Independent Quality Assurance Review

Cornwall Partnership NHS Foundation Trust and NHS Cornwall and the Isles of Scilly Integrated Care Board

StEIS 2016/19955

Final Report
31 January 2023

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31 January 2023

Independent Quality Assurance Review

This report is a limited scope review and has been drafted for the purposes as set out in the terms of reference for the independent investigation alone and is not to be relied upon for any other purpose. The scope of our work has been confined to the provision of an assessment of the implementation of the organisations' resultant action plans against the Niche Investigation and Assurance Framework (NIAF). Events which may occur outside of the timescale of this review will render our report out of date.

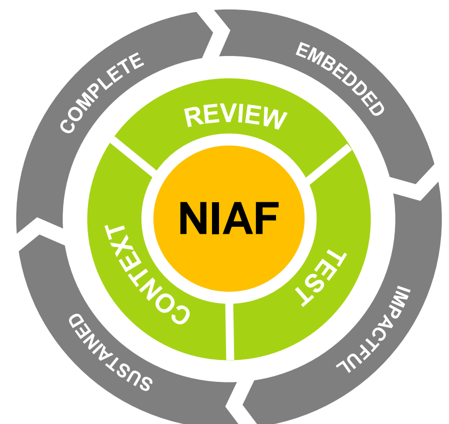
Our report has not been written in line with any UK or other auditing standards; we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information.

This report is for the attention of the project sponsor and stakeholders. No other party may place any reliance whatsoever on this report as it has not been written for their purpose. Different versions of this report may exist in both hard copy and electronic formats and therefore only the final version of this report should be regarded as definitive.

Yours sincerely,

James Fitton
Niche Health and Social Care Consulting Ltd

Niche
Investigation
Assurance
Framework



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1. Method

1.1 Background and context for this review

NHS England commissioned Niche Health and Social Care Consulting Ltd (Niche) to undertake an assurance review using the Niche Investigation Assurance Framework (NIAF). This is intended to provide an assessment of the implementation of the actions developed in response to the recommendations from the Niche independent investigation into the care and treatment of a mental health service user, Mr T, that was published in January 2022.

1.2 Review method

This is a high-level report on progress to NHS England undertaken through desktop review only, without site visits or interviews. The assurance review focusses on the actions that have been progressed and implemented in response to the recommendations made in the independent investigation report.

Our work comprised a review of documents provided by Cornwall Partnership NHS Foundation Trust Cornwall (CFT or 'the Trust') and Cornwall and the Isles of Scilly Integrated Care Board (the ICB)*. These included action plans, policies, procedures, audits, meeting minutes and staff communications.

We have not reviewed any health care records because there was no requirement to re-investigate this case in the review's terms of reference. The information provided to us has not been audited or otherwise verified for accuracy.

1.3 Implementation of recommendations

The Niche independent investigation made 12 recommendations to the above-named organisations; these are listed opposite and overleaf.

1	The Trust must clarify the action that they expect staff to take when there is a question about whether to execute Duty of Candour.
2	The Trust must ensure that the policy on engaging with families of victims of homicide committed by patients known to mental health services reflects best Practice as set out in the NHS England (London) investigation guidance issued in April 2019 on engaging with families after a mental health homicide.
3	The Trust and the ICB (former CCG) must ensure that families are offered appropriate involvement in serious incident investigations and that they are always offered a copy of the investigation report.
4	The Trust must provide robust assurance that they have fully implemented the actions arising from the recommendations of the internal investigation.
5	The Trust and the ICB (former CCG) must address the knowledge and skills gap present in their safeguarding children leads to ensure that those staff fully understand the Local Children Boards Regulations 2006, in particular the requirements relating to actions following the death of a child who was subject to abuse and how to action these.
6	The Trust and the ICB (former CCG) must assess and report the impact of the revised processes and training programmes in relation to improving child safeguarding practices in adult mental health services.

* *Note that NHS Kernow Clinical Commissioning Group (the CCG) is now part of the Cornwall and the Isles of Scilly Integrated Care Board (the ICB).* Some of the actions and d*ocuments within this report originated from before the ICB came into being on 1 July 2022, and some afterwards. For ease of reference, we use the term ICB (former CCG) throughout this report.*

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1. Method (cont.)

7	If the ICB (former CCG) has not already done so, the potential missed opportunities for liaison between health practitioners as a consequence of health visitors moving to the employment of the council must be fully assessed and mitigated.
8	The Trust must ensure that staff understand and undertake their responsibilities for reporting safeguarding concerns when a patient reports historic or current abuse.
9	The Trust must provide assurance that there is an effective process for supporting patients who appear to be under duress due to criminal exploitation/cuckooing/ County Lines, and that these are addressed in care plans.
10	The Trust must conduct an audit of adult mental health staff active engagement in reporting child safeguarding concerns, identifying any areas of concern and implementing appropriate remedial actions where necessary.
11	The Trust must provide assurance that patients who are complex and whose risks are documented as high, are not discharged from Trust services without a clearly documented rationale.
12	The ICB (former CCG) must seek assurance from the Trust that improvements have been made to staff awareness and understanding of children’s safeguarding issues that has led to a significant improvement in clinical practice.

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2. Assurance summary

Scoring criteria key

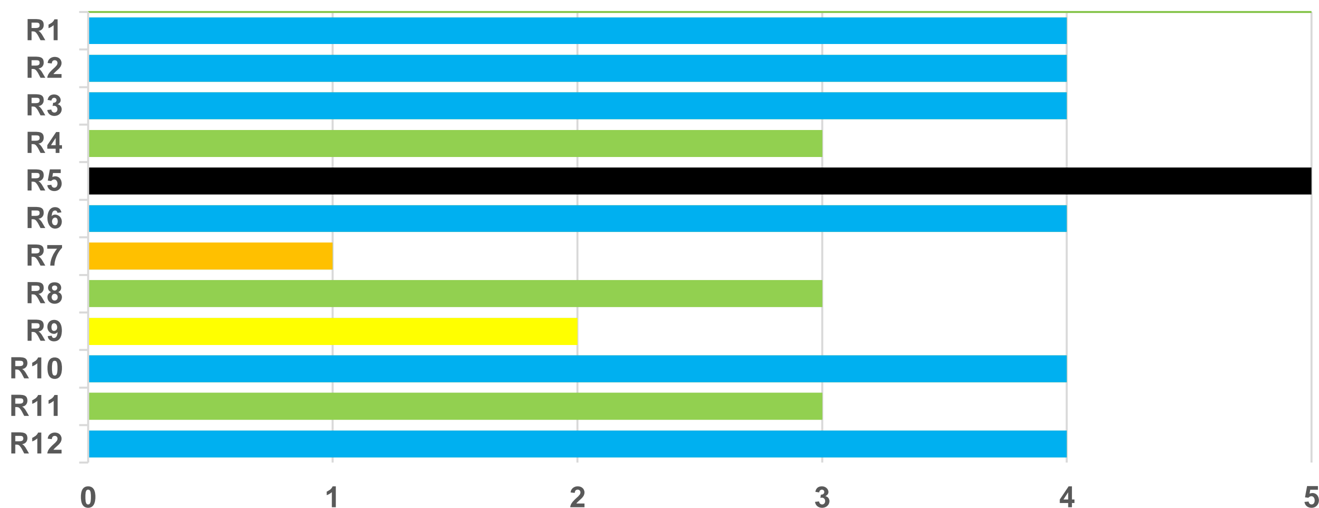
The assessment is meant to be useful and evaluative. We use a numerical grading system to support the representation of 'progress data', which is intended to help the organisations involved focus on the steps they need to take to move between the stages of completed, embedded, impactful and sustained. '3' is regarded as a good score as it reflects action completion. Scores of '4' and '5' are harder to achieve within the timeframe from publication of the investigation report to now, with the latter rating being assigned on more limited occasions primarily due to the cycle of testing that is required to demonstrate that outcomes are being achieved.

Score	Assessment category
0	Insufficient evidence to support action progress / action incomplete / not yet commenced
1	Action commenced
2	Action significantly progressed
3	Action completed but not yet tested
4	Action completed, tested, but not yet embedded
5	Can demonstrate a sustained improvement

Implementation of recommendations

We have rated the progress of the actions which were agreed from the recommendations made. Our findings are summarised in the chart below:

Summary chart showing progress to date for each recommendation



Summary

Progress has been made in relation to the majority of recommendations. There are two recommendations where evidence to support progression is more limited. In these and other cases, we have provided suggestions of further assurance required to demonstrate actions are complete, tested, embedded and/or sustained as appropriate.

Some headline commentary to support these ratings has been provided in the following pages and Appendix 1 (evidence review) provides a more detailed assessment against each piece of evidence which has been submitted to Niche.

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2. Assurance summary (cont.)

Recommendation 1	
The Trust must clarify the action that they expect staff to take when there is a question about whether to execute Duty of Candour.	
Niche assurance rating for this recommendation	**4**
Key findings: The Trust has undertaken a range of work focusing on Duty of Candour (DoC) including: • updating the DoC Policy to confirm that processes should commence as soon as possible and not wait for coroner's verdicts; • providing training and information for staff and Board members; • the addition of a DoC prompt within a number of templates used by staff which are completed for each serious incident and which are checked by the ICB (former CCG) before case closure; and • appointing a member of staff to lead on DoC practice across the Trust. Duty of Candour application has been the subject to internal audit review with progress and compliance overseen by the Quality Assurance Committee, with regular reporting to the Trust Board. This oversight has identified some ongoing concerns, particularly around timeliness and recording of DoC processes.	
Residual recommendations:	
RR1: To ensure improvements are sustained, the Trust should continue to implement actions to improve the timeliness of Duty of Candour contact and to monitor and report on this to the Quality Assurance Committee.	

