Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

Safeguarding
Children and Adults at Risk

Annual Report 2024/2025

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Safeguarding
Children and Adults at Risk

Introduction

This report provides a comprehensive overview of the efforts and achievements made by the Cardiff and Vale University Health Board (UHB) in protecting and promoting well-being of children and adults at risk within the community and when they may receive acute care. It highlights the progress made, challenges faced and outlines strategies for the future.

Protecting individuals from abuse and neglect is a critical responsibility that demands ongoing vigilance and commitment from all parties involved. The UHB has been dedicated to preventing, detecting, and intervening in cases of potential abuse and neglect. The organisation follows relevant legislative guidelines, policies, and procedures to support individuals in the region, actively implementing and enhancing initiatives to identify signs of abuse and neglect.

The 2023/24 UHB Safeguarding Report outlined a forecast for the year, detailing the efforts of the integrated Corporate Safeguarding Team. Key areas were identified as part of the team's work plan to ensure progress and continued development. These forecasted areas highlight the advancements made in safeguarding efforts:

Action	Outcome
Prioritise interim Safeguarding Supervision to specific groups within the UHB	Completed
Evaluate staff responses to the new interim safeguarding supervision arrangements	Completed
Implement the Joint Inspection of Child Protection Arrangements in Cardiff, Action plan	Completed
Consider new arrangements for safeguarding governance through the Safeguarding Steering Group	Completed
Development of Clinical Board Safeguarding Group	Completed
Introduce Mandatory Training for Level 3 safeguarding training across the UHB for Band 6 upwards and F1 upwards	Completed
Develop a Child Health Assessment for use by the School Nursing Service for use at Initial Child Protection Conference	Completed
Develop a Tissue Viability Scrutiny panel in Children & Women Clinical Board to review Grade 3, 4 or unstageable hospital acquired avoidable pressure damage	Completed
Ensure a robust process is established within the Children Looked After Service to complete statutory assessments for children within the Welsh Government timeframe	Completed
Improve safeguarding supervision offered to Midwives	Completed
Consider the structure of the UHB Corporate Safeguarding Team in light of the increased volume and complexity of safeguarding cases	Completed
Prepare a Business Case for consideration of expanding the Corporate Safeguarding Team	Completed
Introduce a digital MARF on ED Workstation	Completed
Develop a leaflet for adult patients to understand an adult at risk referral	Completed
Participate in a Spread and Scale initiative to promote the CSA project in Obstetrics	Completed
Health Lead Practitioners to participate in UHB Level 3 Safeguarding Training	Completed
Participate with the Public Health Wales, Once for Wales, DATIX process for safeguarding referrals	Completed
Ensure full participation with the Cardiff University evaluation of the Violence Prevention Team	Completed
Introduction of Young Persons IDVA in Emergency Department through external funding	Completed
Incorporate the Mental Capacity Act Team in to the Corporate Safeguarding Team	Completed
Arrange a Secondment to LA for a Safeguarding Nurse Advisor to work alongside the Cardiff YEF Team	Completed
Complete a poster and role profile for adult safeguarding Health Lead Practitioners (HLP) within Clinical Boards to raise staff awareness in clinical areas	Completed
Launch the updated Public Health Wales, PRUDiC guidance across the UHB, that includes unexpected death of a young person in adult areas	Completed
Introduce annual audit of MARF and AS1 safeguarding referrals quality across all Clinical Boards	Completed

Action	Outcome
Ensure that a robust process around sexual safety disclosures within the UHB is in place	Completed
Prioritising a targeted increase in mandatory safeguarding training, to achieve a UHB level of 75%	Completed
Introduce Safeguarding Documentation to be used by GP practices across the Cardiff and Vale region. Collaborative work with Children's Services	Completed
Develop with ECOD a preceptorship package for line managers to oversee the compliance of Level 3 Safeguarding Training	Completed
Audit compliance of safeguarding supervision to specific groups working with children within the UHB	Completed
Audit compliance across the UHB of staff accessibility to the Wales Safeguarding App on work mobile phones and clinical desktops across the UHB	Completed
Undertake and implement Offensive Weapons Homicide Training in line with Home Office Guidance	Completed
Launch of UHB Group 3 Train the Trainer Domestic Abuse training	Completed
Commence work with each Clinical Board (CB) to complete a Self -Assessment based on the Safeguarding Maturity Matrix, to demonstrate where each CB consider their safeguarding remit, knowledge and participation to be	Completed
Complete sign off at the UHB SSG meeting for the UHB Three Year Training Strategy	Completed
Implement the Wales Single Unified Safeguarding Review (SUSR) process within the UHB	Completed
Demonstrate partnership working to engage with communities in relation to anxieties around Female Genital Mutilation (FGM) reporting	Completed
Expansion of the Routine Enquiry for Child/ Adult Sexual Abuse within the Midwifery Service, in addition consider evaluation of the pilot in collaboration with Centre of Excellence for child Sexual Abuse	Ongoing Amber
Improve the UHB Level 2 Safeguarding training compliance to meet Welsh Government expectation of 85% of the workforce	Ongoing Amber
Audit of safeguarding themes of cases discussed in supervision	Ongoing Amber
Introduce a standardised proforma to be completed by GPs, Practice Nurses and DoSH when sexual concerns are indicated	Ongoing Amber
Survey of Mental Health staff in relation to safeguarding support from UHB team	Ongoing Amber
Complete a safeguarding template proforma for children under 5 years transferred into area	Ongoing Amber
Develop a review process to ensure that UHB safeguarding documents are accessible to staff across the UHB, and a version controlled	Ongoing Amber
Audit school nurse's notification of minutes from Review Child Protection Conference	Ongoing Amber

