NHS WALES SAFEGUARDING NETWORK

Annual Report 2024-25

GIG CYMRU NHS WALES

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DIOGELU RHWYDWAITH | SAFEGUARDING NETWORK

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Author: Shamala Govindasamy
Email: NSS@wales.nhs.uk
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Chair's Introduction

Welcome to the 2024–2025 Annual Report of the NHS Wales Safeguarding Network.

It is a privilege, as Chair, to reflect on another impactful year of safeguarding activity across NHS Wales. This report highlights the collective effort, innovation, and dedication of our safeguarding community in promoting the health, safety, and rights of the people we serve.

Over the last year, the Network has delivered meaningful progress across a range of complex safeguarding issues. From updated guidance on child protection medical assessments, to national standards for missed appointments, and the development of pathways for managing pregnancy in children under 13, our work continues to respond to the evolving needs of our populations and workforce.

The introduction of a Safeguarding Strategy Template supports all NHS Wales organisations to align to a common vision, while enabling tailored local delivery. This tool promotes consistency, strengthens assurance, and reinforces collective accountability for safeguarding practice.

We have continued to prioritise learning and professional development. Our national Spotlight Sessions have brought safeguarding to life, with powerful, scenario-based learning and expert insight. One session focused on professional curiosity, challenging practitioners to reflect on their thinking, assumptions, and decision-making. Another focused on adults at risk, drawing on recurrent themes from safeguarding reviews and highlighting the importance of keeping the voice of the adult central to service planning and delivery. These events have strengthened practice and inspired reflective learning across health and care systems.

We have also taken deliberate steps to care for the people who lead safeguarding in Wales. Through our Restorative Supervision offer, we've supported the well-being and sustainability of safeguarding leaders, creating safe spaces for reflection, connection and renewal – critical in sustaining the emotional resilience needed for this complex work.

Despite all that has been achieved, we recognise that there is still much to do. Too many vulnerable people in Wales continue to experience poor outcomes. Continued progress depends on embedding learning, prevention and early intervention as core principles of our practice, while ensuring safeguarding remains everyone's responsibility.

We welcome and support the Chief Nursing Officer's (CNO) commissioned Strengthening Safeguarding in Health Review, which provides an important opportunity to enhance quality assurance, governance, learning and national consistency. The establishment of a Delivery Group and dedicated workstreams will shape a deeper understanding of the safeguarding landscape and inform our direction as a system.

As we look ahead to 2025–2026, we remain committed to working alongside Welsh Government and the NHS Wales Performance and Improvement to drive improvements that are ambitious, inclusive, and grounded in what matters most to the people of Wales.

All citizens have the right to live free from fear, abuse, neglect, exploitation, and harm. Together, we are committed to making this a reality.

I hope you find this report both informative and inspiring, and I encourage you to share it widely across your organisation and networks.

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 led 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 a community of practice and facilitators of joint safeguarding improvement activity. 6 sub-groups cover the following areas:

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

Multi-Agency Working

Network partners outside of NHS Wales include the Regional Safeguarding Boards, Older People's and Children's Commissioner Offices, the Wales Violence Prevention Unit 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.

Information and Sharing

A National Approach to Child Protection Medical Assessments

Background

A Child Protection Medical Assessment (CPMA) is a specialised assessment conducted as part of the statutory multi-agency investigation in response to concerns regarding potential child abuse or neglect, focusing on identifying signs of harm and gathering evidence for a report shared with partner agencies including Children's Social Services and the Police.

The examination involves a thorough medical history, including questions about the child's development, health, social circumstances, family history and a head to toe physical examination.

A National Standard

The Royal College of Paediatrics and Child Health (RCPCH) Audit of Child Protection Medical Assessments recommended that an essential part of the child protection medical process was to have a published accessible Standard Operating Procedure (SOP) for Child Protection Medical Assessments.

Guidance

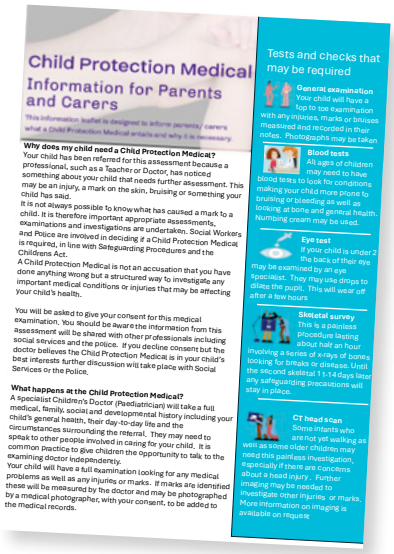
To fulfil this requirement and in order to reduce national variation in examinations, and improve the quality of clinical decision making relating to physical abuse and harm, the Network has produced comprehensive guidance for all medical staff undertaking assessments.

Objectives

The guidance will ensure that all CPMAs are undertaken promptly whilst ensuring they are child focused and of the highest standard. The objectives are as follows:

- Clearly set out the procedures for arranging and completing a Child Protection Medical Assessment.
- To ensure that Health Practitioners understand their role and responsibilities in safeguarding children at risk.
- To ensure all Health Practitioners recognise that safeguarding and protecting children is everybody's responsibility.
- To ensure practice is in accordance with the legislative requirements and expectations of the Social Services and Well-being (Wales) Act 2014 and the accompanying safeguarding guidance.

The guidance includes a referral flowchart to aid clarity and is accompanied by an Assessment Proforma. Additionally a leaflet for Children and families has been developed to explain what to expect in a Child Protection Medical which will inform consent and ensure communication is optimised. Additionally, a patient information video is in production.


Child Protection Medical
Information for Parents and Carers

Why does my child need a Child Protection Medical?

Tests and checks that may be required

General examination

Blood tests

Eye test

Skeletal survey

CT head scan

Guidance for Was Not Brought and No Access Gained

Background

Missed healthcare appointments and no-access visits are recurring themes in Child Practice Reviews, Adult Practice Reviews, and Domestic Homicide Reviews across Wales and the UK. These missed opportunities may reflect neglect or risk of harm, especially when repeated and unexplained. Therefore it is essential that patterns around these appointments are recognised to facilitate optimal multi-agency safeguarding decision making.