Recommendation 2	
The Trust must ensure that the policy on engaging with families of victims of homicide committed by patients known to mental health services reflects best practice set out in the NHS England (London) investigation guidance issued in April 2019 on engaging with families after a mental health homicide.	
Niche assurance rating for this recommendation	**4**
Key findings: The April 2019 guidance describes four principles for engaging with families involved in a mental health homicide; these are to communicate regularly and with sensitivity and clarity, to provide support for both families and staff, to involve families and staff in reviews and investigations and in sharing learning; and to commit to learning. The Trust's Patient Safety Incident Response Plan (PSIRP) is clear on how it will engage with patients and their families during an investigation and covers the points above. The updated Trust DoC Policy similarly contains clear and detailed guidance to staff on engaging with families of patients involved in serious untoward incidents. Patient safety meeting agendas have templates which prompt participants to ensure that key family engagement and support activities have been completed. The Trust reviewed a recent homicide case which showed that the family had been fully involved in development of the scope and terms of reference and review of the draft report prior to finalisation. See also the response to recommendation 3 which details how families are involved in all serious incident investigations.	
Residual recommendations:	
N/A	

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2. Assurance summary (cont.)

Recommendation 3	
The Trust and the ICB (former CCG) must ensure that families are offered appropriate involvement in serious incident investigations and that they are always offered a copy of the investigation report.	
Niche assurance rating for this recommendation	**4**
Key findings: The Trust has introduced a new Family Liaison Officer role and Patient Safety Incident Investigation (PSII) meeting agendas demonstrate that the Trust role has family involvement and Duty of Candour embedded in the process. The Trust shared two letters demonstrating how families were offered appropriate involvement and a copy of the investigation report. A Trust mortality-focussed audit also found that engagement and involvement of the family occurred in nine out of ten serious incident investigations reviewed. The Trust has additionally conducted an internal review of the last 60 serious incident investigations which found that Duty of Candour, including offering family involvement, was completed in all cases except for seven where the family either declined further involvement or no next of kin was found. We were not provided with evidence of how commissioners are assured that families are offered appropriate involvement in serious incident investigations although please see commentary in recommendation 5 and 12 regarding overall ICB (former CCG) improvements in assurance.	
Residual recommendations:	
See commentary in recommendation 12 regarding testing out new assurance structures.	

Recommendation 4	
The Trust must provide robust assurance that they have fully implemented the actions arising from the two recommendations of the internal investigation. *Actions:* 1. *The Trust to discuss the findings of the investigation with the police lead, around information sharing in such high-risk cases, the decision not to ease the bail conditions, and public protection versus support of alleged perpetrators.* 2. *Discussions with relevant staff to take place around the decision not to contact the 'Nearest Relative' and action implemented if indicated.*	
Niche assurance rating for this recommendation	**3**
Key findings: Action 1. The Trust's Head of Social Work and the local Chair of the Criminal Justice and Health Liaison Group for Cornwall met with the Chief Inspector of the Devon and Cornwall Police to discuss the issues raised in the investigation. An information sharing agreement between CFT and Devon and Cornwall Police is now in place although no evidence was provided about the impact this has had. The Trust also noted that the Criminal Justice and Health Liaison Group continues to provide a forum for the review and improvement of information sharing arrangements. Action 2. The Trust also advised that the Head of Social Work and local Chair of the Criminal Justice and Health Liaison Group for Cornwall also met with the staff member involved and considered and reflected on the decisions which were made. The Trust holds evidence of completion of the action plan associated with the serious incident investigation. This was reviewed and signed off at Clinical Quality Assurance Group; however, it was not made clear to us how onwards monitoring of the impact will be reviewed.	
Residual recommendations:	
RR2: The Trust must test, through routine supervision processes and ongoing thematic review of incidents, that the issues raised by this case do not recur.	

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2. Assurance summary (cont.)

Recommendation 5	
The Trust and the ICB (former CCG) must address the knowledge and skills gap present in their safeguarding children leads to ensure that those staff fully understand the Local Children Boards Regulations 2006, in particular the requirements relating to actions following the death of a child who was subject to abuse and how to action these.	
Niche assurance rating for this recommendation	**5**

Key findings: The Trust provided evidence of improved safeguarding training and supervision. New safeguarding structures, new designated roles and links with key committees have been put in place. The new integrated safeguarding service (ISS) received investment in 2021 to increase resources. The revised ISS team structure provides a clear line management and supervision structure and more staff to deliver such support including appointing a children's social worker to the ISS and a designated Adult Safeguarding Officer to support the integrated CMHT.

Additional Safeguarding Supervisor training is being provided and group supervision is being developed to ensure competent and confident safeguarding practice. Named professionals for safeguarding receive specific safeguarding supervision from the ICB (former CCG)'s Designated Nurse in addition to supervision from the Trust's Consultant Nurse for the ISS. Designated safeguarding leads for the Trust and the ICB (former CCG) have undertaken advanced training on risk and decision-making as part of safeguarding.

The safety incident response plan contains specific information about responding to child deaths and a link to further associated guidance. The Trust has recently set up a Safeguarding sub-committee to the Quality Assurance Committee (QAC) to provide assurance of compliance on all matters relating to adult and child safeguarding.

Since this incident, the Children and Social Work Act (2017) replaced Serious Case reviews with child safeguarding practice reviews. A dedicated Children's Safeguarding Review Group has been set up to manage Rapid Reviews and Local Child Safeguarding Practice Reviews (LCSPRs) for the Our Safeguarding Children Partnership (OSCP). Evidence was provided of how the relevant committees are overseeing Rapid Reviews and Local Child Safeguarding Practice Reviews (LCSPRs), and how learning from these has been shared across the Trust, and how safeguarding children leads link in with this group.

The ICB (former CCG) is supporting the OSCP to refresh existing LCSPR procedures and are helping to ensure that these reflect the equal responsibilities set out in the Act, although we have not seen evidence of this as yet. ICB (former CCG) assurance includes NHSE/I quarterly returns, 'deep dives' and scrutiny in the steering group.

As evidence of external scrutiny of these arrangements a peer review of the OSCP by Surrey Safeguarding Children Partnership took place in 2021 to provide assurance of the partnership's effectiveness around safeguarding children. In addition, the ICB (former CCG)'s safeguarding arrangements were scrutinised through the OSCP Quality Assurance and Scrutiny panel in September 2021. The panel reported very favourably on the ICB (former CCG)'s contribution to children's safeguarding practice across Cornwall and the Isles of Scilly over the last two years. Panel members concluded that the ICB (former CCG) is operating well in terms of influencing the development of child safeguarding in the region. They found high levels of knowledge and experience within its safeguarding team, which was mentioned as a strength. They reported that the team's influence is current and relevant and new developments are known and introduced into practice. They also reported positive governance arrangements which allow the ICB (former CCG) to understand levels of performance and the quality of health service delivery.

Residual recommendations:

N/A

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Recommendation 6

The Trust and the ICB (former CCG) must assess and report the impact of the revised processes and training programmes in relation to improving child safeguarding practices in adult mental health services.

Niche assurance rating for this recommendation	4

Key findings: The Trust provided evidence of a range of safeguarding training relating to children which is available to staff within Adult Mental Health Services (AMHS) including Level 2 and 3 mandatory training plus a range of bespoke "Learning Lessons" training.

Safeguarding 'communities of practice' commenced in June 2021, providing an opportunity for all staff to discuss safeguarding practice. A 'Signs of Safety' template is now available on the RiO clinical system to prompt conversations with families around child safeguarding.

There have been concerns, in the past, about the levels of Safeguarding training compliance achieved by Trust staff, for whom this is relevant. However, training compliance is reported to have increased in 2021-22 to an average 80% (for all levels). With a further rise in Quarter 1 of 2022/23 when 89% of staff had attended Level 1 Adult Safeguarding training and 88% Level 1 Children's Safeguarding training, with slightly lower figures for Level 2 (82% and 83%) and Level 3 (78% and 71%). We do not have the specific figures for Adult Mental Health services.

Written feedback from staff who attended domestic abuse training show that staff feel more confident in both identifying and taking action in relation to domestic abuse following attendance at the training. The OSCP minutes in May 2021 describe the training offer across the Trust as "…*a real strength*…"

The Trust acknowledges it is a challenge to provide assurance that their workforce are competent safeguarding practitioners. Currently the Trust only monitors staff compliance relating to attendance at training sessions. The monthly data confirms the challenges in achieving training compliance targets. The proposal going forward is to use a Safeguarding Competency Framework as part of continuing professional development.

The Trust Board has recently signed off a three-year safeguarding training strategy. This aims to increase training compliance and improve staff safeguarding competency through a competency-based approach. A Safeguarding Practice Educator has been appointed to support a pilot of the competency framework. The pilot will begin with adult mental health practitioners.

Evidence was provided to show that the ICB (former CCG) has sought assurances from the Trust with regard to children's safeguarding practice, and that they had noted significant improvements. A monthly ICB (former CCG) Safeguarding Assurance meeting reviews safeguarding data and information from the Trust to identify areas of concern and agree mitigating actions (see also recommendation 12).

The ICB (former CCG) monitors training compliance and the effectiveness of this through a new cloud based safeguarding assurance tool. The refreshed governance arrangements summarised against recommendation 5 provide the mechanism for review and assurance. The ICB (former CCG) also has a representative on QAC where training figures are reported at each meeting. The Trust has also invited ICB (former CCG) colleagues to attend and provide feedback on training.

