

## NORTH EAST AND NORTH CUMBRIA INTEGRATED CARE BOARD Board Development Session — Note of Proceedings

### Part 2: Safeguarding Level 4/5 Refresher Training

Date of session: 26 August 2026 | Chair: Sir Liam Donaldson

Presenters: Richard Scott (Director of Nursing, Neighbourhood Health and Safeguarding); Trina Holcroft-Jones (Deputy Director of Nursing, Safeguarding Lead)

#### 1. Purpose and context

- 1.1 This session met the Board's statutory requirement to refresh Level 4/5 safeguarding training every three years. As with the preceding session on strategic commissioning and quality (see the companion note), the intention was to move beyond a compliance exercise and give members a genuine, locally grounded understanding of the ICB's safeguarding responsibilities: what the Board is accountable for, how assurance should be received and challenged, and what recent local and national cases mean for this ICB specifically.
- 1.2 The presenters set out the scale of activity to frame the discussion: on any given day across North East and North Cumbria, the system generates around 100 adult safeguarding concerns, over 100 domestic-abuse-related crimes, roughly one Prevent referral and 50–60 new child-in-need episodes, with a notification of the serious harm or death of a child roughly every twelve days.

#### 2. Statutory responsibilities and the current assurance model

- 2.1 The Board's statutory responsibilities were presented across six areas:
  - **corporate accountability** (board oversight, executive leadership, safeguarding embedded within quality, safety and risk governance, and a safe organisational culture);
  - **commissioning accountability** (safeguarding standards built into contracts, procurement and provider assurance);
  - **partnership accountability** (active participation across a large number of statutory partnerships - 14 local authority and four police force areas, 14 Community Safety Partnerships, 22 safeguarding board arrangements in total, 14 Domestic Abuse Local Partnership Boards and 14 Families First Partnerships);
  - **provider assurance** (evidence that NHS-funded providers have the right policies, training, named safeguarding professionals, safe recruitment and escalation arrangements);
  - **review and learning accountability** (timely participation in statutory reviews and evidence that learning changes practice);

- **risk accountability** (clear arrangements to identify and escalate emerging harms).

2.2 Presenters were candid that partnership working is well established, but that the ICB needs to strengthen how safeguarding learning is translated internally into commissioning and contracting decisions, and how safeguarding is more visibly evidenced through the ICB's own governance rather than relying on partners' assurance.

2.3 A new health network meeting with providers is being set up to work on this collectively. Members were also updated that the Supreme Court judgment in June 2026 overturned twelve years of case law on deprivation of liberty (removing the previous "acid test"), leaving fewer cases in scope but greater complexity and grey areas in those that remain, and that this has direct implications for local training and process.

### **3. Adverse Childhood Experiences: the evidence base**

3.1 The ten recognised Adverse Childhood Experiences (ACEs) were reviewed - emotional, physical and sexual abuse; physical and emotional neglect; parental substance misuse and mental ill health; domestic violence and abuse; parental divorce or separation; and criminal behaviour in the household - with bereavement and parental incarceration highlighted as under-recognised additions.

3.2 Adults who experience four or more ACEs are markedly more likely to develop heart disease, obesity and type 2 diabetes, to self-harm, to have been in prison, and to die early; six or more ACEs are associated with a 20-year reduction in life expectancy. ACEs were linked directly to demand across general practice, mental health, community health, emergency departments, acute hospitals and public health, at an estimated annual cost of £42.8 billion across England and Wales - a figure presenters stressed is conservative, since it does not capture children's social care, education, youth offending or wider economic impacts.

3.3 A consistent theme, echoed by several members, was that the ICB and its providers are now managing the downstream, adult consequences of unaddressed ACEs, and that addressing root causes - rather than repeatedly treating presenting symptoms - is essential to breaking the cycle.

### **4. Learning from serious case reviews and national inquiries**

4.1 Presenters used several recent cases to ground the statutory duties in lived consequences:

- Arthur Labinjo-Hughes and Star Hobson, both killed by carers during the 2020 COVID lockdowns, illustrated how lockdown isolation, rapid parental cohabitation, and professionals' reluctance to challenge an apparently "protective" parent or to credit family members' concerns allowed sustained abuse to go undetected. The national review called for dedicated, better-resourced multi-agency child protection teams - a recommendation the safeguarding team noted is difficult to resource given that associated funding has gone to children's social care rather than jointly to health.

- Leiland James Michael Corkill (Cumbria, died 2021) and Preston Davey (died 2023), both killed within months of adoptive or foster placement, illustrated gaps in the timeliness and thoroughness of pre-adoptive assessment, information-sharing between GPs and mental health services, and flagging of prospective-adopter status on GP records.
- A Gateshead group-based child sexual exploitation case, prosecuted in 2025 with five convictions, was cited as a live, high-profile local example feeding into current national scrutiny, alongside Operation Beaconport (a national review of previously closed group-based exploitation cases) and the ongoing statutory inquiry into grooming gangs.
- The Southport Inquiry (Phase One) was discussed at some length: the perpetrator waited 77 weeks for an autism assessment, was managed on the wrong treatment pathway, and was discharged from CAMHS six days before the attack with his risk to others recorded as "none" despite a documented history of violence. Members noted the parallel to local autism assessment waiting times, which several felt were comparable or worse.

