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University Health Board



Safeguarding

Children and Adults at Risk

Annual Report 2023/2024



Contents

1. Introduction	02
2. Training	08
3. Safeguarding Activity	12
4. Audit, Survey, Professional Presentations and Publications	18
5. Safeguarding Supervision	22
6. Expert Advice	24
7. Safeguarding Team Achievements	42
8. Forecast for 2024-2025	44
9. Summary	46



Safeguarding

Children and Adults at Risk

Introduction

This report provides a comprehensive overview of the efforts and achievements made by the Cardiff and Vale University Health Board (UHB) in protecting and promoting well-being of children and adults at risk within the community and when they may receive acute care. It highlights the progress made, challenges faced and outlines strategies for the future.

Protecting individuals from abuse and neglect is a critical responsibility that demands ongoing vigilance and commitment from all parties involved. The UHB has been dedicated to preventing, detecting, and intervening in cases of potential abuse and neglect. The organization follows relevant legislative guidelines, policies, and procedures to support individuals in the region, actively implementing and enhancing initiatives to identify signs of abuse and neglect.

The 2022/23 UHB Safeguarding Report outlined a forecast for the year, detailing the efforts of the integrated corporate Safeguarding Team. Key areas were identified as part of the team's work plan to ensure progress and continued development. These forecasted areas highlight the advancements made in safeguarding efforts:



Action	Outcome
Consider a new logo for the UHB Safeguarding Team designed by the Youth Board	Completed
Provide the Executive Team with a monthly Informatics Dashboard on Safeguarding activity across the UHB	Completed
Audit of assault cases referred to Violence Prevention Team in Paediatric Emergency Department	Completed
Safeguarding recovery plan for school nurses to consider the impact of lockdown on children during COVID-19 and service provision available	Completed
Pilot in Paediatric Emergency Department with Action for Children to consider engagement with children and young people in the community to minimise school related violence	Completed
Report evaluation of HV preceptorship training	Completed
Undertake an annual internal UHB Pressure Damage audit across all Clinical Boards	Completed
Audit of young people placed on Acute Adult Mental Health wards	Completed
Consider a new logo for the UHB Safeguarding Team, designed by the Youth Board	Completed
Resume UHB Safeguarding Team Newsletter	Completed
Audit the effectiveness of the multi-agency contextual safeguarding pathway within health	Completed
Participate in a PhD study around facilitating safeguarding group supervision	Completed
Develop a UHB leaflet explaining the PRUDiC process and the overlay aspect	Completed
Launch of Multi-Agency Hub in ED: Cynnwys	Completed
Launch a Child Criminal Exploitation Toolkit	Completed
Complete a Business Case for additional UHB Safeguarding Nurse Advisors	Completed
Consider the UHB position to employing additional IDVAs within the UHB	Completed
Violence Prevention Team to develop training aimed at Year 5 Medical Students raising awareness of Domestic Abuse/ Violence/ Human Trafficking and Honour Based Violence	Completed
Work in partnership with the UHB Patient Experience Team to implement the Duty of Candour in line with Health & Social Care (Quality & Engagement) (Wales) Act 2020	Completed
Update the Safeguarding Training Strategy	Completed
Evaluation of safeguarding training feedback from participants	Completed
Develop a standard letter to patients explaining the adult safeguarding outcome following a referral	Completed
Develop a UHB standard template for an internal safeguarding adult protection plan	Completed
Implement a survey with staff involved in a professional concern process	Completed
Standardise People's Services Incident Fact Finding Form for Professional Concerns	Completed

Action	Outcome
PREVENT champion to be nominated from the safeguarding team	Completed
Launch of Group 2 Mandatory Domestic Abuse Ask & Act Training within the UHB	Completed
Safeguarding overview and alignment with Mental Health for the Multi Agency Public Protection Arrangement (MAPPA)	Completed
Development of Medical Workforce online safeguarding training for UHB staff observers and honorary contracts	Completed
Consider alignment of the UHB Level 2 Safeguarding Adults training with Cardiff Local Authority	Completed
Implement attendance at Vale Children's Services Exploitation	Completed
Implement and embed the updated multi-agency PRUDiC Procedure	Completed
Consider a review of the Safeguarding Training delivered within the UHB by the Corporate Safeguarding Team	Completed
Develop and introduce a Professional Abuse Questionnaire for UHB employees involved in this process	Completed
Develop a pathway for Executives to be informed when safeguarding become aware that a Registered Sexual Offender is admitted as a patient or visiting others	Completed
UHB Safeguarding Team to attend multi-agency Chanel Panel (PREVENT) meetings as representatives for health. This has previously been attended by the UHB Strategic Planning Team.	Completed
Raise awareness across the UHB of the action and reporting required to address emerging themes of "Sexual Assaults in a hospital setting" raised by a published report by Women's Rights Network April 2023	Completed
Expansion of the Routine Enquiry for Child/ Adult Sexual Abuse within the Midwifery Service, in addition consider evaluation of the pilot in collaboration with Centre of Excellence for child Sexual Abuse	Ongoing Amber
Prioritising a targeted increase in mandatory safeguarding training, to achieve a UHB level of 75%	Ongoing Amber
Introduce a standardised proforma to be completed by GPs, Practice Nurses and DoSH when sexual concerns are indicated	Ongoing Amber
Introduce Safeguarding Documentation to be used by GP practices across the Cardiff and Vale region. Collaborative work with Children's Services	Ongoing Amber
Demonstrate partnership working to engage with communities in relation to anxieties around Female Genital Mutilation (FGM) reporting	Ongoing Amber
Complete a safeguarding template proforma for children under 5 years transferred in to area	Ongoing Amber

Action	Outcome
Audit of safeguarding themes of cases discussed in supervision	Deferred Red
Audit of the use of the safeguarding chronology documentation in acute paediatrics	Deferred Red
Survey of Mental Health staff in relation to safeguarding support from UHB team	Deferred Red
Undertake and implement Offensive Weapons Homicide Training in line with Home Office Guidance	Deferred Red
Launch of UHB Group 3 Train the Trainer Domestic Abuse training	Deferred Red
Audit of 16-year olds attending ED and stating attendance at higher education at college or six form college	Deferred Red
Develop and introduce a questionnaire for UHB employees that have received services from the Health IDVAs	Deferred Red
Commence work with each Clinical Board (CB) to complete a Self -Assessment based on the Safeguarding Maturity Matrix, to demonstrate where each CB consider their safeguarding remit, knowledge and participation to be	Deferred Red
Develop and evaluate a questionnaire for staff and service users of the Health Violence Prevention Team	Deferred Red
Participate in the Department of Health and Social Care NHS PREVENT training framework for the UHB	Deferred Red

The work undertaken and completed in green is significantly less than previous years' achievements. This is a reflection, of the increased demand of safeguarding work across the region on a multi-agency basis. The corporate safeguarding team has experienced an increase in all forms of abuse and neglect through submitted referrals for children and adults at risk. There has also been an observation that individual cases are more complex drawing on a number of service areas and organisations to work together to ensure that a safe plan is in place to provide reasonable assurance of safe care and support for individuals. This is recognised through the Regional Safeguarding Board (RSB) partners.

Forecast Population Growth within the Cardiff and Vale University Health Board (UHB) Region

To continue to improve and develop, the UHB Safeguarding Team will consider the growing population of the region to guarantee that the local Public Health plan is respected and provides a benchmark for safeguarding service delivery. The Cardiff and Vale UHB Shaping our Future Well-being Strategy up to

2035 states that the population of Cardiff and Vale of Glamorgan region is 500,000 at present with a forecast of 400,000 in Cardiff alone by 2028. The average age of people in the region is increasing and expected to increase for those over 85 years by 20% over the next five years in the Vale and nearly 50% over 10 years. The region is recognised as one of the most ethnically diverse populations in Wales, with one in five people from a Black, Asian and Minority Ethnic background. There are 1,000 GP practices in the region, 5,220 births in 2022-23, 147,449 people attending Emergency Department, 7,394 planned hospital procedures, 669,346 outpatient appointments for people within the region and 17,232 people employed within the Health Board. In addition, 95% of people in a survey stated that they felt safe and said that the care provided within the Health Board was good and provided by staff who were caring and kind.

These statistics, as well as health inequalities identified in specific neighbourhoods across Cardiff and the Vale of Glamorgan, impact on safeguarding and well-being of individuals and families, resulting in targeting services to meet demand.

The emergence of COVID-19 expedited identified cases of substance misuse, emotional and mental health well-being and unhealthy relationships. Social isolation and loneliness had been identified prior to COVID-19 measures as affecting a quarter of vulnerable people within the region. Isolation restrictions during this period may be the result of increased cases reported, requiring a multi-agency safeguarding response.

Cardiff and Vale Corporate Nursing, Intergrated Safeguarding Team Structure

To promote the safeguarding agenda the Executive Nurse Director leads the corporate team which consists of:

- Head of Safeguarding
- Named Doctor for Safeguarding Children
- Senior Nurse Safeguarding
- Consent and Mental Capacity Act Lead
- Seven Safeguarding Nurse Advisors
- Safeguarding Nurse Advisor (Flying Start)
- Safeguarding Nurse Advisor (Midwifery Services)
- Safeguarding Trainer/Nurse Advisor
- Two Mental Capacity Act Practitioners
- Specialist Safeguarding Liaison Nurse
- Three Health Independent Domestic Violence Advocate (IDVA) two posts are in fixed term external funding positions
- Young Persons Health Independent Domestic Violence Advocate fixed term external funding
- Violence Prevention Team, one Band 6 nurse and one Band 6 advocate fixed term external funding positions
- Administration Team

The safeguarding governance structure sits within the portfolio of the Executive Nurse Director and the Deputy Executive Nurse Director. A bi-monthly Safeguarding Steering Group meeting is held within the UHB and is attended by representatives from each Clinical Board (CB). The CBs consist of Mental Health, Specialist Services, Children and Women, Medicine, Surgery, Primary Community and Intermediate Care (PCIC) and Clinical Diagnostics & Therapeutics. The Designated Nurse for the region represents the National Safeguarding Service. More recently South Wales Police and Spire Healthcare nurses have been represented at the meeting; Cardiff and Vale Local Authorities are invited and have receipt of

minutes. This reflects the ethos of safeguarding being everybody's business and provides assurance to the UHB Board that the safeguarding agenda is being progressed in line with legislative duties and best practice.

The Safeguarding Team locations are: the Noah's Ark Children's Hospital at the University Hospital of Wales, Cardiff Multi Agency Safeguarding Hub (MASH) and the main office for advice and queries based at Woodland House, Heath, Cardiff. The Cardiff MASH was launched in July 2015, hosted by South Wales Police at Cardiff Bay Police Station. Agencies located within the MASH include Cardiff Local Authority (LA) Children and Adult services, South Wales Police, Cardiff Local Authority Education, Health and Probation services. The purpose of the MASH is to ensure that safeguarding of children, adults at risk and domestic abuse has a timely, appropriate multi-agency response and approach. By co-locating agencies to share information immediately that a concern is raised, safeguarding measures are considered and put into place immediately or within 24 hours. Two safeguarding nurse advisors work within the MASH, sharing appropriate health information to ensure the safety of children and adults at risk across the UHB locality.

Significant Legislation that Informs the Wales Safeguarding Agenda

The Safeguarding Team continues to work to provide assurance to the Executive Board that the UHB is discharging its duties in line with the implementation of: The Social Services and Well-being Act (Wales) 2014 (SS&W-bA) and the Violence against Women, Domestic Abuse and Sexual Violence Act (Wales) 2015 (VAWDASV) has determined much of the safeguarding work undertaken across Wales. Ensuring that both Acts are implemented within the organisation has been a priority due to the duty to report and investigate, provide awareness raising training, supporting all staff to undertake their duty, recognise their responsibility and encourage partnership working with other statutory agencies. The Welsh Government (WG), National Training Framework five-year plan for Groups 1, 2, 3 and 6 reflects the UHB's commitment to deliver the raising awareness training across the organisation in line with WG expectation. The UHB has worked with Public Health Wales Safeguarding Service to produce a training

package aimed at Group 2 training following agreement by WG for Health organisations to deliver a single agency package. This has been implemented within the UHB from September 2019. Delivering the training for Group 2 in accordance with WG recommended staff groups is a challenge for the safeguarding team as it is estimated that a figure of approximately 11,000 staff will require this additional training. Group 3 multi-agency VAWDASV training is expected to commence in 2024.

In addition to the Acts, there has been the introduction of Home Office Mandatory Reporting of Female Genital Mutilation (FGM) in October 2015 and Home Office Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016) under section 9(3) of the Domestic Violence, Crime and Victims Act (2004). The Well-being of Future Generations (Wales) Act 2015 requires the development of Public Service Boards (PSBs) in each Local Authority area; the Boards are in place within the region. PSBs are responsible for assessing the well-being of the local population, the Board agree for a Domestic Homicide Review (DHR) to be commissioned. The DHR responsibility is likely to be transferred to the RSB in the coming year.

The Wales Safeguarding Procedures (2019) incorporating Children and Adults at Risk has been implemented since October 2019. The procedures replace the previous All Wales Child Protection Procedures (2008) and reinforce the instructions within the Social Services and Well-being Act (2015) Wales.

Additional recent significant legislation includes: Domestic Abuse Act (2021), The Duty of Candour Procedure (Wales) Regulations 2023, Department of Health and Social Care NHS PREVENT training and competencies framework (September 2022). The Serious Violence Duty (legislated for under section 19 of the Police, Crime, Sentencing and Courts (PCSC) Act 2022 requires specified authorities to “formulate an evidence-based analysis of serious violence in the local area”, to inform bespoke serious violence strategies for the local areas (the boundaries of which are at local discretion).

Meeting the demands of the growing activity surrounding the depth and breadth of safeguarding is a constant challenge for the Executive and Deputy Nurse

Directors and the corporate Safeguarding Team. Ensuring that the UHB is compliant with the legislation is a priority area; however, maintaining the ethos of the UHB's values and behaviours must be considered when work is undertaken with individuals, families and UHB staff.

Effective safeguarding relies on good working partnerships with other agencies utilising an open and transparent approach. This is reflected by the corporate Safeguarding Team working within the UHB; in addition to the work undertaken with GPs, Local Authority, Police, Education, Probation and Third Sector agencies. Since the introduction of the Cardiff MASH the safeguarding referral process across the UHB has been restructured and is transferred to the appropriate LA by the Safeguarding Team electronically via secure e-mail. Safeguarding referrals continue to be more complex resulting in additional staff time in support and supervision of cases, involving more strategy discussions/ meetings, multi-agency investigations and often legal advice. Team members report an increase in violence related referrals through MASH and patients presenting at Emergency Department (ED).

