NHS Wales Safeguarding Network

Annual Report 2023-24

GIG CYMRU NHS WALES

Contents

GIG CYMRU NHS WALES
DIOGELU RHWYDWAITH | SAFEGUARDING NETWORK

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June 2024

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 adults safe.

This report details our key achievements in 2023-2024, a year where our nation experienced the impact of the continued cost of living crisis, high energy prices, and the post pandemic strain on our public services. This disproportionately effects our most vulnerable citizens, with children, young people and adults-at-risk experiencing the impact of a worsening interplay of multiple challenges, inequities and barriers to health and well-being. It is more important than ever that we strive to continually improve our safeguarding services to prevent harm and protect those who need our help the most.

I am grateful to my colleagues within our NHS health boards and trusts for their continued commitment to the Network and for providing excellent safeguarding services in their regions, with their partner agencies. Our ability to collaborate and work together in Wales enables us to provide a consistent high-quality approach to safeguarding that is continually evolving and improving. This report is just a snapshot of the tireless work of safeguarding teams, and what we can achieve collectively.

We are committed to improving quality and assurance in safeguarding, and will be supporting Welsh Government and the NHS Executive to strengthen the need to measure the effectiveness of safeguarding activity and practice. This work has begun, and we look forward to demonstrating safeguarding performance and improvements on a national level.

We will focus also on safeguarding learning; exploring the recurrent themes and challenges emerging from practice reviews, and seek to identify what more needs to be done to turn the dial for improved outcomes. Our planned learning events aim to deep dive these themes, through using other perspectives and expertise such as behaviour science, appreciative enquiry and improvement methodology to create a change in understanding and action. All citizens of Wales have a right to live, thrive, free from fear, abuse, neglect, exploitation, gender-based violence, and other kinds of preventable harms. The Network will continue to build on our strengths and experience to deliver our key strategic priorities and safeguard the people of Wales.

I hope you enjoy reading this report and trust you find it informative. Safeguarding is everybody's business and I urge you to share it throughout your organisation and beyond.

Louise Mann
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.

Collaboration is embedded in the Network's leadership led by Louise Mann from the National Safeguarding Service (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.

The focus of the service is to provide credible system leadership, inspiring others and building quality improvement approaches to safeguarding across the NHS system.

Translating Legislation and Policy into Practice

Unexpected Death in Children – Information for Families

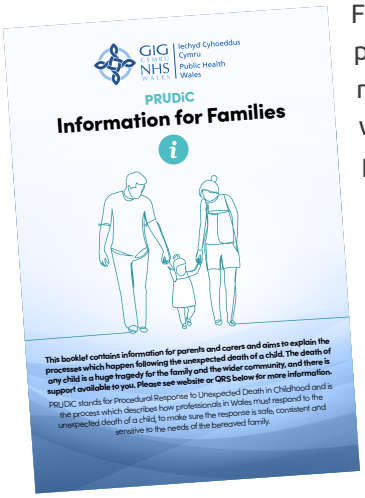
Context

The death of any child is a huge tragedy for the family and the wider community, therefore it important that all unexpected child deaths are carefully reviewed so that we may learn as much as possible, to try to prevent future deaths, and to support families, carers and friends.

PRUDiC stands for Procedural Response to Unexpected Death in Childhood and is the process which describes how professionals in Wales must respond to the unexpected death of a child, to make sure the response is safe, consistent and sensitive to the needs of the bereaved family.

Leaflets for Families and Professionals

Whilst the PRUDiC process is understood by participating agencies such as Health, Local Authorities and Police, a need was identified for clear information for parents and other professionals that explain the processes which happen following the unexpected death of a child.



Following consultation with parent, health and education representatives, two leaflets were produced, one for parents and carers and the other for professionals. The thorough consultation process ensured that the leaflets clearly and compassionately communicate the PRUDiC process to all affected by the child's death.

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

Over the last period the Network VAWDASV Steering Group has mapped their work against the indicators of the VAWDASV National Strategy focussing on the Older Person and Children and Young People. These indicators support the Welsh Government VAWDASV Blueprint approach, which is an action plan to jointly produce a whole societal approach to eradicate gender based violence.

Activity during this period includes:

- Developed FGM Clinical Pathway Audit Tools
- Learning shared from Child, Adult and Domestic Homicide Reviews
- Ongoing engagement in Children and Young People and Older Persons Blueprint workstreams
- New engagement with VAWDASV Research Network
- Co-ordinated national response to Government Consultations

Over the next period the group will continue to actively work as a platform for information sharing and awareness raising for issues relating to VAWDASV, to further strengthen the national response. This system leadership approach will ensure that all victims and survivors of VAWDASV receive the appropriate care, support, and information from highly trained, knowledgeable health professionals.

Deprivation of Liberty Safeguards

Context

The Mental Capacity Act, 2005 (MCA) has been in force since 2007 and applies to England and Wales. The primary purpose of the MCA is to promote and safeguard decision-making within a legal framework to all people 16 years old and above, who may lack the mental capacity to make their own decisions about their care and treatment. It enshrines in law the need to enable people to make their own decisions and establishes a framework to use when someone is unable to make their own decisions.

Deprivation of Liberty Safeguards (DoLS) are part of this act. The procedure protects a person receiving care whose liberty has been limited when they lack decision making capacity, by checking that this is appropriate and is in their best interests.

Activity

As part of the Network's safeguarding remit, the NHS Wales MCA/DoLS Network supports an environment of shared learning, development, support and supervision. The network is positioned to provide a forum for joint working on national projects and a strategic voice on behalf of NHS Wales to highlight issues that need escalation with partner agencies and Welsh Government, in the interest of safeguarding those who lack capacity.

