NHS
Kernow
Clinical Commissioning Group

Annual report Safeguarding children

April 2017 – March 2018

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1 Introduction

The purpose of the designated professionals annual safeguarding children report to the Governing Body is to provide assurance that Cornwall and the Isles of Scilly commissioned health services has robust arrangements in place and is aware of any gaps to meet the statutory requirements to safeguard children from abuse and neglect and to promote the health and wellbeing of all children and young people within NHS Kernow Clinical Commissioning Group (NHS Kernow) working in partnership with Cornwall Council, the NHS and independent health care providers and third sector organisations, to ensure that children and young people are protected. The mandatory safeguarding requirements are contained in The Children Act 1989 and under Section 11 of the Children Act 2004 which places a duty on the NHS to promote the welfare of all children and young people:

- Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.
- Various other statutory duties apply to other specific organisations working with children and families and are set out in appendix one.

2 Governance and accountability local arrangements

2.1 Leadership and governance

Child safeguarding is reported at every Governing Body meeting as part of the quality and performance update; actions are noted and monitored for progress.

The children's safeguarding declaration at December 2017 can be found here: www.kernowccg.nhs.uk/get-info/safeguarding/children/safeguarding-children-declaration/

A clear statement of NHS Kernow's responsibilities towards children – this can be located via this link: http://policies.kernowccg.nhs.uk/DocumentsLibrary/KernowCCG/OurServices/Safeguarding/SafeguardingChildrenDeclaration.pdf (opens PDF).

A clear line of accountability for safeguarding children is outlined in appendix two along with the statutory functions and duties.

During 2017/18 a number of child safeguarding policies have been updated including:

- Child safeguarding policy and procedure.
- Safeguarding children's training policy.
- Child protection supervision policy.
- Managing safeguarding children allegations against health and ancillary staff.

There are a number of groups driving safeguarding across the system including:

- A health safeguarding forum chaired by the designated doctor which continues to meet bi-monthly.
- The safeguarding team meets fortnightly, this is a joint adult child meeting and the chair function rotates between the designates.
- The child death overview panel meeting alternate months.
- Learning sub group monthly are attended and contributed to by all the CCG child designates.
- There is a number of task and finish groups leading themed pieces of work, the designates either lead or are represented on these groups.

The designated nurse safeguarding children post became substantially vacant in July 2017. During the remainder of 2017 temporary cover has been in place whilst the recruitment process took place. Interviews for the designated nurse position were successful in late 2017 with the new incoming designated nurse to commence in April 2018.

3 Cornwall and the Isles of Scilly Our Safeguarding Children Partnership

The executive safeguarding leads from NHS Kernow, RCHT and CFT, are members of the Cornwall and Isles of Scilly Our Safeguarding Children Partnership (CIOSOSCP). The partnership was implemented in 2017 based on the Wood Report recommendations[1].

The designated professionals act as advisors to the executive safeguarding lead for NHS Kernow. There are a number of working subgroups (task and finish groups) which have health representation including designated and named professionals as health advisors and leads for some work streams.

The priorities identified by the partnership in 2017/18 include:

- Child sexual exploitation (CSE).
- Missing children.
- Domestic abuse.
- Neglect.

1 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/526329/Alan_Wood_review.pdf (See Appendix 2 Wood Report Summary)

4 Training

'Working Together to Safeguard Children (2015)'
Makes reference to the importance of all staff attending training at a level appropriate to their role within the organisation that employs them. Training requirements are further strengthened in the following Intercollegiate document / guidance: 'Safeguarding Children and Young People: roles and competencies for health care staff – Intercollegiate document March 2014 (3rd edition). This document states that all health care organisations have a responsibility to ensure that its employees comply with their duty to safeguard and promote the welfare of children and young people. In addition staff that specifically come in to contact with children and young people have a responsibility to safeguard and promote their welfare and should know what to do if they have concerns about safeguarding issues, including child protection. This responsibility also applies to staff who are working primarily with adults who have dependent children that may be at risk because of their parent / carer's health or behaviour. To fulfil these responsibilities, it is the duty of healthcare organisations to ensure that all staff has access to appropriate safeguarding training, learning opportunities, and support to facilitate their understanding of the clinical aspects of child welfare and information sharing.

The Intercollegiate safeguarding competencies[2] are a set of abilities that enable staff to effectively safeguard, protect and promote the welfare of children and young people. Different staff groups require different competencies depending on their role and degree of contact with children, young people and families, the nature of their work, and their level of responsibility. All staff working in a health care setting must know what to do if there is a child protection concern involving a child and or family, know the referral procedure, which includes knowing who to contact within their organisation to communicate their concerns.

The safeguarding children and young people – roles and competences for healthcare staff[3], is an intercollegiate competency framework that identifies levels of competence and gives examples of groups that fall within each of these.

The criteria for levels one to three are as follows:

- **Level one**: This the minimum / basic level at which all health staff are to be trained.
- **Level two**: This is the level at which all non-clinical and clinical staff that has any contact with children, young people and / or parents / carers are to be trained at.

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http://www.rcpch.ac.uk/sites/default/files/page/Safeguarding%20Children%20-%20Roles%20and%20Competences%20for%20Healthcare%20Staff%20%2002%200%20%20%20%20(3)_0.pdf)
3 ADD reference to the document

- **Level three**: This is the level of training required by all clinical staff working with children, young people and / or their parents / carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding / child protection concerns.

Training at levels one and two is delivered 'in house' by either face-to-face sessions or by e-learning. Level three training is of a multiagency nature and should be provided in a classroom / group-based session / face-to-face although some is accessed via e-learning.

Safeguarding training has been provided to board members in keeping with the requirements of the Intercollegiate competencies which recommends that a tailored package be delivered which encompasses level one knowledge, skills and competencies, as well as that specific to board level in order to acquire the knowledge, skills and competences to fulfil their role and responsibilities.

4.1 Staff groups training levels

Health staff can ascertain their required levels of training by consulting the Intercollegiate Document referred to above and/or discussing their roles and responsibilities with their training departments who hold training matrices which detail the required levels of training against job role.

The county-wide training strategy provides staff with more details about timescales, updates and various types of training to ensure compliance levels (available on the CIOSOSCP website).

CIOSOSCP has commissioned an independent company to deliver basic level three training and thematic courses e.g. domestic abuse and parental mental health and an annual safeguarding conference. The conference in 2016 was on the subject of child sexual exploitation (CSE). The conference for 2017 was on the topic of child sexual abuse (CSA). Health and partner agencies have committed to the use of this multi-agency safeguarding training.

The designated professionals have delivered bespoke training to NHS Kernow's Governing Body (to be updated annually from 2018) members and participate in the workforce mandatory training programme. They have also undertaken topic specific multi-agency training on the mainland and on the Isles of Scilly.

4.2 Training statistics

The Care Quality Commission (CQC), in keeping with the guidance in the Intercollegiate Document, has set the child protection training compliance rate at 84.5 percent allowing some flexibility for sickness and leave.

In June 2016, the main health providers; RCHT and CFT have recommenced level three in-house training which is multidisciplinary and open to other agencies if they wish to attend. There are likely to be resource implications with this decision.

Safeguarding executive leads are committed to achieving compliance and have asked named professionals to lead on these courses.

