Meeting Date	**24th January 2019**	**Agenda Item**	**2e**
Report Title	**Safeguarding Report**		
Report Author	• Nicola Edwards, Head of Nursing – Safeguarding		
Report Sponsor	Gareth Howells, Director of Nursing & Patient Experience		
Presented by	Gareth Howells, Director of Nursing & Patient Experience		
Freedom of Information	Open		
Purpose of the Report	This paper aims to provide the necessary assurance that the Health Board's statutory duties under the Children Act 2014, the Social Services and Well-being (Wales) Act and the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 are being fulfilled by having and engaging with appropriate processes across the wider safeguarding remit.		
Key Issues	Safeguarding of services users and their families is central to every aspect of activity within the organisation and has the greatest potential risk to any organisation. Safeguarding both adults and children is everybody's business from the Board to frontline staff both within the organisation and contracted services.		
Specific Action Required ***(please ✓ one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
			✓	
Recommendations	Members are asked to : • **NOTE** the report			

SAFEGUARDING REPORT

1. INTRODUCTION

This report aims to provide an overview of the Health Board Safeguarding processes and provide the necessary assurance that the Health Board's statutory duties under the Children Act 2014, the Social Services and Well-being (Wales) Act and the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 are being fulfilled.

The Health Board recognises every staff member/health professional has a duty to safeguard and promote the welfare of children, young people and adults at risk and protect them from abuse by staff. All allegations of abuse of children or adults at risk by a Health Board employee should be taken seriously and treated in accordance with the appropriate policies and legislation.

2. BACKGROUND

Safeguarding Processes

The Corporate Safeguarding team compiles a bi-annual report, which is submitted to the Safeguarding Committee and the Quality & Safety Committee, which gives an in-depth account and analysis of activity, themes and trends. The following section will outline key areas.

Child & Adult Referrals

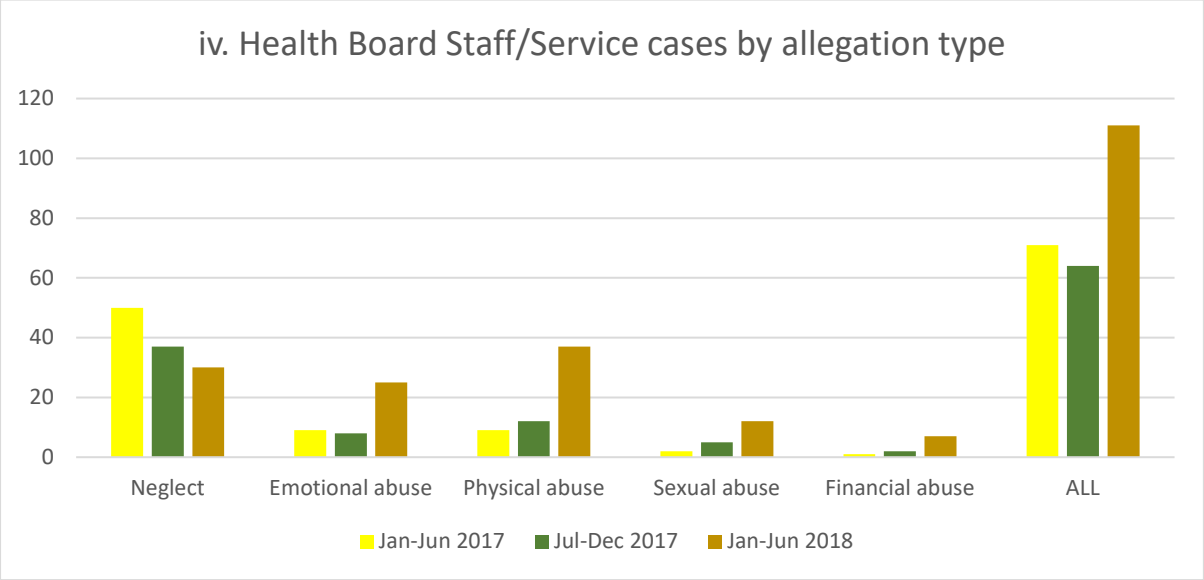
Referrals made in respect of suspected child abuse are sent to the relevant Local Authority Children Services, irrespective of whether the abuse is within the hospital or outside and it is the responsibility of the Local Authority to investigate. Health Board employees have involvement through making referrals, attending strategy meetings and Child Protection Conferences as well as contributing to and implementing Child Protection plans.

