Safeguarding Annual Report 2025–26

Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT)

1. INTRODUCTION

This report provides an overview of safeguarding activity, developments, and assurance across Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) during the period April 2025 – end of March 2026. It sets out how the Trust has met its statutory safeguarding responsibilities in line with the Care Act 2014, the Children Acts 1989 and 2004, and Working Together to Safeguard Children (2026), alongside relevant NHS England standards and contractual requirements.

Detailed safeguarding performance data, audit findings, training compliance metrics, incident reporting trends and assurance activity have been reported throughout the year via quarterly reports to the Safeguarding Management Board. This annual report provides a strategic summary of key achievements, challenges and priorities during 2025/26.

The reporting period has been characterised by significant progress, development, and strengthening of safeguarding practice across the Trust. This has been achieved against a backdrop of increasing demand, system complexity, and ongoing resource pressures, requiring a continued focus on prioritisation, partnership working, and effective use of intelligence to inform practice.

This report outlines the breadth and depth of work delivered by the safeguarding team and wider organisation, demonstrating a proactive, intelligence-led, and partnership-driven approach to safeguarding. It highlights progress in strengthening governance and assurance arrangements, enhancing staff capability through training and supervision, and embedding learning to support continuous improvement.

The progress described within this report provides a strong foundation for continued development, as the Trust remains committed to ensuring that safeguarding is integral to all aspects of service delivery and organisational culture.

2. SAFEGUARDING CHILDREN AND YOUNG PEOPLE (CYP) WORKSTREAM

During 2025–26, the Children and Young People safeguarding workstream has focused on strengthening governance, practice quality, and system oversight, particularly following the integration of Forward-Thinking Birmingham (FTB) services to BSMHFT in July 2025.

2.1 Key Achievements:

The Safeguarding Children and Young People Policy was updated in 2025 to reflect updated statutory guidance (Working Together to Safeguard Children, 2023), the expansion of the West Midlands Regional Safeguarding Collaboration, ratification of the Trust's Safeguarding Supervision Policy, and the expansion of the Child Protection Information System (CP-IS) to include mental health services. These updates ensure that safeguarding practice across the Trust remains aligned with current national and regional requirements, providing staff with clear guidance to support consistent decision-making, effective information sharing, and timely responses to safeguarding concerns. This helps ensure that children, young people, and families receive safe, coordinated, and compliant care.

Significant work has been undertaken to improve attendance and contribution to Initial and Review Child Protection Conferences (ICPCs and RCPCs), enhancing both the quality of professional reports and engagement in multi-agency safeguarding processes. Mental health practitioners are often uniquely placed to provide insights into parental mental health, family functioning, risk factors, and engagement with services, ensuring that conference discussions and subsequent child protection plans are informed by a comprehensive understanding of the family's circumstances. This approach strengthens multi-agency decision-making, improves information sharing, and supports more effective safeguarding plans for children and young people. This has been particularly important in response to increased CYP demand following the transition of FTB services.

A programme of audit and quality assurance activity has been expanded, including reviews of Early Help, quality of safeguarding referrals, supervision, and conference participation. These audits have helped identify variation in practice and informed targeted improvement plans across services.

In line with local partnership priorities, the Trust completed an evaluation of its recognition and response to child neglect, resulting in a detailed action plan. This included strengthening the internal neglect group and embedding a dedicated Key Line of Enquiry (KLOE) within safeguarding assurance visits. These developments support earlier intervention and reduce the risk of children experiencing ongoing cumulative harm.

Active participation in Solihull Safeguarding Children Partnership and its sub-groups, including Learning and Development and Quality and Assurance, has strengthened partnership working, enabled the Trust to influence local safeguarding priorities from a mental health perspective, and supported the translation of multi-agency learning into service improvements that benefit children, young people, and families accessing BSMHFT services.

Engagement and participation with Birmingham Safeguarding Children's Partnership and subgroups continues to grow following the integration of FTB (CYP) services, with requests for representation within Harm Outside the Home, Keeping Vulnerable Babies Safe, and Children Out of Sight workstreams. This enables the Trust to contribute a mental health perspective to local safeguarding priorities and supports the development of more coordinated responses for vulnerable children and families.

The safeguarding team have Participated in Partnership multiagency audits and learning events, contributing to the safeguarding agenda with a mental health lens, ensuring we are able to advocate for our service users and their families.

Oversight has been strengthened through routine review of all Sudden Unexpected Death in Childhood (SUDIC) notifications, providing greater organisational visibility, strengthening learning from child deaths, and supporting service improvements that contribute to safer care for children and families.

A comprehensive suite of 7-minute briefings has been updated and expanded to reflect emerging themes, including harmful sexual behaviour, fabricated or induced illness, hostile or intimidating parents, and care-experienced parents. These resources support workforce development by improving staff awareness, confidence, and understanding of complex safeguarding issues, promoting more consistent and informed safeguarding practice across services.

