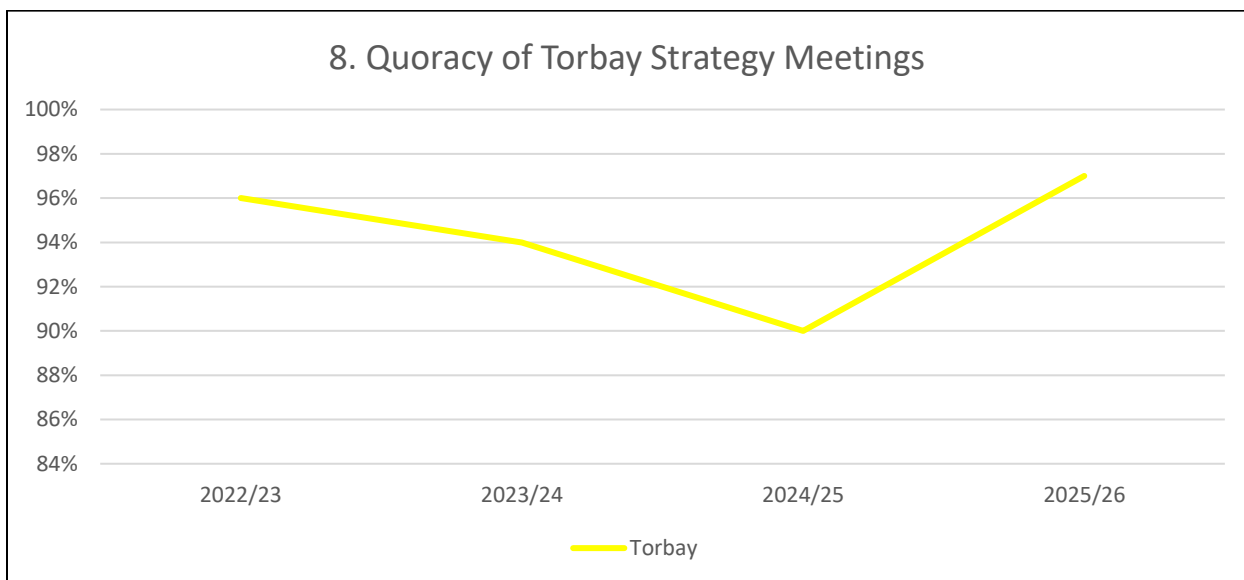
6. Number and Rate of Child Protection Plans Ending					
		2022/23	2023/24	2024/25	2025/26
Number of CP plans ending	Torbay	216	183	226	162
Rate of CP plans ending per 10,000	Torbay	86	73	89	64
	SN	85	87	84	-
	England	54	52	51	-



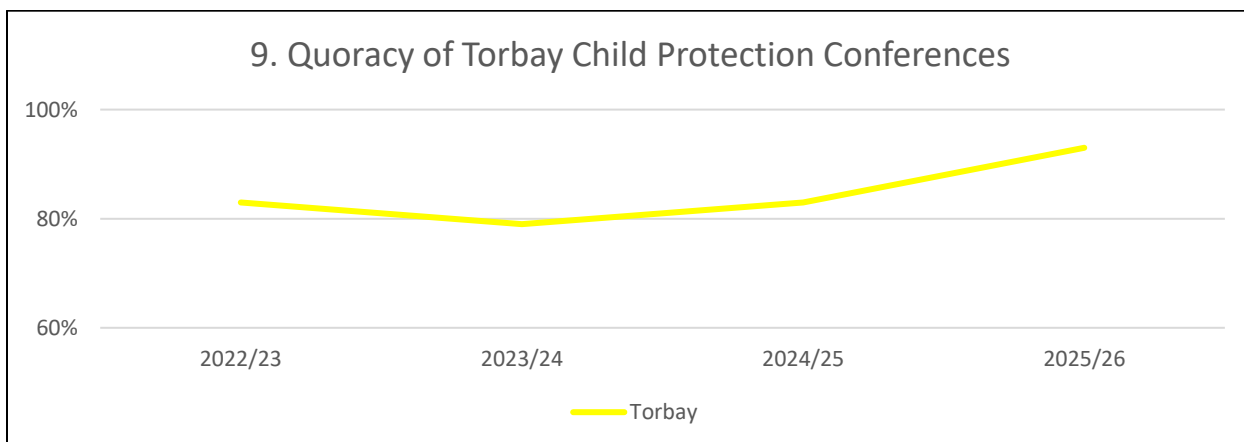
7. Torbay Child Protection Plans by Category of Need as of 31st March								
	2023		2024		2025		2026	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
Emotional	24	16%	22	13%	21	14%	34	21%
Multiple	7	5%	29	18%	37	25%	10	6%
Neglect	113	74%	110	67%	87	58%	106	66%
Physical	8	5%	0	0%	1	1%	3	2%
Sexual	0	0%	2	1%	2	1%	7	4%
Blank	0	0%	0	0%	1	1%	0	0%
Total	152		163		149		160	



8. Quoracy of Torbay Strategy Meetings					
		2022/23	2023/24	2024/25	2025/26
Number of meetings	Torbay	1273	1206	1389	1282
Percentage of quorate meetings	Torbay	96%	94%	90%	97%
	SN	-	-	-	-
	England	-	-	-	-



9. Quoracy of Torbay Child Protection Conferences (Initial and Review)					
		2022/23	2023/24	2024/25	2025/26
Number of meetings	Torbay	703	603	707	552
Percentage of quorate meetings	Torbay	83%	79%	83%	93%
	SN	-	-	-	-
	England	-	-	-	-



5. Reviews/Inspections

Reviews

Between 01/04/2025 and 31/03/2026 the TSCP received three Serious Incident Notification (SIN) referrals. Each of the three referrals related to a single child, rather than a family or peer group. The third referral was subsequently extended to cover a wider peer group due to its theme of youth criminality. SIN criteria were not met in each case, with one of the referrals relating to an 18-year-old care experienced young person. However, as relevant learning was believed to be evident in respect of all three incidents reported, local non-statutory learning reviews have been agreed by the TSCP. The number of SIN referrals submitted in 2025/26 was an increase from the one submitted in 2024/25.

The Department for Education (DfE) publishes its annual [Serious Incident Notification data](#) that reports on the number of SINs submitted nationally between 01/04/2025 and 31/03/2026. In 2025/26 there were 357 notifications made, an increase of 19 from the previous reporting year. This is split into:

- 160 SINs relating to child death.
- 188 SINs relating to serious harm.
- 9 SINs recorded as 'other'.

DfE annual Serious Incident data shows two less deaths recorded than in the previous year but 21 more serious harm incidents. Although these latest figures show a slight increase on the previous year's numbers, they represent the second lowest number of SINs submitted to the DfE according to published data going back to 2019 and mirror the general pattern of reducing SINs experienced by the TSCP, prior to this year. The DfE acknowledge that while one notification can cover more than one child, they are aware that not all incidents that meet the criteria are notified and report a level of caution regarding interpretation of the data. The DfE state the vital importance of further analysis and work being undertaken nationally to understand what factors may have resulted in this reduction and, most crucially, what this may tell us about both the lives of children and the effectiveness of agencies working together to safeguard children.

Aggregated Learning from Reviews

During the current reporting period the TSCP Child Safeguarding Practice Review (CSPR) Panel retained responsibility for the operational management of all TSCP learning reviews, converting

review recommendations into actions, and ensuring oversight of these actions through to resolution. The CSPR Panel also continued to aggregate national and regional learning, CSPR reports provided via the NSPCC repository, and local single -agency audits, incorporating these into learning processes and events where it was felt they would support practice improvement.

Inspections

Torbay Council's Children's Services department reported a full OFSTED inspection in January 2026, undertaken via the Inspecting Local Authority Children's Services (ILACS) model. Inspection dates were 12/01/26 to 16/01/26, with the final grade being Good. The full inspection report can be accessed via [Inspection of Torbay local authority children's services](#). Brief details and grade for each judgement area are recorded in the table below.

Judgement	Grade
The impact of leaders on social work practice with children and families	Good
The experiences and progress of children who need help and protection	Good
The experiences and progress of children in care	Good
The experiences and progress of children care leavers	Good
Overall effectiveness	Good

Torbay Special Educational Needs and Disabilities (SEND) local area partnership was jointly inspected in March 2025 by OFSTED and the Care Quality Commission (CQC). The findings of this inspection stated, 'There are widespread and/or systemic failings leading to significant concerns about the experiences and outcomes of children and young people with special educational needs and/or disabilities, which the local area partnership must address urgently.' The full report can be accessed via [Area SEND inspection of Torbay Local Area Partnership](#). During the 2025/26 reporting period a priority action plan was formulated and on 23/03/26 a Stock Taking session was held to review the actions undertaken since the inspection.

NHS Devon ICB reported no inspections during the 2025/26 reporting period.

Torbay and South Devon NHS Trust reported no child related inspections during the 2025/26 reporting period.

Devon and Cornwall Police reported two inspections by His Majesties Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) during the 2025/26 reporting period. The first was an inspection of the effectiveness of integrity arrangements in Devon and Cornwall Police, published in October 2025. [A report into the effectiveness of integrity arrangements in Devon and Cornwall Police - His Majesty's Inspectorate of Constabulary and Fire & Rescue Services](#)

The second inspection reported by Devon and Cornwall Police was a full Police Effectiveness, Efficiency and Legitimacy (PEEL) inspection published on the 03/06/26, with the findings for that report being informed by performance monitoring and visits during the 2025/26 reporting period. Brief details and grade for each judgement area are recorded in the table below, with the safeguarding cause for concern centring on the forces secondary review of domestic abuse risk assessments

Outstanding	Good	Adequate	Requires Improvement	Inadequate
		Police powers and public treatment	Leadership and force management	Investigating crime
		Preventing and deterring crime	Developing a diverse and inclusive workforce	Safeguarding children and adults
			Responding to the public	
			Managing fraud	

The full report can be access via [PEEL 2025–27: Police effectiveness, efficiency and legitimacy – An inspection of Devon and Cornwall Police](#)

6. Progress Against Statutory Guidance

Implementation of Working Together to Safeguard Children 2026

In March 2026 HM Government published revised Working Together to Safeguard Child arrangements (WT2026) that all Safeguarding Children Partnerships (SCP) are expected to be compliant with. The 2026 version of Working Together is an update of Working Together 2023, rather than a whole rewrite of the previous guidance. The TSCP began incorporating the changes that the new WT2026 guidance brought as soon as it was received. HM Government has indicated that future updates to Working Together will be more incremental in nature, rather than full revisions of the whole document.

Updated TSCP Multi-Agency Safeguarding Arrangements

Following the publication of WT2026, and the changes to one of the four TSCP priority areas, the partnerships [Multi-Agency Safeguarding Arrangements \(MASA\)](#) were updated in the Spring of 2026. The updated MASA is designed to continue providing clarity for local services regarding their role and expectations within Torbay's safeguarding arrangements and provides the public with details on which agencies are covered by the arrangements, both on a statutory and relevant basis, including their role within partnership arrangements. The impact of the updated MASA will be evaluated during 2026/27 and reported on in the subsequent TSCP Annual Report.

Updated TSCP Business Plan

During the Autumn of 2024 the TSCP Executive Group reviewed the impact of the partnership's work in respect of the four existing TSCP priority areas and decided to amend, but retain, the themes of the 2021-2024 Business Plan. The rationale for this decision was based on two key criteria. The primary criterion was based on data that evidenced the themes retaining significant relevance in respect of the safeguarding needs of children and families in Torbay. Secondly, the findings of the Joint Targeted Area Inspection (JTAI) in November 2023 reporting an agreement with the existing four TSCP priority areas.

In late 2025, significant improvements to the level of mental health support received by children and young people in Torbay, formally reported in the Autumn/Winter of 2025, afforded the Executive Group an opportunity to re-evaluate the TSCP Business Plan. This led to a decision to amend the partnership's mental health priority to one themed on child sexual abuse in the family environment (CSAFE), which is acknowledged nationally as a current theme of significant concern. The timeline of the TSCP Business Plan was retained but amended to incorporate the

new priority area and any updates from WT2026. The [2025-2028 TSCP Business Plan](#) lays out and explains the partnership's strategic safeguarding priorities for the three-year timescale in question, including the key principles that the partnership will be guided by to ensure its work remains restorative, child centred, relevant, and accessible to both families and practitioners across the Bay.

Data Dashboard

Throughout the 2025/26 reporting period, development of the TSCP data dashboard continued, with the TSCP purchasing 3 hours per week dedicated data analysis support from the Devon SCP in the Autumn of 2025, which accelerated this process. Updated police and health data sets were revised within the current reporting period and added to the dashboard to improve reporting accuracy. From April 2026 the TSCP will formalise its joint data venture with the Devon SCP, which will involve increasing TSCP analytical time to 11 hours per week and the sharing of a dedicated SCP Data Officer. In addition to this, from May 2026 there are plans for the Plymouth SCP to join with the Torbay and Devon SCPs to work on aligning Key Performance Indicators (KPI) to support the use of consistent data across the Devon geographical area. It is hoped that the Cornwall SCP will join this venture at some point in the future. Full implementation of the dashboard, including analytical reports and subsequent elevated data informed practice, is planned to begin in September 2025, with oversight being managed by the partnership's Quality Assurance Group once DSPs are content that process and application are robust enough.

Education Sector Representation

Until March 2026 education was represented within the TSCP structure by the Torbay Education Support Service (TESS), with the Director of Children's Services (DCS) also being responsible for education within her portfolio. From March 2026 the Head Teacher of a local primary school joined the TSCP Executive Group as a fixed attendee and has actively contributed to DSP level decision making. Education provider attendance at TSCP sub-groups is expected to increase in 2026/27, with at least two further attendees being identified.

Feedback/Input from Children and Families

Although the TSCP has no formal arrangements that directly involve children and families within its feedback/input processes, the Torbay Children's Services Relational Practice Team are permanent members of the partnerships Business and Quality Assurance Groups. This arrangement allows for the views of children and families to be fed into the work of the TSCP via their sub-group attendance and related activities, including the provision of relevant information from views already collated. This arrangement also ensures that the relatively small cohort of local

children and young people engaged with the Relational Team do not get overloaded with requests for their views, in addition to them not receiving multiple similar requests from partner agencies across the Bay.