Action	Outcome
Audit school nurse access to PPN notifications on PARIS documented on children under 5 years of age, consider improved liaison between HVs and School nurses	Ongoing Amber
Improve the UHB use of IT systems, ensuring that safeguarding documents are logged and are providing appropriate information involving multi-agency meetings and outcomes	Ongoing Amber
Participate in the Department of Health and Social Care NHS PREVENT training framework for the UHB	Ongoing Amber
Ensure that Level 2 safeguarding and VAWDASV training is recorded as mandatory on the UHB ESR system	Ongoing Amber
Audit of the use of the safeguarding chronology documentation in acute paediatrics	Deferred Red
Audit of 16-year-olds attending ED and stating attendance at higher education at college or six form college	Deferred Red
Develop and introduce a questionnaire for UHB employees that have received services from the Health IDVAs	Deferred Red
Develop and evaluate a questionnaire for staff and service users of the Health Violence Prevention Team	Deferred Red

The work undertaken and completed in green is significant considering the increased demand of safeguarding work across the region on a multi-agency basis. The corporate safeguarding team has experienced an increase in all forms of abuse and neglect through submitted referrals for children and adults at risk. An emerging theme across the region has been the identification of self neglect. This is likely to be following the Regional Safeguarding Board (RSB) launch of the Self Neglect Toolkit in November 2024. There has also been an observation that individual cases are more complex drawing on a number of service areas and organisations to work together to ensure that a safe plan is in place to provide reasonable assurance of safe care and support for individuals. This is recognised through the Regional Safeguarding Board (RSB) partners.

Forecast Population Growth within the Cardiff and Vale University Health Board (UHB) Region

To continue to improve and develop, the UHB Safeguarding Team will consider the growing population of the region to guarantee that the local Public Health plan is respected and provides a benchmark for safeguarding service delivery. The Cardiff and Vale UHB Shaping our Future Well-being Strategy up to 2035 states that the population of Cardiff and Vale of Glamorgan region is 500,000 at present with a forecast of 400,000 in Cardiff alone by 2028. The average age of people in the region is increasing and expected to increase for those over 85 years by 20% over the next five years in the Vale and nearly 50% over 10 years. The region is recognised as one of the most ethnically diverse populations in Wales, with one in five people from a Black, Asian and Minority Ethnic background. There are 1,000 GP practices in the region, 5,220 births in 2022-23, 147,449 people attending Emergency Department, 7,394 planned hospital procedures, 669,346 outpatient appointments for people within the region and 17,232 people employed within the Health Board. In addition, 95% of people in a survey stated that they felt safe and said that the care provided within the Health Board was good and provided by staff who were caring and kind.

These statistics, as well as health inequalities identified in specific neighbourhoods across Cardiff and the Vale of Glamorgan, impact on safeguarding and well-being of individuals and families, resulting in targeting services to meet demand.

Cases of substance misuse, emotional and mental health well-being and unhealthy relationships has increased in more recent years, particularly since 2020. Social isolation and loneliness had been identified prior to COVID-19 measures as affecting a quarter of vulnerable people within the region. Isolation restrictions during this period may be the result of increased cases reported, requiring a multi-agency safeguarding response.

Cardiff and Vale Corporate Nursing, Integrated Safeguarding Team Structure

To promote the safeguarding agenda the Executive Nurse Director leads the corporate team which consists of:

- Head of Safeguarding
- Named Doctor for Safeguarding Children
- Senior Nurse Safeguarding
- Consent and Mental Capacity Act Lead
- Seven Safeguarding Nurse Advisors
- Safeguarding Nurse Advisor (Flying Start)
- Safeguarding Nurse Advisor (Midwifery Services)
- Safeguarding Trainer/Nurse Advisor
- Two Mental Capacity Act Practitioners
- Specialist Safeguarding Liaison Nurse
- Three Health Independent Domestic Violence Advocate (IDVA) two posts are in fixed term external funding positions.
- Young Persons Health Independent Domestic Violence Advocate fixed term external funding
- Violence Prevention Team, one Band 6 nurse and one Band 6 advocate fixed term external funding positions
- Administration Team

The safeguarding governance structure sits within the portfolio of the Executive Nurse Director and the Deputy Executive Nurse Director. A bi-monthly Safeguarding Steering Group meeting is held within the UHB and is attended by representatives from each Clinical Board (CB). The CBs consist of Mental Health, Specialist Services, Children and Women, Medicine, Surgery, Primary Community and Intermediate Care (PCIC) and Clinical Diagnostics & Therapeutics. A representative from the National Safeguarding Service attends the meeting. South Wales Police and Cardiff and Vale Local Authorities are invited and have receipt of minutes. This reflects the ethos of safeguarding being everybody's business and provides assurance to the UHB Board that the safeguarding agenda is being progressed in line with legislative duties and best practice.