Safeguarding support and supervision arrangements have been embedded within all children-facing teams that transitioned from FTB into BSMHFT. This includes the integration of Think Family principles, a minimum requirement for quarterly safeguarding supervision, but many teams are offered a monthly opportunity to engage in safeguarding supervision.

Safeguarding supervision is delivered using a risk-based and proportionate model. Priority is given to services and roles with the highest level of safeguarding responsibility, risk, and complexity, including services that work across children's and adult populations where risks intersect. Safeguarding supervision, alongside clinical supervision, ensures staff are supported, competent and confident to safeguard children, young people and adults at risk, and to collaborate effectively with partner agencies.

The safeguarding team have increased their visibility to clinical teams, by weekly co-location of safeguarding facilitators within CYP core teams and multidisciplinary team (MDT) meetings, this enables staff to seek advice and support and ad-hoc supervision on cases whilst embedding a visible safeguarding presence and strengthening safeguarding culture within frontline practice.

Safeguarding Assurance Visits were completed across a range of services, including Street Triage and the Psychiatric Decisions Unit (PDU), a Community Mental Health Team (CMHT), and MSU-CAMHS. Assurance visits were also initiated within the CYP Division, with the first visit and report completed for the CYP Crisis and Home Treatment Team (CHTT) for under 18s. These visits have strengthened organisational assurance by providing oversight of safeguarding practice, identifying learning opportunities, and supporting targeted service improvements to enhance the safety and wellbeing of service users and their families.

Existing action plans arising from Child Safeguarding Practice Reviews (CSPRs) involving FTB were incorporated into the BSMHFT Safeguarding Team's external review tracker. Oversight and progress against these plans were maintained, alongside completion of multiple additional action plans where learning had been identified through reviews. This approach ensures that learning from serious safeguarding incidents is translated into tangible improvements in practice, helping to reduce the

likelihood of similar concerns recurring and strengthening the quality and safety of care provided to children and families.

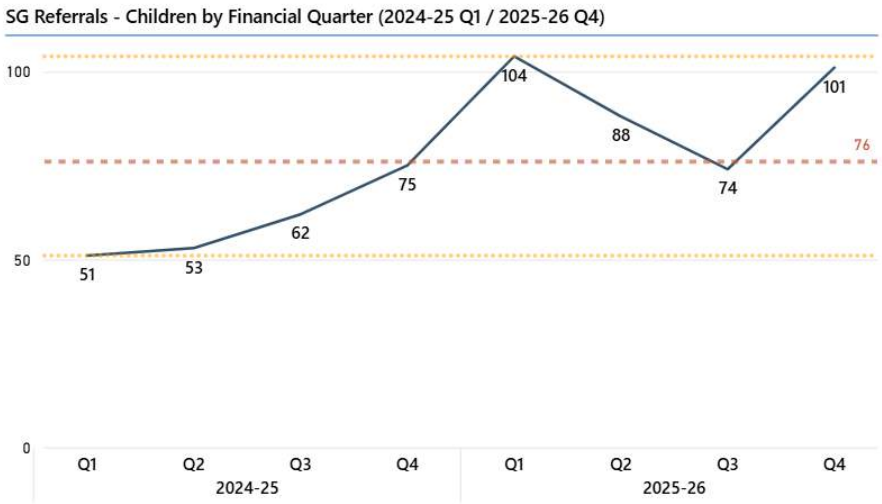
Early Help update sessions were delivered to the safeguarding team by Birmingham and Solihull children's services to strengthen the safeguarding teams' understanding of changes to Early Help models within both local authorities to ensure consistent advice and support for clinical colleagues seeking support. Correspondingly, a 7-Minute Briefing was updated and disseminated via the Safeguarding Hub, training sessions, supervision forums, and the safeguarding duty and advice line.

Safeguarding advice, support, and supervision were provided to Parkview Clinic through a Service Level Agreement between July 2025 and March 2026. A planned and successful handover of safeguarding arrangements back to Birmingham Women's and Children's Hospital NHS Foundation Trust were completed successfully in March 2026.

Changes and improvements to Level 3 Safeguarding Children face-to-face training were implemented. As a direct action arising from safeguarding assurance visits, communications were issued to all senior managers advising that staff working in children-facing services must access BSMHFT-delivered webinar or face-to-face training rather than the NHSE e-learning module. This ensures staff receive training that reflects local safeguarding arrangements, thresholds, referral pathways, and partnership processes, strengthening practitioner confidence and decision-making. As a result, of specialist face to face training, children and young people benefit from staff who are better able to recognise safeguarding concerns, make appropriate referrals, and contribute effectively to multi-agency safeguarding arrangements.