The 2023/24 Safeguarding Report will reflect on the work conducted from April 2023 to March 2024, highlighting and assessing the scope of the safeguarding agenda and the progress achieved across the UHB. It will provide an overview of the collaborative safeguarding efforts undertaken with the Cardiff and Vale Regional Safeguarding Board (RSB), the VAWDASV Regional Strategy, and the NHS National Safeguarding Service, underscoring the significant scale of the safeguarding initiatives across the region and Wales as a whole.

It is important to acknowledge that the UHB, like many organizations globally, has been significantly impacted by the COVID-19 pandemic since early 2020. The planning and execution of the UHB's response to the operational challenges posed by the pandemic—ensuring the necessary resources and provisions were in place as the pandemic inevitably reached the region—took precedence over routine activities. As a result, certain tasks, such as training and meetings (including the UHB Safeguarding Steering Group and multi-agency meetings unrelated to COVID-19 planning), were affected. Efforts were made to either temporarily suspend or reduce the time allocated for these meetings.

Joint Inspection of Child Protection Arrangements in Cardiff

Link to the report here [Publications / Guidance](#)

Cardiff and Vale University Health Board were notified by Health Inspectorate Wales (HIW) in November 2023 of the multi-agency inspection during January 2024. The JICPA reviewed:

- the response to allegations of abuse and neglect at the point of identification
- the quality and impact of assessment, planning and decision-making in response to notifications and referrals
- protecting children aged 11 and under at risk of abuse and neglect
- the leadership and management of this work
- the effectiveness of the multi-agency safeguarding partner arrangements in relation to this work

The summary of findings concluded that “The current children’s safeguarding context is one of persistently high levels of demand and increasing complexity”. The local authority reports a 44% increase in strategy discussions undertaken in 2022/2023 compared to 2019/2020. This is consistent with a similar increase in Section 47 enquiries (46% increase in the same period), reflecting the increase in demand across services. Budget challenges, deficits in the number of practitioners and a competitive market, have resulted in an increasing proportion of newly qualified and inexperienced workers across partner agencies. This exacerbates the challenge of safeguarding children across multi-agency activity. There is, however, a positive focus on safeguarding across the local authority, local police force and health board. A culture of safeguarding is promoted as everyone’s collective responsibility. Professional relationships across agencies are positive with professional differences easily resolved between senior safeguarding leads.

Practitioners mostly understand their roles and responsibilities in the context of protecting children and maintain a positive focus and commitment. Information is generally shared appropriately and in a timely manner when concerns are identified about children’s safety and well-being. The multi-agency response to safeguarding

referrals is generally proportionate to the presenting risk. Child protection enquiries are thorough with a focus on the needs of the child, involvement of relevant agencies and with mostly timely action to reduce the risk of harm to children”.

However, immediate areas of concern were identified by HIW in relation to Cardiff and Vale University Health Board (C&VUHB) safeguarding of children arrangements that were deemed to pose an immediate risk to their safety.

C&VUHB were requested to provide an immediate improvement plan to address:

- Clear documentation of services within the UHB accessing safeguarding supervision
- Safeguarding Level 3 training compliance within the UHB
- Improve pressure damage reporting for children in hospital. All grade 3/ 4 or unstageable, hospital acquired, avoidable pressure damage must be reported to the Local Authority
- School Nurses to attend all Child Protection Conferences and provide a report or health assessment for each child.
- The UHB to improve the completion of health assessments for Children Looked After within the statutory timescale

A comprehensive improvement plan was shared and agreed by inspectors, continued work across all Clinical Boards within C&VUHB will continue with the aim to improve:

- safeguarding governance
- improve mandatory safeguarding training compliance to reach 85% in line with Wales expectation
- consider mandating Level 3 safeguarding training
- improve data collection of safeguarding supervision sessions
- introduce a school nursing health assessment for all children in child protection conferences
- improve the statutory timescale for children looked after assessments
- provide additional scrutiny to pressure damage cases within paediatric inpatients

Training

The safeguarding team are responsible for developing, planning and delivering a range of training events throughout the year. The aim of safeguarding training is to ensure all staff have the skills, knowledge and understanding to inform the ways in which they engage with people at risk of abuse, harm or neglect. Training will ensure that all staff know how to respond to concerns in line with local and national requirements in a confident and competent manner.

Training is developed to reflect guidance from training competencies as identified in the National Intercollegiate Documents:

- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition: January 2019, and
- Adult Safeguarding: Roles and Competencies for Health Care Staff First edition: August 2018

Online Safeguarding training at Level 1 and Level 2 is available through Electronic Staff Records (ESR) and forms part of staff mandatory training requirements.

The safeguarding team deliver classroom-based training sessions and TEAMS training at Level 2, Level 3 training is classroom and TEAMS based. These sessions run regularly throughout the year and are advertised in the UHB training prospectus and are booked through the Education, Culture and Organisational Development (ECOD) office. Additionally, the safeguarding team deliver a number of bespoke training sessions with identified staff groups. During this time period staff training across the UHB was considerably reduced in line with COVID guidance and significant reduction in staff resources in clinical areas for a period of time. This is reflected in the data.

The collected data shows a decline in the number of staff completing training across all areas. Addressing this will be a priority in the coming year, in line with UHB corporate guidance, to ensure a focus on compliance. Safeguarding training is essential in providing both service users and staff with protection against harm by equipping them with the knowledge and understanding of the proper processes to follow.

Online Safeguarding Training Data

Training data for safeguarding training completed/attended 1st April 2023 to 31 March 2024.

Safeguarding Level 1 training (online)

Number and percentage of staff compliant with Safeguarding Children training at **31 March 2024**

Level of training	Headcount (UHB Total)	Number trained	% trained
Safeguarding Children Level 1*	17344	14587	84.1%
Safeguarding Adults Level 1 * Online training only	17344	14737	84.97%
VAWDASV (Domestic Abuse) Group 1 Online Training Only	17344	12929	74.55%

NOTE:

All staff working in Health Services are required to complete **Level 1** safeguarding training, this package is delivered online via ESR. Relevant staff can also access **Level 2** training material via ESR.

Safeguarding Children and Safeguarding Adults (3 Year refresher) available online and face to face classroom sessions

Number and percentage of staff compliant with Safeguarding Adults training as at **31 March 2024**

Level of training	Headcount (UHB Total)	Number trained	% trained
Safeguarding Children Level 2	Only specified staff groups require this level of training -see notes section below	5940	Only specific staff groups require this level of training - see notes section below 78.87%
Safeguarding Adults Level 2	Only specified staff groups require this level of training -see notes section below	5883	Only specified staff groups require this level of training - see notes section below 80.25%
VAWDASV Group 2	Only specified staff groups require this level of training -see notes section below Now mandatory for all staff groups with any patient or client contact	562	This training is organised and delivered exclusively by the safeguarding team. Figures shown are a running total of staff trained to date
VAWDASV Group 3 Multi-Agency training (Champions)	Only specified staff groups require this level of training -see notes section below	13	This training is currently provided by safeguarding Nurse Advisors and Health IDVAS whom have completed the Train the Trainer VAWDASV G3 champion training course

NOTE:

Level 2 safeguarding training and Group 2 VAWDASV training, is relevant for the following staff to attend/complete ie, all practitioners who have regular contact with patients, their families or carers, or members of the public.

ECOD are in the process of including the VAWDASV Group 2 training to the UHB Mandatory field.

Please Note:

More detailed safeguarding training compliance data is available for each Clinical Board through Education, Culture and Organisational Development (ECOD) and Electronic Staff Records (ESR).

Classroom Based Training Data

Throughout the year, the Safeguarding Team would usually provide a number of classroom- based training sessions and study days which are open for all relevant staff groups. Feedback from staff evidences that training through virtual means inhibits fully active two-way engagement and interaction between the audience and trainer. It is important to highlight that technical issues affect some elements of the training flowing freely.

Source: VAWDASV pre/post feedback forms 2023.

Level 2 safeguarding children training session is relevant for the following staff to attend:

Non-clinical and clinical staff who, in their role, have contact (however small) with children, young people and/or parents/carers or adults who may pose a risk to children (Source: Inter Collegiate Document Safeguarding Children, January 2019)

***Level 2 safeguarding adults training is relevant for the following staff to attend all practitioners who have regular contact with patients, their families or carers, or the public. (Source: ICD Adult Safeguarding, August 2018)*

Level 3 Training Sessions from 1st April 2023 – to 31st March 2024

Event	Audience/ Subject delivered	Number of attendees
Child Sexual Exploitation	Level 3	Not held during this time period
Current Themes in Safeguarding Children	Level 3, 2 sessions	27
VAWDASV multi-agency training, train the trainer	Group 3	4 from the Corporate Safeguarding Team
Parental Mental Health and the Impact on Children	Level 3	0 outside speaker unavailable
Legal Aspects of Safeguarding	Level 3	23
Safeguarding Adults at Risk Study Day	Level 3, 2 sessions	16 & 15
Current Themes in Safeguarding Adults	Level 3	16
Bespoke Training		
Health Visitor Preceptorship Induction	Induction	30
Dental Training	Qualified Staff and Students	71
Raising Safeguarding Awareness	Qualified & non-Qualified staff and Students	34
wF2 Safeguarding update	F2 medical staff	62
VPT/Safeguarding	New Starters- ED F2	31
VPT/Safeguarding IDVA	New Nurse Starters- ED	58
VPT/Safeguarding	Major Trauma	57
VPT/Safeguarding IDVA	PING	180
VPT/Safeguarding	ED Nursing Team Day	8
VPT/Safeguarding	ANP Training	13
VPT/Safeguarding	GP ED Training	7
VPT/Safeguarding	Radiology	7
VPT/HUB	CAVHIS	8
VPT	YEF	75
VPT	All Wales Safeguarding Network	54
VPT	Student Nurse induction	13
VPT	1-1 opportunistic teaching	Not recorded (however occurs daily)

Safeguarding Training Meetings Attended

To ensure a robust evidence-based training programme is delivered within Cardiff and Vale UHB, key members of the Safeguarding Team would usually attend local and National Training meetings:

UHB Safeguarding Steering Group Meeting

The meeting is held bi-monthly, the safeguarding training monitoring is a standard agenda item. A UHB Safeguarding Training Strategy has been commenced for the coming year, this will be signed off by the meeting members when completed.

UHB Mandatory Training Steering Group Meeting

The Safeguarding Team attends this meeting to inform the mandatory training agenda and has been involved in work to promote safeguarding children, safeguarding adults training and VAWDASV training.

Cardiff and Vale Regional Safeguarding Board (RSB) training sub-group meeting

This training sub-group reports to the RSB Board and

has previously completed a safeguarding training mapping exercise to consider the different levels and types of safeguarding training partner agencies currently deliver. Recent work has focused on the implementation and embedding training for the Wales Safeguarding Procedures.

Safeguarding Training Network Meeting

This training sub-group meeting meets bi-monthly, reports to the NHS Wales Safeguarding Network Service meeting.

National Training Programme – Violence Against Women Domestic Abuse and Sexual Violence (VAWDASV) Regional Training Group

The aim of this multi-agency regional training group is to share best practice and discuss current training compliance for VAWDASV training. The meeting is also driven by the five-year regional VAWDASV training programme, which includes the development and delivery of VAWDASV training for Groups 2, 3 and 6.

During this time period some meetings were stood down.



Safeguarding Activity

All reports for safeguarding children, adults at risk and domestic abuse are sent electronically by practitioners to a central UHB safeguarding referral e-mail address; the reports are not screened and are sent directly to Cardiff MASH, Vale of Glamorgan Local Authority teams and Police as appropriate, on the same day as they are received. This process also applies to all other LA outside of the region. The report pathway and report forms are available on the UHB Safeguarding Children and Adult web pages on SharePoint. This process is unique to Cardiff and Vale UHB and allows the safeguarding team to collate the activity across the UHB to target service

areas that may require additional training, supervision or advice.

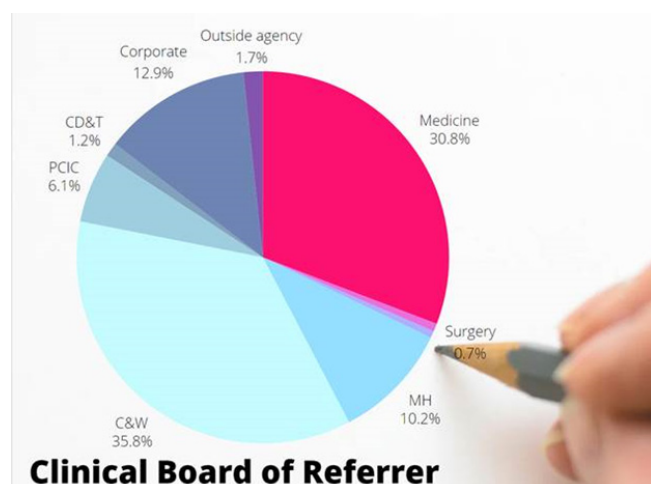
Safeguarding Children Activity

Activity is collated on a monthly basis across the UHB and presented to the Safeguarding Steering Group as a Run Rate Report. The report exhibits activity from 1 April 2023 to 31 March 2024 across all Clinical Boards (CBs). This process will change in the coming year following considerations developed by the UHB in response to the Cardiff Joint Investigation of Child Protection Processes (JICPA) in January 2024.

Table 1: Safeguarding Children Activity: Referrals from Clinical Boards

Clinical Board 2023/24	04	05	06	07	08	09	10	11	12	01	02	03
Medicine	113	156	1148	1127	1131	1130	1177	1155	1169	1193	1179	1159
Surgery	3	1	4	5	5	9	3	5	2	2	1	1
Specialist	1	2	2	7	2	1	4	4	1	5	2	5
Mental Health	38	50	29	51	43	62	52	60	48	52	59	65
Children and Women	137	177	193	183	173	150	197	186	181	181	177	197
PCIC	21	21	45	38	24	31	35	26	29	40	29	26
CD&T	1	5	2	8	11	10	8	9	2	7	6	3
Corporate	54	85	75	63	76	52	59	81	55	65	60	44
WAST	1	5	0	4	0	5	1	2	1	4	8	3
Outside Agency/ Unknown	5	5	7	3	7	8	8	5	2	3	7	5
Total	374	507	505	489	472	458	544	533	490	552	528	508

Table 2: Represents the Clinical Board Areas that have submitted Referrals



The reports made by the Medical CB are generally generated in Paediatric Emergency Department (ED). Children and Women CB referrals are predominantly made by community-based staff such as Health Visitors and School Nurses; however, disciplines within the acute sector make a proportionate number of reports. PCIC referrals will be submitted by GPs and District Nurses.

