OUR SAFEGUARDING CHILDREN PARTNERSHIP FOR CORNWALL AND THE ISLES OF SCILLY

Annual Report 2017/18

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Authors: **Practice Development and Standards Service**

1 Foreword

By Our Safeguarding Children Partnership Independent Chair

Writing the annual report is an important process for Our Safeguarding Children Partnership (OSCP) as it causes us to reflect on what we have achieved, consider where we could have done more and work out how we can let people know what we have been doing.

On reflection, we have had a busy year and one we can be justly proud of. We spend much of our time working out what to improve and comparatively little on celebrating our achievements. In this report I hope we can be more balanced, accurately outline our key achievements, whilst not being complacent, and understand what difference we have made to the lives of our children.

Cornwall and the Isles of Scilly is a fantastic place in which to live and grow up. Our children have opportunities and experiences that many others dream of. We have the responsibility to make sure that as many children as possible are able to take advantage of those opportunities and surroundings.

We are fortunate to have a partnership workforce that matches its surroundings. The professionals who meet and work with our children are energetic, committed and focused on those children who need them most.

Within OSCP the focus has been upon developing those areas where it was felt we could make the greatest improvements on the outcomes we achieve for our children.

Child sexual exploitation has been uppermost in people's minds for a number of years and during 2017/18 the partnership has implemented a number of positive developments and refined existing processes. The routine use of civil orders and powers through a dedicated police and council team is one such development and shows the commitment from our senior leaders. Our performance framework, supported strongly by colleagues from Safer Cornwall, is another positive step forward and one that is already yielding results. We have seen the number of referrals increase and the quality of work improve. I have every expectation this will continue in the coming year.

Our response to neglect has improved during 2017/18. We have strengthened our strategy, developed a number of practical tools, conducted a number of audits and provided a range of training opportunities. The identification of neglect is rising and the overall quality of our responses is improving. Further work is required regarding the consistency and supervision of our efforts but these issues have been identified through auditing and we have plans to address them.

The emotional health and wellbeing of our children is a national concern and we are no different in Cornwall and the Isles of Scilly. Professionals across the partnership recognise the relevance to safeguarding and have developed new approaches during 2017/18. The improvements made on the Isles of Scilly have been impressive and show the value of investing in early interventions. The numbers of children requiring specialist mental health support have reduced. Within Cornwall new plans have been

devised and there is greater optimism. The building of an in-county in-patient facility is welcomed and eagerly anticipated in April 2019. Other plans are intended to reinforce early intervention efforts, reduce waiting times and increase support for children and families. I wait for the conversion of these plans into positive outcomes but I have greater confidence than in previous years.

Domestic abuse continues to affect the lives of too many children but the recognition of this factor and the responses to it are improving. The relationship between our partnership and Safer Cornwall is strong and the recently refreshed county strategy contains an increased focus on children. All organisations are demonstrating their staff to be competent and confident in this area of work.

Child sexual abuse is a topic where we have more work to do. We are concerned that the number of cases recorded appears to be low and have responded accordingly. We have established a task and finish group to improve our approach across a number of themes including prevention, practitioner awareness and immediate response.

Our quality assurance and scrutiny work has been a substantial part of the partnership's work over 2017/18 and we have reviewed all of the organisations represented on the board. We have closely reviewed emotional health and well-being. Other organisations have been subject of our Section 11 self-assessment process and all of our schools completed a Section 175/157 self-assessment.

Additionally we have conducted our own independent case audit into neglect and received the outcomes of a number of case audits completed by single organisations and multi-agency groups.

My observation from audit and scrutiny is that our safeguarding outcomes have improved year on year. The last year has seen further improvements and, although we have much left to do, our overall response is the best it has been in the four years I have been in role.

Children are clearly at the centre of all that we do and there are some excellent examples of where partnerships and individual practitioners develop strong relationships with children. The 'voice of children' can be seen in case work and children are actively involved in their own cases. This is an area where OSCP itself seeks to improve, we have plans to engage more actively with children and we must see these being realised during 2018/19.

Learning across the partnership and our member organisations is strong. Our review processes are aligned to our training delivery and we have been responsive to lessons learned. Our successful training contract with Reconstruct has come to an end and a new training provider has been selected. Child safeguarding training across all organisations is well-considered, varied and delivered by knowledgeable trainers. Despite this we are determined not to stand still and in our desire to improve and challenge ourselves we have identified areas for improvement during 2018/19. These include more effective analysis and robust review of interventions. Our training plans for 2018/19 are focused on these areas.

We have been keen to look beyond our partnership and 2017/18 has seen OSCP develop stronger relationships with others. In particular our relationships with Safer Cornwall and the Cornwall and Isles of Scilly Safeguarding Adults Board are more integrated, open and involve joint working.

This has allowed us to share best practice, reduce demands on staff who work with our different boards and develop new areas of business. The expansion of the Missing and Sexual Exploitation Group to cover young adults was a particularly good piece of work.

Further work is planned for 2018/19 and we are looking at other areas where we can successfully work together.

At the start of this section I said we need to understand what difference we have made to children's lives.

Throughout 2017/18 I have seen greater awareness within our front-line practitioners of the many different factors that can or actually cause harm to children. This awareness has seen increased numbers of referrals and notifications to our child safeguarding specialists. In spite of growing demands the quality of our subsequent safeguarding interventions has improved. The involvement of children and families in the cases that relate to them has increased and our consultation with children is more engaging. Our plans looking forward are child focused, achievable and resourced.

None of this can be achieved without our front-line practitioners, managers and leaders. As pressures have grown and our work has become more complex everybody has stepped up and increased their effort and application. I thank all those involved for their continued support and commitment. I look forward to a busy but rewarding 2018/19.

John Clements
Independent Chair

2 Statutory and Legislative Context

2.1 Legislative Context

Our Safeguarding Children Partnership (OSCP) is the key statutory body overseeing multi-agency child safeguarding arrangements across Cornwall and the Isles of Scilly. Governed by the statutory guidance in *Working Together to Safeguard Children 2015* and the *Local Safeguarding Children Board (LSCB) Regulations 2006*, OSCP comprises senior leaders from a range of different organisations.

2.2 Objectives

The Partnership has two basic objectives defined within the Children Act 2004; to co-ordinate the child safeguarding work of agencies and to ensure that this work is effective.

2.3 Wood Report

In March 2016 the 'Wood Report', a review of the role and functions of Local Safeguarding Children Boards, was published. The Government published its response in May 2016 indicating that changes were going to be made in local child safeguarding arrangements.

2.4 New Safeguarding Arrangements

Following the publication of these reports, and in a desire to move to a stronger set of arrangements, a new multi-agency Safeguarding Children Partnership has been established for Cornwall and the Isles of Scilly. The structure has been based upon the principles suggested within the Government's response report and using the lessons learned from the experiences of the board. The new arrangements are compliant with the proposed statutory changes and, importantly, have been viewed positively since their establishment during January 2017. It is felt they have progressed multi-agency partnership working and how organisations challenge one another.

2.5 Scrutiny Mechanisms

A key emphasis within the new arrangements are the mechanisms that enable OSCP to scrutinise how effectively partner agencies are working together to safeguard children. The different processes are:

- An Independent OSCP Chair
- OSCP sub groups, including a Quality Assurance and Performance Sub-Group and Quality Assurance and Scrutiny Panels to review performance against key quality assurance questions
- Section 11 procedure that reflects OSCP priorities
- Multi agency performance data
- Single and multi-agency case auditing
- Independent multi-agency case file audits
- Review of inspectorate reports
- Serious case reviews
- Child death overview arrangements

2.6 Financial Arrangements

Partner agencies continued to contribute to Our Safeguarding Children Partnership's budget for 2017/18. Partner agencies provided as follows:

Partners	2017/18
Cornwall Council	158,000
Council of the Isles of Scilly	4,800
National Probation Service	1,274
NHS Kernow Clinical Commissioning Group	69,652
Police and Crime Commissioner	24,361
Total Partner Contributions	**258,087**

The total spending in 2017/18 totalled £258,116; Cornwall Council provided £158,000 (61.24%) of this funding. This income ensured that the overall costs of running OSCP were met.

Despite increasing costs, additional income and prudent financial management resulted in an under-spend of £2,372 which has been transferred to the Safeguarding Children Partnership Reserve.

3 Council of the Isles of Scilly

3.1 Overview

To ensure momentum since the Ofsted Single Inspection Framework, the Local Government Association recently undertook a Test of Assurance of the Council of the Isles of Scilly's Children and Adult Services. The findings were positive overall. These are some key quotes relevant to the work of the Safeguarding Children Partnership, who also contributed to the review.

- *Overall our findings were that operational delivery in both adult social care and children and young people's services are meeting statutory requirements, and no immediate operational delivery concerns were identified. There are improvement plans in place for both adult and children's services for areas that need further development.*

- *Partners gave positive feedback on their interface with the Council's services across both services, recognising good leadership, quality of practice and a real drive for a whole community approach. In terms of the statutory guidance the Council, the Lead Member for Children's Services (LMCS) and the Director of Children's Services (DCS) are fulfilling their statutory functions in this area. The LSCB is a joint one with Cornwall and meets six-weekly, known as Our Safeguarding Children Partnership (OSCP). Both the Chair and the DCS feel that the Isles of Scilly now has more prominence on the Board and recognise that as a result of the difference in scale priorities and processes are not always the same for both councils or equally applicable. OSCP carries out an annual audit of cases by the Quality Assurance and Scrutiny Panel which provides robust challenge of multi-agency case work on the Islands.*

- *Working with partners to promote prevention and early intervention, and offer support early when problems first arise, is a strength and the good practice that exists was recognised by Ofsted. Ofsted felt that the threshold for social care intervention for children in need was appropriate, and it is clear that the Senior Manager and two Senior Officers have a pivotal role in pulling partners together to support vulnerable children and young people to ensure fair access to services that meet needs.*

The Isles of Scilly has also received a positive multi-agency Quality Assurance and Scrutiny Panel report –the second one to date. This was again very positive, with even further improvements noted especially around emotional health.

3.2 Emotional Health and Wellbeing on the Isles of Scilly

Context:

- In January 2016 CAMHS reported to the Children's Trust Board that they were working with 17 children at the Five Islands School on the Isles of Scilly – the school aged population of the Isles of Scilly is 280, so this represented 6% of the school children.
- The Member of the Youth Parliament for the Isles of Scilly led consultation

among their peers about key priorities for change – Mental Health was considered the key area for action.
- Children working with Children's Social Care were asked what would have made a difference and prevented problems getting so bad and they said 'someone to talk to'.

It was therefore decided to develop a multi strand project:

- **Support the existing demand** – an enhanced Primary Mental Health function was commissioned from Cornwall Partnership Trust.
- **Understand if there were any environmental factors** driving emotional health issues on the islands – Bristol University was contacted about a research project to look at the potential impact of geographical isolation/small communities on child emotional wellbeing (but not commissioned as need changed quite rapidly).
- **Develop more confidence** among the multi-agency partnership to support children with emotional health issues – The BLOOM model was set up with co-ordination support from Children's Social Care to regularly review and discuss children with emotional health issues (with consent), to share best practice and to provide the best resource to the child, be that a teacher, early years provider, GP etc.
- **Commission a school based Family Support Worker** to have the early conversations with children and their families to prevent escalation and to develop self-help strategies. This worker is now a Thrive Practitioner, has had Trauma Informed Schools training and is linked into the Headstart Programme and supervision from Mounts Bay Academy. Another colleague is now also trained in Thrive.
- **Redesign the Early Help Pathway** – this was co-designed by all professionals to replace the Common Assessment Framework – there are new templates, a simplified process and Lead Professional Training delivered to the multi-agency team.

Outcomes to date:

- Currently there are three children accessing specialist CAMHS services. All primary mental health work is being carried out by the multi-agency team.

