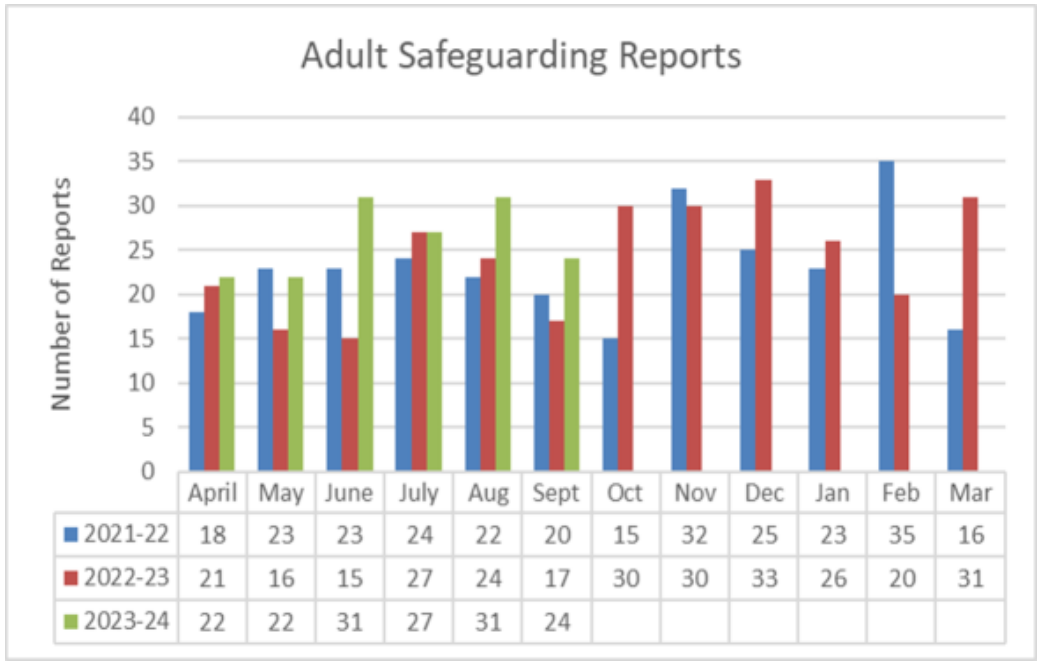
GIG CYMRU NHS WALES
Bwrdd Iechyd Hywel Dda Health Board

Strategic Safeguarding Working Group

Situation

- The most recent meetings were held on 8 August 2023 and 2 November 2023.

