NHS Wales Safeguarding Network

Annual Report 2019-20

GIG CYMRU NHS WALES

Contents

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Chair's Introduction

Welcome to the Annual Report of the NHS Wales Safeguarding Network. It summarises our key outputs and achievements in 2019-2020 profiling the valuable work we have completed together.

The National Safeguarding Team works closely with Welsh Government, Health Boards and NHS Trusts to improve safeguarding across NHS Wales and other partnership agencies. The Network is fundamental to this collaboration. Launched in 2012 the Network has successfully linked local and national policy in support of NHS Wales Health Boards and Trusts discharging their responsibilities for safeguarding. It is led by myself and co-chaired by Ann Hamlet from Aneurin Bevan Health Board who brings invaluable cooperative leadership and expertise.

Collaboration within the Network has facilitated the successful delivery of demanding deliverables in 2019-20 and helped make optimum use of the enormous expertise across the group. Together we have developed specialist professional learning and support, shared good safeguarding working practice as well as information from current national issues by engaging with existing groups.

Thanks to your determined efforts we have made considerable progress regarding:

- Safeguarding Maturity Matrix
- Looked After Children and Adoption
- Chaperone Best Practice Guidance
- Preparation for the Mental Capacity Act changes
- Learning from Safeguarding Incidents
- Wales Safeguarding Procedures
- Routine Enquiry into Domestic Abuse
- Training packages covering Ask and Act in relation to VAWDASV
- Refreshed Safeguarding People training
- Specialist learning events for professional groups.

Dr Aideen Naughton

Sharing for the Long-Term

Whilst delivering on our plan, the Network has been mindful to continuously improve, capturing emerging themes and learning from each other. A key strength has been the willingness to share good practice across organisations – see 'Regional Round Up' section for examples of tailored local delivery.

Throughout our delivery the Network has been mindful to incorporate sustainability in all that we do, applying the principles from the Wellbeing of Future Generations Act (2015). By applying the 'Five Ways of Working' we aim to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs.

Challenges Ahead

Since the release of our last report, the world around us has changed considerably with new pressures and demands arising surprisingly quickly.

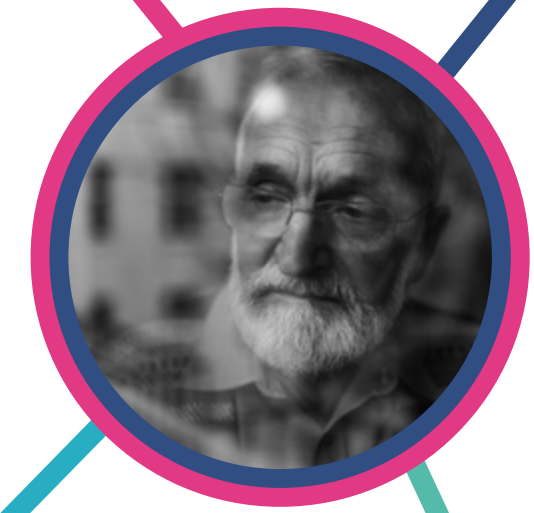
As we move through 2020, our primary challenge has been continuing to deliver in the context of COVID-19. Network partners have been at the forefront of the COVID-19 response for Wales, with staff being redeployed at pace to support this priority. Additionally, key meetings have been depleted, with a move to virtual platforms and their various challenges.

Consequently, the Network has significantly reduced capacity to deliver objectives on the original 2020-2021 Work Plan that has now been scaled to a realisable level. Going forward, the Network will continue to meet virtually on an amended schedule with online communications becoming increasingly significant.

Our shared ambition is that the principles and duties of safeguarding children, young people, and adults at risk should be holistically, consistently and effectively applied as the benefits of all cannot be fulfilled/ realised in isolation. The Network's achievements over the last year have only been possible because of our close partnerships and high level of collaborative cooperation and co-creation. Going forward we need to prove our agility by being flexible in our delivery ambitions and mechanisms.

Thank you for your invaluable commitment to the Network to date – I appreciate your support during this challenging time.

Dr Aideen Naughton
Chair of the NHS Wales Safeguarding Network



Safeguarding Maturity Matrix

Collaborating for Improvement

Measuring the effectiveness of service contribution to safeguarding children and vulnerable adults is challenging and complex.

The SMM is a quality tool, developed by the NHS Wales Safeguarding Network, which enables NHS Wales Health Boards and Trusts to self-assess their organisational safeguarding arrangements. The tool facilitates a baseline position which supports the development of a local Quality Improvement Plan.

