NHS Wales Safeguarding Network

Annual Report 2022-23

Network 10 year *celebration*

Contents

NHS Wales Safeguarding Network
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Chair's Introduction

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 2022-2023, a year that marks 10 years of Network delivery. Against the background of the Cost of Living crisis and the sustained pressure on service delivery post pandemic, the Network has redoubled efforts to enable health organisations deliver high quality services to safeguard the people of Wales.

Our workforce is our greatest asset in the collaborative effort who need the right skills, tools and a supportive safe environment to deliver high quality safeguarding. 'Take 5 Read Safeguarding Bite size' resources, considering the emotional well-being of staff in the review of how we respond to unexpected child deaths, the pilot of a revised SMM tool are all examples of continual learning and improving how we safeguard together in the NHS. The highlight of the year was the NHS Wales Safeguarding Together Conference with the theme of 'Then, Now Next', displaying achievements and progress over 10 years and with a focus on the future to strive to make the network the best it can be for the next decade and beyond.

With enactment of the twin duties of quality and of candour – The Health and Social Care (Quality and Engagement) (Wales) Act 2020 and the establishment of the NHS Executive, there are powerful drivers to focus on improving the quality and effectiveness of safeguarding practice and action across Wales. There is real opportunity to develop new methods of achieving greater understanding with behavioural science for learning from reviews and safeguarding incidents.

Our forward, planning, and horizon scanning sections demonstrate how the Network will develop stronger governance systems for assurance, making the Safeguarding Maturity Matrix (SMM) contemporaneous and quality focused, and create psychological safety for staff with a new model of restorative safeguarding supervision to support a culture of learning and development. Central to improvement is good data and we will develop indicators/measures for quality in safeguarding services using tools to capture service user experience. Despite the challenge this presents in a highly emotive area of practice, we are committed to ensuring their voices are central to driving service improvement.

Building on our strengths and experience gained over the last decade the Network continues to move forward in order to advocate for vulnerable people across Wales.

I trust you find this report informative and urge you to share it throughout your organisation and beyond.

Dr Aideen Naughton
Chair of the NHS Wales Safeguarding Network

About the **National Network**

Launched in 2012 and professionally led by the National Safeguarding Service (NHS Wales), 'the Network' provides a vital bridge between strategies and arrangements at local level and national policy developments to support NHS Wales Health Boards and Trusts in discharging their responsibilities for safeguarding people.

The Network and its subgroups provide a 'community of practice' environment, facilitating collaboration, upskilling, horizon scanning, sharing challenges and best practice, problems solving and innovation. At its heart is evaluation of the efficiency and efficacy of safeguarding arrangements and interventions, as well as reduction in practice variation across the NHS.

A fortnightly Network Communications bulletin is cascaded to a wide range of stakeholders, collating Network achievements, policy, events, learning opportunities and good practice.

Collaboration is embedded in the Network's leadership led Dr Aideen Naughton from the National Safeguarding Team (NSS) and co-chaired by Mandy Nichols-Davis from Hywel Dda University Health Board.

Multi-Agency Working

The Network partners outside of NHS Wales include the Older Persons and Children's Commissioner Offices, the Wales Violence Prevention Unit and other key agencies. This system wide approach facilitates the sharing of good practice, key safeguarding information and the cascading of intelligence to promote effective specialist support across all organisations.

Regional Safeguarding Boards

The six Regional Safeguarding Boards across Wales co-ordinate multi agency safeguarding practice, ensuring effectiveness of local arrangements to safeguard the people of Wales. The Network is represented at the Boards by the National Safeguarding Service who contribute independent expertise and a 'voice of Health' to multi-agency safeguarding practice.

About the **National Safeguarding Service**

The National Safeguarding Service (NSS) has a strategic role in coordinating and managing the Network delivery, ensuring that the group collaborate efficiently to provide a consistent, quality driven service to the people of Wales.

The Service comprises a skilled team of professionals who provide expertise, standardised practice, training, and specialist guidance to colleagues across NHS Wales, multi-agency organisations and Welsh Government.

Post pandemic, the NSS has repurposed with a refreshed focus on leadership, inspiring others and building quality improvement approaches to safeguarding across the NHS system.

‘Then, Now, Next’

Celebrating 10 years

Network 10 year celebration

The NHS Wales ‘Safeguarding Together: Then, Now, Next’ Conference took place at City Hall, Cardiff on 8th March 2023 and was chaired by Jan Williams, the Board Chair of Public Health Wales.

The Conference marked 10 years of the NHS Wales Safeguarding Network and brought together key professionals to listen to expert and high-profile speakers on the latest research and theories relevant to safeguarding.

The event presented a life journey approach, outlining how safeguarding services have evolved and changed in response to legislation, learning from tragic events, and the voice of those abused and neglected. It also highlighted areas the health service needs to improve to protect our most vulnerable populations.

Key speakers included – the Chief Nursing Officer, the Older Persons Commissioner, the Children’s Commissioner, VAWDASV National Advisor, academics and survivors of abuse.

Engagement and Reception

With a total of 79 attendees the conference had good representation from all Welsh health boards and trusts, despite inclement weather, with colleagues from local authorities and Welsh Government.