Next steps:

To work with Commissioner and Provider to consider an integrated offer in 2018/19 to include:

- Roll out Trauma Informed Schools Training
- Clinical Psychologist to attend BLOOM by phone to offer advice and guidance
- Develop ongoing workforce development strategy to increase on-island skills
- Use of technology to deliver therapeutic services
- Shared IT – potential to add module to Children's Social Care recording system for all professionals

3.3 Further Highlights

Further highlights include:

- **Quality Assurance**
  The quality assurance framework and templates have been redrafted to reflect Ofsted's expectations of what 'Good' looks like and to enable non-

social care professionals to audit more effectively.

- **Child Sexual Exploitation**
  The islands activity plan is underway with visits and training to key hospitality providers. Certification is provided to all participants with a sticker designed by a local school child. A survey of young people's understanding is being conducted and school assemblies organised this autumn.

- **Fostering**
  The islands have recruited their first foster carer.

- **Workforce development**
  A knowledge exchange partnership has been developed with Cornwall Council to provide professional supervision to the local team in exchange for auditing, practice development and Independent Chairing. The Family Support Worker participated in the multi-agency Signs of Safety Training and is now an Advanced Practitioner. The Principal Social Worker on Scilly continues to run multi-agency practitioner groups developing a shared language of risk management and support.

- **Local Authority Designated Officer**
  New arrangements are in place to use Cornwall Council's team – this arrangement is working effectively with a very useful Annual Report produced to guide further training and development.

4 Quality Assurance and Performance Framework

4.1 Structure

One of the key objectives of Local Safeguarding Children Boards is:

'To ensure the effectiveness of what is done, by each person or body represented on the Board, for the purposes of safeguarding and promoting the welfare of children in the area'.

Although OSCP has replaced the Local Safeguarding Children Board (LSCB) for Cornwall and the Isles of Scilly it still has the same legal objectives, although these may change when LSCBs are replaced by the new statutory arrangements.

In monitoring this objective the LSCB and OSCP has, over the last three years, used the following means:

- Independent case file audit
- Section 11 self-assessment audit
- Quality Assurance and Scrutiny Panel
- Section 175/157 self-assessments of schools
- Review of inspectorate reports, e.g. Ofsted, Her Majesty's Inspectorate of Constabulary
- Review of reports provided regarding the Local Authority Designated Officer (LADO) role

The LADO report is elsewhere in this annual report. The following sections will outline OSCP's findings from the other measures.

4.2 Independent Case File Audit[1]

The audit was conducted between September and December 2017 and the report outlining its findings was presented to OSCP in January 2018.

By tracking a sample of cases, this practice audit undertook to establish:

- whether the needs of children and young people, where the primary concern was of neglect, were being identified and met appropriately,
- whether children and young people at risk as a result of neglect were being safeguarded effectively, and
- whether outcomes for this group of children and young people were improving as a result of the services provided.

The audit solely focused on practice in Cornwall, as a similar audit had only just been completed on the Isles of Scilly. Twenty cases across a range of complexity and risk were assessed.

The overall assessment of the case audit was that practice required improvement to be consistently good. In six of the cases practice across the partnership was judged to be good. Fourteen of the cases were judged to require improvement.

In twelve of the cases outcomes for the children and young people living with neglect were judged to have not yet improved significantly.

[1] Cornwall and Isles of Scilly LSCB multi-agency practice audit 2017

Of the 10 cases categorised as early help/child in need, only one was judged to be good and there had been some improvement to outcomes in three cases.

Of the seven cases subject to child protection plans two were judged to be good.

Three of the children had come into care as a result of the neglect they experienced and in all those cases outcomes had improved and practice was judged to be good.

Five of the children in the audit sample were 14 years of age or older. Four remained in the community and their outcomes had not improved. Practice was judged to require improvement to be good.

Three of the children and young people had disabilities and complex health needs. In two of these cases outcomes had improved and practice was judged to be good. In the third, outcomes had not yet improved and practice was judged to require improvement to be good.

A series of learning events were held across Cornwall to consider the initial findings, and inform the final report. A number of strengths were identified and these included the recognition of neglect as a priority across and within organisations, a developing strategy with an emerging set of appropriate tools, established multi-agency working relationships and respect, prompt identification and assessment of the risks and good direct work with children and their families.

The key areas for improvement were identified and these included the tools not being fully understood and utilised, assessments and plans not always involving the organisations that were relevant to the child, the under-use of chronologies, stronger analysis in relation to the reasons for the neglect and the viability of change and support from supervisors.

The report was extremely useful for OSCP and has led to the Neglect Task and Finish Group being re-established. The task and finish group is due to add continued momentum to improvements in our response to neglect. The findings were taken into account in the design of the new training contract and OSCP's business plan for 2018/19.

The Learning Lessons Workshop in November 2017 focused on neglect to correspond with the audit being undertaken. A bespoke workshop for the Isles of Scilly is scheduled for early autumn 2018.

4.3 Section 11 Self-Assessment Audit

The Section 11 audit process for 2017/18 was changed due to a streamlining of OSCP's quality assurance processes. The Section 11 self-assessment largely duplicates the Quality Assurance and Scrutiny Panel process and it was agreed those organisations who had been or were due to appear before a panel should not have to complete this self-assessment. The process was therefore completed by the following organisations:

- Cornwall Council – Adult Social Services
- Cornwall Council – Customer and Support Services
- Cornwall Council - Economic Growth and Development
- Cornwall Council – Neighbourhoods

- Dorset, Devon and Cornwall Community Rehabilitation Company (CRC)
- Group of Companies – Cornwall Housing Limited, Cornwall Development Company, CORMAC and Cornwall Airport Limited
- National Probation Service (NPS)
- South-Western Ambulance Service NHS Foundation Trust

A review of the submitted documents was undertaken by a multi-agency group of safeguarding professionals.

The self-assessment consisted of 11 questions relating to OSCP priorities and other key topics, these were:

- Child sexual exploitation (CSE)
- Missing children
- Domestic abuse
- Wishes and feelings of children
- Emotional health and wellbeing
- Neglect
- Identification of safeguarding concerns
- Case auditing
- Performance management of safeguarding
- Promotion of safeguarding
- Training

A significant amount of effort had been put into completing the self-assessments although the quality was variable. A number of the organisations had spent time carefully considering each subject area and their answers reflected the care they had taken. Others had clearly spent less time and an amount of 'cut and pasting' was identified. This was disappointing in the amount of thought that had been given and the lack of progress that had been made.

The review was conducted later than normal this year due to an earlier meeting postponement. Individual feedback is due to be provided in respect of all submissions.

Overall the self-assessment demonstrated continued improved responses to CSE and children going missing. All organisations see this as a priority and large numbers of staff across a wide range of services have been trained. There is a commitment to continue with the progress made thus far and new ideas are still being generated.

Domestic abuse remains a priority for all organisations and additional measures were identified within the self-assessments. A number of organisations have focused on supporting their own members of staff and in so doing recognise the opportunity to help their children.

The response to emotional health had improved again, with a number of new ideas to help and support children. Many of the organisations now covered by the Section 11 self-assessment have limited direct involvement with children although it was gratifying to see they still considered how their service could benefit the emotional wellbeing of children.

The response to neglect was a much improved subject and it was clear that a lot of training had been undertaken since 2016/17. Staff are now more aware of the signs and have a better understanding of what to look for and where to concentrate their efforts.

The identification of safeguarding concerns is sound across all organisations and, in particular, within Cornwall Council the use of safeguarding advocates is seen

to be good practice for developing knowledge and promoting confidence within teams of workers.

The promotion of safeguarding was found to be inconsistent. Some organisations had thought of new ways to promote safeguarding and others had not. It was felt that some organisations had largely stood still while thankfully others had been creative.

Training was found to be variable for the second year running. The commitment to train staff was actively promoted but this was not always borne out by the record keeping or the numbers of staff trained. Performance information was missing in some organisations, a number of organisations had reached their targets and others had not. Some organisations monitor their training outcomes whilst others do not. This is concerning.

Members of the review team were positive with their findings in that safeguarding is seen as important and recognised as a priority. It was agreed that some organisations have not developed as much as they could and more momentum is required. This information will be communicated to the relevant lead officers.

On reflection the Section 11 self-assessment process itself was found to require amendment. The layout and similarity to previous years may lead to not enough consideration and the tendency to 'cut and paste'. This is an area we will seek to improve for 2018/19.

4.4 Quality Assurance and Scrutiny (QA&S) Panel

The methodology for the panel, as outlined in previous years, has largely remained the same. The only key change that has been made is that OSCP members agreed, by a majority, to remove the grading aspect from the assessment and the report. No grades have been awarded since May 2017. The report will reflect simply on the findings of the panels.

Over the course of the business year the following organisations were subject of the full QA&S Panel process.

- Royal Cornwall Hospitals NHS Trust (RCHT)
- Cornwall Council – Children and Family Services (CFS)
- Cornwall Council – Education and Early Years
- Isles of Scilly (multi-agency panel)
- University Hospitals Plymouth NHS Trust

In addition the following themed panels were undertaken:

- Domestic Abuse/Sexual Violence
- Emotional Wellbeing and Mental Health

Individually all those organisations who had previously appeared before a panel were found to have improved since their last appearance. CFS was the last organisation to be graded and was assessed as 'Good'. The Isles of Scilly as a multi-agency group were found to be highly effective and would have been assessed as 'Good' if grades were still attributed.

All of the organisations were found to be effective although a small number of areas for improvement were identified. This was extremely reassuring and pleasing.

In relation to the topics examined at the panels the observations are as follows:

Child Sexual Exploitation (CSE)

The response to CSE has continued to improve and the overall system is now robust and well supported. All organisations have ensured their staff have received training and the training has become more focused and complex. Training to enable staff to engage more effectively with children who are thought to be resistant is a good example.

Positive developments, including the systematic consideration of civil orders and more timely return home interviews, have helped to improve the response.

The number of referrals has increased and the systems to manage the referrals are better resourced. The introduction of an outcomes framework has ensured regular performance management and is providing a meaningful oversight of the quality of the work being undertaken. This is leading to other improvements being made.

The situation in Cornwall and the Isles of Scilly is stable with CSE seen as a routine aspect of child safeguarding. The systems and processes are straightforward. The professional response has improved and there are plans to develop it further. There is one concern, that being the lack of case auditing undertaken and there are plans for regular audits to be completed.

Domestic Abuse

Domestic abuse is still seen as a priority for the Community Safety Partnership, Safer Cornwall, and all organisations across OSCP. This has led to staff being trained and supported. Systems have been put in place to support victims and their children.

Strategically, the focus on children has improved and more clearly than ever there is recognition of the harm children suffer as a result of the abuse they encounter or indirectly receive.

The referrals made in response to domestic abuse are prompt and thorough but the worries, previously expressed, over organisations understanding the difference their efforts are making to children's lives remain.

Neglect

This is an area where improvements have been made across all organisations and throughout multi-agency working. It has been treated as a priority and many staff have been trained. The recognition of neglect is improving and the number of referrals has increased.

Although OSCP's strategy has been adopted and committed to, there are gaps in practical understanding and how the new tools can be used to help children. Further work is required to make sure our front-line practitioners are making the difference to children's lives that we intend.

Emotional Health and Wellbeing

It appears that 2017/18 has seen improvements and new plans that show the promise of a much better multi-agency response in the future. Individual organisations have been conducting outstanding work in supporting children with emotional wellbeing and mental health needs. There are other initiatives underway to improve the emotional resilience of our children.

The plans to open an in-county in-patient mental health facility in April 2019 is a big step forward and one that is seen as an opportunity to improve the overall response. There are further plans to improve the support of children not likely to access specialist mental health support.

It is accepted that many of these plans have to be realised but this is a stronger position than we have been in for a number of years and there is justifiable optimism.

Child Sexual Abuse

This is the subject where the most needs to be done. It is agreed across all organisations that there may be child victims of sexual abuse who are not being recognised. Equally it is felt children could be provided with more preventative advice to stop the abuse in the first place.

When children are identified there has been confidence that the response is prompt and effective. Case audits, however, have identified some gaps regarding the consideration of medical support and this has led to remedial action being taken.

All organisations are committed to improving the current situation and a task and finish group has been established to make this happen.