Table one: Safeguarding training levels as at 31 March 2018

Training requirements in accordance with intercollegiate document 'roles and responsibilities for health staff' (2014) CQC minimum compliance rate 84.5 percent at all levels.

Safeguarding Children training statistics for all health organisations from April 2017- March 2018

Training requirements in accordance with Intercollegiate document 'Roles and Responsibilities for health staff' (2010)

SHA minimum compliance rate 84.5% at all levels

N/A=Not Available

	LEVEL 1	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
		Level 1	Level 1	Level 1	Level 1	Level 1	Level 1	Level 1	Level 1	Level 1	Level 1	Level 1	Level 1
RCHT	Required	6313											
	Trained	5417											
	Percentage	85.8%	86.7%	88.9%	89.8%	90.1%	92.1%	92.4%	92.9%	93.1%	93.50%	93.3%	93.5%
CFT	Required	1590	1581	2334	4160	2120	3575	3563	3564	3562	3545	3486	3572
	Trained	1502	1514	2040	3703	1956	3184	2987	2961	2938	2994	3042	3121
	Percentage	94%	96%	87%	89%	92%	89%	84%	83%	82%	84%	87%	87%
KCCG	Required	282	276	272	263	261	265	267	274	277	279	281	281
	Trained	192	193	195	189	195	204	214	228	238	244	247	252
	Percentage	68%	70%	72%	72%	75%	77%	80%	83%	86%	87%	88%	90%

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	LEVEL 2	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
		Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
RCHT	Required	4240											
	Trained	2815											
	Percentage	66.4%	68.9%	75.1%	76.6%	77.0%	77.5%	78%	77.9%	78.7%	76.20%	74.2%	73.5%
CFT	Required	1122	1119	1673	3103	1598	2660	2643	2656	2657	2647	2646	2592
	Trained	1066	1063	1324	2012	1072	1888	1977	2019	2047	2062	2084	2037
	Percentage	95%	95%	79%	65%	67%	71%	75%	76%	77%	78%	79%	79%
KCCG	Required	3	3	3	3	3	3	3	3	3	3	3	3
	Trained	2	2	2	2	2	2	2	2	2	2	2	2
	Percentage	66.67%	66.67%	66.67%	66.67%	66.67%	66.67%	66.67%	66.67%	66.67%	66.67%	66.7%	67%

	LEVEL 3	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
		Level 3	Level 3	Level 3	Level 3	Level 3	Level 3	Level 3	Level 3	Level 3	Level 3	Level 3	Level 3
RCHT	Required	377											
	Trained	305											
	Percentage	81.0%	83.3%	84.3%	80.7%	81.2%	77.8%	78.0%	81.3%	81.4%	84.60%	84.4%	81.4%
CFT	Required	499	501	472	526	312	498	517	522	523	583	599	583
	Trained	492	493	288	317	215	217	404	402	410	433	541	520
	Percentage	99%	98%	61%	60%	69%	66%	78%	77%	78%	74%	90%	89%
KCCG	Required	6	5	5	5	4	4	4	3	3	3	3	3
	Trained	3	2	2	2	1	2	3	2	2	3	3	3
	Percentage	50%	40%	40%	40%	25%	50%	75%	67%	67%	100.00%	100.00%	100.00%

RCHT : Level 1 & 2 in-house training

RCHT: Level 3 is a mix of internal & external training

CFT level 3 is E-learning

4.3 Percent compliance

Level one
The only organisation fully compliant at this level throughout the year was RCHT. Both CFT and NHS Kernow showed varying levels of compliance although both were fully compliant by the year end.

Level two
No organisation was fully compliant for the year with this level of training although CFT were compliant in the first two months of quarter one. CFT's compliance level was higher than the CCG's and RCHT and they reached a peak of 95 percent and an average of 79 percent in the last quarter compared to an average of 74 percent for RCHT and 67 percent for the CCG in quarter four. In relation to the CCG only three members of staff required this level of training and as only two attended the percentage compliance appears to be worse than it actually is.

Level three
RCHT was only compliant at this level for one month in quarter four and remained at a compliance rate of around 81.5 percent. CFT was fully compliant at this level for two months in quarter one and two months in quarter four and had an average compliance rate of 70 percent for the other eight months of the year. The CCG was non-compliant at this level for the first three quarters but became fully compliant in and for the whole of quarter four.

The CCG reviewed with line mangers the number of staff requiring level three training with line managers and in line with the core skills framework recommendations (Skills for Health) which is why the numbers of staff requiring level training dropped to three. This will be kept under review.

The CIOSOSCP (Partnership[4]) extended Reconstruct training contract which expired in October 2017, the new training contract has been awarded to 'Family Action Training and Consultancy Services'.

5 Child protection supervision

Casework supervision is intended to be a single element, within a framework of education and support to ensure that staff that have a primary role working with children and young people have the necessary knowledge, skills and support to practise competently. NHS Kernow recognises the importance of ensuring that organisations commissioned to provide children's services provide supervision to their staff who work directly with children and young people - specifically in relation to

4 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/526329/Alan_Wood_review.pdf

cases where there are concerns about harm, self-harm or neglect of a child or young person. Safeguarding supervision is acknowledged by NHS Kernow as the 'cornerstone of practice' (Laming 2009) and as such must be given due regard. It also recognises the need for robust safeguarding structures and processes in all organisations and is assured that there are safeguarding supervision policies in place.

Working Together (2015) asserts that '…effective professional supervision can play a critical role in ensuring a clear focus on the child's welfare. Supervision should support professionals to reflect critically on the impact of their decisions on the child and family'.

The designated nurse for child protection provides safeguarding supervision to the named nurses.

During this reporting period the designated nurse for child protection retired. She temporarily returned to undertake a service review, which subsequently was superseded by an independent external review.

Interims were employed whilst the recruitment process for a permanent designated nurse took place. Work fulfilled by the interims included:

- Policy development and updating.
- Providing advice and support across the health economy.
- Representing the CCG in multi-agency task and finish groups.
- Writing the 2016/17 annual report.
- Supporting the recruitment process.

6 Primary care / GP bulletin

Parental neglect is the most common cause of significant harm to children and young people in Cornwall and just over 61 percent of all the child protection plans in Cornwall result from the effect of neglect on children. The Safeguarding Children Partnership has therefore identified the need for agencies working more closely together to prevent neglect, identify the risks early and tackle the impact of neglect on children as a strategic priority for this and the coming business year.

Consequently, this concern led to the CIOSOSCP taking steps to tackle neglect via the development of the Neglect Strategy. It is envisaged that the CIOSOSCP will be able to provide data in the next annual report on the effectiveness of the Neglect Strategy details of which are below:

The Cornwall and Isles of Scilly Our Safeguarding Children Partnership (CIOSOSCP) developed and published a Neglect Strategy during the course of 2017 and this was formally launched in November. The strategy consists of the four following documents:

1) Neglect: Strategy delivering better outcomes '2017/19' launched November 2017.
2) Neglect: Practitioner's guide / toolkit.
3) Neglect: One minute guide.
4) Neglect: Graded care profile.

In order to promote the issue of neglect within the primary care setting arrangements were made with the CCG's communications team to include information about neglect in the GP Bulletin over three consecutive issues during March 2018 - these bulletins are located in appendix three.