In the period January to June 2018, a total of 1,083 safeguarding children referrals or requests for information were submitted to Social Services from the Health Board.

Adult safeguarding concerns are managed differently; as, under current agreed Wales multiagency procedures, the Health Board addresses any adult at risk referrals that relate to alleged abuse or neglect within Health Board premises and referrals within the community where a health employee is allegedly responsible. The Social Services & Well-being (Wales) Act 2014 places a greater duty on Local Authorities to make the necessary enquiries and identify any actions required to safeguard adults at risk.

The chart below gives an indication of the levels of Safeguarding Adult activity from January 2017 to June 2018. Data from July 2018 is in the process of being collated for the forthcoming bi-annual report, which will be presented to the February Safeguarding Committee.

Health Board Safeguarding Adult Cases by allegation type



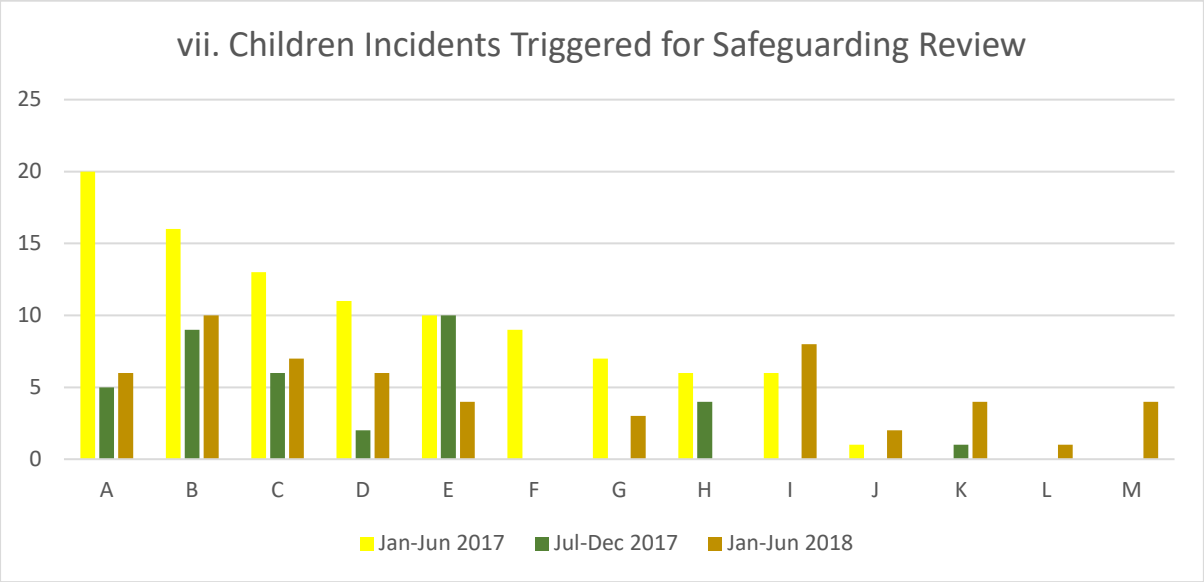
The majority of referrals when assessed by the Designated Lead Manager (the senior Health Board staff member identified and trained to address referrals) are assessed as not requiring formal management under the All Wales Interim Safeguarding Adult Procedures. This continues to reflect the increased awareness of the requirement to report all suspected cases of 'Adults at Risk' (Social Services & Well-being (Wales) Act 2014). Any concerns arising from the assessment of cases that are then not formally managed under these procedures are addressed via other processes such as 'Putting Things Right' or incident reporting; this links in with the continued high numbers of reported safeguarding adult incidents outlined in the next section of the report, thus indicating a positive reporting culture.