Guidance

In response, The Network has developed guidance for NHS Wales staff and relevant safeguarding partners. The guidance outlines key principles and expectations to ensure a proactive and coordinated safeguarding response to situations where a child or adult at risk is:

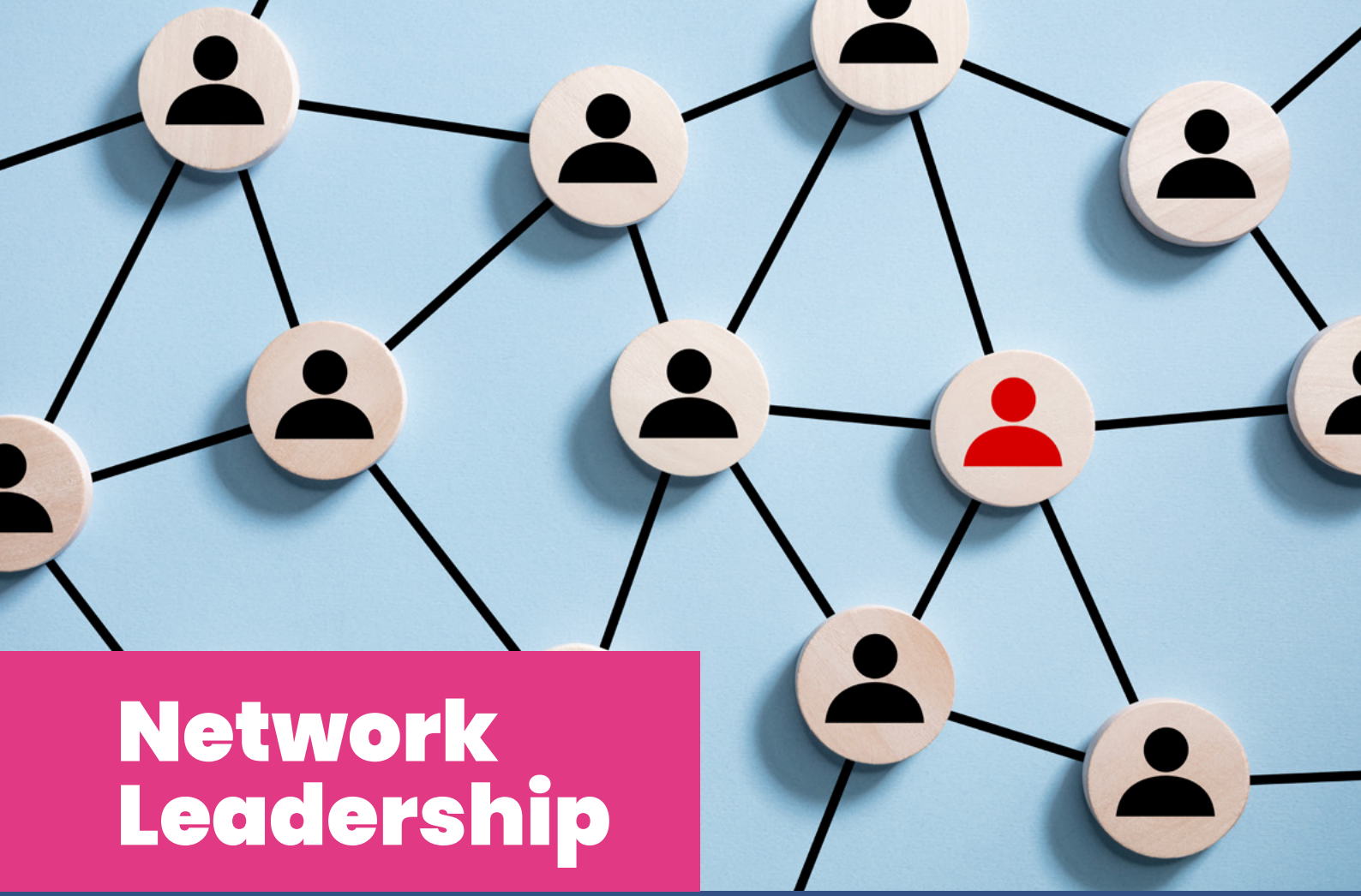
- Not brought to a scheduled appointment (face to face or virtual), or
- Professionals are unable to gain access during a planned home visit.

Whole Picture Approach

To support practitioners in whole picture understanding, a Risk Identification Checklist has been developed to assess risk when children, young people, or adults at risk are not brought to appointments, or when access is not gained for scheduled home or virtual visits. The checklist is for use in conjunction with professional judgement and multi-agency procedures.

Outcome

Going forward the guidance will ensure that missed health appointments and inability to access home visits will not be viewed in isolation or dismissed as routine. By utilising the guidance, NHS Wales can strengthen its safeguarding culture and ensure no child, young person, or adult at risk is overlooked.



Network Leadership

Sexual Safety Principles Fact Sheet

Context

Following numerous reports, media attention and data work it has emerged that sexual safety, in relation to NHS patients, clients, visitors, workforce and estates, is a priority area for greater assurance and improvement.

In response a Sexual Safety National Action Plan is under development, led by the NHS workforce, to promote sexual safety in NHS Wales The Plan will cover national sexual safety policy, guidance, reporting and training considerations.

Fact Sheet

In support this national work, the Network has developed a Sexual Safety Principles fact sheet which supports the aim that: *All health care environments must be safe and supportive for everyone who works, learns, trains and visits the NHS in Wales.*

The fact sheet covers 6 key principles that raise awareness and demonstrate commitment to sexual safety in the healthcare environment, whether they work in it or use it, to feel safe and confident to report issues, feeling supported and heard.

To promote this work, a video infographic is under development to support NHS Wales organisations disseminate the principles across their organisations.

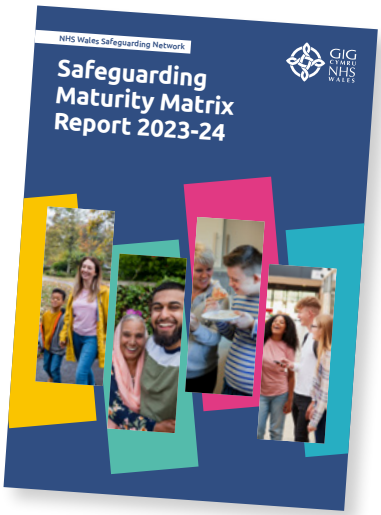
Safeguarding Maturity Matrix: Implementation and Review

The Safeguarding Maturity Matrix (SMM) is a self-assessment tool which supports safeguarding quality improvement across NHS Wales.

It comprises of six domains that underpin the self assessment process and is completed annually by all health boards and trusts as a part of each organisation's assurance system.

