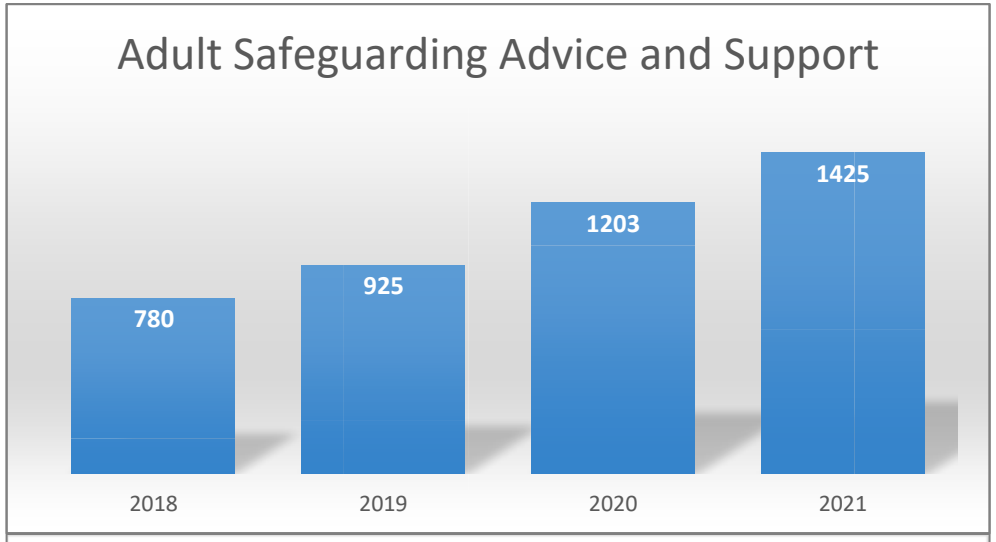
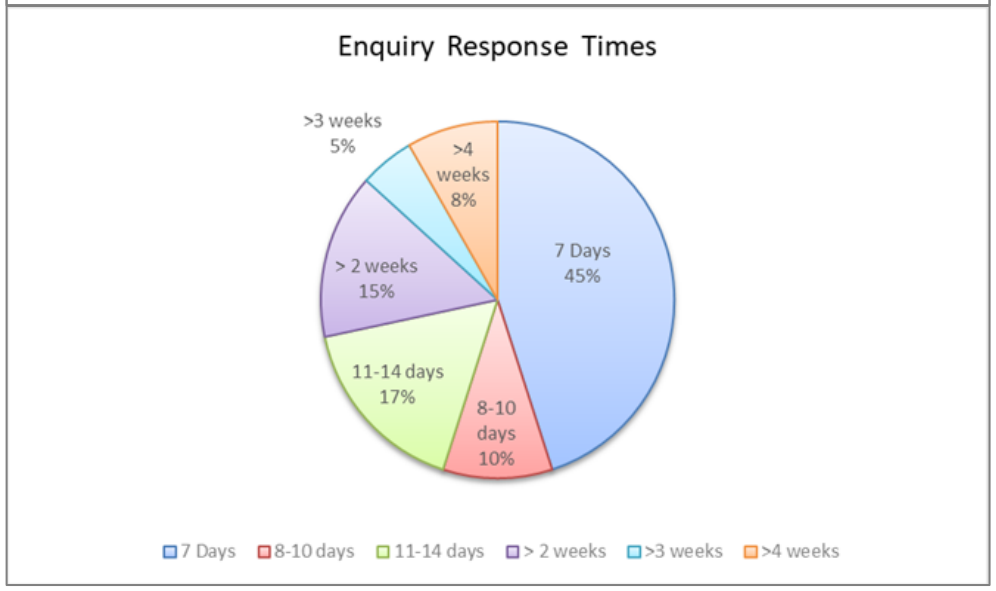
Safeguarding Services Deep Dive Report

