# Quality, Safety and Experience Committee

13 June 2023

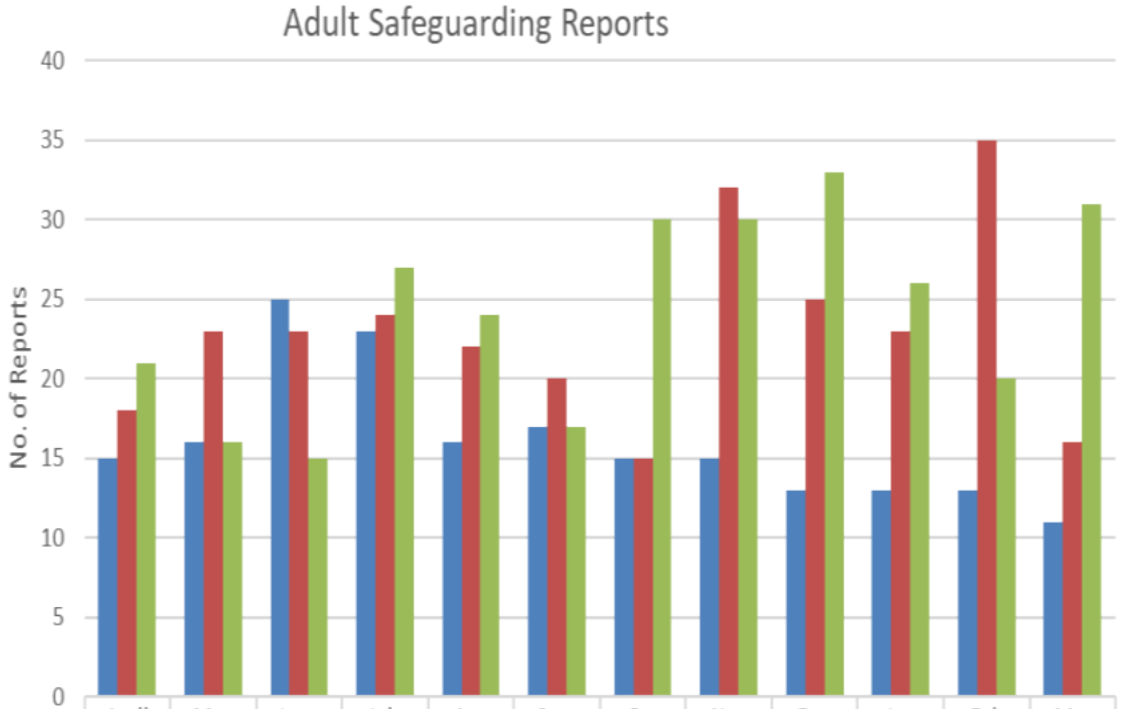
# Strategic Safeguarding Working Group

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

- Meetings held 9 February 2023 and 16 May 2023.

- This report  provides an overview of safeguarding activity at the end of Quarter 4 2022-2023 with assurance and exceptions.

