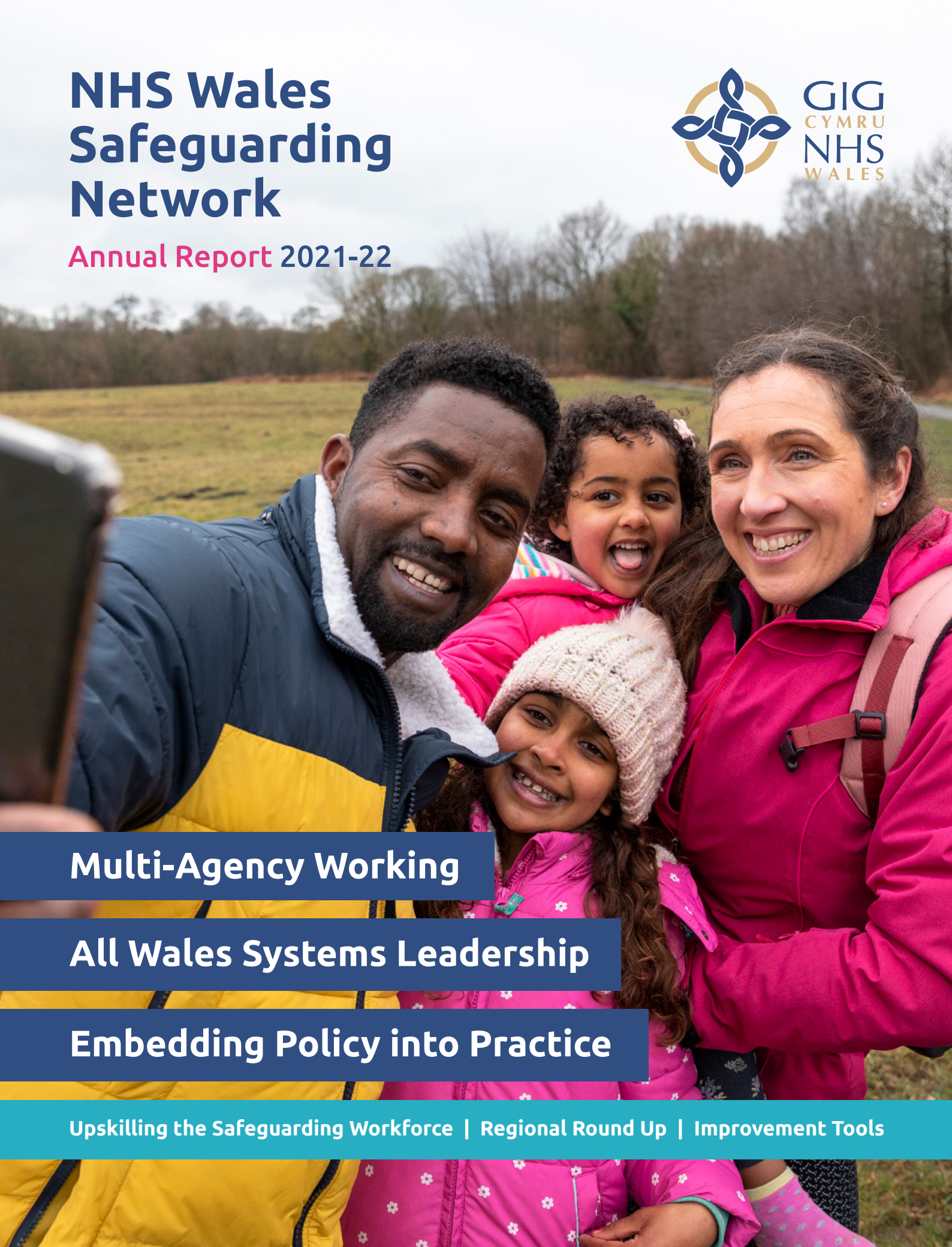
NHS Wales Safeguarding Network

Annual Report 2021-22



Multi-Agency Working

All Wales Systems Leadership

Embedding Policy into Practice

Upskilling the Safeguarding Workforce | Regional Round Up | Improvement Tools

Contents

About the National Network **4**

About the National Safeguarding Team (NST) **4**

Chair's Introduction **5**

Leading and Communicating **6**
Network Collaboration 6
Stakeholder Communication 6

Multi-Agency Working **7**
Partnership Working Principles 7
Regional Safeguarding Boards 7
Wales Violence Prevention Unit 7

All Wales Systems Leadership **8**
Looked After Children 8
Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV) 9
Single Unified Safeguarding Review 10

Expert Review **11**
Suicide Rapid Review 12
Child Death Rapid Review 12

Improvement Tools **13**
Safeguarding Maturity Matrix 14
LAC Notification Pathway Review 16

Embedding Policy into Practice **17**
Changes to Deprivation of Liberty due to the Mental Capacity Amendment Act 18
Once for Wales 19
Routine Enquiry into Domestic Abuse Audit 20
Domestic Abuse Act 20
Ending Physical Punishment in Wales 21

Upskilling the Safeguarding Workforce **22**
Network Training Sub-Group 23
Multi-Agency Safeguarding Standards 23
Ask and Act Training 24
Safeguarding Children's Masterclass 25
Representing at Events 25

Regional Round Up **26**
Cwm Taf Morgannwg University Health Board 27
Cardiff and Vale University Health Board 28
Welsh Ambulance Services NHS Trust 29
Velindre University NHS Trust 30
Hywel Dda University Health Board 31
Public Health Wales 32
Swansea Bay University Health Board 33
Aneurin Bevan University Health Board 34
Betsi Cadwaladr University Health Board 35
Powys Teaching Health Board 36

Plans and Preparedness **37**
Future Priorities 37
Horizon Scanning 38

Conclusion **41**

NHS Wales Safeguarding Network
Author: Shamala Govindasamy
Email: NST@wales.nhs.uk
June 2022

About the National Network

The NHS Wales Safeguarding Network (the Network) is a strategic NHS Wales group that meets quarterly and includes members from Trusts and Health Boards, the National Safeguarding Team, Welsh Government and other key stakeholders. In the past decade the Network has successfully linked local and national policy to develop a collaborative approach to safeguarding delivery across the NHS in Wales.

The Network provides; specialist safeguarding support, learning from incidents, shared good safeguarding practice and collects information from current national issues by engaging with existing groups. By ensuring that good practice and areas of development are shared with safeguarding leaders, children and adults at risk benefit from improved safeguarding provision.

Collaboration is embedded in the Network's leadership led by Dr Aideen Naughton from the National Safeguarding Team (NST) and co-chaired by Mandy Nichols-Davis from Hywel Dda Health Board, who both bring invaluable cooperative leadership and expertise.

About the National Safeguarding Team (NST)

The National Safeguarding Team (NST) comprises a team of specialist Doctors, Nurses, a Programme Manager and Business Support Team who work closely with Welsh Government, and the 7 Health Boards and 3 NHS Trusts, to improve safeguarding arrangements across NHS Wales.

The NST facilitates and co-chairs the Network to ensure that collaboration in safeguarding occurs between the Trust, Boards and key stakeholders.

The NST holds a unique position in the Network, providing a national lens to safeguarding activity occurring within the Trusts and Boards and externally across Wales.

Chair's Introduction

Dr Aideen Naughton

Welcome to the Annual Report of the NHS Wales Safeguarding Network. It is my pleasure as the Chair of the Network to demonstrate the valuable work that has been completed across Wales to keep children and vulnerable adults safe.

This report details our key achievements in 2021-2022, a year when the NHS Wales Safeguarding Network continues to be a crucial resource in yet another challenging year. Safeguarding within a global pandemic has changed and shaped NHS Wales in ways that could not have been predicted. As we emerge to living with COVID-19, safeguarding practitioners benefit from innovative practice developed during the pandemic whilst retaining an agile mindset for the challenges ahead as the world around us continues to present new pressures and demands.

A report published by Public Health Wales in October 2021 set out the cumulative impacts of Brexit, coronavirus and climate change together and their combined influences on health, wellbeing and inequalities in Wales. The range of factors that will be impacted by the three challenges, included health, economic, social and security, mental wellbeing, environment and access to, and quality of services. The report highlights how this 'triple challenge' will have direct and indirect impacts on the population providing insights we must be mindful of for future safeguarding practice. At the time of writing the War in Ukraine following the Russian invasion is in its third month. The resultant shockwaves reverberate across the world with escalating fuel prices and inflation pressures as well as the largest migration of refugees since the 1940s. This further compounds the impacts of the 'Triple Challenge'.

