MAIN REPORT		ABM University Health Board
Safeguarding Committee		**Date: 27 July 2018**
Subject	**Bi-annual Safeguarding Report: January – June 2018**	
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Presented by	Gareth Howells, Director of Nursing & Patient Experience	

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1. PURPOSE

The purpose of this report is to provide the Quality and Safety Committee with an overview of the work taken forward by the Safeguarding Committee and the Corporate Safeguarding Team between January 1st and June 30th 2018.

2. 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 at risk and children as well as concerns regarding violence against women, human slavery and Deprivation of Liberty Safeguards. The Team is managed by a Head of Nursing:Named Nurse Safeguarding who directly reports to the Interim Deputy Director of Nursing & Patient Experience.

3. MULTI-AGENCY WORKING

The benefits of multi-agency working within the safeguarding arena are immense. Information sharing is key to successful outcomes for both adults and children and has often found to be lacking by both practice and serious case reviews. The Head of 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;
- Working together within adult and child Practice Review processes as panel members, chair and reviewers. Participating in Learning Reviews and Extraordinary Board Meetings and with the facilitation of learning outcomes/recommendations;
- Developing a multi-agency strategy for child sexual exploitation and has jointly reviewed Joint Serious Case Review undertaken by Newcastle Safeguarding Board and will be part of proposed scoping exercise;
- Participation through Policy, Procedure and Practice (PPP) sub-group All Wales Protection Procedures Task and Finish Groups regarding domestic abuse;

- Multi-agency ‘Lunch & Learning’ sessions on Trafficking, CSE and Children’s Charter during Safeguarding week – November 2017;

- 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. NHS WALES SAFEGUARDING NETWORK (NWSN)

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

5. HEALTH AND CARE STANDARDS

The Corporate Safeguarding Strategic Work Plan is aligned with Health & 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.

These risks remain consistent from the last reporting period (July-December), however there have been some recognised improvements which are evident within this report. The risk of DoLS breaches has been added to the Health Board Corporate Risk Register. A Safeguarding Risk Register is currently being developed to capture any pertinent safeguarding risks to the organisation.

6. SAFEGUARDING COMMITTEE

The purpose of the Safeguarding Committee is to assist the Quality and Safety Committee to deliver its statutory and mandatory responsibilities in relation to the Safeguarding agenda. It also aims to ensure that the Health Board 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 Safeguarding Committee reflects multi-professional representation of individuals with safeguarding expertise and includes the Head of Nursing:Named Nurse Safeguarding and Safeguarding Leads from all the SDUs. These Leads are responsible for the operational delivery of the safeguarding requirements and priorities. The Committee is chaired by the Director of Nursing & Patient Experience who has executive lead responsibility for safeguarding. The Committee facilitates a presentation which includes safeguarding topics for learning and sharing. During the reporting period topics included:

- Co-Sleeping;
- Update on DoLS;
- Presentation of recently published Adult Practice Review.

7. 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.

7.1 Children

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

7.2 Adults at risk

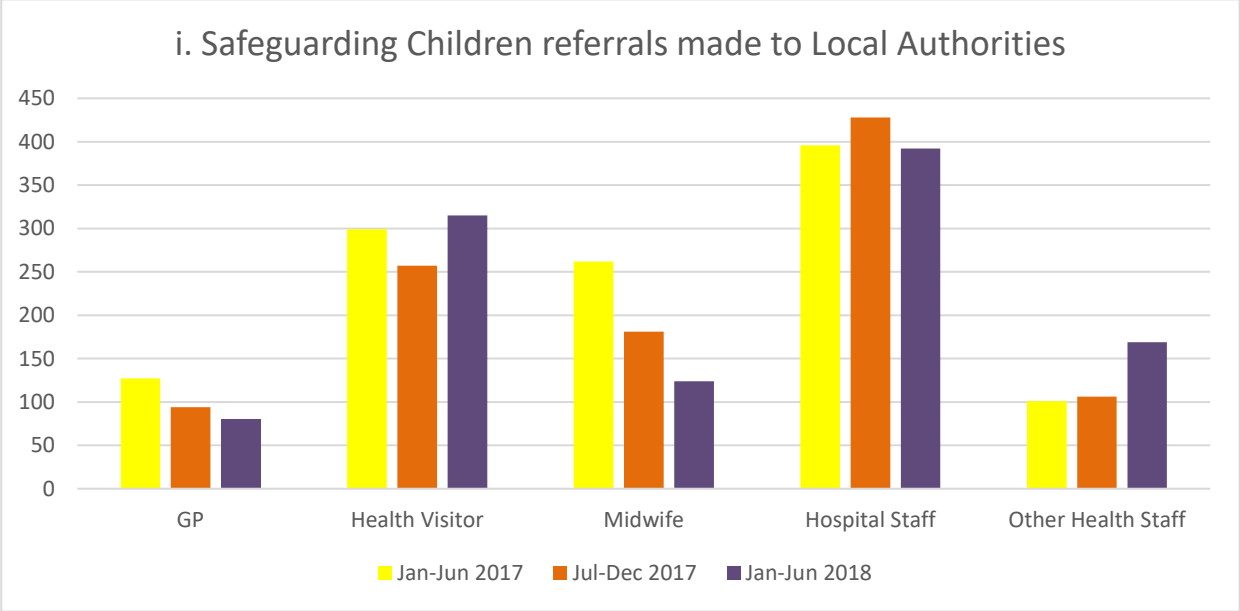
Safeguarding adult referrals are currently managed differently to children safeguarding referrals as the Health Board address adult at risk referrals regarding alleged abuse or neglect that occur within Health Board premises. The HB also manages any referrals

within the community where a health employee is allegedly responsible. At the present time all these referrals are collated by the Corporate Safeguarding Team. The Social Services & Well-Being (Wales) Act 2014 has placed a duty to on Local Authorities to make necessary enquiries and identify any actions required to safeguard adults at risk. Therefore the process by which the ABMU HB currently manages referrals is under review.

7.3 Safeguarding Children Referrals

In the reporting period a total of 1083 referrals or requests for information from Social Services were recorded. The referrals or requests for information submitted to the three Local Authorities (LAs) of Swansea, Neath/Port Talbot and Bridgend by ABMU Health Board staff during the reporting period are listed at Graph **i** and compared with the previous two reporting periods. The referrals are categorised according to the area/staff group which made the referral.

Graph i: Safeguarding Children referrals made to Local Authorities



As is reflected in the figures it would be expected that the staff groups making the highest number of referrals for children with safeguarding concerns would be Health Visitors, Midwives and GPs within the Community and Emergency Department staff within the hospital setting. It has been recognised that there has been a downward trend in enquires and referrals from Midwifery, the reason is unknown however the data collection system within Midwifery has been reviewed and future data should be more accurate as a result.

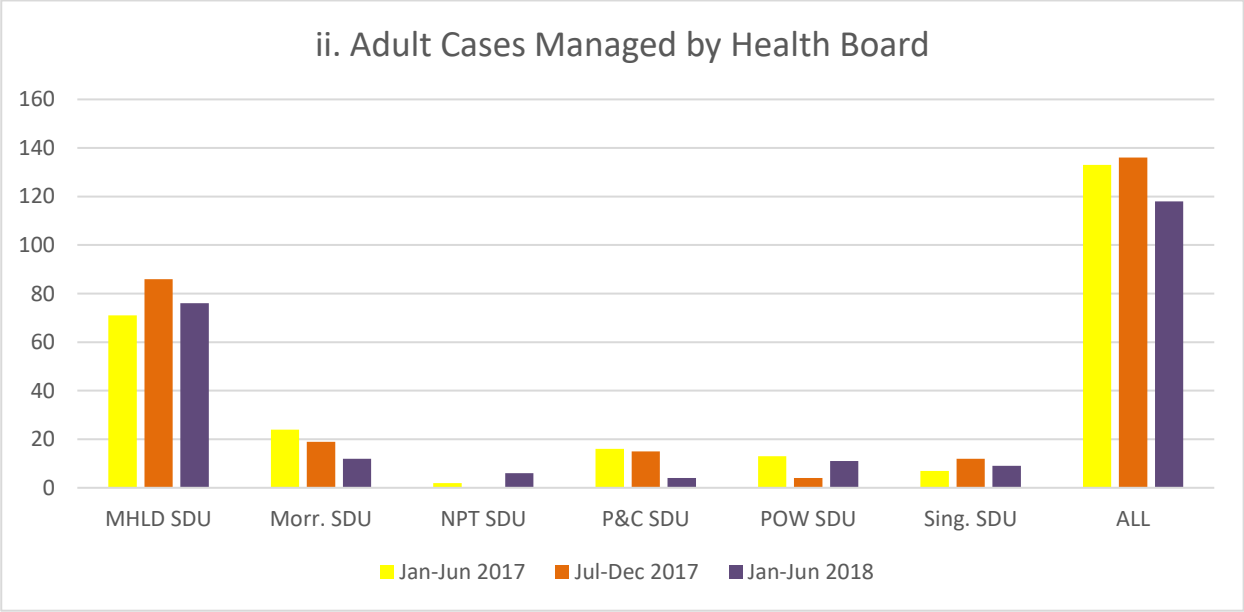
Currently the Corporate Safeguarding Team does not collate safeguarding children data. This data is obtained from each Local Authority – Bridgend, Neath/Port Talbot and Swansea for the purposes of the report. The data that is collected from the Local Authorities is limited and does not distinguish between referrals or requests for information, or categorise the reason for referral eg: neglect/domestic abuse. Data is provided on what category of staff are making the referral or enquiry.

The Corporate Safeguarding Team is working 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 with data such as reason for referral/Local Authority referred to and category of staff. This should provide a more accurate view of safeguarding children referrals and allow better analysis for future reporting.