Allegations Against People that Work with Children

WT2026 and [Keeping Children Safe in Education 2026](#) (KCSIE 2026) place a responsibility on all Local Authorities in England to identify a designated officer (LADO) who is involved in the management and oversight of individual cases of allegations of abuse made against those who work with children. The role of the LADO is to give advice and guidance to employers and voluntary organisations and liaise with the police and other agencies to monitor the progress of cases to ensure that they are dealt with as quickly as possible and are consistent, with a thorough and fair process. Torbay Council ensures effective management oversight of the LADO, including quality assurance, LADO supervision, dealing with developing areas of concern in individual professional cases and facilitating improvements in LADO practice. A more detailed overview of the work of the LADO in Torbay during this reporting period can be found within the [2025/26 LADO Annual Report](#).

Child Death Reviewing Arrangements

Child death reviewing arrangements in Torbay form part of the regional Southwest Peninsula Child Death Overview Panel (CDOP). This service remained commissioned to Livewell Southwest within the reporting year 2025/26, with further details being available in the 2024/25 CDOP Annual Report once this has been published.

Child death review partners are defined in section 16Q of the Children Act 2004, which for the Southwest Peninsula CDOP are:

- Cornwall Council
- Council of the Isles of Scilly
- Devon County Council
- Plymouth City Council
- Torbay Council
- NHS Devon ICB
- NHS Cornwall and Isles of Scilly ICB

The child death review arrangements operate in line with the requirements of the statutory guidance, WT2026, and the Child Death Review: Statutory and Operational Guidance (England)

2018. Within these arrangements, Devon and Cornwall Police join the child death review partners to form quoracy. The child death review process is defined by four stages following the death of a child:

- Immediate decision making and notifications.
- Investigation and information gathering.
- Child Death Review Meeting (CDRM).
- Independent review of the child death by the CDOP.

Following a review of the Peninsula CDOP partnership update/learning process in late 2024, revised arrangements were agreed with CDOP and shared with safeguarding partners in January 2025. Under the new arrangements CDOP will convene collective bi-annual update meetings for Business Group chairs, CSPR Panel chairs and Partnership/Business Managers from the four Peninsula SCPs. These new arrangements are designed to promote a peninsular-wide approach to child death discussions and should improve clarity by avoiding the need to duplicate information to individual SCPs. In between the CDOP bi-annual meetings, NHS Devon ICB Designated Nurses will communicate any learning highlighted for individual SCPs at related individual partnership CSPR Panel meetings. The outcome of TSCP child death actions/interventions continue to be fed back to the CDOP by the agreed ICB or LA representative to complete the learning cycle. Assurance of the child death arrangements is a function of the TSCP Executive Group, conducted on behalf of the LSP's.

Peninsula Business Managers Forum

Throughout the 2025/26 reporting period, Business Managers from Torbay, Devon, Plymouth, and Cornwall have continued to collaborate on partnership functions to support improvements and efficiency in safeguarding arrangements across the Peninsula. Examples of joint working in 2025/26 include shared data construction/analysis and the scoping of a potential Peninsula wide safeguarding learning resource. Business Manager collaboration retains the ongoing support of DSPs and LSPs across the Peninsula and will continue in 2026/27.

7. Independent Scrutiny

Independent Scrutiny provides safeguarding partnerships with challenge, support and assurance regarding the effectiveness their local safeguarding arrangements. Independent scrutiny forms an important part of the partnership's approach to understanding what difference multi-agency safeguarding activity is making for children and families, as well as identifying areas where further improvement is needed.

Independent scrutiny contributes to a wider system of accountability which also includes Torbay's Councils Children's and Young People's Overview and Scrutiny Subgroup, the Children's Continuous Improvement Board and national inspectorates such as OFSTED, HMICFRS and CQC. In Torbay, there are also regular deep dive events led by the Council's Chief Executive (LSP) and Independent Chair of the Children's Continuous Improvement Board.

The LSP governance arrangements are now well established and have provided the partnership with consistent and effective strategic leadership.

For the reporting period 2025/26, there was consistent strategic leadership across the three safeguarding partners. However, since then, the Devon ICB now operates as a single cluster alongside the Cornwall and Isles of Scilly ICB. These significant changes are still ongoing.

Similarly for this reporting period, there was consistent representation at DSP level across the three safeguarding partners. It is also welcomed that education is now better represented at DSP level.

During the year, the Independent Scrutineer considered a range of evidence including partnership performance information, multi-agency audits, thematic reviews, Child Safeguarding Practice Reviews (CSPRs), Rapid Reviews, governance arrangements, workforce development activity, meeting observations and feedback from partners.

A robust governance process is in place for Rapid Reviews and Local Safeguarding Children Practice Reviews (LSCP Rs), with Designated Safeguarding Partners (DSPs) jointly contributing to all decision-making. This strengthens accountability, ensures consistency in decision-making, and supports the partnership in managing demand in a timely and effective manner. During this reporting period, the partnership benefited from the expertise of key individuals experienced in

managing the Rapid Review process, ensuring that when they occur, reviews are conducted in a timely manner, that the voice and experiences of children and families are effectively represented, and that resulting actions maintained a strong multi-agency focus. During this period the partnership had access to an experienced Local Safeguarding Children Practice Review (LSCPR) author, enabling learning identified through Rapid Reviews to be explored in greater depth and translated into wider systemic improvements in safeguarding practice.

The Quality Assurance (QA) subgroup has been strengthened and now benefits from strong representation across partner agencies. Agencies are routinely presenting the findings from their single agency audits and dip sampling activity within the partnership forum. Presentations have included child neglect audits from the local acute trust, Public Protection Notices from the police, and child exploitation audits from children's services. These presentations generate valuable multi-agency discussion, providing opportunities for partners to identify learning, share good practice, and consider how they can collectively contribute to and support improvements across the safeguarding system.

The Independent Scrutineer carried out thematic pieces of work around child exploitation and was involved in multi-agency case audits around children's mental health. The approach in Torbay in respect of child exploitation is strong with effective multi-agency operational groups focusing on the vulnerability of specific children and place-based risk. For this reporting period, the mental health priority did progress better when a Torbay specific partnership group was established.

The partnership continues to deliver annual conferences, providing practitioners with valuable opportunities to network with colleagues from across the safeguarding system, learn from respected expert speakers, and engage directly with DSPs. These conferences remain well attended and are aligned to the partnership's strategic priorities, supporting shared learning, professional development, and the promotion of effective multi-agency safeguarding practice.

8. Financial Arrangements

'The Lead Safeguarding Partners (LSP) should agree on the level of funding needed to deliver the multi-agency safeguarding arrangements. This includes consideration of business and analytical support, independent scrutiny, infrastructure, and core functions including local child safeguarding practice reviews, multi-agency training and learning events. It is the responsibility of the LSP to ensure that adequate funding is allocated and spent in line with agreed priorities.

Funding contributions from the statutory safeguarding partners should be equitable and agreed by the LSPs. Funding for the arrangements should be reviewed on an ongoing basis to ensure that they can meet the financial needs of the arrangements. The funding should be transparent to children and families in the area, and the individual contributions of safeguarding partners and relevant agencies should be clearly set out in reporting. (Working Together to Safeguard Children 2026)'

Contributing Agency	Value of Contribution 2025/26
Torbay Council	£121,000
NHS Devon ICB	£44,657
PCC Devon and Cornwall Police	£18,528
National Probation Service	£888
Total Funding Contributions	£185,073

TSCP funding arrangements for 2025/26 remained in line with the ratios from prior years. As reported previously, equity of partnership funding arrangements has been a consistent theme of debate within the TSCP for a number of years and is a current agenda item at LSP board meetings. LSP's have agreed to review the funding formulas for all four Peninsula SCPs during their September 2026 Peninsula meeting, with new, more equitable, formulas hopefully being negotiated in the near future.

Expenditure Item 2025/26	Expenditure Amount 2025/26
Business Team Staffing	£128,830
Independent Scrutineer	£21,600
Child Safeguarding Practice Reviews	£17,000 to reserves
Contract Costs (CDOP and tri.x)	£7,728
Other (including TASP membership at £750)	£9,915
Total	£185,073

Further to the contributions listed above in the first table the TSCP has also been provided with additional funding 'in kind', since its inception, via hosting arrangements with Torbay Council. These are costs that are not charged to other safeguarding partners. The exact cost of hosting the TSCP by Torbay Council is difficult to gauge and not currently reported on. Additional hosting costs are now part of the wider funding review agenda and will need to be factored into final decision making at LSP level.

'In kind' funding is necessary to cover the following essential business functions:

- Human Resource/Payroll
- Finance
- Website development/maintenance
- IT equipment/support
- Mobile device subscriptions

In addition to the identified hosting costs, Torbay Council also funds learning and development functions that are deemed critical to the running of an effective Safeguarding Children Partnership (SCP). These costs are linked to the following essential activities:

- Multi-agency safeguarding training, administered and provided by Torbay Children's Services Learning Academy. During 2025/26 any identified profit from TSCP training events was moved to the Learning Academy budget to support training and learning event costs incurred by Children's Services. Training funding/costs were reviewed in the 2025/26 reporting period,

with it being agreed that the budget for this element of TSCP activity will move in total to the Learning Academy to improve efficiency.

- Multi-agency safeguarding learning events, managed and hosted by Torbay Children's Services Learning Academy.
- Management and full funding, on behalf of safeguarding partners, of the TSCP element of the online learning platform, iLearn.

As previously reported, regarding value for money, the TSCP has notably lower running costs than its neighbours, despite providing a similar level of service. However, this needs to be weighed against the significant amount of benefit in kind provided by Torbay Council, which clearly increases the financial burden on the local authority in respect of TSCP costs, in addition to the local authority also being the highest contributor to TSCP annual funding.

9. Feedback and Key Priorities from Statutory Partners

Statutory Partner/Provider Impact Reports on TSCP Priorities and Activity

Torbay Council Children's Services

Neglect

Last year, 69% of children subject to child protection planning had a primary category of neglect, and a further 6% had multiple categories inclusive of neglect. Compared to this year, 60.6% have a primary category of neglect, with a greater number compared to last year having multiple categories inclusive of neglect at 16.8%. Torbay is an area with high levels of deprivation, and research demonstrates a clear correlation between this factor and child neglect.

Children's Services jointly provide, with public health, the work undertaken within the Family Hubs and the universal and targeted support provided to families in terms of cost-of-living surgeries and benefits advice, alongside a wide range of community resources including; Torquay Community Larder, Home church (Riviera Life Church) providing a food bank, baby bank (clothes, toys, equipment for babies and children), home starter packs and essentials for home.

As part of the Children's Services redesign, launched on the 1st September 2025, a therapeutic team has been introduced, which is a non-case holding team of practitioners who are specifically commissioned alongside allocated workers to provide intensive support for families who present with a range of needs, including neglect. The team are routinely delivering interventions to children and families including; Incredible Years Parenting Programme, keep safe work, draw & talk, Theraplay informed parenting approaches and Solution Focused Brief Intervention. This complements the work of established Children's Services teams such as Building Futures, Torbay's edge of care provision.

There are further links between child neglect and parental substance misuse both in pre-birth infants and children which can increase risk factors for some children with their basic needs not being routinely met. There are a number of support services delivered through Children's Services, Health, Adult Services, Family Hubs and charitable organisations including; Torbay Drug and Alcohol Service, Torbay Young Person's Drug and Alcohol Service, Narcotics Anonymous and links and phone numbers for various services and support: Frank, Checkpoint, Self-Management and Recovery Training (SMART) on the TSCP website.

For some children assessed to be at high risk of harm, Children's Services commission specific rehabilitation programmes including; parent and child rehabilitation placements, phosphatidyl ethanol (PeTH) testing (used to test for alcohol consumption) and Secure Continuous Remote Alcohol Monitoring (SCRAM) bracelets to promote children remaining within their parents' care.

For pre-birth infants there is a strong partnership approach between Children's Services, midwifery and 0-19 health services. Children's Services have embedded, over the last 12 months, an Unborn Baby Panel which is well attended by health partners and supports the tracking of vulnerable unborn babies to birth, to support a joined-up care planning approach to support identification of needs and risk reduction. This work is supported through care planning and is complimented by the work of allocated social workers in terms of enhancing parental responses and capacity through undertaking parent assessment and direct work with children and families. In the last 12 months Children's Services have invested in training for 20 social workers in a specialist parenting assessment model. The Parent Assess model is a structured, evidence-based parenting assessment framework designed to evaluate parenting capacity, especially for parents with learning disabilities or additional needs.

In January 2026, Ofsted reported a judgement for the experiences and progress of children who need help and protection as graded Good overall. They further reported "for a small but significant number of children who experience neglect and are subject to a mixture of child in need and child protection plans over time, progress is too slow. Children are visited but not always with a purpose linked to their plan, and escalation into the pre-proceedings phase of the Public Law Outline (PLO) is too late, with letters to parents not clearly laying out what is expected of them. Again, for this group of children, opportunities for workers to reflect and problem-solve are not frequent enough. However, in general, the quality of social work in, and leading up to, the court arena is effective. This has led to an increasing number of children being able to remain safely at home. Recent evidence shows that social workers are using the additional rigour of the PLO more quickly when parents do not make progress."

Since January, targeted work has commenced to improve children's experiences where neglect is identified to promote children's lived experiences and increase the timeliness of escalation where necessary. Between 1st April 2025 and 31st March 2026, 85 children from 46 families entered the Public Law Outline process. Of those, 61 children (72%) from 35 families (76%) had a child protection category of neglect only. A further 10 children (12%) from four families (9%) had multiple child protection categories inclusive of neglect.

In the last quarter, between January and March 2026, 23 children entered Public Law Outline pre-

proceedings with a child protection category of neglect. Outcomes for children exiting PLO in the 12-month period included 48 children entering public law proceedings, including 10 babies issued at birth. Eighteen children stepped down from PLO with a continuation of child protection or child in need planning. A PLO training workshop is scheduled for September 2026 to improve the quality of PLO letters and will include feedback from Ofsted, learning from audits and feedback from a parent who has experienced the PLO process.

In February 2026, Children's Services undertook a quality assurance review of neglect. The review consolidated the key learning arising from Torbay Council's Inspection of Local Authority Children's Services (ILACS) in January 2026 and associated quality assurance activity relating to neglect. It explicitly focused on children's day-to-day lived experience and the extent to which interventions are reducing risk, improving safety and care, and supporting sustained progress over time:

- Key safeguarding processes (strategy discussions/Section 47) can enable timely information-sharing and proportionate decisions when they are consistently applied with a clear focus on impact for the child.
- Audit evidence suggests that when Child in Need, Child Protection, Public Law Outline and legal pathways progress, children are more likely to experience clearer oversight, tighter planning and purposeful immediate safety actions.
- Stronger examples suggest child-centred assessments and plans, purposeful review, including Independent Reviewing Officer (IRO) challenge, and meaningful multi-agency input, especially from education.
- The report shows that neglect is usually chronic and cumulative, and that children can drift when concerns are recognised, but thresholds and plans are not stepped up quickly enough.
- There is good practice across the partnership in recognising risk, building relationships with children and families, and responding at the point of escalation, where statutory processes bring pace, multi-agency attention and immediate safety planning.
- The foundations that should sharpen analysis and drive change are not in place or current, most notably the Graded Care Profile (GCP2) and detailed, multi-agency chronologies. This weakens the ability to evidence trajectory, measure impact and hold plans to account when change is not being achieved.

