Birmingham and Solihull
Mental Health
NHS Foundation Trust

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NHS Foundation Trust

Safeguarding Adults and Children Annual Report

April 2022 – March 2023

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April 2023

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1.0 Background/Introduction

All safeguarding work across the Trust is underpinned by our Trust Values.

1.1 This year's annual report provides an overview of safeguarding activity for the period. It summarises the safeguarding work undertaken across the Trust and demonstrates to the Trust Board and external agencies how BSMHFT discharges its statutory duties and responsibilities in relation to Section 11 of the Children Act 2004 and Care Act 2014.

1.2 Staff are supported to work in partnership and to respond proportionately and appropriately to safeguarding concerns for children, young people and adults at risk, who access services across BSMHFT, in accordance with their statutory duties.

1.3 The Trust operates across Birmingham and Solihull and works closely with our local safeguarding partners.

2.0 Governance and Accountability Arrangements

2.1 The Chief Nursing Officer/Executive Director of Quality and Safety is the Executive Director for Safeguarding and provides leadership and oversight of safeguarding arrangements across the Trust.

2.2 The Deputy Director of Nursing and Quality and the Head of Safeguarding have the strategic responsibility for the safeguarding children and adult functions, supported by the Heads of Nursing and AHPs.

2.3 Named Professionals for safeguarding provide the statutory safeguarding functions in line with the Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework (NHSEI, 2019).

2.4 The Safeguarding Strategic Plan (see Appendix 1) is routinely presented at the quarterly Safeguarding Management Board (SMB) and to the Integrated Care Board (ICB).

3.0 Quality Assurance

3.1 All health providers are required to have effective arrangements in place to safeguard children and adults at risk of abuse or neglect and to assure themselves, regulators, and their commissioners that these are working and

effective. (*Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework NHSEI, 2019.)*

This includes:

- Safe recruitment practices and arrangements for dealing with allegations against people who work with children or adults.
- Safeguarding policies and procedures that support local multi-agency safeguarding procedures.
- Effective training of all staff commensurate with their role and in accordance with the intercollegiate competencies for safeguarding children and adults.
- Effective supervision arrangements for staff working with children, families, or adults at risk of abuse or neglect.
- Effective arrangements for engaging and working in partnership with other agencies.
- Developing and promoting a learning culture.
- Identification of named safeguarding professionals.
- Developing an organisational culture where all staff are aware of their personal responsibilities for safeguarding and information sharing.

3.2 The Head of Safeguarding provides evidence against these requirements through submission of the Section 11 and Care Act 2014 compliance audit and is monitored by the Safeguarding Management Board (SMB) with oversight by the Chief Nurse/Executive for Safeguarding.

4.0 Assurance Framework

4.1 The Trust has an internal assurance process. This includes a quarterly Safeguarding Management Board (SMB) which reports to the Quality, Patient Experience and Safety (QPES) committee. The SMB has a performance and quality assurance role and monitors the annual work plan and safeguarding risk register.

4.2 Each directorate has a lead manager representative at the SMB to ensure that safeguarding priorities are embedded at an operational level and this feeds back to their local clinical governance committee.

5.0 Partnership Working

5.1 The Trust is committed to working in collaboration with all partners to protect adults and children from harm. As part of these arrangements, the Trust is represented at Birmingham and Solihull Safeguarding Adult Boards and Safeguarding Children Partnerships to cover the two local authorities where the Trust provides services. These representatives attend and contribute to strategic development regarding local priorities, accountability and assurance. These priorities and deliverables are reported to the SMB.

5.2 Named professionals contribute to multi-agency audits in the local safeguarding adult boards and safeguarding children's partnerships.

5.3 The Trust safeguarding team has supported safeguarding adult reviews; child safeguarding practice reviews; domestic homicide reviews; channel panel and Prevent/ Contest boards throughout the reporting year.

6.0 Safeguarding Training Compliance

6.1 The Trust has a training needs analysis (TNA) in place which is based on the Intercollegiate Document, Safeguarding Children and Young People: Roles and Competencies for Health Care Staff Fourth edition (2019) and Adult Safeguarding Roles and Competencies for Health Staff First edition: August (2018). The TNA outlines the levels of training staff require to be compliant and frequency of training.

