Three Steps for Baby Safety

Evaluation and Impact Report

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Safe Sleep | Safe Handling | Safe Space




Derby and Derbyshire Safeguarding Children Partnership

NHS Derby and Derbyshire Integrated Care Board

Contents

Introduction

It was recognised by the Derby and Derbyshire Safeguarding Childrens Partnership (DDSCP) that there had been a number of cases of babies being harmed by abuse and neglect of which some were historical, and some were more recent and had been subject to a child safeguarding practice Rapid Review. The Child Death Overview Panel (CDOP) had identified a number of babies who had died suddenly and unexpectantly where unsafe sleep practice was a factor. The importance of understanding that babies are intrinsically vulnerable and the ability of practitioners to recognise the impact of parental vulnerabilities is essential to ensure that babies remain safe. Both the DDSCP and CDOP recognised a consistent approach to keeping babies safe was required to support practice and improve outcomes for families with babies.

The partnership work around Keeping Babies Safe (KBS) is a priority for the Derby and Derbyshire Safeguarding Childrens Partnership and has been actively developing and enhancing practice for over 2 years. This report is aiming to showcase the work that has been developed by partners and practitioners, consider the outcomes and highlight the impact on practice and support for babies and their families.

The Keeping Babies Safe Strategy

The strategy was written and published in February 2021. This became the blueprint for the work to support families and ultimately with the aim of keeping babies safe in Derby and Derbyshire. The strategy is researched based and formulated to enable practitioners to be clear about the consistent messages and practice around the key areas to support families whilst having a focus on the intrinsic vulnerability of babies and their parents or carers.

The Three Steps for Baby Safety Partnership Strategy is a key document which underpins the development of work to support families with babies and has three key themes:

- Safer Sleep
- Safe Handling
- Safe Space

Partnership Aim

Derby and Derbyshire Safeguarding Children Partnership (DDSCP) and the Child Death Overview Panel (CDOP) encourage and support partners in all agencies who care for or support families with babies under a year old to utilise this strategy and deliver the clear consistent messages regarding baby safety to families, including all fathers and wider family members, and to their colleagues within their own organisation.

All practitioners in Derby and Derbyshire should have access to research - based practice and information to educate and support parents and carers so that they are able to make safer choices when caring for their baby. The partnership and CDOP aims to reduce the numbers of babies who die or are seriously injured following unsafe sleep practice, unsafe handling and those that die accidentally.

Partnership Objectives

That all learning from national and local Child Safeguarding Practice Reviews and CDOP is disseminated and any recommendations to support and enhance the safety of babies are acted on by all partners:

- To ensure that practitioners across Derby and Derbyshire have a good understanding of:
    - Safer sleep practice
    - The importance of safe handling and the management of crying
    - Safe baby equipment and home safety messages
- To ensure that there are consistent and clear messages regarding the three elements of the strategy which are delivered to all new parents and carers including fathers and wider family members
- To ensure that parents and carers know how to make their home safe for the baby
- That all practitioners who have contact with families with babies know and have the confidence to deliver these messages
- That practitioners remain professionally curious to ensure that all babies are safe and free from harm

Learning

Learning from Rapid Reviews and Safeguarding Child Practice Reviews

Since 2015 and when the strategy was written there have been 13 case reviews (of different types including serious case reviews, local child safeguarding reviews and rapid reviews) where a baby has died or experienced serious harm as a result of abuse or neglect across Derby and Derbyshire.

The risk of a baby suffering serious harm is significantly increased because of their development, intrinsic vulnerability and total dependency on their care giver for their welfare and safety.

Domestic abuse, parental mental ill health, parental substance misuse and stressors occurring for the adults in the family are features apparent in many of the cases where harm has occurred. All professionals and practitioners should be alert to the circumstances of parents or carers and understand the risks to children within the family

Learning from these reviews:

- Understanding that all babies are intrinsically vulnerable, and practitioners should be alert to indicators of poor development or potential harm to babies
- Consider the individual baby's lived experience and make sure that factors affecting the care of the baby are understood.
- Get professional advice where it is needed
- Consider the role of all adults, including fathers, is properly understood and any stress factors routinely explored with individual adults
- Make sure that other professionals involved with the family understand any concerns. This is an individual professional responsibility and underpins good information sharing

Learning from Child Death Overview Panel

The Child Death Overview Panel held a themed panel in 2021 for 6 babies who have died suddenly and unexpectedly.

Identified learning themes:

The recognition of the vulnerability of babies and that infants are intrinsically at risk because of their immature anatomy and physiology and their rapid development

- Identified vulnerability factors in parents and families including mental health concerns domestic abuse and substance misuse
- Unsafe sleep practice and out of routine circumstances for sleep on the night of the death
- Smoking both parental and household
- Parental alcohol use when caring for an infant which was a factor on the night of the death
- Parents known to services either Children's Social Care or the Police

National Learning

During this period, it has to be recognised that there was national interest and learning around the risks to infants. Much of the national learning exhibited similar themes to learning in Derby and Derbyshire and was incorporated into the strategy, training and development of tools and resources.

Outcomes and Practice Improvement

To gain assurance that the partnership aims and objectives for KBS have been met it is important to evidence improvements for babies and their families. This can be evidenced by improvements

in practice, hearing the voices of practitioners and the early identification of babies who are particularly vulnerable who's needs are assessed and then met through the relevant service.

When measuring outcomes is important to understanding the difference that services make. Services may tell us what works – and what doesn't work. Research shows that using evidence-based guidance and improving practice is easier and more likely to happen when the environment for change is right. Therefor It is important to have a shared commitment to quality improvement across the partnership.

It was important to gain the feedback and hear the voices of practitioners as fundamentally it is practitioners working directly with families who will make the greatest direct difference to the safety of babies.

The evaluation of the impact of the KBS initiatives was conducted in several ways:

- Focus groups with practitioners
- Interviews with some smaller services
- Electronic questionnaires to the KBS Champions and KBS steering Group
- Discussions and feedback from leaders from different agencies
- Using feedback gained from families throughout the development of the resources

A note on embedded practice:

There is some evidence that changes in practice have become embedded particularly around introducing KBS visits in Derby City, the 0-5 work in Derbyshire and the changes to pathways and practice in the Peri-natal mental health service. For practice to become truly embedded this needs to be tested over time particularly the use of the KBS resources and evidence should be gained of long-term positive outcomes for babies particularly those living in vulnerable families.

Derby and Derbyshire Quality Assurance and Audit Activity

Derby and Derbyshire Local Authorities recognised the importance of ensuring that babies and their families were receiving a good quality service from children's services. A large case audit was conducted including all cases where there was a baby in the family and assurance was given to the DDSCP of the safety of babies receiving support from Childrens Social Care.

DDSCP Multi-agency Audit

A large multi -agency audit of specific cases related to babies subject to CIN or Early Help was conducted in the City and County and included partnership moderation days.

Learning themes:

- Importance of the messages for safe handling and safer sleep
- Domestic abuse and the importance of routine enquiry
- Importance of the Think Family approach

- Importance of recognising hidden men within a family unit
- Professional optimism and curiosity
- Importance of multi-agency working
- Recognising the barriers to parental engagement

The learning was shared through the DDSCP Quality Assurance Group, and a briefing paper was developed. The themes were shared with The KBS Steering Group and learning supported the KBS action plan.

Health Audit of Safer Sleep and the Parent Education Programme

An audit of Safe Sleep Practice and the Parent Education Programme 'Shaking the Baby is Just Not the Deal' was conducted by Midwifery services and the two 0-19 services in 2020. The report was shared with the KBS Steering Group and the DDSCP Quality Assurance Group.

Recommendations:

- Importance of the engagement of fathers/male care givers and understanding their role in a family
- Antenatal and postnatal education of the management of crying babies particularly with fathers and male care givers
- Multi agency understanding of the Parent Education Programme
- Consistent messaging and assessment of safer sleep practice and seeing where a baby sleeps day and night
- Development of the safer sleep assessment tool for bed sharing
- To encourage a think family approach to smoking cessation

KBS Health Audit – Voices of parents

The second part of the health audit heard the voices of parents/carers through a Survey Monkey shared electronically with parents. Parents were asked what they recollected and what they practiced around the KBS messages on Safer Sleep and the Parent Education Programme 'Shaking the Baby is Just Not the Deal'. The data was analysed, and a report shared with the DDSCP Quality Assurance group and with the KBS Steering Group and the recommendations were sighted on the groups action plans.

