CORNWALL AND ISLES OF SCILLY
SAFEGUARDING CHILDREN BOARD

QUALITY ASSURANCE AND SCRUTINY PANEL

Findings of the panel meeting
held on
Tuesday 23 August 2016

for

SOUTH WESTERN AMBULANCE SERVICE
NHS FOUNDATION TRUST

Published October 2016
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Findings of the Cornwall and Isles of Scilly Safeguarding Children Board
Quality Assurance and Scrutiny Panel
South Western Ambulance Service NHS Foundation Trust
Tuesday, 23 August 2016

Introduction

1. On Tuesday, 23 August 2016 the following representatives of the South Western Ambulance Service NHS Foundation Trust (SWAST) appeared before the Cornwall and Isles of Scilly Safeguarding Children Board’s Quality Assurance and Scrutiny Panel:

   Sarah Thompson          Head of Safeguarding
   Chris Rogers            Named Safeguarding Professional, Devon and Cornwall

2. The panel consisted of the following board members:

   Chair                   John Clements          Independent Chair
   Vice-chair              Mo Read               Lay Member
   Mandy Cox               NHS England
   Jim Pearce              Devon and Cornwall Police - BCU Commander

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

4. As agreed within the terms of reference, the SWAST 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. Panel members had the opportunity to review that material in advance of the meeting. Immediately before the meeting the members conducted their final preparation.

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 and in relation to each question area.

**Findings**

6. In relation to its overall assessment the panel assessed that the South Western Ambulance Service NHS Foundation Trust (SWAST) fulfilled the criteria for **Requires Improvement to get to Good** in respect of safeguarding children.

7. The panel considered that the SWAST had demonstrated a strong commitment to safeguarding children and was impressed by the work that had been undertaken over the last three years. The SWAST safeguarding leads accepted that there was still much work to be completed and that was evident in the majority of the areas examined. It was agreed that the work was focused in the right areas and already making a difference. This was evidenced by the **‘Good’** grades awarded. The panel was satisfied that the SWAST had the capacity to achieve the objectives it had set itself in respect of safeguarding children. The panel members were impressed by the representatives who appeared before the panel.

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

<table>
<thead>
<tr>
<th>Outstanding</th>
<th>Good</th>
<th>Requires Improvement to get to Good</th>
<th>Inadequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>4</td>
<td>7</td>
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**Question 1**

(a) What is the SWAST policy in respect of training its staff?
(b) Can you provide the SCB with up to date information on the number of staff, who have a connection with Cornwall and the Isles of Scilly, who have been trained in accordance with the policy?
(c) What impact has the training had?
(d) How are front-line, call handling and 111 staff supervised?
(e) What developments are you planning in this area?
Requires Improvement to get to Good

SWAST provides a range of emergency and urgent care services across Cornwall, the Isles of Scilly, Devon, Dorset, Somerset, Wiltshire and Gloucestershire. This includes the unitary authority areas of Bristol, Plymouth, Torbay, South Gloucestershire, Bath and North-East Somerset, North Somerset, Swindon, Bournemouth and Poole. It covers fifteen local safeguarding children boards within that area. It has over 4,000 staff spread across 96 ambulance stations, three clinical control rooms, six air ambulance bases and two Hazardous Area Response Teams (HART).

It has an overall Head of Safeguarding, Sarah Thompson, who covers the whole area and has responsibility for children and adult safeguarding. Supporting her she has three safeguarding named professionals who are each responsible for a geographic area plus specific subjects areas. For example the named professional for the West Area is Chris Rogers who covers Devon, Cornwall and the Isles of Scilly. He is also responsible for child death overview, domestic abuse, modern slavery and the safeguarding newsletter.

Also within the team there is a mental health practitioner who, while employed for staff welfare, also provides expertise in mental health matters; a senior safeguarding support worker who is responsible for staff welfare issues and data analysis amongst other responsibilities; an administrative assistant and a triager who is temporarily seconded to the team. The triager is responsible for receiving, reviewing and distributing all the referrals that are made by SWAST staff across its area. When the triager is not available, the role is covered by the safeguarding named leads.

Within Cornwall and the Isles of Scilly SWAST employs 405 front-line staff and a large number of volunteers. Most of the volunteers are community responders, unpaid staff who provide a local service and are often first on the scene of an incident. They undertake initial first aid, including the provision of oxygen and offer reassurance. The community responders are always supported by paid staff, i.e. paramedics.

