NHS
Stockport
Clinical Commissioning Group

Safeguarding Annual Report showing performance against statutory duties 2018/19

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.

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Executive Summary

Please detail the key points of this report

Summary

This report summarises:

- The new safeguarding children partnership and child death arrangements which have been implemented in line with national safeguarding reforms;
- Primary care safeguarding developments;
- Safeguarding adult and children reviews that are underway and those that have been published; links embedded into the report where appropriate;
- Safeguarding Adult Peer review held in August 2018;
- Looked after Children and the details of the CCG's responsibilities for this group of children;
- Achievements and Challenges in safeguarding;
- Safeguarding training figures which are above expected compliance levels;
- Learning Disability Mortality Review programme;
- Appendix 1 – notes from the national safeguarding panel visit around safe sleep

Assurance

As per the "Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (NHS England 2015) the CCG has a range of statutory duties around safeguarding adults and children

- As a commissioner of local health services to be assured that there are effective safeguarding arrangements in place in the services and gain assurance throughout the year to ensure continuous improvement – Full assurance
- Securing the expertise of Designated Professionals – Full assurance
- Training staff in recognising and responding to safeguarding concerns – Full assurance
- Clear policies setting out a commitment and approach to safeguarding – Full assurance
- Effective interagency working with local authorities, the police and the third sector organisations – Full assurance
- Supporting the development of a positive learning culture across partnerships – Full assurance
- Designated clinical experts are embedded in the clinical decision making of the organisation with the authority to work within local health economies to influence local thinking and practice - Full assurance

What are the potential conflicts of interest?

None Noted

Where has this report been previously discussed?

September 2019 – Quality Committee

Presented by: Julie Parker, Head of Safeguarding/Designated Nurse Safeguarding Children

Meeting Date: 5th February 2020

Agenda item: xx

Reason for being in Part 2 (if applicable)

xx

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Dr Jane Connell, Designated Doctor Safeguarding Children

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1. Introduction

The purpose of the joint report is to assure the Governing Body and members of the public that the NHS Stockport Clinical Commissioning Group (CCG) is fulfilling its statutory duties in relation to safeguarding adults, children and looked after children in Stockport.

Our approach to safeguarding is underpinned by a performance management culture, contracting systems and processes that aim to reduce the risk of harm and respond quickly to any emerging concerns.