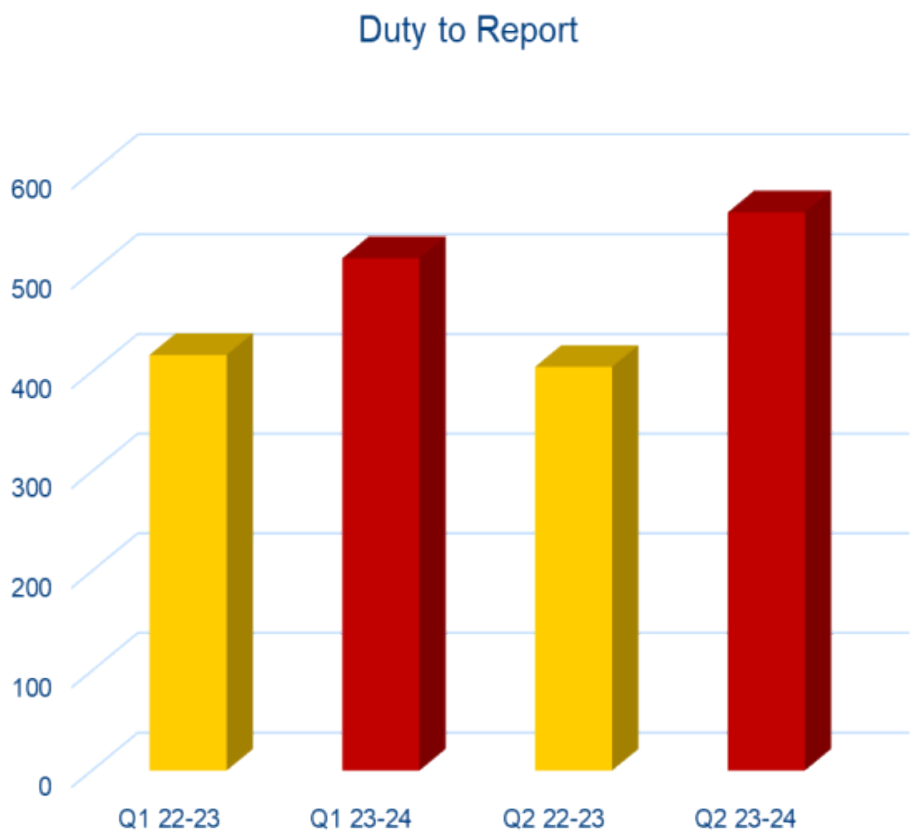
Adult Safeguarding Data and Themes



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	18	23	23	24	22	20	15	32	25	23	35	16
2022-23	21	16	15	27	24	17	30	30	33	26	20	31
2023-24	22	22	31	27	31	24						

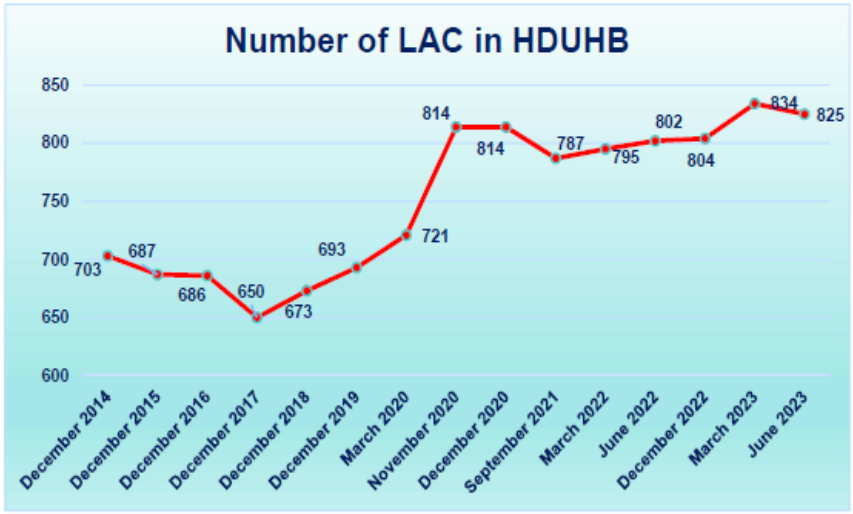
- Reflects the Reports/Referrals made in regard to ‘adults at risk’ who are alleged to have experienced abuse or neglect as a consequence of services delivered or commissioned by the Health Board.
- The number of Safeguarding Reports continue to increase annually. Q1 and Q2 demonstrate a 32% increase on the same periods in the previous year.
- Discharge related reports remains a consistent theme and communication continues to feature heavily, followed by assessments not being consistent with patient status. Heads of Nursing have action plans in place to address discharge planning concerns and feedback on lessons learned from individual cases via the Service Delivery Group.

Child Safeguarding



- Both Quarter 1 and 2 have seen a significant increase in safeguarding children reports forms to the Local Authority Children Services by Health Board employees.
- Since 2022 there has been a continuous increase in submissions. The impact of COVID-19 pandemic and the ongoing increase in cost of living pressures could be contributory factors in this.
- This increase has also been reflected in data that social services have shared reporting increases in the number of children's names placed on the child protection register.
- The reason for the report is due to the impact on child mental health.
- Parental separation continues to be a significant feature in reports alongside parental mental health and domestic abuse.
- The impact of the increase in safeguarding children activity is being monitored by the Corporate Safeguarding Team and some changes to current practice under review to create capacity, particularly related to the completion of safeguarding report forms in Datix Cymru.

Looked After Children (LAC)



- As the linear data shows below there has been a significant increase since December 2019 and this accelerated during the pandemic. Since November 2020 the numbers appear to have plateaued at the higher levels with no significant reduction.

- Continue to monitor the cost pressure to the (LAC) service budget to meet the needs of unaccompanied asylum seeking children placed under a Transfer Scheme could cause a budget deficit.