Residual recommendations:

RR3: The Trust should ensure it is able to demonstrate changes in staff behaviour arising from the new competency based training, within its agreed bi-annual cycle of audit (see Recommendation 10).

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2. Assurance summary (cont.)

Recommendation 7	
If the ICB (former CCG) has not already done so, the potential missed opportunities for liaison between health practitioners as a consequence of health visitors moving to the employment of the council must be fully assessed and mitigated.	
Niche assurance rating for this recommendation	**1**
Key findings: The Trust shared the draft terms of reference for a planned review to understand how the health and social care system share information with and across the Public Health Nursing team, focussing on child/family visits to the Emergency Department (ED) and Minor Injuries Unit (MIU) attendance. The review will also include consideration of what is currently working well and areas for improvement as well the strengths and opportunities for developing information sharing processes (between the Trust and Public Health Nursing services), with a focus on governance and improvement strategies. The ICB (former CCG) plans to consider the output from this review in January 2023. The ICB (former CCG) also submitted a paper to the OSCP about the risks of missed opportunities as public health do not save information received from the trusts unless they relate to an open case.	
Residual recommendations:	
RR4: The ICB (former CCG) should carry out the planned review of information sharing across the health and social care system (including health visiting) with regards to children's safeguarding within the stated time frame, and formulate and progress an associated action plan which is overseen by the relevant ICB (former CCG) assurance mechanisms.	

Recommendation 8	
The Trust must ensure that staff understand and undertake their responsibilities for reporting safeguarding concerns when a patient reports historic or current abuse.	
Niche assurance rating for this recommendation	**3**
Key findings: The Trust provided a range of evidence (as detailed in recommendations 5 and 6) demonstrating that the new Integrated Safeguarding Service has been making significant efforts to increase the accessibility of safeguarding advice and support for staff across adult mental health services. Several key policy documents have been updated to include clearer and more direct guidance to help staff to understand their responsibilities for reporting safeguarding concerns. The operating policy for the Integrated Community Mental Health Team (ICMHT) requires all staff to ask new patients if they care for children and to clearly record this. It states that staff must consider the impact of the parent or carer's mental illness on the child. Where concerns exist for the child, staff are required to discuss these with the Safeguarding team to determine what support should be offered to the family. The Trust's Adult Safeguarding Policy provides guidance for safeguarding referrals but does not make explicit reference to historic abuse.	

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2. Assurance summary (cont.)

Recommendation 8 (continued)
The 2020/21 annual report details a significant increase in Adult Mental Health safeguarding referrals, particularly early interventions which increased by 368% (to 1,837) from 2020/21 to 2021/22. The report attributes much of this to staff having a better understanding of their responsibilities for reporting abuse. Two audits were undertaken to review child safeguarding practice within the mental health service which (reported under recommendation 10) found a mix of improved practice and areas for improvement.
Residual recommendations:
RR5: The Trust should ensure that staff understand and undertake their responsibilities for reporting safeguarding concerns when a patient reports historic abuse. See also RR8 below with regard to including reference to historic abuse within the Adult Safeguarding Policy.

Recommendation 9	
The Trust must provide assurance that there is an effective process for supporting patients who appear to be under duress due to criminal exploitation/cuckooing/County Lines, and that these are addressed in care plans.	
Niche assurance rating for this recommendation	**2**
Key findings: The Trust provided evidence of some progress in implementing this recommendation, although assurance was limited to one case example. This was a patient who had been under duress due to cuckooing and identified how the Safeguarding Team would be involved in the discharge process and how staff were supporting this young person. The Trust have jointly appointed a Mental Health Liaison Officer with the local police to facilitate closer working to support mental health patients who have links with the police/criminal justice system. County Lines and child criminal exploitation is covered within the Integrated Children's Safeguarding Policy of August 2021. These issues are not, however, covered specifically within the Adult Safeguarding Policy. The Integrated safeguarding service provide a practitioner advice line and safeguarding training re: exploitation /cuckooing /County Lines. The Trust has developed seven minute briefings to support lessons learned around exploitation.	
Residual recommendations:	
RR6: The Trust should update the Adult Safeguarding Policy, at the next opportunity to i) refer to the criminal exploitation of young adults in relation to County Lines related abuse and ii) include specific reference to historic abuse. RR7: The Trust should undertake further case review work to evidence that support for patients under duress due to criminal exploitation is being addressed in care plans.	

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2. Assurance summary (cont.)

Recommendation 10	
The Trust must conduct an audit of adult mental health staff active engagement in reporting child safeguarding concerns, identifying any areas of concern and implementing appropriate remedial actions where necessary.	
Niche assurance rating for this recommendation	4

Key findings: Two audits have been conducted to identify whether child safeguarding and other information about children was being recorded appropriately. The first in 2020, by the Head of Safeguarding, considered the notes of 13 adult CMHT patients who reached the threshold for a section 42 adult safeguarding enquiry between July 2019 and August 2020. An action plan was produced with seven actions and embedded evidence of remedial actions taken. Good progress appears to have been made against these actions.

A further audit of 60 sets of case notes, for patients on the generic CMHT caseload, was conducted in August 2022. This found some good practice with respect to risk assessment and liaison with the Safeguarding team. Areas for improvement were also identified relating to the identification of professionals involved, the recording of safeguarding risk alerts and completion of demographic information. There were some concerns regarding the audit tool criteria in this audit which may limit the scope of its conclusions. An associated action plan had seven actions which included a recommendation to repeat the audit on a two yearly cycle.

Residual recommendations:

N/A

Recommendation 11	
The Trust must provide assurance that patients who are complex and whose risks are documented as high, are not discharged from Trust services without a clearly documented rationale.	
Niche assurance rating for this recommendation	3

Key findings: The updated CMHT operational policy contains clear guidance about hard to engage patients with risk and how they should be considered for discharge. This includes a requirement to complete a comprehensive risk assessment and subsequent care plans which reflect the aspects of the individual's non-engagement with support and care.

The Trust provided examples of some work to support improvements in this area including a new CMHT meeting agenda template which prompts teams to consider and discuss patients listed for discharge at their team meetings.

A review of incidents from April – November 2021 identified that the Trust is reporting discharge incidents but none of these directly related to this recommendation. The Trust has not yet completed audits regarding the discharge process for complex patients whose risks are documented as high, but stated that a multi-disciplinary team (MDT) audit will be completed which will inform the need for annual or biannual audit going forward.

Work is underway to change core assessment processes as part of the CMH Transformation Programme. The development of the new policy to support this approach will be out to consultation in December 2022. This work will help shape and inform the Trust's clinical risk management policy.

Residual recommendations:

RR8: The Trust must complete its planned audit work to provide assurance that actions are having the required impact.

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2. Assurance summary (cont.)

Recommendation 12	
The ICB (former CCG) must seek assurance from the Trust that improvements have been made to staff awareness and understanding of children's safeguarding issues that has led to a significant improvement in clinical practice.	
Niche assurance rating for this recommendation	**4**

Key findings: Evidence was provided to show that the ICB (former CCG) has sought assurances from the Trust with regard to children's safeguarding practice and that they had noted significant improvements. A monthly ICB (former CCG) Safeguarding Assurance meeting systematically reviews safeguarding data and information from the Trust to identify areas of concerns/success and agree mitigating actions.

Two ICB (former CCG) representatives sit on the OSCP Quality Assurance and Scrutiny Panel. The ICB (former CCG) has created a safeguarding assurance tool that the Trust populates with information. The Trust is working with the ICB (former CCG) to provide safeguarding assurance information routinely through this tool.

Commissioners noted improved practices in safeguarding supervision which have been reported to and are monitored by OSCP (see recommendation 6). The Panel reported improvements in responses to domestic abuse (which can directly impact on children) across the Trust. Integration of the safeguarding services across CFT and RCHT was felt to have strengthened governance by increasing the focus on child safeguarding. The Panel stated that CFT had "*made a number of improvements, but further progress is required".*

Residual recommendations

N/A

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Appendix 1: Evidence review

Appendix 1: Evidence review

Recommendation 1

The Trust must clarify the action that they expect staff to take when there is a question about whether to execute Duty of Candour.

Key evidence submitted	Niche review
ICB (former CCG): Quality Review of a Root Cause Analysis Investigation Report Serious Incident Investigation Review Template and Contributory Factor Grid, not dated	The Trust confirmed that this document was completed for every serious incident investigation and requires the following information as part of completion: *Q11: Is there evidence of appropriate support and communication for patients and relatives? This should reflect the principals [sic] of 'Being Open', Duty of Candour and (as appropriate) include details of how the findings will be shared. Yes / Partially fulfilled / No.* Commissioners also review this document before closing each case to ensure that all actions have been completed. If this is not evident then further information is requested from the Trust and the incident not closed until it is completed.
Patient Safety Incident investigations (PSII) training programme, not dated	This training programme timetable provides an outline of a two-day PSII training course which includes reference to Duty of Candour (DoC) responsibilities.
Governance Business partner/lead investigator Band 8a job description, not dated	The post holder will work as part of the central assurance team to triangulate intelligence to identify early warning signs of failure and opportunities for improvement. The post holder will also have responsibility and accountability, for the strategic development and management of the arrangements for the DoC, and for regulatory compliance and integrated governance for the defined part of operational services via the business partner mode.
DoC and Family Liaison Officer, Band 6 job description. Commenced January 2021	This job description details a new role to provide leadership and support to staff to carry out their DoC and family liaison responsibilities. A designated role within the corporate governance team for supporting operational teams with DoC commenced in January 2021.
Mortality review update Quarter 1 to Quality Assurance Committee, October 2021	This 15-page report describes findings from the latest quarterly mortality review. Case review included examination of the involvement of families and carers in the review process and in ten cases DoC compliance was reviewed. In eight cases where DoC had been applied, stages 'two' and 'three' had been completed. None had yet progressed to the final stage with the report being shared. In four cases this was due to the investigations not yet being complete, where the delays related to an extension of the timeframe of the investigation (this having being shared with families to keep them informed). Operational pressures and manager capacity were cited as contributory factors in all other cases.
Job description for governance business partner, not dated	A designated role within the corporate governance team for supporting operational teams with Duty of Candour commenced in January 2021

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Appendix 1: Evidence review (cont.)