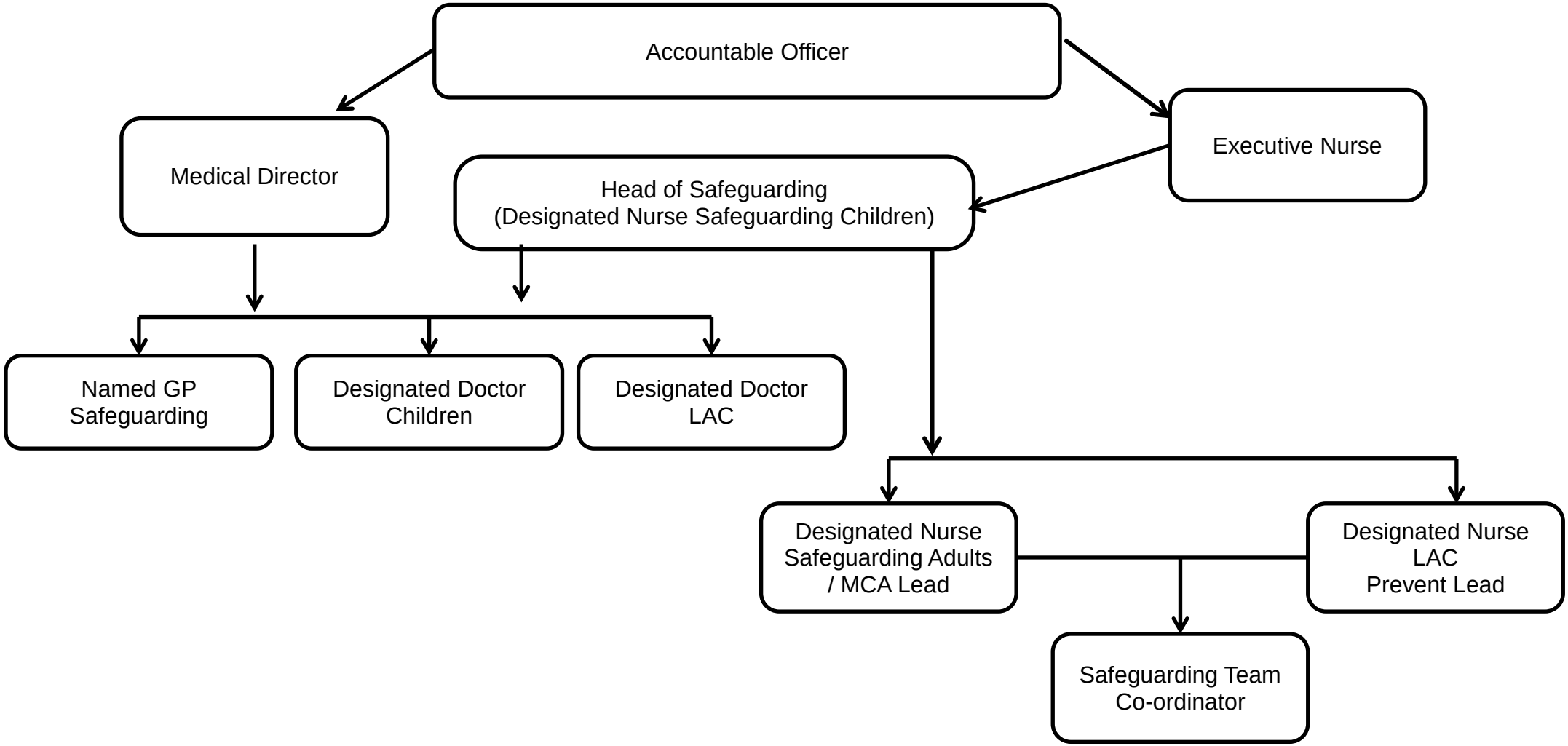
2018-2019 saw the significant priority of designing the new national safeguarding children arrangements with a deadline for publication in every area by June 29th 2019. This arrangement (as per recommendations in The Children and Social Work Act 2017 and Working Together 2018) has been the most significant reform of safeguarding children arrangements in four decades. An agreement was reached to replace the Stockport Safeguarding Children Board with Stockport Safeguarding Children Partnership; the new arrangements are published on NHS Stockport CCG web site. Stronger shared duties have been placed on the CCG, Police and Local Authority to work together to safeguard and promote the welfare of children.

The duties and standards in relation to safeguarding for NHS Stockport CCG are articulated within NHS England Safeguarding Accountability & Assurance Framework (July 2019). It remains the responsibility of every NHS funded organisation and each individual healthcare professional working in the NHS to ensure that the principles and duties of safeguarding adults and children are consistently applied with the well-being of those vulnerable groups at the heart of what they do.

The report reviews the team's work across the year, giving assurance that the CCG has discharged its statutory responsibility to safeguard the welfare of children and adults across the health services it commissions. Information is included about changes, influences, local developments and activity and how challenges relating to safeguarding are being managed.

2. CCG Safeguarding Team

2.1 Accountability Chart



2.2 The CCG safeguarding team consists of:

- Head of Safeguarding/Designated Nurse Safeguarding Children
- Designated Nurse Looked After Children and Prevent Lead
- Designated Nurse Safeguarding Adults and Mental Capacity Act Lead
- Named GP for Safeguarding (1 day per week)
- Designated Doctor Safeguarding Children (1 day per week)
- Designated Doctors Looked after Children
- Safeguarding Team Co-ordinator

The Executive Nurse provides overall leadership and guidance to the CCG in relation to safeguarding vulnerable groups. The safeguarding team ensures the CCG has safe and effective systems in place to ensure patient, staff and the organisation is compliant with CQC Regulation 13, safeguarding service users from abuse and improper treatment.

The Stockport Safeguarding Adult Board (SSAB) and Stockport Safeguarding Children's Partnership Executive (previously Stockport Safeguarding Children Board) representatives are the CCG Executive Nurse and Designated Nurses Safeguarding as clinical advisors.

The Designated Nurses also attends the SSAB and SSCB board sub groups, and both Designated Nurse for Adult and children are the respective chairs of the Quality Assurance sub groups.