This work is now moving toward development of an action plan through the Child Safeguarding Practice Review (CSPR) subgroup, using the After Action Review findings, current audit evidence, and relevant national learning to inform priorities for improvement.

Exploitation

Following the Children's Services Ofsted Inspection in January 2026, the Ofsted report highlighted that "Children who are potentially at risk of exploitation are recognised early, with key factors such as dips in school attendance or changes in peer groups triggering a cohesive response that focuses on reducing risk from medium to low rather than responding to critical incidents. Risk assessments are thorough, showing a strong understanding of the child's needs and risk factors. When children go missing, skillful engagement by members of the exploitation team builds a wider view of the child's lived experience, leading to effective safety plans".

The identification of, and response to, children and young people who are missing or vulnerable to exploitation including criminal, sexual and financial exploitation continues to be an effective area of multi-agency practice. This is supported by sustained and enhanced partnership working, improved data-sharing, and a range of operational and strategic forums where information about children is analysed and interpreted to enable targeted and effective multi-agency responses. This has been further strengthened through the development and implementation of child-led policing teams, which are locality based and align with Children's Services reforms through the Families First Partnership. Practitioners report improved communication between the policing teams and children's social care, and the links developed with the Exploitation and Missing Team have supported meaningful daily dialogue.

The Children's Services Exploitation Team forms part of a multi-agency group of key professionals who communicate daily, meet regularly, and provide support and professional challenge to one another, both internally and externally, in relation to responses for missing and exploited children. Torbay has an exploitation toolkit which is embedded and used by professionals across the TSCP where there are concerns about any form of exploitation. Torbay also has clear and embedded missing children protocols, which trigger child protection strategy meetings for repeated missing episodes or episodes lasting 72 hours or more. There are three distinct operational and practice forums for multi-agency discussion about children where contextual safeguarding concerns are identified: the Weekly Triage Meeting, the Children and Young People Exploitation Group (CYPEG), Practice and Process Panel, and the Child Exploitation and Missing Operation Group (CEMOG). The Missing and Child Exploitation Forum also meets monthly.

From April 2025, the statutory duty for 'return home conversations' returned in-house and is now located within the Exploitation and Missing Team within the Family Help Service. The team of three lead practitioners provides responses for missing children who are not 'open' to Children's Services, as well as children open to the service through Targeted Family Help, Child in Need, Child Protection

and Cared for Children arrangements. The team works closely and effectively across the full scope of the service and beyond, including regular communication with equivalent colleagues regarding children placed in Torbay from out of area and children located in Torbay from other local authorities.

The continued development of the Exploitation Team and associated responses means that risks to missing and exploited children are well understood both internally and across the partnership. The team supports a multi-agency approach to thorough and well-informed mapping activity, which strengthens partnership understanding of wider networks, individuals who may seek to exploit children, and the places and spaces where children may be vulnerable. This informs targeted disruption activity and support plans for identified young people, including escalation to complex strategy meetings where appropriate.

Missing and exploited children are consistently included within Children's Services audit cohorts, reflecting the varied nature of their circumstances and demographics. Themed audits have taken place in each quarter of the audit universe for exploited children. In 2025/26, a number of thematic and comparative audits were completed, including a focus on missing children, the use of the Philomena Protocol and children with National Referral Mechanism (NRM) referrals. Practice confidence in relation to the submission of NRMs has improved significantly. Every child for whom an NRM has been submitted in the last year has, to date, received either a positive reasonable grounds decision, subject to a conclusive grounds decision, or a conclusive grounds decision. This reflects a positive position, demonstrating a clear understanding of the NRM threshold and its application when making submissions. There is ongoing monthly performance review and analysis of missing children, including case status, age, gender and repeat missing episodes, alongside review of exploitation toolkit performance across each service using Microsoft Power BI, business intelligence software, and Exploitation Team trackers.

There was an increase in the number of exploitation toolkits completed in 2025/26, with 380 completed compared with 288 in 2024/25 and 194 in 2023/24. This evidences that the toolkit is well embedded in practice and is being used effectively to identify risk. In relation to the overall number of missing children, there was a significant increase when compared with historic performance in 2023/24, when 466 missing episodes were recorded. This then levelled off in 2024/25 at 401. In 2025/2026, missing episodes increased to 668, relating to 191 individual children.

A Children's Services quality assurance dip sample of 16 children who had been missing between 24th February and 9th April 2026, completed in April 2026, noted that "Most children and young people received a Return Home Conversation (RHC) within expected timescales. For 75% of the sample,

RHCs were completed within 72 hours, with 12% completed within 24 hours. This reflects a generally timely response and recognition of the importance of early engagement following missing episodes". The dip sample also identified that "Where Philomena Protocol forms had been completed, these were generally appropriately targeted at children with recurrent missing episodes. This shows awareness of the protocol as a tool to support safeguarding and information-sharing, particularly for cared for children at increased risk". Following the implementation of the Philomena Protocol in Spring 2024 for missing children, Torbay expanded its remit to include children who are repeatedly missing from home, education or family settings, not only from care settings. Confidence in local practice has increased over the last year, with 48 protocols completed for individual children in 2025/26.

The joint Children's and Adults' Services Transitions Panel is facilitated by Children's Services, with Adult Social Care represented within its membership. The panel continues to oversee transition planning for young people with a red exploitation toolkit or active NRM, mitigating the potential cliff edge experienced during the transition to adulthood. The terms of reference for the Transitions Panel are currently being updated and are proposed to include children supported under Prevent.

A TSCP multi-agency programme of work to develop a Contextual Safeguarding Framework for children in Torbay has concluded, with the proposed framework due to be presented to TSCP decision-making groups for consideration of implementation. The framework identifies clear partnership practice pathways for children at risk of exploitation, adults and locations of concern. It is intended to provide professionals with clear pathways to address key areas of exploitation work, with a strong focus on disruption.

The Family Help Therapeutic Team, established in October 2025, has successfully secured funding through the Serious Violence Fund via the Torbay Community Safety Partnership for Harmful Sexual Behaviour training. This will support an identified gap in the intervention offer for children under 10 and those presenting with lower-level harmful sexual behaviour who would not meet the criteria for support from the Youth Justice Service. The training is scheduled for November 2026, with the aim of developing and implementing an intervention offer for children open to the service by December 2026.

Domestic Abuse

Domestic abuse remains a significant issue for children in Torbay. Between 1 April 2025 and 31 March 2026, it was the second highest primary contact reason in the Multi-Agency Safeguarding Hub (MASH) at 21.99%, just below neglect at 22.1%. Children's Services contributes to the local domestic abuse response through Early Help, the Reducing Parental Conflict Coordinator, links with Standing Tall, delivery of the Domestic Abuse, Recovering Together with You (DAY) programme in schools,

and free Domestic Abuse, Stalking, and Honour Based Violence (DASH) and Domestic Abuse Risk Assessment for Children (DARAC) training for internal and partner agencies. This strengthens practitioner confidence in recognising domestic abuse, assessing risk, safety planning and understanding children as victims in their own right.

An audit undertaken between May and July 2025 considered 20 children and young people with a public protection notification. It identified positive partnership practice, including use of the Healing Together programme by schools and early years settings, Operation Encompass notifications to support children following incidents, and Dingley's Promise training for early years settings. The audit also highlighted the need to strengthen the multi-agency support offer for children affected by domestic abuse. The June 2025 Chief Executive's Deep Dive into domestic abuse and its impact on children found a committed partnership and examples of positive safeguarding impact. However, it also identified that children are not yet consistently recognised and responded to as victims in their own right, and that services are not yet operating as a fully integrated system. The Deep Dive recommended that all agencies strengthen systems, policies and practice so that children affected by domestic abuse are treated as victims in their own right; that TSCP convenes partners to develop an integrated domestic abuse strategy for Torbay; and that organisations improve how they report the impact of their work.

Mental Health

During 2025/26, Children's Services provided emotional wellbeing and mental health support across the wider service, rather than limiting its response to cared for children. Where children and families required more specialist input, Children's Services continued to commission individually tailored therapeutic support. This included Non-Violent Resistance and Dyadic Developmental Practice to help children, carers and families understand and respond to behaviour associated with trauma, abuse, neglect and disrupted attachment. Fostering families also receive bespoke support plans, out-of-hours assistance and intensive support programmes of up to 16 weeks where additional help was needed to sustain a child's living arrangements and relationships.

The wider system response was supported through Torbay's Emotional Wellbeing and Mental Health Group, co-chaired by the Director of Children's Services, with senior safeguarding representation. Its priorities included preventing and meeting need earlier, developing trauma-informed responses, reaching children who may find services difficult to engage with, improving accessible information linked to Family Hubs, mapping services and gaps, addressing health inequalities and strengthening voluntary-sector involvement. Children's Services also worked jointly with health colleagues to review the experiences of children with complex needs and individual commissioning arrangements,

including barriers to accessing appropriate provision.

Corporate Parenting Board information from the Child and Adolescent Mental Health Services (CAMHS) reports that 87% of accepted routine eating disorder referrals were seen within four weeks, 83% of crisis referrals requiring a CAMHS intervention received that intervention within 24 hours, and 91% of wider mental health support referrals were seen within 18 weeks. Earlier Corporate Parenting Board data recorded 88.8% of mental health support referrals were seen within 18 weeks. This data gives some assurance about access to support, while also identifying the need for continued strategic oversight of demand, waiting times, access routes and outcomes for cared for and care-experienced children and young people. There is clearly further work to be undertaken in this area to provide a timelier response for those most vulnerable and in crisis.

Subsequent to the current reporting period, Torbay began participating in the MyVoice pilot with Newcastle University and University College London. MyVoice is designed to support children aged 10–17 living in care and tests a comprehensive emotional wellbeing and mental health assessment package developed with input from care-experienced young people. It provides an additional assessment and identification route for children and young people who may be awaiting specialist emotional wellbeing or mental health support from CAMHS/health services.

The reach of emotional wellbeing screening improved during the 2025/26 school year. Overall, Strengths and Difficulties Questionnaire completion was 84.2%, meaning that more than eight in ten children in scope had at least one completed questionnaire. Most children had two questionnaires, usually completed by school and carers, with some also having a self-report. This multi-informant approach gives professionals a broader view of the child's emotional and behavioural wellbeing across home and education, supporting earlier identification of concerns and more informed discussion within education, care and support planning. The year-group information also provides a clearer basis for targeted improvement. Completion was 100% in Reception and Years 2, 4 and 5, while coverage was lower for older young people, particularly Year 12 at 59.4% and Year 13 at 60%. The data therefore demonstrates that routine identification is well embedded for much of the cohort, while also identifying where engagement and follow-up need to be strengthened as young people approach adulthood.

During 2025/26, Corporate Parenting governance began to move the Strengths and Difficulties Questionnaire from being principally a completion measure towards a tool for monitoring response and change. Agreed work included developing a policy, pathway and flowchart; expanding interpretation training across social workers, education and therapeutic staff; establishing a multi-

agency feedback loop; using questionnaires at the beginning, midpoint and end of interventions; and ensuring that the final assessment before age 18 contributes to transition planning. This strengthens the service's ability to connect identified emotional wellbeing need to planning and intervention, although further outcome evidence is required to demonstrate changes in children's scores or wellbeing following support.

Children's voices have provided an important source of impact evidence and service challenge. Corporate Parenting feedback highlighted a need for more mental wellbeing checks, stronger support systems, better communication between agencies, effective safety planning and being listened to. Young people also described the value of trusted carers, support workers, social workers, family members and school staff in helping them understand sadness, manage worries and access support. Bright Spots feedback added further insight into children's and care leaver's experiences of wellbeing and support. The Corporate Parenting Board identified themes including wellbeing, loneliness, pathway planning, continuity of workers, financial pressures and whether young people felt listened to. The Board required these findings to be translated into proposed service improvements and future reporting that demonstrates what has changed as a result of children's feedback. Developments included strengthening the "You Said, We Did" approach, incorporating Bright Spots findings into governance, and progressing a digital "PA in Pocket" offer for care-experienced young people, although implementation and measurable outcomes fall outside the 2025/26 reporting period. Corporate Parenting oversight has therefore strengthened the connection between performance information, children's lived experience and service development. Strand arrangements established actions to improve the Strengths and Difficulties Questionnaire pathway, monitor the response to identified needs, develop more accessible life-story work and improve how positive outcomes are captured. Wider governance reforms also placed greater emphasis on outcomes, impact, assurance and escalation, alongside clearer reporting of progress and risks.

Overall, the available evidence demonstrates stronger reach of emotional wellbeing identification and more systematic monitoring and clearer participation-led governance. The 84.2% Strengths and Difficulties Questionnaire completion rate provides a substantial evidence base for recognising need, while feedback from children and young people is identifying gaps and shaping priorities. The next stage is to strengthen direct outcome measurement, particularly changes in wellbeing following intervention, the timeliness of follow-up to identified need, and the impact of therapeutic support on children's day-to-day wellbeing, family relationships and stability.

Training

Safeguarding training provides a fundamental foundation for all partners to understand relevant

legislation, best practice, and the signs and indicators of harm. This is critical in developing a shared understanding of risk identification and appropriate responses, while reinforcing that safeguarding is everyone's responsibility.

Within Children's Services, access to multi-agency safeguarding training has ensured that staff remain informed of significant legislative changes, emerging risks, and effective approaches to identifying and responding to harm. This provides confidence that, when working with children, young people, and families, staff can respond in a timely, proportionate, and needs-led manner. It also enables practitioners to undertake assessments confidently and take appropriate action when a child or young person may be at risk of significant harm.

Furthermore, multi-agency training has strengthened collaborative working relationships with partner agencies, supporting a more cohesive and effective team around the child, young person, and family. This collaborative approach helps ensure that safeguarding responses are coordinated, consistent, and focused on achieving the best outcomes.