Recommendation 1 (continued)	
Key evidence submitted	**Niche review**
Example, anonymised DoC letter	This example letter demonstrated appropriate communication with a family by the Trust to apologise and provide other information.
DoC presentation to Board members, not dated	This presentation consists of a comprehensive set of 26 slides concerning DoC requirements. The presentation is not dated, and Board attenders not indicated.
Statement from the Trust in Combined Action Plan December 2021	The Trust has conducted an internal review of the last 60 serious incident investigations. Duty of Candour was completed in 53 cases of the seven cases - where it was not completed, five declined further involvement and in two cases no next of kin was able to be identified. The Governance and Risk Team will have oversight and monitor Duty of Candour compliance and report to Quality Assurance Committee. Compliance with Duty of Candour training will be reported monthly to the operational managers and monitored by the governance and risk team.
Duty of Candour – final internal audit report, December 2021	The objective of the audit was to assess compliance with DoC requirements, including the quality, timeliness and local ownership of recording of DoC within patient records, and of the letters sent to patients and families. The overall findings were: • The Trust has a clear policy; however, the policy was not consistently applied. Fundamental requirements, such as giving verbal apologies as soon as possible after the incident occurs, followed up with a written apology, were not being followed in all cases. • Actions have already been undertaken to improve DoC processes, including a revision to the Trust policy to ensure improved correspondence with patients and families. • Policy implementation is being supported by the development and provision of education and training. It reports that ".*Compliance is being monitored through Performance and Quality Assurance Committees.*". • Poor and untimely record keeping was resulting in inaccurate reporting of DoC related incidents to the Quality Assurance Committee and the Board. A Trust-wide record management audit was being scoped and will be undertaken during 2022/2023. • Roles and responsibilities of various staff groups across the organisation were understood, but there was a continued over-reliance on the Governance team and DoC lead, who had too much hands-on involvement rather than facilitating or supporting staff to undertake DoC. • Areas of poor record keeping were observed, which combined with the findings from previous audit reports, highlighted this as a cultural weakness across the Trust. Recommendations were made for a whole organisation approach to reviewing and improving the culture around record keeping.

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Appendix 1: Evidence review (cont.)

Recommendation 1 (continued)	
Key evidence submitted	**Niche review**
Duty of Candour Policy, February 2022 (continued)	The Policy was updated in October 2021 to confirm that DoC should commence as soon as possible and not wait for a coroner's verdict. The Policy was further updated in January and February 2022 to provide a template letter which included an updated harm rating to include 'near miss' and the the name of the DoC lead.
Duty of Candour Policy, February 2022	CFT has a defined process for DoC as per regulatory requirements. The process is contained in the Duty of Candour Policy and Process which has been revised and was last ratified on 3 August 2021. The Policy clearly covers when DoC does and does not apply.
Quality Assurance Committee minutes, July 2022	These minutes detail an operational plan to address the backlog in DoC. They advise that governance improvement staff are working with teams to address the backlog.
Trust Board minutes, 15 August 2022	The Board minutes detail consideration by the Quality Assurance Committee (QAC) in July 2022 of minutes and actions which state: *"The QAC is aware that the Duty of Candour process is in recovery however there are 110 active cases with 44 over the 70 day response standard. The committee wishes to see the trajectory of recovery from each directorate. This is being actively managed through the Chief Operating Officer team."* The Board considered the findings from an internal audit review of DOC (see summary of findings below). The Board also received the minutes of the Regulatory Compliance Committee (25 May 2022) which raised a concern that there had been a failure to comply with Trust policy in respect of DoC and Structured Judgement Reviews.
ICB (former CCG) Procedure: Patient safety incident closure process. September 2022	The ICB (former CCG) has a documented procedure for closing patient safety incidents. It details pre-closure assurance checks which include the need to complete Duty of Candour requirements. This procedure is followed for each serious incident investigation.
PSII Check and Reflect meeting agenda 7 October 2022	This is a template for a first meeting to discuss a patient safety incident investigation. It includes a prompt on DoC and family liaison.
PSII scoping and planning template, 17 October 2022	This template references PSII standards to prompt information gathering. It also prompts for DoC and family liaison requirements, as well as staff support.
Email from ICB (former CCG) Head of patient safety and patient safety specialist, December 2022	In addition, there is a prompt regarding Duty of Candour being undertaken on the national STEIS reporting system which requires completion of this box prior to closure of the incident by the ICB (former CCG). These are must do actions for the ICB (former CCG).

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Appendix 1: Evidence review (cont.)

Recommendation 2

The Trust must ensure that the policy on engaging with families of victims of homicide committed by patients known to mental health services reflects best practice set out in the NHS England (London) Investigation guidance issued in April 2019 on engaging with families after a mental health homicide.

Key evidence submitted	Niche review
Patient Safety Incident Response Plan (PSIRP) 2021-22	The Trust is an early adopter for the Patient Safety Incident Response Framework. The Trust's PSIRP describes how it will engage with patients and their families (page 25) during a serious incident investigation. This includes both support and involvement. The Trust told us that a mental health homicide is a national priority for a PSII; the PSII requirements are clear about family involvement.
Statement from the Trust in Combined Action Plan December 2021	A review of a recent homicide case shows the family have been fully involved in development of the scope and terms of reference and review of the draft report prior to finalisation. The Trust is working with Hundred Families (a charity that supports families affected by mental health homicides) on recent homicide cases. The Trust is in the process of recruiting a Nurse Consultant for Integrated Community Mental Health. This role will be integral in supporting families.
PSII Scoping and Planning Meeting, agenda template, 17 October 2022	This template prompts staff to record consent for family involvement, the level of support required to enable the family to participate, who is responsible for family involvement, and who will take the lead and when in enabling family feedback on the investigation terms of reference.
PSII Check and Reflect Meeting, agenda template 17 October 2022	This template prompts staff to record who is responsible for family liaison, last meeting date, any barriers, feedback on terms of reference from the family and date of next planned contact
Summary of additional evidence required for Quality Assurance Review, 20 November 2022	The Trust emphasised that they would expect a high level of engagement as part of applying the 'being open' principles during any investigation as standard practice.
CFT Trust website Patient Safety | Cornwall Partnership NHS Foundation Trust (cornwallft.nhs.uk)	The Trust website includes clear links to the NHS England Framework for involving patients in patient safety investigations.

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Appendix 1: Evidence review (cont.)

Recommendation 3	
The Trust and the Clinical Commissioning Group must ensure that families are offered appropriate involvement in serious incident investigations and that they are always offered a copy of the investigation report.	
Key evidence submitted	**Niche review**
Mortality Review Update Quarter 1 to Quality Assurance Committee, October 2021	This review found that engagement and involvement of the family occurred in nine out of ten serious incident investigations reviewed.
Hundred Families email. November 2021	Email correspondence between the Trust and the Hundred Families charity representing one family suggested that giving families seven days to respond to a draft report is inadequate and that families need up to a month.
Statement from the Trust in Combined Action Plan December 2021	The Trust has conducted an internal review of the last 60 serious incident investigations. Duty of Candour was completed in 53 of the seven cases - where it was not completed, five declined further involvement and in two cases no next of kin was able to be identified.
Example anonymised family letter, 4 February 2022	This was a redacted letter to family which demonstrated 'saying sorry', explaining the process to a family and offering support.
PSII Scoping and Planning, agenda template, 17 October 2022	This template prompts staff to record consent for family involvement, the level of support required to enable the family to participate, who is responsible for family involvement and who will take the lead and when, in enabling family feedback on the investigation terms of reference.
PSII Check and Reflect Meeting, agenda template, 17 October 2022	This template prompts staff to record who is responsible for family liaison, last meeting date, any barriers, feedback on terms of reference from the family and date of next planned contact.
DoC and Family Liaison Officer, band 6 job description	This new role is to provide leadership and support to staff to carry out their DOC responsibilities and lead on family liaison.

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Appendix 1: Evidence review (cont.)

