IS-BWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	12 February 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Safeguarding Update: arrangements with the Health Board to meet the Safeguarding duties
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)
Ar Gyfer Penderfyniad/For Decision

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 the 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. The team provides expert advice and operational support across a range of safeguarding functions, including children's safeguarding, adult safeguarding, Children Looked After, and violence against women, domestic abuse and sexual violence (VAWDASV).

Asesiad / Assessment

Quality Assurance

The Strategic Safeguarding Steering Group (SSSG) meets bi-monthly (six meetings per year). The terms of reference have been reviewed and approved by the Quality and Safety Intelligence Group (QSIG) in September 2025. The Executive Director of Nursing, Quality and Patient Experience is the Chair of SSSG. SSSG seeks to provide assurance:

- To the Board via QSIG, that an appropriate system for safeguarding of children and adults accessing health care or health care premises is in place across the University Health Board.
- That appropriate systems are in place for the UHB to discharge its duties in relation to children and adult at risk of abuse and neglect and Children Looked After.
- That appropriate systems are in place for the UHB to discharge its duties in relation to violence against women, domestic abuse and sexual violence.
- That the relevant guidance and standards are achieved or being worked towards in order to reduce risk and ensure the safety and delivery of high standards in safeguarding and public protection work.

With the introduction of the new Clinical Care Groups and the integrated governance arrangements established, work is underway to establish CCG Safeguarding Delivery Groups. Prior to the organisational restructure and introduction of CCGs, delivery groups were in place in each directorate. The directorates were required to report on safeguarding matters to the SSSG. This reporting requirement has now moved to the CCGs.

Partnership and Multi agency working.

The Health Board continues to be an active contributor to the Regional Safeguarding Boards and the National Safeguarding Service, with notable input this period into work streams focusing on Strengthening Safeguarding in Wales subgroups, Section 5 Persons in a Position of Trust (PIPOT) review of guidance and transitional safeguarding. Collaborative working with police and local authority partners also continues to strengthen, particularly in Pembrokeshire, where discussions are underway regarding a local authority–funded Health Safeguarding and Mental Health post within the Front Door service. Cross agency learning from -high-risk- cases and the delivery of multi-agency training remain key priorities.

Quality Planning (and Quality Improvement)

Child Death Review (CDR)
Hywel Dda has recently participated in a review of the child death review system in Wales, prompted by concerns that current arrangements are complex, involve multiple processes, and are affected by legislative gaps and inconsistent incident reporting factors that create risks and limit opportunities to reduce childhood mortality. Welsh Government commissioned the Child Health Network and Public Health Wales to scope these arrangements and develop recommendations to strengthen the national process. A broad stakeholder steering group including representation from Hywel Dda was established, with work streams examining mortality review processes, the Child Death Review Programme, and legislative considerations. A facilitated session on 4 November 2025 identified the need for an All-Wales Child Death Review Framework to provide a strategic, standardised approach and highlighted the importance of securing additional funding to address existing gaps that impact the consistency and quality of reviews. This work remains ongoing.

Strengthening safeguarding in Wales review
Welsh Government is undertaking a review of its child Safeguarding protocols and governance and accountability mechanisms for safeguarding children and adults in Wales. The review aims

to ensure that systems remain effective, responsive and focused on achieving the best outcomes for the people of Wales. The final report will be released in Spring 2026.

In parallel, the National Safeguarding Service is developing a Safeguarding Quality Statement, associated quality standards, quality metrics, and an Assurance and Accountability Framework. Once published, these will be considered by the Health Board to inform the development of an internal safeguarding delivery framework, including strengthened performance measures designed to further improve safeguarding practice.

Quality Control (and Quality Improvement)

Joint Investigation of Child Protection Arrangements (JICPA)
The UHB were involved in a Joint Inspection Child Protection Arrangements in March 2025 in Pembrokeshire, publication of the final report was in June 2025. The UHB did not have any immediate actions but have identified areas for improvement which are being addressed. The main themes being improving training compliance, strengthening multi agency working, the multi-agency and single agency recommendations continue to be monitored via Strategic Safeguarding Steering Group. The actions are recorded on AMaT and included in the HIW section of the regular Quality Assurance report update that QSEC received.

Our Bravery Brought Justice
In November 2025, the Health Board was notified by Welsh Government of the *"Our Bravery Brought Justice"* Extended Child Practice Review Gwynedd 2024 relating to child sexual abuse, which set out 27 recommendations across five themes, with only one split recommendation relating to Health. The Head of Safeguarding has reviewed the requirements and is working closely with regional partners and CAMHS to ensure they are appropriately incorporated into existing safeguarding processes. A focused gap analysis with CAMHS is underway. Early findings indicate that the main challenge relates to current system and IT limitations in aggregating the required data, this is being actively reviewed. Progress will be monitored via SSSG. A corporate response to Welsh Government is required by 3 March 2026.

