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|---|---|
| **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, Quality and Professional Regulation |
| **Cyfnod Adrodd: Reporting Period:** | April 2020-March 2021 |

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

**Meetings**

The Strategic Safeguarding Working Group Terms of Reference and constitution were revised during 2020 to reflect the governance framework in Hywel Dda University Health Board (HDdUHB). The Strategic Safeguarding Sub-Committee became the Strategic Safeguarding Working Group.

The Group meetings have been held on a quarterly basis with the exception of Quarter 3 as follows:

- 1st July 2020
- 16th September 2020
- 15th December 2020 (cancelled due to the second wave of the pandemic)
- 10th March 2021

During 2020/21, the Group met on 3 occasions and was quorate at one meeting.

**Working Group Terms of Reference and Principal Duties**

In discharging its duties, the Strategic Safeguarding Working Group has undertaken work during 2020/21 against the following areas of responsibility in relation to its terms of reference:

**Social Services and Well-being (Wales) Act (SSWBA) 2014**

HDdUHB is able to provide assurance of compliance with the Act and associated statutory guidance through the assurance and exception reports to the Strategic Safeguarding Working Group during 2020/21. Key areas to note are as follows:

- **Adult Safeguarding**

- 2020-21 has been a unique year and the value of direct comparisons with previous years are limited as a result of the disruption and changes brought about by the impact of the COVID-19 pandemic. The first three quarters of 2020/21 reflected a significant increase in referrals regarding HDdUHB services to Local Authority Safeguarding Services compared to previous years. However, Quarter 4 reflected a reduction in the number of referrals.
- A review of the numbers and themes arising from adult safeguarding referrals involving Health Board services highlighted that poor communication related to discharge has been a prevailing theme and actions are being taken forward by Hospital Heads of Nursing, which include multi-disciplinary improvement plans with Local Authority involvement.
- Missed fractures were highlighted as a concern and a thematic review was undertaken and shared with the Quality Improvement Team to inform their work in this area.
- An internal audit undertaken by the corporate safeguarding team provided assurance to Local Authority partners that pressure damage reporting and scrutiny will stand up to external challenge. The audit outcome recommended an improved consistency in evidencing how learning is addressed, which Hospital Heads of Nursing are taking forward.

- Level 2 and 3 adult safeguarding training was delivered via Microsoft Teams during the pandemic, which resulted in a significant increase in uptake and improved compliance in adult safeguarding training.

- **Child Safeguarding**

- The Group received assurance of compliance with the Procedural Response to Unexpected Deaths in Childhood (PRUDiC) and early lessons learned. There were five PRUDiC instances during 2020/21; two identified early learning for services. An Emergency Department response to one PRUDiC was not consistent with HDdUHB management of PRUDiC, therefore, an action plan is currently being managed by the relevant Head of Nursing. Record keeping in Health Visiting services was also identified as an area of learning and is being addressed by the Service Delivery Manager (SDM) and Senior Nurse Manager (SNM).
- Review of HDdUHB Multi-Agency Referral Forms (MARF) to Local Authority Children Services demonstrated a significant increase in MARF submissions Quarter 2 of 2020/21, most likely due to the relaxation of lockdown rules, services returning and becoming accessible to children and families, and increasing opportunities to disclose abuse and neglect. HDdUHB activity remained higher throughout 2020/21 than the previous year, which provides assurance that HDdUHB employees continued to discharge their statutory duty to report a child at risk of abuse or neglect during the pandemic.
- There has been a rise in MARF submissions due to self-harm in children and young people, which has been noted by the Regional Safeguarding Board as an area of concern. The Regional Talk to Me 2 Delivery Group is undertaking work to improve early recognition and intervention in this field. Quarter 4 saw a significant increase in the number of Child Sexual Exploitation (CSE) /Child Sexual Abuse (CSA) related cases. Reasons for this are currently unclear and will require ongoing monitoring. However, it was noted that the CSE/CSA has been a feature of the Safeguarding Newsletter and discussed in Service Safeguarding Delivery Groups. Additionally, specific CSE training was delivered to staff in Autumn 2020 to raise awareness of these areas of abuse.
- Level 3 Child Safeguarding training was delivered via Microsoft Teams, however, compliance remained low during 2020-21. Operational service leads have implemented improvement plans to improve compliance in 2021-22.