The Designated Nurse for Looked after Children is the strategic professional lead across every aspect of health service contribution to Looked after Children within all provider organisations which are commissioned to undertake this service. The Designated Nurse also represents the CCG at all local and GM statutory meetings and forums.

3. Providers Accountability and Assurance

Stockport CCG continues to drive the safeguarding agenda by ensuring that the services it commissions have the necessary systems, processes, policies and procedures in place to protect and safeguard children and adults at risk.

The Designated Safeguarding Nurse continues to work in partnership with colleagues from the Local Authority and the CQC to make enquiries of concerns regarding the quality of care within Nursing and Care Homes across Stockport

The CCG safeguarding standards are included in a schedule contained within all clinical contracts for which the CCG is the lead commissioner. Within this schedule, there is a requirement for each provider to complete an annual audit based on the safeguarding standards specified in the contract. All action plans resulting from the audit findings are monitored by the safeguarding team.

Stockport CCG works in partnership with colleagues from its main providers on a quarterly formal basis; support outside this time is readily available.

The main providers include: Pennine Care NHS Foundation Trust, Stockport NHS Foundation Trust, St Ann's Hospice, Mastercall, BMI and The Priory (whilst care in the Priory is not commissioned by NHS Stockport CCG it is important to have oversight of a large independent health provider in Stockport). Quarterly reviews are undertaken jointly with the Designated Nurses from the six CCGs relating to the assurance required from Pennine Care NHS Foundation Trust.

2018-19 saw rapid mobilisation of services in the GP Federation Viaduct Care. The CCG safeguarding team have supported the Viaduct Care Senior Leadership Team to ensure that they have robust safeguarding arrangements in place.

4. Primary Care

2018-19 was a busy year in primary care with significant focus in many areas of safeguarding:

- Received initial assurance from all practices using the assurance tool designed in 2017/8.
- Completed & launched the safeguarding templates for use in the EMIS record.
- Launched a Stockport-wide all-encompassing GP safeguarding policy (partly in response to the initial assurance returns identifying some gaps in policy prevalence).
- Hosted 3 safeguarding adults' briefings, 2 safeguarding children's briefings & 1 complex cross-agenda briefing.
- Organised practice wide safeguarding training at 3 Masterclasses.
- Signed up all Stockport practices to the NHSE online assurance tool (though engagement with this is not complete due to time restraints & lack of resource to help practices complete this).
- Undertaken the multi-disciplinary Joint Targeted Area Inspection (JTAI) cross-practice audit deep dive theme of child sexual abuse in the family environment to understand the GP's role.
- Undertaken an audit alongside the Local Authority Safeguarding Unit to identify barriers to information sharing in advance of child protection case conferences which has led to new processes which have improved response rates from GPs from 34.1% in autumn 2018 to 61.5% in summer 2019. Work is ongoing to drive this up further still.

5. Safeguarding Children Reforms

5.1 Safeguarding Children Reforms

Following the publication of the Children and Social Work Act 2017 the Stockport Safeguarding Children Board has been replaced with the Stockport Safeguarding Children Partnership. The accountability for the arrangements are shared equally by three partners; Local Authority, Police and CCG. The three partners are required to work together with relevant agencies for the purpose of safeguarding and promoting the welfare of children in the area. There is a real opportunity to work differently; the CCG's Designated Nurse for safeguarding children plays an important role in chairing the Quality Assurance Partnership and scrutinising the effectiveness of the safeguarding arrangements in the Stockport system.

5.2 Child Death Reviews

Alongside new safeguarding children arrangements there has been a national requirement to reconsider how all child deaths are reviewed. The Stockport, Tameside and Trafford Child Death Review Partners have made arrangements in 2018/19 for a structured and consistent approach to review all deaths of children under 18 years of age in line with the recommendations made in Working Together to Safeguard Children, 2018.

It is recommended that CDOPs (child death overview panels) require a total population of 500,000, with an average of 60 child deaths per year. There are four Greater Manchester CDOPs; Stockport, Tameside and Trafford make up one Child Death Overview Panel. The governance and reporting arrangements have transferred from the Safeguarding Children Board to the Health and Well Being Board. Discussions are required between the three CCG's around the commissioning and role of the Designated Doctor for Child Deaths.