The Twitter hashtag **#ThenNowNext10** facilitated digital engagement for those attending both in person and remotely, with a lively exchange of feedback and pictures.

Feedback gathered during and after the event revealed a positive response to the speakers, opportunities to network, as well as challenging ways of thinking and practice.

> **Excellent conference, extremely informative and at times emotive.**

> **An appropriate range of issues raised by speakers.**

Poster Display

A poster presentation displayed case studies of innovative safeguarding practice from NHS Wales health boards and trusts.

Live Illustration

An illustrator at the venue worked in real-time, creating visuals that captured the essence of presentations and discussions. The animation worked well in creatively capturing conference messages, and sparked further discussion throughout the day.

Safeguarding Maturity Matrix (SMM)

SMM Peer Review and Tool Revision

Safeguarding Maturity Matrix

The Safeguarding Maturity Matrix (SMM) is a self-assessment tool which supports safeguarding quality improvement across NHS Wales. The tool is completed by the 7 health boards and 3 NHS trusts within Wales. The National Safeguarding Service receive the information and collate it to provide a national report of the NHS Wales safeguarding services across Wales.

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

Activity

With the support of the NHS Wales Safeguarding Maturity Matrix (SMM) sub group, the Safeguarding Maturity Matrix self-assessment tool and the peer review process were conducted with all clinical Welsh NHS organisations for 2022. The assessments, improvement plans and peer review contributed to the annual SMM report was then used to inform the Network Workplan for 2023-24.

Pilot Evaluation

Following a tool revision in the last period, an evaluation of the pilot was undertaken with the assistance of Public Health Wales research division. Evaluation findings were positive and data gathered was used to amend the document for future use, including a recommendation for development of a digital format.

Challenges and Forward Activity

- The work is continuing into next year and phase 2 of the SMM pilot will proceed with all health boards and trusts taking part
- The main challenge of the SMM programme is the amount of time required by the Health Boards and Trusts to complete the work in already stretched services
- There is an ongoing challenge to make the SMM more contemporaneous and quality focused which will be carried out via a thorough review of the SMM

Safeguarding Staffing and Succession Planning

The 2021 Safeguarding Maturity Matrix report highlighted concerns relating to specialist safeguarding workforce and succession planning across NHS Wales. The Network approved an exercise to scope and analyse this potential issue.

Context

NHS Wales is reliant upon having a strong and sustainable workforce comprising of highly skilled and knowledgeable leaders to effectively carry out its safeguarding duties and responsibilities. Having effective workforce plans which are integrated with service and financial plans is essential to ensure a workforce of the right size, skills and diversity, to deliver quality safeguarding services to the people of Wales.

Activity

A baseline review of existing safeguarding roles across the NHS was conducted to identify positions and/or skills most critical to the organisation for which potential successors are needed. Collaboration with Health Education and Improvement Wales (HEIW) was key to align with workforce and planning tools already in use, supporting a 'Once for Wales' approach.

The survey covered:

- key knowledge, skills and competencies of current safeguarding leaders including title and grade
- professional backgrounds
- career pathways into safeguarding
- age profiles
- recruitment challenges

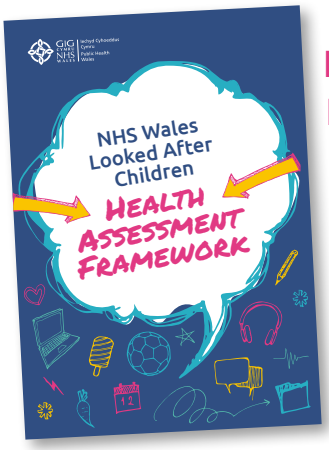
Focus groups

Six focus groups were held involving a variety of safeguarding professionals to discuss the analysed data and agree recommendations.

Recommendations

- Organisations to map their safeguarding structure and baseline information, to proactively plan for the future by identifying any potential knowledge and skills gaps
- To consider safeguarding secondment and shadowing opportunities for all health professionals to inspire the next generation of safeguarding leaders
- Ensure the requirements of flexible working for NHS Wales are promoted
- Ensure job descriptions and roles are realistic regarding responsibilities to avoid overload and improve recruitment
- Network to consider the development of a resource to signpost paediatricians/ other interested doctors to opportunities that will develop their safeguarding skills and interests
- The Network can share of learning where organisations have made improvements in working practice to support workforce planning

Looked After Children Heath Assessment Quality Review



Health Assessment for Looked After Children

Looked after children are amongst the most vulnerable groups in society. Children often come into care with poorer physical and mental health than their peers, meaning that longer term outcomes are also worse for them.

To this end, the NHS Wales Health Assessment Framework for Looked After Children (June 2020) sets standards of good practice for Health Boards working with children who are currently Looked After by the local authority.

The framework outlines Health Assessment processes including the quality of the health assessment and report for each looked after child or young person.

Audit

Over the last period the Network has evaluated the quality of a sample of health assessments in order to:

- Establish areas of good practice
- Identify improvements to inform future practice.