Key Themes:

- The importance of parental views and feedback cannot be underestimated. As leaders and practitioners there needs to assurance that the work being driven forward in Derby and Derbyshire around the keeping baby's safe agenda is being understood and used by those caring for babies

- This anonymous sample of parents/carers has provided some assurance that the messages of how to keep babies safe are being understood and used by parents/care givers.
- Only one father responded to the survey, therefore this report needs to be considered from a female/mother's perspective. It is imperative that we seek and hear the voices of fathers/male care givers and that services are provided that are accessible and engage with fathers/male care givers if the risks of babies being shaken is to be reduced
- Safer sleep messages appear to be well established and understood by most parents/carers. Respondents were able to give examples of what they do in practice with their baby
- The survey confirmed what was suspected and is in line with the national picture that 40% of parents/carers have shared a bed with their baby and that 11% recognised this was unplanned and out of routine
- It is important to note that almost all parents/carers knew how to and accessed support when they needed it, particularly from family and friends and health professionals

Keeping Babies Safe Champions

The KBS Champions have had a key role in developing the KBS resources, ensuring that the key safety messages are shared amongst practitioners and have been inventive in how they are shared with parents and families. There has been palpable enthusiasm from the Champions and without them the pace and degree of work around KBS could not have been achieved. The Strategic Lead for KBS and the Lead Nurse for Child Death Review have trained KBS Champions. The first keeping babies safe champion training was delivered on 5.1.21 and since then a further 6 sessions have been delivered, resulting in 141 practitioners becoming KBS champions. 31 champions have since left their role, but there continues to be 110 active champions across Derby and Derbyshire.

A network event Is delivered to champions twice a year. These meetings provide an opportunity to update champions on KBS work across the system and allow practitioners to share their experiences. The meetings are well attended and receive positive evaluations.

The role of the KBS Champion is to:

- Support practitioners within a service/team to have a good knowledge and understanding of safer sleep practice, safe handling and home safety
- Support and encourage practitioners to confidently deliver clear consistent messages to parents and carers
- Enable practitioners to recognise that some families may have additional vulnerabilities and require extra support to understand the messages and to make the right choices for their baby's safety
- Be a point of contact for colleagues to offer advice/signposting in relation to baby safety
- Support practitioners to keep up to date with key safety messages
- Disseminate any new information or resources across a service/team

Champions Feedback

An electronic questionnaire was sent to all champions earlier this year, to obtain feedback about their champion role. The response rate was low at 20%.

Positive Aspects

- Sharing the information and keeping the strategy at the forefront of everyone's mind.
- I am passionate about baby safety and enjoy being able to keep up to dates with new information to share.
- I found it interesting and informative
- It is enabling me to give up to date advice in the antenatal group I support.
- Being able to share current information with all early year's providers to ensure babies are kept as safe as possible within Derbyshire.
- I feel I can help keep the babies safe that we care for by promoting researched based safe practice

Challenges

- 13 respondents reported no challenges
- Time to do the role justice
- No time to attend the Network training event or administrative time for the role
- Would like a face to face meeting with other Champions in their service

Network Events

- Very helpful and inspiring.
- Examples shared of the application of the KBS strategy undertaken by other agencies
- They are motivating and good to know what is going on in other services
- Hearing shared practice, latest information and impacting case studies to reinforce the importance of KBS
- For support from others
- Fast and easy way of keeping up to date

The Champions were asked specifically about how they have shared the information related to the KBS initiatives.

How have you raised awareness of the safer sleep assessment tool:

- In a presentation on normal sleep/ crying baby and safe sleep, delivered to colleagues
- It is included in the KBS visits we complete
- Promoted during safer sleep week
- Disseminated across maternity staff and discussed at supervision. Tool forms part of the discharge paperwork for parents. Tool also added to the health zone app for parents
- Completed the tool with parents.
- Shared amongst the team
- Hoping to implement into the new alcohol policy and introduce to improve out safe sleeping practice postnatally

How have you raised awareness of the Every Baby Matters Resources:

Some responses were similar to the safer sleep tool:

- Discussed with supervisees and disseminated across all maternity staff
- Used as part of EHA and whilst home visiting with parents
- I have shared this with the team, made print outs for the office to go with pre-birth/keeping baby safe visits

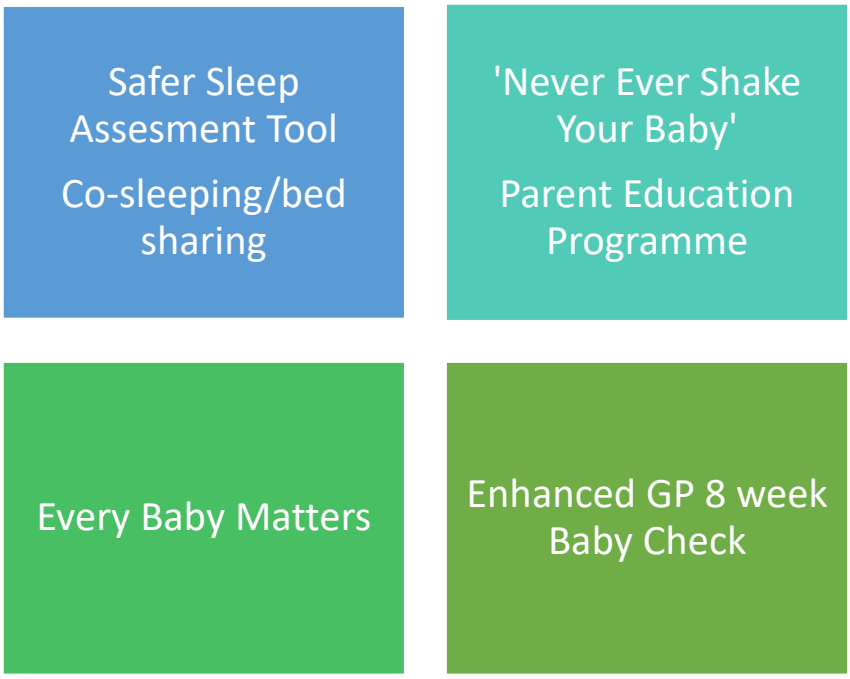
Positive Practice

- Educating parents in the community because I think parents don't always take in all the information we give on the Neonatal unit
- Used tools alongside early help assessments, pre-birth and parenting assessments
- Courageous conversations with parents, revisiting sleep practice within the home
- I have been heavily involved in ensuing KBS is embedded in practice throughout the Children Centres
- Ensuring bedroom checks are completed with families to see where infants / babies are sleeping, will be sleeping, support with obtaining baby equipment
- keeping up to date with sleep safe practice and been advocate for the babies we care for educating parents to ensure the safe sleep message gets across to parents
- We are currently reviewing our pre-birth booklet and creating and in house folder with document assessment
- Home safety checks and pre-birth work
- Updating our information that we share within our antenatal group
- Today we have our first official KBS network to talk about how we can keep KBS at the forefront of everyone's minds

Key Practice Developments

As a safeguarding partnership it was recognised that there was a wealth of learning and recommendations following child safeguarding practice reviews, child death reviews and by auditing practice. The KBS strategy became the blueprint to develop practice however it was clear that practitioners needed support, guidance, and training to really make a difference to families and their babies.

The DDSCP and the keeping babies safe steering group led the way in the development of initiatives, tools and resources that would provide a consistent approach to the messages shared with families whilst meeting a diverse population and considering the many different practitioners across the multi-agency partnership.



Safer Sleep Assessment Tool for Co-sleeping/bed sharing

One of the objectives in the KBS strategy is to ensure that practitioners have a good knowledge of safer sleep practice and that practitioners across the partnership are able to share consistent messages and assess a babies sleep environment.

Research informs us that messaging around safer sleep needs to be delivered clearly and on more than one occasion particularly to families with additional vulnerabilities. All practitioners who support families with babies have a responsibility to understand safer sleep messages and support families to practice safer sleep with their babies. These messages need to be the same across professional groups and organisations to ensure a consistent approach to the safety of babies.

The risks of unsafe sleep practice are reported locally and nationally; babies can and do die in high-risk bed-sharing situations. Information from Child Safeguarding Practice Reviews and CDOP

informs us that bed-sharing is something parents do with their babies. National research and a local audit confirm that 40% of parents bedshare, but don't always share this information with practitioners for fear of being judged or feeling they are doing something wrong. The Lullaby Trust found that if parents are told not to bed share with no explanation, they will then feel they cannot discuss the issue and will not seek the correct safety advice.

All families need to be risk assessed and know how to assess their own situation for bed-sharing. We want families who are identified as low risk to have the researched based information in order to make an informed decision about whether they wish to co-sleep safely and for those that are identified as high risk, not to co-sleep at all. The assessment tool has been developed to support practitioners and families to make an informed choice and should be used in conjunction with all other safer sleep advice. The assessment tool was tested with practitioners and families prior to being launched in June 2022.

If you choose to co-sleep...

Co-sleeping with your baby: advice from The Lullaby Trust

Key Safer Sleep Messages

1. Put babies on their back for every sleep.
2. Babies should sleep in a clear, flat sleep space.
3. Keep babies smoke free day and night.
4. Do not sleep with your baby on a sofa or chair.

For safer co-sleeping/bedsharing:

- Keep pillows, sheets, blankets, any other items away from your baby as they could obstruct baby's breathing or cause them to overheat.
- Avoid the use of a sleep pod or other sleep systems.
- Follow all other safer sleep advice to reduce the risk of Sudden Infant Death Syndrome (SIDS) such as sleeping baby on their back.
- Avoid letting pets or other children in the bed.