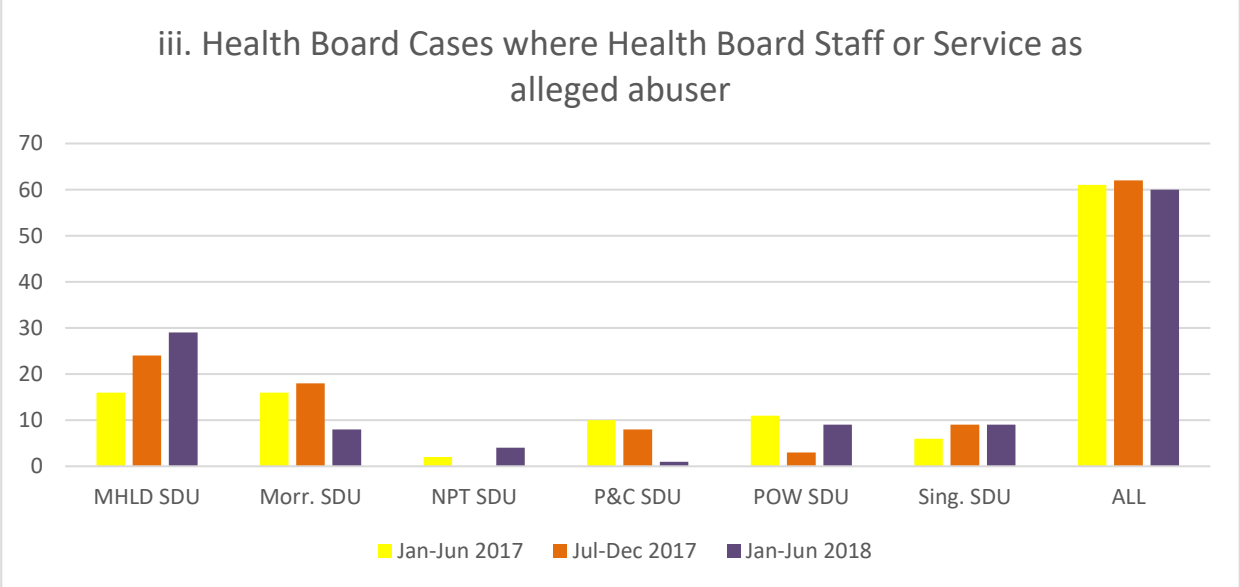
7.4 Safeguarding Adult Referrals

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

Graph ii: Adult Cases managed by the Health Board

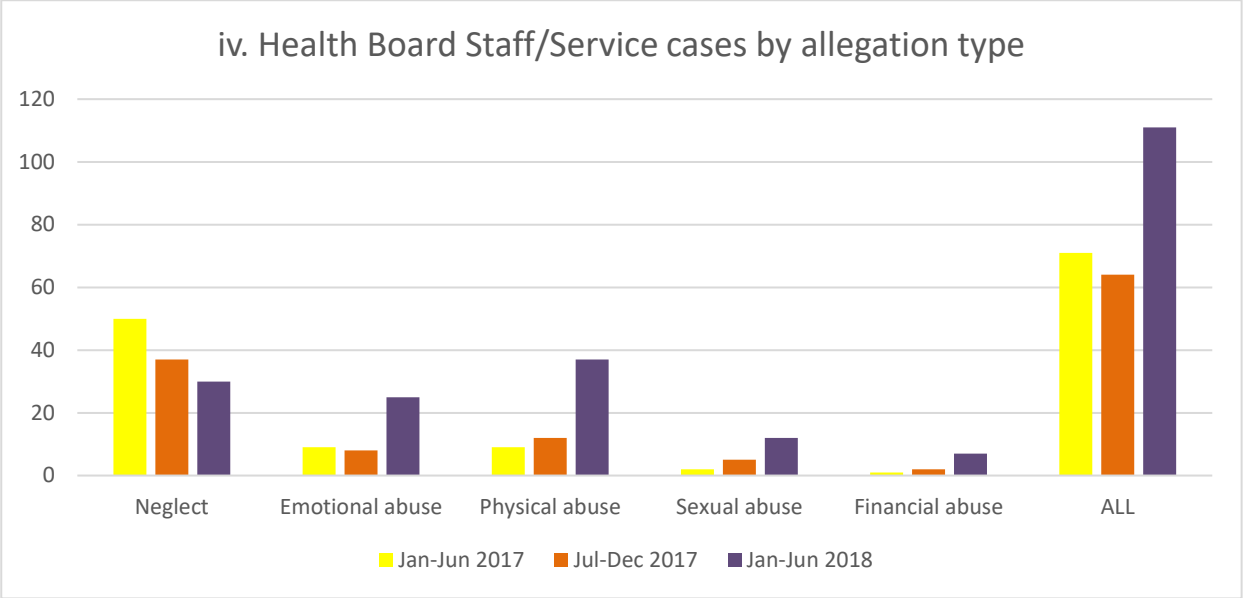


Graph iii: Health Board Cases where Health Board Staff or Service as alleged abuser



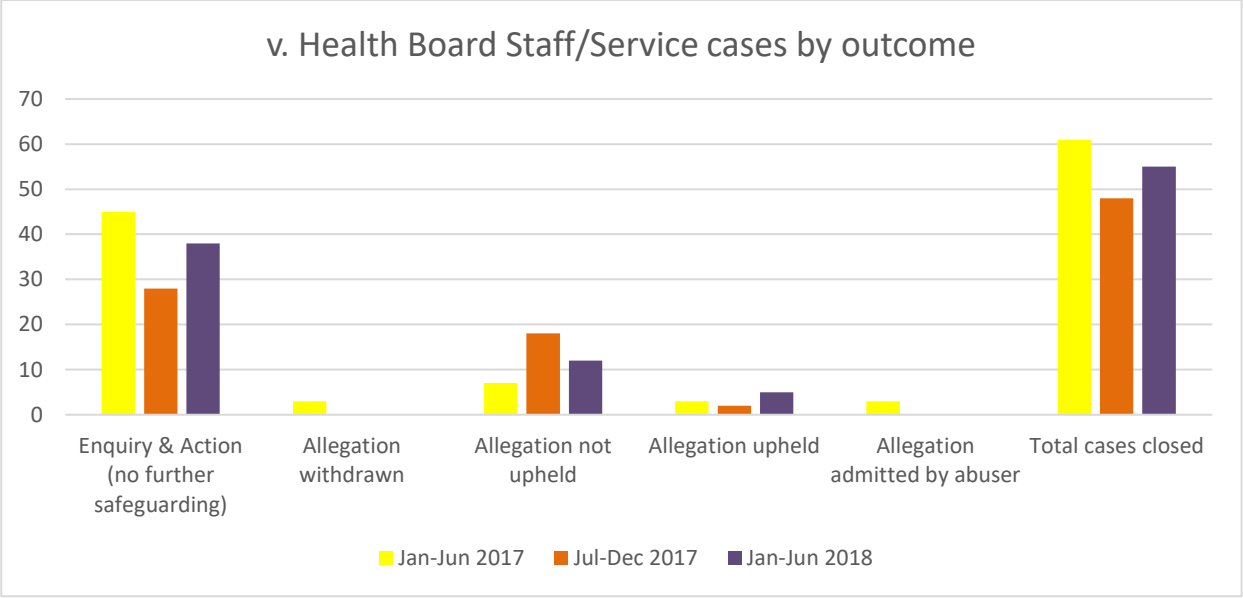
The total number of referrals received where Health Board staff or a Health Board service have alleged to abused an adult are broadly similar over the past six months to previous six month periods (graph iii). There has been an increase in referrals within MHLD SDU, which can be explained in part by a number of referrals being received following multiple unfounded allegations about staff being made by one service user. This has been addressed by the Unit.

Graph iv: Health Board Cases by allegation type



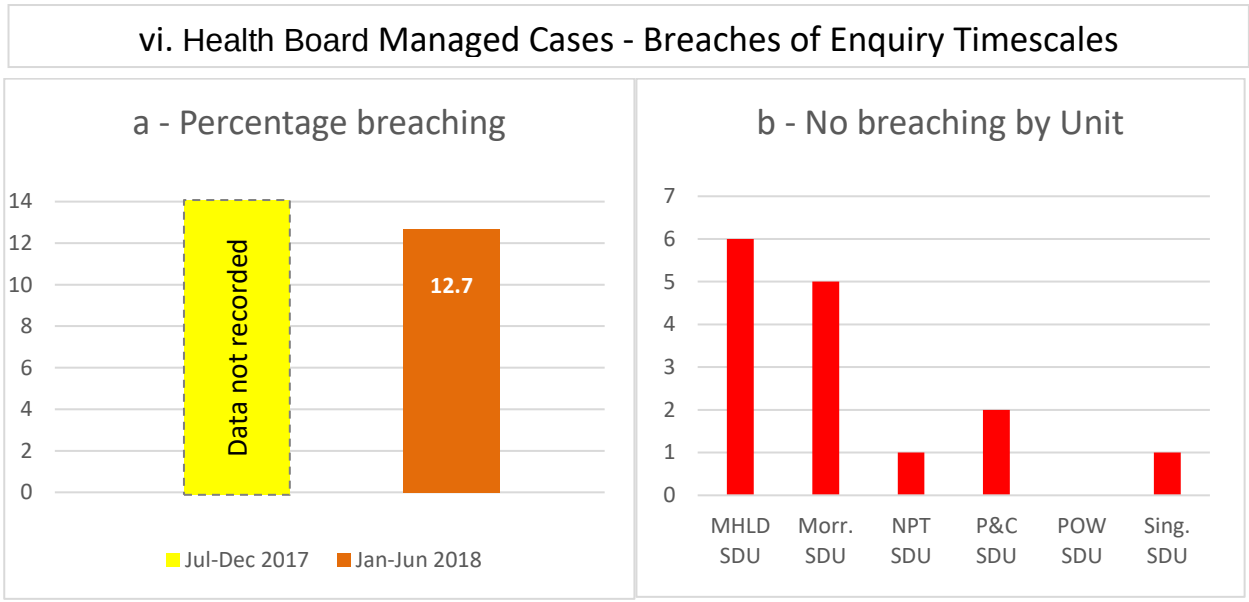
The increase in the total of allegations across all categories (graph iv) is due to an increase in the number of referrals appropriately identifying more than one category of abuse. The increase in the number of physical abuse referrals is in part again due to the service user in MHLD acknowledged earlier.

Graph v: Health Board Staff/Service cases by outcome



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

Graph vi: Health Board Staff/Service cases – Breaches of Enquiry Timescales



The Social Services and Well-being Act requires that the initial enquires made by a DLM into new referrals is completed within seven days. Graph vi (a) demonstrates that this timescale was exceeded in 12.7% of cases over the last six months. All Units (with the exception of POW) breached on at least one occasion (graph vi (b)). In order to address this, breaches are now monitored by the Safeguarding Committee and Units are required to explain why a breach occurred and identify action to prevent a future similar occurrence.