Activity

The audit was overseen by the Looked After Children Steering Group led by the Designated Doctor for Looked After Children, adoption and fostering.

Every health board in Wales submitted a sample of each type of health assessment. These were sent to a group of reviewers who audited the assessments against the framework. Samples were anonymised and results were submitted by electronic survey.

Results

The results revealed areas completed well and those that need improvement as indicated by the table.

Recommendations

Areas of the health assessment requiring improvement identified, training organised to assist improved quality to be delivered throughout the Looked After Children Nurses Cymru meetings throughout 2023.

Areas completed well

- Birth information
- Healthy Child Wales
- Immunisations
- Medication
- Allergies
- GP, ED and health appointments
- Growth
- Vision
- Environment and safety ages 0-9
- Dental
- Sleep
- Parenting concerns
- Contact
- Substance misuse
- Health Assessment Summary

Areas requiring improvement

- Family history
- Past medical history
- Physical activity
- Diet
- Hearing
- Education
- Self care and independence
- Puberty and sexual health
- Environment and safety 10+
- Emotional wellbeing
- Consent

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

Leadership Governance

The Network VAWDASV Steering Group works with NHS Wales health boards and trusts to collate, review and share good practice relating to VAWDASV whilst maintaining a health-based voice and influence across policy makers. Their work plan is mapped against the indicators of the VAWDASV National Strategy. These indicators support the VAWDASV blueprint approach, which is an action plan to jointly produce a whole societal approach to eradicate violence.

Activity this period:

- Evaluation of NHS Wales Ask & Act Group 2 Training, incorporating relevant issues such as the older person
- A scoping exercise looking at how VAWDASV is identified and recorded within all NHS Wales Emergency Departments & Minor Injury Units. The review identified different systems in place and it was agreed that a consistent approach across Wales would be beneficial
- Further scoping work on effective ways to capture the survivors voice within NHS Wales, involving Independent Domestic Violence Advisors (IDVAs) and Welsh Women's Aid

Going Forward

There will be commitment with two of the Blueprint work streams

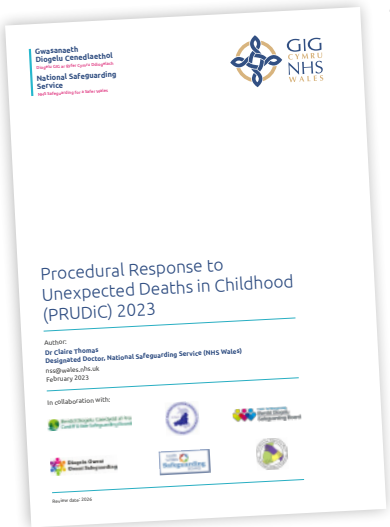
- The Older Person
- Children & Young People

In addition the VAWDASV Steering Group will lead on developing a national FGM audit tool following the implementation of the recently revised FGM clinical pathway.

This will include liaison with health boards and trusts and will be aligned to the existing work plan. In addition there will be links made with the Blueprint Survivor Voice, Scrutiny and Involvement Panel which includes people with 'lived experiences'. This will support the work already underway by the steering group to improve services by listening to victims.

Procedural Response to the Unexpected Deaths in Children

In the last period the Network revised the Procedural Response to Unexpected Death in Childhood (PRUDiC), a procedure that sets a minimum standard for a multi- agency response to unexpected deaths of a child or young person.


Gwasanaeth Diogelu Cenedlaethol
National Safeguarding Service

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Procedural Response to Unexpected Deaths in Childhood (PRUDiC) 2023

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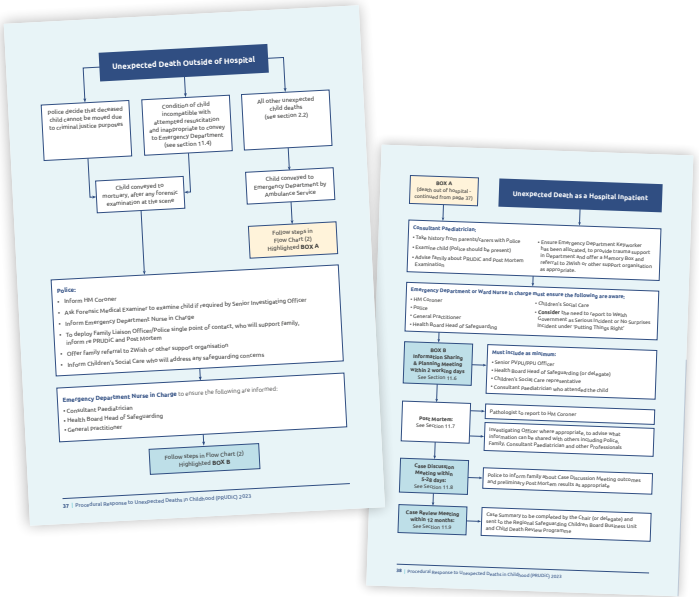
February 2023

In collaboration with:

The PRUDiC document describes the process of communication, collaborative action and information sharing following the unexpected death of a child.

This multi-agency procedural response sets a minimum standard across Wales that is consistent and sensitive to those concerned. The guidance does not prohibit any existing good practice by agencies or professionals to enhance this procedural response.