A total of **5,960** referrals were made by UHB staff and submitted to Cardiff, Vale of Glamorgan LA or a LA out of area by the safeguarding team during this period. There is an increase from the same period the year before when 5,225 referrals were submitted, a

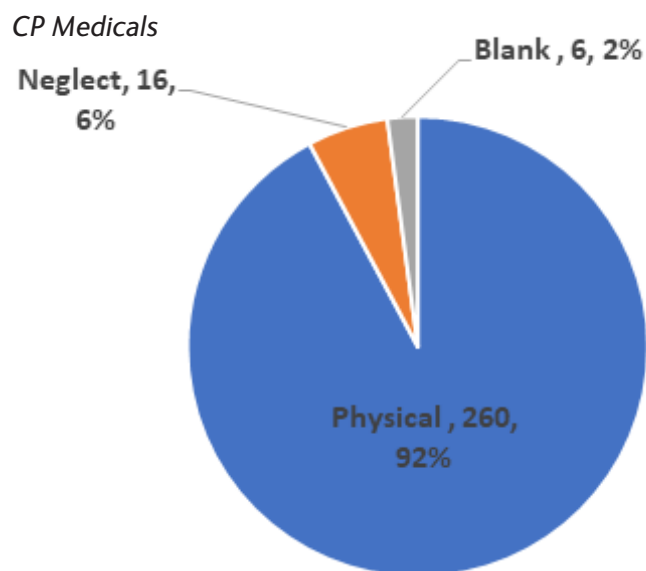
Table 6: Total of Child Protection Medicals Undertaken

Table 6 represents figures for Child Protection medicals that are undertaken by the Community Paediatricians based at St David's Children's Centre during normal working hours. The table below illustrates the reason for the medical and total percentage. In total there were 282 medicals undertaken. Physical assault represents the greatest category with 260 cases reported, 16 neglect cases, child sexual abuse accounted for 0 cases, 6 cases were not stated on the database.

Safeguarding Adult at Risk Activity

Activity is collated on a monthly basis across the UHB and presented to the Safeguarding Steering Group as a Run Rate Report. The report exhibits activity from 1 April 2023 to 31 March 2024 across all CBs. This process will change in the coming year following considerations developed by the UHB in response to the Cardiff Joint Investigation of Child Protection Processes (JICPA) in January 2024.

Table 8: Adult Safeguarding Activity: Referrals from Clinical Boards

Clinical Board 2022/23	04	05	06	07	08	09	10	11	12	01	02	03
Medicine	7	10	12	13	14	10	9	24	10	10	9	10
Surgery	0	2	1	1	2	5	0	0	2	0	1	4
Specialists	1	2	0	2	2	2	1	1	1	4	0	0
Mental Health	7	17	11	12	16	8	8	12	5	15	6	15
Children and Women	0	0	0	0	0	0	0	0	0	0	0	0
PCIC	1	0	3	2	2	0	1	2	0	0	1	0
Corporate	0	0	0	0	0	0	0	0	0	0	0	0
CD&T	0	0	0	0	0	0	0	0	1	0	0	0
Total	16	31	27	30	36	25	19	39	19	29	17	29

A total of 318 referrals were made by health professionals to the local authority during this period, in comparison 289 referrals were made during the same period in the previous year. This is an increase of 29 referrals in this reporting period.

This safeguarding adult data is collated by the number of health-led referrals across the UHB. Each CB has a Health Lead Practitioner (HLP) that take responsibility to lead on the Adult at Risk process for their own area; HLPs are usually Lead Nurses, Senior Nurses or Advanced Nurse Practitioners. HLPs are given additional bespoke safeguarding adult at risk training by the Head of Safeguarding or Senior Nurse to undertake this role. An electronic shared drive has been established to enhance the process allowing HLPs in each clinical area to be aware of cases in their CB to ensure that cases are maintained and progressed should the named HLP be on annual leave or sick leave. There are 50 active HLPs across the UHB. The process has evolved since the implementation of the SS&W-b Act (2014) and since the launch of Cardiff MASH. This may not be a true reflection of all referrals made, it has been noted that health staff based in integrated community teams are sometimes making referrals directly to the LA and bypassing the UHB Safeguarding Team. This is complicated due to the fact that health staff are working from LA computers and facilities, plus their email address is LA. Measures to ensure that this practice is discontinued are being introduced to certify that health staff are following the UHB reporting process.

Table 8: Captures the number of health-led referrals made by each Clinical Board for this period

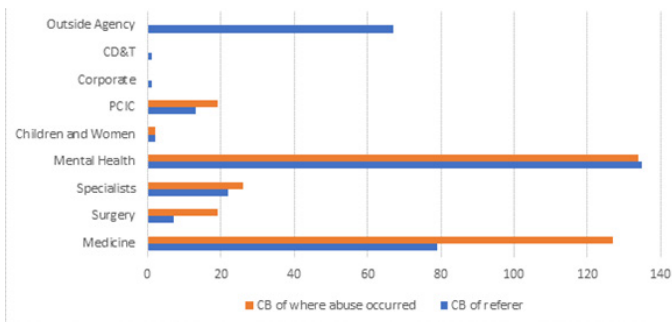
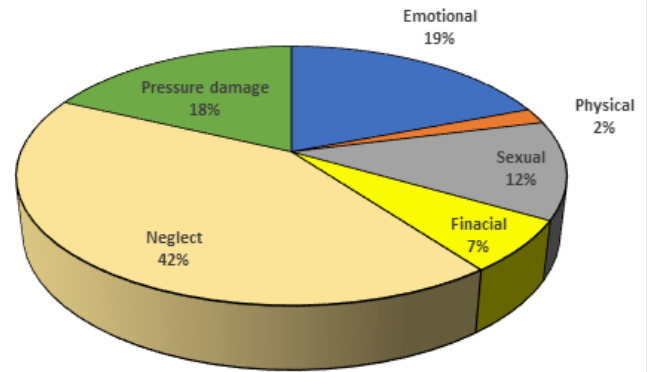


Table 9: Categories of Abuse Described on AS1 Referral Form

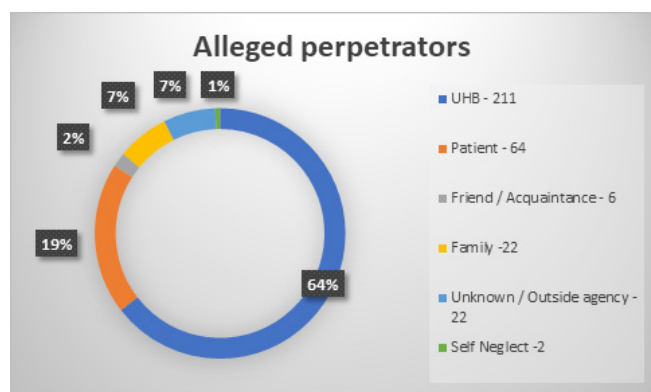


Categories of abuse are easier to capture on the current Adult at Risk reporting form (AS1) as opposed to the Children’s reporting form, as there are tick boxes for practitioners to choose. Highlighted in table 9 are the type of abuse considered by practitioners to be the reason for submitting the report to the LA. The most commonly used category is neglect, possibly reflecting perceived poor care within a clinical area in the UHB. AS1s submitted raising concerns of sexual assault account for 12% of those submitted. Concerns are mainly raised by patients reporting another patient; however, there are also reports alleged by patients against staff. All cases of suspected sexual assault are taken seriously by the UHB and will always be reported to police and LA either as an AS1, if consent is obtained by the reporter, or as a Section 5, Professional Allegation/ Concern of a person in a position of trust, if the allegation is against a staff member. Patients (family members are contacted if the patient is deemed to lack capacity) and staff are always asked if they want to report to police, they would be supported to raise the concern if this is required.

Adult cases often prove to be complex, determining the main issue at the point of disclosure or reporting is often difficult for referrers; this is often not established until further fact finding is undertaken. This may be in the shape of a criminal or non-criminal investigation. The HLP will lead on the case if the situation involves a clinical area within the UHB. Cases, where individual staff members are deemed as the alleged perpetrator of abuse, are managed by the Head of Safeguarding/Senior Nurse to ensure that a consistent approach is in place that aligns with the UHB and RSB Section 5 Professional Allegation/ Concern process. The HLP is central to gathering fact finding statements and keeping in touch with the staff

member during this process. The UHB acknowledges that any allegation involving a member of staff will raise anxiety and often results in the employee taking sick leave. The UHB works closely with People’s Services department (previously known as Human Resources HR) and the line management team to ensure that a proportional risk assessment is in place to support and protect staff members from further accusations whilst this process is in place.

Table 10: Alleged Perpetrator



Often practitioners from the UHB or from an outside agency will not have the information to determine who the alleged perpetrator is, this is evidenced in Table 11 as no person responsible has been identified on the referral. 211 of the cases cites the Hospital or Hospital staff exclusively as being responsible for the abuse. 64 of the cases are alleged abuse from another patient, more often these are cases in Mental Health clinical areas.

Pressure Damage

Due to improved reporting pathways implemented within the Health Board in 2020, only avoidable health acquired pressure damage of grade 3/4 or unstageable damage are currently reported to LA. This has decreased the number of pressure damage referrals to LA. This is in alignment with recent Welsh Government, Serious Incident Reporting and in compliance with the Social Services and Well-being (Wales) Act (2014). In addition, both Medicine and Primary Care (PCIC) CBs have introduced scrutiny panels that consider pressure damage reporting on a weekly basis. This provides a multi-agency assurance of transparency and appropriate referral submission. There were 63 cases of pressure damage referrals during 2023/24.

Table 11: Identifies the age groups of referrals- Age Groups

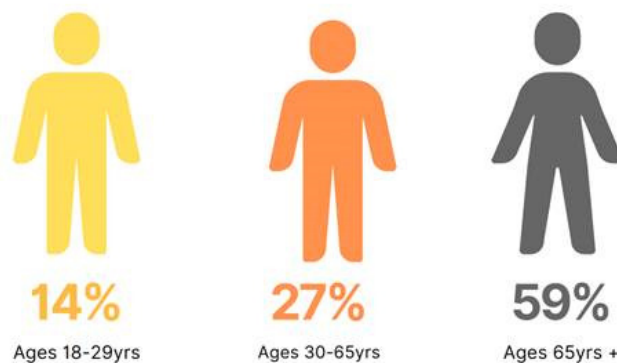
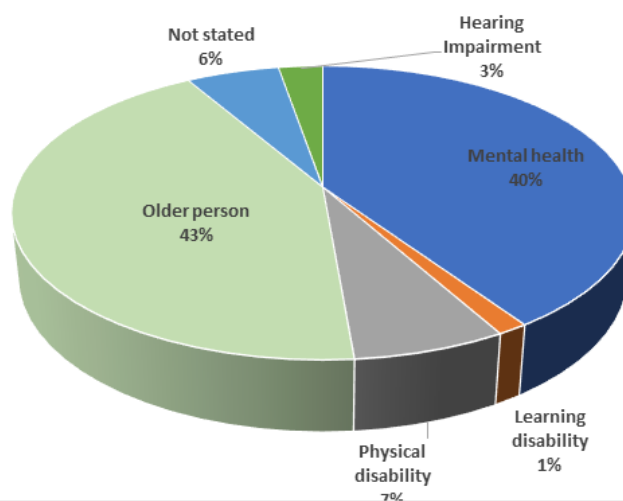


Table 12: Client Groups with perceived Vulnerabilities:



- Mental Health 149 cases
- Older Person 158 cases
- Physical Disability 25 cases
- Hearing Impairment 10 cases
- Learning Disability 5 cases
- Not Stated 21 cases

Section 5: Professional Allegations/ Concern Strategy Meetings

The UHB Professional Allegation/Concern guidance updated in 2021 has formalised the approach to address concerns of employees' behaviour in or outside of work. The process is in alignment to the Wales Safeguarding Procedures (2019). UHB employee line management, Police, UHB Safeguarding, UHB People's Service and LA are invited to each meeting to share information and ensure that the UHB is open and transparent in the approach. Concerns include arrest and police investigation around domestic abuse, sexual assault, physical assault etc, outside the workplace. Some cases will proceed through the disciplinary process following closure by police and/or the Court process.

Number of Professional Meetings

Period 2023-2024

Professional allegation/ concern identified in: 228 cases, in addition domestic/self-harm abuse cases were discussed with managers whereby a member of staff has been identified as a "high risk" Domestic Abuse victim or issues around Mental Health. This is a remarkable increase in support sought by Clinical Board areas from the previous year (**82** cases of domestic abuse raised by survivors and/or self-harm issues). This is likely to be due to a number of issues: Domestic Abuse awareness, Routine Enquiry for all attendees at Emergency Department - this process also includes staff. Improved communication with police, UHB Concern Team, regular meetings with Clinical Boards chaired by the Deputy Executive Nurse Director and UHB People's Services will also factor in the progress made in identifying additional support for staff.

Issues raised with UHB employees relate to allegations made against them by family members, patients or a criminal investigation by police. All employees are notified of the concern raised as appropriate and an immediate risk assessment is completed by the line manager and the People Service Manager (Human Resources) representative to ensure that safeguarding measures are in place. This certifies the protection and support of the member of staff if further allegations are made and gives the UHB assurance that appropriate and proportional measures are in place to protect the public accessing care and services from the UHB. The Head of Safeguarding and the Senior Nurse will provide advice and support to the line manager to achieve a manageable response ensuring that the employee is directed to the well-being service, Occupational Health or General Practitioner (GP) as required.

In the case of commissioned service providers (independent practitioners – GPs, dentists, optometrists, pharmacists), they will be contacted by the Community Director for Quality and Safety/Deputy Clinical Board Director of PCIC, by the Dental Practice Adviser, or Primary Care Optometric Adviser. If the allegation relates to a member of staff as perpetrator, advice will be given to the employer and proportionate measures will be put in place. The circumstances are more complicated regarding Optometric Practices and Pharmacies as many of the practitioners are employed by major multiple organisations (e.g. Boots, Well, Specsavers) as they are guided by their corporate requirements in addition to Health Board expectations.

There has been an increase in reporting nationally of survivors disclosing domestic abuse during lockdown and easing of restrictive measures. Admissions of people and children <18 years of age presenting with mental health or emotional well-being concerns has also increased. This is corroborated in a recent draft report from the Public Health Wales, Violence Prevention Team analysing data.

Audit, Survey, Professional Presentations and Publications

Public Health Wales Safeguarding Maturity Matrix (SMM)

The purpose of collating the information is to assess quality improvement, compare compliance against agreed standards and to demonstrate the learning from incidents and reviews. Organisations completed self-assessments along with improvement plans that were submitted to the National Safeguarding Service to assemble a National picture and to report the findings. The aim being to provide assurance, share practice and drive improvements. Cardiff and Vale University Health Board (C&V UHB) fully participate, drawing on information from across all Clinical Boards to inform the UHB self-assessment and provide a true reflection of the current situation. Overall, the UHB acknowledges that there are always improvements to be made in an ever-evolving field such as safeguarding. Implementing the recommendations is monitored with CBs and reported through the UHB Safeguarding Steering Group. The peer review report demonstrates that C&V UHB is operating in line with other organisations across Wales.