Our forward planning and horizon scanning sections demonstrate how the Network is preparing for emergent challenges; mindful that we will need to look forward whilst simultaneously building on the resilience and knowledge base from the last period.

By retaining this agile approach, the Network continues to be an advocate for vulnerable service users.

I hope you find this report informative and that you are able to share it throughout your organisation.

Dr Aideen Naughton
Chair of the NHS Wales Safeguarding Network

As we emerge to living with COVID-19, safeguarding practitioners benefit from innovative practice developed during the pandemic whilst retaining an agile mindset for the challenges ahead as the world around us continues to present new pressures and demands.

Leading and Communicating

Network Collaboration

The Network is a vital and vibrant resource in Wales, with cohort of experienced, credible and valued system leaders in safeguarding who embed the vision of *'A Wales where everyone is safe'*.

Aligning and sharing practice, translating policy and producing resources are a key part of Network business. Specialist sub-groups report into the Network including Looked After Children, the Safeguarding Maturity Matrix, Safeguarding Training and Violence against Women, Domestic Abuse and Sexual Violence provide a structure for more in-depth work using a planned approach.

Stakeholder Communication

- A Network Communications bulletin is widely cascaded to relevant stakeholders. The bulletin collates Network achievements, policy, events, learning opportunities and good practice examples relevant to safeguarding practice.
- Up to date information on the Network is embedded in the refreshed NST website which also stores key safeguarding tools and reports developed by the Network.
- The Network Annual Report is widely circulated to a range of multi-agency stakeholders.

Multi-Agency Working

Partnership Working Principles

The Network adheres to a system wide approach to ensure organisations have arrangements in place to protect and safeguard children and vulnerable adults who are at risk of abuse and neglect.

To this end Network partners outside of NHS Wales include Welsh Government, the Older Persons and Children's Commissioner Offices. Additionally, the Network provides representation at key multi-agency meetings to support the development of ongoing prevention work.

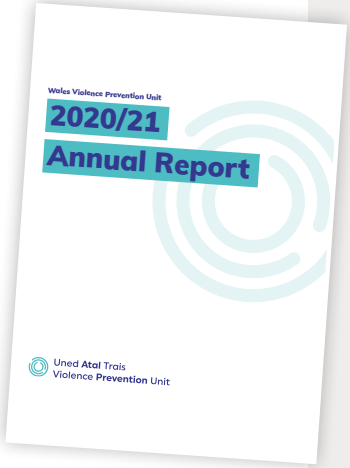
The partnership approach facilitates the sharing of good practice, key safeguarding information and national updates to promote effective specialist support across the organisations and agencies.

Regional Safeguarding Boards

The 6 Regional Safeguarding Boards across Wales co-ordinate multi agency practice, ensuring effectiveness of local arrangements to safeguard and promote the wellbeing of adults at risk, children and young people.

Public Health Wales National Safeguarding Team are members of all Regional Safeguarding Boards providing independent expertise to the work of the Boards to support agencies across the region. As Network representatives they contribute to the ongoing development of the multiagency work and support innovative solutions to overcoming any barriers identified to successful multi-agency working.

Wales Violence Prevention Unit



The Wales VPU (VPU) aims to embed a public health approach to violence prevention across the system, using members and wider partners across relevant networks to deliver the four elements of the VPU model (Aware, Advocate, Assist, Adopt). The Wales VPU annual report, which investigated the financial impact of violence in Wales, revealed that violent incidents cost the NHS £205.4 million each year.

Through associate membership, the Network continues to support the Wales VPU to develop collaboration, community consensus, co production and long-term ambitions that violence prevention should be reflected in all national policy.

More specifically, the NST have collaborated with the VPU to improve the way in which NHS Female Genital Mutilation (FGM) statistics are stored and collated. The VPU have now taken responsibility for collecting the data with a view to formulating a regular reporting framework.

All Wales
Systems Leadership

Looked After Children

Context

On 31st March 2021 a total of 7,625 children were looked after in Wales, an increase of 2% from the previous year representing 115.3 looked after children per 10,000 of the under 18 years population. Of these, 70% were living with foster carers, 16% were living with their parents (or another person with parental responsibility) 7% were in secure units, children's homes or hostels, 3% were adopted and 2% were in residential schools or living independently. 7% of these children and young people had experienced 3 or more placement moves during the year 2020-2021. 220 children left care via a special guardianship order (89% of which were granted to the child/young person's former foster carer) and 266 children were adopted.

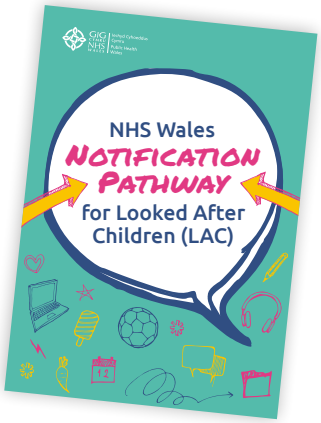
7,625 children were looked after in Wales, an **increase of 2%** from the previous year.

Network Leadership Activity

The Looked After Children Steering Group, managed by the Network, is the vector for providing leadership for health professionals working with looked after children and young people across Wales bridging vital strategic arrangements at local level and national policy developments. This is achieved via quarterly meetings led by the Designated Doctor for Looked After Children, adoption and fostering. →

Activity over the last period includes:

- Collation of reflections and lessons learned during the COVID 19 pandemic.
- Updating the All Wales Notification Pathway to include a more comprehensive risk assessment.



The group is also currently working on the development of a Client Satisfaction tool for use by Looked After Children and Young People following their statutory health assessment. The feedback will be used to improve services and therefore health outcomes for children looked after.

The Designated Doctor will continue to contribute expertise to the Foetal Alcohol Innovative Collaborative to develop appropriate services and diagnostic pathways in Wales for unborn children exposed to alcohol.

Future Activity

- Evaluation of the Looked After Children Health Assessment Framework to establish the impact of the tool on the quality of health assessment since its implementation and to identify further improvements.
- Reviewing health board services for Looked After Children and Young People to assess regulation compliance to identify strengths, weaknesses, delivery gaps as well as how the service has adapted during the pandemic to inform future practice.
- Working collaboratively with the Welsh Government and the National Adoption Service to create a standard operating procedure for use of NHS numbers following the granting of an adoption order.

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

Leadership Governance

The NHS Wales VAWDASV Steering Group works with the Trusts and Health Boards to ensure that governance processes are in place to collate, review and share good practice. Steering Group members collaborate to increase the knowledge relating to VAWDASV across NHS Wales whilst maintaining a health-based voice and influence across policy makers.

A series of speakers gave updates on the following topics: -

- Welsh Government - Evaluation of Welsh Government Wales Ask & Act Training
- Welsh Women's' Aid - the role health plays in relation to VAWDASV
- SARC (Sexual Assault Referral Centre Regionalisation Project - update on the Independent Sexual Violence Advocate (ISVA) provision.

Review of National Strategy

Network representatives attended Welsh Government consultation meetings to review the National VAWDASV Strategy, collating input from Health Boards and Trusts.

The revised strategy will include a blueprint plan to enable a multi-agency approach to tackling VAWDASV. The blueprint will a shared governance structure of both devolved and non-devolved bodies and will ensure partnership across public, private and specialist sectors, including representation from health via the Network representation. →

The impact and implications of the Covid pandemic have been discussed at the VAWDASV Steering Group meetings.

COVID-19 and VAWDASV

The impact and implications of the Covid pandemic have been discussed at the VAWDASV Steering Group meetings. This enabled members to discuss any challenges and share good practice. For example, in some areas, training compliance improved due to online training. Additionally, the promotion and inclusion of minority groups in relation to preventing, protecting and supporting survivors of VAWDASV became more prominent.

Planned Forward Activity

- To review how VAWDASV is identified and recorded within all NHS Wales Emergency Departments & Minor Injury Units.
- Seek assurance that Health Boards and Trusts have incorporated lessons learned from the impact and implications of COVID.
- Review of NHS Wales Ask & Act training Group 2 see **Upskilling Section**.

Single Unified Safeguarding Review

Context

The Welsh Government's Single Unified Safeguarding Review (SUSR) aims to create a single review process where a multi-agency approach is required. This approach will incorporate review processes such as Adult Practice Review; Child Practice Review; Domestic Homicide Review; Mental Health Homicide Review; Offensive Weapon Homicide Review. The learning from these reviews will be saved and coded, whereby a final report will be used to inform professional practice via the Wales Safeguarding Repository.

The approach fulfils a need for a more centralised, proactive, structured approach to facilitate learning from reviews of fatal incidents which, although focussed on Wales, will provide a platform to share practice across England and Wales.

