

Annual Report 2025-26



Contents

Chair's Introduction	4
About the National Network	5
About the National Safeguarding Service	5
Network Leadership, Governance and Assurance	6
Managing Safeguarding Allegations Guidance	6
Strengthening Safeguarding in the Medical Appraisal System	7
Safeguarding Quality Assurance	8
NHS Wales Safeguarding Framework	9
Safeguarding Quality Statement and Metrics	10
Assurance Template to support Prevent Duty	11
Learning from Reviews Dissemination	12
Voice of the Child/Adult at Risk	13
National Child Protection Principles	14
Looked After Children Survey – Feedback Review	15



Assessment and Professional Curiosity	17
Child Sexual Exploitation Risk Questionnaire	17
Chaperone Guidance	18
Safeguarding Learning	19
Launch of Drama-Based Safeguarding Scenario Videos	20
Trusted to Safeguard Conference	21
Strengthening Adults Safeguarding Round Table	22
Safeguarding Celebration Event	23
Innovative Regional Practice	25
Development and Expansion of the Datix Safeguarding Function	26
Strengthening the Voice & Rights of the Child/Adult-at-Risk Award	27
Promises to Care Experienced Children	28
Women's Virtual Health Hub	29
Perinatal Mental Health Support Unit	30
Court of Protection and Mental Capacity Act Advocacy Lead	31
Managing Safeguarding Allegations in Ambulance Services	32
Dual Advocate Service for Domestic Violence and Sexual Violence	33
Digital Mental Capacity Act Assessment Form	34
Implementing Learning from Safeguarding Reviews	35
Alcohol Screening Project	37
Prevent 'Below Threshold' Pilot	38
Improving Safeguarding Leadership Across Public Health Wales	39
Datix Safeguarding Module Implementation	40
Future Priorities	41



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Chair's Introduction

Welcome to the 2025–2026 Annual Report of the NHS Wales Safeguarding Network.

It is a privilege, as Chair, to reflect on a significant year of progress, collaboration, and transformation across safeguarding in NHS Wales. This report highlights the commitment and collective leadership of safeguarding professionals across NHS Wales in strengthening the protection, wellbeing, and rights of the people we serve.

Alongside delivery of the Network's national workplan, this year has been defined by our contribution to implementing the Chief Nursing Officer's *Strengthening Safeguarding in Health Review*. This work has provided an important opportunity to reflect on the future of safeguarding within NHS Wales and to shape a more consistent, accountable, and sustainable approach across the system.

A key achievement has been the development of a new NHS Wales Safeguarding Framework, designed to strengthen strategic direction, governance, quality improvement, assurance, and outcomes. The Framework represents a significant step forward in creating a more connected and intelligence-led safeguarding system, with greater emphasis on prevention, learning, early intervention, and measurable impact for the people of Wales.

Safeguarding practice continues to evolve within an increasingly complex environment. Global instability, digital harms, exploitation, widening inequalities, and the growing complexity of vulnerability continue to influence safeguarding risks across communities. At the same time, workforce pressures across health and care services remain significant, requiring us to support and sustain the wellbeing, resilience, and professional confidence of safeguarding practitioners and leaders.

During the year, national and international events have further shaped the safeguarding landscape. Learning arising from the Southport tragedy and subsequent discussions relating to Prevent and public protection have reinforced the importance of early identification, information sharing, professional curiosity, and partnership working. The publication of the *Our Bravery Brought Justice Review* has also provided stark reflection on organisational culture, accountability, and the need to listen to and act upon concerns at the earliest opportunity. Together, these developments continue to influence safeguarding priorities across NHS Wales and reinforce the importance of horizon scanning, prevention, and system-wide learning.

Throughout the year, the Network has continued to invest in collaboration, peer support, restorative approaches, and professional development, recognising that safeguarding is strengthened through collective leadership and continuous learning.

While much has been achieved, we recognise there is more to do. Our ambition remains clear: to create safer systems, improve outcomes, and ensure that safeguarding remains everyone's responsibility.

I hope you find this report informative and inspiring, and I encourage you to share the learning widely across your organisations and partnerships.

Louise Mann
Chair, NHS Wales Safeguarding Network



About the National Network

Professionally led by the National Safeguarding Service (NHS Wales), 'the Network' provides a vital bridge between strategies and arrangements at local level and national policy developments to support NHS Wales Health Boards and Trusts in discharging their responsibilities for safeguarding people.

The Network and its subgroups provide a community of practice environment, facilitating collaboration, upskilling, horizon scanning, sharing challenges and best practice, problem solving and innovation. At its heart is evaluation of the efficiency and efficacy of safeguarding arrangements and interventions, as well as reduction in practice variation across the NHS.

The Network is chaired by Louise Mann from the National Safeguarding Service (NSS) and co-chaired by Fiona Davies from Velindre University NHS Trust.

Sub-Groups

Network sub-groups act as community of practice and facilitators of joint safeguarding improvement activity. 5 sub-groups cover the following areas:

- 1** Training and Learning
- 2** Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)
- 3** Mental Capacity Act/Deprivation of Liberty Safeguards
- 4** Looked After Children
- 5** Wales Lead Doctors for Safeguarding

Sub-group membership draws on professionals across NHS Wales who are well placed to contribute operational, clinical and strategic expertise. Members add value by providing operational insights that ensure national guidance is relevant and practical. Sub-group Chairs meet regularly via a Community of Practice to share leadership practice, issues, safeguarding concerns and opportunities for co-production.

Multi-Agency Working

Network partners outside of NHS Wales include the Regional Safeguarding Boards, Older People's Commissioner's Office, the Children's Commissioner's Office and other key agencies. This system wide approach facilitates the sharing of good practice, and the cascading of intelligence to promote effective safeguarding across all organisations.

**Gwasanaeth
Diogelu Cenedlaethol**
Diogelu GIG ar gyfer Cymru Ddiogelach
**National Safeguarding
Service**
NHS Safeguarding for a Safer Wales

About the National Safeguarding Service

The National Safeguarding Service (NSS) provides credible system leadership, inspiring others and building quality improvement approaches to safeguarding across the NHS system. The service co-ordinates and manages the Network delivery.

The team comprises skilled professionals who provide strategic expertise, standardised practice, upskilling and specialist guidance to colleagues across NHS Wales, multi-agency organisations and Welsh Government.

Network Leadership, Governance and Assurance

Managing Safeguarding Allegations Guidance

Guidance has been developed to support a consistent, transparent, and legally compliant approach to the management of safeguarding allegations across NHS Wales.

It reflects the Network's shared commitment to placing the safety and wellbeing of individuals at the centre of all decision making, while also ensuring that staff are treated fairly and supported appropriately throughout safeguarding and employment processes.

Context

[Section 5 of the Wales' Safeguarding Procedures](#) outlines the management of allegations and concerns against NHS Wales employees and volunteers (Practitioners/Those in Positions of Trust). It provides a standardised framework for responding to risks posed to children or adults, with a focus on effective reporting, thorough investigation, and ensuring safety through fair, consistent, and timely action.

The Guidance

To support the practical implementation of these requirements, the Network has developed operational guidance to help NHS organisations meet their statutory duties.

This guidance applies to all NHS organisations in Wales and relates to Practitioners/Those in Positions of Trust (PIPOT), including permanent and temporary employees, agency workers, contractors, volunteers, students and trainees.