Unexpected Death Outside of Hospital
Police decide that deceased child cannot be moved due to criminal justice purposes
Condition of child incompatible with attempted resuscitation and inappropriate to convey to Emergency Department (see section 11.4)
All other unexpected child deaths (see section 2.2)
Child conveyed to mortuary, after any forensic examination at the scene
Child conveyed to Emergency Department by Ambulance Service
Follow steps in Flow Chart (2) Highlighted BOX A
Police:
• Inform HM Coroner
• Ask Forensic Medical Examiner to examine child if required by Senior Investigating Officer
• Inform Emergency Department Nurse in Charge
• To deploy Family Liaison Officer/Police single point of contact, who will support family, inform re PRUDiC and Post mortem
• Offer family referral to ZWish or other support organisation
• Inform Children's Social Care who will address any safeguarding concerns
Emergency Department Nurse in Charge to ensure the following are informed:
• Consultant Paediatrician
• Health Board Head of Safeguarding
• General Practitioner
Follow steps in Flow Chart (2) Highlighted BOX B
37 | Procedural Response to Unexpected Deaths in Childhood (PRUDiC) 2023
BOX A
(Steps out of hospital - continued from page 37)
Unexpected Death as a Hospital Inpatient
Consultant Paediatrician:
• Take history from parents/carers with Police
• Examine child (Police should be present)
• Advise Family about PRUDiC and Post Mortem Examination
• Ensure Emergency Department Keyworker has been allocated, to provide trauma support in Department and offer a Memory Box and referral to ZWish or other support organisation as appropriate.
Emergency Department or Ward Nurse in charge must ensure the following are aware:
• HM Coroner
• Police
• General Practitioner
• Health Board Head of Safeguarding
• Children's Social Care
• Consider the need for support to Welsh Government as Serious Incident or No Surprises Incident under 'Putting Things Right'
BOX B
Information Sharing & Planning Meeting within 2 working days
See Section 11.6
Must include as minimum:
• Senior PVPU/DPU Officer
• Health Board Head of Safeguarding (or delegate)
• Children's Social Care representative
• Consultant Paediatrician who attended the child
Post Mortem:
See Section 11.7
Pathologist to report to HM Coroner
Investigating Officer where appropriate, to advise what information can be shared with others including Police, Family, Consultant Paediatrician and other Professionals
Case Discussion Meeting within 7-28 days
See Section 11.8
Police to inform family about Case Discussion Meeting outcomes and preliminary Post Mortem results as appropriate
Case Review Meeting within 12 months:
See Section 11.9
Case Summary to be completed by the Chair (or delegate) and sent to the Regional Safeguarding Children Board Business Unit and Child Death Review Programme
38 | Procedural Response to Unexpected Deaths in Childhood (PRUDiC) 2023

Activity

The 2023 revision was facilitated by the National Safeguarding Service (NHS Wales) on behalf of the Regional Safeguarding Boards across Wales, involving extensive stakeholder engagement. A webinar was held to detail the changes in March 2023, with a wide range of stakeholders attending.

This revision introduces a number of changes to the process to strengthen partnership working around child death. This includes some changes to:

- Information Sharing
- Disagreement on initiation of PRUDiC process
- Emotional safety and support for multi-agency colleagues attending PRUDiC meetings
- New chapters cover:
  - unexpected Neonatal Deaths
  - organ and Tissue Donation in Suicide
  - independent Medical Examiner role
  - when a Child Dies Unexpectedly in Another Area
  - unexpected Deaths on Paediatric Critical Care Unit (PCCU)
  - 16 and 17 Year Olds who are Cared for in Adult Areas of the Health Board

It is envisaged that the publication of the up to date Procedural Response will further enable consistent, supportive and effective investigation of Unexpected Child Deaths within Wales.

Preparing the NHS for Changes to Deprivation of Liberty Safeguards

The Network tasked a sub-group to assist NHS Wales to prepare for the changes due to be implemented with the introduction of the Mental Capacity (Amendment) Act (2019).

Specifically in relation to the transition from the Deprivation of Liberty Safeguards (DoLS) to the Liberty Protection Safeguards (LPS). The sub-group supports shared learning and good practice plus the ability to highlight NHS Wales particular issues needing escalation and raises partner's awareness of the guidance and implications for practice.

Context

The Mental Capacity Act (MCA) 2005, covering England and Wales, provides a statutory framework for people over the age of 16 designed to protect and empower people who may lack capacity to make their own decisions and to allow people who have capacity to prepare for a time when they may lack capacity in the future.

Following a scrutiny report by the Law Commission that concluded that DoLS were not fit for purpose, the LPS were proposed to simplify the process to facilitate better quality care. The changes will also offer greater involvement for families and extend the scope to include sixteen to seventeen year olds and those residing in domestic settings.