All Wales Domestic Abuse Routine Enquiry for Midwives and Health Visitors

Routine Enquiry (RE) questions asked by Midwives and Health Visitors (HV) relating to domestic abuse has been maintained; this involves specific questions asked twice to women accessing services in Midwifery and once to women accessing services in Health Visiting. The results for 2023-24 are:

Routine Enquiry Asked:	Asked Once	Asked Twice
Midwifery Service	88%	78%
Health Visiting Service	94.3%	Not recorded

In total 10% of the number (513) of birth notes were manually checked in Midwifery to calculate the data.

In addition, 241 positive domestic abuse disclosures were made by women in this period. All survivors were signposted appropriately for expert support and counselling. 76 pregnant women were discussed in MARAC or the high- risk daily discussions during this time period.

The Health Visiting percentage has improved dramatically during this period, this has been achieved through improved reporting mechanisms being implemented. Often HV are unable to ask the RE questions at the birth visit as it is deemed to be unsafe if the partner is in attendance.

Paediatric Emergency Department (PED) Safeguarding Meeting

The Paediatric Emergency Department (PED) Safeguarding Meeting is held weekly and involves multi-disciplinary practitioners. The meeting identifies and highlights cases where additional referral or information is required.

PED experienced recorded 32,059 attendances for the year April 1st 2023 - March 31st 2024 compared to 33,873 for the previous 12 months. A total of 1,619 PARIS notifications were completed by the PED team representing just over 5% of all PED attendances during this period.

An increasing trend is observed in ED attendances since COVID 19 which is partially be explained by the challenges, families encounter trying to access medical services in the community. This is reflected by the number of PARIS notifications completed to Health Visitors and School Nurses to inform them of frequent attenders to the ED (348). The objective is to encourage families to engage with other health services within their local community when seeking medical advice for conditions not considered to be non-emergency conditions.

Following the introduction of the Did Not Wait Pathway in 2022, 10 PARIS notifications were submitted for families who 'self-discharged' without being seen by a clinician. This number is lower than last year which reflects a change in clinical practice whereby the Consultant body are tasked with contacting families who did not wait to be seen in the preceding day as part of their Patient Related Activity.

Children and young people presenting to ED with mental health concerns continue to represent a high proportion of attendances evidenced by the number of referrals made from PED last year for behavioural concerns, overdose or other methods of self-harm. A total of 332 PARIS notifications were made to Children's Services, Health Visitors and School nurses last year (159 cases with OD/Self harm, 166 children with behavioural concerns and 7 presentations of alcohol or substance intoxication). Concerns about parental behaviours or anxiety contributed a further 61 referrals.

The weekly safeguarding meeting remains a feature within the PED governance and Safeguarding Steering Group agenda. A total of 50 meetings were held during this time period. The following table summarises the activity of the meeting:

Injuries <12 months old	542 (521 in previous year)
Fractures <2 years old	70 (64 in previous year)
Thermal Injuries	281 (296 in previous year)
Major Trauma Centre Cases	129 (126 in previous year)
Health Visitor/ School Nurse Referrals generated from this meeting	83
Total Cases Discussed	266 HV and 82 School Nurse notifications 69 MARFS for information sharing 42 VPU Referrals
Total Cases Discussed	1105 (1097 in previous year)

The safeguarding meeting provides a means of assurance that vulnerable children and young people are identified within the PED and referred to other agencies or disciplines appropriately. The annual audit demonstrates PED completes 53% of necessary PARIS notifications after the initial ED attendance with the outstanding referrals completed retrospectively at the meeting. Not all injuries in the under 1 year old population necessarily require Health visitor notification if the mechanism of injury is in-keeping with developmental stage. Safety and appropriate supervision is always considered, however, not all incidents where an injury has occurred mandates a PARIS notification This is the function of the Safeguarding meeting to review such cases. The audit indicates improvements can be made, particularly with regards to notifying Health Visitors of fractures in infants under 2years after initial attendance to ED (23%) as per recommendations from a Child Practice Review in 2018.

ED retrospectively review all children/young people brought to the Paediatric Emergency Department for assessment following major trauma as a governance requirement of the South Wales Major Trauma Network (MTN). Information from PARIS is accessed in order to identify any pre-existing safeguarding concerns for patients who reside in Cardiff and Vale. However, this resource is not available to obtain relevant information for children from other regions across Wales. Therefore, a Multi- Agency Referral Form (MARF) is submitted with the patient's details and mechanism of trauma in order to notify the local Children's Services as a safety net. The function of the MARF should prompt the local agencies to alert C&V Safeguarding team of any historic concerns, or can be recorded without action. The audit demonstrated a MARF was submitted for 64% of Major Trauma Centre (MTC) cases from ED following the initial attendance, indicating a need to remind Paediatric Trauma Team members to submit a MARF for major trauma patients once the patient has been stabilised.

PED submitted 19 MARFS last year for concerns of maltreatment of any child/young person under 16years of age. A further 71 MARF notifications were submitted for information sharing with Children's Services. Indications for the notification include assessment of a 'Child Looked After' or for families consenting for additional support.

A total of 139 notifications for assault were documented on PARIS during this period and subsequently referred to the Violence Prevention Team (VPT). Since August 2023, cases where a young person has attended Paediatric ED following an alleged assault have been incorporated into the safeguarding meeting forum. This provides a means of assurance for potentially vulnerable young people and provide them with the opportunity to engage with the VPT. Referral rates to the VPT following initial presentation to ED are 63%, but more recent observations indicate this trend is improving with increasing awareness of the VPT.

A health team consisting of: General Paediatrician, Paediatric Consultants ED and Professor within Dental have been monitoring responses to children injured in community violence. Children and families have been signposted to services and provided with information on bullying. Improvements to the child's experience following attendance at ED has been demonstrated; however, further exploration is required to effectively share information with police and schools to map areas of concern. The information is currently shared with the School Nursing Service, however, greater links with education is required. A pilot initiative with Action for Children looking at ways of engaging young people and minimising community and school related violence has been delayed; however, this will be explored during this coming year.

New projects to improve ways of working have led to the introduction of the electronic MARF in the ED. Its functionality makes it a much more efficient process



for healthcare professionals to generate a MARF in conjunction with drafting the ED discharge summary. Subsequently, more detailed and meaningful referrals are submitted to MASH. Furthermore, the form is designed to automatically populate patient demographic information from EU Workstation thereby mitigating the risk of human error uploading incorrect details.

Adolescent Safeguarding Meeting

This meeting commenced in September 2018, following a pilot scheme in Cardiff and Vale UHB which gathered the opinions of over 300 children and highlighted that 16 and 17-year olds were seen in the adult ED and not paediatrics. This identified gaps and areas for development. The findings dictated that the aim of the initiative was to 'Improve the Safeguarding processes in the Adult ED and introduce a holistic assessment tool for 16 and 17-year olds. The meeting is held on a fortnightly basis. Attendees are a Consultant and Lead Nurse from ED, Violence Prevention Unit, Safeguarding Team, Department of Sexual Health (DOSH), Children's Rights Advocate/Children's Charter & Youth Board, CAMHS and Child Looked after Team (CLA).

The following are areas which require improvement and additional staff training:

- Only the physical symptoms identified and treated
- Not seen as children
- Safeguarding documentation missing
- Referrals to social services not completed
- Warning signs not noticed (CSE, DA)
- No School noted
- No School Nurse referral
- No signposting
- Missing an opportunity for an intervention

This approach aims to empower staff working particularly in health services, but also partner organisations, to recognise the role they have in promoting healthy lifestyles, supporting behaviour change and contributing to reducing the risk of chronic disease.

A casualty card which incorporates the HEADSS (Home, Education, Activities, Drugs/alcohol, Sexuality and Suicide) and SERAF (Sexual Exploitation Risk Assessment Framework) indicators is used. Questions around these areas are asked when red flag attendances occur.



This table identifies the safeguarding cases:

Total number of adolescent attendances in the period March 2023-April 2024	3210
Number of cases discussed at safeguarding meeting	694
Attendance average with safeguarding needs	21%
Average number of actions required following meeting	18 average actions per meeting
Average retrospective referrals	35%
Retrospective Referrals: Figures in brackets represent the year 2021-22	
Violence Prevention Team	118 (29)
CAMHS Referrals	6 (6)
DOSH	15 (2)
Child Looked After (CLA) Notifications	8 (9)
School Nurse Notifications	37 (17)
Safeguarding Referrals	247 (196)
Emotional Well-Being Team	32 (7)
Drug and Alcohol Services	18 (9)
Total Retrospective Referrals	481 (246)

During this period, DOSH and Cardiff and Vale Drug and Alcohol Service CAVDAS have been attending the meetings in person which has resulted in an increase in retrospective referrals to these services.

Indications highlighted are an increase in overdose since the pandemic. The ED are planning to update the current casualty card which will be used with children >12 years of age. The updated card will also incorporate a red flag alert for children suspected of being trafficked or at risk of Female Genital Mutilation (FGM).

Safeguarding Supervision

The Public Health Wales All Wales Safeguarding Best Practice Supervision Guidance (2018) states that:

“The aim is to provide guidance on the implementation and utilisation of supervision and support within the context of safeguarding. It sees safeguarding supervision as a priority to which staff are actively supported to have the time to attend”

This approach has been adopted with safeguarding children and adults at risk within the UHB.

Practitioners report to their supervisor that the learning element of the session is interesting and effective and that transitional skills are adopted through peer discussion around complex cases. The HV supervision groups are working well. 1:1 safeguarding supervision is also available for newly qualified HVs, long term sickness returns or, by request. Safeguarding Nurse Advisors (SNA) have undertaken additional training with Public Health Wales to prepare for the role of facilitator in group supervision. The C&V UHB Pathway has been discussed with other Health Boards through the NHS Network meeting Work in this area continues with Cardiff University, a PhD Study has been presented and findings evaluated.

Group Safeguarding Supervision is provided to Midwives, Health Visitors (HV), School Nurses, Cardiff and Vale Health Inclusion Service (C&VHIS) Nurses, Department

of Sexual Health (DOSHS), Multi-disciplinary staff in Special Schools and Community Therapists and more recently Child and Adolescent Mental Health Service (CAMHS). Safeguarding supervision is provided to other groups such as doctors and acute nurses as required. The aim of supervision is to support staff, facilitate learning and promote best practice.

Safeguarding Supervision Temporary Arrangement for Child Health based staff

During the last quarter the corporate safeguarding team experienced a period of staff change which temporarily impacted on the resources available to deliver the safeguarding supervision programme. This has caused difficulty with the volume of safeguarding cases generating safeguarding advice and support across the UHB in both children and adult services due to the complexity of the concern. As an interim measure the team have suspended the team group supervision sessions for specific individual teams and introduced as a temporary measure alternative multi-disciplinary group supervision arrangement. Sessions are structured for two hours and consist of individual case discussion and group learning.

Individuals attending the sessions are expected to attend as part of their service agreement, be prepared to engage in the process and be open to share



experience. Individuals will be sent learning resources prior to the session. The learning resources will be discussed at the end of the session

Evaluation questionnaires will be shared with participants following the session. This will enable the changes to be evaluated and any new learning explored. It is anticipated that the safeguarding team will review the new arrangements in place and work towards a return to the previous model of group supervision as soon as possible.

Adult safeguarding supervision is provided by the Senior Nurse for Safeguarding to the HLPs as required and through arranged sessions within each Clinical Board and/or through Development Day sessions. The supervision is ideally provided on a three-monthly basis in group supervision sessions using the same agenda as the children's safeguarding supervision. However, during this period there has been a lapse due to the pressures on staffing. All open adult at risk safeguarding cases are reported to the Executive Nurse Director and Deputy on a monthly basis and discussed at Nurse Director Professional Performance Reviews. Cases involving staff are reported through the bi-monthly Executive Quality and Safety meetings.

"Signs of Safety" training: The training has been shared with the Safeguarding Team and rolled out to some areas within the Health Visitor and School Nurse service to enhance cohesive partnership working with partner agencies and families. The Signs of Safety approach is used in supervision sessions.

Peer Review

Within Cardiff and Vale UHB, medical staff peer review is held on a monthly basis. It is made available to all doctors involved in child protection work in order that doctors undertaking in this difficult area of work are well supported and have the opportunity to receive peer review and clinical supervision in order to feel confident and competent. Pragmatically, the peer review process encourages paediatricians to meet the expected standards and prevents practitioners working in isolation.

Peer reviews are held for suspected cases of physical abuse at St David's hospital; additionally, a separate peer review is held at the Sexual Assault Referral Centre (SARC) for cases of suspected sexual abuse.

The meeting is chaired by the Named Doctor for safeguarding children or the Medical Lead for Sexual Assault Referral Centre (SARC).

Attendance is consistently good. All child protection cases from the previous month are presented to ensure the management of the case meets the expected standard of practice. The process involves review of the medical report, photo documentation and the multi-agency working. It is an opportunity for professional development and learning within an appropriate environment and allows staff to debrief following difficult cases.



Expert Advice

Partnership Working

The implementation of the SS&WB (Wales) (2014) Act and VAWDASV (Wales) (2015) has encouraged partnership working across strategic partner organisations and third sector agencies. Ensuring that compliance, knowledge and awareness raising is understood within each agency has required joined up thinking through shared training and guidance from the Cardiff and Vale Regional Safeguarding Board.

Cardiff and Vale UHB (C&V UHB) has close strategic and operational links with both the Regional Safeguarding Board.

The meeting is attended by the Executive or Deputy Executive Nurse Director, Named Doctor for Safeguarding Children or the Head of Safeguarding. Minutes for the meeting are shared with Clinical Boards through the UHB Safeguarding Steering Group meeting. Sub-groups of the RSB are the Delivery Group, Case Review Group the Training Group is expected to be re-scheduled in 2024.

Meeting the demand of the workflow within Cardiff Multi-Agency Safeguarding Hub (MASH) is a daily challenge for the two Safeguarding Nurse Advisors (SNA) representing the UHB in the MASH. - All agencies within the MASH report an increase in the number of referrals and calls made to the MASH in each consecutive year.

The Cardiff MASH demonstrates valued multi-agency working, it has evidenced respect and an understanding of roles amongst the different organisations and broken-down barriers to working in partnership.

Partnership working is evident in the Regional Safeguarding Board sub groups; agencies are brought together to consider available training resources and to undertake specific audits from Child Practice Reviews (CPR) or Adult Practice Reviews (APR) and develop action plans.