Child Protection Rapid Review

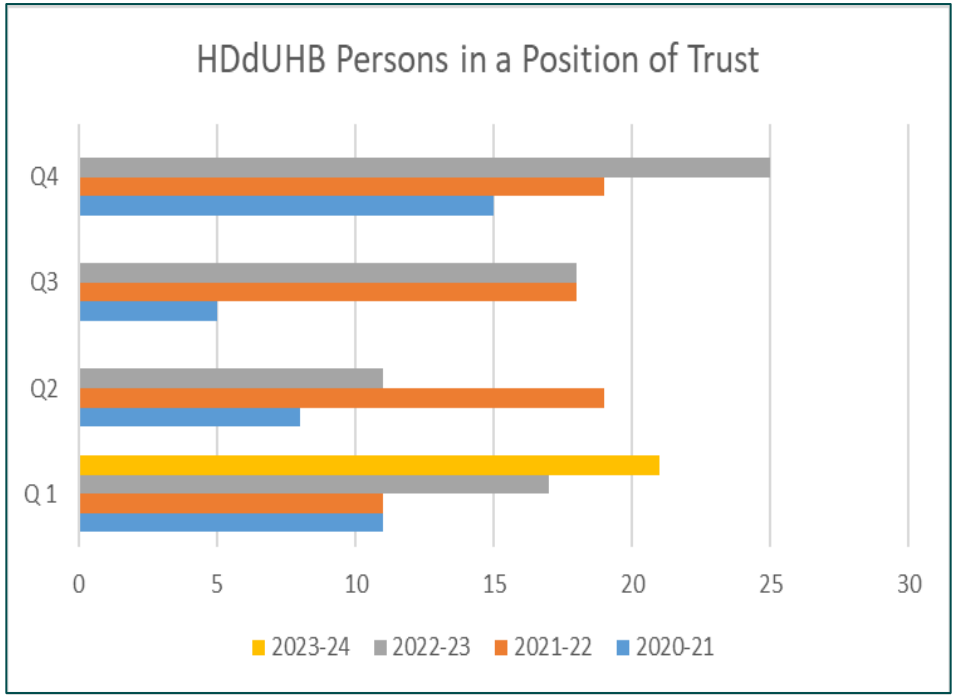
- A report was published in September 2023. Formal reporting arrangements are not yet clear, however, the Health Board will be in a position to respond. An internal action plan is in place which is being monitored via Service Safeguarding Delivery Groups.

- Report and recommendations have been be shared with the Digital Director and Health Board Clinical Informatics Officer for the following recommendation.
    - For Welsh Government (WG) to work alongside Health Boards to commission a centralised, accessible IT system to capture all health information relating to children, including location and non digitalised records.

Sexual Safety

- Further to the Women's' Right Network publication of sexual assaults and rapes in hospitals in England and Wales in April 20203, the NHS Executive has established a National Coordinating Group to review the position in NHS Wales.
- The review flagged challenges with data accuracy and validity in NHS Wales. There is no bespoke system for capturing staff to staff incidents. There is a lack of sexual safety policies; there are challenges with same sex accommodation and gender placement in hospitals.
- The group has drafted a paper for the Chief Nursing Officer and Executive Directors of Nursing with recommendations.
- The Director of Nursing, Quality and Patient Experience has agreed that an internal Sexual Safety Group is established. Membership and Terms of Reference are to be agreed.

Safeguarding Allegations about Practitioners and those in a Position of Trust



- 2021-22 saw a 58% increase in activity compared to 2020-21. Reports in 2022-23 slightly increased on 2021-22.
- 27 reports were received in Q1 received which is a 58% increase on the same quarter in 22-23.
- The Head of Safeguarding & Lead Safeguarding Practitioners support the management of all these referrals under Section 5 of the Wales Safeguarding Procedures 2019 in support of the relevant Line Manager and HR advisor.
- All concerns are subject to risk assessment and on closure under safeguarding procedures, may result in further action under University Health Board (UHB) procedures.
- To note all employees are offered support in line with the process set out in the Managing Safeguarding Allegations and Professional Concerns raised against Hywel Dda University Health Board Staff Policy (246).
- Heads of service report themes and learning at Service Safeguarding Delivery Groups.

