CORNWALL AND ISLES OF SCILLY
SAFEGUARDING
CHILDREN PARTNERSHIP

QUALITY ASSURANCE AND SCRUTINITY PANEL

Findings of the panel meeting
held on
15 February 2017

for

NHS KERNOW CLINICAL
COMMISSIONING GROUP

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Cornwall and Isles of Scilly Safeguarding Children Partnership

Findings of the Cornwall and Isles of Scilly Safeguarding Children Partnership Quality Assurance and Scrutiny Panel

NHS Kernow Clinical Commissioning Group
Wednesday, 15 February 2017

Introduction

1. On Wednesday, 15 February 2017 the following representatives of NHS Kernow Clinical Commissioning Group (CCG), appeared before the Cornwall and Isles of Scilly Safeguarding Children Partnership’s Quality Assurance and Scrutiny Panel:

Natalie Jones  Chief Nursing Officer
Liz Allan  Designated Nurse for Children in Care
Julieann Carter  Interim Head of Quality
Jill Churchill  Safeguarding Nurse, Primary Care
Nita Giles  Locum Safeguarding Lead

2. The panel consisted of the following board members and advisors:

Chair  John Clements  Independent Chair
Vice Chair  Maureen Read  Lay Member
Panel Members  Jack Cordery  Cornwall Council
Mandy Cox  NHS England
Sharon Donald  Devon and Cornwall Police
Advisor  Frederika van Rooyen  Safeguarding Children Standards Unit

3. The panel conducted the meeting in keeping with its agreed terms of reference (appendix A).

4. As agreed within the terms of reference, NHS Kernow had previously provided a written response to the questions posed and
supplied supporting information with their submission. The questions posed are outlined under “Findings” below.

5. The panel considered the criteria outlined within Ofsted’s Framework and Evaluation Schedule for children in need of help and protection, children looked after and care leavers. It has graded its findings overall in relation to each question area.

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Findings

6. In relation to its overall assessment the panel assessed that NHS Kernow Clinical Commissioning Group (CCG) remains **Inadequate** for safeguarding children.

7. The panel members agreed that the CCG had improved its child safeguarding performance in a number of areas since the last panel on 30 March 2016 but there were a number of areas where progress was slow and had not yet reached an acceptable standard. It was felt the CCG was demonstrably better over issues where it had direct control, i.e. looked after children, as opposed to others where it was responsible through a contracted service.

8. The panel was reassured by the improved governance arrangements of, and leadership commitment towards child safeguarding over the last year. These suggested the potential for improved performance but in a number of areas this had not yet been achieved.

9. The panel acknowledged that, at the time it met, the CCG was undertaking a major review of its safeguarding function and had recently recruited additional staff to assist with future developments. This is seen as a positive development.

10. The findings of the panel in relation to the specific question areas are detailed below.

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<th>Outstanding</th>
<th>Good</th>
<th>Requires Improvement to get to Good</th>
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Question 1
(a) What have you done and what are you doing to prevent, detect and disrupt child sexual exploitation (CSE) in Cornwall and the Isles of Scilly?
(b) What impact have your actions had?
(c) What developments are you planning in this area?

Requires Improvement to get to Good

11. The CCG recognises child sexual exploitation as a key priority and has actively supported the Safeguarding Children Partnership (SCP) in developing the area-wide strategy.

12. Within its own organisation it has been active in a number of areas. The Designated Nurse for ‘Children Looked After’ has been a key member of the local Missing and Sexual Exploitation subgroup; has represented her service within the operational Missing and CSE Forums that operate across Cornwall and has facilitated the flow of information between that service and other partners. She has developed a ‘flagging’ system that highlights any child perceived to be at risk of CSE on health recording systems and has participated within the unaccompanied asylum seeking children response contributing to efforts to recognise the risks of CSE.