Despite the delay in the implementation of the Mental Capacity (Amendment) Act 2019, the transition to Liberty Protection Safeguards (LPS) and a new code of practice, the network has been very active in the past year.

- They have forged links with the NHS England MCA Strategic Leadership Forum
- Started to plan the integration of social care into the network
- Formulated a work plan and started to:
  - Develop all Wales paperwork for the DoLS
  - Develop a training framework for MCA and DoLS including updating the current NHS Wales e-learning packages
  - Consider how the principles of the Mental Capacity (Amendment) Act and LPS may be incorporated into current DoLS practice.

Collaborative Products and Tools

Looked After Children Client Satisfaction Survey

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 may also be worse for them. At present there are over 7200 children who are currently Looked After by the local authority in Wales.

Listening for Change

As part of the identified need to develop person experience feedback within safeguarding for shaping services and triangulation of data, a national survey has been developed with stakeholders and crucially with care experienced young people supported by Voices From Care Cymru – a national organisation dedicated to upholding the rights of care experienced children and young people.

Developing a Person-Centred Service

The survey will be used to seek feedback in relation to the statutory health assessments of looked after children and their carers. The aim is to establish a person-centred service, using real time data to drive service improvement that includes what matters to looked after children and their carers, and ensure that the voice of vulnerable children and young people is integral to service provision. The survey will permit standardised responses on satisfaction of service delivery as well as identification of well-being themes and trends, access to services and quality improvement.

Surveys

Three client surveys have been designed for younger children, young people and for carers.

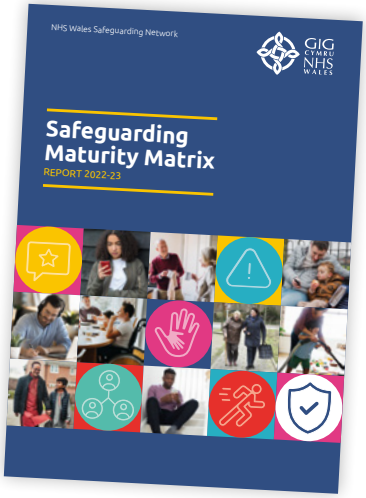
Questions focus on the core values including dignity, respect, safety and most importantly whether the children and young people feel involved in decisions made in respect of their health, that they feel valued and safe and that they have had information shared with them in an age appropriate format. There is also a free text box for the child, young person or carer to suggest improvements health assessment experience. There will be a future option available to complete the questions with an animated theme to express thoughts and feelings in different ways.

Next Steps

Every child looked after and their carer will be given the opportunity to complete the survey via a QR code following their statutory health assessment. Health boards will be responsible for providing access to digital equipment for child and their carers, collating and analysing their own data, and reporting back key indicators to the Looked After Children's Steering Group, which is a sub-group of the Network. This will allow themes to be analysed at a health board level allowing for specific local service developments, and also on a national level to identify and address common themes and issues for improvement.

Safeguarding Maturity Matrix (SMM)

Implementation



The Safeguarding Maturity Matrix (SMM) is a self-assessment tool which supports safeguarding quality improvement across NHS Wales. It is completed by the 7 health boards and 3 NHS trusts and is used by them as a part of their assurance system. The National Safeguarding Service receive the improvement plans developed by each organisation which highlight good practice, innovation, quality improvement initiatives and areas for improvement / development and collate it to provide a national report of the NHS Wales safeguarding services across Wales. The information gathered also helps to identify improvements that would benefit from an all Wales approach and the Network use this information to inform their workplan priorities.

The SMM consists of a set of six 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**

Audit

Following a tool revision in the last period, a qualitative evaluation was undertaken. Findings were positive, with organisations confirming the SMM as a robust assurance tool useful for benchmarking local safeguarding against a national standard. Corporate SMM Improvement Plans were signed off by local safeguarding committees and contributed to Annual Reports. Suggested future improvements include an amended implementation timescale to align with corporate reporting and the development of a live data dashboard model.

Female Genital Mutilation (FGM) Audit Tool

The All Wales Female Genital Mutilation (FGM) Clinical Pathway is a pathway developed by the Network, providing guidance to NHS Wales professionals to respond appropriately to concerns regarding FGM.

It is implemented when:

- **A new case of FGM is identified**
- **A new case of FGM is suspected**
- **There is suspicion that FGM may be planned in the future**

Facilitated through the VAWDASV Steering Group, a national audit tool was developed in collaboration with NHS Wales safeguarding professionals covering the 3 clinical pathways: pregnancy, paediatric and adult. The audit tools will support consistency in the reporting of essential data relating to FGM incidence and identification across Wales, including the age groups, ethnicities and country in which FGM was performed and organisational reporting with the Violence Prevention Unit and statutory services.

All Wales use of the audit tool will provide valuable intelligence which will facilitate increased professional awareness, adherence with correct process, reduce variation and contribute to better outcomes for women and girls experiencing or at risk of FGM.

Upskilling a **Confident, Competent Safeguarding Workforce**

NHS Wales Safeguarding

Leadership Hub

Gwella

HEIW Leadership Portal for Wales

Launched during National Safeguarding Week (November 2023) the Safeguarding Leadership Hub utilises the HEIW Gwella leadership platform and enables network members to access the bespoke Hub material and wider Gwella leadership content.

