# TOPIC ASSURANCE REPORT

| REPORT DETAILS | |
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| **Topic** | **Safeguarding unborn Babies and Children** |
| **Topic Lead** | Nicole Mitchell<br>Strategic Lead and Named Nurse for Safeguarding Children |
| **Exec Lead** | Hayley Peters |
| **Governance Link support** | Lincoln Andrews |
| **QAG meeting date** | October 2024 |
| **Period covered** | April 2023 – March 2024 |
| **Previous level(s)** | **BLUE** |
| **Specialist / oversight group** | Safeguarding Committee |

| ASSESSMENT |
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| **Recommended level** |
| **Acute (MPH/YDH) Community, MH&LD services** |
| **BLUE** |
| **Recommendation(s) for QAG follow-up**<br><br>Quality improvement and assurance:<br>• Review/update of Child Not Brought SOP and re-audit (January 2025)<br>• Development of a *Management of Children involved in Serious Youth Violence SOP* (Autumn 2024)<br>• Consistent approach to Child Protection Medicals across the Trust<br>• Improvement in pre-birth communication across the Health System<br>• Mitigation for multiple recording systems within SFT until Somerset and Dorset have one Electronic System in 2027 |

| TOPIC SCOPE AND OVERSIGHT | |
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| **Scope of the topic** | The scope of this report includes unborn babies, although they are not recognised in UK law, and children, a person under the age of 18 years, and extends across the safeguarding continuum from early intervention/help to child protection.<br><br>Safeguarding unborn babies and children involves a broad range of interrelated workstreams and initiatives enabling Somerset NHS Foundation Trust (SFT) to protect children's right to live in safety, free from abuse and neglect; to protect children from maltreatment and prevent the impairment of children's health and development; to work with other organisations to prevent and stop the risks and experience of abuse or neglect in line with the: |

- Children Act (1989) which established the legal framework for the protection and welfare of children in England and Wales. It sets out the duties and responsibilities of local authorities', health professionals, courts, parents, and other agencies in relation to children. The act includes provisions relating to child protection, adoption and the provision of services for children in need.
- Children Act (2004) which built on the framework established by the 1989 Act and introduced several new provisions. These included establishment of the children's commissioner for England and required local authorities to cooperate in the interests of children.
- Intercollegiate Document (2019) working in accordance with the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff. This framework outlines five levels of competence (one being the lowest level and five the highest) and indicates the job roles that require the different levels of training.
- Working Together to Safeguard Children (2023). Locally this includes working with the Integrated Care Board (ICB) and Somerset Safeguarding Children Partnership' (SSCP).
- Overarching' SFT Safeguarding and Protection of Unborn babies and Children Policy (2021)
- Obligations set out in the NHS England and Somerset Integrated Care Board (ICB) contract.

**Limitations**

The confidence and competence of SFT staff in safeguarding unborn babies and children depend on adherence to Trust Policy, including compliance with mandatory training, safeguarding supervision, and the use of expert advice from the Safeguarding Advisory Service. According to the Intercollegiate Document (2019), annual appraisals are essential to assess and maintain the necessary knowledge, skills, and competence. A revised edition of this document is expected in December 2024.

**Any specifics on which aspects of the organisation are covered (the default being all services throughout the whole organisation)**

All staff who come into contact with children and young people have a responsibility to safeguard and promote their welfare and should know what to do if they have concerns about safeguarding and child protection issues. This is supported by all SFT staff mapped to the appropriate level of training commensurate to their role and responsibility as per the Intercollegiate Document (2019) working in accordance with the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff.

**Any specific arrangements addressing individual areas.**

**CHILD SAFEGUARDING PRACTICE REVIEWS (CSPR)** learning from significant events, including best practices, workstreams, and initiatives, is driven by evidence-based practice and insights gained from national policy, as well as national and local Child Safeguarding Practice Reviews (CSPRs), significant events, and excellence reporting. Somerset contributed to one CSPR in Birmingham during the reporting period,

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| | focusing on joint learning around siblings, particularly highlighting 'Hidden Children,' the definition of a 'welfare check,' and cultural sensitivity (unpublished). Another CSPR will be conducted in the next reporting period following an unexplained injury in Somerset where a baby tragically died, with the aim of gaining multiagency learning. Overall, there has been a reduction in the number of CSPRs, likely due to the National Child Safeguarding Practice Review Panel's (NCSPRP) changes in criteria and the increased focus on addressing learning within local safeguarding partnerships in a timely manner."<br><br>During the reporting period the Safeguarding Advisory Service participated in 12 SFT internal Rapid Review meetings which identified single and multiagency learning where a child(ren) and young people suffered harm. In addition, SFT contributed to three Somerset Safeguarding Children Partnership (SSCP) Rapid Reviews, two relating to unexplained injuries to children 0-1 year and one relating to death of a teenager. Three non-statutory SSCP learning reviews included learning for SFT and the wider partnership which focused on a thematic analysis of multi-agency practice in response to of Serious Youth Violence, missed opportunities to safeguard a vulnerable teenager and an infant who suffered an unexplained injury including Child Sexual Abuse.<br><br>Whilst the overarching theme within SFT and the SSCP learning reviews was unexplained injury (non-accidental injury (NAI), there is an increase in Somerset in respect of learning around serious incidents considering older children at risk of exploitation and risk outside the home, with children often missing or excluded from school, non- fatal strangulation and neglect. During the reporting period SFT Primary Care Dental Services contributed to a non-statutory Dorset BCP Rapid Review involving a teenager who required multiple teeth extraction and multiple fillings in his adult teeth. This case raises concerns about missed opportunities, earlier intervention and systemic issues about the impact of the COVID-19 Pandemic and a lack of dental provision in the UK. Learning was realised across Dorset and Somerset in terms of timely and coordinated responses in the care and treatment for children with neurodiverse conditions.<br><br>**Maternity**<br><br>Six of the SFT rapid reviews identified learning for Maternity. The Named Midwife is working with the Maternity Senior Leadership Team to formulate a thematic action plan in response to learning from recent reviews. Themes included responding to domestic abuse, lack of professional curiosity, timing and frequency of ICON discussion, identifying and responding to missed antenatal care (child not brought), Badgernet clinical recording system, safeguarding processes and information sharing with Primary Care GP and Public Health Nursing.<br><br>**Outline any topic-relevant links to strategy or other high-level Trust objectives.**<br><br>The themes identified within the reporting period continue to align with SFT Safeguarding Advisory Service strategic priorities informed by national learning and will continue to be a focus for safeguarding and protection of unborn babies and children throughout 2023-2026. These priorities seek to gain assurances that the safeguarding arrangements across the Trust are effective in helping to keep children safe. |

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| | **The overarching key priorities are Prevention and Early Intervention** with an emphasis on identifying and responding to concerns at the earliest possible stage, promoting a collaborative approach that puts children at the center, Working Together to Safeguard Children (2023).<br><br>**Early Help**, **Hidden Children** and **Transition** are key areas of focus that have been identified as requiring increased understanding and a safeguarding response supported through:<br>• A culture of creativity, innovation and learning,<br>• Quality improvement,<br>• Compassionate Leadership<br>• Partnership working,<br>• Evidence-based practice,<br>• Equality, diversity, and inclusivity to improve care quality, satisfaction and safety. |
| **Reporting Structure/ Specialist Group oversight** | **For Safeguarding Service assurance framework and governance structure (See Appendix 1).**<br><br>The Safeguarding Committee (SC) is a formally constituted assurance committee providing operating, reporting and oversight within the Trust's integrated governance structure and reports to the Quality Assurance Group as part of the Trust's assurance framework. The committee meets quarterly.<br><br>The SC has delegated authority from the Trust Board to oversee and monitor the Safeguarding of Adults, Children and Young People, Domestic Abuse, Prevent, MAPPA and MCA and DoLs arrangements for the Trust and to ensure that all safeguarding functions are embedded in the governance structures of the organisation.<br><br>The Committee has the authority to request information of relevance to its remit and to require the co-operation of all colleagues associated with achieving its purpose and responsibilities.<br><br>Additional reporting / assurance mechanisms:<br>• Weekly Named Professional Meetings<br>• Monthly Senior Leadership Team meetings<br>• Monthly submission to the Integrated Care Board (ICB) via their Safeguarding Dashboard<br>• Quality improvement workstreams and significant event reporting and collaboration with Somerset Safeguarding Children Partnership.<br>• Yearly to the Quality and Governance Assurance Committee<br><br>Success within the operating the reporting and oversight structure includes co-design and oversight of SFT Safeguarding Policy and Process, significant events and Service quality planning, assurance and improvements. |

| **COMPLIANCE REQUIREMENTS** | |
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| **Regulation** | The CQC has five Fundamental Standards, these being Safe, Effective, Responsive, Caring, Well-led. Safeguarding Compliance Standards: |

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| **CQC Fundamental Standards** | **Regulation 13: Safeguarding service users from abuse and improper treatment.**<br><br>Summary from the regulation:<br><br>"Providers must have robust procedures and processes; to prevent people using the service from being abused by staff or other people they may have contact with when using the service, including visitors. Abuse and improper treatment include care or treatment that is degrading for people and care or treatment that significantly disregards their needs or that involves inappropriate recourse to restraint. For these purposes, 'restraint' includes the use or threat of force, and physical, chemical or mechanical methods of restricting liberty to overcome a person's resistance to the treatment in question".<br><br>"Where any form of abuse is suspected, occurs, is discovered, or reported by a third party, the provider must take appropriate action without delay. The action they must take includes investigation and/or referral to the appropriate body. This applies whether the third party reporting an occurrence is internal or external to the provider".<br><br>Within the incoming CQC Single Assessment Framework, a new quality statement features as part of the provider commitments under the Safe domain:<br><br>*'We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.'*<br><br>The work of the Safeguarding Advisory Service and the ethos for safeguarding throughout the Trust align with these core aims. |
| **Legislation** | **Primary legislation relating to Safeguarding Unborn Babies and Children is as follows:**<br><br>• Children Acts (1989 and 2004)<br>• Children and Social Work Act (2017)<br>• CONTEST – Counter Terrorism Strategy (2018)<br>• Domestic Abuse Act (2021)<br>• Female Genital Mutilation Act (2003)<br>• Modern Slavery Act (2015)<br>• Serious Crime Act (2015)<br>• Serious Violence Duty (2022)<br>• The Health and Care Bill (2021)<br>• United Nations Convention on the Rights of the Child (UNCRC) is an international human rights treaty that grants all children and Young People (aged 17 and under) a comprehensive set of rights. The convention has 54 articles in total. Articles 43-54 are about how adults and governments must work together to make sure all children can enjoy all their rights. The UNCRC is supported by legislation that underpins implementation in England. |

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| **National Guidance**<br><br>**Assessment or accreditation** | • Child Abuse and Neglect (NG76) (2017)<br>• Domestic violence and abuse multi agency working (PH 50)<br>• Every Child Matters (2004 and 2015)<br>• Harmful Sexual Behaviour (NG66) 2016<br>• Intercollegiate Document (2019) Safeguarding Children and Young People: Roles and Competencies for Health Care Staff<br>• NICE guidelines (CG89) When to suspect child maltreatment 2009.<br>• NICE QS 116 Domestic Violence and Abuse<br>• RCPCH guidance Perplexing Presentations (PP)/ Fabricated or induced Illness (FII) in Children 2021<br>• RCPCH Physical Signs of Child Sexual Abuse (Purple Book)<br>• RCPCH Safeguarding Document 2006<br>• Working Together to Safeguard Children (2023), a guide to inter-agency working to safeguard and promote the welfare of children. |

