UHBW Safeguarding Service Annual Report

2023 to 2024

Authors:

Susan Bourne (Interim Director of Safeguarding/Named Professional for Adult Safeguarding NBT & UHBW)

Claire Foster (Interim Associate Director of Safeguarding/Named Nurse for Safeguarding Children, FGM, Children in Care Lead NBT & UHBW)

Contents Page

Executive Summary

University Hospitals Bristol & Weston (UHBW) has a responsibility to protect patients, staff, and carers of all ages, including any children of patients, when they become aware of a concern or harm that may impact an adult or child's welfare.

It has a duty towards adults at risk of abuse or neglect due to their needs for care and support (Care Act 2014), and to safeguard and promote the welfare of children (Children Act 2004), which includes protecting them from maltreatment or impairment of development and supporting them to grow up in circumstances consistent with safe and effective care (Working Together 2023); and to ensure a framework for responding to safeguarding concerns for adults and children during all stages of pregnancy and birth.

The Trust is committed to improving its engagement and quality within the complex safeguarding agenda and recognises there are improvements to make.

Safeguarding advice, guidance, training, and support is available to all staff across the UHBW system and wider safeguarding partnerships within Bristol, North Somerset, and South Gloucestershire (BNSSG) (an Integrated Care System since July 2022) who offer training of all levels to meet the needs of all staff groups.

The impact of the pandemic has increasingly heightened awareness of the importance of the 'Think Family' approach to safeguarding nationally. Many people have been adversely affected by the pandemic which will continue to impact their health, welfare, and the development of children for some time to come. The UHBW safeguarding service will move towards a more integrated all-age approach to ensure that the Think Family agenda is fully embedded in the team and the culture of the trust.

Key achievements:

- **An increase in training compliance in all safeguarding subjects and improved ownership for training within the divisions**. All divisional leads take responsibility for their own compliance, and there are some areas of improvement, contributing to a positive trajectory.

- **Improved relationships and working practices with Local Authority Safeguarding partners**, allowing for a more creative and co-ordinated

approach to statutory processes under Section 42 (Care Act) and discharge challenges related to safeguarding, resulting in some reduction of barriers and clearer understanding of each other's roles and limitations. Joint liaison with North Bristol NHS Trust (NBT) safeguarding and the Bristol Local Authority Safeguarding leads.

- **There is sustained fragility and risk to the trust due to the pressure from increased activity and complexity, lack of robust service review and long-term under-development**. It should therefore be recognised that the team have remained focused, committed, and work very hard and with admirable determination under very difficult circumstances. Work has commenced to embed support around team development and improvement of internal systems, which will be reflected in next year's report.

Key challenges and future priorities:

- **Develop improved governance and clearer reporting and accountability systems that meet the needs of a modern complex safeguarding agenda**. There is duplication in process, and long-standing expectations of the safeguarding team for which they are not legally accountable, leading to over-reliance on the team. Therefore, there needs to be a clearly defined remit for the service. This practice adds operational burden and places the trust and its staff at risk.

- **Data collection will be targeted, meaningful and robust**. The service is not currently able to scrutinise data and information sufficiently to identify a detailed picture of safeguarding activity across the trust or the community it serves. Improving this would allow for refined oversight and drive better targeted quality improvements. Working with BI colleagues to develop smarter ways of gathering data is an area of development for the team.

- **Move to a robust modern all-age model with a skilled workforce developed to meet the challenges of a complex safeguarding agenda**. Significant period of investment and development for the service and safeguarding practitioners will ensure a skilled all-age confident workforce to truly reflect an integrated approach to safeguarding across the trust. This will include improved knowledge in contemporary safeguarding issues such as contextual, transitional and intersectional safeguarding approaches.

- **As with the national picture, safeguarding statutory reviews have increased**. To meet this challenge, the service will work with NBT and wider partners collaboratively to engage and share learning from SARs (Safeguarding Adult Reviews), DHRs (Domestic Homicide Review) and CSPRs (Child Safeguarding Practice Reviews) across the trust and BNSSG safeguarding partnerships.

- **Creation and implementation of smarter working practices** developing a Single Point of Contact (SPOC) model. Good clear governance and assurance processes are key to this.

- **Ensure full compliance, accountability and assurance**. The trust has a duty to work within statutory partnership processes and compliance with the NHS England Safeguarding Accountability and Assurance Framework (SAAF 2024) and Intercollegiate Documents, Care Quality Commission (CQC) quality standards and regulations. This assurance is a priority necessitating engagement in the safeguarding agenda by all levels of seniority across the Trust.

- **Develop a clear 3–5-year strategy and improved workplan for the service** mapped against the trust strategy and values. These improvements will follow the wider safeguarding boards and partnerships (all ages) priorities where appropriate.

- **Ensure sufficient and safe resource.** The service will be reviewed for development and improvement opportunities through the acute provider collaborative framework, with a view to becoming a single managed service under the new hospital group model arrangements.

- **Improved collaboration, reduction in duplication**. Where possible, develop an improved, collaborative, partnership model across the acute hospital services footprint with a view to identifying and supporting reduction in health inequalities experienced across our communities.

Main Report

1.0 Purpose

The purpose of this report is to reflect the safeguarding activity from the previous financial year. The report highlights the good practice, the challenges, and the complexity experienced across the safeguarding systems.

It also provides information for the Executive and Non-Executive Trust Board members around its statutory and mandatory responsibilities and duties. This report covers the period between 1st April 2023 and 31st March 2024.

There has been a number of significant challenges, pressures and changes within the UHBW safeguarding service over the year, and this has unfortunately impacted the ability to collect robust and meaningful data. There has been unprecedented pressure on resource, which is reflected throughout, therefore significant focus in the coming year will be on development of the team and the resource, supporting the team to thrive as well as developing robust and accurate data collection within the internal and external governance processes. The purpose of this report is to reflect an accurate representation of the service to date, but with a positive forward view and focus on quality, improved partnership ambitions, a new joint safeguarding senior leadership model with NBT and ambitious but exciting plans to develop the acute provider safeguarding service within the acute provider collaborative framework

2.0 Operational Activity

The national picture reflects increased activity and complexity when safeguarding children and adults from abuse, harm, and neglect.

2.01 National Picture

Adults[1]

- There were an estimated 587,970 concerns of adult abuse raised to end of 2023, an increase of 9% on the previous year, reflecting the same annual growth as last year.
- The number of enquiries that commenced under Section 42 of the Care Act 2014 during the year increased by 7% to an estimated 173,280, which is a further increase on the previous year, and involved 136,865 individuals.
- The number of 'other' safeguarding enquiries, which did not meet the statutory Section 42 criteria but where local authorities use other powers to make enquiries, was 17,910, a slight decrease on the previous year.
- As for the previous year, the most common type of risk in Section 42 enquiries was Neglect and Acts of Omission, accounting for 32% of risks (1% up on the previous year), and the most common location of the risk was the person's own home at 47%.

- *[1] Data supplied from the Safeguarding Adults Collection (SAC) 2022-23. Data collected directly from councils with Adult Social Services responsibilities in England under the Care Act (2014).*

Children[2]

- Children in Need are legally defined as a group of children (under the Children Act 1989) who have been assessed as needing help and protection as a result of risks to their development or health (Gov.uk, 2023), (incorporating the antenatal period for unborns) including those on child in need plans, child protection plans, those looked after by local authorities, care leavers and disabled children. This includes young people over 18 years who are still in receipt of care, accommodation or support from services.
- In 2023 there were over 403,000 children classed as in need and 51,000 on

protection plans.

- Numbers of children on Child Protection Plans decreased by a tiny amount 0.3% nationally. Completed assessments increased by 1.6% to 655,540.
- Thematic data clearly shows that domestic abuse effecting a parent and parental mental health needs are the most prevalent concerns services are reporting and this is reflected across BNSSG and in NBT's data on safeguarding children concerns and referrals. This highlights the importance of the Think Family approach when working with adult patients.

[2] *Data supplied by Gov.UK Children in need (reporting year 2023)*

The increasingly complex picture of safeguarding activity year on year, nationally, correlates with the increasing picture across the local safeguarding system and the trust. The UHBW safeguarding team has continued to experience a significant increase in contact activity year on year in volume and complexity.