Situation

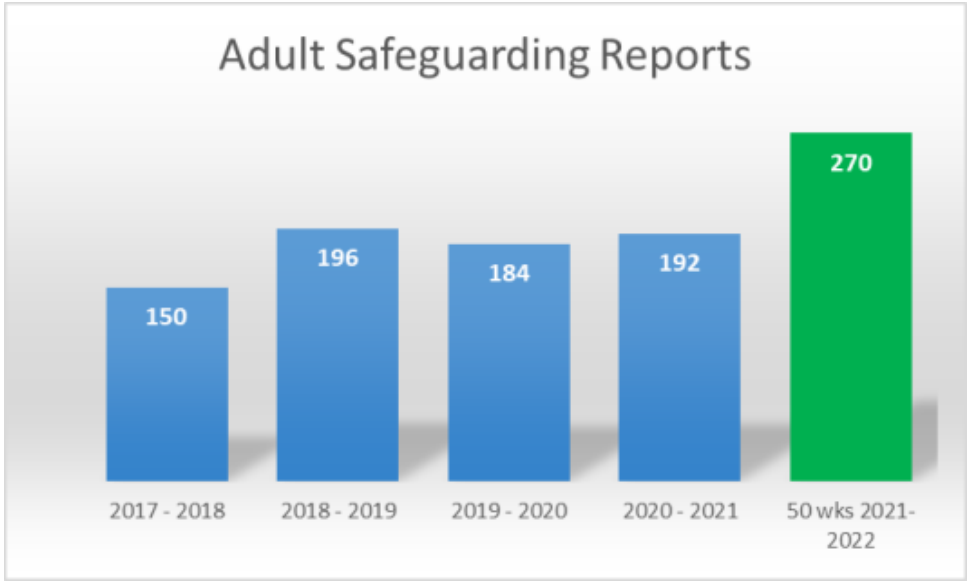
- HDdUHB Corporate Safeguarding activity has increased significantly as a result of the COVID-19 pandemic
- There is an increase in regional statutory reviews
- There has been an increase in the UHB of non compliance incidents with Child Safeguarding statutory duties
- Financial contributions towards regional multi-agency safeguarding work continues to increase

Adult Safeguarding





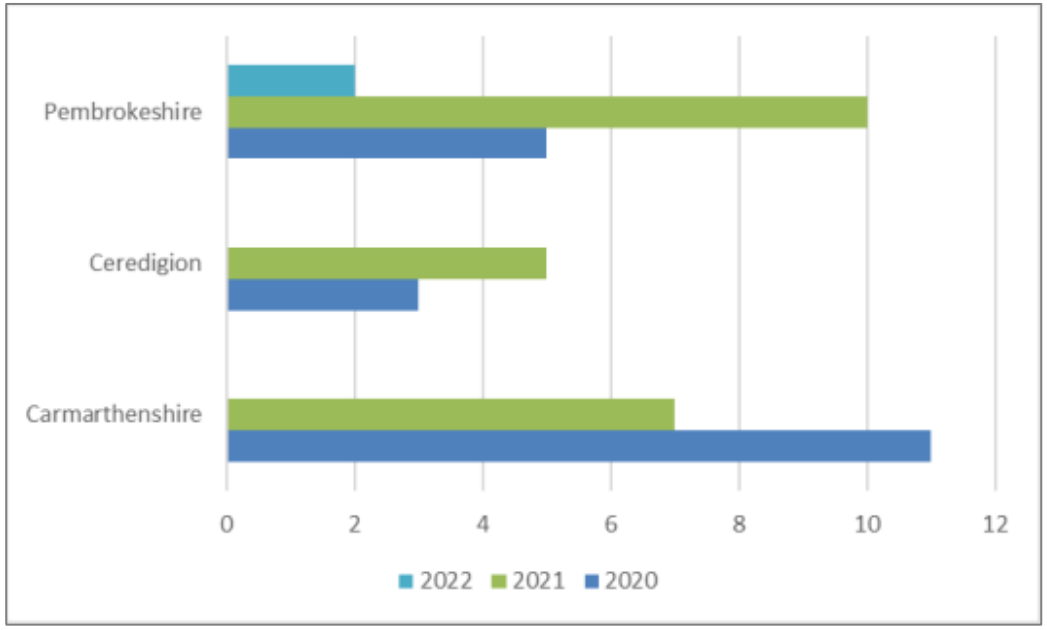
- The Adult Safeguarding Team Single Point of Contact is the most significant area of risk currently due to small fragile resource and an increase in workload
- The Single Point of Contact is a statutory requirement for UHB employees and statutory partners
- Contacts increasing year on year
- Figures represent only the initial contacts and does not reflect the ongoing work generated by many of the contacts.
- The UHB has a statutory duty to co-operate with enquires Social Services Wellbeing (Wales) Act (SSWBWA) - requirement to turn round in 7 days). With only a 45% compliance rate, this requires improvement in the Health Board.



