Meeting Date	**21st February 2019**	**Agenda Item**	**4.2**
Report Title	**Bi-annual Safeguarding Report: June – December 2018**		
Report Author	Nicola Edwards Head of Nursing: Safeguarding		
Report Sponsor	Gareth Howells. Director of Nursing and Patient Experience		
Presented by	Gareth Howells. Director of Nursing and Patient Experience		
Freedom of Information	Open		
Purpose of the Report	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 and December 31st. 2018.		
Key Issues	The paper identifies activity during the 6-month period within the wide scope of 'Safeguarding'. This includes how the Team and Committee work with other key agencies to develop the local and national agenda. It outlines the referral activity by the Health Board in a number of areas including children and adults, forms of criminal exploitation and safeguarding training		
Specific Action Required ***(please ✓one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	✓			
Recommendations	Members are asked to: • **NOTE** the report			

BI-ANNUAL SAFEGUARDING REPORT: JULY – DECEMBER 2018

1. INTRODUCTION

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 and December 31st. 2018.

2. BACKGROUND

Key pieces of legislation (Social Services and Well-being (Wales) Act 2014, Children Act 1989, 2004) place a duty upon Public Bodies such as the Health Board to safeguard children and adults at risk of abuse or neglect. Other legislation regarding violence against women and domestic abuse, criminal exploitation, mental capacity and deprivation of liberty also influence the Health Boards 'safeguarding agenda'.

The Health Board Quality and Safety Committee is responsible for ensuring the organisation meets its statutory requirements under this agenda. The Safeguarding Committee and the Corporate Safeguarding team assist the Quality and Safety Committee to deliver the statutory and mandatory responsibilities and provide an appropriate system for the safeguarding of children and adults accessing healthcare across the Health Board. The Director of Nursing & Patient Experience who has Executive responsibility for Safeguarding chairs the Committee. The Safeguarding Committee and Corporate Safeguarding Team are required to provide six monthly reports to the Quality and Safety Committee on their activities. The report format has been revised to align with the Safeguarding Maturity Matrix.

3. GOVERNANCE AND RISK ISSUES

The paper identifies activity during the 6-month period within the wide scope of 'Safeguarding'.

This includes how the Team and Committee work with other key agencies to develop the local and national agenda. Reference is particularly made to working with the Western Bay Safeguarding Boards and their associated sub-groups to ensure successful outcomes for children and adults locally who may be experiencing abuse or neglect, as well as working on an all-Wales basis via the National Safeguarding Network.

The Health Board's engagement with self-assessment against the safeguarding Maturity Matrix and Health and Care Standards is outlined. Whilst recognising improvement over the period, it is noted that training compliance and the completion of DoLS assessments in within timescale remain the two key areas of safeguarding risk. These areas are being monitored via Safeguarding Committee and the Mental Health & Legislative Committee, with close monitoring of the DoLS improvement plan in conjunction with the Primary Care and Community Service Delivery Unit.

Referral activity and themes are referenced using a number of graphs and for this report (where possible) comparison is provided for the same six-month period in 2017 as well as the preceding six-months. The number of child safeguarding referrals is broadly similar to previous six-month periods, while the number of adult safeguarding referrals that are addressed within the Health Board has increased compared to the previous reporting period.

Training compliance and attendance are also outlined in graphical form. The report notes that training compliance remains at an inadequate level, and confirms that each Service Delivery Unit has been tasked by the Safeguarding Committee to submit action plans to manage improvement, which are reported on to Safeguarding Committee.
The report also makes reference to findings from reviews by Public Health Wales and the findings contained in the Health Inspectorate Wales Inspection regarding supervision, and acknowledges the need to measure current arrangements against national standards, and establish a robust structure to meet requirements for safeguarding supervision.

4. FINANCIAL IMPLICATIONS

This report makes no recommendations to the committee that carry financial implications

5. RECOMMENDATION

Members are asked to:

- **NOTE** the 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		
	✓	✓			✓		
Link to Health and Care Standards ***(please ✓)***	Staying Healthy	Safe Care	Effective Care	Dignified Care	Timely Care	Individual Care	Staff and Resources
		✓					✓

Quality, Safety and Patient Experience
The Health Board self-assessment against the Health and Care Standards and the Safeguarding Maturity Matrix is outlined and whilst recognising improvement over the period, notes that training compliance and the completion of DoLS assessments in within timescale remain the two key areas of safeguarding risk
Financial Implications
This report makes no recommendations to the committee that carry financial implications
Legal Implications (including equality and diversity assessment)
This report makes no recommendations to the committee that carry legal implications
Staffing Implications
This report makes no recommendations to the committee that carry staffing implications
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

Report History	This report has been presented to and approved by the Safeguarding Committee in February 2019
Appendices	

MAIN REPORT	ABM University Health Board
Safeguarding Committee	**Date: 8th February 2019**

Subject	**Bi-annual Safeguarding Report: July-December 2018**
Prepared by	Nicola Edwards; Head of Nursing: Safeguarding
Approved by	Cathy Dowling, Assistant Director of Nursing & Patient Experience
Presented by	Gareth Howells, Director of Nursing & Patient Experience

CONTENTS

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 and December 31st 2018. The report has been redesigned from earlier versions to align with the themes of the Safeguarding Maturity Matrix :

- Governance & Rights based Approach;
- Safe Care;
- Learning Culture;
- Multi-agency Partnership Working.
- Adverse Childhood Experiences (ACE) – this will be incorporated within the above 4 themes.

SECTION 1 GOVERNANCE AND RIGHTS BASED APPROACH

1.1 STRATEGIC LEADERSHIP AND MANAGEMENT OF SAFEGUARDING TEAM

The Corporate Safeguarding Team continues to develop services that address the safeguarding of people. The Team works 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 and children at risk as well as concerns regarding Violence against Women, Modern Slavery and Deprivation of Liberty Safeguards. The Team is managed by a Head of Nursing:Named Nurse Safeguarding who directly reports to the Interim Deputy Director of Nursing & Patient Experience.

The Corporate Safeguarding Team has experienced some workforce changes in the last year with the retirement of two valued Nurse Specialists. A new Head of Nursing: Safeguarding was recruited and commenced in post in December 2018 following the previous postholders successfully securing a role within Public Health Wales' National Safeguarding Team in August. An additional Safeguarding Specialist has been recruited to the team.

Consequently the Team has gone through a period of appraisal and this process is on-going due to long-term sickness and the imminent boundary changes within Bridgend. Moving forward post Health Board boundary change, after April 1st 2019 the EWestern Bay Regional Safeguarding Boards will become West Glamorgan Safeguarding Boards in line with the name of the new region.

1.2 SAFEGUARDING MATURITY MATRIX (SMM)

NHS Wales has an essential role in ensuring that all adults and children receive the care, support and services they need in order to promote a healthy, safer and fairer Wales.

Measuring the effectiveness of health services in the contribution to safeguarding adults and children is difficult and complex.

The Safeguarding Maturity Matrix (SMM) is is a self-assessment tool which addresses the interdependent starnds regarding safeguarding|: service quality improvement, compliance against agreed standards and learning from incidents and reviews. The self assessment tool is completed by each NHS Health Board and Trust annually and the improvement plans and scores submitted to the National Safeguarding Team to inform the national report through the NHS Wales Safeguardinfg Network to the Chief Nursing Officer in Welsh Government. The aim of capturing and collating a national SMM is to provides assurance, share practice and drive improvements towards a 'Once for Wales' consistent approach to safeguarding across Wales.

There are five aspects to the Matrix:

- Governance & Rights based Approach;
- Safe Care;
- Adverse Childhood Experiences (ACE);
- Learning Culture;
- Multi-agency Partnership Working.

It is proposed that the findings will inform a programme of work for the NHS Wales Safeguarding Network to address areas of practice requiring a common solution.

The SMM was piloted across Wales by HBs and Trusts during 2018 and all Health Boards and Trusts in Wales were invited to attend a Peer Review day facilitated by Welsh Government and Public Health Wales 30th November 2018. Following this successful day the NHS Wales Safeguarding Maturity Matrix is to be launched Tuesday 5th March 2019 at the SWALEC Stadium, Cardiff. The Health Board have been allocated ten places, the Safeguardin team are in the process of confirming the names of those attending.

1.3 HEALTH AND CARE STANDARDS

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

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

A Safeguarding Risk Register has been developed to capture any pertinent safeguarding risks to the organisation. The identified risks are detailed below:

- Absence of a dedicated MCA/DoLS Lead;
- The risk to the Health Board if it is unable to complete DoLS authorisations in a timely manner it will be in breach of legislation;
- Mandatory Safeguarding training;
- Complaince with the Social Services and Well-being Act (Wales) 2014 enquiry timescales.

The risk of DoLS breaches has been added to the Health Board Corporate Risk Register.

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

- Multi-Agency Public Protection arrangements (MAPPA);
- Update on DoLS;
- Presentation of a newly published Adult Practice Review.

SECTION 2 SAFE CARE

2.1 SAFEGUARDING REFERRALS

In accordance with the Social Services and Well-being (Wales) Act 2014 and 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.

2.1.1 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 will have involvement through making the referral, attending strategy meetings and case conferences as well as contributing and actioning any child protection plans.

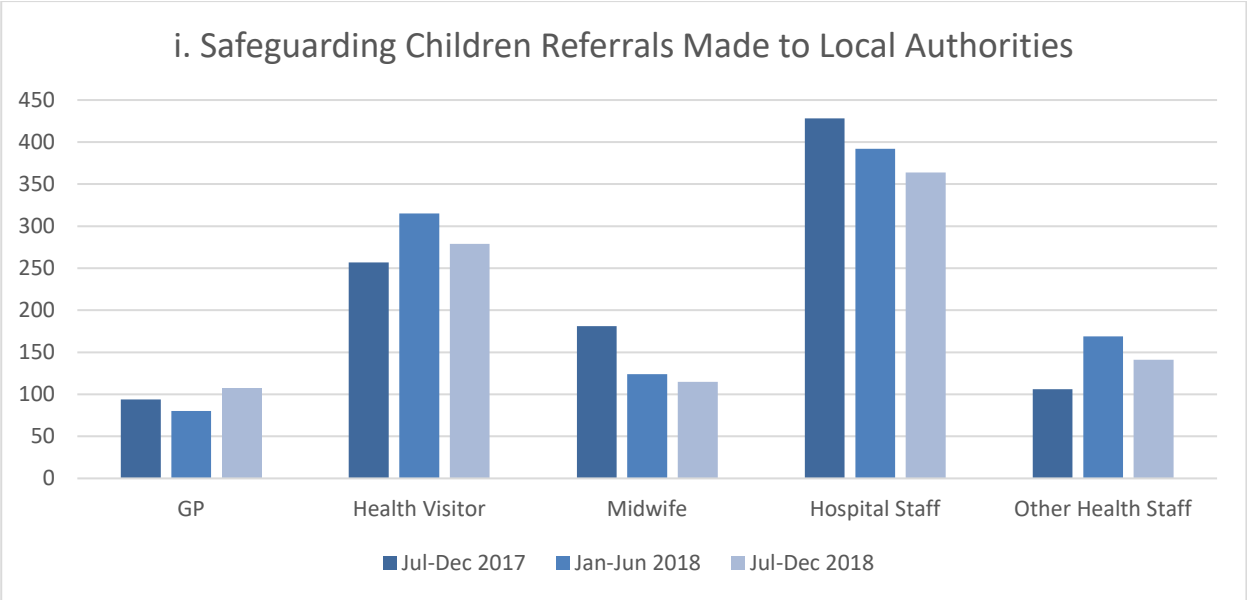
2.1.2 Adults at Risk

Adult safeguarding concerns are managed differently to children, as the Health Board address, under agreed Wales multiagency procedures, any adult at risk referrals that relate to alleged abuse or neglect within Health Board premises. The Health Board also manage referrals within the community where a health employee is allegedly responsible. The Social Services & Well-Being (Wales) Act 2014 placed a greater duty to on Local Authorities to make the necessary enquiries and identify any actions required to safeguard adults at risk. As a result, the Wales multiagency procedures are under review, and expected to be completed by the summer of 2019. The review may amend the current Health Board responsibilities for management of referrals.

