MAIN REPORT	SBU University Health Board
Safeguarding Committee	**Date: 15th October 2019**

Subject	**Quarters 1 & 2 Corporate Safeguarding Report: April 1st – 30th September 2019**
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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 1st April and the 30th September 2019. This report is aligned 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, Domestic Abuse and Sexual Violence, Exploitation, Modern Slavery and Deprivation of Liberty Safeguards. The Team is managed by the Head of Nursing: Safeguarding (Named Nurse) who directly reports to the Assistant Director of Nursing & Patient Experience.

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 strands 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 Safeguarding Network to the Chief Nursing Officer in Welsh Government. The aim of capturing and collating a national SMM is to provide assurance, share practice and drive improvements towards a ‘Once for Wales’ consistent approach to safeguarding across Wales.

The Health Board submitted this year's SMM Improvement Plan on the 29th August 2019.

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 will result in breaches of legislation;
- Mandatory Safeguarding training;
- Compliance with the Social Services and Well-being Act (Wales) 2014 enquiry timescales.

The risk of DoLS breaches is also included in the Health Board Corporate Risk Register. All Service Delivery Units' Performance Reports to the Safeguarding Committee include their Units' Safeguarding Risks.

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 West Glamorgan 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 - 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:

- Adverse Childhood Experiences (ACE) Project
- Introduction of Serious Incident Learning Events
- The Truth Project (Independent Enquiry into Child Sexual Abuse)

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 at present although this is due to change imminently in line with the Wales Safeguarding Procedures which are to be launched during National Safeguarding week in November.

2.1.1 Children

Referrals made in respect of suspected child abuse/neglect are sent to the relevant Local Authority Children Services and it is the responsibility of the Local Authority to investigate. However, Health Board employees will be engaged through making the referral, attending strategy meetings and case conferences as well as contributing and actioning any child protection plans.

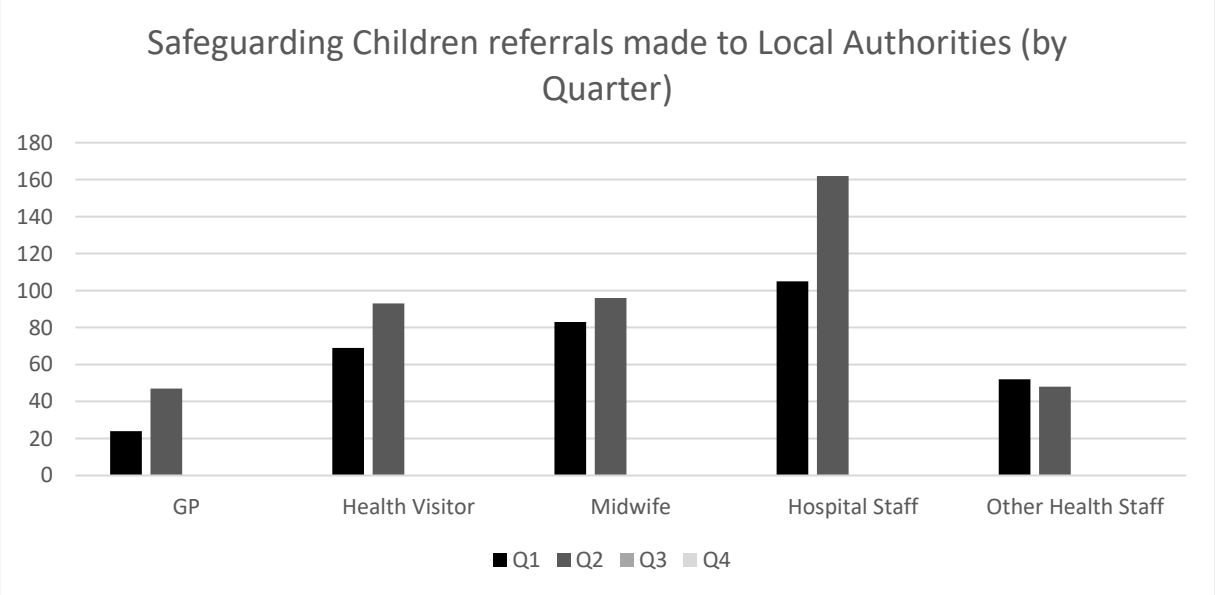
2.1.2 Adults at Risk

Adult safeguarding concerns are currently managed differently to Children safeguarding concerns, as the Health Board address, under agreed Wales Multi-Agency 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 places a greater duty on Local Authorities to make the necessary enquiries and identify any actions required to safeguard adults at risk. The Wales Safeguarding Procedures are due to be launched during National Safeguarding Week 11th – 15th September 2019. The Health Board is reviewing its processes in line with the new procedures, with implementation within the Mental Health & Learning Disabilities Service Delivery Unit of referrals being submitted directly to the Local Authority area where the alleged abuse has taken place (for out-of-area cases only at present). This will be extended to Swansea & Neath Port Talbot for all Service Delivery Units by April 2020, with the introduction of an Integrated Referral Form and associated Guidance for all regional referrals.

2.1.3 Safeguarding Children Referrals

Requests for data in respect to Safeguarding Children referrals for this reporting period were made to Swansea and Neath/Port Talbot Local Authorities. The table below demonstrates the number of referrals made by different staff groups.

Table i



The Corporate Safeguarding Team, with the assistance of the Extended Safeguarding Team, plan to develop in-house data collection systems to ensure more robust data analysis in respect to Safeguarding Children referrals following the implementation of the regional Integrated Referral/Reporting Form.

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 a key identified theme. It is noted that there is a marked increase during Q2; this can be attributed to an increased number of referrals that were submitted for 'low level' incidents.

Table ii: Adult Cases Managed by the Health Board

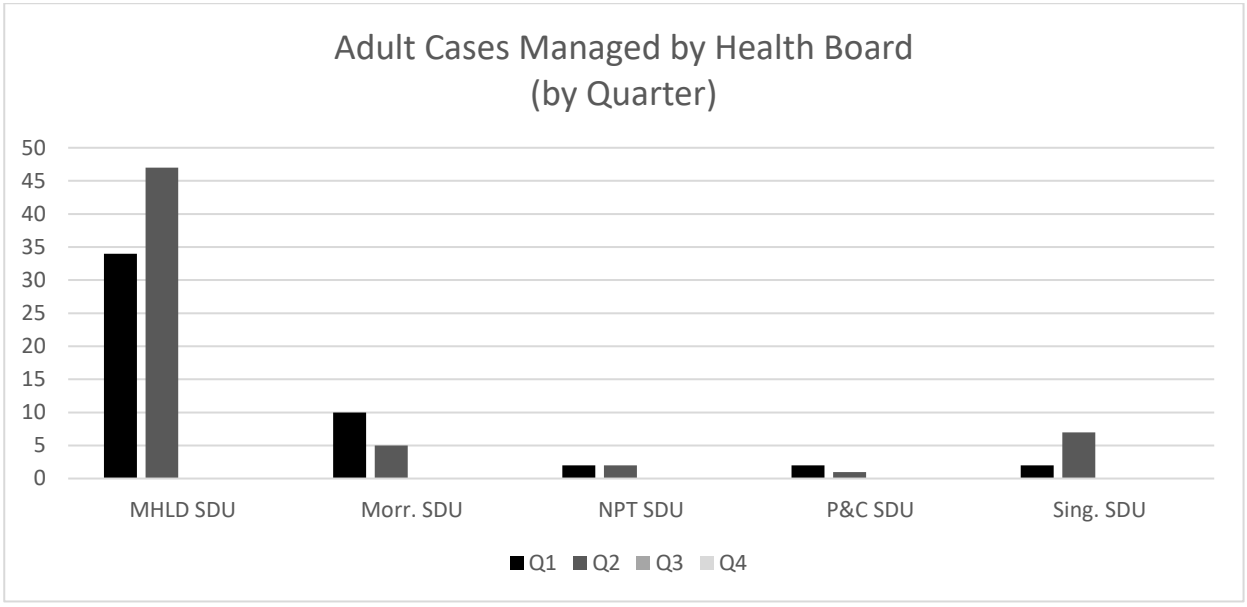
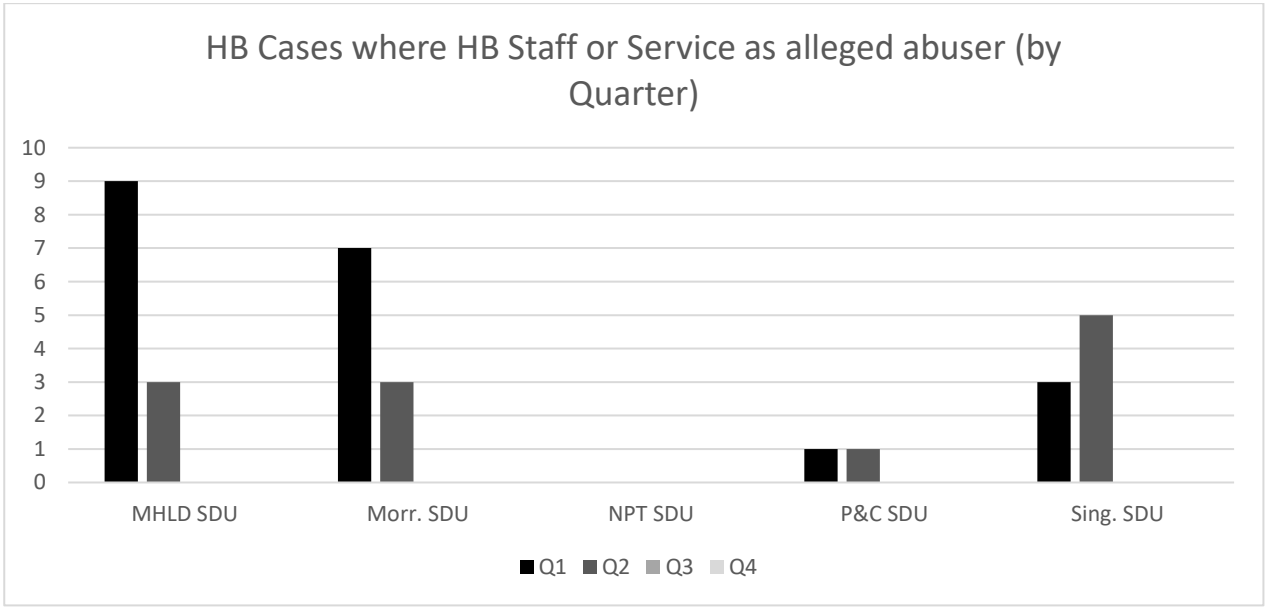
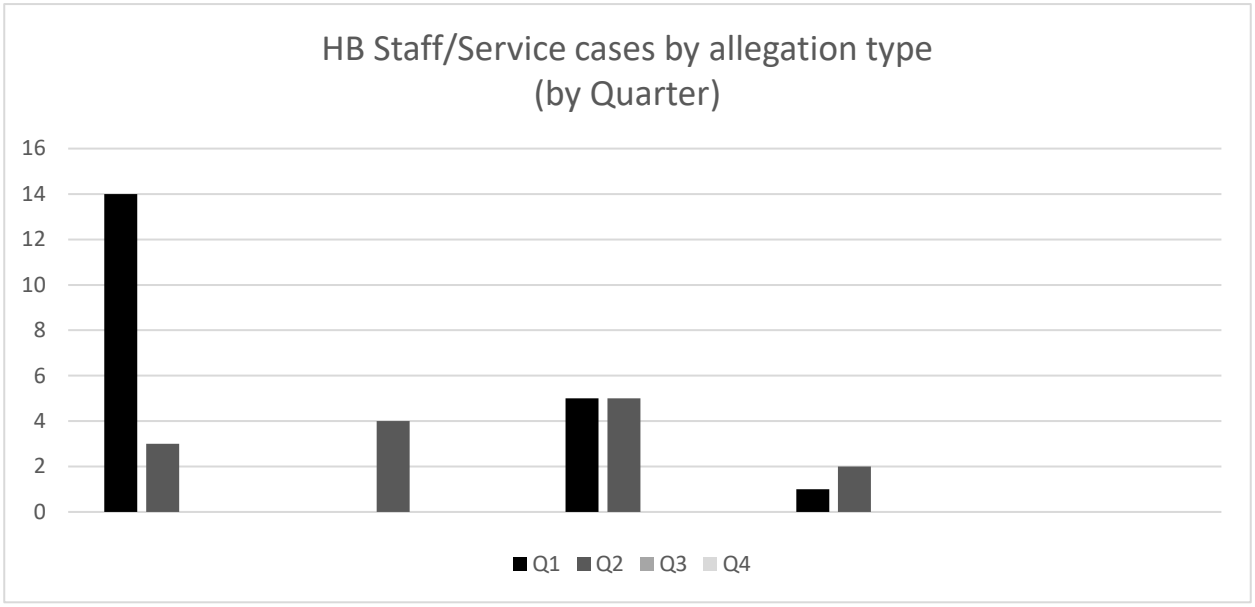