The Safeguarding Team locations are the Noah's Ark Children's Hospital at the University Hospital of Wales, Cardiff Multi Agency Safeguarding Hub (MASH) and the main office for advice and queries based at Woodland House, Heath, Cardiff. The Cardiff MASH was launched in July 2015, hosted by South Wales Police at Cardiff Bay Police Station. Agencies located within the MASH include Cardiff Local Authority (LA) Children and Adult services, South Wales Police, Cardiff Local Authority Education, Health and Probation services. The purpose of the MASH is to ensure that safeguarding of children, adults at risk and domestic abuse has a timely, appropriate multi-agency response and approach. By co-locating agencies to share information immediately that a concern is raised, safeguarding measures are considered and put into place immediately or within 24 hours. Two safeguarding nurse advisors work within the MASH, sharing appropriate health information to ensure the safety of children and adults at risk across the UHB locality.

Cardiff Children's Services will be launching in April 2025 an updated pathway to access services in Cardiff. This will be called Family Support, Advice and Protection (FASPH), the UHB safeguarding team will be integral to the multi-agency commitment to this new approach.

The UHB corporate safeguarding team workplan for the coming year will prioritise safeguarding training and supervision for staff across the organisation.

Significant Legislation that Informs the Wales Safeguarding Agenda

The Safeguarding Team continues to work to provide assurance to the Executive Board that the UHB is discharging its duties in line with the implementation of: The Social Services and Well-being Act (Wales) 2014 (SS&W-bA) and the Violence against Women, Domestic Abuse and Sexual Violence Act (Wales) 2015 (VAWDASV) has determined much of the safeguarding work undertaken across Wales. Both Acts are implemented within the organisation this has been

a priority due to the duty to report and investigate, provide awareness raising training, supporting all staff to undertake their duty, recognise their responsibility and encourage partnership working with other statutory agencies. The Welsh Government (WG), National Training Framework five-year plan for Groups 1, 2, 3 and 6 reflects the UHB's commitment to deliver the raising awareness training across the organisation in line with WG expectation. The UHB has worked with Public Health Wales Safeguarding Service to produce a training package aimed at Group 2 training following agreement by WG for Health organisations to deliver a single agency package. This has been implemented within the UHB from September 2019. Delivering the training for Group 2 in accordance with WG recommended staff groups is a challenge for the safeguarding team as it is estimated that a figure of approximately 11,000 staff require this additional training. Group 3 multi-agency VAWDASV training commenced in 2024.

In addition to the Acts, there has been the introduction of Home Office Mandatory Reporting of Female Genital Mutilation (FGM) in October 2015 and Home Office Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016) under section 9(3) of the Domestic Violence, Crime and Victims Act (2004). The Well-being of Future Generations (Wales) Act 2015 requires the development of Public Service Boards (PSBs) in each Local Authority area; the Boards are in place within the region. PSBs are responsible for assessing the well-being of the local population. During 2024 the responsibility of the PSB to commission a DHR transferred to the RSB in line with the Single Unified Safeguarding Review (SUSR) procedure of undertaking reviews.

The Wales Safeguarding Procedures (2019) incorporating Children and Adults at Risk has been implemented since October 2019. The procedures replace the previous All Wales Child Protection Procedures (2008) and reinforce the instructions within the Social Services and Well-being Act (2015) Wales.

Additional recent significant legislation includes Domestic Abuse Act (2021), The Duty of Candour Procedure (Wales) Regulations 2023, Department of Health and Social Care NHS PREVENT training and competencies framework (September 2022). The Serious Violence Duty (legislated for under section 19 of the Police, Crime, Sentencing and Courts (PCSC) Act 2022 requires specified authorities to "formulate an evidence-based analysis of serious violence in the local area", to inform bespoke serious violence strategies for the local areas (the boundaries of which are at local discretion).

Meeting the demands of the growing activity surrounding the depth and breadth of safeguarding is a constant challenge for the Executive and Deputy Nurse Directors and the corporate Safeguarding Team. Ensuring that the UHB is compliant with the legislation is a priority area; however, maintaining the ethos of the UHB's values and behaviours must be considered when work is undertaken with individuals, families and UHB staff.

Effective safeguarding relies on good working partnerships with other agencies utilising an open and transparent approach. This is reflected by the corporate Safeguarding Team working within the UHB and reflected in the extended membership of the SSG; in addition to the work undertaken with GPs, Local Authority, Police, Education, Probation and Third Sector agencies. Since the introduction of the Cardiff MASH the safeguarding referral process across the UHB has been restructured and is transferred to the appropriate LA by the Safeguarding Team electronically via secure e-mail. Safeguarding referrals continue to be more complex resulting in additional staff time in support and supervision of cases, involving more strategy discussions/meetings, multi-agency investigations and often legal advice. Team members report an increase in violence related referrals through MASH and patients presenting at Emergency Department (ED).

