Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD QUALITY, SAFETY AND EXPERIENCE COMMITTEE	
DYDDIAD Y CYFARFOD: DATE OF MEETING:	**11 AUGUST 2026**
TEITL YR ADRODDIAD: TITLE OF REPORT:	Safeguarding Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Charlotte Westacott, Head of Safeguarding

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/ For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides an update to the Quality, Safety and Experience Committee on the Health Board's safeguarding arrangements, outlining current activity, key developments, and actions underway to strengthen compliance with statutory safeguarding requirements.

Cefndir / Background

Safeguarding duties for health boards in Wales are principally set out in the Social Services and Well-being (Wales) Act 2014, supported by associated statutory guidance. While local authorities hold the primary statutory responsibility for safeguarding the welfare of children, the Health Board—alongside police, NHS Trusts, probation services, and youth offending teams—has a legal duty under Section 28 of the Children Act 2004 to ensure its functions are discharged with due regard to safeguarding and promoting the welfare of children.

Under Part 7 of the Social Services and Well-being (Wales) Act 2014, local authorities must establish Safeguarding Children Boards, with representation from statutory partners including the Health Board. In this context, Local Health Boards and NHS Trusts are recognised as statutory relevant safeguarding partners.

The Wales Safeguarding Procedures set out all-Wales framework for safeguarding children and adults at risk of abuse or neglect. They apply to all practitioners—across statutory, private, and voluntary sectors—ensuring consistency in safeguarding practice regardless of organisational structure or professional background.

The Health Board is an active member of the Mid and West Wales Statutory Safeguarding Board, established under the Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015. To support internal governance, the Health Board has established a Strategic Safeguarding Steering Group (SSSG), which provides assurance to the Quality & Safety Intelligence Group on the organisation's statutory responsibilities relating to safeguarding children, adults, and broader public protection.

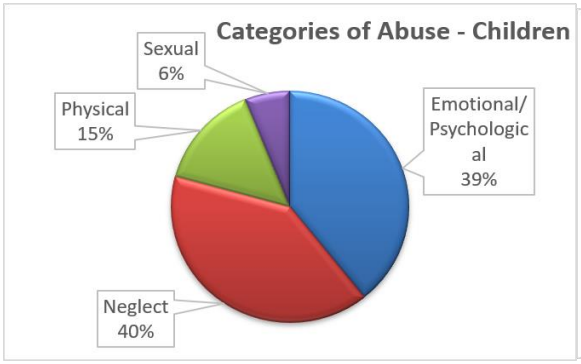
The Health Board's Safeguarding Team supports compliance with the Social Services and Well-being (Wales) Act, the national guidance Working Together to Safeguard People and the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015.

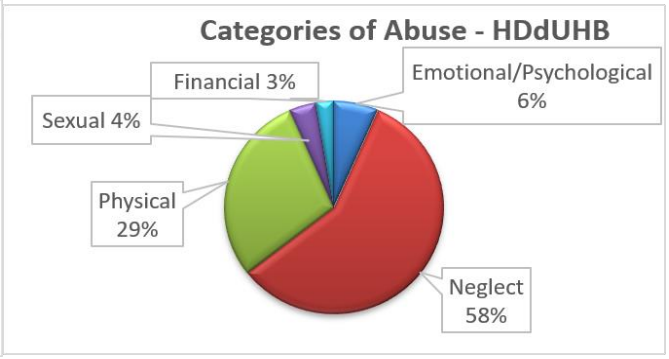
Asesiad / Assessment

Quality Assurance

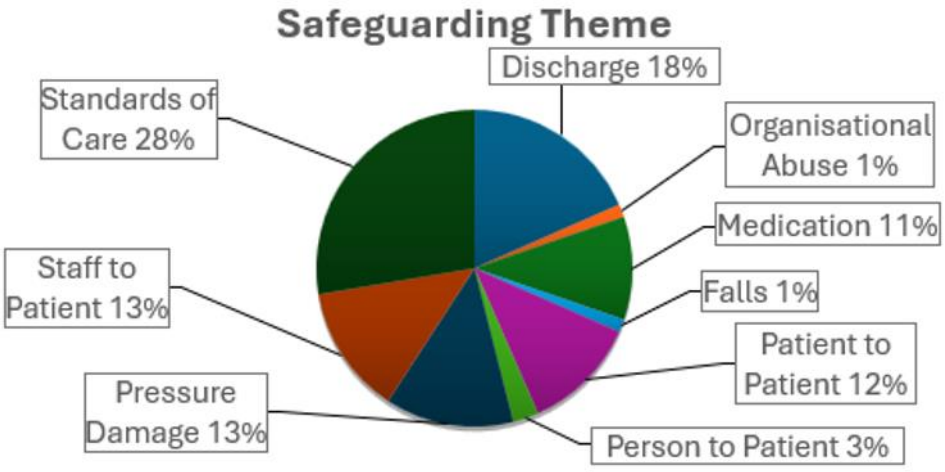
The Safeguarding Team continues to provide comprehensive oversight through established governance arrangements including performance monitoring, supervision frameworks, audit activity, risk review processes and scrutiny through Clinical Care Group (CCG) bi-monthly Safeguarding Delivery Groups and the Safeguarding Strategic Steering Group (SSG).

