ABM University Health Board	
Date of Meeting: 1st February 2018 **Name of Meeting: Quality and Safety Committee** **Agenda item: 4.5**	
Subject	*Bi-annual Safeguarding Report to Quality & Safety Committee*
Prepared by	Virginia Hewitt, Head of Nursing:Safeguarding
Approved by	Cathy Dowling, Interim Deputy Director of Nursing & Patient Experience
Presented by	Angela Hopkins, Interim Director of Nursing & Patient Experience

1. PURPOSE

The purpose of this report is to provide the Quality and Safety Committee with an overview of the work taken forward by the Safeguarding Committee and the Corporate Safeguarding Team between July 1st 2017 and December 31st 2017.

2. STRATEGIC LEADERSHIP AND MANAGEMENT OF SAFEGUARDING TEAM

The Corporate Safeguarding Team continues to develop services that address the safeguarding of people. The team work to support the Health Board to execute their duties to safeguard children and adults at risk within the statutory framework. (Social Services & Well-being (Wales) Act 2014, Children Act 1989, 2004). There is expertise within the team to address some of the most pertinent issues the Health Board may encounter regarding adults at risk and children as well as concerns regarding violence against women, human slavery and Deprivation of Liberty Safeguards. The team is managed by a Head of Nursing:Safeguarding who directly reports to the Interim Deputy Director of Nursing & Patient Experience

3. 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 and has often found to be lacking by both practice and serious case reviews.The Head of Safeguarding and the Interim Deputy Director of Nursing & Patient Experience both attend the Western Bay Safeguarding Children & Adult Boards (WBSCB & WBSCB). There are a number of sub groups associated with these Boards, which members of the Health Board and Corporate Safeguarding Team actively contribute to. In addition, the Corporate Safeguarding Strategic Work Plan has been mapped against the WBSCB/WBSAB Strategic Priorities and Business Plans. The Safeguarding Committee monitor the progress of the plan and required actions. Other examples of multi agency work are illustrated within this report. In addition the Head of Safeguarding attends the South Wales Safeguarding Children & Adults Forum.

4. NHS WALES SAFEGUARDING NETWORK (NWSN)

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 reports 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 provide representation at all of these groups. The Network meets quarterly and is chaired by one of the Designated Doctors in Public Health Wales. The Head of Safeguarding attends this group and is currently vice-chair.

5. HEALTH & CARE STANDARDS (HCS); 2.7 SAFEGUARDING CHILDREN AND ADULTS

The Corporate Safeguarding Strategic Work Plan is aligned with 2.7- Health Care Standards. On reviewing the self-assessment submissions from the six SDUs (Service Delivery Units) within ABMU Health Board some corporate themed risks have been identified.

- Safeguarding training compliance
- DoLS Assessments completed in a timely manner

These risks remain consistent from the last reporting period (January- July). These have been added to the Health Board Corporate Risk Register and work undertaken to address these issues is described within the body of this report. In addition a Safeguarding Risk Register is currently being developed which will include this information

6. SAFEGUARDING COMMITTEE

The purpose of the Safeguarding Committee is to assist the Quality and Safety Committee to deliver its statutory and mandatory responsibilities in relation to the Safeguarding agenda. It also aims to ensure that the Health Board promote and protect the welfare and safety of children and adults who become vulnerable or are at risk at any time.

The 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 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 executive lead responsibility for safeguarding. The Committee facilitates a presentation which includes safeguarding topics for learning and sharing. During the reporting period topics included

- Child Practice Reviews across Wales
- All Wales Female Genital Mutilation Pathway
- Adult Safeguarding High Risk Report which is now subject to a HIW Review.

7. SAFEGUARDING REFERRALS

In accordance with the Social Services and Wellbeing Act (2014) & the Children Act 1989, 2004, the Health Board has a statutory obligation to report children and adults who are at risk of abuse and neglect. The processes associated with the referral mechanism of the two disciplines are managed differently.

7.1 Children

Referrals made in respect of suspected child abuse are always sent to the relevant Children Services irrespective of whether the abuse is within the hospital or outside and are the responsibility of the Local Authority to investigate. However Health Board employees may have involvement through making the referral, attending strategy meetings and case conferences as well as contributing and auctioning
any child protection plans.

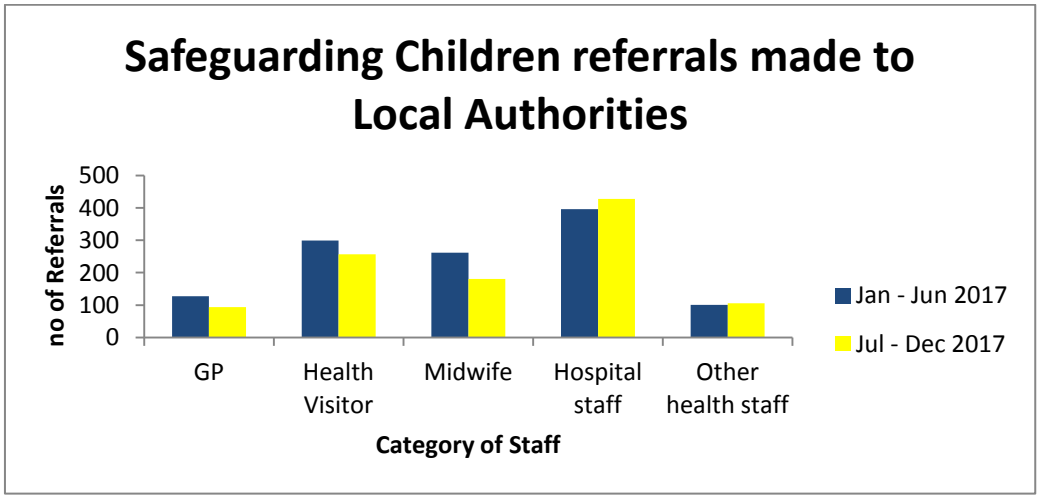
7.2 Adults at risk

The management of safeguarding adult referrals differs, in that the Health Board manage all the referrals that relate to allegations of abuse or neglect that occur within Health Board premises. They also manage any within the community if a health employee is allegedly responsible. This is irrespective of who the alleged abuser may be. At the present time all these referrals are collated by the Corporate Safeguarding Team.

7.3 Safeguarding Children Referrals

In the reporting period a total of 1066 referrals or requests for information from Social Services were recorded. The referrals or requests for information submitted to the 3 Local Authorities (LA) by ABMU Health Board staff during the reporting period are listed at Graph **i** and compared with the previous reporting period. The referrals are categorised according to the area/staff group which made the referral.

Graph i – Safeguarding Children referrals made to Local Authorities



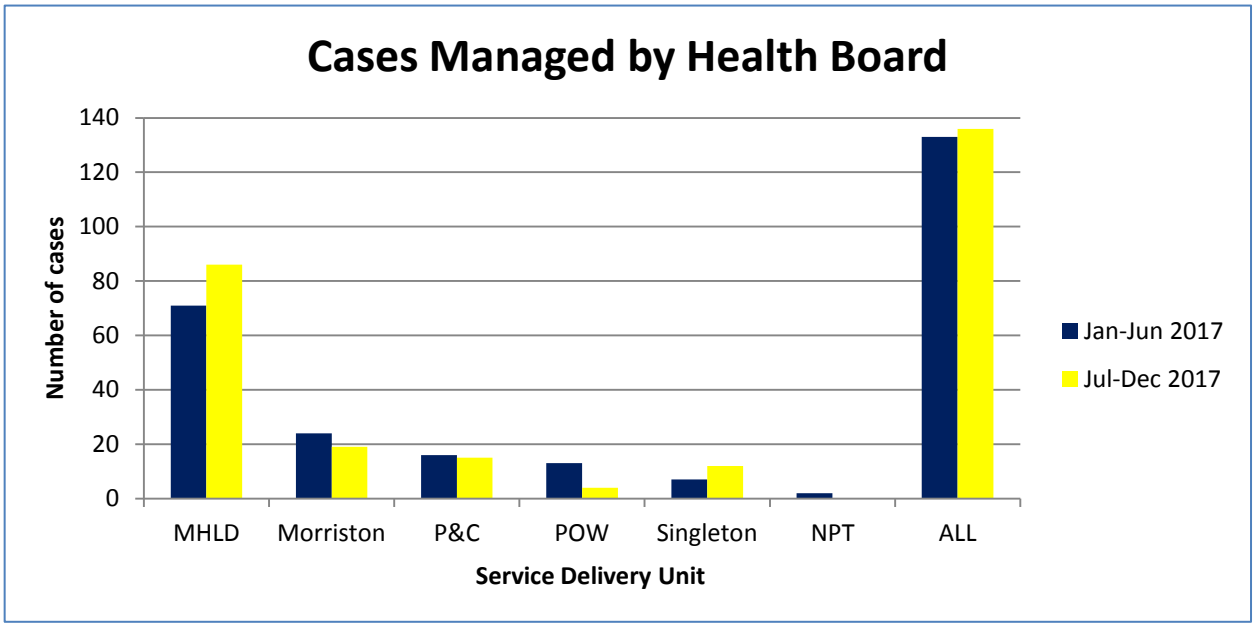
The figures provided are from the Local Authority. In the previous 6 months it was possible to report on the reason for referral but the Local Authority have not been able to provide us with the data breakdown in this period. At present the Corporate Safeguarding Team do not yet collate child protection referrals at the point of referral due to capacity. However the Corporate Safeguarding Team are working with the information management team to move this forward and introduce a system whereby each referral made can be captured electronically at the point of referral. This will enable the Corporate Team to better analyse the referral information for children.