Activity and Output

Work over the last period includes:

- Working with the Welsh Government LPS Implementation Steering Group and relevant work streams to co-ordinate the NHS Wales contribution to ensure that 'the voice of health' is represented
- Delivery of a survey on the effectiveness of the group in improving their understanding and preparedness for the changes
- Creation of generic LPS and MCA risk register narrative for health boards and trusts
- The establishment of MCA/LPS leads in health boards and trusts
- Plans for guidance on how to operationalise LPS in NHS settings
- Agreement to an All-Wales Mental Capacity Assessment Form

Trauma Informed Safeguarding Training

Safeguarding 'Take 5' Bite Sized Learning

The Network Training Subgroup developed a suite of "Take 5 Read Safeguarding Bite size" resources to enable accessible shared learning and good practice for use across NHS Wales.

Topics covered to date include:

- Safeguarding and Public Protection training requirements
- Exploitation and the Prevent duty
- Professional Concerns

The accessible quick read resources on subjects which were either new or topical currently in Wales, will facilitate Adverse Childhood Experiences (ACE) and trauma informed practice being incorporated within training across NHS Wales.

Going forward, a scoping exercise is planned to ascertain how safeguarding information is disseminated, how training is accessed and recorded and how this can be improved.

Innovative Regional Practice

Network members regularly share effective safeguarding practice in order to highlight what works in their area, build effective practice and contribute to improving safeguarding across NHS Wales.

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

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Cwm Taf Morgannwg
University Health Board

Specialist Nurse for Adoption

Cwm Taf Morgannwg University Health Board (CTMUHB) appointed a newly developed role of Specialist Nurse for Adoption in order to form a multi-disciplinary approach to supporting children and young people and to improve the quality of service for those engaged in the adoption process.

Multi-disciplinary Working

The role provides single point of contact for statutory partners, carers and parents, enabling improvements in the early links with Midwifery and Neonatal services, ensuring effective information sharing at point of discharge. The Specialist Nurse gathers all information from carers and parents prior to the child's health assessment, allowing for timely, informed referrals to the medical advisor if necessary. Difficult conversations can therefore take place prior to the assessment, minimising any distress for the child.

Public Health Approach

The Nurse Specialist has worked with local charities to provide toys and activities that facilitate effective distraction, whilst development assessments take place. The public health nursing background of the Specialist Nurse provides a robust assessment of the child's development, early advice, referrals and making every contact count. Medical Advisors have fed back that the new role provided a more child centre approach, shorter clinic appointments and improved links to health and statutory partners.

Going Forward

The role of the Specialist Nurse will incorporate the completion of a university masters module on 'The Advanced Assessment of the Child and Young Person'. This will enable the Specialist Nurse to undertake clinics independently, allowing the medical advisor more time for children with complex health needs.

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Bwrdd Iechyd Prifysgol
Cardiff and Vale
University Health Board

Domestic Routine Enquiry in Emergency Departments

The Corporate Safeguarding Team at Cardiff and Vale University Health Board (CVUHB) set out to improve how they identified hidden victims of domestic abuse, with the view to ensuring their safety during the COVID 19 pandemic when access to support and services was limited.

Background

The UK and Welsh Government guidance in March 2020 for everyone to stay at home increased the risk for people to experience domestic abuse; due to increased household tension, forced coexistence, economic stress, and fears about the virus.

The pandemic also curtailed access to support services for survivors. Furthermore, a Safe Lives study indicated that perpetrators of domestic abusers used the lockdown rules to intensify or conceal violence, coercion and control.

Pre-pandemic CVUHB operated a Domestic Abuse targeted enquiry in the Emergency Department (ED). However, it was recognised that during the pandemic the ED was one place that people could still attend and were required to attend on their own. With this in mind, Routine Enquiry in the ED was introduced.

Method

Front line staff routinely completed Ask and Act domestic abuse questions with every patient who attended ED where there is a safe opportunity to do so.

Outcome

Referrals increased from 259 in 2019, to 433 in 2020 and 610 in 2021 following the introduction of Routine Enquiry. The pilot scheme is now permanently embedded with Ask and Act domestic abuse questions now included in all ED files.

Going Forward

1. Continue to promote awareness of Domestic Abuse Routine Enquiry within the ED
2. Expansion of the service considering Routine Enquiry for 13-16 year olds

Revolutionising Safeguarding Reporting

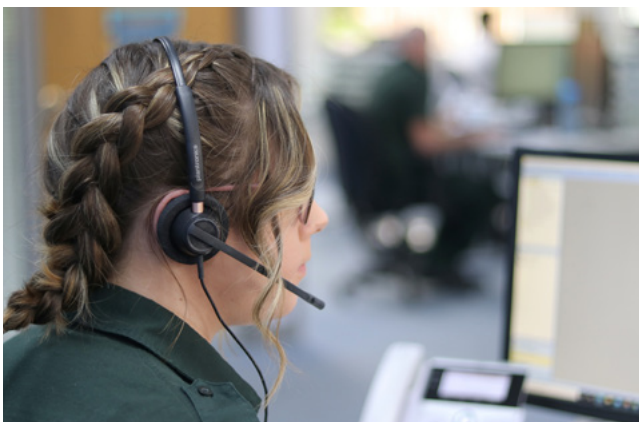
Over the last period the Welsh Ambulance Services NHS Trust (WAST) set out to modernise the way in which WAST colleagues report safeguarding concerns.