The Neglect Strategy aims to reduce the incidence of neglect and provides a working definition of neglect and information on the causes and signs and symptoms. It contains information about multi-agency roles and responsibilities including that of health and GP's. The strategy contains information about the Impact of neglect on different age ranges: 0-5 / pre-school; 5-11 / school-age; 11-18 / adolescents and provides guidance on how to respond to neglect and provide early intervention.

7 Serious incidents and serious case reviews

7.1 Serious incidents

Serious Incidents[5] are reported to NHS Kernow's quality team which has overall responsibility to ensure that investigations are adequately completed within mandated timeframes set out in the NHS England guidance.

Table two: Serious Incidents relating to safeguarding children 2012/17

2012	2013	2014	2015	2016	2017*
10	12	12	7	8	9

* STEIS data financial year 2017/18

The number of serious incidents in relation to safeguarding annually has been relatively static since 2012.

It is difficult to reliable identify themes from the nine cases. There were four STEIS reported from Royal Cornwall Hospitals NHS Trust, the remaining four from Cornwall Partnership NHS Foundation Trust and one from South Western Ambulance Service NHS Foundation Trust.

[5] (https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incidnt-framwrk-upd2.pdf)

7.2 Serious case reviews

Serious case reviews (SCR) are statutory multi-agency reviews conducted by the CIOSOSCP, as specified in 'Working Together to Safeguard Children' guidance (2015) which states that: a serious case is one where abuse or neglect of a child is known or suspected and either the child has died or the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child. The chief nursing officer for NHS Kernow is a member of the panel which decides whether the SCR criteria is met.

The previous CIOSSCB had revised the procedure for referring a case which may meet the criteria for a serious case review. In this financial year there have been two referrals for an SCR consideration; neither were considered to meet the current eligibility criteria. The LSCB publishes the outcomes and learning from SCR's on the website once the SCR has been through the ratification process.

Table three: Serious case reviews 2012/17

2012	2013	2014	2015	2016	2017
1	2	1	1	0	0

The number of cases considered for serious case review in Cornwall has fluctuated since 2012 as shown in the table below.

Table four: Serious cases considered

2012	2013/14	2014/15	2015/16	2016/17	2017/18
1	6	5	0	1	2

Cornwall NHS remains an outlier within the region when compared to geographical counties in the low number of reviews commissioned.

Of the above cases considered; none were recommended to proceed to a local serious case review. But one did proceed to a learning from experience review with external authors; the final recommendations and action plan are yet to be published

The rationale for the numbers of serious case reviews undertaken in Cornwall and the Isles of Scilly over the years remains difficult to analyse with any certainty. The process is anticipated to change based on the 'Alan Wood Report' and the revised Working Together Statutory Guidance due for publication in July 2018[6]. It is suggested that there will be a national body which undertake the serious case reviews investigation and publish and share learning. Locally a modified version takes place to identify lessons which are delivered as workshops. The lessons learnt and the child protection data inform the priorities. Learning points unfortunately

[6] NOTE the Guidance publication was delayed to July 2018.

remain and are not unexpected as they are highlighted in the majority of SCRs across England; communication, information sharing, record keeping and IT systems.

7.3 Recommendations and learning

Where a serious incident has potential learning for other agencies, the designated nurse for safeguarding child protection takes the executive summary to the CIOSSCB Learning Group to ensure outcomes are shared with partner agencies. The CIOSSCB has ratified a 'multi-agency learning from experience' procedure for cases where, following referral, the criteria is not met for a serious case review; but there is potential learning for more than one provider:

https://www.cornwall.gov.uk/health-and-social-care/childrens-services/cornwall-and-isles-of-scilly-safeguarding-children-partnership/learning/newsletter-and-workshops/

The 2017/18 Learning Lessons workshops were:

- The impact of neglect on children's health and wellbeing.
- Dental neglect.

These topics were identified by the number of Cornish children subject to a child in need or child protection plan, see data below.

Health recommendations and learning from serious incidents and serious case reviews are taken forward by the service provider through their governance structures, embedded into the organisation and monitored by providers' internal governance teams. Provider annual audit plans should demonstrate compliance with at least one of the learning outcomes.

The oversight of the embedding of the learning and closure of these cases is the responsibility of NHS Kernow, supported by the designated professionals.

All cases of children who die are also reviewed in line with statutory guidance by the Child Death Overview Panel (CDOP) for the south west peninsula. NHS England is informed of incidents and scrutinises learning outcomes.

As noted earlier, The Wood Report has led to changes being made to the SCR process as indicated in this short summary:

The Wood Report has recommended the discontinuation of serious case Reviews, and to establish an independent body at national level to oversee a new national learning framework for inquiries into child deaths and cases where children have experienced serious harm. This is expected in the Department for Education review of the statutory guidance "Working Together".

8 Child Death Overview Panel

The south west peninsular Child Death Overview Panel (CDOP) has a statutory remit to review the deaths of all children across Devon and Cornwall and the Isles of Scilly. In addition and under certain circumstances, for unexpected deaths, additional local case reviews (LCSs) are undertaken as part of the child death review (CDR) process in order to provide detailed information, learning and recommendations to local agencies and also to the CDOP. The LCRs are chaired by the named doctor for CDR. The remit of any CDOP is to review all the information available to try and understand why children die and highlight any thematic learning that may become apparent with a larger cohort of children. CDOP provides each of the LSCBs in the peninsular with an annual report and also contacts the LSCB chairs ad-hoc with any questions and immediate recommendations as required. The annual reports are not meant for wider publication as there is always a concern of recognising specific children despite anonymization. Therefore the governance for the dissemination of the recommendations from this report is from the LSCB chair and specifically for NHS Kernow, via the executive safeguarding lead.

Table five: Showing the number of notifications to the south west CDOP over the last five years

Safeguarding boards	2012/13	2013/14	2014/15	2015/16	2016/17
Cornwall and the Isles of Scilly	37	23	17 (21%)	27 (36%)	25 (27%)
Devon	33	38	30 (37%)	31 (41%)	42 (45%)
Plymouth	21	15	19 (23%)	9 (12%)	12 (13%)
Torbay	11	10	11 (14%)	6 (8%)	6 (6.5%)
Out of area	4	7	4 (5%)	2 (3%)	8 (8.5%)
Total	**106**	**93**	**81**	**75**	**93**

The main findings from the 2016/17[7] CDOP annual report as follows:

Although several significant themes have been identified in CDOP's review of child deaths in the most recent annual report, the panel recommends that the LSCBs consider paediatric palliative care services in an effort to address disparity in the care pathway.

The provision and configuration of palliative care services varies widely across the south west peninsula. The panel noted occasions when care packages delivered were put in place on an "ad-hoc best endeavours" approach, often as a result of dedicated professionals responding to individual episodes. While demonstrating good care and commitment by staff, it also highlighted challenges of delivering end-

[7] Last published report.

of-life care for children in their chosen place, particularly when in the community and out of hours.

Commissioned services for end-of-life and palliative care for children and young people should provide a consistent offer with a defined care pathway.

As noted earlier, the Wood Report has led to changes being made to the CDOP process as indicated in this short summary:

The national sponsor for CDOPs has moved from the Department for Education to the Department of Health and it should consider how CDOPs can best be supported and sponsored within the arrangements of the NHS. The recommendation is to introduce a National Child Mortality Database.