- **Professional Concerns**

- The Wales Safeguarding Procedures (2019) set out arrangements for responding to safeguarding concerns about those whose work, either in a paid or voluntary capacity, brings them into contact with children or adults at risk. It also includes individuals who have caring responsibilities for children or adults in need of care and support and their employment or voluntary work brings them into contact with children or adults at risk.
- Whilst the procedures clarify that the responsibility sits with the Local Authority for overseeing the process, they support internal disciplinary procedures and provide guidance to deal appropriately with any concerns or allegations of professional abuse, neglect or harm. They ensure that all allegations of abuse made against staff or volunteers working with children, young people and adults at risk are dealt with in a fair, consistent and timely manner.
- Fifty-six professional concerns related to Health Board employees were managed during 2020/21; eighteen related to incidents in the individual's professional life and thirty-eight related to incidents involving an individual's private life. Twelve concerns related to an individual's private life involved concerns about their parenting. Eleven concerns related to individuals involved in perpetrating domestic related incidents. Eight concerns related to

substance misuse in the individual's private life. Eleven concerns involved new staff recruited in response to the COVID-19 pandemic. In seven cases, the concerns were substantiated. All but one of these concerns related to incidents in the individual's private life.

- In all professional concerns, information shared via the Local Authority is shared with the relevant manager and Workforce representative. A risk assessment is set out to ensure that any risks to adults or children receiving services in the Health Board are mitigated. Wellbeing support is also offered to the individual involved.
- Further discussion is to take place with Workforce colleagues to take a co-ordinated approach in ensuring staff are aware that actions in their personal lives can result in a multi-agency information share and be subject to the professional concerns process.

- **Looked After Children**

- HDdUHB has statutory responsibilities in relation to the planning, commissioning and delivery of services in order to address the health needs of Looked After Children (LAC) residing in HDdUHB and HDdUHB children placed in other Health Board areas.
- Assurance and exceptions in compliance with the statutory requirement to provide a minimum of an annual health assessment for children and young people looked after who are over 5 years of age and twice yearly for children under 5 years of age has been received.
- During the COVID-19 pandemic, there was a significant increase in the number of LAC within the HDdUHB area due to a combination of cases from the 3 local authorities and children placed from other health board areas, adding to the increasing workload. As at 31st March 2020, there were 721 LAC, 299 of which were placed from other local authorities. Recent data at 31st March 2021 indicate 816 LAC, which is the highest level in approximately five to six years, 340 of which are children from other areas. This increase within the service has been monitored to identify any variance however, it appears the pattern is continuing and is a reflection of the pressures that families have experienced during the pandemic. Children are now attending school and have the opportunity to share information of how they are feeling and what experiences they have had during lockdown.
- The Strategic Safeguarding Working Group received an evaluation of a new and innovative role in HDdUHB, which is the only post of its kind in Wales. A LAC Nurse specifically for children and young people in residential homes has maintained contact with residential care home managers and children via telephone and virtual means during the pandemic to ensure that their health and wellbeing needs were being met.

- **Statutory Reviews**

- HDdUHB has statutory duties under the Social Services and Wellbeing (Wales) Act 2014 to participate in multi-agency Child and Adult Practice Reviews. HDdUHB participated in two Child Practice Reviews during 2020/21, which are currently ongoing. Early learning has identified the need to implement a procedure for monitoring vulnerable people who are not brought to, or could not attend, appointments. This procedure has been approved and implemented with an audit planned for 2021/22.
- HDdUHB participated in one Adult Practice Review – CWMPAS 1/2019 that was published in August 2020. This review involved a young woman with learning disabilities in a jointly commissioned supported living placement who was subject to physical and emotional abuse by her care workers. This review highlighted the following improvements are required.
    - Improvement in transition arrangements

- Responsibilities of Care Inspectorate Wales (CIW) and commissioners in carrying out unannounced visits and their scrutiny and assurance processes;
- An Independent Reviewing System for adults with learning disabilities whereby Independent Reviewing Officers ensure that placements and care plans fully reflect the needs of the adult;
- The need for respectful uncertainty and professional curiosity by practitioners.