There has been improved incident reporting in relation to children's safeguarding activity, with evidence of more robust recognition, escalation, and response to safeguarding concerns across services, including adult-facing services such as HTTs and CMHTs. This reflects a strengthening Think Family culture, where staff are increasingly considering the impact of adult mental health on children and taking appropriate action to safeguard vulnerable children. Improved reporting supports earlier identification of risk, timely multi-agency intervention, and better outcomes for children and families.

This significant improvement in the completion of incident forms linked to safeguarding children's referrals, demonstrates increased staff awareness and improved governance and oversight of safeguarding through continued engagement with clinical teams via increased visibility, the scope and breadth of the safeguarding supervision offer and increased demand on seeking advice via the team's duty and advice line.



2.2 Key Challenges:

The transition of FTB services into BSMHFT has resulted in a significant increase in safeguarding activity and demand across the workstream. This has placed ongoing pressure on the team, both from an administrator perspective and Named Nurse and Named Doctor capacity. This is due to the volume and complexity of cases requiring advice, consultation, and support.

Challenges have also arisen from dual incident reporting systems (Datix and Eclipse), impacting efficiency and increasing administrative burden. Issues were experienced in the transition of CYP services who use Datix for incident reporting, limiting the BSMHFT Safeguarding Team's ability to maintain oversight. Interim arrangements were implemented, including receipt of weekly reports, followed by direct Datix access. However, this has increased workload pressures due to the continued requirement to monitor and report across two separate systems.

The implementation of the Child Protection Information Sharing (CP-IS) system into mental health services has been delayed due to digital access issues via the Shared Care Record (SCR). This has been escalated to the ICB and NHS England colleagues, who are providing support. The CP-IS launch deadline has now been rescheduled to September 2026.

CP-IS is an important safeguarding tool for mental health services, providing clinicians with real-time access to information regarding children who are subject to Child Protection Plans, Looked After Children, and unborn children with safeguarding concerns. Access to this information strengthens risk assessment, supports the Think Family approach, improves information sharing with children's social care, and enables more informed safeguarding decision-making to improve outcomes for vulnerable children and families.

3. SAFEGUARDING ADULTS WORKSTREAM

The Safeguarding Adults function has made strong progress during 2025–26, with a clear focus on strengthening quality assurance, embedding safeguarding into everyday clinical practice, and using data and thematic learning to drive improvement.

Key developments include the introduction of intelligence-led audit processes, expansion of safeguarding supervision across all inpatient settings, and increased workforce development through targeted training such as PIPOT.

There has been a notable rise in safeguarding activity and reporting, reflecting improved staff awareness, confidence, and governance, evidenced by a significant increase in incident reporting and growing use of the duty and advice line.

Enhanced visibility of the safeguarding team, alongside deeper engagement with clinical services and multi-agency partners, has supported the embedding of the “Think Family” approach and improved organisational insight into complex themes such as self-neglect and hoarding.

While challenges remain, including rising demand, increased Safeguarding Adult Review and PREVENT activity, and the need for consistent practice across services, the overall trajectory demonstrates a more proactive, data-informed, and partnership-driven approach to safeguarding that is strengthening patient safety and outcomes.

3.1 Key Achievements:

Introduction of an audit of incident reporting, enabling identification of high-risk areas and emerging safeguarding themes. Two audits were completed in 2025/26, with more planned for 2026/27. This has enhanced the team’s ability to target support and drive preventative action.

Greater integration of safeguarding into routine clinical oversight through supervision and ward-based engagement has strengthened the identification, assessment, and management of safeguarding concerns within day-to-day clinical practice. This supports earlier recognition of risk, enhances staff confidence in responding to complex situations, and contributes to safer, more person-centred care for adults at risk and their families.

The expansion of safeguarding supervision to all inpatient settings has strengthened safeguarding practice, increased staff confidence in managing complex cases, and supported earlier identification and management of abuse, neglect, exploitation, self-neglect, and other safeguarding risks, contributing to improved patient safety and wellbeing.

A structured PIPOT (People in Positions of Trust) training package was developed, with rollout to inpatient services underway in 2026 and continuing as a priority for 2026/27. The training aims to strengthen staff awareness and understanding of their responsibilities when concerns arise involving people in positions of trust, promoting early recognition, timely escalation, and appropriate management of concerns. This supports a culture of openness, accountability, and patient safety, helping to protect some of the Trust’s most vulnerable patients from potential abuse, harm, or exploitation.