The National Child Mortality Database (NCMD) will collect information about all children in England who die before their 18th birthday. The Healthcare Quality Improvement Partnership (HQIP) is commissioning this programme of work on behalf of NHS England. The NCMD will drive improvement in the quality of health and social care for children in England to help reduce potentially avoidable deaths. It will collect a minimum dataset from the Child Death Overview Panel reviews of all child deaths in England. The collection, analysis and public reporting of information from all child deaths across England will facilitate learning to reduce preventable child mortality. The NCMD programme and its associated work streams will be led by the University of Bristol.

The Department of Health should determine how CDOPs can be organised on a regional basis with sub-regional structures to promote learning and dissemination. They should also give consideration to the membership of CDOP to ensure appropriate representation from both health and non-medical agencies. In considering a common national standard for high quality serious incident investigations for child death the Health Safety Investigation Branch of the NHS should consider the role CDOPs will play in this process. The Department of Health should consider the role that health and wellbeing boards and the joint strategic needs assessment play in dealing with child deaths and the role of a CDOP. Further addition national guidance around child death review processes is expected towards the end of 2018 from the Department of Health, although currently the south west peninsular CDOP is well suited to meet the new and additional criteria published in the draft guidance earlier this year.

9 Professional abuse allegations

The function of the local authority designated officer (LADO) is a key aspect of the overall safeguarding activity of the local authority and partner agencies. The purpose of the LADO is to enable and ensure agencies work together effectively to safeguard children from neglect and abuse by professionals and those in public office (employee, volunteer or student paid or unpaid). Working Together 2015 statutory guidance sets out the requirement for each county level and unitary local authority to

have a LADO or team of officers to be involved in the management and oversight of individual cases. It emphasises the need to ensure that any action necessary to address welfare concerns in relation to the child or children involved should be taken without delay and in a co-ordinated manner. The LADO service consists of the principal LADO, a LADO and a senior LADO administrator.

The Cornwall and the Isles of Scilly Safeguarding Children Partnership (SCP) endorses the LADO service and places a duty on all agencies to co-operate with the LADO service to protect children from neglect and abuse by professionals and people in a position of trust.

The LADO provides:

- Advice and guidance to senior managers and employers to determine at an early stage whether a formal referral is required and to prevent delay in the management of an allegation and ensure that it is child focused.
- Quality assurance and monitoring of multi-agency safeguarding practice and standards and to contribute to the work of the SCP.
- Management and co-ordination of individual allegations against a person in a position of trust who works with children who has behaved in a way that has harmed a child, or may have harmed a child or possibly committed a criminal offence against or related to a child, or behaved towards a child in a way that indicates that they may pose a risk of harm to a child.

In order to ensure that allegations of professional abuse are responded to appropriately NHS Kernow and the health providers it commissions have a policy on allegations against staff which have been written in the light of CIOSOSCP guidance. The workforce development departments in each provider organisation have allegations officers who have close links with the local LADO. NHS Kernow and the providers collect statistics on investigations into allegations which specify whether the allegation has been handled internally or referred to the LADO for wider support. The LADO produces an annual report (2017/18), and notes there were 14 referrals concerning professional abuse by health professionals in 2016/17 (two more than in 2017/18). Of these 14 referrals, six were made from within health (the same number as in 2017). This number remains low, accounting for just three percent despite a substantial workforce and a significant number of front-line staff who work directly with children in complex situations. NHS England recognises that nationally health has a low reporting rate. One factor may be that both professionals and patients use the complaints process or the whistle blowing route, rather than by making an allegation referral. It is an area, which providers need to continually heighten awareness of the process and monitor the outcome.

The LADO annual report 2018 includes a referral data graph following LADO training and this indicates that an increase in referrals appears to be associated with peaks within a month or so of the training being attended followed by troughs. Given the low number of referrals by and about health staff compared to the number of

employees in health there will be some benefit in health staff attending training on this subject.

The primary causes of concern reported to LADO (2017/18) are as follows; physical (45 percent), sexual (33 percent, 'poses a risk' (16 percent), emotional (five percent) and neglect (one percent).

The outcomes of all referrals to LADO were; 42 referrals substantiated, 39 referrals unsubstantiated, 20 referrals unfounded, 19 false referrals and two malicious referrals.

Table 6: LADO referrals about health staff from other agencies

2015/16	2016/17	2017/18
8	12	14

Table 7: LADO referrals from health staff

2015/16	2016/17	2017/18
2	6	6

10 Inter-agency working

Designated professionals, as clinical experts and strategic leaders, are a vital source of advice to the CCG, NHS England, the local authority and the CIOSPB, and provide advice and support to other health professionals. In their role as experts the partnership board should be able to draw on appropriate expertise and advice from the designated professionals and frontline professionals from all the relevant sectors[8].

NHS Kernow's chief nursing officer sits on the partnership board with members of the safeguarding team contributing at sub-group meetings.

The Overview and Scrutiny Panel is the Our Safeguarding Children Partnership (OSCP) and chaired by an independent chair to monitor and challenge the effectiveness of key partners through multi-agency working. The designated nurses and doctor inform the key lines of enquiry and contribute to feedback. The CCG accountable officer is a panel member.

'One Vision' is the multi-agency agreement signed up to by partners, including the CCG to improve children's services; there are commitments to key safeguarding themes as part of One Vision. All the safeguarding work streams include CCG designates as leaders. See this link for more information.

[8] Adapted from Working Together 2015

There is active interagency participation in learning lessons workshops, with designate leads taking key roles.

10.1 Learning lessons workshops[9]

Working with partners to develop, share and disseminate learning across the system has included the 2017/18 conference on the theme of 'The ages and stages of emotional health and wellbeing'.

In June 2017, the workshop focused on signs of safety, highlighting that it is the core multi-agency approach to working with families in Cornwall and the Isles of Scilly and managing risk where children are in need of help and protection. Providers are increasingly using signs of safety as part of assessment and referrals improving shared understanding of concerns for children and families when requesting multi-agency working.

In November 2017, the workshop focused on neglect, highlighting that neglect is the most common cause of significant harm to children and young people in Cornwall and the Isles of Scilly and is also the largest category for child protection conferences and repeat child protection plans. A practitioner's tool kit was launched and circulated to GP's.

In February 2018, the workshop focused on the lessons learned from the recent learning from experience review, highlighting 'working with fathers', 'involving adult mental health' and 'understanding and challenging each other with the language and terms we use'.

10.2 Financial contribution to the partnership

As well as dedicated senior officer time on partnership boards and sub-group interagency working, NHS Kernow as a statutory partner contributed £69,652 to the Our Safeguarding Children Partnership's (OSCP) total budget of £258,116 for 2017/18.

11 Child sexual abuse and exploitation

11.1 Child sexual abuse

The peninsula SARC Commissioning Board is chaired by the medical director from Somerset to which the Cornwall and Isles of Scilly data is submitted enabling regional and local analysis and benchmarking. Locally the SARC working group is chaired by the strategy lead for domestic abuse and sexual violence and serious and organised crime. The designated doctor joins this working group when required. The

[9] Extract from Our Safeguarding Children Partnership for Cornwall and the Isles of Scilly Annual Report 2017/18

medical examination of sexually abused children within Cornwall has been recognised as an exemplary service within the south west peninsular. However, there have been challenges due to both operational shortages locally of both paediatricians and forensic medical examiners alongside the introduction of more stringent standards from the Royal Colleges (Royal College of Paediatrics and Child Health and the Faculty of Forensic and legal Medicine) nationally.