- **1 | Well-led, Effective Leadership, and Governance**
- **2 | Confident and Competent Workforce**
- **3 | Person-Centred**
- **4 | Learning Culture**
- **5 | Multi-agency Partnerships**
- **6 | Responsive and Resilient**

The NSS use this information to provide a report that identifies national improvements seen as beneficial from an all Wales approach. Alongside the SMM Peer Review discussion the analysis and findings aim to inform The Network forward workplan priorities.



Limitations

Whilst the SMM tool is updated to reflect the dynamic safeguarding portfolios across NHS Wales, The Network recognises the analysis and report process has limitations. The thematic information gathered is not contemporaneous and therefore lacks timely outcomes to identify current priorities. The Strengthening Safeguarding in Health Review (Welsh Government 2024) identifies the need for real time quality assurance, and more robust measures for safeguarding.

The NSS will deliver this work as part of the Network 2025/26 Workplan, utilising multi-professional groups working together to progress quality statements, key safeguarding metrics and an accompanying suite of quality measures.

Going Forward

Organisations will continue their use of the SMM, collating their assurance information, reporting and accounting through individual governance processes. The SMM Peer Review will continue, enabling the exchange of good practice, supporting collaboration and highlighting system wide quality improvements.

The NSS will support this work, ascertaining any emerging safeguarding themes, and reporting this into The Network.

Remote Consultation Guidance

Context

The COVID-19 pandemic saw the rise in remote consultations in health care. Initially this rise was a response to isolation and lockdown protocols. However, recently remote consultations are still being used to effectively manage time for clinicians in the face of increasing demand.

Furthermore NHS Wales specialist practitioners, working in out of hours emergency care using remote consultation, highlighted the lack of safeguarding training available to meet this change in their practice.

The Network subsequently commissioned work to explore the availability and suitability of safeguarding training relevant to remote health care consultations in NHS Wales.

The Work

A working group comprising NHS Wales, Health Education and Improvement Wales (HEIW) and the NHS Wales Performance and Improvement came together to complete the following tasks:

1. An overview of the current safeguarding training materials that pertain to remote consultation.
2. Identification of potential gaps.
3. An analysis leading to recommendations to support the implementation of safeguarding training for practitioners using remote consultation.

Recommendations

The recommendations to facilitate a consistent approach and enhanced awareness of safeguarding considerations and protections in remote consultation are as follows:

- National Safeguarding Service to consider the inclusion of spotlight learning session on safeguarding and remote consulting.
- The Network Training and Learning subgroup to discuss the findings and recommendations.

Next Steps

During the upcoming year the National Safeguarding Service (NSS) with the support of wider specialist NHS practitioners will deliver a Spotlight training session on safeguarding in remote consultation situations.

In addition the Training and Learning Sub-group have agreed to share learning materials across Wales and is investigating the use of a hub to facilitate this.

Safeguarding Strategy Template

Context and Purpose

In 2023–2024, it was recognised that there was a need for greater consistency across NHS Wales in how safeguarding priorities, responsibilities, and actions are articulated and implemented within individual health boards and trusts.

In response, a Safeguarding Strategy Template was developed to provide a clear and consistent framework that aligns with the Health Care Quality Standards, and is underpinned by a shared safeguarding vision and statement. This initiative was designed to support organisations in articulating their local safeguarding objectives while maintaining national coherence and compliance.

Our Shared Vision

Safeguarding means protecting people's health, well-being and human rights; enabling them to live free from fear, harm, abuse and neglect. It is an integral part of providing high-quality health care. We promote and protect the wellbeing, and safety of children and adults who become vulnerable or at risk at any time. Where children or adults may be experiencing, or are at risk of abuse or neglect, we take appropriate, timely action and report concerns.

Our Safeguarding Statement

The NHS in Wales is committed to safeguarding children, young people and adults at risk across health care organisations. The welfare of our populations who come into contact with our health services, either directly or indirectly, is paramount, and all our workforce have a responsibility to ensure that practice is robust, evidence-based and complies with statutory requirements.
By working closely with partners and other agencies, it is required that all NHS services deliver good quality, safe and effective care.

Activity and Impact

The template was co-designed with input from safeguarding leads across all NHS Wales organisations, ensuring it is practical, proportionate, and adaptable to different service contexts.
It provides a structured yet flexible approach for health boards to set out their safeguarding priorities, governance structures, workforce responsibilities, training standards, and assurance mechanisms.

By embedding a common language and vision, the strategy template enables improved alignment, assurance, and collective accountability across the system. It strengthens our ability to demonstrate compliance with statutory safeguarding duties, drive continuous improvement, and ultimately ensure that all people who use NHS services in Wales are safe and protected.

Voice of the Child/Adult at Risk

Pregnancy for Children Under 13 Guideline

Context

While pregnancy in children under 13 is a rare event, it is always a result of statutory rape. Under the Sexual Offences Act 2003, children under the age of 13 are not able to consent to penetrative sexual intercourse. Due to the age of the pregnant child, with every week that passes the risk to the pregnant child increases. Therefore it is paramount that clear, pre-arranged guidance is in place to avoid any delays.

Following a landmark legal case for Wales, with a particular focus on lessons learnt for health services, a need was evident for national guidance to consistently and ethically manage pregnancy in under 13s keeping the pregnant child's wellbeing at the forefront of any decision-making. This can be increasingly complex due to the fact that many of these children are already on a safeguarding plan.

Collaboration

The Network coordinated a multi-disciplinary, multi-agency expert group of practitioners including: legal, midwifery, paediatrics, sexual health, neonates and the British Pregnancy Advisory Service (BPAS) to work on All Wales Pregnancy Guidelines for Children Under 13 years.

This guidance is vitally important as there is a significantly increased risk of harm to the child with any delay in understanding what interventions are required. Therefore, actions need to be taken in a timely manner with full consideration and understanding of the legal aspects of consent and parental responsibility.

All Wales Pregnancy for Children Under 13 Guidance

The guidance clearly sets out an equitable, clear procedure for NHS Wales staff managing under 13 pregnancies, ensuring the best outcome for the child.

The guidance considers the child's feelings about continuing the pregnancy or termination of pregnancy (TOP), incorporating practice that does not retraumatise, but does prioritise their safeguarding and immediate medical care to further prevent harm. There are detailed and clear pathways for termination at differing gestations, continuing with the pregnancy and adoption with complexities of consent and when further legal advice is necessary.