13. This has brought about effective responses to the children supported by her service assessed as being at risk of CSE. She has demonstrated to other health professionals a level of commitment and initiative that has improved engagement and forward thinking. A key example of this is the involvement of sexual health professionals who, although acutely aware of patient confidentiality, are equally aware of their safeguarding duties and requirements to share information.

14. The CCG’s other designated nurse has worked with named nurses and staff in key areas to improve levels of knowledge and understanding of CSE.

15. Within primary care the CCG’s named nurse has worked with general practice surgeries across Cornwall to improve levels of understanding of, and response to, CSE. She has reviewed training packs for general practice and has sought material from
other areas that puts CSE in a context that GPs can recognise, i.e. contraception.

16. Booklets have been provided to all general practice clinicians. Work has been undertaken to improve IT systems by providing prompts to identification and suggestions as to action that can be taken.

17. There is a perceived improvement in the level of understanding leading to a number of referrals being made by general practitioners.

18. The CCG has provided ‘in-house’ training for its relevant staff.

19. Children’s Continuing Care (CCC) providers have standard NHS contracts. This includes a stipulation for a named sexual exploitation lead for each provider. The CCG has sought to establish from providers what training nurses/carers delivering CCC receive. This work has recently started. There is a system in place to include CCC providers on a preferred provider list for the CCG.

20. The CCC manager is notified of all incidents and referrals at the time by providers. All safeguarding referrals are included in the annual quality report from providers and are broken down by type of referral. The Children’s Continuing Care team within the CCG are trained to level 3 in both child and adult safeguarding including level 3 sexual abuse and level 3 parental mental health.

21. As a result of pressure from the CCG named nurses within the provider trusts now meet with the manager of the Multi-Agency Referral Unit (MARU) to review the quality of health referrals. A number of referrals are reviewed at each meeting and these include those relating to CSE. Issues are identified at individual and system levels and acted upon.

22. Concerns were raised by the CCG over the lack of CSE referrals from its providers and by the lack of key resources in some key child related health activities, i.e. school nursing (it is acknowledged that school nursing is not a commissioning responsibility of the CCG but remains under the scrutiny of the Designated Professionals). It felt that levels of knowledge amongst Emergency Department (ED) and Minor Injury Unit (MIU) staff had improved.
23. It was apparent that, although the levels of understanding and number of referrals from within health providers had increased, the CCG is still unable to quantify either. The panel expressed concern about the overview of referrals by providers, i.e. numbers from different departments and the volume of different types of abuse. The panel felt this has not been a focus or concern for the CCG.

24. The panel concluded that, due to the significance of CSE, this was a significant gap and that the CCG should have a better understanding of how well its providers were responding, both in relation to contract monitoring and for future planning. For this reason it was agreed that further improvement is required.

Recommendation

1. The CCG should provide the Safeguarding Children Partnership with an analysis of the quality of health related responses to CSE from the services that it commissions. Within six months

2. The CCG should develop an understanding of the number, distribution and type of referrals its health providers make in respect of all child safeguarding issues to inform commissioning intentions in relation to safeguarding. Within six months.

Question 2
(a) What have you done and what are you doing to prevent children from going missing in Cornwall and the Isles of Scilly?
(b) What impact have your actions had?
(c) What developments are you planning in this area?

Requires Improvement to get to Good

25. The CCG felt that this is an area where progress has been made especially with services where missing children are most likely to be encountered, e.g. EDs and MIUs.

26. Work has been undertaken with the staff in those departments to improve their ‘professional curiosity’, recording systems and
information sharing. As with CSE, practice has improved. The systems now contain ‘flags’ that identify children who are at risk of CSE and possibly at risk of going missing. This prompts staff to assess those children and consider if they could be missing or at risk for another reason.

27. The CCG has recently conducted a number of qualitative audits, reviewing a random selection of 20 individual cases. There were no cases involving missing children within this selection.

28. It was suggested at the panel that the CCG may wish to review referrals made to the MARU to establish if any had been received for missing children identified as being at risk by health professionals. This would enable those reviewing to check the timelines and quality of information sharing.