Scan here for more information

Final version | May 2022

Safety first if co-sleeping/bedsharing

Practitioners who visit you to see you and your baby may review this checklist with you. Please use it yourself before you choose to bed share. Please follow safer sleep advice and contact your Midwife or Health Visitor if you have any questions. Do not sleep with your baby on your sofa or armchair this increases the risk of Sudden Infant Death Syndrome (SIDS) by up to 50 times (Lullaby Trust).

If you answer yes to any of these questions you are advised not to co-sleep/bed share due to the increased risk of SIDS (also known as cot death).

Question	Y/N	Why this increases the risk
Do either you or your partner smoke? (including during pregnancy)		Smoking increases the risk of SIDS
Have you or your partner drunk alcohol in the past 24 hours?		Any alcohol use changes your sleep pattern and increases the risk of SIDS
Have you or your partner recently taken any drugs or prescribed medication that may make you sleepy?		Taking any drugs or prescribed medication that can make you sleepy increases the risk of accidental death whilst bedsharing
Are you or your partner very tired? (less than 4 hours sleep in 24 hours)		Excessive tiredness will affect your sleep pattern and is a risk if you bed share
Was your baby born early (before 37 weeks) or weighed less than 2.5kg or 5.5lbs		Babies who are born early or who are very small are at higher risk of SIDS
To reduce the risk of SIDS it is important not to bedshare in 'out of normal routine' situations. For example, if your baby is unwell and doesn't normally bedshare with you; staying with friends; when on holiday.		If it is not your normal routine to bedshare please consider if it is safe to do so by using this check list.

Adapted from NHS North Lancashire leaflet 'Where might my baby sleep'. More information go to the Lullaby Trust.

For support and advice on sleeping your baby safely The Lullaby Trust can help
Visit: www.lullabytrust.org.uk
Contact us on: 0808 802 6869
Email: info@lullabytrust.org.uk

YOU CAN QUIT SMOKING?
Get free 1-2-1 help and support from experts
CALL NOW ON 0300 123 1044

Parent Education Programme – 'Never Ever Shake Your Baby'

The Derby and Derbyshire Safeguarding Partnership Parent Education Programme 'Never Ever Shake Your Baby' has been updated and launched in March 2023.

Non-accidental head injury (Abusive Head Trauma) involving injury to the brain is the most serious form of physical abuse and can have serious consequences for a child's future development and wellbeing. Non accidental head injury is the leading cause of death among children who have been abused. Key considerations:

- Non-Accidental Head Injury is the most common form of abuse in babies under 2 years old
- The immediate and long-term impact is far worse than other head injuries
- Fathers or male partners are 5 times more likely to shake a baby than the mother
- Vulnerable families with more stressors in their life are more likely to shake a baby
- Persistent crying is a known factor and not necessarily due to poor parenting

The Parent Education Programme video is primarily delivered by the Midwifery Service following the births of all babies in Derby and Derbyshire. Both parents are shown the video and are given a supportive leaflet, the management of crying is discussed. The Programme is delivered before the baby is discharged from hospital. Where this is not possible including for babies born at home or those at a non-Derbyshire hospital the Programme is delivered at the first visit by the Midwife.

Health Visitors then check that families have seen the video. The video is shown to all families who haven't seen it and it is shown again as appropriate. Health Visitors discuss the management of crying to both parents and take account of the vulnerability of families as part of their assessments and visits.

The Video is available to be used by other practitioners across the multi-agency partnership and can be found on the DDSCP YouTube channel. The video is available in several languages. Families should be supported when seeing the video and quality conversations should take place regarding the management of crying.

Every Baby Matters

The Derby and Derbyshire Safeguarding Childrens Partnership commissioned a child safeguarding practice review to learn from the lived experiences of two babies. The first recommendation of the review was for the partnership to develop a universal risk assessment tool that could be used within the multi-agency partnership to reinforce the intrinsic vulnerabilities of babies, to support practitioners to identify vulnerabilities within the family including anything putting the family under stress. The aim of the tool is to support practitioners to clearly identify any risks to the baby and keep the baby at the centre of any assessment and decision making.

Recommendation from safeguarding Child Practice Review LDS19/OD20

'A universal risk assessment tool to guide professional practice in safeguarding infants should be developed. Practitioners must clearly understand that an infant has no resilience and is inherently therefore at greater risk. The tool must reflect this and should emphasise a basic assumption of risk factors which are to be assessed so that they can either be excluded or early concerns recognised.

It must identify what is happening in the household, what pressures and stressors exist, how carers are responding or likely to respond to these, be clear about what constitute the risk factors that must be excluded and consider both intentional and unintentional risk'

A group of practitioners and leaders across organisations in Derby and Derbyshire have worked together to develop the research-based resources to support families with babies. The resources

have been tested within teams with families in Childrens Social Care and Health Visiting across Derby and Derbyshire. Every Baby Matters was launched across the partnership in January 2023.

The aim of the resources is to support practice and they are designed to be used in a way to raise awareness of the vulnerability of babies, there is a specific tool to use with families at the early help stage or as part of larger assessments or pieces of work with families. The tool can be adapted to use in the ante-natal period. The resources can also be used to support practice through training, education and supervision particularly for newly qualified or newly into role practitioners.

Resource Poster

The poster has been disseminated widely across the Derby and Derbyshire partnership. The aim is the poster is to remind practitioners or those that have contact with families to consider the baby in the family, remember the core messages and consider if the family need additional support.

Key messages:

- It matters that all babies are safe.
- It matters that their needs are met immediately.
- It matters that families feel supported.
- It matters that we understand the relationship between babies and their parents/carers.
- It matters that we understand any vulnerabilities or risks that affect a baby's care and development.

Every Baby Matter Observations and Conversations Tool

This visual tool is to enhance and support the early conversations with families about their relationship and parenting of their baby. It is designed to give practitioners information on how to increase their awareness of the parent/carer relationship and to identify any vulnerabilities by using skills of observation and open-ended questioning that will produce quality conversations and enhance contacts/visits and assessments. There is no expectation to ask all of the questions or for the tool to be used at one contact or visit. It is not designed to be used as a check list merely to support practitioners to explore and consider the lived experience of the baby and identify any areas where a family would benefit from additional support. The tool looks at six key areas of consideration for a family with a baby.

- Bonding and attachment
- Your baby's development
- Health and well-being
- Knowledge and expectations
- Community strengths and stressors
- Who is your baby's life

Every Baby Matters: observations and conversations

Bonding and Attachment:

- Describe what it is like caring and looking after your baby.
- Explain how you cope when your baby cries a lot or is difficult to settle.
- Tell me about your relationship with your baby. If your baby could speak, what might they say?

Health and Wellbeing:

- Tell me what you are enjoying about being parents. Is there anything that is worrying you?
- How are you feeling?
- Looking after yourself is important. How do you look after yourself?

Knowledge and Expectations:

- Is there someone in your life that you can trust to offer you support and advice?
- Do you find the views/advice from other people (including social media) helpful?
- Where do you get your information from about being a parent/carer?

What is it like to be a baby within the family?

Are there any vulnerability factors?

What support can be offered?

Community Strengths and Stressors:

- Tell me about how you feel about where you live and your local community.
- Do you feel able to access local groups and support from your community?
- Would you like to talk about financial pressures? Do you know where to get advice on benefits?

Who is in your baby's life:

- Does anyone else help you look after your baby?
- If your baby could speak, who would they say is important to them. Who makes them smile or laugh?
- Relationships can often change after a baby has been born. Have you noticed any changes in your close relationships?

Your baby's development:

- Babies born early can sometimes be more vulnerable. Have you got any concerns about your baby's health and development?
- Babies change/develop quickly, what changes have you noticed? Do you feel ready for the next stage of development?
- Tell me about an average day for you and your baby.

Keeping Babies Safe for Practitioners - Think 3 S's

Safer Sleep: See where the baby sleeps day & night.