- The Adult Safeguarding Team (AST) maintain a specific database to capture all activity related to Safeguarding Reports that raise concerns relating to patients in the care of the Health Board or the Health Boards Commissioned Services.
- It enables the AST and relevant services to keep track of the activity as the case is managed through the Safeguarding Procedures, but also provides the opportunity for analysis and identification of themes and learning opportunities.
- Data demonstrates ~~the~~ an increase in the number of referrals since 2017 – 2018, with a significant increase in the last year. The data captured on the table attached provides the activity up to 17th March 2022. The data for 2021-22 highlights a 41% increase in activity since the previous year and an 80% increase in activity in the past 5 years.
- Clinical case management sits with the service, the AST practitioners are accountable for the safeguarding advice they give to the service and when they are representing the Health Board during safeguarding strategy discussions and meetings held as part of the safeguarding procedures.

Other Activity

Channel Panel Activity



- The latter part of 2020 saw the publication of the Channel Duty Guidance, which had the effect of adding more structure to the Channel Pathway for those vulnerable to being drawn into terrorism.
- The Health Board Safeguarding team already supported Channel, however the changes have led to an increase in activity, with cases that have been closed to Channel still requiring review at set times following closure.
- The Leads for Safeguarding Children and Adults hold a caseload in each county, with the Head of Safeguarding managing the largest caseload.

- Professional Concerns are referred to in the Wales Safeguarding Procedures as Safeguarding Allegations/Concerns about Practitioners and those in a Position of Trust.
- Like many responses to the SSWBWA, guidance and procedures, this is an area that has been subject to change. The processes for managing these concerns differ by Local Authority, although are becoming more aligned. What is apparent is the increase in activity within this area.
- The Head of Safeguarding, Lead Adult Safeguarding Practioner and the Lead Nurse for Child Safeguarding manage these referrals.
- The Head of Safeguarding and leads work with the service managers and Workforce colleagues to establish if cases meet the threshold for reporting into the procedure and advise on the risk assessment to comply with UHB Policy for Managing Allegations Against Staff.
- The activity reflected does not capture the time spent on such concerns by the Corporate Safeguarding Team.
- To note all employees are offered support in line with the process set out in the UHB Policy (246)

New Regional High Risk Behaviour including Self-Neglect and Hoarding Policy

- Monthly multi-agency panel meetings will be held to review the identified high risk cases.
- Whilst membership of this panel will, in part, be led by the specific case, a member of the corporate Adult Safeguarding Team will be a constant, with additional Health Board services co-opted in dependent on case.
- Panels will be held regionally to begin with, but it is anticipated as case numbers rise, they will be county led.
- Whilst the panels are yet to be tested, it is envisaged that the preparation work from the Health Boards' perspective will, to some extent mirror that of Channel. It is anticipated that this will impact on the time resources of the Adult Safeguarding resource.