It provides a national framework to support NHS Wales in taking a consistent, proportionate, and lawful approach to managing safeguarding allegations of abuse or harmful behaviour - whether arising in the workplace or in an individual's private life.

The document includes organisational guidance covering:

- A Quality Statement
- Decision making criteria
- Policy requirements
- Roles and responsibilities
- Risk assessment outlining safeguarding specific risk considerations and an accompanying risk assessment tool
- Sharing and recording of information
- Staff support and representation
- Training
- Audit
- Equality and Impact Assessment
- Managing media interest

Going Forward

This guidance will be published on the PHW website and updated periodically to ensure it remains aligned with current policy and legislation.





Strengthening Safeguarding in the Medical Appraisal System

Work has taken place to strengthen safeguarding assurance in the medical workforce by improving quantity and quality of safeguarding-related reflective entries in the national medical appraisal system.

Context

In the previous system, there was no specific safeguarding topic area and therefore no prompt to reflect on safeguarding-related cases or meetings. A tick box existed to record the level safeguarding training achieved but with 'not applicable' as an option. This resulted in a perception of safeguarding as tick box training and lacked meaningful engagement and assurance in medics' safeguarding competencies.

Activity

Work is underway to incorporate a dedicated *Safeguarding Activity* section to the medical appraisal system, supported by clear guidance and resources for appraisers.

Following discussions with Health Education and Improvement Wales (HEIW), safeguarding has been agreed as a key reflective area within the new system.

A design has now been established for the new integrated digital system that will support medical education, training, and recruitment across NHS Wales. Work is now progressing to understand how this system could link with the Electronic Staff Record (ESR), the NHS human resources and payroll system. Establishing this connection would enable improved reporting on training participation and medical compliance metrics for doctors and postgraduate professionals across NHS Wales.

Next Steps

The Wales Lead Doctors in Safeguarding sub-group, part of the NHS Wales Safeguarding Network, will develop training for appraisers outlining expectations and approaches for evaluating doctors' safeguarding competencies and reflective appraisal entries.



Safeguarding Quality Assurance



NHS Wales Safeguarding Framework

Safeguarding People through Assurance, Accountability and Learning

The NHS Wales Safeguarding Framework outlines the approach to safeguarding children, young people, and adults at risk within the healthcare system in Wales. It sets out a unified, system-wide approach to safeguarding, ensuring accountability, transparency, and continuous improvement across NHS Wales.

The Framework's vision is to deliver consistent high-quality safeguarding across NHS Wales that protects and promotes the welfare of children and adults at risk, ensures accountability, and improves outcomes through learning and collaboration.

Context

The development of the framework originates from requirements set out in the 'Safeguarding in Health Review', commissioned by the Welsh Government to assess the effectiveness of safeguarding arrangements in health in 2024.

The NHS Wales Safeguarding Framework consolidates the Listening & Learning Framework, the Quality, Assurance & Accountability Framework, and the Quality Statement & Safeguarding Metrics requirements into a single coherent framework to form a unified safeguarding quality management system for Wales.



The Framework

The Framework comprises the following:

- Safeguarding Enablers including leadership, workforce and use of data insights.
- Learning and Improvement requirements e.g. feedback, adverse event reviews, good practices, voice-led learning, and strategic insights.
- Assurance and Accountability requisites such as collaboration with national and local safeguarding and risk management arrangements.
- Safeguarding Quality Statement and Data Standards
- Detailed metrics and guidance for safeguarding reports, training compliance

Local Implementation and Review Arrangements

National monitoring and assurance against the Safeguarding Framework will be the responsibility of the function of NHS Wales Performance and Improvement. Health Boards and Trusts will be responsible for monitoring and assurance at a local level.

Going Forward

Over the coming year, work will focus on embedding the NHS Wales Safeguarding Framework through existing governance, assurance, and learning arrangements. This will support consistent safeguarding practice and continuous improvement across NHS Wales organisations, with effective system oversight.



Safeguarding Quality Statement and Metrics

An agreed national safeguarding quality statement, accompanying quality standards, and a refined set of safeguarding metrics for NHS Wales has been completed.

This work provides a strengthened foundation for safeguarding assurance, planning, and improvement across NHS Wales, supporting a coordinated, transparent, and evidence-based approach to protecting people and improving outcomes.

Context

This workstream originated from recommendations from the 2024/25 *Strengthening Safeguarding in Health Review* commissioned by the Chief Nursing Officer, Welsh Government.

It reflects a clear national priority to enhance consistency, accountability, and quality in safeguarding practice across all NHS Wales organisations.

What Good Looks Like

The Quality Statement and Safeguarding Metrics define good safeguarding in NHS Wales and offer early warning signals through ongoing monitoring and evaluation.

Developed through expert engagement, they set out:

- A clear national safeguarding quality statement
- A suite of supporting quality standards
- A Minimum Data Set to strengthen governance, assurance, and transparency

Data-Driven

The Quality Statement positions safeguarding as a core component of high-quality care emphasising safe, effective, timely, and consistently applied practice supported by robust governance, reliable data, and a skilled workforce.

The accompanying standards and Minimum Data Set provide clarity on expectations in relation to:

- Leadership and accountability
- Workforce competence and training compliance
- Reporting systems and processes
- Partnership working
- Data quality and consistency

Collectively, they will enable national-level oversight, assurance, comparability, and system-wide learning.

Next Steps

Forward actions include:

- clarifying national assurance mechanisms
- addressing reporting challenges such as:
 - Low volume Practitioners/Those in Positions of Trust (PIPOT) data
 - Determining the future role of the Datix Cymru Safeguarding Module alongside local authorities' collective development of an All Wales Integrated Report Form (AWIR).

Impact

The impact of this work will be tracked through regular national monitoring of the safeguarding Minimum Data Set, supported by routine reporting and comparison across NHS Wales organisations. This will help identify trends, highlight variation, and pinpoint areas for improvement. Progress will also be reviewed through audit activity and feedback from practitioners and partners, providing evidence of ongoing improvements in safeguarding practice and outcomes.



Assurance Template to support Prevent Duty

An assurance template has been developed to enable NHS Wales' health boards and trusts to systematically record and evidence activity in line with the Prevent Duty (2023).

The template will provide assurance on how each organisation meets the requirements of the Prevent Duty within a robust governance framework. Combined with quarterly reporting of referrals, scanning activity and training, it will enhance national understanding of Prevent activity in health and help strengthen the overall safeguarding response.

Context

The Prevent Duty requires specified authorities, including health organisations, to have due regard to the need to prevent people from becoming terrorists or supporting terrorism. It ensures that individuals who are susceptible or vulnerable to radicalisation can be identified and supported, working collaboratively with partners as part of broader safeguarding responsibilities.

Prevent training and awareness supports individuals to recognise signs of radicalisation and to notice, check and share when they identify those signs.

The Template

The annual assurance template captures the governance and leadership arrangements within health organisations, demonstrating how Prevent is discussed, monitored and aligned with wider safeguarding processes.

It enables organisations to demonstrate individual processes for recording health referrals to Prevent and requests for partnership scanning. Additionally, there is an area for reporting on how organisations work as part of the Channel Panel*. I.e., the The template capture specific information on Prevent



awareness training applicable for all staff, alongside training targeted at key staff groups. When reviewed alongside referrals and scanning activity, it can highlight where additional or targeted training may be required.