6.2 The training plan incorporates safeguarding children, adults, domestic abuse and Prevent training. The aim of the training is to support effective safeguarding practice. There are a variety of training opportunities including in house face-to-face, webinar, e-learning and external training opportunities from the Safeguarding Adult Boards and Safeguarding Children Partnerships.

6.3 The TNA has been updated in line with the Adult Safeguarding Intercollegiate Document 2018 and reviewed against existing Children Safeguarding Intercollegiate document 2019. Compliance has been mapped to job role rather than Agenda for Change banding to meet this standard. An additional 1,147 individuals now require Safeguarding Adults level 3 and additional 1,108 individuals now require Safeguarding Children Level 3. To meet the increased demand, additional in-house face to face and webinar training sessions have been provided and an e-learning option has been created to provide additional training opportunities. Staff are required to be fully compliant by December 2023.

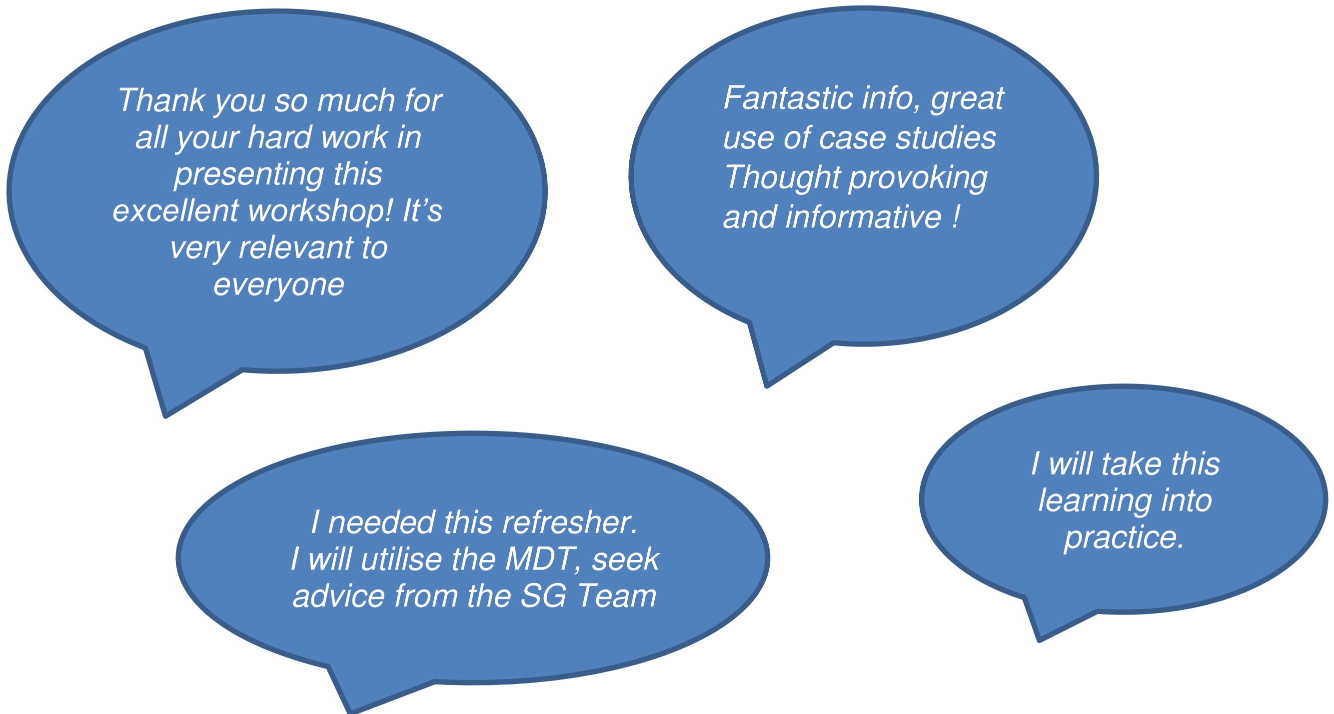
6.4 Level 1 and Level 2 Safeguarding Adult and Children training is completed via an online package and is compliant.