The 2024/25 Safeguarding Report will reflect on the work conducted from April 2024 to March 2025, highlighting and assessing the scope of the safeguarding agenda and the progress achieved across the UHB. It will provide an overview of the collaborative safeguarding efforts undertaken with the Cardiff and Vale Regional Safeguarding Board (RSB), the VAWDASV Regional Strategy and the NHS Executive workplan shared through the NHS National Safeguarding Service, underscoring the significant scale of the safeguarding initiatives across the region and Wales as a whole.

Joint Inspection of Child Protection Arrangements in Cardiff in January 2024

Link to the report here Publications / Guidance
The summary of findings concluded that "The current children's safeguarding context is one of persistently high levels of demand and increasing complexity". This is consistent with a similar increase in Section 47 enquiries (46% increase in the same period considered by the report), reflecting the increase in demand across services. Budget challenges, deficits in the number of practitioners and a competitive market, have resulted in an increasing proportion of newly qualified and inexperienced workers across partner agencies. This exacerbates the challenge of safeguarding children across multi-agency activity. There is, however, a positive focus on safeguarding across the local authority, local police force and health board. A culture of safeguarding is promoted as everyone's collective responsibility. Professional relationships across agencies are positive with professional differences easily resolved between senior safeguarding leads.

Practitioners mostly understand their roles and responsibilities in the context of protecting children and maintain a positive focus and commitment. Information is generally shared appropriately and in a timely manner when concerns are identified about children's safety and well-being. The multi-agency response to safeguarding referrals is generally proportionate to the presenting risk. Child protection enquiries are thorough with a focus on the needs of the child, involvement of relevant agencies and with mostly timely action to reduce the risk of harm to children".

However, immediate areas of concern were identified by HIW in relation to Cardiff and Vale University Health Board (C&VUHB) safeguarding of children arrangements that were deemed to pose an immediate risk to their safety.

C&VUHB were requested to provide an immediate improvement plan to address:

- Clear documentation of services within the UHB accessing safeguarding supervision
- Safeguarding Level 3 training compliance within the UHB
- Improve pressure damage reporting for children in hospital. All grade 3/ 4 or unstageable, hospital acquired, avoidable pressure damage must be reported to the Local Authority
- School Nurses to attend all Child Protection Conferences and provide a report or health assessment for each child.
- The UHB to improve the completion of health assessments for Children Looked After within the statutory timescale.

The completion of safeguarding actions in the introduction, reflects the completed and on-going safeguarding work that is prioritised across the University Health Board (UHB) to ensure that the JICPA action plan remains relevant and consistent. Work continues to ensure that recommendations are embedded across the UHB and Clinical Boards take ownership of ensuring information and reports are shared with practitioners following the UHB Safeguarding Steering Group.

Training

The safeguarding team are responsible for developing, planning and delivering a range of training events throughout the year. The aim of safeguarding training is to ensure all staff have the skills, knowledge and understanding to inform the ways in which they engage with people at risk of abuse, harm or neglect. Training will ensure that all staff know how to respond to concerns in line with local and national requirements in a confident and competent manner.

Training is developed to reflect guidance from training competencies as identified in the National Intercollegiate Documents:

- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition: January 2019, and
- Adult Safeguarding: Roles and Competencies for Health Care Staff Second edition: 2024

Online Safeguarding training at Level 1 and Level 2 is available through Electronic Staff Records (ESR) and forms part of staff mandatory training requirements.

The safeguarding team deliver TEAMS training for Group 2 VAWDASV (Violence Against Women, Domestic Abuse and Sexual Violence) Group 3 and some classroom-based Level 3 safeguarding themed training. These sessions run regularly throughout the year and are advertised in the UHB training prospectus, sessions are booked through the Education, Culture and Organisational Development (ECOD) office. Additionally, the safeguarding team deliver a number of bespoke training sessions with identified staff groups. During this time period staff training across the UHB was reduced due to a significant reduction in staff resources within the safeguarding team and in clinical areas for a period of time. This is reflected in the data.

The collected data shows an increase in the number of staff completing training across all areas. Maintaining this compliance will be a priority in the coming year, in line with UHB corporate guidance, to ensure the focus continues. Safeguarding training is essential in providing both service users and staff with protection against harm by equipping them with the knowledge and understanding of the processes to follow.

Online Safeguarding Training Data

Training data for safeguarding training completed/attended 1st April 2024 to 31 March 2025.

Safeguarding Children and Safeguarding Adults (3 Year refresher)
available online and face to face classroom sessions

Number and percentage of staff compliant with Safeguarding Adults training as at **31 March 2025**

Level of training	Headcount (UHB Total)	Number trained	% trained
Safeguarding Children Level 2 ESR training	Only specified staff groups require this level of training -see notes section below. **7,195**	5,823	Only specific staff groups require this level of training - see notes section below. **80.93%**
Safeguarding Adults Level 2 ESR training	Only specified staff groups require this level of training -see notes section below. **7,013**	5,744	Only specified staff groups require this level of training - see notes section below **80.25%**