The Safeguarding Maturity Matrix (SMM) is divided into five key standards:

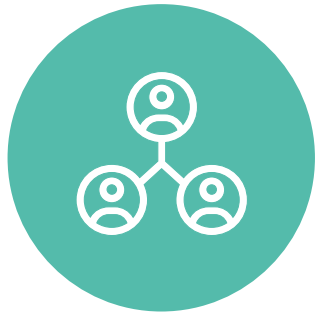
1. Governance and Rights Based Approach
2. Safe Care
3. ACE Informed
4. Learning Culture
5. Multi Agency Partnership Working

Against each standard there are example indicators to assist organisations in assessing their safeguarding services.

Background

The Safeguarding Maturity Matrix was launched in March 2019 and submitted to the NHS Wales Health Boards and Trusts. Through the NHS Wales Safeguarding Network, the National Safeguarding Team (NST) supported the Health Boards and Trusts to develop an organisational improvement plan.

Following submission, the organisational improvement plans and self-assessment scores were collated and sent to Health Boards and Trusts for information and comments in preparation for the Peer Review.



Peer Review – An Enabling Process

The Safeguarding Improvement Plans formed the basis of a Peer Review exercise in November 2019. The review brought together the organisations who, through a facilitated approach, were able to consider and discuss their self-assessment improvement plans in a collaborative and transparent manner.

Utilising the peer review framework in safeguarding provided a positive developmental experience for all those involved. Reviewers were able to learn as much as those being reviewed and were able to take back relevant learning to their own organisations. It was agreed that cross-organisational site visits would be useful in sharing practice and formalising the collaborative approach. The challenge of applying a score to each standard was also discussed.

The review enabled safeguarding leads from Heath Boards and Trusts across Wales to undertake the role of a critical friend - reviewing and sharing plans for improvement. It was decided that a more informal approach to recording review discussions could be used in the future.

Some feedback from the Review:

I felt the session was both worthwhile and supportive. It was really helpful to receive the information from other HBs and Trusts prior to the event.

I particularly appreciated the opportunity to network and learn about the other HB's good practice and also the difficulties they face.

It feels very supportive in that there is an understanding and appreciation of the challenge of the jobs we do from colleagues in other UHBs/Trusts.

It is a learning experience in that it allows us to consider and exchange ideas on what others are doing to ensure safeguarding is effective in their organisation.

Whilst the overall feedback was positive, understanding how best to implement an inclusive continuous improvement process will need to be explored further.

What's Next?

The identified improvement priorities will be discussed and translated into purposeful opportunities for service and practice developments. Going forward the National Safeguarding Team will support the Health Boards and Trusts across NHS Wales to develop these as identified objectives in the NHS Wales Safeguarding Network 2020 Work Plan.

Looked After Children (LAC) and Adoption

Working Together to Improve Outcomes

Looked After Children

The Network provides leadership for health professionals working with Looked After Children (LAC) and Young People (YP) across the health sector in Wales via the LAC Steering Group

The group aims to improve outcomes for LAC by providing a vital bridge between strategies and arrangements at local level and national policy developments. It promotes best practice and supports NHS Wales Health Boards and Trusts in discharging their statutory responsibilities for LAC and Adoption.

Context

As of March 2019 there were 6,846 LAC in Wales. These are a mobile population with 2,125 LAC entering care and 1,678 LAC leaving care in 2019. Although outcomes are improving, LAC and YP have poorer outcomes in terms of education, social and health.