Table iii: Health Board Cases where Health Board Staff or Service as Alleged Abuser



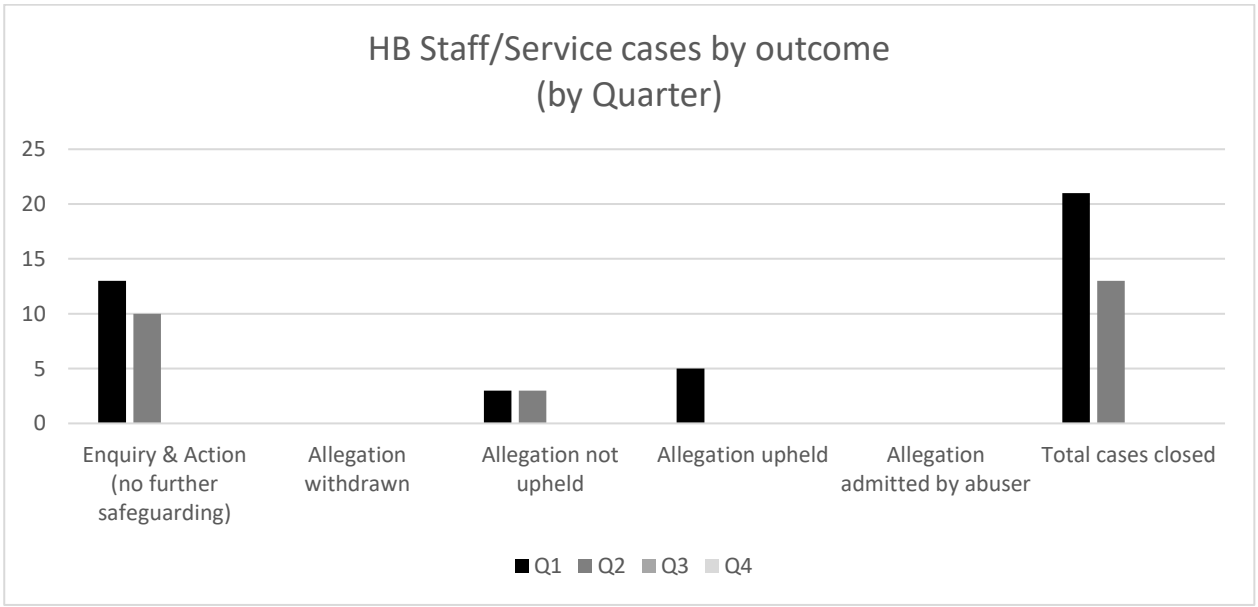
Overall there has been a marked decrease in the number of referrals received during Quarter 2 reporting period where Health Board staff or a Health Board service are alleged to have been responsible for the abuse of an adult.

Table iv: Health Board Cases by Allegation Type



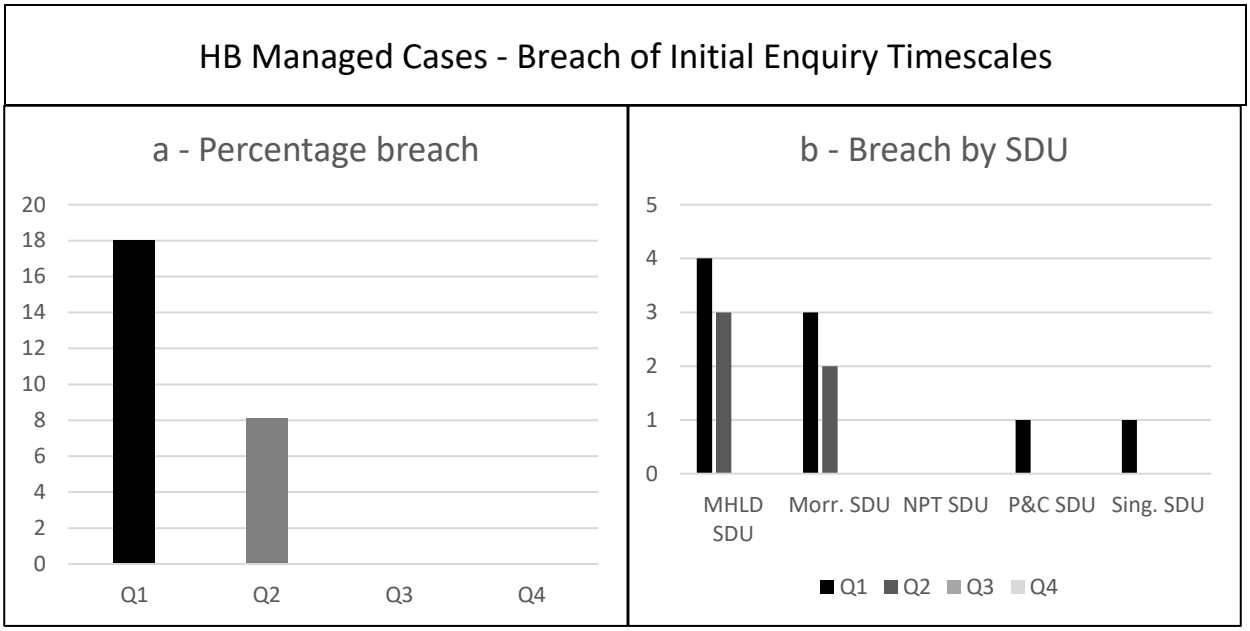
Previously, neglect by a Health Board service was the predominant category of abuse but during Q2 there was a significant decrease. It is interesting to note a rise in reported emotional abuse, as recent Level 3 training has highlighted that this is an often under-reported category of abuse that may often happen alongside other forms 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 Adult Protection Process following completion of the initial enquiry as shown above, this is a consistent trend from previous reports. Concerns arising from cases that are not formally managed through Adult Protection are addressed via other processes such as 'Putting Things Right' or incident management.

