Tuesday, 26 September 2017

(10.00 am)

Welcome by THE CHAIR

THE CHAIR: Good morning to everyone. I am Alexis Jay and, as you know, I am the chair of the Independent Inquiry into Child Sexual Abuse.

May I also introduce the other panel members present: Ivor Frank, Professor Sir Malcolm Evans and Drusilla Sharpling.

The topic of today's seminar is understanding current approaches to the prevention of child sexual abuse in healthcare settings. I am very pleased to welcome all those who have agreed to take part to assist us today, and also to see some familiar faces in attendance in the public gallery.

I want to say something about where the seminar sits within the inquiry's work programme, which I set out in my review in December of last year. Today's seminar sits within a wider programme of inquiry seminars designed to gather information and views on a range of important topics.

Seminars make a valuable contribution to the inquiry's work. Although they cannot be formal evidence-gathering sessions, the information we hear during them helps us in a number of ways. For example,

it helps us to identify areas that require further investigation and scrutiny, and it assists us in gathering current opinion on the matters which the inquiry is considering, including the opinions of those whose work or experiences give them a frontline perspective on the issues.

This is the fifth seminar in the programme, which will be spread across a day and a half of sessions. Throughout the seminar, we will seek to focus on the effectiveness of current arrangements to prevent the sexual abuse of children in healthcare settings, and, secondly, the opportunities to make sure that children who receive healthcare and treatment are best protected from sexual abuse.

My fellow panel members and I are very conscious that in the time we have we will only be able to skim the surface of the topics for discussion. We hope that what we hear today and tomorrow will help to shape the focus of the inquiry's future work in this area.

Given the range and breadth of topics which we will be considering, we will need to use the time well and address the topics in hand as thoroughly as we can. To that end, the panel and I are looking forward to an open, ordered and respectful discussion.

This morning's session will begin with a short

video, in which we will hear the experiences and views of people who have experienced child sexual abuse within a healthcare setting or by a healthcare professional. I would like to take this opportunity, on behalf of myself and the panel, to thank all of those who have chosen to share their experiences with us.

We are pleased that representatives from such a wide range of organisations are present today, and the panel and I will be listening to the discussions with interest and, as I have said, the views and information shared with us will go on to inform the inquiry's future work. So thank you all for agreeing to take part.

It is important to remember the purpose of the seminar is not to gather evidence in a formal or legal sense, and Ms Riel Karmy-Jones QC, who is one of the inquiry's counsel team, will be facilitating our discussions today and tomorrow. She will say more about the format of the seminar and its parameters in a moment.

The seminar is being live streamed over the internet with a short delay to allow those who are unable to attend in person to follow the proceedings. Once again, my thanks to all of you here who are participating and to those who have taken the trouble to be present today in the public gallery.

I will now hand over to Ms Karmy-Jones to start proceedings. Thank you.

Session 1: Opening remarks by MS KARMY-JONES

MS KARMY-JONES: Thank you, chair. As the chair said, my name is Riel Karmy-Jones. I am a barrister, and I am instructed as one of the lead counsel to the inquiry.

One of my areas of expertise is in criminal cases involving sexual abuse, and particularly cases where the victims are particularly vulnerable or they are children. So I am very conscious of the different ways abusers seek to manipulate and control those who are not in a position of power, and the long-lasting impact that child sexual abuse can have on victims and survivors.

My role today, however, is simply to facilitate this seminar, and, as part of that, to try to keep things running as smoothly as possible, to help to encourage friendly discussion and, we hope, a lively and candid debate, and possibly also to draw out where differences of opinion may lie.

Can I at this stage introduce Rebecca Chaloner, who sits over here, who is the director of the health portfolio; Jennifer Byrom, who sits next to me, who is the health policy lead, together with Patrick Harrison and Bethany Atkinson, health policy and engagement officers. Bethany is at the end and Patrick is sitting

in the gallery over there.

They are the people who have been responsible for the preparation and organisation of this seminar, and Rebecca, Jennifer, Patrick, Bethany, can I thank you all in advance for all the very hard work you have put into this.

We also have in this room Kathy and Heather, who are the ushers, who will help us through the day, and Lee, who is the hearing centre manager, and Sue, the deputy hearing centre manager, who spoke to us earlier. Any problems, please revert to them.

Now, the chair has made reference to the inquiry's remit. I just want to set today and tomorrow -- tomorrow, which is a half day -- into some context by referring and reminding those present of the inquiry's terms of reference.

The terms of reference are these: to consider, amongst other things, the extent to which state and non-state institutions have failed in their duty of care to protect children from sexual abuse and exploitation; the extent to which those failings have been addressed; to identify further action needed -- we are hoping to deal with some of that today; to address any failings identified; to consider the steps which it is necessary for state and non-state institutions to take in order to

protect children from such future abuse; and, in due course, to publish a report with recommendations.

So we hope that what we hear today will go some way to assisting the inquiry to deal with some of those issues.

The inquiry set out to investigate whether public bodies and other non-state institutions in England and Wales have taken their responsibility to protect children from sexual abuse seriously and to make meaningful recommendations for change.

As you know, the purpose of this particular seminar is to look at child sexual abuse within the healthcare setting, something that many find extraordinary, very difficult to fathom, and hard to accept, because aren't we all, as children, taught to trust our doctors, our nurses, our healthcare practitioners, to believe that they know best. Often -- usually, even -- that is undoubtedly correct. So it is understandably difficult to come to terms with what is such a serious breach of trust, particularly when there are so many good and caring practitioners, staff members, even volunteers, who give freely of their time out there.

But in recent years, we have all become increasingly aware that this is not always the case, and that within the health sector, just like other professions and areas

of life, there are those who seek to manipulate, control and abuse the vulnerable in their care. We have seen this in the Savile investigation, which, as everyone here knows, began with the ITV "Exposure" programme in 2012 and resulted in Operation Yewtree; we have seen it in the Dr Myles Bradbury investigation in 2014, and many others.

As the chair said in her opening comments, we have a limited amount of time for this seminar. There is an agenda, which the public in the public gallery should have on their seats, and this seminar has been specifically designed to look at how we can best work together across agencies to prevent child sexual abuse because the inquiry wishes to understand the current arrangements in the health sector and the opportunities for improvement; to gather information and views from health organisations and professionals about what they currently have in place to protect children and, again, the scope for improvement.

So we have brought you together, a number of representatives from different agencies across the country, and we hope to explore a range of topics, really focusing on what your views are of the effectiveness of the current arrangements in place and what you see as being the major opportunities to

better protect children.

In preparation for today, a paper has been circulated to a large number of health sector organisations -- I think in the region of 50 -- across England and Wales, seeking views on these and other matters, and in response, the inquiry received a number of very helpful and detailed submissions, which have not only served to help us shape the agenda for today, but will also support the inquiry's further detailed consideration of this topic in the future. So thank you to those organisations and individuals, most of whom -- including those who are represented here, I think most people here have provided written submissions in advance of today.

I am now going to ask those who sit around the horseshoe, our participants, to please introduce yourselves, and, as Sue said at the outset, when you do so, could you please tell us who you are, whom you represent, or if you are here on your own, and just explain why you are here and what you hope to achieve or gain from this seminar. Please remember the mic does need to be turned on and off and it does make quite a difference. It won't pick you up if it is far away from you.

So if we could start over with Anthony.

Introductions

MR OMO: Thank you. I am Anthony Omo. I am the director and general counsel for fitness practice at the GMC, the General Medical Council. In terms of what I hope to get out -- I really hope to contribute to the debate and to see if there is anything we can do over and above what we currently do to assist the inquiry, and to make sure that healthcare professionals do what they have trained to do and what most of them do, which is provide safe care for patients, all patients.

MR HEANEY: Good morning. My name is Albert Heaney. I work for the Welsh Government. I am the director of the social services and integration, and I hope to contribute today around the safeguarding issues about multi-agency working and also our legislation framework within Welsh context.

MS BRAITHWAITE: Good morning. I am Christine Braithwaite. I am the director of standards and policy for the Professional Standards Authority, our organisation overseas, nine professional regulators in the UK, so what is like the General Medical Council. We also have a role in relation to unregulated healthcare workers in the United Kingdom as well. I hope to contribute today to discussions around health professionals and the roles of regulators in that, and also to take account of

the views that I hear during this inquiry, because we are due to review and revise our own guidance on managing professional boundaries.

MR McMORROW: Good morning. I am Ray McMorrow. I am here representing the Royal College of Nursing. In my day job, I am the health lead for an organisation called the NWG who work specifically around supporting the multi-agency network around child sexual exploitation. I am the health lead for that organisation, so I am both hoping to bring our knowledge to the table today, but also that we are a multi-agency organisation for driving change forward as well and supporting organisations in change. I am, by background, a designated nurse and a children's mental health nurse.

MS WARBURTON: Hello, I am Susan Warburton, head of safeguarding for NHS England. What I hope to do today is to share with you some of the work that we have done in NHS England over the past five years and also to contribute to the debate about what we need to do going forward, because we have made some steps but we have much more to do. Thank you.

MS CUPID: Hello. I am Clarisser Cupid and I am here in my capacity as a designated nurse for safeguarding children. I work at Southwark Clinical Commissioning Group and I am here today to contribute around

understanding of health professionals, understanding of safeguarding, but also around their role and responsibilities in early identification and support with the safeguarding of children agenda, but also CSA.

MS CHRISTODOULIDES: Hello. My name is Helen Christodoulides. I am a director of nursing at Leeds Teaching Hospitals Trust. I have been a nurse for 30 years. I'm an adult nurse by background. In our organisation that employs 17,000 staff, I am responsible for safeguarding, which is quite a new position for me. I line manage head of safeguarding. Since I have been doing that in the last ten months I have learnt a lot, and I hope to learn more today and tomorrow, and I hope that I can contribute by explaining, should it be required, what it is like to work in a busy acute hospital with many, many patients and many, many staff and being able to enact some of the recommendations that we might consider would be appropriate.

MS BEAUMONT-WOOD: Good morning. Rhiannon Beaumont-Wood. I am executive director of quality, nursing and allied health professionals in Public Health Wales, but I am here today representing Nurse Directors Wales. My background before the role I'm in was very much head of safeguarding in a number of settings, including the Welsh Ambulance Service and formerly the Swansea NHS

Trust. We also have within Public Health Wales the national safeguarding team which provides leadership to NHS Wales to drive forward through a networked approach with our health boards and other NHS bodies in improving our safeguarding arrangements. So I hope that we can share some of our learning from the Welsh context and understand the best of what England -- and perhaps sharing the practice so we can have -- increase our collective arrangements across certainly England and Wales, but maybe the UK. Thank you.

MR DEAN: Good morning. My name is Simon Dean. I work for the Welsh Government. I'm the deputy chief executive of NHS Wales. So I'm a generalist manager by way of background, primarily the NHS, but currently a civil servant. My main responsibilities are the interface between government and the NHS in terms of planning and performance, so I'm looking to work alongside my colleagues to contribute to the discussions and to take the learning back into my work setting.

DR STEELE: Good morning. I am Alison Steele. I'm a paediatrician and I'm representing the Royal College of Paediatrics and Child Health today. For many years, I have been a designated doctor for safeguarding children and looked after children in the north-east of England, in Newcastle, but this last year I'm actually

based at Great Ormond Street Hospital as their named doctor. Clinically, I have worked for many years in working with and assessing children who have been victims of sexual abuse and assault, including working within the SARC, mainly for the north-east, paediatric SARC, which is based in Newcastle. I also am a member of the RCPCH Standing Committee for Child Protection and chaired the RCPCH working party which wrote the sexual abuse service recommendations.

In terms of today, I'm here to learn. I want to hear everyone's views. I would like to take that back with me to the workplace and into the RCPCH in terms of how we better prevent sexual abuse in healthcare settings.

MR LUCAROTTI: Good morning. My name is John Lucarotti. I'm from the Nursing & Midwifery Council, the UK regulator for nurses and midwives. My role there is head of policy and legislation, especially in relation to fitness to practise where obviously some of these matters do end up. In terms of what I want to contribute today, it's both understanding where the gaps are and also contributing to the ongoing debate.

MR DENHAM: Good morning. I am Giles Denham. I work for Health Education England. My current role there is director of strategic relationships. My background is

as a government policy maker and also as a healthcare manager.

My particular interest, as Health Education England is within England, a national education and training body, commissioning and providing, is obviously to learn as much as possible about other organisations and their work and how we can contribute on the national front in what we do through education, training and provision and already have done in some respects already.

DR TIWARI: Good morning. I am Vimal Tiwari. I am a practising GP here representing the Royal College of General Practitioners. We are a membership organisation, over 60,000 members. I am a practising GP and also named safeguarding GP with a very strong interest in child health and a parallel career in community paediatrics. I have been working in child protection and child safeguarding for over 20 years now. I am here because my college takes child safeguarding very seriously. My various predecessors in the college have worked very hard to improve general practice education in child abuse and neglect. We have produced a certain number of educational tools over the years, the most recent being the 2014 edition of the RCGP/NSPCC Child Safeguarding Toolkit. We are aware that there are inconsistencies and deficiencies in GP education in this

subject and we would like to find the means of improving general practice awareness and of improving consistency of delivery of education in this very important area right across the country.

DR PRICE: Good morning. I am Lorna Price. I'm a designated doctor in the national safeguarding team in Public Health Wales.

I'm also a community paediatrician. I have been working in safeguarding for more than 20 years, formerly a named doctor in a large health board, where I still work in assessing children who have been abused and neglected.

I am here to share the good practice that we have in Wales and to learn from the good practice that you have -- that hopefully I will hear about from England as well. I also sit on the Royal College of Paediatrics and Child Protection Standing Committee along with Alison.

Session 1: Opening remarks by MS KARMY-JONES (continued)

MS KARMY-JONES: Thank you all very much, and welcome. We are very grateful to you all for attending.

Can I just say that we did look for and were rather disappointed to find that there didn't appear to be a survivor group specifically aimed at those who were sexually abused as children within the healthcare

setting. So if, at the break, anyone is aware of such a group, we would be very grateful for you bringing it to our attention and identifying it to us.

A little bit more talking from me, I'm afraid, before we get onto the substance of why we are here. Can I set out some limitations and restrictions? There are a number of things that we aren't going to deal with in this seminar, a number of topics we won't look at, because we do have only a day and a half. Amongst those are the role that the health service organisations and professionals may play in responding to disclosures of abuse that have happened elsewhere, for example, in the home or another institutional setting, and in detecting and responding to signs and symptoms of abuse that have happened elsewhere.

Equally, we are not focusing in this seminar on the therapeutic role of health services in supporting victims and survivors in these discussions. That was part of the focus of the seminar that we had in July. Of course, they are all important. They are all important and relevant parts of the role the health system plays in protecting children, but they are not within the scope of our discussions today.

We have got a lot of ground to cover, some more restrictions and some more guidance on the approach that

we are going to take. As the chair has already said, this is not a legal or formal evidence-gathering process. It is not the place for cross-examination or interrogation, so please bear that in mind. It is not about levelling criticisms at any specific organisation or individuals, although we may want to explore or even challenge some different opinions.

I am only going to allow comments, observations and contributions from those who sit around the horseshoe and the public gallery, questions as to clarification, but not questions that lead on to cross-examination, please.

The programme will focus on matters relating to the healthcare work force, including access to children by those working in healthcare settings. By way of warning, this afternoon's topic will be the regulatory policy and legislative frameworks in which healthcare services operate, and the role that they play in effective prevention of child sexual abuse in healthcare settings. Tomorrow, we are going to look at issues arising out of culture and leadership, and a further couple of matters.

At the end of each session, in the morning, before we have our breaks, we will take 10 or 15 minutes, depending on the time available and the desire to speak

from those in the public gallery to make contribution to the seminar. I will ask those who do wish to contribute to let us know by raising their hands and then Sue will take a microphone around.

We will do our best to take as many comments as we can.

It may be tempting to try to ask questions, but we have a busy agenda, so we will be keeping to that. As I have said, comments, observations, contributions only, please.

Please remember that, because of their function in the wider inquiry, the panel are here to watch the discussion unfold, rather than to take an active part in it. People in the public gallery, you will not be seen on the video feed. If you want to share what you want to say with just those in this room, please just let us know. As you know, the video feed is taken out in the annex, where some people who come late may sit, or those who want to engage in tweeting or social media, they may sit out there. If you don't want what you say to go beyond this room, tell us, and we will cut the video feed.

The delay in the video feed has already been mentioned. Sensitive matters may be dealt with in this. Some people may make reference to things that shouldn't

go beyond this room. If that is the case, again, we will cut the video feed. If I consider anything sensitive to come up, I will pause and ask the chair to address it.

As the chair has already mentioned, these discussions are only one aspect of the inquiry's work and the seminar sits within a much broader programme of work, including the Truth Project, our regional forum events, round table events and a significant amount of research which is being undertaken across a range of topics and across the inquiry's 13 investigations.

You have been introduced to Hannah and Terri who are here to provide emotional support to anyone in the room. Please let yourselves be known to them if you wish to speak to them.

As the chair has said, we are going to begin by playing a video, in which we will hear the views and experiences of people who have, as children, been abused in a healthcare setting.

You will see them in silhouette. They are played by actors, but their words are their own. At this point, I am going to ask for the first video, please, to be played.

(Video played)

MS KARMY-JONES: Just to pause there for a moment and thank

those who took part in making that video and for agreeing to share their views and experiences with us in this public forum.

Moving on to the seminar, we sought views, as I have mentioned in advance, about a broad range of matters relating to the prevention of child sexual abuse. All of you around the horseshoe will have received a report summarising the themes that emerged from the responses that you and others provided. Hard copies are also available for those in the public gallery.

A number of strong themes have emerged. In particular, you all highlighted the role of education and training of healthcare workers to equip them with the knowledge and skills to effectively prevent and respond to child sexual abuse in healthcare settings; the lack of focus on abuse that occurs within healthcare settings; and a need for greater consistency in the education and training provided. These were recurring themes. The safe recruitment of healthcare workers to prevent access to children by unsuitable people, that was also discussed extensively in the responses, many of which also identified various areas where respondents considered that the process for employment checks could be strengthened.

A number of responses also focused on the

arrangements in place to prevent unsupervised or unauthorised access to children who are receiving healthcare and treatment and respondents focused on the chaperoning of workers and visitors and secure access to wards.

So, in our discussions, can I ask you to take account of the following types of questions, and I will be asking questions, but these kind of bullet points: are things working as they currently stand; are there differences between the approaches in different areas of the country, and I look to those who are here from Wales; what isn't working; what's working well; what needs improvement; what is standing in the way of improvement; what's the solution, you know, what do you suggest should be done; why would you do it?

Really, it comes down to this, doesn't it: what real difference will the solution that you suggest make to the protection of children?

In terms of terminology, please bear in mind that when we talk about healthcare or staffworkers, we are talking a broad view of those terms to encompass health professionals such as doctors and nurses, but also other staff who are involved in the delivery of health services and even volunteers who work in healthcare settings. Healthcare settings, also, we are taking

a broad view, so a hospital, a GP's practice or anywhere else where a child might receive healthcare and treatment.

We are going to move on to the questions soon, but a few points. Learning from experience is important, but we would like to avoid entering into detailed discussions about the nature of current policies and processes, and I will try to steer us away if we start going into that sort of territory.

Many of you around the table -- indeed, all of you -- are experienced in working in the health system, but others observing may not be, including those who will be dipping in and out of the live feed and those who may later come to watch the video footage of this on the IICSA website. So please avoid acronyms and jargon as much as possible, and please also do introduce yourself. The video won't always pick up your name and where you are from, and it would help people watching to know that before you answer a question.

The intention of the discussion, as I have said, is not to put anyone on the spot or force them to justify a position that they or the organisation have taken. We may press people a little and ask a little around where there are disagreements, but this isn't an inquisitorial process. So avoid -- another point is, avoid going into

any particular investigation, please. We don't want to go into particular detail about the Savile Inquiry or anything like that, please. It doesn't help us.

The discussion is to help inform the inquiry's work. It is not the end of the process, it is part of the process. And there will be an opportunity outside the seminar to make points and raise evidence and to come back and add anything to what you have said.

Finally, as a matter of courtesy, could I ask everyone, please, to speak through me, not start a public discussion, no matter how tempting it may be, because those watching will lose the thread.

With all of that in mind, let's move on to topic 1: education and training.

Discussion re Topic 1

MS KARMY-JONES: What I am going to do is begin by asking the participants around the horseshoe to start by giving us their views on how well healthcare workers are educated and trained to detect and respond to child sexual abuse within the healthcare setting. Perhaps I can start out by looking to the Royal College of Paediatrics and Child Health.

DR STEELE: Certainly. Alison Steele, Royal College of Paediatrics and Child Health, and a paediatrician. I certainly think that there have been improvements over

the years. Certainly I can remember being at medical school and having no training at all around safeguarding children. I think even in my early years as a paediatrician, having no training, and actually training was much more experiential than any structured form. You learnt often by being involved and seeing children where there were such concerns.