The UHB works in partnership with the Regional Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) group; to ensure compliance with the training programme in line with the Welsh

Government, National Training Framework. The work involves sharing training figures for Mandatory Group 1 training and Group 2. There is the expectation that Group 3 training will be rolled out in the coming year.

The UHB is represented at all Public Health Wales, National Safeguarding Service meetings by the Deputy Executive Nurse Director, Named Doctor for Safeguarding Children and/or the Head of Safeguarding. The meetings bring together Health Boards and Trusts from across Wales, the aim is to maintain standards and to share learning. There are subgroups covering VAWDASV, Training and Child Looked After (CLA). There is representation from the safeguarding team in all meetings, the CLA team attend the sub group for their service.

Female Genital Mutilation (FGM)

FGM is a term used for a range of procedures which involve partial or total removal of the external female genitalia for non-medical reasons. FGM has been illegal in the UK since September 1985 however in 2015 a number of amendments were made to the more recent 2003 Female Genital Mutilation Act through the Serious Crime Act 2015. It is now illegal in the UK to excise, infibulate or otherwise mutilate the whole or any part of a girl or woman's labia majora, labia minora or clitoris (section 1 of the 2003 Act). For a person to aid, abet, counsel or procure a girl or woman to carry out FGM on her own genitalia (section 2). To assist a non-UK person to mutilate girl or woman's genitalia outside the UK (section 3). To fail to protect a girl from risk of genital mutilation while they have responsibility for her (section 3A) and for a UK national or resident to commit or allow any of the above offences to be committed outside the UK. The Serious Crimes Act 2015 placed a mandatory reporting duty on all health professionals to report "known" cases of FGM in under 18-year olds to the police, this duty has been instigated since 31 October 2015.

The All Wales Clinical Pathway for FGM was ratified in July 2016. Work has been on-going within Public Health Wales to update the pathway and a new version was released in March 2022 and is now in use within

the UHB. Specific mandatory training for midwives has been in place since 2014, with approximately 300 midwives receiving the training each year. Additional sessions were introduced to other health professionals through bespoke sessions, an introduction in Level 3 Safeguarding Current Themes and the Level 2 VAWDASV safeguarding training. A continued drive to raise awareness across the UHB has been maintained by the safeguarding team. Midwifery training has been facilitated by the FGM Lead Midwife with additional training across the UHB delivered by members of the safeguarding team. Online FGM training is also available, endorsed by the Home Office; this is accessible to all UHB staff.

Welsh Government requested quarterly updates from all Health Boards across Wales identifying FGM from October 2016 this also included statistics related to number of referrals made to Children's Services where mothers of female children are identified as having experienced FGM. The data collection has since been commissioned to the Violence Prevention Unit and continues to be provided. The reason for referring children to Children's Services ensures that professionals are aware of an increased risk that the female children may experience FGM in the future.



The referral process for suspected or at-risk cases of FGM has been reviewed within the UHB, an example child protection referral is available on the UHB's safeguarding SharePoint (CAVweb), and an FGM Risk Assessment (RA) tool has been added to the Multi Agency Referral Form (MARF) this has been agreed with police and local authority. An increase in recognition has been apparent as a result of the FGM working party training, staff have presented at a South Wales Police (SWP) Conference, BAWSO conferences and the Chief Nursing Officer Conference.

An FGM service model, the Women's Well-being clinic continues across the UHB, the clinic opened in May 2018 following funding secured from the Police for the psychosexual element and from the Iolanthe award. The Women's well-being clinic consists of a service held weekly (1 all day session) within CAVHIS (Cardiff and Vale Health Inclusion Service in Cardiff Royal Infirmary), which is centrally placed for easy access and provides support to victims or those at risk of FGM. The first year saw a total of 147 women referred to the Women's Wellbeing clinic, with 102 young people/women being reviewed in this time. The majority of referrals are from UHW maternity. There are varying reasons for referral including gynaecological and psychological issues with the predominant reason being pregnancy. One family attended clinic to seek refuge due to risk of FGM. Country of origin has been collated with the majority of women reviewed being from the Sudanese community. Self-referrals at the clinic are accepted. The Clinic has completed its fifth year and numbers remained steady. Funding has once again been sourced for a psychosexual service and is due to start shortly. The Women's Well-being clinic has demonstrated a need for this service within the community and is evidenced by the numbers of women that have been reviewed,

Quarter during 2023- 2024	Number of women identified	Child protection referral Made	Mandatory reporting
Q1	17	6	1
Q2	16	5	1
Q3	16	13	0
Q4	16	13	0

future plans include: to continue with the clinic including engaging with the local communities to promote the services within the clinic. Training for community de-infibulation is also being explored as service development. Furthermore in 2023 funding was secured from WG to provide psychological support in Womens Wellbeing clinic for women who have experienced trauma from harmful practices, this service has proved to be an essential addition to the clinic and has resulted in additional funding to provide one full day per week for 2024/2025.

Procedural Response to Unexpected Death in Childhood (PRUDiC) launch of new guidance

The process was first introduced across Wales in 2010 with the aim to *“ensure that the multi-agency response to unexpected child deaths is safe, consistent and sensitive to those concerned and that there is uniformity across Wales”*.

The National Safeguarding Service in Public Health Wales revised the document in 2023. The procedure sets a minimum standard for a response to unexpected deaths in infancy and childhood. It describes the process of communication, collaborative action and information sharing following the unexpected death of a child. The updated procedures refer to children aged 16 and 17 years old and remind all practitioners that the PRUDiC procedures apply in this age group.

The process within the UHB is established; the Head of Safeguarding or Senior Nurse liaises with police to arrange a multi-agency meeting within 48 working hours of the child's death, the meeting is chaired by police, and attendance includes representatives from Children's Services, Education when appropriate, Welsh Ambulance Service Trust, appropriate representation from health professionals involved with the child. The purpose of the meeting is to ensure that there are no suspicious circumstances surrounding the child's death and to make certain that a robust bereavement package is in place for the family.

C&V UHB are fortunate to have Bereavement Nurses that liaises directly with the family and supports them through this extremely difficult time by discussing with them any pathology information, arrangements for visiting the child in the morgue and registering the death. Referrals are made to charitable organisations to support the family long term and a memory box is created. The table below identifies the number of child deaths of children residing in the Cardiff and Vale of Glamorgan locality.

Number of Child Deaths

Period 2023-2024

11 Cases, a further 18 Cases are for children usually residing out of C&V UHB region. The Major Trauma Centre is likely to be the reason for an increase in the figures. Of the C&V UHB Cases, 1 case relates to Young Pearson Suicide

Child and Adult Practice Reviews (CPR and APR)

Guidance for Child and Adult Practice Reviews were updated and came into force from 6 April 2016 following the implementation of the SS&WB (Wales) Act 2014. The guidance is addressed at the Regional Safeguarding Board meetings involving all partner agencies. The purpose of the review is to promote a positive culture of multi-agency child and adult protection learning and reviewing in local areas when there are serious incidents resulting from abuse or neglect, there is a system of multi-agency concise and extended practice reviews. The criteria for child practice reviews are laid down in the Safeguarding Boards



(Function and Procedures) (Wales) Regulations 2015. The outcome is expected to generate new learning to support continuous improvement in inter-agency protection practice.

The process involves agencies, staff and families reflecting and learning from what has happened to improve practice with the focus on accountability and not culpability. This will potentially develop more competent and confident practice, better understanding of knowledge base and perspective of different professional's role and responsibility.

The Head of Safeguarding and Senior Nurse participates in the Regional Safeguarding Board, Case Review sub-group when consideration is given to new referrals and the commissioning of a new review. SNAs participate as panel members to individual reviews and complete a health chronology of each health contact to inform the timeline of events that will notify the reviewers preparing the report once collation of each agency's information has been submitted. Clinical Board representatives are also asked to accompany the SNAs as panel meeting when this is deemed as appropriate to individual reviews.

Recommendations and learning from the reviews will be identified in action plans or from the learning event. Organising a multi-agency approach for the learning event allows professionals to consider the case in detail, reflect on their own practice and to take learning back to each organisation to prevent the same situation happening again. There were no published reviews during this period however, five Child Practice Review are on-going, four Adult Practice Reviews are on-going, a total of seven Multi-Agency Professional Forum (MAPF) are in progress with three completed during this period. In addition, one Single Unified Safeguarding Review (SUSR) pilot commenced and one Offensive Weapons Homicide Review commenced and remain in progress. A total of 10 referrals were received by the RSB during this reporting period.

Domestic Homicide Review (DHR)

Completed DHR	Ongoing Awaiting Publication
9	1 SUSR in progress 1 Offensive Weapons Homicide Review
In Progress DHR	Referrals
1	0

DHRs were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The provision came in to force on 13 April 2011. The Home Office Multi-Agency Statutory Guidance for The Conduct of Domestic Homicide Reviews has been updated in 2016. Domestic violence includes physical violence, psychological, sexual, financial and emotional abuse involving partners, ex-partners, other relatives or household members. A domestic violence incident which results in the death of the victim is often not a first attack and is likely to have been preceded by psychological and emotional abuse. It is likely that many people within agencies may have known of these attacks and circumstances. This can sometimes make serious injury and homicide preventable with early intervention.

A DHR means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect. Similarly, to CPR and APR, the DHR will consider what lessons can be learnt by professionals and organisations to safeguard victims, what change can be identified, update policies and procedures, make every attempt to prevent domestic homicide by improving services to individuals and their children through improved inter-agency working.

Child Practice Review	Adult Practice Review	Multi-Agency Professional Forum (MAPF)
5 CPRs on-going	4 APRs are on-going	7 MAPFs are on-going

The DHRs are commissioned through Partnership Boards in Cardiff and the Vale of Glamorgan localities. Referrals are received from South Wales Police and consideration is given at the Partnership Boards to undertake a DHR. The UHB Executives are formally notified of the commissioning of the DHR; the Head of Safeguarding attends a multi-agency meeting to agree the Terms of Reference for cases.

As with CPR and APR, safeguarding nurses are identified within the team to collate information from each health contact and develop a timeline to inform the DHR report. Representatives from the safeguarding team attend all DHR meetings and participate in the development of the report. There has been nine DHRs undertaken in Cardiff since 2015 and one case in the Vale of Glamorgan. The Welsh Government Single Unified Safeguarding Review (SUSR) pilot has been launched in the Regional Safeguarding Board area during this reporting timeframe. It is anticipated that the SUSR will officially be launched during 2024. The SUSR process will be adopted for all safeguarding reviews to ensure efficiency, continuity and the reduction of duplication reports. This will include CPR, APR, DHR, Mental Health Reviews/ Mental Health Homicide Reviews and Offensive Weapons Homicide Reviews in some circumstances.

The purpose of the SUSR is:

Domestic Abuse

The implementation of the Violence against Women, Domestic Abuse and Sexual Assault (Wales) Act 2015 has seen a change in the referrals, training and width and breadth of the domestic abuse agenda within the UHB as indeed across Wales. More recently the Domestic Abuse Act 2021 has contributed further to this agenda.

The Regional Multi-Agency Domestic Abuse Strategy for Cardiff and Vale of Glamorgan continues to incorporate a plan to address service need and training actions across the locality of Cardiff and Vale of Glamorgan council area. Welsh Government (WG) has provided guidance for all organisations to consider a five-year plan to meet the National Training Framework expectations to raise awareness with all employees within each organisation. Different levels of training are identified with compliance within each organisation expected to be at 100%. No additional resources have been identified by Welsh Government to achieve this target.

The UHB has provided WG with a forecast of the number of staffs completing training over the next five years. During the period April 2023 to March 2024 the Health IDVA (Health Independent Domestic Violence Advisor) has continued to raise awareness of domestic abuse and raise the profile of the IDVA role within the UHB. In line with the Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV) (Wales) Act 2015 the Health IDVA has continued to deliver VAWDASV, Group 1 training which is mandatory for all staff. In addition, The UHB Safeguarding Team also continues to deliver group 2 training in line with the Welsh Government National Training Framework. There is a requirement within the VAWDASV Act that all professionals working with the public in any capacity must undertake this additional training. A broad estimate of 11,000 staff within the UHB will be expected to complete this training, 411 staff were trained within the UHB during this period. There are also plans for Group 3 VAWDASV Training to commence in 2023/2024 in line with the National Training Framework, all staff who attend will be recognised as 'Ask and Act' champions. The Health IDVA has also continued to provide ad hoc awareness raising sessions to departments as and when required including within the Emergency Department.

The UHB is fortunate to now have two permanent Health IDVA positions. During the reporting period, the Safeguarding Team successfully secured additional external fixed-term funding for another Health IDVA post. This demonstrates a positive recognition from the UHB of the need for increased funding in this area. The value of a dedicated health-based IDVA has been acknowledged by other health boards, with Health IDVAs now in place at Aneurin Bevan, Swansea Bay, Hywel Dda, and Cwm Taf University Health Boards.

As an organisation we continue to support the White Ribbon Campaign. Several ambassadors and champions within the UHB have completed online training within their roles and departments to promote awareness and support for patients experiencing these types of abuse. White Ribbon events and awareness raising is delivered annually

In addition to providing training and raising awareness the Health IDVA continues to provide support to survivors of domestic abuse. During the period April 2023 to March 2024, 862 Ask and Act (A&A) referrals were received. This has shown a continued high volume

of referrals with an average of 72 per month which is in line with the average of 52 per month in 2023-2024. Following these referrals, safety planning has been completed with 394 clients either by telephone call or face to face, with an additional 100 of these referrals already engaged with community domestic abuse services. In cases where contact is made, individualised safety plans have been developed with support including: safety plans in hospital, markers and security measures on properties, assistance to report to the police, support at Court, Clare's Law Disclosure requests, signpost referrals for counselling and referrals to specialist support services are completed. Furthermore, 12 clients have been supported to access refuge/emergency accommodation directly from hospital. Of the 862 referrals received 193 declined support. In cases where support is declined or contact is unsuccessful safety planning is completed as far as possible. This will include completion of MARAC referrals on professional judgement where required, ED Domestic Abuse markers and updates to involved staff and GPs with requests to re-visit discussion around domestic abuse support.

Of the 862 referrals received 287 have been assessed as high risk of domestic abuse by the Health IDVA service or police. In addition, the Health IDVA has made 87 referrals to MARAC.

Following the introduction of Domestic Abuse Routine Enquiry in the Emergency Department in 2020 in response to the COVID-19 Pandemic, Routine Enquiry has continued to be promoted within ED.

Domestic abuse and other forms of violence can impact negatively on an employee's health and wellbeing and staff morale. The Health IDVA supports staff members experiencing domestic abuse and within the reporting period has received 54 referrals for staff members. The number of staff members being supported by the Health IDVA team continues to increase year on year. The Health IDVA has supported the staff members by completing regular risk assessments and working in a client led way to develop safety plans for them at home and in work. This includes working closely with managers, the UHB Health and Safety Team and UHB Security.