5.3 Rapid Reviews

Ofsted published guidance on how Safeguarding Children Partnerships should report a serious incident of child abuse or neglect, or the death of a child who is looked after. From 29th June 2018 there has been a requirement for all areas in England to notify the National Safeguarding Practice Review Panel within 5 working days of becoming aware of a serious incident; and a review of the case has to be undertaken with 15 working days of the partners being made aware of the incident. In order to comply with this requirement Stockport has reviewed its process for notification and consideration of serious incidents.

Stockport has notified 10 children's cases to the national panel and completed 10 rapid reviews, 2 of which progressed to a full serious case review. When the rapid review has determined that criteria have not been met for a full review there is often still an opportunity to consider some learning. From June 2019 Serious Case Reviews will be termed Safeguarding Practice Reviews and can be conducted in a more locally determined way. A review will not be commissioned where a recent review has focused on similar themes to avoid duplication. There will be equal emphasis on ensuring that learning is embedded in practice rather than embarking on repeating the same learning.

6. Child Sexual Abuse & Exploitation

The Designated Nurse for Looked after Children is a member of the complex safeguarding sub group of the safeguarding children board. Relationships between the CCG and the specialist social work team is strong; the CCG safeguarding team plan to support the specialist week of action and ensure there are strong safeguarding messages to protect our vulnerable children.

7. Safeguarding Reviews

7.1 Serious Adult Reviews

In 2018/2019 there were nine new referrals for consideration of a Serious Adult Review (SAR), one of those resulted in a Domestic Homicide review (DHR), and was overseen by Stockport Safer Partnership (SSP).

The other referrals received did not meet the criteria for a SAR, although at the end of 2018/19 it was considered there was one case where learning across the health systems was required and a single agency learning review will take place in 2019/20.

During 2018/19, the SAR consideration panel has completed three serious adult reviews. The themes from these reviews identified self-neglect, domestic abuse and interfamilial relationships, mental capacity, sharing of information and the importance of multi-agency working. Five multi-agency learning events took place to share the findings and learning from the completed reviews.

As a result of the learning the safeguarding adult board partner agencies have developed a new multi-agency self-neglect policy and practitioner guidance. The Designated Nurse for Safeguarding Adults is supporting adult social care colleagues in updating the Stockport multi agency Safeguarding Adults policy and procedures which will be completed in 2019/20.

7.2 Learning from Safeguarding Adult Reviews and the changes that have been made:

SAR 3 - Click here for access to the full SAR report and 7-minute briefing paper.
SAR 4 –The full SAR report and 7-minute briefing paper can be found here.
SAR 5 –The following SAR report and the 7-minute briefing paper demonstrates an overview.

7.3 Serious Case Reviews Children

Two serious case reviews have been completed this year involving babies under 1. These remain unpublished until the families have had a full opportunity to read the final reports. It is important to publish reports to ensure that the learning is shared wider than the panel and practitioners involved. The learning in these cases was around understanding the impact of previous trauma on care giving; the impact of alcohol consumption and smoking when caring for a young baby and how this relates to the safe sleep messages; the importance of a multiagency plan which incorporates agreements between families and professionals especially for children who are being cared for in mother and baby foster placements and responding to domestic abuse effectively. Actions plans are being drawn up which the CCG will contribute to around the role that the GP plays in understanding and responding to risk.

7.4 Safeguarding Adult Peer Review

In 2018 Chairs and representatives of the Stockport and Oldham Safeguarding Adult Boards agreed to undertake a reciprocal peer review. The CCG Designated Nurse Safeguarding Adults was a peer reviewer and is supporting the system to address the recommendations.
The focus of the peer review was to scrutinise safeguarding practice, policy and oversight, and compliance with the 2014 Care Act. The objectives were to reflect on each other's approach, identify strengths, learning and areas for development.

Peers at Stockport were looking for additional learning and good practice in process and practice to support their Care Quality Commission Health & Social Care System Review, which was published at the end of April 2018.

The Stockport review took place on 21st August 2018 and recommendations from the peer reviewers included:

- Review of the multi-agency policy and continue to provide training sessions on safeguarding processes
- Improvements to be able to monitor and record Care Act assessments.
- Improve information sharing

The action plan developed is being monitored through the quality assurance adult partnership.