As is reflected in the figures it would be expected that the staff groups making the highest number of referrals for children with safeguarding concerns would be Health Visitors, Midwives and GPs within the community and Emergency Department staff within the hospital setting. This trend is consistent with the previous reporting period and the numbers are comparable.

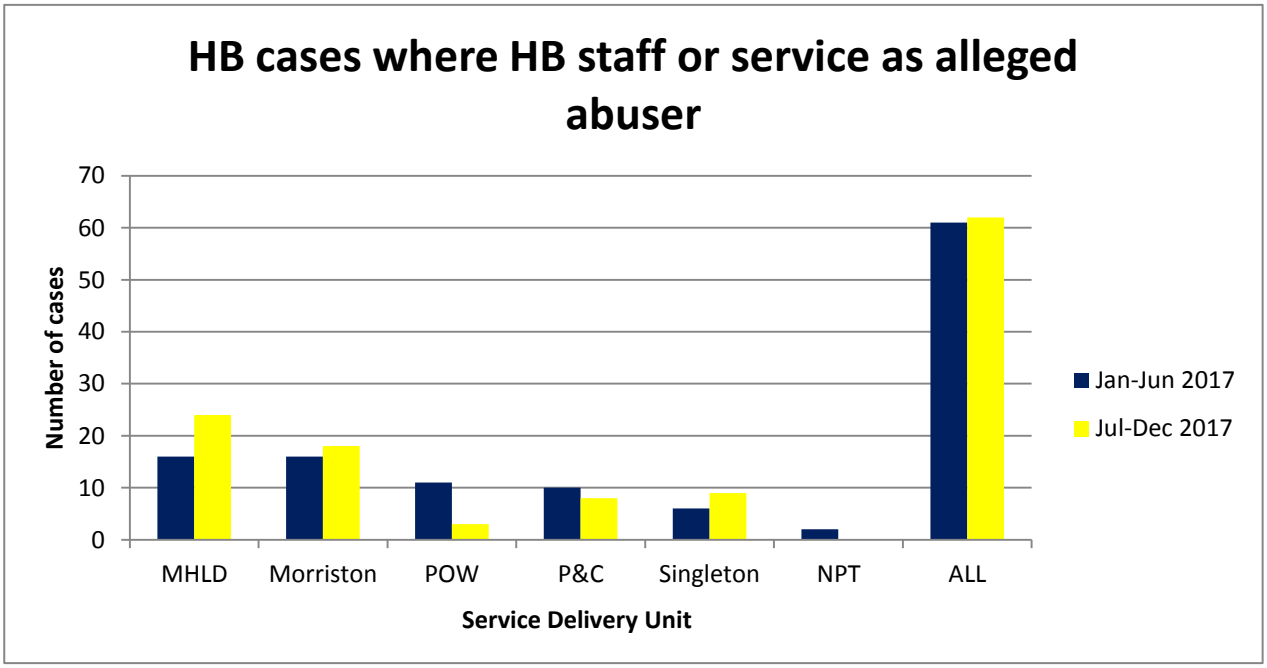
7.4 Safeguarding Adult Referrals

Collation of the safeguarding adult referral continues to highlight that the Mental Health and Learning Disabilty SDU addresses the highest number of referrals. A significant proportion of these cases are as a result of abuse of a patient by another patient.

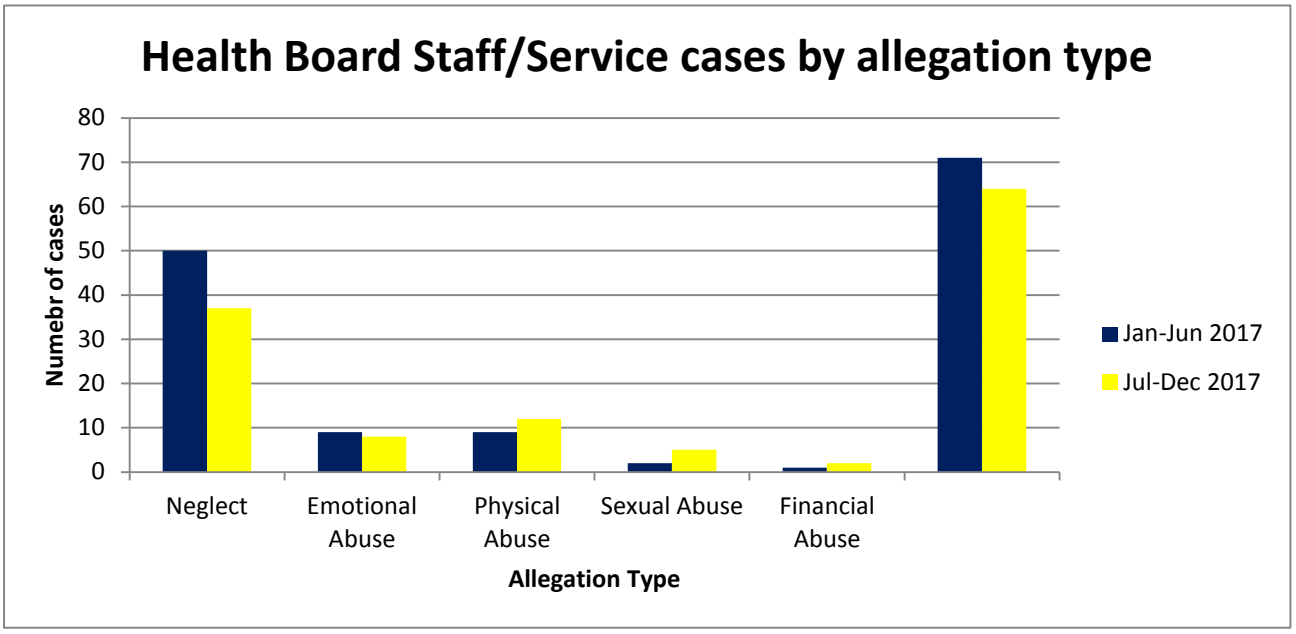
Graph ii - Adult Cases managed by the Health Board



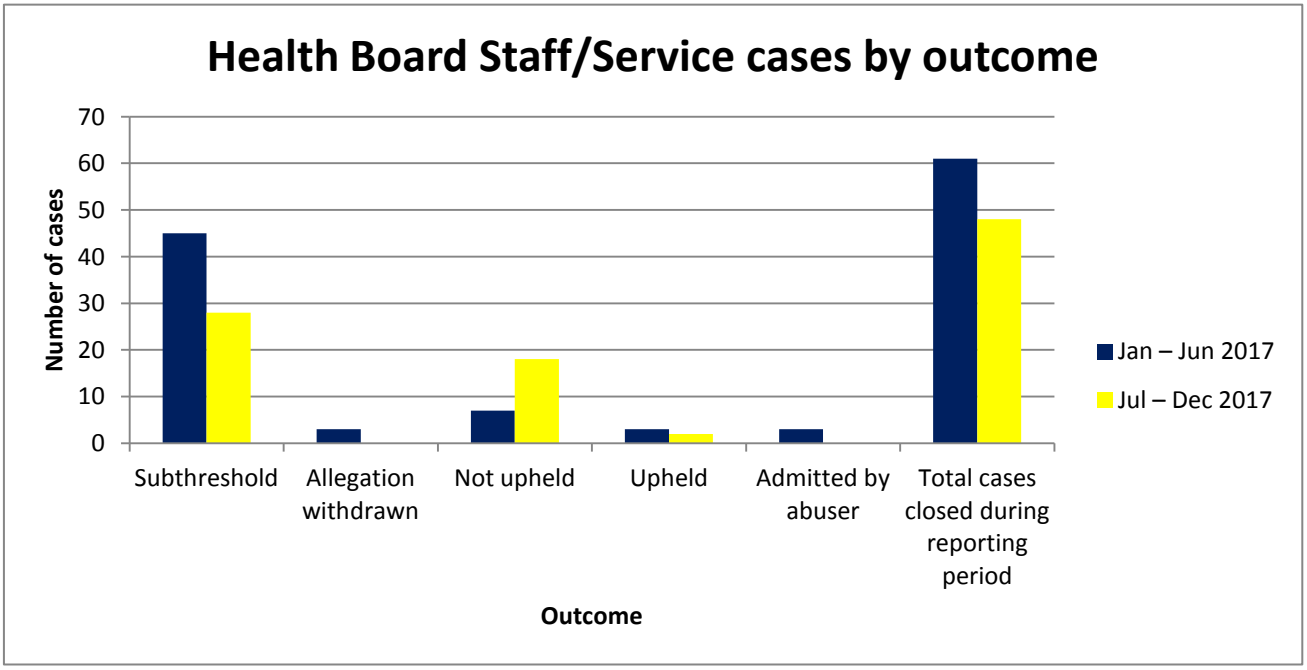
Graph iii - outlines the Health Board managed cases where a Health Board staff member, or the service provided by the Health Board is alleged to have abused or neglected a patient



Graph iv - shows the breakdown of the type of allegation made in referrals about the Health Board services or staff. Allegations of neglect remains the biggest theme, but there has been a increase in allegations of physical and sexual abuse.