29. A number of CCC providers have up to date missing child policies which are reviewed regularly through clinical governance processes. The CCG is aware of one provider that has tested its contingency plans to ensure staff are aware of the policy and how to respond.

30. The panel concluded that the approach within the CCG had improved since the last panel and that the CCG had a better understanding of the different tactics health professionals could be using to more effectively protect missing children.

31. However, the panel members agreed that, although the audits had taken place, this had not provided assurance that staff were responding in an appropriate way. They felt that further work should be undertaken to gain an understanding of the quality of responses and for this reason decided that further improvement is required.

Recommendation

3. The CCG to review other means of assessing health provider responses to missing children, including a review of the quality of referrals to the MARU, and to inform the SCP of its findings. Within six months
Question 3
(a) What have you done and what are you doing to support children who are affected by domestic abuse in Cornwall and the Isles of Scilly?
(b) What impact have your actions had?
(c) What developments are you planning in this area?

Requires Improvement to get to Good

32. The CCG understands the significance of domestic abuse to children and it is a high priority within its safeguarding efforts.

33. The CCG commissions a number of services that specifically relate to domestic abuse victims, including Outlook South West, BeMe, Cornwall Rape and Sexual Abuse Centre (CRASAC), the Women’s Rape and Sexual Abuse Centre (WRASAC) and CLEAR. Services are available to meet a range of needs and all have a focus on children. The service specification for commissioned services relating to domestic abuse includes the requirements of children.

34. The CCG believes that its main health providers are competent in their approach to domestic abuse. Staff within health settings have been provided with training on domestic abuse and are familiar with the signs and symptoms. Staff in key positions, including midwifery, ED and MIUs, are expected to ask questions either as a matter of course or where clear indicators are present.

35. From a developmental position the named nurse for primary care has been involved in a pilot scheme to improve the participation of general practice within domestic abuse responses.

36. The pilot is focused on Newquay and the relationship between general practice and the Restormel multi-agency risk assessment conference (MARAC). Practice staff have been provided with additional training and are now more aware of the risk and their responsibilities. Communication between the MARAC and the practice has been improved, resulting in greater involvement and a better understanding of the risks faced by victims and their children. The six month pilot will be subject of evaluation in the next few months and the CCG will consider how it can improve the service across the whole of Cornwall.
37. The CCG reviews performance in respect of repeat domestic abuse incidents, complaints, serious incidents and situations where children have been exposed to risk or harm. It uses data from a variety of sources and attempts to triangulate it.

38. The panel was reassured that the CCG is focused on domestic abuse and was impressed by its efforts to improve the response of, and relationship with general practice. It was concerned, however, over the lack of understanding of the quality of practice and outcomes being achieved, within the services it commissions.

39. As with CSE there is no overview of the referrals being made and the results of audits previously submitted by the CCG’s providers do not contain sufficient information regarding the outcomes being achieved. This is seen as a key issue for commissioners and for this reason it was agreed that further improvement is required.

Recommendation

4. **The CCG to provide the Safeguarding Children Partnership with an understanding of the outcomes being achieved by health professionals for children affected by domestic abuse. Within six months.**

Question 4

(a) **What have you done and what are you doing to make sure that the child’s wishes and feelings are included in decision making and the design of services in Cornwall and the Isles of Scilly?**

(b) **What impact have your actions had?**

(c) **What developments are you planning in this area?**

Requires Improvement to get to Good

40. The CCG has commissioned young people’s engagement and involvement in CAMHS via a contract with Young People Cornwall who support the CAMHS Young People’s Board (CYPB). Material from this work is included in Turning the Tide (January 2017), the latest edition of the CAMHS Transformation Plan.

41. Similarly, within the ‘Children Looked After’ service, evidence has been provided showing how surveys have been conducted to understand the views of children.
42. The CCG has adapted and amended its services to make improvements based on what it has heard. An example of this is looked after children being able to work with the same health professional, rather than a series of different practitioners. The most recent survey indicating high levels of satisfaction is considered to reflect how well the service has developed in listening to children and responding to their wishes.