## INTERNAL ASSURANCE – Summary information generated within the organisation

| Assessing guidance and measuring the topic internally | |
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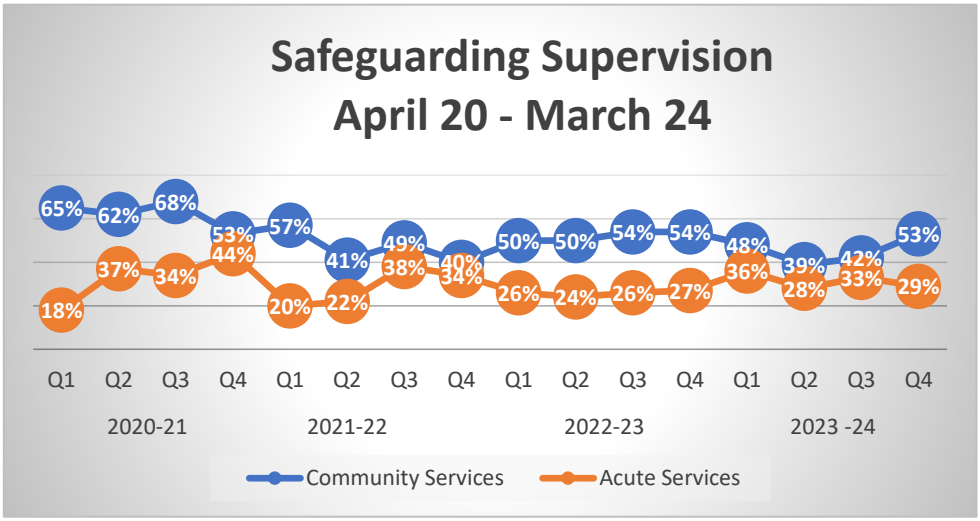
| **Self-Assessment of national guidance implementation** | **Summary of relevant assessments of compliance against national standards/guidance such as listed in the section above titled 'National Guidance / Assessment frameworks**.<br><br>Safeguarding unborn babies and children practice is supported by safeguarding children training and safeguarding supervision to reflect the Intercollegiate Document (2019) working in accordance with the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff. In addition, the Trust's Safeguarding Advisory Service Duty Team provide advice and guidance via a single point of contact (SPOC) and review all children's records (safety net), who present in the Emergency Department's at MPH and YDH.<br><br>Risk is assessed to support decision making in line with the SSCP Effective Support for Children and Families in Somerset Guidance, trust policy and guidance in line with SSCP and the Southwest Child Protection Procedures (SWCPP). SFT staff request Children Social Care (CSC) involvement using an Early Help Assessment (EHA) or undertake verbal referrals e.g. ED departments when unborn babies and/or children are at risk of or have suffered harm i.e., physical, emotional, sexual and domestic abuse and/or neglect. Where there are professional differences that impact risk and decision making the SSCP Resolving Professional Differences Protocol is enacted.<br><br>**Child Abuse and Neglect** (NG76) (2017)<br>SSCP Section 11 Audit (see audit section). Safeguarding and Protection of Unborn Babies and Children Policy. Training (see training section) and safeguarding supervision, compliance data is shared with the ICB on a monthly or three-monthly basis.<br><br>Section 11 of the Children Act 2004 requires effective systems to |

safeguard and promote the welfare of unborn babies and children and support for practitioners who work with children and families; this includes "effective supervision and monitoring". Safeguarding Supervision supports a blended approach to training compliance as per the Intercollegiate Document (2019). Lack of effective Safeguarding Supervision (SGS) is a reoccurring theme in Child Safeguarding Practice Reviews (HM Government, 2022). SGS is identified by the Royal College of Nursing (2019) as any form of conversation or support received in relation to safeguarding children, to improve professional practice and mediate against emotional labour (Appleton and Peckover, 2015). Wallbank and Woods (2012) following a mixed-method systematic review of 12 publications, 11 in the UK and one in Sweden following PRISMA screening of 2185 records, identified SGS moving away from a management surveillance tool (Rowse, 2009), with a 'softer' restorative function capitalising on patient and staff psychological safety through reflexivity (O'Neil *et al.,* 2022).

**Graph 1. Safeguarding Supervision compliance data year on year**




The Safeguarding Advisory Service offer all trust staff who work with unborn babies, and children Safeguarding Supervision.

By the end of the reporting period compliance was similar to that of the previous reporting period, however, remains below the mandated compliance of 85%. Therefore, 59% (n=880) eligible staff do not access Safeguarding Supervision regularly. The impact of the merger may have contributed to an initial drop in compliance with the Safeguarding Advisory Service struggling to meet the demands of wider and more diverse services. To mitigate lower compliance rates, increased access to resources has been made available through the Safeguarding intranet page, which includes 7-minute briefings. Additional support includes ED safety netting, direct communication with Paediatric ward staff at MPH and YDH Hospitals from Monday to Friday, and access to the Safeguarding Advisory Service Single Point of Contact (SPOC) via telephone and email. The introduction of Safeguarding Clinics also provides 'real-time' support and advice throughout the week.

**Intercollegiate Document** (2019) Safeguarding Children and Young People: Roles and Competencies for Health Care Staff. During the

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| | reporting period the Strategic lead and Named Nurse for Safeguarding Children and Learning and Development lead completed re-mapping of all staff who work with unborn babies, children their families and carers. Training and Safeguarding Supervision compliance data is shared with the ICB supporting SFT Safeguarding KPI's, contractual obligations in line with Safeguarding: Standards for Health Service Providers 2023-2024 Schedule 2 part K.<br><br>**Every Child Matters** (2004 and 2015)<br>Safeguarding and Protection of Unborn Babies and Children Policy, training and Safeguarding Supervision compliance data is shared with the ICB. Monitoring of staff contacts with the Safeguarding Advisory Service.<br><br>**Harmful Sexual Behaviour** (NG66) (2016)<br>Safeguarding and Protection of Unborn Babies and Children Policy, training and safeguarding supervision compliance data is shared with the ICB.<br><br>**NICE guidelines (CG89) When to suspect child maltreatment** (2009).<br>Safeguarding and Protection of Unborn Babies and Children Policy, training and safeguarding supervision compliance data is shared with the ICB. SSCP Section 11 Audit.<br><br>**NICE QS 116 Domestic Violence and Abuse and Domestic violence and abuse multi agency working (PH 50)**<br>Domestic Abuse Policy. Compliance data is shared with the ICB.<br><br>**RCPCH guidance Perplexing Presentations (PP)/ Fabricated or induced Illness (FII) in Children** (2021)<br>Safeguarding and Protection of Unborn Babies and Children Policy, training and Safeguarding Supervision compliance data is shared with the ICB.<br><br>**RCPCH Physical Signs of Child Sexual Abuse** 2015 (Purple Book)<br>All acute Child Sexual Abuse (CSA) cases are undertaken by The Bridge - our regional centre of expertise for CSA. All SFT doctors undertaking historic cases of CSA are compliant with current guidance and attend Peer Review at the Bridge on a regular basis.<br><br>**RCPCH Safeguarding Document** (2006)<br>Safeguarding and Protection of Unborn Babies and Children Policy, training and paediatric departmental Peer Review.<br><br><u>YDH Peer Review</u> - eight sessions offered with 24 cases discussed.<br><br><u>MPH Peer Review</u> – eight sessions offered with 29 cases discussed.<br><br>Total cases discussed increased by five compared to the last reporting period.<br><br>Peer review is a reflexive opportunity considering findings from child protection medical assessment to support learning facilitated by the Trust Named Doctor for Safeguarding Children/ Designated Doctor for the ICB or a senior Paediatric consultant. Compliance with Safeguarding training and supervision is integral to medical staff appraisals. All Child Protection Medical Examination reports are quality assured by the Trust Named |

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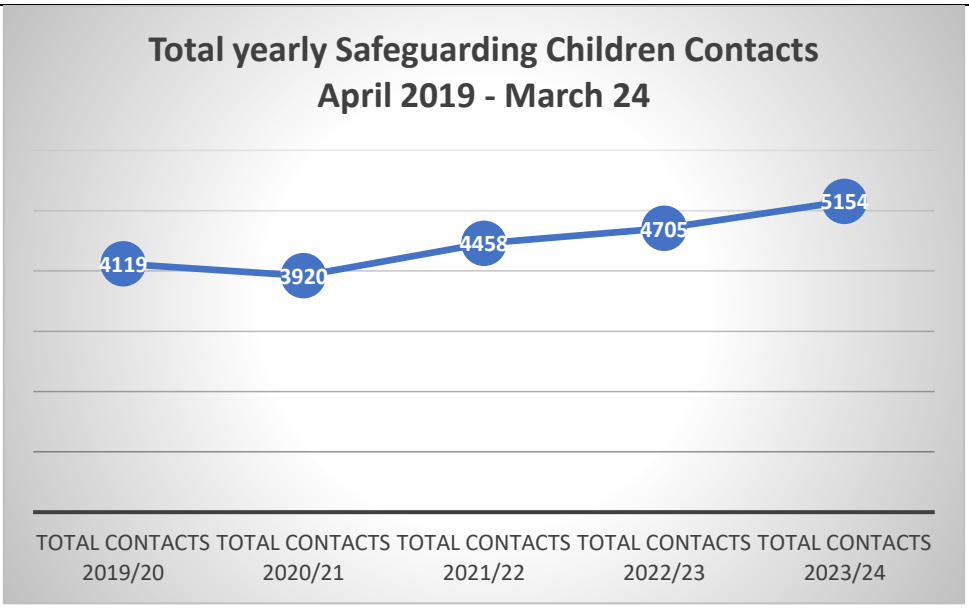
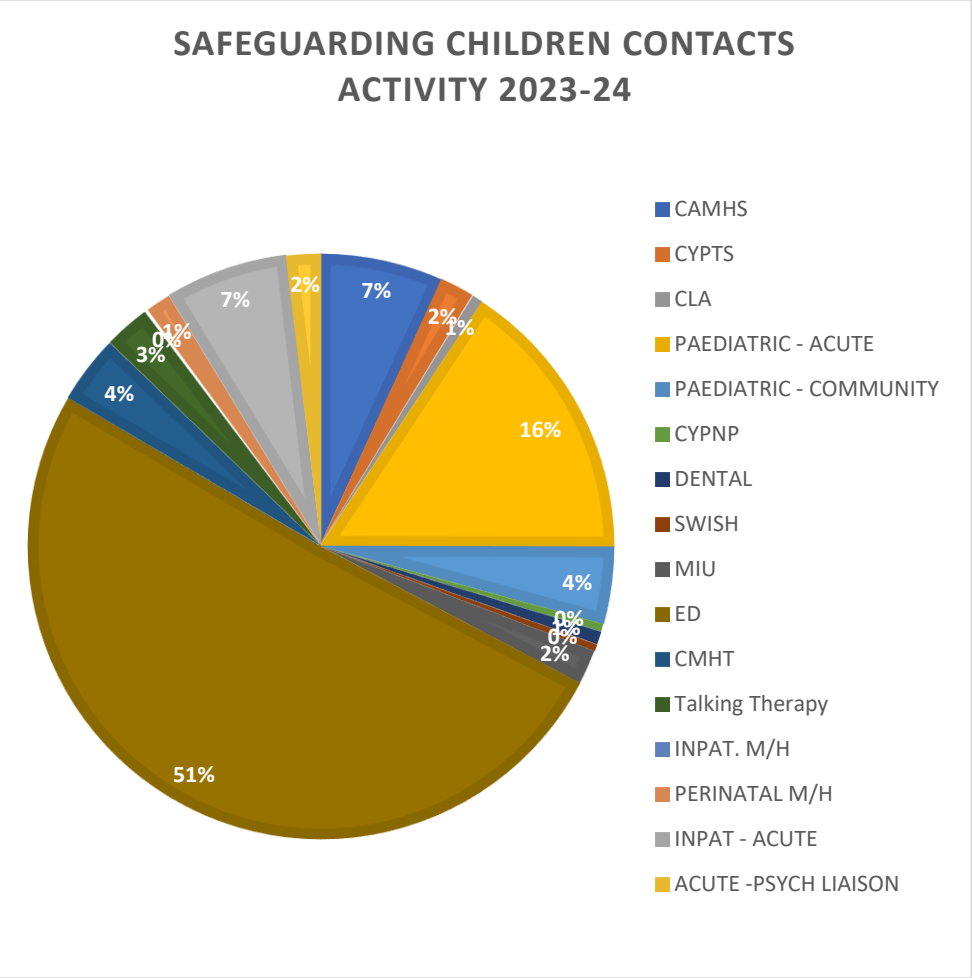
| | Doctor for Safeguarding Children. As part of quality improvement measures Paediatric staff across MPH and YDH will have joint peer review sessions moving forwards, every four months.<br><br>**Working Together to Safeguard Children (2023**), a guide to inter-agency working to safeguard and promote the welfare of children sets the framework for compliance. This includes adherence to the Safeguarding and Protection of Unborn Babies and Children Policy, training and Safeguarding supervision compliance data shared with the ICB. Monitoring of staff contacts with the Safeguarding Advisory Service. Multi-agency quarterly audit of Early Help Assessments requesting Children Social Care involvement, Strategy Discussion and MASH participation, reports completed for Court and SSCP Section 11 Audit findings. |
| **Audit and Measurement – key findings** | **AUDIT AND MEASUREMENT KEY FINDINGS**<br><br>**SAFEGUARDING CHILDREN (SGC) ACTIVITY**<br><br>Data collection and analysis of safeguarding activities undertaken by professionals working with unborn babies, children, and their parents or carers, including support from the Safeguarding Advisory Service, is required as part of the CQC Section 7 outcomes. This data is collated weekly using Statistical Process Control, shared via a Safeguarding Service Tactical Dashboard. This supports monthly and quarterly quantitative data submissions to the Integrated Care Board (ICB) as part of the Safeguarding Advisory Service's contractual obligations."<br>Let me know if you'd like any further adjustments<br><br>Unborn baby and children safeguarding activity data is collated referring to a specific service, practitioner, issue/action and outcome. This level of scrutiny has enabled robust monitoring of concerns, action plans, allocation of resources and evidence of impact and assurance. Activity indicators help to plan work streams supporting services who are intense users and seeking out services who would benefit from additional support with their safeguarding practice.<br><br>**Graph 2. Year on Year Safeguarding children activity (excluding maternity)** |