8. INCIDENT REPORTING

8.1 DATIX safeguarding trigger alerts

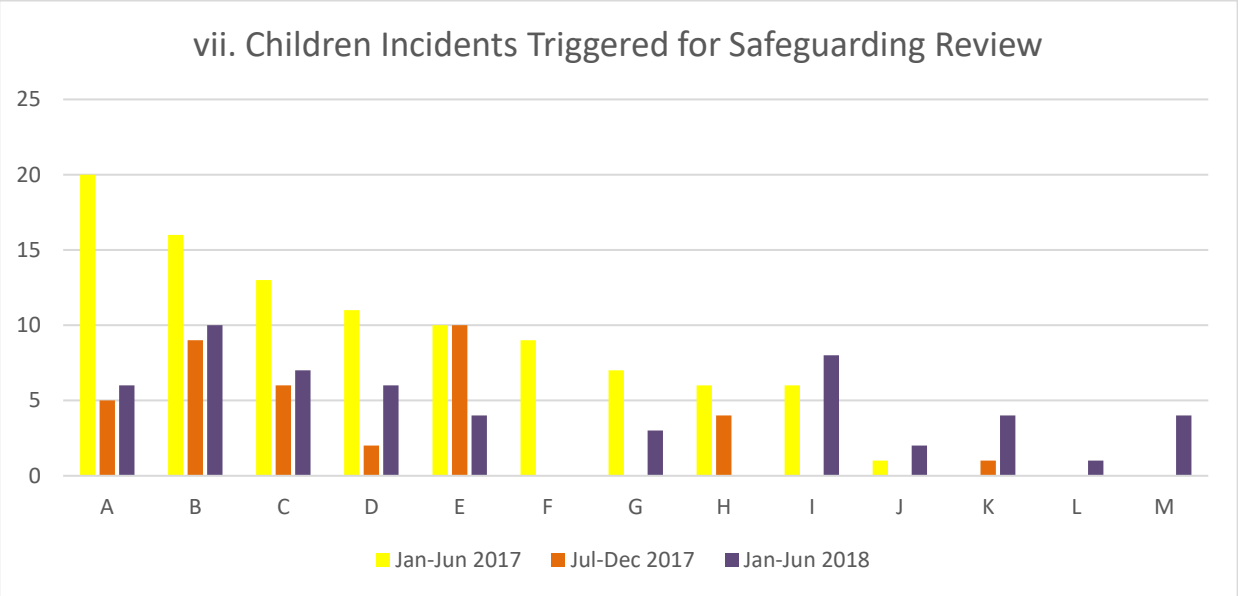
The Corporate Safeguarding Team continues to monitor safeguarding alerts triggered via the DATIX system that do not necessarily require submission of a safeguarding referral. Monitoring of the alerts allows for the collation of information and encourages discussion to take place with the Corporate Safeguarding 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 cases that would require management under adult protection procedures.

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

It is important to reiterate at this point that the children safeguarding incidents displayed in graph vii are only those that are are DATiX reported according to the Safeguarding Children Trigger List and not reflective of the overall children referrals as a child protection referral does not necessarily constitute a DATIX report. The categories for a trigger can be seen in graph vii. This process is currently under review.

8.2 Children

Graph 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	

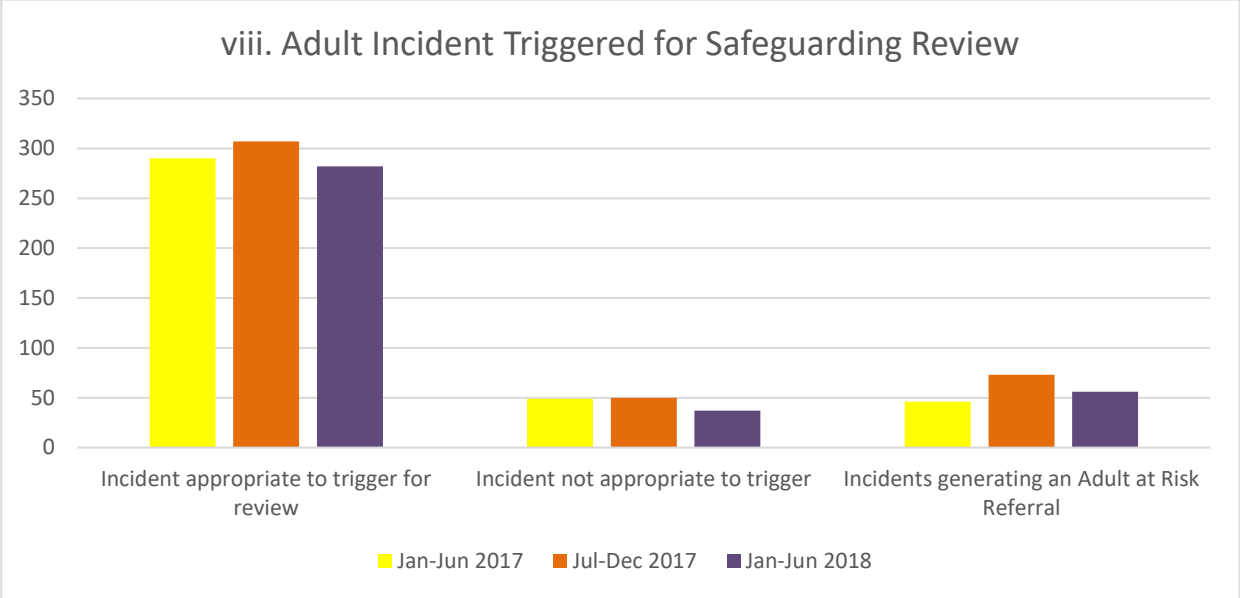
In this period there has been an slight increase in number of incidents which indicate a failure to share information and/or failure to follow guidelines (graph vii). The SafeguardingTeam has reviewed these incidents to ensure the Service Delivery Units have addressed any safeguarding concerns and have put measures in place to avoid a re-occurrence. The Safeguarding Committee has been informed of relevant incidents to ensure learning, and where required, updates have been included in the Level 3 training.

Children nursed on adult wards continue to be reported through DATIX. It has been noted that there has been a fall in the numbers reported over the last six months. A “Risk Assessment Tool” developed to ensure consideration is given to the need to safeguard children when they are being nursed on adult wards, is being rolled out across the Health Board following a successful pilot. The Safeguarding Team has developed guidance for staff to support the implementation of this Tool. The need to

record on DATIX instances where children are cared for in adult wards 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. This will be audited May 2019 following full implementation.

8.2 Adults

Graph viii: Adult Incidents for safeguarding review

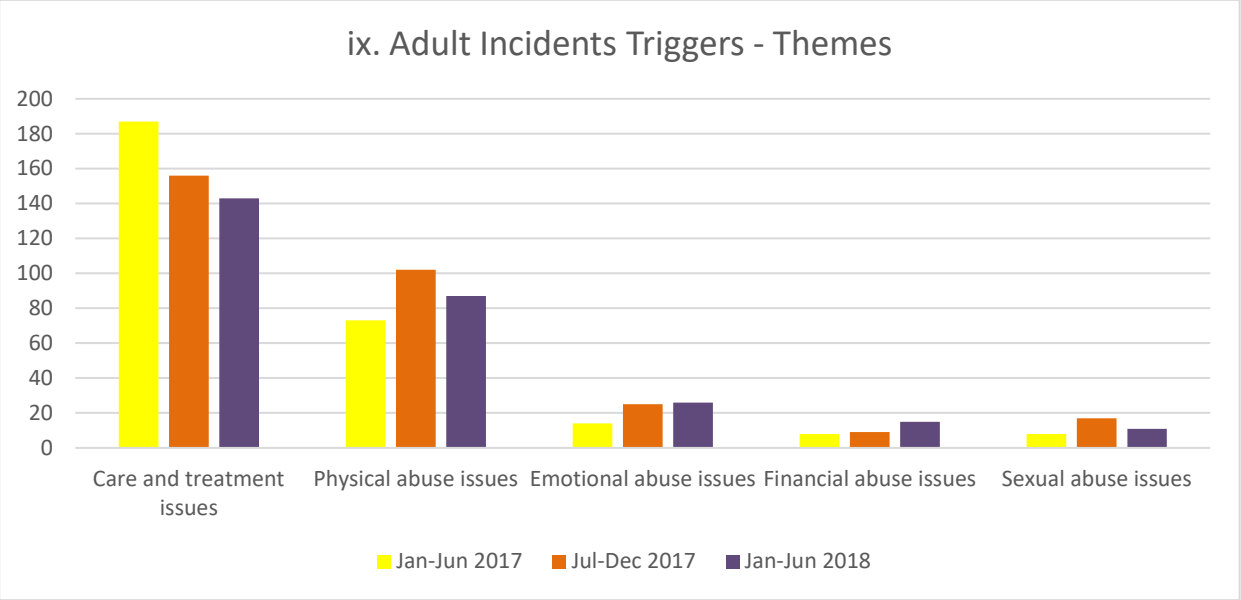


The data indicates slightly fewer incidents were triggered for review by the Safeguarding Team when compared to the previous six months (graph viii). In order to ensure understanding of what constitutes a 'safeguarding adult incident' is embedded in staff knowledge, guidance is contained within the DATIX incident reporting module and incident triggers continue to be highlighted at Designated Lead Manager (DLM) meetings and Level 3 training sessions.

The Safeguarding Team are also planning to undertake an audit (in partnership with the DATIX Team) to identify any 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 for safeguarding review.

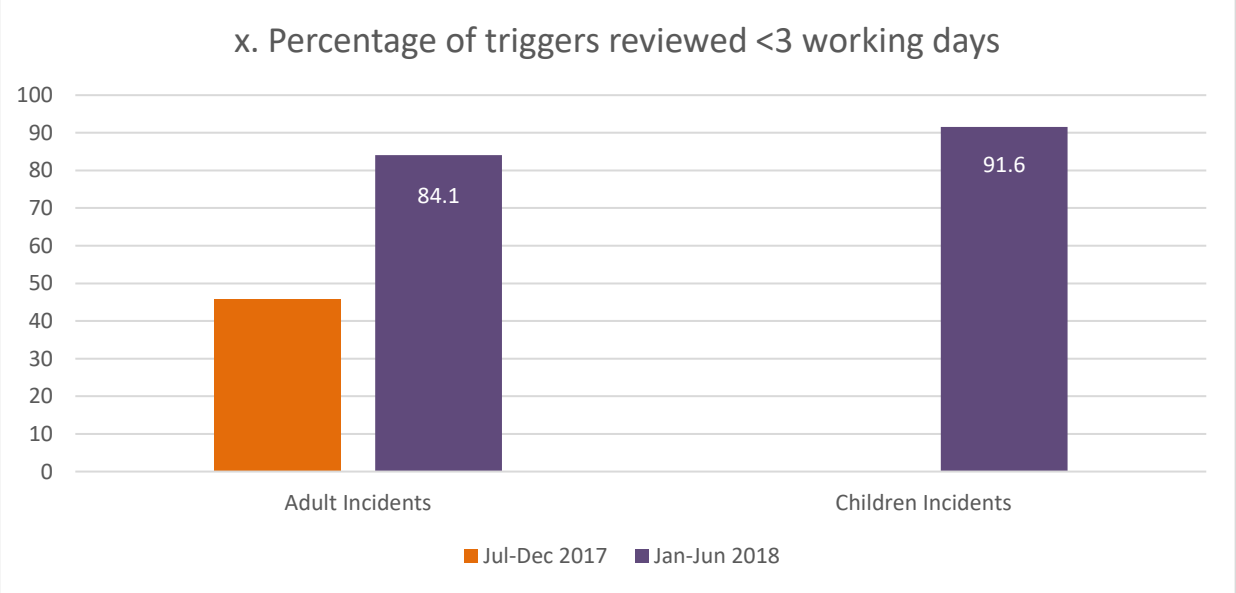
Graph ix: Adult Incidents for Safeguarding Review - themes



There has been a slight reduction in the number of incidents relating to both care and treatment issues and physical abuse (graph ix). Care and treatment issues has a number of 'sub-themes'. The two predominating sub-themes are: incidents reporting pressure ulcer development (n38) and those reporting breaches in DoLS application timescales (n44). The latter is an example where incident triggers are lower than anticipated (see DoLS section below) and is a factor in the Team undertaking the aforementioned audit.