Feedback has been provided and OSCP has learnt that improvements have already been made. The Partnership will closely monitor this aspect over future quality assurance processes.

Overall Progress

The panel provides an objective means of measuring performance across an extended period of time. As mentioned earlier it has been identified, through the panels, that all individual organisations have improved and a number are high performing.

The areas where gaps have been identified are known and actions are in place to address them. None are considered to be serious at this time.

4.5 Section 175/157 Self-Assessments of Schools

The review of the Section 175/157 safeguarding self-assessments was undertaken by Cornwall Council's Education and Early Years Service.

The outcome of the process gives Cornwall Council and OSCP an overview of the key strengths and areas of development in relation to schools across Cornwall.

The quality assurance process was commissioned by Education and Early Years and undertaken during the Summer Term and the early part of the Autumn Terms 2017.

The self-assessment was amended from the previous year's to include sections regarding equality and diversity and children missing from education. The overall format and style did not change. Schools have reported that, although the self-assessment was beneficial and helpful, it was lengthy and repetitive. This feedback has been reviewed and changes have been made for 2018/19.

The results from the 2017 review are as follows:

- There was a 100% return from all 31 secondary and 235 primary schools.

- Every school was provided with feedback highlighting strengths, areas of improvement and recommendations.
- Eight independent schools responded, two more than in 2016.

The other education establishments that responded were:

- Five Islands School, Isles of Scilly
- Two higher education establishments
- Six alternative provision academies
- The virtual school
- Three 'specialist' schools
- Three Bridges – Spectrum
- Oak Tree

The submissions, on the whole, were detailed with many schools providing action plans that demonstrated good use of the self-assessment across the full range of school activities.

There were only two primary schools where significant concerns were highlighted due to a lack of information contained within the self–assessment. As they were both from the same multi-academy trust feedback was given to the safeguarding lead to deal with.

One of the independent specialist schools was given feedback and support about the need for more detail within their self-assessment.

4.6 Review of Inspectorate Reports

OSCP was fortunate in 2017/18 to have a number of inspections conducted by statutory inspectorates. These included:

- Care Quality Commission inspection of Royal Cornwall Hospitals NHS Trust 4 – 7 July 2017, published 5 October 2017
- Care Quality Commission inspection of Cornwall Partnership NHS Foundation Trust (CFT) 25 – 29 September and 3 – 5 October 2017 published 2 February 2018.
- Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) inspection of the Devon and Cornwall Police 'PEEL: Police Effectiveness 2017', published March 2018.
- Joint Ofsted/Care Quality Commission inspection of Special Educational Needs and Disability (SEND) in Cornwall 3 – 7 July 2018, published 18 August 2017.

In respect of the Care Quality Commission (CQC) inspection of RCHT the inspectorate rated the trust as inadequate overall. Surgery, maternity and gynaecology, end of life and outpatient services were rated as inadequate and critical care and children and young people's services were rated as good. The ratings were aggregated with the findings from the core services inspection of January 2017.

Significant concerns were expressed regarding Maternity Services and issues were raised regarding the staffing of the Paediatric Section of the Emergency Department (ED).

Safeguarding was found to be effective in all those areas where it was reviewed, including Maternity Services.

The publication of the inspection report led to a visit to RCHT from OSCP's Independent Chair. He was given information regarding the plans to address the issues, particularly within ED and Maternity Services. The ED issues have been addressed. RCHT is due to appear before OSCP's Quality Assurance and Scrutiny Panel in July 2018.

In respect of the CQC inspection of CFT the inspectorate rated the trust as requiring improvement due to a number of reasons, the relevant one for OSCP being, *'In the specialist community mental health services for children and young people there was not enough provision of service to provide a safe service for the numbers of children and young people needing care'.*

The more detailed comments in the report indicated *'the specialist community mental health services for children and young people service (CAMHS) received more referrals than it could safely work with. The thresholds for accessing the service had been raised by the trust following discussion with commissioners and so children and young people had to be seriously ill before receiving a service. Out of hours support was limited for children and young people and those using the service did not have access to specialist psychiatric support outside of core service hours. The service was not meeting its waiting time targets, with one young person waiting five months for treatment'.*

It noted that *'policies and procedures were in place to support the safeguarding of vulnerable adults and children. The trust had a robust training programme for safeguarding'.*

In response to the CQC report OSCP has sought reassurance from CFT and the commissioner of its CAMHS. A response plan has been developed which is being worked upon. OSCP is satisfied with the plan and how its progress is being monitored. OSCP will continue to monitor progress and oversight.

Within HMICFRS's inspection of the Devon and Cornwall Police it commented as follows in respect of the force's ability to identify vulnerability:

'Devon and Cornwall Police has a good understanding of the nature and scale of vulnerability across the force area. It sees the protection of vulnerable people as a priority and as a central component of its 'mission'. The force defines a vulnerable person as anyone who has been, or is believed to be, at risk of harm, abuse or exploitation following the consideration of their individual circumstances and who is, or may be, in need of support or intervention. Our inspection found that the force has put in place effective ways of agreeing priorities, plans and decisions to co-ordinate responses to vulnerability, with a clear focus on protecting people from harm. Staff who we spoke to in different parts of the force demonstrated good levels of knowledge about differing types of vulnerability. People in the workforce are also knowledgeable about how their roles can help achieve better results for vulnerable people'.

In respect of initial action it reported:

'Devon and Cornwall Police is generally effective at identifying vulnerability when officers and staff are first deployed to incidents, but some procedures need to improve. Officers take immediate steps to protect people from harm when they first arrive at the crime scene. The standardised risk-assessment tools that they use to determine whether vulnerable people need specialist safeguarding support from other organisations include the vulnerability screening tool (ViST), the domestic abuse, stalking and harassment (DASH) risk assessment and the victim needs assessment (VNA)'.

Concerns were raised over some aspects of its recording system, the quality of

crime investigations and how it responds to domestic abuse crimes. The key area of improvement from OSCP's perspective is:

'The force should improve the quality of investigations involving vulnerable people, ensuring that the workloads of specialist investigators are manageable and that such investigations are subject to regular and active supervision'.

OSCP is monitoring the police's response to the relevant comments within the report through its Quality Assurance processes.

The SEND inspection letter stated:

'Leaders and managers from education, health and care drive the local area's strategic direction as outlined in the 'One Vision' plan. They are ambitious to improve outcomes for children and young people who have special educational needs and/or disabilities (SEND) and are delivering improvements despite reducing resources and an increasing demand for services. Local area managers know their children and young people well and take seriously their responsibilities for children's safety and safeguarding. Where a safeguarding concern is raised, they respond swiftly and appropriately'.

'The close professional relationships demonstrated by partners working with early years children and in support of children and young people looked after are a strength of the local area'.

However it stated:

'Children and young people who have autistic spectrum disorder (ASD) are not currently well served by the local area. In the most extreme cases, children and young people were waiting for an assessment of need or diagnosis for over two years.

On too many occasions, communication with parents of children and young people who have ASD is poor, or schools fail to demonstrate an understanding of the needs of the individual child or young person.

The provision for many children and young people who have poor emotional and mental health is limited: too many experience lengthy delays in being seen by specialist services'.

OSCP has recognised the positive comments within the letter and has taken steps to monitor how the local organisations are responding to the areas for improvement identified. It is aware of the plans created in response and is monitoring the progress being made.

4.7 Conclusion

OSCP has been able over the past twelve months to gain a detailed and accurate perspective of the quality of safeguarding activity at both individual organisation and multi-agency levels. Its own efforts have been supported and added to by the work of those organisations and by external scrutiny. This has brought a number of different viewpoints together to create a robust and triangulated assessment.

This is much easier on the Isles of Scilly but allows OSCP to have greater confidence in the accuracy of its oversight. From its assessment OSCP assesses that the overall child safeguarding performance across the islands is good. Children and young people in need of help and support are

readily identified and services respond promptly and effectively. The voice of children is actively sought and is listened to. The services have been good for a number of years and there are no obvious threats to this situation.

Cornwall is not so easy to assess but OSCP feels it has achieved a comprehensive and reliable understanding of performance. The child safeguarding activity is assessed as effective with many good features. The strong multi-agency cooperation based on meaningful professional relationships has continued and the level of improvement reported last year has continued. Children continue to be at the centre of safeguarding efforts and their voices are actively listened to across all key organisations. A number of issues have been identified through OSCP, individual organisations and the inspectorates. The findings are transparent, openly discussed and have been responded to. Some have been resolved and others are still being addressed. OSCP will continue to monitor progress and challenge when it feels progress has not been made or is too slow.

5 Priorities of the Safeguarding Children Partnership

5.1 Principles

Child safeguarding involves a large number of different organisations and is a complex area of activity. It is important that OSCP establishes clear principles and objectively decides upon its priorities for each and every business year.

In establishing our principles it was agreed that they should be universal, child focused and committed to by all organisations. They are:

- Children are at the centre of our efforts
- Visible to all stakeholders across Cornwall and the Isles of Scilly
- Planning based on good quality information and effective analysis
- Effective governance arrangements and operating structure
- Links and clear accountability with other strategic groups across Cornwall and the Isles of Scilly
- A culture of challenge
- Learning is embedded in all agencies and within multi-agency practice
- Authoritative oversight of the quality of performance across agencies, singly and multi-agency
- Understands how it is affecting the quality of performance

5.2 Information

The following information was reviewed in determining what our priorities should be:

- Feedback from the partnership
- Review of joint strategic needs assessment
- Outputs from the previous business plan
- OSCP planning meetings
- Board scrutiny panel
- Serious case reviews – local and national
- Inspection reports

5.3 Priorities for 2017/18

This allowed OSCP to determine the priorities as:

- To prevent and respond to child sexual exploitation
- To prevent and mitigate the impact on children of domestic abuse
- To prevent and respond to child sexual abuse
- To prevent and respond to the neglect of children
- To provide a multi-agency response to children and young people with emotional / mental health difficulties
- To develop the support, scrutiny and challenge role of the SCB

The priorities were largely the same as 2016/17 with the exception that child sexual abuse was separated from domestic abuse as it was felt they needed to be two separate categories. Although the subjects are linked within the Community Safety Partnership it was agreed they are two very different subjects when it comes to children and young people.

6 Safeguarding and Child Protection Activity

6.1 Overview

The implementation of the Signs of Safety model as a framework for practice in the protection of children is at the heart of our mission to improve outcomes for children and families in Cornwall.

Through embedding the Signs of Safety model in the Child Protection Conference process, the voice of the child and of parents/carers, and their views are significantly more evident, informing decision-making and safety planning.

The role of a Child Protection Conference is to bring together the family and professionals in an inter-agency setting, to analyse relevant information and plan how best to safeguard and promote the welfare of the children.

It is the responsibility of the multi-agency conference to make recommendations on how agencies work together to safeguard the children.

6.2 Practice Quality Standards for Multi-Agency Child Protection Conferences

Child Protection Conference Chairs have continued to monitor the quality of the child plans provided for the conferences and multi-agency co-operation using Practice Quality Standards.