The Hub welcomes health professionals working in Safeguarding; those in Safeguarding leadership roles, Specialist Safeguarding positions or Safeguarding champions in their area.

The Hub aims to be a facility that connects safeguarding peers across Wales, permitting access to safeguarding resources to support their professional development. The potential for the Hub is significant, with ambitions to support safeguarding learning competencies, set up a journal discussion club, and hear leadership stories that support personal reflection and succession planning.

The Safeguarding Leadership Hub will extend and develop this community of practice to all those who are leading Safeguarding work across the NHS through:

- Creating online connections between colleagues and peers from health boards and trusts across all Wales.
- Utilising the discussions platform for professional conversations.
- Highlighting contemporary safeguarding resources for information and awareness.
- Keeping professionals up to date with the work of the NHS Wales Safeguarding Network and the National Safeguarding Service.

Restorative Safeguarding Supervision Guidance

Context

Safeguarding workloads are increasing in volume and complexity, and this can feel relentless and exhausting for all professionals. The emotionally demanding nature of child and adult abuse means that safeguarding leaders must maintain high levels of resilience to advise and guide others.

Restorative Safeguarding Supervision aims to promote positive outcomes for children, young people and adults at risk using the supervisory relationship to create a safe contained environment. This supports the practitioner to think, reflect and recover from vicarious trauma of safeguarding. Restorative Supervision provides an opportunity for discussion and learning; it enables practitioners to work through case situations using professional curiosity around the safeguarding needs of children and adults at risk.

Through this work, the NHS Network and NSS have raised the profile of the leaders' wellbeing and resilience as intrinsic to their capacity and capability to effectively lead others. We are recommending embedding the restorative element as fundamental within all safeguarding supervision, for individual and group sessions.

Going Forward

The NSS has proposed a safeguarding Restorative Supervision model, utilising the A-EQUIP model and provided by qualified Professional Nurse Advocates. The focus is on psychological safety, compassionate leadership and quality improvement and bespoke group sessions will be offered to Safeguarding Leads and their deputies from the NSS.

Work will continue towards a pathway and a clear set of competencies for practitioners delivering Safeguarding Supervision, which will set out what good quality Restorative Safeguarding Supervision looks like and how it can support the development of resilient practitioners.

Going forward, this work will be further developed in collaboration with HEIW to address both restorative and wider Safeguarding Supervision, which will be further supported by a progressive programme of education and learning.

Restorative Supervision Workshop

In March 2024 the National Safeguarding Service brought together Heads of Safeguarding, their deputies and senior nurses to a bespoke learning session.

This incorporated psychological safety, compassionate leadership and the presentation of Dr Michelle Moseley's PhD research findings and will inform the development of a model for restorative safeguarding supervision to be used throughout the NHS in Wales.

The peaceful setting of the Elan Valley Lodge provided a reflective space for open discussions and learning with support from HEIW. The workshop improved attendee's awareness of their teams and their own psychological safety, listening to hear and understand as opposed to listening to respond. Colleagues expressed the need to take a more reflective approach and to be kinder to themselves as well as discussing psychological safety within their teams.

Course content meets the safeguarding competency requirements of the intercollegiate document at Levels 4 and 5, which was reflected by a Certificate of Attendance. Network members also agreed to sign the HEIW Compassionate Leadership Pledge.

Future plans include facilitating a similar experience with medical colleagues later in 2024.

Thoroughly enjoyed this inspirational event.

I felt hugely valued as part of the Safeguarding Network and the opportunity to have this experience in a relaxed setting supported my professional practice.

Medical Responsibilities in Corporate Safeguarding Workshop

A safeguarding workshop was delivered to All Wales Executive Medical Directors in September 2023, following learning from a series of high profile deaths of children in Wales.

Learning objectives included:

- Understand the roles within Corporate Safeguarding, lines of responsibility and the relationship with the Medical Director's role and responsibility
- Explore and become familiar with Section 5 of the Wales Safeguarding Procedures (Safeguarding Allegations/ Concerns about those in positions of trust)
- Increase awareness of the systems for assurance and developments to improve compliance by health staff with safeguarding training within NHS Wales
- Gain an understanding of the Health Board as corporate parent for Looked After Children

The session used case scenarios to initiate discussion and evaluated positively including suggestions for further learning with other medical groups.

Great interactive session with thought provoking scenarios.

I will change my practice after today's workshop.

Reassuring to sense check situations we've been in.