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



It is a legal requirement of the Social Services and Well-being Act (2014) that initial enquiries into Adult at Risk referrals are completed within seven days. This timescale was exceeded in 8.1% of cases over the last 3 months, a decrease in comparison to the previous quarter. Breaches were made in 4 out of 5 SDUs (Table vi). Breaches are monitored by the Safeguarding Committee with Units required provide explanation why a breach occurred and identify action to prevent future occurrence. This will be imperative on implementation of the Wales Safeguarding Procedures, as Local Authorities are required to submit monitoring forms to Welsh Government and will need justification from the Health Board regarding any delays.

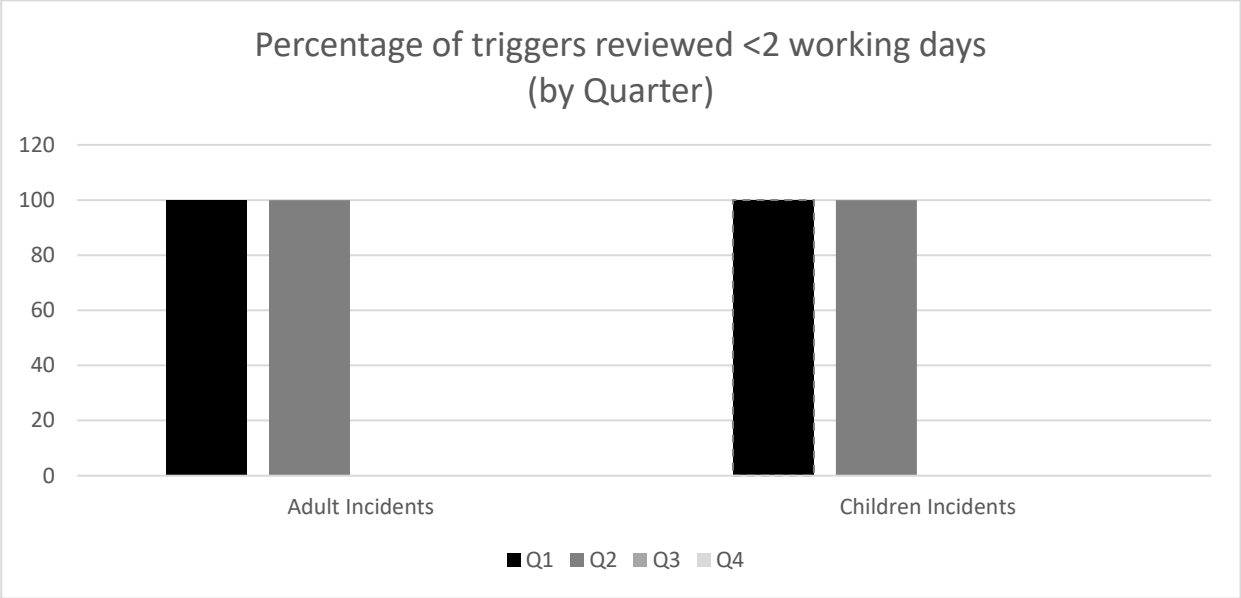
2.2 INCIDENT REPORTING

2.2.1 DATIX Safeguarding Trigger Alerts

The Corporate Safeguarding Team monitors safeguarding alerts triggered via the Health Board 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 and review 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 two working days of an alert and coded according to themes.

Table vii: Percentage of Triggers reviewed < 2 working days



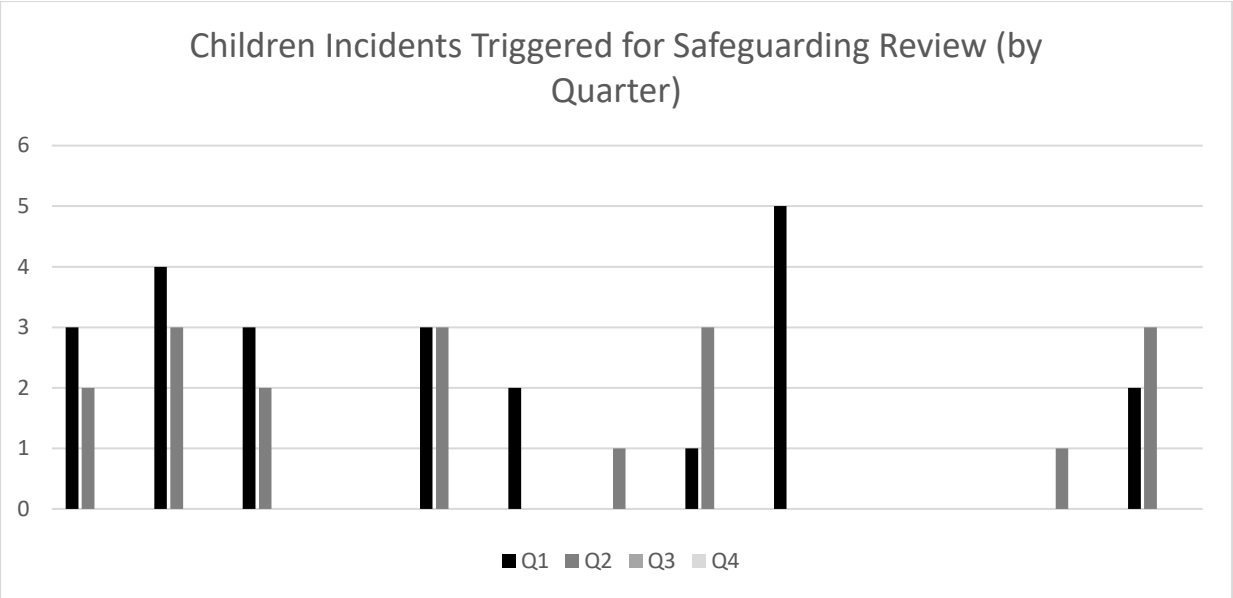
It is relevant to note that the Children safeguarding incidents displayed in Table viii are DATIX reported Health Board incidents, and not reflective of the overall children referrals made by Health Board staff, as such referrals do not necessarily require a DATIX report. The categories for a trigger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

2.2.2 Children

Table viii: Children Incidents for Safeguarding Review

Incidents appropriate to trigger for review	21	18
Incidents not appropriate to trigger for review	13	7

Table viii: Children Incident themes triggered for Safeguarding review



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

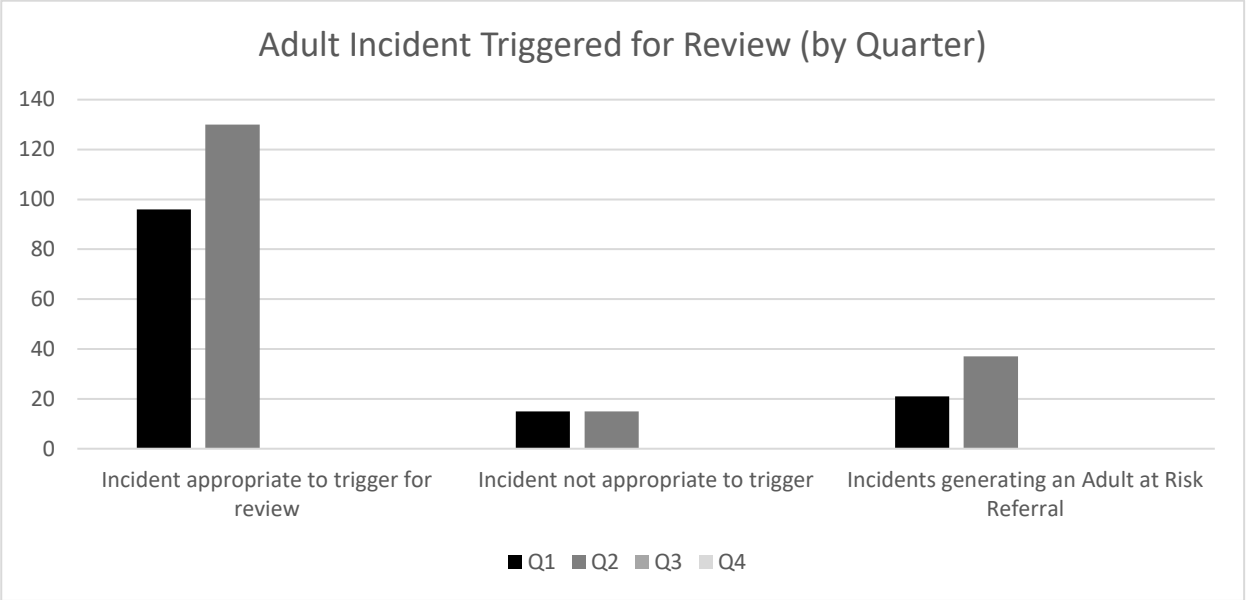
In Q1 there was a drop in reported incidents as expected following the Health Boards boundary changes, but with an increase in incidents relating to a lack of service provision, directly linked to children with identified mental health needs being nursed upon a paediatric ward awaiting an appropriate placement.

During Q2 reporting levels remain fairly consistent. All incidents are reported through the Safeguarding Committee to ensure learning is shared.

2.2.3 Adults

Safeguarding Adult incident guidance is contained within the DATIX incident reporting module and is discussed at Health Designated Lead Manager/Lead Practitioner (DLM/LP) meetings and Safeguarding Adult Level 3 training sessions.