# Adult Safeguarding Data and Themes



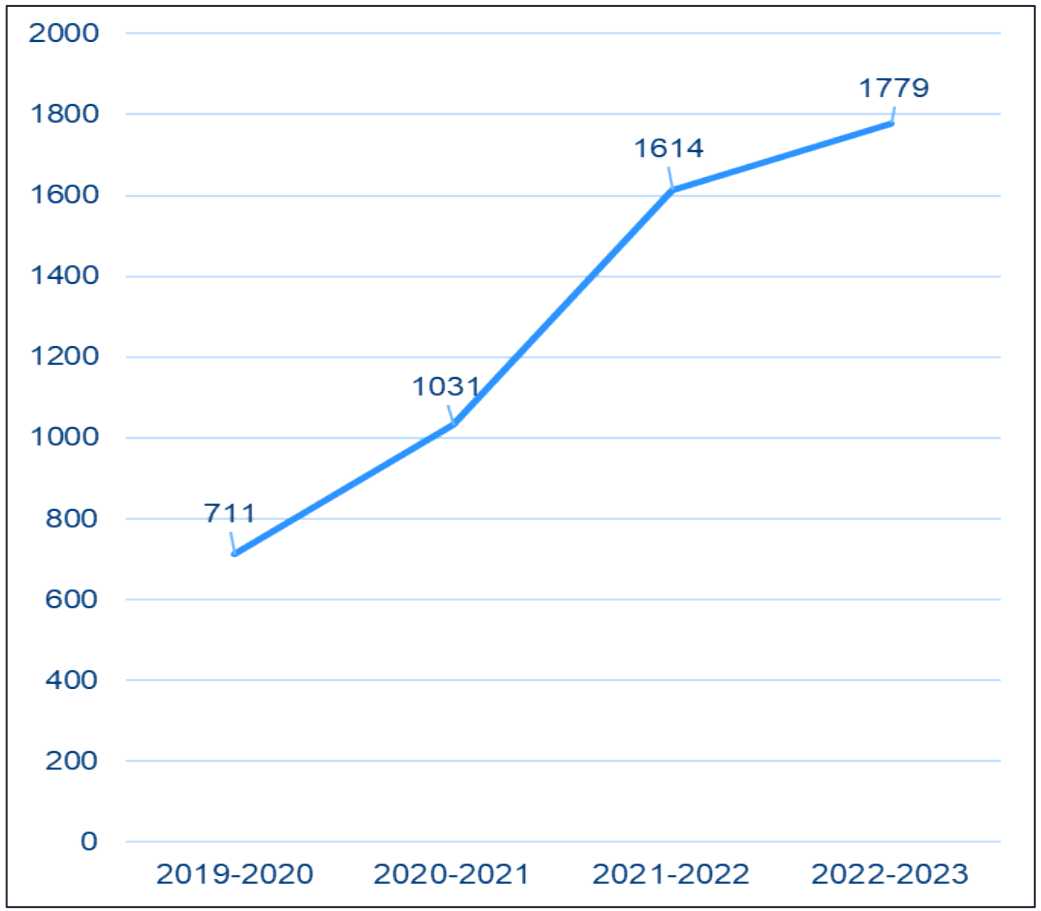

| | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2020-21 | 15 | 16 | 25 | 23 | 16 | 17 | 15 | 15 | 13 | 13 | 13 | 11 |
| 2021-22 | 18 | 23 | 23 | 24 | 22 | 20 | 15 | 32 | 25 | 23 | 35 | 16 |
| 2022-23 | 21 | 16 | 15 | 27 | 24 | 17 | 30 | 30 | 33 | 26 | 20 | 31 |

- The data reflects the Reports/Referrals made in regard to ‘adults at risk’ who are alleged to have experienced abuse of neglect as a consequence of services delivered or commissioned by the Health Board . The preceding 2 years demonstrated a growing increase in adult safeguarding reports compared to the pre Covid-19 period.  Quarter 3 and 4 figures for 2022-23 suggest a further increase in comparison to the same time frame last year.
- Discharge related reports remains a consistent theme and  communication continues to feature heavily, followed by the assessment not being consistent with patient status. Heads of Nursing have action plans in place to address Discharge Planning concerns and feedback on lessons learned from individual cases via the Service Delivery Group.

# Child Safeguarding Data

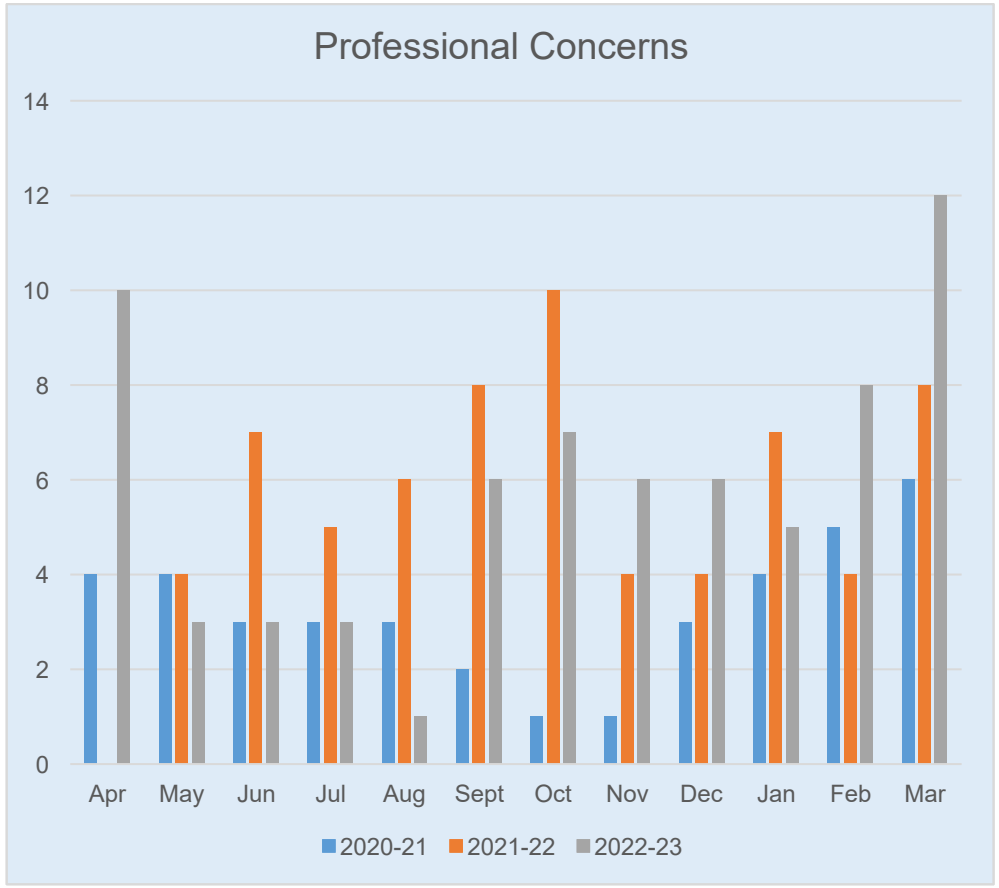
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

