

Chelsea and Westminster NHS Foundation Trust

Safeguarding Annual Report 2025/26

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Foreword

Chelsea and Westminster Hospital NHS Foundation Trust is committed to delivering safe, high quality care through effective and robust safeguarding arrangements for children, young people and adults at risk. Safeguarding is embedded across the Trust as a core responsibility for all staff, supported by strong leadership, clear governance and a culture of professional curiosity, timely action and shared accountability.

During 2025/26, the Trust continued to strengthen safeguarding practice in response to increasing complexity, emerging risks and evolving statutory and regulatory expectations. A strong focus was maintained on prevention, early identification, risk mitigation and Making Safeguarding Personal, ensuring that the voices and lived experiences of those at risk are central to decision making. The Trust worked collaboratively with multi agency partners to provide coordinated, trauma informed responses aligned with national guidance and best practice.

This report provides assurance to the Trust Board and external partners that safeguarding arrangements remain effective, proportionate and continuously improving. Through workforce development, partnership working, learning from reviews and robust quality assurance, Chelsea and Westminster Hospital NHS Foundation Trust remains committed to safeguarding the welfare, rights and dignity of all those who use its services.

1. Introduction

This Annual Report highlights the work undertaken by Chelsea and Westminster Hospital NHS Foundation Trust in fulfilling its statutory responsibilities to safeguard and protect children, young people and adults at risk of abuse and neglect. The report covers adult, children's and maternity services across the Trust.

The Trust's safeguarding duties are underpinned by key legislation and national guidance, including the Children Acts 1989 and 2004, Working Together to Safeguard Children (2023), and the Care Act 2014 for safeguarding adults at risk. Effective safeguarding and the promotion of welfare rely on strong multi agency partnership working, shared accountability and constructive professional relationships. These arrangements are only effective when staff at all levels are knowledgeable, confident and equipped with the skills to recognise concerns, follow procedures and respond appropriately to risks relating to patient safety.

This Annual Report covers the period April 2025 to March 2026 and provides assurance to the Trust Board by outlining safeguarding priorities, activity and performance. It highlights areas of strength, identifies themes for development and sets out the actions taken to strengthen safeguarding arrangements across Chelsea and Westminster Hospital NHS Foundation Trust. Central to this work is a competent and well established workforce, up to date policies and procedures, robust governance structures and a commitment to continuous improvement through learning and collaboration.

2. Key Legislation and National Guidance

Key Legislation

- Children and Social Work Act 2017
- Counter Terrorism and Security Act 2015
- Serious Crime Act 2015
- Care Act 2014
- Health & Social Care Act 2008
- Deprivation of Liberty Safeguards 2009
- Children and Young Persons Act 2008
- Mental Capacity Act 2005
- Safeguarding Vulnerable Groups Act 2006 and the Protection of Freedoms Bill
- Children Act 2004; statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11
- Sexual Offences Act 2003
- Female Genital Mutilation Act 2003
- Human Rights Act 1998
- Public Interest Disclosure Act 1998
- Data Protection Act 1998
- Article 5 - Right to Liberty and security
- Article 8 - Respect for Private and family life
- Article 14 - Prohibition of discrimination
- Children Act 1989
- Mental Health Act 1983
- Domestic Abuse Act 2021

National Guidance

- Working Together to Safeguard Children 2026
- PREVENT duty guidance 2023
- RCPCH 2019 Intercollegiate Document - Safeguarding children & young people roles and competencies for healthcare staff
- RCN 2024 Adult Safeguarding: Roles and Competencies for Health Care Staff
- RCN 2020 Looked After Children: Roles and Competencies of Healthcare Staff
- CQC Fundamental Standards Statement on CQC's roles and responsibilities for safeguarding children and adults November 2022
- FGM enhanced data set 2015
- London Multi-Agency Adult Safeguarding Policy, Practice Guidance and Procedures 2025
- London Safeguarding Children Procedures and Practice Guidance 2026

3. Definitions

Safeguarding means protecting a citizens' health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. Safeguarding children, young people and adults is a collective responsibility (NHS England).

A child is perceived as such until they reach their 18th birthday.

Safeguarding children is the action you take to promote the welfare of children and protect them from harm. Safeguarding means:

- protecting children from abuse and maltreatment
- preventing harm to children's health and development
- providing support to meet children's needs when problems emerge
- ensuring children grow up with safe and effective care, within their family where possible
- taking action to enable all children and young people to have the best outcomes.

Child protection is part of the safeguarding process. It focuses on protecting individual children identified as suffering, or likely to suffer, significant harm. This includes child protection procedures detailing how to respond to concerns about a child (Working Together DfE 2023)

Adult safeguarding, as defined by the Care Act (2014) is protecting an adult's right to live in safety, free from abuse and neglect.

An adult is an individual aged 18 years or over. The Care Act 2014 statutory guidance defines an adult at risk as an adult who:

- Has needs for care and support (whether or not the local council is meeting any of those needs);
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.'

4. Governance

At Chelsea and Westminster Hospital NHS Foundation Trust, the Chief Nurse holds executive accountability for ensuring the Trust meets its statutory and regulatory safeguarding duties for children, young people and adults at risk. Strategic leadership and oversight of safeguarding arrangements are provided through the Corporate Directors of Nursing, working in close partnership with the Safeguarding Practitioner, who leads the operational delivery of safeguarding practice across the organisation.

The safeguarding team operates as a cohesive, multidisciplinary service, working across all clinical and non-clinical settings to provide consistent, high quality safeguarding advice, assurance and leadership. The team works collaboratively across divisions and in partnership with external agencies to ensure that safeguarding legislation, statutory guidance and regulatory requirements are effectively implemented and continuously strengthened.

Governance arrangements are designed to ensure clear accountability, effective escalation of risk and robust assurance to senior leaders and the Trust Board. Safeguarding is embedded within formal governance structures, supported by regular reporting, quality assurance activity and oversight through internal committees and external partnership forums. These arrangements enable the Trust to identify emerging risks, respond to safeguarding concerns in a timely manner and continually improve practice in line with national guidance and local priorities.

The Safeguarding Team at Chelsea and Westminster Hospital NHS Foundation Trust aims to ensure that all children, young people and adults at risk are effectively protected when using Trust services. The team supports robust systems for the early identification of abuse, neglect and exploitation, and for timely, appropriate referral and intervention in line with statutory guidance and local multi agency procedures.

In accordance with Working Together to Safeguard Children (2023) and the Care Act 2014, all staff working within the Trust are expected to:

- Understand safeguarding risk factors and recognise children, young people and adults who may be in need of support or protection.
- Identify parental, family or carer vulnerabilities that may impact on a child's welfare and know how and when to refer for additional support.
- Recognise indicators of abuse, neglect and exploitation across the life course, including domestic abuse, modern slavery, harmful practices and organisational abuse.
- Communicate effectively with children, young people and adults, ensuring that safeguarding responses remain focused on safety, welfare and lived experience.
- Work collaboratively with partner agencies and share information appropriately to safeguard individuals and reduce risk.

The Safeguarding Team provides specialist leadership, advice and assurance across the Trust and undertakes the following core functions:

- Providing expert safeguarding advice, guidance and decision making support to clinical and non clinical staff in relation to children, adults and maternity safeguarding concerns.
- Ensuring that safeguarding policies, procedures and pathways remain current, accessible and aligned with national and London multi agency guidance.
- Delivering safeguarding supervision and reflective practice support to staff managing complex, high risk or emotionally demanding cases, maintaining a clear focus on safety and wellbeing.
- Leading and delivering safeguarding training and education in line with intercollegiate and national competency frameworks.
- Supporting staff with safeguarding reports, chronologies and statements, and attendance at court or multi agency meetings where required.
- Undertaking a programme of audit, quality assurance and service evaluation to provide internal and external assurance.

- Supporting Trust safeguarding governance arrangements, including committee reporting, risk escalation and Board assurance.
- Disseminating learning from safeguarding reviews, incidents and audits to strengthen practice and improve outcomes.
- Acting as a central point of contact for safeguarding matters and maintaining regular engagement with safeguarding partnerships, boards and sub groups across boroughs and the Integrated Care System.

4.1 Internal Report and Assurance

The Trust Joint Safeguarding Group brings together all functions of safeguarding including adults, children's, maternity, learning disability and autism, Prevent, domestic abuse and modern slavery exploitation. The group is chaired by the Deputy Chief Nurse and encompasses both internal and external stakeholders as well as the named designates from the Integrated Care Board (ICB). The group is responsible for ensuring there are systems in place to recognise and support those both at risk of abuse and those who are experiencing abuse as per our statutory function.

The Joint Safeguarding Group aims to ensure the Trust meets all of its statutory obligations regarding safeguarding by:

- Reviewing and analysing data to target improvement focus
- Support a culture of continuous learning
- Work with external partners to support vulnerable at risk
- Drive staff knowledge and education to identify safeguarding risks and manage them to deliver safe and effective care

The objectives of the Joint Safeguarding Group are:

- To monitor the effectiveness of the Trusts safeguarding agenda encompassing all of the safeguarding functions
- To ensure the associated improvement action plan is informed by themes arising from Trust and local data
- To review and implement national best practice guidance
- To ensure participation in local, regional and national audit programmes and to ensure the outputs of these are used to inform the safeguarding improvement programme
- To support staff knowledge and inform education programmes to enable them to consistently provide evidence based practice
- To ensure Trust policy for all safeguarding functions are reflective of national guidance and best practice and to monitor the effectiveness of the policy utilisation
- To work with local partners to ensure that safeguarding functions are effective outside of the Trust boundaries to support the local communities we serve

The following functions report to the Joint Safeguarding Group:

- Adult Safeguarding including prevent
- Children's Safeguarding
- Maternity Safeguarding
- Learning Disabilities
- Mental Health
- Domestic Abuse and Sexual Safety

The following standing updates are received by the group:

- ICS Designate update
- MCA and DOLs
- Human Rights Female Genital Mutilation (FGM)
- Restrictive Practice
- Supervision

The Safeguarding Health Outcomes Framework (SHOF) forms the fundamental basis for the group for which there are seven standards as well as a hot topic which is given to us by the ICS designates.

Bi-Annual assurance from the Joint Safeguarding Group is provided to:

- The Executive Management Board
- Trust Quality Committee
- Trust Standing Committee

4.2 External Reporting and Assurance

The Trust provides assurance to ICB and NHSE via the Safeguarding Commissioning Assurance Toolkit (SCAT) on safeguarding compliancy and Prevent compliancy on a quarterly basis. In addition to this assurance is given quarterly via The Safeguarding Health Outcomes Framework (SHOF) to the ICB. The SHOF comprises of eight standards:

Figure 1: Safeguarding Health Outcomes Framework (SHOF Standards)

Safeguarding Health Outcomes Framework (SHOF Standards)	
1	Standard 1-Leadership & Workforce
2	Standard 2-Training & Supervision in Children & Adults Workforce
3	Standard 3-Partnership Working & Workforce
4	Standard 4-Responding to wider social issues & vulnerable groups (including MCA, DOLS) for Children & Adults
5	Standard 5-Learning from Serious Incidents to improve Safeguarding Children & Adults
6	Standard 6-Maternity
7	Standard 7-Mental Health Services
8	Standard 8 –Abortion Services

4.3 Organisational Principles

The Trust's Human Resource Department governs safe recruitment practices. All staff newly employed and those in substantive posts are subject to:

- Pre-employment checks: Disclosure and Barring Service (DBS) checks at enhanced level. This includes contractors and volunteers working on site.
- To provide quality assurance staff files are checked periodically by HR.
- There is a mandatory safeguarding training plan in place for Trust employees with compliance monitored electronically.
- All staff complete online training at level 1, clinical staff complete online training level 2.
- Identified appropriate staff receive face to face level 3 training; this is delivered by the safeguarding team with input from multi-agency professionals.
- Access to Level 3 via Teams and e-learning for health training is available for staff and has continued to be accessed during mandatory training sessions. In addition the named professionals provided bespoke Safeguarding Level 3 face to face training and also via teams.
- The teams work towards a "Think Family" approach across the safeguarding functions

4.4 Safeguarding Accountability and Assurance Framework

The Safeguarding children, young people and adults at risk in the NHS: safeguarding accountability and assurance framework (SAAF) clearly sets out the safeguarding roles and responsibilities of all individuals working in providers of NHS-funded care settings and NHS commissioning organisations.

The Trust is fully compliant with all elements of the SAAF.

Detail	Compliance Rating
the contractual requirements as laid out in Schedule 32 of the NHS Standard Contract	Compliant
identification of a named nurse, named doctor and named midwife (if the organisation provides maternity services) for safeguarding children	Compliant
identification of a named nurse and named doctor for children in care	Compliant
identification of a named lead for adult safeguarding and a Mental Capacity Act (MCA) lead – this role should include the management of adult safeguarding allegations against staff	Compliant
safe recruitment practices and arrangements for dealing with allegations against staff	Compliant
provision of an executive lead for safeguarding children, adults at risk and Prevent	Compliant
an annual report for safeguarding children, adults and children in care to be submitted to the trust board	Compliant
a suite of safeguarding policies and procedures that support local multi-agency safeguarding procedures	Compliant
effective training of all staff commensurate with their role and in accordance with the intercollegiate safeguarding competencies	Compliant
safeguarding must be included in induction programmes for all staff and volunteers	Compliant
providing effective safeguarding supervision arrangements for staff, commensurate to their role and function (including for named professionals)	Compliant
developing an organisational culture where all staff are aware of their personal responsibilities for safeguarding and information sharing	Compliant
developing and promoting a learning culture to ensure continuous improvement	Compliant
policies, arrangements and records, to ensure consent to care and treatment is obtained in line with legislation and guidance	Compliant

4.5 Risk Register Review

The Trust Risk Register continues to support the identification, escalation and mitigation of safeguarding risks, ensuring robust oversight and executive visibility of emerging concerns. During 2025/26, key historical risks have been mitigated, with remaining risks focused on workforce capability, system complexity, quality consistency and data assurance.

1. Workforce Capability and Training Compliance

While overall safeguarding training compliance has been achieved across core areas, there remains some variation in workforce capability, particularly within specific training elements such as Prevent Level 2 and emerging learning disability and autism training provision. This presents a residual risk in relation to consistent staff confidence and competence in recognising and responding to safeguarding concerns.

Mitigation includes strengthened in-house training delivery aligned to intercollegiate requirements, targeted improvement plans for areas below compliance, and enhanced governance oversight of training data. This risk is reducing and is expected to close subject to sustained compliance.

2. Increasing Complexity and Demand for Safeguarding

Safeguarding cases continue to increase in complexity, often involving multiple and intersecting vulnerabilities such as mental ill health, domestic abuse, self-neglect and substance misuse. This creates increased demand on staff, with associated risks of case drift and complexity in decision-making.

Mitigation is delivered through strengthened safeguarding supervision, targeted training, multidisciplinary working and effective multi-agency collaboration. This remains an ongoing system-level risk requiring continued oversight.

3. Quality and Consistency of Safeguarding Practice

Audit findings demonstrate variability in safeguarding referral quality and decision-making, particularly in relation to clarity of risk, application of safeguarding thresholds and Mental Capacity Act considerations. In addition, risks associated with safeguarding-related discharge planning remain, particularly where safeguarding concerns persist post-discharge and require coordination across multiple agencies.

Mitigation includes targeted training and supervision, strengthened audit and feedback processes, and enhanced discharge governance arrangements, including multidisciplinary review and escalation processes. This remains an ongoing quality risk.

4. Data Quality and System Fragmentation

Safeguarding data continues to be recorded across multiple systems, limiting full visibility, triangulation and consolidated reporting. This creates a risk in relation to the completeness and consistency of safeguarding assurance.

Mitigation includes ongoing work to improve data triangulation, strengthen reporting systems and enhance confidence in safeguarding intelligence presented through governance structures. This remains an ongoing assurance risk.

Overall, safeguarding risks during 2025/26 have been actively managed, with significant improvement in referral process reliability and training compliance. The remaining risks are well understood, subject to clear mitigation plans, and continue to be monitored through established governance arrangements to ensure sustained improvement and Board assurance.

5. Partnership Working to Improve Outcomes for Children's and Adults

Senior nursing leadership, including Hospital Directors of Nursing and Safeguarding Leads, represent the Chief Nurse across a range of safeguarding partnerships and statutory forums within North West London, including Kensington and Chelsea, Westminster, Hammersmith and Fulham, and Hounslow. Representation spans both adult and children's safeguarding arrangements, with engagement in Safeguarding Adults Boards, Local Safeguarding Children's Partnerships (LSCPs), and a wide range of associated sub-groups and operational forums. These partnerships provide critical oversight, enabling shared learning, multi-agency collaboration and assurance regarding the effectiveness of safeguarding systems across the local health and care economy.

The Trust maintains active involvement in partnership structures, including quality assurance groups, safeguarding adults review processes, learning and development forums, case review groups, and specialist networks such as NWL VAWG ICS Group, Risk & Review Panels in tri-borough, Modern Slavery & Exploitation Operational Groups, Multiagency Risk Assessment Conferences (MARACs), Multiagency Criminal Exploitation (MACE) panels, Domestic Abuse Related Death Reviews (DARDRs), Mental Capacity Act and high-risk panels. In parallel, senior nursing and named safeguarding professionals contribute to LSCP governance and subgroups, ensuring alignment with statutory responsibilities under the Children Act 2004 and Working Together to Safeguard Children (2026). This coordinated approach supports effective inter-agency working to safeguard both adults and children.

Collaboration with community and local authority partners continues to strengthen pathways for vulnerable groups. This includes close working with local authority children's services and specialist programmes such as the Violence Intervention Project (VIP), supporting young people presenting with injuries related to violence or exploitation. A targeted pathway is in place to identify and support young people presenting with knife or gang-related injuries, ensuring timely intervention while still in the Emergency Department and ongoing support in the community. Education and training delivered in partnership with external teams has further enhanced frontline staff awareness and response to these risks. Our sexual health services are linked

locally to their respective child sexual and criminal exploitation panels and participate in MACE panels across both sites, working closely with local authority agencies.

The safeguarding team also actively supports organisational processes relating to allegations against staff, working in partnership with Local Authority Designated Officers, Human Resources, senior managers and, where appropriate, external agencies including the police and professional regulators. Staff involved in these processes are supported throughout, ensuring a fair, transparent and proportionate approach.

Across both adult and children's safeguarding, partnership working continues to provide strong assurance of effective system leadership, robust multi-agency collaboration and clear governance arrangements. This enables early identification of risk, coordinated intervention and continuous learning, ensuring the Trust fulfils its statutory safeguarding responsibilities and contributes to improved outcomes for vulnerable individuals across the communities it serves.

5.1 CPIS and CPIS2

The CP-IS and CP-IS2 are due to be approved by the DHSC and NHS England. The areas for CP-IS phase 2 include: Primary Care. Mental Health. Sexual Health. 0-19 Services. Community Paediatrics. Dentistry. CP-IS will be added to the Safeguarding level 3 training package in August. During 2026 CPIS-2 will also be onboarded by our sexual health services, having led on a national specialty response, endorsed by BASHH, BHIVA, CoSRH and NHSE. CP-IS 2 roll out has been delayed until January 2027.

5.2 Cerner Collaboration Work

During 2025/26, the Safeguarding Team worked closely with the Cerner (Oracle Health) programme, Trust Digital and EPR teams, and North West London partners to strengthen the visibility, quality and safety of safeguarding documentation and referral processes within the electronic patient record (EPR). This collaborative work aimed to reduce risk, improve assurance, and support timely, accurate information sharing across clinical pathways.

Key areas of collaboration included the design, testing and refinement of safeguarding referral workflows, improvements to safeguarding alerts and high risk indicators, and enhancements to how safeguarding information is recorded and reviewed within Cerner. This included addressing historical risks associated with incomplete or mis directed referrals, improving staff understanding of correct workflows, and strengthening escalation and failsafe processes to ensure concerns are not missed. Targeted audits and assurance activity were undertaken alongside Digital colleagues to identify system issues and implement mitigations.

The Team also contributed to, working with neighbouring Trusts and Cerner stakeholders to align approaches to adult and children safeguarding referrals, IDVA and MARAC processes, Deprivation of Liberty Safeguards (DoLS) documentation, and the management of safeguarding information in discharge summaries and correspondence. This collaborative forum supported shared learning, consistency across Trusts, and equitable system developments where possible.