Safeguarding Incident reporting

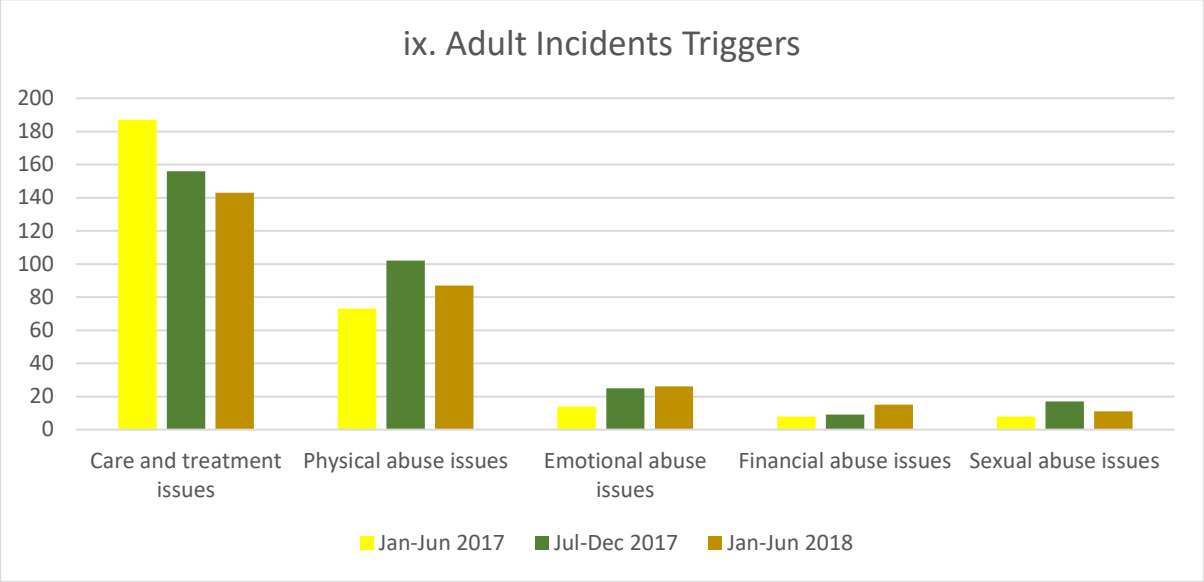
The Corporate Safeguarding Team continues to monitor safeguarding alerts triggered via the DATIX system, thus allowing for the collation of information. This also allows discussion between the Corporate Safeguarding Team and Health Board staff so that advice can be provided with the aim of improving practice to prevent recurrences and allowing for the implementation of safeguarding plans to prevent such incidents progressing to cases that would require management under Adult Protection Procedures.

DATIX incident triggers are reviewed by the Safeguarding Team within three working days of an alert and coded according to themes. Compliance to this standard is consistently above 95%.

Children Incidents for Safeguarding Team Review



Adult Incidents for Safeguarding Team Review



The safeguarding Team compare data across reporting periods to monitor themes and trends. Knowledge and understanding of what constitutes a 'safeguarding referral' is reinforced to staff during training, guidance within DATIX and feedback to incident approvers.

Deprivation of Liberty Safeguards (DoLS)

This is reported in a separate paper; DoLS continues to be an organisational risk but there continues to be progress with the improvement plan.

Professional Abuse and Concern Cases

When a concern is raised, or abuse is alleged to have occurred outside a member of staff's employment, the Health Board implements its Professional Concerns/Abuse policy in order to carefully consider whether the employee presents any risk within their Heath Board working environment. Action within a multi-agency approach is taken against those who deliberately abuse children or adults at risk (or any person in our care) including prosecution, disciplinary action and notification to professional regulators. Support is offered to staff involved in this process.

Period	Professional Abuse (Children)	Professional Concerns (Adult)	Total
Jan-Jun 2017	**10**	**5**	**15**
Jul-Dec 2017	**<5**	**5**	**8**
Jan-Jun 2018	**<5**	**10**	**13**

Monitoring the progress of professional abuse/concern cases is undertaken by the Safeguarding Committee via updates provided by the Service Delivery Units. The Safeguarding Team uses the information provided to subsequently update the 'In-committee' of the Quality & Safety Committee and the Chief Executive.