## Child Safeguarding Reports to Children Services




- Safeguarding children reports to Local Authority Children Services from Health Board employees remains substantially higher than pre Covid-19 figures and demonstrate that there has been no return to the pre Covid-19 figures.
- A breakdown of adverse childhood experiences (ACEs) and themes in Multi Agency Referral Form (MARFs) was discussed.
- The impact of this increase is felt significantly in the Corporate Child Safeguarding Team with no increase in resource and no existing funding to address the gap.
- The impact will also be in operational services who may be involved in more child protection conferences and an increase in child protection case loads.
- There has been a reduction in incidents of non compliance with safeguarding procedures and continue to monitor this via Safeguarding Delivery Groups.

# Safeguarding Allegations/Concerns about Practitioners and those in a Position of Trust




- 2021-22 saw a 58% increase in activity compared to 2020-21 and a further small increase in 2022-23.
- The Head of Safeguarding, Lead Safeguarding Practitioners support the management of all these referrals under section 5 of the Wales Safeguarding Procedures 2019 in support of the relevant Line Manager and HR advisor.
- All concerns are subject to risk assessment and on closure under safeguarding procedures, may result in further action under the Health Board (HB) procedures.
- To note all employees are offered support in line with the process set out in the HB Policy (246).
- Heads of service report themes are learning at Service Safeguarding Delivery groups.
- A detailed analysis of activity, themes and outcomes across all services will be discussed at the next SSWG.

# National Child Protection Rapid Review

- Following the publication of a Child Practice Review in November 2022, the Deputy Minister for Social Services, Julie Morgan MS requested Care Inspectorate Wales (CIW) to lead a rapid review of decision making in relation to child protection.
- The overarching objective is to determine to what extent the current structures and processes in Wales ensure children are appropriately placed on, and removed from the Child Protection Register when sufficient evidence indicates it is safe to do so.
- CIW requested support from Estyn, Health Inspectorate Wales (HIW) and His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) in carrying out the review.
- Pembrokeshire Local Authority (LA) were identified as one of five Local Authorities.
- Hywel Dda University Health Board were required to send records of named children from Pembrokeshire LA.
- The HIW reviewer will not be required to provide the Health Board with a formal report, but will provide informal feedback to the Head of Safeguarding at the end of their review.
- Details for the timescale for publication of national findings of the review have not yet been released.
- All relevant services have been informed of the review.

# Exception Reports from Service Safeguarding Delivery Groups - key area of risk



## Community and Primary Care

- All areas continue to focus on improvement in training compliance across the Health Board.
- Long Term Care risks - further home closures due to inability to recruit and or retain qualified nurses and ancillary staff. A paper has been presented to Board discussing the fragility of the care home sector as well as explaining the work being undertaken on a regional perspective developing a Market Stability Framework with a number of options.

# Exception Reports from Service Safeguarding Delivery Groups - key area of risk



## Women, Children and Public Health Nursing

- Community Paediatrics

Staffing within Continuing Care packages in Pembrokeshire continues to be challenging, reflecting the national picture of a significant shortage of third sector staff. Retention and recruitment is extremely problematic and is subject to review.