Overall, collaboration with the Cerner group during 2025/26 has improved safeguarding visibility within the EPR, strengthened referral reliability, reduced manual workarounds, and provided greater assurance to the Trust Board. This work remains ongoing, with continued joint governance and quality assurance planned to support system developments, innovation releases and evolving safeguarding requirements.

5.3 CQC Alerts

During 2025/26, the Trust received notifications via the Care Quality Commission (CQC). These notifications were raised by patients or families through their local authority rather than directly through the Trust's Patient Advice and Liaison Service (PALS) or formal complaints processes. All notifications were reviewed by the Safeguarding Team, in line with agreed internal response timeframes, and assessed through a safeguarding lens to identify any potential risks of abuse or neglect.

Following initial review, cases were referred to the Complaints Team and relevant clinical divisions to support appropriate investigation and response. Safeguarding colleagues-maintained oversight throughout, ensuring that actions taken were proportionate, risks were appropriately managed, and outcomes and learning were shared with both the local authority and the CQC as required.

None of the notifications met the threshold for a safeguarding referral or for a statutory Section 42 enquiry under the Care Act 2014. Where safeguarding thresholds were not met, concerns were managed through appropriate alternative routes, including clinical governance, complaints handling, and quality and safety processes. This ensured that patient and family concerns were taken seriously, addressed proportionately, and subject to appropriate professional oversight.

The Trust continues to maintain an open, transparent and proactive relationship with the CQC. Where safeguarding concerns are identified internally, referrals are made promptly through established safeguarding pathways and relevant information is shared with external partners and regulators as appropriate. This approach supports regulatory assurance, learning, and reflects the Trust's commitment to openness, accountability and high quality safeguarding practice.

6. Learning and Development

The Trust continues to monitor safeguarding training compliance in line with Key Performance Indicators agreed by the North West London Integrated Care Board, with a target of 90% compliance across all required training levels. As at 31 March 2026, compliance has been achieved across core safeguarding training requirements for both adult and children's services. Preventing Radicalisation (Level 2) remains below the required threshold and is a key area of focus for improvement in 2026/27.

Safeguarding training is aligned to the Intercollegiate Documents, which set out the competencies required for all staff working in healthcare settings. These requirements have expanded, particularly at Level 3, to ensure a broader group of staff are equipped with the skills

and knowledge to recognise and respond to safeguarding concerns across both adults and children. This approach supports increased awareness, early identification of risk and more consistent safeguarding practice across the organisation.

During the year, the Safeguarding Children and Maternity teams have worked collaboratively to develop an integrated Level 3 safeguarding training programme, incorporating both adult and children's safeguarding content within a three-year rolling programme inclusive of domestic abuse. This supports a more joined-up approach to safeguarding education and reflects the increasingly complex needs of individuals across services. Delivery and compliance are supported through Learning and Development systems, ensuring accurate recording and oversight.

In addition to internal provision, staff are supported to access safeguarding training through Local Safeguarding Children's Partnerships and other external partners, further strengthening multi-agency understanding and practice. The Safeguarding Team maintain full compliance with Level 4 and above training requirements, providing assurance that the specialist workforce is appropriately trained to lead, advise and support safeguarding practice across the Trust.

Topic	Compliance
Safeguarding Adults Level 1	93.1%
Safeguarding Adults Level 2	92.2%
Safeguarding Adults Level 3	94.6%
Safeguarding Children's Level 1	94%
Safeguarding Children's Level 2	92%
Safeguarding Children's Level 3	90%
Safeguarding Children's Level 4	100%
Preventing Radicalisation Level 1	94%
Preventing Radicalisation Level 2	76%

Overall, the Trust continues to demonstrate strong compliance with safeguarding training requirements across both adult and children's services, with clear plans in place to address areas of variance. This provides assurance that staff are appropriately equipped to recognise, respond to and manage safeguarding concerns in line with national guidance.

6.1 Key Training Updates

During 2025/26, the Trust continued to strengthen its safeguarding training offer across both adult and children's services to ensure staff are knowledgeable, confident and competent in recognising, responding to and managing safeguarding concerns in line with statutory guidance, including the Care Act 2014 and Working Together to Safeguard Children. Training delivery was overseen by the Safeguarding Teams and aligned to national and intercollegiate competency frameworks.

Safeguarding training was delivered throughout the year using a blended model of face-to-face and virtual sessions, ensuring accessibility across all staff groups, services and sites. Training focused on core safeguarding principles, thresholds for referral, professional curiosity,

safeguarding children frameworks, Mental Capacity Act considerations, and Making Safeguarding Personal. Content was regularly updated to reflect Trust-specific pathways and included practical guidance on completing safeguarding referrals and documenting concerns within the Cerner electronic patient record.

The quality and relevance of training were strengthened through the use of case-based learning drawn from both adult and children's safeguarding activity within the Trust. This included scenarios relating to domestic abuse, child protection, modern slavery and exploitation, pressure damage, complex discharge planning, and safeguarding risks affecting children and young people. Reflective discussion was embedded within sessions to support professional judgement, escalation and effective multi-agency working.

In response to emerging themes, training incorporated increased focus on areas such as modern slavery, exploitation and contextual safeguarding, supported by specialist input within Level 3 sessions. This approach has supported improved identification of risk, strengthened assessment and referral quality, and reinforced partnership working with local authority and system partners across both adult and children's pathways.

The Trust continued to strengthen training governance and assurance processes. Attendance at instructor-led sessions was actively monitored, and discrepancies between learning records and attendance were reviewed and addressed in partnership with Learning and Development teams to ensure accuracy of compliance reporting. Staff were supported to complete mandatory training requirements in line with their role and responsibilities.

Looking forward, safeguarding training will continue to evolve in response to learning from safeguarding activity, audits and reviews. There will be an ongoing focus on improving referral quality, strengthening legal literacy and enhancing staff confidence in managing complex safeguarding risks across both adult and children's services.

Overall, this approach provides assurance that the workforce is appropriately trained and supported to deliver safe, effective and responsive safeguarding practice, with a consistent and integrated approach across the Trust.

6.2 Prevent

The Trust continues to meet its statutory responsibilities under the Prevent duty, with Prevent fully embedded within the wider safeguarding framework and governance arrangements. Concerns relating to potential vulnerability to radicalisation are reviewed promptly and proportionately through established safeguarding pathways, with referrals made using national processes where thresholds are met. Prevent concerns that do not meet the threshold for referral are managed appropriately through alternative safeguarding, clinical or managerial routes to ensure risk is addressed without unnecessary escalation.

Prevent oversight is maintained through Trust safeguarding governance structures, providing assurance that practice aligns with national guidance, statutory expectations and local partnership arrangements. The Trust continues to work transparently with Prevent partners and

safeguarding networks, supporting effective information sharing, learning and regulatory assurance.

In relation to training, mandatory Prevent training remains in place for relevant staff groups and is embedded within safeguarding and induction programmes. As part of ongoing work to strengthen safeguarding training assurance, the Trust is currently reviewing Prevent training data alongside wider safeguarding training data following changes to the safeguarding training offer and reporting arrangements. This includes reconciling learning hub records, ensuring accurate denominators, and strengthening confidence in compliance reporting.

This approach ensures staff remain equipped to recognise early indicators of vulnerability, know how to seek advice, and escalate concerns appropriately, while the Trust maintains clear oversight of training compliance and quality. Overall, Prevent arrangements remain effective, proportionate and well integrated, demonstrating the Trust's commitment to safety, openness and continuous improvement.

6.3 Safeguarding Supervision

Safeguarding supervision is a key component of the Trust's safeguarding framework, supporting staff to manage complex, high-risk and emotionally demanding situations safely and lawfully across both adult and children's services. During 2025/26, supervision remained an integral mechanism for promoting high quality practice, professional accountability and organisational learning.

Supervision is delivered by the safeguarding teams and is accessible to both clinical and non-clinical staff involved in safeguarding concerns. It provides a structured environment for reflection, enabling staff to apply relevant legislative frameworks appropriately, including the Care Act 2014, the Mental Capacity Act, and statutory guidance relating to safeguarding children. Supervision maintains a clear focus on risk management, professional judgement, proportionality and, where appropriate, Making Safeguarding Personal.

During the year, the Safeguarding Supervision Policy was reviewed and strengthened to explicitly incorporate both adult and children's safeguarding. Historically, the framework had been more aligned to children's services; the revised policy now provides clear expectations, scope and governance arrangements across all safeguarding activity, improving consistency, visibility and organisational assurance.

A range of supervision approaches are in place to support staff, including one-to-one supervision for named professionals, group and peer supervision, regular safeguarding team meetings, and dedicated forums such as ward-based sessions, maternity and neonatal drop-in meetings, and paediatric consultant continuous professional development sessions. In children's services, structured peer supervision for paediatric medical teams is delivered monthly, with learning disseminated more widely to ensure accessibility for those unable to attend.

Supervision addresses a wide range of complex safeguarding themes across both adult and children's services, including mental health presentations, self-neglect, fluctuating mental capacity, domestic abuse and sexual violence, exploitation, and complex discharge planning. It supports staff to explore safeguarding thresholds, defensible decision making, escalation pathways and multi-agency working, particularly in situations where risk is cumulative or not immediately clear.

Supervision also plays a critical role in supporting staff wellbeing and resilience. Safeguarding work is often emotionally challenging and ethically complex, and supervision provides opportunities for reflection, debriefing and peer support, reducing professional isolation and maintaining confidence in practice. This contributes to safer care, reduces the risk of case drift and promotes consistency in safeguarding responses.

Learning from supervision is fed into wider safeguarding governance processes, including audit, training development and quality improvement. Intelligence from both internal case review and external review processes is used to inform continuous improvement and strengthen organisational assurance.

Overall, safeguarding supervision continues to provide strong assurance that staff across the Trust are supported to manage safeguarding risks confidently, lawfully and in line with national guidance. The strengthened, integrated supervision framework demonstrates a clear organisational commitment to high quality, reflective and accountable safeguarding practice.

6.4 Dissemination of Learning from Reviews and Incidents

The Trust recognises that effective dissemination of learning from safeguarding reviews, incidents and complex cases—across both adults and children's services—is essential to improving practice, preventing recurrence and strengthening safeguarding systems. During 2025/26, learning was actively shared across the organisation through a range of formal and informal mechanisms to ensure it reached frontline staff, operational leaders and governance forums.

Learning is routinely disseminated through safeguarding newsletters, which provide accessible summaries of key themes, learning points and practice expectations. These communications support awareness, reinforce professional curiosity and highlight changes to guidance, pathways and policy arising from review findings. They are used widely across clinical and non-clinical services to promote a consistent organisational approach to safeguarding practice.

The safeguarding teams contribute to Significant Incident Meetings and wider governance forums, ensuring safeguarding considerations are embedded within incident review, root cause analysis and action planning. This supports early identification of safeguarding risks and ensures that learning is translated into meaningful quality improvement activity. In addition, safeguarding professionals contribute to a range of operational and specialist meetings, including discharge planning, tissue viability and multidisciplinary forums, where learning from safeguarding incidents and reviews is applied to ongoing service delivery.

Learning is further embedded through safeguarding governance processes, where themes and trends from reviews and incidents inform training programmes, audit activity, policy development and organisational priorities. Domestic Abuse Delated Death Reviews (DARDRs) findings are also presented at the respective team's clinical governance meetings to share learning and actions. Intelligence is triangulated with data from safeguarding activity, supervision and audit findings to provide assurance that improvements are implemented and sustained.

For children's services, statutory safeguarding practice review processes are a key mechanism for identifying system learning following serious incidents. Safeguarding professionals actively contribute to Local Safeguarding Children's Partnership (LSCP) case review processes, including Rapid Reviews and decisions regarding safeguarding practice reviews. Both local and national case reviews are regularly discussed within safeguarding and multidisciplinary forums to ensure lessons are embedded in practice. This has informed improvements in areas such as follow-up processes for children not brought to outpatient appointments.

The Trust is also an active participant in wider safeguarding networks, including safeguarding health network meetings and collaborative forums across West London Children's Healthcare. These arrangements support shared learning, alignment of policies and procedures, and consistent approaches across partner organisations. Ongoing collaborative work includes strengthening safeguarding referral processes and exploring more streamlined approaches to delivering safeguarding medical assessments across sites.

Across both adult and children's safeguarding, learning is disseminated through team meetings, training and targeted education sessions, ensuring staff are equipped to respond effectively to safeguarding risks. This integrated approach to learning and improvement provides strong assurance that the Trust is responding proactively to safeguarding intelligence, embedding best practice and continuously strengthening the quality and safety of care for vulnerable individuals.

7. Policies

The Trust maintains a comprehensive and up to date suite of adult safeguarding policies to ensure adults at risk of abuse or neglect are protected in line with statutory duties and national guidance. Adult safeguarding policies provide clear direction to staff on roles and responsibilities, safeguarding thresholds, escalation routes and information sharing, supporting consistent and defensible decision making across adult services.

Adult safeguarding policy is underpinned by the Care Act 2014 and the Mental Capacity Act 2005 and is aligned with the Pan London Adult Safeguarding Policy, Practice Guidance and Procedures. Trust policies are reviewed regularly to ensure they remain current, reflect national and local developments, and incorporate learning from safeguarding reviews, incidents and audit activity.

During 2025/26, the Trust reviewed and strengthened key adult safeguarding policies to improve clarity, consistency and operational relevance. This included ensuring policies reflect contemporary safeguarding risks such as self neglect, domestic abuse, modern slavery and

exploitation, complex discharge planning and fluctuating mental capacity. Policies continue to reinforce the principles of Making Safeguarding Personal, ensuring that adults' views, wishes and desired outcomes remain central to safeguarding responses.

The Trust also updated its Safeguarding Supervision Policy to explicitly include adult safeguarding, alongside children's safeguarding. Previously, the policy was predominantly focused on children. The revised policy now provides clear expectations and assurance arrangements for adult safeguarding supervision, strengthening governance, visibility and staff support across adult services.

In addition, a recent extension and update to the Pan London Adult Safeguarding Policy has been issued. The Trust will incorporate these changes as part of the scheduled policy review in September, ensuring local policies remain fully aligned with updated Pan London guidance and partnership expectations.

7.1 Sexual Safety Charter

On 4th September 2023, NHS England launched its first ever sexual safety charter in collaboration with key partners across the healthcare system. The Trust became a signatory to this charter in 2024 and a member of the Employer's Initiative on Domestic Abuse (EIDA) in February 2025.

Signatories to this charter commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles and actions to help achieve this.

We have signed the Sexual Safety Charter and extended the principles to be inclusive of domestic abuse and sexual violence, as part of our Charter for Change.

As part of our new Charter for Change to create a workspace where everyone feels safe, we have launched the Trust's first Sexual Misconduct, Domestic Abuse and Sexual Safety (DASS) People policy.

It is aligned to our PROUD values and professional codes of practice that encourage people to raise concerns within a just and learning culture.

Staff at Chelsea and Westminster Hospital NHS Foundation Trust can now report any concerns related to sexual misconduct, domestic abuse and/or sexual safety online, either anonymously, with full details, or on behalf of a colleague. The Domestic Abuse & Sexual Safety (DASS) team and ER teams are working closely together on any reports that come through. Training on Handling First Disclosures is due to launch in June 2026 led by the Trust DASS team.

The organisation has a Trust DASS Lead and a Trust DASS Coordinator, supported by 4 Independent Domestic Violence Advisers (IDVAs).

8. Audits

The Trust undertakes a structured programme of adult safeguarding audit activity to provide assurance on the effectiveness of safeguarding practice, compliance with statutory duties and alignment with local and national guidance. Audit activity is used to assess the quality of safeguarding referrals, decision making, documentation, Mental Capacity Act application and multi agency working, as well as to identify themes, risks and areas for improvement. Findings from audits are reported through safeguarding governance structures and inform training development, supervision focus, policy review and quality improvement actions. Where gaps or risks are identified, action plans are developed and monitored to ensure learning is embedded and improvements are sustained. This approach supports continuous improvement in adult safeguarding practice and provides assurance to the Trust Board and external partners.

8.1 Regulatory Partnership Audits

The Trust contributes to a range of regulatory and partnership safeguarding audits to provide external assurance on compliance with statutory duties and the effectiveness of adult safeguarding arrangements. During the reporting period, this included participation in the Safeguarding Adults Peer Assessment Tool (SAPAT) which assess how organisations discharge their safeguarding responsibilities in line with legislation and national guidance.

In addition, the Trust supports and contributes to Safeguarding Adults Board (SAB) audit activity with local authority partners across boroughs. This includes participation in multi agency audits, provision of evidence, case information and professional input, and engagement in audit feedback and action planning processes. SAB audits provide valuable independent challenge and system wide learning, particularly in relation to partnership working, referral quality, information sharing and outcomes for adults at risk.

8.2 Internal Audits

During 2025/26, the Trust undertook a programme of internal adult safeguarding audits to provide assurance on the quality of practice, compliance with statutory duties and alignment with Trust and Pan London safeguarding arrangements. The audit programme focused on areas of higher risk, emerging themes from safeguarding activity, and priorities identified through governance and partnership intelligence.

Pressure damage and safeguarding audit

An internal audit was undertaken to review safeguarding decision making and referral quality in cases involving pressure damage, including use of the Pressure Ulcer Protocol and escalation processes.

Outcomes:

- Improved clarity around safeguarding thresholds in pressure damage cases.
- Closer collaboration established between the Safeguarding Team and Tissue Viability Nurses (TVNs) to strengthen shared understanding and consistency.

- Learning used to inform training, supervision discussions and guidance for clinical teams, particularly around discharge planning and prevention of neglect.

Quality of adult safeguarding referrals

An audit was completed to assess the quality and consistency of adult safeguarding referrals, focusing on documentation, rationale for referral, application of the Care Act criteria and information sharing with local authority partners.

Outcomes:

- Identification of variable referral quality across services, particularly in relation to clarity of risk, mental capacity considerations and desired outcomes.
- Targeted feedback provided to teams, with learning embedded into Safeguarding Adults Level 3 training and supervision.
- Increased focus on professional curiosity and defensible decision making when thresholds are unclear.

Safeguarding supervision audit

An internal review of adult safeguarding supervision arrangements was undertaken to assess availability, consistency and alignment with governance expectations.

Outcomes:

- Confirmation that safeguarding supervision is valued by staff and supports management of complex cases.
- Identification of the need for clearer policy alignment, which informed the update of the Safeguarding Supervision Policy to explicitly include adults.
- Strengthened assurance reporting through safeguarding governance structures.

Internal adult safeguarding audits during 2025/26 supported improved practice consistency, staff confidence and governance assurance. Learning from audits has informed training content, supervision focus, policy development and partnership working, and continues to shape the Trust's adult safeguarding priorities for 2026/27. Audit outcomes are monitored through safeguarding governance arrangements to ensure actions are implemented and improvements sustained.

16–17 Year Old ED Attendances Audit

The audit was undertaken to assess whether safeguarding concerns in 16–17 year old attendances and subsequent admissions from the Emergency Department were consistently identified and appropriately referred, recognising this cohort as particularly vulnerable within urgent and emergency care pathways.

Overall, the findings provided good assurance that safeguarding need is largely recognised across both sites, with referrals completed in the majority of cases where concerns were

identified. However, a small gap in practice was identified, with one admission at West Middlesex University Hospital where a safeguarding concern was recorded but no corresponding referral had been completed. In addition, the audit highlighted that mental health presentations and risk-taking behaviours, including alcohol intoxication, were the most common safeguarding themes within this age group.

In response, targeted actions were agreed to strengthen the consistency and reliability of safeguarding processes. This included reinforcing expectations for referral completion within Emergency Department teams, improving processes to ensure safeguarding teams are notified of all relevant admissions, and promoting uptake of Level 3 safeguarding training among staff.

These actions were implemented through cross-site safeguarding teaching for Emergency Department staff, communication via line managers to increase engagement with training requirements, and clearer expectations for both adult and paediatric ward teams regarding notification of safeguarding concerns.

The impact of this work is increased assurance that safeguarding concerns in older adolescents are consistently identified and managed appropriately, alongside strengthened governance and improved consistency of referral processes across both sites. The audit has also reinforced organisational awareness of mental health and risk-related presentations as key safeguarding risks within this cohort, enabling more focused and proactive safeguarding practice.