6.5 Level 3 Safeguarding Adult training is delivered face-to-face, by webinar and via online learning. Compliance is monitored weekly by the Head of Safeguarding and the Executive for Safeguarding. Reports are provided at the quarterly Safeguarding Management Board (SMB) and compliance is steadily improving.

6.6 The Trust is compliant with WRAP (Workshop to Raise Awareness of Prevent) training.

6.7 The safeguarding adult boards and safeguarding children's partnerships also provide multi-agency training. BSMHFT staff are encouraged to attend and we have seen a greater number of staff attend this training during this reporting period.

6.8 The feedback received from delegates who attended the BSMHFT safeguarding training is positive.



6.9 Chart showing training compliance for the period 2022/23.

NB: expected drop in compliance following realignment of staff to intercollegiate documents.

Safeguarding Training 2022/23 Compliance Target 85%	Q1	Q2	Q3	Q4
Safeguarding Children L1	95%	96%	96%	94%
Safeguarding Children L2	95%	95%	95%	94%
Safeguarding Children L3	84%	83%	85%	64%
Safeguarding Adults L1	94%	95%	96%	95%
Safeguarding Adults L2	95%	93%	96%	96%
Safeguarding Adults L3	83%	84%	84%	65%
Prevent	91%	94%	95%	89%

The training compliance is monitored weekly and is showing an upward trend. A trajectory is not available due to the inability to predict e-learning but it is expected that compliance will be achieved by the end of December 2023. The Trust is monitoring the risk and has mitigations in place.

7.0 Safeguarding Supervision

7.1 Safeguarding supervision provides the opportunity for learning and reflective discussion. It provides protected time to think, explain and understand safeguarding concerns, help practitioners to cope with the emotional demands of the job and help workers identify unknown issues or offer a new view on complex issues.

7.2 The Trust is committed to embedding a culture of Safeguarding Supervision and in 2022 funded Safeguarding Supervision training with an external provider for 32 staff members within BSMHFT. Following the success of the course, a further two cohorts have been funded and 36 professionals have signed up for the training throughout summer 2023. Service areas that did not secure places in the initial training sessions have been targeted with success.

7.3 Those who completed the training in 2022 have an identified person to support them with delivering their safeguarding supervision. This includes offering regular catch ups to explore how the supervision is going, discuss the use of supervision models and any challenges that may have arisen.

7.4 Safeguarding supervisor network meetings are held bi-monthly. There has been three so far covering topics such as neglect and all age exploitation, where we have had professionals from external agencies attend to present. The hope is that the safeguarding supervisors will be able to use the knowledge and resources shared within their supervision and disseminate to their wider team. The upcoming meetings plan to have focus upon self-neglect and domestic abuse, which were suggested by the network.

7.5 During the reporting period there has been a focus on developing the model and training supervisors. A Safeguarding Supervision Policy will be ratified and compliance with supervision for children subject to child protection planning will be monitored and reviewed at the Safeguarding Management Board and the local ICB.

8.0 Prevent Duty

8.1 Prevent forms part of the Counter terrorism and Security Act, 2015 and is concerned with preventing children and vulnerable adults becoming radicalised and drawn into terrorism. NHS Trusts are required to train staff to have knowledge of Prevent and radicalisation and how to spot the vulnerabilities that may lead to a person being radicalised.

8.2 The purpose of Prevent is for staff to identify and report concerns where they believe children, young people or adults may be vulnerable to radicalism or exploiting others for the purpose of radicalisation.

8.3 The Trust Prevent Lead submits a quarterly return to NHS England via NHS Digital and to the local ICB.

8.4 The Trust Prevent Lead attends Channel and represents the Trust at Prevent Operational Groups for Birmingham and Solihull and associated Prevent Delivery Groups.