Learning from Serious Incidents/Learning Reviews

Upon receipt of notifications from the NSPCC Case for Change and Safeguarding Practice Review Repository, relevant Child Safeguarding Practice Reviews (CSPR) and National Reviews are highlighted to key service leads and TSCP representatives within Children's Services for consideration and application within their respective services and groups.

The Children's Services Practice Improvement Forum provides a dedicated space for Team Managers to reflect on findings from Rapid Reviews, CSPRs, and Child Death Overview Panel (CDOP) learning, enabling consideration of potential service improvements and practice developments. Similarly, the TSCP Children and Young People Exploitation Group (CYPEG) and Neglect Sub-Group routinely review CSPRs and learning from serious incidents as part of their governance and quality assurance responsibilities.

The revised TSCP threshold guidance, 'Right Help, Right Service, Right Time,' was launched in January 2024 following collaborative work between the CSPR Sub-Group and the Quality Assurance Sub-Group. This has strengthened understanding and application of thresholds across the partnership, resulting in increased confidence within Children's Services when engaging in clear, outcome-focused discussions with referring multi-agency partners. It has also supported a more consistent application of thresholds and strengthened processes for managing professional disagreement and escalation where required.

Learning that was identified via the CSPR for Marie (accessed via the NSPCC Repository) contributed significantly to evidencing the need for a dedicated role within the Exploitation Team to support unaccompanied asylum-seeking children and young people. This position has now been secured and is intended to strengthen the service response to this vulnerable group. The role will enhance awareness of cultural considerations, including language needs, and support a greater understanding of the risks and harms that may exist within cultural and community networks. Ultimately, this will improve the identification, assessment, and management of safeguarding concerns for unaccompanied asylum-seeking children and young people.

The Voice of Children, Young People and Families

The voice of children and young people is captured through a variety of mechanisms across Children's Services and sits at the heart of our practice. It is central to our Restorative Practice Framework and underpins how we work alongside children, young people, and their families.

We gather the views, experiences, and wishes of children and young people through direct visits, assessments, purposeful direct work, reviews, and planning processes. In addition, a range of well-established participation groups provide further opportunities for children and young people to influence service development and contribute to decision-making.

The voices of children and young people are also embedded within a robust quality assurance framework and clear governance arrangements across Children's Services. This ensures that practitioners actively seek children's views with curiosity, commitment, and a genuine willingness to listen. It also ensures that children's experiences and feedback are considered within key decision-making forums, including those responsible for service development, policy, and strategic oversight. This approach has positively influenced practice in several ways. Findings from quality assurance activity and participation work demonstrate that children and young people are being listened to and that their voices are informing practice. Feedback consistently highlights relationships with allocated workers as a significant strength. This is reflected in practice, where children and young people are actively participating in discussions about the support and interventions they receive, helping practitioners to better understand what is working well and where changes may be needed. As a result, Children's Services is increasingly able to incorporate children's views into planning and decision-making, ensuring that interventions are responsive to their individual needs and experiences. This has contributed to improvements in advocacy for children and young people, with greater emphasis placed on securing specialist support where required and ensuring that children's rights, wishes, and feelings are fully represented. There has also been continued progress in strengthening our 'You Said, We Did' approach, ensuring that children and young people can clearly see how their

feedback has informed service improvements. To further embed participation and co-production across the service, a Children's Services Participation Strategy is currently being developed. This will provide a clear framework for engaging children and young people as active partners in shaping the services they access and the decisions that affect their lives. The Ofsted report from the Children's Services Inspection in January 2026 noted: The voice of the child is consistently evident in plans. Following recent restructuring, workers are better able to spend meaningful time getting to know families and their histories, providing prompt, bespoke, practical help that is relevant to them.

Difference Made by the TSCP

During 2025/26, the Torbay Safeguarding Children Partnership has continued to make a positive collective difference by strengthening shared ownership of safeguarding priorities, improving the use of multi-agency intelligence, and creating forums where partners can identify risk, challenge practice and agree action. The partnership's impact is most evident where it has brought agencies together around children who experience the greatest complexity, including children affected by neglect, domestic abuse, exploitation, emotional wellbeing needs, and placement instability.

The partnership has supported a more coordinated and evidence-informed response to neglect. Neglect remains a significant safeguarding concern in Torbay, but the 2025/26 work has strengthened understanding of cumulative harm, drift, escalation and the need for clearer evidence of sustained change. Learning from Rapid Reviews, the February 2026 neglect quality assurance review, Ofsted inspection findings, and subgroup oversight are being used to shape a more purposeful improvement plan through the Child Safeguarding Practice Review subgroup. This means that the TSCP is not simply identifying neglect as a recurring issue but is increasingly focusing partners on whether multi-agency plans are making a measurable difference to children's day-to-day lived experience, safety and care.

The TSCP has also contributed to stronger partnership responses to child exploitation and children who go missing. During 2025/26, operational and strategic forums continued to support daily and regular information sharing, mapping of peer groups and locations of concern, and targeted safeguarding activity for children at risk of exploitation. The increase in completed exploitation toolkits demonstrates that the partnership is identifying and analysing exploitation risk more consistently. Return Home Conversations, the Philomena Protocol and multi-agency exploitation meetings are helping partners to build a fuller understanding of children's lived experiences, patterns of risk and the support required to reduce harm. This strengthens the partnership's ability to respond earlier and more coherently when children are missing, exploited or exposed to extra-familial harm.

In relation to domestic abuse, the TSCP has helped to create a clearer shared understanding of both the strengths and gaps in the local system. The 2025 domestic abuse deep dive identified committed partnership activity and examples of positive safeguarding practice but also highlighted that children are not yet consistently recognised and responded to as victims in their own right. The impact of the partnership has therefore been to move the local conversation beyond single-agency activity and towards a stronger whole-system response. This has identified the need for clearer strategic leadership, improved integration of services, stronger recognition of children's experiences, and better reporting of outcomes for children affected by domestic abuse.

The partnership has also sustained focus on children's emotional wellbeing and mental health as a safeguarding priority. During 2025/26, partnership activity has helped to resolve gaps in early intervention, access to support and data in respect of outcomes. Children's Services, health, education and corporate parenting arrangements have contributed evidence regarding therapeutic support, Strengths and Difficulties Questionnaire completion, Child and Adolescent Mental Health Services access data, Bright Spots feedback and the MyVoice pilot. This is helping the partnership to understand where children's emotional wellbeing needs are being identified and where further assurance is required about timeliness, access routes and impact. The key difference is that emotional wellbeing is increasingly being considered as part of safeguarding, care planning and partnership governance, rather than as a separate issue.

Learning and improvement activity has become more systematic. Rapid Reviews, Child Safeguarding Practice Reviews, multi-agency audits, dip samples and subgroup activity are providing opportunities for partners to reflect together, test the quality of practice and agree areas for improvement. The partnership has strengthened the way learning is translated into action, for example through work on chronic neglect, cumulative harm, exploitation, domestic abuse and the voice of the child. This supports a culture in which safeguarding partners are expected to identify learning, share good practice, provide professional challenge and evidence what has changed as a result.

Challenges/Barriers

There remains a need to strengthen how the partnership measures impact and outcomes for children and families. The report demonstrates significant activity, including audits, reviews, forums, training and improvement work, but further development is required to evidence consistently what has changed for children in terms of safety, wellbeing, stability, lived experience and family functioning.

Neglect remains a significant and complex safeguarding challenge. Although there is stronger evidence of partnership recognition of cumulative harm and drift, further work is required to ensure

that plans are consistently purposeful, that progress is tested robustly, and that escalation takes place promptly where sustained change is not being achieved. The consistent use of neglect tools, chronologies and evidence-based assessment remains an area for improvement. Capacity pressures across agencies have affected the routine use of tools such as Grade Care Profile 2 within referrals and planning, and further assurance is needed about whether these tools are helping families achieve and sustain change.

There remains variability across the partnership in confidence and understanding when responding to children at risk of exploitation. Professional anxiety can still drive escalation requests, including requests to accommodate or relocate children, before there has been sufficient shared consideration of contextual safeguarding responses, disruption activity and safety planning within the child's existing network.

Placement sufficiency remains both a local and national challenge. The limited availability of well-matched placements can affect decision-making, placement stability, family time, education continuity, emotional wellbeing and risk management for children with complex needs, including children at risk of exploitation or those requiring therapeutic support.

Domestic abuse remains a prevalent factor in children's lives in Torbay. Further work is needed to ensure that children affected by domestic abuse are consistently recognised and responded to as victims in their own right, and that partnership arrangements move towards a more integrated system with clearer strategic leadership, pathways and outcome reporting. There remains a gap in local perpetrator behaviour-change provision for domestic abuse. This limits the partnership's ability to address the source of harm and can result in practice remaining focused primarily on adult and child victims without sufficient intervention to reduce abusive behaviour and repeat harm.

Children's emotional wellbeing and mental health remains an area requiring continued strategic oversight. While there is evidence of therapeutic support, Strengths and Difficulties Questionnaire completion and access data for specialist support, further assurance is needed about timeliness, thresholds, unmet need, follow-up to identified concerns and whether interventions are improving outcomes for children. Engagement with older young people's emotional wellbeing needs requires further focus. Strengths and Difficulties Questionnaire completion is lower in Years 12 and 13, indicating a need to strengthen how the partnership maintains oversight, identifies need and supports emotional wellbeing as young people approach adulthood and transition between services.

Several important developments are new or still embedding, including the Family Help Therapeutic

Team, the Contextual Safeguarding Framework, the Strengths and Difficulties Questionnaire pathway, MyVoice, the Participation Strategy and the “You Said, We Did” approach. The challenge for 2026/27 will be to evidence how these developments are changing practice and improving children’s experiences and outcomes.

Capacity pressures across health, education, police, voluntary sector and social care continue to affect consistency of multi-agency safeguarding practice. This can impact attendance, timeliness, information-sharing, implementation of agreed actions and the ability to sustain improvement across all priority areas. The partnership has made progress in capturing children’s voices through audits, participation work, Bright Spots feedback and direct practice. The ongoing challenge is to ensure that children, young people and families can see how their feedback has influenced decisions, plans, service design and strategic priorities.

Devon and Cornwall Police

Neglect

Devon and Cornwall Police supports front line staff in recognising signs of neglect and encourages them to be professionally curious. The RESPOND (Response/Reaction, Engagement, Speak, Protection/Risk, Observe, Nutrition/Health, Developmental) toolkit has been developed to prompt officers to think about, focus and record the voice of the child, be professionally curious and identify disguised compliance. This is used by officers when completing the Public Protection Notice (PPN).

In Torbay, neglect is currently the second most common reason (29% of all PPNs) for a Child at Risk Question set to be completed within a PPN, marginally behind physical abuse (30% of all PPNs) which is much easier to identify. The PPNs with Neglect recorded as a risk type have increased, in March 2025 the percentage recorded as Neglect in Torbay was 23%.

Risk Type: Sexual, Neglect and Physical remain the 3 main types of risk. Cornwall and Devon have a higher % of ‘Sexual’ than other areas

Main concern type Oct 25 - Mar 26	Cornwall	Devon	Plymouth	Torbay	Out of Force	Total
CSE	6%	8%	9%	10%	21%	8%
Emotional Abuse	10%	13%	16%	14%	10%	12%
Neglect	27%	25%	31%	29%	8%	27%
Physical Abuse	28%	27%	25%	30%	29%	28%
Sexual Abuse	26%	23%	16%	12%	19%	21%
Not Stated	3%	4%	3%	4%	14%	4%
Grand Total	1002	474	375	378	63	2299

The GCP2 was not adopted by D+C Police following a force decision in 2022.

The impact here is positive in that neglect is the second highest risk type evidencing that staff are alive to neglect and better equipped to identify it compared to previous years. By staff being professionally curious and recording concerns the child is more likely to receive early intervention and prevent further incidents of neglect. We know from CSPRs and national reviews that all services need to continue to improve our identification and response to neglect but there has been much work to support staff in spotting the signs and being professionally curious.

A short case study:

Following the report of serious sexual offences within the family home by the eldest child of a family of 6, due to the serious nature of the report an urgent strategy meeting held with partners resulting in police and social care attended the home address to find the living conditions were not suitable for any of the children to remain. All children were placed into Police Protection to safeguard them whilst the Local Authority ensured an Interim Care Order (ICO) was in place. In the proceeding days /weeks the voice of the child was captured resulting in the oldest three children providing visual recorded interview (VRI) about their lived experience ensuring their voices were heard. The criminal investigation into sexual abuse and neglect is on-going whilst all children remain safeguarded. The impact of the immediate action taken by the police and Local Authority working together ensured the safety of the children and evidence secured for the criminal investigation.

Exploitation

South Devon police have a structured response to exploitation in all forms. Police chair the Torbay Missing and Child Exploitation (MACE) forum and the Child Centred Policing Team work closely with the local authority Exploitation team. This collaborative approach resulted in the first Slavery and Risk Trafficking Order for D+C Police in relation to a male perpetrator. The judge said *'Looking at totality and assessing on balance of probabilities, I believe it more likely than not, that there is a risk that you will commit a slavery/trafficking offence. On the second aspect of the test, whether necessary or not to impose an order, applying an aspect of judgment, taking into account, 5 young individuals, vulnerability there, if they are committing, through coercion, very serious offending, burglary and theft, putting themselves at risk, high speed chases, breaking into properties, inherent risk and threats of violence to them and families and occasioned by themselves, fearful of repercussions if they were to engage, that pattern is longstanding and I understand you have been subject to a number of notices, CAWNs over the last year, not complied with those in full, I do take a view an order is necessary to protect persons generally and specific individuals from psychological or physical harm.'* There were significantly restrictive measures put in place for five years. This order gave confidence to the children

involved that they would be listened to and has had a ripple effect across Torbay.

Budget has been set aside for overtime and the allocation of additional resources to support Operation Makesafe delivery across the force. Operation Makesafe supports the prevention of child sexual exploitation, particularly in cases linked to hotels and other forms of accommodation within the hospitality sector. Torbay has arranged days of action to raise awareness of Child Exploitation, deliver training materials and carry out test purchases with police cadets.