The response to reports of sexual assault is currently provided by a number of SARCs and hospitals from Gloucester to Cornwall. Children within Cornwall and the Isles of Scilly who require an acute (forensic) medical are seen in the Truro SARC with a paediatrician and a forensic medical examiner. Children who require a non-acute (historic) medical are seen by two paediatricians within the dedicated suite in the children's outpatients at RCHT.

Table eight: Numbers of child sexual assault medicals undertaken at the Greenaway Suite at Royal Cornwall Hospital or at the Truro SARC April 2017 to March 2018

	Total	SARC	RCHT	Male	Female
Acute medicals seen urgently	13	13	0	0	13
Non-acute cases seen routinely	16	0	16	4	12

The service provision for both adults and children who have been sexually abused has been out to tender by NHS England South West during 2017/18. The current suggested model for children is a centralised one consisting of two paediatric SARCs, one in Bristol and one in Exeter. The new model is planned to commence on 1 October 2018.

During 2017/18 the service provision for both adults and children who have been acutely sexually abused was provided by First Light; an award winning* registered charity. Recognising common values and shared strengths, Twelves Company and Skoodyha merged to become First Light on the 1 April 2017. They are independent of statutory agencies and support thousands of people each year affected by domestic abuse and sexual violence across Devon, Cornwall and the Isles of Scilly.

The local safeguarding children's partnership has noted that there is a discrepancy between the number of children disclosing sexual abuse and known to social care compared to the level of disclosure of childhood sexual abuse in adulthood; nationally.

The vast majority of child sexual abuse is in the family and is perpetrated by people related to, or known to the victim, and often goes unreported and undetected. In 2012/13, nearly half of the young people who contacted the NSPCC's ChildLine

service about child sexual abuse said the perpetrator was a family member[10]. Children who have been sexually abused by a family member have an increased vulnerability to child sexual exploitation, as well as other forms of abuse including physical and sexual violence[11].

The outcome from child sexual abuse can result in:

- Risk taking behaviours.
- Reliance and dependency in substances.
- Homelessness.
- Suicide increased risk and mental illness.
- Sexually transmitted infections.
- Abdominal pelvic – gynaecological problems.

In response to understand and increase professional awareness in January 2018, the first interagency meeting took place. A task and finish group was established, with both designated doctor and designated nurse as members, to consider how to ensuring agencies and professionals are alert to CSA, especially inter-familial abuse including perpetration by family friends.

Three key sub-groups have been developed:

1) Recognition and responsibility.
2) Referral and assessment.
3) Response.

A strategy is underdevelopment which will be launched next year (2018/19). For the number of Cornish children subject to a child protection plan due to sexual abuse as the prime category see section 14 below.

11.2 Child sexual exploitation

Health continues to work closely with the police to review data in order to locate and disrupt child sexual exploitation networks.

11.3 Child protection medicals

Table nine below shows the number of medicals carried out by paediatricians for physical abuse or neglect 2015/16, 2016/17 and 2017/18.

[10] ChildLine (2014), Can I tell you Something?: What's affecting children in 2013?, London: ChildLine
[11] Berelowitz et al (2012), "I thought I was the only one. The only one in the world": The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation In Gangs and Groups: Interim Report, London: Office of the Children's Commissioner.

Table nine

	2015/16	2016/17	2017/18	Examined at
Physical abuse	69	52	75	RCHT
Neglect	15	20	23	Peripheral clinics

There is a medical child protection rota in place, providing access to a paediatrician for advice and, if necessary, timely examination 365 days a year. Medicals for suspected non-accidental injury take place in RCHT at the Greenaway suite in children's outpatients or on an appropriate paediatric ward as an in-patient. Health and wellbeing assessments for possible neglect are carried out in community paediatric clinics throughout Cornwall and the Isles of Scilly.

12 Neglect

The OSCP commissioned an external review of neglect which was undertaken by Vivienne Lines. Following this review the chair of the OSCP requested a revision of the Neglect Strategy to promote the multi-agency understanding of and response to neglect resulting in the re-launch discussed previously. The effectiveness of the revised strategy will be subject to single and multi-agency audit.

13 Audit

During 2017 safeguarding was the subject of two external reviews; the objective was to provide assurance on the CCG's safeguarding governance arrangements for adults and children.

The first review was a due diligence review carried out by NHS England in October 2017. Eight recommendations were made mainly about capacity and process management within the team; six of the recommendations were directly related to safeguarding children. Five of the six recommendations have been completed and the sixth which is in relation to the statutory function of providing a named GP for safeguarding children is being addressed and it is hoped to have a GP in post in the very near future.

In November 2017 NHS Kernow internal auditors, TIAA, carried out an assurance review of safeguarding children and adults teams. The areas reviewed included; processes in place, monitoring, reporting, policies, training and contract monitoring. The overall assurance from the review was one of reasonable assurance which is the second highest of four possible assurance levels. The review made eight recommendations mainly on the subject of policies and processes all of which have been implemented.

A number of audits have been undertaken by NHS Kernow and commissioned providers during 2017/18 themes including: child sexual exploitation; domestic

violence; CARA process; record keeping; health quality and contribution to child protection plans and routine enquiry in maternity.

14 Children in need and with a child protection plan

14.1 Children in need

Health professionals across Cornwall will be involved with a number of children that are being provided with services for children in need (CiN) by the local authority and it is this cohort of children that quite often become subject to child protection investigations and then possibly subject to a child protection plan (see table 10). The CiN cohort for 2017/18 was 7,013 and this includes 4,847 that were referred to the local authority / children's social care during the year. Of the 4,847 referrals received in 2017/18 the majority were made by the police (22.8 percent), followed by schools (17.6 percent) and then health (15.7 percent).

Of the 4,847 referrals the local authority initiated 899 section 47 (Children Act 2004) child protection enquiries and these led to the convening of 467 initial child protection conferences; these conferences led to the initiation of 453 child protection plans being started during the year. The main health providers commissioned by the CCG will have professionals that contribute to assessments and plans for CiN (e.g. midwives, health visitors, school health nurses, CAMHS workers) in order offer help and support of a preventative nature. The designated nurse child protection will provide data in the next annual report about the main health provider's activity / performance with CiN in order to give an overview of the amount and type of work that is provided to this cohort of children and their families

Table 10: Children in need (source: Cornwall Council CiN Census 2017/18)

	2016/17	2017/18
Total number of child records loaded / CiN	5,553	7,013
Number of CiN referrals in year	3,039	4,847
Section 47s enquiries initiated	747	899
Number of child protection plans started in year	435	453

14.2 Child protection plan

The number of children subject to a child protection plan has remained static in the last financial year from 381 in March 2017, to 385 in March 2018. Currently, the child population for Cornwall and the Isles of Silly is approximately 106,100. The current county incidence of children subject to a child protection plan at 3.6 per 1,000 is lower than the national average of 4.2 per 1,000. Table 11 shows the prime category for being made subject to a child protection plan.