8.5 SMB and QPES receives a six-monthly assurance report.

8.6 Prevent and Channel data including comparative data from the previous reporting period.

Referral rate remains low, however compliance with training is good and the Prevent Lead supports discussion with Trust staff regarding Prevent. The data shows an increase in the number of external enquiries in this reporting period, however there is no known explanation for this.

9.0 Domestic Abuse

9.1 The cross-government definition of domestic violence and abuse is:

Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but not limited to:

- *Psychological*
- *Physical*
- *Sexual*
- *Financial*
- *Emotional*

The definition includes honour-based abuse, female genital mutilation and forced marriage and it is clear that victims are not confined to one gender, religion or ethic group.

The Domestic Abuse Act 2021 sees children under 18 as victims of domestic abuse where they see, hear or experience the effect of domestic abuse.

9.2 The Trust includes domestic abuse awareness into the Level 3 Safeguarding Adults and Children Training.

9.3 There are plans to deliver bespoke domestic abuse training for identified teams that will focus on Think Family and Routine Enquiry.

9.4 The Domestic Abuse Policy has been updated to reflect the changes in the Domestic Abuse Act 2021.

9.5 The Trust continues to contribute to the Multi Agency Risk Assessment Conference (MARAC) in both Birmingham and Solihull. The local ICB is developing a model to provide a one health system to support the sharing of information to MARAC and BSMHFT is exploring this opportunity.

9.6 The Trust Named Nurse for Domestic Abuse chairs Birmingham MARAC meetings and represents the Trust at the Domestic Abuse Priority Board, Birmingham and Solihull Governance Committee and supports a review of the Birmingham Domestic Abuse Strategy.

10.0 Domestic Homicide Reviews (DHRs)

10.1 A Domestic Homicide Review (DHR) is a locally conducted multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have resulted from violence or neglect by:

- A person to whom he or she was related, or with whom he or she was or had been in an intimate personal relationship, or:
- A member of the same household as himself or herself.

10.2 DHRs were introduced by Section 9 of the Domestic Violence, Crime and Victims Act 2004 and came into force April 13 2011.

10.3 During the reporting period there was one DHR commissioned by the Community Safety Partnership and BSMHFT has supported the process.

10.4 The Safeguarding team has incorporated the learning from previous DHRs into safeguarding training and dedicated domestic abuse training will be developed and delivered during 2023/24.

11.0 Safeguarding Adult Reviews (SARs)

11.1 Under the Care Act 2014, there is a statutory requirement under Section 44 to undertake Safeguarding Adult Reviews (SARs).

11.2 A SAR is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place.

11.3 The purpose of a SAR is not to apportion blame. It is to promote effective learning and improvement to prevent future deaths or serious harm occurring again.

11.4 A SAR is commissioned when there is reasonable cause for concern about how Safeguarding Adult Board (SAB) members or other agencies providing services worked together to safeguard an adult if:

- The adult dies and the SAB knows or suspects the death resulted from abuse or neglect.
- Whether or not it knew about or suspected the abuse or neglect before the adult died.
- The adult is still alive and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

11.5 The Head of Safeguarding is a member of the SAR subgroup in Solihull and contributes to the reviews.

11.6 SAR professional guidance is available on the Trust Safeguarding pages through a link to the Birmingham and Solihull Safeguarding Adult Board websites. Cases for SAR consideration are submitted by the Trust Safeguarding Adult Lead.

11.7 During the reporting period BSMHFT was involved in the consideration of one case for a SAR, which did not meet the threshold.

12.0 Child Safeguarding Practice Reviews (CSPRs)

12.1 A CSPR takes place after a child is seriously injured and abuse or neglect is thought or known to be involved. It looks at lessons that can be learned to help similar incidents from happening in the future. The reviews are recommended at a local level and then reviewed by the national panel that decides if learning should be disseminated at a local or national level.

12.2 Birmingham and Solihull Children Partnership sub-groups are attended and represented by a member of the Safeguarding team and reviews are supported by the Safeguarding team and clinical teams who are involved with the case, to support the process.