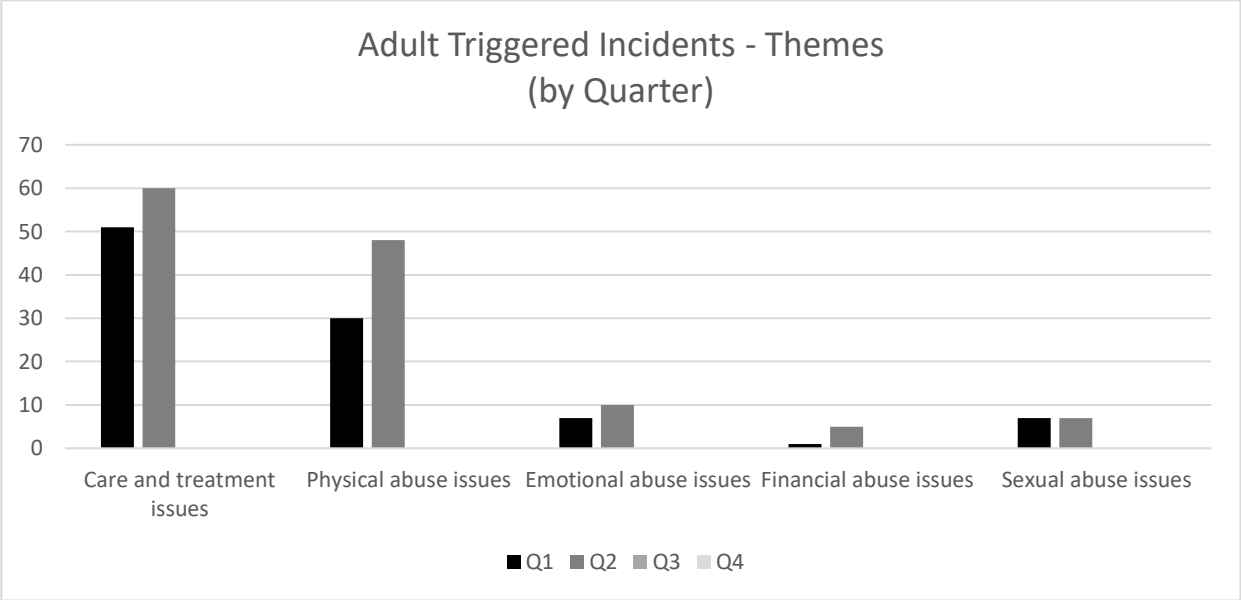
Table x : Adult Incident Triggered for Review



As with Children's incidents there was an expected drop during Q1 following the Health Boards boundary changes. Common themes for inappropriately triggering incidents during this reporting period were similar to previous reports e.g. staff victims following an incident, medication errors and moisture lesions. Feedback is given to the reporter via the Datix incident reporter to advise them why the incident was not appropriate to trigger a Safeguarding review.

During Q2, the proportion of reviewed incidents that also generated an adult at risk referral doubled; when analysed this can be contributed to a higher mumber of 'low-level' patient to patient incidents. Training is being planned in conjunction with the MHLD SDU to address appropriate/inappropriate referrals.

Table xi: Adult Incidents for Safeguarding Review - Themes



NB Some triggered incidents have more than one category

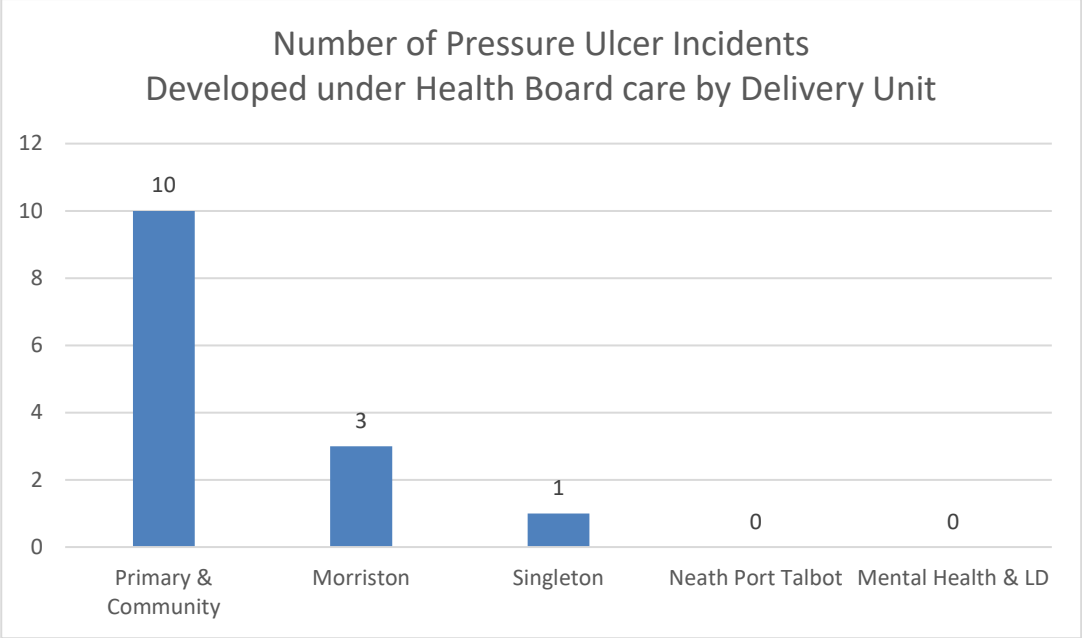
Care and treatment issues have a number of 'sub-themes'. The most prominent sub-theme continues to be the reporting of reporting pressure ulcer development (n31). This trend is consistent with previous reports.

2.2.4 Pressure Ulcer Incidents

The Health Board's Policy for the Prevention and Management of Pressure Ulcers requires that all instances of Grade 3, Grade 4 or Ungradable pressure ulcers that develop when the patient is under Health Board care are forwarded by the incident approver to the Safeguarding Team for review. Approvers may also forward for review other pressure ulcer incidents where there is a reasonable suspicion that neglect may have contributed to the ulcer development, or if evidence suggests that there is a trend or pattern of pressure ulcer development in a clinical area.

During Q1 it was not possible to gain accurate data as the method of pressure incident trigger at that time did not differentiate between those incidents that were avoidable/unavoidable. The DATIX pressure incident trigger has since been revised to set up email notifications for incidents that have been updated to state that they are Avoidable Pressure Ulcers that will automatically notify the Safeguarding Team. The Safeguarding Team are also triggered first notifications of Grade 3, 4 and unstageable pressure ulcers developed under Health Board Care, and all Grades that developed outside Health Board Care. This will allow future monitoring of trends and themes within the Health Board, and also of any external patterns relating to care homes that may result in an 'Escalating Concerns' process.

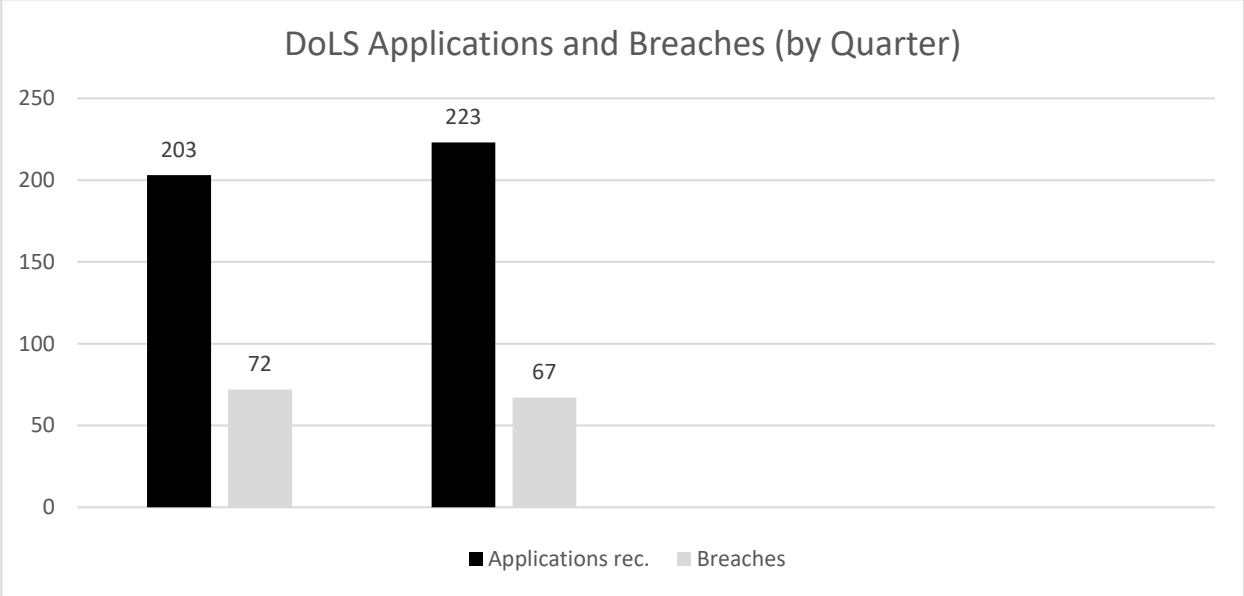
Total Number of Pressure Ulcer First Notifications	51
Number that developed Outside Health Board care	37
Number that developed Under Health Board care	14



2.3 DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)

The Health Board continues to experience a high volume of DoLS applications, with an increase in Q2. The management of these remains a significant issue for the Health Board with a risk of breaches and consequential risk of financial loss. This risk is identified within the Corporate Risk Register. There is now a dedicated DoLS team within the Primary Care and Community SDU managed by the Long Term Care team.