- Health Visiting

The current staffing position, as at March 2023, shows that the overall vacancy position across the Health Visiting service has remained fairly stable.

- School Nursing

There continues to be several ongoing unfilled Specialist Community Public Health Senior Nurse vacancies in each of the counties but especially in Ceredigion, this has resulted in the sharing of safeguarding work between the whole service. A risk assessment is in place and is regularly reviewed. Wok is underway to address the feedback from the Child Protection Rapid Review to include the voice of the child in records and quality of child protection reports.

# Exception Reports from Service Safeguarding Delivery Groups - key area of risk



## Acute Services

- Unsafe discharge remains a key theme in safeguarding referrals. High temporary staffing numbers in some areas impact on the effectiveness of some of the improvement work, supportive roles have been rolled out in some areas to help mitigate this and ensure consistency of approach.
- Safeguarding training compliance remains low across all services. Some targeted improvement is in place but the workforce vacancies and operational pressures are still impacting on staff being released to complete training. It is recognised that this is a risk in ensuring staff are able to identify and respond to the signs of abuse and neglect and their statutory duty to report. Medical staff training compliance is identified as a particular area of poor compliance.

# Exception Reports from Service Safeguarding Delivery Groups - key area of risk

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## Mental Health and Learning Disabilities

No report received – Safeguarding Delivery Group to be held 19 May 2023

# Safeguarding Maturity Matrix

- The Safeguarding Maturity Matrix (SMM) continues to be a self-assessment by each NHS Health Board and Trust and the findings will inform the work of individual organisations.

- A review of the Health Board Improvement Plan for 2022 has been completed.

- Health Boards and Trust in NHS Wales have been asked to complete their self assessment and return their improvement plans by to the Network by 31 July 2023.

- Service Safeguarding Delivery Group Chairs have been asked to carry out the self assessment in their Groups to inform the Health Board overarching self assessment and improvement plan.

# VAWDASV National Training Framework Annual Report

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- The Health Board Annual Report on compliance with the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASDV) has been submitted to Welsh Government.
- The report highlights gaps in training compliance, particularly Groups 6 which is for Chief Executives, Directors and other strategic leaders. This level of training is specifically aimed at strategic leaders to create a culture and infrastructure which support the aims of the National Training Framework on violence against women, domestic abuse and sexual violence
- The Head of Safeguarding has arranged for Welsh Women's Aid to deliver bespoke Group 6 training to Health Board strategic leaders.

# Serious Violence Duty

- Statutory guidance has been issued by the Secretary of State  under Chapter 1 of Part 2 of the Police, Crime, Sentencing and Courts Act 2022 (“the PCSC Act”) and has been produced to support organisations and authorities exercising functions in relation to the Serious Violence Duty.
- This Duty commenced on 31 January 2023 and is for specified authorities defined in section 11 of, and Schedule 1 to, the PCSC Act (Chief Officers of police, fire and rescue authorities, Integrated Care Boards, Local Health Boards, local authorities, youth offending teams and probation services)
- The Duty is a key part of the Government’s programme of work to collaborate and plan to prevent and reduce serious violence: taking a multi-agency approach to understand the causes and consequences of serious violence, focusing on prevention and early intervention, and informed by evidence.
- The existing Regional Serious Violence and Organised Crime Board will provide the governance reporting.
- A Strategic Needs Assessment needs to be developed in partnership and a Regional and Serious Violence Reduction Strategy is to be published by 31 January 2024.

# NHS Wales Safeguarding Network Workforce and Succession Planning

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- The NHS Wales 2021 SMM report highlighted the need for improved workforce and succession plans for safeguarding across NHS Wales. Developing a talent pipeline for key leadership roles is critical for many roles in NHS Wales, and Health Boards and Trusts need assurance that they have a supply of appropriately trained and experienced future leaders to undertake specialist safeguarding roles as well as individuals who could fill other business-critical positions.
- The report has been shared with the Medical Director and Director of Workforce and Organisational Development.

# Regional Safeguarding

- Mid and West Wales regional Safeguarding Board Annual Report – the Health Board submission is attached with this report for noting.
- Mid and West Wales Regional Safeguarding Board Awards - Eight nominations of health board employees were submitted and will be invited to the awards ceremony in June 2023.

# Risks and Mitigation Summary

- Safeguarding Delivery Groups identify and mitigate risks with gaps in safeguarding training compliance. There are more complex cases emerging and there have been non-compliance incidents. Where areas are below the 85% compliance is recorded on the relevant service risk register.