12.3 During the reporting period, BSMHFT has participated in seven CSPRs where the children or adults have been known.

12.4 A rapid review meeting is held in all cases to gather facts about the case, ensure immediate safety of any children involved, consider potential for any safeguarding improvements and decide on next steps. As well as participating in rapid reviews for the above cases, the Safeguarding team was involved in a further eight rapid reviews in which it was identified the threshold for a CSPR was not met, that learning had been gained from the rapid review process or that any learning is being actioned by the partnership already.

12.5 The Safeguarding Management Board receives updates on all learning reviews and actions are monitored by the Local Safeguarding Children Partnerships.

12.6 The Safeguarding team has worked with Solihull Safeguarding Children Partnership to address the findings from the national review into the murder of Arthur Labinjo-Hughes. The review recommended that mental health trusts develop a Think Family approach. BSMHFT has developed a Think Family Strategy and associated delivery plan which is monitored at its Safeguarding Management Board.

12.7 BSMHFT is launching its Think Family strategy in the summer of 2023. The Safeguarding team will monitor the uptake of the guidance, support a Think Family approach through reflective supervision and offer targeted support through local clinical governance committees.

13.0 Learning from External Reviews

13.1 BSMHFT Safeguarding team participates in external reviews, such as DHR, SAR and CSPR. Learning from these reviews - which includes our own single agency learning and wider lessons - is important to develop practice and to reduce the risk of similar issues arising.

13.2 Emerging themes are considered and as a result policies, guidelines and training are updated.

13.3 Assurance that learning has been embedded into practice is key to providing evidence and this is achieved by audits related to specific areas of practice.

13.4 Themes that are emerging from reviews this year are consistent with national findings and include: lack of professional curiosity; sharing information with safeguarding partners in a timely manner; thinking about children in the home and any associated risks; the impact of cannabis use on parenting capacity and gender bias.

13.5 To address these themes, BSMHFT has developed training packages which are delivered by the Safeguarding team to clinical staff including the medical team.

The Think Family strategy has been adopted and will be launched in the summer of 2023. The Domestic Abuse Policy has been updated to remind staff that domestic abuse occurs across all genders, identities and sexuality. Safeguarding supervision will be rolled out across all directorates to facilitate reflective discussions and promote professional curiosity. Additional guidance will be written to support effective information sharing across agencies to support safety planning and identification of risk.

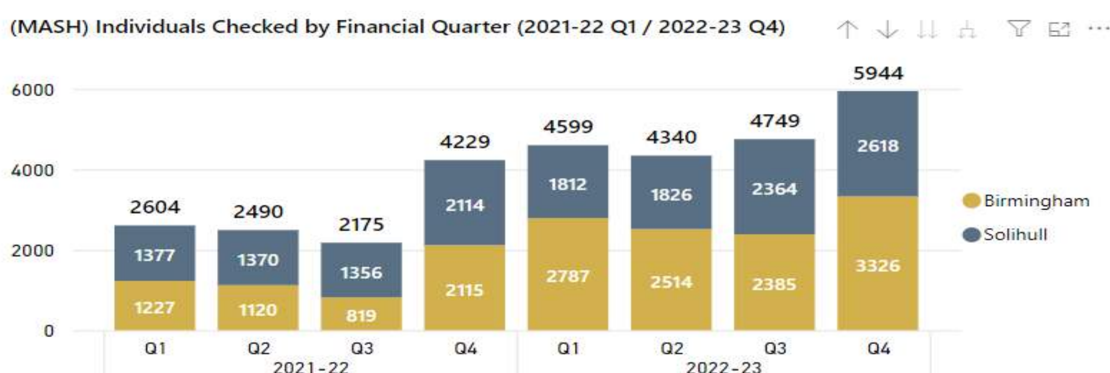
13.6 Audits have been undertaken in specific services to provide assurance that domestic abuse is considered, Think Family principles are applied and referrals are made where safeguarding concerns exist.

14.0 <u>Multi-Agency Safeguarding Hub (MASH)</u>

14.1 BSMHFT is commissioned to provide mental health information into both Birmingham and Solihull MASH. In Solihull, BSMHFT provides information about adults and children and in Birmingham for adults only.