S5 Persons in a Position of Trust (PIPOT)
The Corporate Safeguarding Team continue to support the services with the management of allegations concerning PIPOT in line with statutory safeguarding duties set out in the Social Services and Well-being (Wales) Act 2014, which requires organisations to have clear arrangements for responding to concerns about staff or volunteers who may pose a risk to children or adults at risk. These procedures ensure that allegations are managed promptly, proportionately, and in line with multiagency safeguarding frameworks, including appropriate information- sharing- with employers and regulatory bodies such as the Disclosure and Barring Service. All activity within this area is captured within Datix Cymru (Once for Wales Concerns Management System) ensuring the Health Board carries out their required actions and maintaining organisational memory.

Safeguarding LINC
The Mid and West Wales Safeguarding Board (MAWWSB) is leading an innovative and pioneering programme, unique within Wales and the wider UK. This collaborative initiative will integrate safeguarding related data from partner organisations into a central data warehouse, strengthening information sharing and enabling earlier identification and intervention for children at risk. The programme has significant potential to enhance child safeguarding arrangements across the region and will further support Hywel Dda staff to manage safeguarding cases proactively and reactively in a safe, timely- and effective manner. Hywel Dda is actively engaged in this work, and the Data Sharing Agreements required to underpin the project have now been finalised.

Safeguarding Referrals

The Health Board are compliant with statutory duties. Safeguarding Childrens and Adults at risk referrals continue to be completed by practitioners in a timely way. This is captured effectively by Datix Cymru which allows us to evidence timely identification, reporting, and management of abuse, neglect, or exploitation in accordance with the Social Services and Well-being (Wales) Act 2014 Duty to Report, and Wales Safeguarding Procedures. The system enables the Health Board to monitor safeguarding activity, ensure compliance with statutory duties, quality assure and provide assurance on identification and protection of individuals at risk. Outcomes, themes, and any identified learning are fed back through the Service Delivery Groups to support continuous improvement.

The pilot Independent Domestic Abuse Advocate (IDVA) service at Bronglais Hospital concluded in May 2025 due to the absence of ongoing funding, leaving a gap in dedicated support for victims of domestic abuse presenting to Emergency Departments. This risk extends across all Emergency Departments within the Health Board, where the absence of on-site safeguarding practitioners or IDVA support limits opportunities for timely intervention and sustained outcomes. Establishing consistent safeguarding or IDVA provision within EDs would significantly mitigate this risk and enhance support for individuals experiencing domestic abuse.

Safeguarding training compliance

Safeguarding training compliance remains below the 85% target for Level 3 Child and Adult Safeguarding and Group 2 Ask and Act training. Service Safeguarding Delivery Groups (SDGs) continue to provide detailed compliance reporting by professional group, including clear identification of completed risk assessments and associated mitigating actions. This remains an outstanding action on the JICPA action log and continues to be monitored via the SSSG. To support improvement, work is underway to develop a joint adult and child Level 3 training package aligned to the Intercollegiate Document to improve accessibility, consistency, and compliance trajectory.

Children Looked After

Numbers of Children Looked After (CLA) children on 27 January 2026 are 924 compared to 936 on 27 December 2025, the slight decrease is due to many children turning 18 years of age and some returning to their placing Health Boards.

The CLA Team continue to promote the national CIVICA process to ensure the voices of children, young people and carers are captured and used to shape, influence, and strengthen practice.

Corporate Safeguarding Policy (1097)

The Health Board's Corporate Safeguarding Policy is currently under review. The policy was previously approved by the People, Organisational Development and Culture Committee and it has been agreed that this responsibility will change to QSEC.

The date for review was 15 December 2025. The Head of Safeguarding post has been vacant, and this vacancy delayed the full review of the policy. With the post now filled, review and consultation are progressing with an aim of taking the policy to the Strategic Safeguarding Steering Group for support and then bringing the final policy to QSEC for approval in June 2026. Therefore, QSEC are asked to agree to the policy being extended for six months .

Quality Improvement

Restorative Supervision

The newly introduced restorative supervision sessions have been introduced for the Safeguarding Service which provides a supportive, reflective space for staff managing complex safeguarding cases, helping to reduce stress and burnout, strengthen professional decision making-, and improve wellbeing and resilience. By promoting a learning culture and supporting staff to manage the emotional demands of safeguarding work, restorative supervision enhances practice quality and contributes to safer outcomes for children and adults.