- Action is being taken to address the strategic leader compliance with Group 6 VAWDASV training.

- The Named Doctor and Assistant Medical Director for Professional Standards are taking action to address the risk with medical staff safeguarding training compliance. A breakdown of medical workforce compliance with the level 3 training, by grade of doctor and directorate will be reviewed at delivery groups.

# Recommendation

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

## For QSEC to take assurance from the report  provided.

**DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG**

**SAFE | SUSTAINABLE | ACCESSIBLE | KIND**

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

# Annual Partner Agency Contribution

# to the Mid & West Wales Safeguarding Board's Annual Report 2022-23

Each designated Board member is required to complete the below report template to enable your agency's contribution and safeguarding work to be adequately represented in this year's Annual Report.

Within the context of outcome focused practice, as well as identifying the work that has been undertaken, please give careful consideration as to how your contribution **evidences good safeguarding outcomes for children and adults at risk.**

Please consider responses within the context of the Board's Annual Strategic Plan 2022-23 – see attached reporting spreadsheet.

**Please note this contribution is for the Annual Report to be published by 31st July 2023, which will reflect and report on work undertaken between 1st April 2022 and 31st March 2023 only.**

## Organisational Input into the Mid & West Wales Safeguarding Board's Annual Report 2022-23,

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| **1. How has your organisation/agency contributed to the Board's effectiveness?** | Hywel Dda University Health Board continues to be a consistent member of the Mid and West Wales Regional Safeguarding Board.<br><br>The UHB has in place a Corporate Safeguarding Policy which provides a framework for every service within the UHB, setting out responsibilities in relation to safeguarding children and adults at risk and the means by which the UHB will be assured it is fulfilling its duties.<br><br>This includes ensuring all regional multi-agency policies and procedures are approved for implementation via the UHB Written Control Documentation processes. Such policies and procedures are readily accessible on the UHB corporate governance intranet page.<br><br>We have representation on Board subgroups and each county Local Operational Group. | Strong commitment to partnership and multi-agency working.<br><br>As a statutory partner, we work collaboratively and provide professional challenge across the spectrum of safeguarding work. |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| | The Lead for Safeguarding Children and Senior Safeguarding Adults Practitioner are represented on the relevant multi-agency Heads of Service Groups.<br><br>The Health Board has contributed to the Regional Safeguarding Board Annual Plan.<br><br>The Health Board is represented on and actively engaged in the Regional VAWDASV Strategic Group, Delivery Group and relevant sub groups.<br><br>The Health Board continues to play an active role in development of regional policy and procedures and safeguarding training and active participation in multi-agency reviews and learning events. | |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| **2. How has your organisation/agency worked collaboratively with other bodies or organisations?** | We actively commit to and participate in the Board's subgroups and LOG meetings and work closely with partners to develop and implement regional policy and improve safeguarding practice.<br><br>We provide an assurance and exception report quarterly to each county LOG.<br><br>We have maintained our commitment to Child Practice Reviews, Adult Practice Reviews and Multi-agency Practitioner Forums and DHRs. We are active panel members and have supported the facilitation of learning events.<br><br>Corporate Parenting – the LAC Lead Nurse is a consistent and active member of Corporate Parenting panels.<br><br>CSE – the Lead Nurse LAC is an active member of the three MACE and operational staff attend CSE strategy meetings. | Openness and transparency in our safeguarding work.<br><br>The Corporate Safeguarding Team have been committed to managing the demand of the increase in reviews within the corporate resource.<br><br>Regular reports to multi-agency Corporate Parenting Panels on LAC activity and assurance of compliance with health assessments to ensure the health needs of LAC are identified and met. |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| | HDdUHB worked collaboratively with a manager of a Residential Home to develop and Standard Operating Procedure for LAC who attend the sexual health clinic. | Improving sharing of information. |
| | The Lead Nurse LAC is an active member of the NHS Wales LAC Steering group. | Contribute to consistent quality systems and processes for assessing and meeting the needs of LAC in NHS Wales. |
| | The Lead Nurse Safeguarding Children is a member of the Heads of Children Services meetings and collaborated in drafting the Regional Guideline for Working with Uncooperative Families. | |
| | The Lead VAWDASV and Safeguarding Practitioner has worked in partnership with specialist providers to engage with GP clusters to promote regional learning across Primary Care. | Improving the response to VAWDASV identified by the Primary care sector. |
| | The UHB continues to work in partnership with IRISi, Calan DVS and GP clusters in Carmarthenshire to progress a pilot of IRIS. | Improving the response to VAWDASV identified by the Primary care sector. |
| | The Lead VAWDASV and Safeguarding Practitioner actively | Improved the multi-agency management of risk in response to domestic incidents and ensure |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| | participates in the MARAC Steering Group. | the UHB processes is aligned with the multi-agency requirements. |
| | The corporate adult safeguarding team are members of the multi-agency Modern Slavery MARAC meetings. | Worked collaboratively across agencies to assess and manage risk. |
| | The UHB have consistent membership on each county multi-agency Channel Panel meetings. | Provided senior leadership representation and contributed to discussions to safeguard people at risk of being drawn into extremism |
| | The UHB actively contribute to the NHS Wales Safeguarding Network and subgroups. The Head of Safeguarding is the Vice Chair of the NHS wales Safeguarding Network and UHB lead alongside a Designated Nurse at the NHS Wales Network VAWDASV Steering Group. | |