Table 11: Children subject to a child protection plan as of 31 March 2018

Neglect	241	61.01%
Emotional abuse	93	23.54%
Physical abuse	53	13.42%
Sexual abuse	8	2.03%
Total	**395**	

Child protection conferences are held within the timescales recommended in 'Working Together' and health professional representation is required at each conference. In practice, health visitors and school nurses provide the vast majority of health input to child protection conferences. Regular support and supervision is provided for these staff as the nature of the work can be stressful and may lead to staff becoming 'burnt-out' – One outcome of good supervision is that staff are supported before things become too stressful for them to cope with.

Nationally, child sexual abuse is poorly reported. Research suggests this is because there is a reluctance to ask about or report the issue. However, as a topic it is high on the national agenda and within Cornwall and the Isles of Scilly agencies are continually promoting the issue and one of the CIOSOSCP multi-agency learning lessons workshops planned for 2018/19 will be on the subject of child sexual abuse.

Table 12: Total number of children becoming subject to a child protection plan in the calendar years 2013/18

Calendar year	Number of children subject to a child protection plan
2013	453
2014	494
2015	469
2016	446
2017	381
2018	385

Cornwall does have a higher than national average of children and families who are re-referred and are placed on child protection plans more than once. The designated nurse is part of a multi-agency group, which reviews these re-referral cases with the aim of understanding the reasons for the re-referral. The general themes for re-referral are:

- Removal from plans too soon.
- Over-optimism by staff that change was sustainable.
- Being told an action has occurred without knowing the outcome.
- Poor child protections plans with a lack of ownership and / or contingency plan.

15 Information sharing

The Child Protection Information Sharing (CP-IS) project is an NHS England sponsored work programme dedicated to developing an information sharing solution that will deliver a higher level of protection to children who visit NHS unscheduled care settings.

It proposes to do so by connecting local authorities' child protection social care IT systems with those used by staff in NHS unscheduled care settings. The information sharing focuses on three specific categories of child:

- Those with a child protection plan.
- Those with looked after child status (children with full and interim care orders and voluntary care agreements).
- Pregnant women whose unborn child has a pre-birth child protection plan.

Care settings to use CP-IS are:

- Emergency departments.
- Out of hours GP services.
- Walk-in centres.
- Paediatric wards.
- Maternity wards.
- Minor injury units.
- Ambulance services.

The project will deliver a national system that will enable NHS organisations in England offering unscheduled care services to access timely information, which alert professionals to children in the above three categories. The aim is to help frontline staff to inform a clearer assessment of a child's risk of abuse or neglect. Health and social care have signed up to be part of the project in 2013.

Progress in Cornwall is as follows:

Royal Cornwall Hospital Trust – have been challenged in the roll out, due to IT issues and project lead capacity. However the paediatric wards should be fully operational by September 2018, The Urgent Care Centre will possibly go live October/November and then the emergency Department.
Midwifery is still to be determined.

- 111 / Integrated urgent care service**:** Are a newly commissioned service and IT compatibility is a challenge.
- University Hospitals Plymouth NHS Trust**:** Go live date planned for July 2018 for paediatrics, MIU and midwifery and emergency department September 2018.

- The MIU has implemented the CP-IS process and the RCHT paediatric assessment unit is planning to do so by the end of 2018 followed by the emergency department and midwifery.

The designated nurse for child protection will continue to monitor the implementation of CP-IS with the aim of areas all being live during 2018/19.

16 Primary care

The recruitment of a named GP for primary care remains a challenge, meanwhile support to GP's has been provided by the designated doctor for child protection.

Information and learning has continued to be shared with GP's such as the Neglect Strategy and toolkit.

17 Looked after children / children in care

The looked after children/ children in care designated professionals produces a separate annual report, to report on the performance against key performance indicators and specific issues in relation to this population group.

18 2018/19 priorities

The following topics have been identified for 2018/19 as the OSCP's priorities:

- Adverse childhood experiences (ACEs).
- Neglect.
- Child sexual exploitation.
- Child sexual abuse.
- Domestic abuse.
- Emotional health and wellbeing.

NHS Kernow's safeguarding priorities for 2018/19 are:

- Partnership working on the above priorities.
- Ensure the system thinks and acts to protect children for abuse and neglect.
- System assurance, to implement an assurance score card as part of contractual arrangements from April 2019.
- Named GP, NHS Kernow to recruit to the role.
- Data collection, systemise child safeguarding data collection such as child serious incidents.
- Commissioning, continue to provide safeguarding advice to commissioners.
- Audit themes as indicated by the assurance score card such as health involvement section 47 meetings.

- Safeguarding challenges include new threats to children such as cyber safety and prevention of abuse.

Appendix 1: Statutory Duties Children Act 1989 and 2004 - section 11 (Children Act 2004)

Section 11 places a duty on:

- Local authorities and district councils that provide children's and other types of services, including children's and adult social care services, public health, housing, sport, culture and leisure services, licensing authorities and youth services.
- NHS organisations, including NHS England and Clinical Commissioning Groups, NHS trusts and NHS foundation trusts.
- The police, including police and crime commissioners and the chief officer of each police force in England and the Mayor's Office for Policing and Crime in London.
- The British Transport Police.
- The National Probation Service and community rehabilitation companies.
- Governors/directors of prisons and young offender institutions.
- Directors of secure training centres.
- Principals of secure colleges.
- Youth offending teams/services.

NHS England is responsible for ensuring that the health commissioning system as a whole is working effectively to safeguard and promote the welfare of children. It is also accountable for the services it directly commissions, including primary care. NHS England also leads and defines improvement in safeguarding practice and outcomes and should also ensure that there are effective mechanisms for CIOSSCB and health and wellbeing board to raise concerns about the engagement and leadership of the local NHS.

Clinical Commissioning Groups (CCGs) as the major commissioners of local health services are responsible for safeguarding quality assurance through contractual arrangements with all provider organisations. CCGs should employ, or have in place, a contractual agreement to secure the expertise of designated professionals, i.e. designated doctors and nurses for safeguarding children and for looked after children (and designated paediatricians for unexpected deaths in childhood). In some areas there will be more than one CCG per local authority and LSCB area, and CCGs may consider ‘lead’ or ‘hosting’ arrangements for their designated professional team, or a clinical network arrangement. Designated professionals, as clinical experts and strategic leaders, are a vital source of advice to the CCG, NHS England, the local authority and the CIOSSCB, and offer advice and support to other health professionals.

All providers of NHS funded health services including NHS trusts, NHS foundation trusts and public, voluntary sector, independent sector and social enterprises should identify a named doctor and a named nurse (and a named midwife if the organisation provides maternity services) for safeguarding. In the case of NHS 111, ambulance

trusts and independent providers, this should be a named professional. GP practices should have a lead and deputy lead for safeguarding, who should work closely with named GPs. Named professionals have a key role in promoting good professional practice within their organisation, providing advice and expertise for fellow professionals, and ensuring safeguarding training is in place. They should work closely with their organisation's safeguarding lead, designated professionals and the CIOSSCP.

This report sets out to describe how NHS Kernow Clinical Commissioning Group works together with partner agencies by ensuring the commissioning of appropriate services to safeguard and promote the welfare of all children and young people.