The Mental Health and Learning Disabilities Directorate are involved in the action plan arising from this review.

- Domestic Homicide Reviews are held under statutory guidance under section 9(3) of the Domestic Violence, Crime and Victims Act 2004 and the Health Board is directed to participate in such reviews and share relevant information. HDdUHB has been involved in two Domestic Homicide Reviews during 2020/21, one in Ceredigion and one with Gwynedd and Anglesey Community Safety Partnership. Both reviews involved older people and the review process is currently ongoing. However, early learning has highlighted the need to implement IRISi in Primary Care, which is consistent with the regional priority identified from a previous Domestic Homicide Review in Pembrokeshire and is detailed in the Mid and West Wales Regional Violence Against Women, Domestic Abuse and Sexual Violence Delivery Plan. Three GP clusters in Carmarthenshire have volunteered to participate in a pilot with an evaluation to be reported to the Strategic Safeguarding Working Group via the Community and Primary Care Safeguarding Delivery Group.

**Violence Against Women Sexual Violence and Domestic Abuse Act (2015)**
HDdUHB has duties under the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act (VAWDASV) 2015. The National Training Framework issued statutory guidance under Section 15 of the Act. HDdUHB is required to evidence improvement in compliance with Groups 1, 2 and 6 of the National Training Framework. Progress against this is reviewed by the Strategic Safeguarding Working Group on a quarterly basis and subsequent risks reviewed.

A Mid and West Wales VAWDASV Strategic Group is well established and chaired by Dyfed Powys Police. HDdUHB is engaged in the VAWDASV Regional Strategy under which there are six regional priorities agreed as follows.

1. Improve public knowledge and awareness and challenge attitudes towards equality and domestic abuse among citizens.
2. Increase the awareness of children and young people of the important of safe and healthy relationships and abuse is always wrong.
3. Increase the focus on holding perpetrators to account and providing them with opportunities to understand their behaviour and its consequences.
4. Make early intervention and prevention an integrated priority.
5. Ensure professionals are trained to provide timely and effective responses to victims and survivors.
6. Provide victims with equal access to appropriately resourced services.

The operational delivery against these priorities is through the VAWDASV Delivery Group. HDdUHB has representation on both the strategic and delivery groups and associated Task and Finish Groups. The specific action for the HDdUHB under priority 6 is the implementation of an IRISi pilot in Primary Care. Under priority 5, the HDdUHB corporate safeguarding team led the evaluation of the delivery of Ask and Act training in NHS Wales on behalf of the NHS Safeguarding Network.

During the pandemic, statutory partners did not witness a rise in domestic incident reporting, however, specialist services have reported an increase in the number of victims contacting their services directly. Strong collaborative working in the region is responding to the challenges in specialist services with grant applications to support capacity and service development. The corporate safeguarding team have continued to raise awareness of domestic abuse and support services throughout the pandemic.

HDdUHB is required to submit an annual report to Welsh Government on compliance with the National Training Framework. The National Training Framework places a statutory duty on the UHB for all staff to be compliant with Group 1 VAWDASV e-learning. During the past year, there had been a significant decline in compliance despite taking positive action to address this. This is discussed further in the risk section of the report.

Group 2 Ask and Act training is a requirement for specific groups of staff and compliance in this area has increased as a result of delivery via Microsoft Teams.

Group 6 Strengthening Leadership Series is aimed at public sector leaders and comprises a series of short films, each on an important issue related to violence against women, domestic abuse and sexual violence. The films offer short bursts of information, which can be used to shape strategic direction, share within teams and improve knowledge. Compliance with this training group is currently not possible as it is not linked to the Electronic Staff Record (ESR).

**Other Areas of Responsibility**
During 2020/21, the Strategic Safeguarding Working Group also received, and considered the following:

- Strategic safeguarding work plan and improvement plan for the NHS Wales Safeguarding Maturity Matrix.
- A review against the HDdUHB improvement plan in response to the Healthcare Inspectorate Wales (HIW) Special Review Abertawe Bro Morgannwg University Health Board's (now known as Swansea Bay University Health Board) handling of the employment and allegations made against Mr W.
- Regional Executive Safeguarding Board updates
- NHS Safeguarding Network developments
- Looked After Children – quality of health assessments audit
- HDdUHB contribution to the Regional Safeguarding Board Annual report 2020-21, attached at Appendix 1.