Graph v – Health Board Staff/Service cases by outcome



The majority of referrals when assessed by the Designated Lead Manager (the senior Health Board staff member identified and trained to address referrals) do not meet the threshold for 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 'Adult at Risk'. (Social Services & Well-Being (Wales) Act

2014). Any concerns arising from the assessment of cases that are then not formally managed under the 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.

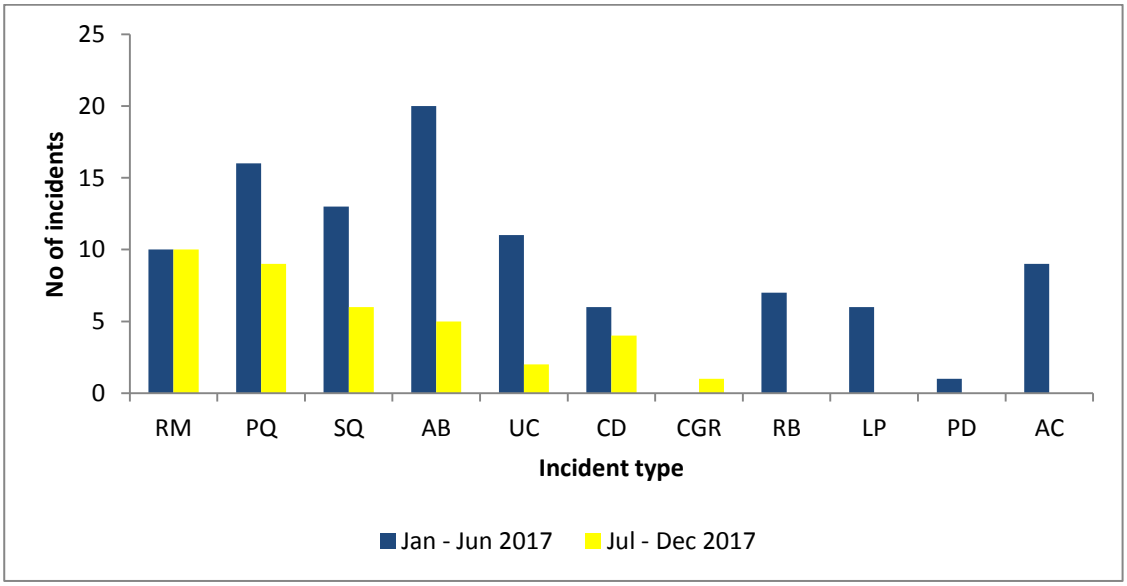
8. INCIDENT REPORTING

8.1 DATIX safeguarding trigger alerts

The use of safeguarding incident alerts on DATIX enables the recording of safeguarding concerns that do not necessarily require submission of a safeguarding referral. Monitoring of the alerts also allows for the collation of information and encourages discussion to take place with the Corporate Safeguarding Team so that advice can be provided with the aim of improving practice to prevent recurrences. In addition, in the case of adults at risk, will allow for the implementation of safeguarding plans to prevent such incidents progressing to cases that would require management under adult protection procedures.

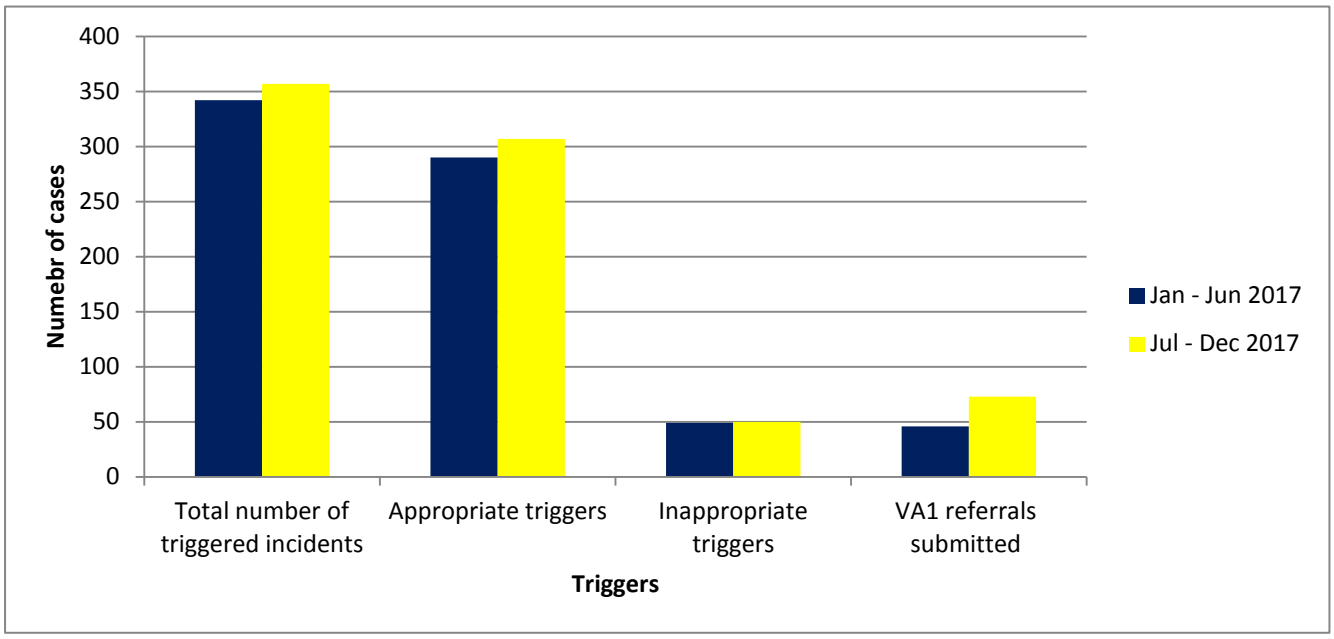
DATIX incident triggers are reviewed by the Safeguarding Team within 3 working days of an alert, and coded according to themes.

Graph vi - Safeguarding Children Appropriately Flagged Incidents

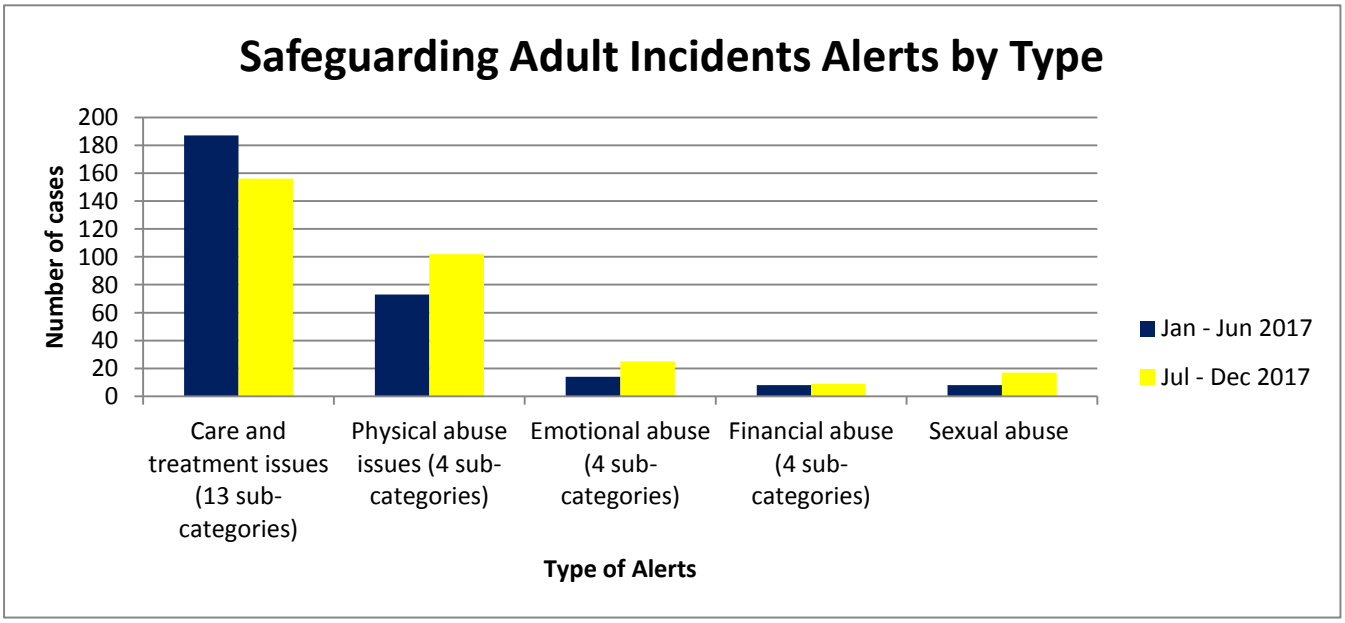


RM	Child nursed on adult ward	CGR	Corporate guidance required
PQ	Failure to share information	RB	Documentation
SQ	Failure to follow guidelines	LP	Lack of service provision
AB	Aggressive behaviour	PD	Professional differences
UC	Uncontollable child	AC	Absconding child
CD	Child death		

Graph vii - Comparison of Number and Apropriateness of Safeguarding Adult Incident Triggers This indicates a fairly consistent number of reported incidents, appropriate and inappropriate triggers across the reporting periods.