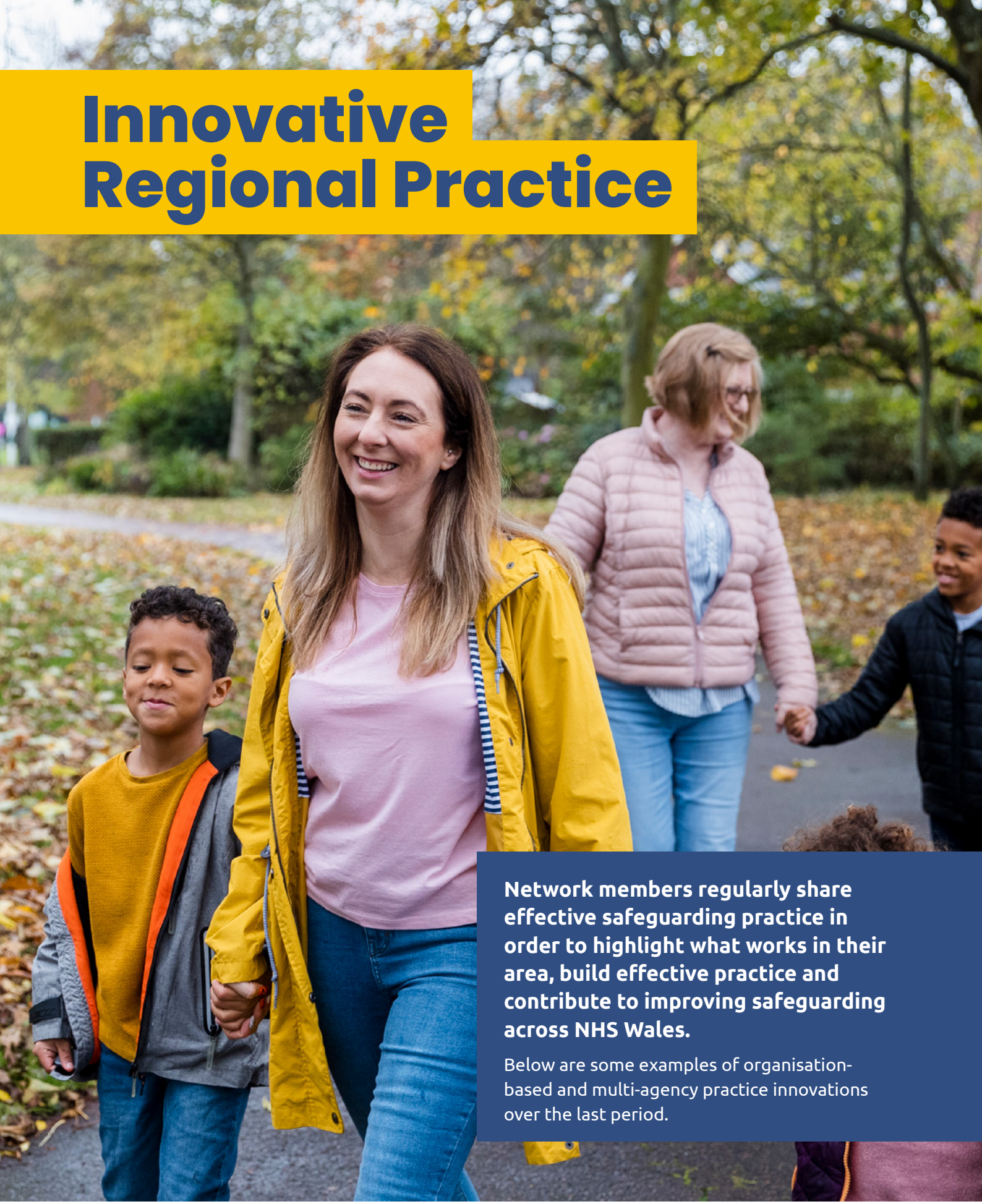
Evaluation of Network Practice and Impact

Collaborative Leadership through the NHS Wales Safeguarding Network and its sub-groups has been evaluated using a range of qualitative and quantitative methodologies.

The Network and sub-groups are universally highly regarded by Network stakeholders as a community of practice and facilitation of joint safeguarding improvement activity.

Reports on the findings and recommendations from the NHS Safeguarding Network Stakeholder Consultation and Network Sub-group Review were considered over the last period. Based on feedback, improvements were made to the efficiency of Network business functions, effectiveness of communication, collaboration and outcome activities. All improvement themes have been addressed and are being continuously reviewed through a tracked action plan.

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.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Improving Quality through Restorative Supervision

During the last period, four Safeguarding Lead Practitioners from Powys Teaching Health Board (PTHB) attended a four-day Restorative Supervision course.

The course aimed to improve their knowledge and skills in providing effective safeguarding supervision, promote a safe and supportive environment, while being able to respond to the increasing demands on the safeguarding team for quality safeguarding supervision in various formats.

The learning enabled the Safeguarding Leads to:

- Empower teams and individuals through coaching and supervision techniques.
- Analyse the quality of relationships in order to assist with the success and well-being of supervisees.
- Explore techniques to overcome barriers in communication.
- Be able to promote safeguarding as core business and offer supervision in an accountable process which supports, assures, and develops the knowledge, skills and values of an individual, group or team.

Implementing Change

The learning inspired the team to review current practice and make changes to how they manage each safeguarding supervision contact.

This includes:

- Reminding practitioners to prepare to share ongoing cases and/or previous experiences within safeguarding situations, for group supervision sessions using the signs of safety model.
- Developing scenarios from Child Practice Reviews (CPRs), Adult Practice Reviews (APRs) and Domestic Homicide Reviews (DHRs) for use in group supervision when practitioners may not provide cases. This enables the process of learning from sharing cases and situations to be demonstrated, whilst also sharing lessons learnt from reviews.
- Increased awareness and skills around how best to encourage practitioners to share and reflect on the emotional aspects of working within safeguarding.

I appreciate you using our safeguarding supervision session to breakdown my case. This helped me get a clear understanding of my client's situation and what steps I needed to make. It was also good to hear from others in the safeguarding group such as the lady from perinatal, who advised how their service could be of use, as well as the general support from others and acknowledgement of how difficult and complex this situation was.

Just a note to thank you for your time and for the clear and concise safeguarding advice, which was helpful in many ways.

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Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Quality Assurance for Reviews

The Betsi Cadwaladr University Health Board (BCUHB) Corporate Safeguarding and Public Protection Team has developed a Quality Assurance Group covering Child Practice Reviews (CPR), Adult Practice Reviews (APR) and Domestic Homicide Reviews (DHR).