2.1.3 Safeguarding Children Referrals

In the reporting period a total of 997 referrals or requests for information were submitted to Swansea and Neath Port Talbot Local Authorities. Bridgend Local Authority have been unable to provide information in respect of children's referrals or contacts due to additional pressures on their service. The requests for information to all three local authorities were made in December in line with previous year's requests. The results based on information returned are listed at Table **i** and compared with the previous two reporting periods. The referrals are categorised according to the area/staff group which made the referral.

Table i: Safeguarding Children Referrals Made to Local Authorities*



***NB Comparative figures for Jul – Dec 2018 exclude data form Bridgend Local Authority.**

Findings from last year remain consistent with Health Visitors, Midwives and GPs making up the highest number of safeguarding referrals for children. School Nursing made only two referrals within the reporting period across the two local authority areas.

Currently the Corporate Safeguarding Team does not collate safeguarding children data directly, but is obtained from each Local Authority. This data is limited and does not distinguish reason for referral, nor does it differentiate requests for children in need of care and support. Further analysis of the data provided indicates that during the reporting period Swansea Local Authority accounted for the highest level of referrals requesting information, advice and assistance or a proportionate assessment. Neath Port Talbot Local Authority reported the highest level of ongoing assessment and support via a Care and Support or Child Protection Plan.

Neath Port Talbot Local Authority provide data that indicates where early help has been accessed however this is not provided by the other local authorities at present, therefore data cannot be accurately compared. From the figures provided it would indicate that during the reporting period 103 HB referrals resulted in the provision of early help within the Neath Port Talbot locality, Health Visiting made up the majority of these referrals.

The Corporate Safeguarding Team continuing to work with the Datix team to develop a data reporting tool that will provide an accurate reflection of children's referrals made by Health Board staff. This should provide a more accurate view of safeguarding children referrals and allow better analysis for future reporting. Furthermore this will facilitate access to data that is not dependent on limitations experienced by outside organisations.

2.1.4 Safeguarding Adult Referrals

Collation of the safeguarding adult referrals continues to identify that the Mental Health and Learning Disabilty Service Delivery Unit address the highest number of referrals

(Table ii), with abuse of a patient by another patient being an idenified theme. The number of referrals July to December 2018 shows an increase compared to the previous six months. However, comparison with the same period in 2017 is comparable.

Table ii: Adult Cases Managed by the Health Board

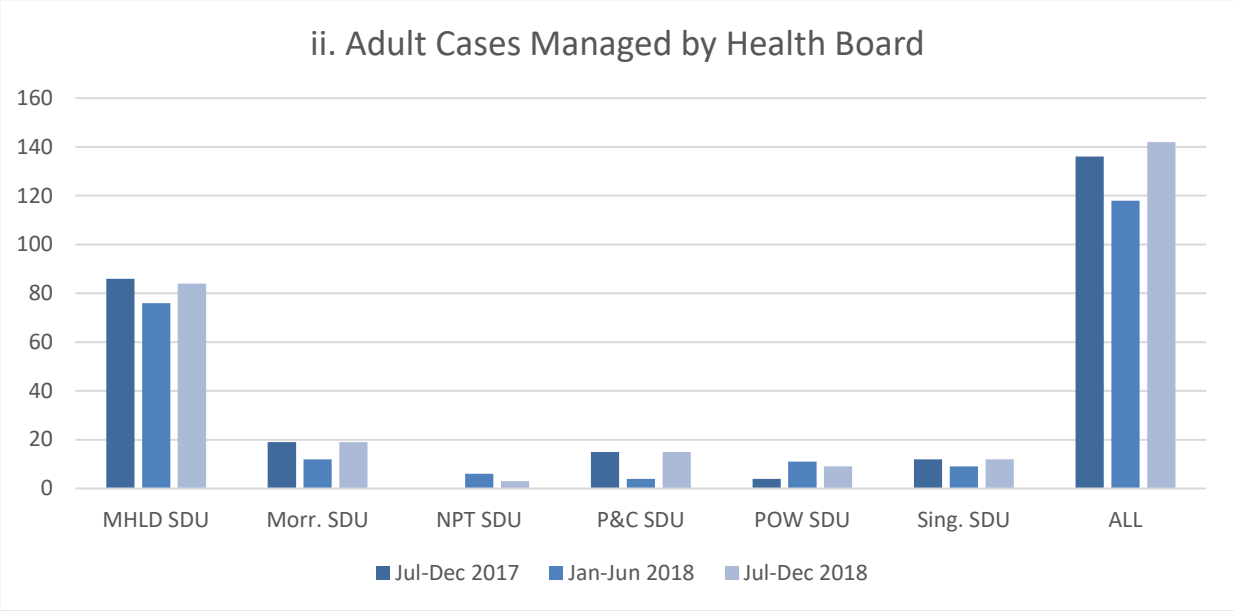
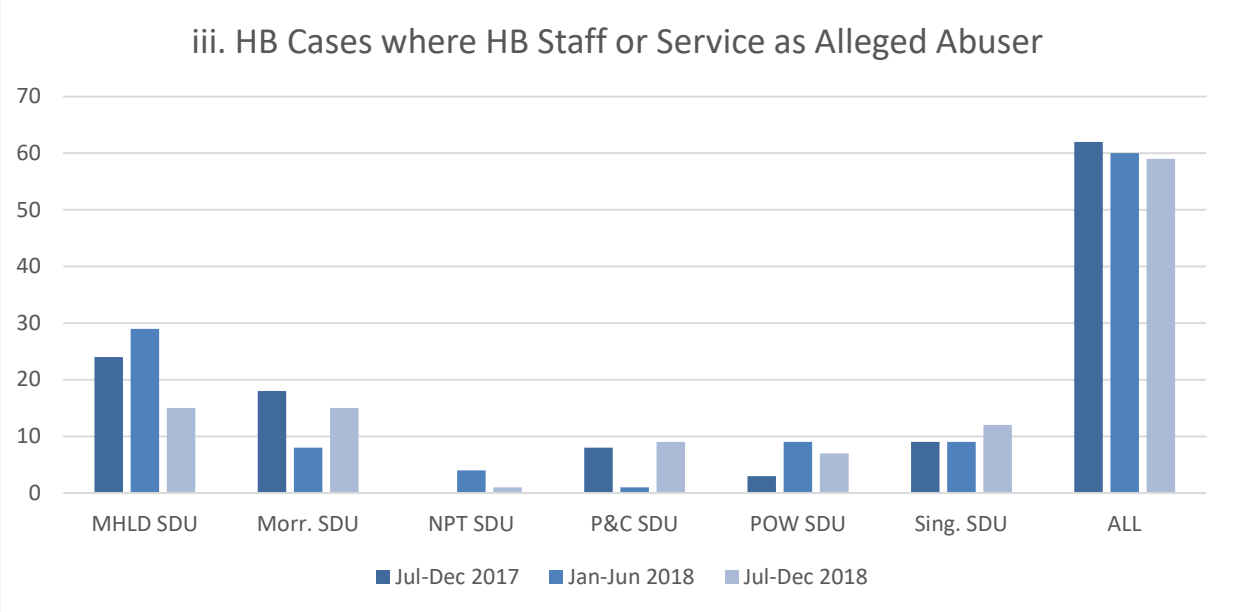
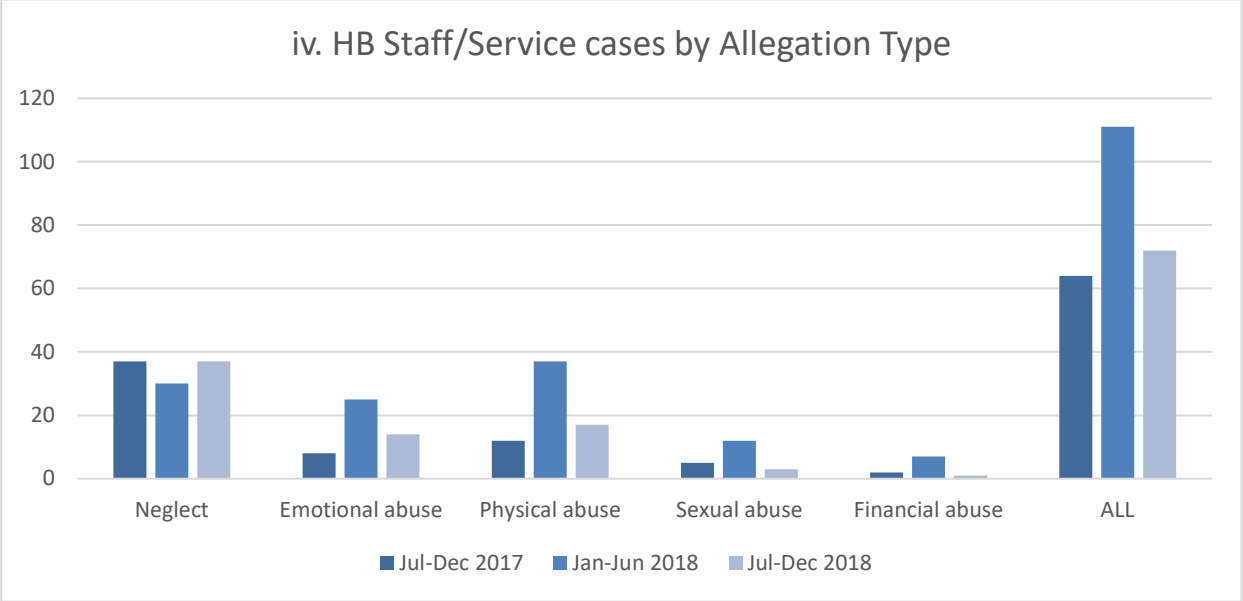


Table iii: Health Board Cases where Health Board Staff or Service as Alleged Abuser



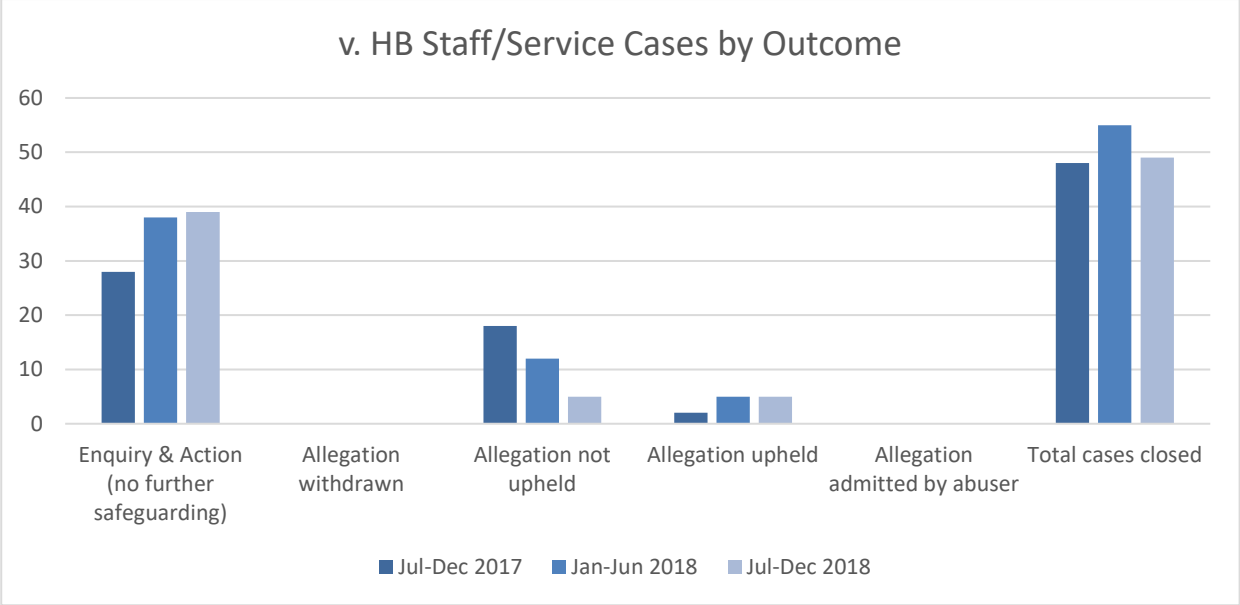
The overall number of referrals received where Health Board staff or a Health Board service are alleged to have been responsible for the abuse of an adult, are broadly similar over the past six months to the previous six month period (Table iii). The fall in the number of referrals within MHLD SDU, can be explained in part, to actions taken by the Unit to address multiple referrals for unfounded allegations made by an individual service user in early 2018.