The guidance comprises:

- A protocol flowchart for when a child under the age of 13 discloses they may be pregnant to a member of staff
- The duty to report to the local authority
- Roles and responsibilities covering health, social care and the police
- Aftercare advice including future contraception, referral to therapeutic psychological support and enhanced post-natal midwifery in the case of a birth

Ultimately the guidance should lead to a streamlined process putting the pregnant child at the centre of all decision making and reducing the trauma to the child, the family and all professionals involved in these very challenging cases.

Deprivation of Liberty Safeguards

Context

The purpose of the Mental Capacity Act, 2005 (MCA) is to promote and safeguard decision-making within a legal framework to all people 16 years old and above, who may lack the mental capacity to make their own decisions about their care and treatment.

Deprivation of Liberty Safeguards (DoLS) are part of this act. The 5 key principles act as a set of rules to protect a person receiving care whose liberty has been limited when they lack decision making capacity, by checking that this is appropriate and is in their best interests.

Activity

The MCA/DoLS Network Sub-Group provides a joint working forum on national projects and a strategic voice on behalf of NHS Wales. The group also highlight issues that need escalation with partner agencies and Welsh Government, in the interest of safeguarding those who lack capacity.

Despite the delay in the implementation of the Mental Capacity (Amendment) Act 2019, the transition to Liberty Protection Safeguards (LPS) and a new code of practice, the network have been busy in the last period.

Key Activities include:

- Production of an all-Wales referral form for DoLS
- Update of the NHS Wales MCA/DoLS level 1 & 2 e-learning package
- Planning with Welsh Government for possible inclusion of aspects of MC(Amend)Act 2019 into current process in Wales
- Working in collaboration with social services MCA and DoLS teams to consider how joint working will work
- Engagement with NHS England MCA/DoLs Strategic Forum

Going Forward

The plans for 2025-26 include:

- Piloting the all-Wales referral form.
- Developing an MCA & DoLS training framework compatible with the Intercollegiate Documents level 3/ National safeguarding training, learning and development standards group C
- Producing an all-Wales assurance matrix for MCA & DoLS

Looked After Children Questionnaire Response

Looked after children are amongst the most vulnerable groups in society.

Children often come into care with poorer physical and mental health than their peers, due to their earlier life adversity, meaning that longer term outcomes may also be worse for them. At present there are over 7200 children who are currently Looked After by the local authority in Wales.

Listening for Change

As part of the identified need to develop person experience feedback within safeguarding for shaping services and triangulation of data, a national survey has been developed with stakeholders and crucially with care experienced young people supported by Voices From Care Cymru – a national organisation dedicated to upholding the rights of care experienced children and young people.

Developing a Person-Centred Service

The survey will be used to seek feedback in relation to the statutory health assessments of looked after children and their carers. The aim is to establish a person-centred service, using real time data to drive service improvement that includes what matters to looked after children and their carers, and ensure that the voice of vulnerable children and young people is integral to service provision. The survey will permit standardised responses on satisfaction of service delivery as well as identification of well-being themes and trends, access to services and quality improvement.

Surveys

Three client surveys have been designed for younger children, young people and for carers. Questions focus on the core values including dignity, respect, safety and most importantly whether the children and young people feel involved in decisions made in respect of their health, that they feel valued and safe and that they have had information shared with them in an age appropriate format. There is also a free text box for the child, young person or carer to suggest improvements health assessment experience. The survey has been built using the CIVICA platform and surveys are available currently in both English and Welsh. Future developments may include providing the surveys in other languages, easy read format and British sign language, and hope that one day voice recording of answers will be a function available to all service users.

Next Steps

Every child looked after and their carer will be given the opportunity to complete the survey via a QR code following their statutory health assessment.

Health boards will be responsible for collating and analysing their own data, and reporting back key indicators to the Looked After Children's Steering Group, which is a sub-group of the Network. This will allow themes to be analysed at a health board level allowing for specific local service developments, and also on a national level to identify and address common themes and issues for improvement.

The survey went live in April 2025 and analysis of the data received from the survey will be report on at the end of this year.

Assessment and Professional Curiosity

Updated Female Genital Mutilation (FGM) Guidance

The Network has updated All-Wales FGM Clinical pathway, to support professional practice in the identification and management of FGM.

Female Genital Mutilation (FGM) is a criminal offence. It is a form of violence against women and girls and in the latter case it is child abuse (UK Crown Prosecution Service, 2024; FGM Act 2003, Serious Crime Act, 2015). FGM is when a female's genitals are deliberately altered or removed for non-medical reasons. It is also known as female circumcision or cutting.

Who is the Guidance for?

There is a mandatory duty for regulated health professionals in Wales to report known cases to the police in girls under the age of 18.

Sanctions for not reporting will be determined by the regulatory authority for the relevant professionals.

The updated guidance for professionals working across NHS Wales advises on how to respond appropriately to concerns regarding FGM and their duty to report. All regulated health professionals are expected to familiarise themselves with the updated pathway and assessment tools FGM (Female Genital Mutilation) - Public Health Wales (nhs.wales)

All Wales use of the audit tool will provide valuable intelligence which will facilitate increased professional awareness, adherence with correct process, reduce variation and contribute to better outcomes for women and girls experiencing or at risk of FGM.

Audit Tool for Routine Enquiry into Domestic Abuse

Context

Routine Enquiry into Domestic Abuse involves asking all pregnant women about abuse regardless of whether there are any indicators or suspicions of abuse. Research has shown domestic abuse often starts or is exacerbated in pregnancy. Disclosures of domestic abuse require privacy, confidentiality, and sensitive questioning by non-judgemental staff.

Minimum Standards

The minimum standards of All Wales Minimum Standards Routine Enquiry into Domestic Abuse, Pregnancy and Early Years (2021) were created so that NHS Wales staff are clear about their roles and responsibilities around the routine enquiry throughout pregnancy and the postnatal period.

Inconsistent Activity

Following a scoping exercise by the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Network sub-group it became apparent that the Minimum Standards, specifically Standard 2, was not being applied consistently across Wales.

Standard 2 states that "All women will be routinely asked about domestic abuse at every opportunity during Pregnancy and Early Years, within Maternity, Neonatal Care and Health Visiting Services".

Evidence showed that recording for quality and assurance purposes was inconsistent, with some using paper records and others different electronic systems and data fields, that did not necessarily demonstrate compliance with the standards.

Audit Tool

An audit tool was subsequently developed to set out clear expectations to ensure Routine Enquiry is undertaken consistently and effectively, to improve response and quality of service provision. The tool has been shared with Network members to monitor and ensure implementation of Routine Enquiry across their organisations.