Violence against Women Domestic Abuse and Sexual Violence (VAWDASV) (Wales) Act 2015 "Ask and Act"

The Health Board's "Ask and Act" training plan is ongoing, with a statutory requirement to submit an annual report to Welsh Government May each year.

Group 1: As of May 2108 80% of Health Board staff had completed Group 1 training. The target set by WG is 100%, ABMU Health Board was the second highest across NHS Wales. Powys Teaching Health Board reported the highest, it must be noted Powys has a much-reduced workforce.

Group 2: From July – December 2018 281 members of staff received Group 2 "Ask & Act" training. Over the last year there have been some issues in relation to this training for HB staff, this was due to a delay in Welsh Government confirming funding arrangements for Third Sector specialist services.

Group 3: Group 3 training has not yet commenced due to the delay in Third sector funding.

Multi Agency Risk Assessment Conference (MARAC)

MARAC is held on a fortnightly basis in each of the three Localities of Bridgend, Neath/ Port Talbot and Swansea. MARAC discusses high risk victims of domestic violence and abuse and agrees a multi-agency plan of action to ensure the safety of the victim and any child involved. A Health Board member attends each MARAC.
During the past year, there has been an increase in other specialist MARACs; for example - Human Trafficking MARACs and sex worker MARACs.

MARAC referrals from ABMU have increased following the introduction of Group 2 Ask & Act training in 2016. There has been an overall increase of referrals by 24%, with the largest area for increase in secondary care with an increase of 42%.

Female Genital Mutilation (FGM)

Female Genital Mutilation (FGM) is illegal in the UK under the Female Genital Mutilation Act 2003 and the Serious Crime Act 2015. It is mandatory for NHS staff to report all cases of FGM in children to the Police and Social Services. The All Wales Clinical Pathway gives staff guidance and has been incorporated into the Health Board's FGM Policy.

ABMU HB's Corporate Safeguarding Team reports all cases of FGM in both women and children to Welsh Government via Public Health Wales on a quarterly basis. HB staff report new disclosures via the FGM Datix Data collection tool.

Child Sexual Exploitation (CSE)

Child Sexual Exploitation (CSE) is a criminal act that has a devastating impact upon children and young people. CSE has had an increasing national profile more recently following significant investigations, which have led to prosecutions. Western Bay Safeguarding Board has a multi-agency CSE strategy and action plan, which the ABMU Health Board is committed to. The purpose of this is to do everything possible to prevent CSE, protect and support those affected by CSE and tackle perpetrators.

Health Board staff in identified priority areas use the All Wales Risk Assessment Tool (CSERQ 15) as a guide to assessing risk of CSE. During the reporting period January to June 2018 566 CSERQ15 were completed and 19 referrals were made to Children's Services. Integrated Sexual Health completed the most CSERQ15 and Midwifery made the largest number of child protection referrals.

Since September 2017 a Standard Operating Procedure (SOP) has been implemented to ensure that the electronic records for all children identified as being at high risk of CSE are flagged so that anyone in health having contact with the child will be aware of the concerns. The Corporate Safeguarding Team is currently undertaking an audit to monitor that children who are considered to be of high risk of CSE have had the appropriate alert placed on their electronic health record.

Human Trafficking/Modern Slavery

Human Trafficking is the movement of adults and children from one place to another using deception and coercive abuse of power into a situation where they are exploited. Modern Slavery encompasses trafficking for sexual exploitation, domestic servitude and forced or compulsory labour.

Since November 2015 specified public authorities have a duty to notify the Home Office of any individual in England or Wales who they believe is a victim of slavery or trafficking using the National Referral Mechanism (NRM). This is a victim identification and support process and is designed to facilitate inter-agency information sharing on potential victims and enable victims to access support, advice and accommodation

A programme of multi-agency Anti-Slavery Awareness training is available for health staff provided by external agencies. The Corporate Safeguarding Team is currently reviewing this training and incorporating it into the facilitated Level 3 training.