Pilot Work Streams

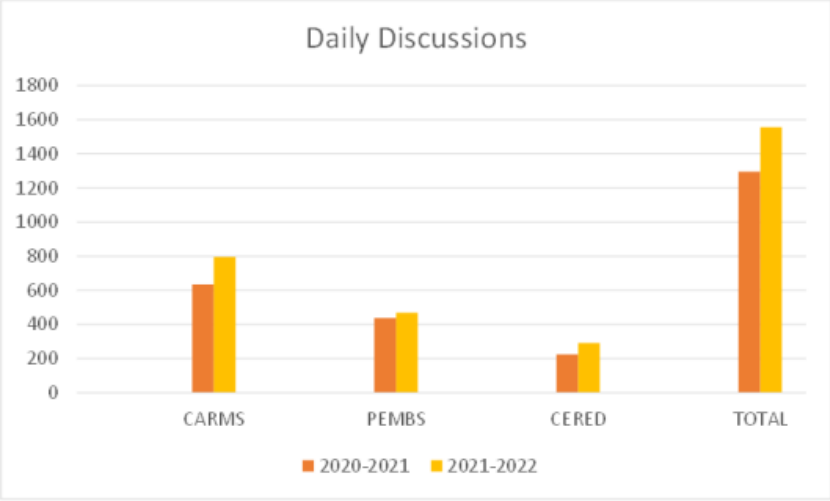
- **Once for Wales Management System**

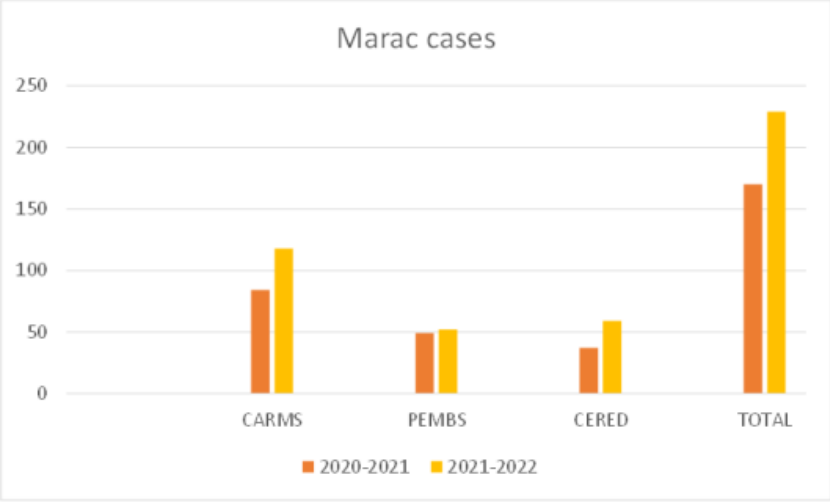
The Corporate Safeguarding Team are leading the regional multi-agency pilot and the development of the management function on behalf of NHS Wales

- **Identification and Referral to Improve Safety**

The Corporate Safeguarding Team leading the pilot within the current resource.

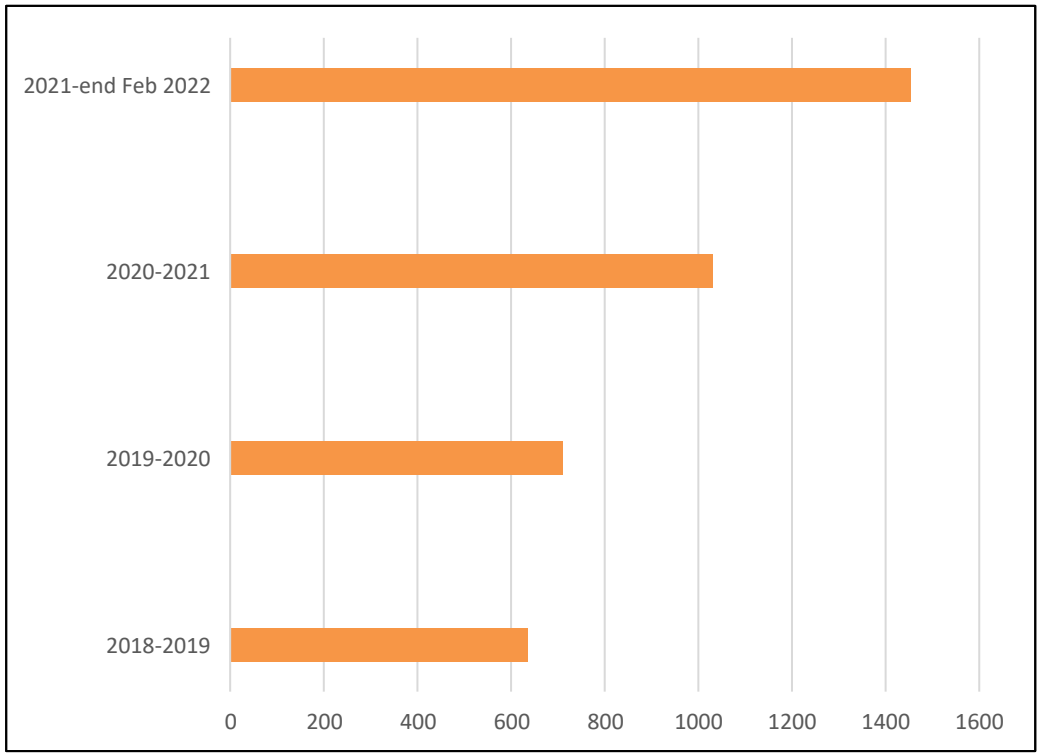
Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)