Analysis

Although referral numbers from individual health organisations tend to be low, understanding their source and the services involved can help target training more effectively and promote cross organisational learning. Data on individuals referred but deemed unsuitable for Prevent is equally valuable in understanding how alternative support pathways can be strengthened.

Next Steps

The NSS will work with health organisations to share the template and support the implementation. This process will provide assurance that governance is in place to meet the requirements of the Prevent Duty and identify any areas that need further actions or support to raise awareness. Going forward, the template will evolve over time based on feedback and effectiveness.

*Channel Panel is a confidential, multi-agency safeguarding programme that supports individuals vulnerable to being drawn into terrorism. Working together, agencies consider the suitability of referrals received, reasons will be recorded and, where appropriate the individual may be redirected to a more appropriate agency or safeguarding pathway for support.

Learning from Reviews Dissemination

The Network conducted a review of current NHS organisational processes for disseminating safeguarding learning from reviews, guided by the principles of process evaluation.

Learning from historic Adult Practice Reviews, Child Practice Reviews and Domestic Homicide Reviews, alongside the emerging Single Unified Safeguarding Review process, continues to highlight recurrent themes across health and partner agencies.

Context

Many of the learning themes found in Single Unified Safeguarding Reviews (SUSRs) are recurring and appear predictable and unchanging, including recommendations specific to Health. This is despite significant efforts to ensure that learning from reviews is disseminated to all areas of practice, action plans are completed, training is provided and lessons appear to be learnt.

Methodology and Findings

A self-reported questionnaire was used to identify key processes involved in communicating the findings of safeguarding reviews within the nine NHS Wales organisations.

Findings included:

- Organisations are investing significant effort into using learning from reviews to inform training and practice, but several challenges make this difficult to implement effectively.
- No organisation has established a formal policy for sharing lessons learned from reviews, resulting in inconsistent approaches across Wales.
- While processes exist to support the dissemination of lessons learned within organisations, there is limited evidence of robust assurance mechanisms to confirm this is happening effectively.
- Although training compliance is monitored, there is no specific assurance that learning from individual reviews is consistently incorporated into training programmes.

Results indicate that the next stage of this work should focus on evaluating existing and emerging methods for disseminating learning from reviews, with particular emphasis on approaches that effectively reach relevant healthcare professionals. This would establish a baseline against which the impact of future changes and trialled modifications can be measured.

Next Steps

The next phase will use quality improvement methodology to identify, test and evaluate approaches that improve the reach and impact of learning from reviews. The Network will work with NHS Wales organisations to share existing good practice and strengthen the Learning Framework so that learning is not only disseminated, but embedded, evidenced and reviewed.





Voice of the Child/Adult at Risk



National Child Protection Principles

Working Principles for Child Protection Conferences (CPC) have been developed to establish a consistent standard for high-quality, well-coordinated safeguarding practice across health services.

The principles align with NHS Wales' safeguarding commitments and statutory duties, supporting consistent and accountable practice.

Background

When a child or young person reaches the threshold for an Initial Child Protection Conference, all concerns about abuse, neglect and significant harm must be fully assessed under the Social Services and Well-being (Wales) Act 2014. Recent trends show increasing numbers of children on Child Protection Plans, with issues such as repeated registration, ineffective long-term planning, and continued harm due to limited intervention.

Health needs can be hidden or overlooked, highlighting the importance of proactively identifying emerging health issues and understanding the long-term impact of Adverse Childhood Experiences (ACEs). National reviews also reveal gaps including limited health representation

for school age children, disengagement when no immediate health concerns are visible, poor communication between services, lack of the child's voice, and reports lacking clear analysis and planning.

Aims

These principles seek to ensure that NHS Wales provides timely and effective input at conferences, strengthening the quality of health assessment for children and young people.

The principles advocate representation from the health professional who knows the child or young person best wherever possible. This will strengthen person-centred, safe, effective and compassionate healthcare input to Child Protection Conferences.

Next Steps

Undertaking a stakeholder consultation provided an early opportunity to understand the views of key professionals and teams across NHS Wales. This information will improve and support the application of the principles operationally.

The principles are as follows:

Gwasanaeth
Diogelu Cenedlaethol
Diogelu GIG ar gyfer Cymru Ddiogelach
National Safeguarding
Service
NHS Safeguarding For a Safer Wales

CHILD PROTECTION PRINCIPLES

Principle 1: Identified Health Lead

- A named health professional is identified as the lead for the child or young person.
- This professional knows the child, can access health records, and conduct assessments.
- Health boards have systems and processes to identify and coordinate lead professionals.

Principle 2: Voice of the Child

- The child or young person is seen face-to-face to inform the health assessment.
- Health needs are assessed in the context of abuse, neglect, and risk of significant harm.
- Children, parents, and carers have clear contact points for health support.

Principle 3: Effective Systems & Communication

- Reports are submitted within agreed local authority and legislative timelines.
- Health records are updated with Child Protection Conference and ongoing Core Group activity outcomes and registration status.
- Health and social care leads are clearly identified.
- Multi-agency partners are aware of the local or regional health offer and how to access it for each child or young person.





Looked After Children Survey – Feedback Review

A review of the feedback responses from the Looked After Children national survey undertaken in 2025 has been completed.

Context

Latest published Welsh Government data show that 7,198 children were looked after in Wales on 31 March 2024 ([GOV.WALES](https://gov.wales)). This underlines the continuing importance of consistent, trauma-informed and child-centred health assessment.

The Survey

A national survey was carried out in 2025 to gather feedback from looked after children and their carers about statutory health assessments. The survey aimed to support the development of a more person centred service by using feedback to drive improvements that reflect what matters most to children and their carers.

Questions focused on core values such as dignity, respect and safety. They also explored whether children and young people felt involved in decisions about their health, whether they felt valued and

safe, and whether information had been shared with them in a way that was age appropriate.

Analysis

Survey data was analysed to identify key themes that will support quality improvement and strengthen the delivery of statutory health assessments and specialist health services for Looked After Children.

Overall findings were positive:

- Most respondents reported that professionals communicated clearly, and demonstrated a compassionate, child-centred approach. They felt listened to, supported, and able to ask questions.
- Carers reported very high levels of satisfaction with the overall experience.
- Home visits were identified as the preferred setting, contributing to a more relaxed and open environment.
- Staff professionalism, empathy, dedication, and the value of relationship-based care and continuity were highlighted as positive



Areas for improvement were identified at practitioner, health board and national levels:

- Some children did not understand the purpose of their health assessment, did not feel listened to, or lacked chances to share concerns.
- These issues were linked to uncertainty about the professional's role.
- Several children were dissatisfied with clinic or school-based settings, and some were not given private time with a health professional.
- Negative feedback raised practical barriers e.g. parking, privacy issues, and the need for more individualised, flexible assessments, especially for children with additional needs.

Summary

The survey shows statutory health assessments are generally positive but identifies the need to improve consistency, communication, and personalised care. Enhancing these areas, along with better survey uptake and data capture, will help ensure the voices of care experienced children and young people continue to shape service development at all levels.