8.3 Multi-agency Audits

The Trust actively participates in multi agency safeguarding audits coordinated through local Safeguarding Adults Boards (SABs) and partnership quality assurance arrangements. These audits assess how agencies work together to identify risk, make effective referrals, share information and deliver proportionate, person centred safeguarding responses. The Trust contributes case evidence, professional analysis and practice reflection to support shared learning and independent challenge. Learning from multi agency audits is reviewed through Trust safeguarding governance structures and used to inform training development, supervision focus, policy review and service improvement. This collaborative approach strengthens partnership working, improves practice consistency, enhances staff confidence and supports robust governance assurance across the safeguarding system.

8.4 Joint Targeted Area Inspections

Joint Targeted Area Inspections (JTAs) are multi-agency inspections undertaken by Ofsted, the Care Quality Commission (CQC), HM Inspectorate of Constabulary and Fire & Rescue Services, and HM Inspectorate of Probation. They assess how effectively local services work together to safeguard children, focusing on specific themes and the quality of multi-agency practice.

Although no JTAs took place within the Trust's locality during 2025/26, the framework provides an important benchmark for effective partnership working and continuous improvement in safeguarding practice.

8.5 Child Sexual Abuse

The Safeguarding Team has maintained active involvement in the management of child sexual abuse cases throughout the reporting year, working in close partnership with multi-agency colleagues to support children and their families. The cases managed were complex, often involving multiple intersecting risk factors including trauma, family instability, missing episodes, online exploitation, mental health concerns, and criminal exploitation.

Comprehensive risk assessments were undertaken, with the team coordinating effective multi-agency safeguarding responses and ensuring that appropriate interventions and support were in place. Regular strategy discussions and robust information sharing were central to promoting safe and timely discharge planning in each case.

The Local Safeguarding Children Partnerships (LSCPs) in LBHF and RBKC are currently undertaking a child sexual abuse audit, with the Trust contributing through case review and multi-agency evaluation of outcomes and information sharing processes. Learning from this audit will be disseminated to strengthen practice and service improvement.

Child sexual abuse, violence and exploitation continue to be routinely monitored within sexual health services across both sites, supported by robust documentation standards and clear escalation pathways to statutory agencies. Cases are regularly reviewed through monthly safeguarding supervision ("safety net"), co-chaired by the Named Nurse for Safeguarding Children and Young People and the HIV/GUM Safeguarding Lead, ensuring ongoing oversight, challenge, and shared learning.

9. Safeguarding Activity

9.1 Safeguarding Children

9.1.1 Children's Safeguarding Team Function

The organisation continues to work to a set of protocols governing the safety of children: "Working Together To Safeguard Children" 2026. This guidance clearly outlines the expectations from partner agencies in relation to safeguarding children and as a result, the Trust has a well-established and dedicated team of clinicians (Named Professionals) on each site:

- Dr Anne Davies Paediatric Consultant (WMH), Dr Paul Hargreaves Paediatric Consultant (C&W) - Named Doctors.
- Daisy Dholoo (WMH) and Faye Mitchison (C&W) -Named Nurses with the remit for strategic development, policy and training, providing support and advice for staff.
- Sarah Green – Consultant Midwife Safeguarding and Public Health (cross site) the Named Midwife for Safeguarding is incorporated into this role)
- Silviya Giffin (WMH) and Wendy Allen (CW) – Safeguarding specialist midwives who lead/support midwives with operational case management, have safeguarding oversight of cases and deliver training with a maternity focus.

- Lotus Resol is the Child Death Lead across both sites. This post is one day per week. Link and key worker for the bereaved families. Supports staff on child death process, training, data keeping and coordinating with the Pan London Child Death Review Team for Joint Agency Response (JAR) and Child Death Review Meetings (CDRM).

The Named Professionals continue to be instrumental in developing and implementing policy at local and strategic level. They are responsible for case management investigations and Case Reviews as determined by the 'Working Together to Safeguard Children (2026)' Guidance.

Access to child protection advice for Trust employees is on a 24hr basis ensuring appropriate support and guidance is available via resident, non-resident Paediatric Consultants and 24/7 Senior Paediatric Nurse and Midwifery Cover who cover both acute trusts.

The named professionals are now meeting regularly with the West London Children Hospital Safeguarding Team, this is valuable in ensuring that we are all standardizing our approach to safeguarding children.

9.1.2 Section 11 – Children's Act 2024

At previous reviews and self-assessments the Trust has been commended for the emphasis and importance put on multidisciplinary working to support the safeguarding function. The organisation continues to build on these standards and reassure the Board with the measures outlined below.

Board Assurance Measure: Trust Boards have been asked 'as a minimum' to assure themselves that:	Organisation rating against S11 standards.
1. There is senior management commitment to the importance of safeguarding and promoting children's welfare.	• The Chief Nurse is the Trust Board Executive Director for Safeguarding. The Deputy Chief Nurse is the executive lead. • The Board receives an Annual Safeguarding Report. • The Joint Safeguarding Group meetings are held across sites face to face and / or using video conference. • Trust wide training compliance is reported and reviewed by the Trust Quality Committee and Joint Safeguarding Group.
2. A clear statement of the Trusts responsibilities towards children is available to staff	• The Safeguarding children policy is available for all staff via the intranet this is reviewed regularly. • Details of the safeguarding team are available via the intranet • All staff receives level 1 training as part of the induction process. • Safeguarding Training records are monitored via Qlikview across both sites.

	• Audits are presented both internally and externally as part of the annual program. • Commissioning agreements include monitoring of S11 responsibilities. • There is a robust complaints process in place.
3. There is a clear line of accountability within the organisation for work on safeguarding and promoting welfare	• The Chief Nurse is the Trust Board Executive Director for Safeguarding. The Deputy Chief Nurse, reporting to the Chief Nurse, is the executive lead for safeguarding • There is a Named Doctor, Named Nurse on each site. • Within maternity there is a B7 specialist safeguarding midwife on each site. They are supported by a Band 6 Safeguarding support midwife at WM and a Band 6 Public health support midwife at CW. The Named Midwife Safeguarding works across site as part of the Consultant Public Health and Safeguarding Midwife role. • Named Professional safeguarding responsibilities are included in the job descriptions. • Details of the named professionals can be accessed by staff via the intranet. • Clear lines of accountability are displayed within the safeguarding policy. • Supervision is available for all staff working with vulnerable families on a regular basis.
4. Service Developments take into account the need to safeguard and promote welfare and is informed, where appropriate by the views of children and families.	• All service developments incorporate the appropriate risk assessment for safeguarding. • Play specialists and art therapists are available to help children communicate their thoughts and concerns to health professionals. • There is a safeguarding/ socially complex midwife within each community midwife team who care for/ have oversight of women and families with socially complex/ safeguarding concerns. There is a peri-natal mental health midwife on each site. • A Perinatal Mental Health Hub is now available in NWL which consists of midwives and psychologists providing additional psychological support for women who have suffered Birth Trauma, pregnancy loss and any on-going mental health concerns during pregnancy/ following birth.
5. Training on safeguarding children is in place for all staff in contact with children.	• There is a training plan in place to ensure that all staff meet the minimum standards required by the intercollegiate guidelines. • In line with the "Safeguarding Children and Young People: Roles and Competences for Health Care Staff", Intercollegiate Document (2019) The team now work towards a "Think

	Family Approach” which covers Children L3 and Adults at level 2. • Training is integral to the induction process for all new staff. • All training is recorded electronically and provides a robust audit trail. • Level 1 & 2 training is available via e-learning for staff however, face to face and target training is also delivered. • Access to Level 3 Teams and e-learning for health training is available to staff and has continued to be accessed during mandatory training sessions. • In addition, the named professionals provide bespoke Safeguarding Level 3 training face to face and via Teams. Staff can also access safeguarding children training in relevant topics via Local Safeguarding Children Partnership’. • Diversity is included as part of the training for staff. • Training includes the key competencies from the recommendations in the Intercollegiate document, this includes PREVENT, CSE, FGM, Domestic Abuse, Modern Slavery, Trafficking and Gang Related crime.
6. Safer recruitment procedures including vetting procedures and those for managing allegations are in place.	• Safer recruitment is in line with statutory guidance. • Disclosure & Barring/DBS checks and references are taken up prior to job offer. • A recruitment training programme is in place for all managers. • Quality assurance processes are in place to check staff files. • Named professionals share responsibility for reporting staff allegations to the Local Authority Designated Officer (LADO).
7. Effective interagency working is in place	• Multi-agency working is evident across the trust. • The team have worked alongside the IT team and practitioners now complete referrals to children social care via our IT system Cerner • Vulnerable children attending ED are referred directly to children’s social care (CSC) when a safeguarding risk is identified. • Hounslow Children Social Care, Richmond and Twickenham Children Social Care, Kensington and Chelsea Children Social Care and the Multi-Agency Safeguarding Hubs (MASH) work in collaboration with the Trust as well as the Child Abuse Investigation Team (Police) and other safeguarding partners. • The Trust’s internal policies are developed in conjunction with other agencies.

	• Multi-agency meetings are in place • A monthly multi- agency meeting takes place across both paediatrics and maternity on both sites in order for staff to come and present cases with the multi-agency partners
8. There is effective information sharing.	• There is a governance protocol in place for sharing information around child protection complying with the GDPR legislation. • Training is given around sharing information and confidentiality. • The Child Protection Information System is in place and has been embedded into the Electronic system of CERNER • FGM is embedded within the Trust and linked to the NHS Summary Care Record.

9.1.3 Psycho-Social Meetings

Information sharing is a basic tenet in Working Together 2026. Constraints in systems and processes for accessing and sharing information between agencies are noted in national and local reviews. Lack of appropriate and timely sharing of information (particularly about siblings, domestic violence, substance misuse and mental health concerns) means that the nature of risk to the child is not always recognised or acted upon. As a result, agencies act in isolation on the basis of known but incomplete information, therefore the Named Nurse for paediatrics and the specialist midwives for maternity chair the meetings which continue to take place in the emergency departments, paediatric wards, maternity, NICU/SCBU and sexual health departments across both sites.

These weekly meetings involve members of the multi professional teams including ED staff, paediatric nurses, doctors, ward teachers, liaison health visitors, midwives, CAMHS nurses and children's social workers from neighbouring boroughs.

A member of the safeguarding team also attends the paediatric handover and/or visits the ward and ED each morning to ensure that safeguarding issues are identified and processes are followed.

9.1.4 Emergency Department Interface

A member of the safeguarding team attends ED on a regular basis to ensure that any issues regarding safeguarding children and families are discussed and referrals are made appropriately, this also includes making contact in the private sectors. In addition to this there is an established Trust wide electronic data base which captures all referrals made by clinicians to Children's Social Care which are regularly reviewed and the data base up-dated accordingly.

Each child, who attends the organisation is routinely checked to see if they are 'subject to a Child Protection Plan' or Child in Need plan this is completed by the CP-IS IT flagging system.

The ED department has dedicated Consultant Paediatricians and a safeguarding nurse link role that are based in both Paediatric EDs. This further ensures that children and young people are safeguarded and processes are followed. Safeguarding Links from the Adult ED department attend the psychosocial meetings and link in with the safeguarding team which has enhanced safeguarding oversight and whilst embedding a Think family approach.

Both sites have an on-site Child and Adolescent Mental Health Services (CAMHS) which is supported by mental health liaison Nurses Mon – Fri 9-5, and also an out of hours psychiatric liaison crisis services. There is also a 7 day service of a Lead Nurse & Deputy Lead Nurse for Mental Health across both sites.

The aim of this service is to:

- Ensure children and young people (0 – 18th birthday) are assessed by a trained and qualified CAMHS professional when presenting to ED with mental health concerns. Once the assessment is completed the child/young person is either admitted onto the paediatric ward for on-going intervention or discharged with a follow up plan in the community with the crisis teams.

9.1.5 Serious Youth Violence and Trauma Attendances

There have been a number of presentations to the Trust during the reporting period relating to serious youth violence resulting in trauma. The Safeguarding Team has worked closely in partnership with Hounslow Children's Social Care (CSC) Adolescent Team to support young people through the Non-Accidental Knife Injury / Violence Intervention Project (VIP) pathway.

A clear pathway is implemented for children and young people (aged 11–25) presenting to West Middlesex Hospital with injuries indicative of serious youth violence or potential gang affiliation. This enables early identification, targeted intervention and timely support, with the aim of preventing further harm and escalation. Referrals are made directly to the VIP team, who engage with the young person at the earliest opportunity, including during hospital attendance where appropriate, and continue support within the community (with consent).

The VIP team has also provided training to Emergency Department (ED) frontline staff to strengthen awareness, recognition and referral processes, with further training planned for 2026/27.

The Safeguarding Team is working collaboratively with partners to explore funding opportunities, via Hounslow CSC, to establish an on-site support worker presence in ED during peak periods (Friday and Saturday evenings). This model is intended to enhance timely engagement with young people, increase referrals, and strengthen opportunities for early intervention and prevention.

9.1.6 Child Protection Medicals

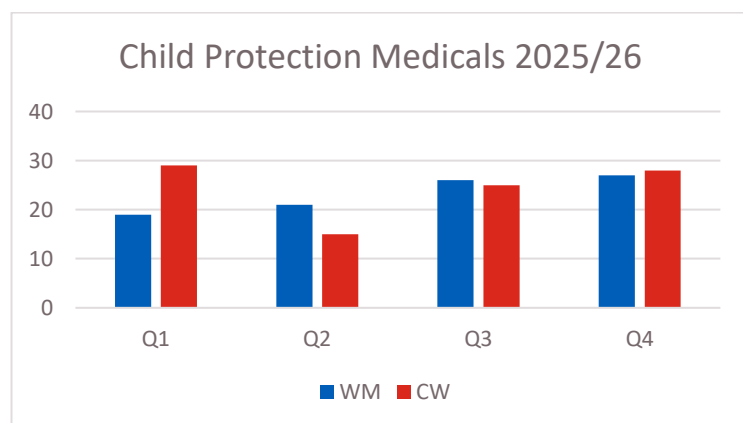
Paediatricians undertake Child Protection (CP) medicals across both hospital sites. These assessments are typically requested by Children's Social Care or the Police where there are concerns regarding potential non-accidental injury or where a child has made a disclosure.

Due to service redesign, CP medical clinics are now delivered on a planned basis three times per week (Monday, Wednesday and Friday), with flexibility to respond to urgent cases as required. The assessment process includes detailed history taking from the child (where appropriate), parents/carers, and involved professionals, alongside a full clinical examination. Additional investigations, including imaging such as skeletal surveys or CT scanning, are undertaken where clinically indicated. A comprehensive report is produced and shared with the referring agency to inform safeguarding decision-making.

Children under two years of age are routinely assessed within the hospital setting due to the increased likelihood of requiring specialist investigations. In addition, any child presenting to the Emergency Department with suspected non-accidental injury will receive a CP medical assessment in line with Trust policy.

As shown in the chart above, activity levels have remained consistent across the year, with a gradual increase in CP medicals undertaken at West Middlesex Hospital (WM), and more variable demand at Chelsea and Westminster (CW). The overall pattern indicates sustained demand for CP medical assessments across both sites, with peaks observed in Q1 and Q4. This reflects ongoing vigilance in identifying safeguarding concerns and appropriate utilisation of CP medical pathways.

Figure 2: Child Protection Medicals



9.1.7 Cases Involving Legal Teams

The Trust Legal Team is actively involved in safeguarding cases requiring multidisciplinary input, providing expert advice and guidance to support clinical and safeguarding staff. This includes supporting staff in the preparation of court reports and ensuring they are appropriately guided through the process of attending court proceedings.

The Safeguarding Team works in close partnership with Legal Services in the management of complex child protection cases, where timely and proportionate information sharing is critical. In these cases, requests for information are reviewed collaboratively with the Legal Team to

ensure compliance with legal and information governance requirements prior to disclosure to multi-agency partners.

The Trust's Domestic Abuse and Sexual Safety (DASS) Team and the Caldicott Guardian work closely with Legal Services in cases involving requests from the police following the arrest of an alleged perpetrator, or in the context of family court proceedings. This ensures that decisions regarding the sharing of sensitive information are robust, lawful, and in the best interests of the child, while maintaining appropriate confidentiality and adherence to statutory frameworks.

9.1.8 Safeguarding Children's Activity

In 2025/26 we have seen an increase year on year in total referrals to Children's Social Care and CAMHS across the organisation. Cases that are presenting to the Trust are more complex and are requiring a more comprehensive approach from the multi-agency teams.

A number of referrals made to Children Social Care related to adults whom had presented to the organisation, practitioners needed to assess potential risks to children/young people that were living in the same household.

Referrals to Children's Social Care are made via Cerner by practitioners and will automatically be sent to the appropriate Borough that the child/young person resides. The safeguarding team also receive the referrals, this is then cross checked at the weekly psychosocial meeting with the social workers present.

Figure 3: Referrals to Children's Social Care 2025/26 – West Middlesex Site

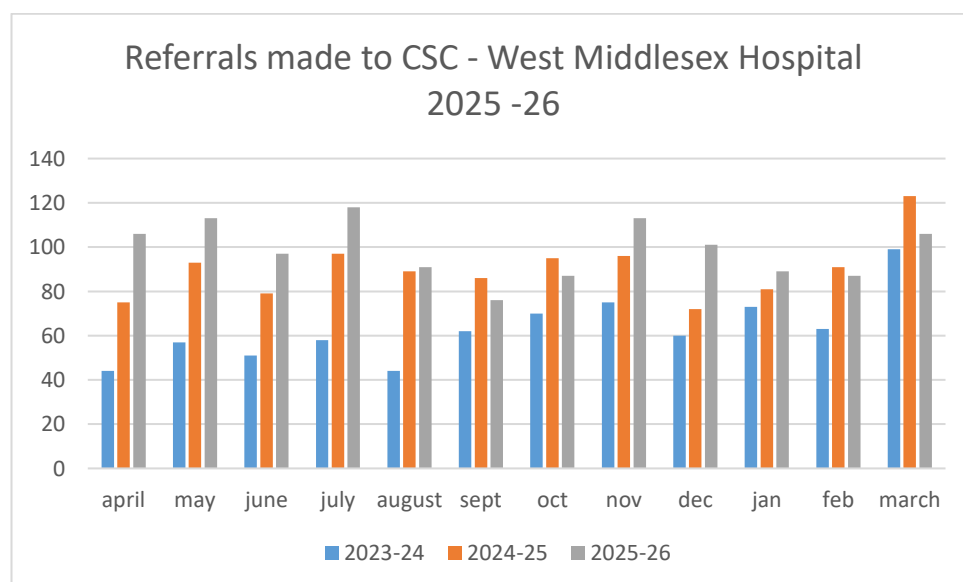
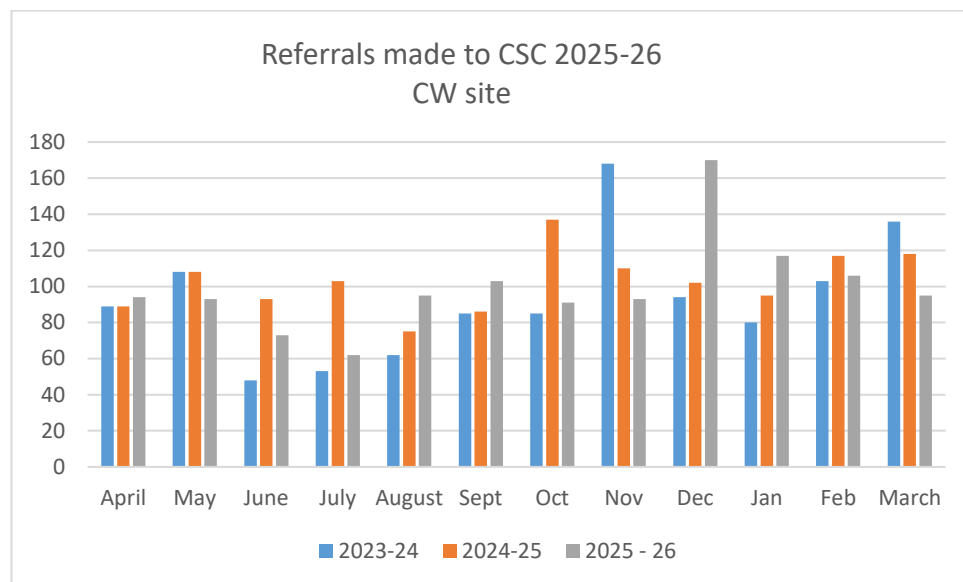


Figure 4: Referrals to Children's Social Care 2025/26 – Chelsea Site



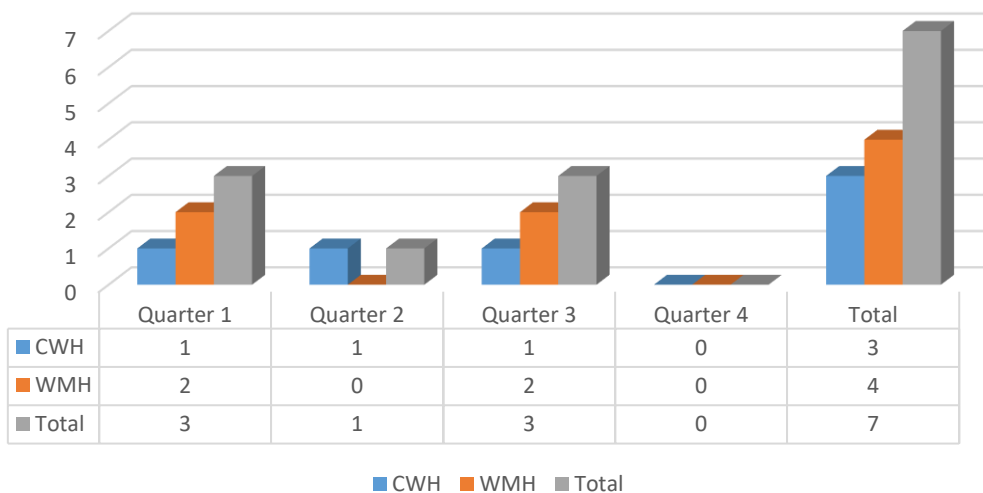
9.1.9 Child Death

A total of 7 child deaths were recorded across both sites during the reporting year, comprising 3 cases at Chelsea and Westminster and 4 at West Middlesex. All cases were reviewed in line with statutory Child Death Review (CDR) processes. There were no child deaths recorded in Quarter 4 (January–March).