We now have a structured training, but it is advisory, so, as you're aware, there's the intercollegiate document between various Royal Colleges that sets out what level of training healthcare professionals should have, depending on their involvement with looking after children. It sets out knowledge and it sets out competencies. So that is a vast improvement to previously.

However, I would say that that document is advisory. It is not statutory. I'm aware that inspectorates do look at that and certainly CCGs and commissioners look at the levels of training. However, I think that one can train to that document, but actually we need to see how we embed that training. So people can go to a training session and then leave it, and how do we know that they are actually putting what they have been trained about into practice? I think that is a very, very difficult issue, about how you evaluate training.

I also think that there are things in addition to training that are reinforcing that we need to be firmer about, particularly around clinical supervision in healthcare settings, whether that be GP practices, wards, emergency departments. I sometimes think that, although -- and it is very much more embedded in nursing practice than I would say in medical practice, although the Royal College of Paediatricians and Child Health does have a document around peer supervision, around looking at particular cases, but I don't think it should be just in supervision around safeguarding. I think if there is a generally robust clinical supervision service within a healthcare organisation, then those sort of issues are going to come up and people are going to be able to discuss them. So I think that, actually, the supervision side of it and the peer review/support side of it are very important.

Obviously I also think -- I know this sort of crosses into another workshop, but just the general culture within organisations, allowing people to actually put into practice what they have been trained about or what they have been supervised about, allowing them to act on any discomfort, to have professional curiosity, and to think the unthinkable.

MS KARMY-JONES: Thank you very much. What about Vimal? Do

you have any views on this?

DR TIWARI: I would reinforce much of what Alison said about the intercollegiate guidance, which is not statutory, but which is followed to a certain extent. I think we need to guard against training becoming just a tick-box exercise. What we have tried to do at the college is to bring safeguarding training into the context of a 10-minute consultation, and to bring it away from a social care perspective to a primary care perspective.

The difficulties we face are that there is underprovision of education across the country, so we have an ally in the Care Quality Commission who have set out their requirements for safeguarding and general practice. They are supporters of our Safeguarding Toolkit, and also the way in which GPs should be educated in safeguarding.

What we have found is that the standard of CQC's -- Care Quality Commission's -- assessment, is variable across the country.

What they have found is that in areas of the country where there is a named safeguarding GP, there is a very appreciable difference in the way practices approach safeguarding. So that's an area of good practice which could be adopted across the country.

One of the barriers to consistency is that local

authorities each have their own thresholds for acceptance of referral. As GPs, we are expected to maintain a consistent standard of clinical practice regardless of which area of the country in which we practise, and this is difficult in relation to working with local authority thresholds. So in some parts of the country, a referral of a child will be accepted, whereas in another part of the country, it might be refused. This is something we really find very difficult. We are holding in some parts of the country -- GPs are holding a number of troubled families in their practices with very little support from other agencies.

MS KARMY-JONES: Thank you. What about Helen? Do you have anything to add to that in respect of the nursing?

MS CHRISTODOULIDES: I honestly don't know what's provided by way of education training to undergraduate nursing training these days. I'm sure colleagues around the table might.

I do know that we have implemented the intercollegiate document and safeguarding training at all levels recently into our organisation in a formal way and that largely is being well received. I would echo what colleagues have said about, generally, education in healthcare improvement, it's a weak form of

improvement, and the comments about culture and leadership are so intertwined with the education and training and the ability then to act as a healthcare professional, it's so interlinked, I -- that's what I was thinking about when you were saying it.

But one of the things in the prereading in the document was about not making it a tick-box exercise, trying to be more innovative. In the run-up to our safeguarding week in our city in our organisation, we are doing a raft of things around safeguarding: introducing them into Schwartz Rounds, which are part of our health and well-being agenda; the coroner is coming to talk to people; we are doing lunchtime sessions. We are slowly and innovatively entering the psyche, I hope, of lots and lots of our staff in different ways, as well as making sure people sit down and do e-learning for two hours on safeguarding training, and I am proud of that and I think it is useful and will contribute.

MS KARMY-JONES: Thank you. Clarisser, what about you? Do you have something to add to that?

MS CUPID: One of the things that we have to recognise is that safeguarding is not just a single agency. We have to work together. One of the things to add to everything that everyone else has said is that multi-agency training is key. It is about understanding

each other's roles and responsibilities which in health we all have our own single agency framework that we follow. We have our induction training and then the intercollegiate document also highlights or sets out different levels of training for each role and responsibility within health. But multi-agency is also key because that's where you have early identification, where you are working together with colleagues from other areas, where there's social care, education, but other services as well, and identifying concerns quite early on.

It is also about setting the standard so that you create a culture, a culture where people feel confident enough that, if they do have a safeguarding concern, they can actually share that, and it is also not just about the training but having the policies and procedures that back that up, that staff feel confident enough to raise a concern. So education alongside supervision and everything else is what we actually need to develop a bit further.

MS KARMY-JONES: Thank you. Just bringing it back to abuse within the healthcare setting, can I ask you all just to focus on something that's come back to us, which is that there is training and there's education, but often there's a lack of focus on the abuse that is carried out

by healthcare workers themselves. Is that something that resonates with you? Helen?

MS CHRISTODOULIDES: I'm desperately thinking, having just done my safeguarding training, how much of a focus did we put on others. I think you might be right. I think that might be accurate. I'm thinking about our chaperoning policy and the views that staff have about the purpose of that policy, and some people have said to me, "It is there to protect me as the healthcare professional", and some people believe it is solely there to protect the patient, and of course it is both. I think that there's a lack of understanding in general and focus on harm that could be caused to patients in hospital by staff. So yes, probably.

MS KARMY-JONES: Anyone else? Ray?

MR McMORROW: I think -- I can't comment for any individual NHS organisation, but I think what I would say is that there is a separation -- there's a lot of drives around compassionate care, and many of them have come around abuse issues with adults, often, disabilities, et cetera, that have led to a drive. That drive isn't separate from safeguarding when we are talking about adult safeguarding, but to me, it feels like in children's safeguarding those things are separated so that, when we train people in safeguarding, we train

them in safeguarding according to the collegiate document, but we segregate that from compassionate care-type models as something else around how you technically do the job, et cetera, in certain cases.

So I think that can be a challenge.

I think, Helen, you touched on the issue of what happens preregistration within organisations. Again, I don't know, but I think it is very hit and miss. There were some a few years ago, some very good interdisciplinary training, because, whilst it is right that the issues of multi-agency are really important, many times in serious case reviews what we see is that interdisciplinary workings within the health community remain a challenge, communicating with each other and training around those issues. I think it is really important as well.

But it has to start preregistration: medical school, those issues. And interdisciplinary training in the most -- I think it was Nottingham University, in the most creative situations, we have seen some very good safeguarding work done, so that the staff come into their profession already tuned into the idea of multi-agency working in safeguarding children.

MS KARMY-JONES: So it sounds like you are drawing a distinction between education and onsite training.

MR McMORROW: Yes.

MS KARMY-JONES: Can I just ask if that is a distinction that others feel is an appropriate one to make?

DR TIWARI: Yes. I would totally support that. Because over the years, we have lost sufficient undergraduate training in medicine in child health, so child safeguarding to me is very much an integral part of child health provision. When I was a medical student, child health was given equal status to subjects like medicine and surgery. Whereas now, in certain medical schools, child health is just barely addressed. We have had trainees coming into general practice who have never been taught to examine a baby, for example, so there is a huge education gap out there for some new doctors entering the profession.

I would totally support Ray's point about somehow trying to ensure that child safeguarding is embedded at an undergraduate level. I am echoing Lord Laming's recommendations from all of those years ago. It hasn't happened yet.

MS KARMY-JONES: Can I then turn to Giles. Can you add anything to this?

MR DENHAM: Yes, Giles Denham. I think I can.

MS KARMY-JONES: You are Health Education England?

MR DENHAM: Yes, we are the arm's-length body, the statutory

body, responsible for national education and training. So we look after the platform, the framework, that is provided through what's called e-Learning for Health, which is where health professionals can access the framework that came out of the intercollegiate document.

I think -- I do try to come back to your point about people being aware of the risks within healthcare settings as being the real focus. I think that is, speaking as someone who used to run a hospital many years ago, a quite uncomfortable thing for people to come to terms with across all professions. I am not so sure whether that will fit comfortably into an undergraduate curriculum. I do think for organisations it almost certainly will, and I think probably, although I'm not authorised to say it, it would be worth somebody looking again at the intercollegiate document to see whether the emphases are sufficiently strong in that area. I think it is great on safeguarding generally, but this is a slightly different area and one we probably do need to think further about.

Can I make one other point while I am talking? There has been a bit of debate about the advantages or disadvantages of having these frameworks and having mandatory training and whether people do turn it into a tick-box exercise. I think that is very wise for

people to be aware of. Equally, if you are in an organisation which doesn't pay any attention to mandatory training, that might itself say some things about the organisation's attitude to training in general and the importance of it. So it is a "both and" for me, not just an "either or".

MS KARMY-JONES: I am going to come back to the tick-box in a minute. Alison, from the Royal College of Paediatricians, can you add something?

DR STEELE: Yes, I wanted to come back to your question about, do we train enough about abuse potentially by healthcare professionals, and I think the answer is, no, we don't. The last intercollegiate document was written in 2014, so it would have been prepared in 2012/13. Before a lot of the issues have come up, particularly around chaperoning. So I think that when we rewrite that document, we need to take into account what we have learnt more recently.

I think it is a very difficult thing to train on. It is incredibly difficult to train in e-learning because what you are asking people to do is to view their colleagues potentially in a different light, people that they socialise with. So I think we need to be saying to people, "You know, if you have a gut feeling that something isn't right, what is it that you

are worried about?" Because these things aren't always blatant. They are not usually blatant. If it is a blatant case, then that is almost easier to deal with. It's the small things, the interactions, the things that you might observe that give you a hint that actually more is going on. So I think that is a very difficult thing and I think that is much more going -- you are going to be able to do that much more in face-to-face training than you are in any sort of e-learning package.

The second thing was around chaperone policy. I think people have chaperone policies and maybe staff don't always understand, you know, why, and I agree that it -- the prime purpose is for the safety of the patient, but it also does safeguard professionals as well. But people need to be trained about how to chaperone, because, actually, there's usually a power differential between the person who is doing an examination and that person that's supposed to be chaperoning. So you need to ensure that they would be able to question, to challenge, to intervene appropriately.

MS KARMY-JONES: I will come back to the tick-boxing, but obviously there is potential for a disparity and a lack of consistency between different organisations. How do we deal with that? Have we got any views on that? Or

is that too wide and too big a question? Ray, I can see you making a gesture.

MR McMORROW: Could you ask it again?

MS KARMY-JONES: Disparity and the lack of consistency. It is something that has been mentioned around the table. Is there any way we can deal with disparity? Is it recognised that there is disparity?

MS BEAUMONT-WOOD: Sorry, I am trying to come in.

MS KARMY-JONES: Sorry, Rhiannon. I was going to come to you.

MS BEAUMONT-WOOD: That's fine. On that particular point, within Wales -- maybe it is easier because of geography -- we do have all-Wales safeguarding procedures and it is multi-agency. Obviously it is there to try to deal with the variation that people have talked about. I'm not saying it is perfect. Certainly in my experience, similar to somebody that mentioned over there, when working with 22 local authorities -- it was over here, actually, it was yourself, wasn't it -- the variation in terms of thresholds. So there is something about getting a more consistent approach and understanding about thresholds.

But I think it is possible to reduce the variation by having a multi-agency set of procedures that can span as wide a geography as possible. As I said, probably

slightly easier in the context of Wales.

Just whilst I'm on my feet, so to speak, I think the other thing is about, where we have a number of topics, and I think it speaks to Ray's point slightly, so in the safeguarding agenda now it has been exponential in terms of what topics sit under it, so if we think about the prevent strategy in domestic abuse, safeguarding children, safeguarding adults, and actually, while we don't want to diminish anything around making sure we equip people to be able to respond and prevent things, I think we need to take the opportunity to look at this in the round, because lots of the things we need people to do are actually quite similar. I think by trying to keep things siloed, it works against organisations being able to grapple with this. I mean, at the end of the day, training is the one thing that every organisation will be challenged by, frontline staff being released to do their mandatory training. Whilst everybody would recognise how important it is, the challenge is it means somebody is not doing something else. We all know about shortages of nursing and the midwives and doctors. The challenges of recruitment across the UK, globally. We need to think about how we do this and make the best use of our time to ensure that we are equipping. I just wanted to say that.

MS KARMY-JONES: Thank you. I wonder if, Simon and Albert, you have anything you want to add to that from the Welsh perspective?

MR HEANEY: Thank you very much. There are a few things I would like to add. The first point I would like to make, I think we have got to raise more profile around the voice of the child, the young person, directly. We are talking today about training and education for staff, but the heart of that has to be engagement in the way we talk and communicate. How do we see the signs of safety? How do we get to communicate? I think that is one of the things just to profile a bit more in the conversation that's taking place.

In terms of training, Wales has gone down the route of mandatory training. It's taken that. It is easier for us, in a sense, because of our size and our scale, although we do find complexities sometimes having 22 authorities. We have tried to reduce that complexity in terms of the way we have approached it.

In terms of that mandatory training, Public Health Wales and others make sure that the standards are adhered to and it is wedded into some of the culture and practice around, you know, management and supervision and accountability.

But to really take it to the level, I think, that we

need to be at, the horrors of child sexual abuse often, to many professionals, and many of us have been involved in the work over the years, have been stories and horrors that we wouldn't have imagined, we wouldn't have thought, and sometimes I think the only way we can truly get more effective awareness and training is through that multi-agency work. That's why what we have tried to do in the Welsh context is build up. So we have now got regional safeguarding children boards that cover a number of authority areas, really getting into that thorny issue, trying to deal with inconsistencies in practice, and alongside that Welsh ministers have created a national independent safeguarding board with a team of experts who are then able to advise us working directly with the regional board. So bringing learning together, enabling us then to begin to tackle together some of the big challenges that we all clearly face.

MS KARMY-JONES: Thank you. Simon?

MR DEAN: Not at this stage, thank you.

MS KARMY-JONES: How does that compare with what takes place here, then?

DR TIWARI: Could I just mention a very exciting initiative which has come from the European Union, which is a series of multi-agency training modules produced and validated across eight countries. These are

multi-agency training modules, and centred very much on the UN Convention on the Rights of the Child. So the child is at the centre. The modules are based on the assessment triangle, which would be familiar to many people.

I would urge -- if we are going to go forward and try to find a consistent means of educating all professionals -- that we start with that as a foundation. Because it is an excellent piece of work.

MS KARMY-JONES: So in terms of consistency, how do you -- you have made a suggestion, Vimal, on that. Is there any lack of consistency between different organisations and also the way training is offered to those who may come into the health service, say, from abroad, from a different training base? One of the things I think you said earlier was that it should be embedded into the undergraduate programme. Well, if undergraduate programmes haven't been undertaken here, how should that be dealt with? Anthony, do you have any views on this?

MR OMO: I do, thanks. So we set the education standards for the UK doctors and, for those coming from abroad, they are required to meet similar standards. So we check, upon registration, a number of things around education and training and that they are then fit to practice. For me, and it echoes what has been said

around the room, education only goes so far. It is a necessary component but it is not sufficient. We do work with employers on this, but the employer, where the doctor is now going to actually practise, has a role to play in making sure that the doctor is up to speed with the local guidance and training. We issue tonnes of guidance across for all doctors, but it is the practicability of it, how it works in practice. So for us, we do the initial checks, but it is a high-level check. What the doctor is actually going to do needs the employer to keep an eye on and make sure that they follow the training and processes there.

MS KARMY-JONES: To some extent, that harks back to the tick-boxing, the tick-box exercise.

MR OMO: Indeed. I think that's -- again, echoing thoughts and comments around the room, I think it is bringing everything together. So the education is necessary, it absolutely is, and some consistency, and we make sure we set out for undergraduates and post graduates that, so, if you train in this country, it is consistent and safeguarding is an absolute part of that, but that only goes so far because doctors practise in all sorts of settings and they don't work alone, and that's where the multi-agency comes in. And we don't regulate others outside the doctor. So I think working with employers,

the culture, it is all quite mixed in. To make sure people know what rights are, what they are doing, why they are doing it and how they're doing it. I think a very important point made about the patient, at the centre of it all, an informed patient, so they can raise things, and you create the environment where they can raise their concerns, be it in a hospital setting or elsewhere. I think that is quite important. That's where I think there is perhaps a gap, because there isn't a patient group per se, in the same way there are colleges and others for doctors, that you can get at to get that education out there.

MS KARMY-JONES: How do we fill the gap?

MR OMO: I don't have the solution right now. I think we continue to work with others, so we work with other regulators, we work with our local safeguarding and local authorities, but as you mentioned, if you go to different ones, you get different responses, and maybe that's something to look at. We have lots of memorandums of understanding where we share information, we refer things to the Disclosure and Barring Service when we need to do so. So I think we are plugged into a whole raft of places and organisations, but they are not all working, if you like, in the same way and at the same pace. Maybe there is something around that.

MS KARMY-JONES: So on that -- yes, Alison?

DR STEELE: Sorry, Alison, Royal College of Paediatricians. Yes, the other thing I think is training passports, because one of the things -- it is mentioned in the documentation, but one of the, I suppose, higher-risk areas for organisations is either honorary -- Trust staff on honorary contracts who work mainly elsewhere or agency staff. Then the essential nature of having some sort of a training passport so that you know that people are up to date with their training immediately they come into your organisation.

The problem with lack of standardisation is, if we want to implement a passport, how do we trust that they have been trained appropriately within another organisation? So I don't know how we tackle this, but it may be that there needs to be -- I tend to be somewhat against increasing prescription, because it goes against, you know, looking at developing sort of professional competencies and curiosity, but maybe we do need to have something in terms of baseline standards so we can actually implement the passport system that would actually help with the higher-risk areas of honorary contracts and agency staff within healthcare organisations.

MS KARMY-JONES: Thank you. I am going to come back to

training passports. I think it was one of the suggestions that came to us in the documentation. But taking that point of a kind of baseline and taking Anthony's point, who is, or which organisation is, best placed to make improvements or to take improvements forward? Because it is all very well for us to recognise that, yes, there are levels of communication, but there is no overarching overview pulling it all together to ensure that everyone is working in the same way. Who is best placed? Alison?

DR STEELE: I think this is where commissioning plays a really important role, and I know that is going to be probably discussed more this afternoon/tomorrow. But I think that commissioners are in a position to be able to demand certain standards, as are inspectorates. So I think the role of commissioners and inspectorates in determining standards and also what might go into a training passport might be an important one.

MS KARMY-JONES: Thank you. What about Sue, on behalf of NHS England? You have an overview, could you make some observations about this?

MS WARBURTON: Absolutely. I agree. I think training passports -- we are seeing it already in the social care setting, and helping people move across the system effectively. As we see more agency staff, more locum

working, more members from other countries coming to work with us, these are the things that will help us maintain the standard that we are talking about.

You have mentioned also about a range of topics this morning, but I would like to particularly pick up around some of the recruitment elements and some of the work that actually is done within organisations when we do bring foreign workers into the health sector. There are extensive programmes of development for those workers when they come and they are nurtured through the system, and I suppose you will perhaps recognise that, when you bring people in, you put them through development, they have safeguarding training of various sorts.

What I think we perhaps do need to do is pick up more of the model that we are talking about in Wales where we are looking more holistically at safeguarding now with those key messages, because we keep segmenting safeguarding and, actually, we need to think more holistically, because we have got -- we are training people in adults but those adults are often engaged with children in care homes, et cetera.

MS KARMY-JONES: Sue, who do you say would be best placed to put this into action?

MS WARBURTON: I think it's a range of people. I think I would agree that the regulators have a role to play.

I think NMC have a role to play in actually making sure that when we are registered, we do have those revalidations and things in place. When we revalidate, we don't have to actually say that we are up to date with safeguarding. Yet, it's the core principle of everything that we do.

MS KARMY-JONES: What are the levers and incentives that might be brought to bear on this?

MS WARBURTON: I think a range of levers. We use our NHS standard contract to good effect. I have been a commissioner previously and put quite rigorous standards in place in a previous role around safeguarding, which allows us then to challenge very effectively our providers on the detail, and I think it is -- that is where it needs to be, it sits within your contracts, it sits within those schedules. So the NHS contract is a start, but it is about the schedules and I have seen some very effective safeguarding schedules within contracts.

MS KARMY-JONES: Rhiannon -- Simon?

MR DEAN: Perhaps just to draw a difference from the Welsh to the English context. My answer to, "Who is responsible?", is the employer. We don't have separation between commissioners and providers in the Welsh system. We have integrated bodies. So my

expectation would be the employer, who is ensuring that their organisation and all the staff that work for it are appropriately trained, supervised and supported; supported by frameworks and others, including by government and with the regulatory input, which, again, is different in the English and the Welsh system. But I personally think the primary responsibility sits with the employer.