The publication of the national review into the deaths of Star Hobson and Arthur Labinjo-Hughes triggered a system redesign for child safeguarding practice and focused attention on the value of highly skilled safeguarding practitioners in supporting organisations to identify and respond to both emerging needs and complex child protection issues. Recruiting, developing and retaining these skilled practitioners continues to be a significant challenge.

Modern slavery

All businesses and public bodies have a responsibility to eliminate modern slavery in their supply chains. More than 21,000 organisations have now uploaded statements to the Government's registry of modern slavery statements on GOV.UK since its launch on 11 March 2021 (Home Office).

Human trafficking, labour exploitation, criminal exploitation, sexual exploitation, and domestic servitude fall under the umbrella term 'modern slavery.' Due to the hidden nature of this crime, it is only possible to estimate potential victims referred to the National Referral Mechanism (NRM) (ONS 2021).

Last year there was a slight decrease in adult referrals from 5,852 to 5,087 however referrals for child victims increased from 4,547 to 4,946. Now, child victims are at their highest ever (7,432) and adult 8,662. This is split by 24% female and 76% male

referrals.

There is no typical victim of modern slavery, they can be adults exploited for labour or whose accommodation is being used for cuckooing, trafficking or sexual exploitation, young people experiencing grooming or being used for drug trafficking, or children being trafficked or sexually abused. Anyone can be affected regardless of their age, gender, nationality, or income. The risk is significantly raised however when the person is vulnerable or experiencing poverty.

The Keeping Bristol Safe Partnership, of which the UHBW safeguarding team are an active partner, are committed to working collaboratively with colleagues from Unseen UK, Avon & Somerset Police, The Salvation Army and Crimestoppers to help eradicate modern slavery across Bristol and the wider partnerships.

Ref: Gov.uk 2024

PREVENT Duty

Under the Counter terrorism and Security Act 2015 “specified authorities” including health, schools. Universities, prisons and local authorities must consider risk of radicalisation during their day-to-day activities.

The 2011 Prevent strategy has three specific strategic objectives:

- respond to the ideological challenge of terrorism and the threat we face from those who promote it
- prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support
- work with sectors and institutions where there are risks of radicalisation that we need to address.
- Since the introduction of the Prevent Duty in 2015, over 4400 referrals have been supported through the Channel Programme. “Channel aims to move individuals away from violent ideologies that could have resulted in harm to themselves or others.” (Home Office 2023). 6,406 referrals to Prevent were made in the year ending on 31 March 2022 and 6817 by end March 2023 which is an increase of 6.4% compared to the previous year.

- This is an overall increase of 30% compared to the year ending March 2021 (4,915), likely to have been driven by the associated impacts of lifting the public health restrictions that were in place to control the spread of the coronavirus (COVID-19) and increasing political platforms.
- 65% were categorised as holding Islamist-extremist views, 28% were categorised as holding Extreme Right-Wing ideologies, and the remaining 8% were categorised as holding beliefs related to other ideologies. These figures include both those that had been convicted and those being held on remand (that is, held in custody until a later date when a trial or sentencing hearing will take place) (Home Office 2023).

The safeguarding team have an identified PREVENT lead and the CNO executive lead for safeguarding holds the executive lead for Prevent as per SAAF 2024. As a trust we are compliant with the Safeguarding Accountability and Assurance Framework (SAAF) 2024 requirements around Prevent duty, in addition to being compliant with the NHS Prevent training and competencies framework (DHSC (Department of Health and Social Care) 2022).

2.2 University Hospitals Bristol & Weston NHS FT (UHBW)

UHBW is committed to meeting the increasing demands of the complex safeguarding agenda.

We have moved away from the urgent priorities of the Covid-19 pandemic and have become more engaged and invested in more collaborative working particularly across the hospital acute services. Towards the end of Quarter 3 the safeguarding team senior leadership from North Bristol NHS Trust (NBT) embarked on a one-year pilot working across University Hospitals Bristol & Weston (UHBW) and North Bristol NHS Trust to provide the senior leadership and safeguarding expertise for the UHBW safeguarding service. It is hopeful this collaborative work will continue into 2024-25 as we consider creative ways through the single managed service model as aligned with the acute provider collaborative initiatives of removing or reducing duplication and improving the experience of patients experiencing abuse or neglect.

The pandemic heightened awareness of the importance of ‘Think Family,’ and this

all-age approach has become the cornerstone of our annual safeguarding strategy. All UHBW safeguarding practitioners moving forward will be expected to develop skills to be all-age with high levels of skill and experience in both adult and children safeguarding legislative and statutory frameworks. Given the pressures on resource through this reporting year this is a significant challenge.

To prioritise and manage the high volume of day-to-day operational activity the team have not been able to collect accurate or consistent data due to this sustained pressure, lack of robust service frameworks and resource concerns. There has been no opportunity to review current processes or develop helpful data collection systems due to this pressure. Therefore, the data below comes with a caveat that only the most basic data is captured. Predominantly this is the first contact data that is made with the team when a member of trust staff has a concern. This does not reflect the complexity nor provide opportunity to provide deep or thematic analysis. Full analysis will only be possible once the service governance systems can capture the level of detail required.

Table 1 below demonstrates the safeguarding team annual activity by contacts throughout the period of 2023-24.

Table 1 safeguarding team activity

There were 2087 initial contacts made with the safeguarding team throughout this reporting period. The figures do not reflect the complexity attached to these contacts, nor the ongoing work that follows the initial contact and the accuracy cannot be guaranteed. The data however is helpful in providing an overview of the highest reporters and raises some concerns over what areas of the trust may be under-reporting. Given there is fragility in the team and pressure on the resource it should be recognised that the team have remained dedicated and have worked very hard under very difficult circumstances. Senior leaders in the service are working closely with the team to develop appropriate data collection and support systems which will be reflected in next year's report.

These figures are the initial contact made with the team for advice, support and guidance and exclude input into statutory reviews, statutory meetings, and liaison with stakeholders, mandatory/statutory or bespoke training, supervision, and ongoing intervention with complex cases where indicated. These contact figures also exclude the DoLS contacts.

Adult data

The Care Act (2014) provides a clear legal framework for how local authorities and other system partners should work together to protect adults at risk of abuse or neglect. Within this is the statutory duty held by the local authorities under Section 42. This duty compels organisations to raise concerns where there is a suspicion that an adult in its area has needs for care and support, is experiencing (or at risk of) abuse or neglect and as a result of those needs is unable to protect themselves against the abuse or neglect.

A referral to the local authority may not result in an enquiry under Section 42, and instead may require a different level of support such as a care needs assessment; however there still remains a duty to refer.

Table 2 demonstrates the referrals made to the relevant local authorities by quarter. It can be assumed that the number of referrals 'not sent' reflects contact made with the team which was not within the safeguarding criteria. This is a significant number which may indicate an opportunity to support better understanding of safeguarding criteria in the divisional teams.