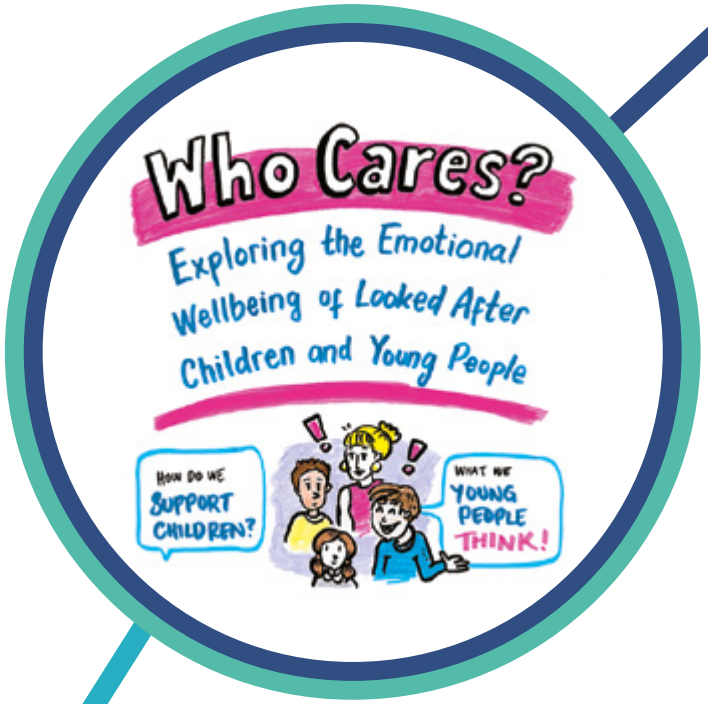
Activity and Achievements

- Facilitation of quarterly meetings of lead LAC health professionals with information cascaded to all LAC nurses and relevant paediatricians
- Development of a LAC health assessment quality framework and audit tool to improve consistency and promote best practice.
- Collation and dissemination of information relating to Unaccompanied Asylum Seekers and Refugees, the National Adoption Service, and the National Fostering Framework, to ensure health professionals in the field are updated and informed.
- Representing the NHS on the National Adoption Service (NAS) Advisory Group, the National Fostering Framework (NFF) Strategic Steering Group and the Improving Outcomes for Children Ministerial Advisory Group (MAG).
- Contributing to the MAG Corporate Parenting Task and Finish Group, working alongside care-experienced young people and multi-agency partners, to raise awareness and strengthen Corporate Parenting responsibilities of public bodies.
- Delivery of a successful national LAC Conference for NHS Staff. See *Learning Events* section for further details.

Going Forward

The group will continue to meet, network, disseminate information and act as a national voice to raise awareness of LAC/YP and their health and wellbeing needs with the aim of promoting healthier outcomes for LAC/YP.

The group will proactively work at a multi-agency level to further Welsh Government's aim of safely reducing numbers of LAC in Wales and preventing the need for children to enter care.



Mental Capacity Act Changes

Understanding and Communicating Change

The Network undertook a review across all Health Boards and Trusts to assess current approaches to implementation of the Mental Capacity Act (MCA) and consider preparedness for the Mental Capacity (Amendment) Act 2019 including Liberty Protection Safeguards (LPS).

The scope of activity was agreed by the Chief Nursing Officer and the Mental Health & Vulnerable Groups Division of Welsh Government.

Context

The LPS are proposed to come into force in October 2020 under the provisions of the Mental Capacity (Amendment) Act 2019. The LPS will replace the Deprivation of Liberty Safeguards (DoLS) and seek to streamline the process for authorising deprivations of liberty.

Activity and Output

An expert group, comprised of representatives from all NHS Wales Health Boards and Trusts and the Office of the Older People's Commissioner (OPC), was convened to carry out this exercise. The group was chaired by the lead GP of the NHS Wales National Safeguarding Team.

Activity Included:

- Taking a 'Once for NHS Wales' approach, the review examined current practice and approaches to increasing the awareness of MCA within the wider quality improvement arena i.e. promotion of evidence-based approach towards safe, compassionate care and less restrictive practice for some of the most complex client groups we serve.
- The Review focused on stage 1 and 2 of the Public Health Approach; (Developing an understanding of epidemiology; demand & capacity issues).
- Stages 3 and 4 of the Public Health Approach (Develop and measure Interventions; Implementation) require further discussions with Welsh Government (as agreed by the Network).
- A provisional overview of current operational models and approaches.
- Production of a draft discussion document developed to shape discussion and information required.

Stakeholder Engagement

The group has approached various specialist organisations and has offered focus groups to help understand the "lived" experience of caring for or being directly affected by Mental Capacity. However, agencies have been clear that it would be ethically difficult to seek views of those with limited capacity without appropriate safeguards in place.

Equality Impact Assessment

The work intentionally took into account the relevance and impact of MCA amendment Act on populations with protected characteristics to produce stronger and more effective decisions by NHS Wales's practitioners.

By using the five ways of working, the group is committed to ensure that relevance and impact on different population groups is understood and used to shape future practice of MCA within NHS Wales.

Next Steps

Over the next period, planned work includes:

- Sharing findings from the scoping exercise with relevant multi-agency partners
- Developing a position statement to include:
  - "What does good look like" with regards to MCA for NHS Wales and Social Care
  - Best practice guidance in regard to the MCA Amendment Act and LPS for NHS Wales and Social Care
  - Proposed service delivery models

Wales Safeguarding Procedures

A Common Standard for all Practitioners

Responding to Need

Over the last twenty years there has been a growing awareness amongst practitioners, managers and policymakers of the common systems and processes required to protect both children and adults at risk of abuse and neglect. Wales Safeguarding Procedures are designed to bring these elements together to standardise practice across all of Wales and between agencies in order to guide and inform child protection practice.

The Procedures

The Procedures detail the essential roles and responsibilities for practitioners to ensure that they safeguard children and adults who are at risk of abuse and neglect. They outline the framework for determining how individual child protection referrals, actions and plans are made and carried out. They help practitioners apply statutory guidance and are intended for all those employed in the statutory, third (voluntary) and private sector in health, social care, education, police, justice and other services.

Wales Leading the Way

With the launch of the Procedures, Wales has become the first part of the UK to introduce a single set of safeguarding guidelines for children and adults at risk. In another first for the sector, the Wales Safeguarding Procedures will only be published digitally via a website and app which means that there will always be a single up-to-date version available to all practitioners.