Incidents in Cornwall and the Isles of Scilly are managed by the Critical Control Rooms outside of the area and the NHS 111 service for Cornwall and the Isles of Scilly is managed by SWAST.
In relation to training SWAST follows the Health inter-collegiate document with training provided across Levels 1 – 4 as outlined.

Level 1 applies to staff in a non-contact role with the trust (personal or telephone) and includes receptionists, administrative staff.

Level 2 includes all its front-line staff who have contact with members of the public, staff within its Critical Control Rooms, staff working within the NHS 111 service, community volunteers, patient transport staff, heads of service, tutors and team leaders.

Level 3 includes all named safeguarding service staff and 20 other staff who have been given additional responsibility for safeguarding within their leadership responsibility.

Level 4 relates to the Head of Safeguarding, the safeguarding named leads, the Associate Medical Director for Primary Care and the safeguarding lead on the SWAST Board.

All staff are provided with the appropriate level of training when they join SWAST and additional training as they move into roles where further development is required. For example for Level 2 a safeguarding training workbook is completed and this is accompanied by attendance at a formal face-to-face training event. Every three years the staff at Level 2 are required to complete a further four hours through a training event, delivered either through SWAST or a recognised alternative, i.e. LSCB.

The Safeguarding Team maintains an overview of the training provided and a spreadsheet was provided to the QA and S Panel.

Of relevance to Cornwall and the Isles of Scilly:

- 99% of front-line staff in the West Division have received their Level 2 training.
- 81% of staff within West Division requiring Level 1 training have received it.
- 88% of patient transport staff for West Division requiring Level 2 training have received their inputs.
- Within the Critical Control Rooms and NHS 111 service 88% of staff requiring Level 2 training have received it.
- The overall target set for all departments is 95%.
The panel was reassured by the number of staff in key roles that had received the appropriate level of training. It was impressed by the oversight the safeguarding team had and the quality of its data.

That said there were a number of areas where the numbers trained were below the targets that had been set. It is recognised that the team are aware of this and have plans to achieve the required numbers to be trained.

SWAST considers the training has made a positive impact and this is demonstrated by the increase in the number of referrals.

In 2013/14 the number of adult referrals was 3755 and the number of child referrals was 2069. In 2014/15 this had increased to 5163 and 2606 respectively. For the last year (2015/16 it had increased again to 7440 and 2878 respectively.

The safeguarding team feel that standards have improved and this has been evidenced during the audits that have been undertaken. The results of these audits are discussed more fully in the next section.

In relation to supervision the situation is not so clear.

The staff within the safeguarding team receive supervision from either their line managers or from relevant staff from other agencies within the area where they work. For example the Head of Safeguarding receives supervision from an external independent consultant. The Safeguarding Named Professional for the West receives supervision from a named nurse from a local NHS trust. This supervision is provided at least quarterly.

For other staff supervision is limited although there are plans to develop the clinical supervision provided to front-line professionals. There is no safeguarding supervision provided to front-line staff.

SWAST has a number of safeguarding ‘champions’ distributed across the trust. There were 20 but the numbers have dropped. These staff members do not receive individual safeguarding supervision but meet in groups with the local safeguarding named professional.

The issue of safeguarding supervision was discussed at the panel and options including ‘champions’ within each control room shift and ‘champions’ covering a specific geographic area were considered.
The issue of supervision and the absence of a formal supervision strategy were raised in the trust’s safeguarding annual report 2015/16. Priority 2 relates to the adoption of a formal strategy and a supervision policy has been prepared. It is due to be considered at the trust’s Quality Committee and it may be discussed at the December 2016 meeting.

The panel was of the opinion that much progress had been made in this area but that there was still work to be done. There were staff still to receive their safeguarding training and SWAST had yet to decide upon/approve a supervision strategy that included safeguarding supervision. In view of this it was considered that the ‘Requires Improvement to get to Good’ grade was appropriate.

Recommendations:

1. To ensure that SWAST trains at least 95% of its staff to the level identified for their role. Within six months.
2. To approve and implement a supervision strategy that includes safeguarding as an ongoing feature for all its staff. Within six months.

Question 2

(a) How does the Trust oversee the referrals made by its staff in respect of children from Cornwall and the Isles of Scilly?
(b) How do the numbers compare to other local authority areas?
(c) What is the Trust’s view on the quality of referrals made by its staff within Cornwall and the Isles of Scilly?
(d) What is the impact of the referrals that have been made?