Review of data indicates the level of safeguarding activity related to unborn babies and children has increased over the last year by over 449 contacts compared to 2022-2023. This may be accounted for by robust data collection across the trust following the merger, alongside bespoke Safeguarding Training and Safeguarding Supervision over the last four years which has led to an increased awareness of safeguarding and child protection across the trust and reflecting a national picture of increasing multi-agency safeguarding activity. However, quantitative data does not reflect the complexity of safeguarding practice impacted by the legacy of the COVID pandemic and the cost-of-living crisis.

**Graph 3. Breakdown and analysis of contacts throughout the reporting period.**




Activity in Quarter 1 included quality assurance of unborn baby/Child Protection - Acute needs - Early Help Assessments (EHA's) requesting Children Social Care involvement. To meet increasing demand for support and advice the Safeguarding Advisory Service no longer quality assure requests for CSC involvement at point of request, however, Named Professionals participate in a multiagency quarterly audit focusing on themes and maintaining effective conversion rates to protect unborn babies, children and vulnerable families.

51% of contacts were accounted for with and from the Emergency Departments (ED) across MPH and YDH (these contacts include review of all children who attend ED by the Safeguarding Advisory Service (SAS) where there are safeguarding concerns), this brings the highest level of activity due to the nature of brief contacts with families in urgent need of medical care. During the next reporting period this process will be enhanced by increased use of electronic clinical systems to support timely response and opportunities for audit and quality improvement.

Acute Paediatric Services and CAMHS are frequent users of the SAS Single Point of Contact as they support families in need of support or where there are child protection concerns.

**MATERNITY - SAFEGUARDING ACTIVITY**

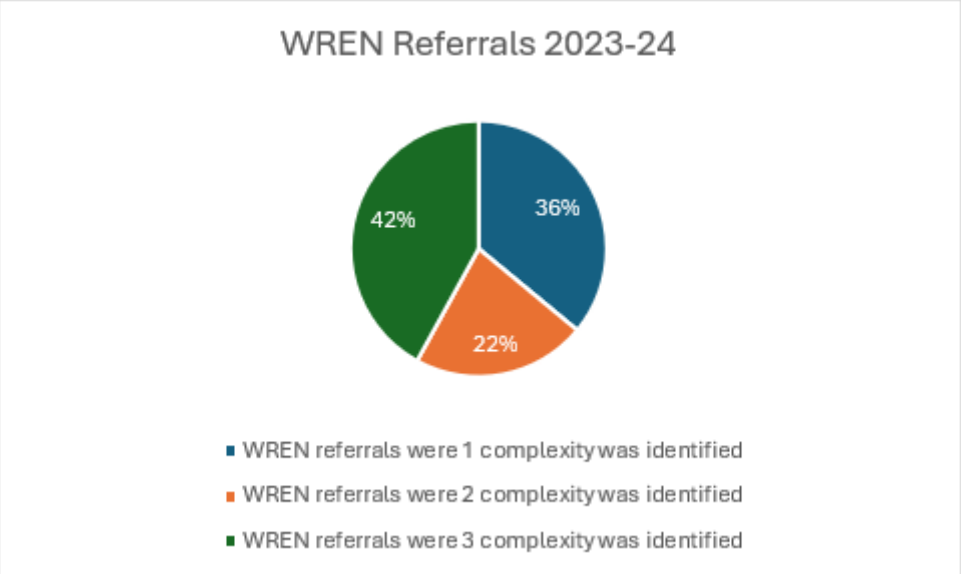
2023-2024 has seen the new Maternity electronic recording system, Badgernet, slowly embed into practice and offers additional support for staff in relation to safeguarding processes.

The number of referrals into (Women Requiring Extra Nurturing) WREN Team where social vulnerabilities were identified has decreased by 17% to 1810 from 2182 in the previous reporting period. Thematic analysis of incidents has identified multiple missed opportunities for referral to the WREN team, this is being addressed by a local action plan.

In contrast, the number of families open to Children Social Care during pregnancy has increased by 21% to 239 from 188, this reflects an increase in the level of social complexity that affects many families in Somerset. Somerset Council data indicates the number of children subject to a child protection plan has risen exponentially in 2023-24 and this is mirrored within maternity data analysis.

Although the number of Wren referrals has decreased, the themes have remained constant, with maternal mental health being a significant factor in 69% of referrals (1257), an increase of 26% compared to the previous year. Maternity services across SFT continue to work closely with Perinatal Mental Health Services, the Maternal Mental Health Team and the Trust Lead Mental Health Midwife, who came into post in December 2023.

**Graph 4. WREN Referrals**




A history of domestic abuse was the second most common social risk factor identified within Wren referrals accounting for 39% of cases (n=705). This includes abuse within a previous relationship or a history of abuse in a current relationship. Increased teaching and support for staff involved in the identification and response to disclosures of domestic abuse is a priority for Maternity Safeguarding identified through learning from incidents. The majority of these were cases occurred out of hours (weekends/nights) when the WREN Team, Named Midwives and Trust Safeguarding Advisory Service were not available, therefore it has been recognised that staff working in clinical settings must be competent in risk and decision making to appropriately safeguard victims of domestic abuse, which includes unborn babies.

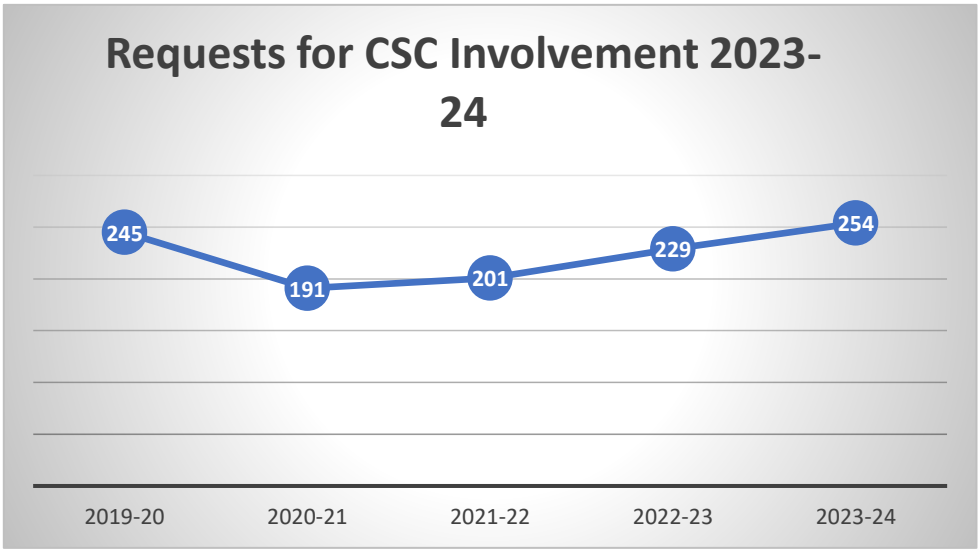
The third most common risk factor identified was previous involvement with CSC 29% (n=521). This includes siblings of the unborn, however, not parents. Maternity staff working with these families are encouraged to seek and share information across the health system and partner agencies to support communication and dynamic risk throughout pregnancy, the intra-partum and post-natal periods.

Data demonstrates, almost half of the WREN referrals completed included women with three or more social vulnerabilities. Lack of previous data does not support comparative quantitative analysis; however, anecdotal evidence suggests women presenting to maternity services with three or more social vulnerabilities has increased, this is reflected in the increase in number of families open to CSC in Somerset.

**CHILD PROTECTION REQUEST FOR CHILDREN SOCIAL CARE INVOLVMENT**

In accordance with the Safeguarding and Protection of Unborn Babies and Children Policy (2021), if unborn babies or children are at risk of or suffering significant harm practitioners can access support for families from Children Social Care (CSC). Whilst there has been an increase in safeguarding activity, requests for involvement have remained consistent with health practitioners increasingly expected to hold risk and work with the Local Authority for example, Family Intervention Service providing Early Help, where previously concerns would have met Statutory Child Services involvement threshold.

**Graph 5. Acute needs Child Protection Early Help Assessments (EHA) requesting involvement from Children Social Care.**

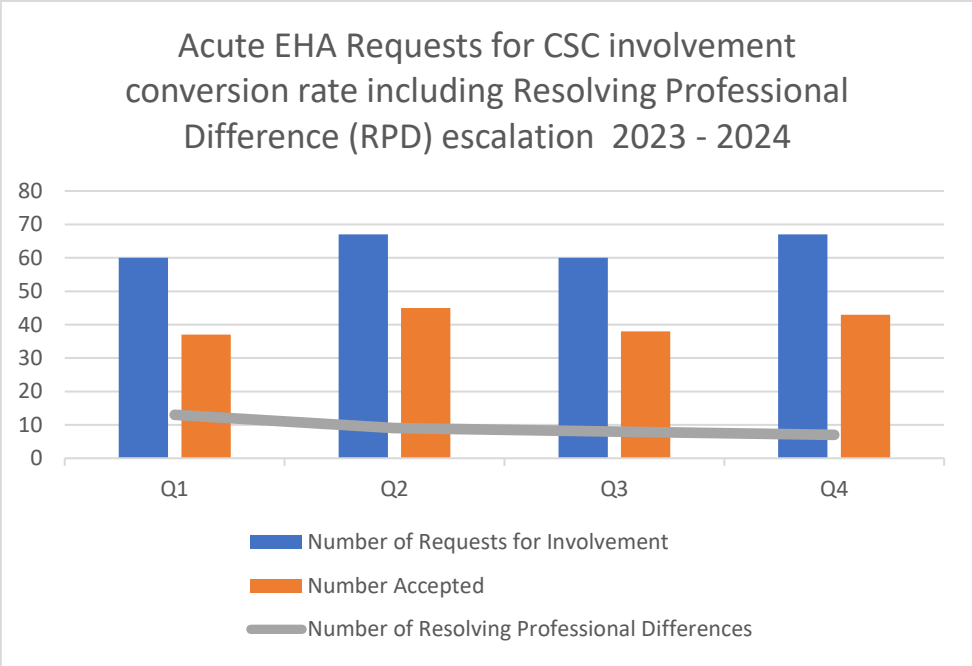



The Safeguarding Service ceased quality assurance of written EHA's requesting CSC involvement in Q2 of the reporting period. This was in response to high workload pressures and to prevent delay in seeking timely support for families. The introduction of Safeguarding Clinics has supported a proactive opportunity to support staff risk and decision making prior to completion of EHA's or when making verbal requests for CSC involvement, i.e. When providing urgent and unscheduled care. This approach has enabled practitioners to be responsible and accountable for

their practice and develop there Safeguarding repertoire encouraging professional curiosity, a trauma informed and 'Think Family' approach.