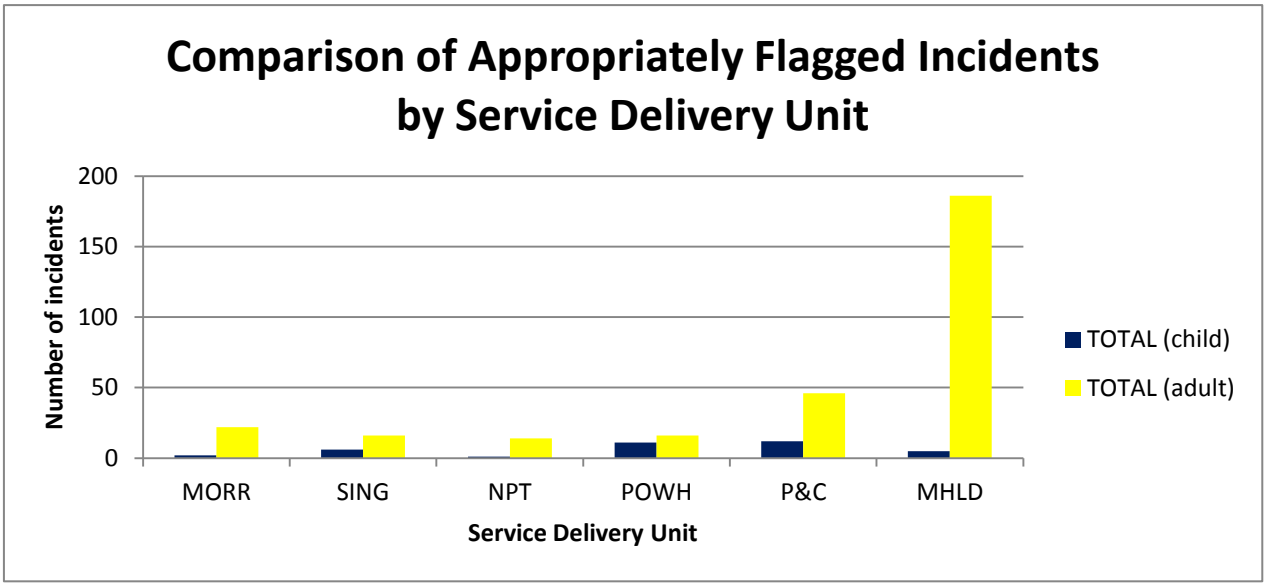


Graph viii – Safeguarding Adult Incidents Alerts by Type



There continues to be a large difference in the numbers of incidents reported through datix for adults compared to those reported for children. This can largely be explained by the fact that for adults datix reporting is required whenever referrals are made to social services. This is not the case for children because the referrals are made directly to social services by staff.

Graph ix - Comparison of Appropriately flagged incidents by Service Delivery Unit



8.2 Themes Identified

8.2.1 Children

- In the last 6 months there has been an increased number of incidents which indicate a failure to share information and/or failure to follow guidelines. The team have reviewed these to ensure the SDUs have addressed any safeguarding concerns and have put measures in place to avoid a re-occurrence. The Safeguarding Committee have been informed of relevant incidents to ensure learning, and where required, updates have been included in the level 3 training, or in newsletters and relevant policies updated as required.

- Children nursed on adult wards continue to be reported through Datix and are consistently the largest reported group. A “Risk Assessment Tool” (RAT) was developed at the request of the Nurse Directors across NHS Wales due to their concern about the high numbers of children and young people who are admitted to non paediatric areas across the NHS in Wales. The Corporate Safeguarding Team have developed guidance to be used by all Health Board staff to support the implementation of this Tool. This will ensure that there is consideration given to the need to safeguard children when they are being nursed on adult wards, by adult trained staff. This work is aligned to ensuring compliance with the ABMU Health Board Childrens Rights Charter.

8.2.2 Adults

- The data indicates a consistent number of appropriately triggered safeguarding adult incidents when compared to the previous six months. This suggests that an understanding of what constitutes a 'safeguarding adult incident' is now better embedded in staff knowledge; guidance is contained within Datix and this continues to be highlighted at Designated Lead Manager (DLM) meetings and Level 3 training sessions.

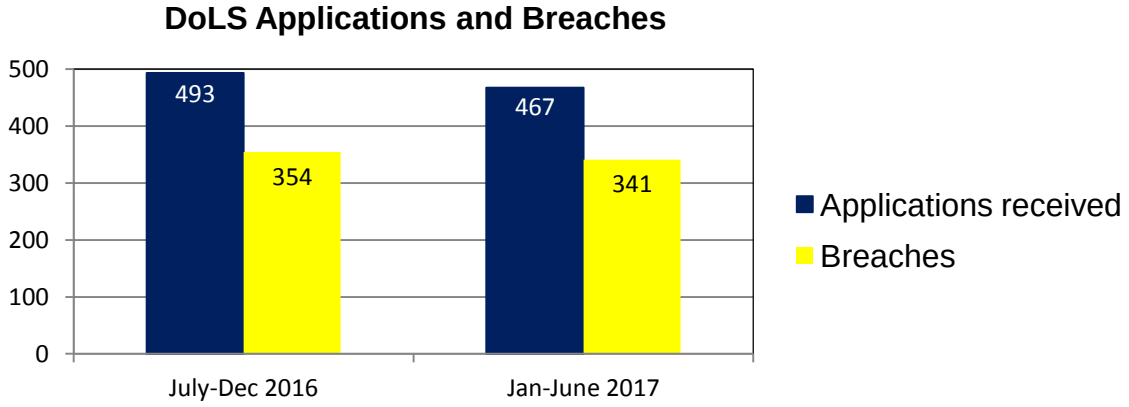
- DoLS breaches – all DoLS breaches are expected to be reported via Datix and triggered as safeguarding adult incidents. Earlier in the year a Standard Operating Procedure (SOP) for raising Datix incidents related to DOLS breaches was agreed. Despite this, breaches are not consistently reported via Datix as the number recorded does not correlate with the number outlined later in this report.

- Ongoing monitoring of inappropriately flagged incidents has identified some common themes such as 'Violence & Aggression' incidents towards staff and 'Slips/Trips/falls'. Whilst these are reportable incidents, not all meet the appropriate criteria for a safeguarding adult incident. Feedback is given to reporters via Datix to advise them of inappropriately flagged incidents.

9. DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)

Following the 'Cheshire West' case in 2014 the Health Board experienced a huge rise in DoLS applications. The figures on the graph x illustrate that although the applications remain high, they have not increased. The figures show a very slight decrease, which is insignificant. Therefore, in order to reduce the breaches and any consequential risk of financial loss, the management of these applications remains a significant issue for the Health Board. This risk is identified within the Corporate Risk Register.

Graph x – DoLS Applications and Breaches



9.1 Breaches

The most significant reason for breaches are due to delays which often result from a very complicated and lengthy process, which has been recognised on a national level. During 2017 the Law Commission recommended that the DoLS process is repealed and replaced by a new scheme called the Liberty Protection Safeguards, which would streamline the process for approving a deprivation of liberty. The Government are consulting with stakeholders to understand how these changes can be implemented and a final response is expected in Spring 2018.

Until any changes are made the Health Board is required to execute the existing process according to statutory guidance. The Corporate Safeguarding Team have been supporting both the Supervisory Body (Primary care & Community Services) and the Managing Authorities (Singleton, Morriston, NPT, MH & LD SDU's) to address some of the issues which lead to delays.

- Delay due to DoLS being signed off - currently there are only 3 members of staff who undertake the Supervisory Body signatory role and this is in addition to their substantive role so often incurs a delay. Recently a plan has been put in place by the Supervisory Body to increase the number of signatories and the Corporate Safeguarding Team has arranged training for additional staff in January 2018 to support this.

- Administrative issues – There is only 1 dedicated DoLS administrator 0.4 wte for NPT Locality. The administration in Swansea and Bridgend Locality relies on a personal assistant to a Head of Nursing. Currently the Primary Care & Community SDU are looking at ways to address this

- Delay with Best Interest Assessors (BIAs)– Further BIA training was arranged in October 2017 to ensure all the Service Delivery Units had representation. The Corporate Safeguarding Team is now working with the SDUs to establish a rota so that Health Board BIAs will carry out the assessments rather than independent BIAs which incur a cost. Some of the issues already identified with using Health Board BIAs are the difficulties releasing them from their substantive posts to carry out the assessments. This needs to be taken into account when developing the rota.

9.2 Support

The Safeguarding Committee commissioned a DoLS Task and Finish Group and is chaired by the Interim Deputy of Safeguarding. This group has evolved into a DoLS Improvement and Support Group. This group meets on a bi-monthly basis with representation from members of the Corporate Safeguarding Team and all SDUs. This group will monitor the number of breaches with a view to an incremental reduction. In

addition, one of the group's actions was to arrange a bespoke DoLS training session for Matrons. This session was delivered by a law lecturer from Swansea University and took place in September 2017 with 30 staff in attendance.

9.3 Multi-agency working

The difficulties of processing applications within timescales has affected all 'Supervisory Bodies' across the Health and Social sectors, including our partner Local Authorities. During 2017 the Western Bay Safeguarding Adult Board commissioned a multi- agency DoLS sub group to support and monitor the ongoing and increasing workload. This group would become a sub group of the WBSAB Policy & Procedure and Practice group which reports directly to the WBSB meetings. This new group has replaced the existing Supervisory Body Support Group. The MCA & DoLS Manager is chair of this group. One of the topics discussed at this meeting has been to consider whether there is a role for regional commissioning of Best Interest Assessors. No decision has been reached as of yet.