Safeguarding Learning

Professional Curiosity Spotlight Session

Context

Professional Curiosity is when a practitioner explores and proactively tries to understand what is happening within a family, or for an individual, rather than making assumptions or taking a single source of information and accepting it at face value.

Session Activity

Our professional curiosity spotlight session challenged practitioners to think differently about safeguarding, to help transform the lives of children, young people and adults at risk. It brought together multi agency practitioners across Wales, to learn more about what professional curiosity means, how they can implement it, and how they can challenge barriers to change.

The session involved drama-based scenarios and input from experts learning, academia and behavioural science.

Attendees heard that to be professionally curious they need to:

- Understand how we think and process information
- Challenge assumptions
- Understand what the barriers to professional curiosity may be
- Listen to the individual and their lived experience.

I had an increasing awareness that I could be missing a piece of the puzzle.

The actors helped cement the theme and showed how to use professional curiosity and encourage others to use it.

By far the best and most well delivered safeguarding event I've attended.

Safeguarding Adults at Risk Spotlight Event

The '*My Voice My Life: Safeguarding Adults at Risk'* event took place in North Wales. The session focused on listening and understanding the lived experience of adults who find it difficult to make their voice heard.

Expertise was provided from academics and specialists in the field of adult safeguarding, advocacy and learning disability.

The event utilised a unique drama-based approach to present powerful real-life scenarios to impart lasting impact and truly effect change. Additional learning came from people and families who have found and amplified their voice; sharing their experiences with attendees highlighted the importance of person centred, holistic approaches to safeguarding.

The scenarios carried out by actors were very powerful.

The focus on lived experience whilst emotionally challenging was so impactful.

I will be cascading the shared resources with my team and other leads.

Restorative Supervision Event for Named and Designated Doctors

Context

The importance of establishing a Restorative Supervision model is clearly outlined in the recently published National Safeguarding Supervision Guidance.

Safeguarding supervision is an essential mechanism to delivering excellent care quality and should take place as part of a supportive and learning culture. In order to ensure succession planning with a resilient staff, this model is vital. This event for Named and Designated Doctors built on the initial Restorative Supervision event which was held for Heads of Safeguarding.

Event

A 2 day event in the Elan Valley focussed on the restorative supervision of Named Doctors and what an appropriate model would look like moving forward. The Level 4 Safeguarding Training, included talks from national speakers around psychological safety, compassionate leadership and wellbeing for Medical Leaders as well as providing a vital opportunity to network.

We need to actively develop safeguarding supervision for doctors to reduce the risk of them experiencing burnout.

The location away from work allowed formation of relationships. This was invaluable as a newer member of the group.

Review of Safeguarding Learning Dissemination

Context

Many of the themes found in Adult Practice Reviews, Child Practice Reviews and Domestic Homicide Reviews are predictable and unchanging, including recommendations specific to Health. This is despite significant efforts to ensure that learning from reviews is disseminated and put into practice.

The UK government and the Medical Research Council suggest that in complex interventions process evaluation should be used to examine how processes work to generate outcomes. Therefore the Network commissioned an examination of the dissemination of safeguarding learning from reviews using this methodology.

The Review

Initial research was carried out on process evaluation methodology in relation to health, education, training and behaviour change.
A questionnaire was shared with the Heads of Safeguarding in NHS Wales health boards and trusts, concerning how learning from reviews is carried out in their organisation inclusive of policies, recommendation dissemination, target workforce recognition and governance.

Analysis

Analysis of the data revealed that no organisations have developed a formal policy in relation to the dissemination of lessons learned from reviews. Indeed there is no consistency of approach across Wales and all the organisations appear to have different methods of distribution.

The review also demonstrated the considerable amount of work that safeguarding teams and wider health organisations are putting into ensuring learning from reviews is used to inform training and practice. Numerous difficulties were reported which include but are not limited to:

- Competing priorities for organisations and staff
- Staff workload
- Difficulties in recruitment leading to understaffing
- Rapid staff turn-over
- Difficulties accessing IT

Recommendation

Going forward it is recommended that the Network run a pilot Quality Improvement project based in one health board to improve the dissemination of learning from reviews. Upon completion, this activity could be considered for use across all NHS Wales health organisations.

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 follow.

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Improving Children's Experience of Colposcopy

Aneurin Bevan University Health Board (ABUHB) has completed the first stage of a programme to improve the holistic experience of children attending for colposcopy.

A colposcopy is an exam that looks closely at the cervix using a microscope.

Context

Children undergoing colposcopy access a standard outpatient appointment for this procedure, regardless of whether it is part of the Child Protection Medical process or connected to other clinical purposes.

It was noted that, while children have access to experienced clinicians, who are able to explain the procedure and support from an appropriately trained chaperone, there was no dedicated specialist safeguarding support.

Specialist Safeguarding Support

Consequently the Corporate Safeguarding Team has undertaken a trial, whereby a Specialist Safeguarding Nurses is able to support the Paediatric Colposcopy Clinic to focus on the voice of the child. They are also able to offer further support to the child, their family, carers and other professionals who may be supporting or accompanying the child. This approach offers all parties additional time to talk either side of the procedure, either in relation to what may be involved clinically or to ask questions related to the wider safeguarding process.

Results and Evaluation

Initial shadowing of the process and fact finding is complete. All intelligence will inform a longer term service improvement project looking at environmental factors and the educational needs of those supporting the clinic. This will include the role of the chaperone and whether appointments slots need to be lengthened to ensure the voice of the child is central to the process.

Initial feedback from children, carers and clinical staff has been positive, with a formal evaluation planned for Quarter 2 2025-2026.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Early Identification of Safeguarding Concerns

Velindre University NHS Trust (VUNHST) provides specialist non-surgical oncology services across South-East Wales for a population of 1.6 million.

The trust also manages the Welsh Blood Service (WBS) which is responsible for the collection, processing, and distribution of blood and blood products to all hospitals across Wales, serving a population of 3.3 million.

Increase in Safeguarding Reporting

Over the last period, an increased focus on safeguarding training and awareness amongst staff has seen an increase in safeguarding reports related to children whose parents are in receipt of care at the Velindre Cancer Service. This provides assurance that the Trust is 'making every contact count' protecting children from harm, abuse and neglect.

Case Example

A newly referred patient met with an oncology nurse prior to beginning treatment at the Cancer Centre. During the consultation, the nurse learned that the patient lived with their partner and baby who was several weeks old.