Table xiii: DoLS Applications and Breaches



2.3.1 DoLS Breaches

The Corporate Safeguarding Team has been supporting the Supervisory Body (Primary Care and Community Services Delivery Unit) to implement the DoLS Improvement Plan that resulted from the DoLS Internal Audit in 2018. The Internal Audit was repeated in August 2019, and found an improved level of assurance. DoLS breaches can be accurately monitored via the DoLS Dashboard that is held by Primary Care and Community Service Delivery Unit. Work is in progress to revise the current DATIX SOP for DoLS breaches to reflect only those that cause harm, in order to reduce duplication of reporting. It is noted that in Q2 there was a reduction in the number of breaches despite the increased number of applications.

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, and is chaired by the Unit Nurse Director of Primary Care and Communiity Service Delivery Unit. A support group has also been established for Health Board BIAs to meet quarterly, with an intention to liaise with Local Authority partners to promote more joint training and support sessions.

2.3.3 Multi-Agency Working

The Corporate Safeguarding Team engages with the multi-agency DoLS sub-group commissioned by the West Glamorgan Safeguarding Board (WGSB) which 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 WGSB Policy, Procedure and Practice Management Group which reports directly to the WGSB meetings.

2.3.4 Audit

The DoLS Internal Audit review undertaken by NHS Wales Shared Services Partnership (NSSP) in 2018 gave a *limited* level of assurance. To address this there is ongoing collaborative working between the Supervisory Body and the Corporate Safeguarding Team on the improvement plan and updates are reported regularly to the Audit Committee. A follow up Audit took place in July 2019, and identified that the majority of actions contained within the DoLS Improvement Plan were completed, allowing the risk rating to improve from 'Limited Assurance' to 'Reasonable Assurance'.

2.3.5 Deprivation of Liberty Safeguards Improvement Plan

The DoLS Improvement Plan was reviewed by the DoLS Internal Audit in August 2019. Following recommendations, the plan is in the process of being reviewed.

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.

Table xiv highlights the number of new professional abuse/concerns referred to the Health Board during the reporting period.

Themes of abuse during Q2:

- Domestic Abuse
- Physical Abuse
- Emotional Abuse

Table xiv: Professional Abuse and Concerns Cases

Reporting Period New cases	Professional Abuse (Children)	Professional Concerns (Adult)	Total
March – June 2019	**3**	**7**	**10**
July – September 2019	**1**	**6**	**7**

Monitoring of progress of professional abuse/concern cases is undertaken by the Safeguarding Committee via updates provided by the Service Delivery Units. This information is used 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)

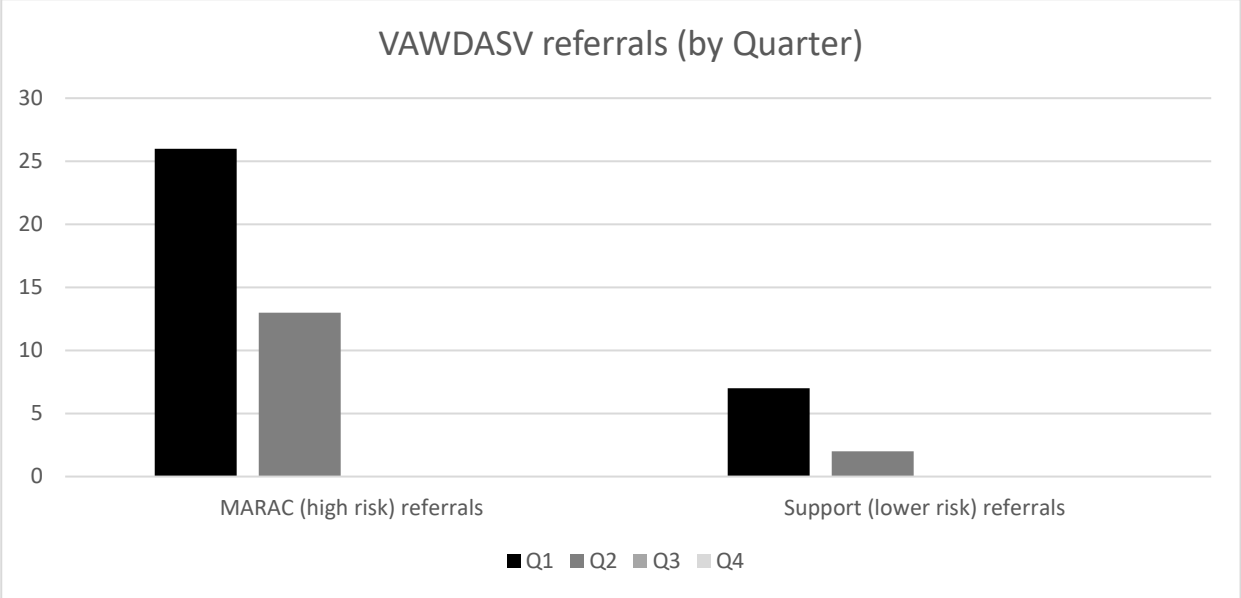
The Violence against Women Domestic Abuse and Sexual Violence (VAWDASV) (Wales) Act 2015 sets out statutory requirements for NHS bodies and other relevant authorities; one of the key mechanisms for delivering the Act is the National Training Framework (NTF). Group 2 training in Quarter 1 reached it's forcasted delivery as outlined in the Health Board's Five Year Ask & Act training plan. Group 3 'Champion training' commenced in September 2019.

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

MARAC is held on a fortnightly basis in each of the two Localities of Neath/ Port Talbot and Swansea. A Health Board member attends each MARAC. The Corporate Safeguarding Team plans on working with Health Board Safeguarding Leads to create a rota that will ensure that health attendance will be representative of the whole Health Board.

Regrettably due to departmental pressures ED, Morriston Hospital were unable to provide numbers of MARAC referrals for Quarter 2 in order for this data to be included in the below graph.

Table xv: VAWDASV Referrals (excluding referrals from ED, Morriston Quarter 2)



2.5.2 Identification and Referral to Improve Safety Interventions (IRISi)

IRIS is a general practice-based domestic violence and abuse (DVA) training support and referral programme. IRISi 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.

SBU Health Board has been pledged £50,000 funding to implement the project from the South Wales Police and Crime Commissioners Office. The funding will allow a Pilot of the IRISi project to commence within 10 GP practices for approximately one year. The pilot 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 IRISi project.

2.6 FEMALE GENITAL MUTILATION (FGM)

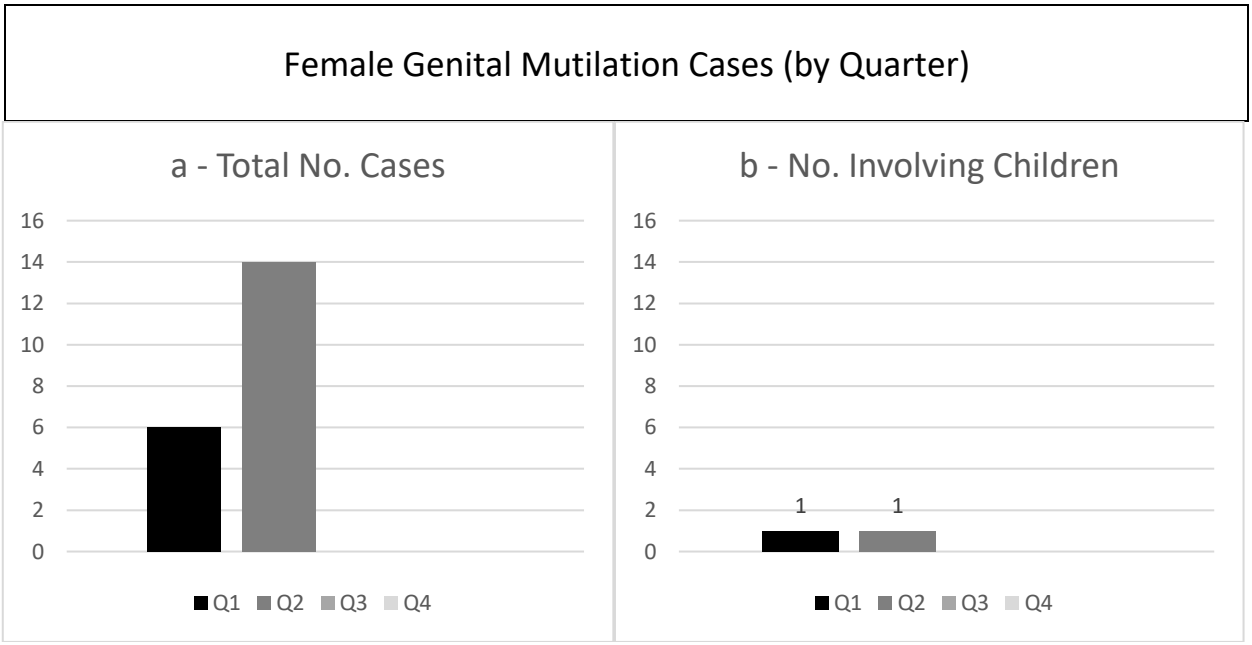
Female Genital Mutilation (FGM) is illegal in the UK under the Female Genital Mutilation Act 2003 and the Serious Crime Act 2015. It is mandatory for NHS staff to report all cases of FGM in children to the Police and Social Services. The All Wales Clinical Pathway gives staff guidance and has been incorporated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

ABMU Health Board's Corporate Safeguarding Team reports any cases of FGM in both women and children to Welsh Government (WG) via Public Health Wales (PHW) on a quarterly basis. Health Board 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 Corporate Safeguarding Team has worked with the Datix Team to update the FGM Data Collection Tool and the updated version has been used by staff since July 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 two reported cases involving a child, the disclosures have been reported to Local Authority Children Services and the Police as required. There have been 20 FGM disclosures to Health Board staff in Quarters 1 & 2, all of which will be reported to Welsh Government.