Recommendation 4

The Trust must provide robust assurance that they have fully implemented the actions arising from the two recommendations of the internal investigation:

Actions:

1. *The Trust to discuss the findings of the investigation with the police lead, around information sharing in such high-risk cases, the decision not to ease the bail conditions, and public protection versus support of alleged perpetrators.*
2. *Discussions with relevant staff to take place around the decision not to contact the 'Nearest Relative' and action implemented if indicated.*

Key evidence submitted	***Niche review***
Serious Incident (SI) action plan with summary notes on progress, 1 February 2017	The action plan briefly describes actions taken in response to the two recommendations arising from the internal investigation. Action 1 – The action plan states: "*Senior Round Table with Executives from both organisations and […] (Head of Social Work; and local Chair of Criminal Justice and Health Liaison group Cornwall) to be held by end of January 2017. […] provided written information of a meeting between himself and the Chief Inspector. Executives from both organisations were invited, but not attended."* Action 2 – The action plan states: "*by end of November 2016 [name] to refer to appropriate senior practitioners to ensure that the Approved Mental Health Professional (AMHP) involved has the relevant supervision. [name removed] provided written information stating he met with the AMPH involved and 'looked in detail' at the information "* Evidence of the outcome of this meeting or of involvement of senior practitioners was not included. *"..the Criminal Justice and Health Liaison group, both locally and in Cornwall and at Peninsula level, will continue to provide a forum for the review and improvement of such information sharing arrangements…"*
Statement from the Trust in Combined Action Plan December 2021	The Trust holds evidence of completion of the action plan associated with the serious incident investigation. This was reviewed and signed off at the Clinical Quality Assurance Group.
	See also evidence under recommendation 9 regarding the appointment of a Mental Health Liaison Officer. This role acts as a conduit between CFT and the police as required

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Appendix 1: Evidence review (cont.)

Recommendation 5

The Trust and the ICB (former CCG) must address the knowledge and skills gap present in their safeguarding children leads to ensure that those staff fully understand the Local Children Boards Regulations 2006, in particular the requirements relating to actions following the death of a child who was subject to abuse and how to action these.

Key evidence submitted	Niche review
Safeguarding Adults Board Escalation Process Draft v3, October 2020	This process describes the steps to be taken if a member of staff needs to escalate issues/concerns due to professional differences in relation to adult safeguarding.
Safeguarding Adults Board escalation process v3, October 2020	This document is a guide on how to resolve any differences of opinion between professionals and services with regard to safeguarding issues. It states as follows: "*Its aim is to assist with developing a quick and straightforward means of resolving professional differences of opinion in relation to concerns about an adult.*" This document refers to adult safeguarding only and does not contain information relating to children's safeguarding.
OSCP Quality Assurance and Scrutiny Panel minutes, 12 May 2021	The panel noted that "*The greater resilience within the ISS and consistent safeguarding provision across CFT has allowed the safeguarding specialists to work more closely with AMHS staff. This has allowed them to identify incidents and situations where they have been able to provide advice and support*."
Children's Safeguarding Review Group – Terms of Reference, June 2021	In June 2021, the Our Safeguarding Children Partnership (OSCP) Board established a dedicated Children's Safeguarding Review Group to manage Rapid Reviews and Local Child Safeguarding Practice Reviews (LCSPRs). This work involves monitoring recommendations and other related review processes, including liaison with the LCSPR National Review Panel regarding identified learning and consequent actions from Rapid Reviews. This work had previously been managed by the OSCP Learning and Quality and Assurance Groups. The Review Group reports quarterly to the OSCP Board and contributes to the OSCP Annual Report. The overarching responsibilities of the Group are: • receipt of Rapid Review referrals and commissioning of Rapid Review Panel meetings to review circumstances and make recommendations about required actions as outlined in the Rapid Review procedures; • commissioning of LCSPRs, including appointing external, independent reviewers; • oversight of completed LCSPR reports, submission to the OSCP and the publication process, including preparation of media statements and communications; • oversight of action plans and monitoring of progress against these; • commissioning of other types of multi-agency review, for example Learning Lessons and Learning from Experience reviews; • receiving single agency reviews that may provide multi-agency learning opportunities across the OSCP; and • liaising with the National Review Panel.

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Appendix 1: Evidence review (cont.)

Recommendation 5 (continued)	
Key evidence submitted	**Niche review**
Children's Safeguarding Review Group – Terms of Reference, June 2021 (continued)	Other review-related functions include: • follow up of learning from Rapid Reviews where no review has been commissioned but actions remain to be implemented; • contributing to, or dissemination of learning from, external reviews, for example, Domestic Homicide Reviews or Safeguarding Adult Reviews, where children from Cornwall or the Isles of Scilly are involved; • learning from other areas – regional/national and other multi-agency reviews such as suicide of a parent or learning from coroner inquests. The terms of reference also state that the OSCP Review Group will: • maintain a log of cases referred for review and the decisions/actions taken to ensure that any learning is integrated into practice; • share multi-agency learning and identified training needs to the OSCP Learning Group for implementation; and • share multi-agency quality issues identified to the Quality Assurance Committee for follow up. Individual organisations are responsible for taking forward their own single agency actions. Terms of reference include the escalation procedure for when there are disagreements within the OSCP Review Group.
Local Children's Safeguarding Practice Reviews (LCSPRs) - Child C July 2020, David and George (pseudonyms) October 2021	There have been two LCSPRs which found multi-agency learning. A 'seven-minute briefing guide' was produced for each and disseminated throughout the Trust. The Child C guide is also discussed at Safeguarding Children Level 3 training.
Patient Safety Incident Response Plan, Board approved version 1.0, October 2021	The PSIRP contains specific information about responding to child deaths and a link to further associated guidance. There is a link to the CDR Statutory and Operational Guidance (England) of 2018 which superseded the 2006 regulations referred to in this recommendation.
Integrated Safeguarding Services Annual Report 2021-22	The annual report states that additional Safeguarding Supervisor training is being provided in September and November 2022 and that consideration is being given to the development of in-house Safeguarding Supervisor training. Integrated Safeguarding Services continue to provide safeguarding supervision across the Trust and group supervision for Safeguarding Supervisors is being developed to ensure they remain competent and confident in their roles.

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Appendix 1: Evidence review (cont.)

Recommendation 5 (continued)	
Key evidence submitted	**Niche review**
OSCP Quality Assurance and Scrutiny (QAS) panel scrutiny review of ICB (former CCG) child safeguarding arrangements. Findings of the panel meeting held on 4 October 2021. Published May 2022	On 4 October 2021 key representatives from the ICB (former CCG) appeared before representatives from the OSCP QAS panel. The ICB (former CCG) delivered a presentation and answered questions based on a framework set by OSCP The panel used the criteria outlined within Ofsted's Framework evaluation criteria and inspector guidance for the inspection of local authority children services as a basis for assessing the quality of responses. A review by the scrutiny panel reported very favourably on the ICB (former CCG)'s contribution to children's safeguarding practice. The panel members stated they were reassured that the ICB (former CCG) is operating well in terms of influencing the development of child safeguarding in Cornwall and the Isles of Scilly. They found high levels of knowledge and experience within its safeguarding team, which is seen as a strength. They concluded that their influence is current and relevant, and that new developments are known and introduced into practice. They also reported positive governance arrangements which allow the ICB (former CCG) to understand levels of performance and the quality of health service delivery. Panel findings are summarised below. • Distinct improvements since its previous review (in November 2019). • ICB (former CCG) child safeguarding staff with good visibility in both senior leader and operational delivery areas. • Experienced, well respected and knowledgeable ICB (former CCG) staff making significant contributions to all aspects of child safeguarding. • ICB (former CCG) able to influence safeguarding activity and future developments positively (both locally and nationally) with a number of examples provided. • ICB (former CCG) leadership built strong relationships with leaders across the local health community ensuring that child safeguarding remained high on the agenda for everyone, particularly during the pandemic. • Learning sessions and publicity campaigns have been undertaken and, as a result, professionals have recognised "suspicious" incidents. • Led and supported best practice around understanding and responding to child criminal exploitation. • Positive governance arrangements which allow the ICB (former CCG) to understand levels of performance and the quality of health service delivery. • The ICB (former CCG) has considered all aspects of its activity to promote and support child safeguarding; for example, to ensure it is explicit in new commissioning and considered within contract management. • The safeguarding of looked after children has strong links with national practice development in this area. This has supported the overall drive to improve standards.

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Appendix 1: Evidence review (cont.)

Recommendation 5 (continued)	
Key evidence submitted	**Niche review**
OSCP Quality Assurance and Scrutiny (QAS) panel scrutiny review ICB (former CCG) child safeguarding arrangements. Findings of the Panel meeting held on 4 October 2021. Published May 2022 (continued)	• The ICB (former CCG) designated professionals have taken a central role in numerous multi-agency case audits (e.g. around child sexual abuse and neglect), allowing the partnership to understand the quality of response. These case audits have been instrumental in bringing about the change and continue with ICB (former CCG) support. • The ICB (former CCG) has maintained oversight of the response to child exploitation within health provider organisations. There are good examples where health providers have recognised key indicators and taken appropriate action. • Child exploitation is understood well and considered by health professionals in both provider trusts and primary care. There has been extensive training delivered to health professionals and health providers have been actively involved in recent child exploitation publicity campaigns in Cornwall. • The ICB (former CCG) safeguarding professionals have undertaken case audits to monitor the safeguarding effectiveness of mental health support services. This has supported the overall drive to improve standards. • The ICB (former CCG) contributed significantly to the safeguarding of children during the pandemic. At strategic and operational levels ICB (former CCG) leaders and staff ensured child safeguarding remained a priority and used their position to influence others. The Panel noted that the introduction of the Integrated Care System (ICS) into Cornwall and the Isles of Scilly had been delayed. It was planned to be introduced during 2022. However, the OSCP had received assurance that child safeguarding would remain a priority for the ICS and that there will be no reduction in child safeguarding staffing levels during the transition.

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Appendix 1: Evidence review (cont.)