The patient raised several concerns regarding their partner including: being dismissive about their cancer diagnosis, shouting at the baby and an isolated occasion of leaving the baby on their own. The nurse gained consent from the patient to share information with the local authority. Arrangements were also made for the patient and baby to stay with a close family member. A Child at Risk report was submitted and all relevant health records updated.

During a following appointment an oncologist noted that the patient was still living with the partner, alongside the partner's negative interaction with the baby. Aware of previous concerns, the oncologist contacted the local authority resulting in an urgent child protection strategy meeting. A unanimous decision was made to trigger Section 47 Child Protection processes which involve a multi-agency assessment to determine the need for action to safeguard a child's welfare.

Learning

This case study highlights the challenges faced by the Trust's staff when trying to safeguard the welfare of children whilst supporting parents/guardians through their cancer diagnosis.

It demonstrates how timely identification of potential safeguarding concerns enables early intervention to prevent potential harm.

Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services University NHS Trust

Welsh Ambulance Quality Improvements

Over the last period the Welsh Ambulance Services University NHS Trust (WAST) have taken various measures to improve the service they provide.

The Safeguarding Team work collaboratively with colleagues within the Welsh Ambulance Service and external agencies to ensure positive outcomes for children and adults at risk of harm. Within the organisation the team respond to a high volume of colleague enquiries related to safeguarding, providing feedback to inform future practice.

Cross Organisation Collaboration

WAST Safeguarding Team work closely with the Patient Safety Team and participate in the WAST Serious Case Incident Forum (SCIF) to address safeguarding issues identified within concerns and adverse incidents. This ensures stakeholder collaboration to support and protect colleagues, patients and service users.

The team fully embrace the Trust's Duty of Candour and 'Putting Things Right' process. They aim to provide a supportive framework for staff to learn from safeguarding incidents and therefore inform continual improvement of safeguarding processes.

National Collaboration

The WAST Assistant Director of Safeguarding chairs the National Ambulance Safeguarding Advisory Group (NASAG). The group promotes a consistent approach to safeguarding across the UK Ambulance Services. It connects, supports and guides the safeguarding practice of its practitioners across the UK providing a space for Ambulance Safeguarding leads to access peer support. This high level engagement helps WAST to incorporate UK wide improvements into their practice.

Upskilling Staff

Induction training for patient facing staff in the organisation resulted in positive feedback indicating improved confidence in practice.

Gives you the ability to help others.

A good outline on how on how to spot and help individuals that may be suffering from abuse in this area of their lives.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Multi-Agency Safeguarding Training

Multi-agency training was developed and facilitated by the Named Doctor for safeguarding, safeguarding paediatricians and clinical nurse specialist for the Child Protection Medical at Hub Cwm Taf Morgannwg Health Board (CTMUHB).

Content

This training was delivered in partnership with colleagues from Sexual Assault Referral Centre (SARC), South Wales Police, Local Authority, the third sector and Education. Content covered child sexual abuse, exploitation, suspected physical abuse and fabricated illness.

Delivery Success

The first training day in April 2024 saw attendees from multiple disciplines within CTMUHB and partner agencies participate in group discussions and receive presentations from subject experts.

Training benefits include enhanced communication and greater understanding between agencies. It is envisaged this will lead a more collaborative and holistic approach to safeguarding, ultimately leading to improved outcomes for children and young people.

Going forward a further health led multi-agency training session is planned for 2025.

> Excellent quality and knowledge of speakers.

> I have an improved awareness of services outside of my organisation.

> I now feel able to explain a Child Protection Medical and a forensic examination following sexual assault.

> My confidence in managing a Safeguarding concern and the following procedures has improved.

Health Independent Domestic Abuse Advocate

Cwm Taf Morgannwg Health Board (CTMUHB) and Rhondda Cynon Taf County Borough Council have collaborated to pilot the role of a Health Independent Domestic Abuse Advocate (IDVA) within one of its district general hospitals, funded by a grant provided by the Police and Crime Commissioners Office.

An IDVA is a trained specialist who provides a service to victims at high risk of harm from intimate partners, ex-partners, or family members.

An Essential Role

The CTMUHB Health IDVA has been integral to the health board's delivery of the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) strategy and blueprint. Over the last year 101 victims were supported, including 76 new referrals.

Service User Feedback

Service user feedback on how they felt prior to support and at the end of involvement with the health IDVA with the following results:

Improved Health & Wellbeing

39

Better informed and empowered to cope with aspects of everyday life

68

Increased feelings of safety

56

Learning and Improvement

Learning from Adult Practice Reviews and Domestic Homicides has recognised the links between domestic abuse and poor mental health. This has resulted in the health IDVA supporting patients and facilitating safe discharge from mental health wards.

Going forward CTMUHB have secured funding from Value Based Health Care to extend the service to 2025-2026.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Violence Prevention Team

A Violence Prevention Team (VPT) based at Swansea Bay University Health Board (SBUHB) is working to reduce crime and associated harm by providing appropriate support and signposting.

They aim to break the cycle of violence by using teachable moments at the point of crisis to eventually reduce the number of hospital attendees who have been assaulted.

Multi-Agency Approach

The Team work in partnership with the Local Authority, Police and third sector agencies to ensure that patients are cared for and receive the appropriate support for their needs.

The importance of the VPT been recognised nationally. Together with Cardiff and Vale University Health Boards Violence Prevention Team they won the 2024 Wales Safer Communities Network award for Safeguarding.

Nurse Led

The Team is a Nurse led initiative that focuses on support for patients who have experienced violence. The VPT take referrals for patients that attend hospital following an assault, or an injury resulting from a weapon such as a knife. While they are based in the hospital Emergency Department, they also support staff with referrals across the Health Board.

Team actions include:

- Providing patients with information and resources to enable them to make informed decisions.
- Ensuring that Safeguarding procedures are followed in a timely manner.
- Supporting staff to report all injuries to Police where a weapon has been used.
- Raising awareness across the Health Board and other agencies to increase awareness of the team's provision.
- Ensuring that staff are aware of the threats relating to knife injuries and how to protect themselves as well as their patients.

Since the team's implementation there have been multiple high-risk cases that have received support, which would have not been possible without this specialist service.

Quality Improvement Measures

Quality Improvement is the cornerstone of safeguarding practices, requiring clear reporting, structures and transparency.

In the last period Betsi Cadwaladr University Health Board (BCUHB) Safeguarding and Public Protection Team has taken a proactive approach to deliver assurance across services.

Safeguarding Reporting Framework

As the Safeguarding agenda continues to grow in scope and complexity, the need for rigorous governance and a quality reporting framework has never been more critical.