8. Looked After Children

This cohort of vulnerable young people continues to challenge the CCG's statutory responsibilities namely:

Ensure that sufficient resources are allocated to meet the identified needs of the looked after children population, including those placed in their area by other local authorities, based on a range of data available about their health characteristics.

The lack of capacity to meet the physical and mental health needs of looked after children has been identified as a risk and is now on the corporate risk register.

	March 2018	**March 2019**	**Flow 2018-19**
Stockport Looked After Children	363	355	585
Looked After Children placed in Stockport	445	470	700

The March figures are just a point in time; the 2018-19 figures are the flow of young people who have been in the care system over that period. It is this figure that is indicative of the resource

required and the reason why the providers are unable to meet the demands within their current commissioned capacity.

There are three statutory performance measures for Looked after Children, which are submitted quarterly to the CCG and update reports have been submitted to the Quality Committee throughout the year. In January 2019 the Governing Body requested a commissioning review and this has resulted in an interim increase in capacity to provide initial physical health checks being approved whilst the long term needs can be assessed and the service specification updated. As yet the increased capacity is not in place. It should be noted that all the young people are receiving their health checks, but not within the statutory time scales.

There are no performance measures for the provision of mental health services for Looked after Children. A recent benchmarking exercise undertaken at the request of GM on the provision of therapeutic mental health services for LAC confirmed that in Stockport out of area children do not have access to the full range of services afforded to our own children. This issue is not unique to Stockport. The Children's Commissioner has been working with our mental health provider to try and address this unwarranted variation; however capacity within the service is already stretched with a significant increase in referrals from the mainstream cohort. At present there is no resolution. If out of area children require this level of intervention their placing authorities are being advised of alternative providers in the private sector.

Greater Manchester Children's Health and Wellbeing Board has commissioned a review of the provision of health services to Looked after Children in Greater Manchester. Grant Thornton commenced this work in May 2019 and is due to report in October 2019. Recommendations from this review could shape the CCG's future commissioning.

9. Prevent

The CCG has a statutory responsibility to ensure that all its own employees are compliant with the Prevent Duty and also to gain assurance that the NHS providers it commissions from, also have the appropriate systems and processes in place. The CCG has the following in place:

- A Prevent Lead
- A policy
- A training strategy – the CCG has >85% of staff trained at the appropriate level
- The Lead represents the CCG at both the NHS E Regional and the Stockport Prevent Forums and has participated in a training Task and Finish Group
- The CCG is represented at the monthly Channel Panel – the multi-agency panel for reviewing radicalisation risks from individuals Stockport CCG monitors Stockport NHS FT and Pennine Care NHS FT via the safeguarding assurance process. This year has seen both organisations fully compliant with the duty.

  From April 19 NHS E require CCG's to obtain the same level of assurance from all NHS contract holders. This is a significant increase in the volume of work required to obtain this assurance and currently how this will be managed has not been agreed.

10. Achievements

- There has been focus on the development of comprehensive polices including the mental capacity act. The policy reinforces the organisational philosophy that safeguarding and mental capacity is everybody's business and that all staff should respond and act to raise safeguarding awareness and address emerging issues. The policy details the roles and responsibilities of the CCG as a commissioning organisation and of its employees, directly or indirectly employed.

- There have been electronic templates devised for GP's to record the details of a person's mental capacity; this was also in response to the learning from a serious adult review where capacity assessments were not always documented well across the health system.
- The team have devised a safeguarding strategy on a page which helps CCG staff to understand priorities which include adopting a Think Family Approach to safeguarding, Looked after Children and ensuring that the principles of the mental capacity act are embedded into assessments
- Focused on the Prevent agenda and ensured staff have been trained at the appropriate level. Over 85% of staff has completed the Prevent training.
- Participated in three themed safeguarding weeks of action events:
- The Designated Nurses set up an area in a local GP practice to talk to patients about how domestic abuse presents. There was a lot of interest in the information provided and several patients were offered further support and signposting.
- The Designated Nurse for Looked after Children and the safeguarding team co-ordinator supported a Hate Crime event in February 2019 at Stockport College seeing over 100 students.
- Another well evaluated event was held in June 2018 around the recognising the importance of annual health checks for people with a learning disability.