Network Activity

The Network has contributed to the Training and Development Sub group which has created a training and development framework for Approved Chairs and Reviewers.

Work continues to develop the draft SUSR Training Resources in line with the Learning and Development Plan. Best Practice examples will be considered to enhance this work.

Expert Review

Suicide Rapid Review

Context

In November 2021 an increase in suspected possible or probable suicide deaths in children, occurring over a short time period was identified. Welsh Government commissioned the Child Death Review Programme (Public Health Wales) to undertake a review of the possible suicides in children and young people aged 8-17 years between 1st January and 30th November 2021.

Network Activity

Designated Doctors from the NST provided expertise to the Welsh Government group that considered the findings and next steps. This ensured that Regional Safeguarding Boards were recognised as key stakeholders for receipt of the learning.

Findings

Key themes from the review covered opportunities for preventative activity and consideration of more focussed support.

The vulnerabilities identified were:

- Looked After Children
- Children on the Child Protection Register
- A history of self-harm
- Family known to social services
- Previously bereaved or directly impacted by a suicide
- Living in more disadvantaged or under-served communities

Impact

In January 2022 a letter sharing the lessons was sent to mental health, substance misuse, education, and safeguarding and youth justice services. It reminded all of the importance of vigilance to provide additional support to these vulnerable children at risk of suicide and to ensure a consistent and sensitive multiagency response to unexpected deaths and included guidance on how to support children and young people.

Child Death Rapid Review

Context

In October 2021, the NST Designated Doctor was commissioned by Cwm Taf Morgannwg Safeguarding Board (CTMSB) to undertake an independent rapid review into the deaths of five children in Bridgend. The NST was chosen as an independent safeguarding specialist was required to assess the effectiveness of multi-agency decision making and evaluate the application of current thresholds for risk and harm in Bridgend in relation to child protection and safeguarding. The Safeguarding Board sought assurance that, in light of these 5 deaths, there were no immediate measures or actions required by the Board to safeguard children and young people within this area.

Review Delivery

The review took place over 6 weeks, using a project management approach, and involved reviewing records, minutes, documents and policies to benchmark against best practice and national standards.

A detailed report including 27 recommendations was presented to CTMSB in December 2021; subsequently a plan has been created to address all recommendations.

In addition, an event was organised to explore how well the multi-agency staff in Bridgend felt that they had been supported to date. This supplied valuable feedback for the multi-agency partners and enabled signposting to support resources as necessary.

Feedback

Stakeholder feedback from the review: -

> **"Undertaken within a short timescale and completed to a high professional standard, involving all the right people"**

> **"Thorough, methodical and detailed approach to the task"**

> **"Objectivity and Independence of the review was commendable"**

Improvement Tools

The Network continue to develop innovative methods and products to improve practice, facilitating an assured NHS Wales wide standard for safeguarding.

Safeguarding Maturity Matrix

Context

The Safeguarding Maturity Matrix (SMM) is a self-assessment tool that was launched in 2018 to replace the previous tool known as the Quality Outcome Framework (QOF). The SMM acts as an all-age self-assessment tool to support safeguarding quality improvement across NHS Wales.

The SMM is completed by the 7 health boards and 3 NHS trusts within Wales. The National Safeguarding Team receive the information and collate it to provide a national report of the NHS Wales safeguarding services across Wales.

Measuring the effectiveness and quality of safeguarding provision is an important part of the Networks role within NHS Wales. The ability for Health Boards and Trust to assess their strengths and gaps each year and to use the findings from the SMM tool to direct their own quality improvement plans and the Network Workplan is key.

As such, the SMM enables the NHS in Wales to review its effectiveness and to verify that fundamental safeguarding legislation such as the United Nations Convention on the Rights of the Child 1989, Human Rights Act 1998 and the Social Services and Well-being (Wales) Act 2014 underpins core safeguarding business.

SMM Standards and Self-Assessment

The SMM consists of a set of five standards that underpin the self assessment process: -

1 | Governance and a Rights Based Approaches

2 | Safe Care

3 | Adverse Childhood Experiences (ACE) Informed

4 | Learning Culture

5 | Multi Agency Partnership Working

Each standard includes several example indicators to assist organisations in establishing their self-assessment score. The scoring is out of 5 with 5 indicating a 'mature' organisation and 1 indicating 'basic progress' with improvements required.

The Trusts and Boards complete the SMM and the related Improvement Plans, including their self-assessment scores. These are then submitted to the NST to inform the national picture of safeguarding and are reported to Chief Nursing Officer in Welsh Government. →

A representative from each organisation was paired with another organisation together with an NST member to act as an independent facilitator.

Peer Review Process

In 2021 the NST coordinated the annual Peer Review process to identify and share examples of good practice and to collaborate for improvement involving 2021 representatives from all the Health Boards and Trusts took.

To adhere to Covid guidance, the process took a different format this year to operate within the Welsh Government Covid guidance at that time. A representative from each organisation was paired with another organisation together with an NST member to act as an independent facilitator. Virtual or in person meetings took place with information shared including annual reports, policies, standard operating procedures, and their safeguarding improvement plans from their latest SMM.

Peer review proformas contributed to an overarching report, and a virtual meeting was held for all small teams to share their learning. Both these activities have informed the forthcoming Network work plan.

Tool Revision

During the past year the SMM group (a sub-group of the Network) was re-established and with the support of the NST a review of the current SMM was undertaken. The findings from this review included: -

- A consensus that the SMM was a definite aid to the Health Boards and Trusts supporting them to identify their strengths and gaps and plan their quality improvements.
- The SMM complements other assurance reports, with examples of the SMM standards being used to structure other reports.
- The current standards were mainly considered as useful to structure evaluation.
- The peer review approach was viewed as helpful
- Scoring of quality was subjective and lacked meaning.
- Scoring examples/indicators only give qualitative examples which means that evidence provided in Improvement Plans are also qualitative and anecdotal.
- The standards are not reflected in the current legislation and policy that Health Boards and Trusts are required to meet.
- A lack of inclusion of specific adult safeguarding requirements, particularly with the Mental Capacity Amendment Act (2020) changes impending.
- In light of the NHS response to Covid, the need for a new standard that recognises that organisations are responsive, resilient and purposeful in the face of unforeseen events.

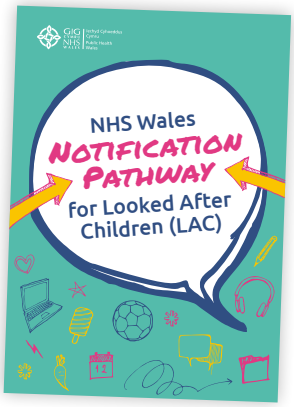
As a result of this review the SMM has been revised with a view to be piloted in 2022-2023. The NST will conduct an evaluation of the pilot and use the findings to inform a final version of a new SMM to launch in 2023.

LAC Notification Pathway Review

Context

Looked after children and young people represent one of the most vulnerable groups in modern society. As a result of their exposure to adverse childhood events most of these children and young people have a multitude of unmet health needs. Additionally, up to 10% of children looked after will experience 3 or more placement moves in any one year which may involve moving to different health boards in Wales or even to another home nation. This can sometimes mean that health needs are overlooked with health appointments being delayed, missed or cancelled. Slow or delayed transfer of health records can have an additional impact on this.

The Pathway



The All Wales LAC Notification Pathway was produced in collaboration with all Health Boards in Wales to facilitate a safe and effective notification process ensuring systems are in place to enable health information and health records to accompany each child. This notification pathway provides standards of good practice for health organisations who are working with children currently looked after by the local authority who have been provided with hard and digital copies of the pathway which has clear and concise minimum requirements for its use.

By utilising the notification pathway, LAC Health Services within NHS Wales are notified of all placements of children or young people who are looked after including pre-adoption placements, change of placements, have a change of legal status, have an adoption order granted or leave the care system. The child's health record and most recent health assessment should follow each child or young person to their area of residence whilst being looked after by the local authority. Through the Pathway's Healthcare Needs Notification Form, NHS Wales will share information relating to the child and young person's general practitioner, dentist and any other relevant health professionals to ensure continuity of care.

Review

Following its introduction in 2020 the Pathway has been used throughout Wales and has been well received both within Wales and beyond. In fact, other regions in England have adopted a similar policy and documentation within their own area having received notifications from Wales using this tool.

Whilst overall the review found the Pathway effective, it was noted that more attention was needed to highlight the general and specific risks of children moving out of area. Therefore, a section specific to risk assessment has been added to the Health Care Needs Notification Form and the refreshed version is due to be circulated and implemented throughout Wales.

