Enw'r Pwyllgor: Name of Sub-Committee:	Exception Report from Strategic Safeguarding Working Group
Cadeirydd y Pwyllgor: Chair of Sub-Committee:	Assistant Director of Nursing for Quality, Assurance and Professional Regulation
Cyfnod Adrodd: Reporting Period:	16/09/2020

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

Strategic Safeguarding Working Group Terms of Reference The Terms of Reference for the reformed Strategic Safeguarding Working Group and the sub structure to service the Safeguarding Delivery Groups were presented and approved.

- **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 2019/20 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.

- **Learning From Reviews**
  Published Adult Practice Review (APR) CWMPAS 012019
  A presentation and 7 minute briefing were presented to the Group following the publication of the above review on 21st August 2020, with the learning for the service involved in commissioning placement noted. The Group was advised that an action plan will be developed by the Regional Safeguarding Board and following completion, progress against any Health Board actions will be reported to and monitored by the Group.

  Adult Practice Reviews
  Members were advised that an Adult Practice Review is due to commence in the Autumn of 2020, with confirmation received that relevant Health Board services are aware.

  Child Practice Reviews
  Members noted that one Child Practice Review is in progress and a further extended Child Practice Review is due to commence in October 2020. Assurance was received that when progressing these reviews, engagement will take place with relevant Health Board services.

  PRUDiC (Procedural Response to Unexpected Deaths in Childhood)
  The Working Group noted that one new PRUDiC was reported on 21st July 2020. All PRUDiC procedures have been followed with engagement from relevant Health Board services and a Police investigation is in progress.

- **Professional Concerns**
  During Quarter 1, 18 alleged professional concerns were noted involving Health Board employees. Whilst all the cases are managed with the relevant services, current records do not allow for the recording of outcomes. This is mainly as a consequence of the process

currently being followed by the relevant Local Authorities. It is anticipated that this will change once there is regional agreement of a professional concerns process and agreeing outcomes becomes embedded in practice. The Health Board database has been modified to improve data capture, including outcomes.

- **Training Compliance**
  Overall compliance for level 2 e-learning for children for Quarter 1 was noted at 85.58%, with safeguarding adult level 2 core e-learning recorded as 82.38%. Improvement and gaps in safeguarding training compliance were noted and the associated risks were reviewed.

- **Assurance**
  The Group received exception reports from the four service Safeguarding Delivery Groups. Key areas to note are as follows:
  - Training compliance – During COVID-19, gaps in training were further evidenced. Agreed actions included all areas to review their compliance with safeguarding training and identify any risks to their current improvement plans, with entry onto service level risk registers required where risks cannot be mitigated. The improvement plans are to be monitored through the delivery groups and exceptions reported to the Strategic Safeguarding Working Group.
  - Long Term Care - Due to the COVID-19 pandemic and subsequent lockdown, there has been no visiting by relatives and limited entry into care homes for health care professionals to undertake routine assurance visits. As a result the bi-monthly focussed assurance checks previously undertaken by the long term care team have been suspended. The Strategic Safeguarding Working Group was advised that this is also the case for Local Authority monitoring and Care Inspectorate Wales (CIW) monitoring. In order to mitigate risks, some monitoring has taken place virtually via Teams and Skype, and access was achieved by the team when they undertook COVID-19 testing, although it was recognised that the purpose of these visits was different. Recently, further access has been permitted, although in Ceredigion this is no longer the case, and this may be repeated across the two other Local Authority areas. This positon will be kept under review by commissioning colleagues working collaboratively across Health and Social Care.

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

The two risks on the register were reviewed as follows.

- Risk reference 703 - service / departmental level risk related to Group 1 Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV) training compliance. This risk will remain on the risk register as compliance fell in Quarter 1 and has not achieved the required 85% compliance. Operational services are to ensure improvement plans are in place.

- Risk reference 167 -Directorate level risk related to capacity of operational teams to release staff to attend training. Operational services are to ensure improvement plans are in place. This risk was reviewed and agreed that it will be removed; where individual services have significant gaps in compliance with core safeguarding training, they will record this on the Directorate risk register, and will liaise with the corporate safeguarding team, where be-spoke training may be considered to support increase in compliance.

Gwella Ansawdd:
Quality Improvement:

- The Head of Safeguarding and Safeguarding Children Specialist Nurse are leading on an evaluation of the delivery of Ask and Act training for NHS Wales.
- Bespoke Ask and Act training to GP clusters to improve their awareness and recognition of abuse and how to respond to concerns identified in Domestic Homicide Reviews has been made available since August 2020. The Primary Care Directorate has been asked to promote uptake of this training with GPs and Practice Nurses particularly. Discussions are ongoing to identify engagement and funding for a pilot procurement of Identification and Referral to Improve Safety (IRIS) in primary care which will support their training needs, recognition and signposting of victims of domestic abuse.

Argymhelliad:
Recommendation:

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

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

15th December 2020