The quantity and quality of EHA's submitted to CSC requesting statutory involvement is now monitored in quarterly meetings with the Local Authority, measuring for sustainable improvement in line with Somerset Safeguarding Children Partnership Effective Support for Children and Families in Somerset guidance threshold. The number of verbal requests for CSC involvement by ED for example, is not captured routinely, however, quality improvement measures have been supported in collaboration with CSC Emergency Duty Team where staff follow a set of pre-designed prompts to ensure the children's voice is paramount and every contact counts in keeping children safe.

**Graph 6. Acute needs EHA request for CSC involvement conversion rate including Resolving Professional Difference (RPD) escalation.**



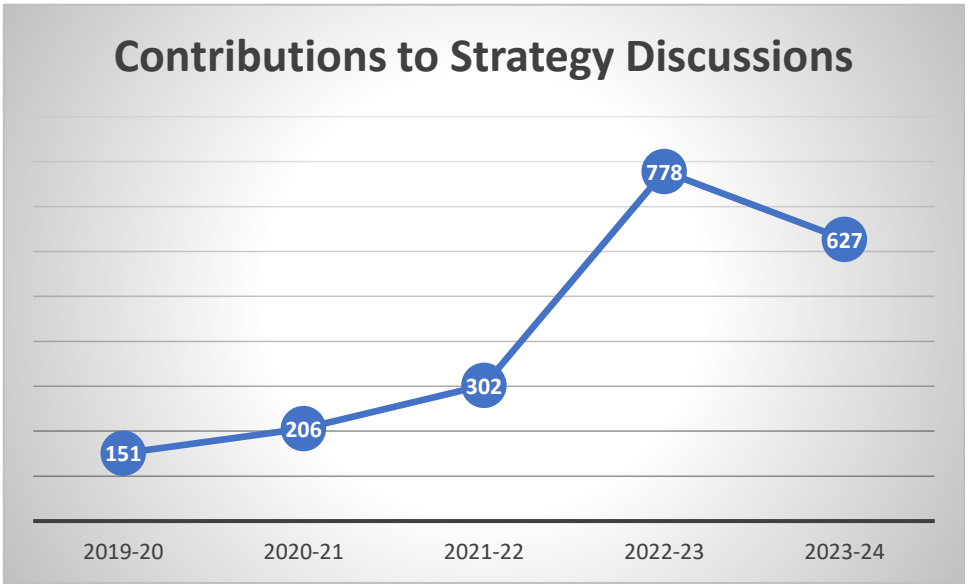

Requests for Children Social Care involvement using the EHA has remained consistent, with an average conversion rate of around or just above 40%. In circumstances where there is professional difference, in terms of CSC involvement, the SSCP Resolving Professional Differences Protocol is enacted through a staged process of discussion between professionals with opposing agency perspectives, to step four accessing support and guidance from the Executive of the SSCP. Of note more RPD's are managed at Step 1 and 2 which makes for improved collegiate working in the long term.

**SECTION 47 STRATEGY DISCUSSIONS**

*Whenever there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm there should be a strategy discussion involving local authority children's social care (including the residential or fostering service, if the child is looked-after), the police, health and other*

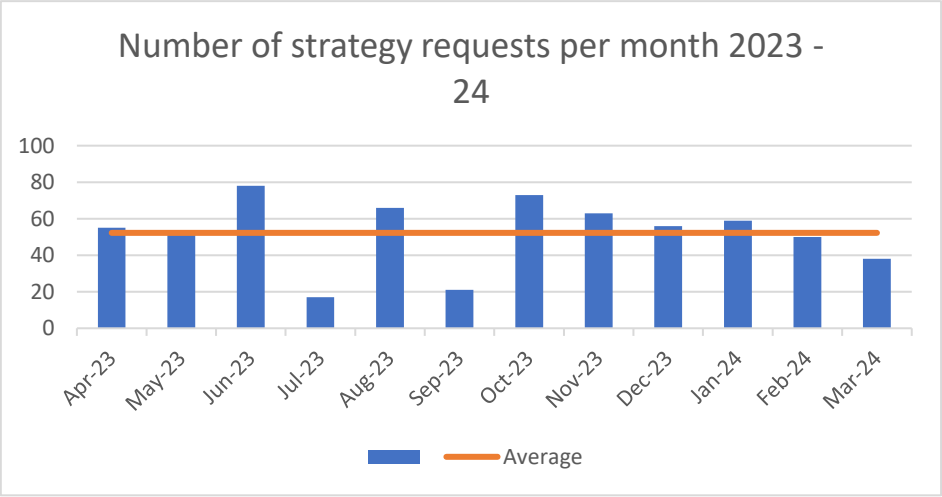
*bodies such as the referring agency. It is for the local authority to decide whether to make enquiries and the strategy discussion should inform this decision. (*Department for Education (2023) Working together to safeguard children*).*

**Graph 7. Strategy attendance - CQC outcome 7**




The Trust continues to support almost 100% of Section 47 Strategy Discussions when invited, providing research and participation. Outside of 9-5 working week, health representation is provided by Trust Paediatricians if there is a relevant health need. Health professionals who are involved with unborn babies, children and families are routinely consulted during the Section 47 enquiry process.

**Graph 8. Shows the number of Section 47 Strategy requests to the Trust's Safeguarding Service between April 2022 and March 2023:**




Section 47 Strategy Discussions in Somerset fell by (n=151) during the reporting period, a decrease of 19.4% with an average of just over 50 Strategy Discussions a month. Whilst there is a reduction, this not always a reflection of multiagency agency understanding of significant harm, as

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| | SFT have noted the main theme of Resolving Professional Difference where there is professional impasse, is in relation to Strategy Discussions not convened despite health request.<br><br>During the reporting period SFT Safeguarding Advisory Service were integral to and/or undertook seven unborn baby/ safeguarding children audits. The 2023-2024 audit plan is determined by the Safeguarding Service, wider Trust and Somerset Safeguarding Children Partnership Priorities.<br><br>Robust audit provides further assurance for SFT and opportunities to understand and influence the Safeguarding agenda across the integrated Care System and included:<br><br>**Somerset Safeguarding Children Partnership Section 11 Audit Self-Assessment 2023-24**<br><br>The Section 11 (Children Act 2004) Audit assesses against the requirements set out in Working Together to Safeguard Children 2023. Throughout the self-assessment, agencies were requested to evidence improved outcomes for children, young people and their families as a result of their arrangements.<br><br>Findings reflected a mostly positive picture around the safeguarding arrangements in Somerset, demonstrating that the partnership is strong and that that single agencies have good safeguarding processes. The areas of particular strength for the partnership are around safeguarding structure and information sharing.<br><br>Key opportunities for development are around listening to the voice of the child, management of allegations, escalation of concerns, and ongoing monitoring of training compliance.<br><br>There is an intention to revisit a Section 11 audit with Peer-workshops in the next reporting period.<br><br>**SSCP SERIOUS YOUTH VIOLENCE AUDIT**<br><br>Outcomes:<br><br>• Assurance from Children's Social Care around other Quality Assurance activity evidencing good quality plans for children.<br>• Assurance from Youth Justice service around work completed to build more robust lines of communication with other agencies when YJ become involved with a child.<br>• Learning shared with Education services to link with work through the Education for Life Strategy aiming to improve school attendance.<br>• Findings informed the formulation of the 2024-26 Somerset Neglect Strategy, including recognition of neglect.<br>• Findings informed the work of the Somerset Trauma Informed Network, a project aiming to coordinate training and learning opportunities and support organisational change towards trauma informed approaches. |

- Audit work has commenced across the health system relating to children not being brought to appointments which will result in a coordinated action plan. (see CNB below audit)
- The SSCP published and disseminated an anonymised good practice example which outlined the positive change achieved for one child to support wider utilisation of the principles.
- The gap between support for mental ill health and complex behaviours has been flagged to the Integrated Care Board for actioning and informing future commissioning.
- In addition, work has commenced to map out Serious Violence Duties across Boards and agencies to ensure clear lines of communication and accountability.

**CHILD NOT BROUGHT AUDIT**

**Aim**

This Audit was undertaken over a three-month period (January – March 2023) in response to development of Trust(s) wide **Non-Attendance (Child not Brought) No Response SOP**, learning from significant events when children were not brought to appointments. In addition, the audit contributed to understanding of current practice as a merged trust and the lived experience of children with health needs who are not brought to appointments.

The Audit included a review of no more than 10 child clinical records from each of the 99 teams audited, total (n=672), where services provide care to children across Somerset NHS Foundation Trust.

**Findings**

There appears to be lack of understanding currently of CNB and actions required by Trust staff. The main area for improvement when a Child is not brought (CNB) is the need for accurate, robust and contemporaneous documentation. Until this occurs it is unlikely, we can be assured practitioners are concordant with the CNB SOP and its intention to safeguard children and young people.

The study sample was chosen randomly, however, Children Looked After (CLA) were **over 13 times** more likely not to be brought to appointments.

There was evidence of some compliance with standards, however no Standard was fully met despite consideration of potential limitations of the tool. Such as, the tool did not include if child/young person was already known to Children Social Care (only new referrals this may have impacted findings). The tool did not incorporate where discharge letters were sent to families and no practitioners or agencies were included. Only Electronic Clinical Records were reviewed for the purpose of the audit due to large cohort/sample.

**SUMMARY OF RESULTS**

The Audit Proposer set the target compliance per standard prior to data collection. Any standard falling short of this target level is addressed in the Key Areas for Improvement and considered for inclusion in the action plan.