Embedding Policy **into Practice**

Changes to Deprivation of Liberty due to the Mental Capacity Amendment Act

The Network tasked a sub-group to help prepare NHS Wales for the Mental Capacity (Amendment) Act (2019), incorporating the transition from Deprivation of Liberty Safeguards (DoLS) to Liberty Protection Safeguards (LPS).

Context

The Mental Capacity Act (MCA) 2005, covering England and Wales, provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to prepare for a time when they may lack capacity in the future.

In some cases people lack the capacity to consent to particular treatments or care that is recognised by others as being in their best interests or which will protect them from harm. Where this care might involve depriving people of their liberty, extra safeguards have been introduced in law to put the person's rights and wishes at the centre of all decision-making.

Currently the Deprivation of Liberty Safeguards (DoLS) are the model to safeguard and protect individuals. A Supreme Court ruling in March 2014 resulted in a very large increase in the number of applications for DoLS authorisations and all public bodies have since seen a constant increase in applications. The House of Lords published a scrutiny report (2014) of the MCA that concluded that DoLS were "not fit for purpose" and recommended they be replaced. In July 2018, the UK Government published a Mental Capacity (Amendment) Bill, that became law in May 2019.

The aim of LPS is to simplify the process so that it will be quicker and less bureaucratic than DoLS so people will have better quality care with minimum restrictions. Amongst other changes it will offer greater involvement for families and extend the scope to include sixteen to seventeen year olds and those residing in domestic settings.

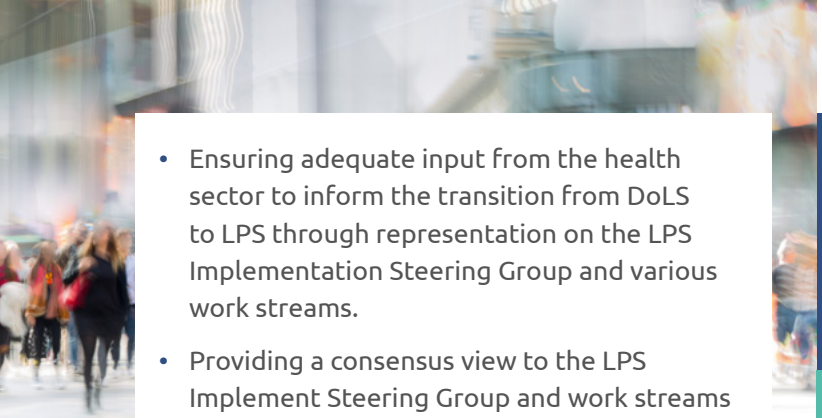
The date for the introduction of the LPS has not yet been decided. It will be finalised after the consultation on the proposed changes to regulations and the MCA Code of Practice.

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.

Work included:

- Working with the Welsh Government LPS Implementation Steering Group and relevant work streams to co-ordinate the NHS Wales contribution. →



- Ensuring adequate input from the health sector to inform the transition from DoLS to LPS through representation on the LPS Implementation Steering Group and various work streams.
- Providing a consensus view to the LPS Implement Steering Group and work streams through collaborative working across NHS Wales organisations and the Older Persons Commissioners Office,
- Facilitating Health Boards and Trusts to share concerns, best practice and progress towards the transition from DoLS to LPS to enable consistent approaches across NHS Wales.
- Production of a collaborative Network response to the MCA Amendment Act Code of Practice consultation to feedback to the UK government.
- Production a collaborative Network response to the draft Welsh LPS regulations consultation to feed back to Welsh Government.

Forward Activity

The next steps for the Network subgroup are: -

- Finalising the combined NHS Wales response to the consultations on the Draft Regulations and the MCA code of practice.
- Continuing to ensure that the 'voice of health' is represented in the LPS Implementation Steering Groups and work streams.
- Providing a consensus view on a proposed Workforce and Training Framework for Wales.
- Considering the implications of the new regulations and code for the implementation of LPS in NHS Wales.
- Collaborating to ensure a consistent approach to the challenges of the transition to, and the implementation of the LPS in NHS Wales.

System Rheoli Pryderon Unwaith dros Gymru

Once for Wales Concerns Management System

Once for Wales

Overview

The Once for Wales Safeguarding Management System has been designed for health organisations to capture all safeguarding activity, to monitor and action safeguarding incidents, concerns and outcomes and identify key learning to drive forward local improvements and to share those insights across all health organisations across Wales. It is a component of the Once for Wales Concerns Management System (OfWCMS).

It will triangulate information relating to Patient Safety Incidents, including incidents relating to Deprivation of Liberty Safeguards and in the future Liberty Protection Safeguards. Through these actions the system will support organisational safeguarding assurance and facilitate quality improvements to safeguard every individual accessing health services in Wales.

Activity

Over the last period, the sub-group of the NHS Wales Safeguarding Network has led on developing the system to effectively capture safeguarding activity across health boards, incorporating alerts for managers to review organisational actions. Other improvements include the generation of graphical safeguarding reports to highlight risks, trends and themes to support wider organisational learning.

Legacy

An effective system that will capture all safeguarding activity and integrate organisational learning to reduce harm and improve patient safety and safeguards across NHS Wales.

Routine Enquiry into Domestic Abuse Audit

Context

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

In the last period the minimum standards of NHS Wales Routine Enquiry into Domestic Abuse for midwives and health visitors have been reviewed to ensure relevance with VAWDASV (Wales) Act 2015

Network Activity

- The revision of the Minimum Standards took place following a multi- agency approach which included collaboration with Welsh Women's' Aid and survivors of domestic abuse.
- All amendments have been incorporated into an agreed revised document which has been distributed to all Health Boards and Trusts to use for audit
- A universal information-sharing protocol has been devised and shared based on an existing process - Sharing Information in Pregnancy (SiP) which was already in use by some Health Boards.

Domestic Abuse Act

Context

The Domestic Abuse Bill for England & Wales was enacted on 29th April 2022. Although this Act includes Wales, the VAWDASV (Wales) Act 2015 remains statute.

The measures in the Act seek to: promote awareness - to put abuse at the top of everyone's agenda, including by legislating for the first time for a statutory definition of domestic abuse. protect and support victims, including by introducing a new Domestic Abuse Protection Notice and Order.

Network Activity

The Home Office are currently leading on a piece of work identifying how the Domestic Abuse Act will affect services and people in Wales in conjunction with the Welsh Government VAWDASV Team.
A timeline of this Act has been shared with the Network VAWDASV Steering Group and all Health Boards and Trusts. The Steering Group are currently considering the implications of the Act for health services in Wales.

Ending Physical Punishment in Wales

Context

In January 2020 the Senedd passed the Children (Abolition of Defence of Reasonable Punishment) (Wales) Act which went live on 21 March 2022. The Act aims to protect children's rights and give all children the best start in life. Wales joined over 55 nations worldwide who have already outlawed physical punishment of children. The law removes a 160-year-old defence of reasonable punishment and gives children the same legal protection from assault as the law provides for adults.

Network Activity

Network members have worked with Welsh Government and key stakeholders to ensure that the ground-breaking law is implemented in the best way possible. Welsh Government led a Strategic Implementation Group that oversaw three task and finish groups to consider the requirements of both practitioners and society to implement the Act. Network chair Dr Aideen Naughton took part in a live Q&A panel during National Safeguarding Week November 2021 attended by over 800 participants from the wider public and third sector. Furthermore, Network expertise has shaped a Factsheet to help health professionals understand what they need to know about the change in the law.

Wales joined over 55 nations worldwide who have already outlawed physical punishment of children.

Upskilling the **Safeguarding Workforce**

Network Training Sub-Group

NHS Wales have a duty to provide their employees with access to child and adult safeguarding training to ensure they develop the knowledge and skills required to undertake their roles to competently safeguard children and adults at risk.

The Network has supported this aim through a Training Subgroup to coordinate contribution from all health boards and trusts in addition to input from Health Education and Improvement Wales (HEIW). The group share resources which can be used across NHS Wales and comment on and critique the content of training packages as necessary. Bi-monthly information briefings and safeguarding topics are now being developed to ensure timely accessible information is available to relevant staff within NHS Wales.

Key current work includes:

- NHS representation on the group developing Multi-Agency Safeguarding Standards (see below for further detail), ensuring that the standards are compatible with current health guidelines
- NHS representation on the group developing a Training Framework for multi-agency use.

Future work includes:

- Reviewing consultation outcomes of the Multi-Agency Safeguarding Standards.
- Agreeing the Training Framework for multi-agency use.
- Consideration of a Quality Assurance Framework for safeguarding training events to ensure both consistency and that meet the agreed standards.
- Consideration of a Multi-Agency Training Certification to promote portability of training within and between agencies.