Table iv: Health Board Cases by Allegation Type



The second half of 2018 has seen a reduction in the number of allegations relating to all types of abuse (especially physical abuse) except neglect. Neglect by a HB service, similarly to the same period in 2017, is the predominant category (Table iv). The reduction in the total number of allegations across all categories is likely to be due to fewer referrals received which identified more than one category of abuse.

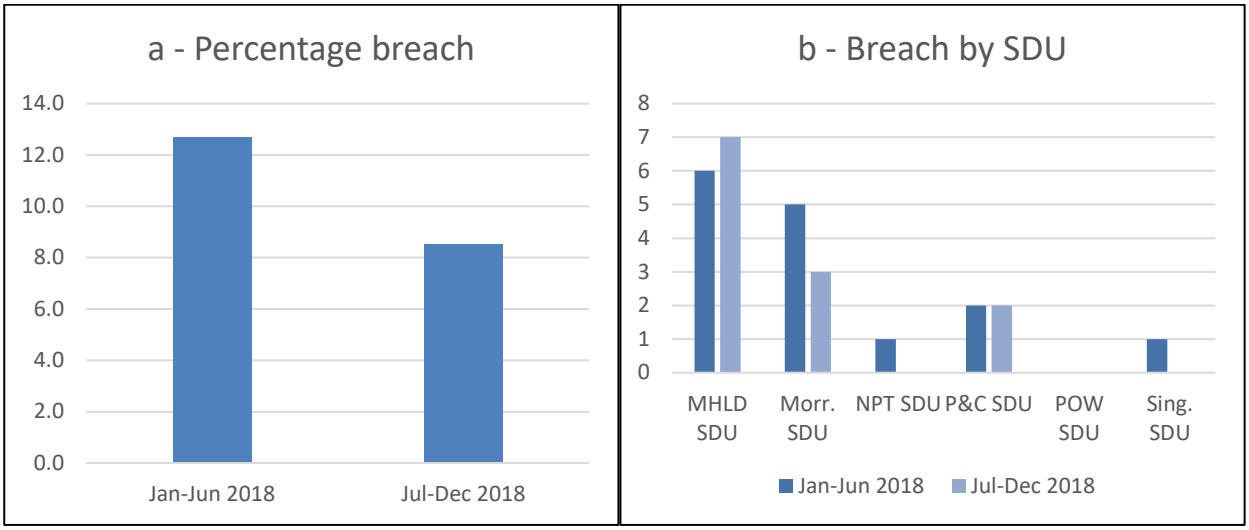
Table v: Health Board Staff/Service Cases by Outcome



The majority of referrals received are deemed as not requiring formal management under the All Wales Interim Safeguarding Adult Procedures following completion of the initial enquiry as shown above. Concerns arising from cases that are not formally managed under the multiagency procedures are addressed via other processes such as 'Putting Things Right' or incident management. Ten cases of alleged abuse by the HB closed between July and December 201, five of which were upheld.

Table vi: Health Board Staff/Service Cases – Breaches of Enquiry Timescale

vi. Health Board Managed Cases - Breaches of Enquiry Timescale



It is a legal requirement of the Social Services and Well-being Act that initial enquiries into Adult at Risk referrals are completed within seven days. Table vi (a) demonstrates that this timescale was exceeded in 8.5% of cases (n12) over the last six months, a reduction from 12.7% identified in the first half-year. Breaches were made in only three SDUs (Table vi (b)). Breaches are monitored by the Safeguarding Committee and Units are required to explain why a breach occurred and identify action to prevent a future occurrence.

2.2 INCIDENT REPORTING

2.2.1 DATIX Safeguarding Trigger Alerts

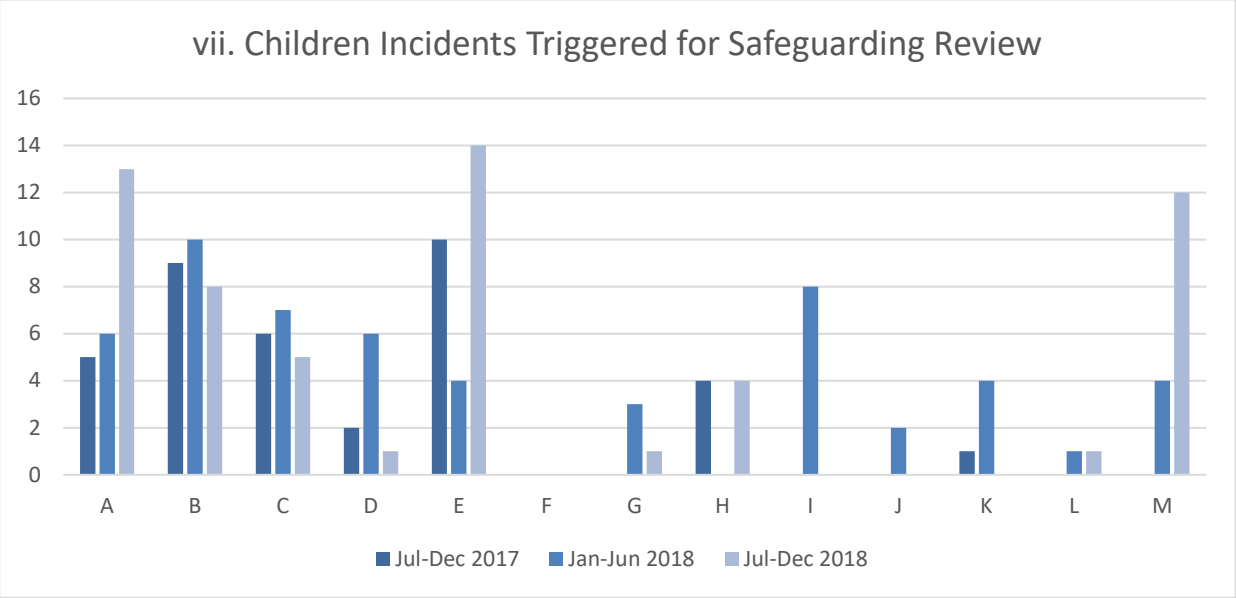
The Corporate Safeguarding Team monitors safeguarding alerts triggered via the HB DATIX system that do not necessarily require the submission of a safeguarding referral. This allows for the collation of information and encourages discussion to take place with the Corporate Safeguarding Team so that advice can be provided with the aim of improving practice to prevent recurrences. In addition, in the case of adults at risk, this will allow for the implementation of safeguarding plans to prevent such incidents progressing to requiring 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.

It is relevant to note that the children safeguarding incidents displayed in Table vii are DATIX reported HB incidents, and not reflective of the overall children referrals made by Health Board staff, as such referrals do not necessarily require a DATIX report. The categories for a trigger can be seen in Table vii.

2.2.2 Children

Table vii: Children Incidents for Safeguarding Review



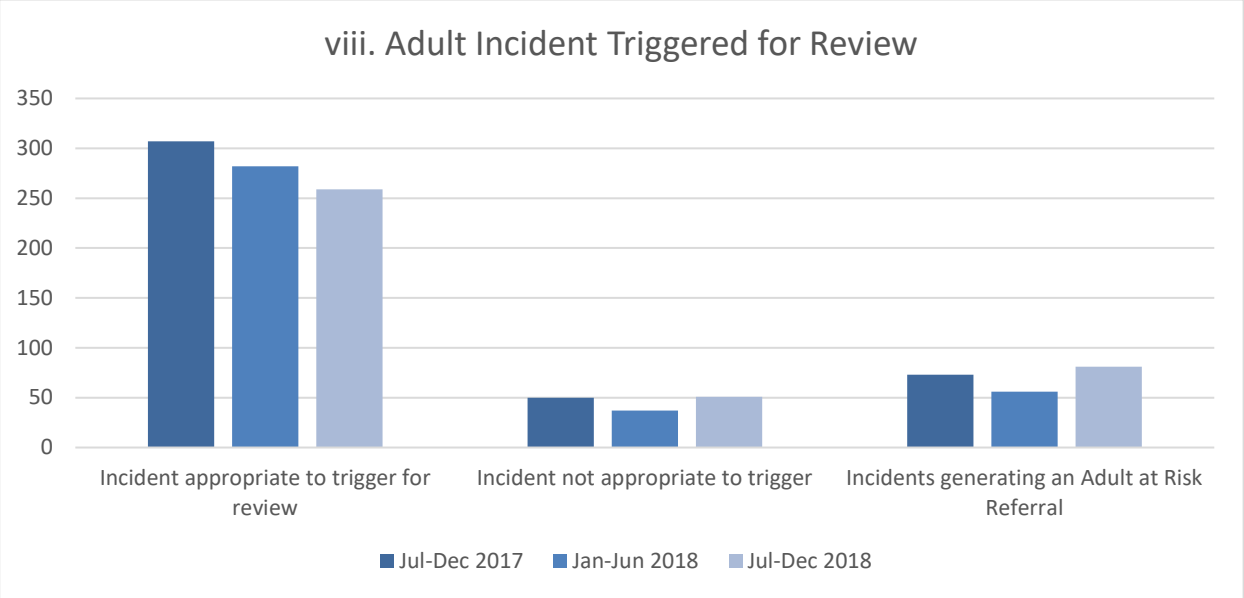
Key	E - Child nursed on adult ward	J - Professional differences
A - Aggressive behaviour	F - Absconding child	K - Corporate guidance req.
B - Failure to share information	G - Documentation	L - Concealed pregnancy
C - Failure to follow guidelines	H - Child death	M - other
D - Uncontrollable child	I - Lack of service provision	

In this period there has been an increase in the number of incidents relating to aggressive behaviour by a parent or family member (Table vii). The Safeguarding Team has reviewed these incidents to ensure the Service Delivery Units have addressed any safeguarding concerns and put measures in place to avoid a re-occurrence, including the need for a child protection referral. The Safeguarding Committee has been informed of relevant incidents to ensure learning.

There has been an increase in the numbers of DATIX incidents reporting children nursed on adult wards. This may be as a result of increased staff awareness of the HB Guidance and risk tool. The need to record these instances is reinforced and monitored via the Safeguarding Committee, and Units are required to report at each meeting the number of such instances occurring within the Unit.