Network Input

The NHS Safeguarding Network provided expert safeguarding health advice to the review of the all wales procedures for safeguarding children and adults. Involvement by the Network provided expert safeguarding health input to influence, inform and shape the review of the wales safeguarding procedures.

A virtual task and finish group was comprised of the heads of safeguarding in Health Boards and NHS Trusts and was chaired by the service lead from the National Safeguarding Team (Network Chair). The group considered proposed content and provided a collaborative response on behalf of NHS Wales to the Procedures Project Board. To ensure consistent input this response was informed by the health advice provided through individual regional safeguarding boards in their collaborative responses as stakeholders to the project board during the consultation phase. The project team included representation from service users and frontline practitioners through focus groups for feedback on proposed content.

The Network chair and vice chair are members of the procedures project board and therefore provide additional scrutiny to the final content in terms of its fit for the NHS.

Launch

The Wales Safeguarding Procedures were launched during National Safeguarding week in November 2019 and are available in digital form through an App and a website **https://safeguarding.wales**. All Regional Safeguarding Boards formally adopted the procedures with implementation from April 2020.

Going Forward

The project board continues to meet to consider amendments to the post launch content - including feedback from participants at awareness raising workshops. Social Care Wales together with New Pathways have developed training modules to support a train the trainer approach to underpin implementation of the safeguarding procedures. The impact of the procedures on the implementation of the Social services and Wellbeing (Wales) Act will form part of the Welsh Government evaluation of the impact of the guidance for Part 7 of this Act.

Learning from Safeguarding Incidents

Towards an Information Portal for NHS Wales

The NST, through the Network, has scoped the feasibility of a developing a national system to integrate organisational learning to reduce harm and improve safeguards for NHS Wales learning. The proposed system will support the development of a sustainable health and care system by mobilising knowledge to improve the health safety and wellbeing of vulnerable people.

Background

It was deemed necessary to identify the current methods used for aligning themes from Serious Untoward Incidents, Patient Related Concerns and 'No Surprises' within individual Health Boards and Trusts and how this informed wider organisational learning.

It also aimed to:

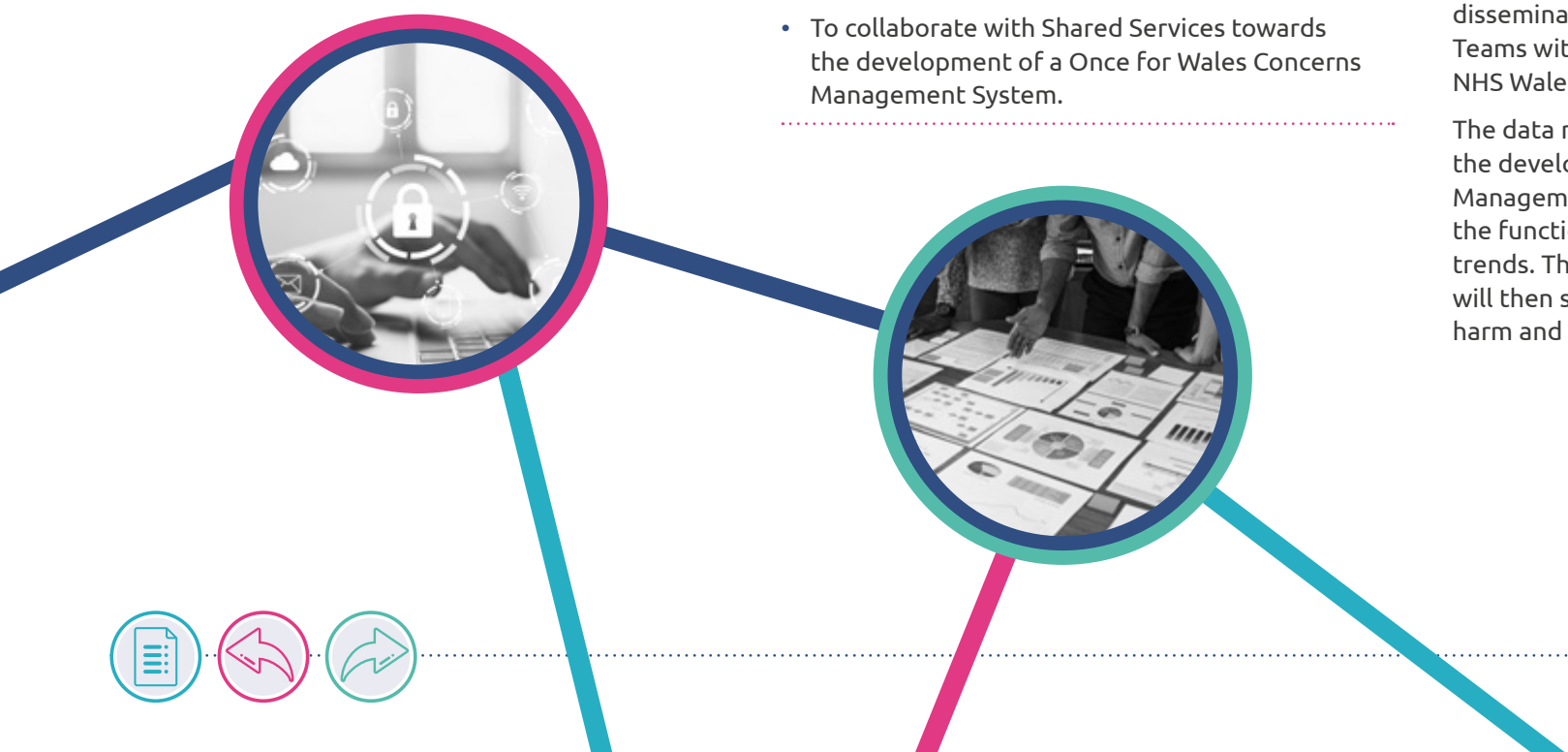
- Identify how safeguarding data was captured and stored within organisations
- Identify how data and themes were received and responded to by Welsh Government.
- To collaborate with Shared Services towards the development of a Once for Wales Concerns Management System.