8.3 Timescale compliance

Graph x: Percentage reviewed by Safeguarding Team within Timescale



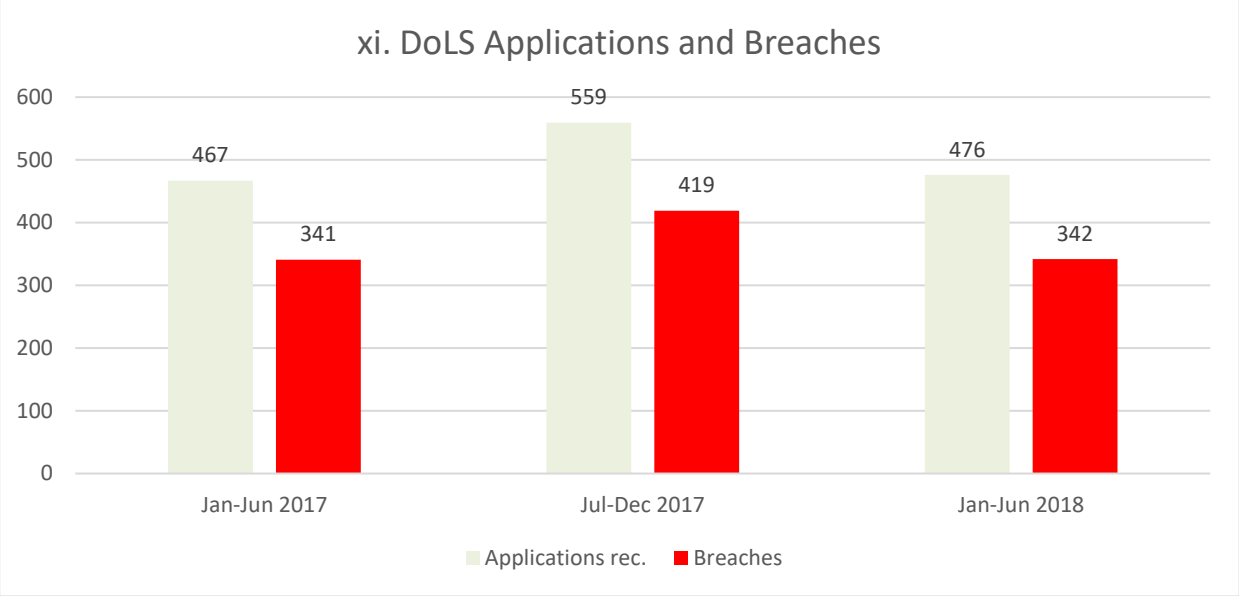
As stated earlier, the Safeguarding Team has identified an internal standard that incidents triggered to the Team are reviewed within three working days. Graph x demonstrates there was poor compliance with this standard by the Team regarding

adult incidents in the second half of 2017 (this information was not recorded for children at that time). Significant improvement has been achieved over the last six months, with 84.1% of adult and 91.6% of children incidents being reviewed within the standard – 100% compliance has been noted since March (adults) and February (children). This improvement is as a result of identifying daily one member of staff (via a rota) to address all telephone enquiries, incident triggers and referrals.

9. 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, graph 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.

Graph xi: DoLS Applications and Breaches



9.1 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 has been recognised as a long and lengthy process which has been recognised on a national level. During 2017 the Law Commission recommended that the Deprivation of Liberty Safeguards process is repealed and replaced by a new scheme called the Liberty Protection Safeguards. This will be recognised under the Mental Capacity Amendment Bill which is to have its second reading in July 2018.

Until any changes are made the Health Board is required to execute the existing process according to 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 which lead to delays:

- Delay in the DoLS applications being authorised. The Corporate Safeguarding Team arranged for four staff to complete training in January 2018 to become signatories; this has increased the number of signatories within Primary Care and Community Services Delivery Unit from three to seven.

- Lack of administrative resources. There remains only one dedicated DoLS administrator 0.4 wte. Further administration relies on a Personal Assistant to a Head of Nursing. The Primary Care and Community SDU is actively looking at ways to resolve this shortfall.

- Delay in appointing a Best Interest Assessors (BIA). Further BIA training was arranged by the Corporate Safeguarding Team in October 2017. Twenty two staff attended training from across the SDUs resulting in an increase from 12 to 34 BIAs. To help address the difficulties encountered in releasing BIAs from their substantive posts, the Corporate Safeguarding Team has developed a BIA rota based on 32 BIAs (retirement of two staff) which will commence on the 1st August 2018.The respective SDUs will be responsible for the on-going management of the BIA rota.

- The Primary Care & Community SDU is in the process of appointing two full time (temporary) BIAs to deal with any backlog of DoLS assessments.

The table below (table 1) displays the number of breaches in timescales of DoLS applications being completed and their causes.

Table 1: Reasons for Breaches

Reasons for Breach	**Number**
Lack of administrative resources	114 (14%)
Non availability of BIAs	106 (13%)
Delayed BIA paperwork	66 (8%)
Section 12 process	69 (8%)
Delay in Supervisory Body authorisation	111 (14%)
Sectioned (Mental Health Act)	5 (0.61%)
Lack of Care and Treatment Plan	2 (0.24%)
Patient respite	12 (1.47%)
Miscellaneous	331 (41%)
Total	**816**

The recorded causes of breaches are listed in Table 1. This shows there is equal parity regarding breaches between lack of administrative support, non availability of BIAs/delayed BIA paperwork and delay in the Supervisory Body authorisation. There were too many categories under miscellaneous to analyse at this point. Further analysis of this category is currently taking place for future reporting.

9.2 Support

The Health Board's DoLS Improvement and Support Group continues and is chaired by the Interim Deputy Head of Safeguarding. This group meets on a bi-monthly basis with representation from members of the Corporate Safeguarding Team and all Service Delivery Units.

9.3 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.

9.4 Audit

An internal audit review of Health Board arrangements undertaken in 2017/18 derived a limited level of assurance. Action was agreed to address issues raised. Therefore this audit is being repeated to confirm that action has been taken to address issues highlighted at the last audit review.

9.5 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 is working 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.

10. PROFESSIONAL ABUSE AND CONCERNS

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

10.1 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.

10.2 Professional Abuse

Professional Abuse Strategy meetings are led by Childrens Services within the area of the Local Authority where the alleged perpetrator lives. The meetings 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.

10.3 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 there has been an increase in the number of professional concerns cases referred to the Health Board. The majority of the ten cases involved issues with alcohol or medication.

Table 2: Professional Abuse and Concerns Cases

Period	Professional Abuse (children)	Professional Concerns (adult)	Total
New cases Jan-Jun 2017	10	5	15
New cases Jul-Dec 2017	3	5	8
New cases Jan-Jun 2018	3	10	13

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.

11. PRACTICE REVIEWS

Adult and Child Practice Reviews take place after an adult or child dies or is seriously injured 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 .

11.1 Adult Practice Reviews (APR)

Table 3 identifies the current status of the eight Safeguarding Board commissioned Adult reviews and Health Board Involvement.

Table 3: Adult Practice Reviews – January – June 2018

Adult Practice reviews	New	Ongoing	Completed	Published	HB Staff Panel members	HB Chairs	HB Reviewers	No of Learning events
	0	5	2	1	8	1	1	2

Of the two completed reviews, one is due for endorsement by the Western Bay Safeguarding Adult Board in July prior to submission to Welsh Government before publication. The other was undertaken as a Multi-Agency Professional Forum (MAPF), as the original referral did not meet the criteria for a full practice review but the potential for multi-agency practice learning was identified. Once approved by Welsh Government, these reports are published and the practice learning and recommendations are shared with agencies.

One ongoing review has been significantly delayed due to legal processes.

11.1.1 Learning points from published APR

The review was triggered by an incident that occurred in a privately managed residential home concerning two vulnerable adults with learning disabilities and challenging behaviour. Due to the individuals' vulnerabilities the exact nature of the incident is unknown but circumstances suggested that a sexual assault was committed by one of the individuals against the other. The following learning points pertinent to Health were identified:

- There needs to be clarity about the responsibility for ongoing ownership of, accountability for, and maintenance of Personal Behavioural Support Plans (PBSPs);
- Commissioners of care need to be assured that providers of residential care homes consistently deliver care of a high standard;
- The need for a clear care pathway to address the health care and forensic medical needs of those who may lack the capacity to give informed consent;
- The Specialist Behaviour Team recognised that where vulnerable adults have learning disabilities there may be a tendency to mitigate the motivation for sexually harmful behaviours and thus minimise them. They have since recognised the need to undertake robust risk assessments and analyse these behaviours in a more forensic manner to inform the PBS;.
- Ensuring advocacy for individuals as part of 'Best Interests' decision-making.

11.2 Child Practice Reviews (CPR)

Table 4 identifies the current status of the five Child Practice Reviews and Health Board Involvement.

Table 4: Child Practice Reviews – January – June 2018

Child Practice reviews	New	Ongoing	Completed	Published	HB Staff Panel members	HB Chairs	HB Reviewers	No of Learning events
	0	3	1	1	5	0	2	2

11.2.2 Learning Points from published CPR

The published review was commissioned following the tragic death of the subject of the Review in a house fire. All the children were on the Child Protection Register under the category of neglect at the time of this event. This was the second period of registration under the same category within the timeframe of the review. The following learning points were identified:

- **Learning Events**

  Two Learning Events were held on separate occasions, one for practitioners and one for managers. Although both events were well attended it was noted that there were also significant absentees including health. It was also identified at these events that some practitioners had not felt supported with regards to the CPR process. Managers and their teams within ABMU HB need to understand the processes around the Practice Review Process and support practitioners to attend learning events. In addition they need to provide supervision and support within this process.