MS BEAUMONT-WOOD: Can I add to that? I agree, but I think, in addition, it is -- it can't be one single agency. I think it is kind of what Albert referred to earlier: regional safeguarding boards hold the multi-agency representatives to account. They have to submit reports to demonstrate how they are complying. The national safeguarding board now can provide that oversight and scrutiny. Health Inspectorate Wales will look at health and care standards, which is our equivalent of CQC. And within organisations, of course, they also have to assure their boards. So I think it is very difficult to say it would be one. I think there are many levers. And I think any recommendations that come out need to think about the difference in terms of the NHS context, because they are quite different in England and Wales, so kind of one or two bullet points may actually, you know, not have the outcome that you would be looking for

as a panel.

MS KARMY-JONES: Thank you. Ray, you had something, and then I will come to you, Christine.

MR McMORROW: Yes, just on a similar theme, the Care Quality Commission I think have moved forward in the past 18 months, bringing specialist advisers on safeguarding into practice, into inspections, et cetera. I think that's a really positive move, to actually engage people who will in some ways know what they are looking at when they are going in. Often former designates, et cetera, going in and actually looking at that. I think that is a positive move because it is about the inspectorates knowing what it is they are looking for. I think that issue about mandatory or statutory, I think they are words, as far as I'm concerned. I think it is actually about how you enforce and ensure there is competency in the system that matters most, and I think CQC have taken some goods steps, although I recognise the resources for them are quite tight as well.

MS KARMY-JONES: I just point out we do have someone from the CQC, the Care Quality Commission, coming a little later this afternoon, I think. So we may be able to turn and ask them for their views a little later. Thank you. Christine?

MS BRAITHWAITE: Thank you. I just didn't want to lose

sight of the concept -- Christine Braithwaite, Professional Standards Authority, apologies -- of the important point I think Alison made early on in the discussion, which is around the importance of developing professional curiosity. I think there is a role for educational institutions in collaboration with regulators in starting that training and education during the undergraduate time and continuing all the way through. It is a lesson really from the aviation industry also in terms of developing constructive mistrust. It is that permission for one group to be able to challenge the behaviour of another group. That requires practice as well as imparting information. So there is an important part in terms of giving information, making sure that information is consistent, but also then in practising those behaviours so that they become ingrained, and that, once students move into the workplace, they can continue to practise them when they actually encounter those real-life situations where they need to act.

MS KARMY-JONES: Thank you. A final observation, perhaps, from Lorna, and then we will move to the public gallery.

DR PRICE: Thank you. Lorna Price, designated doctor national safeguarding team in Wales. Just to say that, in Wales, doctors have an online medical appraisal and

revalidation system in which they are required to state what level of safeguarding training they have undertaken and how recently. So that should be a discussion that's had at appraisal with their appraiser and would inform the responsible officer when they are looking at revalidation, and so on.

The other thing about standards, I suppose, and getting consistency across the piece, Rhiannon mentioned briefly the NHS Wales safeguarding network, which is a collaboration between senior nursing staff responsible for safety and quality and safeguarding from all the health boards and NHS Trusts. Along with the national safeguarding team, we also have representation there from Welsh Government. It is a forum, really, for sharing good practice, but also there is a bit of sort of challenging of one another and nobody wants to be seen as practising, you know, a lesser level than others. So it does work very well and has led to development of tools and audits. It comes to mind things like -- sorry, senior moment. My mind has gone blank. Risk assessment tool for children who are cared for in adult areas within the health service, where they would be particularly vulnerable. So those kind of innovations, really.

MS KARMY-JONES: Giles, just one last point.

MR DENHAM: Very quickly. I would agree with Rhiannon that non-executive boards are a powerful tool within the health organisation. The other thing to say is we have talked a lot about secondary care organisations. Primary care is always quite different because you don't have the standard contracts, so you are possibly more reliant on regulators, but, again, they are spread thinly.

MS KARMY-JONES: I am going to open it up now and see if there is anyone within the public gallery who would like to say something. I see Mr O'Mara has his hand up. If Sue would like to get the mic.

Observations from the public gallery

MR O'MARA: Good morning. Nigel O'Mara from East Midlands Survivors. Core participant and survivor. I have been involved in running workshops for Care Commissioning Groups for GPs in first contact and appropriate referral for the last couple of years, and also working with multi-agency groups in my area to look at the issues around training for victims of sexual abuse and people who are coming into contact with them.

What we do see greatly is this disparity. There is no level playing field. We find that some areas don't send the most appropriate person to those multi-agency meetings, somebody who can't make the right -- the

decisions at the time, and then, when it gets passed back, no further action is taken.

So it is all very well having a multi-agency attitude and approach to it, but unless you have got the right people in those multi-agency meetings, it's never going to actually produce an equal and open training module.

I am also working with the University of Nottingham to prepare an undergraduate workshop for them for next year. I'm finding that, again, there is a disparity. Some parts, they want to use it in some parts, they don't want to use it in others. I think this sort of safeguarding has to be seen as something that needs to be done generically across the whole system. Thank you.

MS KARMY-JONES: Thank you very much. Is there anyone else in the public gallery who has something they would like to contribute?

MEMBER OF THE PUBLIC: I would just like to make a comment on whether things should -- you know, this is a seminar to find out what to do to stop it happening. Now, the last incident, the last seminar, we had a professor there turn around -- and when I've been to it, I took it out the context of what he said. But I have it on my phone here as to what he said. And that is, don't take a note and don't record when somebody is giving you

a disclosure. Can we clarify that? That in these, what you call -- well, what I called a log when I was doing youth work, I had a log of all the things I'd done, and that is the priority. I know doctors and nurses, if I go to them -- or a child goes to them and says something, it's got to be reported immediately. As a youth worker, when one disclosure was given to me, I immediately forwarded it, which you have got to do. When you have a professor telling us, "Don't make a note of something", so can we get that clarified, as to whether they should make notes or not, because that is one of the greatest preventions?

MS KARMY-JONES: That's one of the things which came out of the last seminar, which was to do with record keeping and whether records were kept accurately and stored for a lengthy period of time.

MEMBER OF THE PUBLIC: And the example I give with myself, as I said, was because I have got no record of it being anywhere, I remember that in 1970, it should be on file in the courts, but criminal injuries have denied people compensation because of it, because they have not been recorded. So, on that, the log should say, make sure they record everything.

MS KARMY-JONES: Thank you very much. Anyone else before we break? And those comments we will consider over the

break.

I don't know, madam chair, if that will be an appropriate moment?

THE CHAIR: We will take a 15-minute break now.

(11.30 am)

(A short break)

(11.45 am)

Discussion re Topic 1 (continued)

MS KARMY-JONES: We have talked a bit about multi-agency approaches and the fact that agencies need to work together. I want to move on a little bit from that into some of the practical issues, such as what is the prevalence of child sexual abuse? Do we know what the prevalence is around child sexual abuse in a healthcare setting?

One of the things we do know is that, as a matter of commonsense, there is a greater opportunity, potentially, for abuse in a healthcare setting, given the intimate nature of the relationship between a patient and, say, a doctor, a nurse or others working in a hospital setting, for example. So there is a practical reality to that, and we have to be conscious of the fact that what training can do -- you know, when you are talking about globalising training and making things consistent, what you can do in relation to

a child in one setting is going to be different from what you have the ability to do to a child in another setting.

So I would like to explore, please, what we know about how often the opportunity is exploited; what the prevalence is. Because we have heard of historic cases, but it is still happening. We know in the Davinder case, he was convicted in 2013 of the abuse of two girls under the age of 16 between 2010 and 2012; intimate examinations being filmed. So it still happens.

So what do we know? Are the cases that we hear about in the media just the tip of the iceberg? Is it much more prevalent than that? Who would like to start? Alison?

DR STEELE: Alison Steele, Royal College of Paediatrics and Child Health. I think it is a really difficult question, because I don't think we know what we don't know. I think there may be some more robust ways of measuring that. I know most organisations possibly -- I don't know about sort of general practice, primary care -- have allegations-against-staff-type processes and whether we can actually look at the data collected in terms of returns commissioners around that, you know, how many meetings are being held and what sort of topics. Because it is quite a broad range of things.

It is certainly not the meetings they are having are all about sexual abuse of children. It may be any level of allegation. But I wonder whether different organisations have different processes and whether there is some more data we can collect about what we do know. Because I don't know whether we -- I'm not aware that we collate what we could be collating, but as for knowing what we don't know, that's extremely difficult.

MS KARMY-JONES: Let me just ask Anthony about the data collection and the record keeping. How much is data collated? Does the GMC, for instance, collate data of this kind of allegation?

MR OMO: So, we do, but only where those cases are referred to us, and I suspect that is nowhere near the number that are dealt with locally. So we are, if you like, the end point rather than the start point. We see the most serious of cases, where it is public, it's been found out, as it were, and then referred to us, and we take action. So we have our statistics of the cases we take action -- I don't have them to hand, but we can provide those. But we certainly don't collate across the NHS the numerous incidents. We do have discussions with responsible officers about concerns in general about doctors and those are documented, but I think where they involve any form of abuse of children, and

those become cases and are dealt with. So I'm not able to provide statistics across the NHS.
MS KARMY-JONES: Out of interest, Anthony, just one final thing: your statistics, is your data kept internally or is it published?
MR OMO: So when we have cases, the outcomes are published and we publish an annual report which shows the number of cases, erasures, et cetera. What we don't go into, but can provide, are the actual allegations dealt with, or the types of allegations dealt with. So we can provide that. We don't publish that except on request.
MS KARMY-JONES: Why is that, out of interest?
MR OMO: Just to share numbers that we would be dealing with and the range of allegations. So we provide top-level details of cases, what's happened, and all of that detail is published. So any outcome from our tribunal is published. So it is there. But what we don't do is collate the allegations.
MS KARMY-JONES: Thank you. Christine, you wanted to say something?
MS BRAITHWAITE: I would just say that we have just done a categorisation project in which we have looked at how the regulators, the nine regulators, that we oversee are recording cases on their database. Essentially, the regulators all categorise their cases differently. So

it would be quite difficult for us currently to be able to look across and say, "There are X number of cases in relation to that". It is a piece of work we have been doing recently to try to look at what research could we undertake, carrying out the sort of data that is collected on our own database from our review of the final fitness to practise decisions that the regulators' panels make, but also looking consistently across the regulators to say, could we start to coordinate some kind of trend collection? So that is a very early stage of the report, but the first finding so far is there are lots of different categories, cases are categorised differently, so there are some challenges in relation to pulling that data together.
MS KARMY-JONES: That is a potential problem, isn't it?
MS BRAITHWAITE: Yes, not necessarily insurmountable, but certainly not a quick fix.
MS KARMY-JONES: John, from the NMC?
MR LUCAROTTI: We are in a similar position to the GMC in terms of our data. Although I have to say it is only recently that we have started categorising our allegations in sufficient detail to be able to assist with that sort of question. We are certainly not at the point where that exercise has been going on long enough for us to have confidence in exactly what that data is

telling us. I also agree with Anthony's comments about, you can only get so much of a picture from the fitness to practise referrals and there is a lot that goes before that which may not make its way to us, so, yes, it does give us some information, but probably not the full picture.
MS KARMY-JONES: Sue, does NHS England collate data?
MS BRAITHWAITE: Yes, Susan Warburton from NHS England. We have started to collect allegations data from our primary care review panels that we have, and it is very early stages. What we do know is that they appear very low, considering the large workforce that we have. Similarly, we have conversations with the Disclosure and Barring Service. Again, we find that the amount of referrals from health are extremely low compared with the volume of health professionals, which gives us cause for concern. So we are in the early stages of collating data of our own performers, primary care performers. What we don't have are the range of figures across the health sector.
MS KARMY-JONES: Is that something that you are moving towards, then?
MS WARBURTON: We will be moving towards collecting across the health sector. What we will be looking to do is working with colleagues in other areas, so NMC, GMC,

et cetera, Disclosure and Barring, to see if we can get a more rounded picture of what's going on. Certainly, having worked in local areas, similarly referrals to LADO are very low across the country. We have looked at that also recently.
MS KARMY-JONES: What about Wales? Simon, does NHS Wales collect data and collate it?
MR DEAN: We don't collect data centrally, but Rhiannon might comment from the NHS perspective.
MS BEAUMONT-WOOD: Yes, I would say the NHS organisation, heads of named nurses, named professionals, would be aware, or should be aware, of every concern that gets referred. When I say "gets referred", we have a duty to report into local authority. In Wales, we have a structure called a professional strategy meeting, which may be any category of child abuse, not just sexual abuse. So we would know those numbers of referrals from health into, and local authorities, as I understand it, also have a data collection system themselves and there are some returns that are provided to the Welsh Government in terms of numbers of categories, et cetera.
In terms of publishing, no, they wouldn't, because obviously, at this point, it is a concern. There is nothing proven. In addition to that, in terms of sexual

abuse, they are likely to be small numbers and there would be issues with small numbers guidance in terms of anonymity.

So I would say we do have data. I wouldn't like to say hand on heart it would be absolutely robust, but we do have data.

MS KARMY-JONES: I think, Ray, you wanted to add something to this?

MR McMORROW: Yes, just a bit of clarity on data there. Certainly my experience on the designated nurses, the majority of cases of health professionals that we would refer to LADO or NMC, GMC, were actually not inside the health-related behaviours, they were private behaviours that came to the attention and led to -- so you have two different -- you have behaviours that have been carried out by health professionals but not necessarily in their health role, in their private lives, or whatever, and you have that which is carried out on patients of health services, be they NHS or private sector, and there are two different sets of data, really. I think a lot of what might come through to NMC and GMC may not always be direct practice-related stuff.

MS KARMY-JONES: Trying to move slightly away from the generality of safeguarding issues, which I think everyone acknowledges and is aware of, and dealing with,

really, the point, where do we know children are most vulnerable? Is there a general view or does anyone have a specific view on that?

DR TIWARI: I have a specific concern. With one of my other hats, I work in secondary care. I am concerned about the paediatric ward, which is essentially a mixed ward of adults and children. There are adults staying overnight in paediatric wards. There are hidden areas within the wards, and there may be some CCTV surveillance of certain public areas, but there is not total coverage, and there have been reports of abuse of children in those settings by adults who are not necessarily healthcare workers but adults visiting other children on the ward. To me, that is an area of very great risk over which we currently have no control.

MS KARMY-JONES: So sometimes there are adults who may be parents who are staying, for example, overnight in a ward, and many of us may have had that experience. But equally, in some instances, where an adult does not stay with the child, the child may be left unchaperoned, which brings us back to the chaperone question.

We know it happens. Plainly, we don't know the scale. So what are the greater -- you take the view that that is one of the greatest opportunities for abuse to happen? Is that right?

DR TIWARI: I think it is one of the greatest opportunities because, even if a child is chaperoned, even if there is a parent with a child on a ward, that parent will not be with that child every single minute of the day. There will always be times when the child is left, and it might just be for a few minutes. The parent will not necessarily accompany the child to the bathroom if the child is old enough to be there on their own, for example. We know that bathrooms have been places where serious attacks have taken place.

Staff actually have no means of ascertaining whether the adult accompanying the child is actually related to that child. In hospitals, we don't ask for checks. You know, we don't ask for patients to provide identification to prove that they are a parent or a carer of a specific child. At the moment, that's an area really quite beyond the control of staff.

MS KARMY-JONES: Should that happen?

DR TIWARI: I don't know how we would implement it. It is something we have thought about. But I don't quite know how we would actually go about setting those controls.

MS KARMY-JONES: Access to children is clearly part of this, and, again, those of us who have been in a children's ward may recognise the scenario of just pressing a button and being allowed into the ward by a tired

member of staff behind a desk who doesn't check you at all; maybe someone has tailgated you in through the door, and, as a parent, you won't necessarily check the person behind you. So how do we deal with that? Are there any suggestions?

MS BEAUMONT-WOOD: I want to add to another area as well. It is, again, about equipping staff to be accountable and responsible for that kind of stopping and challenging anybody. Even people they are familiar with who are out of context in that particular moment. I'm particularly thinking around volunteers. You know, WLVS for example, on wards; a common sight, isn't it, with the trolley, selling bits and bobs. How do we ensure our volunteers, which we rely on -- another context is we use volunteer car drivers to take children to and from appointments. Very often, they don't have a parent in the car with them. So, actually, you know, we really -- I know it came out in the report that you did, or the findings from the feedback, the volunteer system I think is a weak link and I do think it is something that we really need to invest some workforce OD-type -- systems around.

MS KARMY-JONES: Sue, what about -- what views do you have on this from NHS England?

MS WARBURTON: I think it would be extremely difficult to

implement such a system. I don't know how you would manage it on a day-to-day basis on a ward. I think it would require an extra band of staff to actually monitor the door. Whether you give people passes, as you do -- I mean, I don't know whether some of you have been on holidays in Florida and you get passes to get into things, in and out of gated communities, it is a similar sort of process, but you would have to put a whole system in place and have individuals on top of -- the nursing staff would not be able to monitor that on top of the day job, I don't think. I think it is very challenging.

In respect of the volunteer question, I think from an NHS England perspective, we have done a lot of work across the system around ensuring that volunteers are well vetted, that good policies and procedures are in place within hospital settings, and that we have worked with CQC so they are aware of that and they check those policies and procedures, particularly, you know, in light of recent events.

So I think we have got quite a lot of those policies and procedures in place. I think what we struggle with is the monitoring on a day-to-day level.

MS KARMY-JONES: So recommendations that have been made, we know that the Bradbury and the Savile cases resulted in

recommendations being made about physical access and chaperoning. How far are those recommendations in fact being followed? Clarisser, can I ask you if you have any views on that?

MS CUPID: Clarisser Cupid, designated nurse, safeguarding children.

MS KARMY-JONES: And also the comments about the effect on nursing staff. Can you deal with both of those?

MS CUPID: I think some of the challenges that frontline nursing staff have is around the clinical care, as well as balancing that against keeping children safe on the ward. It is very difficult, and they work sometimes really hard under extreme conditions as well.

I think what we can do, in order to ensure that we have a secure process in place, as much as possible, because, obviously, we want to make opportunities as little as possible for people who want to abuse children, we want to reduce that level of opportunity for them, is around access. Just having pictures on the wall so people know who staff members are and their roles and responsibilities. It is also about speaking to parents and children and identifying who their main carers are on that day.

But I do know that, in particular, most wards will have a buzz-in system, but it is, as we mentioned

earlier, difficult to monitor that, but something has got to be done in order to provide a secure access.

MS KARMY-JONES: Do you agree with the suggestion that it is almost impossible to deal with it? Or can you see that it could be done?

MS CUPID: That's a difficult question. I wouldn't say it is impossible, but it will be challenging to do.

MS KARMY-JONES: Is it too much of a burden to put on nursing staff?

MS CUPID: I think it is not just nursing staff we have to look at. We have to look at skill mix staff across the ward and responsibilities. Nursing staff has got to juggle -- we have to look at the clinical responsibilities and responsibilities around safeguarding, both equally important. Could the needs be met by skill mix within the team, therefore freeing up the clinical staff time? That's really, really difficult. I think each service will have to look at what is required to maintain that.

MS KARMY-JONES: Helen?

MS CHRISTODOULIDES: Hi, I'm Helen, director of nursing from Leeds Teaching Hospitals Trust. Yes, it is too much of a responsibility to put solely on nursing staff, and we shouldn't, because it is everybody's responsibility. Wards and departments are full of multi-disciplinary

staff that have a responsibility. In fact, it is usually ward clerks and receptionists that you might find closest to nurses' stations and so on, and desks. You don't find many nursing staff sat around desks anymore. So they are often the people that do the meeting and greeting in ward areas, and of course they have had training and education around that, and there is an expectation that everyone is challenged. But it is everybody's responsibility and we have to empower our staff to do so.

I think, apart from putting bouncers on doors, it almost is impossible. That doesn't feel proportionate or correct. It is very difficult. People are very busy. I walk around wards all the time and can, you know, not pass a member of staff for a couple of minutes, and that's just because, you know, they're busy.

MS KARMY-JONES: Can you make any suggestions as to what could be done? You're on the hard line out there. Can you think of anything that you notice?

MS CHRISTODOULIDES: Well, we could perhaps -- again, you know, perhaps we could change the geography of some of the ward layouts. It strikes me in some wards and departments you can enter and be immediately very close to patients, and some perhaps have more atriums and

areas that you could -- there aren't physical barriers, but navigating to get to areas seems a little bit more tricky. But then the design of buildings, we have such varied buildings and accommodation.

Empowering staff. I can't really think of anything that would be easy to do.

MS BRAITHWAITE: I think the issue with these things is identifying exactly what the problem is. The difficulty I see with verifying somebody on entry into a ward is, exactly what kind of check are you going to carry out? Essentially, they might tell you that they are the parent or the relative. How far would you go in relation to the check? But what confirming an identity of somebody, whether or not they have a genuine relationship with the child, doesn't do is tell you what the intentions and the motivations of that person are. So even if you were to institute a sort of type of thing you have if you go into a nightclub or some other place and you get a stamp on your wrist to say we have verified who you are, that is not going to help in relation to actually the risk to the child.