- Worked within the Greater Manchester safeguarding network to look at different ways making safeguarding personal can be embedded into health economy practice in a consistent way by using an agreed GM procedure, audit and slides for training which can be shared with our health partners in Stockport
- Worked very closely with the SMBC quality team and the CCG quality nurse around safeguarding issues relating to poor quality care/acts of omission and neglect.
- Implemented a Domestic Abuse policy for CCG staff
- Designated Nurses have linked with Stockport partners to discuss the future offer of multi-agency Domestic Abuse training and a multi-agency Domestic Abuse pathway is underway across Stockport.
- Designated Doctor facilitated a small audit on understanding any unmet health needs of children who are home educated; the sample was too small to make any hypothesis but will feed into the ongoing work with the SEND programme.
- Designated Doctor updated the medical needs in school policy as it was becoming apparent that children from tertiary care did not always have a robust school health plan This work generated a need to ensure school nurses and health visitors were adequately trained around the implementation of the health plan.

11. Challenges

An internal audit commissioned by the CCG from Mersey Internal Audit Agency (MIAA) was conducted in January 2019 and gave the CCG moderate assurance around the safeguarding arrangements in place. A number of improvements were required including how the DBS refresher checks were reviewed as the auditor saw some outstanding checks on the system. Rigorous focus revealed that the recording of the staff's position in the compliance record was incorrect which significantly reduced the outstanding position. Improvements have also been made about the recording of staff training and the implementation of a serious incident panel. The safeguarding team are standard members of the panel to ensure incidents where safeguarding is an issue are reviewed.

Processes have been improved between the CCG and GMSS who manage the DBS system for the CCG.

12. Safeguarding Training

26th June 2018: Safeguarding Children Level 3 – Drugs and Alcohol
151 booked and attended the GP practice Masterclass.

22nd November 2018: Safeguarding Children Level 3 – Young Carers
149 booked and attended the GP practice Masterclass

19th March 2019: Safeguarding Children and Adults Level 3 – Supporting Children and Young People with Special Educational Needs and Disability (SEND)
95 booked and attended the GP Practice Masterclass

The Head of Safeguarding also delivered a safeguarding adults and children awareness session to 60 Stockport dental practice staff.

Training Compliance NHS Stockport CCG

Safeguarding Adults: 87.79%

Safeguarding Children: 88.55%

Mental Capacity Act: 96.3%

Prevent – Basic 87.02%

Prevent L3: 85.7%

13. Stockport LeDeR Reviews

Since 2017 the CCG has a duty to co-ordinate the review of all deaths in people who have a learning disability; the programme of review is termed LeDeR (learning disability mortality review).

- 19 deaths have been reviewed since inception, co-ordinated by the local area contacts who for the CCG are the designated nurses for safeguarding.
- A multiagency steering group has been implemented by the CCG to ensure that the learning from the completed reviews is disseminated across the health and social care system.

14. Ambitions

- To implement the Child Death Review Plan
- Continue the implementation of the new safeguarding children reforms and work with the current adult board to ensure consistency when considering the Think Family approach to safeguarding
- Plan and take part in the multiagency week of action in March 2020 around Safe Sleep
- Ensure Think Family principles underpin all safeguarding training programmes delivered by the CCG
- Consider how the statutory collection of commissioned services' Prevent data is monitored
- To implement the Liberty of Protection Safeguards (LPS) working with the Local Authority and Stockport NHS FT. The LPS will replace the current DoLS (Deprivation of Liberty Safeguards) on 1st October 2020
- To continue to support the LeDeR (learning from deaths mortality programme) in Stockport
- To reduce unwarranted variation of out of area Looked after Children access to mental health services

The Head of Safeguarding would like to thank the members of the safeguarding team and the Executive Nurse for their contributions to this annual report and for their dedication and commitment to keep vulnerable children and people safer in Stockport.