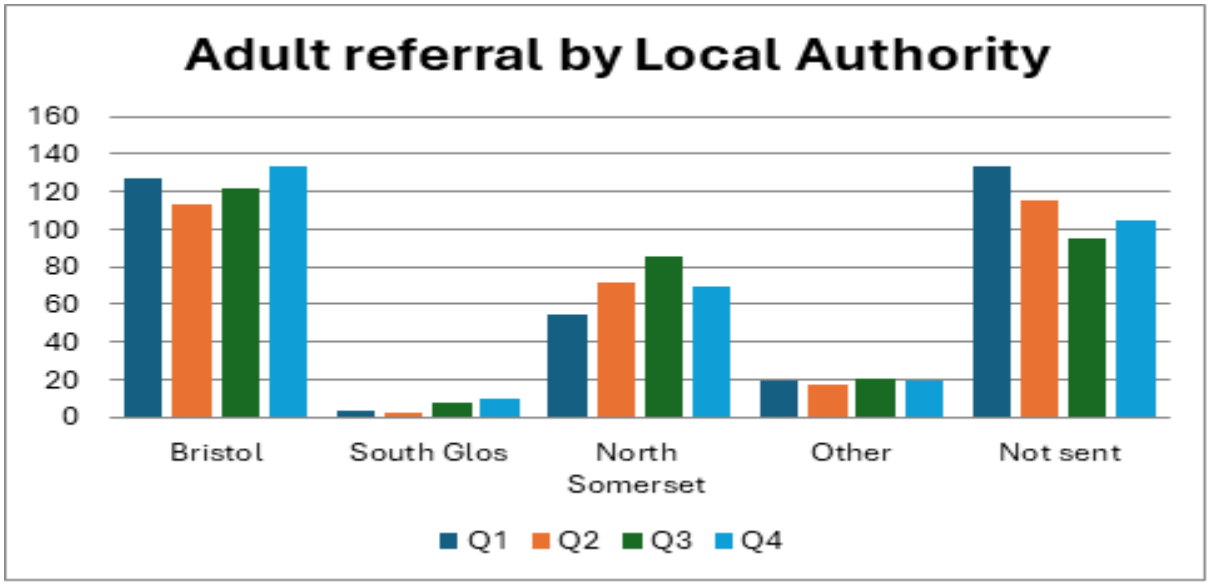

Table 2 Adult referrals to local authority

As demonstrated in table 3 below, the highest referrals made by the safeguarding team originate from the medicine division. This is not unexpected as the front door and urgent and emergency services generate higher levels of concern. Similarly, Weston General Hospital has a high level of older adult services where vulnerabilities will generate safeguarding concerns. However, it is surprising that there are significantly fewer referrals generated from the other trust divisions and this requires deeper analysis as it is impossible to determine whether this is due to under-reporting or a lack of robust data collection.

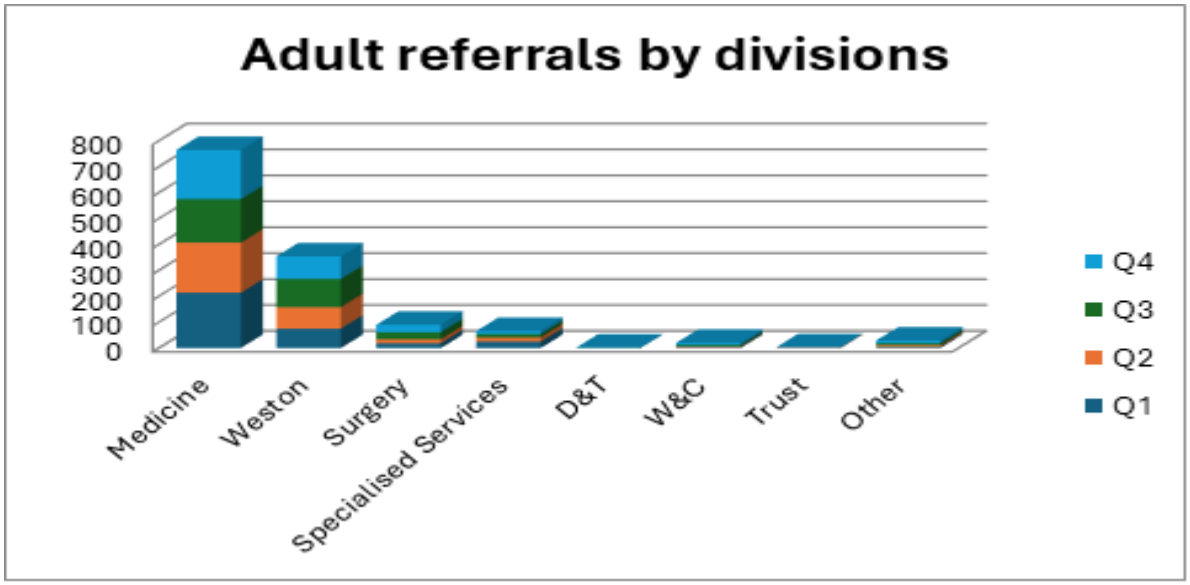

Table 3 by division

Thematic data collected is consistent with the local and national picture (table 4). There has been an increase in domestic abuse concerns post-covid and following the introduction of the Domestic Abuse Act 2021 statutory duties.

Peaks of self-neglect and neglect also correlate with the national picture and across BNSSG there are a number of local initiatives to tackle these areas through learning from statutory review processes.

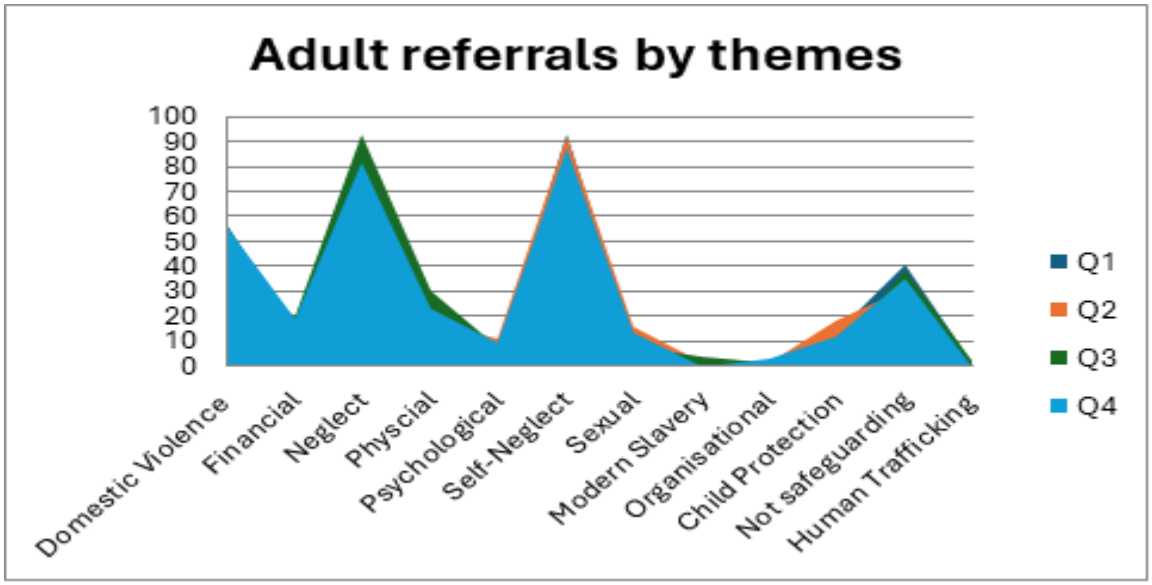

Table 4 adult themes

Deprivation of Liberty Safeguards (DoLS) referrals

Under the MCA (2005), staff must ensure that patients unable to consent to being accommodated in hospital for care and treatment are lawfully deprived of their liberty. This is done through the Deprivation of Liberty Safeguards (DoLS) process. The number of DoLS applications and by divisions are in table 5 below:

Month	No of Referrals	
Apr-23	79	
May-23	88	
Jun-23	81	Q1 248
Jul-23	95	
Aug-23	92	
Sep-23	88	Q2 275
Oct-23	98	Q3 294