43. Within the CCC service the manager speaks with children and families to ascertain their views of services. The Parent Carer Council is also involved within events and service design.

44. The CCC team gathers the views of children, young people and families when completing the assessments for CCC. This is conducted after a 3 month review period and then annually. The CCC team within the CCG consists of nurses who are skilled in gaining the views of children using non-verbal communication and technology. Children and Young People’s views are considered as an integral part of the CCG assessment process for CCC.

45. The CCC team are assured through monthly provider meetings that commissioned providers use technology and satisfaction surveys to understand the views of children and families. It uses the same process to consult on service development. The results are available in provider settings and annual quality reports.

46. Recent audits conducted by CCG staff indicate that, at an operational level, staff are routinely seeking the views of children regarding the action that needs to be taken. The responses received are listened to and are reflected within the plans developed.

47. In relation to the development of services provided by the organisations the CCG commissions it was apparent that it does not have the same level of confidence that children are being consulted, listened to or responded to.

48. In a number of the areas it was conceded that there was a lack of knowledge over what was being achieved through service specifications and contract monitoring.

49. The panel felt there were a number of good examples where the CCG had engaged well with children and their families but there was a significant gap when it came to its understanding of how
well its commissioned services were performing in this area. For this reason it was agreed that further improvement is required.

Recommendation

5. The CCG to review how its providers are gathering the views and opinions of children and families to further develop their safeguarding responses. Within six months

Question 5
(a) What have you done and what are you doing to contribute to the emotional health and wellbeing of the child population of Cornwall and the Isles of Scilly?
(b) What impact have your actions had?
(c) What developments are you planning in this area?

Requires Improvement to get to Good

50. This important issue for children and young people has been the subject of much debate and discussion since the panel in March 2016 and the CCG has spent significant time and effort trying to improve the provision of CAMHS.

51. A CAMHS Transformation Plan has been developed with the latest version produced in January 2017. The development of the plan has included seeking the views of children and families. There has been consultation with professionals and stakeholders across Cornwall and the Isles of Scilly.

52. As the Transformation Plan has evolved improvements have been seen and these include the appointment of additional primary mental health staff, the commissioning of additional resources to reduce waiting times for autism spectrum assessments, additional staff within the eating disorder service, the training of staff, alignment with other projects relating to social, emotional and mental health and support for infant mental health projects. The CCG has facilitated the development of a cross-system transformation plan with effort and input from the local authority and education. It has utilised national transformation monies subject to negotiation with NHS England.
53. The proposed schemes for the transformation plan during 2017/18 include bringing additional expertise from out of the county into the programme;
  • CYP IAPT (Improving Access to Psychological Therapies)
  • I-THRIVE Community of Practice
  • Child Outcomes Research Consortium (CORC)

54. Concerns were expressed regarding the previous lack of progress and the time taken to get to the current position. The CCG representatives reported their confidence with new contract monitoring arrangements and the overview of the CCG’s Governing Body. The Transformation Plan is a key project and one that it is monitoring closely. The Governing Body meets monthly and will be notified if there are any problems with the plan meeting its schedule.

55. The CCG accepted that there was a lack of information regarding the outcomes being achieved for children with emotional and mental health needs. The representatives reported this was an issue the plan intended to resolve.

56. From an operational perspective the CCG uses the NHS framework for Continuing Care for Children and Young People (2017) that ensures detailed assessments consider the emotional support needs of a child, young person and their family.

57. As per the NHS framework (2017), the CCG also keeps ‘the packages of care’ under regular review to ensure the child or young person’s needs continue to be supported. The CCG nurse assessor independently conducts reviews every three months, annually, or more frequently if dictated by the needs of the child.

58. The panel members were assured that the position in respect of supporting children with emotional and mental health needs had improved over the previous ten months and the current plan was the most complete seen to date. There were concerns over the slow implementation of various aspects of the plan and that few of the key actions had been completed. The panel members were reassured by the level of governance now in place.