Compliance Checklist:

Documentation		**Statutory and Local Policy Requirement**	
Cover sheet completed	Y	Change in Financial Spend: Finance Section below completed	N/A
Page numbers	Y	Service Changes: Public Consultation Completed and Reported in Document	N/A
Paragraph numbers in place	Y	Service Changes: Approved Equality Impact Assessment Included as Appendix	N/A
2 Page Executive summary in place (Docs 6 pages or more in length)	N/A	Patient Level Data Impacted: Privacy Impact Assessment included as Appendix	N/A
All text single space Arial 12. Headings Arial Bold 12 or above, no underlining	Y	Change in Service Supplier: Procurement & Tendering Rationale approved and Included	N/A
		Any form of change: Risk Assessment Completed and included	N/A
		Any impact on staff: Consultation and EIA undertaken and demonstrable in document	N/A

Appendix 1

Following the National Safeguarding Panel review held in Stockport (November 25th 2019) around Sudden Death of a Child/Infant – please find below some notes and a summary of the day's events:

The lead reviewer John Harris wanted to provide a huge thanks to the team / partnership for the efforts made. He found the experience extremely positive and felt they had received an excellent response. Ensuring that the teams / practitioners were made available and supported to attend "speaks volumes" and he wanted to thank the practitioners for their honesty, optimism, positivity, reflective functioning and were described as a real credit to our organisations.

The reviewer acknowledged that as a partnership we had expanded our review to capture the learning from other cases. He noted a coordinated and purposeful response to the issue with significant insight into the learning. He felt as a partnership we had "grappled" with the important issues which has supported the national panel review in their thinking and aligned their focus around the child and the family.

The reviewer informed the group that following each review they try to identify 3 areas of key focus or themes but he had to settle on 6 due to the work undertaken across the borough. They have been summarised below:

- Setting the scene – This was thought to be extremely helpful in providing an overview of Stockport and a comprehensive insight into the partnership approach. He was able to ensure there was triangulation of process and relationships. Noted areas were the developments with documentation and policy amendments to support practice changes. This was clearly evident during the practitioner session.

- Strategic approach – it was felt that there was clear evidence of strategic partnership working to address the concern with the aim to reduce SUDI. Clear joint working between, health, LA, and public health in determining a clear plan with reference to key working developments from a regional and sub-regional perspective to embed the approach.

- Understanding safe sleep and the safe sleep environment when there are safeguarding risks. The development of key strategies and developments in the response to the situation – ensuring families are equipped when they are out of routine or under unusual circumstances and ensuring the message is delivered on a number of occasions. Acknowledging the lived experiences of the family to identify the risk and resolve. Considering the family dynamics and relationships that may impact on safe sleep practices.

- Understanding safe sleep to key stages on a timeline – midwifery to NNU to HV to the GP. Acknowledging the professional role and the professional safe sleep conversation to support the process. The need to "tighten up" and ensuring that guidance is explicitly clear regarding expectations dependant on role. Highlighting the nature of support to professionals and the need to develop local multiagency guidance. To ensure there is investment in training across the partnership to apply the restorative practice model. Resource for families – it is essential that we collaboratively work with parents to identify what works and consider other means of getting the message across.

- Learning and quality assurance – the need to revisit each case dependent on the findings from the post mortem and additional investigations / reviews. He noted that this would be an area of national consideration. The reviewer described the 7 minute briefings as being "Excellent" and was impressed about the safe sleep audits completed.

- Preventative capacity –the need for the panel to consider the resource required to ensure a preventive approach is considered inclusive of an enhanced HV offer. He made reference to the FNP model of practice – better addressed with a stronger preventative capacity to support and deliver.

Actions:

- Independent Chair plans to write to each of the practitioner involved to thank them for their extremely positive contribution to the day.
- Amendments to be made to strategy and practice to consider safe sleep – main documents of focus – Neglect strategy, levels of Need, domestic abuse strategy.
- To identify a key partner in a leadership role within public health to support the work streams.
- The identification of a partnership strategic lead to have overall oversight and ensure there is a "threading through" practice / policy / procedure.
- Note the conversations whereby circumstances are out of the ordinary / out of normal routine as part of routine questioning / practice.
- Consider local policy and risk assessment practices.
- To relook at the partnership's priority areas to ensure safe sleep is clearly cited.
- To review Salford's approach to "appreciative enquiries" and secure training for multiagency professionals inclusive of health partners.

The report will be published in the New Year which will provide an overarching response. A round table event is planned in London for the end of January 2020 to review the findings from the 12 deep dive cases identified as part of the review.