2.2.3 Adults

Table viii: Adult Incidents for Safeguarding Review



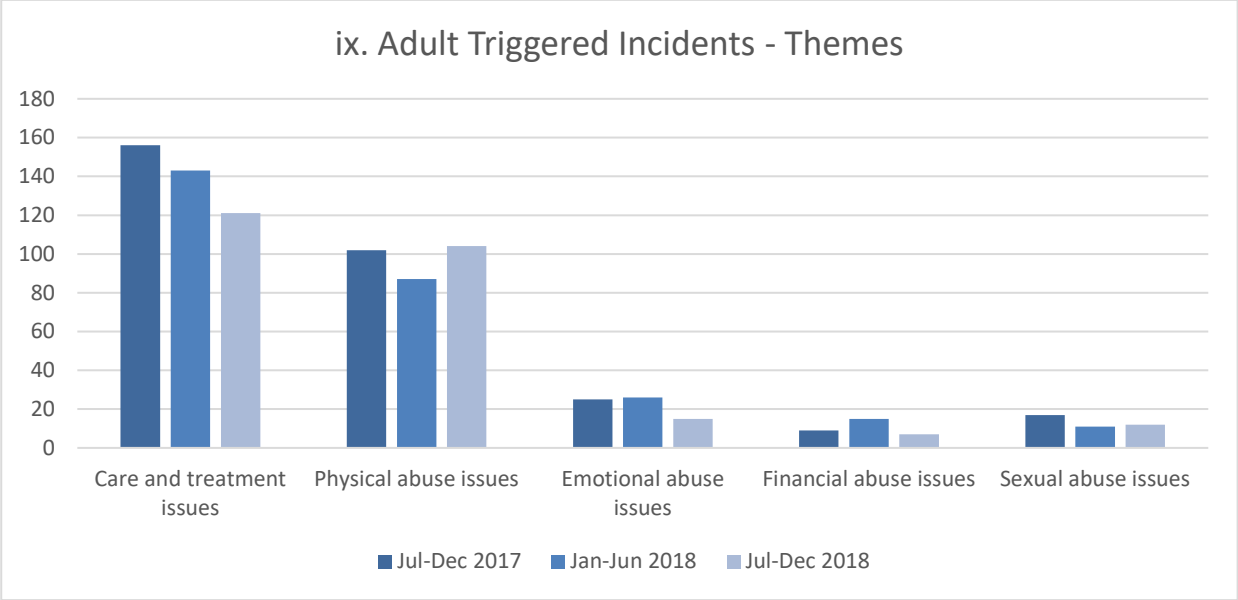
The data indicates fewer incidents were triggered for review by the Safeguarding Team when compared to previous six month periods (Table viii). In order to ensure that staff are aware of what constitutes a 'safeguarding adult incident, guidance is contained within the DATIX incident reporting module and incident triggers are highlighted at Designated Lead Manager (DLM) meetings and Safeguarding Adult Level 3 training sessions.

The Safeguarding Team are planning to undertake an audit in 2019 (in partnership with the DATIX Team) to identify whether there is a discrepancy between what is triggered for review and what should have been triggered but was not.

Monitoring of the inappropriately triggered incidents 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 the DATIX incident record to advise them why the incident was not appropriate to trigger a safeguarding review.

During the last six-month period, the proportion of reviewed incidents that also generated an adult at risk referral increased to 31% from 19%. This is notably higher that the percentage for the same period in 2017 (23%).

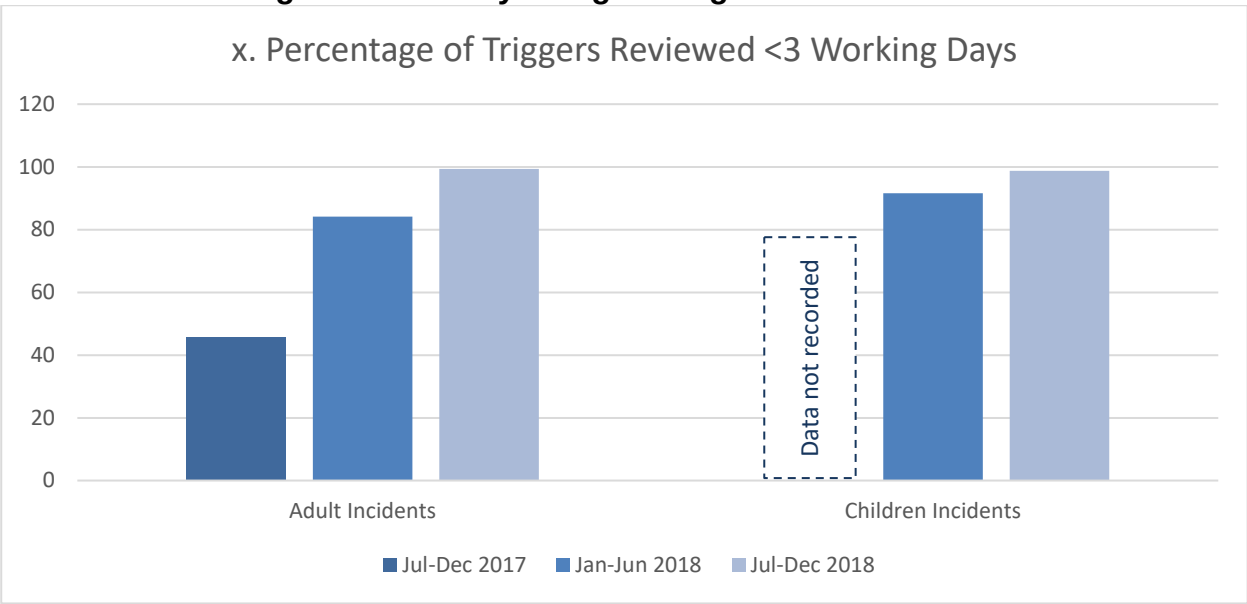
Table ix: Adult Incidents for Safeguarding Review - Themes



There has been a further reduction in the number of incidents relating to care and treatment issues and an increase (comparable to 2017) for those relating to physical abuse (Table ix). Care and treatment issues have a number of 'sub-themes'. The two most prominent sub-themes together accounting for 67% of such incidents are: those reporting pressure ulcer development (n39) and those reporting breaches in DoLS application timescales (n42). The latter is an example where incident triggers are lower than anticipated and is a factor in the Team undertaking the aforementioned audit.

2.2.4 Timescale Compliance

Table x: Percentage Reviewed by Safeguarding Team within Timescale



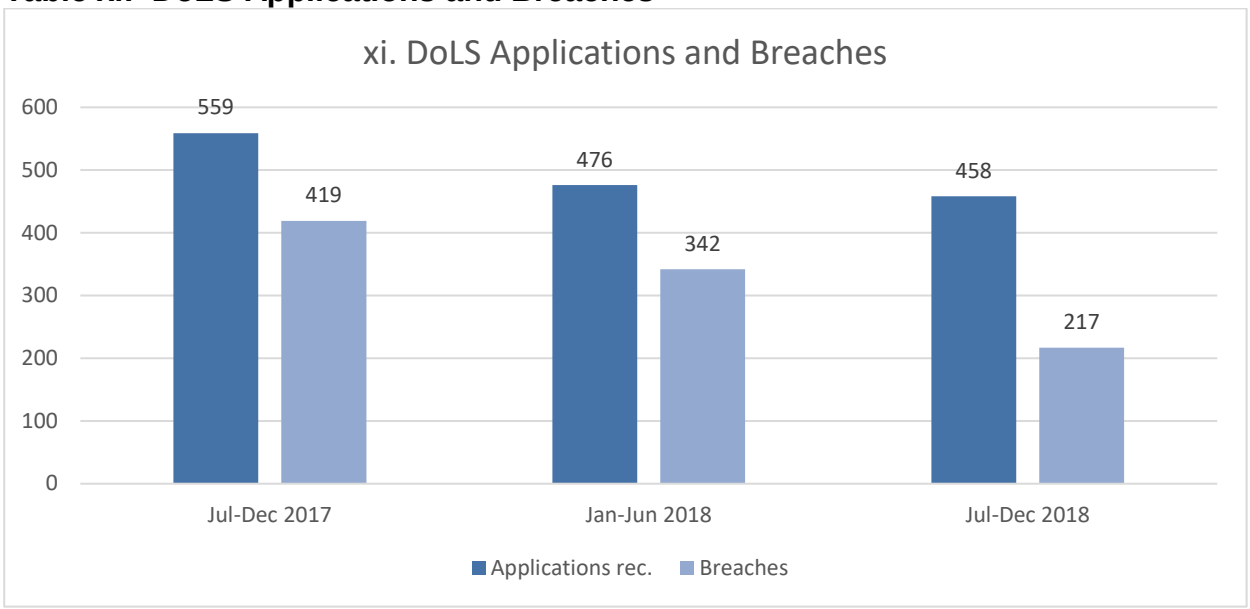
As stated earlier, the Safeguarding Team has an internal standard that incidents triggered to the Team are reviewed within three working days. Table x demonstrates the improvement achieved over the last six months, with 99.4% of adult and 98.8% of children

incidents being reviewed within this standard – 100% compliance has been achieved since 20th July 2018. This improvement is a result of rostering one specialist member of staff each day to address all telephone enquiries, incident triggers and referrals. With the mean review time for the past six months at 1 day for adult triggers and 0.6 days for children, the Safeguarding Team are reducing their internal standard to 2 working days.

2.3 DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)

Following the 'Cheshire West' case in 2014 the Health Board experienced a huge rise in DoLS applications. Since the initial impact of this ruling, Table xi illustrates that the number of DoLS applications in 2017 is comparable to 2018. 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.

Table xi: DoLS Applications and Breaches



2.3.1 Breaches

The Health Board continues to experience a large number of Deprivation of Liberty Safeguard (DoLS) applications and the management of these applications remains a significant issue for the Health Board. There are financial implications for the Health Board if a case is taken to the Court of Protection. The DoLS process can be a long and lengthy process which has been recognised on a national level. The Deprivation of Liberty Safeguards process is to be replaced by a new scheme called the Liberty Protection Safeguards which will be recognised under the Mental Capacity Amendment Bill ; the Bill had it's third reading in the House of Lords in December 2018 and is likely to gain Royal Assent by the summer of 2019. To date it is unclear what the changes will mean for the Health Board; until any changes are made the Health Board is required to execute the existing process according to current statutory guidance.

The Corporate Safeguarding Team has been supporting both the Supervisory Body (Primary Care and Community Services Delivery Unit) and the Managing Authorities

(Singleton, Morriston, Neath Port Talbot, Mental Health and Learning Disablities Service Delivery Units) to address some of the issues listed below which lead to delays:

- Administration backlog;
- Delayed submission of Section 12 doctors' & BIA paperwork;
- Discharged – wards not told;
- BIA Allocation;
- No longer meeting requirements – have capacity;
- Delay in supervisory body authorisations being completed.

Actions taken to date to rectify these issues include:

- An increase in the number of signatories within Primary Care and Community Services Delivery Unit from three to seven;
- Additional administration support has been arranged through bank/agency team, and a substantive post has been shortlisted with interview dates in early February 2019;
- The Corporate Safeguarding Team has implemented a BIA rota based on 31 BIA's which commenced on the 1st August 2018. The initial pilot found that staff could not be released from delivery units in a timely way or the level of productivity was lower than required. As a result, the Supervisory Body will develop a clear team structure and employ its own Best Interest Assessors due to start March 2019 (2 Best Interest Assessor Band 6 posts). DoLS will be managed as part of the Complex Care Team.

2.3.2 Support

The Health Board's DoLS Improvement and Support Group meets on a bi-monthly basis with representation from members of the Corporate Safeguarding Team and all Service Delivery Units. The role of Chair has been assumed by the Unit Nurse Director of Primary Care and Communiity Service Delivery Unit. This group is also looking to establish improved support for HB BIAs.