**Strategic Safeguarding Working Group Developments for 2021/22**
The following developments are planned for Strategic Safeguarding during 2021/22:

- Continue good working relationships with Local Authority and other partner agencies.
- Continued review of the HDUHB self-assessment against the NHS Wales Safeguarding Maturity Matrix and associated improvement plan.
- Concentrated effort to support wider learning from Safeguarding reviews, with consideration to be given to processes to facilitate this.

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

Risk 703: Compliance with the Group 1 VAWDASV National Training Framework has been on the risk register since February 2019 and details the risk that staff would be unable to recognise and respond to violence against women, domestic abuse and sexual violence. This is as a result of failure to complete Group 1 VAWDASV e-learning. This could lead to an impact on statutory compliance with the VAWDASV Act 2015 National Training Framework (2016). Non-compliance with training could result in staff failure to recognise and respond to domestic abuse and lead to harm for people receiving Health Board services.

The Health Board failed to achieve and sustain 85% compliance by March 2021. The compliance deteriorated month on month during the year despite reminders to managers and staff to complete the training. At the end of Quarter 4, compliance is reported at 78.86%. A breakdown of each service compliance has been sent to relevant Executive and operational teams to target areas where compliance is not achieved.

Services and directorates are to identify their improvement plans, which will continue to be monitored via the Strategic Safeguarding Working Group.

This risk will be further reviewed, with anticipated improvement in compliance, at the end of Quarter 1 2021/22.

**Gwella Ansawdd:**
**Quality Improvement:**

- Progress against the Strategic Safeguarding Work Plan and Safeguarding Maturity Matrix training compliance improvements were initially hampered by the COVID-19 pandemic; however, the innovation of delivering training via Microsoft Teams has improved compliance with Level 3 adult safeguarding and Group 2 Ask and Act training.
- The Lead Nurse LAC led on a revised LAC Health Assessment Framework in 2020 and has successfully implemented this in HDdUHB following the training of all Health Visitors and School Nurses.
- All LAC health assessments are quality assured by the LAC Lead Nurse and Specialist Nurses to ensure the quality of care delivered across the organisation is consistent and the organisation delivers effective, safe and person-centred care.
- The LAC Nurse for Residential Homes evaluated the first twelve months of this post in HDdUHB and outcomes for children and young people placed in those care homes.
- The corporate safeguarding team led on an evaluation of the delivery of Group 2 Ask and Act training in NHS Wales and presented the outcome and recommendations to the NHS Wales Safeguarding Network.
- An audit has been conducted six months after attendance at Group 2 VAWDASV Ask and Act training to capture outcomes for survivors of domestic abuse in contact with HDdUHB services.
- The Lead Nurse Safeguarding Children and named Doctor led on a Regional Procedure for the Management of Injuries in Non Mobile Children, which has been approved and implemented across the region.

**Argymhelliad:**
**Recommendation:**

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

| **Dyddiad y Cyfarfod Pwyllgor Nesaf:**<br>**Date of Next Group Meeting:** |
| --- |
| 11th August 2021 |


# Annual Partner Agency Contribution

# to the Mid & West Wales Safeguarding Board's Annual Report 2020-21

Each designated Board member is required to complete the below report template to enable your agency's contribution and safeguarding work to be adequately represented in this year's Annual Report.

Within the context of outcome focused practice, as well as identifying the work that has been undertaken, please give careful consideration as to how your contribution **evidences good safeguarding outcomes for children and adults at risk.**

Please consider responses within the context of the Board's Annual Strategic Plan 2020-21 – see attached reporting spreadsheet.