The table below demonstrates the sustained high numbers of positive disclosures:

Month	Total number of Ask and Act referrals	Positive Ask and Act referrals	Ask and Act referrals from other departments within UHB	Ask and Act referrals with disclosures from ED	Ask and Act referrals with non-disclosures from ED
Apr-23	255	53	17	36	202
May-23	341	90	25	65	251
Jun-23	217	93	24	69	124
Jul-23	304	78	29	49	226
Aug-23	167	71	26	45	96
Sep-23	336	71	18	53	265
Oct-23	366	76	26	50	290
Nov-23	316	62	19	43	254
Dec-23	232	65	17	47	168
Jan-24	554	74	21	53	477
Feb-24	158	69	14	55	89
Mar-24	233	67	26	41	166

Police and Crime Commissioner Funded Project for: Young Person Independent Domestic Violence Adviser. The first in Wales.

The Police and Crime Commissioner has provided funding to Cardiff and Vale University Health Board (C&VUHB) to commence an exciting project for the first health, hospital based Young Person Independent Domestic Violence Adviser (YP IDVA) service, which commenced in November 2022. C&VUHB identified the need for skilled domestic abuse practitioners within the UHB that are able to respond to any disclosure of Domestic Violence or situations around possible unhealth relationships from young people accessing Hospital Services.

Whilst the legal definition of domestic abuse covers those aged 16 and above, we recognise that children under 16 years are disclosing abusive behaviours within intimate and familial relationships and support is currently limited in this area.

The project aim is to support young people presenting at Emergency Department in the first instance between the ages of 11 -17 years old who have:

- Witness of Domestic Violence within the Household
- Victim of Sexual Violence
- Indicators of Sexual Exploitation
- Honour Based Violence

The Domestic Abuse Act (2021) reinforces and recognises that children who see, hear or experience domestic abuse, are victims in their own right.

The aim of the role is to deliver specialist advocacy and high-quality support, to those highest at risk of domestic abuse, relationship abuse and sexual violence, helping young people to be safe from harm and develop their understanding of healthy relationships. The role is the first of its kind within Wales and funding has been secured for 3 years.

Some important aspects of the role include:

1. Information and Communication – Timely and accurate information and age appropriate communication is key to meeting young people's needs.
2. The Child's Voice – Victims want to be listened to and their views and needs taken seriously.
3. Support – The support for victims should always be of a consistently high quality and accessible to all.
4. Specialist Support – Recognition that many victims need access to specialised support.
5. Accountability – Victims should be confident that they will receive the services to which they are entitled.

Statistics collated from November 2023 – April 2024:

- 159 Referrals (Young People aged 11 – 17 years) a significant increase from 34 in 2023

Referrals are generated directly from Emergency Department (ED) attendance at UHW. The service has now expanded to cover the children's wards in the Noah's Ark Children's Hospital, UHW.

It is imperative that the Health based YP IDVA service continues to embed itself within the UHB and continues to grow and develop. Routine Enquiry will continue to be promoted within the ED. Furthermore, awareness of Ask and Act (for 16-17-year olds), the completion of the Health YP IDVA referral form (for 11-15-year olds) and the Health YP IDVA role will continue to be promoted across the UHB. This will be achieved through regular training to staff members.

Violence Prevention Team (VPT)

This multi-agency project launched in October 2019 in Cardiff, hosted by the Wales Violence Prevention Unit (VPU) and funded by the Home Office. Cardiff and Vale University Health Board (UHB) were invited to be part of the unit as the Emergency Department (ED) is situated in the University Hospital of Wales (UHW), which is one of the biggest and busiest in the United Kingdom. Every year thousands of people find themselves within an ED as the victim of serious violence (National

Violence Surveillance Network 2019). The Violence Prevention Team (VPT) consisting of two staff members, a seconded qualified nurse and an advocate embedded alongside clinicians and trauma practitioners within the ED at UHW. This is the first model of its kind in the UK. Together the VPU comprises of members from South Wales Police, the Police and Crime Commission, Public Health Wales, Her Majesty's Prison and Probation Service, Home Office Immigration and Third Sector support services. Together they take a Public Health approach to prevent all forms of violence across Wales.

The health team based within the ED meet with patients of any age attending with Violence with Injury (VWI). Initially the project concentrated on knife related injuries, however this expanded to include all violence which incorporates Domestic Abuse. The health team approach the patient to provide support, advice and guidance as soon as it is appropriate. The focus is on building a rapport, providing personalised, holistic and integrated support, enabling patients to make informed decisions. The aim is to enable empowerment to improve the patient's well-being and then encourage patients to make informed, long-term positive plans to break away from cycles of violence. With the patients consent the team will refer to external agencies, for continued support in the community, if required following hospital discharge.

Violence Prevention Team Training

The VPT training is developed and delivered by its members in a variety of methods, including classroom-based presentations, drop-in sessions, 1:1 on the spot teaching, and recorded/online sessions. ED teaching sessions are arranged by the Emergency Unit Practice Educator often during the departments study days. All levels of staff within the department have received some form of training, including reception staff, doctors and nurses since October 2019.

It has become apparent, that due to staff rotation and turnover of staff within the department, education sessions need to be consistent and regular. The team are also visible in ED to answer staff questions and encourage engagement.

ED staff education entails:

- Raising awareness of the service and its provisions
- Identifying the VPT referral pathway
- Use of referral forms and processes
- Reporting of all knife related admissions
- Encouraging paediatric referrals
- Encouraging all safeguarding measures are met.

The team has also conducted educational sessions on the Level 3 UHB Safeguarding study days. Including the Current Safeguarding Themes full day training, since November 2019, reaching a variety of different UHB staff members.

Raising awareness has been a key part of the VPT, and contributes to the quality of service that the team provide. Within the UHB the team has liaised with other specialities, such as Major Trauma, Poisons, Drug and Alcohol Liaison Nurses and Psychiatry. The VPT have provided training and support to specialist nurses and health care assistants working in the Major Trauma Centre (MTC), and have developed a clear, robust referral mechanism between the MTC and the VPT. The VPT have recently developed a training package for the Radiology Led Discharge Team to support them in their new role within the ED.

The VPT have developed a number of service links externally to the UHB with both statutory and third sector agencies. Since the beginning of this project, work with third sector agencies have assisted, developed and enhanced the service now being provided to ED patients. Work streams have been formed allowing the team to make seamless referrals into these services; continuing support for patients from hospital and into the community. To develop external links, the VPT has presented at the Serious Youth Violence in South Wales Seminar outlining their role to a wider range of professionals and developing new operational networks. The VPT have also joined the National Violence Reduction Network, which is a bi-monthly meeting of violence reduction specialist sharing knowledge, practice and learning.

Patient Outcomes: April 2023 to March 2024

Knife Related Injuries	106 patients	65 engaged	52 accepted ongoing support after discharge
Violence Related Injuries	940 patients	607 engaged	323 accepted ongoing support after discharge
Self-Harm Punch Injuries	70 patients	39 engaged	25 accepted ongoing support after discharge
Retrospective MARFS or AS1 submitted	347 patients		

Evaluation

The Violence Prevention Team has worked with Public Health Wales since 2021 to evaluate the programme and services provided. The primary objectives of the evaluation are:

1. To understand the role of the NHS Violence Prevention Team (VPT) in supporting victims of violence-related injury;
2. To assess the efficacy of the VPT in addressing the needs of patients and preventing future violence related injuries;
3. To assess the effectiveness of the implementation and delivery of the VPT within the ED, and identify any developments to further enhance the role of the team;
4. To explore the value of the VPT, and consider sustainability of the model, potential for scale up, and roll-out of the intervention to other health settings in Wales.

Due to the positive outcome from the VPT evaluation, additional funding has now been provided by the Home Office to expand the VPT and develop a similar provision in Morriston Hospital A&E. The C&V VPT are working to support this team and assist them in their development.

CONTEST

Contest is the UK Government's counter-terrorism strategy. It's based on 4 themes:

- Prevent: to stop people becoming terrorists or supporting terrorism
- Pursue: to stop terrorist attacks happening
- Protect: to strengthen our protection against a terrorist attack
- Prepare: to minimise the impact of a terrorist attack

PREVENT is designed to tackle the problem of terrorism at its roots.

The aim of Prevent is to stop people from becoming terrorists or supporting terrorism. Prevent work also extends to supporting the rehabilitation and disengagement of those already involved in terrorism.

The objectives of Prevent are:

- tackling the ideological causes of terrorism
- intervening early to support people susceptible to radicalisation
- enabling people who have already engaged in terrorism to disengage and rehabilitate

The UHB Safeguarding Team, working directly with the Head of Emergency Preparedness Resilience & Response (EPRR) have developed a UHB referral pathway for UHB employees to follow when they have a concern that a service user or a member of staff maybe at risk of radicalisation.

Training in this area is disseminated to UHB employees via a workshop designed to help make staff aware of their contribution in preventing vulnerable people from being exploited for terrorist purposes.

The Safeguarding Team play a key role in this agenda, working closely with Clinical Boards and the UHB EPRR Team. The UHB are expected to report the number of staff attending the workshop to Welsh Government on a quarterly basis.

A small working group from the safeguarding team, the EPRR team and a practice educator from Emergency Department have an on-going annual work plan to ensure that the Prevent Awareness training is delivered to key groups working with members of the public and/or families in the community.

The UHB are working in collaboration with partner agencies to comply with the Department of Health and Social Care NHS PREVENT training framework (September 2022). The Strategic planning team will be introducing a training programme for champions across each Clinical Board and Corporate teams to share awareness and knowledge across the UHB.

The Corporate Safeguarding Team and the UHB EPRR team attend the monthly, multi-agency Channel Panel meeting where cases of potential concern are discussed for information sharing purposes.

Contextual Safeguarding

The contextual safeguarding agenda continues to evolve within adult and child safeguarding practices. Contextual safeguarding seeks to identify and safeguard young people and adults at risk against abuse not just within the home but within the wider environment, this is termed extra-familial abuse (Firmin 2017). Contextual safeguarding seeks to identify how professionals can safeguard children or adults at risk on a wider scale within the community. The way in which individuals can be safeguarded is to disrupt the environment where the abuse is occurring. Contextual safeguarding is important as family members have little influence over these contexts, the only way to access these contexts is through interagency working. Examples of contextual safeguarding are as follows:

- Criminal exploitation/county lines/sexual exploitation
- Peer on peer abuse
- Radicalisation
- Modern Slavery
- Trafficking
- Online abuse

Within the UHB this means increased multiagency partnership working to share information and establish innovative actions to safeguard individuals or a group of individuals within the community. High risk panel meetings within Cardiff driven by Children's Services, have been established to help address contextual safeguarding, these meetings take place once weekly, the SAFE model within Cardiff region has been introduced. Young people aged under 18 years are referred into the high-risk panel meeting that are

identified as being at imminent or high risk of serious harm. The high-risk panel identifies risks outside of the family home within the community. The safeguarding team have been involved in attending high risk panel meetings to share information and jointly agree a risk management plan with agencies such as children's services, youth offending services, adult services, police, children's services legal team and education. These meetings are complex and at times a group of young people at risk are discussed where there can be numerous risk factors present.

Child Sexual Exploitation continues to be a priority for Welsh Government, Regional Safeguarding Children Board (RSCB) and the National Safeguarding Service team in Public Health Wales. A National action plan has been introduced to ensure that all statutory agencies and Third Sectors consider how to Prepare, Prevent, Protect and Pursuit (police) will be driven through each organisation. The RSCB endorsed a CSE Strategic Group to consider the prevalence of CSE across Cardiff and the Vale of Glamorgan by undertaking a mapping study and each agency identifying the training that is delivered and sharing the resources available. This challenges the effectiveness of the activity undertaken by the Board to safeguard and promote the welfare of the children who are at risk of, or being harmed by, child sexual exploitation across the region. This is particularly pertinent as a Child Practice Review Multi-Agency Professional Forum presented a CSE case in 2016 whereby a number of children were exploited by the same perpetrator. -

Within the UHB an increase in the workload associated with CSE has continued during 2023-24 following the introduction of additional staff in Children's Services and police to tackle the growing problem in Cardiff. This has led to regular weekly CSE, multi-agency safeguarding meetings (MASM), strategy meetings for individual children suspected to be at risk of CSE. Previously health professionals involved or working with the age group, such as school nurse, Department of Sexual Health (DOSH) or Children Looked After nurses, Sexual Assault Referral Centre (SARC) nurses and Paediatric Emergency Department nurses would attend these meetings. Following a scoping exercise conducted by C&V UHB safeguarding team between October 2022 to December 2022 it was established that a safeguarding nurse advisor would attend CSE multi - agency

strategy meetings as health board representatives due to the complexity of the cases and the necessary expertise SNAs have in terms of multiagency working and resources which are available within health. This in turn will continue to reduce the risk to the most vulnerable young people in our locality. This also proved beneficial due to the team being involved within the wider contextual safeguarding meetings and ensuring systematic documentation of the meeting outcomes and actions on PARIS (patient electronic records) in order for Health Board staff working directly with the young person to be fully informed of the outcomes. As with all strategy meetings held through the Wales Safeguarding Procedures (2019), a plan is implemented to support the child and an attempt made to prevent the child from risk of harm through abuse or neglect. In an attempt to reduce the risk associated with this type of abuse, alert flags in Emergency Department at University Hospital of Wales are placed on identified children and young people, considered to be at risk.

Adults at Risk who are identified as potential victims of contextual safeguarding are discussed in multi-agency strategy meetings led by the Local Authority. The initial referral may be generated and submitted by health staff following an attendance at ED, admission to hospital or a disclosure to a staff member. Health staff are trained as part of mandatory safeguarding training to consider professional curiosity if any potential indicators are evident.

National Referral Mechanism (NRM)

The National Referral Mechanism (NRM) is the framework for identifying victims of human trafficking and modern slavery. Cardiff and Vale UHB Safeguarding team are part of a pilot programme which began in June 2021 with 10 sites across the UK however, between February and April 2023 the sites have increased to 20 pilot sites. The outcome of NRM referrals for children currently residing within Cardiff are no longer decided by the Home Office this has been devolved to a localised multi-agency decision, core panel members are Police, Children's Services and Health. The Single Competent Authority - Home Office will review decisions as part of the pilot, it operates a two-stage decision making process, decisions are made within 45 days to determine whether a child is a victim of Human Trafficking and/or Modern Slavery.

There is a newly developed Safeguarding Adolescents from Exploitation (SAFE) model in place within Cardiff introduced by the Local Authority Children's Services. This model has established additional multiagency meetings to share information and discuss strategies to obtain a multiagency response to contextual safeguarding risks.