9.4 Audit

An internal audit was commissioned to review the process for DoLS applications to ensure that these are managed in accordance with the Deprivation of Liberty Safeguards Code of Practice and Health Board procedures.

10. PROFESSIONAL ABUSE

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. 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. As an employer and provider of services the Health Board has a duty to protect individuals in our care from abuse by staff.

10.1 Professional Concerns/ Abuse Strategy Meetings

Where a concern or abuse is alleged to have occurred in an employee's private capacity (i.e. outside of their Health Board employment), careful consideration needs to be given whether the employee presents any risk within their Heath Board working environment. Action within a multi agency approach will be 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 registers. Support is offered to staff within this process.

10.2 Professional Abuse

Professional Abuse Strategy meetings are led by Childrens Services within the area of the Local Authority where the alleged perpetrator lives. The meetings are concerned with any issues that may affect any children that live with or are cared for by the alleged perpetrator. In addition any professional issues are considered.

10.3 Professional Concerns

Professional concerns meetings are led by the Health Board and will be chaired by a representative from the SDU. These meetings are concerned with alleged abuse of a patient whereby there are no issues associated with children.

All cases of professional abuse/concerns are reported to the In committee of the Quality & Safety Committee and to the Chief Executive on a bi-monthly basis.

DATE	Professional Abuse	Professional Concerns	Total
New cases 1st January 2017 – 30th June 2017	**10**	**5**	**15**
New cases 1st July 2017 – 31st December 2017	**3**	**5**	**8**

11. PRACTICE REVIEWS

The Safeguarding Team along with other key staff from the SDUs continue to engage with a number of reviews of practice commissioned by either the Western Bay Safeguarding Boards (Adult or Child Practice Reviews), or the Local Community Safety Partnerships (Domestic Homicide Reviews).

11.1 Adult Practice Reviews (APR)

There are a total of 8 Reviews in the reporting period.

Adult Practice Reviews – July 2017 - to December 2017

Adult Practice Reviews	Ongoing	Completed	Convened	Published
	4	**2**	**2**	**0**

11.1.1 Progress

- Of the two completed reviews one report has been sent to Welsh Government and is awaiting publication and the other is awaiting ratification by WBSAB.
- One ongoing review has been delayed due to legal processes

11.2 Child Practice Reviews (CPR)

There are a total of 7 Reviews in the reporting period:

Child Practice Reviews – July 2017 to December 2017

Child Practice Reviews	Ongoing	Completed	Convened	Published
	2	1	3	1

11.2.1 Progress

- 1 child practice review has been completed but not published. The decision was made by Western Bay Board not to publish the full report as from the child's perspective the report was not completely anonymous. A summary of the report will be completed to ensure the learning is shared.

- The published review was a concise review and considered the circumstances of a 17 month old baby admitted to hospital following a medical referral from her GP after a 3 week history of recurrent vomiting. The baby was found to have sustained a number of injuries, many of which were considered at the time to be non-accidental in origin. The baby's parents/ carers were unable to give a satisfactory explanation for the injuries at that time.There were learning points from this review for the Health Board and these have been incorporated into the Practice Review Action Plan which is implemented by the Corporate Safeguarding Team and reviewed by the Safeguarding Committee.

11.2.2 Learning Points from published CPR

- **Improved communication**
  This was in relation to referrals to the Perinatal Response and Management Service (PRAMS) and also in relation to sharing the police domestic abuse incidents forms with GPs

- **Recognition of Child Abuse**
  Issues with regards to bruising to the ear and multiple attendances at GP practices were recognised as a feature.

- **Being clear about Family Structure**
  The importance of practitioners being aware of this especially in relation to any partners that mothers may have and how this may affect any child living within that family.

11.3 Practice Reviews – Participation of Health Board

Practice Reviews and Health Board Involvement – Each Practice Review

Type of Review	*No. of reviews*	*HEALTH BOARD Staff Panel Members*	*HEALTH BOARD Chairs*	*HEALTH BOARD Reviewers*	*No of Panel Meetings attended*	*No of Learning Events*
CPR	**7**	**7**	**0**	**2**	**5**	**4**
APR	**8**	**8**	**1**	**1**	**6**	**2**
DHR	**4**	**6***	**0**	**10***	**32**	**0**
Total	**19**	**21**	**1**	**13**	**33**	**6**

(*Indicates Health Board staff are involved in more than one DHR)

12. PROCEDURAL RESPONSE TO UNEXPECTED DEATH IN CHILDHOOD (PRUDiC)

There have been 6 unexpected child deaths during the reporting period. One of the deaths occurred in within Cardiff & Vale Health Board which is where the formal PRUDiC

process was carried out with attendance by ABMU Health Board staff. The child had complex medical problems but the death was unexpected at that time.

The remaining 5 deaths were in the community; PRUDICs were convened within ABMU Health Board and all of the deaths were reported to Welsh Government as required via the Serious Incident Reporting process and also to the National Child Death Review Programme, Public Health Wales.

- 1 child died from hanging. Public Health Wales are in the process of conducting a review of young people who take their own lives and this will be the next thematic review they will publish.
- 1 referral from PRUDiC was made to Western Bay Safeguarding Board for consideration of a Child Practice Review. The referral has been accepted and a review has been convened.
- 1 death was a teenager involved as a passenger in a car involved in a road traffic accident
- The remaining 2 deaths were 2 of triplets and were co-sleeping with mother

12.1 Themes

Whilst there is no common theme linking the deaths over the last 6 months, during the last year the deaths of five infants have identified co sleeping as a factor. The Health Board have acted upon this;

- A presentation has been delivered by the Corporate Team to the Safeguarding Committee highlighting the role of all health staff in delivering the Welsh Government “safe sleeping” guidance.
- An intranet Bulletin has been released by the Lead Nurse for Health Visitors.
- With the introduction of the Healthy Child, Wales Programme there is now a requirement for Health Visitors to discuss, view and document baby’s sleeping arrangements.
- Level 3 safeguarding training has been updated to reiterate the current Safe Sleep Guidance.
- Multi-agency partners have also been made aware via the Western Bay Safeguarding Children Board.

13. VIOLENCE AGAINST WOMEN, DOMESTIC ABUSE and SEXUAL VIOLENCE (VAWDASV)

13.1 Five year “Ask and Act” Project: Violence against Women Domestic Abuse and Sexual Violence (Wales) Act 2015

The Health Board completed the 18 month “Ask and Act” pilot in March 2017 and the consequent Progress Report highighted the benefits of a co-delivery training model with the third sector specialist support service services for violence against women, domestic

abuse and sexual violence. The Health Board's "Ask and Act" Five Year Local Training Plan submitted to Welsh Government stated that wider implementation of "Ask and Act" Group 2 training, across the Health Board, would commence in September 2017. Welsh Government agreed to fund the third sector to provide "Ask and Act" training alongside Health Board staff. However, despite on-going communication between the Health Board and Welsh Government, details of the funding arrangements were not provided by Welsh Government until late December 2017. This has delayed the commencement of the "Ask and Act" Group 2 and 3 training. Training dates for Group 2 will now commence in January 2018 and Group 3 in April 2018.

All Health Board staff are required to complete Group 1 training and this is available via ESR. It is a statutory requirement that 100% staff must complete Group 1 training by 31st March 2018. To date, a total of 10,784 (77%) staff have completed the group 1 training. This has increased from 7906 (56%) since end of September 2017. The Corporate Safeguarding Team continue to support the Service Delivery Units to achieve 100% completion rate by 31st March 2018.

13.1.2 Support from Safeguarding Corporate Team to implement the "Ask and Act" Five Year Local Training plan

To provide operational assistance and support to the Service Delivery Units during the early stages of implementing "Ask and Act" across the Health Board, a Task and Finish group is to commence in February 2018 chaired by a member of the Corporate Safeguarding Team.

13.1.3 Annual progress report to Welsh Government

It is a statutory requirement that the Health Board submits an annual progress report on implementation of the five year "Ask and Act" Local Training Plan to Welsh Government Ministers in February each year commencing in 2018. This is currently being prepared by the Corporate Safeguarding Team.

13.2 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. This multi-agency forum discuss high risk victims of VAWDASV that have been referred and a plan of action agreed to ensure the safety of the victim and to ensure the safety of any children involved. A Health Board member attends each MARAC.

13.3 Training

Health Board staff currently do not receive any training with regards to MARAC attendance and/or referral or in relation to completing the risk assessment for domestic

abuse, stalking & honour based violence risk identification checklist (DASHRIC) when they have had a disclosure of VAWDASV. This was identified during the 'Ask & Act' pilot whereby staff who completed the Group 2 training requested specific training on these processes. In response to this, MARAC and DASHRIC training will be added to the Group 2 and 3 training sessions. To enable this, the Corporate Safeguarding Team has liaised with Swansea Domestic Abuse Unit and Calan DVS to provide additional training for the Health Board Group 2 and 3 accredited "Ask and Act" trainers. The number of referrals to MARAC are expected to increase with the implementation of 'Ask and Act' and this additional training will help to ensure that referrals will be appropriate, of high quality and will ensure maximum use of available resources.

13.4 Domestic Homicide Reviews (DHR)

Two women are killed by a current or former partner in England and Wales (Office for National Statistics, 2016). 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 lead the DHRs.

The purpose of a DHR is to establish what lessons can be learned from the domestic homicide regarding the way in which local professionals and organisations worked individually and together to safeguard victims 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. This can only be achieved by developing a co-ordinated multi-agency approach to ensure that VAWDASV is identified and responded to effectively at the earliest opportunity.