BCUHB's Safeguarding Reporting Framework supports frontline to board compliance by ensuring critical safeguarding information, risks and incidents are effectively communicated across all levels of the organisation. It establishes a structured process that ensures accountability, oversight and adherence to statutory responsibilities.

Regular audits, safeguarding reviews, and adherence to quality standards ensure that safeguarding measures are not only compliant but also effective in practice. The framework ensures safeguarding arrangements meet the statutory requirements of true engagement and reporting relating to the National, Regional and Local agenda.

Data Analysis

The support of a dedicated Data Analyst embedded in the Safeguarding and Public Protection Team since 2018, informs the strategic and operational agenda, which evidenced the continued improvement in safeguarding practice across the Health Board. This specialist resource supports the development and identification of IT platforms and collates data that translates to safeguarding performance, risk reporting and analysis.

These real-time updates further support onward reporting within BCUHB and relevant partners. The Organisation is fully engaged in the wider work on National Reporting Dashboards.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cardiff and Vale
University Health Board

Guidance for Birthmarks

Context

There has been a notable rise in inappropriate safeguarding referrals due to misdiagnosis of Congenital Dermal Melanocytosis (CDM), a benign and common birthmark, often mistaken for bruising. This lack of awareness has led to avoidable harm, including:

- Unnecessary child protection medicals involving two sequential skeletal surveys and associated radiation exposure
- Significant emotional distress for families
- Erosion of trust between healthcare professionals (HCPs) and families

A lack of recognition and understanding of CDM among healthcare professionals emerged as a key contributor to this trend, underscoring the urgent need for targeted education and clear clinical guidance.

Training Package

In response Cardiff and Vale University Health Board (CAV UHB) have developed an interactive, evidence-based teaching package to improve awareness, diagnostic confidence, and clinical documentation relating to CDM. Content included:

- Pre- and post-session confidence scales, allowing learners to self-assess their understanding and track progress
- "Spot the Diagnosis" image-based quizzes to reinforce visual learning and highlight key differences between CDM, bruises, and other skin findings
- A 15-minute animated video covering the pathophysiology, epidemiology, and clinical presentation of CDM
- Guidance on documentation best practices, emphasising the importance of recording marks for future reference
- Practical communication tips for explaining CDM to families and colleagues
- A curated set of resources for ongoing learning

The training has been piloted with nearly 100 HCPs across disciplines including General Paediatrics, Midwifery, Health visiting, and Community Paediatrics. Feedback has been overwhelmingly positive, leading to refinements such as clearer side-by-side image comparisons and a real-time quiz feedback.

Next Steps

The teaching pack will be finalized and a stage 2 pilot launched through the Child Health, Midwifery, and Health Visiting Forums.
A wider rollout will follow, with plans to re-audit safeguarding referrals to assess impact.

In parallel, a supportive pathway for community HCPs facing diagnostic uncertainty is being developed. This will enable enabling prompt second opinions from experienced colleagues in a safe, structured, and accessible manner.

The video is great! Really important topic. Have seen a young mum in a lot of distress after being accused inappropriately in ED (Emergency Department).

Loved the video, very useful and clear. Great level of info for all medical professionals as not something we had received teaching on before.

Quality Improvement for Self-Neglect Cases

Context

Over the last year Cardiff and Vale University Health Board (CAV UHB) have been raising awareness of the increase in the number of cases involving adults who are, or are at risk of, self-neglect.

Training

The organisation's Mental Capacity act (MCA) Team have been pivotal in supporting this awareness. As part of National Safeguarding week the team provided a lunch and learn training session titled 'Self Neglect and the MCA'. This was well received and rolled out to staff from November to December 2024.

Toolkit and Assessment

The organisation have also actively promoted the Regional Safeguarding Board's Self Neglect Toolkit to clinicians across the Health Board, with a particular focus on areas that see the higher volume of these cases.

In addition, it is hoped that the new Mental Capacity Assessment Proforma, will prove to be a valuable tool for clinicians to capture relevant information and conduct a robust assessment of the person's capacity where necessary. The proforma aims to improve documentation and compliance with the MCA 2005, which is essential in complex cases such as those involving vulnerable adults at risk of harm due to self-neglect.

Going Forward

To build on this work over the next period the organisation's Corporate Safeguarding Team are developing a Level 3 Self-Neglect study day which will launch in Autumn 2025.

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Professional Curiosity Training

Background

Professional curiosity is an essential skill for health practitioners which enables them to explore and understand the complexities of various situations more deeply. Previously Hywel Dda University Health Board (HDdUHB) collaborated with the Mid and West Wales Regional Safeguarding Board to develop a professional curiosity resource pack. To offset this work the health board have rolled out dedicated professional curiosity training.

Training

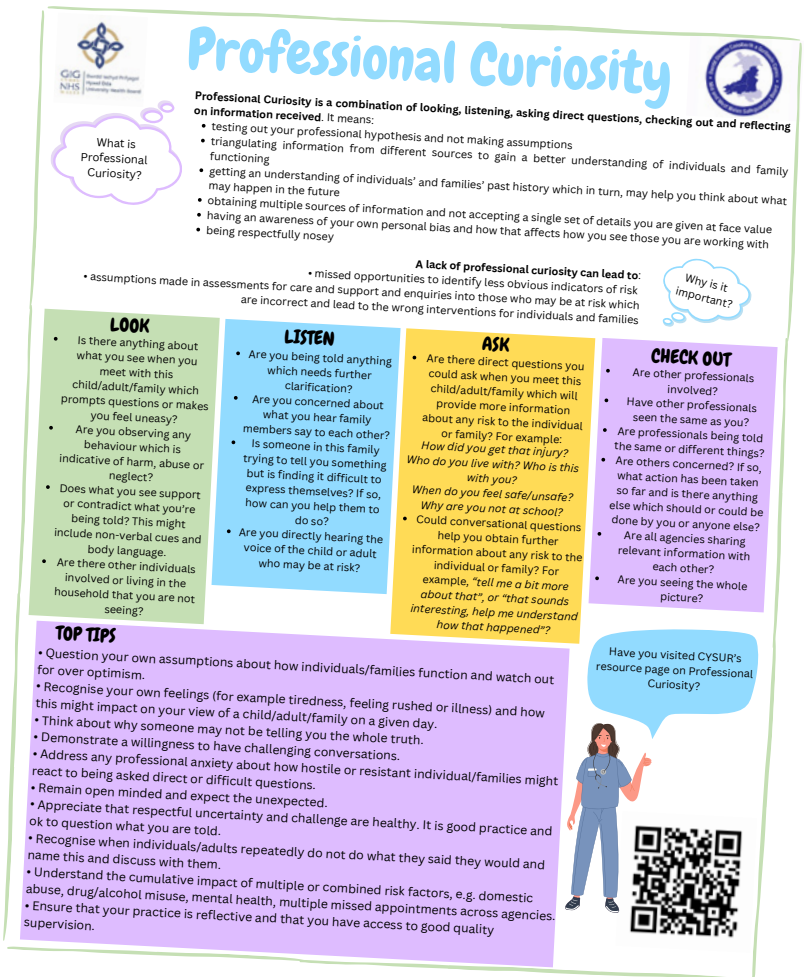
Customised training sessions have been developed which are tailored to accommodate the specific nuances presented by different services. Each session consistently covers key themes including: child and adult abuse and neglect, exploitation, duties under the prevent strategy, violence against women, domestic abuse sexual violence and other safeguarding related topics.