Channel and PREVENT

The Counter Terrorism and Security Act 2015 requires the Health Board to engage with partner agencies in reducing the risk and impact posed by potential terrorist threats, and support individuals who may be at risk from engagement in terrorist acts. The Corporate Safeguarding Team continues to represent the Health Board as a partner agency on the Regional Contest Board (along with colleagues from Corporate Planning) where risks and impact are discussed and actions agreed to mitigate risk. The Team also engages with the three local Channel Panels where persons at risk of radicalisation are discussed and strategies devised to engage and support them away from undertaking potential criminal acts. The Health Board is also required under the Act to ensure staff are appropriately trained in the identification and referral of such vulnerable individuals.

Suicide and Self Harm Prevention

The Wales National Suicide Prevention Strategy 'Talk to me 2' developed by the National Advisory Group (NAG) on Suicide and Self-Harm sets out the strategic aims and six key objectives to prevent and reduce suicide and self-harm in Wales over the period 2015-2020. Three Regional Fora, (North Wales, South East Wales and South & West Wales) have been tasked with developing a Local Suicide Prevention Strategy.

The South & West Wales Regional Forum is attended by a member of the Corporate Safeguarding Team as well as other Health Board members, Local Authorities, HMPS, Railway Services, Samaritans, Swansea University, NAG, WAST, Police and service users.

County Lines

County Lines is the police term for urban gangs supplying drugs to suburban areas and market and coastal towns using dedicated mobile phone lines or "deal lines". It involves criminal exploitation as gangs use children and vulnerable people to move drugs and money. Gangs establish a base in the market location, typically by taking over the homes of local vulnerable adults by force or coercion in a practice referred to as 'cuckooing'. Multi-agency work with ABMU participation has taken place through partnership working with Western Bay. The main features of this has been incorporated into Safeguarding Level 3 Training and additional sessions have been targeted to frontline staff. The Safeguarding Team have recently begun to collate information related to County Lines activity in the Health Board area.

Adult and Child Practice Reviews

The Social Services and Well-being (Wales) Act 2014 Working Together to Safeguard People: Volumes 2 and 3 sets out arrangements for multi-agency Adult and Child Practice Reviews in circumstances of a significant incident where abuse or neglect of a child or adult at risk is known or suspected. The criteria for Adult and Child Practice

Reviews are laid down in the Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015. These arrangements came into force from April 6th 2016.

The purpose of a review is to identify learning for future practice and involves practitioners, managers and senior officers in exploring the detail and context of agencies' work with a child and family. The output of a review is intended to generate professional and organisational learning and promote improvement in future interagency and adult and child protection practice. Any learning is incorporated into training and discussed at relevant meetings, peer reviews and supervision.

The Safeguarding Team, along with other key staff from the Service Delivery Units, continue to engage with a number of Adult or Child Practice Reviews commissioned by the Western Bay Safeguarding Boards.

The below tables identify the current status of the Adult and Child Practice Reviews that the Health Board are involvement in.

Adult Practice Reviews – January – December 2018

Adult Practice Reviews	New	Ongoing	Completed	Published
	0	**<5**	**<5**	**<5**

Child Practice Reviews – January – December 2018

Child Practice Reviews	New	Ongoing	Completed	Published
	<5	**<5**	**<5**	**<5**

All relevant recommendations and learning points are incorporated into the Corporate Safeguarding Practice Review Action Plan, which is monitored by the Safeguarding Committee.

Domestic Homicide Reviews (DHR)

A Domestic Homicide Review is a multi-agency review of the circumstances in which the death of a person, aged 16 or over, has or appears to have resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves. There is a statutory requirement for agencies to conduct DHRs within

Home Office guidance. (*Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2016).* The Community Safety Partnerships within each Locality of Swansea, Neath/Port Talbot and Bridgend lead the DHRs.