13.5 Domestic Homicide Reviews – July 2017 to December 2017

During the reporting period four Domestic Homicide Reviews were ongoing and their progress is outlined below.

DHRs	Ongoing (total)	Early Information gathering	Near completion	Final reports completed
	4	1	1	2

The Committee is advised that the respective Community Safety Partnerships will monitor progress of any DHR and the completed reports are submitted to the Home Office prior to publication. The Corporate Safeguarding Team are currently assessing the

process for reviewing the DHRs prior to submission to the Home Office. All published DHRs will be presented to the Safeguarding Committee and any learning points/recommendations include in the Health Board Practice Review Action Plan. In addition the Western Bay Safeguarding Board's Business Unit have submitted a proposal to the three local Community Safety Partnerships to ensure they are regularly kept updated with regard to current DHRs.

14. FEMALE GENITAL MUTILATION (FGM)

FGM is a form of violence against women and girls and is a criminal offence in England and Wales under the FGM Act 2003. The Serious Crime Act 2015 requires health professionals to report known cases of FGM in girls less than 18 years (children) to the police who they identify in the course of their professional work. There is an All Wales Clinical Pathway for FGM which provides guidance on the statutory reporting and the safeguarding requirements – this is currently being updated by the National Safeguarding Team.

The updated Health Board Policy for Health Professionals re Female Genital Mutilation has been presented to the Safeguarding Committee and ratified by the Quality and Safety Committee and is now available on COIN. It includes a local Pathway for FGM, which works alongside the all-Wales Clinical Pathway (FGM).

ABMU Health Board reports any cases of FGM in both women and children to Welsh Government via Public Health Wales on a quarterly basis. The data is collected via the FGM Datix Data collection tool, which is currently being piloted by ABMU Health Board with the possibility of it rolling out across Wales. Following the update of the all-Wales Clinical Pathway (FGM) the data required by WG and PHW will change and as such it will be necessary to alter the FGM Data reporting tool. The Safeguarding team are working with Datix to update accordingly.

14.1 Reported cases of FGM

January 2017 – June 2017: 10 cases of FGM reported

July 2017 – December 2017: 15 cases of FGM reported.

- Two of these reported cases were children and reported to the Police and Social Services in line with statutory duty.
- There have been no reported cases where FGM was carried out in Wales.

14.2 FGM Training

Face to face FGM training is delivered within Paediatrics, Neonatal, Maternity, Gynaecology, Health Visiting and Integrated Sexual Health. In addition face to face training has commenced in Primary Care for GPs and Practice Nurses. Integrated Sexual

Health have also organised two FGM study days facilitated by BAWSO (Black & African Women Step Out) that all staff attended and staff feedback was positive. Emergency Departments and Minor Injury Units currently access an eLearning package.

FGM is included on the Level 3 Safeguarding Children training. The updated level 3 training from April 2018 will include awareness of the data reporting tool and the local Pathway as well as the updated All Wales Clinical pathway (FGM).

15. CHILD SEXUAL EXPLOITATION (CSE)

15.1 Multi-Agency Working

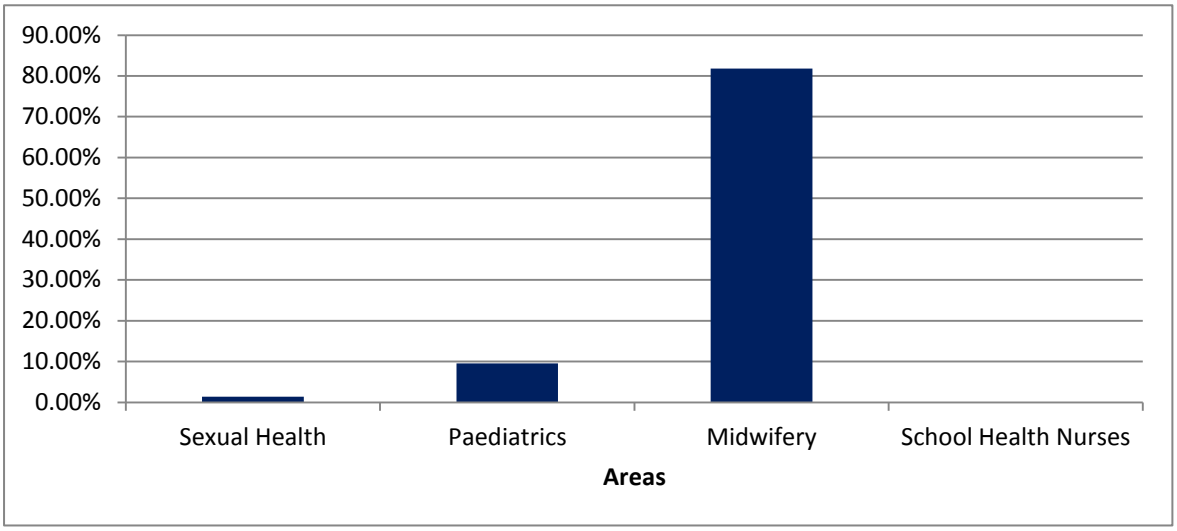
CSE remains a priority area nationally.

- Western Bay Safeguarding Board have now completed the multi-agency CSE strategy and action plan which the Health Board has contributed to. The Western Bay multi-agency CSE training which the corporate team adapted to use for health staff has now been taken forward by a CSE sub group of the National Safeguarding Team and will be delivered in all Health Boards in Wales. The CSE training group set up by the Corporate Safeguarding Team have delivered CSE training in all the priority areas across the Health Board. This programme of CSE awareness raising training continues.
- An emerging theme linked to child sexual exploitation are children going missing, child slavery and trafficking and the exploitation of children as drug runners, dealers and couriers. This is known as 'County Lines' and has been included in the updated level 3 safeguarding children training which means that all staff who attend level 3 training will have an awareness of CSE and the links and not just those in the priority areas.

15.2 CSE Referrals

Health Board staff in identified priorty areas use the all-Wales Risk Assessment Tool (CSERQ 15) as a guide to assessing risk of CSE. The percentage of completed CSERQs which led to referrals to Local Authorities is illustrated in graph xi

Graph xi - % of Assessments Leading to Referrals. July 31 2017-Dec 31 2017



Within Sexual Health Services there were 554 CSERQ15 completed but only 8 referrals were made to social services. In contrast within midwifery 11 CSERQ15 were completed and 9 referrals made. This illustrates that sexual health staff are making adequate numbers of assessments but not referrals. Further work with sexual health is needed to identify why this is. For example an audit to review the completed CSERQ15s.

Within midwifery the percentage of assessments leading to referrals is high. Possible reasons why this is may be:

- All midwives attend an annual CSE training session
- Dedicated Midwifery Service for Teenagers
- Frequent contact with girls during pregnancy

However the actual number of assessments are low and this has been shared with midwifery so that their training is updated to encourage further assessments.

In terms of prevention and safeguarding, whilst it is positive that children are being identified as being at risk by midwives it would be better in terms of outcomes to identify children at risk of or being exploited before they become pregnant. Further, the graph indicates that there are no referrals from school health nurses. These will be priority areas for attention by the Corporate Safeguarding Team

15.3 CSE Information Sharing

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 or as being sexually exploited are flagged so that anyone in health having contact with the children will be aware of the concerns. To date 10 records for children have been flagged. This means that if these children are seen by health staff any relevant information sharing will take place.

15.4 Independent Inquiry Into Child Sexual Abuse

On 12 March 2015, the Home Secretary established the Independent Inquiry into Child Sexual Abuse to consider whether public bodies and other non-state institutions have taken seriously their duty of care to protect children from sexual abuse. In September 2017 the Health Board were required to provide evidence to the Independent Inquiry on Child Sexual Abuse 'on the steps taken by the Health Board since 2015 to prevent children from being sexually abused in healthcare settings'. One of the steps introduced within the reporting period has been the introduction of the all-Wales Risk Assessment for Children on Adult Wards .

The Inquiry has announced 13 investigations to date and following the request in September, ABMU Health Board were required to provide further information on another investigation into Child Sexual Exploitation by Organised Networks. The Inquiry selected a number of local authorities as case studies which represent the range and

diversity of local authorities in England and Wales against certain key factors which could have an impact on child sexual exploitation and how it is dealt with at a local level. Swansea Local Authority were selected which meant the Health Board was required to complete an extensive questionnaire of 49 parts – a detailed response was collated by the Corporate Safeguarding Team.

16. HUMAN TRAFFICKING/MODERN SLAVERY

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

The Western Bay Anti-Slavery Forum is a multi-agency arena which aims to facilitate engagement, partnership working and shared learning between Police, Local Authorities, Health, Education, other Public and 3rd Sector Organisations on the issue of slavery in and across Wales. Meetings are held quarterly and a member of the Corporate Safeguarding Team attends. The Safeguarding Committee is updated accordingly.

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

Health professionals have attended a programme of 'train the trainer' and an on-going programme of multi-agency Anti-Slavery Awareness training is available for health staff. In addition, during 'Safeguarding Week' the Corporate Safeguarding Team delivered some some 'drop in' sessions on this subject.

17. SUICIDE AND SELF HARM PREVENTION FORUM

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 6 key objectives to prevent and reduce suicide and self harm in Wales over the period 2015-2020. This quarterly 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.