Top Tips Approach

During training participants are encouraged to engage deeply and thoughtfully with the material, fostering a comprehensive understanding of the issues at hand. The top tips: LOOK, LISTEN, ASK and CHECK OUT are embedded in each case scenario.

Health care is delivered via many methods, face to face, via telephone, one off contact, or longer term care. The ability to adapt the scenario ensures that the training remains relevant to a range of services, encouraging participants to think beyond the patient in front of them. This approach reinforces the foundation of professional curiosity which should be an integral part of every practitioner's daily practice.

To supplement the training a poster has been developed which provides an overview of professional curiosity, guidance for the top tips and signposts to further resources.



Disclosure and Barring Service Project

A key area of improvement in Public Health Wales (PHW) has been the identification of risks associated with the frequency and compliance with Disclosure and Barring Service (DBS) checks.

This led to an audit and development of an action plan and framework. These steps will assure a safe workforce, which is key to safeguarding the wider public.

Context

The quality improvement initiative followed a series of incidents concerning an NHS Wales Health Board staff member. A review and follow-up report from the Healthcare Inspectorate in Wales (HIW) recommended that Welsh Government should consider how the renewal of DBS checks for NHS staff can be facilitated across Wales as an important part of safeguarding patients.

Action

As a result, PHW's Safeguarding Group led the following:

- An audit of DBS checks compliance with which identified several risks and a corrective action plan
- The frequency of DBS Checks being raised on the organisational risk register

Various initiatives were progressed with Board support to mitigate the current risk and ensure a robust process is in place for ongoing safe recruitment.

These included:

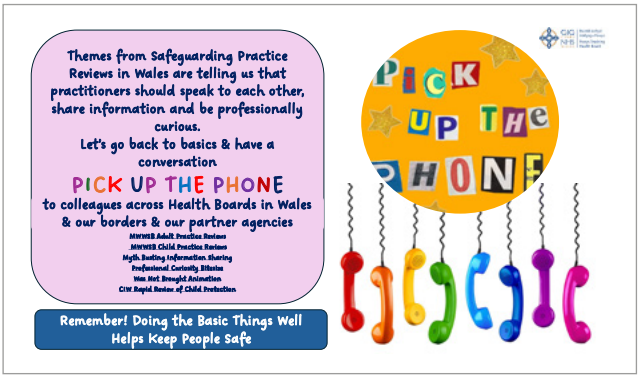
- The development of a DBS policy with consultation from key stakeholders.
- Engagement with Trade Union partners advising the intention to develop and update PHW's DBS policy to support the move to the DBS Update subscription service.
- Work to ensure DBS levels on all active staff are correct enabling PHW to identify and action gaps. This will also facilitate accurate reporting on DBS compliance when subscriptions to the Update Service are in place.
- New DBS checks will be undertaken on all eligible roles to enable colleagues to subscribe to the DBS Update service.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Pick up the Phone Campaign

Context

Over many years it has been noted that Regional Safeguarding Adult and Child Practice Reviews, National Safeguarding Reviews and Joint Inspections highlight similar themes and areas for improvement across many services. These include practitioners working in silos, not sharing timely, relevant and proportionate information and the lack of professional curiosity.



Campaign

In response Powys Teaching Health Board (PTHB) Safeguarding Team added to the work of NHS England-Midlands and designed an electronic poster encouraging staff to go *back to basics! Pick Up the Phone and have a conversation* with colleagues across Health Boards in Wales as well as across borders and with partner agencies.

To further embed the message, the Safeguarding Team highlight the *Pick Up the Phone* message at all opportunities including safeguarding supervision, training and while attending Service Group team meetings.

Safeguarding Management Application Goes Live

Powys Teaching Health Board (PTHB) observed that the production of safeguarding metrics required significant manual effort.

To overcome this inefficiency PTHB implemented a Safeguarding Management App to optimise workflows and improve operational efficiency and effectiveness across key activities including safeguarding quality, assurance and accountability.

Notable benefits include:

1. **Increased Capacity:** Time saved gives the team more resource for complex or high-priority work.
2. **Improved Accuracy:** Automation reduces the likelihood of errors, enhancing the quality and reliability of outputs.
3. **Enhanced Responsiveness:** Faster processing times produces quicker responses to internal and external requests.

These efficiencies ultimately contribute to improved service delivery and long-term sustainability. Ongoing monitoring and refinement will ensure these measures remain effective and will be enhanced to meet evolving organisational needs.

Future Priorities

Looking to 2025/2026 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'.

There will be a strong focus on safeguarding quality and assurance, learning and strengthening partnerships. Future work is driven by current and pending changes in legislation and statutory guidance, learning from the Safeguarding Maturity Matrix, recent safeguarding reviews, recommendation and feedback.

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

Deliverables over the next period include:

- National child protection principles for NHS Wales representation at safeguarding conferences
- A Safeguarding Quality and Safety Framework
- A Safeguarding Learning Framework
- A Safeguarding Quality, Assurance and Accountability Framework
- A Quality Statement and Safeguarding Metrics
- Stage 2 of an All Wales Under 13 Pregnancy Guideline
- A national standard on managing safeguarding allegations against NHS Employees
- An improvement-focused audit on the views of Looked After Children on health assessments
- Safeguarding principles for the use of chaperones
- Guidance in relation to Was Not Brought and No Access Gained (Adults & Children)
- Scoping to commission an update of the Child Sexual Exploitation Risk Questionnaire (CSERQ)
- Delivery of Multi-Agency Safeguarding Listening, Learning and Improvement Events at ICD Level 3 and above