The group monitors review activity across North Wales to ensure that BBCUHB are able to offer assurances in terms of identified learning.

The Quality Assurance Group meets monthly to:

- Identify early learning for the health board and agree any necessary actions
- Identify any challenges/drift within the process
- Identify and share good practice to support learning
- Capture key themes and trends to support future actions
- Capture agreed data
- Respond to any triggers for internal escalation to the Director of Safeguarding and Public Protection

Group members are responsible for disseminating information to the Safeguarding and Public Protection Team, and the wider organisation as appropriate, as well as auditing the group function.

Key functions include:

- Incorporating identified learning into relevant training packages
- Developing relevant Seven Minute Briefings
- Influencing internal and local policy, procedures and guidance
- Ensuring timely escalation and sharing of information
- Communication of learning and information across the Health Board
- Developing expertise in the engagement with and function of CPR/APR/DHR's
- Working in collaboration with the Safeguarding Policies and Procedures Task Group to ensure learning is included in Health Board policies and procedures
- Ensuring the Health Board Safeguarding webpage accurately reflects CPR/APR/DHR learning

Through the above activity the Quality Assurance Group acts as an exemplar of multi-agency learning and embeds an effective foundation for learning.

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Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Establishment of a Robust Safeguarding Champion Network

Velindre University NHS Trust (VUNHST) provides specialist non surgical oncology services across South-East Wales for a population of 1.7 million, and also manages the Welsh Blood Service (WBS) which is responsible for the collection, processing, and distribution of blood and blood products to all hospitals across Wales, serving a population of 3.3 million.

Our ethos at the Trust is to ensure that Safeguarding is 'everyone's business', and that the leadership and delivery of the Safeguarding agenda is the responsibility of all staff at all levels. This is particularly important within the Welsh Blood Service which has blood collections teams based in all areas of Wales, and the dissemination of Safeguarding knowledge to all areas was considered to be a priority in order that the collections teams working in mobile units in any area of Wales could have access to timely Safeguarding support.

In order to drive the culture change and increase the knowledge and skillset of our staff, over the past year, we have worked to develop a strong and robust network of multi-professional Safeguarding Champions throughout the Welsh Blood Service (throughout Wales) and Velindre Cancer Services.

To date 47 staff have become Ask & Act champions, including staff from WBS, radiography, pharmacy, therapies and even a new cohort of international students. In quarter 1 of 2024, our Education & Training team members will also undertake the Ask & Act train the trainer sessions facilitated by Welsh Women's Aid, and this will build further resilience in the delivery of safeguarding training.

In addition, 5 staff have volunteered to be safeguarding champions across divisions from therapies, Human Resources and WBS.

Going Forward

The plan for 2024-2025 is to effectively embed the champion framework building further resilience in the delivery of safeguarding training.

Planned activity includes:

- Re-establishing quarterly meetings which will provide the champions with supervision and support.
- Advertising opportunities for champions to attend external safeguarding training by the Regional Safeguarding Boards.
- The release of WBS staff to undertake the Ask & Act train the trainer sessions facilitated by Welsh Women's Aid

Safe Sleeping Briefing and Video

Briefing

Following a number of sudden infant deaths within Cwm Taf Morgannwg Health Board (CTMUHB) over the last year, the corporate safeguarding team, health visiting and safeguarding midwife collaborated to produce a 7 minute briefing for multi-agency partners. The briefing included learning from child practice and health board reviews, identifying the importance of ensuring partners and extended family are confident in safe sleep practice when caring for infants. Additional learning included the significance of practitioners needing to assess a parent's ability to understand and follow advice, considering mental health, learning disabilities and language barriers.

Video

In recognition of barriers to recalling key health messages, a video demonstrating safe sleep positioning was created and made available to parents, carers and professionals via a QR code.

Dissemination

Both the 7 minute briefing and QR code were disseminated to partner agencies via the regional safeguarding board, ensuring that practitioners working with families were able to promote current, evidence based safe sleep advice and recognise any unsafe sleep practices. The resources were shared through the organisation's social media channels and across acute and community services within CTMUHB to promote safe sleep during safeguarding and safe sleep week. Additionally, a number of emergency departments and paediatric wards set up notice boards to promote key messages to staff and the public.

Going forward, work around the development of learning materials will continue, with the view that advice needs to be revisited regularly, particularly when babies have additional health needs or have hospital admissions.

Trauma Informed Workforce Conference

Over the last period the Welsh Ambulance Services University NHS Trust (WAST) held a safeguarding conference on the 'Trauma Informed Workforce'.

The conference welcomed attendees from across Trust directorates, alongside representatives from external partner agencies and safeguarding leads from other UK ambulance services.

The day comprised of specialist safeguarding presentations across all age groups and diverse impactful survivor stories. A range of stands were present representing various WAST teams and external agencies including 2wish, Mind and South Wales Fire & Rescue Service. In light of the topics under discussion, a dedicated area for wellbeing and support was accessible throughout the day.

Adverse Childhood Experiences

Public Health Wales shared insights into adverse childhood experiences and trauma informed practice, highlighting the importance of empathy and compassion. 'Lads Like Us' contributed their lived experience of abuse during childhood, evidencing the significance of practitioners demonstrating professional curiosity and adopting trauma informed practice.

Live Fear Free

The Live Fear Free Helpline Manager provided invaluable information outlining the support the helpline can provide. Ruth Dodsworth, an ITV journalist, shared an emotional account of her firsthand experience of domestic abuse and controlling coercive behaviour.