Emerging Themes

- Staff understanding that their conduct in their personal life can impact on information sharing decisions by Police and they can be subject to Wales Safeguarding Procedures
- Staff not recognising boundaries between colleagues
- Chaperoning
- Increase in concerns related to younger staff, i.e. under 18 years old

Actions

- Managers should ensure they inform staff on induction to the workplace along with the discussion on standards of behaviour and values.

  NHS Wales Safeguarding Network are agreeing a standard statement on safeguarding for NHS employee job descriptions
- Workforce are reviewing.
- Managers should circulate the Chaperone Policy to staff
- Corporate Safeguarding Team will monitor

Exception Reports from Services

Community and Primary Care

- Nursing homes are reported to be more cautious about accepting individuals which is affecting patient flow from acute sites. Further discussion is to take place to understand the issues.
- Domiciliary Care remain fragile. National working groups have been established to address issues to encourage people to become a carer within the community but it is noted that this is a national challenge.

Acute Services

- Trends in discharge related concerns will be monitored moving forward to demonstrate where improvements are being identified.
- Operational pressures across most sites continues to impact on training compliance with all sites reporting compliance less than 85%, although there has been overall improvement in all areas, particularly across nursing. Medical and surgical clinician training compliance continues to be of concern and has been escalated to relevant leads and communicated to teams.

Women, Children and Public Health Nursing

- Risk number 1733 - There are currently insufficient staff to deliver the Health Visiting Service across the Health Board remains with oversight and monitoring underway.
- Risk Register 1409/1460 – Difficulty in recruiting qualified school nurses resulting in reduced workforce. There are particular challenges to recruitment in the Ceredigion region, and oversight and monitoring is underway.

Mental Health and Learning Disabilities (MHLD); Estates and Facilities; Therapies and Health Sciences

- Training compliance is being addressed.

Pembrokeshire Domestic Homicide Review (DHR)
Death of June in February 2021

- 71 years of age at the time of her death in February 2021.
- Married to Peter, 81 years of age for 51 years. They had four adult children and six grandchildren.
- In mid-February 2021, officers from Dyfed Powys Police attended at June and Peter's address in response to a call originating from South Wales Police. A letter had been posted by Peter to the regional Royal Mail Sorting Office with the following information written in red and underlined on the envelope:

  "*Ring 999 and inform the police that this envelope contains admission of a recent murder and suicide*."

- June died as a result of suffocation and strangulation. Cause of death recorded as unlawful killing.

Overview Chronology and Themes

The DHR examines agency responses and support given to June - examines the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers in accessing support.

Health Board Contacts

- Unexplained injuries between 1980 and 1993
- Attended Emergency Department twice – Oct 15 and May 2016. – latter presentation, routine enquiry undertaken.
- Visited GP only 3 times during the timeline.
- Did not engage in routine health screening / prevention.
- 25 appointments at 2 dental practices between 2012 and 2020.
- COVID pandemic 2020.

Themes

- Coercive control
- Rurality and isolation
- Availability of information for older people and rural communities

Hywel Dda University Health Board (HDdUHB) Recommendations

Lead Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) and Safeguarding Practitioner to work with Primary Care Services to strengthen links with local specialist domestic abuse services	Complete
Acute Services, supported by the Lead VAWDASV and Safeguarding Practitioner to review the documentation used in Emergency Departments to record routine enquiry	Complete
The Corporate Safeguarding Team to recommend to the Strategic Safeguarding Working Group that Ask and Act becomes routine rather than targeted enquiry within Emergency Departments across Hywel Dda University Health Board	Complete
Clinical leads for Acute, Community, Primary Care and Mental Health services, supported by the Lead VAWDASV and Safeguarding Practitioner to communicate expectations in relation to the importance and means of recording whether patients attend alone or are accompanied during presentations/consultations	Complete
The Corporate Safeguarding Team to audit the embedding of the Hywel Dda University Health Board's Ask and Act Policy in practice and report to the Strategic Safeguarding Working Group	Complete
Primary Care to improve compliance with Group 2 Ask and Act training and establish a mechanism for monitoring and reporting compliance	Ongoing