Nov-23	103	
Dec-23	93	
Jan-24	113	
Feb-24	102	
Mar-24	90	Q4 305
Total	1122	

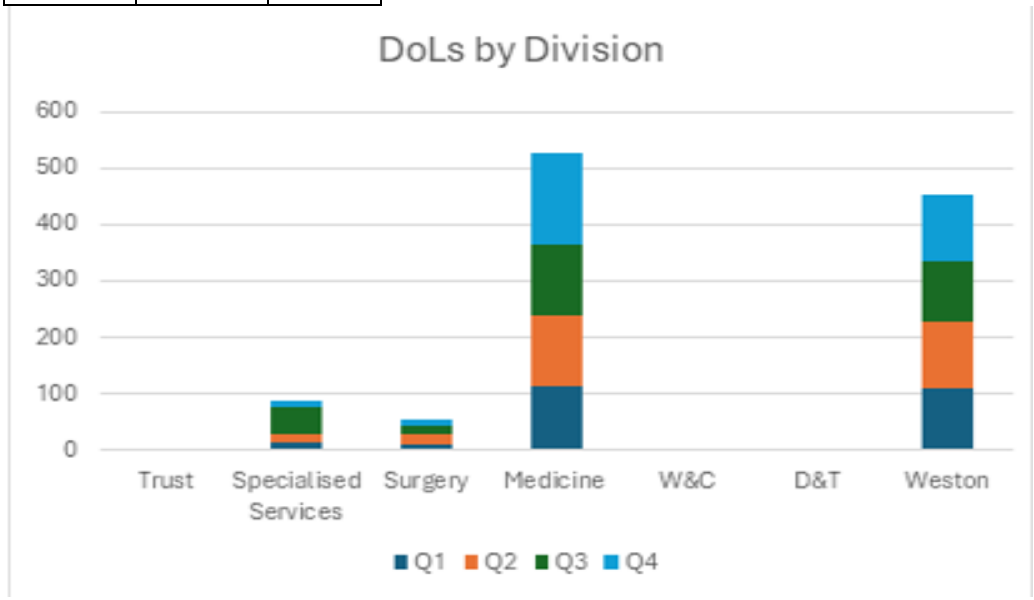

Table 5 Dols applications

The role of the safeguarding team is not to manage the DoLS process or send referrals to the Local Authority as this is the legal accountability and responsibility of the treating clinical teams. Further work will be done on the DoLS process in UHBW as part of the wider service design to ensure the correct processes and accountability around DoLS is in place moving forwards.

Child Safeguarding data

As noted with the adult safeguarding data above we are aware there are gaps in data collection that have impacted the accuracy of reporting in this financial year for children's safeguarding activities. The priorities highlighted within the report seek to address some of this through smarter use of BI processes where possible and a contemporary approach to recording the current activity through the team.

As shown in Table 6 a high volume of contacts to the team come in the form of notifications from ED attendances to the three general ED's in the trust. As expected,

the highest volume is generated through the BRHC ED accounting for 53% of the notifications with the BRI and Weston ED's accounting for 29% and 18% of contacts respectively. At the end of 2022/23 the notifications criteria were modified to exclude those children already known to a social worker presenting with a non-concerning attendance. This communication of attendance is now supported by the Child Protection Information System (CPIS) between the NHS spine and local authority records system. This accounts for a small drop in contacts to the team from 2022/23 to 2023/24 via this route.

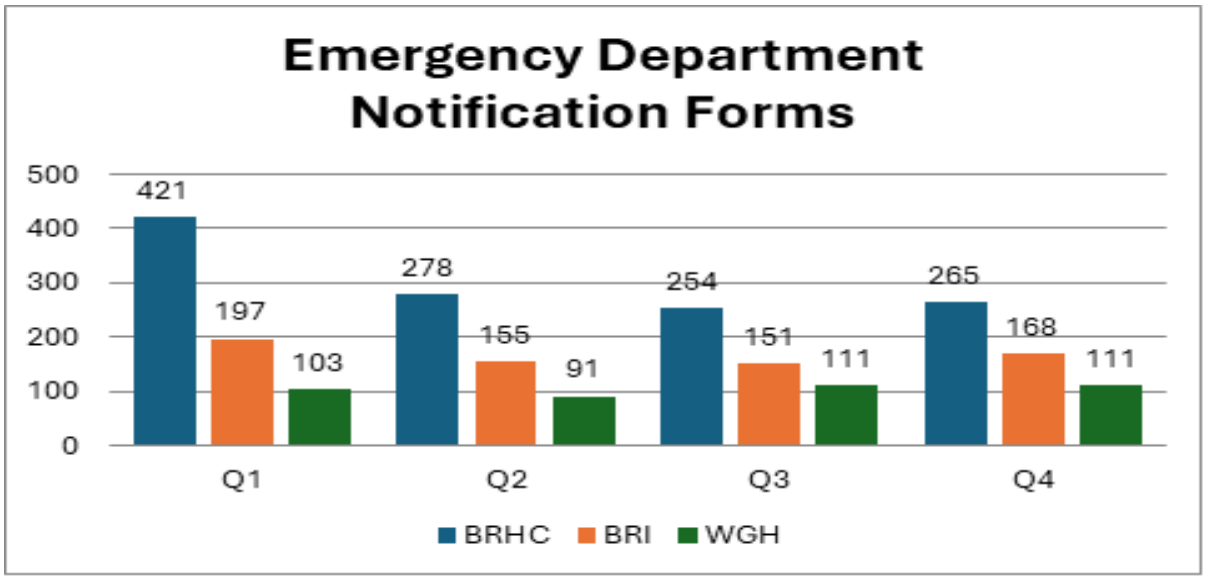

Table 6

Table 7 shows the numbers of referrals sent out to local authority Children's Social Care teams from the concerns raised by staff to the team. There can be significant information gathering, liaison and quality checking by the safeguarding team practitioners prior to a referral being made. Referrals for children can be made due to concerns for the parenting capacity of an adult patient who has direct care of children or due to a concerning presentation of a child. The data includes the maternity referrals made for concerns related to an unborn child and/or their siblings during the perinatal period. Referrals may be highlighting emerging needs for help and support or higher threshold concerns that relate to statutory enquiries under Section 47 of the Children Act 1989. Early help referrals are essential for highlighting need at a point where harm or abuse are prevented from occurring and contribute to addressing health inequalities.

Due to the regional reach of the Children's Hospital, we can see that the team have external contact with not only local authorities of BNSSG but also regularly liaise with children's social care teams across the southwest. In 2024/25 we will be gathering additional data to identify which areas account for more activity with an aim to be able to cross reference with the types of harm or themes being identified. This information can be used to improve our own training and processes within UHBW but also that of wider local authorities as part of multiagency partnership arrangements.

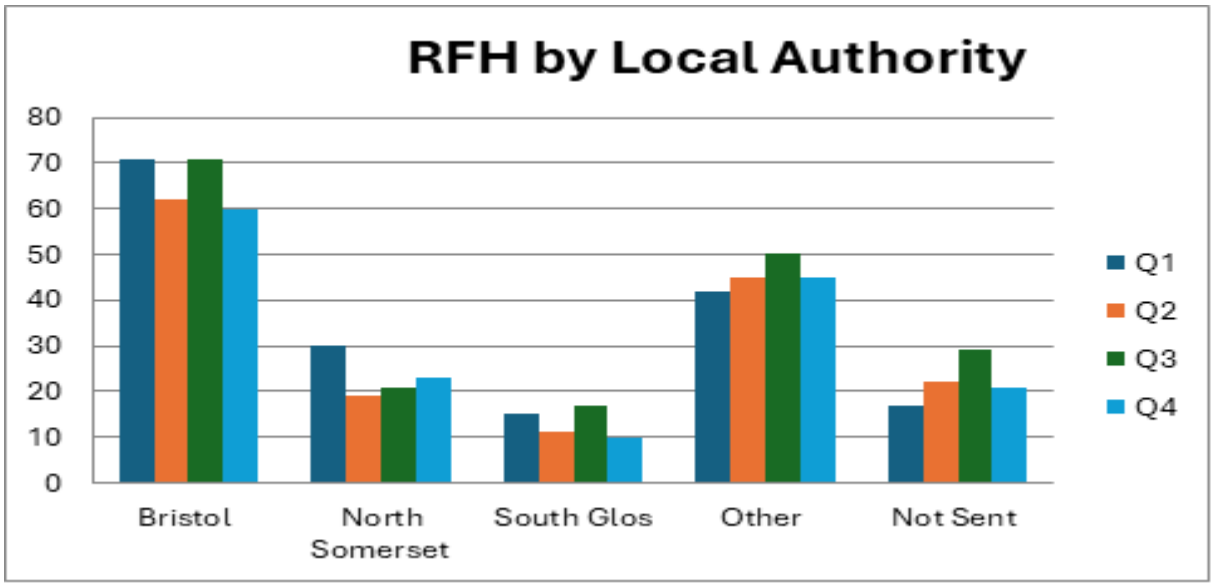

Table 7

When we have looked at the data by division, we can see that the highest reporters are Women and Children's division and Medicine division, and this aligns with the activity of their ED's and Maternity and NICU departments.