Requires Improvement to get to Good

SWAST manages all of its referrals through a central triage position and this allows it to maintain a detailed overview of numbers and quality.

The triage is managed through a red/amber/green process that ensures the most critical referrals are expedited and passed to the relevant local authority or organisation.

SWAST is confident that its staff know how to complete a referral and feel this was borne out during the 2016 Care Quality Inspection of its NHS 111
During that inspection staff were tested regarding their knowledge of making referrals and found to have good levels of knowledge.

Over the past three years the number of referrals made in respect of children across the whole SWAST area has increased year on year:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
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<tbody>
<tr>
<td>2013/14</td>
<td>2069</td>
</tr>
<tr>
<td>2014/15</td>
<td>2606</td>
</tr>
<tr>
<td>2015/16</td>
<td>2878</td>
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</tbody>
</table>

The increases are lower than those demonstrated for adult referrals, i.e.:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
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</thead>
<tbody>
<tr>
<td>2013/14</td>
<td>3755</td>
</tr>
<tr>
<td>2014/15</td>
<td>5163</td>
</tr>
<tr>
<td>2015/16</td>
<td>7440</td>
</tr>
</tbody>
</table>

It is not possible to compare year on year the number of child referrals for Cornwall and the Isles of Scilly as the data has not been provided.

On a station level the panel noted some obvious differences on the overall number of referrals across 2015/16:

<table>
<thead>
<tr>
<th>Station</th>
<th>Number</th>
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<tbody>
<tr>
<td>St Austell</td>
<td>113</td>
</tr>
<tr>
<td>Redruth</td>
<td>58</td>
</tr>
<tr>
<td>Truro</td>
<td>34</td>
</tr>
</tbody>
</table>

It is accepted that the staffing numbers may vary between stations but the panel felt this was an issue that required further investigation by SWAST.

In relation to quality there had been three key audits undertaken and these were:

1. Referral Quality – Between November and December 2015, 1,000 referrals were assessed in relation to their quality. 26% were assessed as good, 62% were assessed as adequate and 12% were assessed as inadequate.

2. SW Audit report, July 2016 – The referrals between March 2015 and February 2016 were reviewed to assess if they were being processed within the appropriate timescales and to the correct agency. Of 9,808 referrals 9,782 were handled as required. This is a compliance rate of 98.7%.
3. Quality Committee Report – A report was submitted in April 2016 where 20 child referrals were reviewed by the Head of Safeguarding and a representative from a local authority children’s social care department. Of the 20 referrals, 15 were considered to be adequate or good and 5 were found to be inadequate.

In relation to the inadequacy it was mainly due to the amount and quality of information contained within the referral. Where this is observed dynamically by the triager, or during dip samples conducted by the Head of Safeguarding, feedback is given to the submitting member of staff.

A plan including the updating of referral forms, updating the Level 2 training, new operational procedures on how to produce a quality referral and the production of a safeguarding pack for operational staff, has been developed and is being delivered.

The safeguarding named professional for Devon and Cornwall has plans to undertake a review of referrals in Cornwall with the named nurse of Cornwall Partnership NHS Foundation Trust during October 2016.

Concerns were expressed by the panel that the ‘triager’ was not an established position and that there was little resilience in the event that this person was not available. It was felt that this was a critical position handling in excess of 10,000 pieces of valuable information annually.

The panel felt that the system in place was effective although there were concerns over the fragility of the staffing of the ‘triage’ post. This was considered to be a risk to the trust and to safeguarding. The panel was concerned over the comparatively high number of referrals that were assessed as being inadequate during the audits. It was considered that the variation in the number of referrals from different ambulance stations across Cornwall was not sufficiently understood. The panel therefore agreed that a ‘Requires Improvement to get to Good’ grade was appropriate.

Recommendations:

3. To review the SWAST safeguarding ‘triager’ post to determine if it should be made an established position. Within six months.
4. To approve and deliver the plan to reduce the number of inadequate child referrals. Within three months.
5. To review the number of referrals across Cornwall and the Isles of Scilly with a view to understanding the current variation across stations. Within six months.

**Question 3**

(a) How does the Trust contribute towards Initial and Review Child Protection Conferences and other relevant child protection meetings?

(b) What is the impact of the Trust’s contribution?

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

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**Good**

SWAST has reviewed whether its staff should be engaged within initial and/or review child protection conferences.

In respect of direct invites SWAST receives very few.