Primary Care to provide assurance that GP Practices have embedded the Mid and West Wales Regional Pathfinder for GPs based on the Safelives GP Pathfinder guidance	Complete
Primary Care to ensure that GPs, Dental Practices and other primary care providers have access to Live Fear Free Helpline resources to display in settings	Complete

Regional and National Recommendations

- **Regional**
  - To share learning from the implementation of Identification and Referral to Improve Safety (IRIS) in Carmarthenshire to shape the roll out across Mid and West Wales
  - Pilot and evaluate a Health Based Independent Domestic Violence Adviser (IDVA) approach within Hywel Dda University Health Board

Update

- Presentation on progress with IRIS to date shared with Community and Primary Care Safeguarding Delivery Group and Mid and West Wales (M&WW) VAWDASV Board
- HDdUHB are piloting a Domestic Abuse Advocate in the Emergency Department (ED) in BGH

- **National**
  - Quality Assurance tools used across Primary Care to be revised and updated to ensure they are consistent with the intercollegiate documents for child and adult safeguarding and the VAWDASV National Training Framework
  - WG to mandate the adoption of IRIS within GP settings across Wales and provide sufficient resource to support implementation
  - WG to clarify expectations relating to the implementation of the National Training Framework and Ask and Act in Primary care services specifically those services which are independently contracted e.g. GP and Dental Practices

IRIS Funding and Sustainability

- Carmarthenshire cluster funding for the pilot ends in March 2024. Primary Care Service Managers are trying to secure funding to extend by a year.
- A round table discussion took place arranged by WG under the direction of the Minister for Social Justice and Chief Whip and Minister for Health and Social Care. Discussion focussed on sustainability and funding. It was agreed that there needs to be an All-Wales approach and agreement that IRIS should be mandated and funding identified as any commitment is not recurring.
- Feed back to the Minister for Social Justice and Chief Whip and Minister for Health and Social Care and agenda for discussion at the VAWDASV National Partnership Board in January, however, it is noted that any decision then would be too late for 24-2025.
- HDdUHB has been approached by IRIS and University of Bristol to take part in a Randomised Control Trial comparing IRIS with a new programme, IRIS Plus which offers a service for children and perpetrators.
- The Health Board would need to fund the core programme.
- A meeting has taken place with one of the Pembrokeshire Primary Care Service Managers and Clinical Lead and a meeting is to be arranged with IRIS and Bristol University to discuss the research further, but the funding of the core programme is likely to be barrier.
- NHS Charities is to be pursued and / or research programme funding opportunities.

VAWDASV Update

- Regional Strategy- Building happier, safer, stronger lives
  Mid and West Wales Violence against Women, Domestic Abuse and Sexual Violence Strategy 2023 – 2027 will be launched in National Safeguarding Week 13 November 2023
- Developed in line with National Strategy for Wales and local needs objectives.
- Includes reference to Domestic Violence Advisor (DVA) role created in Bronglais Hospital (BGH) and IRIS intervention.
- Emphasis on improving response for Older persons, and Children and Young People.
- Increased measures to include survivors voice in planning and delivery of services.

Health Domestic Abuse Advocate in BGH – Emergency Department

- Funded through NHS Charities.
- Pilot for 2 years within BGH Emergency Department.
- Contract awarded to West Wales Domestic Abuse Service and successfully recruited Domestic Violence Advocate for post.
- Objectives include :–
  - Improve support for victims of abuse
  - Education of practitioners, including embedding routine enquiry into the ED.
  - Improve multiagency referrals for those experiencing multiple health needs.
  - Improve identification and referral for those most hidden/less likely to access support- i.e. older victims/ LGBTQ+, those with a disability.

Risks and Mitigation

Summary

- Service Safeguarding Delivery Groups identify and mitigate risks with gaps in safeguarding training compliance. There are more complex cases emerging and there have been non-compliance incidents. Service areas that sit below the 85% compliance are recorded on the relevant service risk register.
- Service Safeguarding Delivery Groups continue to identify themes in safeguarding incidents and evidence improvement.
- Primary Care to consider the IRIS funding risk

Recommendation

For the Quality, Safety and Experience Committee to take assurance from the report provided.