Table 8 gives an overview of the themes of concerns raised in referrals. Themes include issues relating to parental risk for example significant parental mental health concerns, domestic abuse, and parental substance misuse. This aligns with the picture from local data. Domestic abuse remains a significant theme in maternity concerns prevalent in more than 25% of contacts with the team. The data also includes activity that contributes to statutory duties of the safeguarding partnership arrangements for example Section 85 notifications when a child has been in hospital for more than 12 weeks.

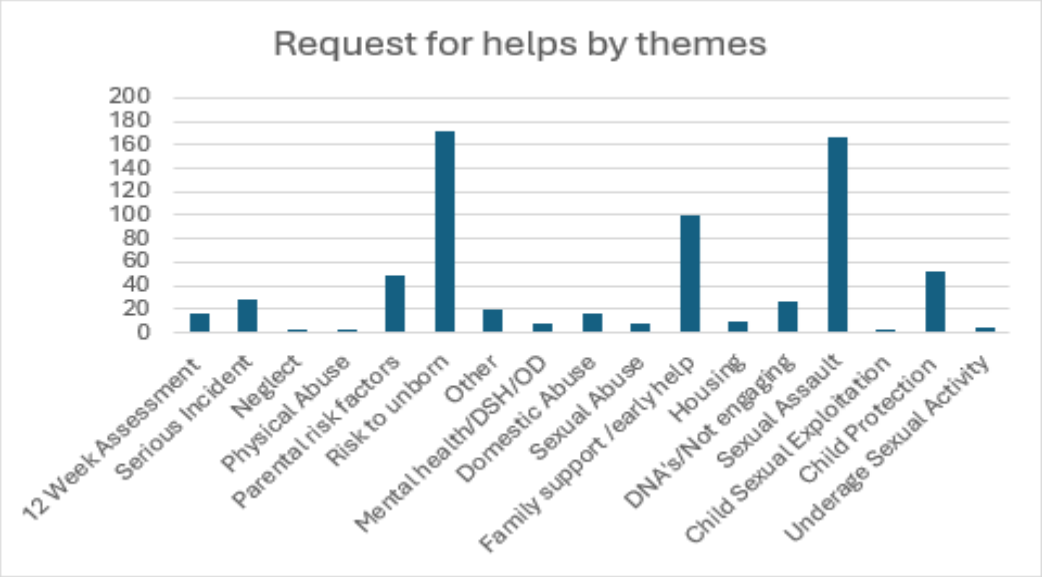

Table 8

2.3 Statutory Enquiries

The role of the safeguarding team is to review each contact and support or provide expert advice to the relevant division around their duties related to the concern. The team will also advise around referral to the Local Authority under Section 42 of the Care Act (2014) for adults.

Concerns around hospital acquired harm or neglect are reported to the safeguarding team and discussed in the Safeguarding Assurance Group (SAG) for review and identification/dissemination of lessons learned. All hospital acquired safeguarding events should be escalated through the clinical divisions and monitored through Trust governance processes. This assurance is a focus for improvements over the coming year.

There were 62 internal Section 42 enquiries throughout this period as reflected in table 9 below:

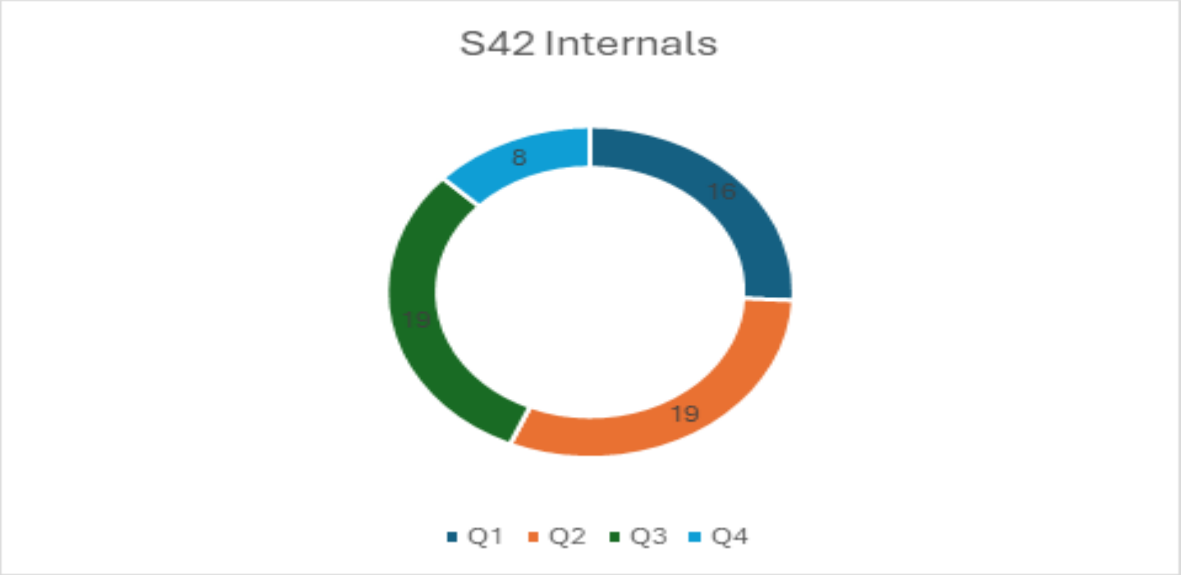

Table 9

Thematic data in table 10 below is consistent with local and national concerns particularly discharge and neglect. However, there is no data available reflecting self-neglect specifically which is a national priority. There will be further work carried out to improve this data collection as already identified.

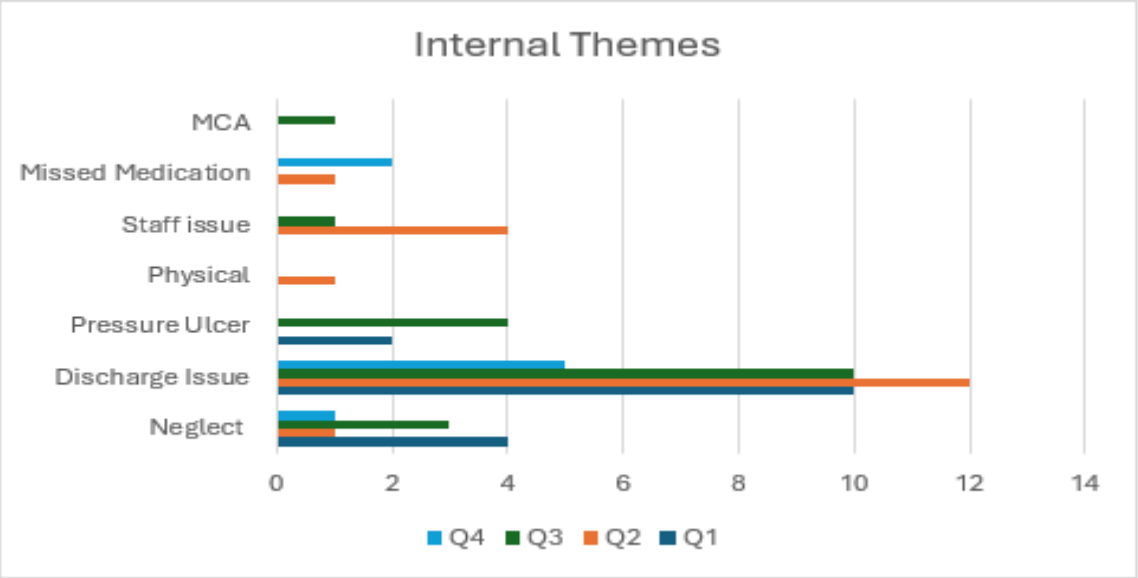

Table 10

Discharge and neglect (including self-neglect) continue to be the main themes of safeguarding adult Section 42's. Problems following discharge are often confused with a 'failed discharge' where a plan did not work, and re-admission was needed.

Throughout liaison with the Local Authorities during these processes, poor communication is often cited as a cause for anxiety, triggering further enquiry into an incident. This highlights the importance of recording actions in the discharge process.