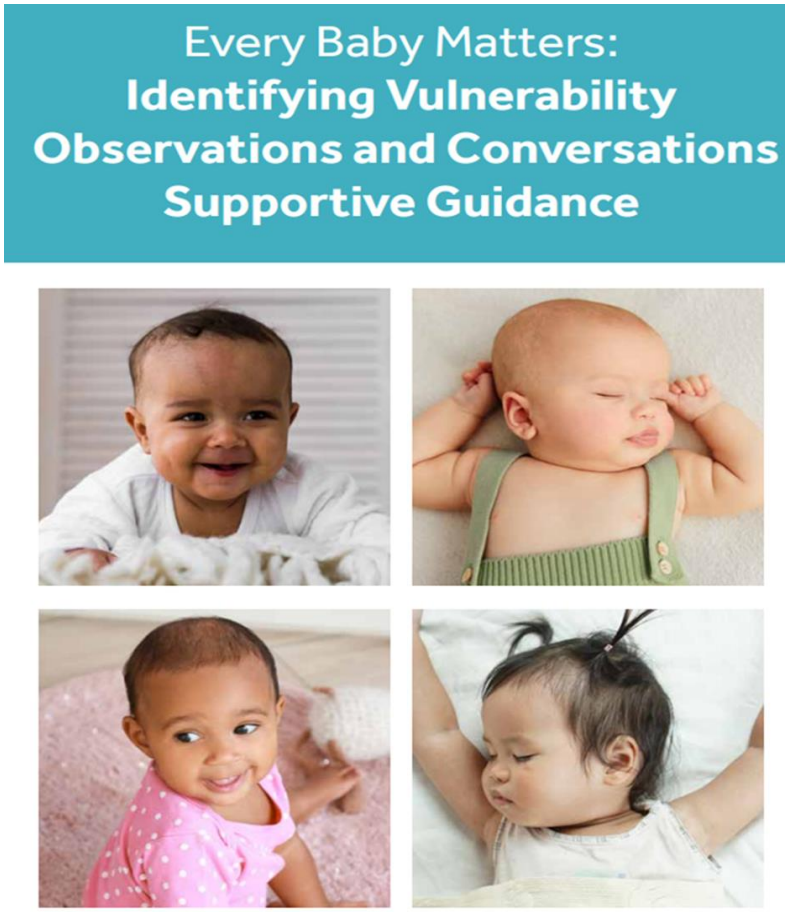
Safe Space: Is it a safe home environment.

Safe Handling: Discuss the management of crying.

Refer to the Every Baby Matters Vulnerability Guidance Document

Every Baby Matters Supportive Guidance

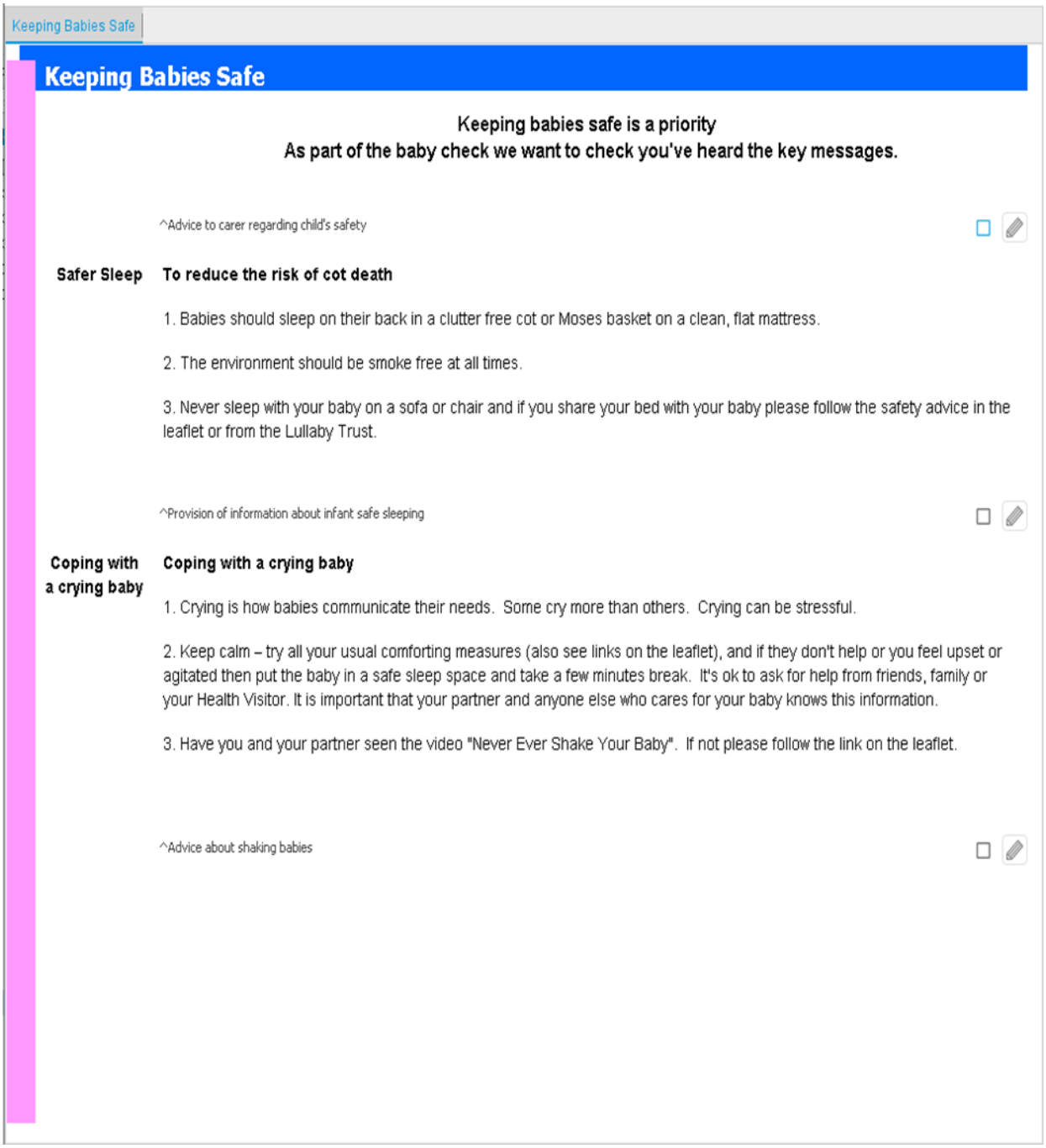
The guidance document explains the resources and how to use the tool including how it can be used with families in the early help stages of support and how the tool can be utilised to support other assessments including during pregnancy.



Enhanced GP 8 week Baby Check

It is important that messages to parents around the safety of babies are delivered consistently and repeated by all practitioners who support families with babies. One 'touch point' where babies are seen in General Practice is the 8 week baby check.

6 short statements have been developed to be incorporated into the 8 week check to reinforce the messages around safer sleep and the management of crying. These appear on an electronic template and can be delivered succinctly during the baby check and are supported by a KBS leaflet. The template and supportive leaflet were launched and agreed for use by GP's in April 2023.


Keeping Babies Safe
Keeping Babies Safe
Keeping babies safe is a priority
As part of the baby check we want to check you've heard the key messages.
^Advice to carer regarding child's safety
Safer Sleep
To reduce the risk of cot death
1. Babies should sleep on their back in a clutter free cot or Moses basket on a clean, flat mattress.
2. The environment should be smoke free at all times.
3. Never sleep with your baby on a sofa or chair and if you share your bed with your baby please follow the safety advice in the leaflet or from the Lullaby Trust.
^Provision of information about infant safe sleeping
Coping with a crying baby
Coping with a crying baby
1. Crying is how babies communicate their needs. Some cry more than others. Crying can be stressful.
2. Keep calm – try all your usual comforting measures (also see links on the leaflet), and if they don't help or you feel upset or agitated then put the baby in a safe sleep space and take a few minutes break. It's ok to ask for help from friends, family or your Health Visitor. It is important that your partner and anyone else who cares for your baby knows this information.
3. Have you and your partner seen the video "Never Ever Shake Your Baby". If not please follow the link on the leaflet.
^Advice about shaking babies

Partners Activity and Evaluation

The information was gained for the evaluation from focus groups of practitioners and leaders including feedback from the KBS Champions.

For all partners KBS has become an integral part of single agency training.

Derby City Local Authority

Childrens Centres and Family Visitors

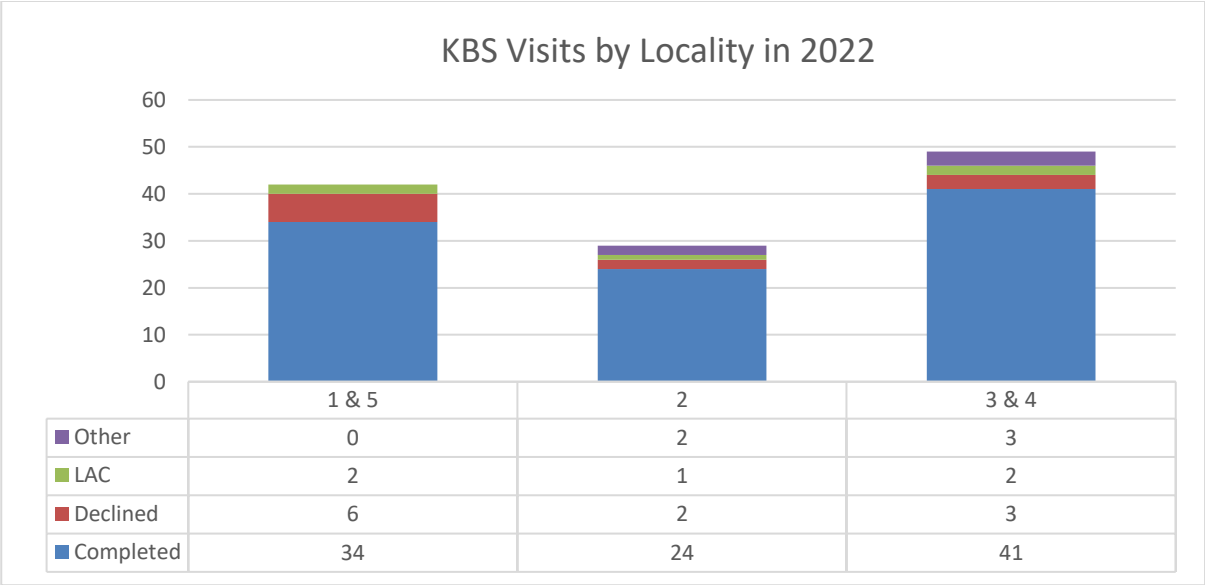
During the COVID 19 pandemic Derby City took proactive steps to ensure that the safety of babies was a priority. All families with babies under 12 months of age who were subject to S47 enquiries or Child in Need were offered a KBS visit. This proactively targeted vulnerable children and families in need of additional protection or support.