The purpose of a DHR is to establish what lessons can be learned regarding the way in which local professionals and organisations worked individually and together to safeguard the victim and to create an action plan based on the learning and recommendations. The goal is to prevent domestic violence and homicide and improve service responses for all VAWDASV victims and their children.

The Health Board is currently involved in four Domestic Homicide Reviews. On completion, reports are submitted to the Home Office prior to publication and identified actions are monitored by the relevant Community Safety Partnership.

Procedural Response to Unexpected Deaths In Childhood (PRUDiC)

The Procedural Response to Unexpected Deaths in Childhood (PRUDiC 2018) sets a minimum standard for a response to unexpected deaths in infancy and childhood. It describes the process of communication, collaborative action and information sharing following the unexpected death of a child. This procedural response is followed when a decision has been made that the death of a child is unexpected. The aim of the PRUDiC ids to ensure that the response is safe, consistent and sensitive to those concerned, and that there is uniformity across Wales in the multi-agency response to unexpected child deaths.

There were seven unexpected child deaths during 2018. Themes are monitored, and whilst there are no common themes linking the deaths, it is important to note that one of the deaths was linked to co-sleeping which was a common theme throughout the previous year. The Health Board has taken a pro-active approach to raise the profile of the Welsh Government “safe sleeping” guidance through disseminating information via Safeguarding Committee, Western Bay Safeguarding Children Board, use of Intranet bulletins, integrating within training and within Health Visitors’ and Midwives practice.

Child & Adolescent Mental Health Service (CAMHS)

During 2018, there has been an increase in the number of young people with self-harming behaviour who present at Emergency Departments (ED) needing additional support, particularly regarding CAMHS. Many of these children have behavioural issues but do not necessarily have a mental health diagnosis. There have been examples of good multi-agency working between ED, CAMHS, Paediatric Services, Mental Health SDU, Local Authorities and the Police. However there have also been challenges with regards to the correct placements and one particular case involved referral to the High Court.

Safeguarding Training and Supervision

Safeguarding Training

Level 1 and 2 Safeguarding Adult and Children training and Level 2 Mental Capacity Act training is provided via e-learning. Compliance is monitored by the Safeguarding Committee via information provided to the Committee by each Service Delivery Unit (SDU) on a bi-monthly basis.

Level 3 Safeguarding Training

Level 3 Safeguarding Children training sessions continue to be delivered monthly across the Health Board area. Eleven sessions were delivered by the Corporate Safeguarding Team during 2018.

Level 3 Safeguarding Adults training differs to that of Level 3 Safeguarding Children in that it solely targets staff who are operational managers who would be responsible for responding to a safeguarding alert. Hence, the number of staff requiring this training is significantly lower than that for Level 3 Safeguarding Children training. During 2018 ten sessions were delivered by the Corporate Safeguarding Team.

The Corporate Safeguarding Team supported by a small number of Unit trainers continues to deliver the WRAP3 Home Office approved training (Prevent). This is an awareness raising session, which enables staff to identify vulnerable individuals who may be susceptible to radicalisation, and to be aware of the need to refer for the appropriate support.

Deprivation of Liberty Safeguards (Level 2) Training

Training is facilitated by the Safeguarding Team and delivered by Swansea University (under the Education Contract) to ward staff on the requirements for making an application for Deprivation of Liberty, and the process for making such applications. There has attended at DoLS training – this is possibly attributed to SDUs encouraging their staff to attend training sessions following discussions at the Safeguarding Committee.

Mental Capacity Act (MCA) Level 2 & 3 Training

Training is facilitated by the Corporate Safeguarding Team and delivered by Swansea University (under the Education Contract). MCA Level 2 is currently taught via e-learning and is for all staff with patient contact.

MCA Level 3 is a workshop based session on the practical implications of the Mental Capacity Act 2005. The training is aimed at Ward Managers, Senior Nurses, Senior Clinicians and any other staff requiring knowledge of the practical implications of applying the Mental Capacity Act in practice.