Increased organisational focus on complex safeguarding themes, including self-neglect, hoarding, and PIPOT, has improved organisational understanding of areas associated with significant risk and vulnerability. This has enabled targeted improvement activity, strengthened safeguarding practice,

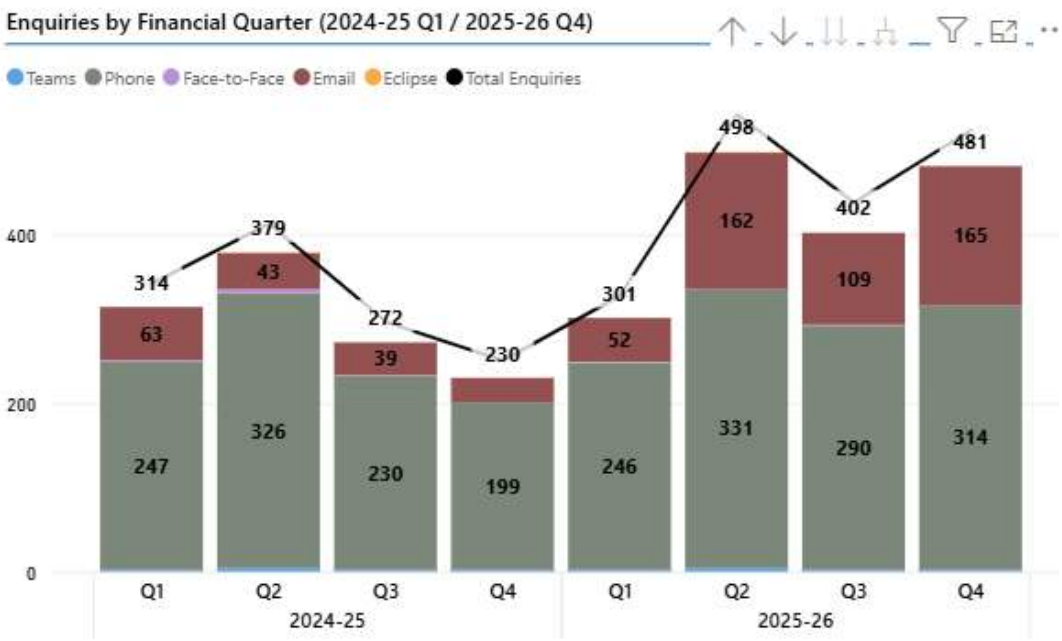
and supported earlier intervention for individuals who may be at risk of abuse, neglect, exploitation, or serious harm.

Completion of thematic audits relating to PIPOT, self-neglect and hoarding has provided valuable assurance regarding safeguarding practice, identified opportunities for improvement, and informed action plans to strengthen the recognition and management of some of the most complex safeguarding concerns encountered within mental health services. The audit work has strengthened organisational insight and informed future priorities. There is an ongoing programme of thematic audits to support learning and service improvement.

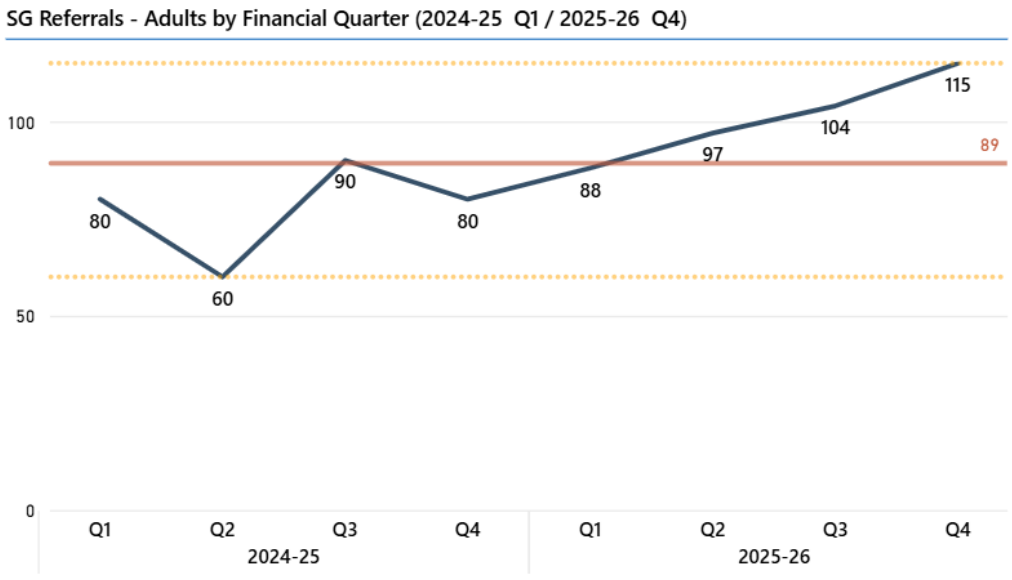
Increased visibility of the safeguarding team within clinical areas, and direct face-to-face engagement with frontline teams, has strengthened the embedding of the Think Family approach across services. Through safeguarding supervision, quality assurance activity, and real-time advice and support, staff have been encouraged to consider the wider needs and risks affecting children, adults, carers, and family members. This has supported earlier identification of vulnerability, improved multi-agency working, and more holistic, family-centred care for service users and their families.