Level of training	Headcount (UHB Total)	Number trained	% trained
VAWDASV Group 1 ESR training	**17,822**	13,246	**74.32%**
VAWDASV Group 2 (Group1 required) TEAMS training	Only specified staff groups require this level of training -see notes section below. Now mandatory for all staff groups with any patient or client contact **7,195**	214	This training is organised and delivered exclusively by the safeguarding team. Figures shown are a running total of staff trained to date. Due to technical difficulties within the UHB the overall figure for Group 2 is significantly reduced from previous years to a mark of 3% showing on ESR. This is due to ESR compliance not displaying that it is mandatory to all front facing staff.
VAWDASV Group 3 Multi-Agency training (Champions) Classroom based	Only specified staff groups require this level of training -see notes section below. **7,195**	26	This training is currently provided by safeguarding Nurse Advisors and Health IDVAS whom have completed the Train the Trainer VAWDASV G3 champion training course. One course only facilitated during this period, launched in September 2024. **0.36%**
Combined Mandatory Level 3 Safeguarding Training (commenced 2024)	**7,195**	276	**3.83%**

NOTE: Level 2 safeguarding training and Group 2 VAWDASV training, is relevant for the following staff to attend/ complete i.e., all practitioners who have regular contact with patients, their families or carers, or members of the public.

ECOD are in the process of including the VAWDASV Group 2 training to the UHB Mandatory field.

Please Note: More detailed safeguarding training compliance data is available for each Clinical Board through Education, Culture and Organisational Development (ECOD) and Electronic Staff Records (ESR).

Classroom Based Training Data

Throughout the year, the Safeguarding Team would usually provide a number of classroom- based training sessions and study days which are open for all relevant staff groups. Feedback from staff, evidences that virtual training has been more accessible although inhibits fully active two-way engagement and interaction between the audience and trainer. It is important to highlight that technical issues affect some elements of the training flowing freely. The training schedule for 2025-2026 will adopt a hybrid approach.

Source: VAWDASV pre/post feedback forms 2024/5.

Level 2 safeguarding children training session is relevant for the following staff to attend:

Non-clinical and clinical staff who, in their role, have contact (however small) with children, young people and/or parents/carers or adults who may pose a risk to children (Source: Inter Collegiate Document Safeguarding Children, January 2019)

***Level 2 safeguarding adults training is relevant for the following staff to attend all practitioners who have regular contact with patients, their families or carers, or the public. (Source: ICD Adult Safeguarding, August 2018)*

Level 3 Training Sessions from 1st April 2024 – to 31st March 2025

Event	Audience/ Subject delivered	Number of attendees
Current Themes in Safeguarding Children	Level 3, 2 sessions	34
VAWDASV multi-agency training, train the trainer	Group 3	40
Parental Mental Health and the Impact on Children	Level 3	31
Legal Aspects of Safeguarding	Level 3	17
Safeguarding Adults at Risk Study Day	Level 3, 2 sessions	157 & 150
Current Themes in Safeguarding Adults	Level 3	163
Bespoke Training		
Dental Training	Qualified Staff and Students	87
VAWDASV Group 6	UHB Executive Board	20
Raising Safeguarding Awareness	Qualified & non-Qualified staff and Students	18
VPT-HUB	New Starters F2 ED	5
VPT-HUB	Paediatric Drs	7
VPT-HUB	Polytrauma Unit UHW	8
VPT-HUB	Medicine CB A1/A1 Link	9
VPT-HUB	ED New Nurse Starters	19
VPT-HUB	ED Student Nurse Induction	23
VPT-HUB	ED Major Trauma	26
VPT-HUB	Assessment Unit (AU) Nurses	25
VPT-HUB	ED Band 7 Away Day	15
VPT-HUB	AU Band 6 Nurses (additional sessions)	33
VPT-HUB	VRU Leads Conference	58
VPT-HUB	Emergency Medicine Trainees	15
VPT-HUB	Humberside UHB	12
VPT-HUB	Preceptorship Teaching	15
		Total: 265

Safeguarding Training Meetings Attended

To ensure a robust evidence-based training programme is delivered within Cardiff and Vale UHB, key members of the Safeguarding Team would usually attend local and National Training meetings:

UHB Safeguarding Steering Group Meeting

The meeting is held bi-monthly, the safeguarding training monitoring is a standard agenda item. A UHB Three Year Safeguarding Training Strategy has been commenced and agreed at SSG meeting.

UHB Mandatory Training Steering Group Meeting

The Safeguarding Team attends this meeting to inform the mandatory training agenda and has been involved in work to promote safeguarding children, safeguarding adults training and VAWDASV training.

Cardiff and Vale Regional Safeguarding Board (RSB) training sub-group meeting

This training sub-group reports to the RSB Board and has previously completed a safeguarding training mapping exercise to consider the different levels and types of safeguarding training partner agencies currently deliver. Recent work has focused on the implementation and embedding training for the Wales Safeguarding Procedures.

Public Health Wales National Safeguarding Service Training Meeting

This training sub-group is a quarterly meeting for all Health Boards and Trusts in Wales.

Cardiff & Vale Regional Safeguarding Board Training Meeting

Multi-agency meeting to share the scope of safeguarding training in individual agencies.