2.3.3 Multi-Agency Working

The difficulties in processing DoLS applications within legal timescales has affected all Supervisory Bodies across the Health and Social sectors, including our neighbouring Local Authorities. The multi-agency DoLS sub-group commissioned by the WBSAB meets bi-monthly to support and monitor the ongoing and increasing workload and to receive updates on case law. This group is 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.

2.3.4 Audit

An Internal Audit, focusing on DoLS activity within ABMU HB, was undertaken by NHS Wales Shared Services Partnership (NSSP) in 2017. The result of this audit gave a *Limited* level of assurance. To address this, collaborative working between the

Supervisory Body and the Corporate Safeguarding Team is now underway. An improvement plan is currently ongoing and findings are being reported to the Audit Committee. A follow up Audit is planned for March 2019.

2.3.5 Deprivation of Liberty Safeguards Improvement Plan

The Supervisory Authority (Primary Care and Community SDU) has developed an improvement plan with timescales to improve performance in the DoLS process thus reducing the number of breaches. The Supervisory Authority has worked with the Informatics Team to develop a Dashboard using data already collected by the DoLS administrator. Included in this dataset is information requested by the Internal Audit Department following the DoLS previous internal audit. This will inform DoLS activity and provide assurance data. The Dashboard is expected to go 'live' in March 2019.

2.4 PROFESSIONAL ABUSE AND CONCERNS

The Health Board recognises every staff member 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 are taken seriously and treated in accordance with the appropriate policies and legislation.

2.4.1 Professional Concerns/Abuse Strategy Meetings

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When a concern is raised, or abuse is alleged to have occurred outside of an employee's Board 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 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 regulators. Support is offered to staff within this process.

2.4.2 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 consider 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.

2.4.3 Professional Concerns

Professional concerns meetings are led by the Health Board and are led by a senior representative from the Service Delivery Unit. These meetings are concerned with alleged abuse of a patient whereby there are no issues associated with children.

Table 2 highlights that although the overall number of professional abuse/concerns referred to the Health Board has remained fairly consistent, there is a shift between the balance of cases with a sharp rise in cases where there are no issues associated with children. Themes of abuse are:

- Domestic abuse;
- Alcohol misuse;
- Physical abuse;
- Sexual abuse;
- Financial abuse.

Table xii: Professional Abuse and Concerns Cases

Period	Professional Abuse (children)	Professional Concerns (adult)	Total
New cases Jan – Dec 2017	**13**	**10**	**23**
New cases Jan- Dec 2018	**4**	**21**	**25**

Monitoring of 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.

2.5 VIOLENCE AGAINST WOMEN, DOMESTIC ABUSE and SEXUAL VIOLENCE (VAWDASV)

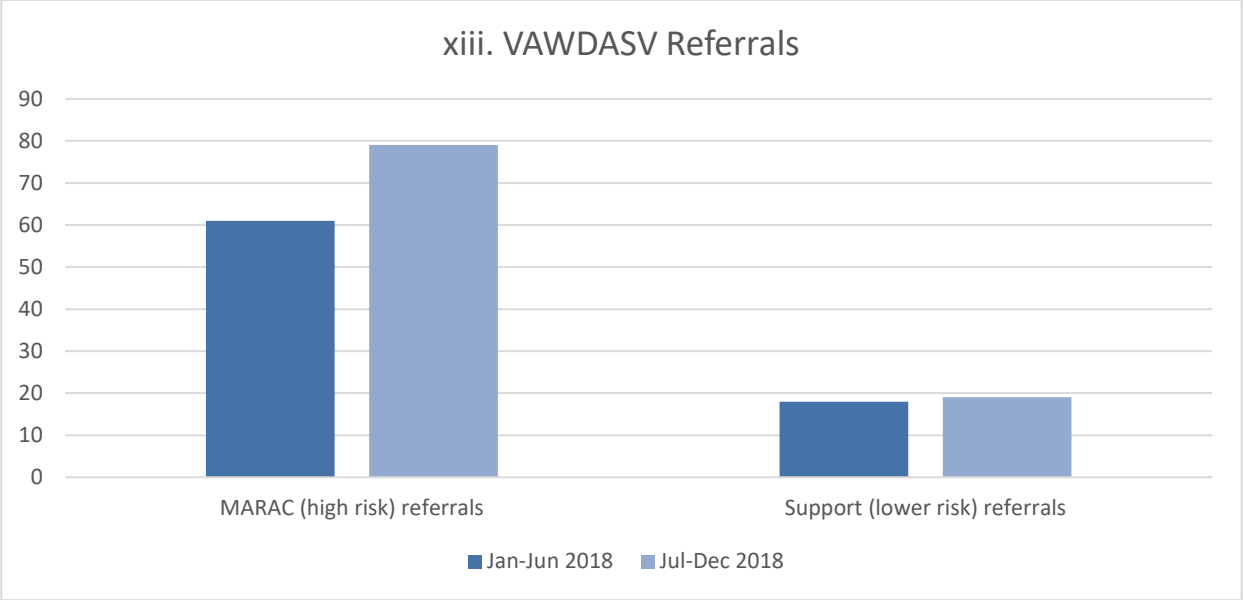
The Violence Against Women Domestic Abuse and Sexual Violence (VAWDASV) (Wales) Act 2015 sets out statutory requirements for NHS bodies and other relevant authorities; one of the key mechanisms for delivering the Act is the National Training Framework (NTF). The National Training Framework specifies that two trainers facilitate the training and that one of those trainers has 'specialist' subject knowledge. The trainer with 'specialist' knowledge is being provided by the third sector, which has a cost implication for the Health Board. Welsh Government have agreed to fund all of the training costs, however there has consistently been a delay in receiving clarification for the funding which has delayed training progress within the HB. For the financial year 2018/19 confirmation of the funding was not received until late July 2018, this had an impact on the training for the first two quarters of this financial year. Group 2 Training sessions commenced as forecasted in September 2018. The Corporate Safeguarding team have had contact with Welsh Government requesting that the further funding is confirmed before the next financial year.

2.5.1 Multi Agency Risk Assessment Conference (MARAC) and Health Board referrals

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 victims of VAWDASV who have been referred because they are considered to be of risk of serious harm or death. From the conference a plan of action is agreed to ensure the safety of the victim and any children or vulnerable adults that may be involved. A Health Board member attends each MARAC.

MARAC referrals from ABMU staff have increased by 85.4% since the introduction of Group 2 Ask & Act training in 2016. The Table below illustrates the increase in referrals over the past six months; the increase is primarily from areas within the HB that have historically made very few referrals.

Table xiii: VAWDASV Referrals



2.5.2 Identification and Referral to Improve Safety (IRIS)

Domestic violence and abuse is a public health issue affecting 1:3 women and 1:6 men. It can have a considerable impact on the victim and their families. Many people that do experience abuse disclose to a health professional especially within a GP Surgery, as they believe that they can offer support and advice.

IRIS is a general practice-based domestic violence and abuse (DVA) training support and referral programme. IRIS is a collaboration between primary care and third sector organisations specialising in DVA. The programme includes training and education, clinical enquiry, care pathways and an opportunity to refer to specialist domestic abuse services. It is aimed at women who are experiencing DVA from a current partner, ex-partner or adult family member and also provides information and signposting for male victims and for perpetrators.

Both Cardiff and the Vale and Cwm Taf Health Boards and implemented the project, it has evaluated well and a multitude of benefits have been reported. The benefits include:

- Reduction of frequency of visits to GP surgeries;
- Reduction in the number of prescriptions issued;
- Reduction in the amount of medication prescribed;
- Reduction in visits to Emergency Units;
- Reduction in visits to Sexual Health Clinics;

- Reduction in hospital admissions;
- Reduction in the use of mental health services.

ABMU HB has received partial funding to implement the project from the South Wales Police and Crime Commissioners Office. The implementation will be supported by the Corporate Safeguarding team, commencing with a steering group the purpose of which is to oversee the effective delivery of the IRIS project.

2.6 FEMALE GENITAL MUTILATION (FGM)

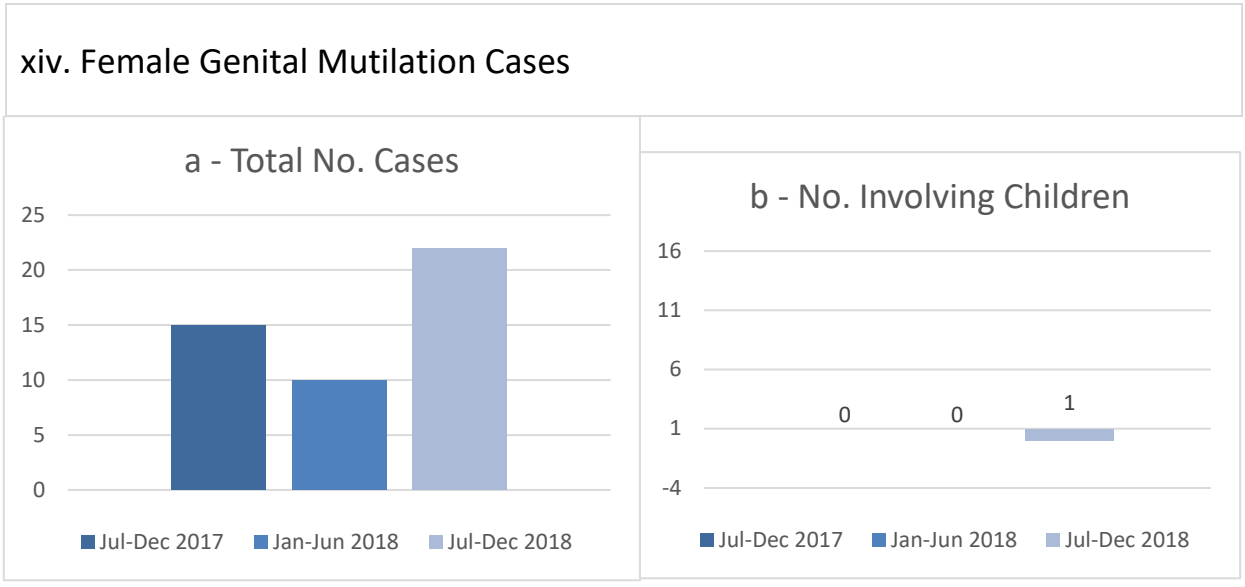
Female Genital Mutilation (FGM) is illegal in the UK under the Female Genital Mutilation Act 2003 and the Serious Crime Act 2015. It is mandatory for NHS staff to report all cases of FGM in children to the Police and Social Services. The All Wales Clinical Pathway gives staff guidance and has been incorporated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

ABMU HB's Corporate Safeguarding Team reports any 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. The All Wales Clinical Pathway (FGM) has recently been updated and the data required by WG and PHW has changed and so it is necessary to alter the FGM Data reporting tool to capture the new requirement of information. The Safeguarding Team is working with the Datix Team to ensure that this is updated accordingly with an expected completion date of April 2019.

2.6.1 Reported Cases of FGM

In the last reporting period there have been no reported cases where FGM was carried out in Wales and just one disclosure of a child that has had FGM. There has been an increase in the number of disclosures made to Health Board staff in the last six months however no obvious reason for this increase has been identified.