Safeguarding Supervision

Safeguarding supervision and support is an essential component of clinical governance (Welsh Government Health and Care Standards 2015. Safe Care 2.1, Effective Care 3.1, Individual Care 6.3 Staff and Resources 7.1). In addition, all Health Boards have a responsibility to ensure staff feel supported in their safeguarding children role, including access to advice, expertise and guidance (Working Together to Safeguard Children, 2013, All Wales Safeguarding Supervision Policy 2017).

The Corporate Safeguarding Team continues to contribute to supervision arrangements as follows:

- Daily *ad hoc* safeguarding advice and support for staff
- One to one individual planned safeguarding supervision for safeguarding children specialists across the Health Board
- Peer group review - bi-monthly for children's safeguarding specialists
- Designated Lead Manager (DLM) support groups.

Multi- Agency Working

The benefits of multi-agency working within the safeguarding arena are immense. Information sharing is key to successful outcomes for both adults and children, this has often been found to be lacking by both practice, and serious case reviews. The Head of Nursing: Named Nurse Safeguarding and the Interim Deputy Director of Nursing & Patient Experience both attend the Western Bay Safeguarding Children & Adult Boards. There are a number of sub-groups associated with these Boards, to which members of the Health Board and Corporate Safeguarding Team attend and actively contribute.

NHS Wales Safeguarding Network

This Network was established to provide a vital bridge between strategies and arrangements at local level and national policy developments to support NHS Wales Health Boards and Trusts in discharging their responsibilities for safeguarding people. The Network meets quarterly reporting to the Chief Nursing Officer and implementation of recommendations of the group is the responsibility of Health Boards and Trusts. Various streams of work are facilitated by sub-groups of the Network and include VAWDASV, CSE, Practice Reviews and Looked after Children (LAC). ABMU Health Board provides representation and actively participates in all of these groups.

3. GOVERNANCE AND RISK ISSUES

The Safeguarding Committee will seek to provide assurance both to the Health Board, via the Quality and Safety Committee and to the Western Bay Safeguarding Children and Adult Boards that an appropriate system for the safeguarding of children and

adults accessing healthcare is in place across the Health Board. Membership of the Safeguarding Committee reflects multi-professional representation of individuals with safeguarding expertise and includes the Head of Nursing: Named Nurse Safeguarding and Safeguarding Leads from all the SDUs. These Leads are responsible for the operational delivery of the safeguarding requirements and priorities. The Committee is chaired by the Director of Nursing & Patient Experience who has the executive lead responsibility for safeguarding.

There is a Safeguarding Risk Register that is monitored alongside the Corporate Risk register.

Current risk issues:

- Absence of a Dedicated MCA/DoLS lead
- Timeliness completion of DoLS Authorisations then the Health Board Duty to Report
- Compliance with mandatory safeguarding training
- Health Board Compliance with SS&WB Act enquiry timescales

4. FINANCIAL IMPLICATIONS

Safeguarding is a core duty of care for the Health Board. Financial implications to meet the statutory safeguarding requirements are within existing budgets.

5. RECOMMENDATION

The Committee is asked to note the contents of this report.

Governance and Assurance							
Link to corporate objectives ***(please ✓)***	Promoting and enabling healthier communities	Delivering excellent patient outcomes, experience and access	Demonstrating value and sustainability	Securing a fully engaged skilled workforce	Embedding effective governance and partnerships		
	x	**x**		**x**	**x**		
Link to Health and Care Standards ***(please ✓)***	Staying Healthy	Safe Care	Effective Care	Dignified Care	Timely Care	Individual Care	Staff and Resources
		x					

Quality, Safety and Patient Experience
N/A
Financial Implications
Financial implications to meet the statutory safeguarding requirements are within existing budgets.
Legal Implications (including equality and diversity assessment)
The Health Board has a statutory responsibility to make arrangements to protect and safeguard the welfare of children, young people and adults at risk Safeguarding policies uphold that patient and service users have the right to independence, dignity, respect, equality, privacy and choice.
Staffing Implications
N/A
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015 - https://futuregenerations.wales/about-us/future-generations-act/)
Improve Population Health through prevention and early intervention

Report History	N/A
Appendices	N/A