**Please note this contribution is for the Annual Report to be published by 31st July 2021, which will reflect and report on work undertaken between 1st April 2020 and 31st March 2021 only.**

## Organisational Input into the Mid & West Wales Safeguarding Board's Annual Report 2019-20,

## COVID-19 Specific:

| Question | Comment and Actions | COVID-19 Specific Comments and Action | What safeguarding outcomes have you achieved? |
|---|---|---|---|
| 1. **How has your organisation/agency contributed to the Board's effectiveness?** | Hywel Dda University Health Board continues to be a consistent member of the Mid and West Wales Regional Safeguarding Board.<br><br>As a statutory partner, we work collaboratively and provide professional challenge across the spectrum of safeguarding work.<br><br>The Health Board continues to play an active role in development of policy and procedures and safeguarding training and active participation in multi-agency reviews and learning events. | We participated in the regional COVID response multi-agency meetings to respond to issues collaboratively. | Strong commitment to partnership and multi-agency working. |

| Question | Comment and Actions | COVID-19 Specific Comments and Action | What safeguarding outcomes have you achieved? |
|---|---|---|---|
| **2. How has your organisation/agency worked collaboratively with other bodies or organisations?** | We actively commit to and participate in the Board's subgroups and LOG meetings and work closely with partners to develop and implement regional policy and improve safeguarding practice.<br><br>We have been committed to and actively participated in Child Practice Reviews, Adult Practice Reviews and Multi-agency Practitioner Forums and DHRs.<br><br>Corporate Parenting – the LAC Lead Nurse is a consistent and active member of Corporate Parenting panels – see COVID 19 specific comments.<br><br>CSE – the Lead Nurse LAC is an active members of the three MACSE and operational staff attend CSE strategy meetings. | Corporate Parenting Panels were held during the pandemic in Pembs and Ceredigion. Carmarthenshire has not met since February 2020. | We have worked collaboratively to develop and implement the Regional Adult Safeguarding Threshold document and Regional Training Framework.<br><br>Identification and sharing of learning within and across agencies.<br><br>The Lead Nurse LAC provides reports to the UHB Strategic Safeguarding Working Group on LAC activity and the assurance of the timeliness and quality of Health assessments for LAC.<br><br>Participate in the reduction of risks of sexual exploitation. |

| Question | Comment and Actions | COVID-19 Specific Comments and Action | What safeguarding outcomes have you achieved? |
|---|---|---|---|
| | The UHB are consistent members of and participate in VAWDASV regional strategic and operational meetings with representation from statutory and non-statutory organisations.<br><br>We have recruited a Domestic Abuse Support Officer who provides consistent attendance and representation at Domestic Abuse Daily Discussion meetings.<br><br>Participation in multi-agency Modern Slavery MARAC meetings<br><br>Consistent members of each county multi-agency Channel Panel meetings.<br><br>Actively contribute to the NHS Wales Safeguarding Network. | | We train staff to identify and respond to domestic abuse and sexual violence and ensure they know how to access support and services for victims and perpetrators. We contribute to the achievement of the regional delivery plan.<br><br>Information sharing to recognise and respond to risk.<br><br>Information sharing to recognise and respond to risk.<br><br>Contribute to the NHS Wales work plan.<br>Identify and share best practice and where consistency in |

| Question | Comment and Actions | COVID-19 Specific Comments and Action | What safeguarding outcomes have you achieved? |
|---|---|---|---|
| | The UHB led of the evaluation of the delivery of Ask and Act training in NHS Wales. | | practice can be achieved on a 'one for Wales' basis. |
| **3. Please outline any key safeguarding training delivered to staff within your organisation this year.** | Level 2 and 3 adult safeguarding<br>Level 3 children<br>Group 2 Ask and Act<br>Commissioned CSE training<br><br>The Named Doctor delivers clinical Level 3 child safeguarding training and offers this to staff from Social Services and Police<br><br>The LAC team have delivered training to all Health Visitors | The UHB responded early to the challenge the pandemic placed on us with the cancellation of face to face safeguarding training. The corporate safeguarding team evolved training to be delivered by Microsoft Teams in response to the pandemic which has significantly improved attendance | Improved staff awareness of legal and policy requirements in safeguarding people at risk of abuse and neglect<br><br>Consistent uptake in multi-agency training<br><br>Implementation of the revised LAC health assessment framework |