The report describes the systems in place to ensure organisational learning from serious incidents and serious case reviews including child deaths.

The report also provides assurance that is fully compliant with the statutory guidance in Working Together to Safeguard Children 2015. New guidance is expected in 2018 and will be reflected in next year's report. In anticipation of changes in April 2017, CIOSSCB has been operating as a partnership, Cornwall and Isles of Scilly Our Safeguarding Children Partnership (CIOSOSCP), which is anticipated to meet the updated Working Together Guidance.

Governance and accountability arrangements

The CCG, as with all other NHS bodies, has a statutory duty to ensure that it makes arrangements to safeguard and promote the welfare of children and young people. The statutory safeguarding duties have in this reporting period been articulated through three national documents:

1. **'Working together to safeguard children: A guide to interagency working to safeguard and promote the welfare of children' (2015)**

   This document articulates the requirements for health services in meeting their statutory duty to safeguard and promote the welfare of children. In order to meet these requirements NHS Kernow has continued to:

   - Have safeguarding quality assurance systems in place through contractual arrangements with provider organisations.
   - Meet the requirement to secure the expertise of designated doctors and nurses for safeguarding children, for looked after children (children in care) and for designated paediatricians for child death. Secured the services of a lead nurse professional for safeguarding children and adults in primary care.
   - Ensure that all practices have a nominated safeguarding lead and deputy for safeguarding children.
   - Be active members of NHS England's south west regional network.
   - Provide professional expert advice and support to named / specialist safeguarding professionals working across the health economy.

The Government is currently consulting with LSCB's and other agencies on a further revised 'Working Together' document which is due to be published in July 2018.

2. **A revision of the national NHS accountability and assurance framework; "Safeguarding vulnerable people in the NHS: Accountability and assurance framework (NHS Commissioning Board 2015)"** - at the time of writing this remains unchanged

   This describes the roles and responsibilities of NHS England, clinical commissioning groups, NHS providers and various other bodies in the health system.

   NHS Kernow has implemented all recommendations from the Safeguarding Vulnerable People in the NHS Accountability and Assurance Framework 2015, to demonstrate that there are appropriate systems in place for discharging their responsibilities in respect of safeguarding, including:

   - Promoting partnership working to safeguard children and young people at both strategic and operational levels.
   - Clarifying NHS roles and responsibilities for safeguarding, including in relation to education and training.
   - Providing a shared understanding of how the NHS operates and both local and national accountabilities.
   - Ensuring the retention of professional leadership and expertise in the NHS, including the continuing key role of designated and named professionals for safeguarding children.
   - Outlining a series of principles and ways of working that are equally applicable to the safeguarding of children and young people in vulnerable situations, recognising that safeguarding is everybody's business.

   In 2014, NHS England announced a revised set of arrangements within the framework; these were required in order to take account of:

   - The wider context for safeguarding, which has changed in response to the findings of large scale inquiries, incidents and new legislation.
   - New and revised statutory and intercollegiate guidance.
   - The changes to the NHS commissioning system; with the introduction of co-commissioning from April 2015, it was seen as important that safeguarding roles were made clear.
   - The restructuring process in NHS England at regional and local level.
   - Following consultation, the revised Accountability and Assurance Framework was published in June 2015.

3. **Intercollegiate Document: Safeguarding children and young people: Roles and competencies for health care staff (March 2014)** – Due for review in 2017, at the time of writing this report update has not been published.

   This third edition of the Intercollegiate Document has been updated to emphasise the critical role of executive teams and board members, whilst taking into account structural changes which have been implemented across the NHS. The framework sets the standards and requirements expected of all health staff.

   All health staff that come into contact with children and young people have a responsibility to safeguard and promote their welfare and should know what to do if they have concerns about safeguarding issues, including child protection. They must also clearly understand their own responsibilities and should be supported by their employing organisation to fulfil their duties. Chief officers and independent contractors, such as GPs, have a responsibility to ensure that all staff across their organisations have the knowledge and skills to meet this requirement. While the responsibility of ensuring staff have access to appropriate safeguarding training rests with health care organisations, the emphasis in the framework continues to be upon maximising flexible learning opportunities to acquire and maintain knowledge and skills utilising lessons from research, case studies, management reviews and serious case reviews.

   Annual appraisal is seen as critical so employers and responsible officers should assure themselves that appraisers have the necessary knowledge, skills and competence to undertake appraisals and, in the case of medical or nursing staff, to oversee revalidation.

   The priorities and governance / accountability arrangements of and NHS England support Section 11 of the Children Act 2004 which requires agencies to have:

   - A local safeguarding children board (CIOSSCB).
   - Senior management commitment to the importance of safeguarding and promoting children's welfare.
   - Contractual arrangements with provider organisations that take into account the need to safeguard children and promote their welfare.
   - Safe recruitment procedures policy 'Guidance for responding to allegations for concerns about a child' (Available on the CIOSSCB / CIOSOSCP website).
   - Effective interagency working and information sharing.

   Executive lead responsibility for safeguarding for NHS Kernow is held by the chief nursing officer. Since the last report NHS Kernow has also appointed a Governing Body lay member as a "champion" for safeguarding. Each of the main provider organisations, Royal Cornwall Hospitals NHS Trust (RCHT) and Cornwall Partnership NHS Foundation Trust (CFT), also has a board-level executive lead for safeguarding. The executive leads are all members of the Safeguarding Children's Partnership Board for Cornwall and the Isles of Scilly which was established in January 2017 following the publication and

recommendations of the Wood Report (2016). The provider organisations are required to have clear lines of accountability and governance arrangements for safeguarding within their organisations.

In April 2016, Peninsular Community Health (PCH) ceased as an organisation and service and CFT took over the provision of community services for adults and children. This resulted in the posts of named doctor and of named nurse for PCH being absorbed into the existing CFT named posts following a restructure of their safeguarding team. There has been a significant turnover of named nurses within health providers which has potential risks for the safeguarding service due to disruption of work streams and the coordination of processes. Currently, across the main health provider organisations, there are no safeguarding post vacancies.

As specified in Working Together 2015, NHS Kernow fulfils the statutory requirement of having adequate resourcing for a senior paediatrician 0.4 whole time equivalent (WTE) and senior nurse 1.0 WTE undertaking the role of designated doctor and nurse for safeguarding children. Following the 2015 CQC inspection and action plan, the designated professionals have introduced alternate monthly meetings with the executive safeguarding leads to review a "rolling" child protection development plan in order to facilitate a 'whole system approach' to the provision of children's safeguarding (see appendix two).

The designated nurse / doctor chairs a bi-monthly health safeguarding forum attended by representatives of the main Health services providers including representation from primary care and South Western Ambulance Services NHS Foundation Trust, with ad hoc invitations for other organisations and commissioners' including the local authority. The forum aims to ensure enhanced communication of children's safeguarding issues alongside joint working on key issues across the health economy.

Appendix 2: Executive safeguarding children leads and designated professionals for safeguarding and looked after children group

Terms of reference

1.0 Introduction

1.1 Executive safeguarding children leads and designated professionals for safeguarding and looked after children group fully endorses and adheres to Cornwall and the Isles of Scilly south west child protection procedures (www.swcpp.org.uk) and will take operational responsibility against the delivery of safety for children across Cornwall and the Isles of Scilly.