- **Record Keeping**

  It was identified in documentation that the terms ‘good’, ‘acceptable’ and ‘unacceptable’ were used when describing home circumstances which are unhelpful in respect of understanding the nature of the home conditions. In addition, it is also possible that what was ‘good’ or ‘acceptable’ may mean different things to different professionals. This was reinforced in the Managers’ Learning Event where it was agreed that professionals’ recordings, in all agencies, needed to be more descriptive in order to tell the story of what is seen and heard.

- **Professional Vulnerability**

  Consideration should be given to professionals who live and work in the same area as their clients which may place the professional in a vulnerable position and can be professionally challenging. It could result in a blurring of

boundaries where families can become over dependent on local professionals which can make the practitioner vulnerable. Managers need to give consideration as to whether this will impact on practice and ensure practitioners are suitably supported.

- **'Think Family' Approach**

  It is apparent that different disciplines within health use different IT systems which can have an impact when booking appointments. For example, different children from the same family both having to attend appointments at different locations on the same day. In addition, there does not seem to be any alert that would identify other children in the family. Therefore it is imperative that all health professionals adopt a 'Think Family' approach.

  It was identified, as part of the review, that the mother and children were registered with one doctor's surgery and each of the fathers were registered at different practices and this is not unusual. However it is important that when treating adults, GPs use respectful curiosity and if they identify parental/caring roles of their patients that they consider the impact of the illness and its treatment on these children. It was also apparent that if the child was on the CPR there was an alert on the child's record but not on either of the parents' records.

All of the relevant learning points are to be incorporated into the Corporate Safeguarding Practice Review Action Plan which is monitored by the Safeguarding Committee. The National Safeguarding Team will incorporate the findings into a seven minute Briefing which SDUs and their teams can use to cascade pertinent messages.

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

There have been six unexpected child deaths during the reporting period. Two of the deaths occurred in other Health Board areas which is where the formal PRUDiC process was carried out with attendance by ABMU Health Board staff; a third took place within another Health Board's service that is hosted within ABMU premises.

Of the remaining deaths, two were infants in the community and one was a neonate in hospital; PRUDICs were convened within ABMU Health Board and all of the deaths were reported to Welsh Government as required via the Serious Incident Reporting process and also to the National Child Death Review Programme, Public Health Wales.

- One child was co-sleeping with mother; there are complexities with this case around previous child protection concerns and mental health issues, and it has been referred to Western Bay Safeguarding Board for consideration of a Child Practice Review. A decision is yet to be made regarding acceptance of the referral;

- One child was a neonate who died shortly after a normal delivery but deteriorated, was intubated and transferred to Special Care Baby Unit for

further treatment but did not respond to full resuscitation and drug intervention;

- The third child suffered accidental asphyxiation whilst in a papoose baby carrier.

12.1 Themes

- Whilst there is no common theme linking all the deaths over the last six months, it is important to note that one of the deaths is linked to co-sleeping which was a common theme throughout the previous year. The Health Board has taken a pro-active approach to raise the profile of the Welsh Government "safe sleeping" guidance through disseminating information via Safeguarding Committee, Western Bay Safeguarding Children Board, use of Intranet bulletins, integrating within training and within Health Visitors' and Midwives practice.

- The issue of any safety warnings associated with papoose baby carriers has been referred to the National Safeguarding Team and Welsh Government. In the interim period, safe sleeping guidance has been re-issued by HVs and midwives within the ABMU HB area.

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

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

The Health Board's "Ask and Act" Five Year Local Training Plan, which was submitted to Welsh Government (WG) in March 2017 with the intention that implementation would commence in September 2017, has been delayed. This has been due to the funding arrangements from WG not being clarified until June 2018. The funding was to provide the use of Third Sector domestic abuse 'specialists' to support the HB trainers as recommended within the VAWDASV Act. However with the support of the Corporate Safeguarding Team and the use of Health Board staff that had developed 'specialist knowledge' of VAWDASV there has been a limited reduction of the forecasted training. Group 2 training is now expected to be delivered as forecasted in the five year local training plan from September 2018

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

The VAWDASV Task and Finish Group was set up with the purpose of providing assistance and support during the implementation of Ask and Act across the six Service Delivery Units (SDUs). The planning of training with the Third Sector takes much coordination and this Group will ensure compliance with the Ask and Act five year training plan. The Group meets on a bi-monthly basis and the VAWDASV Lead, within the Corporate Safeguarding Team, chairs the Group.

As the confirmation for the funding for Third Sector was delayed by WG the Corporate Safeguarding Team has offered support to the SDUs to deliver this training with a member of the team being the trainer with the 'specialist knowledge' which is a requirement as set out in the National Training Framework (The statutory guidance of the VAWDASV (Wales) Act 2015). The Team supports the trainers with their continued professional development offering quarterly study sessions with guest speakers delivering VAWDASV presentations.

13.1.3 Annual progress report to Welsh Government

It is a statutory requirement that the Health Board submits an annual report on implementation of the five year "Ask and Act" Local Training Plan to Welsh Government Ministers in May each year commencing in 2018. The annual report details the progress of ABMU Health Board's implementation of the training plan.

Group 1: 80% of Health Board staff had completed Group 1. The target set by WG is 100% ABMU Health Board was the second highest across NHS Wales with rates of training varying from 40 – 82%. The highest Health Board regarding compliance was Powys which have a much reduced workforce.

Group 2: 176 Health Board staff received Group 2 Ask & Act training between September 2017 and 31st March 2018; this was not the forecasted delivery rate as outlined in our training plan but was due to the delay in the Welsh Government confirming funding arrangements for Third Sector specialist services.

Group 3: Group 3 training has not yet commenced due to the delay in third sector funding. The training is expected to commence in September 2018.

13.2 Multi Agency Risk Assessment Conference (MARAC)

MARAC is held on a fortnightly basis in each of the three Localities of Bridgend, Neath/ Port Talbot and Swansea. This multi-agency forum discuss high risk victims of VAWDASV who have been referred and a plan of action agreed to ensure the safety of the victim and to ensure the safety of any children involved. A Health Board member attends each MARAC.

During the past six months there has been an increase in other specialist MARACS; For example - Human trafficking MARACS and sex worker MARACS. There is also a move to have daily MARACS to discuss urgent issues. This is an additional staff resource issue for the HB and currently there is some work being carried with multi-agency partners to enable HB support of these MARACs in an effective and efficient manner.

MARAC referrals from ABMU have increased since the introduction of Group 2 Ask & Act training in 2016. There has been an overall increase of referrals by 24%. The largest area for increase has been secondary care with an increase of 42% between 2016 – 2017.

13.3 Training

The National Training Framework on Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) is the statutory guidance focusing on the delivery of 'Ask & Act'. Each session is to be delivered by two accredited trainers one of whom should have 'specialist knowledge'. During the early stages of implementation of our five year training plan, Welsh Government has confirmed that they will fund the Third Sector to provide a trainer with 'specialist knowledge'; however it is expected that specialist sector trainer involvement will be scaled back in the subsequent years of the 'roll' out as Health Board trainers develop 'specialist knowledge' of VAWDASV.

To support the Health Board's trainers to increase their knowledge of VAWDASV the Corporate Safeguarding Team, together with Calan DVS; have provided domestic abuse, stalking and honour based violence risk identification checklist (Dashric) and MARAC awareness training. This has been well attended and also evaluated well. All trainers are also encouraged to attend a MARAC.

13.4 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.

13.5 Domestic Homicide Reviews –January 2018 – June 2018

During the reporting period four Domestic Homicide Reviews were ongoing and their progress is outlined below (table 5).

Table 5: Domestic Homicide Reviews – January – June 2018

DHRs	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. The Corporate Safeguarding Team is currently assessing the process for reviewing the DHRs prior to submission to the Home Office. All published DHRs will be presented to the Safeguarding Committee and any learning points/recommendations 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 current DHRs.

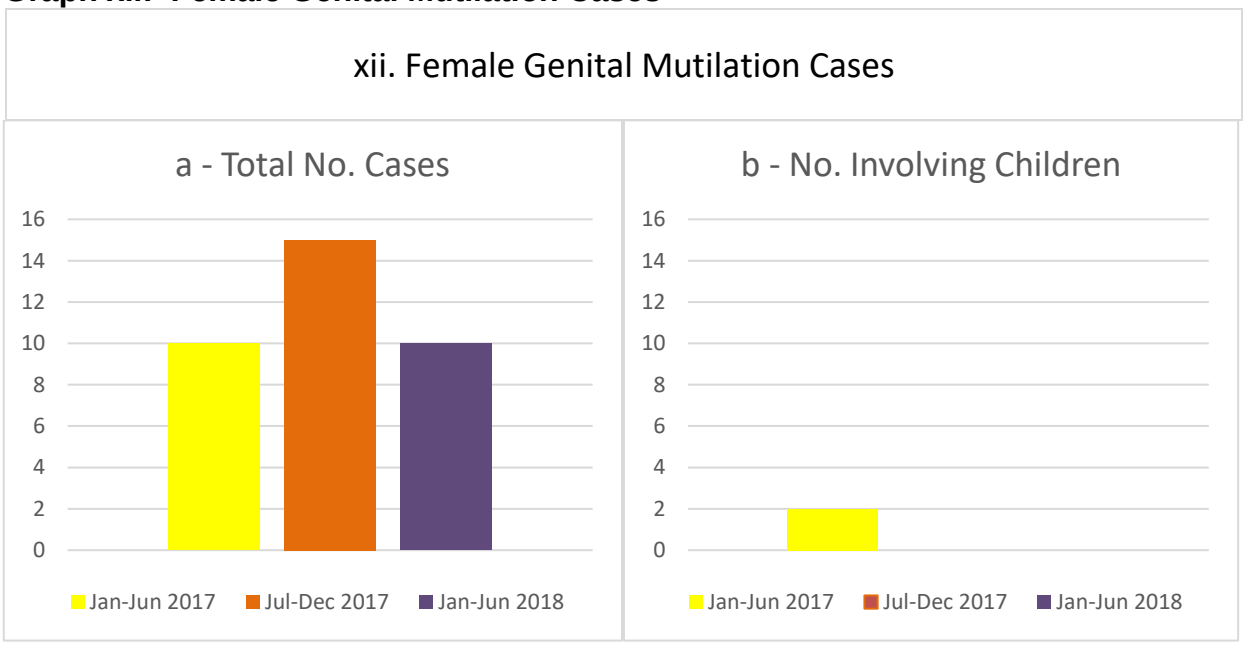
14. FEMALE GENITAL MUTILATION (FGM)

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.