- Continued oversight of safeguarding activity, with **699** safeguarding reports received during April and May 2026, enabling organisational monitoring of safeguarding trends and themes for both children and adults at risk. **476** reports relate to child or unborn baby, 130 of which relate to abuse or neglect.





Neglect is by far the most prevalent alleged abuse type, accounting for over half of all allegations. In addition to capturing the categories, a theme and sub theme is assigned to each report allowing services to analyse and identify patterns and learning opportunities specific to their own area of practice.



Standards of Care remains the most prominent theme, comprising just over a quarter of all themes, continuing to align with the neglect-related concerns. Overall, the thematic profile for April and May 2026 continues to show that care quality, workforce practices, and discharge

processes are key drivers of safeguarding activity, with neglect and physical abuse categories underpinning most concerns.

- Ongoing monitoring of the Joint Inspection Child Protection Arrangements (JICPA) improvement plan continues, with 27 of 34 actions completed and a further 3 in progress with 4 being overdue which continue to be monitored via SSSG.
- Expansion of safeguarding supervision into additional services including Community Nursing and Occupational Therapy, strengthening practitioner support and safeguarding accountability.
- Positive evidence of effective multi-agency safeguarding practice demonstrated through complex Children Looked After (CLA) case management involving legal, medical and nursing teams.
- The number of Children Looked After (CLA) within the Health Board area increased to 968 during April to May 2026, representing a 2.1% increase from the previous reporting period and continuing the upward trend in demand. At the time of reporting, CLA numbers have risen further to 982, this is closely monitored and reported on by the CLA Lead Nurse.
- There are currently 167 children placed out of county (125 in Wales; 42 in England), reflecting increased reliance on external placements reflecting in the associated Health Board expenditure.
- A recent Healthcare Inspectorate Wales (HIW) focused review of the Health Board's arrangements for managing Section 5 Persons in a Position of Trust (PIPOT) has been completed. Stages 1 and 2 of the review found the Health Board's arrangements to be effective, with appropriate processes and governance in place. As a result, the review did not progress to Stage 3, providing positive assurance regarding the Health Board's compliance and oversight in this area.

There is evidence that safeguarding systems are functioning effectively and that governance arrangements provide visibility of risk, performance and compliance.

Quality Planning;

Strategic considerations required to influence safeguarding delivery.
Key planning considerations include:

- Increasingly complex safeguarding presentations among vulnerable children and young people with significant trauma histories are placing growing demands on safeguarding services. Referrals relating to abuse or neglect have increased significantly over the last three years, rising from 679 to 927 in 2025/26, a 36.5% increase. This upward trend reflects growing demand on the safeguarding service, with an increasing number of complex cases requiring specialist assessment, intervention, and multi-agency coordination in turn resulting in sustained pressure on service capacity and staff resources.
- The number of Children Looked After continues to rise, currently at 984, with increasing out-of-area placements creating additional pressures on care coordination, safeguarding oversight, multi-agency working, and Health Board resources.
- There is an anticipated increase in demand for Prevent and Channel activity as vulnerable individuals are increasingly exposed to extremist content online. This emerging pressure continues to be highlighted through internal safeguarding training and remains a standing item within regional safeguarding discussions. Mitigation requires ongoing awareness raising, workforce training across all partner agencies, and continued government-led support and public awareness initiatives to reduce wider Prevent-related risks and strengthen early identification and intervention.

- Uncertainty regarding replacement digital systems supporting Health Visiting and wider community services following discontinuation of existing platforms and a procurement exercise is currently taking place to support this.

The Committee should recognise that future safeguarding risks are increasingly influenced by wider system factors including workforce availability, service demand, digital infrastructure and inter-agency dependency. These factors require continued strategic planning and executive oversight.

Quality Control;

The principal safeguards currently in place include:

- Significant concerns remain regarding capacity, resilience and sustainability of Child Protection Medical Services. This remains the most significant safeguarding risk identified during the reporting period and has been formally escalated through governance arrangements.
- Safeguarding training compliance across the Health Board continues to improve, with strong engagement at Levels 1 and 2. Compliance at Level 3 (Adults and Children) and Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) remains below the 85% organisational target, largely due to a significant increase in the number of staff appropriately role-mapped as requiring these levels of training.
- Additional quality assurance processes have been introduced to review Multi-Agency Risk Assessment Conference (MARAC) referrals and improve consistency in safeguarding decision-making and reporting across services.
- Monthly multi-agency S5 Person in a Position of Trust (PIPOT) review meetings continue to provide robust oversight of complex investigations, enabling the identification and monitoring of delays, risks, and emerging themes. Work is progressing to further strengthen internal governance arrangements, enhancing CCG and Professional Standards oversight, improving accountability and supporting the timely progression and resolution of cases.