Collaboration for Success

The NST consulted with key stakeholders including Chief Nursing Officer (CNO), Executive Nurse Directors and Heads of Safeguarding across NHS Wales to agree the proposal and methodology for developing a national system to integrate organisational learning to reduce harm and improve safeguards for NHS Wales learning.

Further collaboration with the Once for Wales Concerns Management Team supported the development of a questionnaire, designed to capture information about how existing safeguarding data is collected, managed and reported locally. The questionnaire was disseminated and completed by Safeguarding Teams within Health Boards and Trusts across NHS Wales.

The data retrieved will form a baseline to support the development a new Once for Wales Concerns Management Safeguarding Portal, which will enable the functionality to identify concerns, risks and trends. The information identified from the system will then support organisational learning to reduce, harm and improve safeguards across NHS Wales.



Violence against Women Domestic Abuse and Sexual Violence (VAWDASV)

Routine Enquiry into Domestic Abuse

Measuring Compliance

An audit was carried out in order to support NHS Wales staff to gain clarity on their compliance with Routine Enquiry into Domestic Abuse.

Background

The Routine Enquiry into Domestic Abuse involves asking all pregnant women about abuse regardless of whether there are any indicators or suspicions of abuse. This is because research has shown domestic abuse often starts or is exacerbated in pregnancy.

The All Wales Antenatal Routine Enquiry was introduced over 10 years ago and has developed slightly differently both, within Health Visiting and Midwifery Services and according to area.

The process of routinely asking about domestic abuse had previously been monitored through the NHS Wales Safeguarding Network using a self-assessment tool known as the Quality Outcomes Framework (QOF). However with the QOF no longer in use it was unclear whether the All Wales Routine Enquiry Domestic Abuse Standards were being utilised effectively.

Aim

This work looked to co-produce a national audit tool drawing on previous work completed via the Betsi Cadwaladr University Health Board (BCUHB) representative on VAWDASV Steering Group. This complemented the Network objective to undertake a national audit of routine enquiry into domestic abuse by midwives and health visitors across NHS Wales.

Activity

A designated nurse from the NST and a Head of safeguarding from BCUHB collaborated to identify a national audit tool – the minimum standards from the All Wales Antenatal Routine Enquiry into Domestic abuse.

The audit used a mixed method approach with options for both quantitative and qualitative data collection. The design of the audit tool allowed for the simple collection of data directly related to each Standard and entry of responses to the subsequent question.

The audit was distributed to the seven Welsh health boards, which all have their own maternity and health visiting services, to complete.

Findings

This audit has provided a national picture in relation to how the All Wales Routine Enquiry into Domestic Abuse is being implemented across Health Boards in Wales. The results identified inconsistencies across the seven Health Boards related to the current practice of routine enquiry, including auditing of the process in relation to frequency, sample size and findings.

It was concluded that in cases where the routine enquiry had not been asked there were some valid reasons why – the most common one being that women were not alone – thus had been a longstanding difficulty since the introduction of the process. It is important to ask women when they are alone to ensure their safety and so Health Boards need to ensure that there are mechanisms in place to ensure that alternative approaches are explored.

On a positive note, the audit established strong evidence of professionals' knowledge concerning domestic abuse and how to refer women to appropriate services. This included their understanding of safeguarding children issues and how and when to make a referral to Children's Services.

Going Forward

Recommendations from the Review have been discussed with the Chief Nursing Officer and Directors of Nursing across Wales. Some of these recommendations will be actioned through the NHS VAWDASV Steering Group. The report will be circulated to Health Boards and Trusts with an expectation of action on any additional recommendations.