Then

The old processes to report safeguarding concerns within WAST were outdated, comprising two different systems. Clinical Contact Centre (CCC) and NHS 111 Wales staff used a different method to frontline colleagues to record and refer concerns to the Local Authority. Both multi-step systems were deemed inefficient, prone to issues and not reflective of current legislative language.

Now

After listening to staff concerns and armed with a wish to move to an a more efficient system, WAST chose DocWorks Scribe to digitally submit safeguarding reports. Operational staff access the programme via their iPads and office based staff utilise the same system on desktop computers. All colleagues now submit online safeguarding forms which are automatically sent to the relevant Local Authority at the time of submission.



Next

The WAST Safeguarding Team are proud to have implemented a new process during the pandemic.

Clear benefits include:

- An increase in the number of safeguarding reports submitted.
- Saving on time and resources
- Improved opportunities to ensure that WAST make every contact count to safeguard the most vulnerable people in Wales.

GIG CYMRU NHS WALES
Ymddiriedolaeth GIG Felindre
Velindre NHS Trust

Enhancing Organisational Safeguarding Practice

Velindre University NHS Trust (VUNHST) has continued to focus on enhancing the quality of safeguarding practice in the organisation and ensure all necessary safeguards and support are in place for patients and donors, carers and family members, our employees, and the Trust.

Relevant workstreams are outlined below:

Training and Education

A refreshed organisational training needs analysis was completed, and a compliance dashboard created. This activity has resulted in a valuable evidence base, a robust training plan and monthly safeguarding compliance reports which allow managers to assure their team's position and align areas of focus.

Engagement

A staff survey assessed the knowledge base of safeguarding procedures, awareness of key individuals with safeguarding responsibilities in the trust and awareness of internal and external resources that offer guidance on safeguarding matters. The results offer organisational understanding of how to further support our staff in fulfilling their statutory duties. Moving forward the Trust intends to engage patients and donors to further inform quality improvement for safeguarding provision across the Trust.

Staff Development

A Safeguarding Nursing Champion Development Plan was implemented in Velindre Cancer Centre, with six individuals recruited. The champion role is integral to assess and implement change and ensure services are constantly improving.

Audit

An audit on the completion of the safeguarding section of the Welsh Nursing Care Record showed 100% compliance. Additionally, an audit of compliance to the Nice Guidance Domestic Violence and Abuse provided assurance of process in VUNHST, with an action to increase number of Level 3 VAWDASV Champions in the Trust over the next year.

Once for Wales Safeguarding Module

VUNHST have adopted the Once for Wales Safeguarding module to record all safeguarding activity within the Trust. This has proven beneficial in capturing data to inform levels of activity, identify themes and trends and support their corporate functions. VUNHST look forward to collaborating with partners within the network to further develop this system.

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Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Sharing Safeguarding Information in Pregnancy Database

Background

In 2019, Hywel Dda University Health Board (HDdUHB) Corporate Safeguarding Team conducted a mapping and scoping exercise of Sharing of Safeguarding Information in Pregnancy (SIP) paper based process and found that compliance with the process was poor and that the paper mechanism of sharing information required an overhaul.

The Innovation

The Named Safeguarding Midwife commenced the transition of the SIP process from paper to a digital system. Working with the Information Technology, Lead Software Developer, and Information Governance Team, an electronic database was developed, providing a secure and robust mechanism for sharing information with other professionals. This prevented delay or loss in the sharing of vital information within the SIP 2, relating to the well-being and safeguarding of the pregnant person, unborn infant or new-born and the system provided organisational memory, for audit and compliance purposes.

The system has now been made accessible to all qualified midwives, and qualified Neonatal Unit staff. To support implementation throughout the Health Board, the HDdUHB Sharing Safeguarding Information Procedure was developed. Additionally, training to relevant parties accompanied the implementation of this electronic system.

Ongoing Innovation

To ensure a consistent approach the procedure and database were reviewed and further developed in April 2022. This resulted in all SIP information relating to all pregnant persons being entered onto the database.

Further to this the organisation have developed a new mobile app development, which enables timely access to up to date information for Community Midwives.

Improving Consent for Screening Participants

A Quality Improvement (QI) Project was led by The Named Lead of Safeguarding in Public Health Wales. Consent is a key theme for complaints within Public Health Wales (PHW).

Therefore, Public Health Wales has focused on improving the process of taking consent for participants lacking capacity attending screening programmes. Public Health Wales have implemented a consent form for service users assessed as lacking capacity, this allows practitioners to make best interest decision in line with the Mental Capacity Act.

Bespoke training has been delivered to PHW employees in Screening Programmes around The Mental Capacity Act. The project worked collaboratively with staff to outline the change idea. QI tools including process mapping to identify driving and restraining forces were used in addition to collecting qualitative and quantitative data which included views of PHW employees in relation to the change idea.

The implementation of the new process resulted in a marked reduction in complaints relating to screening being declined for participants lacking capacity.