Appropriate controls are in place; however, some risks, training compliance and Child Protection Medical Service resilience, remain only partially mitigated and continue to require executive oversight.

Quality Improvement;

Several improvement initiatives have progressed during the reporting period:

- Delivery of the JICPA improvement programme and continued oversight of outstanding actions continues to be monitored by SSSG.
- Development of improvement action plans following Midwifery audit findings relating to safeguarding in pregnancy communication and handover processes.
- Expansion of safeguarding supervision across additional professional groups. An audit of the quality of safeguarding supervision is due to take place.
- Organisational learning from Single Unified Safeguarding Review (SUSR)'s and National learning is being disseminated through governance structures.
- Identification of discharge communication failures as a recurrent organisational learning theme requiring system-wide improvement.
- Development of revised Terms of Reference for SSSG aligned to the Quality Management System governance framework.
- Children's Safeguarding Team practitioners are now attending MARAC, strengthening information-sharing processes and improving the identification of additional risks from

health information, promoting more in-depth discussions and professional challenge around safeguarding actions and management of risk.
- Additional safeguarding specialist posts are being considered with funding support from Specialist care to strengthen safeguarding expertise, support the delivery of high-quality safeguarding practice with specialist oversight.

There is evidence of a positive improvement culture, with audits, reviews, incidents and external scrutiny being translated into improvement actions. The key challenge remains achieving sustainable improvement in areas where risks are driven by workforce and system capacity constraints.

Additional assurance is required regarding:

- The sustainability of the Child Protection Medical Service remains a statutory risk and is currently under review. An assessment is underway, with an associated action plan to be developed and monitored through SSSG to ensure service resilience and statutory compliance.
- Safeguarding training compliance remains a key focus. Ongoing work to align ESR role profiles has recalibrated compliance percentages and reflects improved alignment with National Safeguarding Training Standards and Intercollegiate guidance. Sufficient training provision is available, CCGs remain accountable for improving and sustaining compliance, with performance monitored through Safeguarding Delivery Groups and SSSG.
- Organisational responses to discharge-related safeguarding concerns remain a strategic priority. Work is ongoing through the Community Integrated Medicine Clinical Governance Group to review current arrangements and identify opportunities for improvement. This includes strengthening collaborative engagement with Local Authorities to enhance safeguarding processes, support effective multi-agency decision-making, and improve the safety and quality of discharge pathways for vulnerable individuals.
- The increasing demand and complexity within Children Looked After (CLA) services, including the impact of children placed out of county, continue to present significant operational and financial challenges for the Health Board. Discussions are ongoing with Local Authority partners through Corporate Parenting arrangements to strengthen strategic oversight and joint planning. In addition, an internal review of the CLA financial position has been undertaken to better understand current pressures, inform future service planning, and support the sustainable delivery of health services for this vulnerable population.

Argymhelliad / Recommendation

The Committee is asked to receive assurance that robust safeguarding governance arrangements are in place and functioning effectively; however, assurance is moderated by ongoing workforce, service capacity and compliance risks which require continued executive and Board oversight.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.20 Provide assurance in relation to the organisation's arrangements for safeguarding vulnerable people, children and young people.

Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Child protection medical risk. Risk No 2391.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	2. Culture and valuing people
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	6. Safe, Timely, High Quality Care
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	7. Improve health and well-being by focusing on prevention and early intervention, while working in partnership to ensure everyone has equal access to care and opportunities for good health
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	5. A more preventative approach, including earlier identification and intervention, will be taken to support people to maintain and improve their health and wellbeing.
Gwybodaeth Ychwanegol: Further Information:	

Ar sail tystiolaeth: Evidence Base:	Social Services and Well-being (Wales) Act 2014, Children Act 2004 Wales Safeguarding Procedures Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015. Working Together to Safeguard People Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015
Rhestr Termau: Glossary of Terms:	Included within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Clinical Care Group (CCG) Safeguarding Delivery Groups Safeguarding Strategic Steering Group (SSG).

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Contained within the report
Gweithlu: Workforce:	Contained with the report
Tegwch Iechyd: Health Equity:	Not applicable
Risg: Risk:	Contained with the report
Cyfreithiol: Legal:	Contained with the report
Enw Da: Reputational:	Not applicable
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	Not applicable