## **5. Current scale and risk themes**

- 5.1 Members were shown that 313 safeguarding reviews are currently active across the footprint (172 adult, 130 child, 11 uncategorised), each generating at least one meeting and a report, with complex reviews running 12-18 months.
- 5.2 Presenters were candid that the volume of review activity risks becoming a "treadmill" of report production unless matched by evidence that learning genuinely changes frontline practice and commissioning.
- 5.3 Domestic abuse was highlighted as a public health issue in its own right (a domestic-abuse-related call to police roughly every 30 seconds in England and Wales, with only around one in five victims calling police, and 262 domestic-abuse-related deaths and 98 suspected suicides in the latest year, with an emerging link between suicide and children having been removed from the mother's care).

## **6. Discussion themes**

### **6.1 What, precisely, is the Board accountable for?**

- 6.1.1 The Chair pressed presenters on where individual and collective board accountability comes into effect, given the ICB cannot itself supervise front-line care in every home or placement. Presenters distinguished individual professional accountability (where a named member of staff or a provider has personally failed to act) from board-level accountability, which arises from systemic failure - evidence that concerns were known and not adequately addressed.
- 6.1.2 The Chair tested this with a direct question - what sequence of events would land accountability on an individual board member - and drew on his own experience of a historical public inquiry to illustrate how a legally framed inquiry can attach individual accountability quite differently, and less forgivingly, than day-to-day

practice suggests. Members agreed the most instructive discipline is to ask, of any live issue, whether the Board would withstand the scrutiny the Southport Inquiry applied to health partners in that case.

- 6.1.3 A related distinction was drawn between a systemic, multi-agency failure (where the Board can point to shared partnership accountability) and a failure that is largely health-generated but does not immediately surface through multi-agency channels. This was felt by one member to be the more dangerous scenario for the Board's own exposure, drawing a parallel with how a previous non-safeguarding service issue was initially contained locally before eventually requiring wider escalation.

## **6.2 Connecting safeguarding to commissioning intentions**

- 6.2.1 Several members pressed for a clearer route from safeguarding intelligence into commissioning decisions and strategic priorities - echoing the discussion in the Part 1 session.
- 6.2.2 Specific gaps raised included the earlier decommissioning of an independent domestic violence advocate service, the relatively limited support available in primary care to identify and respond to domestic abuse and parental mental ill health, and the disconnect between local funding for early-help/front-door reforms sitting with local authorities and the ICB's own commissioning levers.

## **6.3 Root causes, trauma-informed practice and prevention**

- 6.3.1 Members discussed the shift in professional thinking from "what's wrong with you" to "what's happened to you", and the difficulty of translating this into commissioning practice: presenting symptoms (chronic pain, frequent GP attendance, self-neglect in older people) often mask underlying domestic abuse, mental ill health or isolation. It was noted that adult social isolation and self-neglect, not only child safeguarding, form part of the same broader pattern of unmet need.
- 6.3.2 Members also acknowledged the political and financial difficulty of investing in upstream prevention whose savings are realised years later and by other parts of the system, citing the dismantling of the Sure Start programme as a cautionary precedent, while asking whether the ICB - even within current financial constraints - could do more within the "left shift" agenda to reduce the future burden it will otherwise inherit.

## **6.4 Equity, social context and vulnerable communities**

- 6.4.1 A member raised the Board's wider duty of care in the context of the current social and political climate, referencing Michael Marmot's argument that health outcomes are substantially determined by social justice, and asking what the ICB is doing to ensure vulnerable or marginalised residents are not deterred from accessing care. Presenters pointed to the ICB's role within community safety partnerships and violence-reduction boards in each local authority area as the main current mechanism for reaching at-risk groups.

## **6.5 Resilience and protective factors**

- 6.5.1 The Chair asked whether any programmes build resilience in children exposed to adverse experiences, rather than focusing solely on preventing or responding to harm. Presenters and members pointed to the protective value of a single trusted adult relationship (a teacher, youth worker or health visitor), to mental health support teams already established in schools, and to early-help provision under the social care reforms - while noting the well-documented "care cliff" faced by young people leaving the care system without an equivalent support network.

## **6.6 The role of the voluntary and community sector**

- 6.6.1 Discussion turned to the contribution of voluntary and community organisations. The Prince's Trust was raised as an example, with members noting its reach tends toward more engaged young people, while organisations such as the Newcastle United Foundation were cited as reaching more deprived and disengaged communities through sport and informal contact. Presenters agreed the sector's reach extends well beyond statutory services, but noted that short-term, time-limited grant funding undermines the certainty and stability these organisations need to sustain that reach.

## **7. Actions and follow-up**

- Continue strengthening the internal links between safeguarding intelligence, contracting and commissioning decisions, including through the planned health network meeting with providers.
- Review current processes and training against the Supreme Court's June 2026 deprivation-of-liberty judgment, given the removal of the previous "acid test" and the resulting grey areas.
- Continue the planned move from four child death review panels to one, for improved compliance with national guidance.
- Strengthen how the Safeguarding Assurance Group reports to the Board - covering governance, risk, actions and evidence - so that assurance becomes more visible through the ICB's own structures rather than relying primarily on partner reporting.
- Consider how commissioning intentions can more explicitly reflect safeguarding-identified gaps, including primary care support for disclosure of domestic abuse and parental mental ill health.

## **8. Closing note**

- 8.1 Members thanked the presenters for a session judged unusually accessible and engaging for a mandatory training topic. The session closed with a brief introduction to the day's third and final item - a briefing on all-age continuing healthcare, described in the Part 1 note as one of the Board's most challenging current areas.