**Table 1. RESULTS**

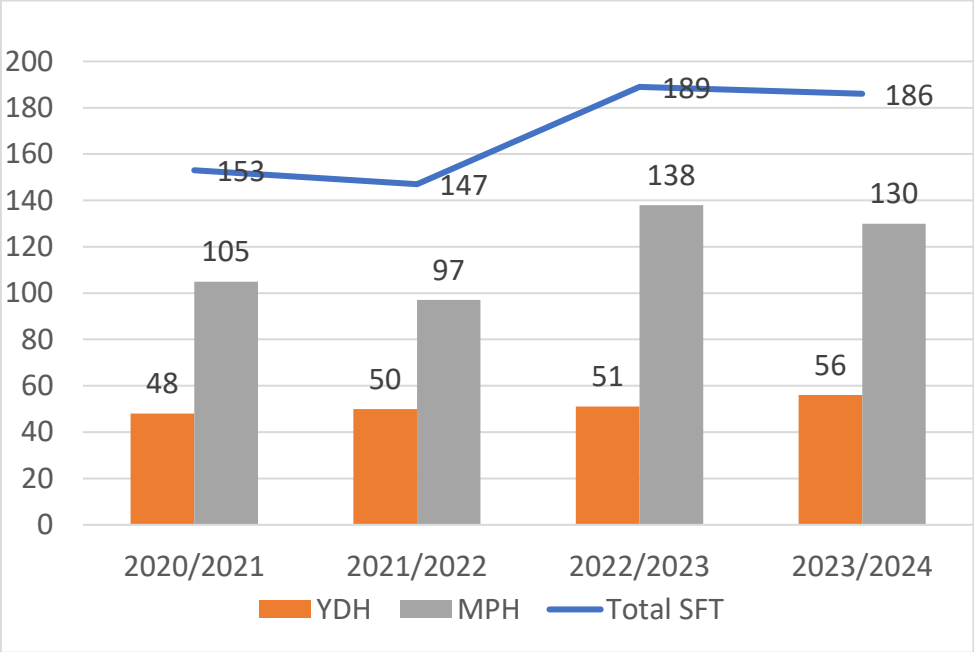
| | **STANDARDS** (all taken from the Trust Non-Attendance (Child not Brought) No Response SOP) | **EXCEPTIONS** | **TARGET COMPLIANCE** | | | **Compliance:** |
|---|---|---|---|---|---|---|
| | | | **%-%** (Red) | **%-%** (Amber) | **%-%** (Green) | |
| 1 | In all cases of CNB, family details (including address and contact number) should be checked to ensure they are correct. | None | < 70 | 70-84 % | ≥85 % | **43%** (288/672) |
| **Child not brought for neonatal screening (n=0):** | | | | | | |
| 2 | Child Health Information Services should be informed at first non-attendance. | None | < 70 | 70-84 % | ≥85 % | N/A, no cases |
| **First appointment for new patients, no safeguarding concerns identified (n=141):** | | | | | | |
| 3 | GP should be contacted to discuss clinical need for appointment | None | < 70 | 70-84 % | ≥85 % | **23%** (32/141) |
| 4 | Second Appointment offered if not brought and discharged with letter to GP and PHN. | | | | | **0%** (0/141) |
| **First appointment for new patients, safeguarding concerns identified (n=40):** | | | | | | |
| 5 | GP should be contacted regarding clinical need for appointment | None | < 70 | 70-84 % | ≥85 % | **13%** (5/40) |
| 6 | Safeguarding Service should be consulted | | | | | **10%** (4/40) |
| 7 | Referral to Children Social Care to be considered | | | | | **15%** (6/40) |
| **Child known to services, no identified safeguarding concerns (n=385):** | | | | | | |
| 8 | Clinical needs should be considered | None | < 70 | 70-84 % | ≥85 % | **51%** (198/385) |
| 9 | Second Appointment offered if not brought and discharged with letter to GP and PHN. | | | | | **0%** (0/385) |
| **Child known to services, safeguarding concerns and/or clinical needs indicate (n=106):** | | | | | | |
| 10 | Safeguarding Service should be consulted. | None | < 70 | 70-84 % | ≥85 % | **11%** (12/106) |
| 11 | Referral to Children Social Care to be considered | | | | | **19%** (20/106) |

**Recommendation**

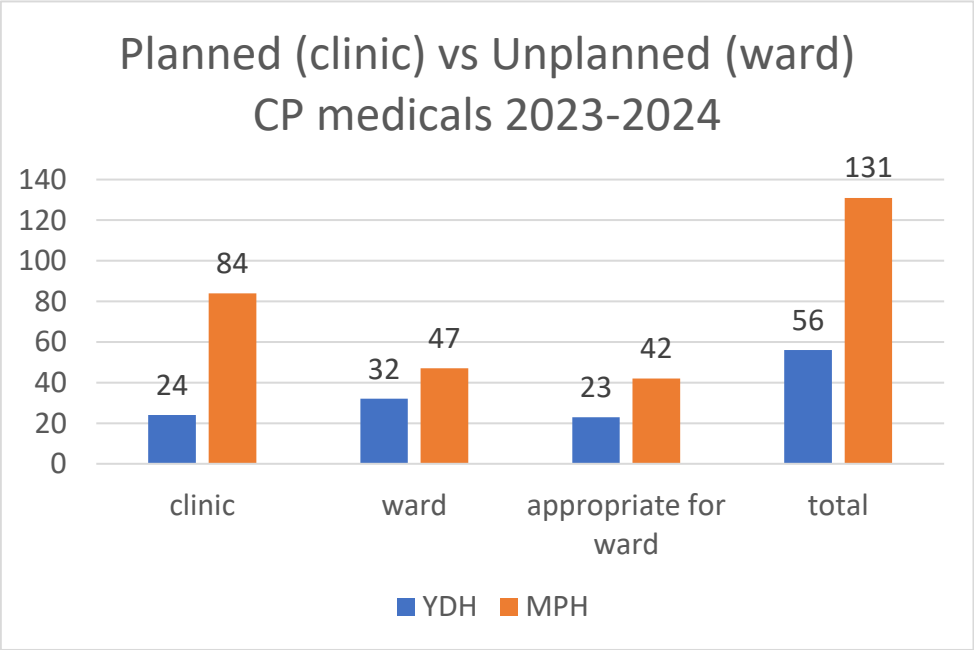
In response to these findings, an Action Plan has been implemented, which includes a revision of the CNB SOP to clarify the responsibilities and accountability of both the receiving service and the referrer. A re-audit is scheduled for January 2025.

**CHILD PROTECTION MEDICALS -** Safeguarding Clinics 2023-2024

**Graph 9. Number of children seen year on year for CP medicals**




**Graph 10. Planned (clinic) vs Unplanned (ward) CP medicals 2023-2024**




68% of unplanned ward admissions were necessary; however, 32% of admissions for Child Protection (CP) could have been managed in clinic

(MPH). As part of our quality improvement efforts, we are establishing Child Protection Clinics at YDH in the next reporting period.

**RCPCH guidance advises that all acute safeguarding cases need assessment within 24hrs and a Section 47 Strategy Discussion to decide upon the need for a child protection medical.**

**Findings during the reporting period**

- In 80% of cases a Strategy Discussion was convened prior to a Child Protection Medical
- 17% there was a telephone call to the Children Social Care emergency team
- 3% of cases there was no Strategy Discussion before the Child Protection medical

**AUDIT OF THE COMPLETION OF PARENTING OBSERVATION FORMS IN MATERNITY**

**Aim**

The purpose of the audit was to evaluate whether maternity staff were competent in completing formal parenting observations as directed by the safeguarding birth plan to support dynamic risk assessment.

**Findings**

The audit highlighted that patient demographics were documented correctly, observation forms were initiated promptly, forms were completed once per shift, and all sections were filled out. However, concerns not being escalated appropriately, along with incomplete relevant documentation needs improving.

**Recommendation**

It was identified that staff require further support to be competent and confident with dynamic risk assessment and is further supported in hospital Safeguarding Supervision and maternity mandatory training. This audit will be repeated in the next three years

**MATERNITY COMMUNICATION SOP AUDIT**

**Aim**

This audit was completed to understand the use of the maternity communication SOP (updated and relaunched in January 2023). The purpose of the SOP is to ensure that GPs, Midwives and Health visitors share risk information on receipt of a maternity booking form.

**Findings**

Poor evidence of risk assessment and information sharing between GPs, Midwives and Health visitors on receipt of the maternity booking form.

| | |
|---|---|
| | As a result of these findings, an Action Plan is in place with a re-audit planned. |

| **Policy and assurance of meeting policy standards** | |
|---|---|
| **Policy and review status** | The Trust has the following current policy, procedures and processes in place to Safeguard and protect unborn babies and children.<br><br>• Assessment of Gillick Competence and the use of Fraser Guidelines<br>• Child Protection Information System (SOP)<br>• Children who are in Hospital more than three months (SOP)<br>• Court procedures for Safeguarding Unborn Babies and Children (SOP)<br>• Disclosures of Alleged Non-Recent Abuse<br>• Domestic Abuse Policy<br>• Femail Genital Mutilation (SOP)<br>• Investigations of Suspected Physical abuse in Children (SOP)<br>• Management of Children with concerns regarding Factitious or induced illness (SOP)<br>• Managing allegations against staff that constitute Safeguarding concerns for Patients (SOP)<br>• Maternity Safeguarding Standard Operating Procedure (SOP)<br>• Non-attendance (Child Not Brought) No Response (Did not attend) (SOP)<br>• Prevent: Safeguarding from Radicalisation Policy.<br>• Safeguarding alert and significant events (SOP)<br>• Safeguarding Children and Young People from Exploitation Policy<br>• Safeguarding Supervision Policy<br>• Safeguarding and Protection Unborn Babies and Children Policy (2021) – review date – 2024 (in progress)<br>• Sexual Assault Disclosure Protocol<br>• Somerset Safeguarding Children Partnership (SSCP) Effective Support for Children and Families Guidance<br>• SSCP Resolving Professional Differences Protocol<br>• SSCP Under 13 TOP Policy<br>• Strategy Discussion SOP |
| **Monitoring policy compliance** | **Safeguarding and Protection of unborn Babies and Children Policy (2021)**<br><br>Element of policy for monitoring / Monitoring method / Item Lead / Monitoring frequency / Arrangements for responding to shortcomings and tracking delivery of planned actions<br><br>Assurance that policies, SOPs and processes are safe / Annual audit of safeguarding or child protection process when / Safeguarding Service / Annually / Review by Named Professionals in conjunction with Director of |

| | | | | |
|---|---|---|---|---|
| | a Safeguarding/ Child Protection concern has been identified this audit will include a review of the guidance, advice and process undertaken | | | Safeguarding reporting to the Trust Integrated Safeguarding Committee (SC) |
| Untoward event and incident reporting | All untoward incidents should be recorded and investigated within the relevant incident reporting processes (is guidance reflected in Practice | All untoward incidents should be recorded and investigated within the relevant incident reporting processes (is guidance reflected in Practice | Responsive to Radar alert and incident reporting information | Senior Leads within Safeguarding Advisory Service Reporting to the SC Information from this process will be incorporated in training and Safeguarding Supervision |
| Training and competencies requirements | Collation of data for mapped training compliance and competencies | Named Nurse Safeguarding Children | Monthly<br><br>Quarterly<br><br>Annually | Monthly ICB DASHBOARD data reporting<br>Trust Safeguarding Committee Annual Report |

The above audits (see Audit and Measurement – key findings) give assurance trust staff are working within the Safeguarding and Protection of unborn Babies and Children Policy, or have mitigation and action plans in place, including reporting incidents where there is a need to improve practice or where a child has been harmed to enact the serious incident process. Training compliance is mapped and monitored (see training section).