59. Overall the panel members recognised the progress made but were cautious as many of the actions are still outstanding. It was agreed there are many improvements that still need to be made and these include understanding the outcomes being achieved for
children. For these reasons it was agreed that further improvement is required.

Recommendation

6. The CCG to provide the Safeguarding Children Partnership with detailed updates on the outcomes being achieved by the CAMHS Transformation Plan every three months. Within three months

7. The CCG to provide the Safeguarding Children Partnership with an understanding of the outcomes being achieved by health professionals for children with social, emotional and mental health needs. Within six months

Question 6

(a) What have you done and what are you doing to support children that are subject of neglect within Cornwall and the Isles of Scilly?

(b) What impact have your actions had?

(c) What developments are you planning in this area?

Inadequate

60. This is a subject for which the CCG accepts it still has “much to do”. It is supportive of neglect being a local safeguarding children priority and agrees it needs to review how it can work with its providers to improve the outcomes for children and their families.

61. In the past the CCG and its staff have helped circulate briefings and notification of workshops.

62. No evidence was provided to indicate how the CCG has communicated with its health providers or how adjustments have been made to service specifications. Representatives were unable to say how the CCG had worked with its providers to shape their future plans.

63. Within primary care the named nurse has been active and has distributed the partnership strategy to all practices. She has had discussions with safeguarding leads about the signs of neglect and how to combat the acceptance within some families of care that would not be tolerated in others. She has supported primary care
in being more aware of the early help options that are available. This includes the Early Help Hub (EHH), which provides advice and guidance to prevent escalation to child protection.

64. Concerns were raised in this discussion about the difficulty designated nurses are having with those areas of health provision that are now commissioned by the local authority, i.e. health visiting, school nursing and Family Nurse Partnership practitioners. The CCG is clear regarding the role of the designated professionals but a question was asked regarding the commitment to the role of the designated professionals within Local Authority commissioning processes.

65. The situation where individual providers are subject of overlapping contracts from different commissioners was discussed. It was felt there were opportunities to hold joint contract monitoring meetings and a sharper focus on safeguarding practice.

66. Discussions also took place over how the CCG leads on co-developing new priorities and influencing its providers beyond the formal procurement and contracting arrangements.

67. The panel members felt this was a subject area where the approach of the CCG had not influenced how its providers responded when a priority had been identified by the multi-agency Safeguarding Children Partnership. Although it was positive about what it could do in the future, gaps existed despite neglect having been a priority for the previous eighteen months. For these reasons the panel members agreed the response of the CCG to this area of safeguarding had been inadequate.

Recommendation

8. The CCG to review how it can influence health providers when new priorities are identified and report its findings to the Safeguarding Children Partnership. Within six months

9. The CCG to review with other commissioners of health services the use of designated professionals. Within six months

10. The CCG to liaise with commissioners of the same providers to consider the viability of joint contract monitoring arrangements. Within six months
Question 7
(a) Please describe your use of case audits to determine the quality of practice, together with any findings.
(b) What action have you taken to rectify shortfalls and to improve services as a result of audit activity?
(c) What impact have your actions had?
(d) What developments are you planning in this area?

Requires Improvement to get to Good

68. The CCG has a standard NHS contract with all providers that contains a local quality schedule. The schedule is developed every year in conjunction with the providers. The CCG seeks consistency across all its providers but has to be proportionate in the approach as some are much smaller.

69. Within the schedule the CCG stipulates audits of safeguarding practice and this is included as part of the contract. The panel understood that information is submitted to the contract team and, in the case of safeguarding, is forwarded to the safeguarding team for consideration. This is the same process as for any other requirements of the same provider.

70. The current schedule has recently been re-drafted and requires monthly returns by the 20th of each month.

71. Providers are required to undertake three qualitative child safeguarding audits each year, one of its own choice, and another relating to a recommendation from a serious case review, serious incident or CQC recommendation. There is no reference to the priorities agreed by the SCP.