It is acknowledged that the work carried out locally is vital to the prevention of suicide, and guidance on local suicide and self harm prevention planning has been issued by the NAG. The 3 Regional Fora, (North Wales, South East Wales and South & West Wales) have been tasked with developing a Local Suicide Prevention Strategy. The National

Strategy ‘Talk to Me 2’ provides a framework for development of a local strategy using the following 6 priority areas:

- Improving awareness of suicide and self-harm amongst the public and professionals
- Delivering appropriate responses to crisis and managing suicide and self-harm
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Reduce access to the means of suicide
- Support research, data collection and monitoring.

A Talk to Me 2 Action Plan Workshop was held 22.11.17, the discussion and information gathered has been developed to identify actions necessary to meet each of the 6 prioritity areas identified in the NAG guidance.This information will enable submission of a first draft of the South & West Wales Local Strategy to the NAG in February 2018.

18. 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 continue 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 action agreed to mitigate. The team also engage with the three local Channel Panels where persons at risk of radicalisation or engagement 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 (see training section). Health Board staff have made one referral into the Channel process during the reporting period.

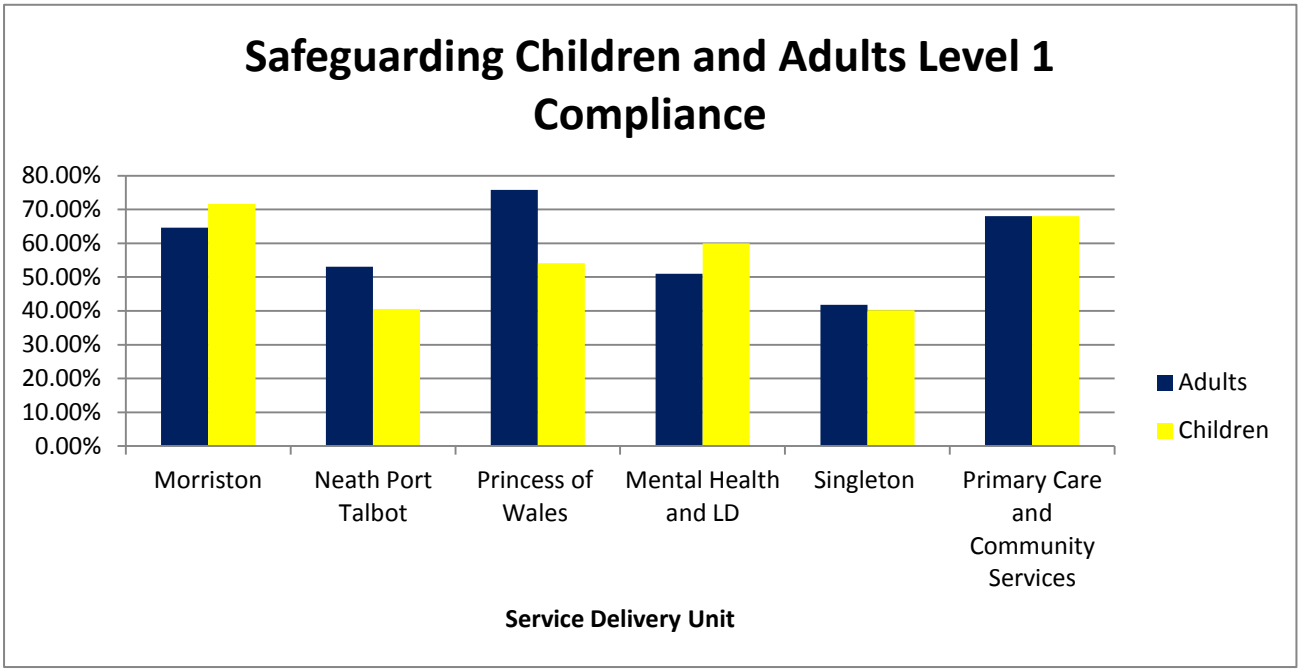
19. SAFEGUARDING TRAINING AND SUPERVISION

19.1 Level 1 & 2 Safeguarding Training

Level 1 and 2 training for Safeguarding Adults and Children 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 SDU on a bi monthly basis.

There have been difficulties encountered by the SDU obtaining this information accurately due to a problem with e-learning completion not always being picked up by the ESR system. This issue has now been resolved by the NHS Wales Shared Services Partnership. All Units have been informed on how to capture the necessary information.

Graph xii - Safeguarding Children and Adults Level 1 compliance

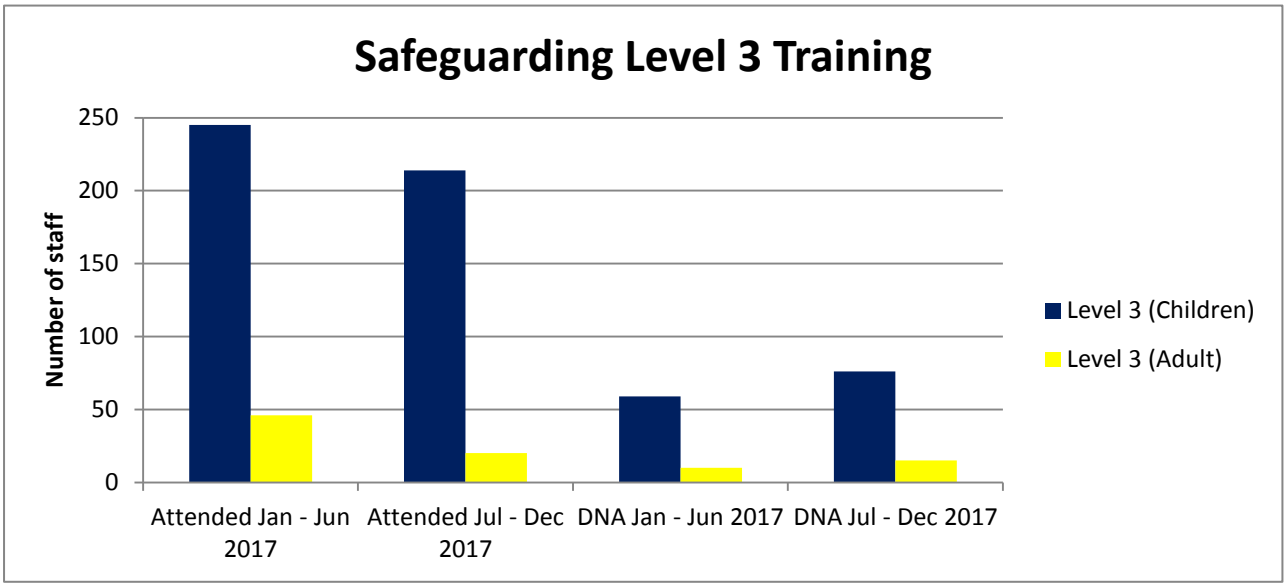


It is of concern that training compliance remains at an inadequate level. Each SDU has been tasked by the Safeguarding Comittee to submit action plans to identify actions when mandatory training compliance will be achieved.

19.2 Level 3 Safeguarding Training

Level 3 Safeguarding Children sessions continue to be delivered monthly across the Health Board areas. 5 sessions were delivered during the reporting period.
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. During the reporting period sessions were delivered bi-monthly.

Graph xiii – Numbers of staff attending Safeguarding Level 3 training



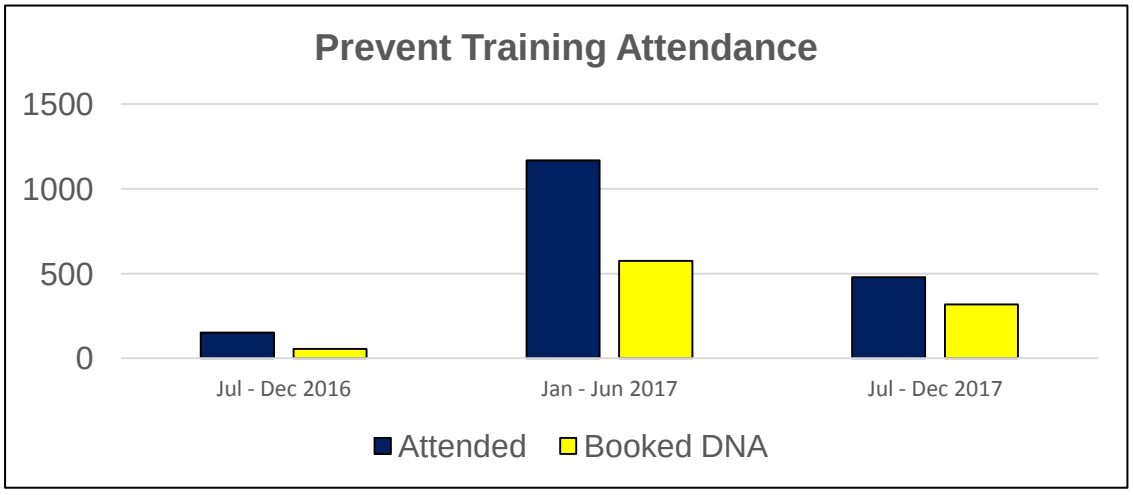
Attendance and DNA rates for Level 3 Safeguarding Children training continues to be consistent. Reduction in attendance and increased non attendance for Level 3 Safeguarding Adult training may partially be attributable to long-term sickness within the Corporate Safeguarding Team and subsequent need to prioritise workloads which has sometimes resulted in postponing or re-arranging training dates.

In order to analyse the figures more accurately it would be useful if each Service Delivery Units completed a training needs analysis for level 3.