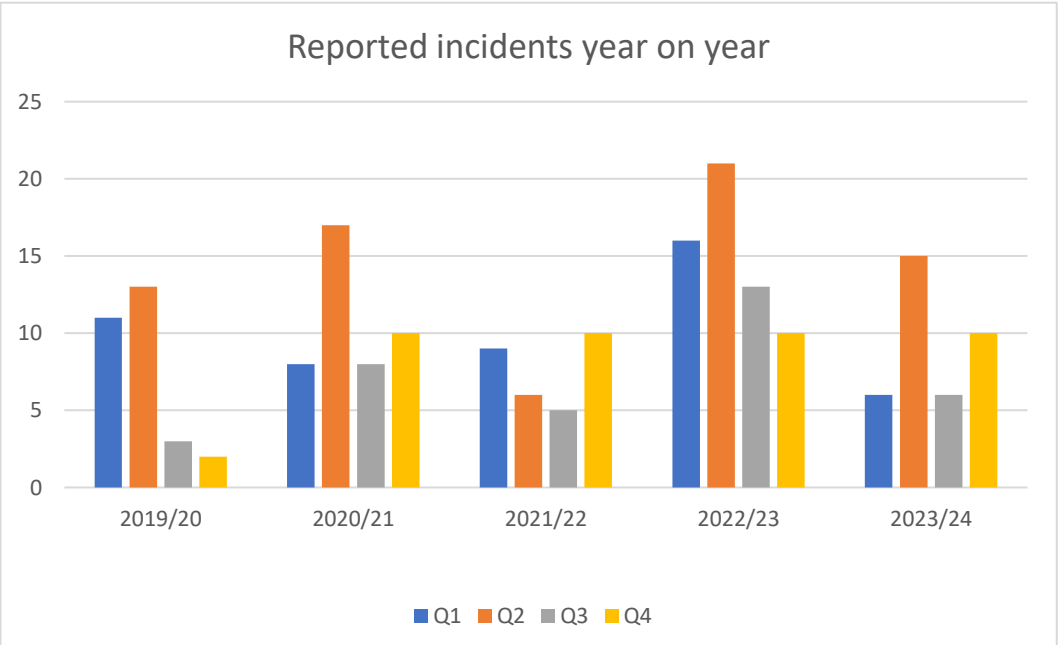
**INCIDENT REPORTING**

Where there are safeguarding concerns in relation to significant events, incident reporting is mandated in line with the Safeguarding and Protection of Unborn Babies and Children Policy (2021). Managed through Learning from Patient Safety Events (LFPSE) within the Patient Safety Incident Response Framework (PSIRF) learning, policy development and risk identification and analysis involving unborn babies and children is shared and monitored thought SFT training and Safeguarding Supervision, learning events and news briefings facilitated by the SSCP.

**Graph 11. Incident reporting year on year**

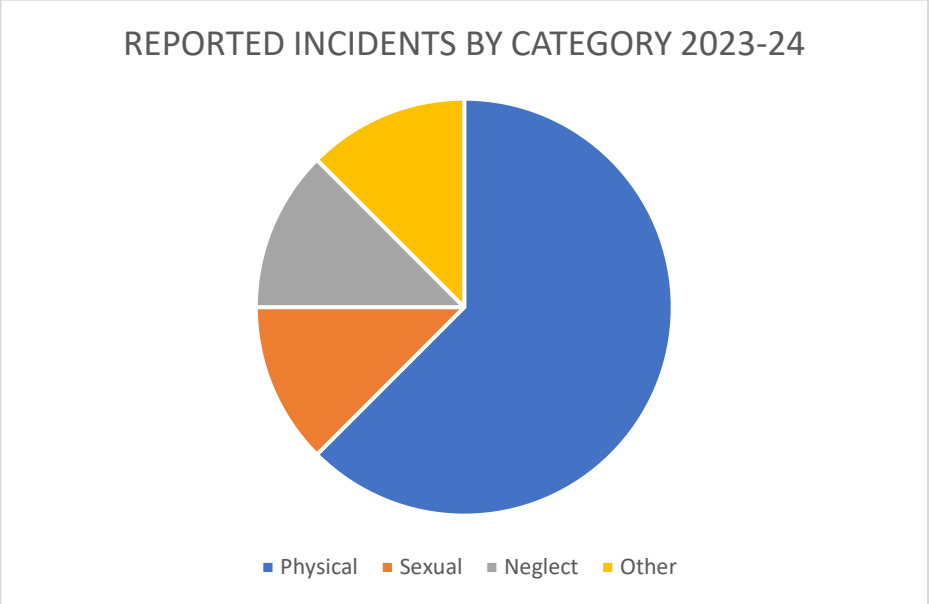

There has been a 38.3% (n=23) decrease in incident reporting across the merged Trust despite an increase in staff and services who work with unborn babies and children. This may reflect a change in the  incident reporting sytem to RADAR Turst wide and a fall in unexplained Injuries to young babies (Non-accidental injuiries) compared to 2023-2024 and will continue to be monitored. Consistent use of one incident reportng system RADAR in the next reporting period may realise the benefit of incident reporting to support compassionate engagement and involvment of those affected by patient safety incidents.

**Graph 12. Reported Incidents in respect of Safeguarding Children**



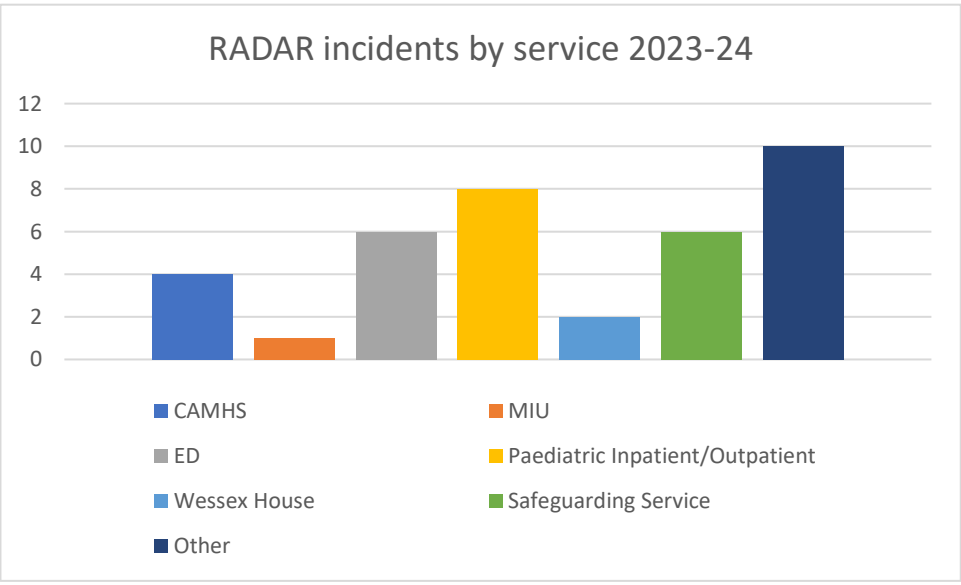
Data suggests there was an increase in incidents reported in Q2 of the reporting period, this aligns with an increase in infatns sufferign unexplained injuries (NAI's) similar to three out of the four previous years.

**Graph 13. Incident reported by category of abuse.**



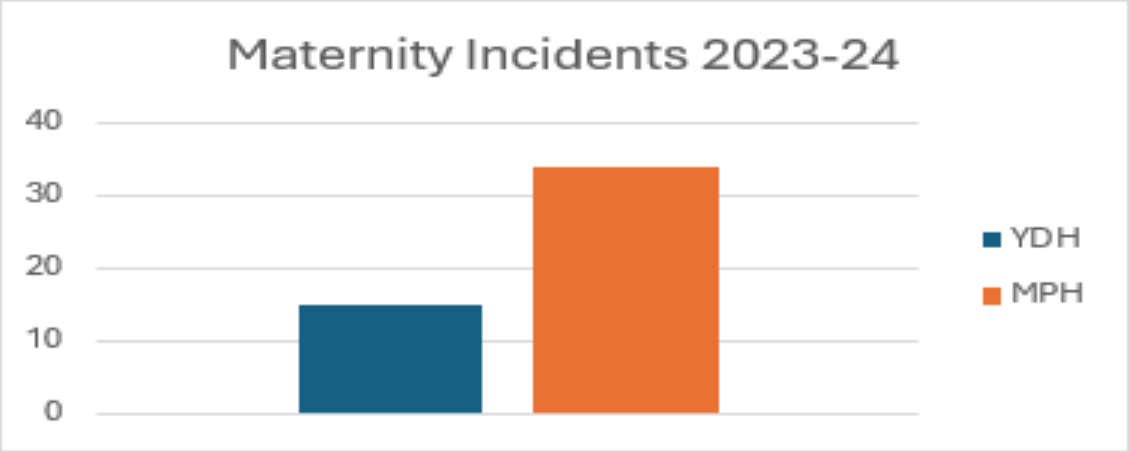

Incidents relating to Safeguarding Children where there was physical harm accounted for 63% of incidents (n=15). This reflects staff general recognition and escalation of safeguarding and protection concerns compared to Neglect which account for only 13% (n=3). In addition, informs Safeguarding Training and Safeguarding supervision to increase staff knowledge around all forms of Child abuse.

**Graph 14. Incident reporting by service in respect of Safeguarding Children**




ED and Paediatric services complete the greatest number of RADARs, this is due to the number of urgent and unscheduled admissions and is further reflective of the number of NAI's and child deaths during the reporting period.

. **Graph 15. Maternity safeguarding incident reporting**

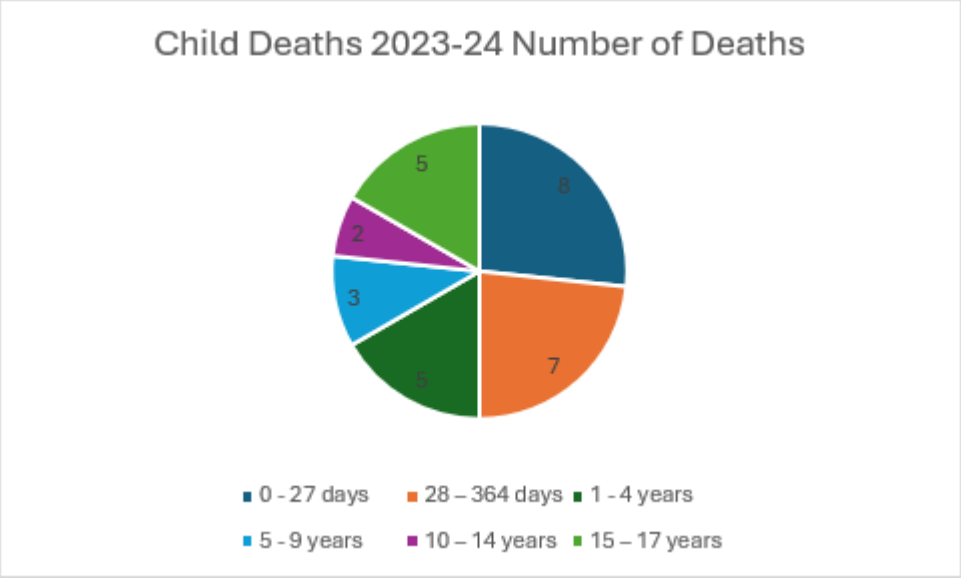



34 incidents were reported where women planned or booked to have their babies or were cared for by midwives in and around West Somerset. Anecdotal evidence suggests the main area of learning is around pre-birth planning including WREN Team referrals and subsequent social plans not being completed by the allocated midwife. This is reflected in several SFT Rapid Reviews involving unborn babies and infants under one year. (see risk section)

**Graph 16. Maternity safeguarding incident reporting**


**CHILD DEATHS**

**Graph 17. Number of Child Deaths by age.**




Child deaths are reviewed within the Child Death Overview Process (CDOP). (A separate report is compiled by the CDOP members and learning shared by the Named Doctors for Death across the trust and wider partnership). It is of note that Somerset have seen an increase in Child deaths, including unexpected deaths. Learning is particularly important in respect of modifiable factors.

**Safeguarding Supervision Policy (2023)**

| Element of policy for monitoring | Monitoring method | Item Lead | Monitoring frequency /reporting frequency and route | Arrangements for responding to shortcomings and tracking delivery of planned actions |
|---|---|---|---|---|
| Overall processes for safeguarding supervision to policy | Monthly/Quarterly dashboard data reporting | Named Professionals | Monthly Quarterly – Service groups, Directorates ICB Annually | Monthly/ Quarterly ICB DASHBOARD data reporting Trust Safeguarding Committee Annual Report |
| Assurance that supervision is supporting competency and confidence with safeguarding | An audit of safeguarding supervision commitment, competency and confidence of supervisees. | Named Professionals | Annually | Reviewed by Named Professionals in conjunction with Director of Safeguarding reporting to the Trust |

| | | | | |
|---|---|---|---|---|
| (policy outcome) | | | | Safeguarding Committee. |

Safeguarding supervision was offered across both Trusts during Q4 2022-2023. Overall compliance for the period of interest is 52% for staff who work in the community, including Child and Adolescence Mental Health Services (CAMHS) and 26% for staff who work in the Acute setting (see graph 2). Poor of compliance is being addressed through risk assessment and raised within department clinical governance meetings to board level. A Silver Quality Improvement Programme and a BDO safeguarding supervision audit is being considered to help areas for improvement and identify effectiveness of the Policy, safeguarding practice, including understanding of reflexivity and the impact on improving outcomes for children and vulnerable families and reducing inequalities.