14.2 Information is shared in line with statutory guidance to safeguard children. (Working Together to Safeguard Children 2018). Effective sharing of information between practitioners and local agencies is essential for the early identification of need to keep children safe. Serious Case Reviews have highlighted that missed opportunities to share relevant information in a timely way can have serious consequences for the safety and welfare of children (Triennial analysis of serious case reviews (SCRs) 2022. Learning for the future: Messages for child and family social care from SCRs conducted 2017-19 (Research in Practice and University of Birmingham).

14.3 The number of enquiries is monitored quarterly and reported to the Safeguarding Management Board and local Integrated Care Board (ICB). The number of enquires has significantly increased this year across Birmingham and Solihull with an average of 10% of all enquires having service users known to BSMHFT. The ICB funds three nurses to work in MASH across Birmingham and Solihull.



15.0 Safeguarding Adult Incident Reporting Data

15.1 All service user safeguarding incidents are reported on the internal incident reporting system (Eclipse). The incidents are reviewed and screened by the Safeguarding team to identify cases where suspected abuse or neglect has been indicated. This supports staff in their decision-making to consider any safeguarding concerns and to make the appropriate local authority safeguarding referrals.

15.2 There were 217 adult safeguarding referrals raised by BSMHFT staff in 2022/23 compared to 183 in 2021/22. This year the referral rate is higher which could indicate an increase in Trust staff awareness of safeguarding issues.

15.3 The nature of safeguarding referrals is recorded with physical and psychological abuse having the highest number followed by financial and domestic abuse.

15.4 The Dementia and Frailty team raised the highest number of safeguarding incidents (54) followed by Acute Care (43).

15.5 In areas where there are low numbers of reporting, the Safeguarding team is doing targeted safeguarding awareness work.

16.0 Safeguarding Children Incident Reporting Data

16.1 There were 168 children safeguarding referrals raised by Trust staff in 2022/23 compared to 158 in 2021/22. This year the referral rate is similar to last year which indicates continued awareness of child safeguarding issues.

16.2 The nature of safeguarding referrals is recorded with emotional abuse and neglect being the highest reported, which is in line with local themes.

16.3 Urgent Care and Recovery raised the highest number of safeguarding incidents (36 each). Solar - BSMHFT's Emotional Wellbeing and Mental Health Service for Children, Young People and Families in Solihull – raised 32 incidents.

16.4 In areas where there are low numbers of reporting the Safeguarding team is doing targeted safeguarding awareness work.

17.0 Citizen Story

17.1 BSMHFT had considered adding a citizen story to this annual review but was unable to meet this wish within the timescales and will be included in next year's annual review.

18.0 Conclusion

18.1 In the reporting period, the Safeguarding team has promoted the importance of safeguarding supervision and Think Family being a standard operating process in all aspects of service delivery.

18.2 BSMHFT is committed to building safeguarding capacity throughout the Trust which incorporates 60 safeguarding supervisors and additional recruitment to the corporate Safeguarding team.

18.3 Links between the Patient Safety and Safeguarding teams have strengthened in this period and BSMHFT will continue to prepare for the implementation of the Patient Safety Incident Reporting Framework (PSIRF) in the coming year, where safeguarding is an integral component.

18.4 Finally, this report needs to acknowledge and provide focus to the numerous excellent safeguarding achievements which have occurred in this reporting period. There are a great number of committed staff who work impeccably to support and serve our service users and their families and the Safeguarding team would like to acknowledge them all.