National Training Programme – Violence Against Women Domestic Abuse and Sexual Violence (VAWDASV) Regional Training Group

The aim of this multi-agency regional training group is to share best practice and discuss current training compliance for VAWDASV training. The meeting is also driven by the five-year regional VAWDASV training programme, which includes the development and delivery of VAWDASV training for Groups 2, 3 and 6.

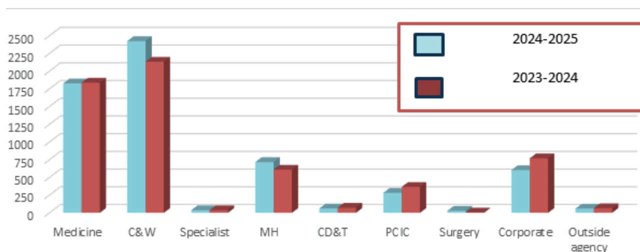
Safeguarding Activity

All reports for safeguarding children, adults at risk and domestic abuse are sent electronically by practitioners to a central UHB safeguarding referral e-mail address; the reports are not screened and are sent directly to Cardiff MASH, Vale of Glamorgan Local Authority (LA) , Out of Area LA teams and Police as appropriate, on the same day as they are received. The report pathway and report forms are available on the UHB Safeguarding Children and Adult web pages on SharePoint. This process is unique to Cardiff and Vale UHB and allows the safeguarding team to collate the activity across the UHB to target service areas that may require additional training, supervision or advice.

Safeguarding for Children < 18 years Activity

Activity is collated on a monthly basis across the UHB and presented to the Safeguarding Steering Group. The report exhibits activity from 1 April 2024 to 31 March 2025 across all Clinical Boards (CBs).

Table 1 & 2: Safeguarding Children Activity: Reports from Clinical Boards (CB)

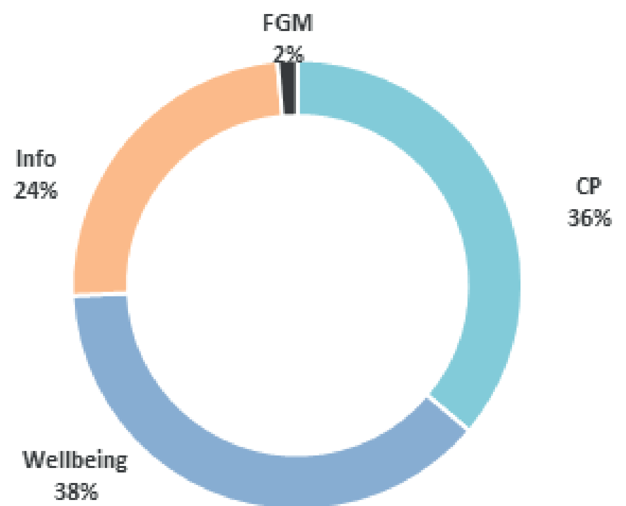


The reports made by the Medical CB are generally generated in Paediatric Emergency Department (ED). Children and Women CB referrals are predominantly made by community-based staff such as Health Visitors and School Nurses; however, disciplines within the acute sector make a proportionate number of reports. PCIC referrals will be submitted by GPs and District Nurses.

A total of 6,037 reports were made by UHB staff and submitted to Cardiff, Vale of Glamorgan LA or a LA out of area by the safeguarding team during this period. There is an increase from the same period the year before when 5,889 reports were submitted, a difference of 148 in total. The Corporate Safeguarding Team are increasingly submitting a number of reports which are generated retrospectively from the internal safeguarding meetings for children and another for adolescents within ED, 603 referrals were submitted by the safeguarding team in 2024/25.

Table 3 represents the type of referral captured on some of the report received by the safeguarding team. A number of reports submitted lack information for the administration team to determine the category of abuse when collating information. The table represents Child Protection, Information sharing, Well-being assessment and Female Genital Mutilation as the categories of abuse.

Table 2: Type of Safeguarding Report



implementation of the Early Help Hub in Cardiff during 2019 identifies reports that are to be progressed to MASH and those that will be signposted to other services for additional support.

Table 3: Age of Children Referred

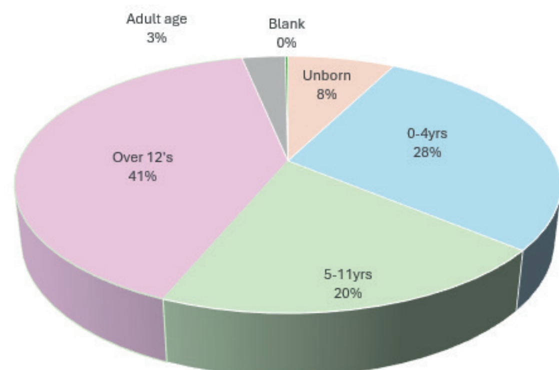


Table 4: Categories of Abuse

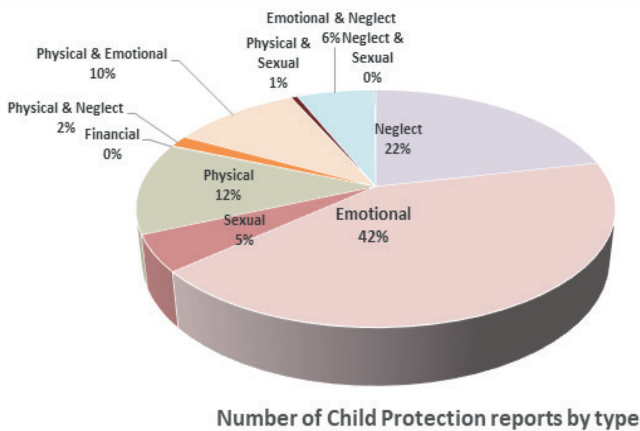


Table 4 recognises the known categories of concern acknowledged on the report form by the UHB referrer. Once the report has been reviewed and assessed by Children's Services the category may change. During this period 3 pressure damage referrals were submitted.