The Strategic Safeguarding Improvement Hub conducted an end-to-end review of Devon and Cornwall Police's response to child victims. The purpose of this task was to review incidents and recorded crimes involving children as victims with a particular focus on the identification and grading of risk from the victims first contact with Police within the Control room and then follow the investigation onward right through to finalisation. The data reviewed was within the date range January to June 2025 and included the crime categories:

Child Cruelty

Child sexual Offences

Child Abduction

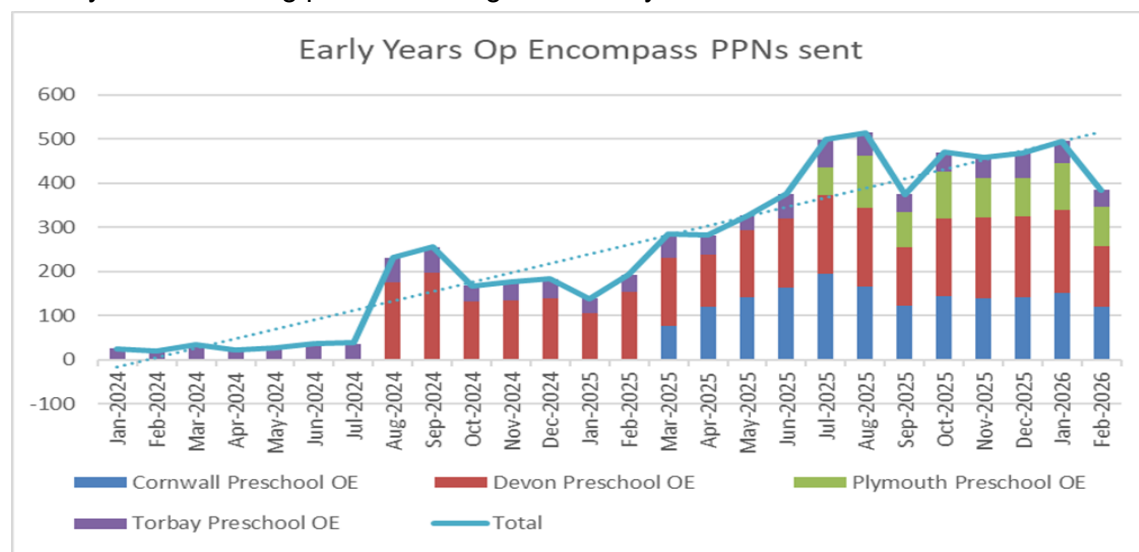
Child assault with injury

Child missing person report- over 3-7 days missing.

The results were broadly positive indicating that vulnerability and risk is correctly being identified within the Control Room and crimes reported by the victim are being recorded on first contact. Crimes are then allocated to the correct department for onward investigation. Duty Inspector 24hr missing reviews were all compliant. Missing prevention interviews were 99% compliant. Investigators are identifying risk and these are being raised via Strategy meetings. The voice of the child was captured in 22 occurrences; some were located out of Force. Only 4 occurrences highlighted no attempt/record of the voice of the child. We were compliant using a single Officer in the Case (OIC) where there was a child suspect with multiple offences. There were several identified areas for improvement which will be taken forward by the organisation within relevant improvement plans.

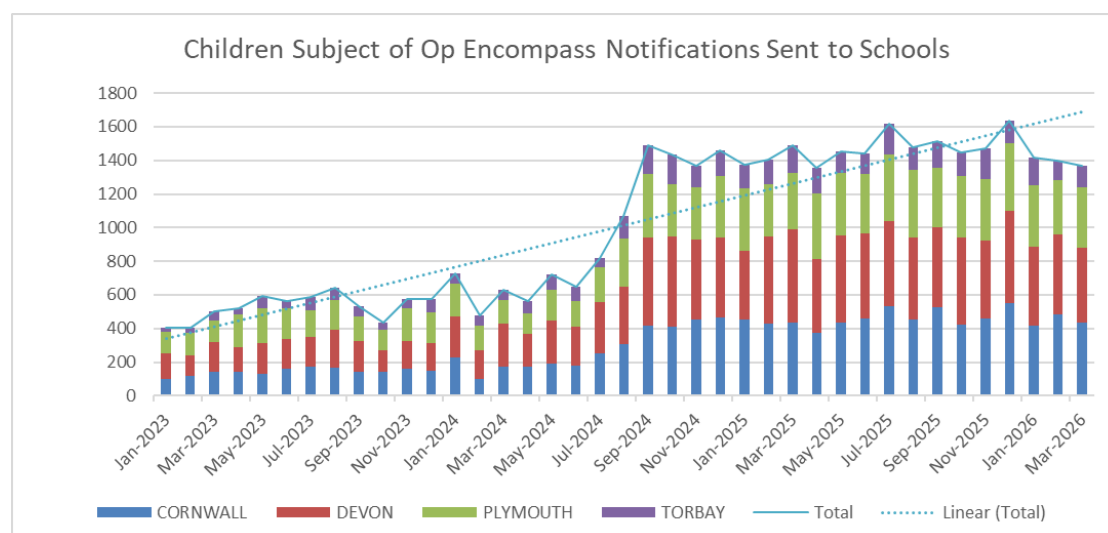
Domestic Abuse

Operation Encompass is a police led, multi-agency domestic abuse programme, that informs local agencies of domestic abuse incidents where children were present or residing and enables protection and support for children to be enacted at the earliest opportunity. Additionally, Operation Encompass Early Years is in place in Torbay, who acted as the pilot local authority area, and has supported the roll out across the peninsula as a result. The provision of early years is being brought into statute and Torbay are in a strong position having led the way in this area.



There is work ongoing to support schools who experience challenges with IT, the force is seeking to move away from Zip files to secure email to share the Operation Encompass details with schools.

There has been an IT change to PPNs which has resulted in officers having to opt out of a child concern question set rather than opt in, this saw an increase in the identification of children at domestic abuse incidents which has remained stable.



The impact on children of Operation Encompass can easily be felt as the ethos of the scheme is to ensure there is an early 'arm around the child' at school, following their exposure to domestic abuse. It is important the school are aware of the exposure to domestic abuse as they will be more alive to the child's lived experience and any potential for associated trauma, they are also well placed to respond to the child's immediate needs and concern. The increase in notifications translates as more children being supported by schools.

Mental Health

All reports are subject to a THRIVE assessment and a risk-based grading applied to all child concern questions sets in the PPN. The PPN is then shared via the relevant pathways. If mental health is a concern, then this is listed on the PPN when the referral is shared with partners and advice given to parents about accessing mental health services would be provided. Mental health needs are a consideration for all people (including children) when entering custody via liaison and diversion which is a network of NHS mental health clinicians based in custody centres across the force.

Training

Level 3 Safeguarding training is a mandatory requirement for police staff in the Public Protection Unit as well as the Child Centred Policing Team and is monitored for compliance. Training has been an area of focus for the HMICFRS specifically related to police in the MASH. The launch of a new modular system of training for DDMs is supplemented by the L3 training and can now be evidenced to HMICFRS that we invest in the development of staff, this will ensure a more consistent approach to children at risk.

The annual TSCP conference allows for continuing professional development and networking with other agencies, building these relationships supports the ability to challenge and support through daily business where appropriate. The Conference guest speakers will have an impact on how staff think and encourage professional curiosity when speaking to families and children. The CPD allows for confidence building and improved knowledge for staff.

The increase of PPN submissions over the last 12months also evidences the impact on children as their voice is facilitated through the PPN to partners. Training will have a part to play on that increase.

Police have attended Multi Agency Engagement Workshops such as The Family First Partnership Programme (FFPP). Attending the workshops allows police to understand the changes taking place within the Local Authority. Training has been attended by police colleagues in the BCU to include

Child Exploitation and Families First workshops to support the co design of FFPP.

Learning from Serious Incidents/Learning Reviews

All learning is shared through the relevant forums and communication methods in force. Actions and recommendations are tracked and monitored by performance and analysis. Staff take an active role in any multi agency learning event held by the partnership, for example the domestic abuse focused event held recently. Positive feedback on PPN quality was received from the deep dive and shared with teams in force. The sharing of the learning influences the change in the organisation processes and therefore should directly impact children.

The Voice of Children, Young People and Families

The voice of the child is a requirement of the PPN. The RESPOND (Response/Reaction, Engagement, Speak, Protection/Risk, Observe, Nutrition/Health, Developmental) toolkit has been developed to prompt officers to think about, focus and record the voice of the child, be professionally curious and identify disguised compliance. This is used by officers when completing the PPN. The absence of this is fed back to officers and line managers to improve and maximise the opportunities to record the voice of the child.

The voice of the child was also a key topic at the Force Vulnerability training day for front line staff and is an area of focus when review PPNs / cases as a multi-agency. 63% of the cases looked at as part of the end-to-end review of DCP's response to child victims had the voice of the child recorded. For those cases where the voice of the child had not been recorded for 26% of the cases the child was either too young or was not located within the force area. For 11% of cases there was no attempt to record the child's voice.

Difference Made by the TSCP

The Slavery and Trafficking Prevention and Risk Orders (STRO) referenced above was achieved because of all agencies working together.

There is good partnership engagement at both a strategic and operational level with police chairing MACE and the TSCP's Executive and Children and Young Person Exploitation Groups (CYPEG).

Challenges/Barriers

The Force are engaged with all four Peninsula Local Authorities to deliver the Families First Partnership Programme and its co-design but there is a clear requirement that the model needs to be aligned with all local authorities across the peninsular to allow for an equal offering to all families and

to allow the Police to have resilience and flex in their workforce. A locality-based model in Torbay does not replicate the staffing model for Devon and Cornwall Police.

Whilst Torbay is moving at pace to deliver the FFPP requirements, police can support the test and learn phase but will need to be sighted on all four local authority models and be resourced appropriately before fully embedding the new way of working. Challenges remain regarding the funding of the FFPP, police have requested a relative percentage of the funding to support the allocation of transition period resources, allowing for the test and learn phases to commence. This has not been secured in Torbay and is a risk as other local authorities are financially contributing.

NHS Devon Integrated Care Board

Neglect

From an ICB perspective, evidence regarding outcomes for children in relation to neglect is drawn from system-wide assurance, provider oversight, multi-agency audits, and safeguarding reviews, rather than direct intervention with families.

Key sources of evidence include:

- **Provider assurance processes**

Commissioned providers report on safeguarding activity through contract monitoring, quality dashboards, and safeguarding assurance frameworks. This includes:

- Compliance with safeguarding training (including neglect and GCP2 where applicable)
- Evidence of timely recognition and escalation of neglect concerns
- Audit findings demonstrating application of local neglect pathways

- **Multi-agency audit activity (via TSCP)**

Participation in partnership audits provides qualitative evidence of practice, including:

- Improved identification of neglect indicators (e.g. cumulative harm, disguised compliance)
- More consistent use of multi-agency assessment tools and frameworks
- Evidence of earlier escalation and more coordinated responses

- **Safeguarding Children Partnership intelligence**

Learning from local and national Child Safeguarding Practice Reviews highlights themes such as:

- Increased professional curiosity and challenge
- Better recognition of chronic neglect and its long-term impact
- A shift from episodic to more holistic, longitudinal assessment of children's lived experience

- **Designated professional oversight**

The ICB safeguarding team undertakes:

- Thematic reviews (e.g. neglect, missed health appointments, vulnerable families)
- Deep dives into provider safeguarding arrangements
- Triangulation of data across health providers and partner agencies

Exploitation

From an ICB perspective, evidence regarding outcomes for children experiencing exploitation and sexual harm is derived from provider assurance, multi-agency intelligence, audit activity, and safeguarding review learning, rather than direct clinical or front-line intervention.

Key sources of evidence include:

- **Provider assurance and contract monitoring**

Commissioned providers report on safeguarding performance through quality and safeguarding dashboards. This includes:

- Staff training compliance in relation to child exploitation (including CSE/CCE) and sexual harm
- Evidence of timely identification, risk assessment, and escalation of concerns
- Audit findings demonstrating the application of local exploitation pathways and protocols

- **Multi-agency audit and partnership activity (via TSCP)**

Multi-agency audits provide qualitative insight into frontline practice, including:

- Improved recognition of vulnerability to exploitation (e.g. missing episodes, online risk, peer exploitation)
- More consistent use of risk assessment tools, including AIM where appropriate
- Evidence of improved multi-agency information sharing and coordinated responses

- **Safeguarding Children Partnership and review learning**

Learning from local and national Child Safeguarding Practice Reviews highlights:

- Increased professional curiosity regarding extra-familial harm and contextual safeguarding
- Greater recognition of the complexity and overlap between exploitation, trauma, and vulnerability
- Improved understanding of the need for ongoing risk assessment and disruption activity.

- **Designated professional oversight within the ICB**

The ICB safeguarding team undertakes:

- Thematic reviews (e.g. exploitation, frequent attenders, missing children)

- Deep dives into provider systems for identifying and responding to sexual harm and exploitation
- Triangulation of data across health providers and partner agencies

Domestic Abuse

As an ICB, our contribution to improving outcomes for children affected by domestic abuse is primarily through system leadership, safeguarding assurance, commissioning, and partnership influence. The following evidence demonstrates impact:

- Delivery and commissioning of domestic abuse and safeguarding training across health providers has led to increased confidence in recognising and responding to domestic abuse.
- Increase in routine enquiry in maternity, health visiting, and primary care services.
- Evidence of better recognition of the child as a victim in their own right.
- Active participation in Community Safety Partnerships, Domestic Abuse and Sexual Violence Executive Group and Safeguarding Children Partnerships.

The ICB ensures health learning from statutory reviews is embedded and translated into practice improvements

Examples include:

- Strengthening professional curiosity
- Improving information sharing
- Enhancing recognition of disguised compliance

Mental Health

Increased access and early intervention

Commissioned services, Mental Health Support Teams, MyWay, and Mood, Emotions and Relationships Service (MERS), have significantly expanded access to support. MyWay alone is designed to support 5,000 young people annually through community and digital interventions, improving early access and reducing escalation to specialist services.

Improved reach and system coverage: Mental Health Support Teams now reach over 70% of school-aged children, with extensive delivery including:

- 52,545 children and young people reached through workshops.
- 13,397 referral-led interventions and an additional 13,035 children receiving direct 1:1 or group support.

- This demonstrates substantial system-wide impact in prevention and early help.

Improved timeliness of support

Waiting times for specialist services (MERS/CAMHS) have reduced significantly, with:

- No children waiting over 52 weeks.
- Trajectory to under 18-week waits for assessment by January 2026.
- Earlier access reduces risk of deterioration and crisis.

Effective early intervention outcomes

Digital therapeutic intervention (Lumi Nova) shows clear clinical impact:

- 90%+ of children experienced improvement or stabilisation.
- 97% of children with SEND showed improvement or stabilisation.
- This evidences measurable improvements in emotional wellbeing.

Improved coordination and appropriateness of care

A Single Point of Access and multi-professional triage ensures children are directed to the right service first time, reducing inappropriate referrals and delays.

