Countess of Chester Hospital NHS
NHS Foundation Trust

Safeguarding Strategy Board

Terms of Reference

1. Purpose

The Safeguarding Strategy Board reports to the Quality, Safety & Patient Experience Committee and is responsible for ensuring that Safeguarding is a strategic objective within the Trust providing strong leadership and divisional accountability by making Safeguarding integral to care.

2. Duties

- To ensure that safeguarding standards are monitored and reporting mechanisms are properly established and working throughout the Trust so assurance can be given to the board
- To provide an annual assurance report to the Board of Directors on all issues relating to Safeguarding.
- To ensure systems and processes are in place to detect, prevent and respond to ***concerns about abuse or neglect*** and ensure that lessons learnt from incidents are disseminated across the Trust.
- To approve policies and procedures relating to safeguarding issues and ensure that these are impact assessed to meet the requirements of specific vulnerable groups
- To ensure that we meet our statutory requirements responding to external enquiry/ recommendations in relation to safeguarding.
- To ensure that the Trust is reporting effectively to external agencies when we have safeguarding concerns.
- To review all high level reports / recommendations and national documents relating to safeguarding and provide a response to the Quality, Safety & Patient Experience Committee. Where an action plan is required monitor the implementation of this within divisions and the improvements made through a standing agenda item.
- To review patient experience feedback from a variety of sources to inform future direction and ensure that the patients voice is heard

Countess of Chester Hospital NHS
NHS Foundation Trust
The Countess of Chester Health Park
Liverpool Road
Chester
CH2 1UL
Tel: 01
Fax: 01

I&S

Alison Kelly
Head of Safeguarding
Director of Nursing and Quality, Executive Management
Countess of Chester Hospital NHS Foundation Trust

Dear Alison,

I am writing to you as the safeguarding lead for the trust in relation to the increased neonatal mortality rates. Usual neonatal mortality prior to 2015 has been 1-3 deaths per year. From June 2015 to June 2016 there were 13 neonatal deaths and a number of unexpected collapses of previously well babies. There has been a RCPCH review of the neonatal unit. There have also been coroner's inquests for some of the deaths. I am not aware of the outcome of these investigations nor is it my remit to review these reports. However, as the named doctor for safeguarding for the trust, I would like to ensure the safety of all the babies on the neonatal unit and the paediatric ward.

Therefore, I would like to pose 2 questions:

- As with most safeguarding cases, I would like to know, based on the balance of probability (in relation to the outcome of investigations) if there has been an increased risk of harm for babies admitted to the COCH neonatal unit or can such risk be excluded? As you know, in safeguarding cases, priority is given to the safety of the child based on the balance of probability of harm, even in the absence of strong evidence which is rare in most child protection cases.

- Have we identified the reason for the rise in neonatal mortality rates during this period, so that lessons can be learnt and unexplained deaths can be avoided in future?

If there is adequate evidence to suggest that there is no increased risk of physical harm to the babies on the neonatal unit then no additional investigations or safety measures would be warranted. On the other hand if these questions cannot be answered, then further investigations may be warranted to ensure that we are safeguarding children in our care and to ensure that we can protect our babies from future risk.

Looking forward to your response

Yours sincerely,

Dr Howie Isaac
Consultant Community Paediatrician and Named Doctor for Safeguarding