Table 5: Reason for Referral Identified on Multi-Agency Referral Form

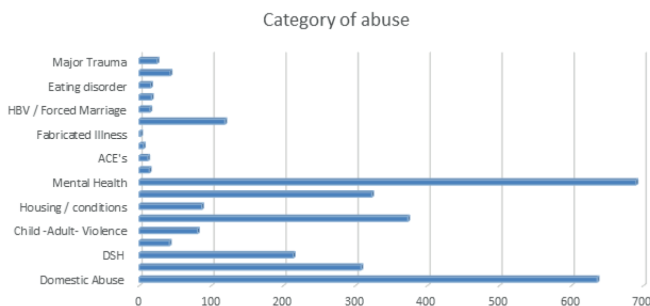


Table 6: Total of Child Protection Medicals Undertaken

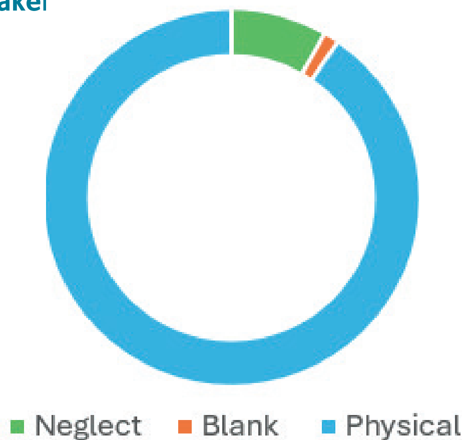
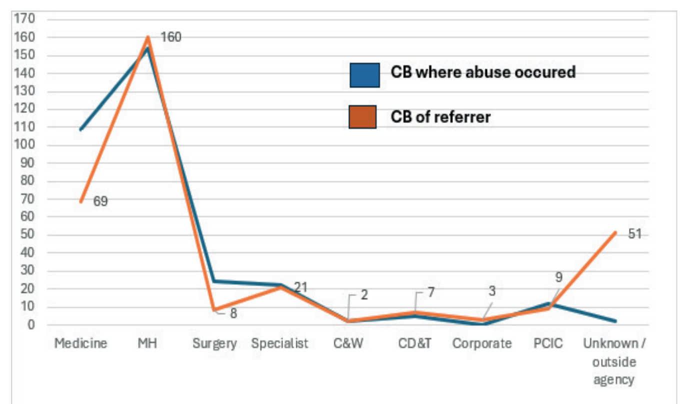


Table 6 represents figures for Child Protection medicals that are undertaken by the Community Paediatricians based at St David's Children's Centre during normal working hours. The table below illustrates the reason for the medical and total percentage. **In total there were 231 medicals undertaken. Physical assault represents the greatest category with 209 cases reported, 19 neglect cases, child sexual abuse accounted for 0 cases, 3 cases were not stated on the database.**

Safeguarding Adult at Risk : Activity

Activity is collated on a monthly basis across the UHB and presented to the Safeguarding Steering Group. The report exhibits activity from 1 April 2024 to 31 March 2025 across all CBs.

Table 7: Adult Safeguarding Activity: Reports from Clinical Boards



A total of 330 referrals were made by health professionals to the local authority during this period, in comparison 364 referrals were made during the same period in the previous year. This is a decrease of 34 reports in this reporting period.

This safeguarding adult data is collated by the number of health-led referrals across the UHB. Each CB has a Health Lead Practitioner (HLP) that take responsibility to lead on the Adult at Risk process for their own area; HLPs are usually Lead Nurses, Senior Nurses or Advanced Nurse Practitioners.

HLPs are given additional bespoke safeguarding adult at risk training by the Head of Safeguarding or Senior Nurse to undertake this role. An electronic shared drive has been established to enhance the process allowing HLPs in each clinical area to be aware of cases in their CB to ensure that cases are maintained and progressed should the named HLP be on annual leave or sick leave. There are 51 active HLPs across the UHB. The process has evolved since the implementation of the SS&W-b Act (2014) and since the launch of Cardiff MASH. This may not be a true reflection of all referrals made, it has been noted that health staff based in integrated community teams are sometimes making referrals directly to the LA and bypassing the UHB Safeguarding Team. This is complicated due to the fact that health staff are working from LA computers and facilities, plus their email address is LA. Measures to ensure that this practice is discontinued are being introduced to certify that health staff are following the UHB reporting process.