Multi-Agency Safeguarding Standards

About the Standards

The purpose of the standards is to make sure that everyone in Wales receives consistent and good quality training relevant to their role and responsibilities, and that we, as practitioners, can safeguard people to the best of our ability.

Currently there are no multi-agency national standards for safeguarding training in Wales. This means that there is a lack of consistency in the design, content and provision of safeguarding training across organisations in Wales. In some there is also confusion around the appropriate levels of safeguarding training for the workforce.

The aims of the standards are:

- The creation of a set of safeguarding standards that underpin training, learning and development activity related to children and adults in Wales.
- A multi- agency set of standards for all levels of safeguarding, linked to the competencies and knowledge required.
- A way to map specialist topics or “other” safeguarding training outside of the core modules across to the set of standards
- An ability for these to be used across agencies, regions and differing needs within the public facing sectors.

Network Input

The Network are part of a multi-agency national group lead by Social Care Wales to develop Multi-Agency National Safeguarding Training Standards. Current work includes coordination of an NHS Wales response to the latest consultation to ensure the health aspect is understood and included.

Ask and Act Training

Context

Ask and Act training covers an organisational duty to encourage relevant professionals to "Ask" potential victims, in certain circumstances (targeted enquiry) and to "Act" to increase identification of those experiencing VAWDASV to offer referrals and interventions for those identified at the earliest opportunity.

The training upskills professionals to:

- recognise the signs that someone is being abused
- talk to that person sensitively (if appropriate)
- offer options and services to them quickly and efficiently

The Network adapted the existing Welsh Government Group 2 Ask and Act training package to ensure relevance within health settings, and that that service users affected by VAWDASV were appropriately supported.

Evaluation

- The VAWDASV Steering Group will undertake an evaluation of the Ask & Act training package.
- The evaluation will ensure training is up to date and consistent with any new evidence, national priorities and legislation changes, including the emerging Safeguarding National Training Framework.

Next Steps

VAWDASV Network Sub-group to review NHS Wales Ask and Act training to ensure it: -

- Sufficiently addresses the risk to older people in the context of domestic abuse
- Aligns with the emerging safeguarding training standards and framework

Safeguarding Children's Masterclass

Masterclass for Paediatricians

Due to the success of the 2020 event, an additional Masterclass for paediatricians via webinar took place in June 2021.

Sessions covered:-

- Perplexing Presentations (PP) or Fabricated or Induced Illness (FII) in children
- Supporting Sudden Death in Children and Young Adults
- Safeguarding and Dermatology
- A Year of Reflection: what changed for looked after children and adoption in 2020

Feedback

The event had over 80 attendees. A selection of attendee feedback from the event, as below: -

> **"Great line up of speakers and topics, with insights which were aspirational"**

> **"I will use the knowledge gained today in the appropriate clinical contexts to improve care for the children seen for safeguarding medicals"**

> **"The session reminded me to always see young people on their own as well and to consider sexual exploitation in re-attenders"**

Representing at Events

Family Justice Council Medical Event

A Designated Doctor and a member of the Network were appointed in a leadership role as Medical Co-Chair of the Wales Family Justice Council Medico legal committee which is a forum to improve relationships between health professionals and the judiciary with the aspiration of increasing the pool of expert witnesses within Wales.

They arranged the inaugural event for the Committee which was attended by 179 people from a wide variety of backgrounds across medicine, psychology, CAFCASS and law. The session focus was Giving Evidence in Perplexing Presentation and Fabricated Illness in Children Cases. It proved an opportunity to discuss the Royal College of Paediatrics and Child Health (RCPCH) guidelines. This included the different approaches suggested and how this may affect the way agencies manage these cases, and the consequences for the subsequent judicial process and how experts may give evidence.

British Paediatric Dentists Webinar

In October 2021 the British Paediatric Dentists society held its Biannual scientific webinar attended by over 600 participants from across the UK. The NST service lead Dr Aideen Naughton was invited to talk about the impact of childhood adversity on brain development and the lifelong consequences for society and citizens physical and mental health

Webinar on Impacts of COVID-19 on our Children and Young People

In September 2021 Network Designated Doctor Claire Thomas was invited to talk on a Public Health Network Cymru webinar focussing on The Wider Impacts of COVID-19 on our Children and Young People and families. The fully attended webinar noted that COVID-19 has been a devastating pandemic for all but especially for our children and young people and the effects of this on their health, education and wellbeing will continue for years to come. The webinar explored these impacts and some of the ways in which this is being addressed within Wales, culminating in a lively question and answer session.

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, thereby improving the overall arrangements for safeguarding in NHS Wales.

Corporate safeguarding teams across NHS Wales maintained agility during another turbulent year, delivering innovative initiatives while returning to full service alongside the challenges of the ongoing pandemic.

Below are some examples of organisation-based practice and innovations over the last period: -

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Cwm Taf Morgannwg University Health Board

Child Protection Safeguarding Hub

In the last period Cwm Taf Morgannwg University Health Board (CTMUHB) Corporate Safeguarding Team has concentrated on the development of a child protection safeguarding hub that places children at the centre of the safeguarding process. The Hub was developed in response to several issues and the recommendations of an external audit.

About the Hub

The Hub is a centre for the physical assessment of children aged 1 to 17 years who require an urgent child protection physical examination (Child Protection Medical) in the Board area. Staff include Consultant Paediatrician Clinical Nurse Specialist and administrative assistant who provide a single point of contact for colleagues, partner agencies and families, and ensure a quality, evidence-based approach to care is maintained.

Hub Benefits

- The legal responsibilities of the health board are met in an effective manner
- Effective time management for health board resources involved in the safeguarding process such as the expertise of paediatricians.
- A dedicated team to ensure that a child is seen at the 'right time by the right person'.
- Consistent management of referrals, providing quality and ensuring that information is shared in a timely manner.
- A dedicated child friendly environment, which is reportedly an improvement from the previous acute clinical environment.
- Improved ward resources through the reduced need for a bed in an acute ward.
- Ability to access medical illustrations, further clinical investigations and follow up services.
- Increased training opportunities for all health board staff to gain experience in safeguarding as well as students wishing to undertake bespoke placements.

Effectiveness and Feedback

The effectiveness of the Safeguarding Hub has been measured in a variety of ways to ensure it provides an exceptional care to children and families, meets the standards set out by the Royal College of Paediatrics and Child Health (RCPCH) and improves ward efficiency.

Feedback has been collated from parents and professionals, with the voice of the child established through child friendly forms.

Response themes include: -

- Helpful, supportive and friendly
- Professional and knowledgeable
- Child focused
- Good time management
- Excellent communication

By obtaining feedback from children, young people and families in a sensitive and compassionate manner the service aims to evolve and facilitate a good experience in the most challenging of circumstances.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cardiff and Vale
University Health Board

Cardiff and Vale University Health Board

The Corporate Safeguarding Team at Cardiff and Vale University Health Board (CAVUHB) have been working on a variety of initiatives covering Sexual Abuse, pressure damage alongside upskilling and resourcing activities.

Routine Enquiry on Sexual Abuse

The Board has commenced a pilot within the Midwifery Service at University Hospital of Wales on Routine Enquiry (RE) around Childhood or Adult Sexual Abuse.

Designated areas within Midwifery are being used as a starting point, with RE questions being asked to those booking in with the Elan Team (for women who require additional social support) and the Pregnancy Advisory Service (PAS).

Early indications are that while there are no new cases indicated or onward referral to police or Sexual Assault Referral Centres (SARC) required, survivors noted that the case for them was addressed at the time. Whilst individuals have expressed that they were pleased that this process was being piloted, they would have liked the Enquiry to have been in place when they had been experiencing sexual abuse.

Additional training is being considered around difficult conversations with survivors, to upskill staff in feeling confident to open up discussions and offer support.

The pilot is ongoing and not evaluated yet. Meanwhile the Board are in discussion with the Centre of Excellence around how to progress the work further with a view to a wider roll out.

Pressure Damage Audit

CAVUHB are undertaking an internal audit to look at pressure damage that is not reportable to Local Authorities under the Social Services and Well-being (Wales) Act, as it is deemed to be unavoidable. The Board will examine internal processes to give robust assurance to Local Authorities that accurate reporting is in place.