| | HDdUHB have led the pilot of a Once for NHS Wales Safeguarding Management System on behalf of NHS Wales. | Imprve the quality of data collection systems ando analysis. |
| | The Senior Safeguarding Adults Practitioner represented the UHB and | Provided active and consistent represented from health. |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| | NHS Wales at the National Safeguarding Standards Group.<br><br>The UHB is a key partner in the implementation of the Rapid Response to Suspected Suicide pilot for 3 counties.<br><br>The UHB has formally endorsed the Multi-Agency High Risk and Self Neglect Procedure | <br><br>Provide active and consistent representation from health to share information and form a wider risk assessment and response.<br><br>HDdUHB are members of the high risk panels. |
| **3. Please outline any key safeguarding training delivered to staff within your organisation this year.** | Level 2 and 3 adult safeguarding – ongoing training programme<br><br>The adult safeguarding team delivered bespoke Adult Safeguarding training for GP trainees<br><br>Level 3 child safeguarding – ongoing training programme<br><br>The Named Doctor delivers Level 3 clinical recognition of abuse and neglect (child safeguarding) training and offers this to staff from Social Services and Police.<br><br>Group 2 Ask and Act training – ongoing training programme | Monitoring our compliance with training to provide assurance that Health Board employees know how to recognise and respond to indicators of abuse and neglect and comply with their statutory duty to report and identify risks and gaps in assurance. |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| | Commissioned Lucy Faithfull Training:<br><br>• Professionals Protect.<br>• Digital resilience<br>• Understanding harmful sexual behaviour<br>• Sexual Exploitation Awareness<br><br>The Lead Nurse Safeguarding Children and Named Doctor continue to deliver PRUDiC training<br><br>The adult safeguarding team presented at the UHB Dementia Awareness Day – on Safeguarding and Dementia in September 2022. Feedback from 89 participants was received.<br><br>The adult safeguarding team presented a lunch and learn session during National Safeguarding week on Safeguarding and the older person<br><br>The adult safeguarding team delivered Level 2 training to 2nd yr nursing students in Aberystwyth University | |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| | The Lead Nurse VAWDASV and Safeguarding a presentation to Out of Hours GPs on VAWDASV during National Safeguarding Week<br><br>SY delivered blended level 3 training - face to face and Teams to GP trainees<br><br>The LAC Team provide Health Assessment training quarterly for HV's and SN refresher or new staff into service, also students. Introduced Animation clip from Junior Safeguarding Board as part of the training.<br><br>The Junior Safeguarding Board animation has been distributed via Safeguarding Delivery Groups, the Strategic Safeguarding Working Group and CYP Working Group.<br><br>We also use our quarterly safeguarding newsletter to promote awareness across of the spectrum of safeguarding, highlight learning opportunities. Similarly, we keep our safeguarding intranet page up to date | Promoting the voice of children and young people. |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| | with relevant links to CYSUR and other web sites.<br><br>Practitioners in HDdUHb attended multi-agency professional curiosity training and we have commissioned further training.<br><br>We have developed an all age Think Family presentation to empathise the importance of professional curiosity.<br><br>Training rolled out to Adult Heads of Service and service leads in the UHB on the use of the Safeguarding Management Function with the Once for Wales management System including the development of electronic support documents/videos. | Effective use of UHB safeguarding related data. |
| **4. Please highlight key challenges facing your organisation in respect of safeguarding practice.** | There has been significant increase in the number of Looked after Children within the HDdUHB geography which impacts on the corporate LAC team and also Health Visiting and School Nursing Services in terms of LAC Health Assessments.<br><br>There has been an increase in the number of children placed in residential | We have sustained our service provision on the corporate safeguarding team to fulfil our statutory obligations and meet the health needs of the most vulnerable.<br><br>Where appropriate risk assessments have been carried out to ensure service continuity. |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| | homes, many of these children and young people have complex health and emotional needs.<br><br>There has been an increase in children placed under the National Transfer Scheme which places further pressure on UHB resources with no additional funding.<br><br>The Health Visiting service are particularly challenged with workforce shortfalls which are subject to senior overview and risk management.<br><br>Increase in Channel referrals and meetings.<br><br>Increase in child and adult safeguarding reports and complexity of cases.<br>Increase in professional concerns activity.<br><br>All of the above has impacted on capacity in the corporate safeguarding team and operational services within the UHB. | |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| | We are challenged by the increase in multi-agency meetings and impact of Multi Agency Self Neglect Panels and particularly the Rapid Response to Suicide Pilot with no additional resource.<br><br>Capacity for child safeguarding supervision | |
| **5. What are your agency's top 5 safeguarding achievements in 2022/23?** | HDdUHB has continued to prioritise safeguarding and respond to the challenges of the increase in workload.<br><br>The LAC Specialist Nurse identified a gap for children and young people who are experiencing constipation and associated symptoms. A quality improvement initiative commenced with the support of the Enabling Quality Improvement in Practice Team (EQliP; a group of six School Nurses, Health Visitors, Children Disability Teams, Community Children Nurses and LAC Nurses formed a project team. The team developed resources for professionals to use in their day to day roles; including a poster to display in | We have sustained the single point of contact for UHB staff and external partners and continued to provide safeguarding supervision and training.<br><br>Improving the lived experiences of CYP who lived with constipation and other associated symptoms, across the health board area. |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| | areas of the health board and other community settings.<br><br>The UHB was successful is being awarded a NHS Charities Bid to progress pilot of a Domestic Abuse Advocate in ED<br><br>UHB employees were recognised in the Regional Safeguarding Board awards for their commitment to safeguarding.<br><br>The UHB were recognised at NHS Wales Conference with the successful submission and display of posters promoting development work to safeguarding people. | The pilot is yet to commence but we will improve our response to VAWDASV in the ED.<br><br>Raised the profile of the UHB and valued our employees contribution to safeguarding in practice. |