It is more about what are the opportunities, where are the places that things happen, and staff being aware and vigilant about the opportunities for that type of abuse to take place, and empowering the children

themselves and empowering the other parents in there in terms of knowledge and what to do and how to speak out if people behave in ways that aren't that which you expect.

I referred earlier to some professional boundaries guidance which we produced back in 2008, and we did a suite of guidance there for educators, for employers, for professionals and for members of the public so that everyone was clear about the behaviours that should be expected of the health professional, so that the child and patient and relative would understand what the behaviours are that should take place and, in terms of parents, also potentially advising them of some of the warnings to look out for. I think providing information and training to people about the opportunities and empowering/equipping them with the ability to be able to check and challenge and prevent that would be more effective than trying to undertake some of the more mechanical-type things, like having a bouncer on the door, and checks which also have potentially unintended consequences, in terms of the climate and the environment that it's creating in which the child and the family are having to deal with highly stressful events anyway.

MS KARMY-JONES: Anthony, I think you had something to add?

MR OMO: Thank you, Anthony Omo, GMC. For me, it is a combination of what's been described in terms of supervision and controlled access. But I wonder if the answer lies in going back to where you started, which is do we understand the prevalence, because, if you do, then you could work out what a proportionate response is. And I don't think we have that answer. It may be different across different settings, it may be different across different countries. One answer, one solution, won't work everywhere. I do wonder if there is more to be done to get that data, understand the issue and then we can try to work out what is a proportionate response, which probably will be a combination of what's been suggested.

MS KARMY-JONES: So it comes down to the fact that we don't really know, because the data isn't collated. Does everyone agree with that? No-one is disagreeing. That in itself may be seen as a bit of a problem, I suspect.

What about the opportunities in community practice? We are talking about hospitals. But what about the opportunities in community practice? Does anyone have any observations about that? Rhiannon, what's it like in Wales?

MS BEAUMONT-WOOD: I think the opportunity in community settings is even greater, in terms of the risks, for

obvious reasons: there is less people around, and it depends -- I know -- I think you said earlier about not looking at the context of "the home", but obviously, in the community context, the home is where a lot of care, and more and more care, is currently being delivered and plans to do even more delivery of care at home.

So, again, I sort of took to the point Christine made. I think we need to do an awful lot more to empower the public, family members, children and young people themselves. I think an awful lot of energy needs to go into empowering individuals to understand what is, you know, within the realms of a therapeutic, proper service provision and what's crossing boundaries.

I do think that we could do something, and even in acute settings, where collectively -- I say this quite deliberately -- multi-disciplinary teams could do risk assessments of the environment in which they work to understand where their weak points are. It definitely shouldn't be left to one person to say, "You have got to do the risk assessment for this quarter", it has to be done as a multi-disciplinary exercise so everybody is brought into, "This is a risk assessment" so we all collectively understand where the vulnerabilities in our working context are.

I think potentially -- that doesn't happen, as

I understand it, at the moment specifically, but that might be something that we could explore in whatever setting.

But, again, I think it is putting -- how we do some mass public awareness family context, and using third sector organisations that clearly do a lot of work in this space, like Barnardos and NSPCC, is just something we need to do a lot more in, in empowering families to increase their confidence to challenge health professionals in particular.

DR STEELE: Alison Steele, Royal College of Paediatricians and Child Health. I also think we need to be cognisant of the fact that maybe some groups of children and young people are potentially more vulnerable to being abused by staff because of potentially their age, their disability, their past life experiences. Because these are often the very sort of children that people who are preying on children will actually pick, because they realise they may not be able to speak, may not be able to say, they may not be able to be believed. So I think we just need to sort of put that into the mix when we are looking at protective factors, which obviously have to be proportionate. We talked about proportionate response, and I think that's very true. If you go back to the '40s and '50s, we had children locked up in

hospitals, it was almost like prisons, and parents not actually being able to visit them, and the damage that did to children in terms of their development, and the need, when they are sick, to have people close to them.

So I think it is important to get this response proportionate, which is what people have already been discussing.

MS KARMY-JONES: We have had quite a lot of observations, and it is right, it is difficult, and there are a lot of areas that it needs to cross and a lot of different settings that it falls under, but it has been done in relation to other types of things, perhaps not quite on this level, but the NHS certainly has implemented campaigns that have been successful around things like the hand washing, that is certainly something that's changed a lot, and there is a culture, isn't there, much more so now, of people being picked up on washing their hands, sanitising their hands, before they go into a ward.

"My name is ..." is another campaign that has been successful.

Why not this? Why can't we deal with this in a similar way?

MS WARBURTON: Susan Warburton, NHS England. I would argue the point that we have done a considerable amount in the

same way, working with children and young people, co-producing products, and videos, and all sorts of things to raise awareness of professionals, and their parents and other children and young people, on this topic.

I think we have done a range of work with Ray's group that, again, has got some really key messages. We have the Superhero campaign that is currently ongoing. I think those things are there. We will continue to work on those campaigns and build momentum. It might not be as big as the "Hello, my name is ...", as yet, but there is certainly a lot of work ongoing to promote CSC and CSA across a range of public, rather than just focusing on health professionals or focusing here, but actually raising awareness of everybody. It's been said many times today, you know, that we have to raise awareness of the public, what is acceptable, what is not, and that's the only way, rather than gating wards, which I would absolutely disagree with. We need to make sure people are aware of what's not acceptable.

MS KARMY-JONES: Is there consistency, though, with other areas of healthcare?

MS WARBURTON: Consistency in what respect?

MS KARMY-JONES: In that kind of approach. You are doing a lot. You have outlined some of the things that

NHS England are doing. What about other areas of healthcare?

MS WARBURTON: I believe so. We work consistently with voluntary sector organisations, with our CQC, with Health Education England, and others. So we are getting the approaches. If you have got one message -- we are back to the one message conversation -- we haven't got one message on CSC. Maybe that's the direction we should be going, one message, rather than having several messages, because it worked in the "Hello, my name is..." campaign to have that one key message all the time. I think similarly looking at safeguarding in general about what is and what is not acceptable behaviours might be a way forward.

MS KARMY-JONES: Thank you. Giles?

MR DENHAM: I was going to agree strongly, I think, with Rhiannon that I think part of the answer to this is, where you don't have really good data, you do have to do a fairly specific risk assessment on the best you can. I think that is really important because actually individual wards, individual settings, think about that, they will help themselves identify where their weak points are and what might sensibly be done rather than the kind of one size fits all.

Conversely, I think when you come to a campaign, the

ones that have worked and got quite simple, single messages, and we have done things with the voluntary sector on things like dementia, and I think Susan is right that if you do go down that route, you have to keep it simpler, but that may be a "both and" again between doing something local that is relevant to particular settings and thinking, is there something national that is straightforward we can get across?

MS KARMY-JONES: Thank you. There is such a diverse range of professions that the healthcare service deals with. How do you get the message across the diverse range of professions?

MS WARBURTON: Susan Warburton, NHS England. I think it is -- the professions all have safeguarding as a core within them. We are there to do no harm in the first instance. So that core is always there. It is there throughout training and education, whether you are in social care, whether you are in healthcare. So I think whatever message -- we have got doctors using "Hello, my name is ..." as well as nurses as well as physios. It is back to that core message.

MS KARMY-JONES: It is also kind of back to what we started the morning with, about consistency between training, isn't it, and there are a number of healthcare professions that don't fall within the same kind of

regulations as hospitals and GPs, and so on.

So surely we must be looking to going beyond those bodies and enveloping people who maybe deal with physiotherapy or deal with other areas that are less regulated. Aromatherapy, they might put themselves forward as a healthcare professional. How does that happen? How do we encompass them as well?

MS WARBURTON: I think, again, it is that message that it is everybody's business. We talk about it a lot, but safeguarding is everybody's business. No matter where you are within the broad range of healthcare settings, or providing aromatherapy, which is a very valuable thing, actually, for some individuals, the safeguarding is the core of all of that training. Whether, from an NHS England perspective, we can influence at that level, I think we probably can, by getting those key messages out there, and talking about healthcare in its broadest sense, rather than just looking at the regulated professions. We talk about -- you know, I know that within some of the training programmes now for some professions, whether it is physiotherapy, paramedic training, safeguarding, it is embedded within all of those. So we can do it. I think it is just, like you say, getting everything together with those key messages.

MS KARMY-JONES: And how?

MS WARBURTON: How? We get it into policy. We continue to support organisations. At the moment, we are looking at the "Working Together to Safeguard Children" document. It is coming to consultation. We may talk about that later. We are all working to those standards, those core standards. As we start to rewrite those standards and get the nuances of what we have learned over the past sort of three or four years in there, we will start to include other professional groups and make sure that it actually spans that body of individuals rather than just only ever looking at regulated professions, and start to encourage the system, really.

MR DEAN: I wanted to build on this point about broadening it out because there are many, many occupations in the NHS, not all professions, but reporters, domestic assistants, administrative staff. That takes me back to the responsibility of the employer to make sure they have a suitably trained, experienced, supervised workforce and within frameworks set by regulatory bodies for those professions that are regulated within frameworks set by governments. I do think there is a critical responsibility on the employer to make sure this is embedded, and it comes to the subject of a later workshop into culture. For me, that is a critical

leadership responsibility. The point about risk mitigation rather than risk elimination is critical here. So where are the most significant risk issues and how do you target appropriate action that focuses specifically on those areas? It is a very important one.

I currently work in a government role and have been chief executive of a number of NHS organisations and that would be certainly the approach that I would be promulgating through my organisation, to understand risk and then to take appropriate steps to take action to manage the risk and then to oversee that management of risk within the organisational context.

MS KARMY-JONES: How do you go about understanding the risk?

MR DEAN: I think you have to involve all staff in understanding the context within which they are working. You have to involve the patients who are experiencing that healthcare context. And there are differences of risk, whether it is the type of patient group or the geographical setting within which patients are cared for. I think it is the leadership responsibility in the broader sense to understand those risks.

MS KARMY-JONES: You put that on the employer, on the individual hospital?

MR DEAN: Yes. It has to start with the employer to ensure

they are providing a safe context within -- for staff to work and for patients to be cared for. I think others can provide frameworks, that can help, and they can provide checks and balances, but when things get to regulatory bodies, that is, sadly, often after the act has occurred. The key has got to be to prevent things happening and I do think an understanding of risk and then appropriate proportionate action in response to that risk is the right approach.

What the answers to those risks are, I don't know. That's beyond my competence. But as a chief executive, that's what I would be looking for: do we understand our vulnerabilities? Do we understand the risks? Have we got the right controls in place that are proportionate to that risk?

MS KARMY-JONES: Thank you. We hope -- we will try to find some of the answers today.

So we have talked about -- Clarisser?

MS CUPID: Clarisser Cupid, designated nurse. I just wanted to add to what was said earlier, actually. Commissioners and the local safeguarding board have the responsibility to ensure that all agencies, including all health providers, are compliant with what we call section 11, and that gives them the assurance that each provider agency and health agencies, whether

commissioned or not, comply to legislation around safeguarding.

It also gives us an idea as to the culture of the organisation in understanding risk and how to deal with it, whether they are a transparent agency or not in terms of, you know, raising, identifying concerns and sharing those concerns so we can learn from them as well.

Now, this section 11, it is a self-assessment. It is an audit that we give out to primary care, it is given out to acute hospitals, the community health services, and everyone self-assesses to see where the gaps are in terms of risk for that organisation.

Therefore, they then have to come up with a plan on how we can mitigate against those risks to ensure that we keep children safe.

This is usually undertaken every year. Within the CCGs as well, providers are required to report quarterly on areas that we have identified or areas of risk and they can report that as often as possible as well, and they are challenged against those.

So if there are areas of risk identified, those are things that we would expect something to be done about.

MS KARMY-JONES: One of the things that's been mentioned in the answers is the position of auxiliary staff. We

touched on parents having access, but there are also the cleaners, there are the locums, there are the people who come in with the trolleys. What about them? How do we regulate them? Sue?

MS WARBURTON: Susan Warburton, NHS England. I think it is back to those core recruitment standards that we have put in place for things that we have learned from Savile and Bradbury about the sort of recruitment process and the Lampard review. But, also, it is back to that core -- watching people, understanding what's acceptable, what's not, and actually giving everybody the responsibility around to spot a problem and have the confidence to actually act on that. That is about culture, leadership within organisations and the way people feel within organisations to raise a concern. So I think it is very hard to actually put in a regulation around individuals and their behaviours, because people's behaviours change. So if you are okay when you walk into an organisation, two years later you may not be, and we talk a lot about Disclosure Barring and we go through all of these processes, but actually it is only good on the day you do it. So it is actually about raising the standard of education and constructive discussion across your organisation around what is acceptable and what is not.

MS KARMY-JONES: So intercollegiate guidance, I understand, specifies that all auxiliary staff should have what they call level 1 training. First of all, are they getting that? Second of all, is that sufficient? Or should it be more? Does it cover things like sexual abuse happening within the healthcare setting by colleagues who may be senior, in a position of power, over you?

MS WARBURTON: My view would be, no, it doesn't. It gives people a very broad understanding of what safeguarding means. If you are very clever, you can whiz through it within a few minutes and actually not achieve very much at all. So we talk a lot about mandating training, and it has its place perhaps, but what is more important, in my view, is a training that actually educates individuals back to that original point: what is acceptable and what is not by behavioural standards. Are the professionals or auxiliary staff picking people up when it is not right? We have done quite a bit of work about sort of acceptability of behaviours and values and behaviours within the health sector. We are doing more work around values and behaviours and there is a lot more to do, in my view.

MS KARMY-JONES: As I understand it, again, it is built into a standard contract for NHS services that a certain level of training should have been achieved, but how is

that policed? It may be in the contract box, it may be ticked, but how is it policed that it is actually done? Is it adequately policed. Christine?
MS BRAITHWAITE: I don't think we know the answer to that. I don't think we would be in a position to, as the Professional Standards Authority, I'm afraid, in relation to it.
MS KARMY-JONES: Do you have a view on unregulated workers?
MS BRAITHWAITE: Yes, I do have a view on unregulated workers, certainly. The primary responsibility for unregulated workers has to rest with the employer, because they are the frontline in terms of making sure that the people who are working within their organisations are safe and following the organisation's policies and procedures correctly, so I completely endorse Simon's views earlier in relation to that.
There are, however, other groups of workers, healthcare workers, who are not regulated by law, but nevertheless are -- and see themselves as being a part of the profession, so they may belong to a voluntary register often operated by their professional bodies. So counsellors and psychotherapists, for example, you mentioned aromatherapists. There is a register for people who practise complementary therapies too.
Since 2012, our organisation was given a new role,

which was to set standards for those organisations that hold voluntary registers and to accredit those that meet our standards. We have standards that relate to the management of risks within that and we certainly expect the organisations that we accredit to ensure that they have covered safeguarding within their education and training and that that's covered in their ethical frameworks, just as with the regulators that we oversee, all nine of the regulators we oversee, cover professional boundaries within their standards.
And the registers that we accredit, similarly do. They also make reference to the professional boundaries guidance that I referred to earlier.
But there is a very important gap in relation to that. I don't know whether you want me to talk about that now, because I think you want to talk about regulation and legislation this afternoon. I will come back to that point there. There is certainly a gap in relation to people who are on the voluntary register, but it is a strength and protection if people belong to an accredited register.
MS KARMY-JONES: Thank you. Is there someone else who had a comment? Giles?
DR DEBELLE: Yes, I'm not a salesman for mandatory training, but it is possible to measure how far people have

followed it using e-Learning for Health and part of the systems that works around. Again, I can only speak for my organisation, but certainly our board is interested in how many of the staff have completed all the modules of their mandatory training.
Now, if you get the mandatory training content right and better, obviously it is more powerful, but, as I say, it only takes you so far. But it is one indicator of the organisation taking things seriously, I guess.
MS KARMY-JONES: Again, with the e-learning and like the suggestion that it might be encompassed into CPD points, continued professional development, for example, something that came out of some of the responses that we got. Do we not again run the risk of it becoming a box-ticking exercise?
MR DENHAM: You always run that risk. Equally, I suppose you are then weighing the benefits, aren't you? Is it better to have had everyone do something than nothing happen at all? As I say, it is a start. It can only take you so far. As I say, I would argue it is an indicator and it does mean it is the content that is important. There are other resources, clearly, people can make available. We produced a film earlier this year to help NHS organisations that wanted to use it --

of course, it couldn't be mandated -- to help staff increase their awareness of child sexual exploitation or abuse. So there are resources out there, but ultimately, I think I would agree with Simon that employers do have to take responsibility for how they implement and how they take it seriously locally.
MS KARMY-JONES: Thank you.
MS BEAUMONT-WOOD: Can I add one thing, because you asked the question how do we know. In Wales, and I'm sure in England too, we have the electronic staff record. Actually, board committees do receive regular reports on compliance rates in terms of statutory manager training, of which this would be part.
Colleagues across NHS Wales, my nurse director colleagues, there is some variation in terms of reliability on ESR data, because obviously it is only as good as what we put in, but there is, nevertheless, regular reporting and monitoring. So I just wanted to make that point.
MS KARMY-JONES: Thank you. I would just like to move on to something that's been mentioned --
MS CHRISTODOULIDES: Sorry, just to add to that, as an employer, I'm entirely responsible for those training figures and show my Trust board and commissioners, but just reflecting on the comment you made earlier about

the campaigns that we have had in the NHS that have been successful, I think we have all said the shortcomings of mandatory training. The way to change things is to make it uncomfortable for people in the organisation to act a certain way. So Kate Granger, the doctor who died and started the campaign around "Hello, my name is ...", did a very successful social media movement that was simple, and now it is uncomfortable on those wards where she worked -- in my hospital, actually -- to not say that. It is not written in any policy of ours, I'm sure it isn't, that you will say, "Hello, my name is Helen", we haven't written that down, we've just changed through the power of people wanting to do the right thing. Kate was, you know, a brilliant advocate for that. So it is uncomfortable now not to do that. The same with washing your hands. It is uncomfortable now -- we all look at each other when people come on to wards if you don't -- well, we have gone from gelling to washing hands and backwards and forwards a couple of times. But part of that, when you mentioned that, I thought, but the prevalence of healthcare-associated infections at the time was so big that it was difficult to ignore, which made me think about our earlier points about the prevalence of this, and because we don't describe it, it's difficult, I think, to use that as a lever, but

certainly that was a significant lever in the campaigns around washing your hands. I think -- I don't know if there is a person like Kate that could, you know, create a social movement around this. I don't know if you can engineer them. But they were my reflections when you mentioned those things.

MS KARMY-JONES: That's very helpful because it is a question, from what you say, of creating that sense of discomfort and that real feeling -- it is almost an emotional feeling, to make people want to comply rather than to turn a blind eye to it.

MS CHRISTODOULIDES: All the staff -- all the myriad staff that have a professional body to report to have an appraisal, are much more influenced by what that culture in their ward/department/GP practice/operating theatre do; that's what changes behaviour, rather than -- there are plenty of nurses, I'm sure, that don't quite know what's in the NMC Code of Conduct, but they know how their local area operates and they know what feels right and feels wrong, and that's translating policy, isn't it, into the real world?

MS KARMY-JONES: As we will come on to later, being able to voice it, feeling they are able to voice it.

MS CHRISTODOULIDES: Absolutely.

MS KARMY-JONES: We will come on to that. I am actually

going to pick up on something you mentioned earlier, Helen, and Alison mentioned as well, and that's the idea of chaperones. I wanted to ask, how well do the current arrangements -- first of all, what exactly are the current arrangements and are they consistent and then how well do those arrangements work to prevent unsupervised access during treatment? Can I turn to you, Alison, at this point?

DR STEELE: Yes. Alison Steele, Royal College of Paediatricians and Child Health.

I think there have always been chaperone policies in place, but I think they're actually starting to really develop more sophistication and more understanding of the issues around chaperoning, and that's recently, particularly following the recent case, the Myles Bradbury case. I think organisations have always had a chaperone policy, but it is a bit about taking it off the shelf, blowing a little bit of the dust off it, maybe, and actually thinking about, you know, the situations that chaperones are needed, who should do the chaperoning, how we train people to do the chaperoning. So having a lot more thought about it. I think that is what the recent case has actually done.

So there isn't a national chaperone policy as such, but the policy that Cambridge came up with after the

case is seen as a bit of an exemplar because they obviously learnt from what happened within their organisation. So they have written a policy in response to that.

I think chaperoning is very important but I do think it is not as simple sometimes as people think. It is about actually understanding -- really understanding what it is about, rather than just sort of almost going through a process because you know you have to do it. So really understanding that there is an associated risk if this isn't done appropriately, both to the patient, most importantly, but potentially to the staff as well, and how we actually train people to chaperone.

I think it is very interesting because if people don't know what to expect for a certain procedure or an examination, they can't possibly chaperone that procedure and examination, because they need to know what normally happens when you do a genital examination or you take a smear or you do whatever it is that you are doing. So unless they actually are experienced in chaperoning that particular procedure, they certainly won't be in a position to challenge if anything appears to be not right.

MS KARMY-JONES: So specific chaperones for specific things?