1.2 Section 11 of the Children Act 2004 creates a duty for the NHS Kernow to performance-manage provider arrangements (NHS, private and voluntary sector) to ensure that 'it has regard to the need to safeguard and promote the welfare of children in exercising its functions'.

1.3 Section 10 places a duty on health organisations to take part and co-operate in inter-agency arrangements to improve children's well-being and positive outcomes.

1.4 The group is taking its definition of children and young people to be up to 18th birthday and incorporate unborn children (where there is cause for concern for a pregnant woman and her unborn baby) and their families.

1.5 NHS Kernow and providers are required to have Executive safeguarding children leads who are Board Members within their own organisations. Their role is to promote and embed safeguarding into their organisation.

2.0 Aims

2.1 To provide a governance and accountability structure for safeguarding children for health organisations

2.2 To provide strategic direction for executive safeguarding leads and designated professionals in relation to safeguarding children.

2.3 Promote the welfare of children, young people, in the context of its duties under the Children Act 1989 and Children Act 2004 and associated guidance such as Working Together to Safeguard Children – a guide to inter-agency working to safeguard and promote the welfare of children (2015).

2.4 The group will provide evidence that adequate systems are in place to identify and manage risk and to integrate activities relating to safeguarding children across the whole health community. They will seek opportunities for innovation and integration as directed.

3.0 Constitution and accountability

3.1 Executive safeguarding children leads and designated professionals for safeguarding and looked after children group will participate in sharing good practice with the local safeguarding children board executive group and its sub-groups as appropriate.

4.0 Membership, quorum and chairmanship

Function in relation to safeguarding children	Job title	Name
NHS Kernow Executive: Safeguarding children lead	Chair of the group	Natalie Jones, Chief Nursing Officer
NHS Kernow Designated nurse for safeguarding children	Designated nurse for safeguarding children	Judy Mace
RCHT Executive: Safeguarding children lead	Deputy director of nursing, midwifery and allied professionals	Kim O'Keeffe
RCHT Designated doctor for safeguarding children	Designated doctor for safeguarding children	Dr Roger Jenkins
CFT Executive: Safeguarding lead	Executive safeguarding lead / Director of nursing	Sharon Linter
NHS Kernow Designated nurse for looked after children	Designated nurse for looked after children	Liz Allan
Named GP for primary care	Named GP	Vacant
RCHT Named midwife for midwifery	Named midwife	Suzie Williams Bernie Dolan
CFT Named Nurse	Named nurse for safeguarding children	Jane Wilkinson
RCHT Named Nurse	Named nurse for safeguarding children	Wendy Perkin
Safeguarding lead for adults and children in NHS 111 and GP OOH –	Safeguarding nurse: Children and adults	Jill Churchill

Function in relation to safeguarding children	Job title	Name
contract with RCHT and NHS Kernow - Community Interest Company		

4.1 One person from each organisation and one designated professional must be present in order for the group to be quorate. If the chair is not present, he or she must delegate the role to another group member.

4.2 The executive safeguarding children leads group has the ability to request others to attend its meetings where such attendance may be helpful in terms of items on the agenda.

4.3 Executive safeguarding children leads and designated professionals for safeguarding and looked after children group has the ability to co-opt new members as the need arises, subject to the agreement of the group.

5.0 Administration

5.1 Meetings of the group will be minuted by a member of the group. Minutes will be in bullet form and any action plan produced will be monitored at each meeting. Ten days prior to the meetings, an email will be sent to members requesting agenda items. The chair may wish for standing agenda items which will to be addressed at every meeting and supporting papers will accompany the agenda.

The agenda will contain standing agenda items around training, serious incidents (SI) and serious case reviews (SCR).

5.2 The size of the group requires members to prioritise attendance to ensure the meeting is quorate. Apologies for nonattendance must be submitted at the earliest opportunity to ensure agenda items are adjusted to needs the meets of the group or to enable the meeting to be cancelled

6.0 Frequency

6.1 The group shall meet prior to every CIOSSCP Executive Safeguarding Children Board meeting. The meetings will take place at County Hall. Further ad-hoc or extraordinary meeting may be convened as required.

7.0 Conduct of business

7.1 Decisions will normally be reached by the agreement of the members present. Those invited to attend meetings of the group should be treated as non-members and therefore without voting rights unless, and until such time the executive safeguarding children leads and designated professionals for

safeguarding and looked after children formally co-opts them as group members.

7.2 The group's terms of reference will be reviewed annually to ensure that the group is working effectively and responding to changes in legislation.

8.0 Reporting arrangements and accountability

8.1 Reporting arrangements and accountability to be using the system leadership principles of an overt decision-making model of care

Signed by: …….

Chair: .....

Name: .....

Date: .....

Appendix 3: Primary care / GP bulletin

The Cornwall and Isles of Scilly Our Safeguarding Children Partnership (CIOSOSCP) Neglect: Strategy Delivering Better Outcomes '2017/19' - the strategy can be accessed via this link:

http://www.safechildren-cios.co.uk/health-and-social-care/childrens-services/cornwall-and-isles-of-scilly-safeguarding-children-partnership/safeguarding-topics/neglect/

The documents below are the three March 2018 Neglect GP bulletin articles:

Neglect information for GP Bulletin - 16 March 2018
Inserted in the bulletin by NHS Kernow's Communications team

Neglect strategy for Cornwall

Did you know that parental neglect is most common cause of significant harm to children and young people in Cornwall? Sixty per cent of all the child protection plans in Cornwall result from the effect of neglect on children.

The Cornwall and Isles of Scilly Safeguarding Children Partnership has overall responsibility for co-ordinating, supporting and improving the way statutory and voluntary organisations work together to protect children and promote their welfare.

As part of the commitment to reduce the incidence of childhood neglect the partnership has developed the Neglect Strategy for Cornwall 2017/19.

It sets out how GPs to teachers and police to social care workers can play their part in preventing neglect, identifying the risks early and tackle the impact of neglect on children.

You can read the strategy here. Look out for Neglect – One Minute Guide and Neglect – A Practitioner's Guide in future editions of this bulletin for handy, quick read tips.

Neglect information for GP Bulletin - 21 March 2018
Inserted in the bulletin by NHS Kernow's Communications team

Neglect Practitioner's Guide

As mentioned in last week's bulletin the Cornwall and the Isles of Scilly Safeguarding Children Partnership has developed the Neglect Strategy for Cornwall 2017/19.

There is a handy Neglect - A Practitioner's Guide to support the work that you do around this strategy.

The guide provides information on how to recognise neglect according to particular age ranges (o-5; 5-11; 11-18) and provides examples of how neglectful parenting impacts children.

Click here to read the guide.

Neglect information for GP Bulletin - 28 March 2018
Inserted in the bulletin by NHS Kernow's Communications team

Neglect, a one minute guide

The final update in the three part series regarding the neglect strategy for Cornwall 2017/19.

As mentioned in previous bulletins the Isles of Scilly Safeguarding Children Partnership has developed the neglect strategy.

The one minute guide is meant to provide at a glance information about neglect and what you need to do if you think a child is suffering from neglect. Read more here.