The safeguarding named professional for Devon and Cornwall has personally explored whether he should be attending initial child protection conferences across the area. It was felt that, as he covers four local authority areas, he would not be able to attend enough conferences regularly.

SWAST has therefore explored whether the information held by the trust is available to the conferences that are held.

For each person that a member of staff has contact with a notification is completed and forwarded to his or her general practitioner. This includes the NHS 111 service where the information is conveyed electronically.

Where a child is taken to a hospital the ambulance notes will be provided and these will be retained within the hospital’s notes. These will be available should the hospital be contacted regarding the child.

In addition, for those cases where specific concerns are identified, referrals are forwarded to the trust’s triager. All referrals for Cornwall are forwarded to the multi-agency referral unit (MARU) and those for the Isles of Scilly are notified to childrens social care on the islands.
Where enquiries are instigated checks with general practitioners should ensure that the child’s contact with SWAST is identified and understood. If further, specific information is required the safeguarding named professional is known to be the contact point.

The panel felt that the systems had been engineered to ensure that the involvement of the trust with a child should be known to at least one point of contact during any subsequent information gathering process. The information provided should give an insight of what the member of staff had dealt with. Where further information was required there was a means of requesting and gathering the relevant information. This was considered to be a robust arrangement and as such the panel considered a ‘Good’ grade was appropriate.

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**Question 4**

(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?*

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**Requires Improvement to get to Good**

CSE and missing children are priorities for the trust and a specific plan has been developed. The plan is designed to make staff and managers aware of the problem, be able to identify children at risk of CSE and make appropriate referrals regarding their concerns.

The plan is due to start in September 2016 and a series of events are planned over the next nine months culminating with an evaluation scheduled for July 2017.

CSE is already part of SWAST’s Level 2 training and is a category within its referral database. Staff are now being provided with the NHS England CSE pocket guide.

As a result of the database recording, SWAST is able to report that it has handled 12 referrals relating to CSE across the whole area during the past 12 months. Of those, four were cases within Cornwall.
The named safeguarding professional responsible for Cornwall has previously been involved in the Missing and Child Sexual Exploitation Forums (MACSE) but has not been involved since they were updated in April 2016.

The panel felt CSE had been a LSCB priority for the past two years and that there had been a Devon and Cornwall CSE strategy for a number of years. It was therefore surprising to discover the SWAST plan was due to be rolled out in September 2016. It accepted the SWAST safeguarding team was covering a large area, with 30 different safeguarding boards, but CSE was an issue for all safeguarding children boards.

The panel agreed the SWAST position was not as advanced as it thought it should be and that ‘Requires Improvement to get to Good’ was the most appropriate grade.

**Recommendation:**

6. To ensure all SWAST staff within Cornwall and the Isles of Scilly receive the additional CSE training. Within six months.
7. To ensure all SWAST staff with a relevance to Cornwall and the Isles of Scilly understand the referral pathways relating to CSE, i.e. perpetrators and locations. Within three months.

**Question 5**

(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**

SWAST’s approach to missing children is part of the CSE strategy that is being implemented during September 2016. Missing children is seen as a key feature where CSE may be occurring and staff are being briefed accordingly.

The representatives considered staff would be curious if they encountered a child in a situation that was not thought to be appropriate, i.e. not at school, in a strange flat.
The panel was concerned as this was an area where SWAST did not appear to consider itself as having a responsibility. Although missing children are specifically dealt with by the police and childrens social care, it was felt there was a likelihood that SWAST staff would encounter children who were missing from school or home and in risky situations.

It felt that this was an area where SWAST could do more with its staff to alert them to the risks faced by missing children and to develop professional curiosity within its staff. As such it was felt that ‘Requires Improvement to get to Good’ was an appropriate grade.

Recommendation:

8. SWAST to ensure all their front-line staff are made aware of the risks faced by missing children and SWAST to consider how front-line staff may identify children who are or who may be missing. Within six months.

Question 6
(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?

Good

Domestic abuse is seen as a key safeguarding topic by SWAST and all operational staff were provided with inputs on domestic abuse during an annual training day in 2014. All staff joining since have been provided with a similar input.

SWAST is confident that staff are aware how domestic abuse affects children within the family and how important it is to convey information to partner agencies.

Where ambulance staff attend a domestic abuse incident the police are routinely notified and often they are at the same address together. In that situation staff would expect the police to deal with the domestic abuse and they would deal with the medical issues.
Referrals relating to domestic abuse are regularly submitted by SWAST staff and the quality has been assessed as being of a high standard. Feedback has been received indicating staff have gathered detailed information regarding children, the environment encountered and information regarding schools/nurseries the child is attending.