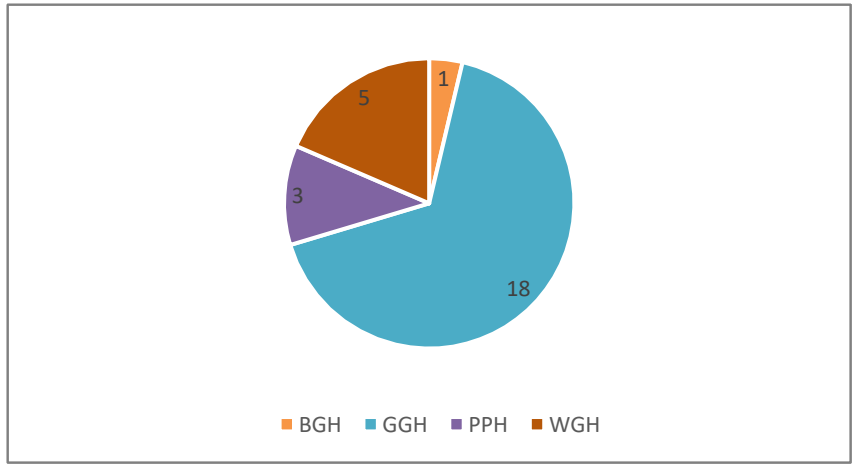
- The Child Safeguarding Team and Domestic Abuse Support Officer specifically receives a notification of all domestic incidents involving children from Dyfed Powys police. These are shared appropriately with other UHB professionals and flagged on the Welsh Patient Access System (WPAS) if high risk.
- While the number of domestic incident notifications has not increased significantly as a result of the pandemic, the number of Multi Agency Risk Assessment Conference (MARAC) daily discussions has, which requires attendance by the Domestic Abuse Support Officer who co-ordinates information sharing.
- Further to this, the number of cases identified as high risk and discussed at MARAC meetings has increased in the last 12 months, meaning an increase in the number of meetings attended by the Domestic Abuse Support Officer and co-ordination of UHB representation and reports.
- Daily discussions and MARAC meetings can generate actions for the UHB which the Domestic Abuse Support Officer will co-ordinate.