Positive impact on children and families

Qualitative feedback demonstrates:

- Improved confidence, resilience, and school engagement
- Reduction in anxiety, depression, and disordered behaviours
- Increased parental confidence and satisfaction with support

For example, one young person reported sustained recovery from anxiety and depression following intervention, while parents described improved school attendance and wellbeing.

Strengthened whole-system capability

Workforce training and whole-school approaches have reached:

- 14,050 education staff and 4,211 parents/carers.
- This has improved early identification and response to mental health needs across universal services.

Training

From an ICB commissioning perspective, the safeguarding training provided through the TSCP has made a positive contribution to strengthening assurance, consistency, and shared understanding across the system.

Although the ICB does not deliver direct services to children and families, the training has supported our designated safeguarding professionals and wider commissioning teams to maintain up-to-date knowledge of statutory safeguarding responsibilities, local procedures, and emerging risks. This has enhanced our ability to:

- Provide robust scrutiny and challenge to commissioned providers regarding the quality of their safeguarding arrangements
- Seek assurance that safeguarding training within provider organisations aligns with local multi-agency expectations
- Promote a consistent, system-wide approach to safeguarding practice across health providers
- Better understand the multi-agency context in which commissioned services operate

The availability of multi-agency training through TSCP also strengthens relationships and shared language between partner organisations, which is important for effective system leadership and collaborative safeguarding oversight.

Learning from Serious Incidents/Learning Reviews

Learning from multi-agency audits, Rapid Reviews, Child Safeguarding Practice Reviews (CSPRs), and other partnership learning events is a key driver for improving system quality, strengthening safeguarding practice, and influencing better outcomes for children and families in Torbay. Although the ICB does not provide direct services, learning is embedded through commissioning, provider oversight, and system leadership, with a clear focus on translating learning into measurable improvements in practice.

Learning from reviews and audits is systematically incorporated into:

- Provider contract monitoring and quality schedules, ensuring that key themes (e.g. professional curiosity, voice of the child, recognising cumulative harm) are reflected in service expectations.
- Safeguarding assurance frameworks, asking providers to demonstrate how learning has been implemented and embedded in practice.
- Designated professional scrutiny and challenge, including deep dives and thematic reviews linked to identified learning.

This ensures that commissioned services in Torbay demonstrate evidence of practice change, not just awareness of learning.

Impact is demonstrated through:

- Multi-agency audit findings showing:

- Earlier identification of safeguarding concerns.
- More consistent application of risk assessment frameworks.
- Improved quality of recording, including clearer analysis of risk and protective factors.
- Rapid Review and CSPR follow-up activity, where action plans are tracked through partnership governance, and providers report on progress against recommendations
- Provider reporting, which evidences:
 - Improved compliance with safeguarding supervision and reflective practice.
 - Increased safeguarding training uptake aligned to identified learning themes.
 - Strengthened internal audit processes focusing on priority areas such as neglect and exploitation.

The Voice of Children, Young People and Families

From an ICB perspective, the voices of children, young people and families are captured indirectly through commissioned services, partnership working, and system-level intelligence, rather than through direct engagement.

The ICB gains insight into children and families' experiences through multiple sources:

Commissioned providers are required to collect and report on service user feedback, including:

- Patient experience surveys.
- Friends and Family Test data (where applicable).
- Feedback from health visiting, school nursing, CAMHS, and acute services.
- Complaints, compliments, and Patient Advice and Liaison Service (PALS) enquiries.

This provides insight into how children and families experience services and identify areas for improvement.

Through safeguarding assurance processes, the ICB might review:

- Case file audits, which include evaluation of how well the child's voice is captured and reflected in decision-making.
- Evidence of "lived experience" being documented in assessments and plans.
- Findings from TSCP multi-agency audits highlighting strengths and gaps in capturing the child's perspective.

Difference Made by the TSCP

The TSCP provides a strong framework for joint working, accountability, and shared learning across health, local authority, police, and wider partners. This has resulted in:

- More coordinated and timely responses to safeguarding concerns.
- Clearer pathways for escalation and information sharing.
- A shared understanding of local priorities and risks.

This collective approach reduces fragmentation and supports children and families to receive more joined-up and effective support and is evidenced in the most recent ILACS.

Through training, audit activity, and review learning, the TSCP has contributed to:

- Improved recognition of risk, including neglect, exploitation, and extra-familial harm.
- Greater professional curiosity and challenge.
- Stronger focus on the child's lived experience.

Multi-agency audits increasingly evidence more consistent and higher-quality practice, which supports earlier intervention and better safeguarding decision-making.

Challenges/Barriers

From an ICB perspective, while there are many strengths within multi-agency safeguarding in Torbay, there are also some ongoing challenges and system pressures that warrant continued focus to further improve outcomes for children, young people and families.

Across all partner agencies, including health, there are increasing demands relating to:

- Rising complexity of need (e.g. mental health, exploitation, neglect, domestic abuse).
- Workforce pressures and vacancies in key services.
- Increasing thresholds and demand on specialist safeguarding services.

These pressures can impact on:

- Timeliness of response.
- Continuity of care.
- Opportunities for preventative and early help interventions.

The most recent Rapid Review has been a good context for evidencing these pressures and the resulting impact.

While strong practice is evident, there remains some variability in:

- Recognition and response to cumulative harm, particularly neglect.

- Application of tools and frameworks (e.g. GCP2).
- Quality of recording and analysis of risk.

The partnership demonstrates strong learning from reviews and audits; however, a common challenge is:

- Ensuring that learning is consistently embedded and sustained over time.
- Evidencing the direct impact of learning on outcomes, rather than process changes alone.

Torbay and South Devon NHS Foundation Trust

Neglect

The Trust Safeguarding Nurse Practitioner is a trainer for GCP2. Whilst there has been challenges for the training programme, the information is being disseminated via safeguarding supervision and internal training delivered to staff. Neglect focussed group supervision discussions, training sessions and individual case discussions have been considered with a strong emphasis on capturing the impact on the child.

The Safeguarding Nurse Practitioner and other health representatives are regular attendees of the TSCP Neglect group. Learning from the meetings and specific case discussions, including those from the NSPCC repository are shared in group supervision sessions led by the Safeguarding Children Team.

Highlight on 'Safe Sleep' overlaps with learning from CSPRs, both locally and nationally. Torbay 0 to 19 staff have embedded practice to see the sleep space, share sleep advice from the Lullaby Trust and to encourage conversations with parents about times when they may find following advice a challenge, reflecting the recommendations from local reviews.

Hospital based staff have updated practice to clearly document discussions with parents during admission and on discharge related to safe sleep. Record systems have been designed to capture this information and accessible advice is provided, accounting for any varying communication or learning needs.

All Trust safeguarding supervisor's trained additional to their clinical role, join the Safeguarding Children Team members from Torbay and South Devon NHS Foundation Trust (TSDFT) and Child

and Family Health Devon (CFHD) for quarterly update sessions. These are led by the Named Nurse and include learning from the neglect subgroup work, NSPCC repository reviews, Devon Thematic review of neglect and sharing of good practice examples to support professional curiosity and service development considerations.

Exploitation

There is a consistent Safeguarding Nurse Practitioner from the Safeguarding Children's Team who provides health representation at MACE, Triage, CEMOG and the Named Nurse is the Deputy Chair for TSCP CYPEG. The Safeguarding Children Team also support attendance at South Devon MACE, enabling shared learning and supporting mapping process.

Trust staff are fully aware of and utilise the Police intelligence process to support multiagency collaboration. There is routine flagging of health records for young people vulnerable to / victims of exploitation.

Trust staff deliver trauma informed practice training and are supported to attend appropriate additional training. Regular audit is completed to consider how this is delivered. There is a planned multi-agency audit for July 2026 to consider whether professional curiosity is embedded in practice, following the JTAI recommendations and TSCP led work on the professional curiosity model.

Emergency Department (ED) staff and Safeguarding Children Team support consideration of SARC service intervention. There is information available in the ED and the team are able to contact the service, or the general Sexual Health Service, for any queries related to a child's presentation. This information is included in training sessions for all clinical staff and good practice is shared in clinical scenarios included in the mandatory study days for child health and emergency department staff. Also, the Paediatric Liaison nurse service has a presence in ED to support staff professional curiosity. This has led to an increase in completion of the HEADSSs assessment tool – considering aspects of Home, Education, Activities, Drugs/Alcohol, Sexuality, Suicide/Mental Health and Safety. This is the health model designed for use in the hospital setting which is the equivalent to the AIM assessment tool. The use of the

AIM assessment tool is not embedded in the acute hospital but is in the community services for children, including CAMHS. Audit of the inclusion of contextual safeguarding factors in child protection medical examinations was completed in Sept 2025. This evidenced strong practice and 97% of all reports identified factors which were shared for multiagency consideration and inclusion in safety planning for the child / family.

The improvements in practice have resulted in prompt interventions for young people, including strategy meetings and collaboration with Police. The referrals to CAMHS crisis team and collaborative safety plans for young people have resulted in trauma informed approaches being used which have supported earlier de-escalation of emotional outbursts for children which would previously have resulted in harm. Open discussions between staff and children are commonly completed in practice, particularly in the Emergency Department, and this has linked directly to Torbay meetings (MACE) via the Safeguarding Nurse. Learning and concerns are also shared with the Emergency Department to heighten professional curiosity for staff. This has been evidenced in increased information sharing and appropriate safeguarding referrals resulting in interventions and additional safety planning for children and families.

Domestic Abuse

In December 2025 an audit related to Public Protection Notice (PPN) processes was completed. This arose from activity at TSCP Quality Assurance meeting, attended by the Named Nurse and followed on from a police audit undertaken on the quality of information. It evidenced good responsive practice supported by the NHS Trust pathways and actions taken for families where there was benefit to the safety of the children.

TSDFT have a Hospital IDVA, provided in collaboration with TDAS (Torbay Domestic Abuse Service). This provides intervention for patients, usually arising from attendances to ED, but support can continue into their inpatient stay in hospital. This has resulted in updated policies and resources and supported increased staff awareness. For the midwifery service, an action was identified from a CSPR for increased staff awareness of routine enquiry. The IDVA is currently providing this at midwifery mandatory training which will cover the whole service staff cohort over 1 year.

The Safeguarding Children Team provide MARAC representation to Devon and Torbay meetings. The information shared allows for staff to evidence impact on children and enables flagging of records to support professional curiosity and enhance opportunities for routine enquiry. The patient records flagging process has been transferred to the Trust's new patient record system, which will allow all trust staff awareness of risks.

Additional awareness of safe sleep activity has been completed in response to learning from local and national reviews where incidents occurred during a period of intervention/rehousing due to domestic abuse incidents. Staff have a heightened knowledge and awareness of the partnership responsibility in ensuring safe sleep facilities are in place for babies.

Mental Health

Mental health information is routinely gathered for MASH enquiries to ensure oversight and analysis is supported by an informed view of the impact on young people further to concerning incidents or as a result of long-term situations.

Improved collaboration with mental health services has enabled direct referrals to the CAMHS crisis team from the Emergency Department., allowing young people to access timely assessment and support. This intervention can be provided in the Emergency Department and, where identified, may result in further support via CAMHS outreach services.

Joint working arrangements are established with the Children and Young People's Disordered Eating Service, a multidisciplinary team providing specialist assessment and treatment. The Safeguarding Children Team delivers regular safeguarding supervision to clinicians working within the service, promoting safeguarding awareness, professional curiosity, and the timely identification of risks. This collaboration supports robust safeguarding practice and enables prompt intervention where concerns are identified.

The Team have also supported a number of professional differences contacts, in accordance with TSCP guidance, where family situations are complex, with emerging escalating needs. The team hold ward rounds which are inclusive of families and patients to support restorative and trauma informed practice.

Multiagency discharge planning meetings are embedded into practice. These are designed to support collaboration for safety planning with professionals and families coming together, including the child where appropriate.

The 'All About Me' assessment document is used within inpatient settings to enable children and young people to share information about their individual needs and preferences. This supports trauma-informed practice, facilitates reasonable adjustments and personalised care, and contributes to the implementation of recommendations from National Child Mortality Database (NCMD) audits.

Mental Health First Aid training is available for staff on the inpatient ward. There are identified Mental Health Nurse and Medical Leads who are working in collaboration with other health partners under One Devon to support care pathways.

Torbay Recovery Initiatives service (TRI) provides the community drug and alcohol service for adults.

They have three practitioners who are trained as safeguarding supervisors additional to their clinical role who attend safeguarding supervisor updates with the Named Nurse for TSDFT. The Safeguarding Children Team also provide regular safeguarding supervision for practitioners working with adults who are parents. The team attend Level 3 TSCP training and had a recent half day MDT training event considering the impact of alcohol on the whole family. The Service Lead attends TSDFT safeguarding children governance meetings to ensure oversight of learning/training/process to support inclusion and collaboration with wider services.

Training

TSDFT staff attend Level 3 multiagency training, Foundation and Refresher courses, and the TSCP Annual Conference. This was an agreed decision by the Trust Board in recognition of the positive impact this has on practice and the positive feedback from staff attending the courses.

Staff who have attended courses demonstrate that they have been empowered by the information shared at training and this is often raised/referenced in supervision discussions and team events led by the Safeguarding Children Team. This prompts reflection in the group and then results in changes to practice.

The updated TSCP threshold guidance, Right Help, Right Service, Right Time, has been well received and is commonly referenced in safeguarding supervision sessions to support understanding the impact on the child and capturing the child's voice.

Learning from Serious Incidents/Learning Reviews

C110/111/112 CSPA; safe sleep, observation of sleep space, discharge process and practice in SCBU/Louisa Cary Ward, practice change in ED, documentation and evidence of parental choice.

CYPEG exploitation audit; system alerts, use of 'HEADSSs' assessments for patients over 12yrs old (secondary school)

Audit; consideration of contextual safeguarding evidenced in child protection medical examinations, presented September 2025 to Specialised Commissioning Oversight Group (SCOG) following JTAI recommendations and practice changes.

Audit; health process following receipt of PPN, presented December 2025 to TSCP Quality Assurance subgroup.

Audit; evidence of the child's voice captured in ED records, presented December 2025, repeat audit following JTAI to evidence embedded practice.

Torbay 0 to 19 Public Health Service, September 2025, identified as area of good practice for mandated 2.5yr developmental review resulting in visit from Department of Health/government representative.

Audit; maternity records inclusion of marks on newborn babies, August 2025, repeat internal audit following learning from CSPR evidenced positive improvements.

Collaborative development to enable consistent information gathering and sharing, working with ICB and Peninsula Safeguarding Children Partnership Business Managers resulting in data dashboard and consistent information sharing now established. This has enabled future planning to be able to present this data as power BI format which will improve sharing into partnership meetings.