19.3 Prevent Training

The Corporate Safeguarding Team continue to deliver the WRAP3 Home Office approved training (Prevent). This is an awareness raising session which provides information that will enable staff to identify vulnerable individuals who may be susceptible to radicalisation, and to be aware of the need to refer appropriately. Following a significant increase in the number of staff trained between January and June 2017 trainers have noted that attendance numbers have decreased in the second half of 2017, the total being 479. However this still exceeds the numbers trained during the same period last year. There is an e-learning module from the Home Office which will shortly be available and this may help with training compliance.

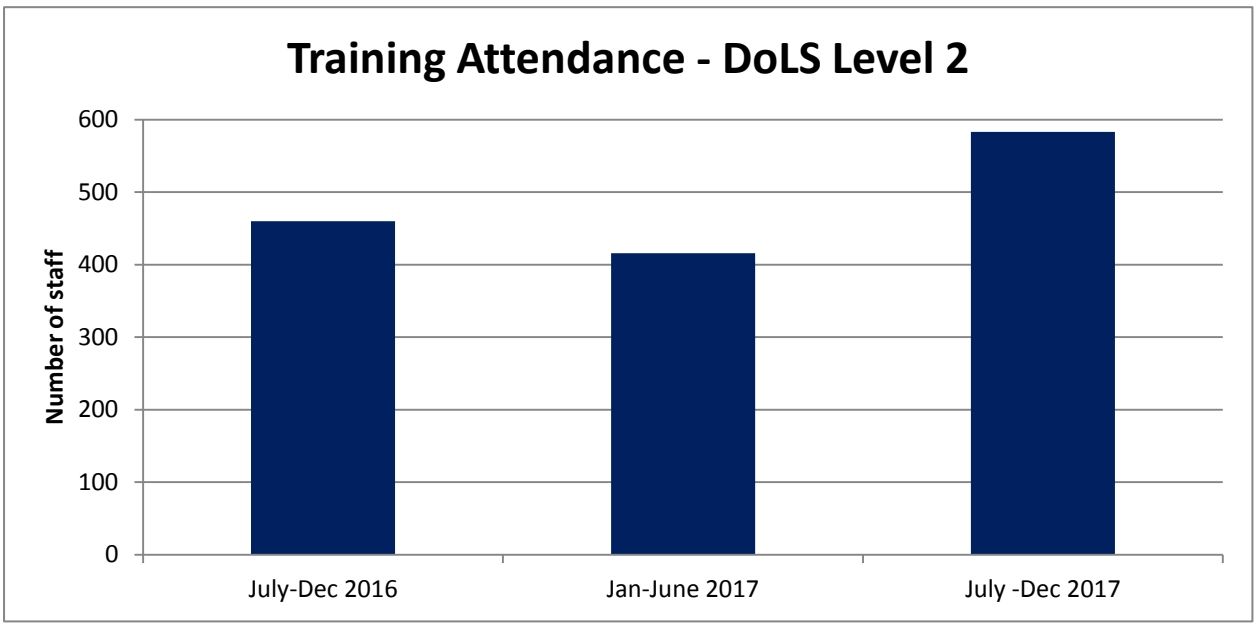
Graph xiv indicates that although attendance has dropped, it is still higher than the comparable period in 2016.



19.4 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 been an increase in attendance at DoLS training which is possibly attributed to Service Delivery Units encouraging staff to attend training sessions. (Graph xv.)

Graph xv – Training Attendance – DoLS Level 2

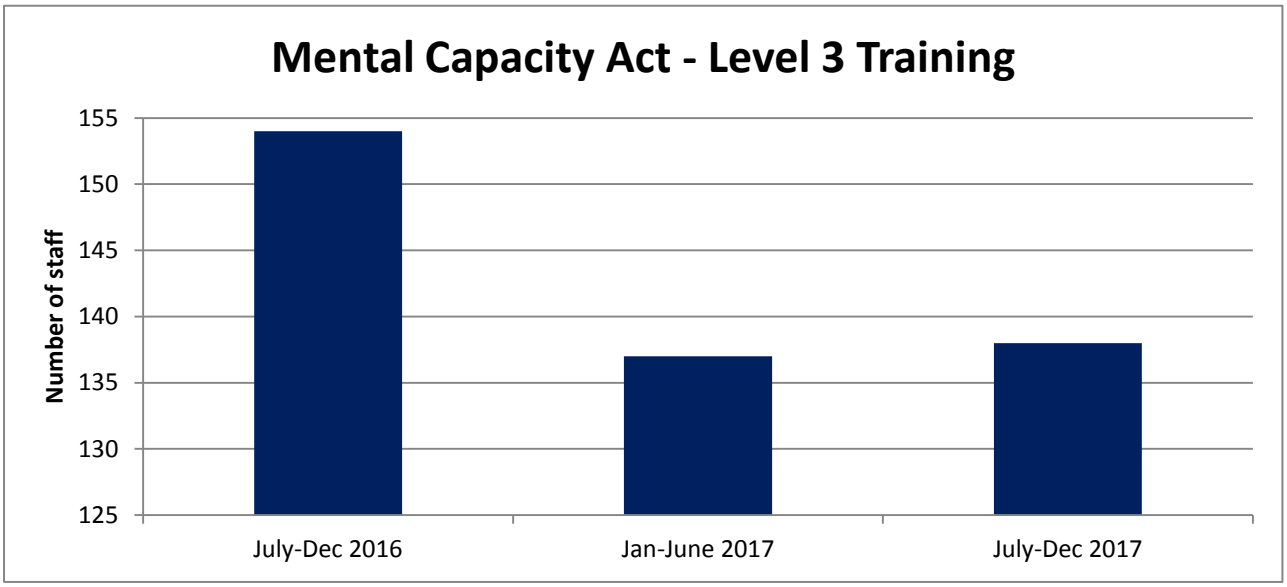


19.5 Mental Capacity Act (MCA) Level 2 Training

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.

19.6 MCA Level 3

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 (graph xvi)



19.7 Safeguarding Week

ABMU Health Board joined other organisations across Wales in November 13-17 to mark 'National Safeguarding Week'. During the week, the Corporate Safeguarding Team held events for ABMU staff and outside agencies to raise awareness of Safeguarding children, young people and adults at risk.

A number of training sessions were delivered across the Health Board:

- Child Sexual Exploitation
- Modern Slavery and Human Trafficking
- Children's Rights, ABMU Health Board Children's Charter
- DASHRIC awareness sessions

The team then supported 'White Ribbon' day on 25th November and held a cake bake sale in order raise awareness for the White Ribbon campaign This is a global movement to end male violence against women and girls. The sale raised £104 which will be used to contribute to the White Ribbon campaign.

20. 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)

In the reporting period the Corporate Safeguarding Team have made improvements to the supervision arrangements as follows:

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

20.1 Safeguarding Supervision Audit

During the reporting period an audit on safeguarding supervision was completed and recommendations made

- Ensure staff are aware of Corporate Safeguarding Team and who to contact for safeguarding advice and support within their SDU.
- All SDUs to establish group supervision for those groups of staff identified in the audit as requiring this. The Corporate Safeguarding Team will provide support to the staff in the Units in establishing and facilitating group supervision..
- SDUs to facilitate access to 1:1 supervision *if required*. The Corporate Safeguarding Team will support this.
- For specialist nurses/lead nurses involved in safeguarding to continue peer group supervision.
  Safeguarding Children - peer group supervision
  Safeguarding Adults - Designated Lead Manager Support Sessions.

The implementation of this will ensure that all Health Board staff are able to access an appropriate form of safeguarding supervision in line with the guidance from the *All Wales Safeguarding Best Practice Supervision Guidance (NHS Wales Safeguarding Network 2017*)

21. FUTURE WORK

21.1 Safeguarding within Service Delivery Units

It has been identified that, in order to support the SDU in their safeguarding responsibilities, it would be advantageous if there was more visibility from the Corporate

Safeguarding Team. In addition the number of safeguarding adult referrals have increased significantly and the Corporate Safeguarding Team no longer have the capacity to process them and it is pertinent that the individual SDU takes ownership of their own referrals. This is to be taken forward by the Corporate Safeguarding Team as an initial pilot for 3 months within Singleton SDU from February 2018. A member of the team will work within the unit to increase visibility and supporting staff in this transition. It is planned to roll this out across the Health Board within a year.

21.2 Safeguarding Newsletter

The Team has contributed to the Corporate Nursing Newsletter with regards to 'learning lessons' within safeguarding and this will be a regular item

21.3 Prisons

A recent inspection of HMPrison Swansea identified a need to improve health involvement particularly in relation to suicide prevention and governance reporting. Primary Care & Community Services SDU are currently considering this report and the Corporate Safeguarding Team will be contributing with regards to safeguarding issues. A member of the team already attends the Child Protection & Safeguarding Committee at Parc Prison, Bridgend whereby safeguarding advice is offered in relation to governance and training including self harm, reported injuries and professional abuse.

21.4 Practice Education Facilitator

The Team has been fortunate to secure the post of a practice education facilitator who will be able to support the team in the increasing portfolio of training and in turn able to support the Service Delivery Unit to improve training performance management.

21.5 Performance Management

The Corporate Safeguarding Team is working with IT to develop a robust procedure for collating data and plan to develop a Safeguarding Health Dashboard.

22.0 RECOMMENDATION

The Quality & Safety Committee is asked to note the contents of this Report.