Any Section 42 enquiries regarding care in UHBW will be reviewed by Bristol City Council as statutory lead for safeguarding adults, whom the safeguarding team have a good relationship with. Ongoing liaison and improved partnership work ensures improved understanding of our acute processes and a timely response to concerns enables swift assessment and closure of enquiries in the Part 1 element of the process, therefore reducing negative impact or confusion.

3.0. Statutory and mandatory training

Mandatory safeguarding training uptake across the workforce is captured electronically on the Kallidus system. All staff, volunteers, board members and contractors need to complete adult and children safeguarding training pertinent to their roles and responsibilities. Those who hold clinical responsibilities are also required to have Mental Capacity Act (including DoLS) training.

The role of the safeguarding team is to ensure the training is accessible, fit for purpose and meets the requirement of the Intercollegiate Documents 2019 and 2024. It is the responsibility of the relevant divisional leaders to ensure their staff teams are compliant with the training and have the appropriate skills and knowledge commensurate with their role. The safeguarding team are available to support divisional and wider trust staff to meet their safeguarding responsibilities. Mandatory and statutory training is one method of developing knowledge and skills.

The figures reported in Tables 11 and 12 are measured against the ICB Quality Contract for the 2023/24 period. Overall training compliance is positive at 80% for all safeguarding training subjects across the trust up to end of March 2024. The individual subjects are broken down in tables below and the majority meeting the required compliance level. Exceptions to this are adult safeguarding level 3 (46%), Children’s safeguarding level 3 (core) (70%) and Children’s safeguarding level 3 (specialist) at 52%. Training compliance is monitored and discussed in the trust Safeguarding Assurance Group and divisional leads have responsibility for

improvement in their areas of outstanding concern where actions are identified/mitigated.

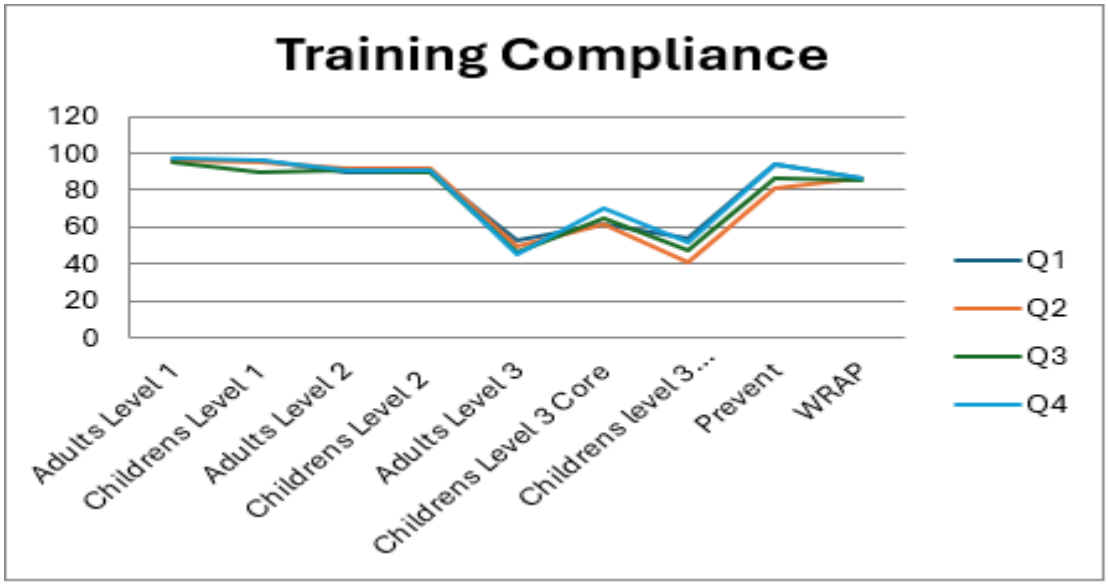

Table 11

	Q1	Q2	Q3	Q4
Adults Level 1	96	96	95	97
Childrens Level 1	96	95	89.3	96
Adults Level 2	90	92.3	94	91
Childrens Level 2	90	91.8	90.6	91
Adults Level 3	53	49	64.9	46
Childrens Level 3 Core	61	61.4	47.6	70
Childrens Level 3 Specialist	54	40.7	46.5	52
Prevent	94	81	85.9	94
WRAP	86	86.3	84.9	87

Table 12

The Named Professionals and Operational Leads review the training and learning options on offer each year, to maximise flexibility of learning and ensure the content is up to date and reflects recent learning from reviews. Options for webinars, e-learning and in-person learning were readily available throughout the year. Due to the pressure on service capacity however it was not possible to provide additional training throughout much of the year.

Safeguarding supervision contributes to learning and is a forum for regular reflection outside of formal safeguarding training. There is currently no identified model for formal safeguarding supervision in place for adult front-line practitioners and the statutory children's supervision is only provided by two maternity practitioners and two nurses in the children's team. This is a risk as regular reflection on safeguarding practice or cases and affirming areas of good practice alongside identifying gaps, can help improve confidence and competence of patient facing staff with safeguarding processes. It is identified nationally, particularly in Safeguarding Practice Reviews, that supervision undertaken regularly improves trust between teams and alleviates workplace pressures such as stress, anxiety and burnout. Within the safeguarding children framework supervision is a statutory requirement. It also helps staff increase skills in identifying, responding, reporting and escalating safeguarding concerns. Due to the pressure on service capacity resulting in prioritisation of day-to-day safeguarding activity; safeguarding supervision has not been regularly offered and it is an area of identified need for professional development for the practitioners to be able to offer this to trust wide colleagues.

3.1 Board level training

The revised 2024 Intercollegiate Document (ICD) for Adult Safeguarding was published at the time of authoring this report. It cites the Chief Executive Officer as having overall executive responsibility for the safeguarding strategy and policy with additional leadership at board level by the Chief Nursing Officer. All board members must be trained at level 1 for adults and children as well as additional knowledge-based competencies by virtue of their board membership or non-executive safeguarding role.

The updated guidance is outlined as training must be provided over a three-year period, and board level staff should receive a refresher equivalent to a minimum of two hours. This should be a tailored package encompassing level 1 knowledge, skills and competencies, in addition to board level specific areas as identified in the ICD.

All UHBW board members are compliant in level 1 safeguarding training and the board updates are planned for 2024/25 as per the ICD's.

4.0 Safeguarding Adults Reviews (SAR) and Domestic Homicide Reviews (DHR) and Child Safeguarding Practice Reviews (CSPRs)

As a partner in the systemwide multiagency safeguarding arrangements, the trust is expected to participate in statutory and non-statutory processes. During 2023/24 the safeguarding team provided investigative timelines or Individual Management Responses (IMR) and engaged with all SAR, CSPR and DHR Safeguarding Board and Partnership reviews. The purpose of all these processes is to identify learning and improve systems of work to safeguard those where multiagency working is integral to better outcomes.

Below outlines the statutory review processes by theme that have taken place over the previous year:

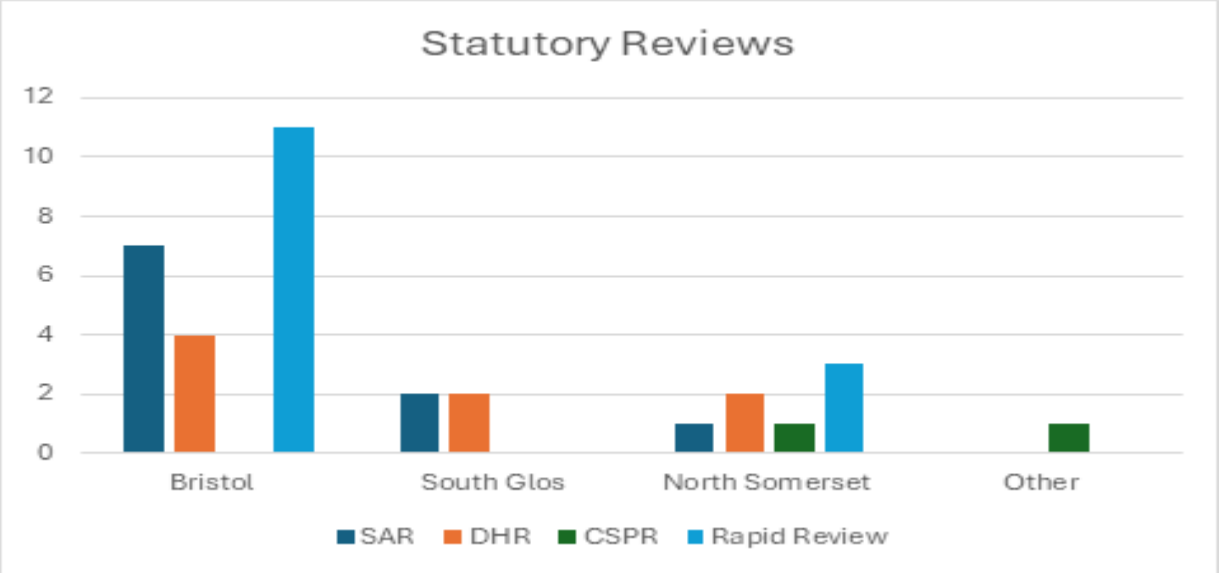

Table 13

We have experienced an increase overall in rapid review activity and we have also seen a significant increase in Child Safeguarding Practice Reviews (CSPR) in