Figure 5: Child Deaths per Quarter

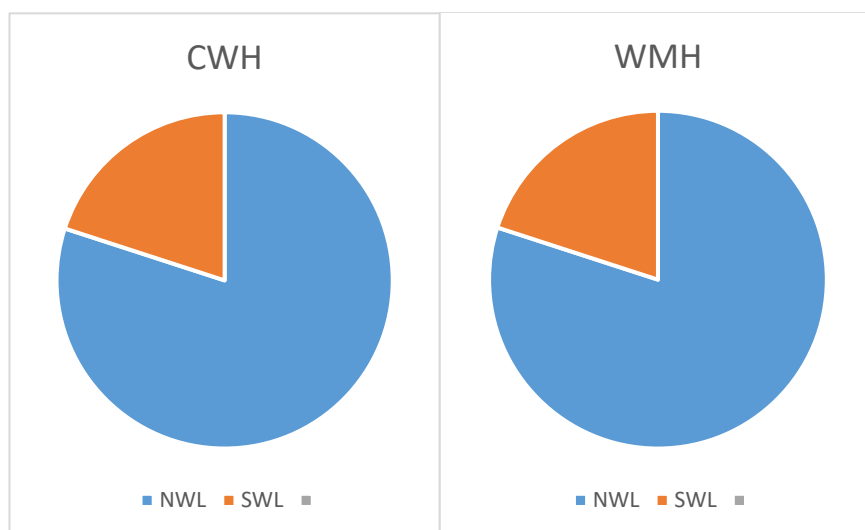
	CWH	WMH	Total
Quarter 1	1	2	3
Quarter 2	1	0	1
Quarter 3	1	2	3
Quarter 4	0	0	0
Total	3	4	7

Child Death April 2025-2026 March



Deaths were identified across multiple Child Death Overview Panel (CDOP) areas, including North West London, South West London, South East London and Surrey. Cases included both expected and unexpected deaths, with themes identified where appropriate; one case remains pending final classification following receipt of a post-mortem report.

Figure 6: Child Deaths per ICS



Engagement with the Child Death Review process remains strong, with clinicians demonstrating high levels of participation in Joint Agency Response (JAR) meetings and Child Death Review Meetings (CDRM), supporting robust multi-agency review and learning. Although the West London Children's Healthcare (WLCH) monthly child death meeting with the North West London CDR team is currently on hold due to system capacity constraints, updates continue to be sought on an ad hoc basis to ensure statutory reporting timelines are maintained.

Figure 7: Category of Child Deaths

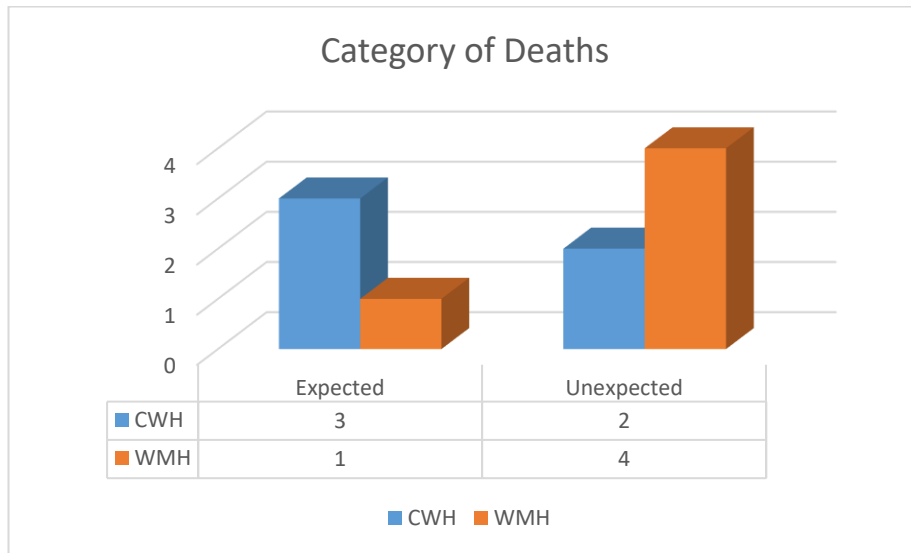
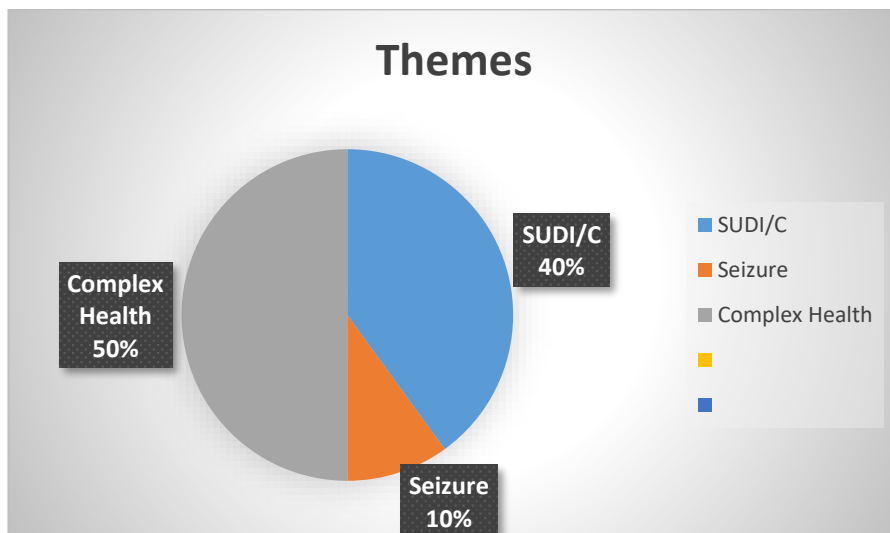
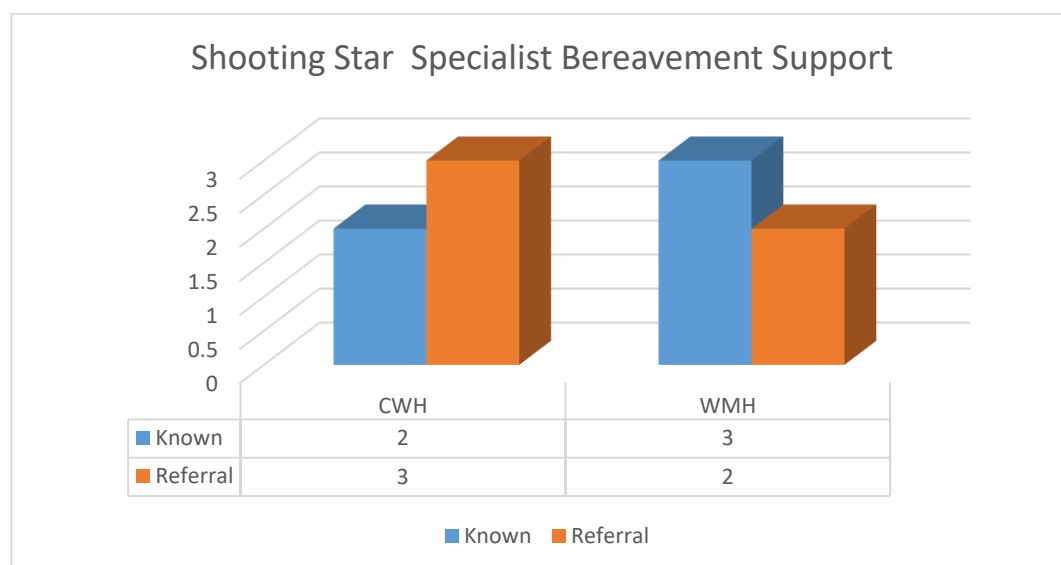


Figure 8: Themes



Bereavement support is available to families across both sites through Shooting Star Children’s Hospices, with referrals made where appropriate. In cases not meeting service criteria, families were signposted to alternative local support to ensure access to appropriate bereavement care. While referrals are recorded, data is not currently available to confirm uptake of support following referral, and this remains an area for further development.

Figure 9: Access to Bereavement Support



Overall, the Trust continues to demonstrate effective engagement with child death review processes, strong multi-agency collaboration and appropriate support for bereaved families, providing assurance that statutory requirements are being met and that learning opportunities are identified and acted upon.

9.2 Safeguarding Maternity

9.2.1 Bookings

Total Number of Maternity Bookings	Q1	Q2	Q3	Q4	Year Total
WM	1366	1221	1255	1216	5058
CW	1750	1579	1642	1455	6426

Between the two sites there were a total of 39 women who presented to be un-booked.

When this is the case both CPIS and also the National Alerts sent out from LA are checked to see if they are known to safeguarding teams. The team will also check with previous hospitals and LAs before anyone is discharged

9.2.2 Socially Complex and Vulnerable Families

There are monthly multi-agency meetings at WMH and CW which are chaired by the Safeguarding Specialist Midwives and include representation from Children's Services, perinatal mental health midwife, socially complex midwives and safeguarding advisors/ HV health visitors. The remit of the group is to review safeguarding/ socially complex cases, provide safeguarding supervision, and act as a safety net to ensure good information sharing and planning is in place.

In addition the Specialist safeguarding midwives also attend the weekly SCBU and NNU meetings to discuss and advise on any safeguarding cases. The consultant midwife provides safeguarding supervision for the NNU team on a weekly basis.

The safeguarding midwives and perinatal Mental Health midwife attend the Hounslow social care meeting to discuss new referrals. They also attend the meeting with the Perinatal Mental Health liaison / psych teams to ensure plans have been put in place for women and families. The consultant midwife has been working with the Early Help lead in the different boroughs to try and improve links and therefore referrals into these services.

9.2.3 Removals

During 2025/26, there were a small number of cases across both maternity sites where babies were removed under an Interim Care Order (ICO) prior to discharge (6 cases at Chelsea and Westminster and 8 cases at West Middlesex). These cases were characterised by high levels of complexity and risk, requiring robust multi-agency planning and coordination. The Safeguarding Team worked closely with maternity, paediatric, legal and social care colleagues to ensure safe and timely decision-making, with comprehensive risk assessments and clear discharge arrangements in place.

This activity sits alongside a high level of safeguarding engagement more broadly, evidenced by 231 multidisciplinary meetings at Chelsea and Westminster and 366 at West Middlesex, and a combined total of 57 children subject to Child Protection Plans and 81 to Child in Need Plans. In some cases, safeguarding complexities resulted in delayed discharges (17 at Chelsea and Westminster and 3 at West Middlesex), reflecting the need to ensure appropriate safeguarding plans and placements were in place prior to discharge.

Overall, the data demonstrates effective identification and escalation of risk, with strong multi-agency collaboration ensuring that safeguarding decisions, including the use of ICOs where required, were managed in line with statutory processes and prioritised the safety and welfare of the infant.

9.2.4 Delayed Discharges

During 2025/26, a number of delayed discharges were recorded across both maternity sites due to social and safeguarding complexities (17 cases at Chelsea and Westminster and 3 cases at West Middlesex). These delays were primarily associated with the need to ensure that robust safeguarding plans, appropriate placements, and multi-agency agreements were in place prior to discharge.

The Safeguarding Team worked proactively with maternity services, Children's Social Care, housing and wider partners to facilitate safe and coordinated discharge planning. While delays can impact flow, they reflect appropriate risk management and a prioritisation of infant safety, ensuring that discharge does not occur until safeguarding risks have been effectively mitigated.

This activity demonstrates the Trust's commitment to safeguarding governance and multi-agency collaboration, with a focus on ensuring that all infants are discharged into safe and supportive environments, even where this requires extended inpatient stays.

9.2.5 Maternity Safeguarding Activity

There were 242 referrals to social care from the Chelsea and Westminster site and 346 from West Middlesex. Over the last year, this represents a slight reduction in referrals from the West Middlesex site alongside an increase at Chelsea and Westminster.

Across both sites, there is also a growing pattern of referrals requiring escalation, particularly where initial referrals have been closed without a formal assessment. This has resulted in the safeguarding team needing to re-refer or request reassessment to ensure that appropriate safeguarding oversight and intervention is in place.

Figure 10: Maternity Referrals to Children's Social Care 2025/26

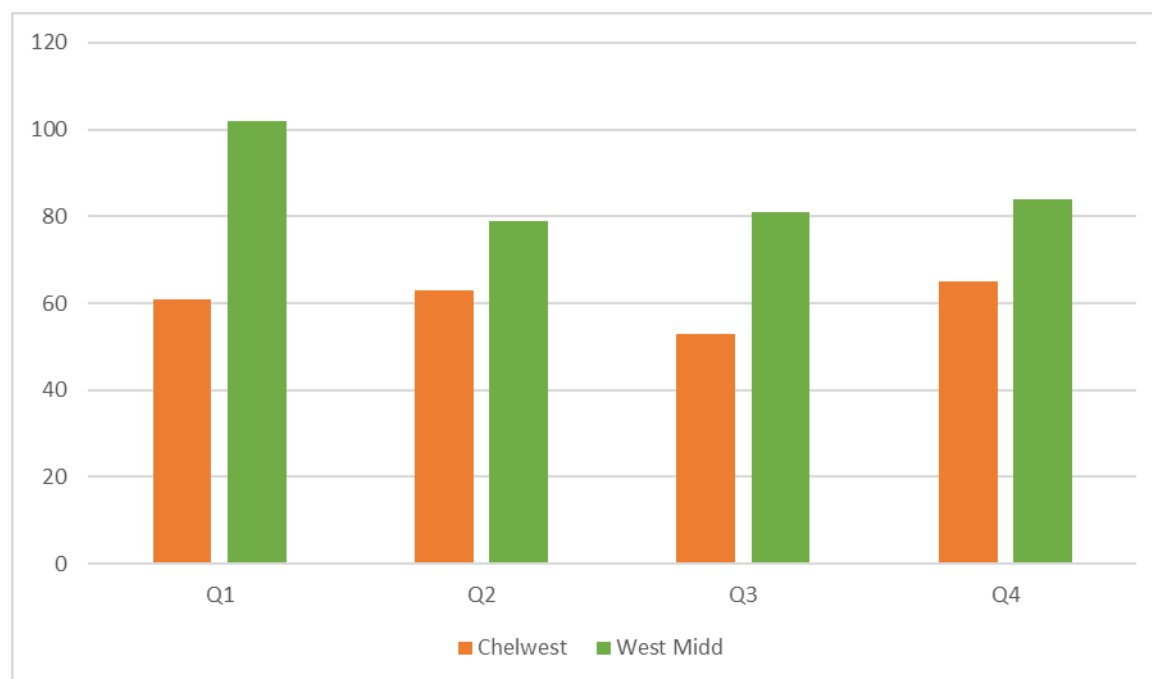


Figure 11: Maternity Categories of Referral – West Middlesex

Category	Q1	Q2	Q3	Q4	Year Total
Domestic Abuse	21	22	15	19	77
Substance/ Alcohol Abuse	2	6	11	12	31
Mental Health	14	6	18	17	55
Previous CSC involvement	11	9	9	13	42
Looked after Child	0	1	0	2	3
Asylum Seeker/ Immigration Issues	8	8	3	1	20
Housing	3	1	5	4	13
Concerns re the FOB / partner	4	2	3	2	11
Teenage Pregnancy	0	0	2	1	3
Unbooked/ Non engagement	0	1	1	0	2
Trafficking	0	1	0	0	1
Learning Disability	1	0	2	1	4

Figure 12: Maternity Categories of Referral – Chelsea and Westminster

Category	Q1	Q2	Q3	Q4	Year Total
Domestic Abuse	18	13	7	17	55
Substance/ Alcohol Abuse	7	15	11	7	40
Mental Health	11	23	13	18	65
Removal of previous children	1	0	1	0	2
Prev social care involvement	8	5	6	0	19
Previous Looked after Child	3	2	1	0	6
Asylum Seeker/ Immigration Issues	1	0	0	2	3
Housing	5	6	4	2	17
Concerns re the FOB / partner	2	5	4	3	14
Teenage Pregnancy	0	0	0	1	1
Unbooked/ Non engagement	2	1	4	5	12
FGM with safeguarding concerns	0	2	1	0	3
Trafficking	1	1	1	0	3
Learning Disability	0	0	0	0	0

Figure 13: Maternity Safeguarding Plan / Professional Meetings

Chel West Maternity Safeguarding Plans/ Professional Meetings	Q1	Q2	Q3	Q4	YTD Total
Professional MDT Meetings attended to discuss safeguarding cases	51	65	48	67	231
Cases subject to a CP plan	4	9	7	6	26
Cases subject to a CIN plan	17	13	16	14	60
Removal under an ICO prior to discharge	0	4	0	2	6
Delayed Discharges due to social / safeguarding issues	1	8	3	5	17

West Mid Maternity Safeguarding Plans/ Professional Meetings	Q1	Q2	Q3	Q4	YTD Total
Professional MDT Meetings attended to discuss safeguarding cases	87	93	75	111	366
Cases subject to a CP plan	8	4	7	12	31
Cases subject to a CIN plan	2	3	3	13	21
Removal under an ICO prior to discharge	4	1	2	1	8
Delayed Discharges due to social / safeguarding issues	1	2	0	0	3

The maternity safeguarding teams at Chelsea and Westminster and West Middlesex managed a high-volume, complex caseload across the reporting year, with 588 social care referrals across both sites. Referrals at West Middlesex showed a modest reduction whilst Chelsea and Westminster saw an increase year-on-year.

Domestic abuse, mental health and substance misuse remained the dominant safeguarding categories across both sites, consistent with national MBRRACE-UK findings. It has been observed that there has been an increase in the need to escalate following social care closures without formal assessment

The teams attended 597 multi-agency professional meetings, supported 57 Child Protection plans, 81 Child in Need plans, and managed 14 Interim Care Order removals prior to discharge — we are currently working in close partnership with the MNVP to support affected mothers through charitable-funded Hope Boxes and specialist training.

Housing and homelessness continue to drive delayed discharge and increased clinical risk, requiring ongoing system-level escalation.