72. The Designated Nurse has participated in multi-agency audits led by the local authority’s Safeguarding Standards Unit. The named nurse for primary care is working with general practice to create a culture of audit to review and improve the quality of safeguarding practice.

73. The designated professionals have recently conducted a number of ‘deep dive’ audits to examine the quality and effectiveness of provider safeguarding. The findings are currently with the health providers before being shared with the SCP.
Quarterly and annual quality reports from CCC providers include a summary of safeguarding case studies including the outcome of referrals.

The results of all audits are reviewed by the designated professionals and key recommendations are added to the on-going safeguarding action plan which is monitored by the Executive Leads for Safeguarding, who meet every six weeks.

The CCG considers the audits have identified issues that have in turn been resolved. It feels the audits have provided assurance that proposed developments and earlier recommendations arising from the CQC safeguarding inspection have been embedded into practice.

Panel members expressed concerns over the quality of ‘Provider’ audits and the lack of focus on outcomes. They queried how the CCG was monitoring this information to ensure that recommendations had been implemented by providers and how this had affected the quality of service or outcomes for children.

The panel acknowledged that CCG staff were now conducting audits but considered that information of this type should be routinely supplied by providers.

The panel members agreed the CCG was demonstrating a commitment to improve its use of case audits in quality assurance and performance management. They felt, however, that case audits had not yet provided a sufficient insight into how effective provider services were in safeguarding children.

Improvements are planned to achieve the required standard and for this reason it was felt that a grade of requires improvement to get to good is appropriate.

**Recommendation**

11. *The CCG works with its providers to develop a style of auditing that determines the relevant outcomes being achieved within each specific area of activity. Within six months*
Question 8
Please supply relevant safeguarding performance data and explain how you use this in relation to child safeguarding.

Inadequate

81. The CCG is provided with performance data from its providers which includes information relating to serious incidents, Local Authority Designated Officer (LADO) referrals, audits, training, child protection medicals, health and well-being assessments, child sexual abuse examinations and referrals to the MARU.

82. In addition the CCG is able to access the individual provider’s data sets.

83. The information is gathered by the Quality Team within the CCG and is provided to the monthly Quality and Performance Committee meetings where issues are raised by exception.

84. The Quality and Performance Committee meeting covers a wide range of activities that the CCG commissions.

85. Annually the Designated Nurse for ‘Children Looked After’ provides a report to the CCG detailing the activity for the previous business year, including specific safeguarding issues. The Designated Nurse and Doctor provide their own annual report regarding broader safeguarding issues.

86. Concerns were raised about the absence of regular oversight of referral activity, their distribution by area/team and the risks they related to, i.e. physical abuse, sexual abuse, CSE, neglect. This information is not routinely gathered and until recently the CCG was not aware that one of its providers was not collecting this data.

87. Examples were not provided to demonstrate data being used to identify an issue that required an intervention. Additionally examples were not provided to demonstrate further questions being asked or action being taken to remedy an issue of concern.

88. The panel members felt the use of performance data was limited, particularly in relation to action taken to address deficits. The yearly review of certain aspects through an annual report was seen to be of limited value. The lack of clear oversight of key information such as the nature, distribution and quality of referrals.
by health providers was considered to be a significant gap, as was the lack of understanding of how health providers themselves are using their data to improve safeguarding practice.

89. The panel members considered these to be serious omissions and agreed the approach of the CCG in this area is inadequate.

Recommendation

12. *The CCG to review how it and its providers gather, analyse and use performance data, and provide an update to the Safeguarding Children Partnership. Within six months.*

Question 9
(a) How does the leadership of the CCG ensure that child safeguarding is given sufficient focus amongst its competing areas of activity?
(b) How does the CCG provide governance and oversight/contract monitoring for the child safeguarding performance of the organisations it commissions?
(c) How is the CCG getting assurance that any improvements identified and communicated to providers are being implemented and evaluated?
(d) How has the CCG improved its governance and oversight/contract monitoring for the child safeguarding performance of the organisations it commissions?
(e) How does governance within the CCG work?
(f) Can the CCG provide examples where standards have risen as a result of its governance and interventions?