The Voice of Children, Young People and Families

Voice of the child is captured in inpatient and outpatient documentation. Child views, observations of child, speaking with child and capturing their worries or aspirations is commonly included in documentation, including outpatient letters.

- Example; child worried about impact of fracture on her ballet classes. On discharge from care, consultant wished her good luck in pursuing her dream of becoming a professional ballerina.
- Example; Orthoptist documented that missed appointment for child requiring patching intervention for squint may result in surgical intervention, impacting on his learning and socialising with friends, resulted in child being brought to appointments and completing treatment.
- Example; child sharing information to nurses, worries about going home, multiagency discharge planning and support for safety planning-maintained family relationship and supported safe discharge home.

'All about me' document used on inpatient ward for emotional wellbeing/neurodiverse consideration of reasonable adjustments.

- Example; young person struggling with noises and smells from kitchen whilst in adolescent area of ward, moved to different area, able to settle and engage with care.
- Example; child with autism struggling with ward environment. Play Team facilitated a musical keyboard for him to play, which he used to calm and settle anxiety.

Additional support for missed appointments following feedback from parent/child about barriers, following 'was not brought' communication.

- Example; child with autism was afraid of hospitals and was not brought for dental care. Play Specialist support was requested following discussion with parent prompted by 'was not brought' letter. Few weeks later child was able to attend for dental extractions completed in Day Surgery Unit.

Difference Made by the TSCP

The TSCP has provided the ability to network and share learning resources and have a diverse view of the services and needs of children living in Torbay.

Challenges/Barriers

Time constraints on partner agencies. TSCP could consider location of events held, to support improved accessibility, perhaps consider early morning/evening events to support wider attendance.

Devon and Torbay Probation Service

Neglect

All staff have attended their mandatory child protection training which outlines the signs and impact of neglect. All people on probation receive a home visit as part of their period of time on probation and we encourage repeat visit where there are children in the home that are not in school. Information about the impact on neglect has been shared with staff and they are asked to consider this on their home visits. Consideration is made of referrals to the MASH or early help where there are concerns. Managers discuss cases where there are children in their supervision.

The impact for children is that probation practice helps identify hidden harm in households where adults are under supervision. Home visits provide an opportunity to observe the lived experience of children, including home conditions, adult presentation, family dynamics and whether children appear visible, safe and appropriately supported. Where concerns are identified, referrals and information sharing with children's services support earlier intervention, helping to reduce the risk of neglect continuing unseen.

Exploitation

We do not work directly with children, so the impact on this priority is primarily linked to ensuring that we are effectively managing those that pose a sexual risk of harm to children and also attending the MACE to share information and ensure disruption of adults. We know that all of the people we are working with who pose a known sexual risk receive an intervention to address that risk.

The impact for children is through prevention, disruption and risk reduction. Effective assessment and management of adults who pose a sexual risk supports safer family and community environments for children. Attendance at multi-agency child exploitation meetings enables probation to share intelligence about adult risk, contribute to disruption activity, support safeguarding plans and ensure that restrictions, licence conditions and enforcement action are considered where this is necessary to protect children.

Domestic Abuse

All staff have attended their mandatory child protection training which outlines the signs and impact of domestic abuse. All people on probation receive a home visit as part of their period of time on probation and we encourage repeat visit where there are children in the home that are not in school. Information about the impact on domestic abuse has been shared with staff and they are asked to consider this on their home visits and in their day-to-day work with people on probation.

Staff actively exclude those that pose a risk of harm that relates to domestic abuse from addresses where there are children, where that has been assessed as the most appropriate option. We can also use electronic tags to monitor compliance with this. Consideration is made of referrals to the MASH or early help where there are concerns. Managers discuss cases where there are children in their supervision.

The impact for children is that risk posed by adults is considered in the context of the household and the child's daily life, rather than only through the behaviour of the person on probation. Address restrictions, exclusion requirements, electronic monitoring and information sharing with partners can reduce children's exposure to domestic abuse, coercive control and unsafe adult behaviour. This supports children to remain safer in their home environment and helps partner agencies to act quickly where risk escalates.

Mental Health

We do not work directly with children and therefore cannot comment on direct mental health outcomes. However, where staff become aware that a child may need support, this is considered within safeguarding discussions and staff would signpost parents, share information with relevant

partners or consider referral routes where appropriate.

The impact for children is that concerns arising from adult probation contact are not viewed in isolation; they are considered as part of the wider family context, supporting earlier identification of emotional distress, trauma or unmet need where this is visible through our work with parents and carers.

Training

Currently all staff are mandated to attend His Majesty's Prison and Probation Service (HMPPS) training in relation to safeguarding. We do always share the training available from Torbay and feedback has been positive where staff have been able to attend.

The primary impact of the training has been the ability to network with other safeguarding colleagues which supports the network to remain strong and relational. This has a practical impact for children because stronger professional networks support quicker advice, clearer escalation routes and more confident decision-making when probation staff identify safeguarding concerns. Training also reinforces the importance of professional curiosity, focused questioning and timely information sharing, which helps ensure that children connected to adults under probation supervision are more visible to services.

Learning from Serious Incidents/Learning Reviews

Middle and senior managers attend serious incident and learning reviews. All actions are completed and then fed back in quarterly safeguarding briefings to staff.

The impact for children is that learning from reviews is translated into frontline practice through briefings, supervision and management oversight. This helps staff recognise recurring themes such as disguised compliance, cumulative neglect, domestic abuse, exploitation, information sharing gaps and the need to understand the child's lived experience. Embedding this learning supports more consistent safeguarding practice and reduces the likelihood that risks to children are missed or considered too narrowly.

The Voice of Children, Young People and Families

We do not routinely have direct contact with children and therefore do not directly capture the voice of the child. However, probation staff are encouraged to consider the child's lived experience through home visits, safeguarding checks, conversations with parents or carers, liaison with children's services and information shared by partner agencies.

The impact on practice is that staff are prompted to consider what life may be like for the child in that household and whether the adult's behaviour, relationships, accommodation, substance use, mental health or domestic abuse risk may be affecting the child's safety and wellbeing.

Difference Made by the TSCP

The TSCP provides an important forum for keeping children visible across the partnership, particularly where risk is generated by adults and may not always be immediately apparent through child-facing services alone. From a probation perspective, the partnership strengthens the ability to share information, escalate concerns, understand patterns of risk and coordinate responses around families.

The collective impact is improved identification of hidden harm, better multi-agency understanding of adult risk factors, and more timely safeguarding responses for children and young people in Torbay.

Challenges/Barriers

A continuing challenge is ensuring that adult-facing services consistently understand and evidence the impact of adult behaviour on children. Probation may not always have direct contact with children, so effective safeguarding relies on timely information sharing, clear referral pathways and strong professional curiosity from all agencies. A further consideration is ensuring that children are not invisible where the primary service involvement is with an adult, particularly in cases involving domestic abuse, sexual risk, neglect, substance use, mental health or unstable accommodation.

Further Comment

Probation's contribution is often indirect but significant. By assessing and then managing people on probation and enforcing where there may present risk within families and communities, probation contributes to safer environments for children. Continued focus on the child's lived experience, professional curiosity and partnership information sharing will support children to be better protected where adult behaviour creates risk.

Torre Church of England Primary School

Neglect

Torre primary school is committed to recognising, responding to and reducing the impact of neglect through early identification, multi-agency working and targeted family support. The school recognises that neglect is often cumulative and therefore prioritise early intervention to improve outcomes for children before concerns escalate. School staff routinely identify indicators of neglect through daily

contact with children and families. Concerns are recorded promptly, discussed with safeguarding leads and, where appropriate, shared with partner agencies to ensure timely intervention.

Evidence of positive outcomes includes:

- Early identification of emerging neglect, concerns leading to Early Help assessments and coordinated support for families.
- Improved school attendance and punctuality following targeted work with parents and carers.
- Increased engagement from families with support services
- Improved hygiene, nutrition, presentation and emotional wellbeing of children following coordinated multi-agency support (0-19 partner support)
- Effective information sharing with Children's Social Care, Health, Education and Early Help services, ensuring children receive the right support at the earliest opportunity (still ongoing)
- Designated Safeguarding Lead (DSL) attended the TSCP Neglect Forum in the spring term.

Exploitation

Torre primary school is committed to recognising the signs and indicators of child exploitation, including child sexual exploitation (CSE), child criminal exploitation (CCE) and other forms of sexual harm. Through effective safeguarding procedures, staff receive regular safeguarding training and are vigilant in identifying concerns, sharing information and working collaboratively with partner agencies to reduce risk and improve outcomes for children.

School staff maintain a child-centred approach and respond promptly to concerns by:

- Identifying and recording indicators of exploitation or sexual harm.
- Making timely safeguarding referrals where risks are identified.
- Sharing information with Children's Social Care, Police, Health and other safeguarding partners to support coordinated risk assessment and intervention.
- Contributing to multi-agency meetings and child protection processes.
- Supporting children to identify trusted adults and understand how to seek help if they feel unsafe.
- Delivering age-appropriate safeguarding education through the curriculum, helping children understand healthy relationships, personal safety, consent and online safety.

Where concerns have arisen, early identification and effective multi-agency working has enabled children and families to access appropriate support, reducing risk and promoting safety.

The school has not completed any AIM assessments during this reporting period. Following a recent meeting with Forensic CAMHS, staff were advised that the AIM Assessment Tool requires specific training before it can be used appropriately and consistently. As a result, we have not undertaken AIM assessments directly. Where exploitation or harmful sexual behaviour concerns are identified, we continue to refer to and work alongside appropriately trained professionals, contributing relevant information to multi-agency assessments and planning. We will review our future training needs should the use of the AIM Assessment Tool become appropriate within our service.

Domestic Abuse

Torre primary school recognises the significant impact that domestic abuse can have on children's safety, emotional wellbeing, behaviour and development. We are committed to identifying concerns at the earliest opportunity, responding appropriately and working in partnership with families and safeguarding agencies to minimise the impact of domestic abuse on children.

Staff receive regular safeguarding training, including recognising the indicators of domestic abuse and understanding its impact on children, even when they are not the direct victims. Practitioners remain vigilant to changes in children's presentation, behaviour, attendance, emotional wellbeing and engagement, ensuring concerns are recorded and acted upon promptly.

Torre primary school supports positive outcomes by:

- Identifying early indicators of domestic abuse and making timely safeguarding referrals where appropriate.
- Working closely with Children's Social Care, Police, Health, Early Help and specialist domestic abuse services to ensure coordinated support.
- Contributing to Child Protection Conferences, Core Groups, Team Around the Family (TAF) meetings and Early Help planning.
- Providing a safe, consistent environment where children feel listened to and supported by trusted adults.
- Supporting children with emotional regulation and wellbeing through pastoral support and regular check-ins.
- Maintaining effective communication with parents and carers where appropriate, while ensuring the safety and welfare of the child remains paramount.

Through effective multi-agency working, children and families have been able to access specialist domestic abuse services, safety planning and wider family support, helping to reduce risk and improve children's emotional wellbeing and engagement in education.

Mental Health

Supporting children's mental health and emotional wellbeing is a key priority within our school. We recognise that good mental health underpins children's ability to learn, build positive relationships and reach their full potential. We are committed to identifying concerns early, providing appropriate in-school support and working collaboratively with external agencies to ensure children receive timely intervention. Our staff are trained to recognise early signs of emotional wellbeing and mental health difficulties and work closely with families to ensure children receive the right support at the right time.

A significant strength of school provision has been our close partnership with the Mental Health Support Team (MHST). Access to the MHST has been invaluable in enabling children to receive timely, evidence-based interventions without the delays often associated with specialist services. The team has provided direct therapeutic support for pupils, consultation for staff and advice for parents, allowing concerns to be addressed before they escalate.

The impact of this partnership has included:

- Earlier identification of children experiencing anxiety, low mood and emotional distress.
- Timely access to targeted mental health interventions and support.
- Improved emotional wellbeing, resilience and engagement in learning for children receiving support.
- Increased confidence among staff in recognising and responding to mental health concerns through advice and consultation from MHST practitioners.
- Stronger partnerships with families, enabling parents and carers to better understand and support their children's emotional wellbeing.
- Effective joint working between school, MHST and other professionals to ensure mental health support complements wider safeguarding, SEND and care planning arrangements.

Where children require additional support beyond the school's provision, referrals are made to appropriate services, including CAMHS and other specialist agencies, with the school continuing to provide pastoral support throughout the referral process. Unfortunately, these aren't always accepted.

Training

The safeguarding training provided through the TSCP has had a positive impact on our organisation by increasing staff knowledge, confidence and professional curiosity when responding to safeguarding concerns. In particular, attendance at the TSCP Neglect Forum, which included presentations from a range of professionals and partner agencies, has strengthened our understanding of the cumulative impact of neglect on children and families. Hearing from different

speakers provided valuable insight into the lived experiences of children, current local safeguarding themes and the importance of effective multi-agency working.

As a result of this training, staff are more confident in:

- Recognising the early signs and indicators of neglect.
- Shared with other Trust DSLs that weren't at the training
- Recording concerns with greater clarity and evidence.
- Challenging assumptions and maintaining professional curiosity.
- Understanding the roles of partner agencies and when to seek advice or make referrals.
- Contributing more effectively to multi-agency meetings and safeguarding plans.

The training has reinforced the importance of early intervention and has supported a more consistent approach to recognising and responding to safeguarding concerns across the school.

The impact for children and families has included earlier identification of emerging concerns, more timely referrals to appropriate services and improved collaboration with partner agencies. This has enabled children to access support at an earlier stage, helping to reduce risk and improve their safety, wellbeing and educational outcomes. We value the high-quality safeguarding training provided by TSCP and appreciate the opportunity to learn from a range of local professionals. This continues to strengthen our safeguarding culture and ensures that children remain at the centre of our practice.

Learning from Serious Incidents/Learning Reviews

Torre primary school's Designated Safeguarding Lead (DSL) regularly attends virtual multi-agency learning events, including Rapid Reviews, Child Safeguarding Practice Reviews and other safeguarding learning sessions facilitated by TSCP. These sessions provide valuable opportunities to reflect on local learning, emerging themes and best practice.

Following attendance, the DSL reflects on current safeguarding practice within the school, shares key learning with relevant staff where appropriate, and considers whether any changes are required to strengthen our procedures or approach. This ongoing reflective practice helps ensure that our safeguarding arrangements remain child-centred, responsive and informed by local learning. The impact of this is increased professional curiosity, improved confidence in decision-making and a continued focus on early identification and effective multi-agency working, contributing to better outcomes for children and families.