| Question | Comment and Actions | COVID-19 Specific Comments and Action | What safeguarding outcomes have you achieved? |
|---|---|---|---|
| | and School Nurses on LAC and the health assessment framework<br><br>The Wales Safeguarding Procedures 2019 are embedded in all safeguarding training. | | |
| **4. Please highlight key challenges facing your organisation in respect of safeguarding practice.** | We are committed to APRs, CPRs, DHRs and MAPFs as they are an important learning process for the organisation and practitioners. Capacity to respond to the number of reviews taking place across 3 counties simultaneously is a challenge for us. We have skilled team members through action learning to support the facilitation of MAPFs.<br><br>Increased number of LAC in the region and the impact on the Corporate LAC team and Health Visitors and School Nursing services | During the second wave of the pandemic, three corporate safeguarding team members were redeployed into clinical practice to support operational services. The corporate safeguarding team implemented the service Business Continuity Plan. We have since returned to normal business. | Maintained business continuity in the corporate safeguarding team. |

| Question | Comment and Actions | COVID-19 Specific Comments and Action | What safeguarding outcomes have you achieved? |
|---|---|---|---|
| | Capacity in the corporate safeguarding team to attend three individual county multi-agency meetings, e.g. LOGs, Channel<br><br>Capacity in operational services to attend three LOGs, DADD, e.g. S-CAMHs, Mental Health service | | |
| **5. What are your agency's top 5 safeguarding achievements in 2020-21?** | • LAC Nurse Residential Homes<br><br>• Innovating training delivery via Microsoft Teams early in the pandemic and increasing uptake<br><br>• The Named Doctor and Lead Nurse for Safeguarding Children led the development of regional procedure for the | The LAC Nurse was innovative in establishing and maintaining contact with children and young people in these homes during the pandemic. | This is a unique post in NHS Wales. The first year has been evaluated including feedback from young people and managers of these homes.<br><br>Improved staff awareness across the spectrum of safeguarding.<br><br>Consistency in practice across the region. |

| Question | Comment and Actions | COVID-19 Specific Comments and Action | What safeguarding outcomes have you achieved? |
|---|---|---|---|
| | management of injuries in non-mobile children<br><br>• The LAC Lead Nurse led the development of a NHS Wales LAC health assessment framework<br><br>• The UHB led the evaluation of delivery of Ask and Act training in NHS Wales. | | Consistency in practice for LAC health assessments and a quality assurance framework across NHS Wales.<br><br>Identify and share best practice and where consistency in practice can be achieved on a 'one for Wales' basis. |
| **6. What in your opinion, do you consider to be the Board's key achievements and successes in 2020-21?** | Sustaining partnership working during the pandemic and progressing with reviews and regional policy development.<br><br>Establishing the COVID 19 response meetings<br><br>Virtual meetings | | Good engagement, attendance at meetings and partnership working |