DR STEELE: I personally believe that chaperones need to

understand what it is that's happening, whatever they are chaperoning, and why they are there to do that. So, again, it comes down to training, but it also comes down to an ability to challenge, which I think is one of the really important things about culture. So we have talked about lots of things here, but it is about, you know, ability to challenge anything that's blatantly obviously wrong, but also how you challenge when you have an uncomfortable feeling or it is not quite right, how you pursue that, and having an organisation which will listen to staff's concerns in those more difficult, possibly grey cases.

MS KARMY-JONES: So where are chaperones drawn from at the moment?

MS CHRISTODOULIDES: A mixture of registered and -- registered nurses and clinical support workers and registered nursing auxiliaries, as you described. So in the outpatient settings, there's often clinical nurse specialists, who will be registered nurses, either running clinics alongside consultants and medical staff that are often available -- this is in the acute hospital setting. But equally, there are, in the emergency department -- thinking of recent examples in our organisation, and I do know this happens -- clinical support workers, unregistered staff, are asked to go in

and chaperone.

I completely agree with what Alison says: we have had examples where people clearly see chaperoning as a passive role and it is not passive, it is active. People, I don't think, have appreciated that enough. As an employer, I feel it is my duty and responsibility to enforce that and support people and get them to understand, you know, what it really is there for.

MS KARMY-JONES: You can imagine, actually, that if a chaperone doesn't know the area of examination, for example, that there's a gland check, they may not know that it is not appropriate, for example, for the gland check to descend down to the breasts or other areas, so there must be quite a high level of training or specificity to who chaperones what.

MS CHRISTODOULIDES: Yes, and that is a gap currently that we will address, but that's certainly a gap. And people have to have -- you know, we have talked about having the ability to challenge that authority gradient that exists between professions and pay bands and within the hierarchy. We have actually worked really hard in, for example, operating theatres to make sure that checks are in place and people can challenge learning from the aviation industry about checks, and some of the work -- I'm not suggesting we put -- well, we might put checking

into chaperoning, but a lot of that work has been about culture and being able to challenge. So the scrub nurse can say to the surgeon, "I think you might be operating on the wrong side", for example, but that kind of work around culture and empowerment needs to go on as well as training about what is it you're chaperoning, you are not just standing at the room at the head of a patient having five minutes off your very busy, busy job. It is an active role.

MS KARMY-JONES: Can I ask about chaperoning in a primary care setting? Vimal, can I turn to you and then Lorna about in?

DR TIWARI: Yes, I think we have been very slow to become aware of the responsibilities because traditionally GPs have asked their practice nurses to do this when the nurse is available. If there is no nurse on the premises, then the receptionist tends to be pulled in. So GPs are now becoming aware of the necessity to have trained chaperones. In smaller surgeries, this is actually quite challenging and a difficult thing to accomplish.

In larger surgeries, obviously there could be dedicated people who are there all day and available to do this. Smaller surgeries, there will quite often be periods of the day when there is no suitable individual

available, and so there is a real gap. I think there is also not a clear enough understanding of the role that Alison described so graphically of the active chaperone and of the chaperone being aware of the intricacies of every examination and what needs to happen and having the power to challenge.

So these are all going to be difficult to implement in general practice. Obviously, we will have to do it. It is going to require a large education campaign.

MS KARMY-JONES: It is interesting, the idea of a receptionist being pulled in is odd.

DR TIWARI: It is.

MS KARMY-JONES: Would you say that that is a chaperone who is there more for the protection of the practitioner than the patient in those circumstances?

DR TIWARI: Traditionally, historically, it has been for the protection of the practitioner and in fact it has not been a very good protection, because often the receptionist will stand somewhere distant from the examination couch and will try and not intrude upon the process, will try to preserve the patient's modesty. So, for example, in an intimate examination, the receptionist would be at the patient's head, perhaps talking to the patient, and not paying any attention to what's happening lower down.

So it has been totally inadequate as a process all round. It doesn't protect anyone. So, yes, that obviously needs to change.

MS KARMY-JONES: So that focus may need to shift. Lorna, do you have any views on this from the Welsh perspective?

DR PRICE: Not particularly from a Welsh perspective, but from the perspective of a community paediatrician who has been practising for quite a long time, I think it used to be, when we did clinics in the community, we always had a nurse with us, and then they were withdrawn and there was a little bit about, "Oh, it wasn't a suitable activity for a nurse to be a doctor's handmaiden in a clinic setting", but I have had very good experiences of working with nurses, usually doing child protection assessments, where they are more than a chaperone and really an advocate for the child, and certainly are able to challenge if they feel that things aren't being done as they should be.

That's just my reflection on the conversation.

MS KARMY-JONES: Thank you. John, do you have anything on this? Any observations?

MR LUCAROTTI: I don't have anything to add on this.

MS KARMY-JONES: Is there anyone else who wants to add anything around this at this point, before I move to taking some questions or comments from the public

gallery? Yes, Clarisser?

MS CUPID: Clarisser Cupid, designated nurse. It is just to add to the fact that it is not just about challenging, but being able to escalate the concern if they do have a concern. I think, within health, we work very closely with our colleagues and may not necessarily feel confident, if we do raise a concern, what we need to do about it. So it is about being able to escalate it and that there are safeguards to protect us if we do have to escalate the concern as well.

MS KARMY-JONES: Is that a potential problem with it being managed locally, so managed by the employer, do you think?

MS CUPID: I think potentially it can be. It depends on probably the person undertaking the examination and the person who is actually raising the concern, because it is a power balance or imbalance. So it potentially can be. But I think we have actually got -- we have learnt from recent cases -- the Bradbury case, for example -- and we know there are now safeguards in place that can protect people to push things forward if they need to.

MS KARMY-JONES: We are coming up to the 10-minute time. Yes, Alison?

DR STEELE: I'm really sorry, but I just wanted to bring to the panel's attention another topic, and that's around

recruitment and the value-based interviewing. Obviously we rely on lots of checks and DBS checks and points systems in interviews and we rely on references, but there is something called value-based interviewing, which I'm not in any way an expert at, and I haven't actually done it but I've seen a presentation around it and it is around putting scenarios to people and asking them what they see in that scenario. My understanding is you can actually pull out people's values and approaches from that, which is actually sometimes far more telling than their references, so it is just a thought to maybe look into that a bit further.

MS KARMY-JONES: Some people I think are leaving us this afternoon. Is there anyone who is leaving us this afternoon who wants to make a final observation on this point before I move to the public gallery? This is your last chance.

Let's turn to the public gallery, then. I am going to go to Chris, who is sitting in the public gallery.

Observations from the public gallery

MS TUCK: Hi, everyone. My name is Chris Tuck and I am a survivor myself. Just a few things: the key message is zero tolerance to child sexual abuse. That is the clear and ultimate message. It, in itself, is powerful and uncomfortable and will make people stand up, and

that becomes the culture and that becomes your practice, that becomes your policy, "If you see or hear anything, this is the policy, this is the procedure, this is what you need to do in order to safeguard children and safeguard yourselves".

I just want to know, really, what the whistleblowing policy is in all your organisations and what effect that has on the whistleblowers and have people left their jobs because of it, and things like that. So do you protect your whistleblowers? If we have a culture of zero tolerance to child sexual abuse, maybe we don't need a whistleblowing policy because everybody is on the same page.

One question that I want to put forward is, how do health services involve survivors in their training, as survivors are the experts by experience? That's a question I would like some sort of clarification on, please.

How are GPs vetted, because obviously, as you said, some GP practices are one or two people and some are great big groups of doctors. So how are they vetted and how is child sexual abuse, you know, practice vetted in that incidence?

I worked in a healthcare setting for six years, working with patients as a fitness therapist, and

I would be on my own with vulnerable people, vulnerable patients. Often, the wards were understaffed, there was a high level of agency staff and there was no time to teach these agency staff, which had a high turnover, about policy and procedure, so how is that looked at and operated?

The staff there knew me and they trusted me. Maybe sometimes that trust is misplaced. Sometimes you get too comfortable with the people that you are around and, you know, you like them, you trust them, you know them, or so you think, and this is where perpetrators often pop up. So how do we acknowledge that and pay attention to that, really? Thank you.

MS KARMY-JONES: Thank you. We will come back to some of those after lunch. Thank you very much for those observations.

Mr O'Mara?

MR O'MARA: Nigel O'Mara, East Midlands Survivors.

The question of chaperones, what Dr Steele was saying earlier. I think we can go a little bit further than that, because if somebody isn't trained properly and abuse does take place, then they are seen as condoning that abuse by the survivor. They are seen as being part of that abuse by the survivor. So unless there is proper training and proper resources put into

it, it could end up adding to the problem rather than taking away from it.

Now, I think a way that that could be possibly achieved is very similar to the pupil premium that's put into schools. Has a vulnerable patient premium been put into hospitals and healthcare settings where, when they have people who are vulnerable, they get a budget to be spent on chaperoning and training?

MEMBER OF THE PUBLIC: One comment on the children's wards in hospitals, the security there. Now, if I take the little lad out with me, he's 6, and I talk to a stranger, the mother goes mad, "Don't talk to strangers", this is what we get nowadays. Yet, if I walk into a ward and it's a children's ward and there's a mother in front of me, she'd open that door and I'd just walk in behind her. I don't know, because I haven't been for a long time, but surely, if they're doing it to me, the kids are doing it -- "You can't talk to strangers", this should be put on. I think a lot of it should be on the responsibility of the people going to them hospitals to make sure they don't let strangers just walk in behind them and just put the notices on, "Please make sure you know who is behind you". That's all I'm saying.

MS KARMY-JONES: Thank you. Is there anyone else in the

public gallery?

Does anyone wish to address any of the points raised there now or would you like to take lunch and reflect on some of those and we will come back to them? Shall we do that?

DR TIWARI: I can talk about checks on general practitioners. I'm Vimal Tiwari from the Royal College of General Practitioners. Any general practitioner starting a new post is required to have a Disclosure and Barring check. A subject of debate is then how often these checks should be repeated, because, at the moment, there is no mandated time interval. So a GP can go 20 years in the same post without having any further checks, and of course circumstances change. And the same applies to our staff. So we ask them -- we check our staff at the time of recruitment, but what do we do about the very dear, well-loved people who have been with us for decades?

MS KARMY-JONES: Circumstances change and behaviour changes and how do you check behaviour?

DR TIWARI: And also relatives. They may have people at home who are abusers and they may be passing on information about vulnerable patients. That is one of our great concerns in general practice. So how do we control it?

MS KARMY-JONES: Food for thought, perhaps, chair, over the lunchtime adjournment.

THE CHAIR: Thank you very much. And thanks to everybody present for a very interesting discussion in this part of the morning.

We will reconvene at 2.00 pm. Thank you to anybody who will not be returning this afternoon. We will see you at 2.00 pm.

(1.00 pm)

(The short adjournment)

(2.00 pm)

Session 2: Opening remarks by MS KARMY-JONES

MS KARMY-JONES: My name is Riel Karmy-Jones. I am facilitating this seminar. Can I just note we have got some changes in participants from the morning session. Welcome, all.

Briefly, I am going to just recap: my role is just to assist the conversation, the discussion, the debate. There will be some gentle challenges to some of the things that are said. But we are not here to cross-examine anyone. I just ask that, where comments are made, that they are directed through me and discussions and debates don't spring up between people across the table, because it makes it very difficult for those who are following on the video feed to follow.

As a general rule, could I ask everyone to give their names and which organisation, if any, they are representing when they give an opinion or a view or an answer to a question.

At the end of each session, before the breaks, we will invite some observations from the public gallery. I am going to, in a moment, ask everyone, in fact, so that everyone knows, to introduce or re-introduce themselves and their organisation, and perhaps I could just ask the new people to tell us what they are hoping to achieve or gain from the session that they are attending today. So can I start with you, again, Anthony.

Introductions

MR OMO: Yes, thanks. Anthony Omo, director of fitness to practise and general counsel at the General Medical Council.

MR HEANEY: Good afternoon. Albert Heaney, Welsh Government director for social services and integration.

MS BRAITHWAITE: Good afternoon. Christine Braithwaite, director of standards and policy at the Professional Standards Authority.

MR DE SOUSA: Good afternoon. Eustace de Sousa, national lead for children, young people and families in Public Health England, sponsored by the Department of Health.

MS WARBURTON: Susan Warburton, NHS England.

MS HORSLEY: Angela Horsley, head of children, young people in transition, NHS improvement. I'm hoping to gain, I suppose, a better understanding of where NHS Improvement, as a relatively new organisation, fits into the bigger picture and to get safeguarding in its entirety higher on the agenda.

MS GALLAGHER: I'm Professor Ursula Gallagher, deputy chief inspector at the Care Quality Commission. In that responsibility, I am the national lead for safeguarding and also for the inspection and regulation of children's services and people in the criminal justice system.

MS CUPID: Clarisser Cupid, designated nurse for safeguarding children for Southwark CCG, Clinical Commissioning Group.

MS CHRISTODOULIDES: Hello, I'm Helen Christodoulides. I'm a director of nursing at Leeds Teaching Hospital Trust.

MR FRANK: Good afternoon. My name is Ivor Frank, I'm a member of the inquiry panel.

THE CHAIR: I'm Alexis Jay and I'm the chair of the inquiry panel.

PROF SIR MALCOLM EVANS: Malcolm Evans, member of the inquiry panel.

MS SHARPLING: Drusilla Sharpling, member of the inquiry panel.

MS BEAUMONT-WOOD: Rhiannon Beaumont-Wood, an executive director of quality, nursing and allied health professionals in Public Health Wales, but here today representing nurse directors NHS Wales.

MR DEAN: I'm Simon Dean, deputy chief executive of NHS Wales.

DR CHAMBERLAIN: Kate Chamberlain, chief executive of Healthcare Inspectorate Wales, and I'm here really because I'm interested in how we can use what we do effectively to support improvement in the services and make sure things are being done to the most effective way.

MR LUCAROTTI: John Lucarotti, head of policy and legislation at the Nursing & Midwifery Council.

MR VINEALL: I'm William Vineall, director of acute care of quality at the Department of Health and in respect of today, my responsibilities are particularly that, whistleblowing, speaking up and investigations. When I was doing the investigations work, I had the oversight of the Jimmy Savile investigations that the department did. So what I am interested in is how our general messages about learning and accountability can be applied in this sphere.

DR TIWARI: Vimal Tiwari, safeguarding GP representing the Royal College of General Practitioners.

DR PRICE: Lorna Price, designated doctor national safeguarding team, Public Health Wales.

Session 2: Opening remarks by MS KARMY-JONES (continued)

MS KARMY-JONES: Thank you very much. Just by way of reminder, in terms of specific enquiries and investigations, I think there is more than one person here who has had some involvement in some of the high-profile investigations that have taken place in recent years. Just bear in mind, we are not going to deal with the detail of those inquiries or investigations, and we are going to try to avoid mentioning specific names and specific organisations -- that's a comment as much for the public gallery, should anyone wish to make any comment later. We are on a live video feed and, if anything inappropriate is said that might trespass on inquiries or investigations in other spheres, we will cut the feed. There is a five-minute delay that some of you are already aware of. Just as a safeguarding measure that we have, we will cut the feed to ensure that nothing goes into the public domain that shouldn't.

This morning's focus, there was a lot of generality, a lot of good stuff came out of this morning, a lot of generality. I just want to remind everyone, and certainly the new participants, that we do want to focus

on difficult questions around what isn't working, what is working well, what needs improvement, what is standing in the way of improvement, how are we going to improve things, how are we going to prevent child sexual abuse within a healthcare setting, and what real difference will solutions make? What solutions do you suggest? Can you suggest any? What real difference will they make? Why would you do the thing that you may suggest?

So we do hope to get some answers to some of the difficult questions today.

Discussion re Topic 2

MS KARMY-JONES: I just want to pick up on some -- to follow up on some of the questions that arose this morning. One of the points that came up this morning was that children are, on occasion, still being treated in adult settings. I want to ask whether there is any understanding about how often that happens and why. Can anyone help with how often that happens and why? Let's turn to the Welsh position? Rhiannon? Does it happen frequently in Wales?

MS BEAUMONT-WOOD: So it happens, but I wouldn't say it happens frequently. If it does happen, then a risk assessment is undertaken to ensure that mitigations obviously are put in place to safeguard the young person

in that setting.

MS KARMY-JONES: Sue, NHS England?

MS WARBURTON: I think, similarly, it does happen across the health sector in England. We aren't particularly good at monitoring it. I think we could be a lot better at how we monitor those occurrences because the figures, again, don't translate often to the reality.

MS KARMY-JONES: We did just a brief check and found that in 2014/2015, 391 children were treated in adult mental health wards in England. That's just in the mental health ward section. Can that ever be justified and, if so, why is there a justification and what is it?

MS WARBURTON: I think initially we look at the individual, so when you say you have got a child in a mental health ward, I think sometimes it is the circumstances by which they have landed there, and sometimes it might be the most appropriate setting and the safest setting, given the circumstances for that child. It depends whether we are talking child or young person. So I think we just need to understand that, in the first instance.

But, as a rule, there shouldn't be an instance, unless it's been truly risk assessed that that's the most appropriate place for that child to be.

MR VINEALL: I was only going to say, I'm no expert on this, but I'm sure it happens because it is the least worst

option, not because it is preferable.

MS KARMY-JONES: Is it in part, do you think, because there are insufficient resources or units available that are specifically geared towards children? I mean, mental health is an easy one to focus on.

MS WARBURTON: Again, Susan Warburton, NHS England. Yes, I do believe that. I think we do struggle to accommodate, at times, the needs of some young people in the most appropriate setting and it is, as you quite rightly say, the least worst option. There has been a lot of work, I have to say, across NHS England recently to look at what we need to commission differently and work with local authorities to commission those placements. But we still have a bit of a way to go.

MS BEAUMONT-WOOD: I think the other thing is being very child-centred -- child- and young-person-centred in the decision making. Obviously, at a point in time when you need to have your family in reasonably close proximity, choosing a place of care that's closest to home has to be equally considered in the decision-making process.

MS KARMY-JONES: Right. So people sometimes might be made to move, you mean, move away from their families, so sometimes they might be put into an adult setting because that's closer, the proximity may be closer?

MS BEAUMONT-WOOD: Obviously, the first decision would be to choose an appropriate setting which is geared up for children, young people. But when, then, you are considering about numbers of beds, et cetera, et cetera, the other thing to take into consideration is, I'm saying, about having access to your family, and that they can come and spend time with a young person who has been admitted. So I think it is taking all of those things into consideration when deciding where to place children for care.

MS KARMY-JONES: Can it ever be justified, placing children now in an adult setting? Ursula, do you have a view from the CQC, Care and Quality Commission, perspective?

MS GALLAGHER: I think there is a policy view that says, while, as we have heard, it is sometimes unfortunately the least worst option, as William said, it is not something that we should -- the system should either be complacent about or not, on occasions, feel very distressed about it, itself. I think we, as you may be aware, are in the middle of carrying out a review into child and adolescent mental health services, the first paper of which will be published in the middle of October, and, again, I think some of the other issues relate to the complexity of the children and young persons' presentation, and, again, in my work, I also

see many children and young people who come to the attention perhaps through the criminal justice route, so it is not only about child and adolescent mental health services, it is about the interface with police, prisons and other places of safe custody, and, again, whether those settings have the right balance of safety and therapeutic intervention in order to attempt to improve the life chances of those children and young people in those complicated circumstances.

We recognise what colleagues have said, but the work that we are doing does indicate that planning, good partnership relationships and effective leadership will, to try to do something differently, means there are certain parts of the country that are doing really well with this and there are certain parts of the country that are doing less well. It is a universal challenge, but the ability to respond to the challenge varies across the country.

MS KARMY-JONES: The ability to respond or just the way the responses are being dealt with?

MS GALLAGHER: Both.

MS KARMY-JONES: How can we address that? What's the problem and how can we address it?

MS GALLAGHER: So I think, from our work, one of the challenges always is the focus and the skills in any

particular area to think about how you assess those needs of children and young people, how you are involving clinicians and parents and service users themselves in the planning and development of appropriate models of care, particularly how early identification systems is always a difficulty if a child presents in absolute crisis unknown to the system, and that's where you are in the least worst option situation, but it is about where partners work well together to address those vulnerabilities and where there is a leadership passion and will that can make a difference, but people are battling competing priorities at the moment. Sometimes the needs of very small numbers of children and young people are not always heard in a very complex health and social care system.

MR VINEALL: I was going to add that one of the reasons the cross-cutting reviews Ursula mentioned are so useful is because you get a look across a system. For instance, if you just look at a hospital, you just look at a local authority or somewhere else, you will see a bit of a problem. Often, if you look across the piece, you can see there is a shortfall in totality or it is one institution that the others are making up for, but it gives you the picture, because, for health, it is not

a single isolated issue. So the fact that CQC is a regulator across health, social care, mental health gives us a better picture.