Table xvi: 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. West Glamorgan Safeguarding Board has a multi-agency CSE strategy and action plan to which SBU Health Board is committed, 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. Only two out of the five identified priority areas using the tool have been able to provide data in respect to the use of the CSERQ 15 during this quarterly reporting periods. Therefore full analysis of its use and referral rate has not been possible.

From the information provided, it appears that Intergrated Sexual Health staff continue to complete the most CSERQ 15, completing 306 in this reporting period, which resulted in 9 referrals to Local Authority Children's Services.

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 and the recommendations were presented to the Safeguarding Committee.

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 Health Board 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 was held with Sue James, Head of the Inquiry Office, Wales on the 15th of April 2019 to discuss how the Truth Project can be supported further by the Heath Board. Sue James also attended the Health Board's Safeguarding Committee on the 30th of July 2019 and provided 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 Corporate 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 West Glamorgan Safeguarding Board.

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3.1.1 Learning points and recommendations from published Reviews

The Corporate Safeguarding Team continues to monitor and review the learning points from published Child and Adult Practice Reviews. This is to ensure that actions attributed to health are completed in accordance with the findings from reviews. The Corporate Safeguarding Team disseminates the learning points and associated actions to the relevant Service Delivery Units so that they can in turn provide assurances that processes are in place to ensure that any recommendations for health are reflected in current practice; this will be reported to Safeguarding Committee in October 2019.

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 Authority area 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 Health Board are involved in seven Domestic Homicide Reviews which are ongoing and their progress is outlined below.

Table xvii: Domestic Homicide Reviews, Quarters 1&2

Ongoing (total)	Gathering Information (review stage)	Nearing completion (draft report stage)	With Home Office (pre publication)
7	4		3

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.

There have been no published DHR's within this reporting period; three reports are with the Home Office Quality Assurance Panel.

3.2 PROCEDURAL RESPONSE TO UNEXPECTED DEATH IN CHILDHOOD (PRUDiC)

During this reporting period there have been two unexpected child deaths. PRUDIC meetings were convened and chaired by South Wales Police, the deaths are 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 15 year old was found hanged. There were no suspicious circumstances and no one else is believed to be involved.

- A two month old baby was was found unresponsive by parents in bed whilst on holiday abroad. CPR was commenced and the baby was transferred to hospital where was sadly pronounced deceased.

3.2.1 Themes

There has been no theme identified during the reporting period.

3.3 SAFEGUARDING TRAINING AND SUPERVISION

3.3.1 Level 1 & 2 Safeguarding Adult and Children Training

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

Table xviii: Safeguarding Adults Level 1 training percentage compliance

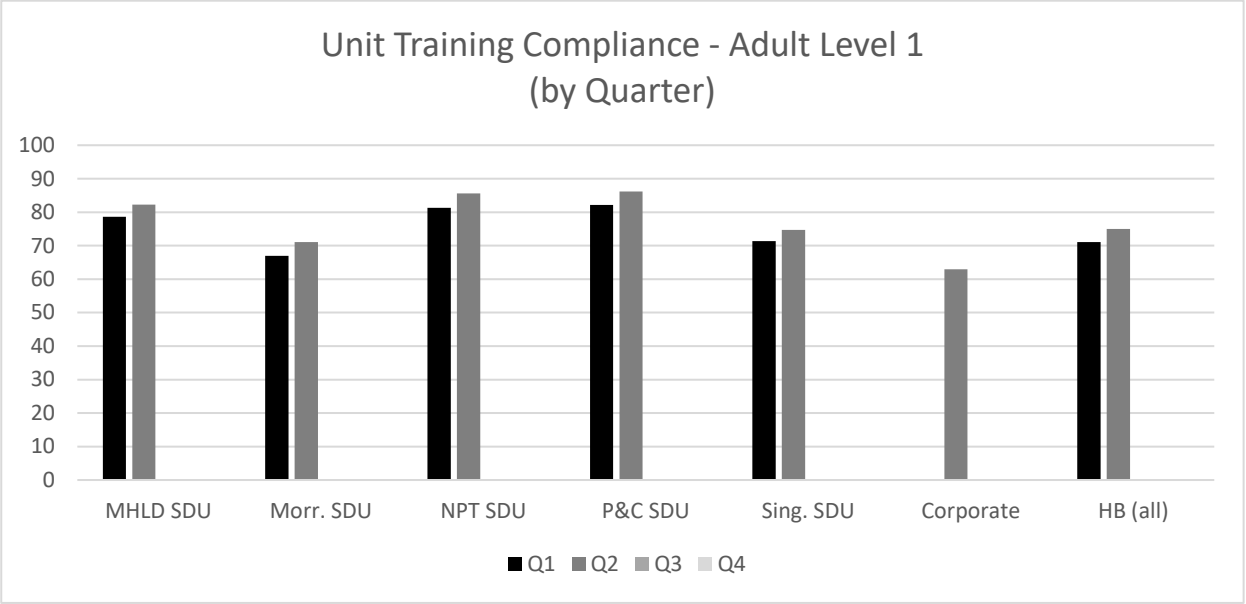
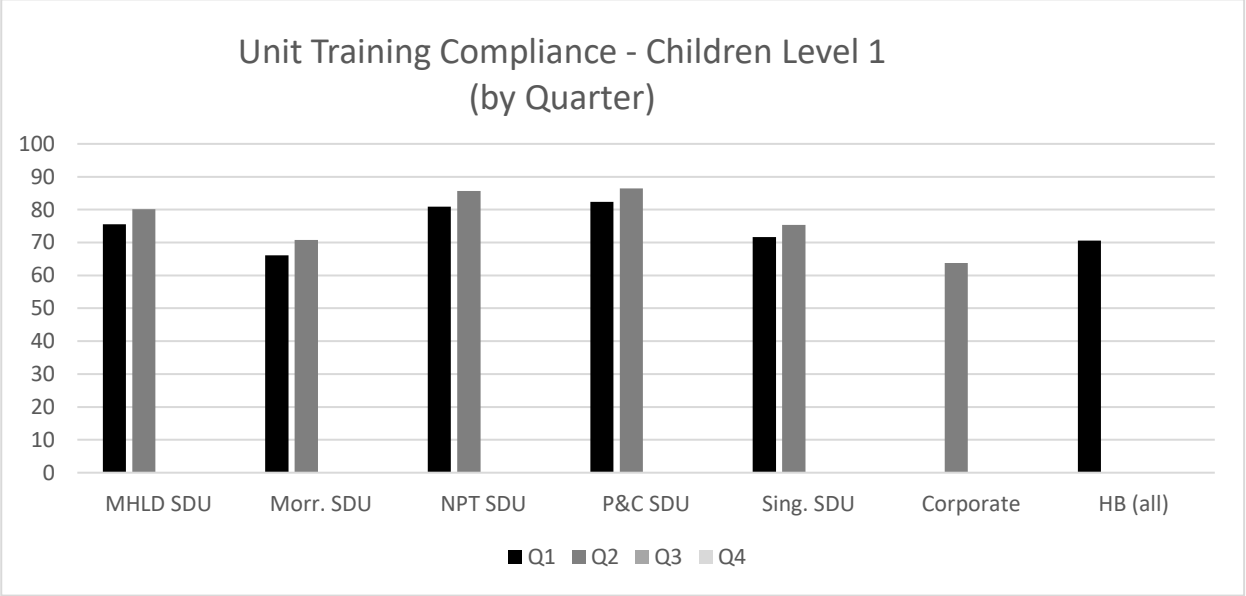


Table xix: Safeguarding Children Level 1 training percentage compliance



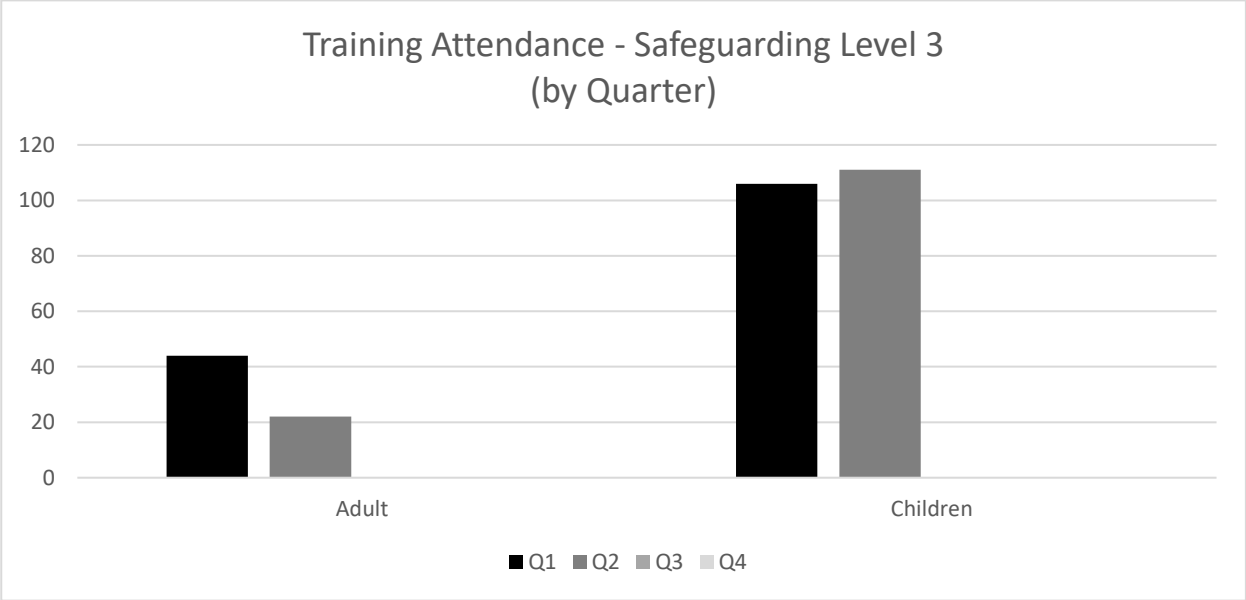
It was highlighted in the previous report that all SDUs maintained their compliance around the Health Board total average compliance. This has continued to be the case throughout Q1 and Q2 also, as evidenced in Tables xv and xvi above.