Next Steps

- Practitioners to be reminded of the importance of introductions and the need to individualise assessment approaches as necessary.
- Health boards to review their health assessment processes to ensure children and carers are seen in the most appropriate settings. Health boards should also ensure continuity of health professionals involved in the health of looked after children wherever possible.
- The National Safeguarding Service to consider creating a national introductory resource for children entering care, outlining the purpose of statutory health assessments and the role of specialist Looked After Children health services.

Feedback from children

"X was nice and she treated me like I was 10 and yeah so X is good dont fire her."

"She was kind and helpful. she listened to me when I needed to speak to her. she didn't interrupt me or talk over me. In my opinion o thought she was very kind and caring overall."

"X is always professional and arrives with a smile on her face."

Feedback from carers

"the LAC Health nurse was very friendly and was genuinely interested in the Child in my care."

"The nurse used professional and sensitive approach."

"the nurse was really kind and lovely. She didn't rush us and I could tell she was really interested in what I had to say."



Assessment and Professional Curiosity

Child Sexual Exploitation Risk Questionnaire

A scoping exercise has been undertaken to identify the requirements for commissioning an update of the Child Sexual Exploitation Risk Questionnaire (CSERQ).

The findings will inform commissioning requirements, strengthen multi agency collaboration, define quality standards, ensure alignment with learning from the Independent Inquiry into Child Sexual Abuse (IICSA), and incorporate the voices of young people.

Context

The Child Sexual Exploitation Risk Questionnaire (CSERQ), developed in 2015, remains widely used across NHS Wales to help identify child sexual

exploitation. Its integration into the Welsh Nursing Care Record (WNCR) in 2024 prompted a review of its relevance, particularly regarding online harms, appropriate language, and alignment with current safeguarding policy. Practitioners value the tool's practicality and its ability to support sensitive conversations, strengthened by updated guidance and a new training video. However, key gaps remain, including outdated wording, limited data on how the tool is used, and a lack of recent consultation with young people regarding barriers to disclosure.

Stakeholder Engagement

A July 2025 stakeholder session highlighted the need for better understanding of how the CSERQ is used across Wales and for stronger evidence to guide future commissioning. Stakeholders also noted that national developments – such as the Welsh Government's emerging 10 year Child Sexual Abuse (CSA) strategy and Barnardo's multi agency indicators work – may change expectations for



CSA assessment tools, making it essential that any future CSERQ revision aligns with these developments.

Analysis

This scoping analysis concluded that while the CSERQ remains the only established and research based CSE assessment tool widely used within NHS Wales, it requires review and modernisation to ensure continued relevance.

Key preparatory actions include:

- An all Wales audit of CSERQ use, including patterns of deployment, professional roles, and links to referral pathways.
- Qualitative engagement with practitioners and direct consultation with children and young people.
- Ongoing monitoring of national Child Sexual Abuse strategy developments and emerging multi agency tools.
- Early definition of commissioning requirements for a trauma informed, evidence based, contemporary tool.

Going Forward

This work provides the foundation for commissioning an updated CSERQ, ensuring that future versions align with national priorities, reflect lived experience and remain effective within modern safeguarding practice.



Chaperone Guidance

The Network has refreshed Chaperone Guidance for NHS Wales practitioners.

The guidance sets out Good Working Practice Principles for the use of chaperones during intimate examinations, procedures and investigations across NHS Wales. Its primary purpose is to ensure that practice is safe, dignified, consistent and person-centred, while strengthening safeguarding for patients and protection for healthcare practitioners.

It establishes a clear expectation that a formal, trained chaperone is actively offered for all intimate procedures, regardless of setting or operational pressures, and aligns practice with Welsh legislation and safeguarding requirements.

Content

The guidance covers the following:

- Definitions and Role of the Chaperone
- Active Offer, Consent and Communication
- Declining a Chaperone and Managing Risk
- Safeguarding and Professional Curiosity
- Roles and Responsibilities
- Specific Patient Groups and Settings
- Documentation, Emergencies and Assurance

Next Steps

The updated guidance provides health practitioners with Good Working Practice Principles aligned with Welsh legislation and suitable for organisations to share with practice areas.



Safeguarding Learning

In the last period the Network has delivered a variety of safeguarding learning opportunities for practitioners.

The events aim to foster collaborative, evidence-based improvements in safeguarding practices that enhance the collective capacity of agencies to protect vulnerable people.



Launch of Drama-Based Safeguarding Scenario Videos

The Network launched a powerful new learning resource designed to support reflective, high-impact safeguarding learning across agencies in Wales.

The resources were launched at a Cardiff based Train the Trainer event that guided professionals through the offer, supporting them to embed safeguarding learning within their own teams and organisations.

About the Resources

A portfolio of drama-based video scenarios, produced by training experts *AftaThought*, explore key themes covering professional curiosity, managing disclosures, strategy discussions, mental capacity, home invasion, disguised compliance, and hearing the voice of families and carers. They are accompanied by a Safeguarding Training Pack to embed consistent, evidence-based learning across services.

They are intended for adaptation and use across NHS Wales and wider partner agencies.

The materials are suitable for:

- Safeguarding trainers and leads in health and care organisations
- Professionals delivering internal safeguarding training
- Multi-agency practitioners seeking shared understanding and consistent practice



What's Covered – and Why Now?

The video scenarios focus on two critical safeguarding priorities:

- **Professional Curiosity** – Encouraging practitioners to explore beyond the surface, challenge assumptions, and notice when “something doesn’t feel right”.
- **Voice of the Adult at Risk** – Emphasising the importance of truly listening to and understanding adults at risk – not just hearing their words, but interpreting their behaviour, context, and lived experience.

These themes are timely and relevant given recurrent review and audit findings that have highlighted missed opportunities to intervene earlier due to lack of curiosity or failure to hear the adult’s voice.



“Fantastic, nuanced videos, really prompting discussion with those on the table.”



“These scenarios are going to make a huge difference to our safeguarding training programme.”



Trusted to Safeguard Conference

‘Trusted to Safeguard’ provided a focus on managing safeguarding allegations against Practitioners / Those in a Position of Trust (see earlier section re NHS Wales Guidance).

The one-day conference, held in February 2026, aimed to support multi-agency delegates to implement Section 5 - Management of NHS Wales’ Employees’ Guidance, of the [Wales Safeguarding Procedures](#).

Drawing on learning from recent high profile safeguarding reviews, the event workshops enabled practitioner involvement to develop a consistent, fair and proportionate approach to risk assessment, and assure the quality of referrals made into local authorities. In addition, the conference considered safe employment and staff wellbeing as an essential component throughout the Section 5 process.

Learning Together

Safeguarding experts shared national learning, psychological insight and practical experience.

Multi-agency partners then worked together to explore the following areas to shape the final guidance:

- How to balance safeguarding duties, employment responsibilities and fair treatment
- How people who abuse, exploit or groom can function effectively in public services and positions of trust, often hiding in plain sight
- What good risk assessment looks like while allegations are being considered
- How to best support staff without compromising safety
- How NHS Wales can improve consistency, assurance and learning around managing allegations.



Going Forward

Following finalisation of Section 5 to the Wales Safeguarding Procedures the NSS will move to publication of national guidance for Managing Allegations in NHS Wales.



“Really practical insights and perspectives to inform decisions around PIPOT [People in Positions of Trust] cases.”

“Brilliant opportunity to network and learn what other agencies are doing.”