DR TIWARI: Just to add to something Ursula has touched on, in general practice, we struggle with the gaps and deficiencies in mental health provision for children and young people in some parts of the country. It is very limited, tiers 1 and 2 provision, so children are not being helped and supported at the first presentation, and what service users themselves have said in a number of different research projects, that if they had had the help earlier, they would not have presented in crisis. So I think there is a huge amount of work to be done in delivering appropriate services upstream.

MS KARMY-JONES: How would you address that? A huge amount of work to be done. Where do we start?

DR TIWARI: Putting an investment into tiers 1 and 2 services and ensuring they are effectively monitored and regulated.

MS KARMY-JONES: Angela?

MS HORSLEY: Angela Horsley, NHS Improvement. Again, just following on from that as well, hopefully, some of the monies that came from the future in mind could potentially be directed to changing some of those models of care for children and young people. But of course,

in order to get the appropriate model of care, you also need the correct workforce as well, and at the moment we are fishing out of a very small pool of people. So there are things called the Children and Young People's IAPT, and that's the access to psychological therapies, and there is a lot more collaboratives now being formed throughout England to really start to recognise the need to, you know, train up more healthcare professionals for that.

MS KARMY-JONES: One of the things that was raised before the break was the question of ward architecture as a method of perhaps helping to prevent child sexual abuse in a healthcare setting, specifically obviously in a hospitalised setting. We just wanted to probe a little bit on that and to see what the views were around that. Is it a realistic or a helpful thought that wards could be designed in such a way as to prevent or assist in the identification of child sexual abuse or is that a red herring?

MR DEAN: I don't think it is a complete red herring, but I think we need to just be conscious of the practicalities. NHS in Wales, I'm sure the same is true in England, has a massive amount of estate of variable age and variable design and variable quality. I would expect that any new build or refurbishment,

taking account of any key constraints, would make sure that there is a whole range of factors taken into account, and this should be one of them, making sure that patients can be cared for as safely as possible. But it would be a significant, costly, lengthy proposition, I would suggest, to remodel the whole NHS estate with that in mind.

MS KARMY-JONES: There is a lot of new build going up, I think, in England certainly, and resources is obviously something that's going to run through a lot of these discussions underlying this, do we have the money, can we find the resources through which to deal with the issues.

Can I just ask Ursula, is it something we hide behind? Is resources something that gets hidden behind to stop actually dealing with the problem? That's not an accusation to you -- it is not meant that way. This is something that comes up in a number of different areas across these discussions.

MS GALLAGHER: I think we would all -- it would be a disservice not to say, of course, there is a resource challenge, but I think what we would say in our work is that there is sufficient and very clear variation of response that is not simply linked to disparity of resources. So the choices and the priorities that areas

make, the way in which they identify and prioritise the needs of their population and the way in which they work together means that you can have a look at areas that, on the face of it, seem to have, however you look at it, in terms of capitation funding or size of workforce that are delivering very different outcomes, both in terms of clinical outcomes and service user experience. So I think we always need -- and we would hope in our role -- both to be challenging about that but also to be able to be a conduit for some of that best practice and in our encouraging/improvement role, that's what we would see and help people to connect between those that are doing better and those that are doing less well.

MS KARMY-JONES: Just to finish on the architectural point, is there anyone else who has an appetite for that view of remodelling wards?

MS GALLAGHER: Can I just say something, because obviously, from our perspective, that does very much fit in a broader conversation about the role that architecture might play in a whole number of aspects of safety and the delivery of safe care, and there are some issues about how you think about preserving lines of sight. I'm very elderly in this room, but while there were lots of things against the old Nightingale Ward, I could sit at one end of it and look down the whole of it. Some of

the newer designs -- so balancing out the lines of sight with the privacy and dignity conversation with the single room conversations aren't easy, but I think that we are recognising, particularly where we are needing to make best use of workforce and think about how it is that workforce works, I think the other thing that would go alongside that is designing in some of the technology issues. I think it is a combination of architecture and technology that, again, in some of the best places that we have seen there are some of those very good examples of really creative thinking in those areas that would address a number of safety concerns, including reducing opportunities for abuse.

MS HORSLEY: Angela Horsley, NHS Improvement. Again, just thinking about the 391 of children who were admitted to adult mental health wards, there is a lot of children/adolescent mental health patients who are now admitted to general paediatric wards as well. Again, I think just sort of like taking into consideration some of what Ursula said, I think there is something very important about knowing who children and young people are who are going to be admitted and really mitigating the risks, because those numbers are increasing as well.

MS KARMY-JONES: Thank you. William?

MR VINEALL: I just wanted to answer on both points on

resources and design. Certainly when there was all the work done about safe staffing levels three or four years ago, one of the issues that came up as a part of it was the question, a little bit, about design of institution because certain designs allow you to more effectively deploy your capability. So it is definitely a factor.

On the question of resourcing, there is some work going to be starting shortly, which has sort of been developing this year, which will be looking at use of resources and being more explicit through CQC in conjunction with NHSI about how a group of resources is used in a certain area, be it for the area we are talking about now or others. So that would start to be a partial answer to that question.

DR TIWARI: Just to reinforce what Ursula has just said, there is a considerable overlap between patient safety generally, staff safety and safeguarding. There has been some work done on creating safe spaces in schools. There has been a piece of research. And on finding solutions to unsafe spaces, which are not necessarily expensive. It is about using spaces in a different way. So I think it is possible without vast investment.

MS KARMY-JONES: Thank you. Christine, I think you had something you wanted to add to that?

MS BRAITHWAITE: Thank you. Just in relation to resources.

Christine Braithwaite, Professional Standards Authority. Just in relation to Vimal's point earlier about tiers 1 and 2 and children getting support earlier on to prevent them ending up presenting in crisis, and that is that there is still a tendency to think about workforce issues in relation to the workforces that people already know about and are used to using, and just to flag up that there are 50,000 counsellors and psychotherapists on accredited registers, some of whom work currently within the NHS. So child psychotherapists, for example, are employed within the NHS, but a vast number of them who work independently outside of the NHS, but nevertheless are available and could be made use of in terms of future planning for workforce and resourcing of mental health services for children who aren't currently considered. Just to flag that up.

MS KARMY-JONES: It does bring us on to the next point which is again from this morning, that obviously there are a lot of people who move in and out of organisations, be they locums, agency staff, clinical rotations, residents, contract and temping staff. Arising from this morning is the question of how people are vetted, how we apply a standard to all of the workforce, including agency staff, and even volunteers, and ensure that those people are -- that we get the right people

coming in.

Are there any views about that on this? Helen, do you have any views?

MS CHRISTODOULIDES: Hi, Helen, director of nursing, Leeds Teaching Hospital Trust. Our volunteers are subject to the same NHS employment checks as substantive staff. I have to say, it's done nothing for my volunteer pipeline, and I'm not suggesting that we amend the recruitment checks, but the reality is, our volunteers drop out whilst they are waiting to be processed, interviewed, DBS checks and so on.

MS KARMY-JONES: Such a long process administratively?

MS CHRISTODOULIDES: It's a long process, and I think the nature and types of people that volunteer -- Riel, you said that the WRVS and the ladies or gentlemen pushing trolleys around wards is very familiar. It is not that familiar anymore, really.

I get approached by lots of students, 17/18-year-olds, who might want to come and volunteer at the hospital quickly, before they have to fill out an application form for university, and, you know, the people that want to volunteer aren't what you might imagine typically with the volunteers certainly a long time ago. So that's my reflection on that. But they are subject to NHS employment checks, and that does take

a bit of time. Of course, they don't have the same staying power to stick to that process as people who are coming for a paid job. That would be my reflection.

MS KARMY-JONES: One of the things that arose before lunch -- Vimal, you mentioned this about the DBS checks and them not being done frequently enough. One of the questions we had was how well, in general, current arrangements are working for pre-employment checks. It seems they are not working terribly well.

Also tied in with that is the question of, even if the DBS checks are done more regularly, will that actually really assist, because aren't they only as good as -- well, it is only if something comes up in the 20 years that they will pick up on something, won't they?

DR TIWARI: Vimal Tiwari, Royal College of General Practitioners. We have thought about how to tackle this. One idea was self-declaration: asking staff at their annual appraisal whether anything in their circumstances has changed. So we are dependent on staff disclosure. I don't know how well that would work. Because a DBS check is a snapshot, it is that moment in time. It is not very meaningful. I mean, it can be. It's the possibility and the likelihood and the risk assessment. I mean, how likely is it that somebody who

hasn't committed a crime in the first 40 years of their life is then going to go on to commit a serious crime in the next 40 years? We don't know, because people change, human behaviour changes. I don't quite know how we actually address this problem.

I am not concerned about the people who aren't given -- I mean, okay, so we do the DBS checks. It is not a perfect system. Perhaps we should be doing them at some sort of regular interval, like every three years, but what about the people who've never, ever had them in general practice? Some practices make a decision that none of our reception staff need these checks. Well, your reception staff have access to patient records in most cases. They can look at the records, they can assess patient vulnerabilities, they could pass that information on to people who might be very interested for reasons of their own, for manipulation or grooming or whatever. I think that we have a serious gap there.

MS BEAUMONT-WOOD: Can I answer just to that point: it is not a choice about who chooses to have enhanced or standard. Actually in law, we can't ask for an enhanced check for somebody who doesn't fit the criteria. So I think there is loads of grey area around some of those roles that may not have everyday contact with children

and young people, but may infrequently and wouldn't be reaching the criteria to have the enhanced check.

MS BRAITHWAITE: Just a couple of issues from me in relation to this.

The first is, you were asking earlier, what about all the various other people that go in and out of NHS establishments, who makes sure that they are okay? I know that NHS England was certainly concerned about that issue and so they have been doing work looking at credentialling and there have been conversations with the Academy of Healthcare Sciences which is one of the accredited registers about the possibility of the academy opening up a credentialling sector for its register which would potentially offer a route forward in relation to some of the other occupations that aren't covered by regulation.

There is the second thing, which is that professional regulators and, indeed, the accredited registers -- the professional regulators, they require that people declare any convictions they have. So whilst DBS checks might not be repeated again, there is an ongoing requirement on health professionals to self-report if they get themselves in trouble in relation to that.

MS KARMY-JONES: Out of interest, can I just -- do we

actually know how many actually comply with that requirement?

MS BRAITHWAITE: I don't have an exact figure, but my understanding, it tends to be as part of the renewal process for the regulators. Their processes differ, but they tend to require it as part of that. Certainly with the accredited registers, they would require that as part of the renewal on the accredited registers programme.

There is a gap, however, which we mentioned in our formal response to the inquiry here, with regard to those people who are not regulated by law, they are not covered by either the Disclosure and Barring Scheme or by the Rehabilitation of Offenders Act or, indeed, by the Safeguarding Vulnerables Act. It is an issue that we flagged up with the Department of Health, who I know have been in conversations with the Ministry of Justice and the Home Office to see whether we can close some of that off. But at the moment, counsellors and psychotherapists, for example, can't be required by their registering body to undertake a DBS check or to -- they don't have to declare criminal convictions under the Rehabilitation of Offenders Act in the same way that it also causes difficulties for those organisations when they are trying to investigate any concerns that are

referred through to them in relation to some --

MS KARMY-JONES: It sounds like there is quite a lot of reliance on the honesty of the person who is fulfilling --

MS BRAITHWAITE: Yes, there is.

MS KARMY-JONES: Bearing in mind they may be someone who has a criminal record, relying on their honesty and self-reporting may be flawed?

MS BRAITHWAITE: Yes, that is a gap. We flagged it up in our annual report to parliament this year and the previous year. It is a gap that needs to be closed.

MS KARMY-JONES: One of the understandings that we have is that the NHS employers' guidance is that enhanced DBS checks should be renewed every three years, but that's only guidance.

MS BRAITHWAITE: Yes.

MS KARMY-JONES: It is not mandatory?

MS BRAITHWAITE: Not that I'm aware of, no.

MS KARMY-JONES: It ties in with what I think Vimal was saying, that sometimes it is not for 20 years that they are repeated, if the person being checked is a known quantity.

Albert, I think you had something you wanted to add.

MR HEANEY: Albert Heaney from the Welsh Government. In Wales, Welsh local health boards have the responsibility

for recruitment and checks for staff. You mentioned guidance, the Welsh Government has issued guidance and it is clear around the recruitment process and clear around three-year DBSs. The issue I want to raise is, I don't think we should be thinking of it as either/or. This is a whole array of how you create a ring of safety. So we should be doing DBSs, we should be having checks that test out, we should be having conversations. But that's got to be alongside the culture, the practice, the way we do things around our business, and it isn't an either/or. I think that's the point I want to make. It is really important that we get that whole picture right, and so, therefore, we create the ring of safety.

You mentioned earlier on about physical premises. Well, physical premises, certainly we should be going to those, but we should also be working with local government partners to think about how we do our business together and how we are thinking about how we are reaching out and taking on the challenges. Because ultimately -- certainly, if you think about adverse childhood experiences and the experiences that children and young people have, the only way that we are going to reach out in a different way to well-being is by, as partners, working together in a very different focus.

I appreciate this is a conversation about, you know, safeguarding and child sexual abuse, which is the cornerstone, but I think you have got to build layers on the way our culture and our approach takes place.

MS KARMY-JONES: Thank you very much.

MS GALLAGHER: Can I follow on from that, which is, I think, the wider conversation of this afternoon around governance and accountability, so, again, it is very interesting what we see from the inspections around organisations that rely on the structures and the systems or organisations that own the governance and accountability themselves. So if there is a feeling that there are gaps in the governance system, whether it is the DBS check system or the self-declaration, different organisations at the moment -- some organisations we see respond to that very well, and that's still a conversation about, "So what risk do I, as a leader in that organisation, think that that poses for the children and young people in my care and my ability to keep a focus on their safety and well-being, and what am I going to do about it?", so it could be everything from, "I am therefore restricting people's roles and I am monitoring those restrictions of roles to lessen their opportunities", and I think, as was just said, it is about how we join that up to say, "This is

about a system. There are decisions and choices in that system", but the accountability and the governance always pointing in the direction of, how is this going to keep children and young people safe and how is this going to improve their outcomes. In the best organisations, you see that seen as a whole manner of things. In the organisations that are doing less well with this, it is slightly more of the tick box, "Well, everybody has had a DBS check and everybody has had level 2 safeguarding training" and they've done this tick-box, but they are not asking the question of, "What difference is this making and am I assured that it is actually making the difference that I set out to or that I was told it might make?".

MR VINEALL: Can I make a quick comment? Linking up those various points, your previous question, which was all about DBS checks and checking and employment practices and all those sorts of things, they were all things that Kate Lampard made recommendations about, lessons learned after the Savile investigation, and we did a piece of work with the NHS which kind of, in the typical way, showed most people were doing most of these things and the people who weren't were going to pull their socks up and improve in the light of that report. Okay.

I think the point that Ursula made at the end is, if

you look at the wider story about, how do you get organisations in general, be it child sex abuse or anything else, to actually step up to the mark, it's partly that the leadership is quite strong on the issue, but it's secondly that you do actually measure and gather the data in, so you can bring the two to bear on practice.

I think, you know, the DBS system is quite complicated to enable that, because, as you say, it is recommended that it's for three years, but that is for local discretion in the light of guidance. So you have got an issue there.

MS KARMY-JONES: Thank you. Just looking at regulation and the question of setting boundaries of acceptable behaviour, how should we set boundaries of acceptable behaviour and how should that be linked to professional regulation? Anthony, do you have any views on that?

MR OMO: So we currently do set in our guidance the boundaries we seek between doctors and patients and we review that periodically, to make sure that is current and up to date and reflects current practice, working with the colleges, the public and others. But it is how, for us, that is then put into practice. That relies on employers and others, because we can set it and then, I think, as John said, we see it when things

go badly wrong. In between, there is a whole wealth of things that happen. That's where I think the employers and others come to bear and bring their working practices, shall we say, into play.

So we have got, as I said, a wealth of guidance on the boundaries, what you should and shouldn't do, how you should go about doing it, and we review those with some regularity. But the key is, how it is put into practice and how doctors put it in. It links to some of the conversations around the table around cultures, people being able to speak up, people challenging things that go against guidance, that people feel are outside, in the institutions they are in, raising those concerns and them being dealt with and just linking to the sort of DBS point. I think it is part of a picture of things that need to be done, but actually, if nothing happens when concerns are raised, or nothing happens when nobody does the check or when soft intelligence becomes available, then these things go around and people move from organisation to organisation. So part of the challenge, I think, and it is employers in the frontline in the first instance, is the DBS check tells you one thing, it is a picture, it is a snapshot. People hear things. You always hear things locally. What will employers do to respond to that and do they

just move the problem on, which is what I tend to see, we see in our fitness to practise role. When you dig into it, it's been going on for quite a while. Everyone is aware of the guidance, they know what the boundaries are, but no-one challenged and no-one did anything about it. I think we need to get to the bottom of why that is.

MS KARMY-JONES: Which will bring us on to whistleblowing later on as well.

Obviously, the question is relevant to wider organisations as well, because it is not just the registered or regulated professions that perhaps need to deal with this, and the question of who is going to oversee that and to ensure consistency across the board is another one that needs to be considered and addressed.

MR LUCAROTTI: John Lucarotti, Nursing & Midwifery Council. It strikes me that there are really two groups of professionals that we are talking about, certainly from a professional regulation point of view. There are the ultimate perpetrators and then there are those that assist in, or lead to the development of the culture where such -- and things carry on. Of course, our regulator responses are different in relation to those two groups. We discuss here the boundaries question,

how clear it is. I suspect, in most of the cases that come before the fitness for practice arena, the Nursing & Midwifery Council, actually the question for the people who have perpetrated abuse is not a question of boundaries, it is self-evidently wrong and there is no question of ambiguity there, but it is the other group that more guidance is required for. And of course, talking about whistleblowing and ability to speak up in certain circumstances, that's key, that's a key part of what needs to be out there.

MS KARMY-JONES: So the other group, more guidance is required for, but who is going to deal with that? How are we going to deal with it? Do you have any suggestions?

MR LUCAROTTI: Again, from the NMC's point of view, along with other regulators, we do have our guidance out there, we have the code which has already been referred to today. Indeed, it is quite clear, I suggest, in that code, what the responsibility of the registrant is about, you know, the safeguarding issues, prevention of harm, that sort of thing. But it is a question of how that is actually implemented into the wider culture, and I think there are differences of approach, and I suppose the question that's raised there is, what can the regulator do in conjunction with the employer to make

sure that it's actually put in place?

MS KARMY-JONES: We are going to move more and more into the regulation and accountability side, but it would be -- our aim is to emphasise on how we can work together to prevent now -- to deal with the prevention of child sexual abuse in the healthcare setting. What do we actually do, what do we want to do, about it?

How do the professional regulators have the right powers and the sanctions at their disposal? Christine, do you have any observations on that?

MS BRAITHWAITE: Well, the GMC has quite a nice model of regulation. I think the important thing, thinking about regulation, is always to put it into its context. It is one part of the patient safety system and there it can only ever be one part of the patient safety system, it can't do more than that. Professional regulation works by virtue of an individual person signing up to standards and holding themself to account and being responsible for that. So that's the first layer of protection for the child or for the public, is the standards that the person follows and adheres to themselves.

The second level is the employer and the employer reinforcing the standards and making it possible for a person to work within those standards.

The third level is the regulator who sets the standards in the first place for the individual and then holds those individuals to account for those standards if they fall apart.

I think what we have said is that there is tremendous variation between regulators currently because they were set up at different times, they were set up under different legislation, they have different powers. It is difficult to get consistency through that because of that legislative difference in part, although there are some things that can be done even in the absence of legislative reform. But overall, we have said that there needs to be legislative reform in the professional regulation field, and we were very hopeful before the election that we were going to get a Regulatory Reform Act. We still are hopeful that that will eventually transpire and we will get that because we think that the sector is definitely well overdue for a reform of legislation and that needs to be done.

Some of the examples of that probably -- most important is the ability for regulators to be able to apply interim suspension, for example, to people. They can't currently do that. So if a complaint is made and you have a concern about somebody, you can't necessarily put them on interim suspension which is clearly an

important power for a regulator to be able to have. Sorry, I will stop because I have slightly lost track of where I was going.

MS KARMY-JONES: You were saying, and we were going to make the observation, that some statutory regulators are not able to impose interim conditions, for example, and the standards of sanctions are not the same across the bodies and I think you were saying that legislation needs to reform, there needs to be legislative reform, to pull things into line and to ensure consistency across the board.

As a general point, are powers and sanctions -- those that are available to regulators, are they being used appropriately? Anthony?

MR OMO: I think we would say yes. I mean, we are fortunate, we do have a range of sanctions, we can impose interim sanctions, but of course all that depends on something surfacing and getting to the regulator. What we introduced in 2012 was an employer liaison service where GMC senior employees go out and talk to responsible officers in Trusts about emerging concerns, so things that may be bubbling under or any of their doctors that are concerned about. So we have early conversations and we are able to advise them on what action they might be able to take to protect

patients. These are the low-level cases, before they get to us. Obviously, if something surfaces and it is about child abuse or something more serious, then that comes straight to us, we can impose an interim order and stop the doctor from working. So we think we do have -- one of the things we think is missing, and Christine is right, is, in the more serious cases, where someone is proven to have assaulted/abused a child and been convicted of it, we have to go through a ridiculous process of reproving the conviction so it means they are not fit to be a professional. We think we should be able to remove them from our register automatically. That is something we have been calling for for a while.