Recommendation 5 (continued)	
Key evidence submitted	**Niche review**
Statement from the Trust in Combined Action Plan December 2021	The ICB (former CCG) designate practitioners provide supervision for the senior Trust team. There has been a revised Child Death Review (CDR) arrangement since Working Together (2018). Designated and lead professionals attend the south west NHSEI designated professionals forum, which offers peer support and advice. ICB (former CCG) actions: The ICB (former CCG) reviewed the capacity of the safeguarding team to increase safeguarding provision, support and enable challenge. The ICB (former CCG) developed a safeguarding accountability and assurance framework, which describes what they are accountable for. It also describes the routes of escalation when there are concerns about the system's response to a safeguarding incident. Safeguarding governance has been strengthened with the introduction of a separate safeguarding assurance meeting that links directly to the Quality Assurance Committee. It also has delegated authority for decision making. The ICB (former CCG) also report strengthening of NHSE support to their staff through refreshed safeguarding governance. The ICB (former CCG) provides regular reports to NHSE which are then scrutinised by the team and through the NHSE south west safeguarding steering group. This is evidenced by ICB (former CCG) quarterly reports to NHSE, attendance at the steering group and 'deep dives'. Data from seven areas are presented and can be analysed to compare and contrast between areas and identify trends. The steering group also scrutinise any outlying data. **External scrutiny of arrangements**: Peer review of the OSCP by Surrey Safeguarding Children Partnership took place in 2021 to provide assurance of the partnership's effectiveness. The report is in draft form. The ICB (former CCG)'s safeguarding arrangements were scrutinised through the OSCP scrutiny panel in September 2021 to provide assurance on their effectiveness. As a statutory partner, the ICB (former CCG) is supporting the OSCP to develop a new structure which will enable the ICB to function more effectively as an equal partner. Since this incident, the Children and Social Work Act (2017) replaced serious case reviews with child safeguarding practice reviews. The ICB is supporting the OSCP to refresh existing CSPR procedures and will ensure that any procedures reflect the responsibilities set out in the Act. New posts of Deputy Director of Nursing, Head of Nursing and Named GP For Adult Safeguarding were created by the ICB (former CCG) following the review of capacity. The safeguarding review tracker was an agenda item at the NHSE professionals meeting in December 2021.

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Appendix 1: Evidence review (cont.)

Recommendation 5 (continued)	
Key evidence submitted	**Niche review**
Statements by the Trust within document Mr T Assurance Plan, 30 August 2022	The Safeguarding team received additional investment in 2021 to increase the workforce and diversity of skills. A children's social worker has recently joined the team on a fixed term contract. The Trust assurance plan states that: • There has been 100% CFT attendance at OSCP Review Group meetings where decisions are made regarding Rapid Reviews and LCSPRs. • CFT safeguarding representatives act in an advisory role on the OSCP Review group. Decision-making responsibility sits with the ICB (former CCG) representative. • Named professionals continue to participate in continued professional development, including Level 4 Safeguarding and Safeguarding Master Modules. • Named professionals undertake specific safeguarding supervision from the ICB (former CCG) Designated Nurse in addition to line management supervision from the Consultant Nurse for Integrated Safeguarding Services.
Trust email, 20 November 2022	The Trust provided an example (from 2019) of where the children's safeguarding lead disagreed with the panel and requested a LCSPR and as a result the National Panel asked the OSCP to review the decision again. The Trust's Safeguarding Children Lead attends the Review group as an advisor.
Trust email, 20 November 2022	The Trust confirmed that the designated safeguarding leads have undertaken a Masters module in risk and decision-making in safeguarding.
Trust organisational safeguarding structure, not dated	This document shows where Children's Safeguarding Leads (nursing and medical) fit into the safeguarding structure, and how they are supported.
Child Death Review Arrangements - Cornwall Council From Council website	NOTE. National guidance has changed since this recommendation was made. The child death review (CDR) process covers children up to the age of 18. A child death review must be carried out for all children regardless of the cause of death. Working Together to Safeguard Children 2018 says that: • CDR partners must make arrangements for the analysis of information from all deaths reviewed • CDR partners must publish their arrangements for child death • CDR partners make arrangements to review all deaths of children normally resident in the local area. Also, if appropriate, for any non-resident child who has died in their area. Trust staff work in partnership with other key partners and the ICS will support this process going forward.

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Appendix 1: Evidence review (cont.)

Recommendation 6

The Trust and the ICB (former CCG) must assess and report the impact of the revised processes and training programmes in relation to improving child safeguarding practices in adult mental health services.

Key evidence submitted	Niche review
Domestic Abuse Strategy 2019-22	The Trust has developed a domestic abuse strategy.
OSCP minutes, May 2021	The minutes report that *"the training offer across both trusts has become a real strength and health staff are in a good position to receive high quality safeguarding training. The panel recognises the issue regarding training compliance in CFT and acknowledges the efforts to address this."* The panel set a recommendation for CFT to bring its training performance up to expected levels within 12 months and acknowledged the work done to date.
Statement from the Trust in Combined Action Plan December 2021	Safeguarding referrals and access to supervision information is submitted monthly to the Executive Trust Board and to QAC. The ICB (former CCG) monitors training compliance and the effectiveness of this through a new cloud-based safeguarding assurance tool called the safeguarding assurance scorecard. We have seen a screenshot of this. They state that the refreshed governance arrangements detailed in recommendation 5 provide the mechanism for review and assurance. The Trust has provided an invitation to ICB (former CCG) staff to attend and provide feedback on training.
Statements by the Trust within Mr T Assurance document dated 30 August 2022	The Trust advised that Care Groups report on their training compliance at the Safeguarding Children Operational Group (SCOG). Compliance increased in 2021-22 to around 80% of staff required to attend this, across CFT, although we do not have this disaggregated for Adult Mental Health Services. The Trust report that they do monitor this by work area. Level 2 Safeguarding Children's training is available as an e-learning package.
Job description for the Safeguarding Practice Educator role, no date	A Safeguarding Practice Educator has been appointed for a six-month fixed term to support the pilot of the competency framework. The pilot will begin with Adult Mental Health Practitioners.
Domestic abuse training video. Not dated	The Trust has developed a staff training resource video about domestic abuse for use in upskilling staff.
RiO template. Not dated	A 'signs of safety' template is now available on Rio to facilitate conversations with families around child safeguarding.

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Appendix 1: Evidence review (cont.)

Recommendation 6 (continued)	
Key evidence submitted	**Niche review**
Trust Integrated Safeguarding Service newsletter, summer 2022	Safeguarding mandatory Level 3 training, for all frontline staff, has been mapped against the Skills for Health competencies. The mandated training includes Think Child, Think Adult, Think Family. It includes specific examples of factors in the home such as "*domestic abuse, substance abuse, alcohol misuse, mental health problems and financial strain."* Part of the mandatory training focuses on neglect, which explicitly includes substance and alcohol misuse. The newsletter also contains a lot of information and support around domestic abuse in relation to safeguarding. It also confirms that safeguarding 'communities of practice' commenced in June 2021 which provide an opportunity for any staff to discuss current safeguarding practice in a "*safe and supportive*" environment.
Domestic abuse training material and participant feedback, June 2022	One-day domestic abuse training is offered to all frontline staff; facilitated by the Integrated Safeguarding Service (ISS) and delivered by Barnardo's. Evaluations were provided to us following training delivered in June 2022. These show that staff reported feeling more confident in identifying and taking action in relation to domestic abuse after undertaking this training.
Learning Lessons Programme for Autumn 2022	The ISS continue to deliver 'Learning Lessons', one-hour bespoke training. The content includes the Mental Capacity Act 2005, Think Family, Self-Neglect, MARU (Multi-Agency Referral Unit) Masterclass, Practice Learning Review from recent child deaths from other areas. .
Integrated Safeguarding Service Training Strategy 2022-25	The three-year safeguarding training strategy was recently signed off by the CFT Trust Board. The proposal going forward is to use a Safeguarding Competency Framework through a continuing professional development approach. The strategy aims to move away from a sole focus on training compliance. The plan is to increase the number of safeguarding sessions accessible to all staff to support an increase in training compliance and improve staff competency. The team continue to promote a Think Family approach within training sessions and supervision sessions. The strategy notes the challenges for the Trust in providing assurance that staff are competent safeguarding practitioners. Currently the Trust only monitors compliance data for staff attending training sessions. The strategy notes that the monthly data on training (which varies by month) confirms the challenges in achieving compliance rates. The new approach is planned to be trialled as a three-month pilot commencing in June 2022. The ICB (former CCG) provided investment to support this change in practice. The strategy and its impact on safeguarding practices was planned to be trialled.

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Appendix 1: Evidence review (cont.)

Recommendation 6 (continued)

Key evidence submitted	Niche review
Quality Assurance Committee minutes 23 August 2022	Data on training is reported regularly to the Joint Quality Assurance Committee. The ICB (former CCG) have a representative at this group and receive copies of approved reports. The QAC minutes include the data below for Trust wide Safeguarding training compliance in Quarter one of 2022/23.

	Level 1	Level 2	Level 3
Adult Safeguarding Training	89%	82%	78%
Children's Safeguarding Training	88%	83%	71%

The CFT target for compliance is 85%, so the Trust is currently above this level for level 1, but below this level for levels 2 and 3 for both Adult and Children's Safeguarding Training.

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Appendix 1: Evidence review (cont.)

Recommendation 7

If the ICB (former CCG) has not already done so, the potential missed opportunities for liaison between health practitioners as a consequence of health visitors moving to the employment of the council must be fully assessed and mitigated.