Activity to the safeguarding team's duty and advice line has continued to increase during 2025/26, demonstrating that staff feel increasingly confident in seeking safeguarding advice, guidance, and support. This reflects a growing safeguarding culture across the Trust, where practitioners are proactively discussing concerns, seeking professional challenge, and accessing specialist expertise. As a result, safeguarding risks are more likely to be recognised, appropriately managed, and escalated where necessary, supporting safer outcomes for adults at risk, children, and families.

Analysis of duty and advice line activity demonstrates particularly high levels of engagement from Primary Care and Specialist Psychotherapy Services (SPS), Community Mental Health Teams (CMHTs), and Acute and Urgent Care services, reflecting the complexity of safeguarding concerns managed within these settings and the value placed on accessing specialist safeguarding support.



There has been improved incident reporting in relation to safeguarding activity, with evidence of more robust recognition, escalation, and response to safeguarding concerns across services.



The significant improvement in the completion of incident forms linked to safeguarding referrals demonstrates increased staff awareness, strengthened safeguarding culture, and improved organisational governance.

- Q4 2024–25: 80 incident forms
- Q4 2025–26: 115 incident forms

- This represents a 40% increase in reporting.

The increase provides assurance that staff are more confident in recognising and escalating safeguarding concerns, seeking appropriate support, and fulfilling their safeguarding responsibilities. Improved reporting also strengthens organisational oversight, enabling the Trust to identify emerging themes, monitor risk, share learning, and implement targeted improvements to safeguard adults at risk and improve patient safety. Whilst an increase in incident reporting does not necessarily indicate an increase in safeguarding incidents, it does demonstrate improved recognition, professional curiosity, and confidence amongst staff, strengthening the Trust's ability to identify risk and intervene and share information appropriately.

The safeguarding team has continued to actively engage with Birmingham and Solihull Safeguarding Adult Boards and their sub-groups, including Learning and Development and Quality and Assurance. This strengthens partnership working, ensures mental health perspectives are reflected in local safeguarding priorities and decision-making, and supports the implementation of multi-agency learning to improve safeguarding practice and patient outcomes across the Trust.

Participation in Safeguarding Adult Board multi-agency audits and learning events has enabled BSMHFT to contribute a mental health perspective to the wider safeguarding agenda, ensuring that the experiences and needs of people accessing mental health services are reflected in partnership learning and service development. This supports stronger multi-agency responses to safeguarding concerns, promotes shared learning across organisations, and enables the Trust to advocate for improved outcomes, safety, and wellbeing for service users, carers, and their families.

3.2 Key Challenges:

Rising demand: There has been a notable increase in Safeguarding Adult Review (SAR) activity during 2025/26, placing additional pressure on safeguarding team capacity and requiring sustained organisational engagement in information gathering, review activity, action planning, and assurance processes. Whilst these reviews provide important opportunities for organisational learning and practice improvement, the increasing volume and complexity of SAR activity creates additional resource pressures for both the safeguarding team and operational services.

Growth in PREVENT activity: The Trust has experienced a continued increase in PREVENT-related activity over the past two years, requiring ongoing staff support, training, advice, and multi-agency collaboration. The evolving nature of radicalisation risk and vulnerability requires organisations to maintain workforce competence and ensure timely identification, assessment, and management of concerns.

Consistency of practice: Ensuring consistent safeguarding practice across a large and diverse organisation remains an ongoing challenge. Continued focus is required to embed the Think Family approach, maintain safeguarding awareness, and support consistent reporting and escalation of safeguarding concerns across all services and care settings. Variations in clinical settings, patient groups, and staff experience require sustained investment in training, supervision, quality assurance, and safeguarding support.

4. DOMESTIC ABUSE AND SEXUAL SAFETY WORKSTREAM

The Domestic Abuse and Sexual Safety workstream has made significant progress in 2025–26 across training, culture, system improvement and strategic leadership. Key achievements include the expansion of bespoke training and awareness initiatives, particularly in relation to Domestic Abuse Related Death Reviews, sexual safety, and Adult Child to Parent Abuse; alongside the development of new resources and co-delivered programmes with specialist partners.

The Trust has strengthened a culture of routine enquiry and "Think Family" practice through targeted engagement, supervision, and leadership forums, while enhancing tools, pathways, and guidance such as MARAC processes, risk assessment training, and IDVA provision.

Strong multi-agency collaboration and leadership remain evident through active participation in governance structures, audits, and national forums. These efforts have contributed to improved reporting of domestic abuse and sexual safety concerns, demonstrating increased staff awareness and confidence, alongside ongoing assurance work and the continued embedding of trauma-informed safeguarding across services to enhance patient safety and outcomes.

4.1 Key Achievements:

The safeguarding team has continued to raise awareness of key themes arising from Domestic Abuse Related Death Reviews (DARDRs), including the links between domestic abuse and suicide, the importance of Routine Enquiry and Think Family approaches, and Adult Child to Parent Abuse (ACPA), through bespoke mandatory domestic abuse training. This helps staff to identify domestic abuse earlier, understand its impact on mental health and family functioning, and take timely action to improve safety and outcomes for service users and their families.