High Risk Panel Meetings have been established as part of the SAFE model, Cardiff and Vale UHB Safeguarding team have been representing health at these meetings the meetings take place weekly. The purpose of the panel meetings is to discuss children/young people that are considered at immediate risk of harm in relation to contextual safeguarding, these involve complex criminal exploitation and child sexual exploitation cases. The meetings aim to establish if a young person is at high risk of exploitation and to maintain oversight of the case. Involved agencies jointly agree a risk management plan and have a collective responsibility. Agencies will look at a form of disruption for the individual or group of young people that are being exploited. Many of the young people discussed, have difficulties with engagement, are frequently deemed as missing. This often requires ongoing strategies to try and locate and engage with the young person. We have approximately three to four high risk panel meetings taking place weekly.

SAFE Locality Operational Groups is a further multiagency meeting that has been developed as part of the SAFE model. A pilot for this group has been taking place within North Cardiff. The health Violence Prevention Team (VPT) represent health at these meetings. The group involves a wide range of professionals within the area – head teachers from local schools, local police in the area for example - PCSOs, children's services managers in the area, Media Academy Cymru, Neighbourhood Housing, Early Help, PA Service. The purpose of the operational group is to focus on areas of concern within Cardiff and share information amongst agencies. Information and local intelligence relating to contexts/locations where harm is being seen within the area is shared with partner agencies and information on peer networks. The group discuss strategies to disrupt the context/environment that the abuse is taking place.

Panel meetings held since April 2023 to March 2024 which has safeguarding nurse present as a decision maker include:

Referrals	Year
2022-2023	70
2023-2024	100

Modern Day Slavery

The Modern Slavery Act 2015 outlines frontline staff responsibility to identify potential victims of modern slavery and human trafficking, refer potential victims and ensure that victims have access to services to which they are entitled. UHB employees are identifying victims and are following the Multi-Agency Response Pathway for suspected cases. Human Trafficking Multi-Agency Risk Assessment Conferences (HT MARAC) are held in Cardiff on a monthly basis, the Safeguarding Team represent the UHB at the meeting. Training for Modern Slavery is incorporated in to the Level 3 Current Themes (adult) Study Days provided by the Safeguarding Team. The training is available for UHB and GP employees.

County Lines

County Lines is a national issue that poses a significant threat to communities and exploits the most vulnerable members of society. Vulnerable local residents will be exploited, coerced and forced to participate. Their properties are targeted and occupied (cuckooing); vulnerable people including children are groomed, intimidated and/or threatened into transporting and hosting drug related activity. The emerging themes for children and adults at risk with this activity is exploitation and abuse in all its forms, human trafficking and any associated criminal action.

Information and training have been shared by South Wales Police (SWP) to raise awareness of the growing issue identified as County Lines. Resources have been provided to partner agencies, to cascade training within their own organisations to frontline staff who are likely to see people presenting with injuries or sickness associated with the culture and crime surrounding County Lines.

The nature of any person presenting at C&V UHB is likely to be a child under the age of 18 years old or an adult deemed to be vulnerable. The threat linked to County Lines is not only a drug problem but is exacerbated by how the criminality is carried out. SWP are reporting an increase in knife crime connected to the gang culture.

Bespoke training from the safeguarding team has been provided to specific areas within the UHB most likely to come into contact with county lines activity - these areas include ED, Maternity Unit, Mental Health, GPs, DOSH, HVs and school nurses. This has informed and reinforced existing reporting arrangements to ensure raised awareness and cascading of information to all UHB staff to be alert to this emerging phenomenon. The safeguarding team are working with police and social services to provide assurance that the effects of county lines activity is addressed by health services.

Deprivation of Liberty Safeguards (DoLS)

The Cardiff and Vale UHB DoLS team operate the supervisory responsibility on behalf of Cardiff and Vale UHB, Vale of Glamorgan Council and Cardiff Council through a Partnership Management Board consisting of senior representatives of each supervisory body. The DoLS team provide advice to Care Homes, hospital wards and Health and Social Care staff across the sector in relation to Mental Capacity Act (MCA) and DoLS.

The UHB refers, on average, 20 requests for authorisation per week however, a high proportion of DoLS requests are withdrawn within health due to a number of reasons including: the patient regaining capacity so authorisation is no longer required, the patient may be discharged before the assessment process is complete or sadly, due to the patient's death. Additional funds have been put towards DoLS assessments for the last year to increase assessment capacity and to try and improve timescale for assessment.

Since January 2024 it has been agreed that the Vale of Glamorgan Local Authority will be responsible for this post going forward, as the hosting organisation. DoLS/MCA training is to be delivered by the UHB's MCA team. The training is incorporated into existing safeguarding training however, bespoke sessions are also provided to individual wards, dietician's and physiotherapists as requested.

Liberty Protection Safeguards

On 5 April 2023, it was confirmed that the UK Government had announced their intention to step away from the introduction of the Liberty Protection Safeguards (the LPS) and the implementation of the Mental Capacity (Amendment) Act 2019 (the 2019 Act). UK Government confirmed that the necessary legislation to implement the LPS would not be brought forward within this Parliament. Welsh Government voiced their deep disappointment with this decision not to proceed with implementation at this time; outlining that the right to liberty is one of our most fundamental human rights.

Despite this, the Welsh Government have committed to continue to provide funding to promote improved awareness and understanding of the Mental Capacity Act (MCA) and strengthen the Deprivation of Liberties Safeguards (DoLS) system in Wales.

Mental Capacity Act

Following the appointment of two full time Mental Capacity Specialist Practitioners a significant amount of work has been undertaken to identify the needs of the UHB to strengthen the MCA application in practice and ensuring effective safeguard of patients accessing services and care across the UHB region. Over the last year, the team has carried out an MCA Scoping Audit to identify issues and areas of good practice. This will support the team vision for the future and will assist in identifying areas for improvement.

Mental Capacity Act training at Level 1 and 2 is available through Electronic Staff Records (ESR) and forms part of the mandatory training requirements for staff depending on their role. Level 2 classroom-based training is available to all staff on a monthly basis and rotated between UHW, UHL and Teams. Bespoke sessions for clinical areas are also available on request. This has now been supplemented with the introduction of a new training module 'Practical Application of the MCA: How to assess and support decision making'. This is a half day course designed to help staff develop their practical skills and apply theory into practice.

Due to the funding available from Welsh Government, the MCA Team have been fortunate to be able to commission external training through Edge Training Ltd

which looks at how to assess decision making capacity and make decisions, following the best interests process. The training has been targeted at registered professionals, with a total of 743 staff receiving the training across all disciplines.

In addition, 17 staff have now been funded to undertake an MSc module provided by Swansea University entitled 'Assessing Decision Making Capacity'. The aim of this module is to provide high level knowledge and expertise in carrying out complex mental capacity assessments. Staff who have completed this course are expected to become part of a mentor supervision network to provide support to staff carrying out mental capacity assessments, stay up to date on developments, highlight issues of concern and act as a link with the MCA Team.

Awareness of the MCA and its principles has been raised through the development of posters and leaflets for staff and patients. The MCA Team have also been attending Quality and Safety meetings to highlight the work of the team and outline the support available for staff.

The MCA team aim to expand on this work in 2024/25 and add training topics such as : Safeguarding and the MCA, Self-Neglect and the Court of Protection.

Sexual Assault Referral Centre (SARC), Ynys Saff

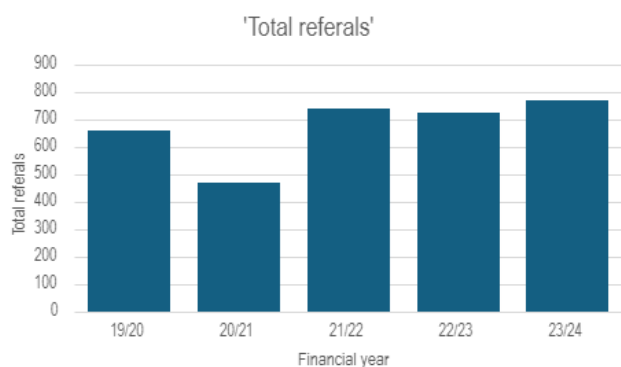
Sexual Assault Referral Centre (SARC), Ynys Saff Cardiff and Vale UHB hosts Ynys Saff, the multi-agency Sexual Assault Referral Centre (SARC), in Cardiff Royal Infirmary. The service delivers a comprehensive quality service for victims of sexual assault for adults and children in Cardiff and the Vale of Glamorgan. Ynys Saff remains the South Wales Paediatric Hub, offering a provision for children across South and Mid Wales region who are victims of an acute assault. The Regional SARC Hub and Spoke model continues to be developed and Ynys Saff is now the main acute SARC Hub for the South East area for Wales, with most forensic medicals now being seen within Ynys Saff, rather than in Risca or Merthyr SARCs. This ensures that as we move towards ISO accreditation, forensic medical examinations all take place within facilities that meet the stringent forensic standards. Ynys Saff sits within the governance framework of the Children and Women Clinical Board.

ISO accreditation

Work has been completed to create and update forensic suites to allow forensic medical examinations in line with ISO accreditation. The ISO accreditation work continues at pace, with hope to meet all standards required by October 2023.

Referral Data

Total referrals have remained high following a decrease over the lock down periods of 2020/2021. Numbers will be expected to rise further over the 2024/2025 years as acute forensic medical for adults are now being performed within Ynys Saff as the regional Hub and spoke model is implemented.



Paediatric Data.

54 children up to the age of 14 have been seen for sexual assault medical examinations over the past year by pediatric clinicians, with 41 of these being acute forensic medical examinations accompanied by a forensic medical examiner.

Support Services.

The service continues to provide interview facilities for the police.

Independent Sexual Violence Advocate (ISVA)

Due to the decision by the Police and Crime Commissioners Office to recommission the ISVA service within South Wales, Gwent and Dyfed Powys Police force areas, a tender was put out and New Pathways

won the bid. As a result, Ynys Saff will be losing the health run ISVA service. ISVA staff currently based in health, will transfer to New Pathways Third Sector. The ISVAs will commence employment on the 1st July with New Pathways, however, the TUPE consultation process is still ongoing and this could be subject to change.

Counselling

Waiting time for counselling at present:

Adults: 12 weeks for phone/Attend Anywhere and face to face counselling

Children: 10 weeks for phone/Attend Anywhere and 16 weeks for face to face

A review will be commissioned into counselling services by the regional programme for a service model paper to be submitted to the WSAS Programme Board, so there is a possibility counselling services in the SARC will also change.

Sexual Health

Ynys Saff continue to work closely with the Department of Sexual Health, ensuring all options are offered to the client to meet their health needs. ISVAs attend the Sexual Health Safeguarding Meetings to update on any concerns and for the sharing of information for vulnerable clients. It is not known whether this will still occur following the recommissioning of the ISVA service.

Regional SARC developments and Welsh Sexual assault services (WSAS)

Ynys Saff are now receiving Risca out of hours cases Monday to Friday and it is hoped that weekends and Bank Holidays will be facilitated by the end of June. This will complete the Regional plan to convert Ynys Saff into a Hub. There has been no update from Welsh Government regarding the Outline Business case for the wider CRI development.

Ynys Saff SARC continues to host the interim Paediatric regional service for children across the whole of the South and Mid Wales region. During this period 54 children under the age of 14 years were seen for sexual assault medicals within Ynys Saff. This remains a vast under representation number of children who are

experiencing sexual assault, and work is continuing to work with multiagency teams to increase disclosures and ensure clear pathways are in place to ensure all medical needs are met. The interim model offers five afternoon clinics (Monday to Friday) with provision for:

- Acute service for children and young people up until their 14th birthday who may have experienced rape or sexual abuse
- Historic cases requiring a medical assessment of children residing in Cardiff and Vale UHB, and Cwm Taf Morgannwg UHB.

Regular peer review is held within Ynys Saff for Paediatricians. A regional remote peer review should be able to launch this year once we have approval from information governance teams.

The Out of hours services remains a high-risk area of service as it has not yet been possible to launch the regional out of hours rota. 6 out of the 8 clinicians required are identified. Funding has been secured. The issue has been escalated to the medical directors for wider regional support. There are ongoing efforts to identify interested clinicians from allied professions such as GPs, and to look at addressing any training needs.

The paediatric SARC facilities are due to be completed in the coming months and funding is in place to build the workforce for that hub.

Children Looked After Team

Children Looked After represent one of the most vulnerable groups of children in modern society. It is well evidenced that these children and young people have adverse health outcomes owing to their early life adversity. Cardiff and Vale UHB have both corporate parenting responsibilities as well as statutory obligations to perform health assessments aimed at identifying unmet health needs, improving health outcomes and reducing health inequalities.

Within 5 working days, the UHB should receive notification from the Local Authority that a child has become looked after. The initial health assessment must be completed within 28 days of the child entering care with review assessments required

annually for children over the age of 5 years, and 6-monthly for children under 5 years of age. A small but dedicated team of staff are employed to fulfil these requirements. Following several audits and case load reviews the team have positively recruited to the specialist nurse roles resulting in a total of 6.2WTE nurses. The nurses care for all children looked after over the age of 5 years.

The team have introduced a pilot scheme whereby 4.2WTE health visitors manage caseloads of children looked after under the age of 5 years. They deliver the Healthy Child Wales Programme and any additionality depending on acuity and the need of the child and family. In addition, the health visitors undertake the review health assessments 6 monthly for this youngest cohort. If a child moves home or placement they remain with the same health visitor ensuring continuity of care and continued communication is maintained. Cardiff and Vale are the first Health Board in Wales to consider provision in this manner which has had a positive impact on the health assessment compliance and continuity of care.

Vacancies remain within the medical team for looked after children, adoption and fostering which is having a significant impact on both children where adoption is being considered as in their best interest for permanency and for adult health assessments in adoption, fostering, kinships and special guardianship.

There has been a consistent increase in children in care in Cardiff and the Vale of Glamorgan rising from:

2017	840
2022	1,275
2023	1,469
2024	1,578

Of these 160 children were under adoption regulations and 379 are placed outside of the Cardiff and Vale area. It is clear that whilst the numbers are increasing, the complexity of the cases and difficulties faced by these young people are also rising.

Historically, as a city of sanctuary, Cardiff and Vale UHB have always received unaccompanied asylum-seeking children who fall under the remit of Children Looked After being cared for by the Local Authority. The

introduction of the National Transfer Scheme across Wales has resulted in Cardiff and Vale UHB receiving 63 unaccompanied asylum-seeking children. No additional resources have been received to meet this increased demand.

In addition to the health needs of the children and young people, the paediatricians are responsible for reviewing the health needs of all adults applying for positions as foster carers, kinship carers and adopters and attending adoption and fostering panels.