Clear benefits include of the QI project:

- An improved patient experience for a vulnerable client group.
- Improved confidence of The Named Lead in Safeguarding in leading a QI project.
- The development of a bespoke Consent Form for PHW for individuals lacking capacity to support best interest decisions

Key Learning

- Building key relationships with staff is key to engagement
- Quality Improvement can start with a set of measures that can be built upon
- Analysis of the information gives the narrative required to communicate a story
- Leading an improvement project requires sustained motivation and drive to keep activity on track

Aim In order to achieve this aim…	**Primary Driver** We need to ensure…	**Secondary Driver** Which requires…	**Change Ideas** Ideas to ensure this happens…
By implementing a consent form in AAA screening, there will be an annual reduction in the number of complaints associated with services users who lack capacity being declined screening to 5 and below by August 2022.	**Staff/Workforce**	Adequate staffing levels Staff motivation and commitment	Monthly meetings with Regional Coordinators for AAA screening
	Capacity and Consent Assessment	Continuous Professional Development of staff to maintain competence and skills/education/training	Staff training Development of Z-cards to prompt staff understanding of assessment process
	Communication	Effective collaboration between Named Lead for Safeguarding and AAA screening programme	Number of completed Consent forms Forms to be imputed into database Development of audit tool

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

Multi-agency Suicide Rapid Response Meeting

Swansea Bay University Health Board

Local Authorities, together with South Wales Police, piloted a Suicide Rapid Response Meeting (SRRM) to consider those impacted by the death of someone who had died through suicide.

A working partnership with Swansea Bay University Health Board Corporate Safeguarding and Mental Health Teams and the Care After Death Service was key to the initiative. The process was extended in 2022 to include those that significantly attempt to take their life.

Research indicates that those impacted by suicide increase their risk of dying by suicide by 65%. To reduce this risk, it is important these individuals receive the right support at the right time. Moreover, it is recognised that significant suicide attempts impact more people than the person that has attempted to take their own life.

The partnership sensitively defined a significant attempt, plus the support and networks available to those who attempted to take their own life.

The SRRM meeting itself aims to prevent further significant harm occurring to those impacted by the death or significant suicide attempt, through provision of appropriate support services. The meeting endeavours to identify those impacted within 48 hours of the incident occurring.

The pilot has now been successfully embedded using existing service structures and resources including committed staff.

I wouldn't be here if it wasn't for the support I was given.

National Referral Mechanism

In the last period the ABUHB corporate safeguarding team worked as part of Gwent partnership, including Police and Newport Local Authority, to pilot the National Referral Mechanism (NRM) at a local level.

About the NRM

The National Referral Mechanism (NRM) is the UK's framework for identifying and referring potential victims of modern slavery and ensuring they receive the appropriate support.

Rationale for Taking Part

A significant back log of children waiting for a decision on their NRM were left without access to support. Consequently, the Home Office asked local authorities to bid to allow the NRM decision to be made locally with central support and guidance.

Pilot Programme Objectives

- To test whether determining if a child is a victim of modern slavery within existing safeguarding structures is a better model for making modern slavery decisions for children.
- Improve decision-making times for child potential victims of modern slavery
- Empower local authorities and their safeguarding partners, i.e., Health and Police, to make decisions and improve capability in identifying child potential victims of modern slavery
- Improve understanding of modern slavery and encourage a cohesive approach amongst safeguarding partners when considering support a child victim may need.
- To develop a robust and resilient system of identification for child potential victims of modern slavery

Ongoing Activity

A fortnightly panel involving police, social services or third sector organisation working with Unaccompanied Asylum Seeker Children consider incoming referrals. These vary from Welsh children involved in drug running to children who have fled countries such as Eritrea, Sudan and Libya who have been picked up and abused by traffickers.

Within ABUHB, staff upskilling has increased in professionals' confidence to make referrals, which has in turn benefited vulnerable children through improved implementation of appropriate services provision.

The pilot in Gwent has met it's Home Office objectives and has now been extended.

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

Safeguarding Spoke Placements – Students Nurses and Midwives

Betsi Cadwaladr University Health Board (BCUHB) Corporate Safeguarding Team collaborated with university partners to offer safeguarding placements for student nurses and student midwives.

This gives 2nd & 3rd year student nurses and student midwives the opportunity of a 5-day spoke placement within the Safeguarding Team across North Wales as part of their main placement.