Safeguarding supervision has undergone significant transformational development, now reaching a broader range of service areas across the Health Board. Compliance is monitored through the Service Delivery Groups, with clear accountability for delivery and oversight maintained by individual service leads.

Learning From Reviews

The Health Board is currently involved in one single unified safeguarding review (SUSR) with 2 MAPF's in line to commence shortly. Key emerging themes include information sharing, the need for improved professional curiosity in the community.

Multi-agency learning action plans are ongoing from previous reviews, and the Safeguarding Team is monitoring implementation with service leads. Learning will be disseminated once finalised via SDG's, training and supervision sessions.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to:

- **Receive assurance** on the Health Board's safeguarding arrangements and the current activity, key developments, and actions underway to strengthen compliance with statutory safeguarding requirements.
- **Agree** to a six-month extension for the Corporate Safeguarding Policy

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.21 Provide assurance in relation to the organisation's arrangements for safeguarding vulnerable people, children and young people.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
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)	6. All Apply

Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives 8. Transform our communities through collaboration with people, communities and partners

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 Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Strategic Safeguarding Steering Group (SSSG) Quality & Safety Intelligence Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	The partnership working through the Mid and West Wales Statutory Safeguarding Board does has financial implications for the Health Board. For example, the Health Board contributes 25% of the cost for Domestic Homicide Reviews that relate to cases within Hywel Dda UHB. Requests for other contributions are also made in year through sub-groups to the Mid and West Wales Statutory Safeguarding Board which means that it is difficult to forecast the budget required for the safeguarding work.

Ansawdd / Gofal Claf: **Quality / Patient Care:**	Safeguarding activity has a direct impact on the quality and safety of patient care. Delays in identifying abuse, neglect or exploitation, missed opportunities for early intervention, and inconsistent multi-agency working can all increase the likelihood of harm to vulnerable children and adults. Service gaps—such as the absence of onsite safeguarding or IDVA support in Emergency Departments—reduce timely responses, affect continuity of care, and limit support for those at highest risk. Additionally, low safeguarding training compliance leads to inconsistent practice, reduced professional confidence, and an increased risk of missed safeguarding indicators, all of which can compromise patient safety.
Gweithlu: **Workforce:**	Safeguarding activity places significant demands on the workforce, with staff managing complex and emotionally challenging cases that can contribute to stress, burnout, and reduced wellbeing. Service gaps—such as limited onsite safeguarding or IDVA support—can increase pressure on frontline teams and impact their ability to respond effectively. Variability in safeguarding training compliance can also lead to inconsistent practice and reduced professional confidence. The introduction of restorative supervision and strengthened safeguarding oversight structures helps to support staff resilience, promote reflective practice, and ensure the workforce is equipped to deliver safe and effective safeguarding responses.
Risg: **Risk:**	Safeguarding activity presents a number of risks, including delays in identifying abuse or neglect, missed opportunities for early intervention, and service gaps such as limited onsite safeguarding or IDVA support, all of which may increase the likelihood of harm to vulnerable individuals. Variability in safeguarding training compliance also risks inconsistent practice. These risks are mitigated through strengthened governance via the Strategic Safeguarding Steering Group, ongoing multi-agency working, enhanced monitoring through Datix Cymru, development of improved training packages, and the introduction of restorative supervision to support staff in managing complex cases. Where required, risks are further assessed and managed through the Integrated Impact Assessment process

Cyfreithiol: **Legal:**	Safeguarding activity carries potential legal implications where delays, gaps in practice, or failures to meet statutory safeguarding duties could expose the Health Board to legal challenge. Compliance with the Social Services and Well-being (Wales) Act 2014, Children Act 2004, Wales Safeguarding Procedures, and associated regulations is essential to demonstrate that the organisation is discharging its legal responsibilities appropriately.
Enw Da: **Reputational:**	Safeguarding activity carries inherent reputational risk, particularly where delays, gaps in practice, or service deficiencies—such as lack of onsite safeguarding or IDVA support—may lead to harm or missed opportunities for intervention. Such incidents can attract political, media, or public scrutiny, potentially undermining confidence in the Health Board's safeguarding arrangements. Ensuring robust governance, consistent practice, timely reporting, and clear evidence of compliance with statutory duties helps mitigate reputational exposure and demonstrates organisational accountability.
Gyfrinachedd: **Privacy:**	Safeguarding activity involves the collection, use, and sharing of sensitive personal information, which carries potential risks to individuals' privacy rights and confidentiality if data is not handled appropriately. Inadequate information-sharing practices, system limitations, or breaches in security controls could lead to unauthorised access, inappropriate disclosure, or misuse of safeguarding information. To mitigate these risks, all information-sharing must follow relevant legislation, organisational policies, and secure systems.
Cydraddoldeb: **Equality:**	Not required for this report.