Strengthening Adults Safeguarding Round Table

A Strengthening Adult Safeguarding Round Table Event – Approach to Physical Injuries took place in Cardiff in March 2026. The event was hosted by The Faculty of Forensic Legal Medicine (FFLM) and supported by the National Safeguarding Service.

The event brought together professionals to examine the way adults at risk are protected when they present with injuries that may indicate physical abuse.

Activity

The event included presentations exploring whether there is a need for change, highlighting current UK practice, and looking at potential approaches to adult safeguarding in the future. Discussions highlighted the importance of building a strong evidence base and considered the benefits for clinicians, patients and services across Wales.

Through interactive small groups, attendees explored potential future approaches to improving practice, including:

- strengthening clinicians' skills in injury assessment
- the need for an improved evidence base for practitioners
- gathering case studies from across Wales to identify where current processes have either supported or failed adults
- developing a common language across Wales to describe observed injuries
- the need for a Named Doctor for adult safeguarding within health services.



Going Forward

- The Faculty of Forensic Legal Medicine will take this work forward including presenting to the British Medical Association (BMA)
- Attendees will share this information with their Regional Safeguarding Boards and other agencies, raising inequities in support for vulnerable adults, including potential for roles such as a Named Doctor for safeguarding adults-at-risk
- GP leaders will put in place training around injuries of concern in vulnerable adults.



“Inspiring speakers and positive discussions.”

“Face to face discussions felt very valuable.”

“Valuable ideas for taking the initiative forward which I will be sharing with my team.”





Safeguarding Celebration Event

Recognising Safeguarding Excellence Across NHS Wales

The inaugural NHS Wales Safeguarding Celebration Event took place in March 2026 at Cardiff Castle. The event recognised safeguarding excellence across teams and individuals, highlighting the meaningful and impactful work taking place every day throughout NHS Wales.

Context

Safeguarding is a vital, complex and often unseen area of practice. Colleagues from all professions, disciplines and services work to protect people's safety, dignity and rights — frequently in challenging circumstances and without formal recognition. This event offered time to pause, reflect, and celebrate that contribution, and to recognise safeguarding practice that has made a real difference to people's lives.



Nominations

Nominations were encouraged from all professional groups, disciplines and service areas – not only those in designated safeguarding roles.



Effective safeguarding is everyone's responsibility, and many outstanding examples sit within frontline care, leadership, service improvement, education, research and partnership working.

Entries were reviewed by a senior safeguarding judging panel using clear and consistent criteria.

Angela Wood, Executive Director of Nursing and Midwifery at Betsi Cadwaladr University Health Board opened the event with a keynote address, recognising the courage, compassion and commitment needed to safeguard our most vulnerable people, and Claire Birchall, Executive Director of Nursing, Quality and Information Governance at Public Health Wales closing remarks, thanked all award winners for their inspiring and valued contribution to safeguarding. Celebrations concluded with a musical recital and afternoon tea at the Cardiff Castle venue.



Award Winners

Award category	Winner	Organisation
Lifetime Contribution to Safeguarding	Linda Hughes-Jones	Cardiff & Vale University Health Board
Partnership and Multi-agency Working	Michelle Chaplin	Gwent Police
Improving Services and Outcome for Looked After Children	Sarah Phippen	Cardiff & Vale University Health Board
Rising Star in Safeguarding	Lucy Farthing Gwenan Jones-Parry	Digital Health and Care Wales Welsh Ambulance Service NHS Trust
Excellence in Front Line Safeguarding	Cyfannol Safeguarding Hub, Emergency Department, UHW	Cardiff & Vale University Health Board
Strengthening the Voice and Rights of the Child/Adults at Risk	Carol Jones Michele Pengelley and First Floor Ward Staff	Betsi Cadwaladr University Health Board Velindre University NHS Trust
Safeguarding Innovation, Improvement, Learning and Research	Katharine Thomas	Swansea Bay University Health Board
Safeguarding Leadership	Claire O'Keefe	Cwm Taf Morgannwg University Health Board



“I hope this marks the beginning of a regular celebration, recognising the incredible safeguarding work that is so often carried out quietly and without recognition. Creating space to celebrate this work feels important, and we look forward to building on this in the years ahead.”

Louise Mann, Director of Safeguarding at Public Health Wales



Innovative Regional Practice

Network members regularly share effective safeguarding practice in order to highlight what works in their area, build effective practice and contribute to improving safeguarding across NHS Wales.

Organisation-based and multi-agency practice innovations over the last period are as follows:





Development and Expansion of the Datix Safeguarding Function

Hywel Dda University Health Board (HDdUHB) has significantly strengthened its use of the Datix Safeguarding Function to support effective safeguarding governance.

Context

Datix is the NHS's primary incident reporting and risk management system, supporting patient safety and organisational learning. HDdUHB has used Datix since its introduction in 2016 to record safeguarding concerns relating to Adults at Risk where alleged abuse or neglect involved Health Board-provided or commissioned services. Although initially limited in scope, this early adoption established a consistent, auditable approach to safeguarding reporting and oversight.

The system enabled extraction and analysis of safeguarding data at service and organisational levels, supporting identification of trends, emerging risks and areas for improvement. Secure document upload to individual records further strengthened information governance, organisational memory, auditability and professional defensibility.

Safeguarding Module

Subsequent developments introduced a dedicated Safeguarding Module, marking a significant expansion in functionality and ambition. This enhanced the Safeguarding Team's ability to record, link and oversee a wider range of safeguarding activity across the organisation and with partner agencies.

Information Capture

The module now captures a broad range of safeguarding activity, including Channel cases, Single Unified Safeguarding Reviews (SUSRs), concerns about practitioners (internal and external), Multi-Agency High Risk Panels, Procedural Response to Unexpected Deaths in Childhood (PRUDiC) processes, rapid responses to suspected suicide, Modern Slavery cases, VAWDASV Multi-Agency Risk Assessment Conferences (MARACs), and safeguarding advice and support. This breadth reflects both the evolving safeguarding landscape and the organisation's growing maturity in safeguarding governance.

Impact

Record linking within Datix has provided HDdUHB with a holistic view of safeguarding risk over time, connecting related concerns, advice, incidents and complaints. Overall, Datix has evolved from a reporting tool into a robust safeguarding governance system, offering enhanced oversight, assurance and support for managing complex, multi agency safeguarding activity across the organisation.



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Strengthening the Voice & Rights of the Child/Adult-at-Risk Award

At the NHS Wales Safeguarding Celebration Event in March 2026 held at Cardiff Castle, a team from Velindre University NHS Trust (VUNHST) won a Strengthening the Voice & Rights of the Child/Adult-at-Risk Award.

The event recognised safeguarding excellence across teams and individuals, highlighting the meaningful and impactful work taking place every day throughout NHS Wales.

This award went to Michele Pengelly and the First Floor Ward Staff at Velindre Hospital and recognises exceptional commitment to ensuring that the voices of children and adults at risk are heard, respected, and acted upon.

Whole Family, Multi-Agency Approach

The award nomination highlighted the team’s exceptional care for a family where the sole parent had a terminal prognosis with no wider family support.

Staff recognised the emotional burden on the children, prioritising their wishes, worries, and hopes. Through sensitive conversations, the team helped the family feel safe to engage with social services, co-producing a referral that placed the voice of the children at the centre of decision making.