I think the regulation works for us, certainly, in terms of doctors, but it is, as such, a level removed from the workplace, as it were. As I said, it really depends on things surfacing and getting to us. You know, we work with the police, as another example, and we have an agreement where they will report serious crime to us when they are investigating so again we can take appropriate action in the interim. But that is when it's already happened. We are trying to get -- I don't like the word -- upstream to try to get at things before they become problems.

One of the things we see is soft intelligence, so,

as I said, you know, we see this time and time again in fitness to practise. A doctor who is a concern, has been a concern and eventually people say, "Yes, everyone knew that". Well, not everyone did. But clearly enough people knew and nothing was done about it locally before it eventually came to us. There are many, many cases like that.

So we think the service we introduced in 2012 that seems to be working well is one part of that. It is having those early conversations, empowering responsible officers who are senior doctors to have the conversation locally, to be able to take action locally and work with the regulator on cases that hopefully won't get to us because they can be dealt with early enough or are dealt with in time and not moved on from organisation to organisation.

MS KARMY-JONES: Thank you. So one of the things that you would call for is an automatic removal of licence to practise in the event of a conviction for sexual abuse against a child?

MR OMO: Absolutely.

MS KARMY-JONES: What about the significant proportion of those working in the healthcare setting who don't need to be registered in order to practise? What about them?

MR OMO: I think this is where I completely agree with what

Simon said about where the employer kicks in, because, ultimately, they are responsible for the people they employ to do the job and they need to make sure these people are fit to practise. I don't think you need to regulate everyone who works in a healthcare setting but I certainly think some of the principles of regulation, as outlined by Christine, you know, the right person, right education, right training, right standards, some sort of self-assessment and then the employer having supervision and checking arrangements to make sure who is there, what they are doing and why they are doing it. I think the employer has to take that responsibility where they are not regulated.

MS KARMY-JONES: What about regulating the employer? Who checks the checker?

MR OMO: I'll look that way.

MS GALLAGHER: Hello, here I am.

MS KARMY-JONES: Christine. I will come back to you, Ursula.

MS BRAITHWAITE: So those who aren't regulated, I mean, I would agree with Anthony that the first port of call has to be with the employer. I think there are a couple of gaps that need to be filled. One of those is it is clearly important that any reference that is given to somebody who is moving on from one place of employment

to another is an accurate reference. So that can be an issue in relation to being able to ensure that anybody transferring to a new employer is safe and the record is known.

The second issue is, in relation to the Disclosure and Barring Scheme, one of the issues that the HCPC certainly -- sorry, the Health and Care Professions Council has raised previously is, if they, as a regulator, make a referral through to the Disclosure and Barring Scheme, the cases that they think should be taken up by the DBS are not necessarily taken up. So roughly a third of the referrals they make they say will get accepted. Even if they report things as seriously concerning as sexual abuse, it may not result in the Disclosure and Barring Scheme taking action. So there may be a piece of work looking at the threshold, the Disclosure and Barring Scheme, in relation to that.

With the unregulated staff, those of them who -- I referred earlier to the accredited registers, those of them who are registered by an accredited register, so that includes people like counsellors and psychotherapists, and so on, also healthcare scientists, who aren't necessarily in a regulated occupation, there is a whole range of different people. If they are on an accredited register, then that register will investigate

complaints against them and it will remove them from their register. It doesn't act the same way as a statutory regulator in that it is not then an automatic bar from practising in that occupation. Somebody could continue to practise as a counsellor or psychotherapist. So the protection from the accredited registers programme comes from deliberately choosing people who are on the accredited register. It's a bit like a consumer protection scheme. So it is an added level of protection for patients and the public. It is also an added level of assurance for employers or commissioners in terms of, if they are choosing people from an accredited register, then there is another level of vetting that is happening and another level of setting standards and holding people to account for those standards.

MS KARMY-JONES: Thank you. Ursula?

MS GALLAGHER: In terms of the organisational regulation, clearly, the vast majority of that sits with us right across the health and social care system. As you know, we have just completed in England our national programme, having inspected the vast majority of institutions now and conducted over 80,000 organisational inspections in the last three years. We have put some of the learning in, in our submission.

I think one of the things that I would say is that -- or two things, really. One is the strong need for overlap between the professional and the system regulators, because we have often got bits of the story and it is that classic conversation about how that comes together. I think the second thing that I would mention is that, actually, within our regulations, we have a regulation that requires regulated providers to inform us of concerns that they have in other people providing regulated activities. It is something that we are (a) reminding people of, but (b) starting to take action under. So I don't have any examples with respect to child sexual abuse, for example, but where we have had issues of neglect and abuse in the adult care sector, saying, "Well, actually, there have been a huge plethora of community nurses, GPs, all sorts of people, going in and out of this place who actually have a duty to inform us of those concerns". I think these are some of the bits of the regulatory system that we need to join up and then how we link that in with professional regulation and responsibility.

I think the point about references is very well made, and I think it is one -- because one also gets conflicting advice from employment lawyers about issues in relation to references, and I'm sure this panel will

have a great interest in that subject. But also, a significant proportion of the unregulated workforce are in some form of line management relationships and supervisory relationships with the professional workforce. Those are the things that we look at in terms of when we go in on inspection about how do those accountability systems operate; how does -- not only line management, but clinical and professional supervision take place; what are the safe spaces within organisations, and I know we will come on to whistleblowing later, but I think it is about more than whistleblowing. It is about, how do organisations profess that professional and organisational curiosity? Who is asking the difficult questions? And, in a sense, who is in charge of thinking the unthinkable, because part of this has to be about the preparedness to think that, "It could be going on in my organisation, and how am I sure that it isn't?". And then to test that out both in terms of the specific process that we take up with the executive team, but then we triangulate that in our local visits. So when we visit a community clinic, do they say the same thing is happening locally to what the director manager might say or what the executive nurse or chief executive might say? So it is that constant triangulation up and down how the organisation

says they are doing it.
Most of the time -- or quite often in our inspections, particularly since safeguarding has been a particular issue that comes up when we regulate safe, so if you look at our regulation of acute trusts, regulation under safe is the most significant area in which organisations will have been found to require improvement or inadequate. From our perspective, it is not simply how well were the systems and processes operating, but actually, how well was that demonstrating that it was making a difference to all the people within the organisation, but in the context of this conversation around children and young people, and particular concerns, actually, not when children and young people are in children's services but actually when they are in other parts of the hospital or where they are the children or relatives of people that are within the system and are you asking those questions about children and young people visiting your services as well as children and young people being cared for within your services.
MS KARMY-JONES: Thank you. I just want to bring in Kate as well here, Health Inspectorate Wales.
DR CHAMBERLAIN: Kate Chamberlain from the Healthcare Inspectorate. We don't regulate the NHS in quite the

same way that CQC does in England. We have done a number of governance reviews of health boards where we look specifically at how they use what is coming through from the concerns system, the complaints system, the serious incident reporting, to actually identify patterns. I think, in terms of the conversation that we have been having, it is quite an important identification, preventative tool to be able to look at patterns of what might be quite small issues that are bubbling up in order to be able to identify where there might be an issue with either a service or an environment or an individual.
But I think, going back to what was said about soft intelligence, soft intelligence is incredibly important. You need to get people to report and to raise concerns at, I think, possibly a lower level than we do at the moment. Whistleblowing, as a term, I don't think is particularly helpful. It almost feels like you have to have a lot of courage to do it. Also, when you start talking about raising concerns, maybe raising concerns about the practice of colleagues, again, it feels a little bit confrontational. Whereas, actually, it is in everybody's interests that we are raising concerns, actually, if we focus on the individual, about whether that individual is having their risk managed properly,

is safe and, quite often, raising an issue with a colleague about the way in which they are behaving could be presented as protecting them as well. You wouldn't want to be seen to be operating in a way which is not in accordance with policies and procedures, it could be risk review, you need to help look after yourself. So I think language in this context as well is really important and that needs to flow down through the education and training.
Because soft intelligence and pattern spotting doesn't work unless you have the data coming up to you in the first place.
MS KARMY-JONES: Thank you very much. I'm just conscious of the time, and I need to go to the public gallery, but I will come back to you after the break, if I may.
Is there anyone in the public gallery who would like to make an observation? Mr O'Mara?
Observations from the public gallery
MR O'MARA: Nigel O'Mara, East Midlands Survivors. I just wanted to get a couple of very small clarifications.
Ms Gallagher, earlier on, when you were speaking about the adult wards and you said that very small numbers of children were being put into these adult ward situations, is there any way of us finding out what that actual number is on that?

MS GALLAGHER: I think there is some data that's been available and that has been shared. I think I would want it to be clear that we need to tackle even very small numbers, because it is not the right thing at all. I think what I did say is that one of the difficulties in planning services is that children across the country present with very niche and particular needs that we need to be able to meet in terms of how it is that we develop targeted services, and that's why sometimes we need to plan at populations greater than the local area.
MR O'MARA: Also, Mr Omo, you said that you had some policies in place around boundaries, et cetera. Are those policies publicly available?
MR OMO: Yes, they are.
MR O'MARA: Lovely. Thank you. Where would they be accessed?
MR OMO: On our website.
MS KARMY-JONES: Mr Omo is for the General Medical Council. If you look, the General Medical Council website actually contains a huge amount of guidance and policy data, including details of individuals, I think, that you can even do checks on, on the website. It is very well filled out.
MR OMO: Yes.
MS TUCK: Just quickly, other VSCP members who are watching

the live stream have two questions. Sheila Coates:
"How well are health staff trained to understand the vulnerability of girls, including BME girls, on mixed-sex, adult mental health wards? How is this vulnerability risk assessed and mitigated?"
Second question:
"What processes are in place for children to be able to access an independent advocate when they are resident in a healthcare setting?"
MS KARMY-JONES: Thank you for those. We will reflect on those over the break, if that is all right, and come back on that.
Chair, is that an appropriate moment?
THE CHAIR: Yes, thank you. We will return at 3.15 pm.
(3.00 pm)
(A short break)
(3.15 pm)
MS KARMY-JONES: Can I just touch on something? I think, Mr O'Mara, you were asking about data and where it can be found, so I just thought I would tell you where we found our little piece of information that we gave earlier about there being 391 children in 2014 and 2015 who were treated in adult mental health wards. That came from a Freedom of Information request from The Guardian, of NHS Digital, who don't, we understand,

routinely publish. It is from a Guardian publication. But as far as we are aware, NHS Digital don't routinely publish data.
MR O'MARA: Thank you.
MS KARMY-JONES: If that helps. Some of the other questions that have been raised we will touch on tomorrow when we come to culture and leadership.
Discussion re Topic 2 (continued)
MS KARMY-JONES: Now I want to turn, first of all, please, to William, because you had something you wanted to raise before the break.
MR VINEALL: Two quick things: one for the record, that the government is considering options about how to progress the reform of professional regulation and I think the analysis that the others gave of what the issues are is a very reasonable one.
The only contrast I was going to then make was the comments that Ursula made, that that, in a sense, is the pinnacle of the response and, actually, a lot of things can be gathered by more local activity on the ground, which I know is something you are going to come on to.
MS KARMY-JONES: Thank you very much. The next topic, then, that we want to move on to is the legislative framework and the roles and responsibilities within that.
The question, really, that we have is: how well do

you consider the legislative framework and the current roles and responsibilities within the health sector support the effective prevention of child sexual abuse in healthcare settings? Perhaps we could start out with NHS England and see what your views are on that?
MS WARBURTON: I think we have got a range of frameworks that we use, particularly within NHS England. We have got our own framework, the safeguarding accountability and assurance framework, which sets out quite clearly our expectation of the health sector, including ourselves as a commissioner and system leader. We use a variety of other policies. We have talked about the competencies frameworks and the other sort of frameworks we use around legislation, things like the Care Act and some of the requirements on us in the Care Act, the Children Acts and of course, most recently, the Children and Social Work Act, which is about to reform a lot of what we do around children safeguarding. It might be worth perhaps drifting into that, because there are some concerns around the potential for such localisation within that reform that we could lose some of the outcomes that we are trying to achieve.
MS KARMY-JONES: Thank you. William, do you have anything to say on this point?
MR VINEALL: I was only going to say that obviously from the

government's point of view there needed to be some changes because we passed the legislation that came into force at the end of April with a view that the changes that would be made would put, I suppose, an additional impetus on the police, social care and the health system to form up together locally to look at these significant issues, and the feeling that the previous arrangements that we had weren't always as thorough as they might have been. Now, that hasn't been implemented yet, but clearly the government's position is, there is room for improvement, or we wouldn't have changed the legislation.
MS KARMY-JONES: Can I bring in NHS Wales on that, please?
MR HEANEY: Albert Heaney. There has been a range of legislation changes taking place in the Welsh context. The first one to cite, really, is the Social Services and Well-being (Wales) Act. Sometimes criticised because it is called Social Services and Well-being (Wales) Act and doesn't reference the other agencies, but the duties placed upon it do fall to other partners.
The first thing to say is around safeguarding. One of the gentlemen from the public gallery raised about taking notes during potential disclosures. The Act actually puts a formal duty on the professionals involved in children's safeguarding and child work to

formally report that concern through, so it goes further than note taking into duties placed upon.

MS KARMY-JONES: Have you done a comparison between the English legislation and the Welsh legislation?

MR HEANEY: Yes, of course we have looked, and when we were going through the legislation journey, the Act was passed in 2014, implemented in 2016, we had a lot of discussions across border, discussions, as you would appreciate. There were some differences.

There were some issues that we also had to work through during the passing of the legislation about devolved and non-devolved legislation, there are competencies, and of course that is another added issue in terms of the considerations that need to take place, because there are non-devolved organisations involved in child protection, such as the police, probation, et cetera.

One part of the Act which I wanted to reference, because I think it is important when we are thinking about solutions and how we do things differently, the Act is about well-being. I have mentioned some of the duties and strengthening around safeguarding but also well-being duties are placed -- duties upon the health and social care, housing and third sector partners to formally come together in regional

partnership boards to plan together completing population assessments and introducing joint area plans. What's interesting about the scale of that, it's been based on a regional footprint that's aligned to our local health boards, so we capture the issues across that particular front and footprint. There is other legislation but, without going into all that, I know we can share some of that. There is a whole lot of work taking place around the Regulation and Inspection of Social Care (Wales) Act and other legislation around the healthcare as well.

MS KARMY-JONES: William, presumably, we have here looked at what is going on in Wales and drawn some comparisons with it?

MR VINEALL: I wasn't close to the piece of work, so I can't answer that question, I'm afraid, but I can come back to you.

MS KARMY-JONES: Thank you very much. Does the way the system is organised effectively prevent child sexual abuse and account for effective prevention? Does anyone have any observations on how the system is currently organised? Christine?

MS BRAITHWAITE: Christine Braithwaite, Professional Standards Authority. I think we would offer one observation that we have increasingly become aware of

over the last few years. About seven years ago now, we began looking to see how effective professional regulation actually was in terms of impacting on people's behaviour, and both we and the regulators have been undertaking various research projects in relation to that.

I think what's become very clear to us is that it is very hard now to separate the regulation people from the regulation of places, because people work in places and they are affected by the environments in which they provide care. I think we have heard numerous examples today, as we have been going through, about the importance of workplace environments in terms of trying to prevent opportunities for sexual abuse taking place. So I think we would say now, if we were all starting with a blank sheet of paper, we probably wouldn't separate out the regulation of people from the regulation of places. That said, we clearly have a vast amount of legislation and I'm not imagining we would just do away with it all now, but I do think that there is merit in looking at the connection between professional regulation and system regulation and thinking about how those things can be coordinated and carried out in a way. That means emphasis being put on professionals being provided with a workplace

environment that is supportive of them carrying out their responsibilities properly and effectively towards patients.

MS KARMY-JONES: In England, we have heard, and this has been part of some of the responses, that the greater decentralisation of the NHS structure is leading to a greater variety in local practices, so what impact has that had on prevention of abuse within healthcare settings? Ursula?

MS GALLAGHER: I think from our work, establishing simple cause and effect is actually quite difficult to do in what we have already highlighted is quite a complex system. So actually in some areas, as I said earlier, the variation actually means that the way they have implemented things locally is really good and is really working effectively to prevent child sexual abuse. In other areas, ostensibly working under the same legislative framework but taking their own local interpretation, it is not working quite so well. So I think there is always that slight concern about, you know, a legislative Holy Grail that would be the answer to all of this, and it comes back to some of those things that we have referenced already.

Certainly, in our own child exploitation report "Time to Listen", you will, I am sure, recall that we

did see some really, really effective practice working within the legislative frameworks, but it was about a group of leaders coming together to use that framework to its best.

I think that that is a real reflection and challenge for us, which is about how, in an area like this, do we assess that degree of variation and, again, for us, it is about continuing to focus on the issues about how the outcomes are measured and assessed more than it is getting into the minutiae about how people tick-box all the issues around the systems and the processes.

I think one of the areas that we also regulate and is worth referencing here is actually the independent health sector, so, again, most of the colleagues around the table are from the NHS, but actually there are a lot of -- significant numbers of vulnerable children and young people and there are also children and young people in circumstances we know already make them vulnerable, in circumstances such as domestic abuse and violence or children who are already in the "children looked after" system, and, again, I think we see there considerable variation in practice and sometimes considerable disagreement about what best practice looks like and, again, I think some of the challenges are about -- I say clinical in the broadest sense of

the word, but actually, the clinical evidence base around what works and the extent to which a culture of, if we haven't invented it here, it won't be right, as opposed to cultures that are very open and porous to bringing in new ideas and challenging them themselves and keeping that focus on, are we sure we are doing the best by our children and young people in terms of prevention.

As I said earlier, the areas that do really well are the areas who constantly challenge themselves. If their numbers are low, they don't make the assumption that that's because they're really good at preventing it. They first ask the question, "Are we really good at detecting it?", and it is that constant challenge that says, actually, zero might not be a reassurance, and that's what those -- when you hear -- when you talk to those leaders, that's what you hear them talking about.

MS KARMY-JONES: Thank you. Eustace, can I bring you in on this and just ask you your views on whether the fragmentation, for want of a better word, of the healthcare system in England means at times -- first of all, what impact has it had on the prevent of abuse within healthcare settings and does it at times mean accountability is unclear? What's your view?

MR DE SOUSA: Eustace de Sousa, Public Health England.

I think it is certainly the landscape is much more complex than it was 15/20 years ago, both in terms of what's commissioned in terms of child healthcare services, and also the plethora of providers that we now have. But that's not necessarily a bad thing. So for children and young people and their families, it can actually mean greater choice, it can mean access closer to home, it can mean provision of innovative services.

So I think when we use the term -- I understand you have used it in inverted commas, as it were, "fragmentation" -- it can bring good things. But I think what it has done is brought complexity to the system. I think what we have heard today is, actually, we can look at individual silos, so we can look at Trust A, we can look at GP surgery Y, et cetera, and that's important, and we have heard from three colleagues why that's important, but actually we need to look at how this works across the local system. The work that William described earlier and the government's proposals around revising working together to provide greater impetus and a role for the local system, the tripartite system, to address that is really important.

I think the other issues, just around prevention, I think clearly it hasn't worked because we still have far too many cases of children being abused in

healthcare settings and other settings.

From a public health point of view, I'm sure my other colleague will bear this out, actually healthcare settings -- we have tended to talk today about very classical buildings, if you like, a hospital or a GP surgery. From a public health point of view, the healthcare setting is anywhere where healthcare is provided. So that could be on the street corner through street-based work, it could be in a school as well. I think we need to make sure we are broadening our overview of this so that it is inclusive of those other settings.

I think we have also got, because of that, a great deal to learn from social care around this as well, both in terms of the oversight, expectations of staff and setting a culture. I'm not saying social care is perfect, but clearly they have a great deal of experience in this particular area.

MS KARMY-JONES: Thank you very much. Susan, do you have anything to add to that about the fragmentation of the system and its effect on accountability and child protection as a whole?

MS WARBURTON: I think it seems a quite a lot more complex for our commissioners when they are trying to monitor a range of healthcare settings with different providers,

with different service certifications and it's put a complexity in there, which they're now grappling with. There is a fragmentation, I agree with you, but it brings a lot of opportunities as well and we have seen some really good examples of children's care and good outcomes coming out of that change, but it has created challenges. I think when you start to think about your Clinical Commissioning Groups, it is about the expertise within those groups, and some of you will be aware that some Clinical Commissioning Groups are now coming together to collaborate on commissioning and hopefully get some of the expertise back in the system that we perhaps lost for a while with the smaller CCG groups.

MS KARMY-JONES: Thank you. Yes, Angela?

MS HORSLEY: Angela Horsley, NHS Improvement. I suppose the other, I suppose, opportunity is the fact that there are joint regional chief nurse posts now between NHS England and NHS Improvement. So I think that enables, you know, improved communication, especially when sort of like dealing with the different provider trusts.