**Organisational Input into the Mid & West Wales Safeguarding Board's Annual Report 2019-20:**

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| **7. Please evidence how children and young people, families and adults at risk have been involved in service development in your agency.** | LAC in residential homes and managers provided feedback to support the evaluation of the LAC Nurse in residential homes. | Improved service provision to meet the needs of LAC in residential homes. |
| | The Named Doctor for Safeguarding Children actively engages with parents / carers of children with complex needs to agree appropriate care and support plans | A co-ordinated child centred multi-agency response to the management of children with complex needs. |
| | The Health Board has established a Voices of Children and Young People multi-agency group. | Support the development of appropriate guidance, policies and procedures to ensure the importance of learning from children and young people is recognised and considered by the Health Board.<br>Provide support to ensure children and young people influence the strategic direction of the organisation.<br>Ensure the voices of children and young people influences services and staff across the organisation. |
| | The Health Board is working in partnership with Dyfed Powys Police, Dyfed Powys Office of the Police and Crime Commissioner and Mid and West Fire to develop a 'blue light' | This approach is in line with current advice from the Children's Commissioners for Wales Office. |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| | children's rights charter informed by children and young people across the Dyfed Powys footprint. | |
| **8. Please highlight any learning themes or outcomes that your agency has identified and how this information has been disseminated within your organisation.** | A thematic breakdown of referrals to adult safeguarding about Health Board services is provided quarterly to the UHB Strategic Safeguarding Working Group. Discharge from hospital has been a recurrent theme over the last 12 months. Acute services have an Acute Hospital Discharge Improvement plan, which is monitored through the Acute Service Safeguarding Delivery Group.<br><br>The NHS Wales Safeguarding Maturity Matrix identifies being Adverse Childhood Experience (ACE) informed as a key area for Health Boards and Trust within Wales. The electronic safeguarding children module allows themes ACE's and their impact to be | We aim to ensure that none of our patients come to harm through an unsafe discharge from hospital.<br><br>Aim to inform operational services of the themes to enable them to ensure the effectiveness of preventative services. |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| | identified from the narrative of the MARF.<br><br>All the LAC health assessments are quality assured by the LAC Lead Nurse and Specialist Nurse to ensure the quality of care delivered across the organisation is consistent and the organisation delivers effective, safe and person-centred care. The themes are reported to the Senior Nurses for School Nursing and Health Visiting and reported to Strategic Safeguarding Working Group quarterly and W&C DG.<br><br>Presentations to inform the Health Board Strategic Safeguarding Working Group of multi-agency and health recommendations from Child Practice Reviews, Adult Practice Reviews and Domestic Homicide Reviews locally and from across Wales is embedded. This is further supported by the distribution of 7-minute briefings via global email; Safeguarding Delivery Groups and the Health Board quarterly | Improved timeliness and quality of LAC health assessments.<br><br>Share lessons learned from safeguarding practice across different specialities in the UHB to improve outcomes for people at risk of abuse and neglect. |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| | safeguarding newsletters and publication on the safeguarding intranet page.<br><br>Redesigned the safeguarding intranet page as an all age information, support and learning hub<br><br>Lessons learned from internal practice and multi-agency learning are disseminated via a number of methods as mentioned above.<br><br>We have established a regular PRUDiC / Serious Incident meeting to ensure a seamless process for the reporting and monitoring of all incidents generated following an unexpected child death.<br><br>Distributed Live Fear Free resources to vaccination centres<br><br>Children who are not brought to appointments has been a theme for | Shared learning across the Health Board.<br><br>The group is responsible for ensuring that there is a streamlined process for the management of Serious Incidents that fall under the PRUDIC process. The Group will also oversee any Health Board actions arising from PRUDIC. Improved awareness of safeguarding legislation, policy and practice and how to recognise and respond to abuse and neglect across all age groups.<br><br>Make the public aware of domestic abuse and access to support<br><br>The UHB has an approved Procedure for Monitoring Vulnerable People who are not |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| | the UHB. Further, complex cases in the community involving adults at risk and access provided practice challenges.<br><br>Professional curiosity has been a recurring theme in reviews for all agencies. HDdUHB are reviewing what we can do to support improved practice in relation to professional curiosity.<br><br>The Senior Safeguarding Adult Practioner and Specialist Nurse Safeguarding Children led an interactive workshop of the UHB STAR Leadership programme and used a domestic abuse scenario involving older people as a victim and perpetrator of domestic abuse. | brought to appointments, could not attend and no access visits.<br><br>Improved recognition and response to domestic abuse in older people by clinical nursing leaders |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| **9. In relation to safeguarding, how do you quality assure practice within your organisation?** | There is a clear governance structure in place within the Health Board in relation to safeguarding across the lifespan. | Robust processes in place for assurance and exception reporting in relation to safeguarding matters. |
| | Each Directorate has a Safeguarding Delivery Group who provide assurance and exception reports to the Health Board the Strategic Safeguarding Working Group | The Health Board is open and transparent with our governance processes. |
| | We are required to submit an annual self-assessment against the NHS Wales Safeguarding Maturity Matrix, which is subject to peer review. | The Health Board is open and transparent with our governance processes. There is shared learning of best practice across Wales and the peer review informs the NHS Safeguarding Network annual work plan. |
| | Regular audits of safeguarding work related to children, adults and LAC health assessments. | Assessment of compliance with statutory and policy requirements and actions to improve practice |
| | Post Group 2 Ask and Act training audit | Audit conducted 6 months after training to capture outcomes for survivors |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| | The Safeguarding Team offers a single point of contact for all Health Board and Local Authority staff to access for advice and support.<br><br>Weekly quality assurance of advice and support provided to operational staff<br><br>Safeguarding children supervision and peer review is well embedded in the organisation.<br><br>The Named Doctor Chairs Clinical Liaison meetings in each county | Timely and accessible support to all UHB staff in recognising and responding to safeguarding concerns across the life span.<br><br>Consistency in practice and sharing learning<br><br>Development of practitioner knowledge and skills in relation to safeguarding to ensure staff are confident and competent in safeguarding practice.<br><br>Multi-agency professionals and clinical peers discuss issues and good practice to improve outcomes for children |
| **10. What are your agency's key priorities in relation to safeguarding training within your workforce** | Improved compliance with Level 3 child and adult safeguarding training and Group 1 and 2 VAWDASV training.<br><br>We have identified that professional curiosity is a theme that we need to address internally and would | Improved knowledge and awareness amongst the workforce in HDdUHB.<br><br>There are governance structures in place to monitor progress with training compliance across the UHB.<br><br>Improve outcomes for people at risk |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| | appreciate a collaborative approach across the region.<br><br>The Named Doctor will continue to offer training to partners.<br><br>Provide regular FII and PRUDiC training<br><br>Exploitation workshops<br><br>Reflective learning events | Delivery of multi-agency training<br><br>Children and adults at risk will be safer via improved professional knowledge and improved safeguarding practice |