The safeguarding named professional is currently exploring the possibility of passing key information to schools in advance of any affected students going to school on a particular day. The panel was able to outline that police colleagues are involved in a very similar piece of work and agreed to put the relevant staff in contact.

The panel was assured that SWAST sees domestic abuse and staff understand its destructive nature for children. Staff are communicating concerns when they arise. In all cases of domestic abuse they notify the police. The panel felt the SWAST position was clear and committed. It felt the appropriate grade was ‘Good’

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**Question 7**

(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?

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**Requires Improvement to get to Good**

SWAST uses a range of social media including Facebook and Twitter to make contact with children as a means of encouraging them to contact and make use of its services.

When staff encounter children they are given ‘I want, I need’ cards to elicit feedback from them about the service they have received.

SWAST has an engagement plan for 2016/17 which includes visits to schools. Since April 2016 nine schools have been visited by the public engagement teams.

SWAST has a teddy bear mascot which is being used as a means of engaging with small children. It also uses child size uniforms to build relationships and to remove any fear they may have of ambulance staff.
SWAST uses activity packs and mini medic books that inform children how to call ‘999’ or undertake CPR.

At an older child level it has been involved in ‘Learn to Live’ educational sessions that have worked with 17 – 24 year olds in reducing the number of road traffic collisions.

The panel felt the effort being made and the different approaches being used by SWAST to engage with children were commendable. It was felt, however, that these rarely focused on safeguarding and that SWAST was missing an opportunity. SWAST has a public engagement member of staff who supports the approaches outlined above. It was suggested that safeguarding efforts could be explored with him to see how SWAST could develop its role. It was considered that ‘Requires Improvement to get to Good’ was the appropriate grade.

Recommendation:

9. To discuss with the SWAST public engagement member of staff how the trust could engage more effectively with children to identify safeguarding concerns. Within six months.

Question 8
(a) What have you done and what are you going to do 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

SWAST front-line professionals regularly come into contact with children suffering with emotional or mental health difficulties. This includes children suffering from anxiety and those who have self-harmed. They are prepared for these incidents and regularly submit referrals to the MARU. Where children are in serious distress they are taken to the Emergency Department and no child is left at risk of harm.

Representatives were confident that staff understand how incidents including domestic abuse, parental substance abuse and parental mental
health affected the emotional health of children. Staff are encouraged to make referrals where they see the obvious signs of children being adversely affected.

The safeguarding team is aware of the harm children can suffer when they witness or are involved in traumatic incidents. A leaflet has been developed to distribute to such children. The leaflet is just about to be rolled out.

The representatives and the panel members discussed what happened to children who had been on the periphery of incidents and where referrals were not submitted. What safeguards were in place to identify their issues? The representatives pointed out that all contacts were notified to the relevant general practitioner. Concerns were raised that this did not necessarily mean the potential harm was being identified and that those attending may be in a better position to recognise those children who were suffering.

The panel, although accepting that SWAST staff were providing a valuable service to the health of children in this area, wondered if more could realistically be done. It felt it would be worth conducting an audit to establish what referrals are being made for children who are affected by incidents involving their parents. This could focus on serious incidents and establish if the system was failsafe. On the basis of this being a potential gap it was felt that ‘Requires Improvement to get to Good’ was the most appropriate grade.

**Recommendation:**

10. To conduct an audit of recent incidents attended by SWAST, where parents were involved in a serious incident, to establish if the potential emotional harm suffered by any child was identified and referred. Within six months.

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**Question 9**

(a) **What have you done and what are you going to do 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?**
Good

SWAST operational staff have submitted 36 referrals over the past 12 months in respect of children being neglected. Positive feedback has been received for a number of these cases.

Neglect features within Level 2 training and this includes the range of signs that staff may encounter either in person or via a telephone call.

The panel voiced an opinion that the training did not appear to show that emotional neglect was being considered. The representatives stated that this was an underlying theme and, although not explicit, was covered during the training. Emotional harm can be less obvious but it is often present as a consequence of the other physical features, i.e. lack of supervision.

The panel recognised that SWAST is an alerting service in relation to neglect and that staff were recognising the signs. It was therefore agreed that a ‘Good’ grade was appropriate.