Key evidence submitted	Niche review
Statement from the Trust in Combined Action Plan December 2021	The ICB (former CCG) had planned to develop a proposal for health input into the multi-agency referral unit in discussion with public health and the OSCP The proposal remains to be implemented and evaluated. The ICB (former CCG) also submitted a paper to OSCP about the risks of missed opportunities as public health do not save information received from the trusts unless they relate to an open case.
Public health nursing service review (PHNS) final terms of reference. Taken to NHS Cornwall and Isles of Scilly ICB Board 15 November 2022	This paper provides the final terms of reference for a review of public health nursing services relating to the attendance of children aged 0-19 years at local emergency departments or minor injuries units. The PHNS report will be presented at the January 2023 ICB Board meeting as well as the executive Our Safeguarding Children Partnership (OSCP). It has also been discussed by the System Quality Group (meeting agenda has been provided). The purpose of the review is stated clearly to: • "*provide a review of decisions made in relation to the transfer of the service and service records from the PHNS (provided then by Cornwall Partnership NHS Foundation Trust) to Cornwall Council in April 2019.* • *provide a clear understanding of the history and governance to date in relation to this transfer of services and records, including lessons learned and identified risks and how these were mitigated and outline the current position of this information sharing process.* • *provide an options appraisal for Cornwall and Isles of Scilly of best practice examples, both regionally and nationally, of how information sharing for children and young people attending ED and MIU could meet regulation and best practice going forward.*"
Supplementary information received	An email (dated 21 October 2022) from the Designated Nurse Safeguarding Children confirms that the Health Visitor leadership team sits in the local authority's Early Help framework.

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Appendix 1: Evidence review (cont.)

Recommendation 8

The Trust must ensure that staff understand and undertake their responsibilities for reporting safeguarding concerns when a patient reports historic or current abuse.

Key evidence submitted	Niche review
Adult safeguarding poster 2017	This poster sets out the various kinds of abuse that can occur and reminds staff of their responsibilities to report these.
Adult Safeguarding Policy, January 2020	The Policy sets out clearly what is relevant for a safeguarding referral and what staff should do. It does not make reference to historic abuse.
Integrated Safeguarding Services Annual Report 2021/22	The annual report details a significant increase in all safeguarding referrals for Adult Mental Health, particularly early interventions which increased by 368% (to 1,837) from 2020/21 to 2021/22. Within the Trust overall, Children's Safeguarding referrals have increased by 152% (from 274 in 2020/21to 417 in 2021/22). Within Adult Mental Health, early interventions were 95% (n=1747) of safeguarding activity in 2021/22, up from 87% (n=373) in the previous year. There was also an increase of 55% in Section 42 enquiries. The report attributes much of this to staff having a better understanding of their responsibilities for reporting abuse: "*...the safeguarding team have been making significant efforts to increase accessibility of safeguarding advice and support for staff across adult mental health services. This is reflected in the increase in activity and the increase in early interventions...*" It states that, to support the increase in activity, there has been significant additional investment from RCHT and CFT, enabling the successful recruitment of an additional eight whole time equivalent staff. Restructuring and investment in the team means there is now a designated Adult Safeguarding Officer to support integrated Community Mental Health Teams. The revised team structure also enables succession planning and provides a clear line management and supervision structure within the team.
Statement from the Trust in Combined Action Plan December 2021	The integrated safeguarding service provides awareness training to staff to assist them in understanding the significance of historic and current abuse. Safeguarding children Level 3 training also includes training on adverse childhood experiences to ensure staff recognise the importance of a trauma informed approach.
Rio extract July 2022	This extract shows how staff supervision details can be recorded on Rio.
Operating Policy for the Integrated CMHT, August 2022	The Policy includes direction to all staff to ask new patients if they care for children and to clearly record if this is the case. It requires staff to consider the impact of the parent or carer's mental illness on the child. The document also provides the safeguarding team number to encourage staff to report safeguarding concerns. Where concerns exist for the child, staff are expected to discuss the concerns with the Safeguarding Team to decide what support should be offered to the family.

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Appendix 1: Evidence review (cont.)

Recommendation 9

The Trust must provide assurance that there is an effective process for supporting patients who appear to be under duress due to criminal exploitation/cuckooing/ County Lines, and that these are addressed in care plans.

Key evidence submitted	Niche review
Adult Safeguarding Policy, January 2020	There is no reference to historic abuse or to criminal exploitation linked to County Lines, cuckooing etc., in this policy.
Agreement between the Police and CFT for funding of Mental Health Support Officer/Constable. Not dated	This document details how the new role will work, be managed and funded between the Trust and the police. It will be based at the Trust and provide both support and advice. The Trust reports the post holder is now in place.
Integrated Safeguarding Services Annual Report, April 2020 to March 2021	Within Adult Mental Health Safeguarding, data is collected on the primary type of abuse. A pie chart provided in the report shows the different categories which include modern slavery but not cuckooing or County Lines.
Mental Health Liaison Officer band 8a Job Description, not dated	The job description states that the postholder will work closely with police to *"provide advice, guidance and direction to mental health and community staff, police officers and police staff on best practice in providing a service to persons suffering with a mental health disorder in a criminal justice setting; in order to meet their individual needs…"*
Integrated Safeguarding Children Policy v1, August 2021	This policy is a comprehensive document which includes a section on child criminal exploitation including involvement in County Lines. It includes clear definitions and links to guidance including sharing information with the police.
Statement from the Trust in Combined Action Plan December 2021	The Integrated Safeguarding Service provide a practitioner advice line and safeguarding training re: exploitation/cuckooing /county lines. The Trust has also developed seven minute briefings to support lessons learned around exploitation.
Statements by the Trust within document Mr T Assurance Plan, 30 August 2022	The Trust states that the Integrated Safeguarding Service provide information to MACE(Multi-Agency Child Exploitation), MARAC (Multi-Agency Risk Assessment Conference) and CHANNEL (a multi-agency approach to safeguarding, supporting and protecting children, young people and vulnerable adults at risk of radicalisation, extremism or terrorist-related activity) and to the local authority. Patients discussed at these forums have updates recorded on their RiO records.
Evidence of risk assessment September to November 2022, and two extracts from care plan for the patient	This redacted section from a patient's risk assessment and care plan highlights concerns about cuckooing activity. It refers to a plan to include safeguarding in the discharge planning process for this patient. It also includes details of how he was to be safeguarded whilst on leave and how the staff would support him.

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Appendix 1: Evidence review (cont.)

Recommendation 10

The Trust must conduct an audit of adult mental health staff active engagement in reporting child safeguarding concerns, identifying any areas of concern and implementing appropriate remedial actions where necessary.

Key evidence submitted	Niche review
Audit Report by the Head of Safeguarding, 2020 plus resulting action plan	The Head of Safeguarding conducted an audit of 13 case records for adults within the mental health service who reached the threshold for a Section 42 adult safeguarding enquiry, between July 2019 and August 2020; the audit assessed the case records against standards from 'Working Together to Safeguard Children' (2018). The key findings were as follows: • Children's demographic information was not added to the client record meaning it was unclear which children the adult had contact with without searching through progress notes. • There was very limited liaison with staff from children's social care. • There was little evidence of liaison with other health agencies such as Child and Adolescent Mental Health Services, Children's Speech and Language Therapy and Health Visiting. • The impact of adult abuse and mental ill health on children was not clearly documented or explored. • Evidence of accessing children's safeguarding support was poor. • Three cases audited resulted in the author intervening to safeguard the children. In summary it found that the impact of adults' safeguarding risk and of adult mental ill health on children was not being effectively considered and recorded in the RiO clinical system. It concludes that risks to children were not being identified and managed effectively to ensure that children were safeguarded. An action plan was produced with seven actions. This aimed to ensure that CMHT staff evidence they are considering transferable risks to children and access supervision from the Safeguarding team. We reviewed an action plan with embedded evidence of remedial actions taken. Good progress appears to have been made against these actions. One action was to repeat the audit in April 2022 for patients on the generic caseload (rather than just those above the safeguarding threshold).

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Appendix 1: Evidence review (cont.)

Recommendation 10 (continued)	
Key evidence submitted	**Niche review**
Audit Proposal Form, not dated	This proposes an audit of 60 RiO records from general CMHT patient referrals from April 2020 to April 2022. The aim was to review whether child safeguarding and other information about children is being recorded. The audit was to be reported by the end of August 2022.
Audit Findings – Safeguarding Children, September 2022	This reports the results of the above audit of general CMHT referrals and safeguarding children practice. This found evidence of some good practice and improvements since the previous audit. Good practice included: • The integrated CMHT frequently consider the child in their risk assessments. • When risks are identified, MARU referrals are being made. • If concerns arise, staff are readily discussing these with the safeguarding team. Areas for improvement were: • Full details of social care professionals involved are frequently omitted, making identifying which services and professionals are involved in the case challenging, which may hinder timely information sharing. • Basic recording of information relevant to child safeguarding, such as including the child's details in the patient demographics and putting a safeguarding risk alert on the client's record. The report concludes that *"the integrated CMHT are actively considering any risks to the child when working with their clients, and take robust action when concerns arise, including readily sharing information with relevant social care and safeguarding services. However, fuller documentation of these instances may improve transparency and ease of information sharing between services."* The report noted a potential weakness in the audit method, that "…*suboptimal inter-rater reliability of audit tool criteria may limit the scope of conclusions drawn from the present audit..*" The final report contains an action plan with seven actions including one to repeat this audit every two years.

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Appendix 1: Evidence review (cont.)

Recommendation 11

The Trust must provide assurance that patients who are complex and whose risks are documented as high, are not discharged from Trust services without a clearly documented rationale.