The day was closed by the Older People's Commissioner's Office who provided eye opening statistics in relation to older people experiencing abuse. With them was a survivor who graciously shared his experience of abuse later in life.

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Bwrdd Iechyd Prifysgol Cardiff and Vale University Health Board

Timely Health Assessments for Children Looked After

Through an initial pilot, C&V UHB have implemented a new way of completing heath assessments for children that are Looked After.

A prolonged and increasing backlog of the assessments required an immediate response and improvement to comply with the Statutory Duty.

As a result, the Health Visiting Service have been supporting the Named Paediatrician to complete the health assessments in a timely manner.

Children under the age of 5 years are assessed by a qualified Health Visitor, a practice that has evaluated well with an immediate reduction in the waiting list.

Safe Sleeping Poster

A Safe Sleeping poster has been developed by multi-disciplinary practitioners at Cardiff and Vale University Health Board (C&V UHB), incorporating professionals from the Corporate Safeguarding Team, Paediatrics, Midwifery and Health Visiting together with South Wales Police.

The requirement for a parent leaflet, which included the criminal offence of overlay* was identified. This information was missing from current leaflets available to parents/ carers.

The need for this information to be shared with parents/ carers has been identified in PRUDiC case discussions in the region. The organisation has shared the leaflet with other NHS Wales organisations via the Network for national use.

*overlay is explained as suffocation (not being caused by disease or the presence of a foreign body in the throat or air passages).

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Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Connecting Mental Health

The Perinatal and Infant Mental Health Service at Hywel Dda University Health Board (HDdUHB) were awarded the Special Achievement in Mental Health at the 2023 Consultant Connect Awards.

The Perinatal Mental Health line connects healthcare visitors, community midwives and GPs with the Perinatal Mental Health Team. Previously, direct access to the team was difficult and often under-utilised, resulting in patients being signposted to inappropriate pathways.

The Perinatal Mental Health Team reviews cases before referral, creating more bespoke patient management plans. The initiative has led to improved knowledge of available and appropriate pathways, shifting to a patient-centric approach to care.

Domestic Abuse and Menopause

HDdUHB's Lead Nurse VAWDASV and Safeguarding Domestic Abuse and Menopause drafted and widely distributed a 7 minute briefing to raise awareness of Domestic Abuse and Menopause.

She presented on the same subject to GP trainees on World Menopause Day 10/11/23 and at the Health Board Pelvic Health Conference.

Fostering Masterclasses

Looked After Children Nurses in HDdUHB have supported The Fostering Network by being key contributors of the regional fostering masterclasses delivered to foster carers.

The Fostering Wellbeing programme has been designed from the perspective of a child's journey through the care system and the relationships they build. Representing children in care by delivering a multi-agency programme across social services, health, education and youth justice. This programme recognises that in improving outcomes, multi-agency working through a partnership framework is essential.

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Safeguarding Procedures relating to Microbiology Specimens and Clinical Enquiries

The Issue

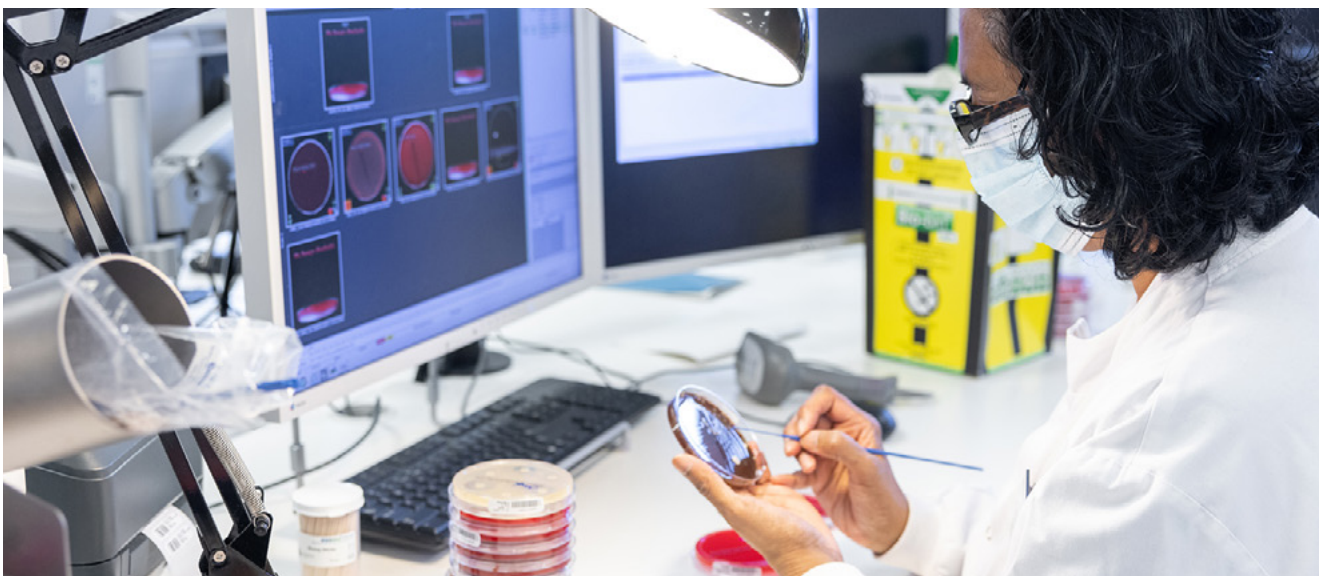
A significant concern around suspected child sexual abuse was identified within the Microbiology department at Public Health Wales (PHW) through a safeguarding concern reported through DATIX incident reporting system. As a result a sexual health screening was requested for a young child which led to further investigations and enquiries by the Named Lead for Safeguarding. Through direct contact and supervision with the requesting practitioner, it was identified that the child had a long history of safeguarding concerns. Advice was given to submit a referral to the relevant local authority for suspected child sexual abuse.