**Safeguarding Children and Young People from Child Exploitation Policy (2023)**

| Element of policy for monitoring | Monitoring method | Item Lead | Monitoring frequency /reporting frequency and route | Arrangements for responding to shortcomings and tracking delivery of planned actions |
|---|---|---|---|---|
| Assurance that policy and processes are safe | Audit of safeguarding and child protection process when CSE/CCE has been identified this may include: • Review of RADAR incidents referencing CSE/CCE • Random sampling of staff via questionnaire • Internal audits • External auditor, investigations and reports • Complaints monitoring • Supporting multi agency learning reviews • | Named Nurse, Named Doctor Safeguarding Children & Transitional Safeguarding & Exploitation Lead | Annually | Review by Named Professionals in conjunction with Director of Safeguarding reporting to the Trust Safeguarding Committee (SC |

| | | | | |
|---|---|---|---|---|
| | Participation audits | | | |
| Training compliance and competencies requirements | Collation of data for mapped training compliance and competencies | Named Nurse Safeguarding Children/ Learning and development Lead | Monthly Quarterly Annually | Monthly dashboard data reporting Trust Safeguarding Committee Annual Report |

The Child Exploitation (CE), Transition and Modern Slavery Lead is a member of the SSCP CE sub-group. The SSCP Section 11 audit and the JTAI CE audit give confidence that trust staff are working within the Safeguarding Children and Young People from Child Exploitation Policy to keep children safe. Learning around CE is fundamental to Safeguarding Children training and SFT will be integral to the development of the planned revision of the SSCP CE screening tool during the next reporting period.

**Court Procedures for Safeguarding Unborn Babies and Children Policy (2021)**

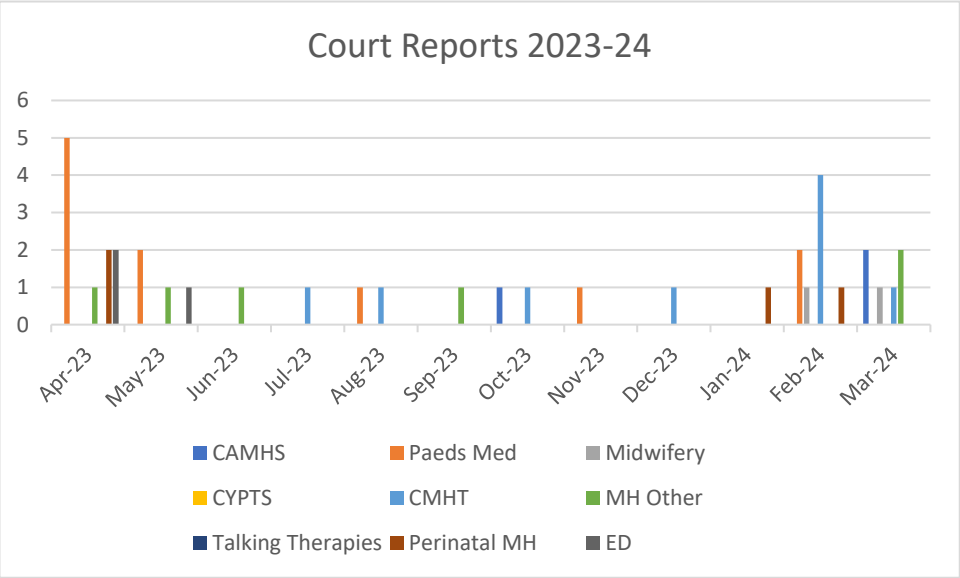
| Element of policy for monitoring | Monitoring method | Item Lead | Monitoring frequency /reporting frequency and route | Arrangements for responding to shortcomings and tracking delivery of planned actions |
|---|---|---|---|---|
| Assurance that policies, SOPs and processes are safe 5 The quality of legal statements and reports will be monitored by the Trust Safeguarding Service Named Professionals Annually Audit this may form part of The SG Children audit programme | The quality of legal statements and reports will be monitored by the Trust Safeguarding Service | Named Professionals | Annually | Audit this may form part of The SG Children audit programme |
| Assurance For the Care Quality Commission | Numbers of legal statements and reports | Safeguarding Advisory Service | Quarterly | ICB Data Compliance DASHBOARD |

| | | | | |
|---|---|---|---|---|
| the trust is complying outcome 7. | produced will be measured as part of the quarterly Care Quality Commission data collected by the Safeguarding Service to illustrate compliance with CQC Outcome 7. | | | |

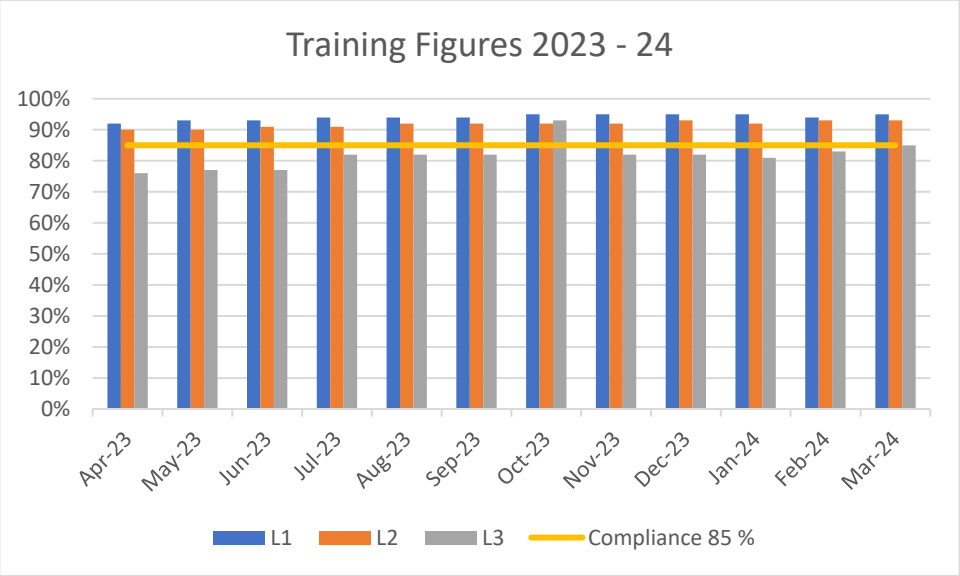
The Court Procedures for Safeguarding Unborn Babies and Children supports Trust staff navigate requests for court. The Safeguarding Advisory Service facilitate the legal process by quality assuring all Trust staff Court or Public Law Outline reports and offering support during the court process.

Since October 2020, all requests for court attendance and reports are triaged through the Safeguarding Advisory Service this has provided assurance that SFT complies with court requests in a timely manner, supports individual staff members and protects our most vulnerable children and families.

**Graph 18. Quality assurance of reports for court by the Safeguarding Advisory Service**




Scrutiny of data has identified Mental Health and Paediatric services undertake the majority of reports for Court supported by the Safeguarding Advisory Service who provide both a quality assurance and restorative function due to the associated emotional labour.

| Colleagues: Training and competencies | |
|---|---|
| **Training and competency requirements** | Intercollegiate Document (2019) working in accordance with the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff. The framework outlines five levels of competence (one being the lowest level and five the highest) and indicates the job roles that require the different levels of training. |
| **Training Compliance** | **SAFEGUARDING UNBORN BABY CHILDREN TRAINING**<br><br>During the reporting period 2023 - 2024 the ICB training standard continues to be set at 85%. This was to allow for the merger of Somerset FT and YDH, as compared to the Intercollegiate Document (2019) of 90%.<br><br>Structures are in place to achieve recommended compliance identified within the Training Strategy and action plan. Oversight of risk will be cited within the Safeguarding Committee action log. Contingency planning has seen a month on month rise in compliance.<br><br>Training resources are continuously updated, and additional training opportunities have been added to the Safeguarding Advisory Service training portfolio, for staff to engage in Continuous Professional Development, in key areas of safeguarding directly linked to learning from Local and National Child Safeguarding Practice reviews (CSPR), statutory and non-statutory reviews.<br><br>**Graph 19. Safeguarding Children training compliance**<br><br>  <br><br><br>Compliance rates are consistent with the blended learning approach, now established. Offering webinars as an interactive virtual forum to meet Intercollegiate Guidance (2019) keeps service users and staff safe alongside return of some face-to-face sessions when venues allow. |

**EXTERNAL ASSURANCE – Summary of topic-relevant feedback**

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| **External Reviews / Assessments** | During the 2023-2024 reporting period, a CQC inspection of maternity services identified a gap in safeguarding training related to identifying and protecting individuals from abuse. In response, a review of the trust's safeguarding children mapping was conducted. The findings provided assurance and confidence that the trust's mapping process for Safeguarding Children aligns with the recommendations of the *Intercollegiate Document: Safeguarding Children and Young People: Roles and Competencies for Health Care Staff* (2019). |
| **External / Internal organisational Audits** | **SAFEGUARDING – SINGLE POINT OF CONTACT (SPOC) DECEMBER 2023 (BDO Audit)**<br><br>The Safeguarding SPOC provides a service across the Trust whereby safeguarding concerns or queries can be logged and advice given through a single team contact, accessed via email, telephone and virtual clinics. A small duty team of around five trained individuals and a duty manager manage/coordinate the SPOC inbox.<br><br>**Methodology**<br>During the audit 20 contacts were reviewed (alongside governance arrangements) that had been managed by the Safeguarding Duty Team, from June to September 2023. The BDO auditor performed a detailed walkthrough assessing the initial contact, SBAR, alerts, recommendations and outcomes. The sample was split evenly across YDH, SFT, children and adults (with five contacts from each group). The Duty team introduced changes to their process in August 2023 to manage capacity, as part of the review effectiveness and quality was assessed.<br><br>Further additional data analysis was undertaken across the enquiry's trackers from June to September 2023, looking at the number of enquiries proportion of referrals and those requiring further actions, no trends or findings were identified.<br><br>**Capacity** - Changes to the service were successfully implemented in August 2023, to improve the process and capacity to handle additional enquiries.<br><br>**SBAR entries** – sample testing of 20 cases showed in all cases an SBAR entry had been made in the relevant system (TrakCare or RiO). This showed significant improvement from the last audit in September 2020, where 75% (15/20) had no evidence of the SBAR approach.<br><br>**Findings**<br><br>The audit highlighted several areas of good practice, including the communications across the Trust, management of complex cases and governance and oversight arrangements with additional learning around resolving professional differences, timeliness of responses and quality of SBARs.<br><br>**Areas of concern**<br><br>• The Resolving Professional Differences process had not been accurately applied in (n=2/3) sample cases (**Medium, Finding 1**) |