14.1 Reported cases of FGM

Graph xii: Female Genital Mutilation Cases



In the last reporting period there have been no reported cases where FGM was carried out in Wales and no disclosures of children that have had FGM.

14.2 FGM Training

FGM training is delivered 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).

15. CHILD SEXUAL EXPLOITATION (CSE)

15.1 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 the ABMU Health Board is committed to, the purpose of which is to do everything possible to prevent CSE, protect and support those affected by CSE and tackle perpetrators.

15.2 CSE Training

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

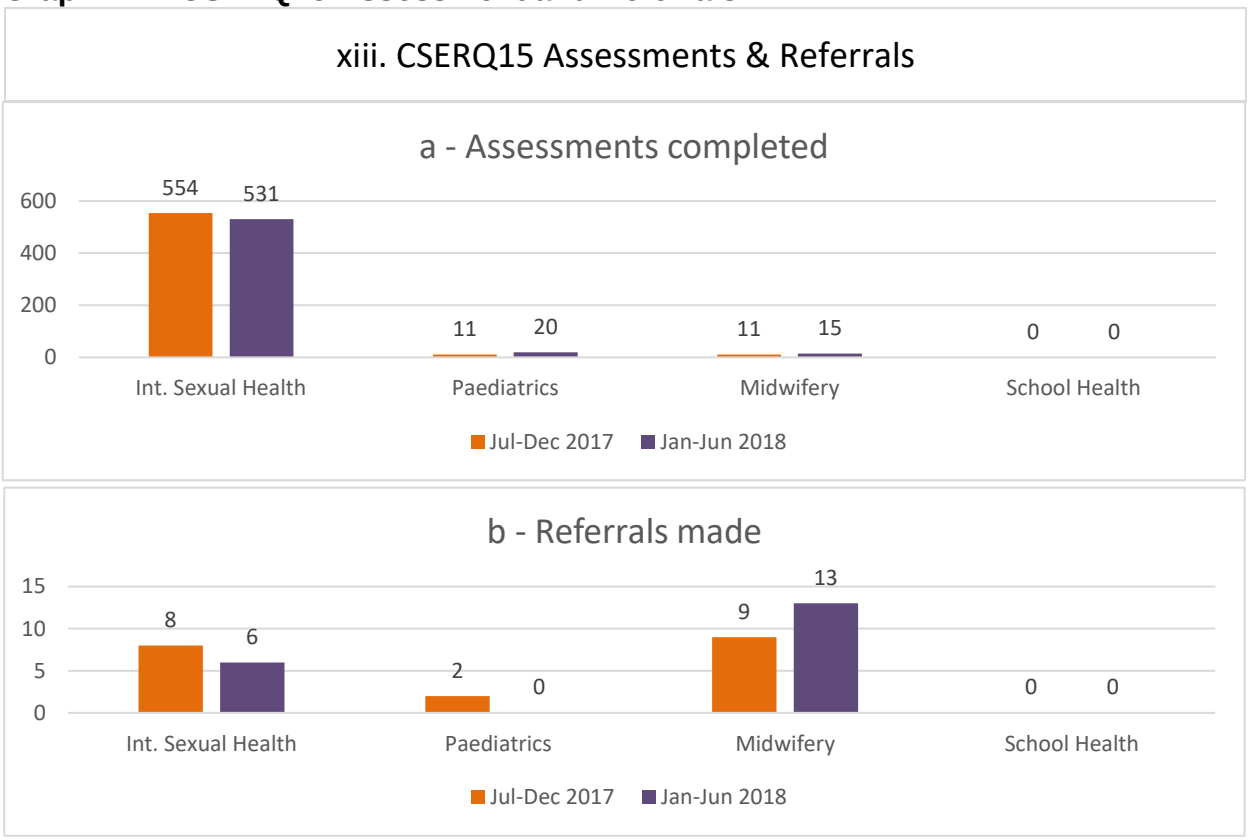
A new training package has been developed and trialed by Betsi Cadwalader University Health Board it has evaluated well and been accredited by NHS Wales. It is expected to be available for use in September 2018, the training package has been developed taking into consideration multi-agency working.

15.2 CSE Referrals

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

During the reporting period 566 CSERQ15 were completed however only 19 referrals were made to Children's Services. Integrated Sexual Health completed the most CSERQ15 and Midwifery made the largest number of child protection referrals. This is consistent with the last reporting period.

Graph xiii: CSERQ15 Assessment and Referrals



If it is possible Integrated Sexual Health (ISH) will complete a CSERQ15 on all children that attend their service however their referral rate is low, this is consistent with the last reporting period. In comparison with Midwifery the completion rate is low however the rate is high. Midwives appear to be recognising indicators of CSE and referring rather than completing the CSERQ15 on a larger number of children. Further work is needed with ISH and Maternity to identify why this is.

15.3 CSE Information Sharing

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

15.4 Independent Inquiry Into Child Sexual Abuse

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 Inquiry was informed that current arrangements to protect children from sexual abuse within the health sector could be improved. Discussion covered the adequacy of existing training, the barriers that prevent concerns being raised about child sexual abuse and the vulnerability of children when receiving treatment on adult wards. The latter is being addressed across ABMU HB with the introduction of the Risk Assessment Tool for children nursed on adult wards.

The Report also discussed the important role that chaperones play. The Inquiry has confirmed that national policies for the use of chaperones in the NHS and other healthcare services in England and Wales are not available. As a result, the Inquiry has recommended that national policies are introduced to help improve the consistency and quality of chaperoning. Within Wales the Chair and Panel have recommended that Welsh Government develops a national policy for the training and use of chaperones in the treatment of children in healthcare services. ABMU HB (along with other HBs) is currently working with the PHW's National Safeguarding Team to develop a such a policy.

The Truth Project – this is a project that allows victims and survivors of sexual abuse to share their experience with the Inquiry. To date, over 1000 victims and survivors have participated. ABMU HB has issued leaflets and displayed posters regarding this.

16. HUMAN TRAFFICKING/MODERN SLAVERY

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

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

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 receive updates from Welsh Government on the number of NRM referrals made nationally and regionally, information updates on any local cases from the police, and discusses 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 currently reviewing whether this could be brought in-house, and incorporated into Level 3 training

17. SUICIDE AND SELF HARM PREVENTION FORUM

The Wales National Suicide Prevention Strategy 'Talk to me 2' developed by the National Advisory Group (NAG) on Suicide and Self-Harm sets out the strategic aims and 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.

The Regional Forum has developed a draft local strategy using the following six priority areas:

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

The first draft was submitted to the NAG in February 2018.

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.

18. CHANNEL AND PREVENT

The Counter Terrorism and Security Act 2015 requires the Health Board to engage with partner agencies in reducing the risk and impact posed by potential terrorist threats, and support individuals who may be at risk from engagement in terrorist acts. The Corporate Safeguarding Team 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 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 the reporting period.

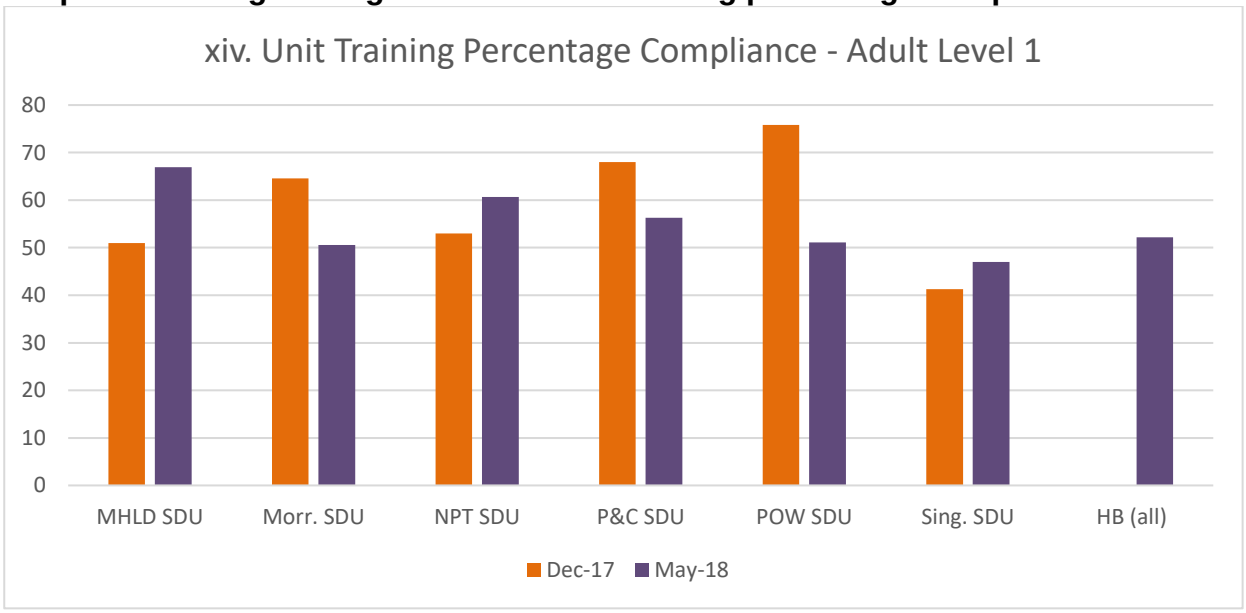
19. SAFEGUARDING TRAINING AND SUPERVISION

19.1 Level 1 & 2 Safeguarding Training

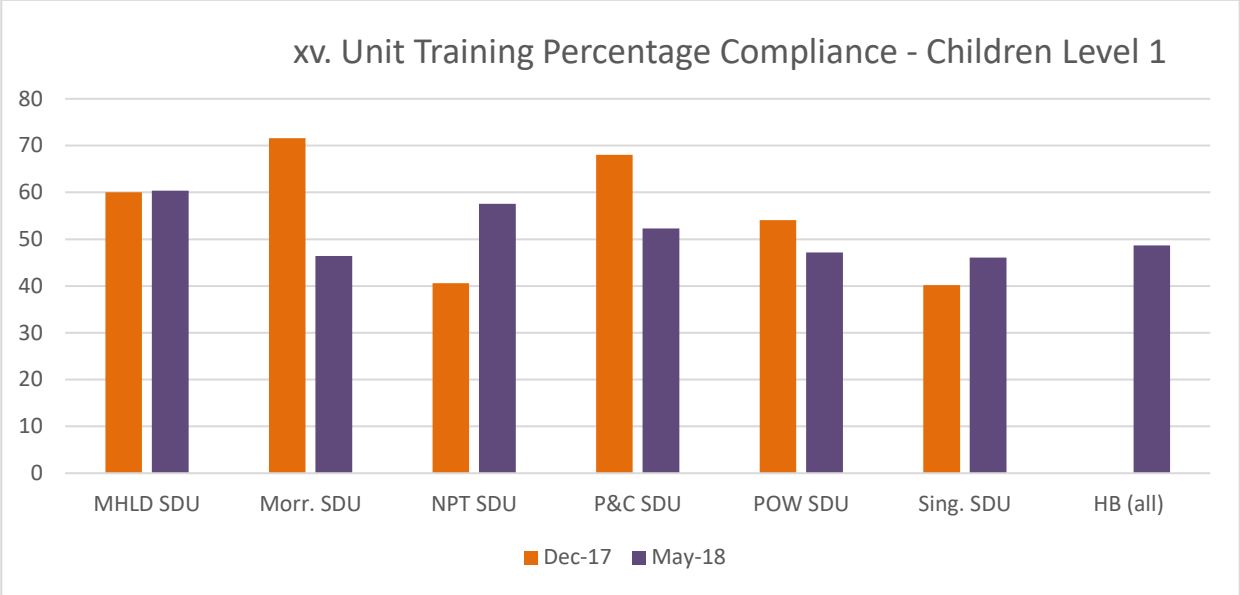
Level 1 and 2 training for Safeguarding Adults and Children and Level 2 Mental Capacity Act Training is provided via e-learning. Compliance is monitored by the Safeguarding Committee via information provided to the Committee by each Service Delivery Unit (SDU) on a bi-monthly basis.