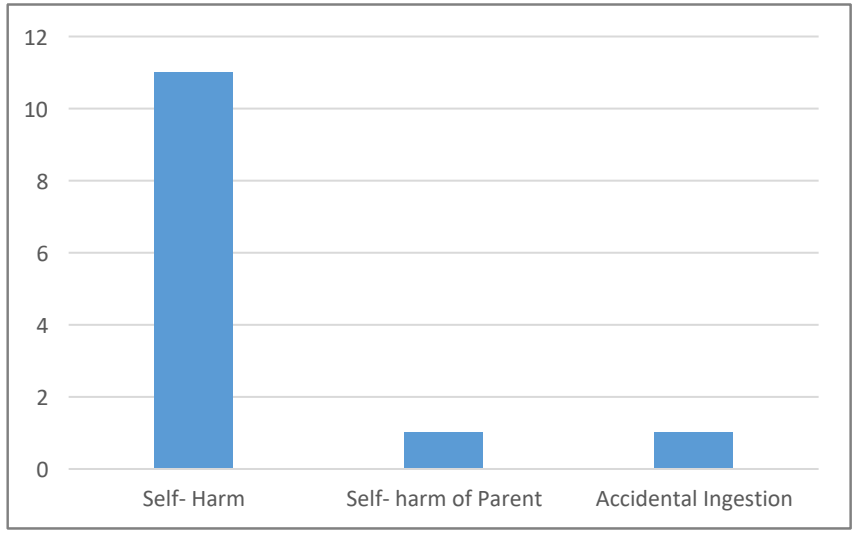
Child Safeguarding



- There has been a significant increase in the number of child safeguarding reports made to Local Authority Children Services by Health Board staff. Since the financial year 2028-2019, to the end of February 2022 there has been 128% increase in activity.
- While activity has increased in relation to child safeguarding reports submitted by UHB employees, there is more practitioner resilience in the Corporate Child Safeguarding team in terms of capacity which can be increased with re-organisation.
- The shortfall is in administrative support.
- The team provide Safeguarding Supervision for around 200 Health Visitors (HV), School Nurses, Midwives and Neonatal Nurses.
- There are between 2 and 14 calls to the Child Safeguarding Single Point of Contact on a daily basis.
- The Corporate Safeguarding Team respond to an average 13 Dyfed Powys Police and Child Exploitation and Online Protection requests monthly
- Statutory reviews have increased for children
- Procedural Response to Unexpected Deaths in Childhood activity can vary

Non-compliance with Child Safeguarding Procedures and Processes





- Mid July 2021, there appeared to be an increase in the number of incidents of compliance with child safeguarding procedures

- Immediate action was taken to address the risks and learning include the following.
  - Services reviewed their training compliance and requirements
  - 7-Minute briefing for Executive Directors (ED's)to remind them of their statutory duty to report
  - Referral pathways to S-CAMHs
  - Review the Safeguarding Children and Young people in - Emergency department/ Out of hours service Procedure (405) to include the S-CAMHs referral pathway
  - ED's to consider a designated safeguarding role

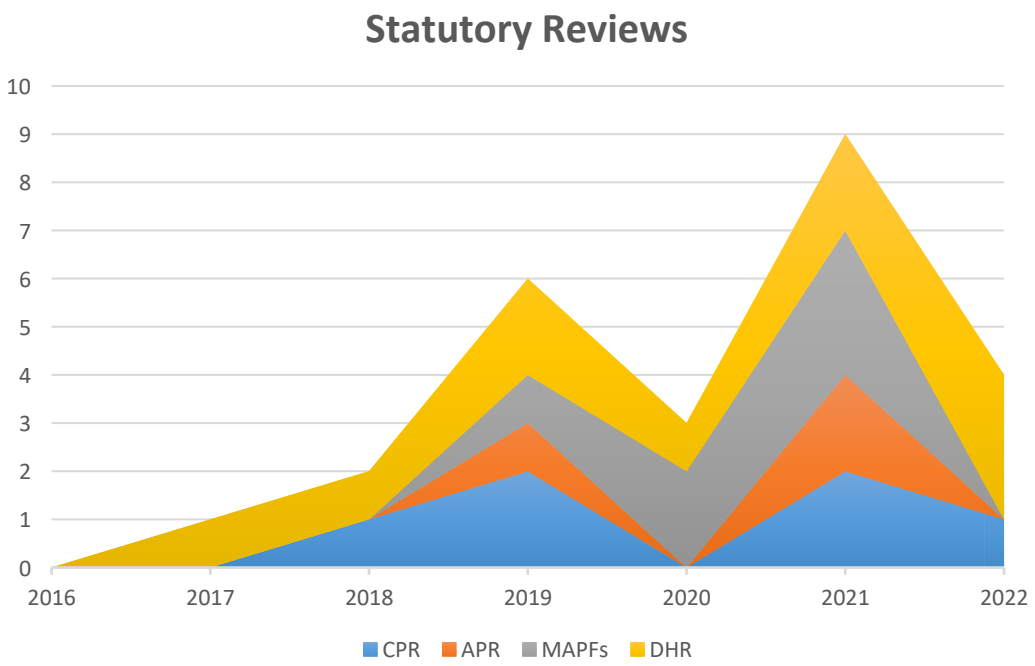
- It is indicated that incidents of non compliance have significantly decreased since November 2021 with 2 incidents in January and one in February 2022.

