GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Enw'r Pwyllgor: Name of Sub-Committee:	Exception Report from Strategic Safeguarding Working Group
Cadeirydd y Pwyllgor: Chair of Sub-Committee:	Sian Passey, Assistant Director of Nursing for Quality, Assurance and Professional Regulation
Cyfnod Adrodd: Reporting Period:	10th May 2022

Materion Ansawdd, Diogelwch a Phrofiad:
Quality, Safety & Experience Matters:

Strategic Safeguarding Working Group Meetings

Since the previous report to the Quality, Safety & Experience Committee (QSEC), the Strategic Safeguarding Working Group has met on 10th May 2022.

- **NHS Wales Safeguarding Maturity Matrix**
  The NHS Wales Safeguarding Maturity Matrix addresses interdependent strands regarding safeguarding: service quality improvement, compliance against agreed standards and learning from incidents and statutory reviews. The 2020/2021 Health Board self-assessment against the five standards and the improvement plan were approved by the Group for submission to the National Safeguarding Team at Public Health Wales. Regular reporting to the Strategic Safeguarding Working Group will monitor the improvement plan. The Group were asked to update the relevant sections for 2022/2023 for submission to the Director of Nursing which needs completing by September 2022.

- **Training Compliance**
  The Safeguarding Children Level 3 training compliance made a very slight improvement in Quarter 3, although dipped again slightly in Quarter 4 as reported by Workforce Information. The review completed by the Lead Nurse Safeguarding Children in August 2021 and reviewed again with Workforce Information has demonstrated an improvement in compliance overall in the UHB. Adult Level 3 virtual training does not cap by numbers, the compliance depends on the attendees returning their electronic evaluation form and this is being discussed at the delivery groups.

  Members noted a slight improvement in compliance with the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Group 1 E-learning. Group 2 Ask & Act was given temporary funding via the Regional VAWDASV training grant to aid compliance by March 2022. A Domestic Abuse Support Officer has now been given this responsibility to provide extra training.

  The Group was informed that Group 6 of the VAWDASV National Training Framework has been developed for Strategic Leaders within Public Sector organisations. Welsh Government (WG) has noted that uptake of Group 6 is significantly low across Wales.

  Links to Group 6 training resources have been previously shared and consist of a series of videos 'Strengthening Leadership' available on YouTube. However, in Hywel Dda University Health Board (HDdUHB), similar to other Health Boards in NHS Wales, we have been unable to report on an uptake of this training by Executives. Links to Group 6 training resources via

the WG microsite have been shared via the Board Secretary for Board Members to complete this training. The training is comprised of a series of videos ‘Strengthening Leadership’ available on YouTube. WG will monitor compliance directly via the microsite

Professional Curiosity Training has been commissioned by the Regional Safeguarding Board and is currently running as a pilot.

The Group received exception reports from three of the four service Safeguarding Delivery Groups. A key area to note is as follows:

- Training compliance – During COVID-19, gaps in training were further evidenced. All services have identified where improvements need to be made and have put plans in place. The improvement plans are to be monitored through the delivery groups and exceptions reported to the Strategic Safeguarding Working Group.

- **Assurance**

Looked After Children (LAC)
The Group was informed that during the first lock down in response to the pandemic, there was a significant increase in the number of Looked After Children within the HDdUHB area. This was a combination from 2 Local Authorities and children placed from other areas which added to an increased workload. The increase has been monitored by the LAC service to see if it constituted a variance. It appears the pattern has levelled off over the summer and the number has slightly reduced from 814 to 787 LAC at the end of Quarter 2, 2021/22. The number of LAC remains significantly higher than it was approximately 5 to 6 years ago.

Child Safeguarding
The Group received a report on child safeguarding activity and noted there is a sustained increase in Multi Agency Referral Forms to Children Services. This increase could be due to the continuing relaxation of COVID-19 pandemic restrictions and the commencement of face-to-face consultations and contacts.

Members noted there have been 22 incidents of noncompliance with child safeguarding procedures involving Health Board services. All incidents are reported to relevant service leads with assurance that they are being addressed. Collated reports will be reviewed at Service Safeguarding Delivery Groups to enable individual and collective incidents to be addressed by the directorates and sites concerned and ensure that training and supervision is tailored to address the areas of concern.

Services have been provided with seven minute briefings to remind staff of their statutory duty to report a child at risk of abuse or neglect.

Adult Safeguarding
A report on adult safeguarding activity in HDdUHB also noted an increase in referrals to Local Authority adult safeguarding teams. A breakdown of the themes involving HDdUHB services noted that discharge from hospital is a consistent theme in safeguarding reports. Referrals related to discharge amount to twenty seven which is the same figure as Quarters 1 and 2. The Health Board’s Adult Safeguarding Team undertook a thematic review of the 55 cases that occurred during 2021 to identify specific themes. This report was shared recently with the

Listening and Learning Sub Committee and a task and finish group has been commenced led by quality improvement leads.

VAWDASV
The Group received a report which provided a general update and noted that the number of Multi-Agency Risk Assessment Conferences (MARAC) Daily Discussions has increased over the pandemic however the number of Domestic Incident Reports has not increased significantly. Only a small number of referrals are coming from Health with majority coming from the Police.

Financial Contributions
Head of Safeguarding has submitted reports identifying the number of financial requests being requested via safeguarding as there is no funding available which will be discussed further at the next meeting.

Regional Safeguarding Board Awards
Dr Catherine Burrell and Dr Shaun Jones have been nominated and shortlisted for their commitment to Safeguarding. Other nominations which have been shortlisted include:
- Heather Howells for Training and Teams
- Ruth Harrison for work with reviews
- Sian Maynard for developing the Sharing Information in Pregnancy database

Procedural Response to Unexpected Deaths in Childhood (PRUDIC)
The PRUDIC Document 2018 is now due for review. A review consultation has been circulated and the Lead Nurse Safeguarding Children has met with key service leads across the Health Board. The key parts that need assessing are around neonates and viability and the inclusion of suicides in children and young people is being proposed.

NHS Wales Safeguarding Conference
To note the National safeguarding team will be holding a conference in March 2023.

Risgiau:
Risks (include Reference to Risk Register reference):

There one risk on the risk register which was discussed.

- Risk reference 1114 IRISi. The risk identifies that without maximising the opportunities for early identification and strengthening the use of preventative remedies available to primary care services through IRISi, we will not be able to intervene early in response to domestic violence and abuse.

  An overarching group with primary care representatives has been commenced to consider how this risk can be addressed.

Gwella Ansawdd:
Quality Improvement:

- The HDdUHB submission of the NHS Wales Safeguarding Maturity Matrix improvement plan is to be subject to peer review.

- Detailed scrutiny of the themes in discharge safeguarding referrals is to be taken through quality improvement work.

Argymhelliad:
Recommendation:

- The Committee is asked to discuss whether the assurance and actions taken by the Strategic Safeguarding Working Group to mitigate the risks are adequate.

Dyddiad Cyfarfod Nesaf y Grŵp Gweithredol:
Date of Next Group Meeting:

22nd June 2022