The Voice of Children, Young People and Families

Children, young people and families are at the heart of our safeguarding practice. We actively seek their views through daily interactions, pastoral support, pupil voice activities, parent meetings, surveys and during safeguarding and Early Help processes. Children are encouraged to share their thoughts, worries and experiences with trusted adults, and staff ensure that their voices are listened to, recorded and reflected in planning and decision-making.

Parents and carers are encouraged to work in partnership with the school and are involved in discussions about support and interventions wherever it is safe and appropriate to do so. Feedback from families helps us tailor our approaches to meet individual needs and strengthen home-school relationships.

Capturing the voices of children and families has led to more personalised support plans, improved communication with parents, earlier identification of concerns and interventions that better reflect each child's lived experience. This child-centred approach has strengthened our safeguarding practice and contributed to improved wellbeing, engagement and outcomes for children and their families.

Difference Made by the TSCP

The TSCP makes a positive difference to children, young people and families by strengthening the knowledge, skills and confidence of professionals through high-quality safeguarding training, forums and shared learning opportunities. These events promote consistent safeguarding practice, encourage effective multi-agency working and ensure professionals remain informed about local priorities and emerging risks. Collectively, this helps improve the early identification of concerns, supports timely interventions and contributes to better outcomes for children and families across Torbay.

Challenges/Barriers

One of the key challenges for local multi-agency safeguarding is the high turnover of staff within some social care teams. Frequent changes in allocated social workers can make it difficult to maintain continuity, build effective professional relationships and ensure consistency for children and families.

At times, communication can also be challenging, with delays in responses from social workers. We often find that we need to copy team managers into correspondence in order to receive a timely response or update. This can impact the efficiency of multi-agency working and create uncertainty when information is needed to support children effectively.

Continued focus on workforce stability, clear communication and timely information sharing would further strengthen partnership working and improve outcomes for children and families.

Further Comment

The Torbay Education Support Service (TESS) has provided a fantastic service when supporting Torre primary school. Their timely response to queries (often frantic ones) are really supportive.

Torbay Domestic Abuse and Sexual Violence Service

Exploitation

Following a competitive Peninsula-wide procurement process, Torbay commissioned a dedicated Sexual Violence Service for children and young people, delivered by The Children's Society, with Devon Rape Crisis and Sexual Abuse Services (DRCSAS) acting as the Lead Partner. The service commenced in February 2026 and provides a trauma-informed, child-centred response to children and young people who have experienced sexual violence. As a newly established provision, this service forms an integral part of Torbay's whole-system safeguarding response, strengthening the partnership's collective ability to prevent harm, respond effectively, and support recovery. It reflects a strong commitment to collaborative commissioning and delivery, bringing together specialist partners to enhance local capacity, capability and expertise. This model represents positive progress in embedding a coordinated, multi-agency approach to tackling sexual violence and improving outcomes for children and young people across Torbay.

Domestic Abuse

Recognising and responding to children impacted by domestic abuse remains a core priority for Torbay commissioned Domestic Abuse and Sexual Violence (DASV) services. Torbay continues to deliver a strong and coordinated service offer through both commissioned provision and grant-funded community initiatives. This approach is underpinned by a whole-family model of support, ensuring that interventions are trauma-informed, inclusive, and responsive to the diverse needs of children and their families. There is a clear strategic emphasis on delivering flexible, age-appropriate support pathways that promote equitable access and inclusion, enabling children to receive timely and proportionate intervention based on assessed need. To further strengthen outcomes, the development of a more integrated adult and children DASV strategy has been identified as a key priority for the coming year. This will support improved system alignment, enhance multi-agency collaboration, and ensure a more cohesive and effective response to children affected by domestic abuse across Torbay.

TSCP Training Offer

E-learning

In addition to the in-person courses detailed under 'Attendance Data' below, the following e-learning is also available. The Children's Services LMS Officer has updated fourteen modules across the year 2025/26.

- Level 1 Induction into Safeguarding Children and Adults
- Level 2 Safeguarding: Introduction to Child Protection
- Level 3 Safeguarding Children: pre-course e-learning

- Cared for Children Practitioner Training
- Early Help Module – e-learning option
- Reducing Parental Conflict (e-learning)
- Youth Homeless Prevention Training (e-Learning)
- Course: Introduction to Domestic Abuse **Updated**
- Course: Introduction to Sexual Violence **Updated**
- Responding to Sexual Violence Disclosures **Updated**
- MAPPA Awareness V3
- Introduction to MARAC **Updated**

- 'PREVENT' training:
 - Level 1 Awareness
 - Level 1 Awareness Refresher
 - Level 2 (WRAP)
 - Level 2 (WRAP) Refresher

- Online Safety
- Whistleblowing with confidence **Updated**
- Drug & Alcohol Awareness **Updated**
- Self-Harm Awareness **Updated**
- Honour Based Violence: Forced Marriage **Updated**
- Introduction to Female Genital Mutilation (FGM) **Updated**
- Introduction to Modern Slavery **Updated**
- Epilepsy Awareness **Updated**
- Autism Awareness **Updated**

- Learning Disability Awareness **Updated**
- Downs Syndrome Awareness **Updated**

Attendance Data

Course	Number of Courses delivered	Places Available	Booked	Attended	Attendance Rate	Places Booked Vs Available
Best Practice Forum: TSCP Conference 2025	1	160	164	157	96%	102%
Best Practice Forum: C109	1	100	33	25	75%	33%
Level 3 Safeguarding Children – Foundation	6	204	194	190	98%	97%
Level 3 Safeguarding Children – Refresher	12	335	271	266	98%	81%
Child Exploitation in Torbay	2	32	23	21	91%	72%
Project M Exploitation Courses:	8					
• CSE	1	24	12	12	100%	50%
• CCE	1	24	8	8	100%	34%
• Slavery & NRM	3	72	41	38	93%	57%
• CYP who go missing	3	72	43	36	84%	60%
DASH Risk Assessment	4	136	84	79	94%	62%
DARAC Training	2	33	26	25	96%	79%
GCP2 Training	3	60	31	30	97%	52%
Restorative Practice Awareness	10	161	122	105	86%	76%
Restorative Language Workshop	10	154	120	108	90%	78%
Early Help Module (also offered as e-learning)	1	18	16	11	69%	89%
Introduction to Family Group Conferences	3	52	45	32	71%	87%

10. Future Planning/Next Steps

Two key workstreams for the TSCP in 2026/27 will be based on the implementation of major changes mandated under recent national government guidance. The first will be the implementation of practice amendments required within the updated WT2026 arrangements, and the second will be to oversee and support local agencies to implement the significant changes brought about by the new Families First Partnership Programme (FFPP). Key elements of FFPP include a broader local family help offer, the management of S17 Child in Need work by non-social work qualified practitioners and arrangements for organising and operating a Torbay co-located Multi-Agency Child Protection Team (MACPT), with the TSCP committing to a 'test and learn' MACPT system commencing in October 2026. Alongside these significant changes, improvements to practice identified via TSCP and single-agency quality assurance processes, and improved use of data, will also drive future planning and will be included in 2026/27 partnership work streams.

In addition to the aforementioned specific items, there are a number of areas where the need for further improvements and/or the management of changes have been identified by the TSCP during the current reporting period, with these being:

- Ongoing implementation of the Families First Partnership Programme (FFPP) reforms.
- Continuing the expansion and improvement of data use and analysis within the TSCP, including increasing dedicated data staffing resource and reviewing and revising how data feeds into the partnership to better inform and improve multi-agency practice.
- Organising and maintaining a TSCP sub-group focused on reducing risk relating to child sexual abuse in the family environment (CSAFE).
- Expand on the recent addition of education providers into the TSCP group structure/work streams, including the potential for an LSP level attendee.
- Improved integration of the voices of children and families into partnership working.
- Support the ongoing LSP led funding review of Peninsula SCPs.
- Support Peninsula Business Managers to continue their ongoing review of the effective use of existing resources and improved cross-border collaboration where possible. The agenda for this is set by LSPs/DSPs and is currently focused on data, funding, training (including learning from reviews) and Independent Scrutiny.
- The impact of Local Government Review (LGR) on multi-agency children's safeguarding arrangements.

11. Conclusion

During the reporting period 2025/26 the TSCP implemented the remaining requirements of WT2023, with the changes made becoming embedded in local multi-agency safeguarding practice, including improved engagement with education providers. FFPP reforms also became more prominent within the work of the TSCP, with this being likely to increase further during the 2026/27 reporting period. Alongside these changes, improvements to practice identified via TSCP and single-agency quality assurance processes, and improved use of data, also drove the partnership's commitment to continuing practice improvement. The development of data use accelerated through 2025/26, with dedicated TSCP data analysis time beginning in the Autumn of 2025, and an agreement made to provide additional funding to increase dedicated data resource from April 2026. It is envisaged that data use will be managed via the TSCP Quality Assurance Group from September 2026, with data increasingly supporting sub-group work-streams from the Autumn of 2026 onwards.

During 2025, significant improvements made to mental health/wellbeing services for children and young people in Torbay afforded the opportunity for the TSCP to review the need to continue with its mental health priority. Subsequently, it was decided that, with ongoing oversight, the mental health priority could close and be replaced by a priority themed on child sexual abuse in the family environment (CSAFE). The impact of the CSAFE sub-group will be reported on in next year's TSCP Annual Report.

The TSCP published its updated Threshold Tool (Right Help, Right Service, right Time) in January 2026, with initial feedback from partner agencies being positive. Effective use of the new tool will be reviewed by the partnership's QA Group as part of their auditing cycle and has been incorporated into the current Quality Assurance Group work plan.

The fourth TSCP Annual Conference was held in June 2026, with the conference theme being based on neglect. As in previous years, the conference was very well attended, with 'in-person' attendance being fully booked and further delegates attending via video link. In addition to this, the TSCP, via the local authority's learning academy, provided a significant level of multi-agency safeguarding training to ensure appropriate professional development across services working with children and families in Torbay.

With the ongoing support of LSPs/DSPs, during 2025/26 Business Managers from across the Peninsula continued to meet on a monthly basis, with additional meeting time being dedicated to

cross-Peninsula projects. Cross Peninsula work is currently focused on data, training, independent scrutiny, SCP funding, and the serious incident process, but is likely to cover more areas as partners progress with Local Government Review (LGR) reforms during 2026/27.

In conclusion, the TSCP has continued to make good progress towards improved safeguarding arrangements for children in Torbay during the 2025/26 reporting period. However, we retain an awareness that improving the safeguarding of children is both a varied and continuous journey. Ongoing improvements/changes required by the TSCP are listed in section 10 of this report and will be actioned in 2026/27, alongside any other concerns that may arise during that reporting period.

12. Glossary

Acronym	Full Name
AIM	Assessment, Intervention, Moving on
BCU	Basic Command Unit
BPF	Best Practice Forum
CAMHS	Child and Adolescent Mental Health Service
CCIB	Children's Continuous Improvement Board
CDOP	Child Death Overview Panel
CDRM	Child Death Review Meeting
CEMOG	Child Exploitation and Missing Operational Group
CFHD	Children and Family Health Devon
CQC	Care Quality Commission
CSAFE	Child Sexual Abuse in the Family Environment
CSP	Community Safety Partnership
CSPR	Child Safeguarding Practice Review
CYPEG	Children and Young People Exploitation Group
DARAC	Domestic Abuse Risk Assessment for Children
DASH	Domestic Abuse, Stalking and Harassment
DASV	Domestic Abuse and Sexual Violence
DASVEG	Domestic Abuse and Sexual Violence Executive Group
DBS	Disclosure and Barring Service
DfE	Department for Education
DDM	Dedicated Decision Maker
DRCSAS	Devon Rape Crisis and Sexual Abuse Services
DSL	Designated Safeguarding Lead
DSP	Delegated Safeguarding Partner
EHCP	Education, Health, and Care Plan
FGDM	Family Group Decision Making
FFPP	Families First Partnership Programme
GCP2	Graded Care Profile 2
GDPR	General Data Protection Regulations
HEADSS	Home, Education, Activities, Drugs, Sexuality and Suicide Safety
HMICFRS	His Majesties Inspectorate of Constabulary and Fire and Rescue Services
HMPPS	His Majesty's Prison and Probation Service
ICB	Integrated Care Board
ICO	Interim Care Order
IDVA	Independent Domestic Abuse Advisor
ILACS	Inspecting Local Authority Children's Services
IRO	Independent Reviewing Officer
JSNA	Joint Strategic Needs Assessment
JTAI	Joint Targeted Area Inspection
KCSIE	Keeping Children Safe in Education

KPI	Key Performance Indicator
LADO	Local Authority Designated Officer
LGR	Local Government Review
LSP	Lead Safeguarding Partner
MACA	Multi-Agency Case Audit
MACE	Missing and Child Exploitation forum
MACPT	Multi-Agency Child Protection Team
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MASA	Multi-Agency Safeguarding Arrangements
MASH	Multi Agency Safeguarding Hub
MERS	Mood, Emotions and Relationships Service
MHST	Mental Health Support Team
NCMD	National Child Mortality Database
NRM	National Referral Mechanism
NSPCC	National Society for the Prevention of Cruelty to Children
OFSTED	Office for Standards in Education
PALS	Patient Advice and Liaison Service
PCC	Police and Crime Commissioner
PEEL	Police Effectiveness, Efficiency and Legitimacy
PEP	Personal Education Plan
PPN	Public Protection Notice
RCRP	Right Care Right Person
RHC	Return Home Conversation
SARC	Sexual Abuse Referral Centre
SCBU	Special Care Baby Unit
SCOG	Specialised Commissioning Oversight Group
SCP	Safeguarding Children Partnership
SCRAM	Secure Continuous Remote Alcohol Monitoring
SDQ	Strengths and Difficulties Questionnaire
SEND	Special Educational Needs and Disabilities
SIN	Serious Incident Notification
SMART	Self-Management and Recovery Training
STRO	Slavery and Trafficking Prevention and Risk Orders
TAF	Team Around the Family
TDAS	Torbay Domestic Abuse Service
TESS	Torbay Education Support Service
TNA	Training Needs Analysis
TSCP	Torbay Safeguarding Children Partnership
TSDFT	Torbay and South Devon NHS Foundation Trust
THRIVE	Therapeutic, Habit, Relational, Individual, Values and Emotional factors
VRI	Visual Recorded Interview
WT2023	Working Together to Safeguard Children 2023
WT2026	Working Together to Safeguard Children 2026