Looked After Children (LAC)

Q3 Data 2021	Looked After Children	Number Placed in HDUHB by Other LA'S	Total
Pembrokeshire	226	72	298
Carmarthenshire	169	184	353
Ceredigion	98	49	147
Total	493	305	798

- There are no significant current risks to report, however, potential impact of unaccompanied children from Ukraine
- The LAC team are supporting the Ceredigion Health Visitors with LAC Health Assessments

Statutory Reviews Activity



- The Corporate Safeguarding Team lead and co-ordinate the UHB response to statutory reviews. This includes attending multiple panel meetings, collating the UHB chronology of involvement, supporting Health Board managers in the analysis of learning; preparing practitioners and managers for attending learning events and share learning.
- To note, dates refer to year of incident. There are 2 Child Practice Reviews (CPRs) and 1 Adult Practice Review (APR) to commence this year.
- One Domestic Death Review is commencing this year.
- The UHB have also been involved in out of area Child Practice and Domestic Homicide Reviews.
- Most reviews should be completed in 6 months. This often is not the case due to delays in commencing as there may be parallel processes and / or capacity issues within the Regional Safeguarding Board Business Unit.
- It is likely statutory reviews will continue to increase with the implementation of the Single Unified Review Process to be implemented in April 2022.

Financial Contribution to Regional Safeguarding Work

National Regional Safeguarding Board Funding Formula	
Local Authorities 60%	Ceredigion 15%
	Powys 25%
	Carmarthenshire 35%
	Pembrokeshire 25%
Health 25%	HDUHB 75%
	PTHB 25%
Police 10%	
NPS 5%	

- The UHB has a statutory duty to contribute towards the functions of the Regional Safeguarding Board
- Currently contributing towards the Regional Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Perpetrator Pilot
- Statutory partners are also being asked to contribute towards the Regional Co-ordinator roles and Independent Domestic Violence Advisor contract as the VAWDASV Grant from WG does not cover the strategic priorities and service delivery plan for the region

Risks and Mitigation

Risks	Mitigation
Fragility of Corporate Adult Safeguarding service to provide assurance of compliance with statutory duty to safeguard adults at risk of abuse or neglect	Business Continuity Plan Continue to limit travel across sites / Local Authorities Review attendance at regular UHB and multi-agency meetings Triage requests for advice and support Lead Safeguarding Adult Practitioner covers the single point of contact when there is unplanned absence in the team. Cancel adult safeguarding training if necessary to meet other priorities. Review structure to improve capacity and enable succession planning through re-organisation and additional resource Opportunities for secondments – developmental roles
Delay in adult safeguarding enquiry responses	Corporate adult safeguarding team co-ordinate all enquiry responses via the Safeguarding Enquiry Page (SEP) on SharePoint. Service managers are sent regular alerts via SEP that they have not yet responded to the enquiry request. Corporate safeguarding team quality assure enquiry responses prior to returning to the relevant Local Authority. Provide Service Safeguarding Delivery Groups with their compliance data quarterly to drive improvement within operational services.

Risks	Mitigation
Fragility of resource to manage Domestic Incident Notifications, MARAC Daily Discussions and MARAC meetings	High risk domestic incidents are prioritised for information sharing and flagging Attendance at MARAC Daily Discussions and MARAC meetings are prioritised by the Domestic Abuse Support Officer Lead VAWDASV and Safeguarding Practitioner supports managing Criminal Justice Secure eMail notifications Safeguarding Children practitioners attend MARAC daily discussion and MARAC meetings in the absence of the Domestic Abuse Support Officer Review resource in the corporate safeguarding workforce to provide sustainable capacity to meet workload demands
Increase in statutory reviews	Review structure in adult and child safeguarding teams to increase capacity and enable succession planning Operational services to take a more active role in reviews
Wellbeing impact on team with volume of work and complexity of cases	Listening space Restorative supervision Social connections

Recommendation

For QSEC to take assurance that the UHB is:

- Fully engaged in the regional safeguarding activity
- Leading elements of the national safeguarding activities
- Taking steps to mitigate the risks identified.