Following review of incident reporting, safeguarding intelligence and emerging practice themes, the safeguarding team has commenced development of a dedicated adult child to parent abuse (ACPA) training video resource. This work will continue into 2026/27 and aims to strengthen staff awareness, recognition, and response to a form of abuse that can often remain hidden or poorly understood. Improved practitioner understanding will support earlier identification of risk, more effective support for affected families, and a more coordinated safeguarding response.

The team has delivered a series of Safeguarding Sexual Safety bite-size awareness training sessions to targeted inpatient teams. This work supports the Trust's commitment to creating safe, therapeutic environments by improving staff confidence in recognising and responding to sexual safety concerns, promoting professional curiosity, and encouraging a culture of openness, reporting, and early intervention. The ultimate benefit is improved safety, dignity, and wellbeing for patients receiving inpatient care and for staff providing the care. This work will continue as a priority in 2026/27.

The safeguarding team has co-facilitated Domestic Abuse Awareness Training across the Trust, based on the IRIS model and delivered in partnership with BSWAID's Independent Domestic Violence

Advisor (IDVA). This approach combines mental health expertise with specialist domestic abuse advocacy, strengthening staff understanding of domestic abuse, its impact on mental health, and the importance of early identification and intervention. As a result, practitioners are better equipped to recognise abuse, undertake routine enquiry, assess risk, and support service users and their families to access appropriate safeguarding and specialist support.

Delivery of additional targeted safeguarding training is informed by intelligence gathered through Eclipse incident reporting, calls to the safeguarding duty and advice line, safeguarding supervision, assurance activity, and learning arising from statutory review processes. This ensures workforce development remains responsive to emerging risks, organisational learning, and areas of greatest need, supporting continuous improvement in safeguarding practice and enhancing safety outcomes for service users and their families.

The Trust has continued to strengthen its Independent Domestic Violence Advisor (IDVA) provision, which operates across five clinical teams and is available to all female staff across BSMHFT, with access now extended to CYP staff. Male staff requiring support are signposted to appropriate specialist services. The IDVA role provides specialist advice, advocacy, safety planning, and support for individuals affected by domestic abuse, helping to reduce risk, improve access to support services, and promote safer outcomes for both service users and staff experiencing abuse.

Routine Enquiry, Think Family principles, and the recognition and response to domestic abuse have continued to be promoted across mental health services through training, safeguarding supervision, the duty and advice line, and staff consultation. This has strengthened staff confidence in identifying domestic abuse, understanding its impact on adults, children, and family relationships, and responding appropriately to concerns. Increased awareness supports earlier identification of abuse, timely referral to specialist services, and improved safeguarding outcomes for service users and their families.

To further expand the Trust's broad and inclusive safeguarding supervision model, the safeguarding team extended the offer of safeguarding supervision to three Community Mental Health Teams (CMHTs) as a pilot, alongside CYP Crisis 18+. The CMHTs were selected using intelligence gathered through MARAC notifications, safeguarding duty and advice activity, and learning arising from statutory review processes. This targeted approach ensures that safeguarding support is focused on services managing higher levels of complexity and vulnerability, strengthening staff confidence, professional curiosity, and decision-making. The supervision model supports earlier identification of risk, promotes effective multi-agency working, and contributes to improved safeguarding outcomes for service users, children, and families. The pilot commenced in early 2026 and will continue throughout 2026/27, with evaluation informing future development of the supervision model.

The Named Nurse for Domestic Abuse and Sexual Safety attended a range of internal committees and forums, including the People Committee, Medics CPD Master Class, Matrons Away Day, and Freedom to Speak Up Guardian Away Days, promoting awareness of domestic abuse and sexual safety to a broad range of colleagues across the Trust. This has increased the visibility of these important safeguarding themes, strengthened leadership engagement, and supported the development of a culture where concerns are recognised, discussed, and responded to

appropriately. Increased awareness amongst leaders and frontline staff contributes to earlier identification of risk, improved support for those affected, and safer experiences for service users and staff.

A Non-Fatal Strangulation, DASH and MARAC referral training package was developed and delivered to clinical teams. Informed by organisational and partnership intelligence, the training has improved staff awareness of high-risk domestic abuse indicators and strengthened confidence in risk assessment, referral pathways, and multi-agency working, supporting earlier intervention and improved safety outcomes for victims and their families.

The safeguarding team provided support and advice to Urgent Care Matrons to review the Home Treatment Team (HTT) triage tool, embedding Think Family principles within the assessment process. This has strengthened the identification and consideration of children connected to service users at the earliest point of contact, ensuring that potential safeguarding concerns affecting children and family members are recognised and responded to appropriately. The revised approach promotes more holistic assessment, improves understanding of family circumstances, and supports earlier intervention to enhance the safety and wellbeing of service users, children, and their families.