MS KARMY-JONES: William, is there something you wanted to add to this?

MR VINEALL: I was only going to say the new Act, the Children and Social Work Act 2017, does explicitly give greater flexibility for local areas to determine how

they arrange services to safeguard children. So I wouldn't characterise that as fragmentation -- I know the point that you are making -- that is the reason why you have to have a strong regulator, to inspect these things. It is also the reason why, if you give people local flexibility, you need strong boards that are accountable, have a good grasp of data and can actually justify what data means without the number being lower, meaning necessarily you don't have a problem. There is a whole range of work in this area and others about encouraging open reporting of events, be they child sex abuse or other things, because that gives you a picture of what the issues actually are.

MS KARMY-JONES: If the data is collated and disclosed.

MR VINEALL: Yes, if the data is collated and disclosed and if you have the right leadership at the board level, the two together can be quite powerful for addressing issues, but you need both of those. I don't think having local flexibility then to resolve problems is necessarily a bad thing.

MS KARMY-JONES: One of the issues we found this morning was that there may be an issue around data and its availability. Would you agree with that? Are you aware of that?

MR VINEALL: I don't know. I shouldn't think data is

consistent.

MS KARMY-JONES: I'm just going to ask, Vimal, actually, if you have anything to add to this?

DR TIWARI: I think, as general practitioners, we find it all very difficult because the system changes have resulted in a couple of years of uncertainty during which time the pressures on general practitioners have increased. Even now, there are changes again with the Clinical Commissioning Groups going to -- there is delegated commissioning and taking over responsibility for commissioning services. The difficulties lie, as I think someone rightly said, in the level of expertise within these commissioning groups, and how well they understand the services they are commissioning and, therefore, to what standard they can be monitored effectively. What does "good" look like if you are a commissioner without the experience of running a particular service?

MS KARMY-JONES: Thank you. Clarisser?

MS CUPID: Someone mentioned about a fragmentation of the NHS and the challenge around, you know, safeguarding arrangements across the different providers, so to speak. Now, within each borough, within each locality, there should be a designated professional that takes on that responsibility for ensuring that safeguarding

across all health -- the whole health economy, whether commissioned or not commissioned by the CCG, have a sound approach, so to speak, and is compliant with safeguarding arrangements.

The designated function, and that could be the designated nurse or doctor, would link up via the safeguarding board to ensure that provider services, whether they are commissioned by the CCG or by local authority or -- is a voluntary agency at all, they would ensure that safeguarding arrangements are up to the standard that's required.

I just wanted to ensure that we have that in consideration when we make our recommendations.

MS KARMY-JONES: Several of the submissions that we received noted that there is no specific mention of healthcare services in child protection legislation. Does that have an impact on how well the law works to prevent abuse within those settings? Can I ask you, Anthony? Do you have a view on that?

MR OMO: Not really one for me, but I don't think it is necessarily about what's written into the legislation, because it is a last -- it is a sort of last defence rather than a first defence. I think it is more about the intent and how -- as I think Clarisser has just said, people in place to actually put it into practice.

The question I had when Clarisser was speaking was, is a single person sufficient to actually carry out that function, given the breadth in some of these areas? But I can defer to others on what the legislation says or doesn't say.

MS BEAUMONT-WOOD: Can I just offer an observation? While I think we will always need people in a specific dedicated leadership role, such as designated doctors, nurses, et cetera, it can also be our weakest link, because, actually, the point that's been made several times is, it is everybody's business. If it is seen to be the job of somebody "over there", that sort of diminishes the ownership of an individual health professional in its broadest context. We will need it to provide leadership and work on things, but I think we need to be careful that it is not instead of, it is to complement and support the workforce per se.

MS KARMY-JONES: Thank you. Vimal?

DR TIWARI: Yes, Vimal Tiwari from the Royal College of General Practitioners. Just to come back to the important point about the duties of the designated team, what happened immediately after the Health and Social Care Act was that commissioning went in two directions. So primary care was commissioned by NHS England, whereas secondary care and tertiary care and community care were

commissioned by the CCGs.

The designated -- the guidance at that time was that the designated team had a responsibility towards the CCGs, which left primary care under the care of NHS England. So there was a difference. There was a difference in the way the services were monitored and in the way standards were applied depending on locality. It is changing again because of delegated commissioning, and, really, I think things are becoming much more straightforward and much easier for primary care providers to understand.

MS KARMY-JONES: Thank you. In England, what opportunities do plans under NHS England's five-year forward view, for example, the implementation of new models of care and sustainability and transformation plans, what opportunities does that create for the way that services protect children from abuse?

MS WARBURTON: Susan Warburton, NHS England. I think the five-year forward view actually gives a wealth of opportunity to reshape services for children, young people and protection of those children within those services. We have got a unique opportunity. It is a once in a lifetime, probably, opportunity to get it right. Because of the work that we are doing and have learned from some of the investigations that have gone

previously, we can start to embed some of that learning into children's services going forward and the collaboration that we are doing with local authorities and Public Health England and others to actually build services that are fit for purpose going forward, I think will actually help rather than hinder us. I think there is a unique opportunity, but we have really got to learn the lessons that we are being faced with. Some of the things we have been talking about today can actually be embedded in some of those new models of care.

MS KARMY-JONES: Thank you. Angela, do you have a view on that?

MS HORSLEY: Angela Horsley, NHS Improvement. I am sitting here, obviously, from NHS Improvement and I'm also sitting here as a senior children's nurse by background as well. I think there is something about children on the agenda and I think when you are looking at the five-year forward view, it is not just to take that literally, it is to ensure that there is a consideration for all those work streams to put children there in actual fact, and, as you are putting children there, you are also thinking about the unthinkable and where does safeguarding, in its broadest term, fit into all of that as well.

MS KARMY-JONES: Thank you. Helen, what about you?

MS CHRISTODOULIDES: Riel, I'm so glad you mentioned it. I thought everyone had forgotten about the five-year forward view and the opportunities that surely will arise from local STPs. As I sit here thinking about the work streams and what opportunity might we exploit, I think, as much as the physical changes, it is learning to work together with partner organisations, building trust, and there has been a barrier in the NHS, I think. So I think that those cultural changes, learning to operate with adult social care colleagues as a nurse by background, someone that's worked in the NHS, is valuable for me, and vice versa, and I think those relationships that will emerge are as important as the structural changes we make for services. That would be my comment.

MS WARBURTON: I think I just wanted to add, really, that some of the new service models that are being looked at across the country are in co-production with children and young people, and actually we are starting to hear their views about what they would value in a service delivery for them, which is something that maybe we haven't done particularly well previously, but it is certainly an opportunity we have now.

MS KARMY-JONES: It ties in very much with one of the questions we had from the public gallery, which was,

how much account is being taken and how much collaboration is there with the victims and survivors of this kind of offending and this kind of abuse. Is there a great deal of collaboration?

MS WARBURTON: There is. At the moment, I am involved in some work in NHS England around developing and making a framework for commissioning sexual abuse services where there's been an enormous amount of collaboration with survivors. Many workshops, they have been involved in every part of the structure of that commissioning framework, and that's added such an enormous value in the actual context in which we are building the commissioning for the future. But they've been from the ground up, really, in building the essence of it..

MS KARMY-JONES: Thank you.

Eustace, did you have something that you could add to this?

MR DE SOUSA: Eustace de Sousa from Public Health England. Just to endorse the couple of comments that have just been made in particular by Sue. I think the five-year forward view offers us a really exciting opportunity to really shift the way in which services are provided and delivered to children, young people and their families.

I think there are a couple of challenges. There is obviously the challenge about resources and competing

demands. I think there is a challenge around, sometimes in some areas children might not be as visible as they are in others. Ursula has already advised us of that variability.

I think there is an issue around how we, as system leaders, help to galvanise the best to come to the surface for all the other areas as well.

I think the other point to raise, which kind of links to the point that we were talking about earlier about fragmentation, is, the local systems haven't stood still. Because of the fragmentation, as you described it, in most areas now they are moving towards integrated commissioning and service delivery, and that is as a direct response to some of the challenges that we heard earlier.

I think it is really important to bear that in mind. Again, it is not to be complacent, but it is to recognise that actually, at a local level, generally they understand some of these challenges and they are looking at ways in which they can resolve that within the current legislation.

MS KARMY-JONES: Thank you very much.

William?

MR VINEALL: Yes, STP. They allow local organisations to plan beyond a single institution, which is an advantage.

There is quite a strong accountability back to NHS England, and it does allow you to have more population-wide services. So for all the things we are talking about here, they are advantageous.

MS KARMY-JONES: Thank you.

I would just like to tie things up with a question, and, really, I would like as many answers as possible to this, and as many different views: what changes would have the biggest impact to ensure that roles and responsibilities for the prevention of child sexual abuse are clear, stringent and effectively enforced? What would you recommend? Let's start with you, Anthony?

MR OMO: I think following, discussions this morning and this afternoon, I would say a consistent approach to education and standards across regulated and non-regulated staff in the health setting, so everyone is clear about what is required of them and there's accountability there.

The other point I would make is: some sort of education or information programme for patients so they understand what to expect, and/or their carers or families, so when they go into these settings they know what is normal and what is not normal and they can deal with it themselves.

MS KARMY-JONES: Thank you. Albert, do you have any observations on this?

I would like to go around, actually, and see if everyone can contribute something.

MR HEANEY: Thank you very much. Two points, then. First one is, I think, related to training and development being across partnership organisations so that you use the learning. There have been many inquiries held over many years, and the learning is cross-referenced if we look for it.

The second one is a bit of a curve ball, but Coventry University, there was research certainly recently that showed quite a correlation between deprivation and the outcomes for children around child sexual abuse. I think that is something we have to look at in more detail and consider how we can look at the future together.

MS KARMY-JONES: We are going to come on to particularly vulnerable individuals tomorrow and how that's addressed in the learning curve.

Christine?

MS BRAITHWAITE: Thank you. I think mine would be an emphasis on practising constructive mistrust, so that is as part of education and training but also within the workplace and having a proper support mechanism in place

for people to be able to do that.
MS KARMY-JONES: Eustace?
MR DE SOUSA: I think just to incorporate the points from my two previous colleagues, really. So not a single a solution, I don't think it is as straightforward as that.
Clearly, we need a competent workforce that's able to -- around professional curiosity and challenge. You heard that earlier in the session this morning.
We need to make sure we have an informed and confident public, patient, who understands what they can expect from a particular health interaction and what their rights are. So it is more of a rights-based approach, particularly when we are talking about children and young people because you are often involving their carers as well, depending on the age of the child.
We clearly need strong regulation and accountability.
But I think all of that is wrapped up around a culture of how we see children, how society sees children, and how we deem what is acceptable in terms of their treatment. So I think a kind of culture would oversee that, and I know that's the subject of your session tomorrow.

MS KARMY-JONES: We will come back to that tomorrow, but it is helpful to get those views so we can refine what we are going to ask tomorrow. So thank you.
Susan?
MS WARBURTON: I think, for me, it is very much around the undergraduate education, and actually embedding it at the beginning of professional training and education. But also, picking up, as we did this morning, that broader sense of what is acceptable, what should we be accepting, as a population; do we know what's right and what's wrong? And particularly around when we talk about chaperoning and chaperones, and that almost professional role that perhaps needs to be developed around that and not the passive "I will stand there and do my emails while I'm waiting" type of approach.
So I think there are a few things, but it all comes down to accountability.
MS KARMY-JONES: Thank you.
Angela?
MS HORSLEY: For me, it is about raising the profile of children and young people and really recognising their needs from a safeguarding point of view. And then, from an NHS Improvement point of view as well, it is really getting together with NHS England and really working out who is doing what, because, as I said earlier,

NHS Improvement is a relatively new body of Monitor and the TDA coming in together, and I think when it comes to safeguarding and CSA, it is very much in its infancy at the moment.
MS KARMY-JONES: How can that be done?
MS HORSLEY: I could get together with the regional chief nurses, and also Susan as well. We have already made some of those arrangements.
MS KARMY-JONES: Good. Excellent. Ursula?
MS GALLAGHER: It certainly is the $24,000 question, isn't it, this one. I would echo what people have said.
All organisations that are registered with us begin by giving us their statement of purpose. If you actually look at those statements of purpose -- there can't be a list of every single subpatient group that they might be going to serve, but actually children and young people are very rarely mentioned in them specifically and some of those issues around outcomes, how do we see that change in focus, particularly as these new care models come along?
What are then the measures and rewards that the wider system thinks about putting into place, and aligning some of those incentives; you know, as we come into winter, and what it is that the system thinks it has to prioritise at the moment. These are the moments,

I think, when children and young people get lost in the system.
I think, as William has said, we need to do both, which is strengthen local accountability while also making sure that system accountability -- very important, particularly in relation to transparency and enabling local people to be able to compare how well their neighbourhood is doing with somewhere else, that they can be part of that challenge.
But I think from a system accountability perspective, we need not to get in the way either. We need to be really sure that what we are doing adds value to the answers to these questions.
MS KARMY-JONES: Thank you.
Clarisser?
MS CUPID: For me, it is about developing a culture where people feel confident enough, they feel safe enough, to actually raise concerns. It is about training and development, and echoing what everyone else has added on today, but for me it is definitely about having that culture that makes people feel safe that they can report concerns, and holding the child at the core of everything.
MS KARMY-JONES: Helen? You have addressed it to some extent.

MS CHRISTODOULIDES: The word I would add, and I think people have said it in a different way, is empowering people, empowering our young people, empowering our staff.

We have mentioned accountability. And I think strong leadership in organisations. We have talked about that, about organisations setting the tone by executives, chief executives, setting the tone, being authentic about their leadership and allowing that to resonate out through the organisation. That is crucial.

MS KARMY-JONES: Thank you.

Rhiannon?

MS BEAUMONT-WOOD: I would agree with all of the comments that have gone beforehand, and I want to also emphasise the importance of leadership and culture at all levels.

But I think I also want to say that that can't be all about the top down and that, actually, that ethos of continual improvement actually needs to be from the bottom up.

I think one thing that we could do to strengthen all of our organisations is to wholeheartedly be able to demonstrate how we comply, if you like, with the United Nations' Rights of the Child. I think that was very, very evident in organisations, and I think one thing that we could do -- and we certainly do it in some

of our performance and planning approaches -- is actually have a peer-review-type process that allows critical friends, if you like, rather than the sledgehammer to crack a nut. I think it has to be about the emphasis on learning. Because, actually, that challenge of, one minute you have to be in a command and control situation because it is an emergency situation, and then the next minute we want people to flip in to be able to escalate a concern, it is actually a very nuanced thing to do. So I think the peer review might help with that critical challenge just becoming more embedded within healthcare settings.

MS KARMY-JONES: Simon, is there anything you want to add to that?

MR DEAN: I am in danger of repeating what others have said, but I strongly believe that leadership sets a culture which, in turn, drives practice, and, to me, the leadership is the key issue here. Again, I don't mean just from the board or the chief executive, it is individual leadership, it is team leadership, organisational leadership and the system leadership. That needs to be supported by and underpinned by frameworks, policies, legislation and appropriate regulatory mechanism.

So I think the leadership piece, which takes you

into accountability as well, is a critical issue from you having set the right tone of expectation.

MS KARMY-JONES: Thank you.

Kate?

DR CHAMBERLAIN: Just to give the other side of that, really, and to echo the comments that were made by particularly Eustace about the educated and informed public, which I think is really important, but the other part that has to be there is, if the educated and informed public are uncomfortable or not happy with what's happening, is it clear where they can go, where they can get the support; is the advocacy there; are the lines available to them to be able to raise those concerns and feel that they are going to be heard and listened to? I think the presence of the public in every interaction means they are one of the most powerful agents of change.

MS KARMY-JONES: Thank you.

MR LUCAROTTI: I support the emphasis on professional curiosity that's been mentioned by a few people today. I suppose that would then lead to some degree of analysis of where we go with soft intelligence and its status.

Speaking from a regulatory point of view, soft intelligence is often the start, but, clearly, what's

been carried out with that soft intelligence from an employer point of view is key often to the direction the case takes from a regulatory point of view.

So, yes, as much soft intelligence generating and processing and understanding as is possible, but an awareness that that, certainly from a regulatory point of view, is often the start of the journey.

MS KARMY-JONES: Thank you.

William?

MR VINEALL: I think making clear that local organisations are the first line of accountability is vital, and that boards need to report and understand data and challenge it and encourage those in the organisation to do the same.

MS KARMY-JONES: Thank you.

Vimal?

DR TIWARI: Coming back to something I said this morning about the importance of child health education in prevention of child sexual abuse, general practitioners are generalists, but our training period, our postgraduate training period, is two years less than that of hospital specialists, and what's missing is the child health element. What is missing from our contractual obligations is a child health element. There is an urgent need for that to be pulled into our

education, our practice, our policies, and everything we do.

Without understanding how abuse affects the whole child, we can't set out to prevent it.

MS KARMY-JONES: Thank you.

Lorna?

DR PRICE: I know we have been talking about fragmentation of the system in England. I think in Wales, over the years that I have been practising, we have developed a more joined-up and mature safeguarding system. I spoke earlier about the NHS Wales safeguarding network.

But to go back to sort of education and learning, I think what we have also done is to try to develop a more multi-agency/multi-disciplinary system of education, so within peer review for doctors, for instance, different specialties other than just paediatrics, child health.

In our team, for instance, we have a GP who is a named GP for Wales, and our child practice reviews, which have replaced serious case reviews in Wales, are much more about bottom-up learning, learning from practitioners, having multi-agency/multi-disciplinary learning events, and also, when concerns don't reach that level, having multi-agency professional forums to

share learning.

I think what I will take away from today that we could use to improve our systems would be the ideas about having an educated and informed public, and also very much about including survivors and consulting with them in trying to develop services and improved systems going forward.

MS KARMY-JONES: Thank you. I am just going to turn now to the public gallery and see whether anyone in the public gallery wants to make a contribution around that question?

Observations from the public gallery

MS TUCK: Again from my colleagues that have been watching the live stream, the five-year forward view, to what extent have you included survivors in the five-year forward view, their comments, their lived experiences? Have you spoken to children in this five-year forward view?

Often policies and procedures are put in place without consultation with the end users' involvement so it is not fit for purpose, so if anything is going to be put in place going forwards, to maximise it, to make sure it does work, then it does need the end user involvement.

Are health actively engaging with specialist sexual

violence abuse organisations and working in partnership to achieve best practice?

It is not my question; that is from one of my colleagues. Thank you.

MS KARMY-JONES: We touched briefly on the engagement with victims and survivors, I think, Susan. Did you want to add anything in response to that query?

MS WARBURTON: Just to reinforce the fact that all elements of the five-year forward view and its creation involved a range of individuals, including survivors and service users. So those documents in themselves had a lot of engagement from children and young people in those elements of those documents.

There has also been specific involvement with survivors of sexual abuse in the development of some of those specific services. So I mentioned the Sexual Abuse and Assault Service, and that was very much influenced by the comments early on which took it from looking at one particular service to actually a pathway of care, and a trauma informed pathway of care, and that was directly because of the work that survivors did with us to help us understand at NHS England that we needed a broader pathway than perhaps we were planning.

MS KARMY-JONES: Thank you.

I am going to turn to Mr O'Mara. What changes would

you say have the biggest impact?

MR O'MARA: Nigel O'Mara, East Midlands Survivors.

I think one of the biggest changes which seems to have been highlighted today by the gentleman talking about the Welsh model being different from the English model, it seems that, although it is not there by name, there seems to be a form of mandatory reporting within that, so that when people do have concerns, they do need to log it and they do need to make it clear in going forward that there is a concern so that if there are several small concerns raised, that can automatically trigger a larger investigation.

MS KARMY-JONES: Thank you. Just by way of reminder, because we are getting to -- we are past, indeed -- the close of the session, but tomorrow we are covering culture and leadership, and we will pick up with some of the things that have been raised today that we have gone into a little bit but we would like to go into a little bit more detail, things like: how do you go about raising concerns; the questions around whistleblowing and whether that is an appropriate word to use or not; the issues around staff, parents and children; advocacy for children -- one of the questions that was raised in the public gallery; creating the right environment for disclosures to be made and reporting.

We will also look at how we support people in thinking the unthinkable and the training perhaps that needs to be gone into.

I know not everyone here is going to be back with us tomorrow, so can I thank everyone who has attended today, and just ask those who will return to give some reflection overnight to those points.

Unless there is anything, chair and panel, that you wish to raise at this stage for consideration tomorrow, this might be an appropriate moment?

Closing remarks by THE CHAIR

THE CHAIR: No, I think you have covered some of the issues that I was hoping you were going to address tomorrow in what you have just said, Ms Karmy-Jones. So my thanks to everyone for their participation today and thanks to yourself and the team for all of the arrangements that were made and for it going so smoothly.

Thanks also, particular thanks, to the two people whose words we heard this morning on the video.

We will reconvene tomorrow at 10.00 am. Thank you very much.

(4.05 pm)

(The hearing was adjourned to Wednesday, 27 September 2017 at 10.00 am)

I N D E X