Bristol, these will commence in the following year 2024/25. This is related to an increase in serious youth violence and in particular knife crime. This increase in statutory review activity is reflected nationally and continues to be a growing concern. The impact of the incredibly sad recent murders city wide remains very current and emotive for the team and agencies working together.

Learning from these statutory reviews remains a partnership priority. The safeguarding service provide quarterly themed updates to divisional staff around statutory reviews, however due to operational pressure and capacity issues there has not been opportunity to follow up or seek assurance or feedback or evaluate attendance at these updates.

5.0 UHBW Safeguarding Senior Leadership

The CEO of NHS trusts provide strategic leadership, promote a culture of supporting good practice regarding safeguarding within their organisations and promote collaborative working with other agencies.

The Chief Nursing Officer (CNO) is the trust executive safeguarding lead for safeguarding adults and children (including PREVENT) supporting the CEO and this remains the case in the revised 2024 Safeguarding Accountability and Assurance Framework (SAAF). They are represented at the Safeguarding Adults Boards (SAB) and Partnerships, Safeguarding Children Partnerships, subgroups, multi-agency partnership meetings and strategic leadership groups for BNSSG by the Interim Director of Safeguarding and Interim Associate Director of Safeguarding for UHBW and NBT.

Overall strategic and operational leadership for safeguarding is provided by the Interim Director of Safeguarding who alongside the Interim Associate Director of Safeguarding aspire to develop a robust all-age safeguarding service at UHBW. The Interim Director of Safeguarding also holds the Named Professional for Safeguarding Adults role, and is the MCA (Mental Capacity Act), Position of Trust lead and PREVENT lead (Executive lead for Prevent is the CNO (SAAF 2024)). The Interim Associate Director of Safeguarding also holds the role of Named Nurse for Safeguarding Children, FGM lead and Children in Care lead for the period of the joint senior leadership pilot. This arrangement is unsustainable in the longer term, so a

systematic review of the safeguarding arrangements is planned in line with the acute provider collaborative framework.

Appendix 1 shows the attendance at SAB Boards, Children's Partnerships, subgroups, and meetings for BNSSG.

5.1 Leadership and development in the wider Trust

Safeguarding is everyone's core business and the responsibility for identifying, reporting, and taking action to protect our patients from abuse or neglect sits with the registered clinicians providing the direct care or treatment. The UHBW central safeguarding team are specialist practitioners who provide the expert guidance, high level support, training and supervision for the clinical teams to meet their safeguarding accountabilities.

As the pressure on safeguarding services has increased nationally in volume and complexity, the role and remit of the safeguarding service in UHBW requires full review in order for them to be able to meet their legislative and regulatory responsibilities, and to ensure that the responsibility for safeguarding individual patients is recognised in the clinical areas where the accountability for that patient remains.

The safeguarding service sits within the accountability of the CNO but responsibility for safeguarding itself sits across all the areas and disciplines trust wide.

The role of the safeguarding team is primarily to ensure the trust meets its statutory, regulatory and legislative safeguarding duties as per national guidelines and frameworks and that the UHBW safeguarding service works in partnership with wider colleagues to aspire to ensure the trust meet these requirements. There is work planned for 2024/25 to ensure the trust does meet these requirements.

It is the responsibility of all trust staff, managers and leaders to understand their responsibilities around safeguarding as per their professional registrations and trust policies.

In addition to divisional colleagues, the safeguarding team will work with other trust colleagues such as the healthcare legal team, people team, patient safety and the

learning disability service to support on extraordinarily complex and challenging situations including staff allegations.

There has been a number of key vacancies in the team and a turnover of experienced senior safeguarding leaders which has had an impact on the function, stability and sustainability of the service. This has put added pressure on the team practitioners and a priority for 2024/25 is to ensure the service has strong, visible leadership to develop a sustainable robust service.

The team consists of an 8b Deputy Director of Safeguarding role and two Safeguarding Operational Leads (Band 8a), one for adults and one for children's safeguarding. A part time Senior Safeguarding Midwife (Band 7) supported by part time Band 6 Safeguarding Midwives, a part time Senior Safeguarding Nurse for Children (Band 7), supported by 2.6 WTE Safeguarding Nurses (Band 6). The adult safeguarding provision had two Senior Safeguarding Practitioners (Band 7) supported by 2.2 WTE Band 6 nurses. The team are supported by a Band 5 Administration Manager and a Band 4 and Band 3 Administrator. The team have had consistent periods of long-term vacancies including the Deputy Director role being vacant for half the financial year. Some of the vacancies have been supported by part time substantive staff picking up additional bank hours to support the team.

The Named Midwife role sits within the Divisional Director of Midwifery role.

There are three Named Doctors in place. One for Safeguarding adults and two for safeguarding children. The safeguarding service works alongside a consultant paediatrician rota who respond to urgent and complex statutory safeguarding incidents that present predominantly via the ED at the BRHC. This is led by the two Named Doctors for Safeguarding Children and supported by a part time administrator role.

From quarter 4 2023/24 the two most senior safeguarding leads at NBT were asked to provide overarching senior leadership across both NBT and UHBW. This was established as a pilot for 12 months. The aim of the pilot was to look at opportunities for further collaborative working, reduction/removal of duplication and to develop a more quality driven sustainable model for the future to meet the needs of our

communities. This model remains under review at the time of this report through the Acute Provider Collaborative Single Managed Service scoping process.

6.0 Safeguarding Governance

The Safeguarding Assurance Group (SAG) is a senior level forum to discuss all high-level safeguarding activity. The role of the SAG is to hold the wider trust to account for its statutory responsibility around safeguarding (all ages) by protecting a person's right to live in safety, free from abuse and neglect. Its purpose is to provide oversight and scrutiny of best practice in identifying, protecting, and supporting children and adults and those of a transitional age at risk of abuse or neglect and to undertake this through a structured process of leadership, accountability and working arrangements for effective clinical governance. These governance arrangements are under review and require further development to meet expected assurance requirements.

In addition to oversight and accountability, this committee aspires to highlight quality improvement opportunities and good practice and provide a clear governance process for all divisions to demonstrate commitment and engagement in the trust, national and BNSSG Safeguarding agendas, as well as meeting requirements of the SAAF (2024), the NHS Standard Contract and the ICB (Integrated Care Board) Quality Contract and related frameworks in a rapidly growing safeguarding agenda.

The Safeguarding Assurance Group upwardly reports to the Quality Oversight Committee (QOC) and the Clinical Quality Group (CQG), which in turn escalates to the Trust Board.

The Chair of the SAG is accountable for the duties set out in the Terms of Reference.

The SAG meets quarterly. Membership of the SAG includes:

- Deputy Chief Nursing Officer (Chair)
- Interim Director of Safeguarding (Deputy Chair)
- Interim Associate Director of Safeguarding
- Divisional Director of Nursing Medicine
- Divisional Director of Nursing ASCR
- Divisional Director of Nursing NMSK

- Divisional Director of Nursing W&C
- Head of Professions and Nursing CCS
- Named Doctor for Safeguarding Adults
- Named Doctors for Safeguarding Children

The Safeguarding Children and Adults Operational Group (SOG) is designed to meet quarterly. The group has core membership representatives from the divisions, named and specialist professionals; and specialists from other areas are invited to the group to present specific pieces of work. This group remains an area of development and is a priority for 2024/25.