Table xiv: Female Genital Mutilation Cases



2.7 CHILD SEXUAL EXPLOITATION (CSE)

2.7.1 Multi-Agency Working

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

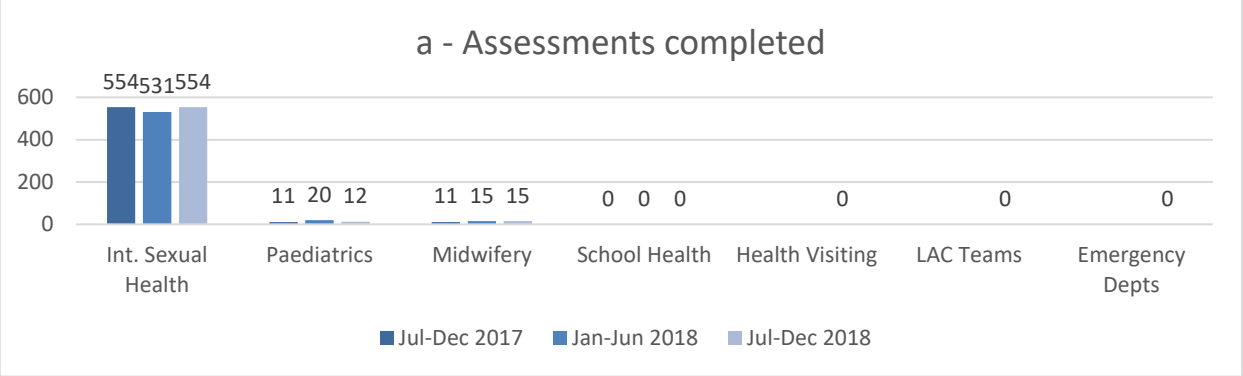
2.7.3 CSE Referrals

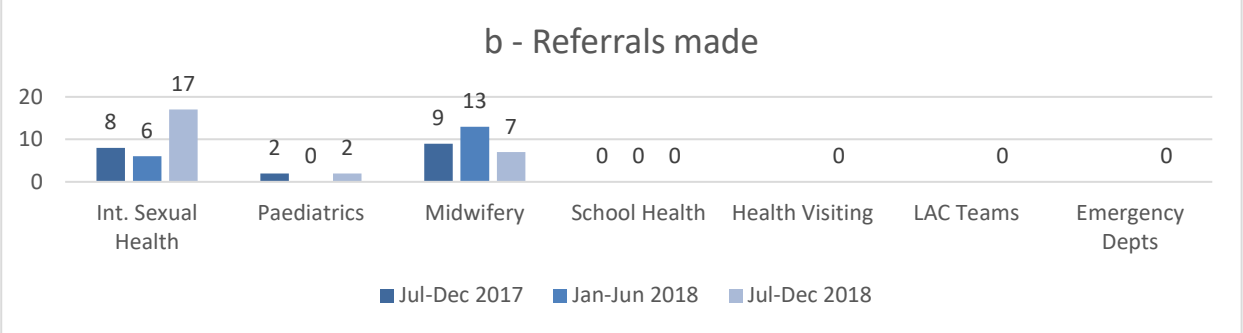
Health Board staff in identified priority areas use the All Wales Risk Assessment Tool (CSERQ 15) as a guide to assessing the risk of CSE. The percentage of completed CSERQ's which led to referrals to Local Authorities is illustrated in Table xiv.

During the reporting period 581 CSERQ15 were completed, however only 26 referrals were made to Local Authorities. In this reporting period Integrated Sexual Health completed the most CSERQ15 and made the largest number of child protection referrals. Their referral rate remains comparatively low albeit increasing from the last two reporting period. Midwifery in contrast consistently report a low completion rate but higher comparative referral rate. Work is ongoing in other identified priority areas such as ED to increase the use of the CSERQ 15.

Table xv: CSERQ15 Assessment and Referrals

xv. CSERQ15 Assessments and Referrals





2.7.4 CSE Information Sharing

Since September 2017 a Standard Operating Procedure (SOP) has been implemented to ensure that the electronic health records for all children identified as being at high risk of or as being sexually exploited are flagged so that Health Professionals having contact with the children will be aware of the concerns. The Corporate Safeguarding Team are reviewing electronic health records to ascertain if children that are considered to be of high risk of CSE have had the appropriate alert placed on their electronic record. An audit has commenced the findings will be presented to the next Safeguarding Committee.

2.7.5 Independent Inquiry Into Child Sexual Abuse (IICSA)

On 12 March 2015, the Home Secretary established the Independent Inquiry into Child Sexual Abuse (IICSA) 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 was required to provide evidence to the IICSA 'on the steps taken by the Health Board since 2015 to prevent children from being sexually abused in healthcare settings'. In April 2018, the IICSA published its Interim Report to provide an update on the progress made.

The recommendations of this report were presented to the last Safeguarding Committee and an update of ongoing actions outlined in the last Safeguarding report are set out below:

- A Risk assessment tool has been implemented in respect of children receiving treatment on adult wards. Compliance is monitored by the Corporate Safeguarding team;
- ABMU HB (along with other HBs) is continuing to working with the PHW's National Safeguarding Team to develop the All Wales Chaperone Policy. This is currently in draft, it is anticipated that a final document will be completed by March 2019.

2.7.6 The Truth Project

This project allows victims and survivors of sexual abuse to share their experience with the Inquiry. To date, over 1000 victims and survivors have participated. Uptake within Wales has been relatively low in comparison to other parts of the UK. ABMU HB has engaged in the promotion of the project by way of poster display and distribution of leaflets. The Health Board recognises that there may be additional actions needed to assist with raising the profile of the work being undertaken by the project. A meeting has been arranged with Sue James, Head of the Inquiry Office, Wales on the 15th of April 2019 to discuss how the Truth Project can be further supported by the Heath Board. Sue James will in turn attend the HB Safeguarding Committee on the 24th of May to provide a presentation on the project.

SECTION 3 LEARNING CULTURE

3.1 PRACTICE REVIEWS

Adult and Child Practice Reviews take place following the death or serious injury of a child or adult and abuse or neglect is thought to be involved. Any learning is incorporated into training and discussed at relevant meetings, peer review and supervision.

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

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3.1.1 Adult Practice Reviews (APR)

Table xvi identifies the current status of the three Safeguarding Board commissioned Adult Practice Reviews.

Table xvi: Adult Practice Reviews – July to December 2018

Adult Practice Reviews	New	Ongoing	Completed & Published	HB Staff Panel members	HB Chairs	HB Reviewers	No of Learning events
	1	2	1	3	1	2	2

3.1.2 Child Practice Reviews (CPR)

Table xvii identifies the current status of the four Child Practice Reviews and Health Board involvement. One Child Practice Review has been sent back to PRMG for reconsideration following the initial panel meeting as it was felt by panel members and reviewers not to have met the criteria for a Review and one CPR has been recommenced following the conclusion of the police investigation.

Table xvii: Child Practice Reviews – July – December 2018

Child Practice Reviews	New	Ongoing	Completed & Published	HB Staff Panel members	HB Chairs	HB Reviewers	No of Learning events
	1	3	1	6	0	1	3

3.1.3 Learning points and recommendations from published Reviews

The Corporate Safeguarding Team continuously monitor and review the learning points from published Child and Adult Practice Reviews in order to disseminate the findings to

the wider Health Board. This is to ensure that actions attributed to health are completed in accordance with the findings from reviews.

During the last reporting period there were twelve learning points and associated actions from Practice Reviews attributed directly to the Health Board. The Safeguarding team are in the process of receiving assurances from the relevant Delivery Units that processes are in place to ensure that any recommendations for health are reflected in current practice. This will be reported to the next Safeguarding Committee.

3.1.4 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 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.

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

Table xviii: Domestic Homicide Reviews July – December

Ongoing (total)	Gathering Information (review stage)	Nearing completion (draft report stage)	With Home Office (pre publication)
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.All published DHRs will be presented to the Safeguarding Committee and any learning points/recommendations included in the Health Board Practice Review Action Plan. In addition the Western Bay Safeguarding Board's Business Unit has submitted a proposal to the three local Community Safety Partnerships to ensure they are regularly kept updated with regard to DHRs.

There have been no published DHR's within this reporting period progress, two reports are with the Home Office Quality Assurance Panel. One DHR is nearing completion and one DHR has recently commenced and currently at the chronology stage.

3.2 PROCEDURAL RESPONSE TO UNEXPECTED DEATH IN CHILDHOOD (PRUDiC)

During this reporting period there have been three unexpected child deaths.

PRUDIC meetings 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.

- A three year old child was brought to Morriston Hospital Emergency Department in respiratory arrest, due to the rapid deterioration in his condition he was transferred to the University Hospital of Wales where sadly he later died. He had a known syndrome which wasn't expected to be life limiting however the cause of death was attributed to his condition.

- One neonate died 35 minutes after birth despite resuscitation. During labour there were no concerns regarding fetal wellbeing and the baby was not expected to be born in such poor condition. Western Bay Safeguarding Board have commenced a Child Practice Review following concerns that were raised at the PRUDiC. There had been ongoing safeguarding and substance misuse concerns with this family. An inquest has been opened by the Coroner; Post Mortem results have not yet been made available.

- A child died at home whilst co-sleeping with a parent, this child had a known syndrome and associated medical conditions one of which was known to be life limiting, despite this the child was not expected to die at this time. No definite cause of death was found at the preliminary Post Mortem, however there were no suspicious circumstances surrounding the death. The final Post Mortem results have not yet been made available.

3.2.1 Themes

No theme has been identified from these three reported deaths however one of the deaths is linked to co-sleeping which was a theme identified in 2017. The Welsh Government's 'safe sleeping' guidance has been disseminated through the HB via the Safeguarding Committee and is part of Midwives and Health Visitors' practice. 'Safe sleeping' and associated risks of co-sleeping are included on the Level 3 Safeguardng Children's training which reaches a far greater audience than just Midwives and Health Visitors'.

3.3 SAFEGUARDING TRAINING AND SUPERVISION

3.3.1 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 Service Delivery Unit (SDU) on a bi-monthly basis.