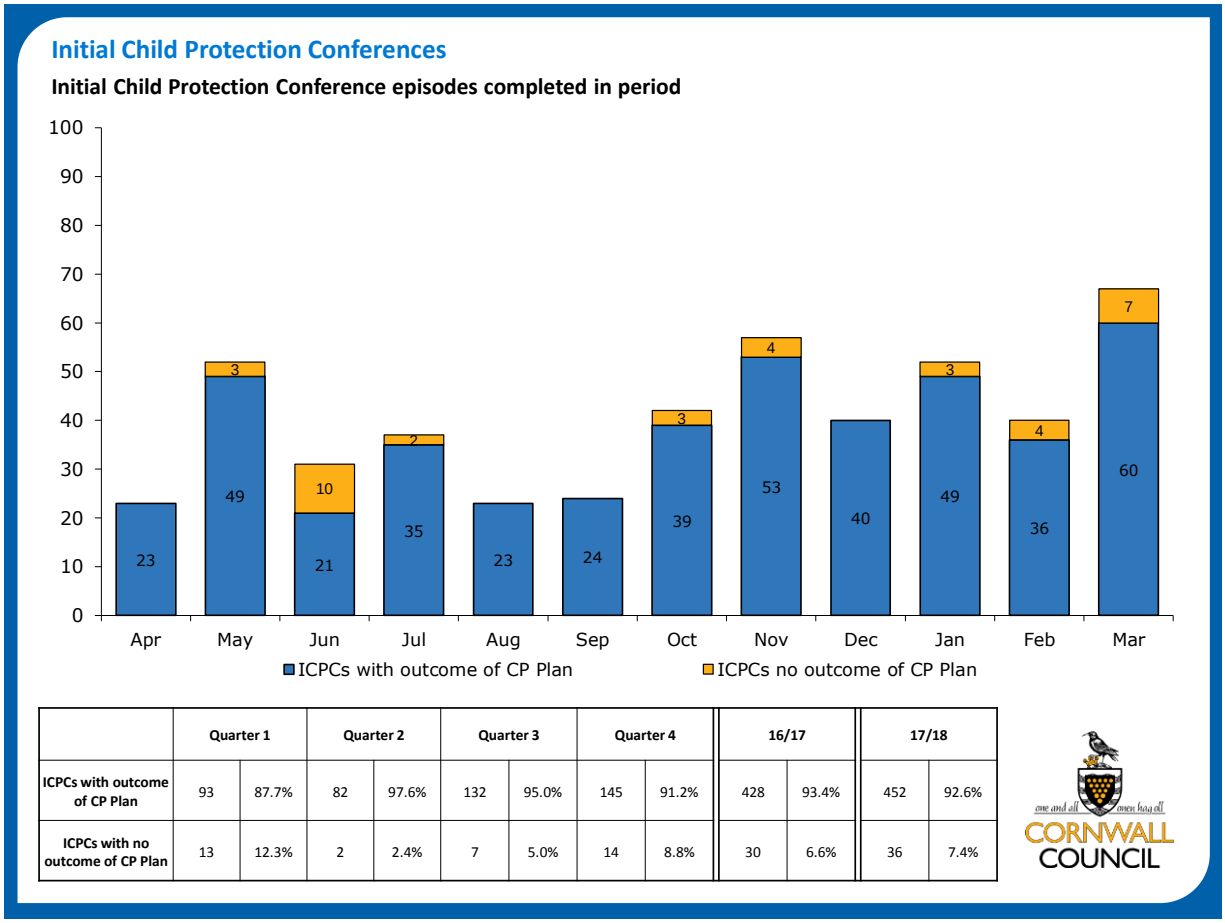
The Practice Quality Standards have been reviewed and adapted following consultation with partners and practitioners during the past year to ensure they are more purposeful and focus on outcomes for children.

The new standards were ratified by the Board in Spring 2018. The new standards will apply from 2 July 2018.

6.3 Relevant Statistics

The graphs below provide details of the number of Initial Child Protection Conferences that were held during the 12 month period and the number of open Child Protection Plans at the month end.

Initial Child Protection Conferences

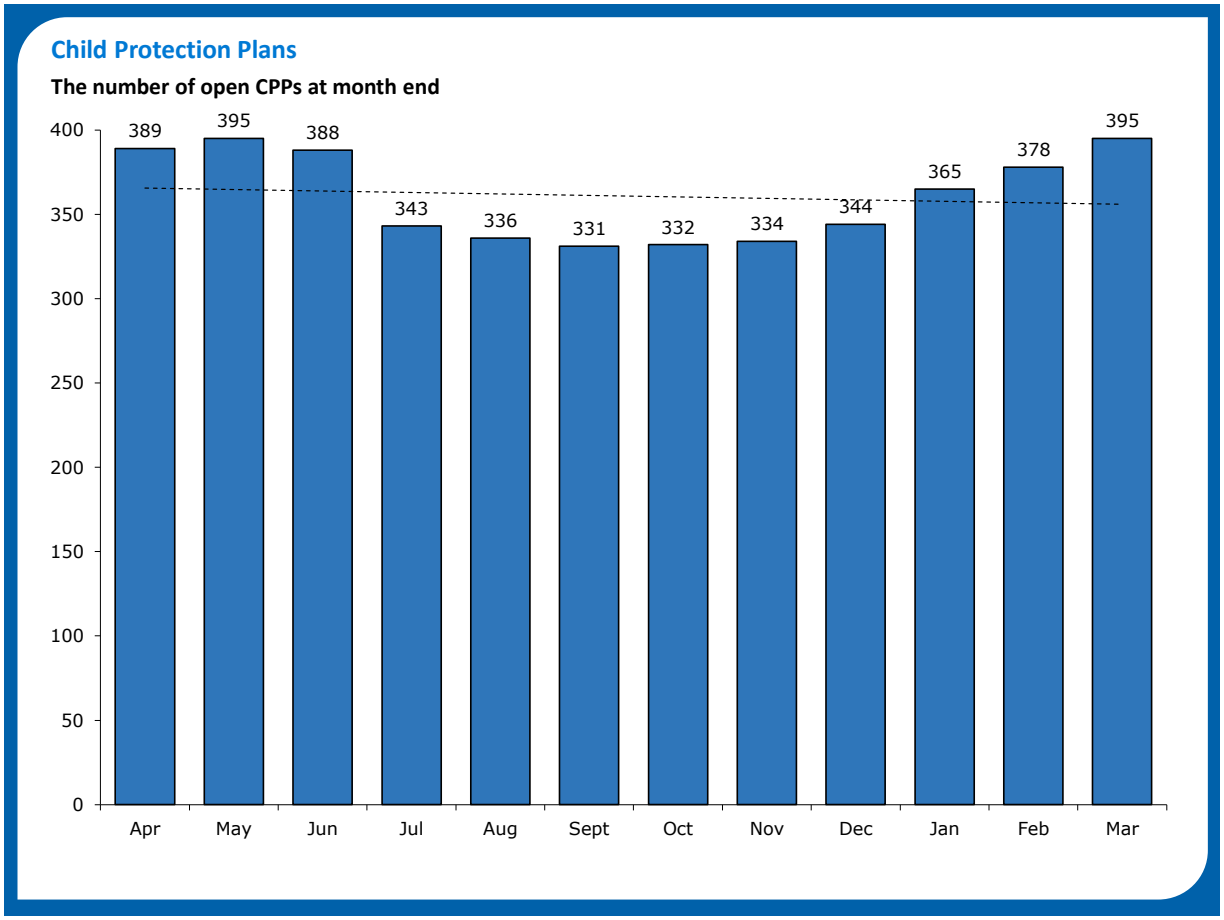


	Quarter 1		Quarter 2		Quarter 3		Quarter 4		16/17		17/18	
ICPCs with outcome of CP Plan	93	87.7%	82	97.6%	132	95.0%	145	91.2%	428	93.4%	452	92.6%
ICPCs with no outcome of CP Plan	13	12.3%	2	2.4%	7	5.0%	14	8.8%	30	6.6%	36	7.4%

During 2016/17 there were in total 458 requests for ICPCs and in 2017/18 there were 30 more requests namely 488, which is an increase of 6.1%.

The number of ICPCs dropped during the school holidays in August and September. There were also fewer requests for ICPCs during December. There has been a significant spike in ICPCs requests during March.

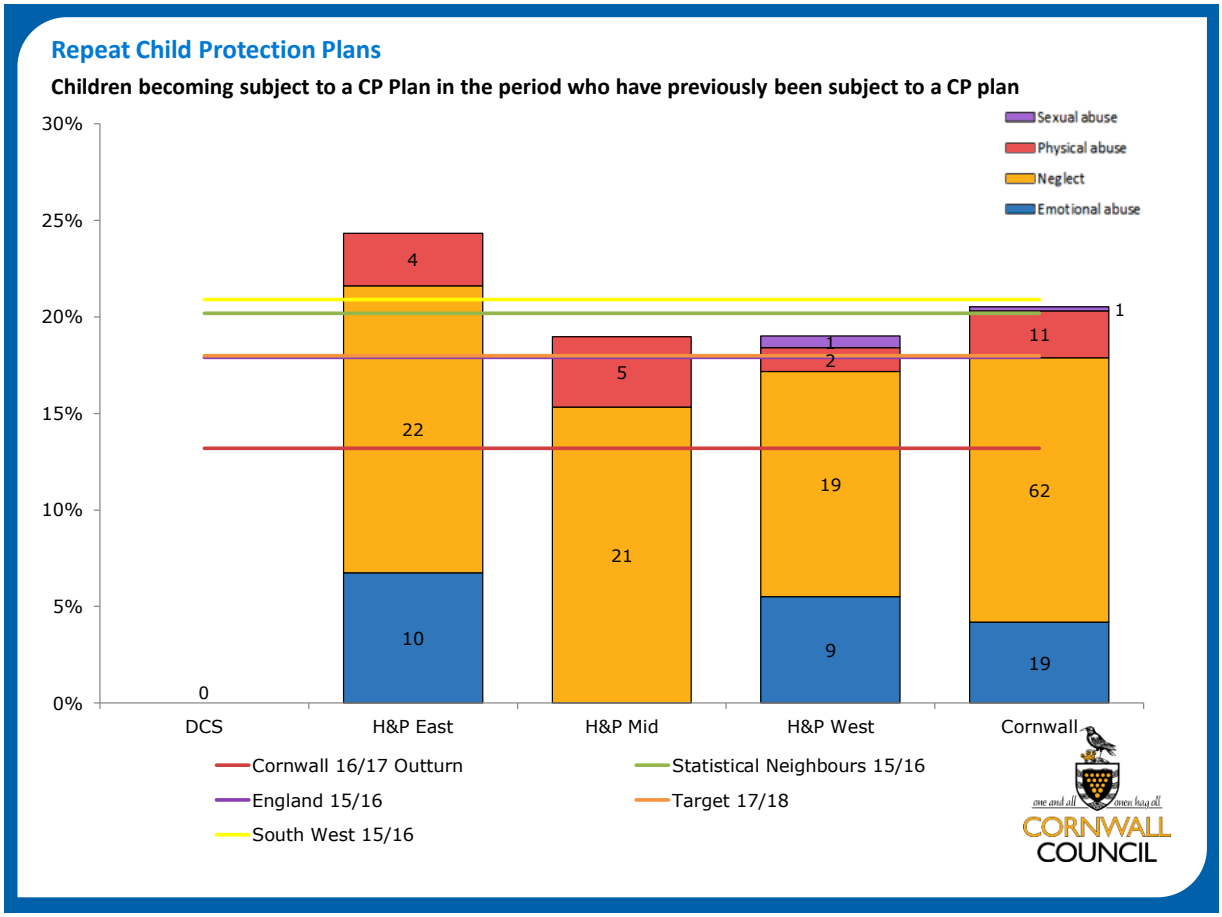
The number of open Child Protection Plans at month end



The numbers of open Child Protection Plans at month end significantly dropped during July 2017 to 343. Since October 2017 there has been a steady increase of numbers until March 2018, with 395 open Child Protection Plans.

The graphs below provide details of the number of repeat Child Protection Plans and children made subject of a Child Protection Plan for the second time.