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| | • (n=1/20) sampled enquiries (5%) was not responded to for eight working days (**Low, Finding 2**). (n=3/20) SBARs samples did not have clear headings and points for each area, limiting the clarity of the recommendations (**Low, Finding 3**)<br>• There were some differences with the clinical recording systems used across the Trust, the inconsistencies noted above could also be improved through the availability of further detailed guidance (**Low, Finding 4**). |
| **National Audits / Surveys** | No National Audits / Surveys were carried out within the timescale of this report. |

| **ENGAGEMENT AND INVOLVEMENT** | |
|---|---|
| **Colleague engagement** | The Trust's values of Respect, Kindness, and Teamwork are fundamental to the Safeguarding Advisory Service mission.<br><br>*To empower Trust colleagues to deliver effective safeguarding practice, by working collaboratively within and across services to promote better health and social care outcomes*<br><br>Feedback is sought from colleagues attending the safeguarding children level 3 training, most of which is positive with colleagues telling us that they will take what they've learnt into practice and utilise the resources shared during the training.<br><br>Examples include:<br><br>• *As an ED doctor I am frequently faced with safeguarding issues, and this will give me more confidence in dealing with the processes.*<br>• *"Increased awareness, highlighted seriousness of the subject, find out facts not assumptions, continue discussing with my team at supervision which is very helpful. Use of the resources on intranet.*<br>• *As a sonographer it will help safeguard vulnerable children and even unborn children by ensuring expectant parents are given necessary support to care for their children.*<br>• *I feel more skilled to recognise the different level of safeguarding concerns and share information with the relevant agencies in Somerset.* |
| **Patient and public involvement** | Whilst the Safeguarding Advisory Service is not patient facing, we do offer support and guidance to trust colleagues and will seek to understand patient experience through colleague forums due to the direct correlation between colleague engagement and satisfaction and service user experience, satisfaction and safety.<br><br>An opportunity to have service user representation on the Safeguarding Committee would go some way to improve the interface between |

| | |
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| | Safeguarding and the public in the future. This will be explored with the patient experience team over the coming months. |

| ONGOING ISSUES & ACTIONS | |
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| **Current Issues** | **SITUATION**<br>The improvement team completed a piece of work in April 2023 to explore and understand the varied and inconsistent use of record-keeping systems, risk alerts, and IT platforms across Somerset Foundation Trust (SFT) which was presenting significant challenges. This mapping exercise identified Trust staff lacked accessible, consistent risk information, making it difficult to support informed decision-making across the healthcare system. This puts unborn babies and children at risk.<br><br>SFT, a recently merged organization (two mergers over four years), uses the RiO Console as the primary recording system for Community and Mental Health Services. RiO is the most reliable platform for the Safeguarding Advisory Service documentation. However, at Musgrove Park Hospital and Yeovil District Hospital, many staff continue to rely on paper records, and even where electronic systems are available, they are used inconsistently. Additionally, some staff groups, such as Somerset Talking Therapies, Emergency department and Urgent Treatment Centres, do not use electronic records consistently outside of their own services, limiting access to vital safeguarding information.<br><br>**BACKGROUND**<br>Historically, the Safeguarding Advisory Service primarily used RiO, which met their needs. However, over the years, RiO has undergone changes, and new systems have been introduced due to departmental mergers and evolving requirements, not specific to the Safeguarding Advisory Service. As a result, the Safeguarding Advisory Service now faces a significant increase in workload, having to access and input data across multiple systems. For example, research for the "Adult at Risk" meeting involves up to 18 steps and the use of 10 different systems.<br><br>**ASSESSMENT**<br>Fragmentation of use of Clinical Recording Systems creates potential risks, as decision-making and professional judgment are often based on observations of individual care episodes, rather than the broader context of vulnerable adults, children, and families. While TRANSFORM Family View and SIDeR have been cited as potential mitigation tools, they are not yet fully embedded or relied upon.<br><br>**RECOMMENDATION**<br>Action is required to address the current system issue until the full Electronic Health Record (EHR) system is delivered.<br><br>A review is planned for the next reporting period to integrate these tools with RiO for better information access.<br><br>An Alert/Significant Event Standard Operating Procedure (SOP) has been developed to promote consistency of alerts across all clinical recording systems and ensure alerts are pulled into SIDeR. This SOP is |

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| | currently under review due to the implementation of TRANSFORM Family View.<br><br>Increase in Admin staff in Safeguarding Advisory Service to reduce administration burden for Safeguarding Professionals |
| **Integration status** | **POLICY** – All safeguarding unborn baby and children related Polices and Standard Operating Procedures for Somerset NHS Foundation Trust are in date or managed through the approval and ratification process. Where there has been slippage extensions have been granted.<br><br>**GROUP / COMMITTEE STRUCTURE, MEMBERSHIP AND REPORTING** – The safeguarding committee membership includes key leaders and decision makers across Acute, Community and Mental Health services who have an operational and strategic role, The non-executive director and ICB representation provide additional assurance.<br><br>**OPERATIONAL SYSTEMS AND PROCESSES (SUCH AS DOCUMENTATION IN USE)** – The Safeguarding Advisory Service existed in its current state since November 2022. Process have been aligned for Acute, Community and Mental Health Services including but not exclusively, methods of contacting the Safeguarding Advisory Service using the SPOC, Training, and Safeguarding Supervision.<br><br>Documentation in terms of data capture, analysis and submission to the ICB are seamlessly aligned. Recording across clinical recording systems using the Situation, Background, Assessment and Recommendation (SBAR) safety tool including applying alerts remains an issue and is currently on the Trust Risk Register with a robust plan in place.<br><br>**INTERNAL ASSURANCE PROCESS, INCLUDING AUDIT AND MEASUREMENT** – No change to internal assurance has been realised, as process across the trust including reporting to the ICB and NHSE, in addition to governance and safeguarding committees.<br><br>**ALL APPLICABLE TRAINING REQUIREMENTS** - Safeguarding training was reviewed and re-mapped in January 2023 to ensure colleagues across the Trust are mapped correctly to the competency's framework.<br><br>The **CNB Audit** was the first cross cutting audit across SFT Acute, Community and Mental Health Services and has helped understanding of safeguarding practice, resource management and the importance of co-design to support care quality and sustainable improvement. |
| **Topic-related Risks** | **SAFEGUARDING SUPERVISION -** current risk score 12 (15 if non-compliant with safeguarding supervision and training)<br><br>IF- colleagues do not access Safeguarding unborn babies and children supervision that is a requirement for all Trust colleagues within Somerset NHS Foundation Trust who work with unborn babies, children as set out in the Intercollegiate Document; S*afeguarding Children and* |

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| | *Young People: Roles and Competencies- Jan 2019 and Looked After Children: Roles and Competencies of Healthcare Staff Dec 2020.* The requirement for attendance is three monthly.<br><br>THEN- unborn babies and children will be at risk which will increase if staff are neither compliant with Safeguarding Supervision nor training.<br><br>MITIGATION<br>• Safeguarding Supervision Policy published March 2023.<br>• Greater use of Learning and Development platform for Safeguarding Supervision access across Community and Child and Adolescent Mental Health Services<br>• Increased face to face/hybrid model offered to acute and hard to reach services.<br>• Safeguarding Supervision will be an audit topic for Q4 2024/2025.<br>• Strategic Lead and Named Nurse is currently working with the Associate Director of Planning and Performance to consider Safeguarding Supervision within the Board Assurance Framework – specifically to this looking at S4 Inequalities<br><br>**WREN PLANS NOT FOLLOWED WITHIN MATERNITY SERVICES:** current risk score 12<br><br>IF- Social vulnerabilities are not appropriately identified by MatNeo staff and/or subsequent plans to explore, support and address these vulnerabilities are not complete<br><br>THEN – children and families in Somerset may not receive the help and support they need in a timely manner as per effective 'Support for Children and Families in Somerset' guidance.<br><br>MITIGATION<br><br>• Community Team Leads will commence regular caseload reviews to support both the initial identification of vulnerabilities and to provide an oversight of the progress of completion of expected tasks.<br>• Named/Deputy Named Midwife will attend community team meetings to discuss the above incidents/identified risk.<br>• Community midwives to be encouraged to escalate any capacity issues in completing these tasks to their line managers.<br>• All community midwifery staff should be accessing maternity Safeguarding Supervision offered quarterly but can attend more frequently than this if required.<br>• Unborn babies open to Children Social Care or Family Intervention Service are being regularly discussed in Pre-Birth |
| **Action plan delivery** | **SAFEGUARDING CHILDREN AND UNBORN BABY RELATED ACTION PLANS**<br><br>All action plans cited within this report (increasingly multi-agency action plans) relating to Local Child Safeguarding Practice Reviews, Serious |

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| | Incident reviews and thematic reviews are on target and monitored at the following Trust and Multi Agency committees.<br><br>• Trust Safeguarding Committee<br>• Somerset Safeguarding Children Partnership<br>• Learning and Improvement SSCP Subgroup<br>• Quality and Performance SSCP subgroup<br>• Child Exploitation SSCP Subgroup<br>• Health Safeguarding Leadership Group<br><br>Collaborative working alongside Somerset FT services i.e., formal and ad hoc Safeguarding Supervision and support and training including with multi-agency partners provides further opportunities to reflect and learn from incidents and untoward events in accordance with agreed action plans. |
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| **Other Supporting Information** |
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| • 33 Safeguarding Stars were awarded to staff across SFT in recognition of good practice and positive outcomes for children, adults at risk, and families. |

**APPENDIX 1**

**Safeguarding Advisory Service Assurance Framework – Governance Structure**


Trust Board - annual
Quality & Governance Assurance Committee - annual
Quality Assurance Group
Integrated Safeguarding Committee - quarterly (CSC, ASC & ICB invited)
Safeguarding Senior Leadership Team - monthly
Named Professionals Meeting - weekly
Whole Service Meetings - monthly
Daily triage of Safeguarding SPOC

## Reference – Assurance level definitions

| Green | Blue | Amber | Red |
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| **Definition – assurance / concern characteristics** | | | |
| Good systems of assurance<br><br>High confidence in the quality of the evidence available.<br><br>Positive findings from measurement / assessment / monitoring sources, minimal variability.<br><br>No significant concerns in the period covered. | Assurance systems in place – adequately functioning.<br><br>Sufficient confidence in the quality of the evidence available.<br><br>Acceptable findings from measurement / assessment / monitoring sources, acceptable variability.<br><br>No evidence of any significant issues in the period. Any issues /concerns are well-managed via clear, monitored plans. | Assurance systems in place – issues evident with functioning.<br><br>Lower confidence in the quality of evidence / due to gaps in information available<br><br>Findings from measurement / assessment / monitoring sources indicate concerns / variability.<br><br>Issues of concern are not accompanied by assurance of clear, monitored plans to address. | Assurance systems are not adequately designed and/or not all functioning well.<br><br>Concerning low quality of evidence, significant gaps.<br><br>Findings from measurement / assessment / monitoring sources indicate concerns warranting escalation.<br><br>Serious issues identified that present risks to the Trust and in the absence of an effective plan to address. |
| **Application of the level – guidance and conventions**<br>**The level applies when..** | | | |
| There is agreement that there is overall high confidence that all is well.<br><br>Minor issues only.<br><br>An external review today would likely find no issues. | There is agreement that sufficient confidence that all is well.<br><br>Issues can be left with the Lead to take forward.<br><br>An external review today likely to find issues are managed. | The consensus is that improvements are required before there can be fuller confidence.<br><br>Issues may require support to resolve.<br><br>An external review today may find concerns and weaknesses in managing them. | It is evident that all is not well.<br><br>Issues warrant escalation to achieve resolution.<br><br>An external review today would find concerns and would likely take action. |
| **Onward reporting conventions** | | | |
| At one year -<br>Light-touch update report | At one year –<br>Update briefing with focus on actions progress – targeting the issues previously reported and any new issues arising since | On consensus from QAG review:<br><br>At six months -<br>An update on areas of concern and position update on improvement planning<br><br>At one year –<br>An update as above accompanied by an updated assurance report | On consensus from QAG review:<br><br>Within 1 month -<br>Specific briefing provided to accountable Executive and other relevant leads or stakeholders.<br><br>Topic review meeting held 1-6 months. Aim – to support development and improvement to address issues / concerns<br><br>At one year –<br>Full updated assurance report reflecting progress and plans |
| **Templates** | | | |

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| Simple update briefing | Issue-specific briefing / progress briefing | Issue-specific briefing / progress briefing<br>Assurance report (update) | Escalation briefing / progress briefing<br>and SMART plan<br>Assurance report |