Engagement

This led to several meetings being held with Microbiology to understand processes when receiving and processing samples where safeguarding concerns may be identified. Safeguarding is everybody's responsibility, and subsequently a main theme of learning identified through practice reviews is professional curiosity. Microbiology has a key role in understanding whether Safeguarding Procedures have been followed when Safeguarding concerns are identified, through receiving specimens or clinical enquiries.

A Safeguarding Procedure for Microbiology in NHS Wales

This led to a working group within Microbiology and the Named Lead for Safeguarding to develop a Safeguarding Standard Operational Procedure for Microbiology within NHS Wales. This area of Safeguarding improvement recognises that everyone has a responsibility in understanding their professional responsibilities associated with safeguarding and that abuse may not always be visible. Development of the procedure has led to improved relationships, collaboration and an increase in potential safeguarding concerns being reported within Microbiology.



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Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

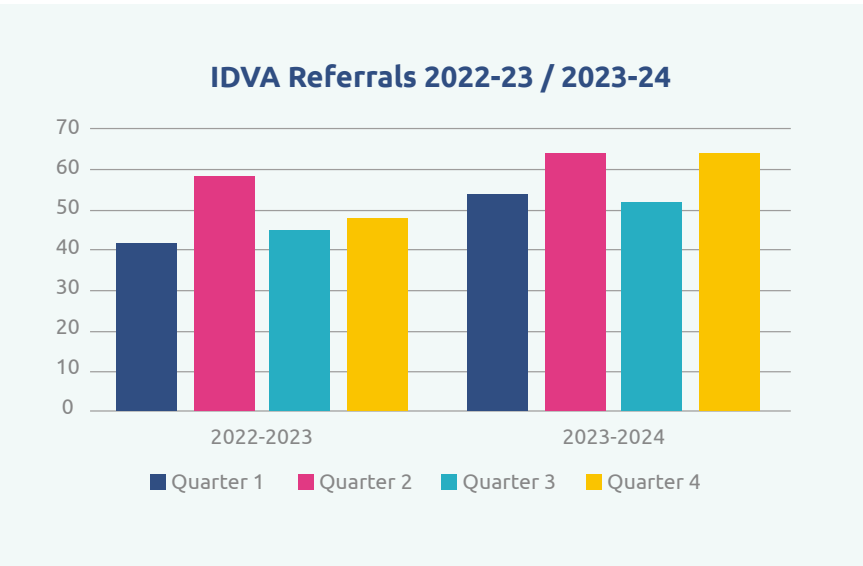
Independent Domestic Violence Advocate (IDVA)

Swansea Bay University Health Board's IDVA provides frontline support based within the Emergency Department, with referrals also coming from across the Health Board. Support is provided to individuals depending on assessed risk and need with referrals made for ongoing support.

The Health IDVA also provides support to patients attending Outpatient appointments, providing a safe space for patients experiencing domestic abuse; whilst inpatients can access the service on a short term basis.

Over the last period the service saw in increase in referrals for staff victims of Domestic Abuse, who are able to access the service. The IDVA will discuss available support - including access to hospital accommodation (if it is not safe for them to return home), a mobile phone and hospital canteen meal vouchers.

The increase in referrals, as demonstrated by the referrals chart, demonstrates the necessity for the service and further highlights VAWDASV as an issue.



Identification and Referral to Improve Safety (IRIS)

SBUHB has implemented the IRIS programme within GP practices across Swansea, Neath and Port Talbot.

The initiative is a training, referral and advocacy model that helps clinicians to better support their patients affected by domestic violence and abuse (DVA). Hosted by Calan, a DVA specialist organisation, it is aimed at women experiencing DVA from a current partner, ex-partner or adult family member and provides information and signposting for male victims and for perpetrators of DVA.

The team consists of two Advocate Educators who provide specialist DVA support to patients referred to the service and a GP clinical lead. The training and support helps GP practice staff to recognise indicators of DVA, gives confidence in asking appropriate questions and an opportunity to refer to a specialist advocate who is a DVA specialist. The programme evaluates well both with patients and staff.

I have come away with nothing, but I have got my freedom and I have got everything.

PATIENT FEEDBACK

Multi-Agency learning from Child Safeguarding Cases

In the last period Aneurin Bevan University Health Board (ABUHB) observed that there are many Child Safeguarding Cases where the threshold for a Safeguarding Practice Review is not met, due to a safe outcome being achieved for the child.

However it was noted that there remained opportunities for agencies involved to learn together to strengthen practice.

These opportunities are often in cases where there has been a positive outcome and stand out as either areas where working together has excelled, or as cases where existing systems and processes did not fit, presenting a variety of chances to innovate.