The NHSE Safeguarding Star Award, presented to the Public Health Support Midwife for her work around supporting mothers with the ICO process reflects the exceptional quality and impact of the team's work this year.

The specialist midwives provide both formal and ad hoc supervision to the midwives holding socially complex/ safeguarding cases. They also hold multi-agency psychosocial meetings and attend the SCBU and NICU weekly meetings. One of the priorities for the following year is to remap the supervision pathway as it can be challenging for midwives to attend due to capacity within the teams. Maternity also have PMAs who provide supervision and if there has been a challenging case there will be a debrief for staff following this

The Consultant Midwife for Public Health and Safeguarding has carried out 49 episodes of case review and supervision with the Specialist Midwives throughout the year and provides supervision to the NICU team on a weekly basis.

Priorities for next year will be to remap the clinical supervision pathway, and strengthening multi-agency responses to threshold concerns across North West London.

9.3 Safeguarding Adults

9.3.1 Safeguarding Adults Team Function

The Trust operates in line with national safeguarding legislation and guidance, ensuring a robust and consistent approach to safeguarding adults across all services. A dedicated Safeguarding Adults Team provides expert leadership, advice and oversight, supporting staff to respond appropriately to safeguarding concerns and fulfil their statutory responsibilities. The team plays a key role in policy development, case management and organisational learning, ensuring safeguarding practice is effective, proportionate and aligned to best practice.

The Safeguarding Adults Team comprises:

- Lead Adult Safeguarding, LD and Prevent
- Nurse Lead: Learning Disability
- Deputy Nurse Lead Adult Safeguarding/ Learning Disability
- Adult Safeguarding & Learning Disability specialist practitioner
- Adult Safeguarding & Learning Disability specialist practitioner
- Adult Safeguarding Project Officer
- Trust Domestic Abuse & Sexual Safety Lead
- Trust Domestic Abuse and Sexual Safety Co-ordinator

9.3.2 Safeguarding Adults Activity

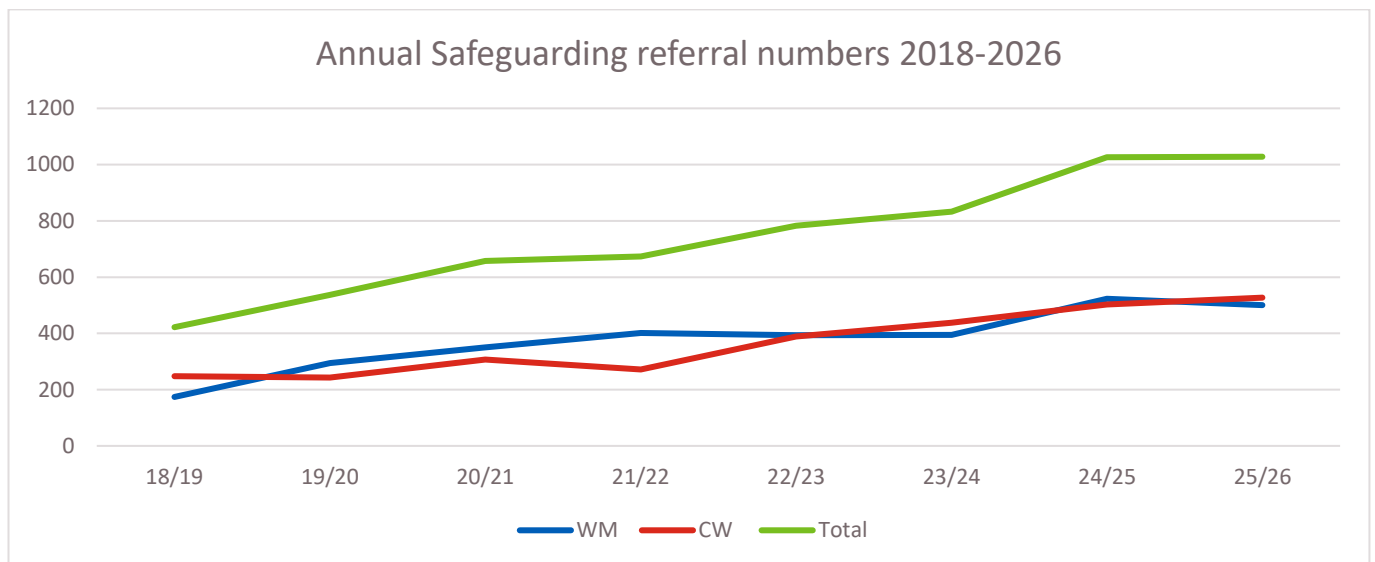
Figure 14: Safeguarding Adult Referrals by Borough:

LA		Category										Total			
	Total LA refs	D A	Ph ys	Fi n	Self neglect	Psy ch	Ne g	Sex ual	MSlav ery	Discr im	Or g	Q 1	Q 2	Q 3	Q 4
LBHounslow	335	99	22	15	74	27	98	4		2	4	55	93	97	90
RBKC	188	17	13	15	79	10	45	1	6		2	37	43	52	56
LBWandsworth	107	13	5	5	42	6	31	1	1		3	21	21	35	29
LBHF	104	16	4	3	31	5	38	2	1		4	26	18	29	31
LBRichmond	92	11	5	2	27	6	41					19	28	22	23
Westminster	66	13	7	2	23	1	18			1	2	26	12	14	14
LBEaling	49	13	4	2	10	1	19					13	9	20	7
LBLambeth	9	2			3		4						2	3	4
Hertfordshire	8	3			3		2						2	4	2
LBBrent	7	1			1	3	2					3	2	2	
LBSouthwark	5		1		3		1						1	3	1
LBBarnet	4	1		1	2							2		2	
LBHillingdon	4	1					3					1		1	2
LBCamden	3		3										2		1
LBCroydon	3						2		1			1	1		1
LBGreenwich	3		1		1								1		1
LBMerton	3				1		1				1	2			1
LBTower Hamlets	3	1				2						1	1		1
Surrey	3	2	1									1	2		
Buckinghamshire	2	1						1					1		1
Cambridge	2		1				1							1	1
LBHaringey	2	1								1	1		1	1	1
LBHarrow	2			1	1										2
LBIslington	2		1		1								1	1	
LBLewisham	2				1		1					1		1	
LBSutton	2						2								2
NFA	2				1	1							2		
RB Kingston upon Thames	2	2										1			1
Coventry	1					1						1			
Dorset	1	1												1	
East Sussex	1				1								1		
Hampshire	1						1							1	
LBBromley	1				1								1		
LBNewham	1	1												1	
Leeds	1		1										1		
Pembrokeshire	1							1				1			
Reading	1						1					1			

swansea	1				1							1			
total	1023	19 9	69	4 6	307	63	31 1	10	9	4	17	21 4	24 6	29 1	27 2

Figure 15: Referrals per Year

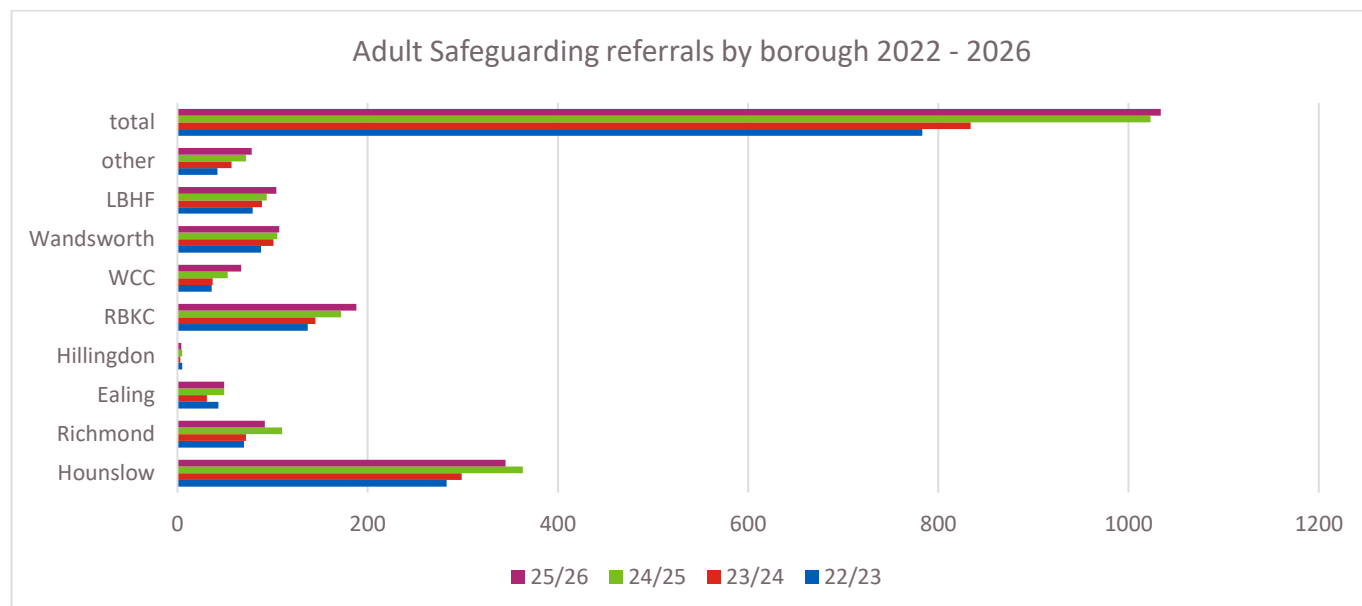
Year	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26
WM	174	294	350	401	394	395	523	501
CW	248	243	307	272	389	438	503	527
Total	422	537	657	673	783	833	1026	1028



During the reporting period referral activity remained high throughout the year, reflecting both the increasing complexity of patient need and improved staff awareness, professional curiosity and confidence in escalating safeguarding concerns through appropriate pathways.

Referral volumes were distributed across all four quarters, with activity remaining consistently high rather than seasonally peaked. This pattern supports assurance that safeguarding concerns are being identified and escalated in real time, rather than being delayed or held until risk escalates further. Quarterly totals demonstrate sustained operational demand on safeguarding services throughout the year, reinforcing safeguarding as a core quality and safety function rather than episodic activity.

Figure 16: Referrals per Year by Borough



As expected for a large acute Trust serving diverse populations, the highest number of referrals related to residents of Hounslow, Kensington and Chelsea, Hammersmith and Fulham, Westminster, Wandsworth and Richmond, reflecting local population flows and service utilisation. Smaller numbers of referrals were also received from a wide range of other local authorities, highlighting the complexity of patient journeys and the Trust's role as a tertiary provider for patients well beyond its immediate footprint. It is important to note that not all safeguarding referrals progressed to statutory Section 42 enquiries under the Care Act 2014.

Overall, safeguarding referral activity during 2025/26 provides assurance that safeguarding concerns are being identified early, escalated appropriately and managed. The volume and nature of referrals reflect a maturing safeguarding culture within the Trust, with staff increasingly recognising safeguarding as integral to patient safety, quality of care and dignity. Continued monitoring of referral trends, quality of documentation and outcomes remains a priority for 2026/27 to ensure safeguarding responses remain timely, proportionate and effective.

9.3.3 Section 42 Enquiries under the Care Act 2014

Under the Care Act 2014, a Section 42 enquiry is required when a local authority believes an adult may be experiencing abuse or neglect and needs protective action, regardless of whether care and support services are provided.

This report is based on data drawn from multiple sources, including incident reporting systems, safeguarding records and partnership intelligence. Safeguarding activity is recorded across a range of systems and is not limited to formal referrals alone; concerns may also be identified and managed through professional dialogue, multidisciplinary meetings, escalation through clinical teams, and liaison with external agencies. As a result, not all safeguarding involvement is captured within a single dataset.

During the reporting period, the safeguarding team had at least 82 instances of involvement in Section 42 safeguarding enquiries, including a minimum of 34 multi agency meetings held under Section 42. It is recognised that in several cases, safeguarding meetings were attended

by clinical teams directly, with the safeguarding team providing advice, oversight, or follow up outside of the formal meeting structure. In addition, some Section 42 activity progressed beyond the inpatient episode, with safeguarding plans continuing following discharge and led by community or partner agencies. These factors mean that formal meeting attendance and recorded involvement may under represent the full extent of safeguarding input across the system.

Despite these limitations, assurance is provided through robust governance, triangulation, and oversight arrangements. Safeguarding activity and themes are reviewed through established Trust governance forums, supervision processes, audits, and learning reviews, and are supplemented by qualitative intelligence from complex case discussions and statutory review activity.

9.3.4 Deprivation of Liberty Safeguards (DoLS)

A Deprivation of Liberty Safeguard (DoLS) may be required when it is considered to be in a person's best interest to restrict their liberty to keep them safe, due to a lack of capacity to make decisions about their care or safety. DoLS must be authorised by the local authority and are managed locally by ward teams, the site team, the safeguarding team, and the Mental Health Law Office at Central and North West London (CNWL) NHS Foundation Trust. Detailed information on DoLS is contained within the MCA and DoLS annual report.

9.3.5 Advocacy

Independent Mental Capacity Advocates (IMCAs) are a legal safeguard under the Mental Capacity Act 2005. They are instructed to support individuals who lack capacity to make important decisions such as where they live or whether to undergo serious medical treatment and who have no one independent of services, such as a family member or friend, to represent them.

9.3.6 Court of Protection Involvement

The Court of Protection (CoP) is responsible for making decisions about a person's care and living arrangements when they lack capacity and there is a dispute that cannot be resolved informally—typically involving the Trust, the patient, and/or family members. While applications are most made in relation to adult patients, they can also apply to children in specific circumstances.

During 2025/26, the Trust was involved in a small number of Court of Protection cases concerning adult patients who lacked capacity, where decisions relating to care, residence or welfare could not be resolved through best interest decision making alone. Court involvement was exceptional and proportionate, reflecting the Trust's commitment to resolving matters within the principles of the Mental Capacity Act 2005 wherever possible.

The Safeguarding Team provided oversight and specialist input to these cases, including safeguarding risk assessment, advice and coordination. Throughout the year, the team

continued to work closely with Mental Health services, Legal Services, and relevant clinical and corporate departments across the Trust to ensure a coordinated, lawful and person centred approach. This multi disciplinary working supported robust decision making, protected patient rights, and ensured that safeguarding principles and Making Safeguarding Personal remained central to Court related processes.

9.4 Prevent Referrals

During the reporting period, the Trust recorded no Prevent referrals. A review of Prevent related correspondence confirmed that no cases met the threshold for escalation under the Prevent duty during the reporting year. Any Prevent related communication identified during this period related solely to historical cases originating prior to April 2025, with no new concerns requiring referral to the Metropolitan Police or local Prevent partners. The Trust is assured that Prevent considerations continue to be embedded within routine safeguarding practice, supported by established escalation pathways, multi agency information sharing arrangements, and ongoing staff training. This provides assurance that the Trust remains compliant with its statutory obligations under the Counter Terrorism and Security Act (2015) and is well positioned to identify, assess, and respond appropriately should Prevent concerns arise in future periods.

9.5 Allegations Against People in Positions of Trust

The Allegations Against People in Positions of Trust (PiPoT) framework is a nationally agreed process for responding to concerns raised about individuals working with adults who have care and support needs. The Trust has a supporting policy in place, along with a staff-facing guidance leaflet to promote awareness and understanding.

When allegations involve Trust staff—whether substantive, bank, or contracted personnel—cases are jointly managed by the Consultant Nurse for Safeguarding and Named Professionals, working alongside the Local Authority Designated Officer (LADO) or Safeguarding Adults Manager (SAM), depending on the nature of the concern. Allegations may relate to professional conduct or matters arising in an individual's personal life.

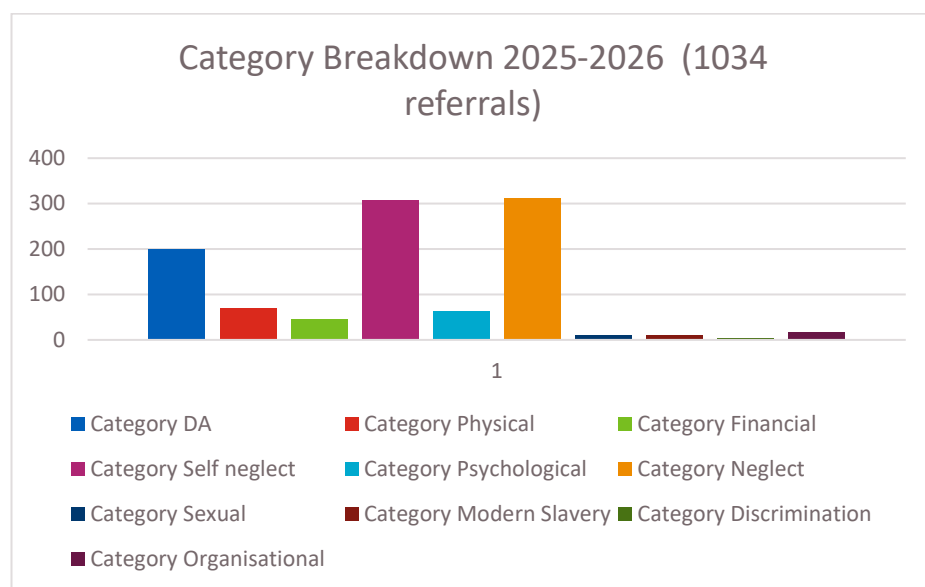
During the period, The Trust was involved in safeguarding cases where consideration was given to whether concerns met the threshold for the PIPOT process. These cases were reviewed in line with local and Pan London safeguarding arrangements, with advice sought and multi agency discussions undertaken as appropriate. Following assessment, it was determined that no cases required formal escalation through the PIPOT process during the reporting period. In a small number of instances, concerns relating to staff conduct or behaviour were instead managed through LADO processes or internal HR and disciplinary pathways, where this was deemed the most appropriate route. The Trust is assured that robust decision making frameworks, clear escalation pathways, and multi agency oversight arrangements are in place to ensure that concerns involving individuals in positions of trust are identified early and managed proportionately, in line with statutory guidance and safeguarding best practice.

9.6 Domestic Abuse

Domestic abuse remains a significant safeguarding concern and continues to have serious long-term consequences for the physical and mental health of those affected. It contributes to increased hospital attendances and repeat admissions, particularly where abuse intersects with issues such as poor mental health or substance misuse. The Trust has a dedicated Domestic Abuse and Sexual Safety team.

9.6.1 Cases Involving Domestic Abuse

Figure 17: Safeguarding Cases by Category



Domestic abuse continued to feature within several adult safeguarding cases during the 2025/26 reporting period. These cases were often complex and characterised by overlapping risks, including mental ill health, learning disability, substance misuse, social isolation and fluctuating mental capacity. Domestic abuse was frequently identified alongside other safeguarding concerns such as self neglect, neglect and safeguarding related discharge risks.

Where domestic abuse concerns met safeguarding thresholds, cases were managed through adult safeguarding pathways in line with the Care Act 2014, with appropriate referral to local authorities and multi agency risk management arrangements. This ensured risks were addressed without unnecessary escalation, while remaining subject to review and governance oversight.

Safeguarding decision making in domestic abuse cases often required careful balancing of adult autonomy and consent with the duty to protect from foreseeable harm, particularly where individuals chose to remain in, or return to, environments associated with ongoing abuse. In line with Making Safeguarding Personal, safeguarding practice focused on the individual's views and desired outcomes, while ensuring risks were clearly identified, recorded and escalated where required.

Domestic abuse cases contributed to wider learning within adult safeguarding, informing safeguarding supervision, training and governance discussions. Themes such as coercive control, cumulative risk and professional curiosity were embedded into practice development

activity. Overall, assurance is provided that domestic abuse is appropriately recognised and managed as a core adult safeguarding issue.

9.6.2 IDVA

At CWFT, we have four Independent Domestic Violence Advisers (IDVAs) based across both sites. Three of our IDVAs are externally employed by Victim Support and are placed in the Trust to enable quick access into specialist support for victim/survivors of domestic abuse. One of our IDVAs is externally employed by Galop and works Trust-wide providing specialist support for all victim/survivors identifying as LGBTQ+. CWFT is the only Trust in England to have four WTE IDVAs co-located.

Their support is free and confidential and they will support BOTH patients and Trust workers experiencing domestic abuse.