Table xix - Safeguarding Adults Level 1 training percentage compliance

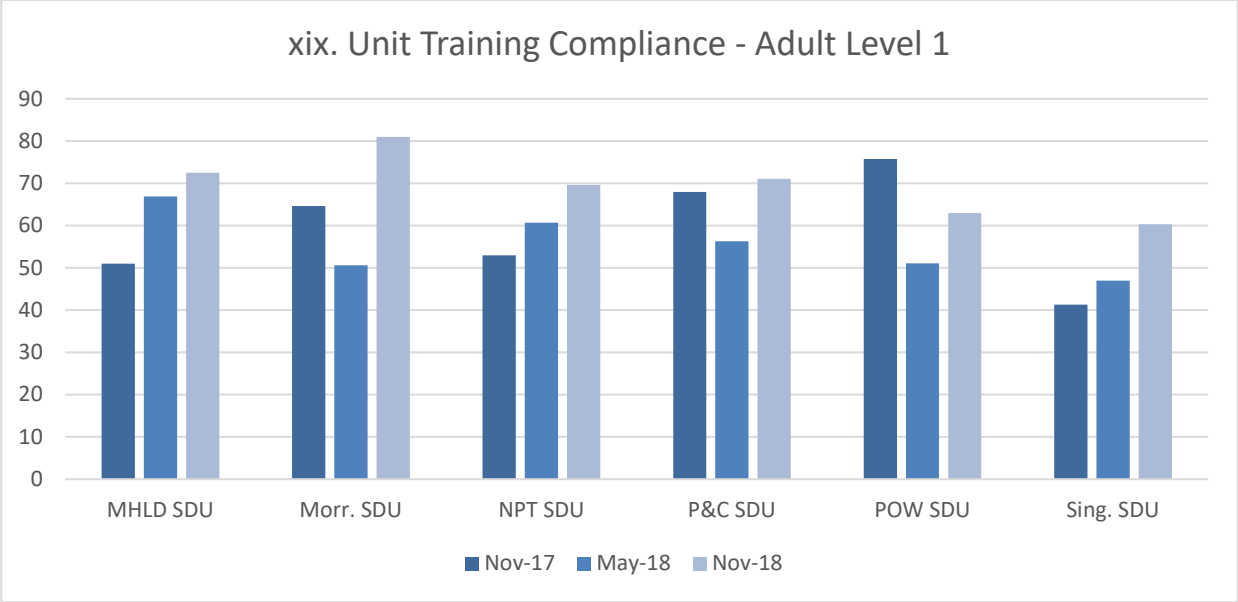
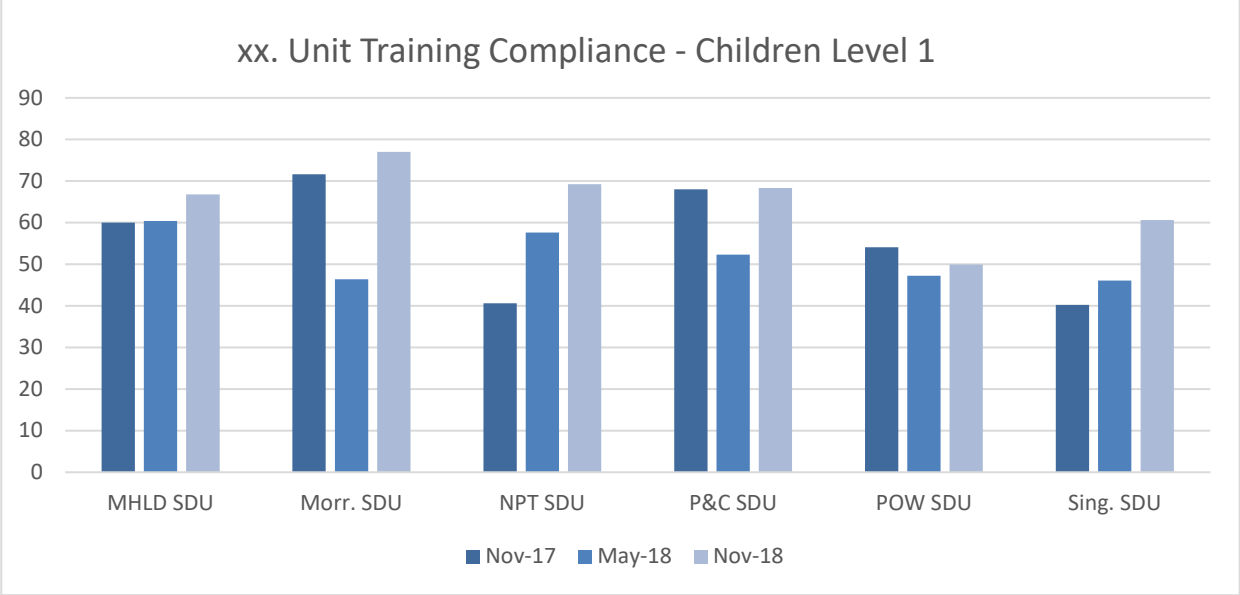


Table xx: Safeguarding Children Level 1 training percentage compliance



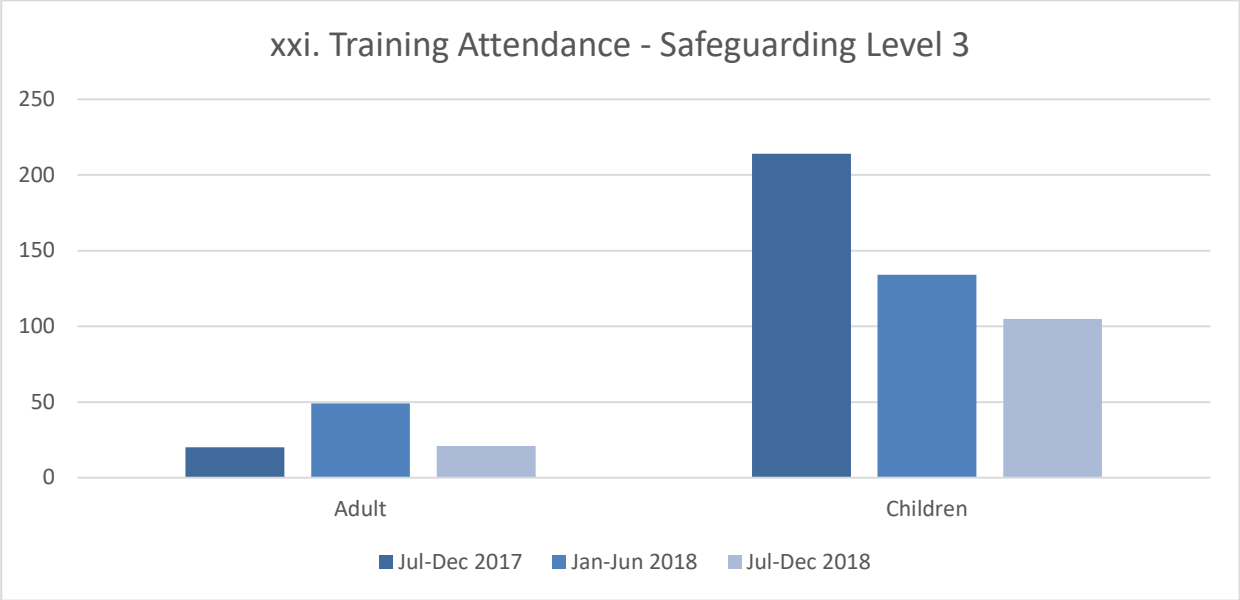
It was highlighted in the previous report to the Committee that Service Delivery Units were tasked by the Safeguarding Committee to identify and implement actions to address poor safeguarding mandatory training compliance. The previous tables demonstrate that all SDUs have made improvements in their compliance at both Adult and Children Level 1 e learning over the last six-months.

3.3.2 Level 3 Safeguarding Training

Level 3 Safeguarding Children training continue to be delivered by the Corporate Safeguarding team monthly across the Health Board and six training sessions were delivered during the reporting period.

The full-day Level 3 Safeguarding Adults training delivered by the Corporate Safegaurding Team has a different target goup to that of Level 3 Safeguarding Children training. Level 3 Safeguarding Adult training is aimed at operational managers who are responsible for responding to a safeguarding alert (usually at band 6 or 7), hence the number of staff requiring this training is significantly lower. During the reporting period four sessions were delivered. This was two fewer sessions than for January-June, due to no sessions being held during the peak 'summer hioliday' period.

Table xxi: Training Attendance - Safeguarding Level 3



From the above table it is evident that attendance rates for Level 3 Safeguarding Children training has continued to fall. The number of training sessions delivered by the Safeguarding Team has remained constant during each of the last three half-year periods, and so the reduction in numbers can only be attributable to fewer staff booking or being released for training.

Attendance levels for Safeguarding Adults training is commensurate with the same period for 2017. As indicated earlier there were two fewer training sessions offered during the July/December period.

3.3.3 FGM Training

FGM training continues to be deliveres to staff in priority areas: Paediatrics; Neonatal; Midwifery; Gynaecology; Health Visiting; Integrated Sexual Health and GP surgeries. FGM is included on the Level 3 Safeguarding Children training and raises awareness of the data reporting tool and the updated All Wales Clinical pathway (FGM).

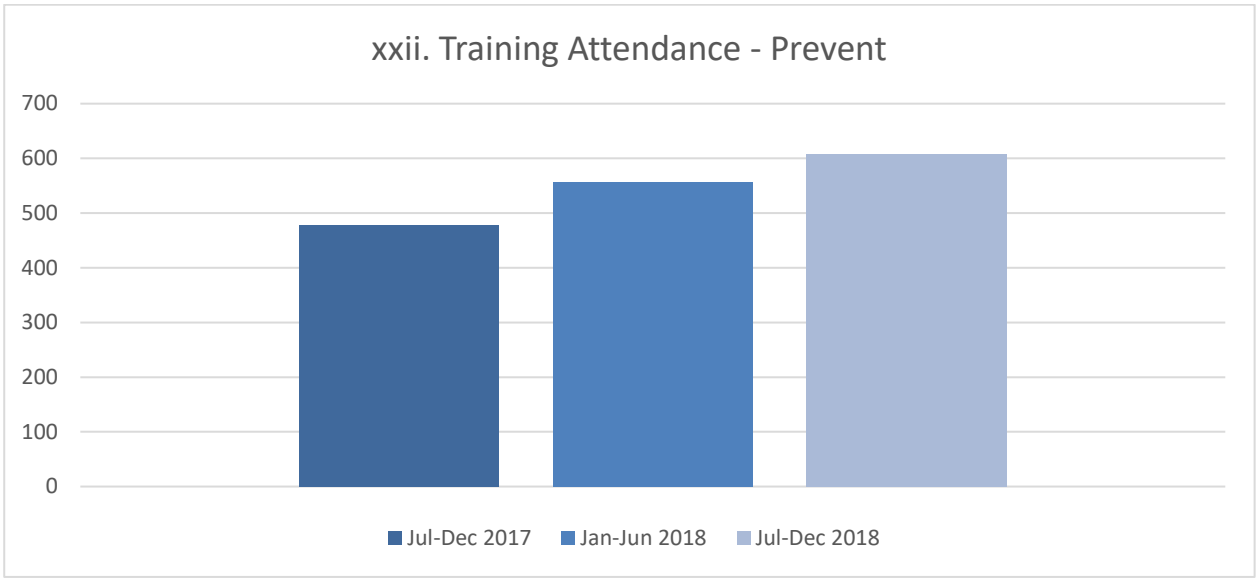
3.3.4 CSE Training

Identified priority areas (Midwifery, School Health Nurses, Paediatrics and Integrated Sexual Health services) receive CSE training and updates. Level 3 Safeguarding Children's training includes CSE thus ensuring that all staff who attend Level 3 training have an awareness of CSE and not just those in the identified priority areas.

3.3.5 Prevent Training

The Corporate Safeguarding Team supported by a small number of Unit trainers continues to deliver the WRAP3 Home Office approved Prevent training. 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. Table xxi demonstrates that attendance increased during 2018. Over 3,800 staff have completed this 'one-off' training since its commencement in October 2015.

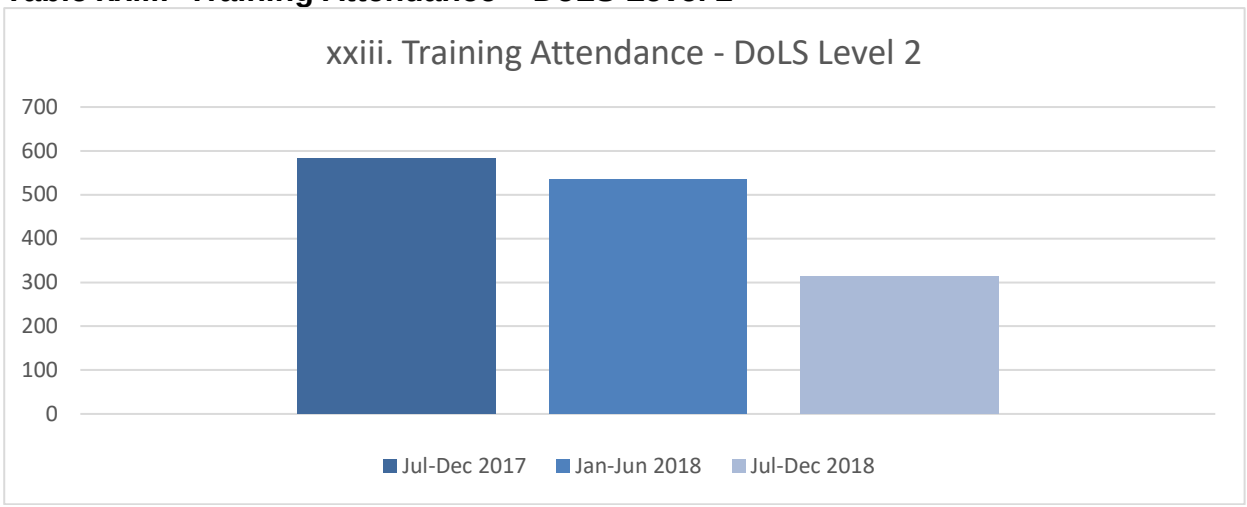
Table xxii: Training Attendance - Prevent



3.3.6 Deprivation of Liberty Safeguards (Level 2) Training

Deprivation of Liberty Safeguards (DoLS) Training is arranged 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 a fall in attendance at this training during the last six-months. (Table xxiii.)