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

Graph xiv - Safeguarding Adults Level 1 training percentage compliance



Graph xv: Safeguarding Children Level 1 training percentage compliance



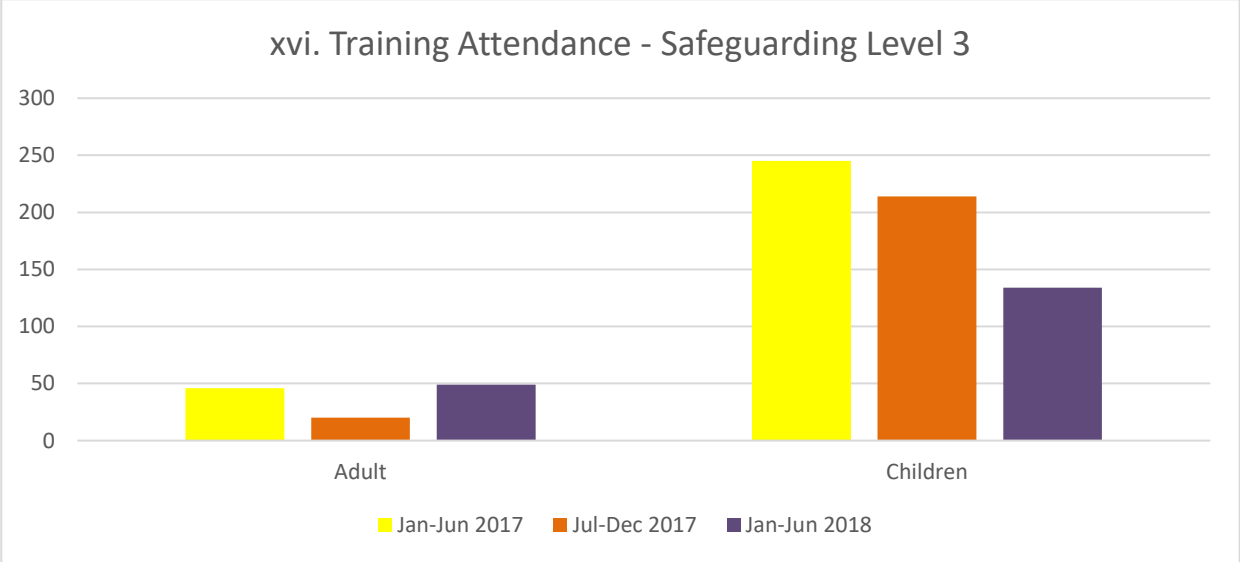
It is of concern that training compliance remains at an inadequate level. Each SDU has been tasked by the Safeguarding Committee to submit action plans to identify actions when mandatory training compliance will be achieved.

19.2 Level 3 Safeguarding Training

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

Level 3 Safeguarding Adults training differs to that of Level 3 Safeguarding Children in that it solely targets staff who are operational managers who would be responsible for responding to a safeguarding alert, hence the number of staff requiring this training is significantly lower than that for Level 3 Safeguarding Children. During the reporting period sessions were delivered bi-monthly.

Graph xvi: Training Attendance - Safeguarding Level 3



Attendance rates for Level 3 Safeguarding Children training have reduced during the reporting period (graph xvi). This may partially be attributable to long-term sickness within the Corporate Safeguarding Team and subsequent need to prioritise workloads which has sometimes resulted in postponing or re-arranging training dates.

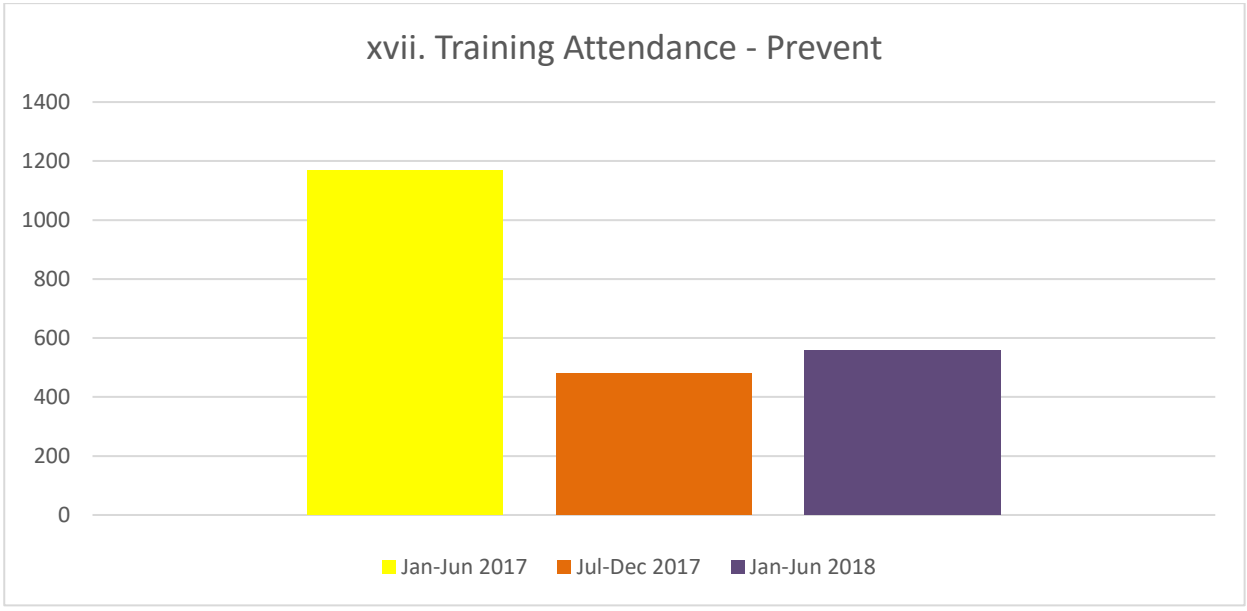
Attendance levels for Safegaurding Adults training is commensurate with the same period for last year. It is important to note that there are fewer training sessions offered during the July/December period which will affect the training figures.

In order to analyse the figures more accurately it would be useful if each SDU completed a training needs analysis for Level 3 and this will be monitored by the Safeguarding Committee.

19.3 Prevent Training

The Corporate Safeguarding Team supported by a small number of Unit trainers continues to deliver the WRAP3 Home Office approved training (Prevent). This is an awareness raising session which enables staff to identify vulnerable individuals who may be susceptible to radicalisation, and to be aware of the need to refer for the appropriate support. A significant number of staff were trained between January and June 2017 (graph xvii). During this period training attendance was opened out to all Health Board staff, having initially targeted to staff working in key clinical areas (e.g. Mental Health, Learning Disabilities, Health Visitors, School Health Nurses). It is noted that attendance has increased in the first half of 2018 compared to the July/December 2017 period. Nearly 3500 staff members have completed this 'one-off' training since commencement in October 2015.

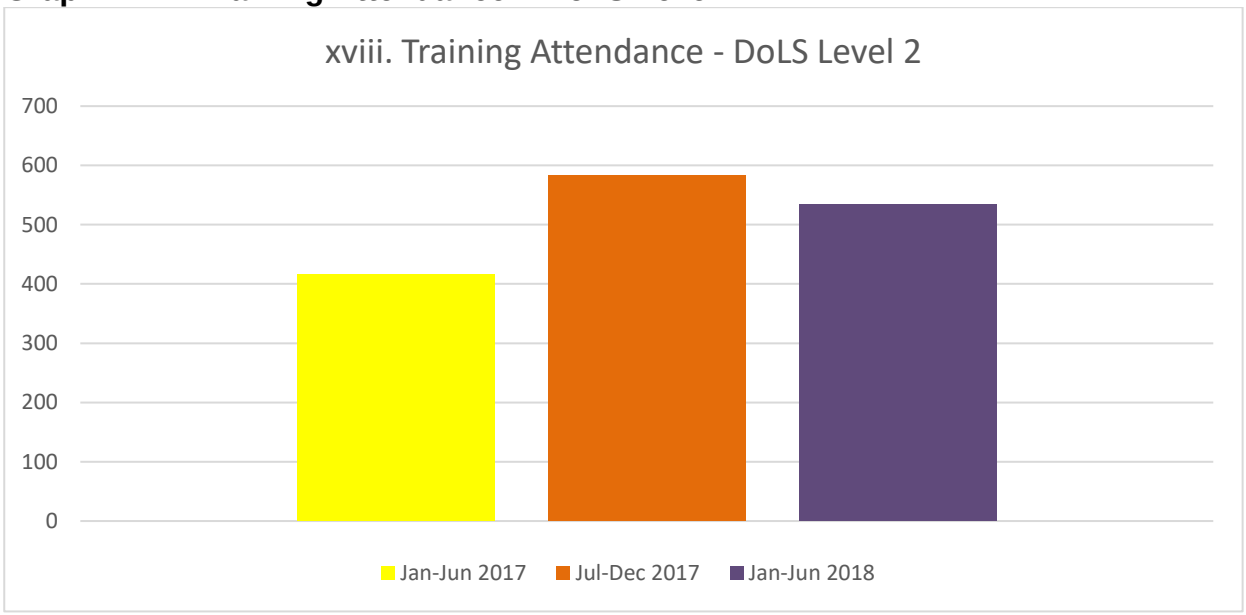
Graph xvii: Training Attendance - Prevent