Future work for the Network includes a potential revision of the minimum standards and production of a consistent universal audit tool for routine enquiry.

Ask and Act Training

Learning for Prevention, Protection and Support

The National Safeguarding Team led on establishing an agreement across NHS organisations and with Welsh Government for the development and delivery of a training package to ensure a "Once for NHS Wales" approach to the prevention, protection and support of people affected by Violence against Women, Domestic Abuse or Sexual violence.

This work aims to ensure any victims of VAWDASV receive a consistent response and support from NHS Wales.

Background

The Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 introduced significant changes in the public sector. Ask and Act covers national targeted enquiry across Public Authorities in Wales for violence against women, domestic abuse and sexual violence.

It refers to:

- An organisational duty to encourage relevant professionals to "Ask" potential victims in certain circumstances (targeted enquiry); and
- to "Act" so that harm as a result of the violence and abuse is reduced

Activity

The NHS Wales VAWDASV Steering Group, a subgroup of the Network, identified that the roll out of Ask and Act Group 2 training was inconsistent across NHS organisations. Group 2 describes the group of professionals who will "Ask and Act".

In response the group produced and supported the delivery of a "Once for NHS Wales" Group 2 training package that met the competences and requirements of the National Training Framework on Violence against Women, Domestic Abuse and Sexual Violence.

This was supported by the Network, the Chief Nursing Officer and the Executive Directors of Nursing. The group developed a policy statement for Ask and Act clearly noting the approach NHS Wales would take to ensure we met the needs of the population we serve.

Ask & Act training will assist NHS Wales staff to:

- Recognise the signs and symptoms of violence against women, domestic abuse and sexual violence
- Understand the purpose of and demonstrate an ability to undertake targeted enquiry
- Demonstrate knowledge around data protection and the duty of confidentiality
- Understand the purpose of risk identification in relation to some forms of violence against women, domestic abuse and sexual violence

Impact

All Health Boards and Trusts within NHS Wales are now offering a Ask and Act Group 2 training. This roll out facilitates the wider aim of ensuring any person affected by Violence against Women, Domestic Abuse or Sexual violence receives a consistent response and support from NHS Wales.

Evaluation and Next Steps

The NHS Wales VAWDASV steering group will lead on the evaluation of the training, to feed into the Welsh Government review of the Ask and Act process.

Safeguarding Upskilling Events

Paediatrician's Training Day

Paediatricians supported to meet the highest standards of Safeguarding.

The Safeguarding Training for Paediatricians event helped paediatricians update their safeguarding knowledge to the required level 3 professional standards. It was attended by 70 clinicians from across NHS Wales at the Life Sciences Hub Wales in Cardiff Bay in November 2109.

The training day facilitated valuable networking across paediatric specialities providing space for discussion on controversial issues and expert advice on specific cases.

Consultants from Wales and Great Ormond Street Hospital explored many key areas including the role of dermatology in differentiating intended harm from medical conditions, the use of radiology in the differential diagnosis of inflicted skeletal injuries in childhood, fabricated or induced Illness and perplexing presentations.

The importance of multi-agency team working, good record keeping and communication were also reiterated to ensure a consistently high-quality of service for those with complex case histories and backgrounds.

Topics for future sessions were planned to help reinforce the peer-to-peer learning and sharing of best practice in Wales and these will include:

- Assessment and description of attachment behaviour in consultation
- Therapies for treating attachment based difficulties
- Emotional and psychological support for safeguarding professionals
- Safeguarding and children with complex needs
- Eye changes in non-accidental injuries
- Forensic dentistry – how to differentiate and identify bite marks
- Challenging court case experiences

Thanks to its success and positive feedback, this training will become an annual event used to reflect and discuss current issues and meet the training needs of Wales' paediatric workforce.

As I'm in the early stages of paediatric training, it was valuable to expand my awareness of different aspects of child protection – knowing more of the theory and stats behind it is useful clinically.

Interesting, varied and informative – also a great networking opportunity!

Adoption was well covered; good to highlight needs of adopted children.

Presentations focused on relevant, informative topics from a local to national level.

Update on 'smacking ban' interesting and topical.

LAC "Who Cares?" Conference

Spotlight on Emotional Wellbeing and Lived Experience

LAC and Care-experienced young people have a higher prevalence of mental health difficulties.

To raise awareness and improve practice across the sector, the LAC Steering Group delivered a conference in February 2020 entitled: "Who Cares? Exploring the Emotional Wellbeing of Looked after Children and Young People".

The fully funded event, held at the Life Sciences Hub in Cardiff, enabled LAC health professionals to network and share good practice focussing on the views of young people.

An essential component of the conference was giving a platform to and involving care-experienced young people. Over 90 LAC health professionals attended, including LAC specialist nurses and managers, paediatricians, school nurses, health visitors, GPs, psychologists and CAMHS workers.