IDVAs will work with any CONSENTING patient or Trust worker, aged 16+, who is experiencing abuse from a current or former intimate partner or family member, regardless of gender or sexual orientation. The referrals include health related fields to highlight prominent risks as part of the abuse disclosure and these forms will be adopted by the whole NWL APG, as part of the Cerner work that the DASS team has contributed to.

They do not work with perpetrators of domestic abuse, but will signpost staff to the relevant services the individuals may access.

The Domestic Abuse & Sexual Safety (DASS) Co-ordinator works across all sites, providing advice, support and training on domestic abuse and sexual safety to Trust workers, resulting in increased awareness, identification and support for patients, staff and their families

The Trust Domestic Abuse & Sexual Safety Lead works with the Domestic Abuse & Sexual Safety Team and other safeguarding professionals across the Trust, in addition to regional and national groups, to support and embed an aligned organisational response to all those affected by domestic abuse or issues related to sexual safety.

Figure 18: 2025/26 IDVA Referrals by Site

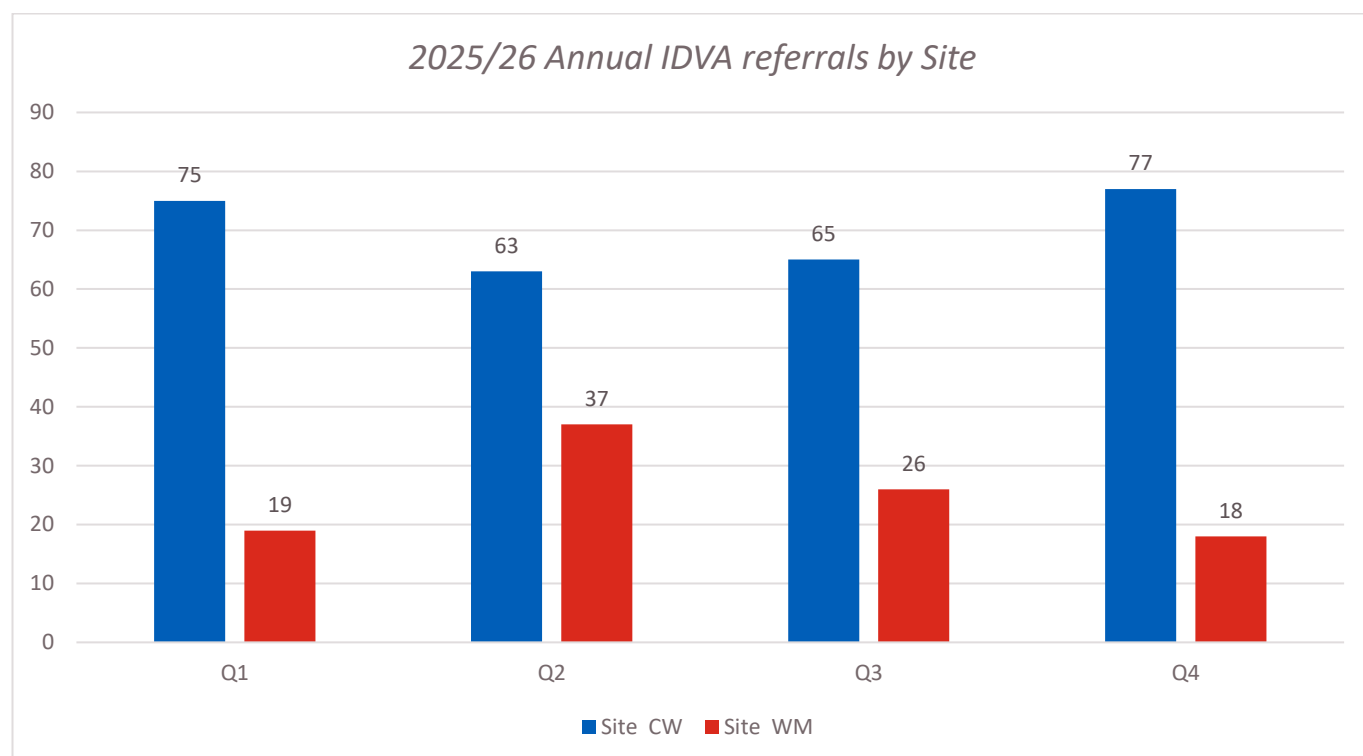


Figure 19: 2025/26 IDVA Referrals by Specialty

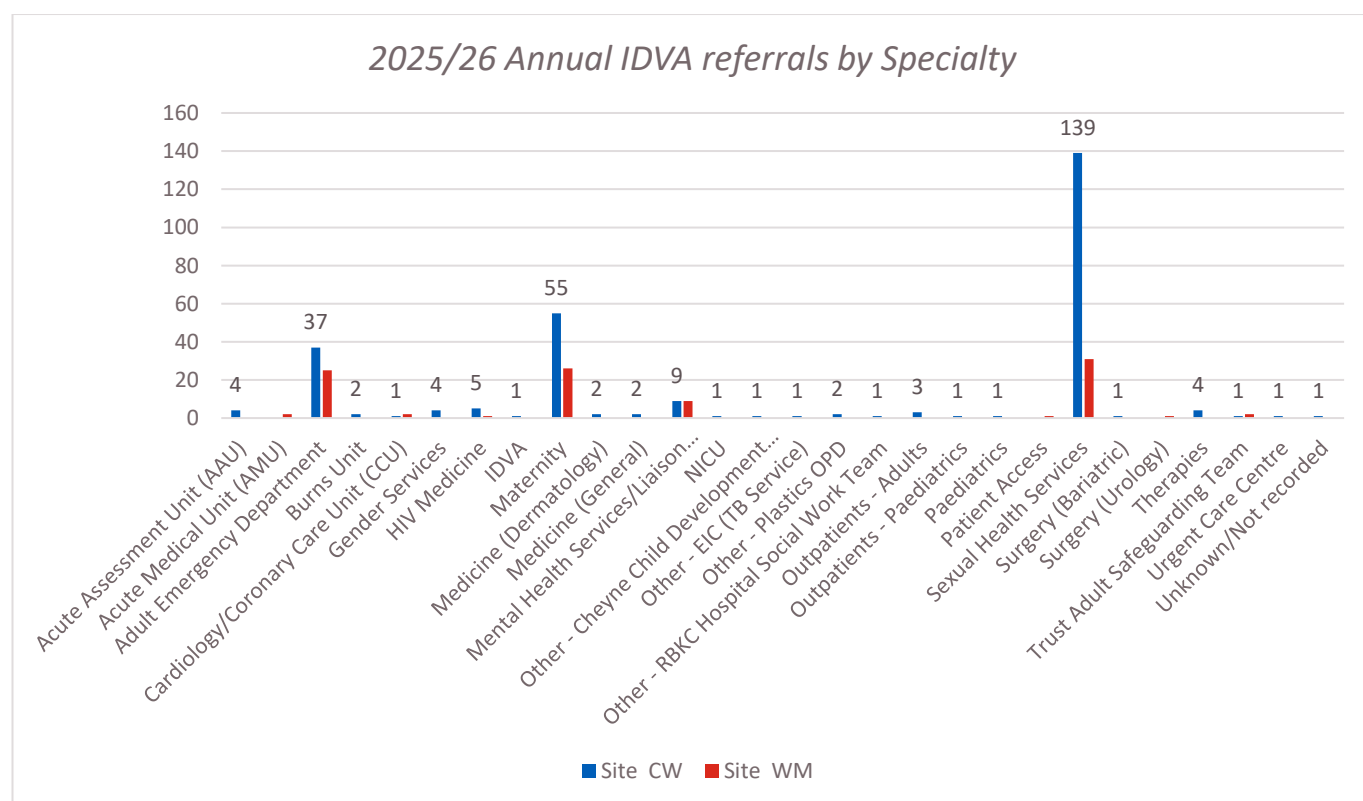
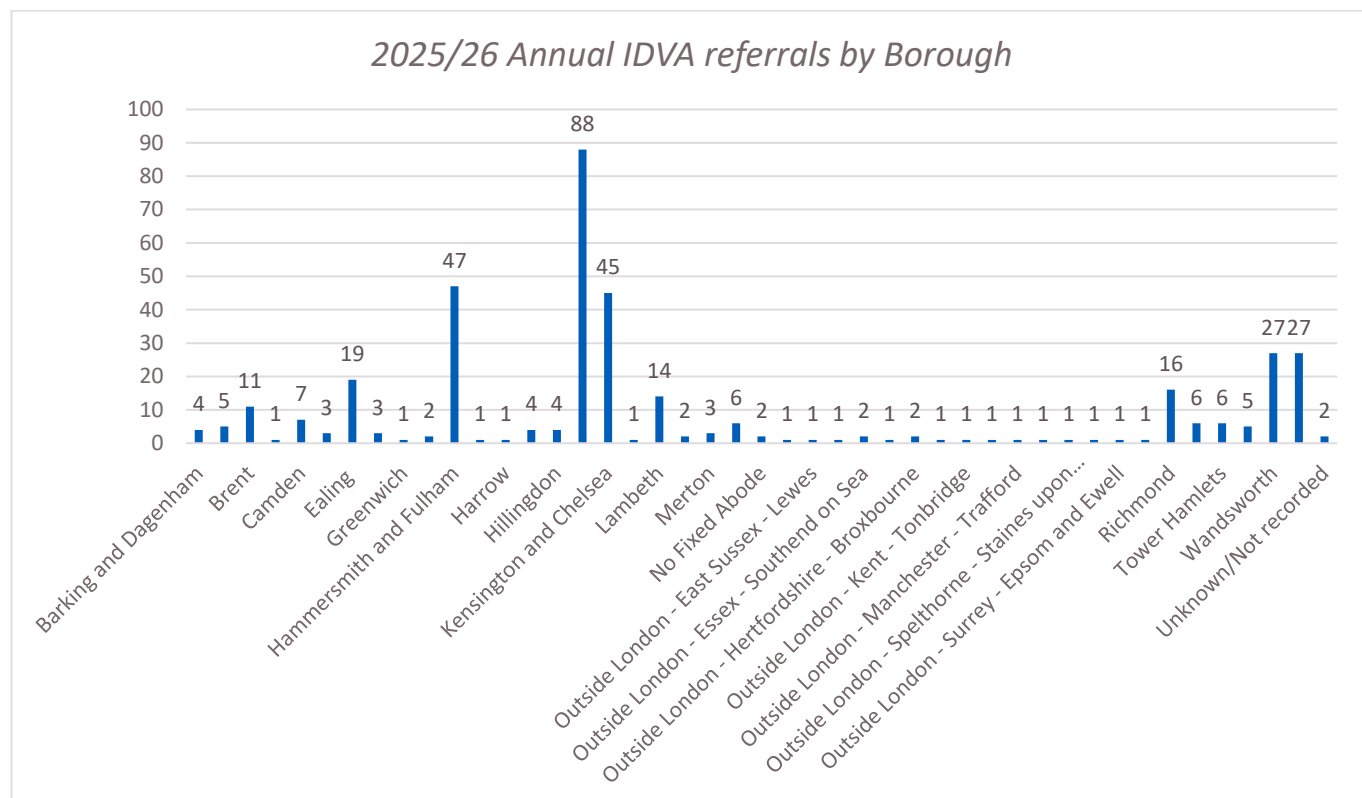


Figure 20: 2025/26 IDVA Referrals by Borough



9.6.3 Multi-Agency Risk Assessment Committee (MARAC) Referrals

This group is led by the Police and has multi- agency representation.

The aim is to:

- Share information to increase the safety, health and well-being of victims/survivors - adults and their children;
- Determine whether the alleged perpetrator poses a significant risk to any particular individual or to the general community;
- Construct jointly and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm;
- Reduce repeat victimisation;
- Improve agency accountability; and
- Improve support for staff involved in high-risk domestic abuse cases.

The Trust, across both sites, have moved to a single point of referral for MARAC. This negates the need to have different forms for different boroughs. All our referrals are sent internally to chelwest.marac@nhs.net, where the Trust Domestic Abuse and Sexual Safety Co-ordinator will forward the referrals on to the respective boroughs. The MARAC referral forms highlight key risks for the individual referred and target the referrer to considering the areas the victim/survivor needs most help with.

Figure 21: 2025/26 IDVA MARAC Referrals by Site

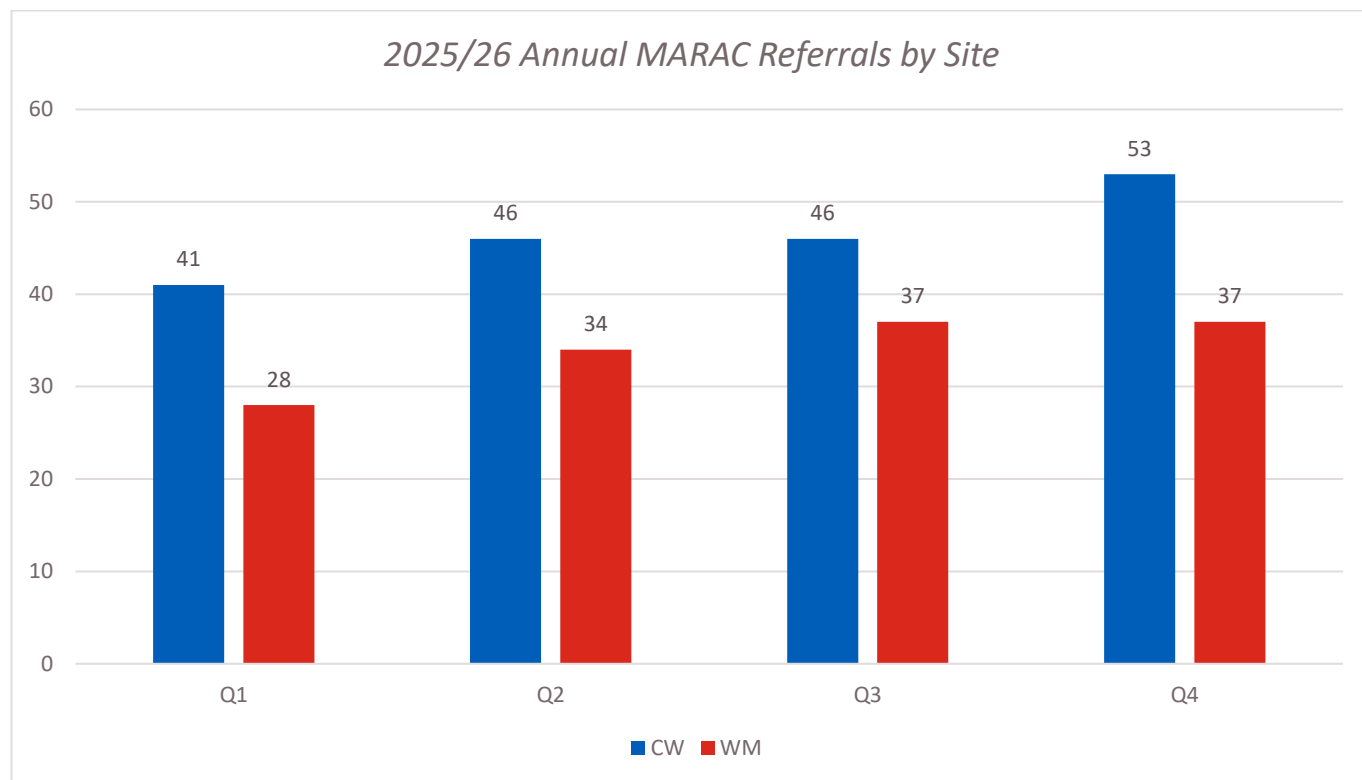


Figure 22: 2025/26 IDVA MARAC Referrals by Speciality

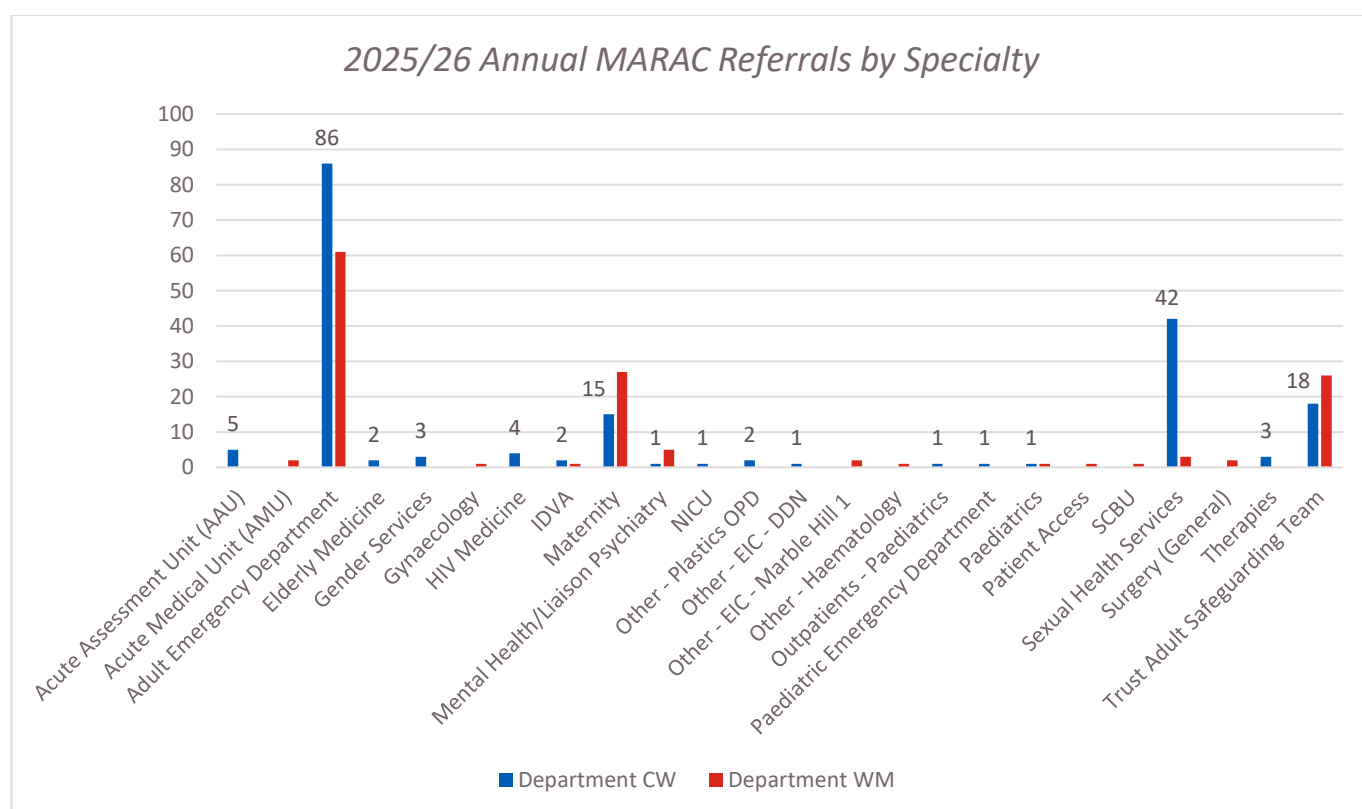
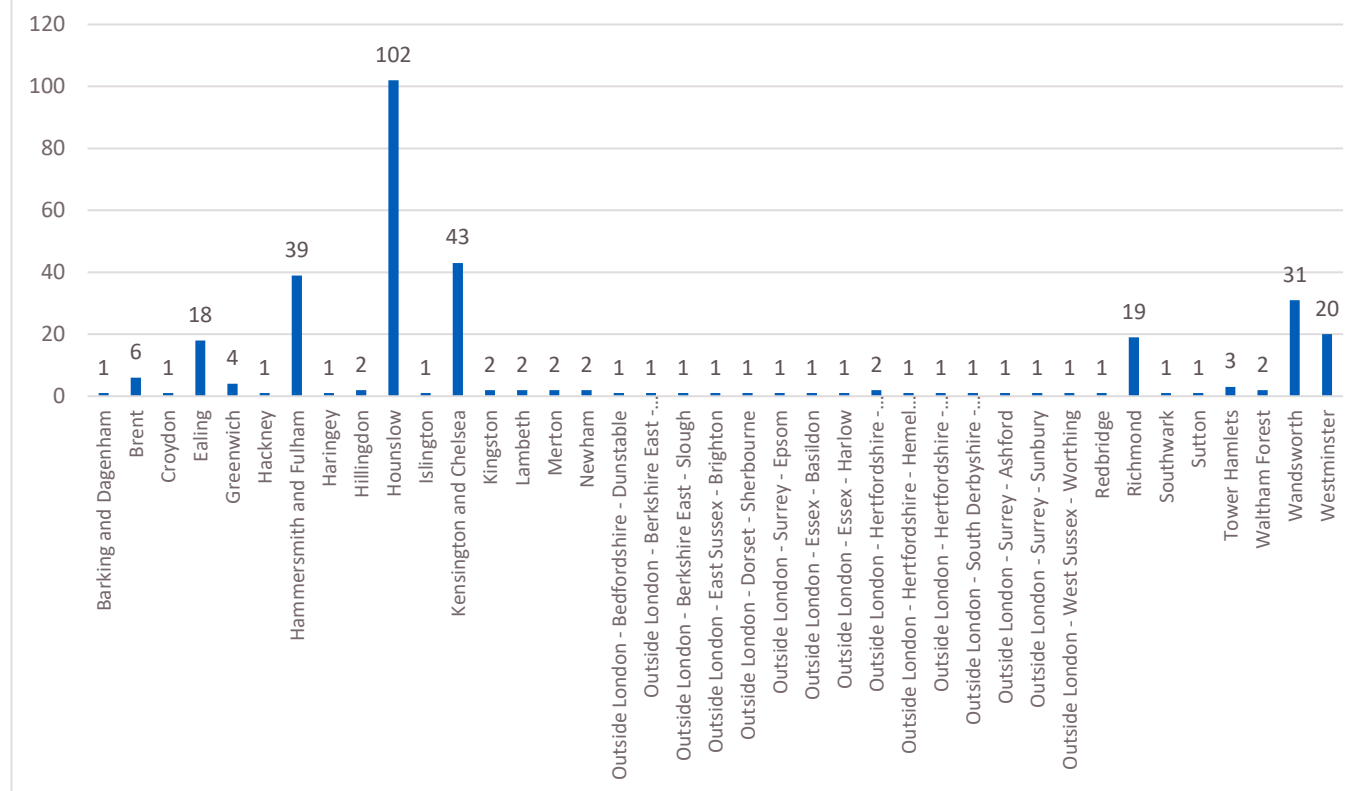