19.4 Deprivation of Liberty Safeguards (Level 2) Training

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

Graph xviii: Training Attendance – DoLS Level 2



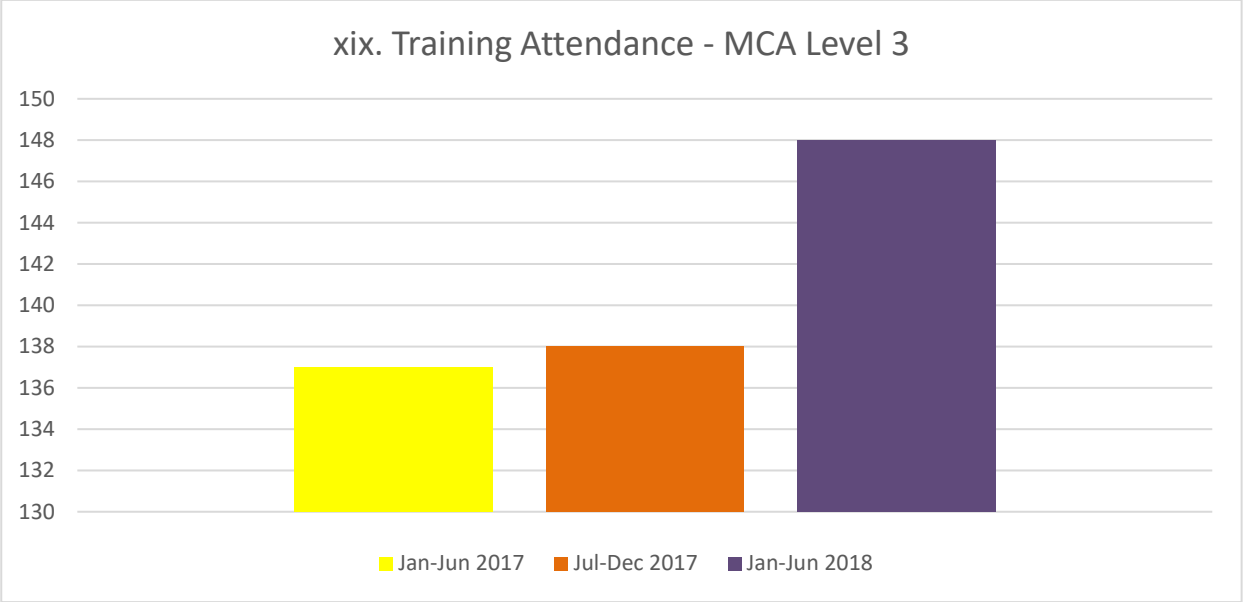
19.5 Mental Capacity Act (MCA) Level 2 Training

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

19.6 MCA Level 3

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

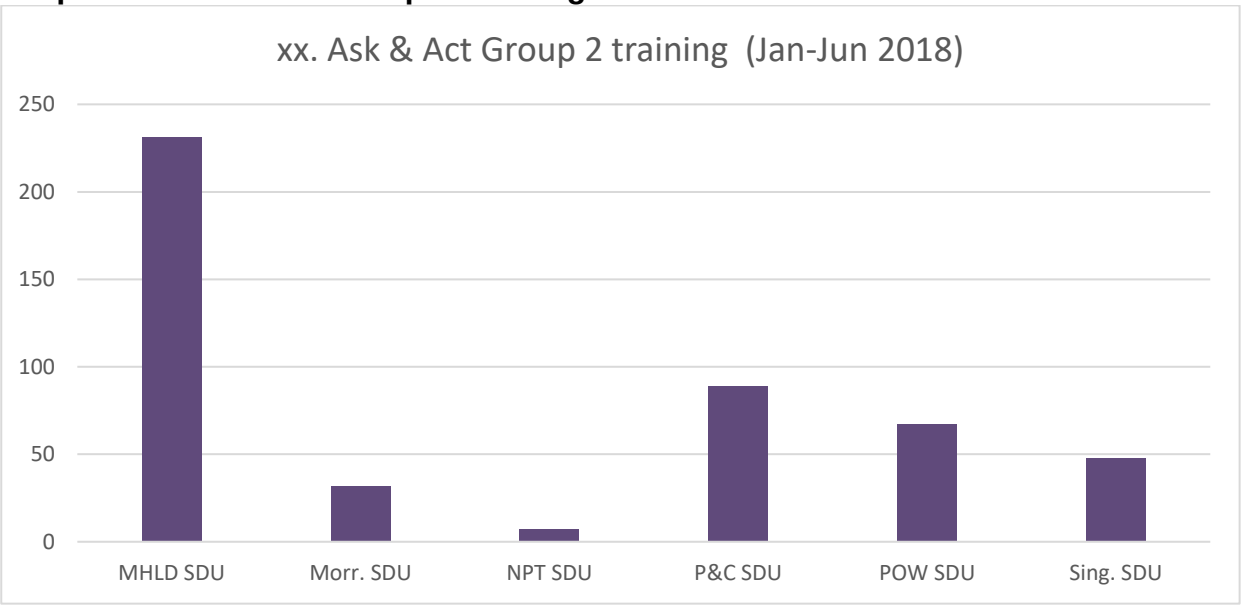
Graph xix: Training Attendance – MCA Level 3



19.7 Ask and Act Group 2

Ask and Act Group 2 training has commenced throughout the Health Board. All SDUs have been offered support during the implementation of our training plan by the Corporate Safeguarding Team. There are noted differences between the SDUs and the amount of training delivered, this is in part due to the availability of trainers and staff being released for the training (graph xx). This is monitored by the Safeguarding Committee.

Graph xx: Ask & Act Group 2 Training - SDUs



19.8 Safeguarding Supervision

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

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

- Daily *ad hoc* safeguarding advice and support for 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.

Through the Safeguarding Committee, the SDUs have been tasked with creating a tiered model position for supporting safeguarding supervision and to complete risk assessments. This will be supported by the Corporate Safeguarding Team.

20. DEVELOPMENTS WITHIN THE REPORTING PERIOD

20.1 Supporting Safeguarding within Service Delivery Units (SDU)

It was previously identified that in order to support the SDUs in their safeguarding responsibilities, it would be advantageous if there was more visibility from the Corporate Safeguarding Team. In addition the number of safeguarding adult referrals have increased significantly, impacting upon the capacity of Corporate Safeguarding Team to be able to process them and it is pertinent that the individual SDU takes ownership of their own referrals. An initial three month pilot took place within Singleton SDU in early 2018 where a member of the Team worked within the Unit on a weekly basis to increase visibility and to support staff in this transition. Following the pilot, the following points were identified:

- There were variances in expectations of the pilot;
- The SDU was satisfied with pre-existing levels of support from the Corporate Safeguarding Team;
- Agreed that for Singleton SDU, regular attendance by a member of the Corporate Safeguarding Team at their Nursing and Midwifery meetings would provide an appropriate forum for safeguarding governance;

- The SDU agreed that it would be able to take ownership of its referrals with support from itsadministration team and training from the Corporate Team. This has been delayed due to processes for managing referrals between Health and Local Authorities being agreed.

Discussions are currently ongoing with Princess of Wales SDU to undertake a similar programme and it is anticipated that this will extend to all SDUs within a year.

20.2 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 aTrain the Trainer session.

20.3 Prisons

20.3.1 HMPrison Swansea

A recent inspection of HMPrison Swansea identified a need to improve health involvement particularly in relation to suicide prevention and governance reporting. Primary Care & Community Services SDU 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 (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 will be evaluated.

20.3.2 Parc Prison, 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.

20.4 Child & 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 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. A meeting will be arranged with Cwm Taf (CAMHS), ABMU HB and the Local Authorities to meet and discuss a framework to support these challenging cases.

20.5 New Posts

The Corporate Safeguarding Team has experienced some workforce changes since January with the retirement of two valued Nurse Specialists. In addition the current Head of Nursing: Safeguarding has secured a role within PHW's National Safeguarding team and will be leaving ABMU HB in August. Consequently the Team has gone through a period of appraisal and is currently recruiting to new posts. This process is on-going due to long-term sickness and the boundary changes within Bridgend.

- The Team has employed a Practice Education Facilitator who will be able to support the Team with the increasing training portfolio and in turn able to support the SDUs to improve training performance management. This role will also be involved with audit and evaluation.

- A further Safeguarding Specialist post is currently out for advert

- The post of Head of Nursing: Safeguarding will be advertised shortly.

20.6 Performance Management

The Corporate Safeguarding Team continues to work with IT to develop a robust procedure for collating data and plan to develop a Safeguarding Dashboard. This is at an early stage and further information will be provided in future reports as developments are are implemented.

20.7 Tawel Fan – Independent Investigation

An independent investigation, commissioned by Betsi Cadwaladr University Health Board, took place in August 2015 has recently been published (May 2018). The investigation examined the care and treatment which was provided on Tawel Fan ward in a hospital in North Wales. This was following concerns raised by the families of patients who had received care and treatment there between January 2007 and December 2013. The investigation identified that, although there were areas of good standard of care and treatment provided, there were nine key factors. These factors, on occasion, compromised the quality of the patient and family experience. The report is pertinent to other areas within the HB not just safeguarding. However, with regards to specific safeguarding issues, the report identified

- A lack of robust systems and structures to support the protection of adults at risk;

- Lengthy processes and failure to meet timescales;
- Ward staff managing interim risks without sufficient external scrutiny and support.

The Cabinet Secretary for Health and Social Services has requested an outline of how ABMU Health Board will use the findings to improve the services we deliver and a collective response has been drafted for submission by the end of July. Any learning from this report will be incorporated into the Corporate Safeguarding Team's Strategic Workplan Plan and progress of this will be monitored by the Safeguarding Committee.

20.8 Safeguarding Maturity Matrix (SMM)

This is a self-assessment tool which needs to be completed by each NHS Health Board and Trust whereby any findings will inform the work of individual health organisations and support their safeguarding agenda.

There are five aspects to the Matrix:

- Governance & Rights based Approach;

- Safe Care;

- Adverse Childhood Experiences (ACE);

- Learning Culture;

- Multi-agency Partnership Working.

In addition any relevant data from the organisations' improvement plans will be collated and analysed to inform safeguarding practice in the NHS across Wales. 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 is to be piloted across Wales by HBs and Trusts during August 2018 and the findings collated and a report prepared by The National Safeguarding Team, Public Health Wales, later this year. The pilot will test the feasibility of obtaining useful safeguarding data to support national benchmarking and test the concept for a digital solution in the future.

The Corporate Safeguarding Team is currently obtaining the relevant data and this will be reported on within future safeguarding reports.

21.0 Conclusion

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.