Content

Topics presented included:

- Exploring an evidenced based approach of the concept of latent vulnerability and PTSD;
- Research measuring subjective wellbeing of children in care across Wales.
- Delivery of trauma services for looked after children
- An NSPCC briefing on how care experienced children and young people's emotional and mental health needs are being assessed and supported via the 'Listen, Act, Thrive' project.
- A lively presentation from care-experienced young people covering the lived experience of being in care – barriers, challenges and stigmas – alongside improvement suggestions.

An illustrator captured the information presented into a memorable live graphic and real-time conversation was facilitated via a Twitter hashtag.

Positive feedback was collated with the view to holding another LAC focussed learning event in the next period.

Hearing from Young People about their care experiences was truly incredible and insightful.

Illustrator was excellent and really captured the flavour of the day.

Networking with other LAC Teams was brilliant.

I will feed back to my team and ensure they continue to treat every Looked After Child/Young Person with dignity and respect and do not make them feel like they are just a tick box exercise.

Quality Safeguarding Training

Competence Framework and Training for all Health Professionals

NHS Wales have a duty to provide their employees with access to child and adult safeguarding training, to develop the knowledge and skills required to undertake their roles and competently safeguard children and adults at risk. As well as employees, training can be accessed by volunteers, independent contractors and board members.

Activity

In response to this duty, the NST in collaboration with Network members, developed a Safeguarding Training Framework that incorporates the range of CPD requirements across the sector. The framework informs training package development by laying out core competences and connecting them with learning methodologies and frequency of learning activity.

The framework acknowledges that in addition to traditional 'classroom' training events, there are different routes to learning e.g. e-learning, workshops, supervision and practice based reviews.

Level 1 Safeguarding People Training, accessible via e-learning, has been developed to support health organisations comply with their safeguarding responsibilities in accordance with legislation and guidance. The reworked training package reflects the competencies and requirements set out in the framework.

The Level 2 Safeguarding Adults at Risk and Level 2 Child at Risk e-learning training packages are currently being developed and on track for release in Autumn 2020.

Leadership and Development Programme

Developing the Leaders of Tomorrow

The Network aims to support succession planning in NHS Wales by collaborating and developing existing leadership, development and mentorship programmes. In doing so, it invokes the Future Generations Act by building and mobilising knowledge and skills to improve health and wellbeing across Wales.

The work aims to co- create a leadership and development programme for safeguarding by NHS Wales by:

- Conducting a scoping exercise to determine target audience
- Identifying integration and alignment with other leadership and development programmes being established across NHS Wales.

Activity

Activity to date has incorporating a joint scoping exercise with the Head of Safeguarding in the Welsh Ambulance Service NHS Trust (WAST) to establish existing safeguarding roles within NHS Wales and any existing succession planning within their organisations.

Impact and Going Forward

The scoping exercise to establish existing safeguarding roles has enabled Health Boards and Trusts to consider their individual safeguarding succession plans and any associated actions. With regard to a national picture the scoping exercise supports the need for safeguarding to be incorporated into any leadership and development plans.

Cohesive links have also been established with Health Education and Improvement Wales (HEIW) who are interested in the exercise with the view that the scoping exercise has potential to feed into future leadership and development programmes. HEIW conduct strategic workforce planning for NHS Wales incorporating leadership development, therefore continued partnership with the organisation ensures a joined up approach.

Regional Round Up

In the spirit of collaboration and innovation, Network members regularly share effective safeguarding practice. This allows them to highlight what works in their area, build effective partnerships and expand their ideas of what good practice looks like.

Below are some examples of organisation-based practice across Wales:

Welsh Ambulance Services NHS Trust (WAST)

- Development of an electronic safeguarding reporting process.
- Presentation at Gwent Police PRUDIC (Procedural Response to Unexpected Deaths in Childhood) Awareness Day where WAST outlined their role within the response process.
- Creation and publication of an Adverse Childhood Experiences (ACES) Booklet.
- WAST Safeguarding Conference featuring presentations by Police and voluntary sector with strong attendance from multi-agency partners.
- Creation of a video for training purposes, outlining a Paramedic's testimony as a victim of domestic abuse.

Velindre University NHS Trust

- Wales Safeguarding Procedures have been promoted across the Trust including on display screens in public areas.
- A Learning Log established to consider transferrable learning from published reviews including Child Practice Reviews (CPR) Adult Practice Reviews (APR) and Domestic Homicide Reviews (DHR).
- A Safeguarding Training Improvement Plan developed in line with the NHS Training Framework.