Additional Activities

- Safeguarding training has resumed, with a refreshed focus on targeting difficult to reach groups such as District Nurses, by offering biannual bespoke training.
- Safeguarding group supervision for adult based Health Lead Practitioners has recommenced.
- Routine Enquiry in the Emergency Unit has commenced.
- Additional funding from the VAWDASV Board has facilitated additional Independent Domestic Violence Advisor (IDVA) capacity.
- Secondments into the safeguarding team commenced in January 2022, to support succession planning and sustainability.
- Also in January 2022, a Safeguarding Nurse advisor was seconded to the Local Authority Adult safeguarding team for upskilling and facilitation of better multi-agency working.

Welsh Ambulance Services NHS Trust

Welsh Ambulance Services NHS Trust (WAST) launched various innovative initiatives over the last period.

Joint initiative to safeguard vulnerable people at home

WAST partnered with fire and rescue services to launch a new initiative to better protect vulnerable people at risk of an accident in their home. The system allows ambulance crews to e-refer at-risk patients to their fire and rescue service counterparts across Wales for a 'Safe and Well' check.

When visiting to deliver a medical intervention, Ambulance crews may notice red flags, for example that the patient has cigarette burns on their clothes or furniture, or that the patient's hoarding has blocked an escape route. By using an iPad referral form they can enlist a fire crew to visit the property to mitigate any risks.

Nikki Harvey, the Welsh Ambulance Service's Head of Safeguarding, said:

"Anything that we can do collectively to improve patient safety, mitigate the risk of accidents and prevent harm could reduce 999 calls in the future."

Tim Owen, Community Safety Manager at North Wales Fire and Rescue Service, noted:

"This agreement will enable us to extend this work, identifying those most at risk and vulnerable in our communities to make them safer."

Digitisation of the Live Fear Free Pathway

Since 2014, WAST have used a bespoke pathway where victims/survivors of VAWDASV can be signposted to the Live Fear Free helpline (a 24/7 service that provides support to victims of domestic abuse and sexual violence). WAST have now updated the Live Fear Free referral pathway by launching a digital referral form during National Safeguarding Week. It is important to note that this pathway supports both patients, service users and WAST employees.

Safeguarding Training Scenarios

Due to COVID, safeguarding CPD sessions have shifted to focus on the clinical aspects of different organisational roles, with mandatory and statutory CPD being completed virtually. This new approach will be rolled out during the 2022/2023 period.

To progress this work, the Safeguarding Team are collaborating with the National Ambulance Training College to develop safeguarding scenarios related to VAWDASV, self-neglect and child and adult at risk. These topics reflect relevant concerns and will therefore better equip practitioners to discharge their safeguarding duties.

GIG CYMRU NHS WALES
Ymddiriedolaeth GIG Felindre
Velindre NHS Trust

Velindre University NHS Trust

The key achievements for the Velindre University NHS Trust (VUNHST) Corporate Safeguarding Team in the last period are as follows: -

- The scope of the role and function of the Trusts Safeguarding & Vulnerable Adults Group extended to include the Vulnerable Adults agenda including cognitive impairment, dementia, older persons and learning disability.
- Continued full compliance with its statutory responsibilities by reporting safeguarding concerns and working with multiagency partners.
- Safeguarding supervision and advice was accessed from both the Cancer Centre and Welsh Blood Service.
- Safeguarding training continued to be delivered virtually and via eLearning.
- Continued regional partnership training for domestic abuse.
- Continued supporting the national safeguarding work and regional board responsibilities.
- The divisions improved their processes for reporting safeguarding activity and assurances to the senior management teams.
- Safeguarding newsletters were developed and disseminated across the Trust with key messages. Screens in patient facing areas were utilised to communicate messages to service users and staff.
- Audits completed utilising the Welsh Nursing Care Record.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Hywel Dda University Health Board

Hywel Dda University Health Board (HDdUHB) has continued to prioritise safeguarding and respond to the challenges of the last period. They have sustained a single point of contact for all staff and external partners, while continuing to develop staff across the organisation.

Role Development

Appointment of a leadership post to facilitate delivery on the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) agenda has improved engagement across Primary Care clusters and facilitated shared learning from domestic homicide reviews.

Learning Culture

- Safeguarding Level 3 training compliance has improved.
- Appointment of a Domestic Abuse Support Officer has improved capacity for Group 2 Ask and Act training.
- The Named Doctor and Lead Nurse Safeguarding Children have delivered multi-agency (Procedural Response to Unexpected Deaths in Childhood) PRUDiC training.
- The Lead Safeguarding Adults Practitioner and Lead VAWDASV and Safeguarding Practitioner have delivered bespoke safeguarding workshops on the STAR Leadership programme.
- They above named practitioners have also delivered sessions on Domestic Abuse and Older People to the wider organisation and specific teams.
- The adult safeguarding team have delivered bespoke sessions on self-neglect, discharge planning, professional concerns and the provision of information to the enquiry process.
- The Lead LAC Nurse has recorded a video to support the Health Board's professional curiosity training resources.

Improvement and Assurance

- The Lead Safeguarding Adult Practitioner worked with digital service to enhance the system for recording advice, support and strategy discussions.
- The Named Midwife worked with digital services to enhance the Sharing of Information in Pregnancy (SIP) database and plan to release a mobile app for community midwives.
- HDdUHB are leading the pilot of the safeguarding report form in Once for Wales Management System report form on behalf of NHS Wales.
- Multi-agency working includes:
  - Contributing to the High-Risk Behaviour Procedure (including Self Neglect and Hoarding)
  - The Lead Nurse Safeguarding Children led on the development of regional Guidance on Working with People who are Uncooperative in partnership with a Local Authority.
- The LAC team worked with the organisation's Enabling Quality Improvement in Practice (EQIiP) initiative to develop resources that support young people, carers and professionals with urinary/faecal soiling which may risk placements.

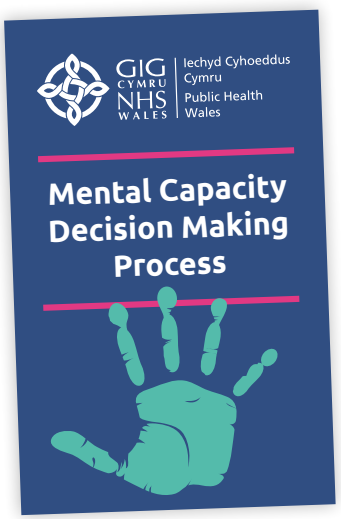
The Lead Safeguarding Adult Practitioner worked with digital service to enhance the system for recording advice, support and strategy discussions.

Public Health Wales

In 2021, the public health agency for Wales, Public Health Wales (PHW) saw a new appointment to the Named Safeguarding Lead role who has driven forward quality and improvement in Safeguarding across the organisation.

Best Interest Decisions in Screening

PHW have implemented an innovative way of gaining consent for members of the public attending screening who lack capacity. This novel approach has been developed in partnership with Welsh Risk Pool and Welsh Health Legal, specifically for non-registered health care workers as decision makers. Training has been delivered and the form has been successfully implemented in one screening programme using a quality improvement methodology.



PHW aims to implement the form throughout all screening programmes supported by the Safeguarding Lead. Additionally, information cards have been developed to support non-registered health care workers to better understand the decision-making process.

PHW have implemented an innovative way of gaining consent for members of the public attending screening who lack capacity.

A Children's Rights Approach

Work has been progressed with an organisational benchmarking exercise against the Children's Commissioner's "The Right Way Matrix" based on the 5 principles from "The Right Way" guide. Engagement throughout the organisation has been positive and findings are currently being collated and analysed. The resulting organisational position will be used to engage the Young Ambassadors in developing an approach that will ensure Childrens Rights are embedded within PHW and considered in decision making at every level and when working with children.

Clinical Governance

Public Health Wales has developed a Directorate Clinical Governance Group to identify how information available within the directorate including Safeguarding can be better utilised to identify areas of clinical and quality risk. The group will inform and promote continuous improvement of services, functions and programmes supporting effective clinical governance across the organisation. The group will also improve the understanding of how information can be better presented, flow and inform the wider organisational operating frameworks and complement the Safeguarding Maturity Matrix submission.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Swansea Bay University Health Board

Swansea Bay University Health Board (SBUHB) Corporate Safeguarding Team continue to progress with innovative work in the context of the competing priorities and the ongoing pressures of the pandemic.

Effective Information Sharing

The SBUHB Safeguarding SharePoint collates Safeguarding information, resources and policies, training dates and campaigns. The single point of access has increased the Corporate Safeguarding Team profile.

Rapid Response to Suicide of an Adult

SBUHB continue to engage with the regional Adult Rapid Response to Suicide Meetings and are working with partner agencies to amend the Terms of Reference to include the sudden death of a person under 21 years and significant suicide attempts.