Figure 23: 2025/26 IDVA MARAC Referrals by Borough

2025/26 Annual MARAC Referrals by Borough



9.6.4 Domestic Abuse Training

Figure 24: Domestic Abuse Training

Category of training	Session No. Q1	No. trained Q1	Session No. Q2	No. trained Q2	Session No. Q3	No. trained Q3	Session No. Q4	No. trained Q4	No. trained 2025/26
Level 1 (Basic DA Awareness):	28	2497	16	2023	35	2231	29	2112	8863
Level 2 (DA Awareness):	14	295	10	165	21	404	15	368	1232
Level 3 (DAL Training):	1	8	2	7	3	21	3	10	46
Level 4 (DAL Supervision and specialist training):	1	4	2	4	2	5	2	2	15
TOTAL:	44 (+E-Learning)	2804	30 (+E-Learning)	2199	61 (+E-Learning)	2661	49 (+E-Learning)	2492	10,156

9.6.5 Violence Against Women and Girls (VAWG)

The Trust DASS Lead attends the Tri-borough VAWG Strategic Board and Risk & Review Panel, the Hounslow Domestic Abuse Partnership, a member of the NWL VAWG ICB group,

the NHSE DASV Leaders (domestic abuse and sexual violence) Forum, the London Sexual Safety Community of Practice Forum, INCADVA (Intercollegiate forum), and co-chairs the London Regional Crossing Pathways group in partnership with Standing Together. They are a member of a National Working Group, collaborating with the GMC, NMC, Royal Colleges, specifically looking at supporting nurses and doctors impacted by domestic abuse.

The Trust DASS coordinator also attends the NWL VAWG ICB group and the DA Coordinator Forum sharing best practices across health organisations.

Our Trust contributes to the respective local VAWG strategies and priorities and contributes to significant quality improvement projects and published research in this field. CWFT contributed to a large Sexual Health London Needs assessment, providing data around VAWG and safeguarding, ensuring a robust evidence base for the development of a safeguarding tariff uplift in sexual health services, given the volume of work now carried out routinely as part of clinical work streams that is currently not remunerated. The NWL ICB is aligning sexual health services to use the same EPR system, and there will be an adoption of the detailed safeguarding documentation proforma used by CWFT after approval from the other sites. This will strengthen identification and documentation of VAWG, harmful practices and other safeguarding issues, improving data collation for commissioning of services.

Our sexual health services have a very strong track record of identifying and providing intersectional responses to domestic abuse and sexual violence in all groups, working collaboratively with agencies in the respective local authorities including sexual assault referral centres (SARCs). The Trust DASS Lead is a member of the BASHH Sexual Violence and Domestic Abuse Special Interest Group and has contributed to national guidelines on the management of survivors of sexual violence presenting to sexual health services.

The Trust has a wide network of Domestic Abuse Links (DALs) > 300 across different specialties, who support their peers and patients and can access regular supervision.

The Trust has a longstanding working relationship with Victim Support, Galop, SafeLives, Respect, EIDA, Aymara, and the Modern Slavery and Exploitation Operational Groups.

9.7 High Intensity Users

During the reporting period 2025/26, no new safeguarding referrals relating to High Intensity Users were recorded through formal safeguarding referral pathways. However, safeguarding concerns and vulnerabilities were identified and managed through alternative mechanisms, including professional meetings, multi-disciplinary discussions and partnership forums. These routes enabled concerns to be considered holistically, drawing on clinical expertise, safeguarding oversight and multi-agency perspectives without the need for escalation to statutory safeguarding processes.

The Safeguarding Team worked closely with operational services, discharge teams and external partners to support early identification of risk and coordinated responses for individuals identified as High Intensity Users. Professional meetings provided structured opportunities to

share information, apply professional curiosity and agree proportionate actions, ensuring that safeguarding principles were embedded within care planning and decision making. This approach supported early engagement with relevant services, including community, social care and specialist provision, allowing plans to be developed at an early stage to manage risk, reduce repeat attendances and prevent escalation.

Safeguarding oversight remained integral to this work, with clear escalation pathways in place should concerns meet safeguarding thresholds at any stage. The use of professional forums enabled timely review of complex cases, supported defensible decision making and ensured that risks of abuse, neglect or self-neglect were actively considered and managed in line with the Care Act 2014 and Making Safeguarding Personal principles. Where appropriate, safeguarding advice was provided to clinical teams to strengthen risk management, documentation and partnership working.

Assurance is provided to the Trust Board that safeguarding arrangements for High Intensity Users during 2025/26 were robust, proportionate and effective. Governance structures, access to specialist safeguarding advice and strong partnership working ensured that safeguarding risks were identified early, managed appropriately and kept under regular review, supporting safe care, improved outcomes and prevention of avoidable harm.

9.8 Transitional Safeguarding

During the reporting period 1 April 2025 to 31 March 2026, the Trust was involved in a small number of safeguarding cases in which children and young people under the age of 18 were identified or considered as part of wider patient, family, or contextual safeguarding concerns. These cases were frequently complex and involved overlapping risks affecting both adults and children, particularly where young people were approaching adulthood or where family dynamics extended across age defined safeguarding pathways. In all cases, professional judgement was applied to determine the most appropriate safeguarding response. Where concerns related specifically to children or unborn babies, these were escalated through safeguarding children or maternity pathways, rather than being managed through adult safeguarding processes.

Due to the way safeguarding activity relating to children and young people is recorded across multiple systems and specialist teams, including Safeguarding Children, Maternity Safeguarding and partner agencies, a single consolidated numerical figure is not reported within this Annual Report. However, assurance is provided that appropriate referrals, information sharing and multi-agency engagement took place wherever risks to children or young people were identified.

The complexity of safeguarding activity during 2025–26 required effective joint working across adult safeguarding, children's safeguarding, maternity services, local authorities and wider partnership networks, reflecting the reality that safeguarding concerns do not always align neatly to age based thresholds. The Trust has therefore continued to strengthen its transitional safeguarding approach, recognising the vulnerabilities faced by adolescents and young adults as they move between children's and adult services.

A focus on transitional safeguarding has been integral to the team's practice, ensuring that risks to young people aged 16–25 are identified, understood and addressed in a coordinated way, particularly where adverse childhood experiences, exploitation, family violence or contextual risks are present. This approach supports continuity, prevents threshold related gaps in safeguarding responses, and reinforces the Trust's commitment to safeguarding across the life course.

9.9 Harmful Practices

The Trust recognises that harmful practices are a form of abuse and coercive control, rather than behaviours attributable to culture, community or religion. Harmful practices can affect children, young people and adults, and often intersect with domestic abuse, gender based violence, exploitation, honour based abuse and controlling family dynamics. The Trust's safeguarding approach is therefore focused on identifying harm and risk, rather than categorising behaviour through narrow or culturally biased definitions, in line with partnership learning and national safeguarding principles.

Harmful practices may include, but are not limited to:

- Honour based abuse
- Female genital Mutilation
- Forced marriage
- Breast ironing/flattening
- Virginity Testing
- Hymenoplasty
- Other forms of control, punishment or restriction that cause physical, emotional, sexual or psychological harm

The Trust recognises that harmful practices do not belong to any single community and can present across a wide range of social, family and relational contexts. Viewing harmful practices solely through a cultural lens risk both over surveillance of some communities and the under recognition of harm in others. Safeguarding practice within the Trust therefore emphasises professional curiosity, trauma informed enquiry and a focus on coercive control, rather than assumptions based on background or identity.

During the reporting period, the Trust was involved in safeguarding cases where harmful practices were considered as a potential factor within broader safeguarding concerns. These cases were often complex and required multi-agency collaboration, including liaison with local authorities, safeguarding partnerships, police, and specialist services. The Trust worked closely with safeguarding adults, safeguarding children, maternity services and external partners to ensure that risks were identified early and managed appropriately, recognising that harmful practices frequently span age based safeguarding thresholds and family systems.

The Trust is assured that harmful practices are appropriately recognised, assessed and responded to within its safeguarding arrangements. Safeguarding responses are grounded in

partnership working, trauma informed practice and an understanding of the complex power dynamics that underpin harm. The Trust remains committed to strengthening awareness, professional confidence and multi-agency collaboration to ensure that individuals at risk of harmful practices are safeguarded effectively and with dignity.

The Trust's sexual health services address harmful practices with regular teaching sessions in this area and close affiliation to respective specialty groups.

9.10 Complex Cases

During the reporting period, the Trust continued to manage a number of complex safeguarding cases, characterised by multiple and intersecting risk factors affecting individuals, families and wider systems of care. These cases often involved overlapping themes such as mental ill health, learning disability, fluctuating mental capacity, domestic abuse, self-neglect, substance misuse, family conflict, and safeguarding concerns spanning both adults and children. The complexity of such cases required sustained professional oversight and careful, defensible decision making.

Many complex cases did not align neatly to single safeguarding pathways or thresholds. Instead, they required a whole system and proportionate approach, with safeguarding risks evolving over time and presenting differently across care settings. These included cases involving complex discharge planning, repeated hospital attendances, disengagement from services, and situations where individuals experienced competing risks relating to autonomy, capacity and safety. Safeguarding responses therefore focused on risk management, partnership working and person centred outcomes, rather than solely on procedural escalation.

An additional and emerging challenge during the reporting period has been the increased use of artificial intelligence-enabled tools and automated systems in the identification, documentation and referral of safeguarding concerns. While these systems have the potential to support earlier identification of risk, they have also introduced significant complexity and pressure for clinical teams. Safeguarding information generated through automated prompts or AI supported documentation has at times lacked sufficient clinical narrative, context or continuity, requiring clinicians and safeguarding teams to spend considerable additional time clarifying, triangulating and validating information. This has impacted workflow, increased cognitive and administrative burden, and placed added pressure on already stretched clinical staff, particularly where safeguarding concerns are time critical. Ensuring that safeguarding decision making remains person centred, clinically informed and proportionate has therefore required enhanced professional judgement, oversight and follow up, reinforcing the importance of human expertise alongside digital systems.

The Trust worked closely with multi-agency partners, including local authorities, safeguarding adults' boards, safeguarding children's partnerships, police, mental health services, community providers and voluntary sector organisations. This collaborative approach supported shared understanding of risk, joint decision making and coordinated responses, particularly where safeguarding concerns crossed organisational or statutory boundaries. A strong emphasis was

placed on transitional safeguarding, recognising the vulnerabilities of adolescents and young adults whose needs span children's and adult services.

Safeguarding practice in complex cases balanced autonomy, consent and protection, particularly where individuals had fluctuating capacity or were resistant to engagement. In line with Making Safeguarding Personal, staff prioritised outcomes that mattered to the individual while ensuring risks were clearly identified, recorded, reviewed and escalated appropriately. Staff were supported through safeguarding advice, supervision and senior oversight to make defensible, proportionate decisions.

Review of complex safeguarding cases during the reporting period identified several recurring and interconnected themes. Many cases involved multiple and intersecting vulnerabilities, rather than a single safeguarding concern, including combinations of mental ill health, learning disability, substance misuse, physical frailty, domestic abuse and social isolation. A frequent challenge was the presence of fluctuating mental capacity, requiring repeated assessment and careful professional judgement to balance autonomy, consent and protection. Self-neglect and disengagement from services were also common features, often necessitating sustained, coordinated multi agency responses rather than single interventions. Safeguarding risks were frequently embedded within family and relational dynamics, including carer stress, inter-generational conflict or abuse by relatives, which added further complexity to assessment and intervention. Many cases crossed adult, children's and transitional safeguarding pathways, highlighting the importance of continuity, shared responsibility and partnership working where age based thresholds risk fragmenting responses. Across these cases, professionals were required to balance respect for individual choice with the duty to protect, particularly where decisions increased personal risk. System pressures, including challenges associated with hospital discharge, availability of community support, and the evolving digital safeguarding landscape, also featured in some cases, reinforcing the need for collaborative problem solving and clear governance oversight.

9.11 Safeguarding Related Discharges

During the reporting period, the Trust managed several discharges where safeguarding considerations were a central feature of discharge planning and decision making. These cases frequently involved heightened or ongoing risk following discharge and required robust assessment, coordination and multi-agency working to ensure patient safety and continuity of care beyond the acute hospital setting.

Safeguarding related discharges often arose in the context of complex circumstances, including self-neglect, domestic abuse, family conflict, fluctuating mental capacity, housing insecurity, substance misuse, and risks associated with returning to environments where harm had previously occurred. In many instances, discharge planning extended beyond clinical readiness and required careful consideration of safeguarding thresholds, legal frameworks, and the availability of appropriate community and social care support.

To strengthen oversight and consistency, the Trust has embedded formal discharge governance arrangements, including the implementation of Discharge Governance oversight and Discharge Concern Meetings, which are now held at least monthly with relevant clinical, safeguarding and operational teams. These meetings provide a structured forum to review high risk discharges, share professional concerns, escalate safeguarding risks, and agree clear actions and accountability across services. This has strengthened collective ownership of safeguarding risks associated with discharge and supported early identification and mitigation of concerns.

Some safeguarding related discharges required extended decision making due to tensions between managing significant risk and respecting individual autonomy. In line with Making Safeguarding Personal, the Trust sought to balance patient choice with its duty of care, ensuring that decisions were defensible, person centred and subject to appropriate governance oversight. Attention was given to transitional safeguarding, recognising ongoing risks for young people and adults with long term vulnerabilities whose safeguarding needs did not cease at the point of discharge.

9.12 Martha's Rule

During the reporting period 2025/26, the Trust continued to support the principles underpinning Martha's Rule, which aim to strengthen patient safety by ensuring that concerns raised by patients, families and carers about deterioration or unmet need are heard, responded to and escalated appropriately. Martha's Rule aligns closely with safeguarding principles, including listening to lived experience, professional curiosity, early intervention and timely escalation of risk.

During 2025/26, no safeguarding referrals were recorded specifically in relation to Martha's Rule. Safeguarding oversight remained embedded within patient safety and escalation processes, providing assurance that concerns raised by patients or families were considered appropriately and escalated where safeguarding thresholds were met.

9.13 Pressure Ulcers

During the reporting period, the Trust continued to recognise pressure ulcers as a potential indicator of neglect or abuse, particularly where concerns related to acts of omission, failure to provide appropriate care, or wider breakdowns in care delivery. In line with national guidance, pressure damage was not automatically treated as a safeguarding issue but was considered within the context of everyone's clinical condition, level of dependency, mental capacity, and the quality and timeliness of care provided. Cases were reviewed collaboratively by clinical teams, the Tissue Viability Team and the Safeguarding Team to ensure proportionate and defensible decision making, with safeguarding referrals made where thresholds were met and alternative quality or clinical governance routes used where appropriate.

Based on a review of safeguarding related email correspondence, at least two pressure ulcer related cases were formally raised and recorded as safeguarding referrals during the reporting year, supported by requests for Pressure Ulcer Decision Guide (PUDG) assessments and root

cause analysis documentation. These cases were often complex, involving multiple vulnerabilities and care delivered across different settings, and frequently intersected with discharge planning and continuity of care. Learning from these cases reinforced the importance of early identification, clear documentation, timely escalation and effective communication between teams. The Trust is assured that pressure ulcers are appropriately considered within safeguarding frameworks, with robust links between clinical quality processes and safeguarding governance to promote safe, dignified and person centred care.

10. Learning Disability and Autism

CWHFT has a Learning Disability Lead, a Deputy Lead and a Practitioner for Learning Disability. This leadership aims to improve care, reduce health inequalities, and prevent premature mortality of people with a Learning Disability and autistic people by supporting early intervention, advising staff and supporting people and their families/carers who use Trust services. The leadership also coordinates contributions to the Learning Disability mortality Review (LeDeR) programme.

The team contributes to delivering local service improvement, learning from the experience of people using the hospital, LeDeR reviews (regional and national levels) about good quality care and areas requiring improvement. There is a separate annual report detailing the work of CWHFT relating to learning disabilities.

11. Learning from Incidents to Improve Safeguarding

11.1 Adult Safeguarding

The Trust is an active participant in the four local Safeguarding Adults Boards (SABs) and contributes to adult safeguarding review activity across partner boroughs, including participation in case review sub groups and practitioner learning forums. This engagement ensures that learning from serious adult safeguarding incidents informs both Trust level practice and wider system improvement.

During 2025/26, the Trust was involved in several adult safeguarding reviews and partnership review processes, either directly or through contribution to multi agency learning. These reviews varied in scope and complexity and, where required, included preparation for media or press statements. Immediate learning was acted upon following the preparation and review of chronologies, with safeguarding professionals ensuring that emerging risks or practice concerns were escalated promptly through Trust governance mechanisms. Where appropriate, frontline practitioners attended learning events and reflective forums to ensure reviews were informed by lived clinical experience and operational realities. All reviews were anonymised, and some were published publicly in line with Safeguarding Adults Board processes. Partnership wide action plans were often developed, and learning was implemented even where the Trust was not directly named within a case.

Key themes identified from Safeguarding Adults Reviews and partnership learning included:

- Complex and intersecting vulnerabilities, particularly where self neglect, mental ill health, learning disability, substance misuse and physical frailty co existed
- Fluctuating mental capacity and variability in capacity assessment, documentation and best interest decision making
- Challenges in identifying and applying safeguarding thresholds, especially in cases where risk accumulated over time rather than arising from a single incident
- Self-neglect and disengagement from services, requiring sustained, coordinated and proportionate multi agency responses
- Safeguarding related discharge risks, including tensions between autonomy, choice and protection
- Information sharing and system wide communication, particularly across organisational and geographical boundaries

Learning from these adult safeguarding reviews has been embedded through a range of mechanisms, including safeguarding training programmes, safeguarding supervision, audit and quality assurance activity, governance reporting and the annual safeguarding work plan. Review themes have directly informed training content, supervision focus areas, audit priorities and policy development, strengthening defensible decision making and consistency of practice across adult services.

11.2 Child Safeguarding Practice Reviews (CSPR)

A Child Safeguarding Practice Review (CSPR) is undertaken when a child has died or experienced serious harm, and where abuse or neglect is known or suspected. Following an initial Rapid Review, a decision is made as to whether a review should be commissioned at a local or national level to identify learning and improve safeguarding practice.