Question 10

(a) Please describe your system for undertaking case audits of the quality of practice, together with your findings.
(b) What action have you taken to rectify shortfalls and to improve services as a result of your audit activity?
(c) What impact have your actions had?
(d) What developments are you planning in this area?

Requires Improvement to get to Good

The SWAST safeguarding team is regularly completing audits and this has already been referred to within this report in the section regarding referrals.

In addition the trust has been inspected twice by the Care Quality Commission. Firstly in March 2016 the NHS 111 Service was inspected. Secondly the whole trust was inspected during June 2016. The report relating to the NHS 111 Service inspection was published in June 2016. The June 2016 inspection report had not been published at the time of the panel meeting.
In the course of the internal audits the positive features were the timeliness of the referrals and the high quality of a number. Gaps were identified regarding the quality of other referrals with 25% of referrals on one audit being assessed as inadequate.

As a result, the referral forms have been updated, Level 2 training has been updated, procedures on how to produce a quality referral have been approved, a statement writing policy has been produced and a safeguarding pack for operational staff has been produced.

At a structural level the audits have provided the Head of Safeguarding with information that she has used to submit a business case to increase the number of staff within her team. This has happened.

The representatives were asked about benchmarking with other ambulance trusts and the Head of Safeguarding reported that, of the 10 ambulance trusts that exist, SWAST is the only one that has a triage function for referrals. This allows it to send referrals to organisations other than just childrens social care and to monitor the quality daily.

The panel queried the outcomes being achieved as a result of the audits and the representatives considered the increase in number was one obvious one. It was not possible to determine how the changes had directly benefited children other than the increase in numbers of referrals.

The panel considered SWAST had an active approach to auditing its safeguarding efforts and was impressed by the stance it had taken. It was felt that more could be done to establish the outcomes being achieved for children. For this reason it was agreed that a ‘Requires Improvement to get to Good’ grade was appropriate.

Recommendation:

11. Within the case audit process extend the parameters to assess the outcomes being achieved for children. Within six months.

Question 11

*Please supply relevant single-agency data and explain how you use this to understand performance you are responsible for in relation to child safeguarding.*
Good

SWAST gathers a significant amount of data regarding its safeguarding efforts. This includes the number of referrals, the stations where the referrals emanate, the nature of the referrals and the amount of feedback received. It does this for a number of different geographic areas which is useful for many LSCBs.

It produces data on the number of staff trained at the various safeguarding levels, the number of child deaths and comparative data across the whole area.

The panel was impressed by the range and quality of the data. It was evident where the data was being used effectively, e.g. training where the numbers of operational staff trained were above the targets that had been set. In other areas it was not as clear how the data had been used, e.g. variation in referrals from different stations.

The panel appreciated the number of dedicated safeguarding staff across the trust and the amount of time that was available to devote to analysing the data. It therefore considered a ‘Good’ grade was appropriate.

Next steps

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

**Within three months**

<table>
<thead>
<tr>
<th>Rec 4</th>
<th>To approve and deliver the plan to reduce the number of inadequate child referrals.</th>
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</thead>
<tbody>
<tr>
<td>Rec 7</td>
<td>To ensure all SWAST staff with a relevance to Cornwall and the Isles of Scilly understand the referral pathways relating to CSE, i.e. perpetrators and locations.</td>
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</table>

**Within six months**

<table>
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<th>To ensure that SWAST trains at least 95% of its staff to the level identified for their role.</th>
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<td>Rec 2</td>
<td>To approve and implement a supervision strategy that includes safeguarding as an ongoing feature for all its staff.</td>
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<tr>
<td>Rec 5</td>
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</tr>
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</tr>
<tr>
<td>Rec 9</td>
<td>To discuss with the SWAST public engagement member of staff how the trust could engage more effectively with children to identify safeguarding concerns.</td>
</tr>
<tr>
<td>Rec 10</td>
<td>To conduct an audit of recent incidents attended by SWAST, where parents were involved in a serious incident, to establish if the potential emotional harm suffered by any child was identified and referred.</td>
</tr>
<tr>
<td>Rec 11</td>
<td>Within the case audit process extend the parameters to assess the outcomes being achieved for children.</td>
</tr>
</tbody>
</table>

The Quality Assurance and Scrutiny Panel asks that the South Western Ambulance Service NHS Foundation Trust provides an update report in respect of these areas for improvement before 31 December 2016 (three months) and 31 March 2017 (six months).

**John Clements**  
Independent Chair