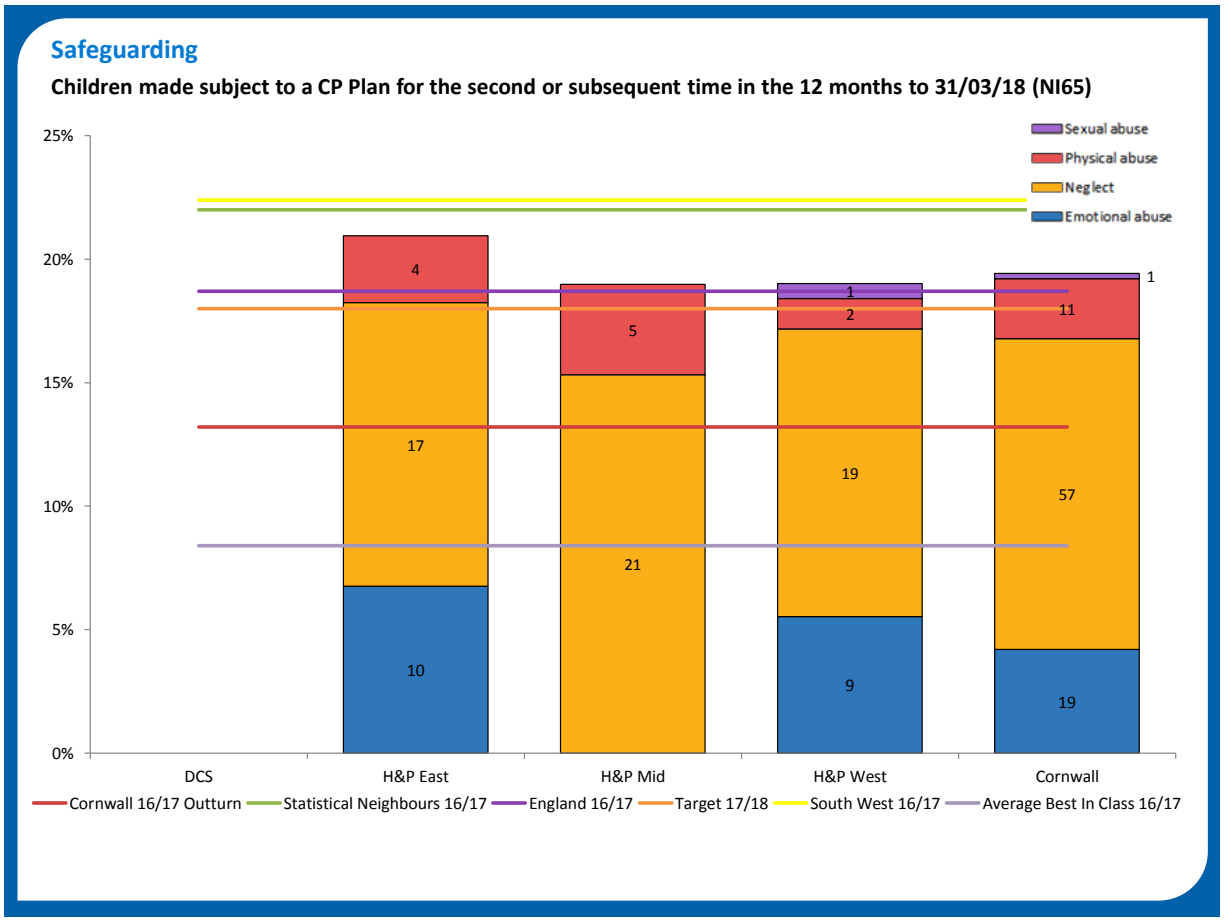
Repeat Child Protection Plans



The repeat Child Protection Plans are slightly higher in the East of the county. Of note is that the category 'at risk of sexual abuse' remains low. Two thirds of children are subject to CP Plans due to neglect which may reflect the endemic nature of neglect. Neglect has been a focus for OSCP including the independent audit undertaken in respect of neglect looking at effective change.

Repeat Child Protection Plans are lower than the South West and on a par with Statistical Neighbours. The number is above last year's and our target. This is an area for the Partnership to consider in 2018/19.

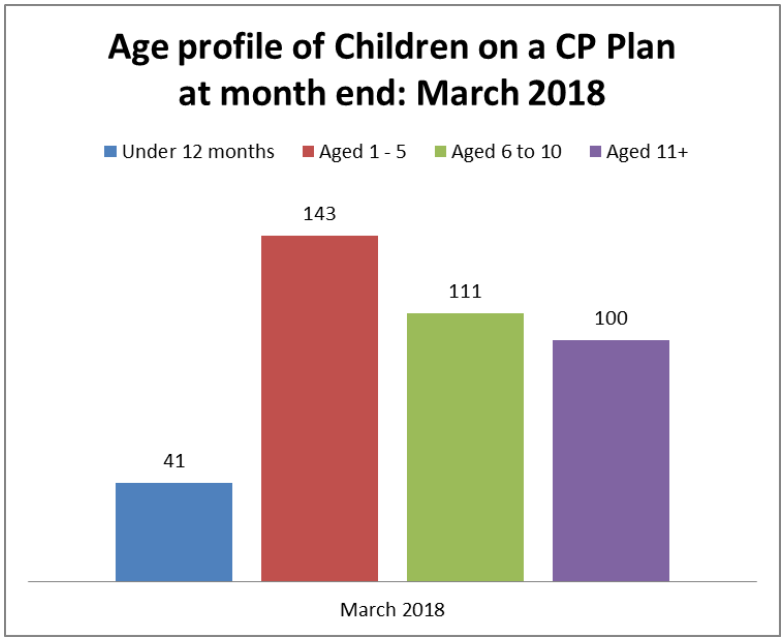
Children made subject to a CP Plan for the Second or Subsequent time in the 12 months to 31/03/18



The performance indicator for Second and Subsequent Child Protection Plans enables us to determine whether the families achieved and sustained sufficient change to protect their children. It can also give an indication as to whether the plan of support was successful and the support following the ending of a Child Protection Plan met the needs of the child and his/her family.

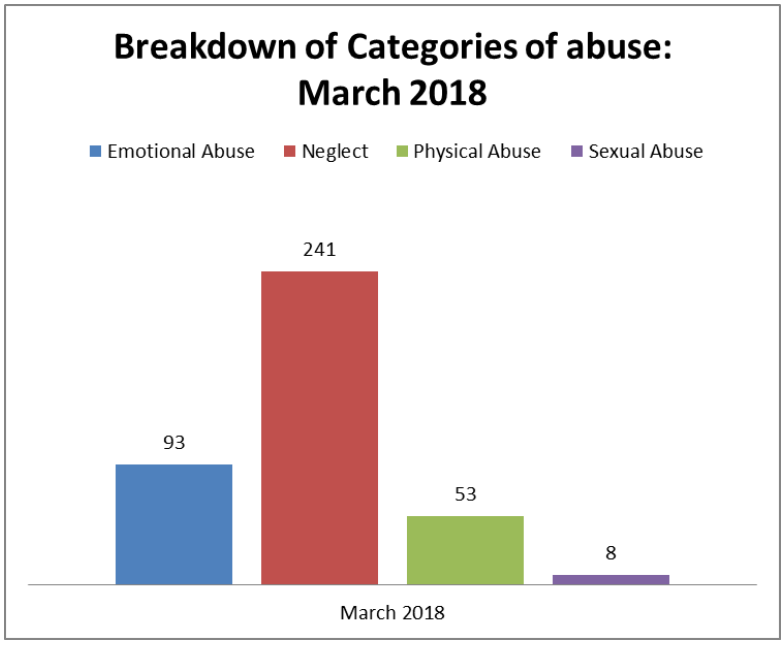
There are more children subject to a Child Protection Plan for a second or subsequent time in 2017/18 than in the previous year, although we are close to our target. The number is lower than the South West and our Statistical Neighbours, but higher than the high performing authorities we use to benchmark practice. This will still be an area for consideration for the Quality Assurance and Performance Sub-Group.

Age Profile of Children on a Child Protection Plan



Most of the children subject to a Child Protection Plan at month end March 2018 were in the age range of 1–5 years with the second highest in the age range 6–10 years.

Breakdown of Categories of Abuse



While reflecting the trend of national data, it is of note that the number of children who have a plan for child sexual abuse is low. In recognition of this, the Board convened a Task and Finish Group to review this trend and to improve the multi-agency approach across a number of themes including prevention, practitioner awareness and immediate response.

6.4 Next Steps for 2018/19

1. Ensure that the voice of the child and the child's lived experience inform the analysis of harm, danger, strengths and safety, decision-making and safety planning.

2. Promote consistency in the practice of the multi-agency partners during Child Protection Conferences continuing to embed the Signs of Safety as the core approach.

3. Consistent application in quality assuring practice against the multi-agency partners' agreed standards. Develop and promote the shared understanding of what 'good safety planning' looks like.

7 Child Death Reviews

7.1 Child Death Reviews

The child death review processes for Cornwall and the Isles of Scilly are part of a larger set of arrangements that cover the Devon and Cornwall peninsula. OSCP works with Devon LSCB, Torbay LSCB and Plymouth LSCB to jointly commission a service that reviews child deaths across a population of in excess of 1.8 million people.

For the 2017/18 business year there were 99 deaths of children and young people across the South-West peninsula, an increase of six on the previous business year. Of the 99 deaths, 32 related to children and young people from Cornwall and the Isles of Scilly. This is an increase of seven deaths from 2016/17.

During 2017/18 86 deaths of children and young people were reviewed at child death overview panels. Twenty of those deaths related to children and young people from Cornwall and the Isles of Scilly. Of those 20 deaths, four were assessed as modifiable[2] (20%).

From the panels a number of issues have been identified and within Cornwall and the Isles of Scilly the following action has been undertaken.

7.2 Sudden Infant Deaths (SID)

OSCP has continued to work with Public Health over a range of approaches that are all seen to support SID prevention. These include smoking prevention, safe sleeping advice and advice over heat and swaddling. Maternity and Health Visiting Services are still focused on SID reduction and provide routine advice to all parents. It remains a focus of Public Health.

7.3 Palliative Care

The provision of Palliative Care previously reported as a concern has significantly improved with better communication with parents, improved inter-agency cooperation and families reporting fewer concerns. It is reassuring to see such an important service improve so positively.

7.4 Suicide

Suicides continue to be a concern although there is no increase in numbers. The suicide prevention and response strategy remains in place and is assessed as effective. OSCP continues to work with Public Health regarding its currency and relevance to children. OSCP is satisfied that it is effective for the children of Cornwall. Due to small number of children on the Isles of Scilly and the broader way of working on the islands, OSCP is satisfied that the response to suicide would be as effective as its other child safeguarding activity.

[2] The panel has identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths

8 Learning from Experience and the Serious Case Review Recommendation Panel

8.1 Learning from Experience

In September 2016, following a recommendation by OSCP's Serious Case Review (SCR) Recommendation Panel, the Independent Chair commissioned a 'Learning from Experience Review' in respect of the death of Child A.

Although there had been effective multi-agency involvement with this family and communication between professionals (and therefore did not meet the criteria for a Serious Case Review), it was felt that there were potential lessons. All agencies participated in this review with the exception of Adult Mental Health.

Key Findings

There were nine key findings from the review, set out in OSCP's action plan under the following headings:

1 Use of the Signs of Safety model
2 Professionals' use of overarching terms
3 Use of Devon and Cornwall Police information by partners
4 Referrals and the Multi-Agency Referral Unit (MARU)
5 Representation at key multi-agency meetings
6 Attendance of parents at child protection conferences
7 Professionals across agencies working below the social care threshold.
8 Working with parents with mental health or development difficulties
9 Assessment and analysis

Immediate actions were taken in respect of some findings; including administrative systems for attendance at case conferences, and clarity of agency responsibility in communications such as the status of advice and guidance from the MARU vis a vis designated safeguarding leads in the different agencies, and use of Child at Risk Alerts (CARA) and Vulnerability Information Screening Tools (VIST) from the Police.

An action plan agreed by OSCP is in place, with clear tasks for individual agencies, OSCP and sub-groups across all agencies. The Learning Group has actioned recommendations with regard to learning, including the Learning Lessons Workshop held in February 2018, and the inclusion of key lessons from the Review in the newly commissioned OSCP Training Contract. The Quality Assurance and Performance Group has been tasked to audit and monitor compliance with the learning across all partners.

8.2 Serious Case Review Recommendation Panel

Regulation 5(1)(e) and (2) of the Local Safeguarding Children Boards Regulations 2006 set out an LSCB's function in relation to serious case reviews, namely:

5(1)(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

5(2) for the purposes of paragraph (1)(e) a serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either:
(i) the child has died; or
(ii) 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.

Cases which meet one of these criteria (i.e. regulation 5(2)(a) and (b)(i) or 5(2)(a) and (b)(ii) above) must always trigger a serious case review. In addition, a serious case review should always be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children's home, or where the child was detained under the Mental Health Act 2005. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide.