Multi-Agency Learning Sessions

The Health Board's Named Doctor for Safeguarding Children has arranged for 6 sessions, opening up the existing Paediatric Department learning structure to colleagues from the five Gwent Local Authorities and Gwent Police. The sessions will focus on specific cases or themes picked up via departmental audit and were well attended by partner organisations. They will allow for difficult conversations to be had in a safe environment, with awareness raised on unconscious bias and the diverse challenges agencies experience. Conversations will agree individual actions, likely relating to a need for updating educational offers or amending Policy or Operating Procedures

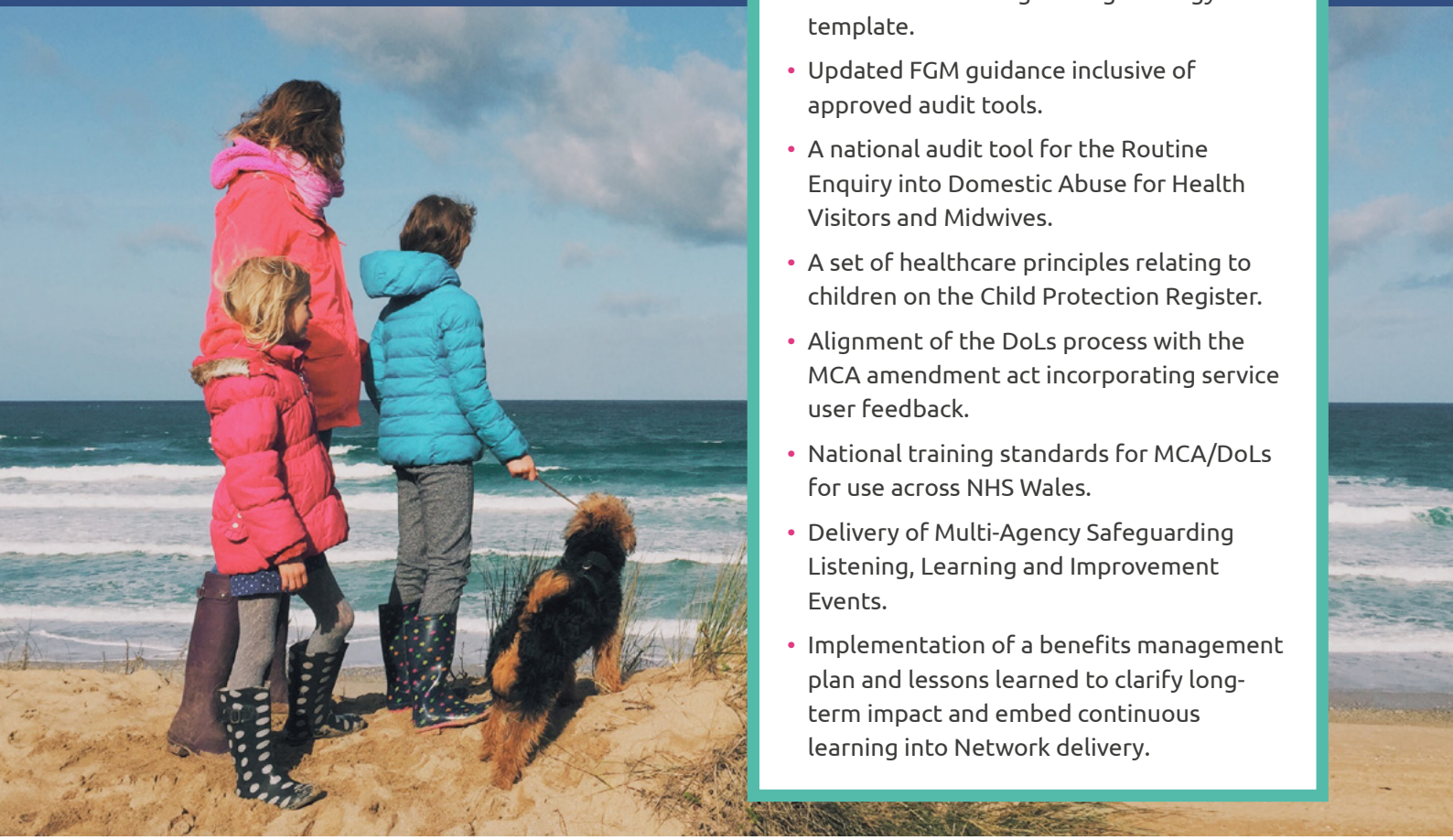
Rollout Potential

Following the successful progress of these sessions in a paediatric setting, there is a wider organisational appetite to adapt this model to learning from individual cases in the adult safeguarding arena.

Future Priorities

Looking to 2024/2025 the Network will continue to build upon the strong relationships and knowledge base they have built to date, working together to achieve 'A Wales where everyone is safe'.

There will be a strong focus on safeguarding quality and assurance, learning and strengthening partnerships. 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 emerging issues that would benefit from leadership and consistency across NHS Wales.



Deliverables over the next period include:

- NHS Wales Sexual Safety national guidance and training.
- A process evaluation of disseminated safeguarding learning to understand how effectively this reaches front line practitioners.
- National guidance relating to Was Not Brought (Adults and Children) which has been identified as a significant risk factor in cases of abuse and neglect.
- A referral process for when a child becomes Looked After to enhance the current notification from the Local Authority.
- A national approach to Child Protection Medical examinations and reporting.
- National safeguarding guidance for remote consultations by health practitioners.
- An NHS Wales Safeguarding Strategy template.
- Updated FGM guidance inclusive of approved audit tools.
- A national audit tool for the Routine Enquiry into Domestic Abuse for Health Visitors and Midwives.
- A set of healthcare principles relating to children on the Child Protection Register.
- Alignment of the DoLs process with the MCA amendment act incorporating service user feedback.
- National training standards for MCA/DoLs for use across NHS Wales.
- Delivery of Multi-Agency Safeguarding Listening, Learning and Improvement Events.
- Implementation of a benefits management plan and lessons learned to clarify long-term impact and embed continuous learning into Network delivery.