The visit includes:

- Safer sleep assessment including the use of the co-sleeping/bedsharing tool and assessment of where the baby is sleeping day and night
- Home safety check list
- Advice on safe baby equipment
- Using the resources and signposting to the Lullaby Trust
- Think family approach of who may care for the baby including tips and support for grandparents and other carers

Evaluation of the KBS visits

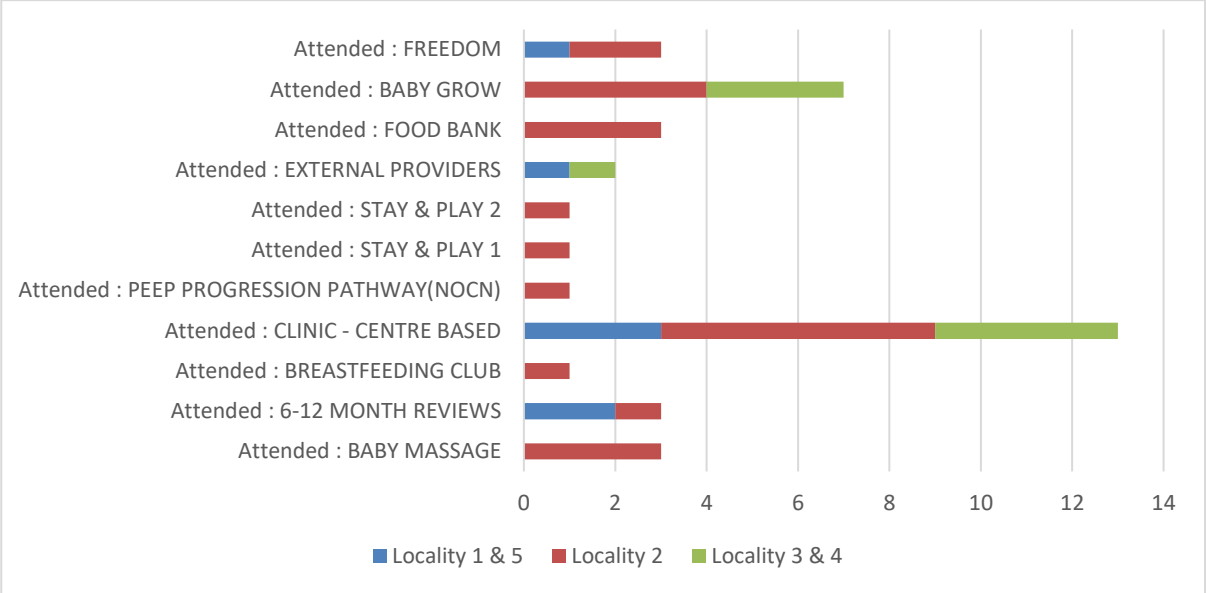
There is evidence that the babies and their families who have received KBS visit are then registered with the Childrens Centres where they go on to access more support services appropriate to need. This is a positive consequence of the KBS visit as a way into building positive relationships and supporting families' more long term.



	1 & 5	2	3 & 4
Other	0	2	3
LAC	2	1	2
Declined	6	2	3
Completed	34	24	41

In 2022 there were 99 KBS visits. Most families were registered with the Childrens Centres however the KBS visit generated 26 further registrations of vulnerable families and their babies.

Activity of parents following KBS visit



Pre-birth assessment and programme

- Every Baby Matters adapted and incorporated into the prebirth programme
- Sessions about managing a crying baby and coping with stress
- Session on bonding and attachment
- Session on home safety and equipment

Practitioners have expressed increased confidence in the use of the information gathered around KBS when escalating a case into the vulnerable children's meetings

The KBS strategy and tools have helped with new arrivals and diverse communities and have helped to support and explain any cultural differences to families and why advice and practice maybe different. This is particularly relevant to co-sleeping/bedsharing where the assessment tool is very helpful.

Reception Service

There is evidence that KBS support is seen as a priority by the reception Service. During a recent internal inspection, cases that were audited made specific reference to completing KBS work as a priority and in one case, a family visitor had been allocated to start this quickly. This was highlighted as good practice for that case and positive that KBS is considered for all cases where there is a baby in the family.

Areas for Developments

- Formal evaluation of the KBS visits
- Development in the liaison and passing on of work between family visitors and social workers
- Consideration of families in specific circumstances such as those in temporary accommodation, asylum seekers and those who have no recourse to any funds
- Gain more understanding of the risks of vaping to unborn and babies
- Engaging fathers

Derbyshire Local Authority

Derbyshire Childrens Services have incorporated the KBS messages into the quality assurance reflective case review activity. The KBS information and resources are available on the Childrens Services Information HUB for all practitioners to access.

Childrens Centre 0-5 Teams

The Children's Centres' 0-5 teams are embedded within the Early Help service. There are six 0-5 teams within Derbyshire, one in each of the six localities.

Chesterfield Children's Centre coordinator and practitioners have led the way in embedding the KBS strategy and resources into their 0-5 work with families. The team have formulated a 0-5 and pre-birth working framework which incorporates the pre-birth protocol for assessment and intervention, learning from children safeguarding practice reviews and has all of the elements of the KBS strategy to ensure families are receiving research-based information and safety messages at the earliest opportunity. Joint working between Childrens Centres Family Support Workers and social work teams has been strengthened with a joint home visits and consideration of the needs of the unborn/baby at the earliest opportunity.

Positive outcomes:

- Improved joint working between Childrens Centres and Children's Social Care
- the Children's Centre intervention in pre-birth cases is valued and felt to be time effective for the families in line with the Pre-Birth protocol
- Formal parental feedback highlights positive responses in increased parental knowledge and confidence in supporting the care of their baby
- The narrative feedback from parents was positive and emphasised an increase in knowledge and confidence and understanding of parental intentions when their baby arrives
- Increased confidence in practitioners

This work has now been replicated across the 6 locality areas to ensure a consistent offer to all families.

Feedback from practitioners

Practitioners report that direct work is making a difference. The safer sleep assessment is indicating a better judgement of risk and practitioners like the way they can leave the tool with families. Practitioners feel that the tools help in the assessment of vulnerability and need and that young mums are taking on board the safer sleep advice and like the visual nature of the resources including those on the Lullaby Trust website

- The PEP 'Never Ever shake your baby' is discussed with parents
- Every Baby Matters is being incorporated into the KBS work and is felt to be parent friendly and opens discussions with parents. One practitioner felt that the tool captured the voice of non-verbal babies and used it as part of a parenting assessment. They found that the observations were useful during home visits and family time
- Some 0-5 practitioners linked the KBS tools with the Graded Care Profile and could see how there would be a continuum to further CSC Single Assessment
- If a baby is subject to a single assessment there should be a referral to the 0-5 practitioner to support with the KBS work
- Bump to Baby and Baby Buddies Programme utilise the KBS messages and research-based tools and resources including the use of the virtual babies – one mothers comment 'Every family should do this'
- Family Time practitioners in the Pathfinders Team feel they have lots of opportunity to continue the positive messaging around KBS and support parents particularly those where reunification of babies with their parents is the plan
- Social Workers expressed there is closer working with the 0-5 teams and the KBS Champions. There appears to be an increase in confidence in the messages around KBS and Practice Supervisors are using the messages and resources in supervision
- KBS work incorporated into the single assessment including safer sleep and the PEP. Social workers rely on the information in the packs
- Social Workers report improved working relationships between Health Visitors and Midwives, shared multi-agency responsibility and shared language around KBS

Areas for Development

- The effectiveness of the communication and dissemination of new initiatives and tools to the workforce, very few practitioners who took part in the evaluation were aware of the Every Baby Matters resource
- Promote the new Childrens Services Information HUB
- Promote the visibilities of the tools within teams
- Promote the inclusion of KBS messages within the Induction for new starters, bank staff and newly qualified Social Workers
- Ensure that Social Worker 'information packs' are kept up to date
- Face to face liaison between Social Workers and Health Visitors as part of induction for new starters and newly qualified practitioners
- Engaging more Foster Carers in the KBS agenda

- KBS considerations and practice when commissioning IFA's
- Should KBS training be mandatory for practitioners?
- Concerns about a reliance of using email to disseminate information when practitioners are overwhelmed with emails

Health Services

The keeping baby's safe agenda is not new to universal health services particularly Midwives and Health Visitors. Safer sleep and the Parent Education Programme were previously seen as mainly health initiatives and 'health's' responsibility to ensure parents received the information they needed to make an informed choice regarding the safety of their baby. Over the last 2 years there has been a shift to KBS becoming a multi-agency responsibility which ensures that messages are consistent, shared more than once and there is a shared understanding of the need to ensure that vulnerable families receive additional support around their baby's safety.