Identification and Referral to Improve Safety (IRIS)

IRIS has been successful with a rise in first time referrals and a high percentage of referrals in the 60+ age group. A Health Data Scientist evaluation has established early indicators of health and economic benefits including financial benefits of £44k alongside an 8% increase in Quality Adjusted Life Years (QALY).

Violence Prevention Team and Health Independent Domestic Violence Advocate (IDVA)

The Violence Prevention Team at SBUHB is the second of its kind in Wales with a focus on support and advice for patients experiencing violence with injury, aiming to help break the cycle of violence. Complementing this funding was secured for a Health IDVA.

Training & Learning

- Together with their Nurse Education Team, SBUHB have embedded Safeguarding as part of Nurse Induction covering Level 3 Safeguarding People and "Ask and Act" Group 2 training.
- Lunch and Learn Safeguarding themed sessions have provided an opportunity for co-workers from different teams to share expertise.
- Safeguarding Supervision Training Days were delivered for staff from SBUHB, CTMUHB and C&VUHB with excellent feedback received and further dates planned.

Joint Inspectorate Review of Child Protection Arrangements (JICPA)

Together with respective partners SBUHB participated in a JICPA pilot inspection, contributing to the multi-agency response and Action Plan, monitored by the Health Board Safeguarding Committee.

Mother & Baby Unit ("Uned Gobaith/Unit of Hope")

SBUHB have set up a local Unit to help women who experience serious mental health problems during pregnancy and following birth. It is the only inpatient Unit of its kind in Wales offering multidisciplinary mental health care to women from 32 weeks of pregnancy until their baby's first birthday.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Aneurin Bevan University Health Board

Aneurin Bevan University Health Board (ABHUB) continued to develop its safeguarding hub, commented on the hidden costs of lockdown and hosted a child death review.

Early Intervention and Prevention Hub

ABUHB Corporate Safeguarding Team set up the Gwent Early Intervention and Prevention Hub in 2021, to address the increasing amount and complexity of the safeguarding concerns being seen within the Health Board.

The hub provides internal support to the Health Board, so that professionals could have a single point of contact to discuss safeguarding concerns in easy and timely ways. This has been hugely successful in raising the profile of safeguarding in the Health Board and providing support to frontline professionals when they require it.

The hub facilitates multi-agency working as it coordinates Duty to Reports to the Local Authority from the Health Board. Thereby the Health Board can better contribute to the identification, collation, and coordination of information to inform initial decision making for safeguarding cases. Additionally, Hub staff attend all strategy discussions for cases involving health to ensure information sharing is holistic and inclusive.

Child Sexual Exploitation (CSE) and Lockdown

A lead ABUHB nurse published an article in the British Journal of Nursing on Child Sexual Exploitation (CSE) in relation to the social isolation of COVID 19. The publication gave examples of the effects of social isolation on young people and the growing concerns around CSE and online grooming, noting poignantly that isolation should be considered an adverse childhood experience.

Child Death Review

Due to a significant number of child deaths related to asphyxiation, the Board worked with Welsh Government on a rapid review to ascertain themes of the cases along with several near misses. Findings revealed that most of the children were already know to children services and were or had been on the Child Protection register. There were also links within community and or school. This then led to the development of a strategic group within the Gwent Safeguarding Board, whose work is ongoing to look at prevention regarding suicide and self-harm for young people.

Independent Domestic Violence Advocate

The Health Board trialled an Independent Domestic Violence Advocate (IDVA) in the Mental Health. The successful pilot supported training and practice development for people impacted by domestic abuse and coercive control seeking mental health support. The IDVA will support the Emergency Department – an exciting development for 2022-23.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Betsi Cadwaladr University Health Board

The Corporate Safeguarding Team at Betsi Cadwaladr University Health Board (BCUHB) have carried out a wide range of innovative practice, collaborations and learning activities over the last period.

Focus on Falls

BCUHB have increased organisational awareness of the correlation between falls and adult at risk reporting through attendance and presenting at key Governance Groups and Adult Safeguarding Supervision. A Strategic Falls Group have created a Falls Policy and training in line with Wales Safeguarding Procedures to support all staff. A wide range of teams review all falls with harm within the District General Hospitals with the learning shared through daily Safety Briefings.

Co-Production for Safeguarding Week

Co-Production with people in their service is a passion at BCUHB. Within a community hospital, a dementia support worker facilitated patients to learn about modern day slavery upon their request. Patients shared information and created a collage poster raise awareness with other residents.

Coping with Crying Audit

Following a Child Practice Review, it was recommended that BCUHB audit compliance with the Coping with Crying Guideline. The audit included midwifery, neonates and health visiting practice, with findings expected to be published in Spring 2022.

Independent Domestic Violence Advisors

A pilot has commenced for two health Independent Domestic Violence Advisors (IDVAs) to be based within the Corporate Safeguarding Team. The roles are based in community and hospital settings and aim to empower survivors to increase their options, make positive choices/decisions, and increase their confidence, safety and recovery.

Identification and Referral to Improve Safety (IRIS)

A pilot has commenced in South Denbighshire of the IRIS Project which involves training and support for GPs to identify patients affected by domestic violence and abuse and refer them to specialist services.

Agencies Domestic Abuse Perpetrator Tasking (ADAPT)

Chaired by North Wales Police (NWP), ADAPT is a multi-agency approach to domestic abuse perpetrators with the aim to aim to introduce offenders to support programmes and reduce the risk they pose to their victims. Multi-agency meetings incorporate Health representatives including the substance misuse service, mental health division and corporate safeguarding.

Additional Activity

- 5-day bespoke placements for 2nd year Bangor University student nurses in the Safeguarding Team
- Children at Risk Level 3 training delivered to North Wales Police Custody Nurses
- Formation of a Strategic Steering Group to prepare for the Abolition of Reasonable Punishment Act (Wales) 2020, due for implementation on the 21st March 2022.

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Powys Teaching Health Board

Communicating and sharing

The Powys Teaching Health Board (PTHB) Safeguarding Team developed resources to strengthen sharing of information across the Health Board.

Monthly newsletter topics have included: -

Virtual Safeguarding Hub

A Virtual Safeguarding Hub has been introduced to act as a single point of contact into the Safeguarding Team for all PTHB employees and partners

Functions include:

- Managing flows of information
- Managing and responding to requests for advice and support
- Attending adult and child strategy discussions, actioning daily domestic incidents and Once for Wales Incident Reports.

The Hub has improved time efficiency, established positive relationships with the Local Authority and provided consistent health input into adult and child strategy discussions.

Acting on Audits

Audits have resulted in the following actions: -

- A rewrite of the PTHB *Was Not Brought/No Access Visit Protocol*
- Introduction of a Significant Event Chronology function on the Welsh Community Care Information System (WCCIS)
- A Standard Operating Procedure for training to ensure that changes are cascaded effectively.

High Risk Behaviour Procedure

PTHB contributed to a Regional Task and Finish Group to develop a new document on behalf of Mid and West Wales Safeguarding Board - *High Risk Behaviour Procedure (Including Self Neglect and Hoarding)* - which is now being embedded in practice.