Local CSPRs typically focus on identifying opportunities for improvement in areas such as early intervention, information sharing, and the effectiveness of multi-agency coordination. National reviews are commissioned in cases of significant harm or death where there are complex or systemic issues, or where the circumstances have wider national relevance, including in settings such as residential or custodial care.

11.3 Rapid Reviews

In accordance with Working Together to Safeguard Children (2026) and the Children Act 2004, where a child has been seriously harmed or has died and abuse or neglect is known or suspected, the local authority is required to notify the Child Safeguarding Practice Review Panel. [gov.uk], [traffordsa...hip.org.uk]

The Trust has a responsibility to contribute relevant information where there has been involvement with the child, young person, or their family. This information is coordinated by the Local Safeguarding Children Partnership (LSCP) and provided to inform the Rapid Review process.

A Rapid Review is a multi-agency process undertaken to establish the facts of the case, identify any immediate safeguarding actions, and determine whether further learning can be achieved through a local or national Child Safeguarding Practice Review. The Rapid Review must be completed within 15 working days of the notification, ensuring timely analysis and identification of learning to improve practice and strengthen safeguarding systems.

11.4 Safeguarding Adult Reviews

Safeguarding Adults Reviews (SARs) are statutory, multi-agency processes undertaken by Safeguarding Adults Boards. Their main objective is to examine whether serious harm or death experienced by an adult with care and support needs could have been predicted or prevented. SARs serve to identify learning opportunities that enhance practice, foster stronger partnership working, and reduce the risk of future abuse or neglect.

Throughout the reporting period of 2025/26, the Trust maintained active engagement with local Safeguarding Adults Boards and participated fully in partnership review processes. The Safeguarding Team oversaw SAR activity across boroughs, ensuring timely and appropriate responses to notifications, requests for information, and opportunities for shared learning.

When the Trust was directly involved in SAR activity, safeguarding professionals contributed to the preparation of chronologies, individual management reviews, and reflective learning. This collaborative approach with partner agencies supported a transparent and proportionate review process. Immediate learning was incorporated into safeguarding governance arrangements, and actions relevant to Trust practice were identified and implemented without delay.

In addition to direct involvement, the Trust reviewed the SARs undertaken within the reporting period highlighted several key themes. These included the recognition of complex and intersecting vulnerabilities, challenges in identifying safeguarding thresholds, variability in mental capacity assessment, and the need for improved multi-agency information sharing. SARs also emphasised the importance of recognising suicide, self-neglect, and substance misuse—including Chemsex—as safeguarding issues, alongside emerging digital risks and vulnerabilities during transitions of care. These findings have shaped Trust training, policy development, and partnership working, contributing to strengthened safeguarding practice and early intervention.

11.5 Domestic Homicide Reviews/ Domestic Abuse Related Death Reviews

The Trust DASS team participate in requested DARDRs across both hospital sites, contributing to the chronologies, individual reports and panel meetings. During 2025/6 the team contributed to 11 reviews, which in some cases can take over 12 months due to trials and sentencing restrictions. The team present the key findings and action plans of all reviews to the respective specialty that has most contact with the deceased's care in a Clinical Governance meeting and to the joint adult and children's safeguarding group. We also include the review reports on the intranet under DARDR to ensure we include the findings for a wider audience to read.

11.6 Learning from Trust Incidents

Throughout 2025/26, safeguarding considerations became an integral element of the Trust's incident management and governance frameworks. This approach ensured that risks associated with abuse, neglect, or organisational harm were consistently identified, reviewed, and addressed in a manner aligned with Trust policies.

Collaboration remained central to the Trust's safeguarding efforts. The Safeguarding Team worked in close partnership with clinical services, patient safety teams, complaints departments, and quality governance functions. This collaborative approach supported the comprehensive review of incidents where safeguarding concerns or vulnerabilities were present. Safeguarding input contributed to robust and proportionate decision-making, clarified safeguarding thresholds, and ensured that incidents were appropriately routed—whether through safeguarding pathways, clinical governance, or quality improvement processes.

To facilitate the dissemination of learning, the Trust employed a variety of mechanisms, including safeguarding governance forums, training sessions, supervision, newsletters, and professional discussions. These channels ensured that learning extended beyond individual cases and was embedded throughout organisational practice. Key themes emerging from incident reviews informed updates to training content, supervision priorities, audit planning, and policy reviews, thereby supporting ongoing improvement in safeguarding standards.

When incidents revealed complexities such as challenging care scenarios, discharge planning, mental capacity issues, self-neglect, pressure damage, or partnership working, these themes were scrutinised through safeguarding and quality governance processes. This oversight enabled appropriate action and ensured that the Safeguarding Team contributed effectively to incident reviews and action plans. The Trust's commitment to safeguarding principles, Making Safeguarding Personal, and relevant legal frameworks was consistently demonstrated throughout these processes.

A review of safeguarding-related correspondence identified eight distinct cases during the reporting period in which the Safeguarding Team was directly involved alongside the Complaints Team and/or Patient Safety Framework (PSF). These cases spanned safeguarding threshold assessments, Datix investigations, staff-related allegations, concerns regarding unsafe discharge, and formal reviews managed under the PSF. It is noteworthy that not all cases resulted in statutory safeguarding enquiries, reflecting the Trust's commitment to proportionate, policy-aligned decision-making.

12. Key Achievements

12.1 Safeguarding Governance and Board Assurance

During the 2025/26 reporting period, the Safeguarding Team significantly strengthened governance and assurance arrangements, ensuring safeguarding risks were consistently identified, scrutinised, and escalated through established Trust governance structures. Regular reporting to the Joint Safeguarding Group and integration with Board level assurance mechanisms enabled safeguarding intelligence to directly inform organisational oversight and decision making. Safeguarding activity, trends, and risks were aligned with the Safeguarding

Health Outcomes Framework (SHOF), supporting assurance to the Integrated Care Board (ICB) and NHS England on statutory compliance and system wide performance.

Safeguarding data was no longer presented in isolation but contextualised alongside operational pressures such as increased referral volumes, case complexity, and workforce capacity. This approach strengthened executive understanding of safeguarding as a quality and safety issue rather than a purely procedural function.

12.2 Increased Safeguarding Activity and Improved Risk Identification

A key achievement in 2025/26 was the Safeguarding Team's response to a continued rise in safeguarding referrals across adult services, reflecting improved staff awareness, confidence, and professional curiosity. Joint Safeguarding Group discussions confirmed a sustained increase in referrals, with notable variation between sites, prompting targeted analysis to understand differences in referral pathways and staff decision making.

Rather than viewing increased referrals as a negative indicator, the Safeguarding Team positioned this trend as evidence of a strengthening safeguarding culture, with staff more willing to escalate concerns early. This proactive approach supported earlier intervention, reduced the risk of harm escalation, and aligned with Making Safeguarding Personal principles.

12.3 Robust Management of Complex and High Risk Safeguarding Cases

The Safeguarding Team demonstrated enhanced capability in managing complex, high risk safeguarding cases, particularly those involving self neglect, mental ill health, domestic abuse, homelessness, and high intensity service users. Quarterly safeguarding reports highlighted the increasing complexity of cases requiring multi agency coordination and sustained professional oversight.

Explicit examples discussed at governance forums included safeguarding cases involving unsafe discharge, repeated emergency attendances, and overlapping mental health and social care risks. Safeguarding practitioners provided case based advice, coordinated multi disciplinary discussions, and supported proportionate decision making where statutory thresholds were not met but risk remained high. This ensured safeguarding responses remained lawful, defensible, and person centred.

12.4 Enhanced Multi Agency Partnership Working

Partnership working remained a central achievement throughout 2025/26. The Safeguarding Team maintained active engagement with Local Authorities, Safeguarding Adults Boards (SABs), NHS England, and ICB partners. This included participation in Safeguarding Adults Reviews (SARs), Case Review Groups, and practitioner learning events, ensuring the Trust contributed effectively to system wide learning and improvement.

Multi agency collaboration supported coordinated responses to complex safeguarding concerns involving housing, substance misuse, domestic abuse, and mental health services. Evidence from Joint Safeguarding Group meetings demonstrated that safeguarding practitioners were

routinely involved in strategy discussions, escalation decisions, and learning dissemination across partner organisations.

12.5 Learning from Serious Incidents, Complaints, and PSF Reviews

A significant achievement in 2025/26 was the systematic use of learning from Serious Incidents, Safeguarding Adults Reviews, complaints, and Patient Safety Framework (PSF) reviews to drive service improvement. Safeguarding related complaints and Datix incidents were reviewed to determine safeguarding thresholds and ensure appropriate escalation or alternative governance pathways were applied.

Learning from these reviews informed updates to safeguarding guidance, targeted training sessions, and supervision discussions. This ensured that safeguarding learning translated into tangible changes in practice rather than remaining confined to individual case reviews.

12.6 Workforce Development, Training and Safeguarding Supervision

Workforce development was a major focus and achievement during the reporting period. The Safeguarding Team supported delivery of safeguarding training across adult, children's, maternity, learning disability, and domestic abuse and sexual safety services. Quality Friday safeguarding sessions and targeted training initiatives reinforced key messages around early recognition, professional curiosity, and escalation pathways.

A notable achievement was the expansion of safeguarding supervision to include adult services, following updates to the Safeguarding Supervision Policy. This enabled structured one to one supervision, group supervision, and debriefing sessions for staff managing complex safeguarding cases, supporting staff wellbeing and defensible practice.

In addition, work commenced on developing in house Level 4 safeguarding training, strengthening internal capability and reducing reliance on external provision.

12.7 Improved Safeguarding Systems and Operational Integration

Safeguarding processes were further embedded into Trust systems during 2025/26. Continued development of electronic safeguarding referral processes and closer alignment between Datix, complaints, and safeguarding workflows improved consistency, traceability, and governance oversight.

Safeguarding teams worked closely with clinical and digital colleagues to ensure safeguarding risks were visible within patient records and operational dashboards, supporting earlier identification and escalation.

12.8 Focused Support for Vulnerable Groups

The Safeguarding Team contributed to improved outcomes for vulnerable groups, including adults with learning disabilities and autism, individuals experiencing domestic abuse and sexual violence, and patients with complex mental health needs. Governance discussions highlighted

increased safeguarding referrals involving learning disability and autism, often linked to neglect or self neglect, prompting targeted safeguarding input and partnership working.

Domestic abuse and sexual violence services reported increased disclosures and high risk referrals, supported by safeguarding training and improved referral pathways, demonstrating the impact of workforce development initiatives.

12.9 Strengthening Safeguarding Culture and Staff Confidence

Through sustained engagement, training, and governance presence, the Safeguarding Team played a key role in embedding a culture where safeguarding is recognised as everyone's responsibility. Staff were encouraged to raise concerns based on reasonable belief rather than absolute proof, resulting in improved escalation and recording practices.

This cultural shift was evidenced by increased referral activity, improved quality of safeguarding documentation, and greater staff engagement with safeguarding advice and supervision.

Overall, the 2025/26 reporting period demonstrates a Safeguarding Team that has strengthened governance, enhanced partnership working, improved workforce capability, and embedded safeguarding more effectively across Trust systems and practice. These achievements provide robust assurance that the Trust continues to meet its statutory safeguarding duties while adapting to increasing complexity and demand.

13. Improvement Areas

13.1 Consistency and quality of safeguarding referrals

While safeguarding awareness and escalation have continued to improve, variation remains in the quality and consistency of safeguarding referrals across services. Further work is required to strengthen professional judgement, clarity of risk description, application of Mental Capacity Act considerations, and articulation of desired outcomes to support effective decision making and partnership responses.

13.2 Managing increasing complexity and demand

Safeguarding cases continue to increase in complexity, often involving multiple and intersecting vulnerabilities such as mental ill health, self-neglect, learning disability, domestic abuse, homelessness and substance misuse. Sustained focus is required to ensure staff are supported to manage cumulative risk, prevent case drift and balance autonomy with protection through proportionate, defensible practice.

13.3 Discharge planning and safeguarding related discharges

Safeguarding related discharges remain an area for ongoing improvement, particularly where risk persists post discharge or where community support is limited. Continued strengthening of discharge governance, early escalation of safeguarding concerns and improved multi agency coordination are required to reduce delays and mitigate risk following discharge.

13.4 Mental Capacity Act application and documentation

Although awareness of the Mental Capacity Act has improved, audits and case reviews indicate ongoing variability in capacity assessments, best interest decision making and documentation. Further training, supervision and quality assurance are required to ensure consistent and legally robust practice.

13.5 Data quality and reporting assurance

Safeguarding activity is recorded across multiple systems and pathways, which can limit the ability to provide consolidated reporting in some areas, including transitional safeguarding and complex cases. Continued work is required to improve data quality, consistency and triangulation to strengthen assurance and trend analysis.

13.6 Embedding learning consistently across services

While learning from incidents, Safeguarding Adults Reviews and audits is disseminated through multiple forums, further work is required to ensure learning is embedded consistently at frontline level and translated into sustained changes in practice across all divisions.

13.7 Training compliance and targeted workforce development

Although overall safeguarding training compliance remains strong, gaps remain within specific staff groups and specialist areas. Targeted interventions are required to improve compliance, strengthen role specific competence and support staff confidence in managing complex safeguarding scenarios.

13.8 Partnership working across boundaries

Safeguarding concerns increasingly span organisational, geographical and statutory boundaries. Continued focus is required to strengthen information sharing, escalation and joint decision making with partner agencies, particularly in complex, high risk and transitional cases.

14. Priorities

14.1 2025/26 Priority Progress

During 2025/26, the Safeguarding Team made significant progress against its agreed priorities, with a strong focus on strengthening operational practice, improving workforce capability and embedding safeguarding across Trust systems and culture.

Safeguarding and Prevent were successfully embedded within corporate induction programmes, including tailored sessions for international nurses, healthcare assistants, doctors and other patient facing staff. This ensured staff were equipped with safeguarding knowledge from the outset, with feedback demonstrating improved confidence and understanding of safeguarding responsibilities.

Operational safeguarding support was strengthened through regular engagement with clinical teams, providing advice, supervision and support in managing complex cases. This was particularly impactful in areas such as pressure damage, safeguarding related discharges and cumulative risk, increasing visibility of safeguarding practice across the Trust.

Collaboration between the Safeguarding Team and the Tissue Viability Team improved the application of the Pressure Ulcer Protocol (PUP), supporting clearer safeguarding decision making in pressure damage cases. Targeted training and joint working improved staff confidence and consistency in applying safeguarding thresholds.

Work to strengthen domestic abuse and sexual safety awareness was progressed through targeted campaigns throughout the year, staff training and improved referral pathways, with a particular focus on older adults. This supported earlier identification and timely intervention.

The 'Think Family' approach was further embedded across services, encouraging staff to consider the wider family context and inter connected risks when responding to safeguarding concerns.

Safeguarding training compliance remained strong, with ongoing review of training content to increase operational relevance. Safeguarding supervision was expanded across services, providing structured support for staff managing complex and high risk cases and reinforcing defensible, reflective practice.

Learning from Safeguarding Adults Reviews (SARs) was actively disseminated through webinars, practitioner events and team meetings, ensuring staff were informed of local and national learning and able to apply this to practice.

Overall, these improvements provide assurance that safeguarding practice during 2025/26 was strengthened, with increased staff confidence, improved governance oversight and more consistent application of safeguarding principles.

14.2 2026/27 Priorities

Building on the progress made in 2025/26, the Safeguarding Team has identified the following priorities for 2026/27 to support continuous improvement and respond to increasing complexity and demand.

Learning Disability and Autism Engagement

The Trust will expand engagement initiatives for individuals with learning disabilities and autistic people, including open days and hospital familiarisation visits. Priorities include targeted staff awareness sessions, strengthened safeguarding supervision to improve referral quality, and improved communication with families and care providers to support coordinated, person-centred care planning.

Mental Capacity Act (MCA) and Best Interest Decision Making

Improving the consistent application of the Mental Capacity Act remains a priority across all services. Focus will be placed on strengthening capacity assessments, best interest decision making and documentation through enhanced training, supervision and multidisciplinary best interest meetings, particularly in complex safeguarding and discharge scenarios.

Domestic Abuse and Sexual Safety

Specific improvement priorities for the DASS team include: the roll out of training and awareness on the new Sexual Misconduct, Domestic Abuse and Sexual Safety People policy; building our Charter for Change through wide staff engagement measuring progress across an assurance framework and expanding routine enquiry on domestic abuse in patients, across a wider range of specialty areas.

Workforce Development and Training Compliance

The Trust will work towards achieving 90% safeguarding training compliance across the workforce, aligned to newly mapped role requirements. This will include strengthening induction programmes and delivering role-specific, scenario-based training. Training approaches will be informed by learning from audits, incidents, supervision and safeguarding reviews to ensure relevance and impact across both adult and children's services.

Safeguarding Quality Assurance and Audit

A robust programme of safeguarding audits will be maintained, with a minimum of four audits completed annually. Findings will inform targeted quality improvement actions and strengthen assurance around safeguarding practice, including referral quality, consistency of decision making and outcomes for service users.

Operational Safeguarding Support and Supervision

The Safeguarding Team will continue to provide structured operational support and supervision to teams managing complex safeguarding cases, including those relating to self-neglect, pressure damage and safeguarding-related discharge. This will support defensible decision making, improve practice consistency and enhance staff confidence in managing risk.

Partnership Working and System Collaboration

Partnership working will remain central to safeguarding delivery, with continued collaboration across local authorities, safeguarding boards, health partners and specialist services. The Trust will also continue to work closely with West London Children's Healthcare partners to ensure safeguarding policies, pathways and practice are standardised, reducing variation and improving outcomes for children and young people across the system.

Family, Carer and Community Engagement

Improving engagement with families, carers and community partners will be prioritised through clearer communication strategies, structured engagement opportunities and improved

information sharing. This will ensure that individuals and families are appropriately informed, involved and supported throughout safeguarding processes.

Safeguarding Children as a Strategic Priority

The Trust will continue to maintain safeguarding children as a core organisational priority, ensuring strong executive oversight, effective governance arrangements and clear integration of safeguarding within operational decision-making. Ongoing work will include strengthening multi-agency pathways to support early identification, intervention and coordinated care for vulnerable children and young people.

These priorities reflect both the progress made during 2025/26 and the key risks and themes identified through safeguarding activity, audit and partnership intelligence. They provide a clear, proportionate and forward-looking plan for 2026/27, focused on strengthening practice, improving outcomes and ensuring the Trust continues to meet its statutory safeguarding responsibilities.

15. Conclusion

Overall, safeguarding activity during 2025/26 demonstrates a maturing and increasingly embedded safeguarding culture across the Trust. Increased awareness, earlier identification of risk and strengthened professional curiosity have supported more proactive and proportionate safeguarding responses, particularly in complex cases that do not always meet statutory thresholds. Improvements in governance, training, supervision and partnership working have enhanced the Trust's ability to manage risk consistently, defensibly and in line with statutory requirements.

The Trust continues to operate within a context of significant organisational change, including service transformation, workforce pressures and evolving patient safety and quality frameworks. Alongside this, safeguarding risks are becoming increasingly complex and dynamic, characterised by cumulative risk, self-neglect, safeguarding-related discharges and overlapping vulnerabilities. These factors require a skilled and confident workforce, supported by strong governance and effective multi-agency collaboration, with an emphasis on early intervention and professional judgement rather than reliance on statutory escalation alone.

Safeguarding practice across the reporting period reflects a more confident and responsive organisational approach, underpinned by strengthened training, supervision, audit and learning processes. This has improved staff confidence and supported consistent, person-centred and legally robust decision making. Continued focus on embedding learning and improving consistency of practice across all services remains essential as safeguarding demand and complexity continue to evolve.

The priorities identified for 2026/27 provide a clear and proportionate focus on consolidating progress while addressing key areas of risk. In particular, strengthening Mental Capacity Act practice, safeguarding-related discharge governance, workforce capability, data quality and

partnership working will ensure safeguarding arrangements remain responsive, effective and aligned with statutory and regulatory expectations.

Overall, assurance is provided to the Trust Board that safeguarding arrangements during 2025/26 were robust, effective and continuously improving. The Trust is well positioned to build on this progress and remain adaptable, vigilant and committed to safeguarding excellence in an increasingly complex healthcare environment.