The safeguarding team have continued to actively contribute to multi-agency Domestic Abuse Related Death Reviews (DARDRs), providing specialist mental health expertise to inform analysis, strengthen inter-agency learning, and ensure that recommendations are effectively translated into practice. This includes supporting services to implement agreed actions, monitoring progress, and embedding learning into policy, training, and clinical pathways to enhance safeguarding practice and improve patient safety outcomes.

The safeguarding team have revised and implemented a smarter BSMHFT MARAC administration process to ensure the timely upload of BSOL MARAC notifications onto the Trust's clinical system, enabling clinical teams to be promptly informed of high-risk domestic abuse concerns for service users open to BSMHFT and supporting appropriate risk management and intervention.

Clinical oversight from the safeguarding team has been provided in relation to actions agreed at MARAC for the Trust, including attendance at, and support to staff participating in, multi-agency professionals' meetings to ensure effective implementation and coordinated risk management.

The Named Nurse for Domestic Abuse & Sexual Safety continues to represent BSMHFT at the Priority Operational Group (POG), contributing to the delivery and oversight of Birmingham's Domestic Abuse Strategy. This ensures that mental health perspectives are embedded within the city-wide action plan and informs strategic decision-making reported to the Domestic Abuse Board.

The Named Nurse for Domestic Abuse & Sexual Safety provides senior representation for BSMHFT within MARAC governance structures, including active participation in external MARAC audits, strengthening multi-agency accountability, improving information-sharing, and enhancing partnership effectiveness in managing high-risk domestic abuse cases.

The Named Nurse for Domestic Abuse & Sexual Safety chairs Birmingham MARAC meetings, providing strategic leadership to ensure robust multi-agency risk assessment, coordinated safety planning, and effective oversight of actions to safeguard high-risk individuals and families.

The Named Nurse for Domestic Abuse and Sexual Safety presented BSMHFT's Domestic Abuse and Sexual Safety Workplan to the Violence Against Women and Girls (VAWG) Team at the National Police Chiefs' Council in London. This provided an opportunity to contribute to national strategic discussions, share innovative safeguarding practice, and showcase learning from within mental health services. Engagement at a national level helps ensure that emerging best practice and learning are reflected within Trust services, strengthens BSMHFT's reputation as a leader in safeguarding, and supports the continuous development of approaches that improve safety and outcomes for service users and their families.

There has been a sustained increase in domestic abuse reporting through Eclipse, demonstrating improved staff awareness, confidence, and willingness to identify and respond to safeguarding concerns. This enhanced visibility supports earlier intervention, contributing to improved safety outcomes for service users and reducing risk of escalation for individuals and their families.

A rise in Sexual Safety incident reporting, through both Eclipse and direct disclosures, reflects a strengthening culture of openness and psychological safety. This ensures that concerns are recognised, escalated, and addressed appropriately, with strengthened governance through reporting to the Safeguarding Management Board and TCSE. The impact is improved recognition of harm, enhanced support for victims, and a safer care environment for service users and staff.

Targeted safeguarding assurance visits to South Neighbourhood Mental Health Team (NMHT) and North Community Mental Health Team (CMHT) have enabled the identification of service-specific risks and learning needs, leading to tailored interventions including joint teaching sessions focused on domestic abuse. The introduction of ongoing quarterly safeguarding supervision for North CMHT supports sustained improvement, enhances practitioner confidence, and drives consistent, high-quality safeguarding practice that directly benefits service users and their families.

The team have, during 2025/26, continued to embed trauma-informed safeguarding approaches across BSMHFT services to strengthen person-centred care, ensuring that the safety, dignity, and rights of service users and staff remain central. This approach supports more compassionate, responsive interventions, improves engagement with services, and recognises the wider impact of trauma on individuals and their family networks, contributing to better overall wellbeing and recovery outcomes.

4.2 Key Challenges:

The BSMHFT Safeguarding Team encountered sustained challenges and delays in securing funding for a bespoke Level 3 domestic abuse training resource. The design of this resource is aligned with statutory refresher requirements, necessitating renewal every three years, and as such it is not suitable for repeated delivery to the same staff cohort. The current training provision is due to reach the end of its usable lifespan in November 2026.

Whilst Sexual Safety Awareness Training has been well received, operational pressures continue to impact staff release and training attendance within inpatient services. This presents a challenge to achieving consistent organisation-wide awareness and may slow progress towards embedding a culture where sexual safety concerns are routinely recognised, addressed, and escalated, supporting safer experiences for patients and staff.