Public Health Wales (PHW)

- Developed the role of Safeguarding ambassadors within PHW. Ambassadors are volunteers who act as an access point in their department, promoting safeguarding training, support and information whilst working as a conduit with the Head of Safeguarding. They are committed to improving support for potential victims/and/or survivors.
- A series of awareness raising events was held in National Safeguarding Week to reinforce the message that *'safeguarding is everyone's responsibility'*. Sessions topics included Forced Marriage and Honour Based Violence, FGM and Breast Ironing and the Launch of Public Health Wales Safeguarding Ambassadors.
- Roll out of NHS Wales VAWDASV training.

Hywel Dda Health Board (HDUHB)

- Appointment of a LAC Nurse specifically for residential homes, focussing on health promotion and prevention.
- Active contribution to the planning and facilitation of multi-agency practitioner learning events.
- Delivery of an All Age Learning Event with the theme of self-neglect incorporating learning from a published Child Practice Review.
- The Sharing Safeguarding Information in Pregnancy database is fully digital, enabling safe and timely sharing of information between professionals.

Cym Taf Morgannwg University Health Board (CTUHB)

- Network presentation and discussion on safeguarding for twin and multiple births, introducing an enhanced, universal pathway of midwifery care and health visiting for twin and multiple births up to the first birthday.
- Network information sharing of Independent Maternity Services Oversight Panel outlining the events and resulting actions relating to the Ministerial Intervention in Cwm Taf Morgannwg UHB.

Cardiff and Vale University Health Board (CVUHB)

- Establishment of a Violence Prevention Unit with two full-time safeguarding posts. The Unit is based in Emergency Department at University Hospital Wales in Cardiff and fully funded by the Police and Crime Commissioner.
- Support provided to Nursing Students on weekly placements during the COVID-10 period, incorporating safeguarding competences and evaluation.

Betsi Cadwaladr University Local Health Board (BCUHB)

- Development of virtual-training packages to support mandatory Safeguarding Training, Level 1 and Level 2 (Level 3 under development) allowing learning continuity during the COVID-19 period.
- Implementation of Trauma Risk Management (TRiM), a safeguarding driven activity, to support staff who have experienced a traumatic event.
- Development of Safeguarding checklists and prompts within the Mental Health Learning Disability (MHLD) Division for clinicians, taking into account the inclusion of family presenting a, comprehensive approach to assessment.
- Development of a Corporate Safeguarding COVID Action Plan to ensure maintenance of the safeguarding agenda. The Plan incorporates virtual supervision and training, lessons learned, and engagement with high risk areas for early mitigation.

Powys Teaching Health Board (PTHB)

- Development of Deprivation of Liberty Safeguards Policy and Procedure and training pack.
- Development of Mental Capacity Act Policy and training pack, 7 minute briefing on changes to the Mental Capacity Act to support newly released polices and training
- Launch of Training and Competency Passports to record safeguarding training at both individual and organisational level and to offer a reflective learning log.

Swansea Bay University Health Board (SBUHB)

- In collaboration with regional partners, SBUHB developed an Integrated Reporting/Referral Form for Safeguarding Concerns/Concerns of Professional Abuse.
- Commenced the implementation of IRIS (Identification and Referral to Improve Safety) - a general practice-based domestic violence and abuse (DVA) training support and referral programme. IRIS represents a collaboration between primary care and third sector organisations.
- Contributed towards the development of a Multi-agency Exploitation training day for delivery across all statutory and voluntary agencies.
- Set up an Extended Safeguarding "Duty Desk" in response to COVID-19, to provide staff with Safeguarding advice and support.
- Development of a full day programme for Level 3 Safeguarding People training incorporating both adults and children.
- Continuing delivery of "Ask and Act" training, alongside incorporation within the New Manager's Pathway training programme. Commenced roll out of Group 3 Champion training.
- As a further response to COVID-19 Safeguarding training has been converted to virtual to ensure ongoing staff competency.
- In anticipation of the increase in VAWDASV during the pandemic the Corporate Safeguarding team have visited priority areas with posters, leaflets and highlighted to staff the concerns of DVA during lockdown, resulting in an increase of referrals.

Aneurin Bevan University Health Board (ABHUB)

- ABUHB Head of Safeguarding and the Safeguarding Service Manager for Newport Social Services led on the successful pilot for a Unified Practice Review for Welsh Government - a new approach to Domestic Homicide Reviews, Adult Practice Reviews and Mental Health Homicide Reviews.
- As a result of a Concise Child Practice Review undertaken by Gwent Safeguarding ABUHB, in partnership with the Gwent Safeguarding Board, has developed a Multi-Agency Protocol for the Management of High Risk Cases of Self Harm and Potential Suicide.
- Delivery of a multi-agency awareness training day on the Procedural Response to Unexpected Deaths in Childhood (PRUDiC)
- The campaign "Safe Sleep: Safe Environment" was developed to raise awareness of safe sleeping environments for babies.
- In partnership with the Charity "2 Wish upon a Star" ABUHB piloted a staff counselling service for those have experienced a traumatic event following the unexpected death of a Child whilst on shift.