This led to a coordinated, multi-agency approach that addressed both emotional and practical needs. Throughout, Michele and staff on first floor ward worked with professionals on removing obstacles, rather than imposing solutions, enabling the children to navigate an incredibly difficult period with dignity and stability.

Thanks to this compassionate, child centred approach, the children continued to receive support following their parent’s passing and were able to fulfil the goals they had set from the beginning.



Louise Mann, Director of Safeguarding at Public Health Wales noted:

“Specialist Nurse Michele Pengelly and the First Floor Ward Staff at Velindre University NHS Trust supported a young family facing a terminal diagnosis, placing the family at the centre of every decision. Through sensitive communication, compassionate care, and coordinated multi-agency working, they ensured the children’s wishes and concerns guided every decision and plan – from maintaining their home to accessing education and bereavement support.”





Promises to Care Experienced Children

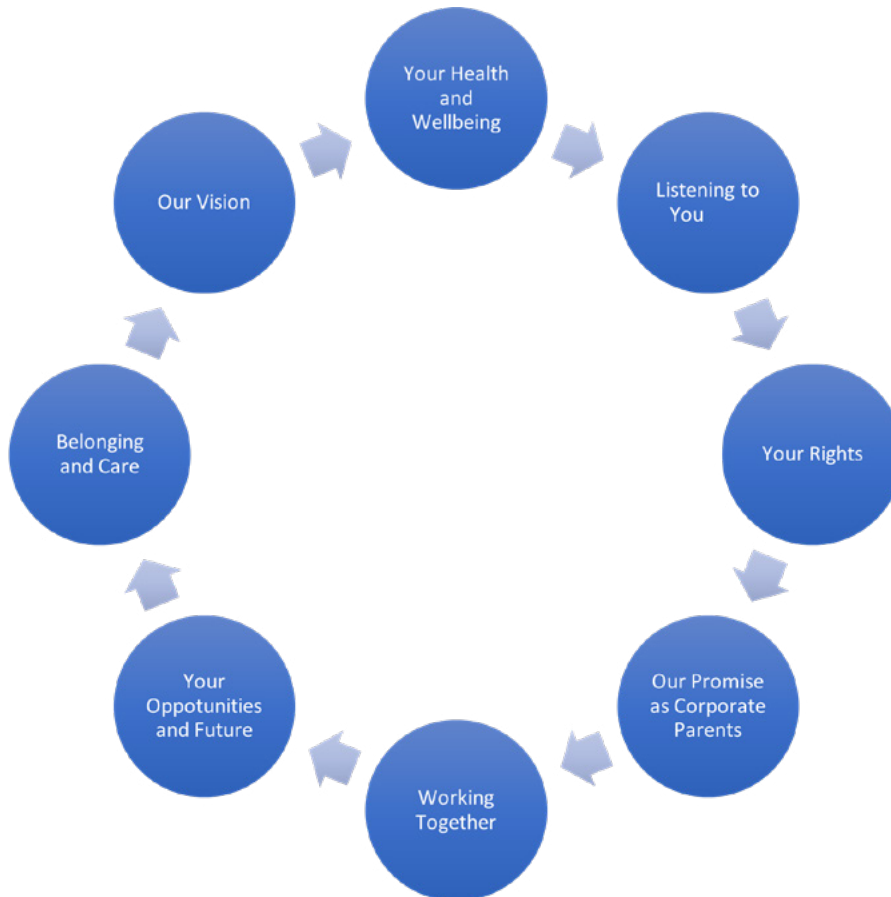
In 2025 Powys Teaching Health Board (PTHB) signed the Corporate Parenting Charter, making a clear public commitment to become “corporate parents” and deliver on the relevant principles outlined in the Charter.

PTHB’s next step is to ensure their Corporate Parenting role extends from strategic senior leaders to all employees across the health board, enabling them to collectively act as a responsible parent would for their own child.

To support this aim, and to meet the Principles within the Charter, the organisation has developed 8 Promises to Care Experienced Children covering how they will be taken care of.

The Promises are based upon the principle of nothing about you, without you, and will be delivered by a Corporate Parenting Promises Task and Finish Group.

PTHB’s 8 Promises to Care Experience Children are:





Women's Virtual Health Hub

Violence against Women and Girls Section

Powys Teaching Health Board's Virtual Women's Health Hub demonstrates the health board's proactive approach to preventing all forms of VAWDASV, while also protecting and supporting those who have experienced it.

Hub VAWDASV content, along with the associated training resources for health staff, are being co produced with victims and survivors who are members of the Mid and West Wales VAWDASV Survivor Panel. This approach recognises victims and survivors as experts who hold a key role in shaping the Hub's content, design, and supporting resources.

Facilitated workshops are currently taking place to gather survivor insights and ensure the work aligns with the Health Board's objectives for the Hub, which are:

- To develop engaging, accessible, bilingual and trauma informed public facing assets for the Women's Health Hub.
- To create complementary training resources for health professionals that can be integrated into existing training packages (e.g. case vignettes, lived experience narratives, short animated explainers).
- To ensure alignment with the NHS Wales Women's Health Plan and the Powys Women's Health Needs Assessment priorities, with a focus on prevention, equitable access, and reducing inequalities across the life course.





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Perinatal Mental Health Support Unit

Swansea Bay University Health Board (SBUHB) has established a dedicated unit to support women experiencing significant mental health difficulties during pregnancy and after the birth of their child.

Uned Gobaith ('Unit of Hope') is the only inpatient service of its kind in Wales, providing multidisciplinary mental health care for women from 32 weeks of pregnancy until their baby reaches one year of age.

Context

Previously, mothers who required intensive mental health support were either cared for in the community, admitted to acute mental health wards without their babies, or had to travel to specialist mother and baby units in England.

The Unit

The unit offers six individual bedrooms for women and their babies, alongside shared living and kitchen areas, a playroom, a quiet room, and a sensory room. Accommodation is also available for family members who need to travel from further afield to visit their loved ones.

Care is delivered by a comprehensive multidisciplinary team including psychologists, mental health nurses, psychiatrists, social workers, health visitors, and midwives. Nursery nurses are also on hand to support by caring for babies while mothers rest or receive treatment.



At the time of the unit's launch, Eluned Morgan, then Minister for Mental Health and Wellbeing, said:

"It is fantastic news that we have our own perinatal mother and baby unit in Wales to support those struggling with their mental health.

This will make a significant difference to the experience of new mothers as they will be able to get the specialist support that they and their babies need closer to home."



Court of Protection and Mental Capacity Act Advocacy Lead

Upholding the Rights of the Person

Swansea Bay University Health Board (SBUHB) was the first organisation in NHS Wales to appoint a dedicated Lead for Court of Protection (CoP) and Mental Capacity Act (MCA) Advocacy services.

This unique dual role strengthens systems for managing CoP cases and MCA advocacy, supporting lawful, consistent, and rights based decision making across the Health Board.

The Lead maintains expert oversight of relevant legislation and works closely with the Deprivation of Liberty Safeguards (DoLS) Team, Service Groups, and Independent Mental Capacity Advocate (IMCA) services. This collaborative approach ensures that the wishes, feelings, beliefs, and values of people who lack capacity are fully understood and remain central to all decisions made on their behalf. Learning and best practice are shared across the organisation through 7 Minute Briefings, supporting staff development and improving patient outcomes.