| **6. What in your opinion, do you consider to be the Board's key achievements and successes in 2022-23?** | Joint collaboration – commission professional curiosity training resource.<br><br>M&WW RSB Awards Ceremony<br><br>Supported Junior CADW in the development of the animation | |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| **7. Please evidence how children and young people, families and adults at risk have been involved in service development in your agency.** | Patient stories at Board meetings<br><br>CYP Working Group and Voices of Children Group<br><br>The UHB promotes opportunities for everyone to get involved in heling to the shape the future of health services through 'Have Your Say'.<br><br>Service user, family and carer engagement in relevant Service improvement Programmes. | |
| **8. Please highlight any learning themes or outcomes that your agency has identified and how this information has been disseminated within your organisation.** | Professional Curiosity and Information sharing have been recurrent themes. The UHB participate in the development of regional training resources and have actively promoted the self-directed learning resource.<br><br>Where there are recurrent themes in services, the relevant service(s) implement a service improvement plan monitored by the service Safeguarding Delivery Group. | Promoted and shared learning to inform practice |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| | We disseminate learning in training; 7 min briefs; the Corporate Safeguarding Newsletter; Intranet; Safeguarding Delivery Groups; Primary Care briefing<br><br>Any emerging themes for services can be identified from the Safeguarding Management Function in the OfWMS prospective<br><br>A recommendation of the recent DHRs for Emergency Departments and Minor Injury Units, is for staff to ask patients routinely about domestic abuse. Whilst patients seen within inpatient services are asked about VAWDASV and other safeguarding questions as part of their initial assessment, this information is not evident with emergency department documentation. The Lead VAWDASV and Safeguarding Practitioner is currently exploring how this can be evidenced, with the ongoing work with the NHS Network. Additionally, there | |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| | will be opportunities in the future for this to form part of the electronic documentation processes in line with the nursing records. However in the interim, emergency departments are asked to promote the use of routine enquiry when all patients (aged over 16years) attend. | |
| **9. In relation to safeguarding, how do you quality assure practice within your organisation?** | There is a clear governance structure in place within the Health Board in relation to safeguarding across the lifespan, depicted in the UHB Corporate Safeguarding Policy.<br><br>Service Safeguarding Delivery Groups receive assurance and exception reports from individual service managers on all age safeguarding matters, including training compliance, professional concerns, themes from safeguarding referrals about services, audits and evidence of lessons learned and they are also required to report risks and provide assurance of mitigation. | Robust processes in place for assurance and exception reporting in relation to safeguarding matters.<br><br>Able to provide assurance of robust internal governance |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| | Any service improvement plans in response to themes from safeguarding referrals are monitored via the Safeguarding Delivery Groups, e.g. discharge from hospital.<br>Each Directorate has a Safeguarding Delivery Group who provide assurance and exception reports to the Health Board Strategic Safeguarding Working Group.<br><br>We review and update our internal safeguarding policies regularly.<br><br>All national and regional policies and procedures are approved via the UHB Written Control Document process.<br><br>The UHB self-assess annually against the NHS Wales Safeguarding Maturity Matrix and have been subject to the national peer review process.<br><br>Internally, Pressure Damage scrutiny meetings continue. | The Health Board is open and transparent with its self-assessment and our governance processes.<br><br>Avoidable pressure damage is reported to LOGs. |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| | The Corporate Child Safeguarding team provide regular safeguarding supervision to Health Visitors, School Nurses and Midwives.<br><br>The LAC team provide LAC supervision.<br><br>Bespoke safeguarding supervision for any age is available to any individual / or teams in the UHB.<br><br>The following reviews of practice have been undertaken.<br><br>• CSERQ<br><br>• FGM<br><br>• Routine Enquiry<br><br>• Looked After Children Health Assessment plans<br><br>• Non-Compliance with Child Safeguarding Procedures<br><br>• Review of implementation of the Was not Brought Policy | Development of practitioner knowledge and skills in relation to safeguarding to ensure staff are confident and competent in safeguarding practice.<br><br>Assessment of compliance with statutory and policy requirements and actions to improve practice |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| | • Enquiry Response Form Compliance<br><br>The LAC team quality assure all Looked After Children Health Assessments.<br><br>The UHB has an all age Safeguarding Enquiry Database which records all contacts for advice and support / multi-agency information shares, etc<br><br>The Safeguarding Team offers a single point of contact for all Health Board and Local Authority staff to access for advice and support.<br><br>The Named Doctor continued to Chair Clinical Liaison meetings in each county | Provides an audit trail of decision making and information shared.<br><br>Timely and accessible support to all UHB staff in recognising and responding to safeguarding concerns across the life span.<br><br>Multi-agency professionals and clinical peers discuss issues and good practice to improve outcomes for children |