There is a wealth of health services who deliver direct care to babies and their families. There are a wide range of KBS Champions across services such as the Neonatal Units, Paediatric wards, Substance Misuse Service and Peri-natal Mental Health.

0-19 services for Derby and Derbyshire

The two 0-19 services, Derbyshire Community Health Services NHSFT and Derbyshire Healthcare NHSFT have embraced the KBS agenda and have worked together on some of the initiatives to ensure a co-ordinated approach across Derby and Derbyshire.

Bedsharing Assessment Tool

Is embedded into practice and available to all families in the baby's red book. Safer sleep is discussed at the first birth visit, at the 6-8 week review and at all development reviews. Health Visitors across Derby and Derbyshire see where a baby sleeps day and night at the first visit and thereafter if any vulnerability factors or concerns are identified.

Feedback from Health Visitors is that the pictorial element of the tool is helpful and that it is positive to have conversations where parents don't feel judged about their decision making but are given the information to understand when it is a risk to bedshare and why. Practitioners report feeling more confident to talk about co-sleeping. Practitioners are also using the pictorial resources and games from the Lullaby Trust particularly with young parents or those with additional support needs.

Every Baby Matters

This is being utilised as an additional resource and some Health Visitors are using EBM antenatally where there is more time to explore any vulnerability factors. This is a particularly useful resource for newly qualified practitioners and has been embraced by the Practice Teachers /Educators who have used this in training for practitioners.

Never Ever Shake Your Baby

The new video has been very well received by Health Visitors who 'love it' and they report that the video has a greater impact on families and is more accessible than the previous video. The video is often shown at the first visit even if the family have seen it prior to hospital discharge as it is a good conversation starter around the management of crying and fathers are often present.

Home Safety House

The 0-19 services have agreed to commission the Harlow Safety Houses. A home safety pictorial resource that will be added to the baby's parent held record (red book). This will guide parents to look at their home through the eyes of their baby and young child to help identify any home safety issues. The safety houses are pictures that will also help family members who have learning needs or where English isn't their first language.

Dadpad

Dadpad has been commissioned by DCHS and can be accessed by a father or father to be who has a Derbyshire postcode.

DadPad gives new dads and dads-to-be the knowledge and practical skills necessary to support themselves and their partner, so that babies get the best possible start in life.

DadPad has been specifically written for dads, on the topics that dads and health professionals said they wanted and needed to know about, the tool has been developed with expert input from NHS and Public Health professionals.

An important element of DadPad is a focus on 'getting the language right', so that dads feel engaged and included. The research evidence tells us that – for dads to actively engage in parent-focused material – they need to feel that it hasn't been intended for mums. Writing materials for dads, in dad-focused wording at all times, is key to overcoming this, and helping dads feel welcomed and valued as a co-parent.

The DadPad has more intended purposes than being 'just' a guide book or resource to help dad find out more about the skills that he needs to be a hands-on father; it's also designed to be used by relevant health professionals as an embedded engagement tool**,** as part of their whole family approach to perinatal care.

DadPad can be localised to meet local needs and utilise local resources including the work around KBS.

There is some initial data from Derbyshire parents on the uptake and usefulness of DadPad. The data is positive in that approximately 60% found the hard copy of DadPad very or extremely useful and 80% of those that had downloaded the App found it very or extremely useful. There needs to be more analysis of the data around DadPad to give a true reflection of the effectiveness in Derbyshire.

All the resources have been shared with families through parent facing websites or via SMS messages. The Co-sleeping assessment tool and the Safety Houses will be in every red book so that families can access the information when required.

Peri-natal mental health

The Peri-natal mental health service is provided by Derbyshire Healthcare NHSFT and is made up of 2 large community teams, outpatient clinics and an inpatient unit of 6 beds for mothers and their babies. The service is part of a national offer and 50% of the service users in the inpatient unit normally reside outside of Derby and Derbyshire.

The tragic death of a baby who was an inpatient on the perinatal unit focused both the leadership and the independent authors of the two reviews on the needs of the baby when their mother is extremely unwell needing psychiatric care. The reports highlighted the need for a cultural shift from a baby being seen as a guest on the unit to a dependant in their own right.

The leadership have whole heartedly embraced the KBS agenda. The KBS messages are embedded into the pathways for peri-natal mental health. The leaders report that this has become normal practice.

The unit have KBS Champions and 80% of inpatient staff have completed the Level 3 KBS training.

The Lead Nursery Nurses has taken a lead role for KBS and developed a strap line for staff to consider 'Keeping Baby in Mind – What does it feel like to be a baby on the Unit'.

Practice Improvements

KBS messages are embedded into the all the pathways for peri-natal mental health services

Safer Sleep there is a framework to risk assess and deliver the messages to all inpatients.

Lead Nursery Nurse and KBS Champions ensure that KBS remains central to the care provided

Health Visitor and Social Worker are new members to the team to provide the link between hospital and community

Impact on mothers and babies

All mothers and their families receive safe sleep information and are risk assessed

Co-sleeping and Bedsharing are discussed and the multi-agency tool is used to help mothers understand the risks

Information is shared in a sensitive way taking into account a mother's illness and particular needs

Parents are asked if they have seen the video 'Never Ever Shake Your Baby'

The safer sleep messages are shared again prior to discharge and parents signposted to the Lullaby Trust

Impact on Practitioners

80% have completed Level 3 KBS training

Community Nursery Nurses have stated that the KBS information and resources has made a difference to their practice

Increased confidence and awareness across the workforce

Improved knowledge around the physical and health and development of babies for mental health trained nurses

CPN's are having conversations about safer sleep prior to hospital admission to prepare families

Areas for Development

- Increasing the knowledge of baby's physical health needs and child development in a workforce of nurses who are mental health trained. A programme of training is being developed across the service and the perinatal network
- Liaison between the unit and other out of area local authorities particularly if there is a child protection issue
- Diversity and specific needs of some families and the appropriate resources being available

EMAS

The EMAS Safeguarding Team have used several methods to ensure that the messages around the KBS agenda are shared and considered by frontline staff who are seeing families and their children within the home environment.

- Regular communications to crews in relation to safer sleep this is achieved by eNews, the intranet 'Workplace' and direct communications
- KBS is part of the Level 3 safeguarding training
- Signpost to the Lullaby Trust
- Raising the importance and awareness of professional curiosity
- Think family approach and sight on the baby in the family

The safeguarding team are working with EMAS in updating the app used by crews on scene for clinical guidance to ensure that the needs of babies and children are considered, and information is available to crews at the time they need it.

DHU/111

The Safeguarding Team include the KBS messages in all their training to staff. The team also have oversight of all calls and referrals to CSC for children under 5 years old and will contact the Health Visitor if required. KBS is part of DHU/111 audit activity.

Derbyshire Constabulary

The focus for the Police is to promote the messages of the KBS strategy so that frontline Officers consider the baby when they have contact with families.

This has been achieved by:

- Circulating all new KBS information and resources
- KBS resources are available on the Police Connect Intranet
- Developed a series of VLOGS regarding child neglect which incorporated the need to observe a child's living environment including seeing where a baby sleeps
- Officers should always consider the child/baby when attending for domestic abuse and this would be reflected in the PPN's

There is evidence to suggest that Officers who are attending homes where there are children have a better understanding of the need to check and see the children including seeing where the children sleep.

Learning, Development and Training

Learning development and training has been a significant element of the KBS agenda across the multi-agency partnership. There have been several learning opportunities for practitioners to utilise. All agencies have included KBS as part of their internal training and development opportunities.