Where a case is being considered under regulation 5(2)(b)(ii), unless it is clear that there are no concerns about inter-agency working, the LSCB must commission a serious case review.

The final decision on whether to conduct the serious case review rests with the LSCB Chair. If a serious case review is not required because the criteria in regulation 5(2) are not met, the LSCB may still decide to commission a serious case review or they may choose to commission an alternative form of case review. (*Working Together - 2015*)

The SCR Recommendation Panel is made up of Board representatives from the partner agencies, and is chaired by the Head of Service, Practice Development and Standards. Information is provided by all agencies involved with the child and family, and agency representatives can be called on to present information as required. The SCR Recommendation Panel advises the Independent Chair who holds the decision as to whether a serious case review should be commissioned.

There were two SCR Recommendation Panels held in December 2017 and February 2018. Both related to the death of children under two years of age. The panel agreed that the criteria for recommending a serious case review had not been met in either situation, and they were unanimous in agreeing that no recommendation for a serious case review, or any other multi-agency learning review, should be made to the Independent Chair of the Safeguarding Children Partnership. The Independent Chair agreed that the criteria for recommending a serious case review had not been met in either situation.

New arrangements for notifying serious incidents and information to the National Child Safeguarding Practice Review Panel

From 29 June 2018, the National Child Safeguarding Practice Review Panel becomes fully operational. From that date, local authorities will be required, under a new statutory duty, to notify the Panel of incidents where they know or suspect that a child has been abused or neglected and:

(a) the child dies or is seriously harmed in the local authority's area; or

(b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England.

These notifications should be made within five working days of the local authority becoming aware of the incident. The local authority should also report the incident, within the same five working days, to the relevant LSCB, or to the new local safeguarding partners when they become established.

The new Panel will, as part of its role in considering whether to commission national reviews, also consider LSCBs' decisions on the initiation and publication of serious case reviews.

LSCBs should, therefore, now send all information about decisions not to initiate or to publish a serious case review to the new Panel at Mailbox.NationalReviewPanel@education.gov.uk

9 Partnership Sub-Groups

9.1 Learning Group

In September 2017, the newly appointed Head of Practice Development and Standards and Principal Child and Family Social Worker from Children and Family Services became the Chair of the Learning Group.

Since September, there have been five main areas of focus for the Learning Group:

Training Provision

For 2017/18, OSCP's training programme was provided by Reconstruct. They had provided the training for a number of years and continued to do so through extensions of the contract while the new training was commissioned and procured.

Reconstruct presented their annual report to the Board in spring 2018 https://www.cornwall.gov.uk/media/34332095/reconstruct-annual-report-2017.pdf

The Learning Group recognised that custom and practice had evolved whereby the Level 3 training was not being accessed by the appropriate practitioners and supervisors across the partnership. Each agency committed to redressing this practice in their own service. This has involved agencies being clear about their responsibility for Level 1 and Level 2 safeguarding training, and the requirement for their staff to have completed that before accessing Level 3 training.

Representatives from across the partnership worked together to develop a new specification for Level 3 Multi-Agency Safeguarding training and to evaluate the bids submitted by potential providers. After this initial procurement exercise was unsuccessful in awarding the contract, the Learning Group proposed an alternative approach which would recognise that training providers have differing areas of expertise. It would also enable OSCP to have greater direct influence on the provision of training. A new specification was written by the multi-agency group to commission up to 50 one-day Level 3 Working Together to Safeguard Children courses each year. This included evening and weekend sessions and a session on the Isles of Scilly. The contract for this training was awarded to Family Action at the end of March 2018 and the delivery of training began in June.

OSCP Conference

This year the conference was on the theme of 'The Ages and Stages of Emotional Health and Wellbeing'. It brought together professionals working with children at different ages and stages in Cornwall and the Isles of Scilly, and further afield. It was a tremendous opportunity to learn from each other and to reflect on what we can do differently as individuals and as organisations to improve outcomes for children and their families.

Our keynote speaker was Dr Margot Sunderland, Director of Education and Training at The Centre for Child Mental Health. Dr Sunderland's address on Trauma Informed Schools highlighted the benefits to children, making clear why this is an important development in Cornwall.

Focussing on emotional health and wellbeing at different developmental stages were key speakers on:

- Perinatal mental health and the emotional wellbeing of very young children,
- The I-Thrive Framework,
- The Wave Project and the value of Surf Therapy,
- Supporting the emotional wellbeing of college students.

The conference was well attended with 135 colleagues attending from health, schools, early years settings, social care, the police and voluntary organisations.

The conference was conceived, developed and organised by a sub-group of the Learning Group which was a break from the previous process of commissioning the training provider. This proved very successful and will be the process by which the 2019 conference is arranged.

Learning Lessons Workshops

The Learning Lessons Workshops continue to be well attended by a wide range of partners. The themes for the workshops are determined by the Learning Group, and are in response to relevant priorities for the partnership, and both local and national learning. A summary of the three workshops held this year is below:

In June 2017, the Learning Lessons Workshop focussed 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.

In the session professionals learnt about the Signs of Safety approach, heard from practitioners about the impact of Signs of Safety on their work, and practised some of the core aspects of the model in group discussions.

The workshops were well attended by a number of agencies with over 100 people per session. Positive feedback was received, eg 'an informative session and very interesting'.

In November 2017, the Learning Lessons Workshop focussed 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.

In the session professionals learnt about the impact of neglect, including dental neglect, on children's health and wellbeing, with reference to the Neglect Strategy, the Graded Care Profile and the Practitioners Guide.

The workshops were well attended by many agencies, particularly professionals from Social Care, Health and Education. This enabled information to reach over 100 people per session, who were then able to champion this information within their own organisations.

In February 2018, the Learning Lessons Workshop focussed on the lessons learned from the recent Learning from Experience Review. In the session professionals heard an overview of the findings of the Learning from Experience Review from OSCP's Chair. Presentations were provided on the day, focussing on some of these findings, ie 'working with fathers', 'involving adult mental health' and 'understanding and challenging each

other with the language and terms we use'.

There was good attendance, particularly from Children and Family Services, with the workshops again catering to around 100 people per session.

Signs of Safety

The Partnership has renewed its commitment to Signs of Safety as a framework for all agencies in their child protection practice.

In January 2018, the Children and Family Services lead for Signs of Safety attended the Learning Group, and the Board, to discuss options for refreshing Signs of Safety as a model of practice across the partnership. This was ratified at both forums. Children and Family Services funded a five-day training opportunity, open to the whole partnership, to encourage and develop practice leaders in Signs of Safety. The Signs of Safety lead has subsequently met with representatives from a number of agencies to look at next steps.

The Child Protection Conference Service continues to use Signs of Safety as the ethos and structure for strengths based safety planning for the most vulnerable children and their families.

Signs of Safety has been used by all partners on the Isles of Scilly following their two day training in May 2016. There are two Advanced Practitioners on Scilly who coordinate two monthly Signs of Safety Practitioner scenario based meetings to augment the skills and knowledge for all partners. Signs of Safety is the ethos and structure with a strength based approach to planning in all areas of work from single agency intervention to early help, child in need and child protection. Follow-up training has provided additional support in the development of the use of words and pictures.

Going Forward

In 2018/19, the Learning Group plans to build on the excellent progress made this year. The group will continue to commission training for the partnership in line with the Board's priorities, informed by the work of the sub groups, and the learning from audits and other reviews. Planning has started for the next OSCP Conference, building on the success of the conference held in 2018.

The programme of embedding Signs of Safety across the partnership will continue with practice leads from partner agencies.

An area of priority for the Learning Group is to upgrade and update OSCP's website.

9.2 Missing and Sexual Exploitation Group

The understanding of CSE and the thinking around the best ways to prevent, disrupt and detect cases of it have changed significantly in recent years and continue to do so. As a result, The Missing and Child Sexual Exploitation Strategy has been refreshed.

Key drivers for the strategy were recent scrutiny and inspection findings, but the Organised Crime Local Profile has also ensured new and emerging patterns of CSE are taken into account. For example instances of peer on peer exploitation and also of cyber as an enabler. Alongside the strategy, the work-plan is the group's tool to ensure accountability is ever present in the work it does. In light of the new

strategy, the work plan was also significantly refreshed.
The final, and perhaps most complex, piece of this jigsaw was a brand new outcomes framework. Supported by the Amethyst team, a fresh approach was taken to identify and then measure the key outcomes required to achieve the strategy. Relevant data is being gathered from a wide range of sources and work is still in progress to make this an even more accurate picture when measuring outcomes in the areas of missing and sexually exploited people.

It is recognised by the Missing and Sexual Exploitation (M&SE) Group that even when these final gaps are closed, data can only tell you so much and the outcomes framework exists to give us pointers as to where to look.

It is then the role of the group to investigate further and, where appropriate, populate the work plan. As such, there is a continuous cycle between these three areas; the strategy, the work-plan and the outcomes framework.

It has been agreed that the M&SE Group will be responsible to three statutory boards namely OSCP, the Safeguarding Adults Board and the Safer Cornwall Partnership. The strategy, work-plan and outcomes framework reflect this and have been signed off by all three boards.

The group is now in a place where it can really test its ability to identify and respond to important issues. A good example of this is a recent finding within the outcomes framework that the number of people going missing, particularly young people, is increasing. This has been raised into the group and a clear course of action set to explore the subject further.

Two task and finish groups have been established by the M&SE Group, as follows:

1 Work Plan

Key objectives:
- To identify gaps within any management information needed to populate the plan,
- To ensure the 'who, what and when' is clearly identified and agreed.

2 Missing and Child Sexual Exploitation Group (MACSE) Terms of Reference

Key objectives:
- To broaden the scope of the MACSE in the light of the increasing complexity of exploitation,
- To ensure the MACSE is fit for purpose to meet these wider demands and respond accordingly.

The M&SE Group has engaged with a number of different events throughout the year to identify any further areas it should be focussing on. For example the Chair attended both the Safeguarding Adults Board carers' conference and also the Safer Women's conference at the Eden project. The latter in particular identified concerns around vulnerable young women in the county, and work continues with some of the third sector organisations that may help the M&SE Group to better understand what needs to be achieved.

In addition the group is linked into the Peninsula CSE Group which brings together those involved in MACSE meetings from across the whole of Devon and Cornwall. This helps to monitor the balance between focussing on the needs of Cornwall and the Isles of Scilly whilst ensuring best practice is shared with

neighbouring colleagues, that we work with maximum efficiency and that MACSEs work effectively for young people who travel around the two counties and beyond.

The chair of the M&SE Group currently sits on the Isles of Scilly Children's Trust Board and travels to the islands when they meet. This ensures that the needs of the islands in this area of business are met.

A good example of this cross county and island approach was the recent bid for Home Office funding on the 'Trusted Relationships' scheme. Unfortunately the bid was ultimately unsuccessful, but it saw representatives from across the whole peninsula work together and understand what could be improved with additional funding.

The group recognised that a more proactive response was required when it came to actually disrupting CSE and in particular in using some of the civil legislation available. In December 2017 a joint CSE disruption team was set up on a pilot basis involving Children and Family Services and the Police.

The aim was to ensure that effective action is taken to prevent CSE and other forms of exploitation by targeting and disrupting known and suspected perpetrators, persons and locations of concern. A key focus has been translating existing information, intelligence and evidence of concern into effective action.

The disruption team is the first example, outside of Cornwall's Multi-Agency Referral Unit (MARU), of a dedicated Children and Family Services (CFS) and Police operational team to tackle a specific aspect of practice, and the first time CFS and Police staff have been complemented by a dedicated legal assistant.

The work of this team has led to eight cases being progressed by Devon and Cornwall Police legal services for people and locations of concern identified by the disruption team.

The review of the disruption team continues in order to identify how this can become a sustainable resource whilst catering for further areas of vulnerability.

During 2018/19 the M&SE Group will focus on getting the best from the three strategic documents (described earlier) and the operational tactics available to us. In particular more work is required to align the membership of the group with the agreement to expand into young adults and this will be done through close working with the Safeguarding Adults Board.

