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:	9th November 2021

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 11th August and 9th November 2021.

- **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.

- **Learning From Reviews**
  Published Child Practice Review (CPR) CYSUR 7 2018
  This review was published on 29th July 2021. The Group was advised that the action plan has been approved by the Regional Safeguarding Board on 7th October 2021. Statutory agencies and partners of the Regional Safeguarding Board are to review which processes and support mechanisms are in place to support staff wellbeing following the occurrence of an unexpected death or traumatic incident. The Health Board response to this will be reported to and monitored by the Group.

  Child Practice Reviews
  Members noted that there are two Child Practice Reviews in progress and a further two waiting to commence. Assurance was received that when progressing these reviews, engagement will take place with relevant Health Board services.

  Adult Practice Reviews
  Members were advised that one Adult Practice Review is in progress with confirmation received that relevant Health Board services are aware. One further review is waiting to commence.

  PRUDiC (Procedural Response to Unexpected Deaths in Childhood)
  The Group noted that there have been four new PRUDiC during Quarters 1 and 2, 2021/22. All PRUDiC procedures have been followed with engagement from relevant Health Board services.

Domestic Homicide Reviews

The Group received an update on the progress of three Domestic Homicide Reviews, noting that a further two will commence shortly. The final report for one review has significant actions for Primary Care services. A learning event has been held in relation to a second review with the relevant acute services and a further event is planned with Mental Health services.

In terms of the further two reviews due to commence, the Group noted that they have significant Primary Care, specifically GP Practice, involvement and are likely to highlight the need for an evidence-based programme such as IRISi to be implemented in GP Practices across the UHB. This is being discussed with the Assistant Director for Primary Care and Deputy Medical Directors for Primary Care.

- **Professional Concerns**

  The Group received a report outlining activity and themes related to professional concerns involving Hywel Dda University Health Board employees made known to the Health Board Corporate Safeguarding Team during Quarters 1 and 2, 2021/22.

  Assurance was received that in all professional concerns, whether they occur in an individual's personal or professional life, information is shared via the Local Authority, with the relevant manager and workforce representative and a risk assessment is undertaken 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 to the multi-agency procedures, there may follow internal processes, which could include disciplinary investigation, supervision, termination of employment, referral to Disclosure and Barring Service (DBS) and / or professional body, as appropriate. The corporate safeguarding team are not always informed of the outcome of internal procedures. This is managed between the service and workforce representatives. Following the professional concerns process under the Wales Safeguarding Procedures (2019), it is the responsibility of the manager to take and conclude any further action as appropriate.

- **Training Compliance**

  Overall compliance for Level 3 Safeguarding Training for Children at the end of Quarter 2 was noted to be 64%. The slow improvement in compliance has been an area of concern despite a review by the Corporate Safeguarding Team to ensure the correct competencies are mapped onto the Electronic Staff Record (ESR), hence there remains a lack of confidence in the accuracy of ESR reporting. This has been communicated with Workforce and Organisation Development. However, it was noted that Level 3 Adult Safeguarding training has improved since the introduction of training via Microsoft Teams.

  Members noted a decline in compliance with the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Group 1 E-learning throughout 2020/21 and into 2021/22. Accountability for managing and mitigating the risk sits with service managers as agreed at the Strategic Safeguarding Working Group on 11th August 2021. Compliance with the Directorate/Site improvement plans is monitored by the operational delivery groups.

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.

A recent Strategic Workshop delivered by Women's Aid and the VAWDASV National Advisor for Wales identified the need for Public Sector leaders to refocus on VAWDASV strategies and policies to support lasting change.

Current findings demonstrate a lack of active involvement from leaders, often considering VAWDASV to be a Safeguarding or Community Services issue. The VAWDASV Act also recognises the need to address workplace support for victims of abuse, with additional responsibilities to address sexual harassment in the workplace. Sexual harassment is an often under-reported issue, with very few reported cases resulting in dismissal. Therefore, it is recommended that there is a need to identify champions at senior leadership level, and acknowledge any actions to address VAWDASV as a corporate responsibility. Discussions are to take place with the Board Secretary to consider how best this can be taken forward.

Links to Group 6 training resources have been previously shared and consist of a series of videos 'Strengthening Leadership' available on YouTube. However, in HDdUHB, similar to other Health Boards in NHS Wales, we have been unable to report on an uptake of this training by Executives. WG is establishing a microsite with links to the Strengthening Leadership resources developed by Women's Aid, which is due to go live imminently. Details of this will be shared when the site is live to enable accurate compliance reporting directly to WG from HDdUHB.

Child Sexual Exploitation and Child Sexual Abuse

Members received a report which provided assurance on key issues in relation to Child Sexual Abuse and Exploitation, including multi-agency strategic and operational arrangements and internal processes.

- **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. Discharge action plans are in place across all four acute hospitals, with some currently being reviewed in partnership with other agencies. The Health Board's Adult Safeguarding Team plans to undertake another review specifically related to discharge referrals to identify specific themes. Feedback will be provided at the next Acute Service Delivery Group, with the aim of influencing the improvement plans that are in place.

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.

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.

  This risk is to be reviewed with Primary Care and to seek agreement that it sits within that service.

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 take place at the Acute Safeguarding Delivery Group.

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:**
8th February 2022