| **Any other organisational practice, events or activities that you wish to highlight for the Annual Report that has contributed to good safeguarding outcomes within 2020-21:** |
|---|

Included below is some feedback from young people and managers in residential care homes for LAC following the first 12 months evaluation.

**From children and young people**
*'I know that I need to keep myself healthy and keep taking my medication'*

**From managers.**
"*Direct link to a responsible individual is good for good lines of communication"*
*"Having a person to be able to go to that will know the health needs of the individual"*
*"Great for a point of contact perfect for building relationships and giving advice to the staff and young people."*
*'Young people have the opportunity to become familiar with the nurse and have the opportunity to talk about health concerns they may have. Quick support if needed'*
*'Hollie has been on hand to give advice and information throughout the C-19 and any health concern with the young people'*

**NHS Evaluation**

**Training feedback**
**Clinical Level 3 child safeguarding**
*'The topic is a difficult one, but you managed to engage a fairly large audience on MS Teams which is not the easiest forum for sensitive and important transfer of information. You have an easy yet professional style, and engaged everyone very well. You managed to be encouraging yet scrutinised attendees' knowledge and awareness.*

*I was very impressed… as you can probably tell!'*

**Core Level 3 child safeguarding**
'*Clear and in-depth but not over complicated. Excellent delivery.'*
*'Everything was really useful and thoroughly presented.'*
*'It was a lot of valuable information, some of which I was not familiar with. I intend to look at the Safeguarding Intranet to read further'.*

**LAC Health Assessment Training Feedback**

**'***Was comprehensive and will help with all health assessments. Gave clarity on aspects of the paperwork. Framework will support clinical practice.'*

*'I am better informed about how to complete health assessments for all aged children. I will ensure that I include as much information as possible to create a holistic picture of the child's emotional, physical and mental well-being'.*

**VAWDASV Training- Post training Audit – Staff were asked to record any feedback from survivors**

*'The victim had a mistrust of all professionals, however she was given an 'open door' policy to access our service and when she felt ready she engaged. The female is now in a safe refuge in England'*

*' Feedback received from the mum who has found the support very helpful and has made her feel more secure'*

*'Yes the victim felt supported by social services and her employers and left the perpetrator'*

**Level 2 and 3 Adult Safeguarding training Feedback**

*'Both Level 2 and 3 delivered this afternoon via video link was brilliant. Very well presented and informative with all recent information that is needed for us as individuals to provide a comprehensive referral. THANK YOU'*

*'Very well presented for a subject that is quite unwieldy and often difficult to put across all the relevant aspects required. We are all coming to terms with our new ways of working and as result this was managed very well and presented with confidence.'*

*'Well delivered. A lot of information to take in for both level 2 and 3, however reassured that the safeguarding team are there for support whether it is to speak to a member of the team beforehand and gain some advice.'*