The role places a strong emphasis on upholding patients' human rights, particularly where decisions are made for individuals who lack capacity. The Lead also maintains close engagement with the NHS Wales MCA/DoLS Network to share best practice and support the development of robust, practical policies and processes. This enables staff across SBUHB to apply the Mental Capacity Act, Deprivation of Liberty Safeguards, and the Human Rights Act safely, lawfully, and consistently in everyday practice.





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University NHS Trust

Managing Safeguarding Allegations in Ambulance Services

Over the last period, the Safeguarding Team within Welsh Ambulance Services University NHS Trust (WAST) has made significant improvements to the way safeguarding allegations are identified, assessed and managed across the organisation.

This work demonstrates a strong commitment to protecting patients, supporting staff and maintaining public confidence through clear, consistent and transparent safeguarding practice.

Comprehensive Review

In response to national priorities across Wales – including addressing sexual harassment, strengthening safer recruitment to positions of trust, and promoting positive organisational cultures – the team undertook a comprehensive review of safeguarding allegations management. This highlighted the need for clearer guidance to help staff recognise when concerns, particularly around professional conduct and sexual safety, may require safeguarding consideration.

Key Improvements

To address these gaps, an enhanced safeguarding process was developed and implemented. Central to this are a new Safeguarding Risk Assessment Template and Safeguarding Allegations Checklist, which provide a clear, practical framework to support consistent decision making and improve understanding of safeguarding thresholds.

The tools were informed by national learning, internal case audits and feedback from operational colleagues, ensuring they are practical, evidence-based and aligned with best practice.

Early Feedback and Impact

Early feedback indicates the new process has strengthened governance by ensuring safeguarding concerns are recorded, reviewed and escalated in a structured and auditable way. Staff report increased confidence in identifying safeguarding concerns, particularly in sensitive areas such as sexual harassment and domestic abuse, alongside greater clarity about when behaviours warrant safeguarding action.

Overall, the new approach supports earlier identification of risk, more robust assessment and timely, transparent decision making. It has reduced uncertainty for managers, promoted shared professional judgement and embedded a more proactive safeguarding culture across the Trust. This reinforces professional standards, supports challenge and accountability, and contributes to the wider safeguarding agenda in Wales.





Dual Advocate Service for Domestic Violence and Sexual Violence

With the support of Value Based Health Care (VBHC) funding, Cwm Taf Morgannwg University Health Board (CTMUHB) has established a dual role Independent Domestic Violence Advocate (IDVA) and Independent Sexual Violence Advocate (ISVA) service.

Strategic Context

This work aligns directly with the Women’s Health Plan and Sexual Safety Strategy and provides clear evidence of delivery against the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Strategy and national Blueprint workstreams.

Service Offer

The service comprises a team of three advocates, each based within the Health Board’s District General Hospitals. They provide timely advice and specialist support to both patients and staff affected by domestic abuse and sexual violence.

This innovative model demonstrates the Health Board’s commitment to prevention, partnership working and evidence based approaches to safeguarding and public protection.

Impact

The service aims to improve access to specialist advocacy within healthcare settings, promote early intervention, and strengthen trauma informed, person centred care. Its effectiveness will be evaluated using Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs), supporting continuous improvement and demonstrating the service’s contribution to healthier, safer lives.





Digital Mental Capacity Act Assessment Form

Cwm Taf Morgannwg Health Board (CTMUHB) has implemented a digital Mental Capacity Act (MCA) capacity assessment form to support consistent practice that is compliant with evolving case law.

Context

Valid consent to healthcare intervention must be given freely and voluntarily, without coercion, by an individual who has the appropriate information and the mental capacity to consent to the specific treatment or intervention proposed.

The Mental Capacity Act (MCA) provides a legal framework for supporting individuals aged 16 and over who may struggle with decision making. Capacity assessments must relate to the specific decision being made and must consider and evidence the person's wishes, feelings, beliefs and values. When assessing capacity, practitioners must focus on the specific "matter" of the decision, as required by case law.

The Form

The form provides structured guidance for practitioners and sufficient space to evidence how the MCA has been applied in practice, ensuring that the individual remains central to the decision making process. This approach supports compliance with the Act and affords statutory protection to healthcare professionals.

Benefits

By embedding a person centred, legally robust approach to consent and capacity assessment, the Health Board strengthens practice, reduces the risk of complaints, and mitigates potential financial and reputational impact.

Furthermore, this approach demonstrates ongoing commitment to transparent and person-centred care.

Implementing Learning from Safeguarding Reviews

In the last period Betsi Cadwaladr University Health Board (BCUHB) Safeguarding and Public Protection Team has implemented learning extrapolated from the following safeguarding reviews.

“Our Bravery Brought Justice”

The Gwynedd Child Practice Review (CPR) was commissioned by North Wales Safeguarding Board in relation to a former Headteacher.

This was a complex and demanding Review which considered the multi-agency activity relating to eight child victims/survivors of sexual abuse and four child victims/survivors of restrictive processes and restraint.

The Review identified 52 missed opportunities. While the findings were presented through themes relating to abuse in a school setting, the recommendations are cross cutting and provide a framework for improvement at both local and national levels. They are intended to be practical and achievable, although some may require changes to national safeguarding and school governance guidance.

The review made two direct recommendations to Betsi Cadwaladr University Health Board (BCUHB):

a) Data Sharing

Consideration should be given by the Health Board to the sharing of anonymised CAMHS data with Local Authorities to identify hotspots and thematic concerns.

b) Safeguarding Assurance

Provide reassurance to the Regional Safeguarding Children’s Board that health professionals seek safeguarding advice when a child presents at an appointment accompanied by an adult without parental consent.

Through a structured and collaborative approach, in line with the oversight and monitoring arrangements of the North Wales Safeguarding Board, BCUHB have developed and monitored the implementation of the recommendations and audit compliance.



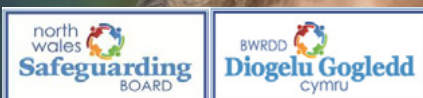
Abusive Head Trauma

Recommendations from Child Practice Reviews resulted in the BCUHB launch of 'ICON' which is an initiative to prevent Abusive Head Trauma (AHT) in babies and children. AHT can cause lifelong neurological conditions and is the most common cause of death from child abuse in the UK.

The programme helps mums, dads and other carers understand the normal crying patterns of newborns, and encourages families to use simple comforting methods. It makes it clear that it is acceptable to leave a baby somewhere safe and walk away for a few minutes if their crying gets too much. It also urges parents and carers to never, ever shake a baby – no matter how stressed or frustrated they become.

From November 2025, all parents/carers of babies discharged from inpatient Maternity, Neonatal, and Home Birth settings receive the ICON message through core touchpoints.

The Health Board is the first in Wales to adopt ICON and has worked with programme leaders to make Welsh language support materials available for parents and carers for the first time. The programme is funded and supported by North Wales Safeguarding Board and phase 2 will see the implementation of multi-agency interventions.



Are you struggling with your baby crying?
Speak to your Midwife or Health Visitor about ICON

Ydych chi'n ei chael hi'n anodd gyda'ch babi'n crio?
Siaradwch â'ch Bydwraig neu Ymwelydd Iechyd am ICON



For more information, please scan the QR code.
Os gwelwch yn dda, sganwch y côd QR am fwy o wybodaeth.