Operational safeguarding issues are discussed at this meeting, providing a more informal reflective and supportive forum for safe and confidential discussion and cross divisional sharing of information, learning and best practice.

7.0 Assurance and Quality

7.1. Quality Contract

An ICB Quality Contract remains agreed ahead of the financial year and returned quarterly. These returns outline progress against the NHS Quality Standards for the period 2023-2024.

7.2: Safeguarding Policies

Responsibility for the production, monitoring and review of Trust safeguarding policies sits within the Safeguarding Team. The SAG has the authority to approve new or amended policies. The Chief Nursing Officer is the Executive Director with authority to give final approval of these policies. All policies are checked and ratified against legislation, best practice, and consistency.

All safeguarding policies state the responsibilities of all Trust employees and outline expectation of adherence by staff. It is the responsibility of individual staff members to ensure they are clear on the policy content and procedures within.

The safeguarding team are responsible for the following policies:

- Mental Capacity Act Policy
- Safeguarding Integrated Policy

- Child Abduction Policy
- Managing persons who present a risk of harm to children in a healthcare setting (being reviewed in line with staff allegations and PiPoT/LADO).
- Did Not Attend for children and young people (to be amended to ‘Was Not Brought’).
- Domestic Violence and Abuse trust policy
- Safeguarding Adults Procedures
- Safeguarding Children Procedures

The safeguarding team intranet webpage has information for staff, including policies, procedures, protocols, and guidelines including support; as well as easy to access material for staff.

Conclusion

Throughout 2023-2024, the UHBW Safeguarding Team has strived to provide a safe service to the Trust against a backdrop of challenges. The service has not had opportunity to robustly engage fully in the increasingly complex safeguarding agenda, which is a priority for 2024/25, in order to provide full assurance. The safeguarding team members are ambitious, keen to develop, and have patients and their families at the heart of all they do.

2023/24 has produced unprecedented safeguarding challenges nationally and locally, challenges which are acknowledged by the trust and wider stakeholder partners. Plans to improve opportunities are being scoped under the acute provider collaborative.

The team have struggled to demonstrate compliance with all the relevant statutory frameworks, policies and procedures on behalf of the trust due to the clear and present challenges reflected in the report, particularly around resource, recruitment and retention, governance systems and processes. However, there is clear commitment from the most senior members of the trust to support the necessary improvements.

Appendices

Appendix 1 Safeguarding Boards and Partnerships and Subgroup membership and attendance for 2022/23

Safeguarding Adults Board or Subgroup and wider membership South Gloucestershire Bristol North Somerset BNSSG & wider	**Trust Representative**	**Frequency and Time Required** (includes preparation and travel time where known)
South Gloucestershire SAB	Interim Director of Safeguarding NBT & UHBW	Quarterly
South Gloucestershire Quality Assurance subgroup for adults	Interim Director of Safeguarding NBT & UHBW	Quarterly
South Gloucestershire SAR subgroup	Interim Director of Safeguarding NBT & UHBW	Quarterly
South Gloucestershire Policy & Procedures subgroup	TBA	Quarterly
South Gloucestershire Learning & Development subgroup	TBA	Quarterly
South Gloucestershire Best start in life – complex needs	Interim Associate Director of Safeguarding NBT & UHBW	Quarterly
South Gloucestershire Quality Assurance subgroup for Children	Interim Associate Director of Safeguarding NBT & UHBW	Quarterly
CSPR & Rapid Review group	Interim Associate Director of Safeguarding NBT & UHBW	As required by case
South Gloucestershire Children's Partnership Work Streams Event	Interim Associate Director of Safeguarding NBT & UHBW	Twice Yearly

(KBSP) Keeping Adults Safe	Interim Director of Safeguarding NBT & UHBW	Quarterly
Bristol Keeping Children Safe Delivery Group	Interim Associate Director of Safeguarding NBT & UHBW	Quarterly
Bristol SAR & DHR subgroup	Interim Director of Safeguarding NBT & UHBW	Quarterly
MARAC Bristol	Safeguarding Team Practitioners	Fortnightly
KBSP Child Protection Conference Review Group	Interim Associate Director of Safeguarding NBT & UHBW	Bi-monthly
KBSP CSPR, Rapid Reviews, SAR, DHR timeline reviews/Full IMR's	Interim Director and Interim Assoc. Director of Safeguarding NBT & UHBW	As required
Bristol Domestic Abuse Operational Group	Operational Leads UHBW	Monthly
KBSP Contextual Safeguarding Group	Interim Associate Director of Safeguarding NBT & UHBW	Quarterly
KBSP Transitional Safeguarding Group (Adults and Children)	Interim Associate Director of Safeguarding NBT & UHBW	Quarterly
KBSP Serious Violence Prevention Group	Interim Associate Director of Safeguarding NBT & UHBW	Quarterly
Bristol Prevent Board	Deputy Director of Safeguarding	Quarterly
KBSP Multiagency Audit Group (Children)	Deputy Director and Operational Lead	Quarterly
North Somerset CSPR	Interim Associate Director of Safeguarding NBT & UHBW	As required
North Somerset SAR/DHR	Interim Director of Safeguarding NBT & UHBW	As required
North Somerset ROTH subgroup	Interim Associate Director of Safeguarding NBT & UHBW	6 weekly
BNSSG Named Safeguarding Professional Forums (adult and children)	Named Professionals	Quarterly

LPS Southwest NHSE/I	Interim Director of Safeguarding NBT & UHBW	6 weekly
BNSSG Strategic Health System Group	Interim Director and Interim Associate Director of Safeguarding NBT and UHBW	6 Weekly
Safeguarding Adults National Network (SANN)	Interim Director and Interim Associate Director of Safeguarding NBT and UHBW	Monthly
National Maternity Safeguarding Network	Named Midwife	Quarterly
Southwest Safeguarding Adults Health Leads Network	Interim Director and Interim Associate Director of Safeguarding NBT and UHBW	Bimonthly
NHS England Southwest Regional Prevent Leads Network	Interim Director and Interim Associate Director of Safeguarding NBT and UHBW	Quarterly

References

Broadhurst, K., Alrouh, B., Mason, C., Ward, H., Holmes, L., Ryan, M. and Bowyer, S. (2018). Born into care: Newborns in care proceedings in England. Nuffield Family Justice Observatory.

Child Safeguarding Practice Review Panel (2021) “The myth of Invisible Men” Safeguarding children under 1 from non-accidental injury caused by male carers.

Child Safeguarding Practice Review Panel (2022) Child Protection in England National review into the murders of Arthur Labinjo-Hughes and Star Hobson - GOV.UK (www.gov.uk)

H M Government. Counter Terrorism and Security Act 2015

HM Government. Care Act (2014)

HM Government. Children Act (1989/2004)

HM Government. Domestic Abuse Act 2021

HM Government. Mental Capacity Act 2005 and associated Code of Practice Deprivation of Liberty Safeguards and associated Code of Practice Mental Capacity (Amendment) Act 2019

HM Government. Modern Slavery Act 2015

HM Government. Working Together to Safeguard Children (2023)

NHS Digital (2022). Safeguarding Adults (official statistics), England, 2021-22

NHS England. Safeguarding Adults National Network (2023).

NHS England. Safeguarding children, young people, and adults at risk in the NHS: Safeguarding Accountability and Assurance Framework (2022)

ONS (2021) Modern Slavery in the UK. See below for latest

Gov.Uk (2024) Modern slavery: National Referral Mechanism and Duty to Notify statistics UJ, end of year summary 2023.

Royal College of Nursing. (2018). Adult Safeguarding: Roles and Competencies for Health Care Staff. Intercollegiate Document. First Edition

Royal College of Nursing. (2019). Safeguarding Children and Young People: Roles and Competencies for Health Care Staff. Intercollegiate Document. Fourth Edition