Requires Improvement to get to Good

90. The panel welcomed the fact that the CCG has been open in stating that ‘NHS Kernow is not sufficiently assured that the safeguarding function has the capacity, capability and leadership to ensure that the population of Cornwall and Isles of Scilly are safeguarded effectively’. To that end it has commissioned an independent external review of safeguarding adults and children which commenced on 23 January 2017. It is envisaged that the report and recommendations will be completed and presented to the March meeting of the NHS Kernow Quality and Performance
Committee and to the Governing Body at the beginning of April 2017.

91. The panel saw this as a strong commitment from the CCG and affirmation that safeguarding children is being seen as a higher priority in procurement and contract management. Additional training was provided in January 2017 to members of the Governing Body regarding their personal and collective responsibilities towards safeguarding.

92. The CCG representatives at the panel are confident that the Governing Body has a stronger focus on safeguarding.

93. The contracts with provider organisations have been reviewed and the monitoring arrangements strengthened. The Quality and Performance Committee provides an initial forum where good practice or poor performance can be discussed. However, it is too soon to tell whether these measures will deliver the intended outcome.

94. Safeguarding is embedded within the CCG Continuing Care practice through the CCC Panel and monthly provider performance meetings. Safeguarding is a standing agenda item on the CCC panel and provider meetings. Monthly performance meetings are conducted with providers and assurance is gained through meetings and action registers.

95. The CCC panel and the CCC Specialised Project Manager have oversight of the organisations that provide CCC. The CCC manager holds a live database of transition, Deprivation of Liberty Standards (DoLs) status/applications and safeguarding issues reported to the CCC team by providers.

96. The overall governance arrangements within the CCG have been strengthened. The panel members were more assured by the level of scrutiny and the means of communication between the relevant groups within the CCG.

97. The panel members were also assured by the approach of the Governing Body and the lines of communication that have been opened up for safeguarding. The review will provide an insight into the future requirements of contract monitoring, although this SCP process has identified a number of gaps, many of which the CCG is already aware of.
98. For these reasons it was agreed that further improvement is required.

**Recommendation**

13. **The CCG to complete its safeguarding review and provide the Safeguarding Children Partnership with its findings. Within three months**

14. **The CCG to develop and implement a plan that responds to the findings of its safeguarding review. Within 12 months**

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**Question 10**

(a) **How is the CCG working with other commissioners of services, where children are safeguarded, to create an effective multi-agency response?**

(b) **Can the CCG provide examples where it has jointly developed effective multi-agency child safeguarding arrangements?**

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**Good**

99. The CCG has developed a strong working relationship with Cornwall Council and together with providers has created the ‘One Vision’ Partnership Plan designed in part to create a means of co-commissioning children’s services in the future.

100. A comprehensive Transformation Plan is being developed and is due to be ratified in autumn 2017. When approved it is intended this will lead to significant re-commissioning during 2018/19.

101. CAMHS Transformation has been able to secure nominated leads from Cornwall Council’s Children and Family Services to join its work with Public Health and Education in developing the THRIVE framework locally.

102. Although much of this work is at an early stage and it is too early to tell whether it will have the desired impact, this represents a significant improvement on what the CCG was doing in March 2016. At that point there were no aligned or joint commissioning plans provided to the panel. The plans that have been developed appear to be well considered, thorough and child focused. There is a strong emphasis on safeguarding in the ‘One Vision’ Partnership Plan. The panel members agreed this reflected well
on the way the CCG is now working with its partners and it was seen as good performance.