| Question | Comment and Actions | What safeguarding outcomes have you achieved? |
|---|---|---|
| **10. What are your agency's key priorities in relation to safeguarding training within your workforce** | We need to build on our improvement in compliance with child and adults Level 3 safeguarding training and Group 2 Ask and Act.<br><br>Review our training criteria and outcomes against the National Safeguarding Learning and Development Standards<br><br>Ensure professional curiosity training accessible on an ongoing programme | Improved knowledge and awareness amongst the workforce in HDdUHB to improve outcomes for people at risk.<br><br>There are governance structures in place to monitor progress with training compliance across the UHB |

| **Any other organisational practice, events or activities that you wish to highlight for the Annual Report that has contributed to good safeguarding outcomes within 2022-23:** |
|---|

To celebrate NHS Wales Safeguarding Network 10th Anniversary, a conference was held “NHS Wales Safeguarding Together: Then, Now, Next” at City Hall, Cardiff on 8th March 2023

Hywel Dda University Health Board were shortlisted to display 5 posters out of 10 that were displayed at the conference. The shortlisted posters displayed were:

Strengthening with Safeguarding Looked After – Katie Psychological Health Assessment Edmunds Lead Nurse Safeguarding in – Sian Maynard Midwife Role for VAWDASV – Davies Head of Munkley Lead Nurse Women, Domestic Violence and FRAILTY – Quality Safeguarding – Frailty Clinical Nurse


SCAMHS for CYP Needs & Children O'Shea S-CAMHS Therapies Lead Framework – Janet LAC Pregnancy Database Named Safeguarding

Mandy Nichols Safeguarding/Rachel Violence Against Abuse, Sexual Safeguarding Improvement Veronica Jarman Specialist