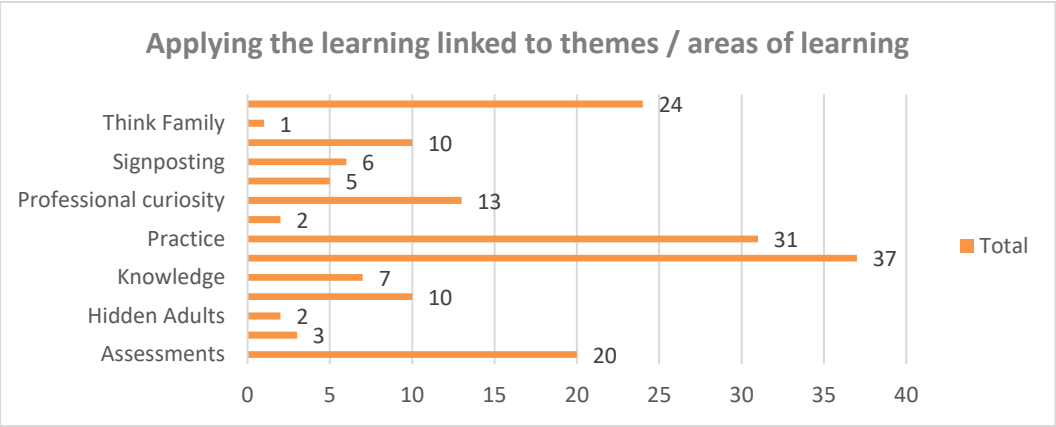
Examples of learning and development opportunities:

- Derby Childrens services 'Lunch and Learn'
- Derbyshire Childrens Services learning sessions
- Bespoke Safer Sleep training for Social Workers in Derby and Derbyshire
- Level 3a enhanced training for Health Visitors included KBS
- GP safeguarding Training on KBS
- CDOP seminar on Sudden and Unexpected Deaths in Infancy
- Training and Network Events for KBS Champions

The Three Steps to Baby Safety Conference

The Three Steps to Baby Safety Conference took place on Friday 2nd July 2021 and was the first DDSCP Stakeholder Conference to focus on the learning from Children Safeguarding Practice Reviews (CSPRs) regarding babies. The Conference provided professionals and frontline practitioners, from a wide range of sectors, with the opportunity to hear insights about the latest strategies, local reviews, and national learning to protect babies from harm.

There were 174 participants. Feedback has been received from 40% of participants. The conference was very well received, and the feedback was positive with the majority rating the conference as good (5 out of 5). As part of the evaluation participants were asked: How do you expect to apply this learning at work? What changes might you make to your frontline practice?



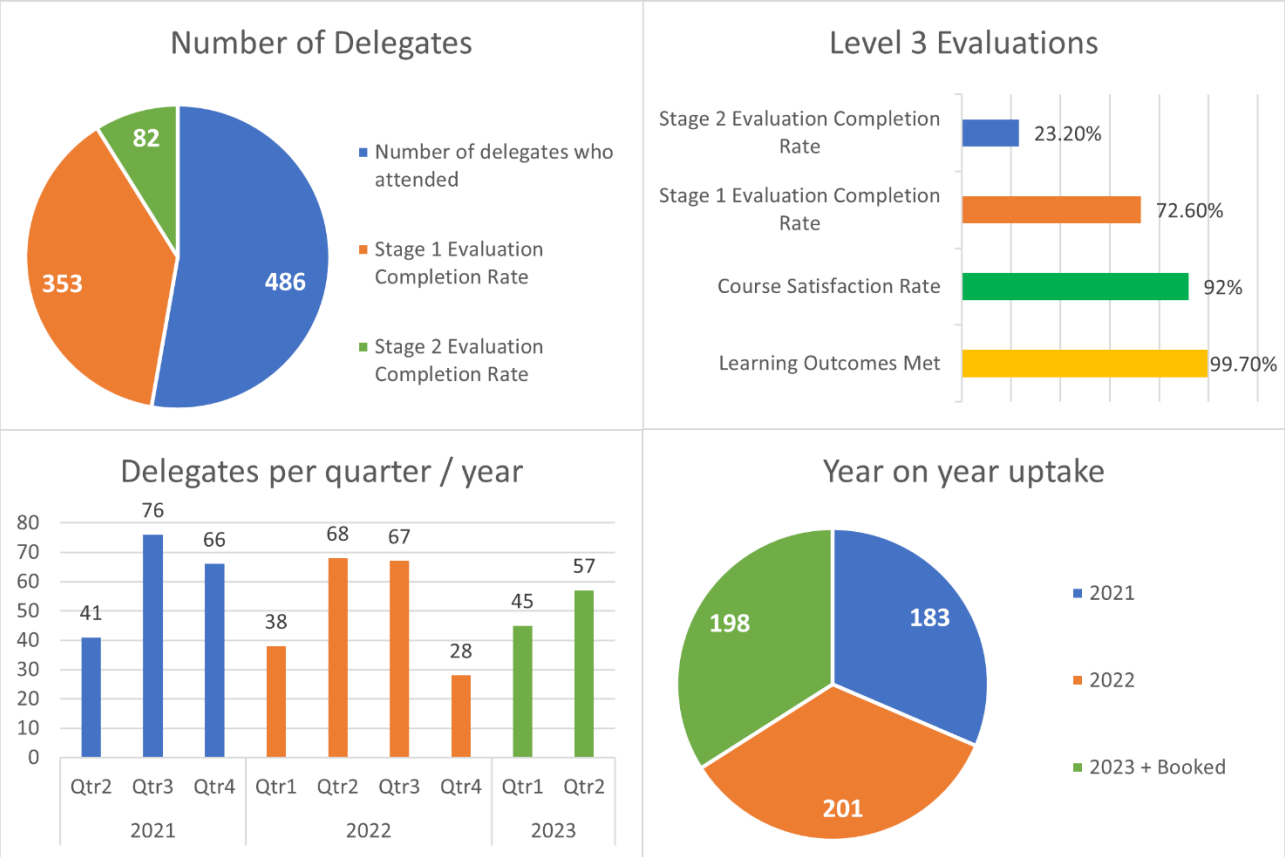
Following the conference, a Keeping Babies Safe Briefing Document has been produced and disseminated within the partnership.

DDSCP Multi-agency Training

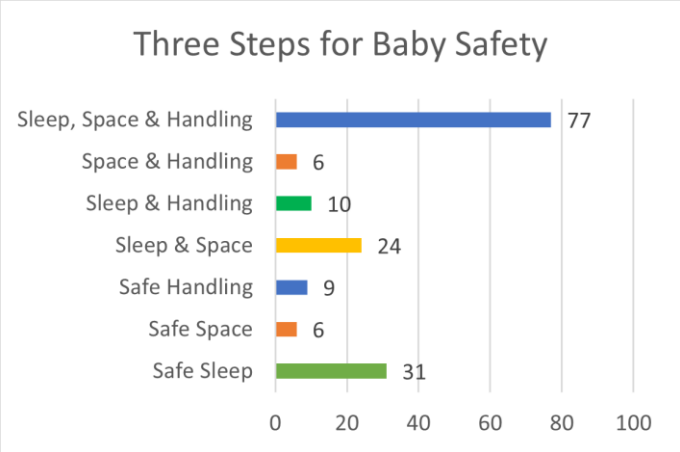
General Course Information (up to and including 3rd May 2023)

Level 3 training commenced on 30th April 2021 and has been attended by **486** practitioners up to and including 3rd May 2023. An average of 30 delegates have attended each event delivered over eight sessions per year. The course has been attended by practitioners from the statutory partners as well as a wide range of associated agencies.

Level 3 Training

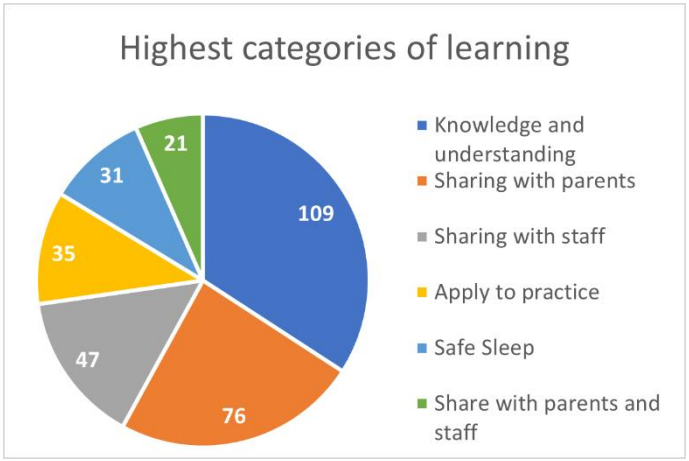


The number of practitioners attending per year has been consistent over the last three years, with initial uptake higher in 2021 following the launch of training. Overall completion rate for Stage 1 evaluations is high and in line with the global completion rate. Completion of the Level 2 evaluation, which measures how delegates have put the training into practice, is significantly lower but is three times higher than the global completion rate.



14% of all delegates regarded Safer Sleep, Space and Handling jointly as the most important message to take from the training. *'support safer sleep message at 8 week checks' (GP – Safeguarding Lead)* with a fifth of all delegates stated their knowledge and understanding had improved.