9.3 Child Sexual Abuse Task and Finish Group

In the autumn of 2017, while recognising the progress that had been made across the partnership in respect of Child Sexual Exploitation, OSCP Board identified that the reporting of Child Sexual Abuse (CSA) was particularly low in Cornwall.

CSA is defined in *Working Together 2015* as:

"Sexual abuse is a form of **Significant Harm** which involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration

(for example rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children."

The Board appointed a Task and Finish Group of representatives across the partnership, chaired by the Service Director for Children and Family Services, to improve the multi-agency response to CSA, especially in respect of inter-familial abuse and that perpetrated by family friends and others with similar connections to the child.

This group met during the spring, working on a CSA strategy and practice guidance focussing on three key areas:

- Recognition and Responsibility
- Referral and Assessment
- Response

A Learning Lessons Workshop will be held on 3 July in which colleagues from across the partnership will be invited to participate in an interactive learning event. The contributions from this workshop will inform and develop an inclusive strategy that incorporates all agencies, and the views of children, young people and their families.

A Conference on Child Sexual Abuse will be held in September 2018, at which the CSA Strategy for Cornwall and the Isles of Scilly will be launched.

9.4 Neglect Task and Finish Group

The Neglect Task and Finish Group has revised the strategy document to:

(a) Promote partnership responsibilities,
(b) Take into account findings of recent JTAI inspections,
(c) Bring it in line with areas that have been judged outstanding in JTAI inspections, and
(d) Incorporate multi-agency outcome measures.

This revised strategy was presented to OSCP Board on 9 October 2017.

A Practitioner toolkit has been developed. This includes use of the Graded Care Profile as a primary assessment tool for children's social care in neglect cases, with the tool being used selectively by other agencies.

The Practitioners Quick Guide (used in agreement with Devon) was launched with the toolkit at the Learning Lessons Workshop held on 27 November 2017.

Topics covered in the workshop were:

(a) Summary of learning from Joint Targeted Inspections,
(b) Teaching on the 'Impact of Neglect on Children's Health and Development', and
(c) Teaching on 'Dental Neglect'.

The neglect strategy was circulated to GPs by the Interim Safeguarding Adviser at NHS Kernow CCG. Agency websites were updated in December 2017 following the official launch of the toolkit. The safeguarding newsletter published in November 2017 highlighted neglect issues.

Education and Early Years networks have now been offered familiarisation events regarding the neglect strategy, eg Early Years cluster groups around the county, CAPH and CASH and 'Neglect' information sharing sessions with the school safeguarding leads across the county.

The neglect strategy will be presented to the Safeguarding Adults Board in summer 2018.

It is planned to repeat the Neglect Training workshop on the Isles of Scilly in late summer 2018.

A range of audits has been undertaken or are planned regarding neglect.
The Designated Doctor for Child Safeguarding has undertaken a Health audit regarding supervision and case management. He has been invited to present his findings at the Neglect Task and Finish Group meeting on 2 July 2018.

Cornwall Children's Social Care will be undertaking a practice audit re neglect in July and August 2018.

It is proposed that there should be a multi-agency audit to review the contributions at core group meetings which will focus on monitoring of the plan, challenge, and escalation. This will be undertaken by members of the task and finish group.

Further work is required on the engagement of GPs in case conferences and core group meetings.

It is planned that the chairmanship of this group will pass to the recently appointed Designated Nurse for Safeguarding Children at NHS Kernow CCG and that the membership will be extended to include public health commissioning.

9.5 Safeguarding Practitioner Reference Group

The Safeguarding Practitioner Reference Group has been established and an inaugural workshop was held for members of the group on 21 July 2017, facilitated by the Independent Chair and the Safeguarding Children Partnership Manager.

The Safeguarding Practitioners discussed how the Reference Group should operate and how they felt they could best contribute to the work of the Partnership and discussed and agreed the terms of reference.

The second workshop for members of the Safeguarding Practitioner Reference Group was held on 8 May 2018 facilitated by the Independent Chair. The focus of the workshop has been on consultation in order to influence the Safeguarding Children Partnership business planning and Level 3 training. The following matters were the focus of this Workshop:

- Safeguarding Children Partnership Business Plan
- Safeguarding Children Partnership Level 3 Training Contract
- Future Safeguarding Children Partnership Conferences

The contributions of the group members have been valuable and regular consultation workshops will be held with the selected members.

10 Local Authority Designated Officer (LADO)

10.1 Role of the LADO

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 that each county level and unitary Local Authority should 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 corresponding 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 a Principal LADO, a LADO and a Senior LADO Administrator.

OSCP endorses the LADO Service which covers Cornwall and the Isles of Scilly and places a duty on all organisations to co-operate with the LADO Service and to adopt the Allegations Against Staff or Volunteers procedures contained in the South West Child Protection Procedures (SWCP Procedures)

The LADO Service is committed to supporting The Partnership Plan 'One Vision' by contributing to:

- Priority Outcome 3 Helping and protecting children from the risk of harm by co-ordinating investigations where domestic abuse, child sexual abuse and child sexual exploitation are identified

- Priority Outcome 5 Making a positive contribution to the community in respect of community safety by raising awareness of the LADO role within the voluntary and community sector

10.2 What does the LADO do?

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 OSCP

- 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

- 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

10.3 How does the LADO work?

All LADO referrals are submitted via the Multi Agency Referral Unit (MARU), but anyone can phone the LADO for advice and guidance.

The LADO will determine what is the best route of investigation including liaising with partner agencies, contract and commissioning services, Ofsted, Education and Skills Funding Agency, Independent Schools Inspectorate and Her Majesty's Inspectorate to co-ordinate:

- A criminal investigation
- A joint Police and Social Care investigation
- An internal disciplinary investigation by an employer/fitness to practice

The LADO determines on a multi-agency decision basis whether the allegation is unfounded, malicious, unsubstantiated or substantiated. A final Case Summary and Recommendation is prepared which is endorsed by all parties and represents a shared understanding of the outcome of the investigation and ramifications for those involved.

The LADO considers with the employer whether there is a need to refer the outcome for disciplinary procedures, training or advice or to the DBS and/or professional regulatory body.

10.4 Overview of Professional Allegations Data (1 April 2017 to 31 March 2018)

There has been a slight rise in overall cases to 490 with 40% being dealt with as formal multi-agency referrals and 60% as single agency 'light touch' advice and guidance episodes. The ability to determine early on whether a formal referral is required enables a faster and more focussed response, with referrals taking on average nine weeks to complete and advice and guidance episodes three weeks to complete. This reduces the anxiety for both the child and the adult accused if we can keep timescales within the SWCP Procedures guidelines of 12 weeks. We promote the practice of an early phone call to speak to a LADO and to comply with the SWCP Procedures of notification within one day.

The number of referrals from Social Care (26%), the Police (19%) and the Education Sector (35%) has remained fairly static for the last three years. However we are beginning to see an increase in referrals from sports associations and residential settings which may indicate the impact of LADO workshops and presentations on safeguarding awareness. We continue to build upon connections with the wider community to ensure that organisations know who to contact; this was identified in a recent LADO survey where 62% of participants rated the experience of dealing with the LADO as very positive

In terms of the primary cause for concern, physical abuse remains the highest, accounting for 45% of the referrals and 33% sexual abuse. 17% of referrals meet the third part of the LADO threshold – where it is deemed that an individual may pose a risk of harm to a child.

The 'pose a risk of harm' category has been further explored under the National LADO Principles which have recently been presented to OSCP and set out a fuller definition of this category to include a transferable risk from home/private life to working with children; for example violence, substance misuse. This should assist in raising safeguarding standards within the children's workforce

The actions taken by employers as a result of the LADO referrals demonstrate a rise in the number of suspensions to 32% to create interim protective measures with 100% of the final dismissals resulting in a referral to the Disclosure and Barring Service. It is surmised that this is partly due to the agreed Case Summary produced at the end of each case and the increased engagement between the LADO Service and the various HR providers to ensure consistency of approach and compliance with the DBS 'two stage harm test' which obliges employers to make a referral to the barring list.

The LADO Service was specifically mentioned in the Ofsted Inspection report in June 2016 as a result of which Children's Services in Cornwall are rated Good. At paragraph 30 it states '*Cases seen by inspectors demonstrated a good response, with prompt and appropriate steps taken to protect children, and active follow-up to ensure that children are protected.*'

This year the LADO Service undertook a survey to check on progress and was pleased to note that 86% of participants considered that the LADO had contributed to keeping children safe.

The LADO work continues with the co-operation and support of the children's workforce in Cornwall and the Isles of Scilly with continued focus on what measures effectively work to raise safeguarding standards which this year will be promoted through school and academy networks, Cornwall's licensing committee, sports seminars and OSCP.

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11 OSCP Strategic Business Plan 2017/18

11.1 Business Plan

The Safeguarding Children Partnership developed a business plan to guide the activities of the Board during 2017/18. https://www.cornwall.gov.uk/media/34332099/oscp-business-plan-2017-2018.pdf

The aims and objectives of the Safeguarding Children Partnership and the key principles guiding multi-agency collaboration are the following:

11.2 Aims and Objectives

Section 14 of the Children Act 2004 sets out the objectives of LSCBs, which are:

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

11.3 Key Principles

- Visible to all stakeholders across Cornwall and the Isles of Scilly
- Planning based on good quality information and effective analysis
- Effective governance arrangements and operating structure
- Links and clear accountability with other strategic groups across Cornwall and the Isles of Scilly
- A culture of challenge
- Learning is embedded in all agencies and within multi-agency practice
- Authoritative oversight of the quality of performance across agencies, singly and multi-agency
- Understands how it is affecting the quality of performance