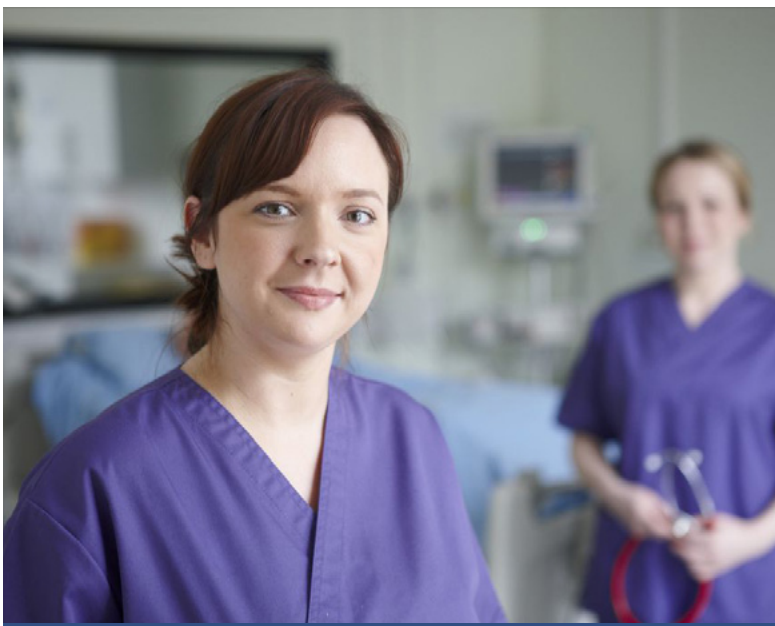
The Placement

Students are allocated a designated Practice Supervisor for each practice learning experience and are part of a buddy system with other registrants contributing to a 1:1 model.

Objectives and Experiences

Below are a selection of objectives and experiences available to students:

- Awareness of the implications of safeguarding legislation, inter-agency policy and national guidance.
- Observation at multi-agency safeguarding meetings, covering the decision making process
- An appreciation of the effects of Adverse Childhood Experiences (ACEs) on parenting.
- An understanding of the principles of confidentiality and information sharing
- How to relate theory to practice and give rise to reflection.
- Awareness of processes relating to Domestic Homicide Reviews, Child and Adult Practice Reviews and how they influence learning, practice and policy.
- Understand the Procedural Response to Unexpected Deaths in Childhood (PRUDiC).
- Awareness of the wider safeguarding agenda e.g., PREVENT, Modern Day Slavery, Exploitation, County Lines.
- Awareness of Violence Against Women, Domestic Abuse & Sexual Violence (VAWDASV) legislative and legal perspectives.
- Awareness of the Mental Capacity Act 2005, principles of Best Interests alongside observation of a capacity assessment



The exposure and experience created by the placements provides students with a firm platform for future safeguarding best practice. This foundation will help them to protect the most vulnerable adults and children across North Wales and beyond.

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

Safer Sleep

Powys Teaching Health Board's Safer Sleep Standard Operating Procedure has been developed by the Safeguarding Team in response to a number of unexpected child deaths within the county over the last 18 months, where risk factors associated with unsafe sleep were present.

A task and finish group was formed, including colleagues from Midwifery, Health Visiting and Safeguarding, in order to produce a definitive advice to support practitioners.

Context

To minimise the risk of sudden infant death syndrome (SIDS) associated with unsafe sleep practices and environments, health professionals involved in antenatal and postnatal care, should provide families with consistent, evidence based safer sleep advice that is also tailored to the context of each family.

Activity

The document was launched and shared widely across the organisation inclusive of General Practices and Local Authority colleagues working in domestic abuse services. This will ensure that unsafe sleeping practices and environments can be recognised by all professionals visiting homes and providing care to families with babies.

Midwifery documentation was updated to include safer sleep postnatal pathways to ensure these important messages are being shared with parents and carers. Lullaby Trust QR codes have been embedded into the postnatal pathways, shared on posters displayed in healthcare settings and on stickers within the Child Health record to ensure parents and carers have easy access to information, advice and support.

I love the QR codes on the red books - I can get parents to scan and have the links open on their phones.

MIDWIFE

I have shared the QR codes at visits. One Dad has opened and read it whilst I have been at the visit and initiated discussion particularly on co sleeping.

HEALTH VISITOR

Future Priorities

Looking to 2023/2024 the Network will continue to build upon the strong foundations and relationships we have built, working together to achieve 'A Wales where everyone is safe'.

Future work is driven by current and pending changes in legislation and statutory guidance, learning from recent safeguarding reviews, recommendation and feedback. Added to these are identified improvements drawn from the annual assurance review process of the Safeguarding Maturity Matrix; alongside common issues that would benefit from leadership and consistency across NHS Wales.

Future work themes over the next period include:

- Development of an **NHS Framework for Organisational Safeguarding Strategy** and quality priorities.
- Establishment of an **online Leadership Hub** to improve the dissemination of safeguarding learning across Wales and the impact on practice behaviours.
- Creation of a sustainable model and upskilling resources for **Restorative Supervision** to support psychological safety of staff working to protect of children/ vulnerable adults
- Accessible communication material for families, to clarify the Procedural Response to Unexpected Deaths in Childhood (PRUDiC)
- **Medical Masterclass Webinar** covering learnings from the Child T Child Practice Review including culture, hierarchy and duty to report.
- National Audit on the Female Genital Mutilation (FGM) clinical pathway.
- A review of **Safeguarding Training accessibility** for all NHS Wales staff.
- The development of **indicators/measures for quality in safeguarding services**, incorporating Person Reported Outcome Measures (PROMs) and Person Reported Experience Measures (PREMS), ensuring the centrality of the service user voice
- Production of a **Safeguarding Trainer Appraiser Guide** to align systems and provide guidance for managers.
- Alignment of the Network VAWDASV objectives with the **National VAWDASV Strategy**, as part of the Welsh Government multi-agency blueprint plan.