Safeguarding Team Annual Plan 2022/23

Workstream	Objective	Action Required	Responsible Person	Timescale	Evidence / Progress
1. Quality Assurance Provide a comprehensive Quality Assurance Framework which monitors standards and improve outcomes					
	Safeguarding dashboard to reflect quality standards for services and the Trust including Think Family Standards	Review current dashboard and agree what needs to be included	Head of Safeguarding HOS	Dec 22	G
	Improve the link between learning from safeguarding reviews and organisational quality goals to drive improved clinical effectiveness	Review current tracker to ensure outstanding actions are completed	HOS		G
		Audit programme to be developed to provide assurance	HOS and Named Professionals		G
		Support Learning from incidents and SI's using framework such as After-Action Reviews	HOS		G

	Embed Think Family Strategy	Linked to delivery plan for Think Family	SG Team and Heads of Nursing AHP’s		A
		Quality Improvement Framework to include Think Family	HOS		A
2. Domestic Abuse Work in partnership with our local partners to identify victims of domestic abuse and protect them from harm					
	Ensure BSMHFT actively supports and provide information to MARAC to safeguard service users	Work with the ICB IVT nurses to ensure mental health information is shared at MARAC	Named Nurse DA		A
		Develop a supervision/ practice standard for service users who are discussed at MARAC	Named Nurse DA		A
	Support the development of IDVA role within BSMHFT	Develop a collaborative approach with BWA to evaluate the pilot	Named Nurse DA		A
	Review themes from DHRs to ensure learning has occurred	Review previous learning events and identify gaps	Named Nurse DA		A
3. Safeguarding Adults					

Develop a comprehensive programme to support teams to identify safeguarding incidents and report					
	Accurately report numbers of BSMHFT referrals to Adult Safeguarding	Remind staff to use Eclipse and explore ways to obtain this data from the Local Authority – link with designated nurses and raise at Birmingham and Solihull operational group	Safeguarding Adult Lead		G
	Understand and review how BSMHFT supports section 42 enquiries to make safeguarding personal	Identify service users who are subject to S42 and develop RiO alert and data capture mechanisms	Safeguarding Adult Lead	Dec 22	A
	Support the introduction of Liberty Protection Safeguards with our Mental Health Legislation Colleagues	Review policies and SG training to include new guidance	Safeguarding Adult Lead and LPS lead		G
		Develop links with Mental Health Legislation colleagues to ensure that the link between safeguarding and mental capacity is better understood	Adult Safeguarding Lead	June 23	A

	Report numbers of PiPoT	To link with HR to ensure SMB is cited on these numbers	HOS and HR Lead		G
4. Safeguarding Children Develop a comprehensive programme to support teams to identify safeguarding incidents and report.					
	Develop our contribution to MASH in Solihull and initiate a MASH rotation of staff	Recruit to CCG funding	HOS and Named Nurse children	Dec 22	G
		Support development of the "Health Offer" within MASH	HOS and Named Nurse children		G
	To provide the children workforce with a SG SV model to ensure SG concerns are identified early	Develop a Children SG SV Policy/Standard	HOS and Named Nurse children	Dec 22	A
		Evaluate the Medic Supervision pilot in Perinatal MH Teams and consider how to roll this out to Solar	Named Doctor SG Children	Dec 22	G
	Accurately report numbers of BSMHFT	Remind staff to use Eclipse and explore ways to obtain this data from the Local	Named Nurse SG Children		G

	referrals to Children Safeguarding	Authority (LA) – link with designated nurses and raise at Birmingham and Solihull Operational Group			
	Report numbers of LADO referrals to the LA	To link with HR to ensure SMB are cited on these numbers	HOS		G
	Develop a system to identify children who are subject to CP plan LAC	Develop links with the LA to obtain these numbers weekly and update the RiO system	HOS and Named Nurse children		G
	BSMFHT to monitor attendance of staff at CP meetings	BSMHFT to receive all invites to meetings and monitor attendance	Named Nurse children		G
5. **Training and Development** Provides a comprehensive training programme designed to meet the requirements set out in the Intercollegiate documents and to meet the Trust targets					
	To ensure BSMHFT staff have access to Safeguarding training relevant to their role	Safeguarding HUB to publish the available courses and provide booking information	HOS and Training Facilitator		G

	Accurately report compliance of SG training to commissioners and address deficits with a focus on FCAMHS and Solar	Identify staff who are not compliant and request Head of Nursing and AHP ensure compliance	HOS and Training Facilitator		G
	Develop resilience in the team to deliver training alongside Jason	Review Partnership and SAB offers and ensure these are available to staff and attendance is logged with L&D	Training Facilitator		G