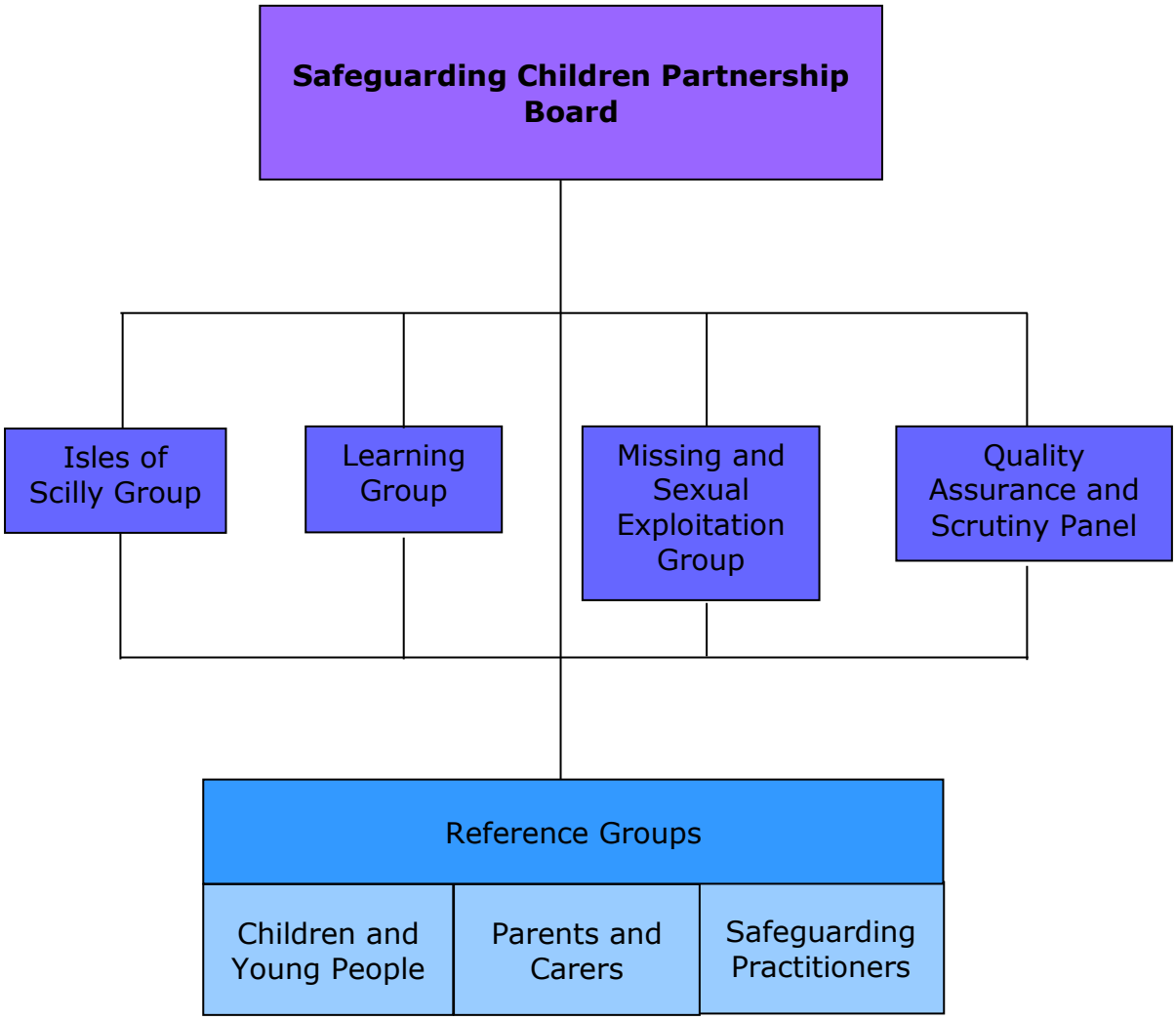
Appendix 1

OSCP Board Membership

Organisation	Representative
Independent Chair	John Clements (Chair)
Statutory Safeguarding Partners:	
Cornwall Council:	
▪ Director of Children's Services	Trevor Doughty (Vice Chair)
▪ Service Director for Children and Family Services	Jack Cordery
▪ Service Director for Education and Early Years	Jane Black
Council of the Isles of Scilly - Director of Children's Services	Aisling Khan (Vice Chair)
Devon and Cornwall Police:	
▪ Cornwall Basic Command Unit Commander	Jim Pearce
▪ Public Protection Unit Superintendent	Sheon Sturland
NHS Kernow - Executive Safeguarding Lead	Natalie Jones
Safeguarding Partners:	
Cornwall Association of Primary Headteachers	Ian Bruce
Cornwall Association of Secondary Headteachers	Tina Yardley
Cornwall Partnership Foundation Trust - Executive Safeguarding Lead	Sharon Linter
Further Education Colleges	Cheryl Mewton
Office of the Police and Crime Commissioner	Lyn Gooding
Participant Observers:	
▪ Cornwall Council - Lead Member for Children's Services	Sally Hawken
▪ Council of the Isles of Scilly Lead Member for Children's Services	Joel Williams
Royal Cornwall Hospitals Trust - Executive Safeguarding Lead	Kim O'Keeffe
Safeguarding Children Partnership Manager	Frederika van Rooyen
Safer Cornwall Partnership - Chair	Paul Walker
Silent Observer –Quality Assurance and Scrutiny Panel Lay Member	Maureen Read
Sub-Group Chairs:	
▪ Learning Group	Marion Russell
▪ Missing and Sexual Exploitation Group	Matt Longman
▪ Quality Assurance and Scrutiny Panel	*John Clements*

Appendix 2

OSCP Structure Chart



Appendix 3

OSCP Board Members' Attendance during 2017/18

Agency	Representative	Apr	Jun	Jul	Sep	Oct	Dec	Jan	Mar
Independent Chair	John Clements	✓	✓	✓	✓	✓	✓	✓	✓
Statutory Safeguarding Partners:									
Cornwall Council:									
▪ Children and Family Services	Jack Cordery	✓	✓	Sub	✓	✓	✓	✓	✓
▪ Children, Families and Adults	Trevor Doughty	Sub	✓	Sub	Sub	Sub	Sub	✓	✓
▪ Education and Early Years	Jane Black	✓	✓	✓	Sub	Sub	✓	Apol	✓
Council of the Isles of Scilly	Aisling Khan	✓	✓	✓	✓	✓	Apol	✓	✓
Devon and Cornwall Police – Basic Command Unit (BCU)	Jim Pearce	Apol	✓	✓	✓	Apol	✓	✓	✓
Devon and Cornwall Police – Public Protection Unit (PPU)	Steve Parker / Sheon Sturland	✓	Apol	✓	Apol	Apol	Apol	✓	✓
NHS Kernow	Natalie Jones	✓	✓	✓	✓	✓	Apol	✓	✓
Safeguarding Partners:									
Cornwall Association of Primary Headteachers	Ian Bruce	✓	✓	✓	✓	Apol	✓	✓	Apol
Cornwall Association of Secondary Headteachers	Tina Yardley	✓	✓	Apol	✓	✓	✓	Apol	✓
Cornwall Partnership Foundation Trust	Sharon Linter	✓	✓	✓	✓	Apol	✓	✓	Sub
Further Education Colleges	Cheryl Mewton	✓	Apol	Apol	✓	✓	✓	✓	✓
Office of the Police and Crime Commissioner	Jo Robison / Lyn Gooding			Sub	DNA	Sub	✓	✓	✓
Participant Observers:									
▪ Cornwall Council – Lead Member for Children's Services	Andrew Wallis / Sally Hawken	Apol	Apol	✓	DNA	✓	✓	Apol	✓
▪ Council of the Isles of Scilly – Lead Member for Children's Services	Fran Grottick / Joel Williams	Apol	DNA	Apol	✓	DNA	✓	Apol	DNA

Agency	Representative	Apr	Jun	Jul	Sep	Oct	Dec	Jan	Mar
Royal Cornwall Hospitals Trust	Kim O'Keeffe	Sub	Sub	✓	Apol	Sub	Sub	Apol	Sub
Safeguarding Children Partnership Manager	Frederika van Rooyen	✓	✓	✓	✓	✓	✓	✓	✓
Safer Cornwall Partnership	Paul Walker	Apol	Apol	Apol	Apol	Apol	✓	Apol	Apol
Silent Observer – Quality Assurance and Scrutiny Panel Lay Member	Maureen Read	✓	Apol	Apol	✓	✓	✓	Apol	✓
Sub-Group Chairs:									
▪ Learning Group	Karen Dale / Marion Russell	✓	✓	Apol	✓	✓	✓	✓	✓
▪ Missing and Sexual Exploitation Group	Matt Longman		✓	✓	✓	✓	Apol	✓	✓

Appendix 4

OSCP Budget - Out-turn Position for 2017/18

The table below shows the out-turn position for 2017/18 for Our Safeguarding Children Partnership's operational budget. The position shows an under-spend of £2,372 which has been transferred to the Partnership's reserve.

SAFEGUARDING CHILDREN PARTNERSHIP BUDGET REPORT OUT-TURN 2017/2018					
Safeguarding Children Partnership	**%**	**2017/18 Budget (£)**	**Current Budget YTD (£)**	**Actuals YTD (£)**	**Budget Variance (£)**
Employee Costs		51,000	51,000	56,712	5,712
SCP Independent Chair		22,000	22,000	21,840	-160
Child Death Overview Panel		33,000	33,000	34,773	1,773
Learning (including Local Learning Inquiries)		20,000	20,000	0	-20,000
Serious Case Review Quality Assurance Supervision		0	0	1,375	1,375
Office Supplies		12,000	12,000	10,398	-1,602
Independent Auditors		20,000	20,000	31,688	11,688
Training Costs		100,000	100,000	101,330	1,330
Gross Expenditure Total		**258,000**	**258,000**	**258,116**	**116**
Cornwall Council	61.24	-158,000	-158,000	-158,000	0
Council of the Isles of Scilly	1.94	-5,000	-5,000	-4,800	200
National Probation Service	0.39	-1,000	-1,000	-1,274	-274
NHS Kernow CCG	27.13	-70,000	-70,000	-69,652	348
Office of the Police and Crime Commissioner	9.30	-24,000	-24,000	-24,361	-361
CAFCASS				-550	-550
Income from Training	0.00	0	0	-1,851	-1,851
Income Total		**-258,000**	**-258,000**	**-260,488**	**-2,488**
Net Expenditure Total		**0**	**0**	**-2,372**	**-2,372**

Reserve Position for 2017/18

The table below shows the position of the Partnership reserve for 2017/18. The table includes the above transfer of the 2017/18 under-spend to the Partnership reserve.

Opening balance of the Partnership reserve April 2017	**£99,181**
Financial year end under-spend 2017/18 to reserve	£2,372
Opening balance of the Partnership reserve April 2018	**£101,553**

Partner Contributions for 2017/18

The table below shows the partner contributions that have been built into the 2017/18 budget.

Partners	**2017/18**
CAFCASS	550
Cornwall Council	158,000
Council of the Isles of Scilly	4,800
National Probation Service	1,274
NHS Kernow Clinical Commissioning Group	69,652
Police and Crime Commissioner	24,361
Total Partner Contributions	**258,637**

Appendix 5

NHS Kernow Contribution regarding Successes, Shared Learning and Impact

Successes:

Following the retirement of the Designated Nurse Child Protection (DNCP) in December 2016 (and her subsequent return to her post on a temporary basis until July 2017) NHS Kernow identified the need to maintain and strengthen its capacity in relation to safeguarding children as well as the need to enhance its service provision to looked after children in keeping with national guidance relating to the time that should be given to fulfil the role. Consequently, NHS Kernow successfully recruited to the posts of Designated Nurse Child Protection (DNCP) and Designated Nurse Looked After Children (DNLAC). They took up their posts in April 2018 and June 2018 respectively.

In relation to the DNCP post, NHS Kernow has sought to improve the governance arrangements for the providers it commissions with a particular emphasis on the main ones which are Royal Cornwall Hospitals NHS Trust (RCHT) and the Cornwall Partnership NHS Foundation Trust (CFT). The DNCP is developing a safeguarding children audit tool / score card which will be used as part of NHS Kernow's commissioning arrangements, with the purpose of being better able to benchmark and scrutinise provider safeguarding children arrangements and thereby ensure a high standard of service delivery and the drawing up of action plans to address any areas where a need for improvement is identified via the audit tool / score card. The Designated Doctor for Child Protection offers supervision to the Named Doctors of the provider organisations and Primary Care.

In relation to the DNLAC post, NHS Kernow has increased the capacity from 0.4wte to 1.0wte in keeping with national guidance relating to this important post and in order to ensure that the health services to looked after children remain of a high standard and that their health needs are met and health assessments take place within the appropriate timescales. The DNLAC has worked with the DNCP to ensure that LAC requirements are integral to the safeguarding children audit tool/score card.

Shared Learning Together:

OSCP developed and published a Neglect Strategy for Cornwall in November 2017. NHS Kernow has ensured that the main service providers (RCHT and CFT) have circulated this strategy to all their staff and provided awareness raising training across the workforce as well as reference to the strategy being made at planned Level 2 and Level 3 Safeguarding Training for specific staff groups (e.g midwifery, health visiting and school nursing). In addition RCHT has included reference to the strategy in an edition of its Safeguarding Newsletter and NHS Kernow circulated the strategy and associated documents to Primary Care via a series of contributions placed in the Primary Care weekly bulletin. The Designated Doctor has presented the preliminary findings to the Learning Sub Group of his audit of the totality of health information available at Initial Child Protection Conferences (ICPCs) for cases of Neglect. This audit will be finalised and made available via the next annual report. The Designated Doctor has also undertaken shared audits with the SLT from

the Local Authority around health information and health input and shared decision making into Strategy Meetings as part of the S47 process. The outcome of this work will be shared with the OSCP Board via the Chair of the Learning Sub Group.

Impact / difference made:

The designated professionals have been involved in supporting named professionals, and a range of other health professionals in their practice to safeguard children. This has included development of the MACSE processes in the county, the transfer of safeguarding cases into Cornwall and the facilitation of a co-ordinated multi-agency response, and the audit and review of safeguarding practice across the health economy to promote positive outcomes for children and young people.

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