Practitioners' understanding and application of safe enquiry in relation to domestic abuse continues to be a recurrent theme identified through Domestic Abuse Related Death Reviews (DARDRs) and safeguarding assurance visits. This highlights a persistent gap between policy expectations and frontline practice, indicating the need for a more targeted and systematic approach to workforce development. Where domestic abuse is not routinely or confidently explored, opportunities to identify risk, understand the experiences of victims, and intervene at an earlier stage may be missed. Strengthening practitioner confidence and competence in this area is therefore critical to improving the early identification of domestic abuse, enhancing risk assessment and safety planning, and ultimately improving safeguarding outcomes for adults, children, and families affected by abuse.

5. QUALITY ASSURANCE & TRAINING WORKSTREAM

5.1 Key Achievements and Progress:

The Section 11 / Children's Act (S11/CA) compliance self-assessment achieved an overall rating of 'Good', reflecting a marked improvement from the previous assessment where some areas required improvement. This demonstrates strengthened organisational assurance and a more robust approach to safeguarding children, supporting improved outcomes for children and families in contact with services.

Safeguarding assurance visits have progressed from a pilot phase to being fully embedded as business as usual, providing a consistent mechanism for identifying risks, sharing learning, and driving continuous improvement in clinical practice. This has supported earlier identification of safeguarding concerns and more responsive interventions for service users and their families.

Successful transition of safeguarding supervision and training arrangements following the FTB transfer/TUPE process has ensured continuity of support for staff and minimised disruption to safeguarding practice. This has been critical in maintaining safe, effective care and consistent safeguarding standards for service users and their dependents during a period of organisational change.

There has been a notable increase in internal audit activity across safeguarding workstreams, strengthening the Trust's ability to identify themes, monitor compliance, and target improvement activity. This data-driven approach enhances organisational learning and promotes safer, more consistent care delivery.

Practice development and capacity building have been strengthened through the introduction of a Safeguarding Champions pilot, supporting the development of local expertise within teams. This model promotes sustainable safeguarding knowledge, increases staff confidence, and improves the quality of care provided to service users and their families.

We have improved the Training evaluation feedback forms to evidence pre and post training knowledge and confidence in safeguarding. The evaluation has demonstrated improved staff confidence in key safeguarding practice areas, indicating that workforce development is translating into improved recognition of risk, more effective decision-making, and better support for individuals and families experiencing vulnerability.

Safeguarding training compliance has remained consistently above 85%, for both level 3 adults and level 3 children with compliance maintained between 89% and 91% over the past 18 months. Compliance is routinely monitored by Learning and Development and the Safeguarding Team, with oversight and assurance provided through the Safeguarding Management Board and by operational scrutiny at monthly quality assurance group (QAG).

5.2 Challenges:

Further work is required to improve and strengthen the identification, analysis, and presentation of safeguarding themes and trends to ensure intelligence is consistently translated into strategic action and service improvement, building upon the work already done in 2025/26 this will be a key focus for 2026/27.

Ongoing assurance is needed to ensure the consistent embedding of the Think Family approach and carer-focused practice across operational teams, so that the needs and risks of children and families connected to service users are systematically recognised and addressed.

6. PRIORITIES FOR 2026/27

- Work with digital colleagues to Implement CP-IS across identified teams and clinical areas.
- Continue embedding the Think Family approach across the Trust, including the CYP Division.
- Work with Women in Theatre to develop a new domestic abuse training resource with a focus on Adult Child to Parent Abuse (ACPA).
- Continue the rollout of face-to-face Sexual Safety training across inpatient services.
- Further develop safeguarding intelligence to inform priorities and improvement activity.
- Continue expansion of the safeguarding supervision offer.
- Continue delivery of the Safeguarding Assurance Visit Programme to strengthen organisational assurance, support triangulation of safeguarding intelligence, identify learning and development opportunities, and drive continuous improvement in safeguarding practice across the Trust.

5. CONCLUSION

Overall, 2025/26 has been a year of significant progress, development, and strengthening of safeguarding practice across BSMHFT. Despite increased demand, system complexity, and resource challenges, the breadth and depth of work delivered is a testament not only to the commitment and dedication of the safeguarding team, but also to the commitment, engagement, professionalism, and support of clinical colleagues, managers, corporate services, and partner organisations across the system. There is a strong sense of pride in the achievements outlined within this report, which collectively demonstrate a more proactive, intelligence-led, and partnership-driven approach to safeguarding. The progress described has been made possible through a shared organisational commitment to safeguarding, with staff across the Trust continuing to recognise, respond to, and act upon safeguarding concerns to improve outcomes for service users, families, carers, and wider communities.

These developments have not only strengthened governance, assurance, and staff capability, but have also contributed to improved safety, wellbeing, and experiences for service users and their families through earlier identification of risk, stronger partnership working, and more effective safeguarding interventions. As we move into 2026/27, there remains a clear commitment to building on these foundations, continuing to embed learning, drive improvement, and ensure that safeguarding remains central to all aspects of service delivery.

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