Key evidence submitted	Niche review
CFT CPA Policy August 2017	The Care Programme Approach Policy has not been amended since 2017 (see comments below regarding the move to Dialog+). The Policy confirms that it is the responsibility of the consultant, ward manager and care coordinator to identify, at an early stage, when a service user's discharge should be arranged.
ICMHT Operating Policy May 2019	The Operating Policy has a detailed section on discharging patients. It states that: • *"Discharge should be an integral part of care planning for patients.* • *The discharge pathway should ensure that detailed pathways for contingency planning are in place.* • *If a patient is on CPA [Care Programme Approach] that a Community Discharge Planning Meeting takes place to finalise discharge arrangements.* There is also specific information about those hard to engage patients with risk and how they should be considered for discharge. This includes a requirement to complete a comprehensive risk assessment and subsequent care plans which should reflect the aspects of the individual's non-engagement with support and care.
MDT standardised agenda template for CMHTs, July 2021	The CMHT meeting agenda template prompts teams to consider and discuss patients listed for discharge for whom there are safeguarding concerns.
Statement from the Trust in Combined Action Plan Dec 2021	This states that an MDT audit will be completed which will inform the need for annual or bi-annual audit going forward but we have seen no evidence of this being completed.
Email from the Trust Patient Safety Specialist,18 November 2022	The email refers to current developments as a result of the Community Mental Health Transformation Programme. The Trust is moving to DIALOG + which is an approach that puts individual's priorities at the centre of the care system. The output of the DIALOG+ assessment will be a care plan that the service user and health professional create together that is specific, co-produced and clear. The care plan will be updated regularly as agreed with the service user. This work is part of the ongoing Community Mental Health Transformation Programme. The development of a new policy to support this approach is in progress and will be out to consultation in December 2022. The transformation work around clinical management will help shape and inform the Trust's clinical risk management policy. The email also referred to a review of incidents and the discharge process A review of incidents from April to November 2021 identified that the Trust is reporting discharge incidents, but none directly related to this recommendation**.** The Trust has not yet completed audits regarding the discharge process.

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Appendix 1: Evidence review (cont.)

Recommendation 12	
The ICB (former CCG) must seek assurance from the Trust that improvements have been made to staff awareness and understanding of children's safeguarding issues that has led to a significant improvement in clinical practice.	
Key evidence submitted	**Niche review**
OSCP Quality Assurance and Scrutiny Panel minutes, 12 May 2021	There are two ICB (former CCG) representatives on this panel. Minutes note that the Trust is working with the ICB (former CCG) to provide safeguarding assurance information regularly and routinely. The ICB has created a safeguarding assurance tool that the Trust populates with information. It was noted that the integration of the RCHT and CFT Safeguarding teams commenced in April 2020. The combined team, the Integrated Safeguarding Service (ISS), is led by a consultant nurse who works across both Trusts. MARU referrals made by staff at both Trusts are overseen by the ISS. The minutes state that Safeguarding supervision is now provided within Children's Community Mental Health Services to all practitioners who regularly work with children. This is an improvement-on what was previously provided, that being, supervision to only those involved in Child Protection and Child In Care work. There is a dedicated team of safeguarding supervisors who have been trained to provide safeguarding supervision individually and within groups. Improved practices are reported to and monitored by OSCP. The panel concluded that " *the availability of safeguarding advice and support across both trusts is good, leading to increased confidence and improved performance*". The panel felt this was a very positive aspect of the scrutiny process with" *both Trusts sharing a very clear commitment to developing the rights of the child. There have been clear improvements over the past 12 months and there are plans to develop this further."* With regards to domestic abuse, the minutes state: *"..the responses to domestic abuse across both trusts has improved. In particular there are clear improvements within CFT…"* The panel was reassured by the overall quality of child safeguarding across the two Trusts stating, *"…the safeguarding services are forward thinking, child focused and outward looking…"* *"The two Trusts, at a strategic level, have given the subject of child safeguarding integration a good amount of consideration. There is one senior director covering both trusts responsible for child safeguarding and there is one joint Quality Assurance Committee which receives quarterly reports."* RCHT has an established a Safeguarding Children Operational Group (SCOG) which monitors themes, influences training, checks progress and ensures lessons are disseminated to divisions across the Trust. At present this does not cover all services across CFT although CAMHS is included. There are plans to extend this further across CFT.

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Appendix 1: Evidence review (cont.)

Recommendation 12 (continued)	
Key evidence submitted	**Niche review**
OSCP Quality Assurance and Scrutiny Panel minutes, 12 May 2021 (continued)	The representatives at the panel reported that integration has strengthened governance by increasing the focus on child safeguarding. There are weekly meetings called 'huddles' that have improved communication and team working. This enables issues to be raised regularly and these are now looked at more closely. Senior leaders are kept updated on significant issues as they arise. The panel noted that the contribution of Adult Mental Health Services (AMHS) to child safeguarding has been an area of concern for some time. They commented "…i*t is clear CFT has made a number of improvements, but further progress is required…"* *"Since September 2020 the ISS has delivered sessions promoting the Think Family approach including for AMHS within CFT. The greater resilience within the ISS and consistent safeguarding provision across CFT has allowed the safeguarding specialists to work more closely with AMHS staff. This has allowed them to identify incidents and situations where they have been able to provide advice and support"* The minutes state that there has been a mix of good practice and missed opportunities. This has allowed staff within the ISS to recognise the good practice and address the opportunities. Members of the ISS based within CFT have recommenced monthly safeguarding supervision with AMHS leads. Being able to relate the supervision to live examples has enabled communication to be more meaningful. The minutes state that there is now a children's social worker working as a dedicated adult mental health safeguarding officer. This is felt to be supporting the improvement of child safeguarding within the service. In addition, there is a robust process to ensure that AMHS professionals are alerted when the child of an adult with mental health difficulties, known to AMHS, is made subject of an initial Child Protection Conference. The minutes stated, *"An audit has been completed to examine the quality of practice in this area. It emerged that although there is good practice this is not consistent across all of AMHS. Work is planned to address the gaps identified. Further training is being provided, supervisors are being targeted and a further audit is due to be conducted in April 2022."* The panel recognised the progress made within CFT although there is still more work to be done. It noted the plans to continue training, provide support and supervision and to conduct a further audit of practice. The OSCP asked to be kept updated of the further progress made.

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Appendix 1: Evidence review (cont.)

Recommendation 12 (continued)	
Key evidence submitted	**Niche review**
Safeguarding Assurance Meeting Terms of Reference, December 2021	The document sets out the terms of reference for the monthly ICB (former CCG) assurance meeting for adult and children safeguarding. It notes that a safeguarding accountability and assurance framework is in place that sets out how the ICB (former CCG) meets its statutory duties and how assurance is sought of safeguarding arrangements in commissioned services. The purpose of the Safeguarding Assurance meeting is to ensure compliance with the framework and identify and address areas of non-compliance. The terms of reference state that the Safeguarding Assurance Meeting will systematically review safeguarding data and information across its commissioned services, identifying areas of concerns/success and agreeing mitigating actions. The meeting will also review the effectiveness of how commissioners meet their statutory safeguarding duties both as an independent organisation and as a statutory partner in each safeguarding board and partnership in the Cornwall area.
Statement from the Trust in Combined Action Plan December 2021	Every year the OSCP complete a quality assurance process on all partner agencies. The integrated service was interviewed and presented its assurance in May 2021. The ICB (former CCG) were part of the panel. A partnership approach will be taken forward through the ICS.
OSCP Quality and Scrutiny Panel minutes, March 2022	These highlighted improvements in safeguarding practice at CFT which were fed back to the Integrated Safeguarding Service (ISS).
Safeguarding sub-committee Terms of Reference July 2022	The Trust QAC set up a quarterly sub-committee called the Safeguarding sub-committee which is authorised to request assurance of compliance on matters relevant to safeguarding including but not limited to: • Safeguarding adults • Safeguarding children • Mental capacity act • Deprivation of liberties • Liberty protection safeguards • Modern slavery act 2015.
Example of Think Family in action, email 2 September 2022	The email states: "*I took a duty call on Tuesday from Clinical Lead of Home Treatment Team, he was seeking advice around a mother who he had undertaken a crisis visit to, the previous day. The Police had attended as well and had said they would put in a safeguarding referral in however he wanted to check if he should do anything re this mother's child who was present. I advised he should speak with the MARU, to ascertain if they had been alerted by Police and to follow up with a referral with the information he had. The child's immediate safety was attended to as she had been collected by Grandparents. I wanted to let you know as this was a great example of using the Think Family Approach.*"

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Appendix 2: Glossary of terms

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AHMS	Adult Mental Health Service
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CFT	Cornwall Partnership NHS Foundation Trust
CHANNEL	A multi-agency approach to safeguarding, supporting and protecting children, young people and vulnerable adults at risk of radicalisation, extremism or terrorist related activity
DoC	Duty of Candour
ED	Emergency Department
ICB	Integrated Care Board
ICMHT	Integrated community mental health team
ISS	Integrated Safeguarding Service
LCSPR	Local Child Safeguarding Practice Reviews
MACE	Multi-Agency Child Exploitation
MARAC	Multi-Agency risk assessment conference
MARU	Multi-Agency Referral Unit
MDT	Multi-disciplinary team
MIU	Minor Injuries Unit
MOU	Memorandum of Understanding
NIAF	Niche Investigation Assurance Framework
OSCP	Our Safeguarding Children's Partnership
PSII	Patient Safety Incident Investigation
QAC	Quality Assurance Committee
RCHT	Royal Cornwall NHS Foundation Trust
RiO	The Trust's electronic patient/care record system

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