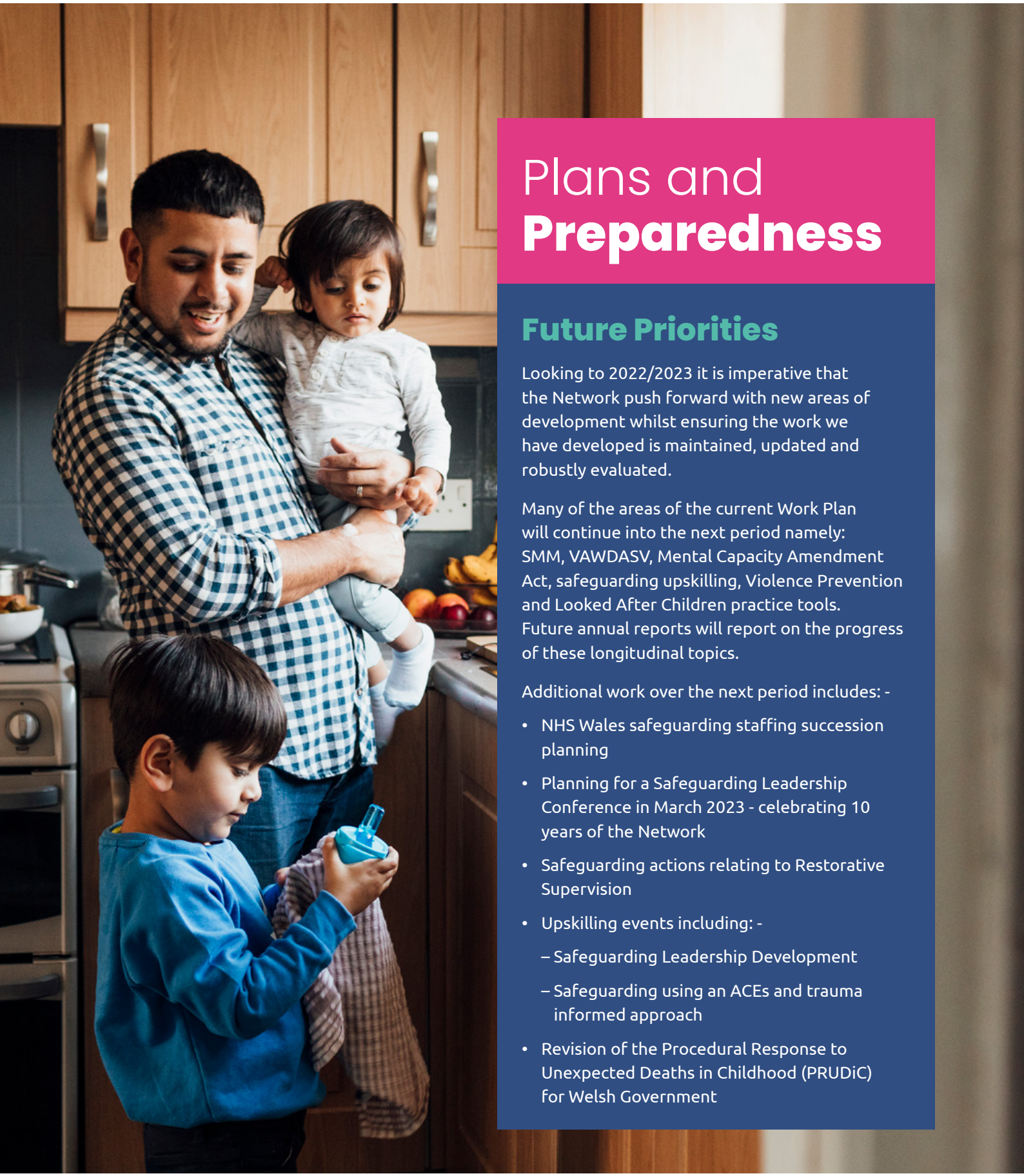
The document presents a multi-agency guide for practitioners working with individuals displaying high-risk behaviours, that emphasises the importance of multi-agency partnership working to build a fuller picture to better support people.

Health Assessment Choices for Looked After Children

Although Health Questionnaire for looked after children is already in place, in person assessments can be difficult to arrange and are occasionally refused by vulnerable children who dislike unfamiliar contact.

During the COVID 19 pandemic PTHB introduced virtual health assessments by necessity, however it became evident that delivery choice needed consideration. As a result, the Health Questionnaire was digitised and redesigned with input from the children and carers.

The new questionnaire went live in February 2022 with an improvement in returns alongside positive responses from the children and carers. Children now have a choice for their Health Assessments - face to face, virtual via Teams or via the Health Questionnaire. By valuing the children's needs and choices practitioners are less likely to encounter refusals and can provide the support they need.



Plans and **Preparedness**

Future Priorities

Looking to 2022/2023 it is imperative that the Network push forward with new areas of development whilst ensuring the work we have developed is maintained, updated and robustly evaluated.

Many of the areas of the current Work Plan will continue into the next period namely: SMM, VAWDASV, Mental Capacity Amendment Act, safeguarding upskilling, Violence Prevention and Looked After Children practice tools. Future annual reports will report on the progress of these longitudinal topics.

Additional work over the next period includes: -

- NHS Wales safeguarding staffing succession planning
- Planning for a Safeguarding Leadership Conference in March 2023 - celebrating 10 years of the Network
- Safeguarding actions relating to Restorative Supervision
- Upskilling events including: -
  - Safeguarding Leadership Development
  - Safeguarding using an ACEs and trauma informed approach
- Revision of the Procedural Response to Unexpected Deaths in Childhood (PRUDiC) for Welsh Government

Horizon Scanning

By taking a Horizon Scanning approach, the Network can consider predicted societal trends and shifts that threaten the safety of children and adults at risk. This context informs our short and long-term work planning, maximising our resource base through early stage upskilling.

Emerging issues currently on the Network's radar include: -

Gender Identity and Gender Dysphoria Advice

At present there is a lack of defined clinical pathways or agreed best practice for assessment and intervention. NHS staff would benefit from further advice and guidance from professional bodies who may need to provide care to patients with gender identity concerns while patients are waiting to access support from specialised gender dysphoria services.

Forced Marriage of People with Learning Difficulties

Forced marriage of children and adults with learning disabilities is an issue that has been highlighted by many frontline professionals including teachers, social workers, health professionals and police officers. It is, as with many other types of abuse, a largely hidden issue and likely to be vastly underreported. The Forced Marriage Unit has noted that guidance provided to professionals required improving and locating within evidence-based practice.

Unaccompanied Asylum Seeking Children

Unaccompanied Asylum Seeking Children (UASC) are children and young people who are seeking asylum who have been separated from their parents or carers. Cardiff and Vale UHB and Aneurin Bevan UHB have been part of the pilot for the National Transfer Scheme which is now being rolled out across Wales. This means more health boards will be receiving UASC, despite no additional resources being allocated to meet this demand, which will have a direct impact on the children themselves.

Unaccompanied Asylum Seeking Children (UASC) are children and young people who are seeking asylum who have been separated from their parents or carers.

Unregulated Care Settings

An increasing number of looked after children are being placed in unregulated care settings where they live semi-independently with minimal support or assurance checks. The number of children entering care has been rising annually, alongside the increase in complexity of these children's needs. These factors have led to a lack of suitable placements; hence some vulnerable young people are being placed in unregulated accommodation where significant safeguarding concerns are emerging.

The impact of poverty and family adversity on adolescent health

An analysis using the UK Millennium Cohort Study assessed the clustering of trajectories of household poverty and family adversities and their impacts on adolescent health outcomes. Results showed that that persistent poverty and/or persistent poor parental mental health affects over four in ten children. The combination of both affects one in ten children and is strongly associated with adverse child outcomes, particularly poor child mental health.

The relationship between Poverty and Child Abuse and Neglect

It is now widely accepted that poverty and inequality are key drivers of harm to children although to date, changes in policy and practice responses have been limited.

New evidence from the University of Huddersfield has confirmed that poverty affects every aspect of family life. Poverty is inextricably implicated in other factors which increase the risk of harm: including domestic violence, poor mental health and substance use. Furthermore children's age and ethnicity interact with poverty in ways that increase inequalities.

Results showed that that persistent poverty and/or persistent poor parental mental health affects over four in ten children.

Practitioners also need to be able to enhance victim safety through trauma-informed advocacy services.

Strangulation and Suffocation Offence

A new specific offence of strangulation and suffocation will come into force in England and Wales in June 2022. Strangulation and suffocation are sadly widespread; being strangled not only leads to potential serious medical consequences that should be identified early on, it also raises by seven-fold the risk of becoming a future domestic homicide victim.

Upskilling is now required for health staff for them to identify the signs and symptoms of non-fatal strangulation and suffocation cases. Practitioners also need to be able to enhance victim safety through trauma-informed advocacy services.

Quality and Engagement Act

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 received Royal Assent on 1 June 2020 and will be brought into force in spring 2023. The Act is part of the much broader agenda to improve the quality of care across NHS Wales organisations and social services.

The Act will:

- ensure that NHS bodies and ministers think about the quality of health services when making decisions
- ensure NHS bodies and primary care services are open and honest with patients, when something may have gone wrong with their care
- create a new Citizen Voice Body to represent the views of people across health and social care
- support the appointment of vice chairs for NHS trusts

NHS Wales will need to work together to prepare for these key legislative changes.

Piloting of Offensive Weapons Homicide Reviews

Commencing December 2022 Wales, along with London and the Midlands, will be one of the first regions to trial a collaborative new approach to prevent future deaths involving offensive weapons, such as knives and guns. These multi-agency reviews aim to provide a more holistic understanding of offensive weapons homicides to better inform preventative actions to save lives in the future. The Wales Violence Prevention Unit (VPU) has been closely involved in the development of this initiative by acting as a link with the Home Office who are funding the pilot.

Conclusion

Over the next period, the Network will continue working together to achieve 'A Wales where everyone is safe' highlighting the need for safeguarding to be recognised as an essential service throughout the NHS in Wales.

Thank you for your attention to the NHS Wales Safeguarding Network Annual Report 2021/2022; we look forward to reporting back on our delivery progress next year.