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**Question 11**

(a) *How does the CCG ensure child safeguarding is included as a part of its Sustainability and Transformation Plans?*

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**Good**

103. The Sustainability and Transformation Programme (STP) for Cornwall and the Isles of Scilly, establishing the vision and future high level priorities, was set out within the strategic outline case.

104. Public and practitioner engagement events were run in January 2017 with the aim of developing a more detailed business case. The designated and named safeguarding professionals have been consulted and asked to comment on the production of the proposals and the work-streams.

105. Prior to public consultation the health executive leads for safeguarding formed part of a clinical and practitioner oversight group that conducted a quality impact assessment to ensure the business case was fit for purpose.

106. The STP remains an agenda item at the Health Safeguarding Executive meeting chaired and led by the CCG. This ensures there is a continued focus on wider service developments that may affect children.

107. The ‘One Vision’ Partnership Plan is effectively the children and young people element of the STP and this has been developed with a strong focus on child safeguarding, reflecting the priorities of the SCP.

108. The ‘One Vision’ plan has been presented to a number of strategic and partnership boards including the Safeguarding Children Partnership Board. The comments received have been positive.

109. The STP is seen as a means to achieve significant development of health and social care services across Cornwall and the Isles of
Scilly. To date the CCG has ensured children and those in need of safeguarding are appropriately considered. Further work is required to ensure that parents/carers are prioritised for mental health, drug and alcohol services given that these parental problems pose such a significant risk of harm to the welfare and safety of children. The panel members were reassured by the approach taken and felt it amounted to good performance.

**Recommendations**

110. The following recommendations have been identified as requiring completion following the publication of this report:

**Within three months**

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<th>Rec 6</th>
<th>The CCG to provide the Safeguarding Children Partnership with detailed updates on the outcomes being achieved by the CAMHS Transformation Plan every three months</th>
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<tr>
<td>Rec 13</td>
<td>The CCG to complete its safeguarding review and provide the Safeguarding Children Partnership with its findings.</td>
</tr>
</tbody>
</table>

**Within six months**

<table>
<thead>
<tr>
<th>Rec 1</th>
<th>The CCG should provide the Safeguarding Children Partnership with an analysis of the quality of health related responses to CSE from the services that it commissions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rec 2</td>
<td>The CCG should develop an understanding of the number, distribution and type of referrals its health providers make in respect of all child safeguarding issues to inform commissioning intentions in relation to safeguarding.</td>
</tr>
<tr>
<td>Rec 3</td>
<td>The CCG to review other means of assessing health provider responses to missing children, including a review of the quality of referrals to the MARU, and to inform the SCP of its findings.</td>
</tr>
<tr>
<td>Rec 4</td>
<td>The CCG to provide the Safeguarding Children Partnership with an understanding of the outcomes being achieved by health professionals for children affected by domestic abuse.</td>
</tr>
</tbody>
</table>
Rec 5  The CCG to review how its providers are gathering the views and opinions of children and families to further develop their safeguarding responses.

Rec 7  The CCG to provide the Safeguarding Children Partnership with an understanding of the outcomes being achieved by health professionals for children with social, emotional and mental health needs.

Rec 8  The CCG to review how it can influence health providers when new priorities are identified and report its findings to the Safeguarding Children Partnership.

Rec 9  The CCG to review with other commissioners of health services the use of designated professionals.

Rec 10  The CCG to liaise with commissioners of the same providers to consider the viability of joint contract monitoring arrangements.

Rec 11  The CCG works with its providers to develop a style of auditing that determines the relevant outcomes being achieved within each specific area of activity.

Rec 12  The CCG to review how it and its providers gather, analyse and use performance data, and provide an update to the Safeguarding Children Partnership.

Within twelve months

Rec 14  The CCG to develop and implement a plan that responds to the findings of its safeguarding review.

111. The Quality Assurance and Scrutiny Panel asks that NHS Kernow Clinical Commissioning Group provides an update report in respect of these areas for improvement before 31 July 2017 (three months), 31 October 2017 (six months) and 30 April 2018 (twelve months).

John Clements
Independent Chair