3.3.2 Level 3 Safeguarding Training

Level 3 Safeguarding Children training continues to be delivered by the Corporate Safeguarding Team across the Health Board area and 8 training sessions were delivered during the reporting period.

The Level 3 Safeguarding Adult training delivered by the Corporate Safeguarding Team has a different target group to that of Level 3 Safeguarding Children training. Currently 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 three sessions of Safeguarding Adult Level 3 training was delivered.

Table xx: Training Attendance - Safeguarding Level 3



There was an increase in attendance rates for both Level 3 Safeguarding Children and Adult training across Q1. During Q2 there was a decrease in attendance for Safeguarding Adult Level 3 training.The number of training sessions delivered by the Safeguarding Team has remained constant for Level 3 Safeguarding Children in Q1 and Q2.

3.3.3 FGM Training

FGM training and updates continue to be delivered to staff in priority areas: Paediatrics; Neonatal; Midwifery; Gynaecology; Health Visiting; Integrated Sexual Health and GP surgeries within their Service Delivery Units. FGM is included on the Level 3 Safeguarding Children training, as well as Ask and Act Group 2. Both raise awareness of the data reporting tool and the updated All Wales Clinical pathway (FGM) ensuring Health Board staff are aware of their roles and responsibilities in relation to FGM.

3.3.4 CSE Training

Identified priority areas (Midwifery, School Health Nurses, Paediatrics and Integrated Sexual Health Services) continue to receive CSE training and updates within their Service Delivery Units. In addition West Glamorgan Safeguarding Board has developed multi-agency Exploitation Training which will include CSE training for key professionals. Train the Trainer sessions have been delivered regionally and the Health Board has been

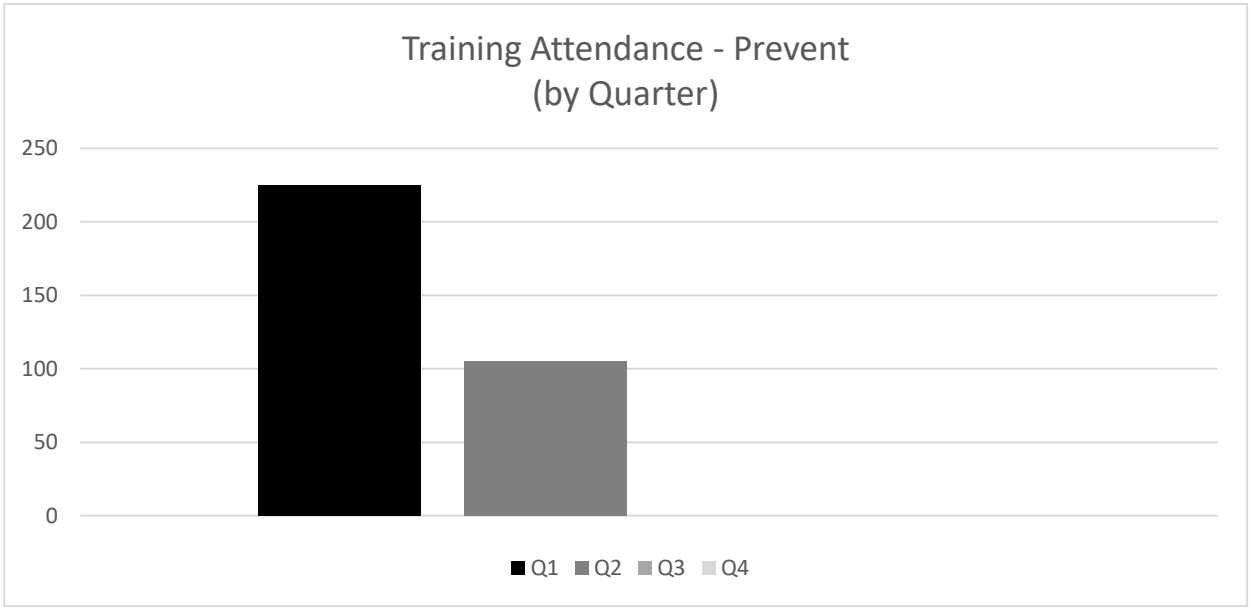
represented at these events. All Health Board staff working in identified key areas will be able to access the multi-agency Exploitation Training day, with roll out expected to commence in November 2019. In addition to this, the same Exploitation Training Day will be rolled out within the Health Board itself for all staff to attend from November 2019, this will be Level 3 Safeguarding Child and Adult training. Currently, Level 3 Safeguarding Children's training includes CSE ensuring that all staff who attend have an awareness of CSE, alongside the in-depth training received by staff in priority areas.

3.3.5 Prevent Training

Whilst the Home Office continue to review their WRAP training package, the All Wales Health Prevent Forum are currently developing an alternative training package to reflect current trends in relation to the ongoing global threats and forms of radicalisation. Whilst this development is ongoing the Corporate Safeguarding Team, supported by a small number of Unit trainers, continue 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 xviii demonstrates that attendance continued to increase during the Q1 of 2019/20. Q2 shows a drop in attendance, however it is important to note that this period reflects a time when fewer sessions were delivered. 320 staff accessed Prevent training during Q1 and Q2, bringing the overall total number of staff who have received awareness training to approximately 4,350.