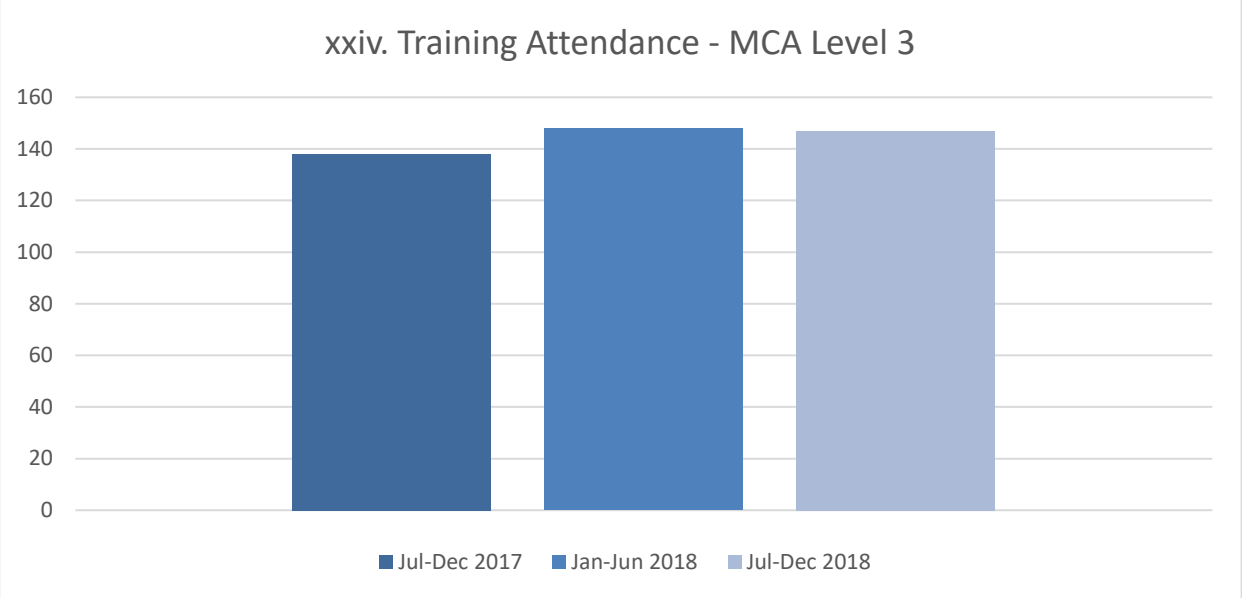
Table xxiii: Training Attendance – DoLS Level 2



3.3.7 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. Similar numbers of staff have attended during each of the last three half-year periods (Table xxiv).

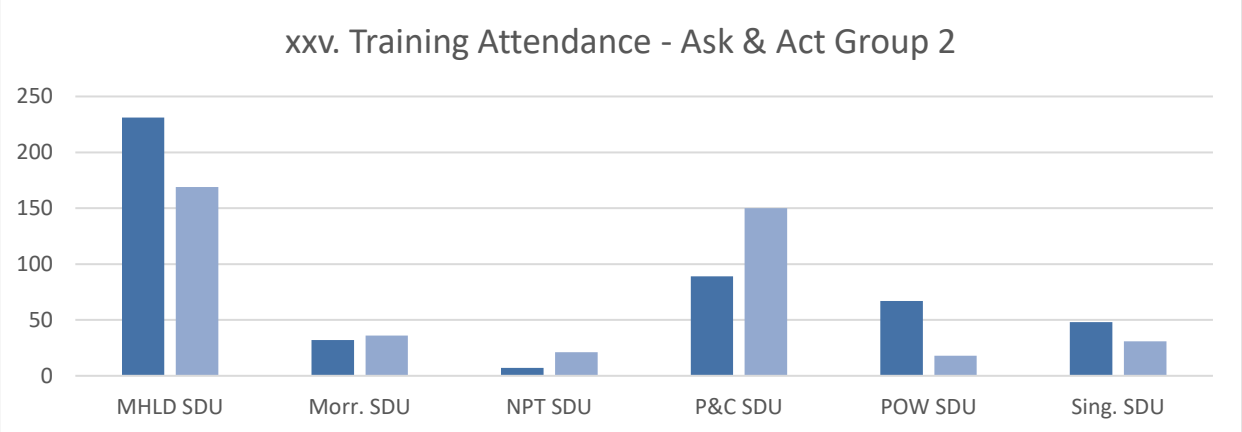
Table xxiv: Training Attendance – MCA Level 3



3.3.8 Ask and Act Group 2

Ask and Act Group 2 training has continued throughout the Health Board. All SDUs have been offered access to training allow greater flexibility to release staff to attend. There are noted differences between the numbers of staff from each SDU accessing this training, this could be in part due to the specific demands on SDU's at particular times of the year (Table xxv). To improve the overall attendance levels, all SDU's are encouraged to release as many staff as possible for each session to ensure the Health Board meets its training target as agreed with Welsh Government. This is monitored by the Safeguarding Committee.

Table xxv: Ask & Act Group 2 Training - SDUs



3.4 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). Abertawe Bro Morgannwg University Health Board has a duty under section 28 of the Children Act to safeguard and promote the welfare of children. Effective supervision is important in promoting good standards of practice and to supporting individual staff members. In addition the Hhealth Board has a responsibility to ensure staff feel supported in their safeguarding children role (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 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.

A review of Child and Adult Practice Reviews undertaken by Public Health Wales in 2018 highlighted the lack of appropriate supervision as a contributing factor in the failings of staff in recognising and responding to signs of abuse. Health Inspectorate Wales report into the handling of the allegations against Mr W, emphasised the need for robust safeguarding supervision. As a result of this the Corporate Team will undertake an audit of supervision arrangements within the Health Board to ensure these standards are being met, the findings of this and recommendations will be reported to the Safeguarding Committee.

SECTION 4 MULTIAGENCY PARTNERSHIP WORKING

4.1 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 Nursing:Named Nurse 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. Examples of multi-agency work are illustrated below:

- Deprivation of Liberty Safeguards (DoLS) collaborative work has included multi-agency guidance and updates on case law;
- Review of many policies and participation in joint audits;
- Participation in Adult and Child Practice Review processes and Domestic Homicide Reviews as panel members, chair and reviewers;

- Involvement in Learning Reviews and Extraordinary Board Meetings and the facilitation of learning outcomes/recommendations;
- Participation through regional Board Policy, Procedure and Practice (PPP) sub-group and contributed to consultations of the update of the All Wales Protection Procedures;
- Presentation to PPP group regarding the evaluation of ABMU HB's 'Ask & Act' pilot - VAWDASV (Wales) Act 2015;
- Presentation to Practice Review Management Group (PRMG) - seven minute briefing Co-Sleeping – same presented to WBSCB;
- Presentation to WBSAB regarding ABMU HB's KW Review.

In addition, the Corporate Safeguarding Strategic Work Plan has been mapped against the WBSCB/WBSAB Strategic Priorities and Business Plans and the National Safeguarding Board's Annual Plan. The Safeguarding Committee monitors the progress of the plan and required actions.

4.2 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 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 provides 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.

4.3 PARTNERSHIP WORKING TO ADDRESS 'CRIMINAL EXPLOITATION'

4.3.1 Human Trafficking/Modern Slavery

Human Trafficking as defined in the Modern Slavery Act 2015 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. 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 trafficking using a National Referral Mechanism (NRM).

The Western Bay Anti-Slavery Forum is a multi-agency meeting which aims to facilitate engagement, partnership working and shared learning between Police, Local Authorities, Health, Education and Public and Third Sector organisations on the issue of slavery across the region. Meetings are held quarterly and updates are received from Welsh Government on the number of NRM referrals made nationally and regionally. Information and updates on any local cases from the police are discussed as well as any key local issues. A member of the Corporate Safeguarding Team attends these meetings and the

Safeguarding Committee is updated accordingly. A programme of multi-agency Anti-Slavery Awareness training is available for health staff provided by external agencies. The Corporate Safeguarding Team is assessing whether this subject area can be incorporated into an extended Level 3 training session in 2019.

4.3.2 CHANNEL and Prevent

The Counter Terrorism and Security Act 2015 requires the Health Board 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 action agreed to mitigate. The Team also engages with the three Local Authority led 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). No referrals by Health Board staff were made within this last reporting period.

4.3.3 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 child criminal exploitation (CCE) 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'. A presentation regarding this was given to the Safeguarding Committee. 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 Training Level 3. In addition two HB staff have attended a Train the Trainer session.

4.4 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.

Suicide has been a feature of both Adult and Child Practice Reviews within the ABMU HB region and the Health Board is considering mechanisms on how suicide and self-harm prevention can be driven locally.

4.5 CHILD AND ADOLESCENT MENTAL HEALTH SERVICE (CAMHS)

During this reporting period there has been an increase in the number of young people with self-harming behaviour who present at Emergency Departments (ED) and need additional support particularly regarding CAMHS. Many of these children have many behavioural issues but do not necessarily have a mental health diagnosis. There have been good 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.

4.6 NATIONAL SAFEGUARDING WEEK

ABMU HB joined other organisations across Wales to mark 'National Safeguarding Week' on 12th-16th November and raise awareness of Exploitation. 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 events were delivered across the Health Board area:

- Lunchtime learning events on Child Sexual exploitation and County Lines;
- Awareness stands at Morriston, Singleton and Princess of Wales Hospitals;
- Western Bay Safeguarding Board Learning Event;
- Launch of Safeguarding Web-clip via Mobilisation Team.

The Team supported 'White Ribbon' Day, annual International event on 25th November, by holding a two bake sales, one in Port Talbot and one in Morriston in order raise awareness for the White Ribbon campaign. This is a global movement to end male violence against women and girls. The sales raised a combined total of over £180 which will be used to contribute to the White Ribbon campaign and to provide key Health Board areas with resources to support potential victims.

4.7 PRISONS

4.7.1 HMP Swansea

A recent inspection of HMP Swansea identified a need to improve health involvement particularly in relation to suicide prevention and governance reporting. Primary Care & Community Services SDU is currently considering this report and the Corporate Safeguarding Team will be contributing with regards to safeguarding issues.

A pilot comprised of hands-on activities and provision of public health information, has been delivered by Health Visitors and Health Visiting Nursery Nurses within Swansea Prison in partnership with Prison Advice and Care Trust (PACT). There is significant evidence that children with adverse childhood experiences (ACE's) will be likely to experience poorer long-term health, social and educational outcomes and place greater demand on public sector services (PHW 2016). A parent in prison is one such ACE and for many of these children they will experience other ACE's. It is estimated that in England

and Wales 200,000 children have a parent in prison and the impact upon them of parental imprisonment is significant.The contact with prisoners will have opportunities to discuss relevant parenting and public health issues. This pilot commenced in January 2018 for six months and we are awaiting the evaluation.

4.7.2 HMP Parc, Bridgend

A member of the Corporate Safeguarding Team attends the Child Protection & Safeguarding Committee at Parc Prison, whereby safeguarding advice has been offered in relation to governance and training including self-harm, reported injuries and professional abuse.

The Corporate Safeguarding Team will continue to monitor safeguarding activity across the Health Board and produce a bi annual report for the Quality & Safety Committee.

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