Learning Disability

Learning from three Serious Incident reviews in 2015 and a Safeguarding an Adult at Risk case in 2016 highlighted the need for service improvements required for Learning Disability (LD) patients within the UHB. Progress has been made to improve the quality of care provided to patients with LD. This has been achieved through the “1000 Lives” care bundle launch and implementation development of a “flagging” system of immediate alerting across acute areas, modification of NEWS escalation of deteriorating condition response, risk assessment of immediate need and reasonable adjustments required to care. 250 resource files giving staff advice on implementing the care bundle has been obtained and distributed across Adult, Mental Health and Children and Women service areas. In addition, a daily Business Intelligence System (BIS) report gives notification of all in-patients with LD allowing prompt review of this vulnerable group. There is also a weekly report of mortality within LD patients, allowing level 2 mortality reviews to be chased for learning. Easy read qualitative feedback questionnaires are automatically sent out to patients with LD and also to family and carers after an admission or an outpatient appointment in order to enable learning has been introduced.

The launch in November 2018 of UHB LD Champion Roles, identified staff from all wards and departments to take the lead and raise awareness within their clinical area. Over 150 staff have been trained to date, training is provided on a six-monthly basis (COVID-19 permitted). This will enhance dissemination of available resources and share good practice across the breadth of C&V UHB. An additional Level 3 Safeguarding Themes (Adults) training session incorporates information for

practitioners, this event was launched in November 2019. We have worked with Hijinks Drama Company to produce 4 film clip learning from real life situations which challenge staff to appropriately care for patients, with LD. The UHB continues to work in partnership with Swansea Bay Health Board for LD services that are commissioned in community settings. In addition, we now have two UHB Acute Liaison Nurses since June 2020. The posts support all areas with training and advice when individuals with LD are admitted to hospital. The post was identified as a priority within the joint LD commissioning strategy developed for the region. The priorities also include the progression of LD primary care liaison targeted at raising awareness and training on management of individuals and to improve the uptake of an annual health check. An action plan to progress work in this area is in place, both Cardiff and Vale of Glamorgan Local Authorities as well as the UHB are committed to this workstream.

Since the service began in April 2020, 256 employees have been trained in this area of work.

Two Band 2 Health Care Support Workers are employed on a full-time basis within the UHB via RPB utilising Regional Integration Funding. Both individuals have a learning difficulty and they provide invaluable support to Learning Disability Services bringing lived experience and quality assurance from a patient focus. Their remit is to explore ways to improve services, and share their lived experiences. They work closely with the Clinical Leads and the Hospital Liaison Nurses and have been co-facilitating delivery of Learning Disability Champions training and have broadened their reach across all health services. In 2023/24 they have reached 508 professionals and 255 people with lived experience between April and December 2023.

Updates include:

- The RIF proposals for 2024/25 include the introduction of a Children’s Learning Disability Liaison Nurse This post would provide an interface between hospital service delivery across the Children’s Hospitals and community-based learning disability and nursing teams, including young people who are transition age. They will work closely with the LD liaison nurse for adult learning disability which is funded through improving lives funding and

scope out the opportunities to develop an all age approach to liaison nursing between the hospitals and community services.

- Primary Care are currently exploring the opportunity to identify a pathfinder cluster, to improve access to GP health checks for people with a learning disability across the region with a view to upscaling across all clusters. The approach will need to be community focussed, place based, scalable and ensure people with lived experience are involved in design.
- An multi-disciplinary team, Task and Finish Group in Swansea Bay UHB has been formulated to review current practice and challenges in Community LD Teams. Resources have been secured to deliver training that supports Specialist LD staff in work that involves the court of protection. This will cover the formal elements of CoP work in relation to restrictions placed upon individuals in community settings, statement/report writing, and also practical elements such as attending court, presenting at court. The intention is to ensure staff are confident and supported in articulating least restrictive options for individuals and delivering best outcomes.

Cardiff and Vale UHB Youth Board

C&V UHB, Children & Women Clinical Board have a well-established Children and Young People's Health Board. There are currently 65 young people aged from 14 – 20 years participating in UHB work, the children and young people are recruited through the UHB Volunteering Department which provides a Governance Framework and induction training for all participants. The purpose of the Youth Board is to fulfil the national recommendations of the Children's Commissioner for Wales to embed a UNCRC Children's Rights approach within all health services across Wales. The Youth Board provide consultation and engages in meaningful participation to develop, improve and evaluate health services across Cardiff and Vale region and beyond in the rest of Wales. Cardiff and Vale UHB is only the second Health Board in Wales to have their own Youth Board, and continues to excel in the differences it influences for all children and young people. The Youth Board has been highly commended by the Children's Commissioner for Wales and is described as an exemplar of excellence, being used regularly as an example of best practice in the Children's Commissioners national reports.

Youth Board actions / ideas/ influence has resulted in:

1. The Emotional Wellbeing Website for parents / carers and children and young people. This was designed by the children and young people from concept to launch and continues to be populated by them. There are ongoing improvements and changes required to continue to improve the content and market the website.
2. The Hangout: Six years ago, when the Youth Board began, the children and young people asked for a place for immediate mental health support, somewhere accessible, not looking too clinical and which welcomes their individuality. 'The Hangout' opened in 2023 and was launched by members of the Youth Board (old and new) and the Children's Commissioner for Wales. The children and young people have many ideas about mental health services and support, from prevention, early intervention to crisis support. The success of The Hangout, primarily from listening to what children and young people want and need is evident as they are now opening a new venue in Barry to meet demands on the service. The success comes directly from hearing what is needed from those who use the service, which then impacts positively on financial and treatment success. This was highlighted as an excellent example of direct impact by the Royal College of Nursing in Wales gaining the Youth Board further celebration across National forums. (Impact matters in health care | Royal College of Nursing (rcn.org.uk))
3. Immunization consultations with Public Health Wales, HEIW and School Nursing teams from all across Wales, has resulted in new and innovative ideas on how to educate and reach children and parents with accurate and evidence-based information on vaccination. The Youth Board continues to be a big part of this work which has the potential to save young lives and reduce incidences of disease.

Future work includes close partnerships with the Noah's Ark ambassadors to embed the real lived experience of children accessing health services, decisions and change. More children and young people who experience complex or long term care will hopefully join the Youth Board team in the future.

Safeguarding Team Achievements

- Launch of Group 3 multi-agency VAWDASV training
- Two Group 4 Trainers identified within the safeguarding team and completed Train the Trainer
- Safeguarding Nurse Advisors participation in the Home Office NRM process for Cardiff
- Implementation and awareness training across the UHB in relation to Children (Abolition of Defence of Reasonable Punishment) (Wales) Act 2020
- Updated Safeguarding Training Strategy
- Participating in a stakeholder's scrutiny of the Joint Inspection of Child Protection Arrangements (JICPA)
- Involvement in a C&VUHB Spread and Scale project incorporating Child Sexual Abuse consideration
- Introduction of Health Lead Practitioners from Clinical Boards (HLPs) presenting at Level 3 safeguarding training, sharing experiences of the work they undertake in clinical areas
- Participation by the VPT in research undertaken by Cardiff and John Moore's University



Forecast 2024-2025

Continuing with the achievements made, sustaining and maintaining the safeguarding agenda workload is challenging for the UHB safeguarding team. This is an area that continues to evolve with emerging themes such as the overarching Contextual Exploitation. Ensuring that the UHB staff are prepared and aware of their professional duty to report, through providing specific training has been considered and discussed with all appropriate clinical areas. Additional training resources from within the team will be required through 2024-2025 across the UHB, in line with WG expectation of 85% compliance. The safeguarding team has proved that it is an innovative team that demonstrates the ability to adapt to contemporary situations. Ensuring

that staff resources are available to cover three sites is often demanding, particularly considering the amount of work generated within Cardiff MASH, the multi-agency commitments to the RSB and Public Health Wales Safeguarding Service workplan. The team will strive to resume the energy demonstrated to address the safeguarding agenda and ensure that staff and the public are safeguarded appropriately by the UHB. However, the UHB may need to consider if additional resources are required to bolster the safeguarding team to achieve the ambitious actions for the coming year. Further work during 2024-2025 will include:

Action	Service Delivery
Prioritise interim Safeguarding Supervision to specific groups within the UHB	Corporate Safeguarding Team
Evaluate staff responses to the new interim safeguarding supervision arrangements	Corporate Safeguarding Team
Implement the Joint Inspection of Child Protection Arrangements in Cardiff, Action plan	Corporate Safeguarding Team & Clinical Boards
Consider new arrangements for safeguarding governance through the Safeguarding Steering Group	Corporate Safeguarding Team & Clinical Boards
Development of Clinical Board Safeguarding Group	Corporate Safeguarding Team & Clinical Boards
Introduce Mandatory Training for Level 3 safeguarding training across the UHB for Band 6 upwards and F1 upwards	Corporate Safeguarding Team, ECOD & Clinical Boards
Improve the UHB Level 2 Safeguarding training compliance to meet Welsh Government expectation of 85% of the workforce	Corporate Safeguarding Team, ECOD & Clinical Boards
Develop a Child Health Assessment for use by the School Nursing Service for use at Initial Child Protection Conference	Children & Women Clinical Board
Develop a Tissue Viability Scrutiny panel in Children & Women Clinical Board to review Grade 3, 4 or unstageable hospital acquired avoidable pressure damage.	Children & Women Clinical Board
Ensure a robust process is established within the Children Looked After Service to complete statutory assessments for children within the Welsh Government timeframe	Children & Women Clinical Board
Improve the UHB use of IT systems, ensuring that safeguarding documents are logged and are providing appropriate information involving multi-agency meetings and outcomes	Corporate Safeguarding Team & Clinical Boards
Improve safeguarding supervision offered to Midwives	Corporate Safeguarding Team & Clinical Boards

Action	Service Delivery
Develop a review process to ensure that UHB safeguarding documents are accessible to staff across the UHB and a version controlled	Corporate Safeguarding Team
Audit compliance across the UHB of staff accessibility to the Wales Safeguarding App on work mobile phones and clinical desktops across the UHB	Corporate Safeguarding Team
Audit compliance of safeguarding supervision to specific groups working with children within the UHB	Corporate Safeguarding Team
Audit school nurse access to PPN notifications on PARIS documented on children under 5 years of age, consider improved liaison between HVs and School nurses	Corporate Safeguarding Team and Children & Women Clinical Board
Audit school nurse's notification of minutes from Review Child Protection Conference	Children & Women Clinical Board
Develop with ECOD a preceptorship package for line managers to oversee the compliance of Level 3 Safeguarding Training	Corporate Safeguarding Team, ECOD and managers
Consider the structure of the UHB Corporate Safeguarding Team in light of the increased volume and complexity of safeguarding cases	Executive Nurse and Deputy Nurse Director, Head of Safeguarding
Prepare a Business Case for consideration of expanding the Corporate Safeguarding Team	Executive and Corporate Safeguarding Team
Introduce a digital MARF on ED Workstation	Corporate Safeguarding Team & Paediatric Emergency Department
Develop a leaflet for adult patients to understand an adult at risk referral	Corporate Safeguarding Team, Mental Health Clinical Board
Participate in a Spread and Scale initiative to promote the CSA project in Obstetrics	Corporate Safeguarding Team, Children & Women Clinical Board and the Child Sexual Abuse Centre of Excellence
Health Lead Practitioners to participate in UHB Level 3 Safeguarding Training	Corporate Safeguarding Team & Clinical Boards
Participate with the Public Health Wales, Once for Wales, DATIX process for safeguarding referrals	Corporate Safeguarding Team, Patient Safety Team and Clinical Boards
Ensure full participation with the Cardiff University evaluation of the Violence Prevention Team	Corporate Safeguarding Team Violence Prevention Team, Cardiff University & Medicine Clinical Board
Internal Safeguarding Audit to be undertaken	Executive and Corporate Safeguarding Team
Introduction of Young Persons IDVA in Emergency Department through external funding	Corporate Safeguarding Team

Action	Service Delivery
Incorporate the Mental Capacity Act Team in to the Corporate Safeguarding Team	Corporate Safeguarding Team and Mental Capacity Act Team
Arrange a Secondment to LA for a Safeguarding Nurse Advisor to work alongside the Cardiff YEF Team	Corporate Safeguarding Team and Cardiff Local Authority
Complete a poster and role profile for adult safeguarding Health Lead Practitioners (HLP) within Clinical Boards to raise staff awareness in clinical areas	Corporate Safeguarding Team and Clinical Boards
Launch the updated Public Health Wales, PRUDiC guidance across the UHB, that includes unexpected death of a young person in adult areas	Corporate Safeguarding Team and Clinical Boards
Introduce annual audit of MARF and AS1 safeguarding referrals quality across all Clinical Boards	Corporate Safeguarding Team and Clinical Boards
Introduce a Midwifery safeguarding newsletter	Corporate Safeguarding Team Midwife
Ensure that a robust process around sexual safety disclosures within the UHB is in place	Executive and Corporate Safeguarding Team and People's Service



Summary

Since April 2014, the National and indeed International safeguarding landscape has broadened. We have seen the introduction of two significant Acts of law in Wales which has impacted on the safeguarding work stream across the UHB requiring significant changes in process, additional training and supervision as well as relocation of existing resources. Further legislation from the Home Office has also defined the need to raise awareness of Domestic Homicide and FGM. The Modern Slavery Act (2015) is another area whereby the safeguarding team need to work with partner agencies to raise staff and public awareness. Emerging Acts and other legislation require significant resources to ensure that Cardiff and Vale University Board is aware and compliant with the duty obligations. Substantial potential risks may be identified should safeguarding training, safeguarding supervision, professional advice and support line, good multi-agency partnership working and immediate safeguarding individual support to survivors of violent crime is not in place and accessible to members of the public and employees within the Health Board.

During the time period of this report the NHS has experienced significant issues in recruitment and retention of staff across all areas. The use of agency and bank staff has been widespread across clinical areas. This has identified learning around staff mandatory training and increased professional concerns due to

care provided to patients. This has been addressed appropriately at the time however the increase in advice and management of safeguarding cases has impacted on the UHB Safeguarding Team. The team workplan reflects how we are able to map targeted training and supervision of staff. Through staff surveys and audit of the team service delivery we aim to provide a good quality safeguarding service within the UHB. However, the UHB will need to consider how the corporate safeguarding team are able to achieve the growing demands of an increasing workload and the ability to achieve effective results given the forecast of areas that are needing to be addressed.

The Cardiff and Vale University Health Board Safeguarding Team will strive to continue to meet all of the demands set by the UHB and Welsh Government to ensure the safety and safeguarding of children and adults at risk that become known to us. This will only be achieved by continuing to work collaboratively with our strategic partners and internally within the UHB through the Executive Teams and Clinical Boards; ensuring that communication and decision making is embedded in open, honest and transparent practice.

Acknowledgement is given to all UHB professionals who contributed to this report, thank you.