Table xxi: Training Attendance – Prevent

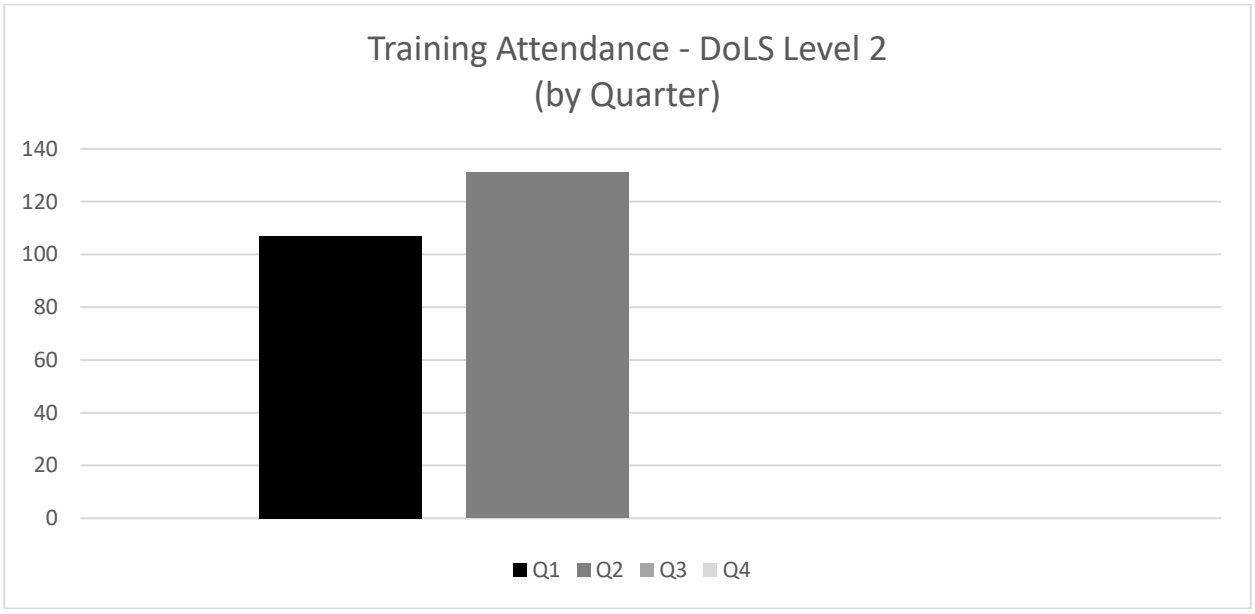


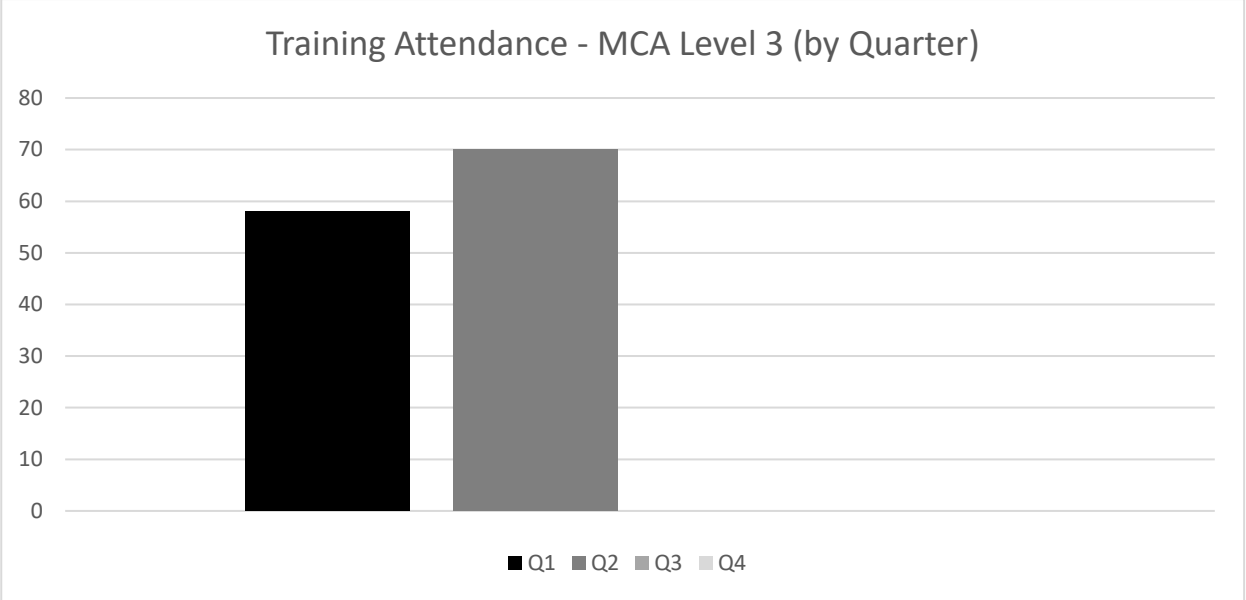
3.3.6 Deprivation of Liberty Safeguards (Level 2) and MCA Level 3 Training

Deprivation of Liberty Safeguards (DoLS) Training is arranged by the Corporate Safeguarding Team and delivered by Swansea University (under the Education Contract) to Health Board staff and informs staff of the requirements for making an application for Deprivation of Liberty and the process for making such applications.

MCA Level 3 is a workshop-based session, again delivered by Swansea University, 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. Table xix outlines activity for this training during the reporting period. During Q2 there was an increase in attendance at both DoLs level 2 and MCA level 3 training.

Table xxii: Training Attendance MCA & DoLS

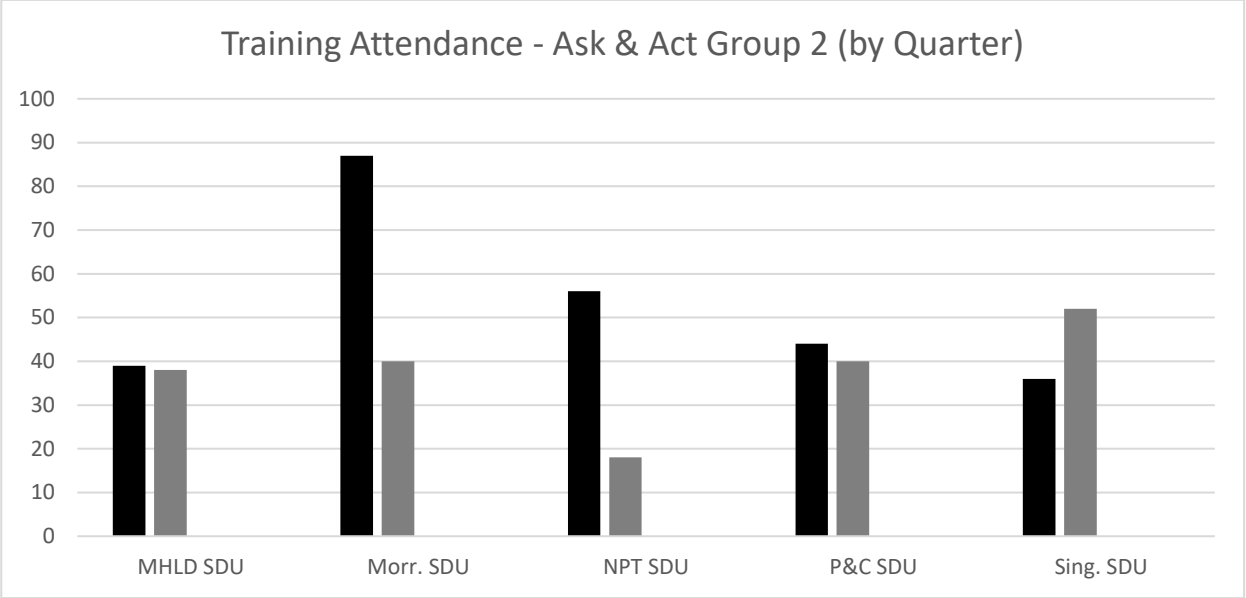




3.3.8 "Ask and Act" Group 2 Training

"Ask and Act" Group 2 training has continued throughout the Health Board. There continues to be difficulties in releasing trainers to facilitate training from some SDU's, and in these areas, the Corporate Safeguarding Team has provided sessions supported by Health Board "Ask and Act" trainers from other SDU's. Also in areas where it has been difficult to release staff to attend the training, the Corporate Safeguarding Team have delivered bespoke sessions during team meetings/training days to increase awareness across all SDU's. Further, staff from all SDU's have accessed training to become "Ask and Act" trainers. These staff will complete an Agored accredited workbook prior to commencing delivery, to ensure training is of a high standard. All SDUs continue to be 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. A total of 476 staff have accessed training across Q1 and Q2. Since "Ask and Act" training was introduced in 2016 a total of 2,535 staff have attended. A continued commitment from all SDUs to both release trainers and staff to attend training is required to support the Health Board to meet the requirements of the "Ask and Act" delivery plan.

Table xxiii: 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). ABMU 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 Health 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 safeguarding practitioners
- Designated Lead Manager (DLM) support groups for Adult safeguarding practitioners

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 Safeguarding Team has completed an audit of supervision arrangements within the Health Board to ensure these standards are being met, the findings of this and recommendations were reported to the Safeguarding Committee July 30th . In line with recommendations of the Health Inspectorate Wales Review of the KW case, the DLM support group has been amended

with a new Terms of Reference to reflect its role as a peer supervision and support group to mirror the Childrens group.

SECTION 4 MULTIAGENCY PARTNERSHIP WORKING

4.1 MULTI-AGENCY WORKING

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 Assistant Director of Nursing & Patient Experience both attend the West Glamorgan Safeguarding Board. There are a number of sub-groups associated with this Board to which members of the Health Board and Corporate Safeguarding Team actively contribute. 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 contribution to consultations and the update of the Wales Protection Procedures

The Health B oard have also contributed to the West Glamorgan Safeguarding Board Section 135 audit.

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, Training and Looked after Children (LAC). ABMU Health Board provides representation at all of sub groups. The Network meets quarterly and is chaired by one of the Designated Doctors in Public Health Wales. The Head of Nursing - Safeguarding attends this group.

4.3 PARTNERSHIP WORKING TO ADDRESS ‘CRIMINAL EXPLOITATION’

4.3.1 Human Trafficking/Modern Slavery

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 provided by external agencies is accessible to health staff. The West Glamorgan Safeguarding Board's multi-agency Exploitation Training also includes awareness of Modern Slavery and Human Trafficking and will be available to all Health Board Staff to attend. The Corporate Safeguarding Team remains committed to developing an extended Level 3 training session in 2019/20 under the 'umbrella' term of exploitation that considers all forms of exploitation and links common themes.

4.3.2 CHANNEL and Prevent

The Counter Terrorism and Security Act 2015 requires the Health Board to engage with partner agencies in reducing the risk and impact posed by potential terrorist threats and support individuals who may be at risk from engagement in terrorist acts. The Corporate Safeguarding Team continues to represent the Health Board as a partner agency on the Regional Contest Board (along with colleagues from Corporate Planning) where risks and impact are discussed and action agreed to mitigate. The Team also engages with the two 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). One referral by Health Board staff was made within Q2.

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'. Multi-agency work with ABMU Health Board participation will continue via partnership working with Western Bay Safeguarding Board. The main features of this has been incorporated into Safeguarding Training Level 3. In addition two Health Board 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, Her Majesty's Prison Service, Railway Services, Samaritans, Swansea University, NAG, Welsh Ambulance Service Trust, Police and service users.

Suicide has been a feature of both Adult and Child Practice Reviews within this region and the Health Board is considering mechanisms on how suicide and self-harm prevention can be driven locally. More recently a sub-regional Suicide and Self-Harm Prevention Group has been set up and the Health Board will be involved in this sub-group moving forward.

4.5 CHILD AND ADOLESCENT MENTAL HEALTH SERVICE (CAMHS)

The management of young people with self-harming behaviour who present at Emergency Departments (ED) and need additional support particularly regarding CAMHS remains a challenge for the Health Board. Many of these children have many behavioural issues but do not necessarily have a mental health diagnosis.

4.7 PRISON

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 iss 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 (ACEs) 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 ACEs. 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.

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

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SAFEGUARDING TEAM
SAFEGUARDING PEOPLE