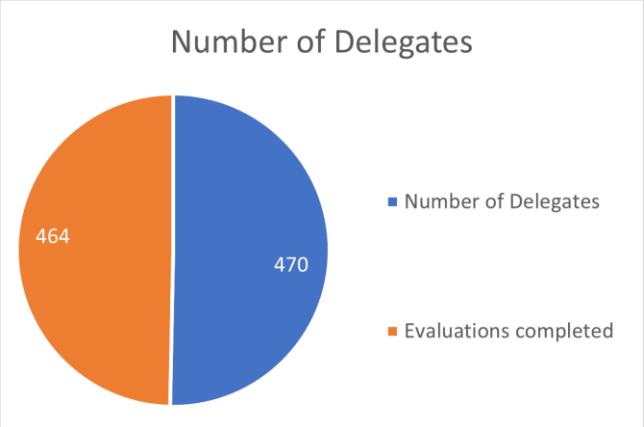
Increased understanding of the complexities of additional parental vulnerabilities such as domestic abuse, alcohol misuse and parental mental health, *'have more knowledge now to support pregnant Mums or concerns with keeping baby safe' (Substance Misuse Practitioner)*, *'impact of domestic abuse and alcohol and substance misuse on the unborn baby' (Play Worker, Children's Centre)* and the implication of this in terms of increased risk *'identify risk, vulnerabilities, taking appropriate action' (Staff Nurse)*.

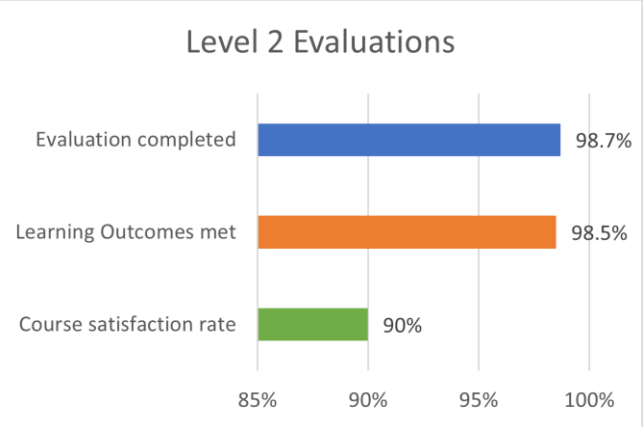


Only 3% of delegates specifically referred to how professional curiosity could support them in their practice *'When supervising staff working with unborn babies, look for evidence of professional curiosity – query have they seen the sleeping areas, are there any hazards, are they any underlying vulnerabilities within pre-birth assessments' (Child Protection Manager)*. This is lower than in the Level 2 evaluations, but this could be attributed to more experienced staff attending the Level 3 training.

Level 2 Training – General Course Information (up to and including 19th May 2023)

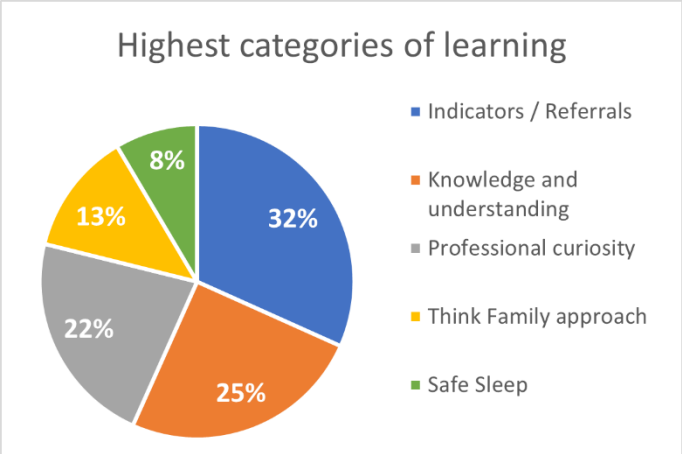
Level 2 training was introduced on 19th June 2021 and has been completed by **470** practitioners up to and including 19th May 2023. There are a further **84** practitioners currently completing the course. The course has been completed predominantly by staff from the early years sector, followed by staff from Derbyshire and other non-statutory agencies. 98.7% of delegates completed the Stage 1 evaluation, compared to 72.6% of delegates attending the Level 3 training. The data for meeting learning outcomes and course satisfaction was similar.





The learning gain was higher for delegates completing the e-learning (0.84) compared to reported learning by practitioners (0.64) attending the Level 3 training. Improved levels of confidence in practice were highlighted in the evaluations for:

- increased knowledge of indicators
- knowledge and understanding
- professional curiosity
- confidence in reporting concerns / or making referrals
- applying a Think Family approach – only practitioners completing the Level 2 course mentioned specifically applying this to their practice going forward.



Learning linked directly to the Three Steps for Baby Safety also varied slightly. The data for 'Safe Sleep' was similar with only a 1% difference, whilst the response for 'Safe Handling' was approximately double in the Level 2 training, which may suggest that practitioners within the early years sector had less confidence prior to training in knowing how to speak to parents around crying and bruising.

The evaluations suggested that professionals were now more aware of bruising in non-mobile babies than before the training, *'questioning marks and bruises more on babies and children' (Early Year's Professional, Private Day Nursery)*, understood the importance of having professional curiosity, *'support staff around the importance of asking challenging / curious questions and how to pose these questions' (Early Help Co-ordinator, Local Authority)*, and had a greater confidence in raising and reporting concerns following completion of the training, *'more confidence in recognising when something is wrong and reporting it' (Early Years Leader, Pre-School)*.

Guidance, Policies and Procedures

All guidance, policies and procedures related to KBS has been reviewed and updated by the Strategic Lead for KBS with support from the Policy, Procedures and Regulation Officer of the DDSCP and have been agreed by the Policy and Procedures Group of the DDSCP. All KBS documents can now be found in the KBS section of the document's library.

The KBS Champions Toolkit can be accessed by all the Champions and members of the KBS Steering Group this is available through the DDSCP website and the NHS Futures website.

The video 'Never Ever Shake Your Baby' is available through the DDSCP YouTube channel and can be shown in many languages and is subtitled to support accessibility.

Governance and Reporting

There has been a governance and reporting structure around the Keeping Babies Safe workstreams.

The Strategic Lead for Keeping Babies Safe has a responsibility to:

- To provide expertise and leadership to the DDSCP and across the partnership on the KBS agenda
- To manage, coordinate and lead on the KBS developments and workstreams
- Chair the KBS Steering Group
- Report to CDOP
- Report quarterly to the DDSCP Board
- Inform and advice the DDSCP Board on any risks or concerns around KBS

The Keeping Babies Safe Steering Group (subgroup of CDOP) have a responsibility to:

- Manage and monitor the KBS action plan
- Lead on any workstreams and developments
- Quality assures any developments and resources

Strategic Lead Role

The role of the Strategic Lead has been successful in managing the KBS agenda and is a model that could be replicated for other specific areas of safeguarding work. The strengths are in having the overall vision, knowledge, and leadership to ensure that initiatives are developed and completed, encouragement is given, and enthusiasm is maintained. The challenge is always time; however, it is important to do the job well so that practitioners on the ground working with families feel empowered to assess families with a baby and deliver the consistent messages in a way that recognises vulnerability and meets individual needs. The Strategic Lead role was supported from leaders from each of the statutory partners and by the DDSCP Partnership Manager and Team.

Recommendations for consideration

- Update the Keeping Babies Safe Strategy – The Three Steps for Baby Safety
- Multi-agency audit of the effectiveness of the safer sleep messages in 2024
- Health audit of the Parent Education Programme 'Never Ever Shake Your Baby' in 2024
- Quality Assurance activity around the use and effectiveness of the Every Baby Matters resources in late 2024/25
- Seek the views and voices of families who care for a baby on the effectiveness of KBS practice and initiatives
- Consideration of the commissioning of DadPad in Derby City
- Partnership consideration of how embedded practice has had positive outcomes for babies and their families
- Focus on supporting Early Years providers with the KBS agenda in 2024
- Additional support and resources for preterm infants and the neonatal units around the KBS agenda
- Engagement with refuges for victims of domestic abuse
- Continue to support and develop the KBS Champions
- Consider further Champions training in 2024
- Review and develop any learning and training opportunities
- Report annually to the DDSCP on the activity and impact of the KBS workstreams
- Report annually to CDOP on the activity and impact of the KBS workstreams
- Share the learning, initiatives, and outcomes regionally and nationally particularly with NHSE and the National Child Safeguarding Practice Review Panel

Conclusion

It is debatable to say if the work around the KBS agenda has been transformational as the research and information to support practice around KBS has been available and used by practitioners with the exception of the Every Baby Matters project. The difference is the approach – Derby and Derbyshire have had a consistent multi-agency approach, there has been real enthusiasm, some say a 'buzz' around the KBS work. Practitioners and leaders have been committed to helping families make the right choices for their baby particularly vulnerable families. The KBS work will continue and the aim that the KBS tools and resources become further embedded across the Derby and Derbyshire multi-agency partnership and babies are protected from abuse and harm.

A big thank you

This work could not be achieved without many practitioners and leaders across the partnership. I have been supported and encouraged along the way. I would like to thank Kayleigh McMahon who has been by my side throughout and has actively supported the KBS work. Mark Sobey and the DDSCP team, including Amanda Ratcliffe and Sarah O'Brien. My manager Michelina Racioppi who has put up with me! Particularly the KBS Champions and all the practitioners who have worked so hard to make a difference to families. Finally, the families who have helped provide feedback on the resources and tools we have developed and are the reason we all do what we do.