Babies Cry, You Can Cope!

Mae babanod yn crio, fe allwch chi ymdopi!





Alcohol Screening Project

The Alcohol Screening Pilot Project at University Hospital of Wales (UHW) is a vital new addition to the hospital's frontline care, delivered in close partnership with Cardiff and Vale University Health Board (CVUHB) Corporate Safeguarding Team.

This collaboration ensures that every patient identified through screening is supported by a safety net of experts, all working within a nationally recognised centre for safeguarding excellence.

Strengthening Existing Support

By integrating alcohol screening into the Emergency Unit, the project strengthens the specialist support already offered by through the Emergency Department (ED) Safeguarding Hub. This hub - recently awarded a Safeguarding Excellence Award at the Public Health Wales Recognition Awards - acts as a central point for multi-agency intervention, enabling immediate and holistic responses for vulnerable patients.

Impact

- **Integrated Safeguarding:** the project ensures that alcohol-related risks are identified and managed with the same rigour as other statutory safeguarding concerns.
- **Enhanced Support Network:** The screening adds a proactive layer to the hub's existing services (such as domestic abuse and mental health support) by identifying hazardous alcohol use early and linking patients directly to specialists like Cardiff and Vale Drug & Alcohol Service (CAVDAS).
- **The Cardiff Model in Action:** By combining routine screening with the hub's collective expertise, the project aims to reduce alcohol-related harm and prevent repeat hospital attendances.
- **Award-Winning Environment:** Delivery from the ED Safeguarding Hub ensures the project operates within a proven, high-performing setting recognised for excellence in multi-agency collaboration and patient protection.

Prevent ‘Below Threshold’ Pilot

The Cardiff and Vale University Health Board (CVUHB) Corporate Safeguarding Team and Cardiff Children’s Services have been integral partners in the Home Office “Below Threshold” Prevent pilot.

The pilot aligns with the Cardiff and Vale Regional Safeguarding Board’s priority of early intervention, preventing lower-level concerns from escalating into more serious risks.

Prevent Duty

The Prevent duty is a legal requirement under the Counter-Terrorism and Security Act 2015 that requires public bodies to take steps to stop people being drawn into terrorism, by identifying those at risk early and providing safeguarding support.

The Initiative

This national initiative was specifically designed to address the “grey area” of referrals where an individual does not meet the high statutory threshold for Channel Interventions, but still exhibits significant vulnerabilities that require multi-agency support.

To facilitate the pilot Cardiff established a Below Threshold Panel to ensure children and young people who fall outside formal counter terrorism processes still receive safeguarding oversight and support.

Collaborative Framework

- **Cardiff Children’s Services:** coordinate Prevent referrals and ensure any concerns are addressed within broader social care safeguarding processes.
- **CVUHB Corporate Safeguarding:** contributes clinical expertise, ensuring vulnerabilities like mental health, trauma, or neurodiversity are addressed through appropriate health pathways.



Improving Safeguarding Leadership Across Public Health Wales

During the reporting period, Public Health Wales (PHW) experienced a notable increase in requests for safeguarding advice and support relating to employees.

While these matters were managed internally, the trend indicates an increasing organisational awareness of safeguarding as a core responsibility. It also highlights the importance of confident, compassionate leadership in supporting staff through complex and emotionally challenging situations.

Feedback

There were multiple instances of staff engaging directly with the safeguarding team for advice, reassurance, and professional support. Feedback from a retiring colleague noted the team's consistent accessibility and the value of constructive guidance provided in challenging circumstances.

This feedback demonstrates the important role of safeguarding leadership in supporting both public protection and workforce wellbeing.

Reflective Practice

The safeguarding team has further strengthened reflective practice across PHW. Following a challenging incident, staff were offered structured reflection sessions to review the situation, identify learning, and inform improvements to organisational processes.

Feedback from participants highlighted the value of being supported to reflect and contribute to service improvement. This approach has reinforced a culture of openness, learning, and continuous improvement.

Service Improvement

Reflections from senior colleagues have highlighted the impact of staff harm and the benefits of earlier engagement with safeguarding support. This has reinforced the need to recognise safeguarding as integral to staff wellbeing, rather than solely a public-facing function.

In response, PHW is strengthening organisational awareness, enhancing leadership engagement, and further embedding safeguarding within wellbeing frameworks. This represents a shift from a compliance-based approach towards a more compassionate, supportive organisational culture.

In addition to increasing organisational awareness, PHW has continued to strengthen its statutory and safeguarding responsibilities to ensure that individuals undertaking roles involving vulnerable groups are appropriately vetted. A Disclosing and Barring Service (DBS) policy has been implemented, introducing the mandatory use of the DBS Update Service and providing greater clarity regarding the responsibilities of managers and staff.



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Datix Safeguarding Module Implementation

In April 2025 the Aneurin Bevan University Health Board (ABUHB) Corporate Safeguarding Team led on the implementation of a new digital system to track all safeguarding children, safeguarding adult and people in position of trust (PIPOT) cases.

The system was introduced to ensure that all safeguarding cases were recorded on one system and to enable cases to be linked, where more than one family member involved was.

Context

Prior to its implementation there were separate recording systems in place for Child Safeguarding, Adult Safeguarding and PIPOT, which did not provide the opportunity to autogenerate reports, requiring manual interpretation of data.

Now that the system having been in place for a full year, the Health Board Corporate Safeguarding Team have developed dashboards that allow activity reports to be automatically generated. These reports enable more effective analysis of safeguarding activity and support the identification of emerging themes and trends.



Benefits

As the system has been developed nationally, all reports generated are drawn from a fully verified dataset and can be used confidently to meet both local and national reporting requirements. The system also significantly improves the team's ability to respond to Freedom of Information requests in a timely manner, with minimal disruption.

Going Forward

National work is currently underway –with active contribution from ABUHB – to integrate the system fully into the safeguarding referral process. This will ensure that all relevant safeguarding information can be held securely and accessed within a single, comprehensive system.



Future Priorities

Looking to 2026/2027 the Network will continue to build upon the strong relationships and knowledge base they have built to date, working together to achieve ‘A Wales where everyone is safe’.

Future work is driven by current and pending changes in legislation and statutory guidance, learning from the peer reviews, recent safeguarding reviews, recommendation and feedback. The Network will continue to align safeguarding activity with the next phase of VAWDASV strategic planning, with particular attention to prevention, early intervention, survivor voice, workforce confidence and the interface between safeguarding and specialist support.

There will be a strong focus on implementing the safeguarding quality and assurance products developed over the last period. Learning events will be responsive to recurrent or emerging safeguarding themes.

Emerging issues that would benefit from leadership and consistency across NHS Wales are considered throughout the delivery period.

Deliverables over the next period include:

- Implementation of the Safeguarding Learning Framework using learning to refine practices and enhance national safeguarding effectiveness.
- Implementation of the Quality Statement and Safeguarding Metrics including the roll out of the Datix Safeguarding Module.
- A Scoping Programme for Primary Care Safeguarding Engagement & Learning.
- Development of a Level 5/6 Safeguarding Training Programme for NHS Wales Boards and Executive Leaders.
- Multi-Agency Safeguarding Listening, Learning and Improvement Events, responding to recurrent or emerging safeguarding themes.