Table 8: Captures the number of health-led referrals made by each Clinical Board for this period.

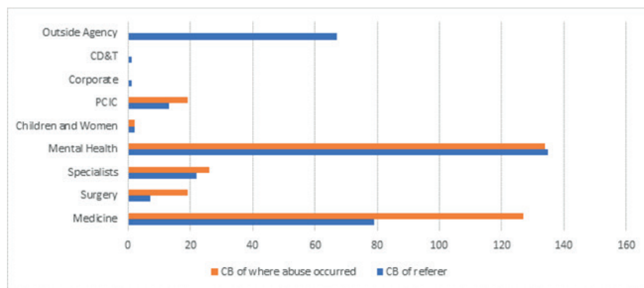
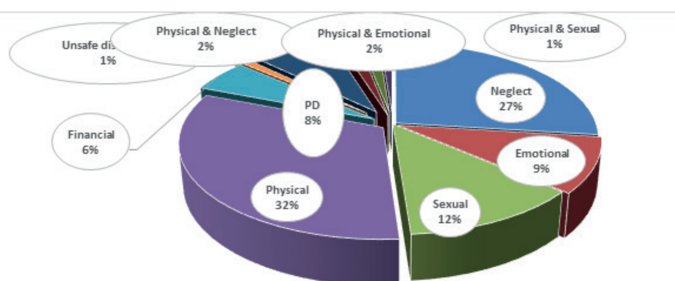


Table 9: Categories of Abuse Described on AS1 Reporting Form



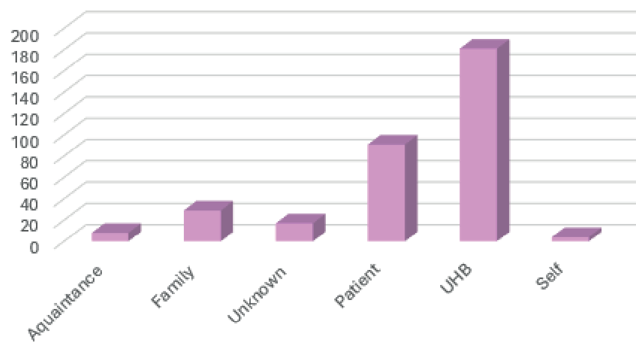
Number of Adult Protection referrals by type

Categories of abuse are easier to capture on the current Adult at Risk reporting form (AS1) as opposed to the Children's reporting form, as there are tick boxes for practitioners to choose. Highlighted in table 9 are the type of abuse considered by practitioners to be the reason for submitting the report to the LA. The most commonly used category is physical abuse, there has been an increase in reports and complaints made by patients and families during this period. AS1s submitted raising concerns of sexual assault account for 12% of those submitted. Concerns are mainly raised by patients reporting another patient; however, there are also reports alleged by patients against staff. All cases of suspected physical and sexual assault are taken seriously by the UHB and will always be reported to police and LA either as an AS1, if consent is obtained by the reporter, or as a Section 5, Professional Allegation/ Concern of a person in a position of trust , if the allegation is against a staff member. Patients (family members are contacted if the patient is deemed to lack capacity) and staff are always asked if they want to report to police, they would be supported to raise the concern if this is required.

Adult cases often prove to be complex, determining the main issue at the point of disclosure or reporting is often difficult for referrers; this is often not established until further fact finding is undertaken. This may be in the shape of a criminal or non-criminal investigation. The HLP will lead on the case if the situation involves a clinical area within the UHB. Cases, where individual staff members are deemed as the alleged perpetrator of abuse, are managed by the Head of Safeguarding/ Senior Nurse to ensure that a consistent approach is in place that aligns with the UHB and RSB Section 5 Professional Allegation/Concern process. The HLP is central to gathering fact finding statements and keeping in touch with the staff member during this process. The UHB acknowledges that any allegation involving a member of staff will raise anxiety and often results in the employee taking sick leave. The UHB works closely with People's Services

department (previously known as Human Resources HR) and the line management team to ensure that a proportional risk assessment is in place to support and protect staff members from further accusations whilst this process is in place.

Table 10: Alleged Perpetrator



Often practitioners from the UHB or from an outside agency will not have the information to determine who the alleged perpetrator is, this is evidenced in Table 10 as no person responsible has been identified on the referral. 181 of the cases cites the Hospital or Hospital staff exclusively as being responsible for the abuse. 91 of the cases are alleged abuse from another patient, more often these are cases in Mental Health clinical areas.

Pressure Damage

Due to improved reporting pathways implemented within the Health Board in 2020, all avoidable health acquired pressure damage of grade 3/4 or unstageable damage are reported to LA. This has decreased the number of pressure damage referrals to LA. This is in alignment with recent Welsh Government, Serious Incident Reporting and

in compliance with the Social Services and Well-being (Wales) Act (2014). In addition, all CBs have introduced scrutiny panels that consider pressure damage reporting on a weekly basis, Patient Safety and the Tissue Viability, Wound Team are involved in this process. This provides a multi-agency assurance of transparency and appropriate referral submission. There were 36 cases of pressure damage referrals during 2024/25.

Table 11: Identifies the age groups on reports - Age Groups

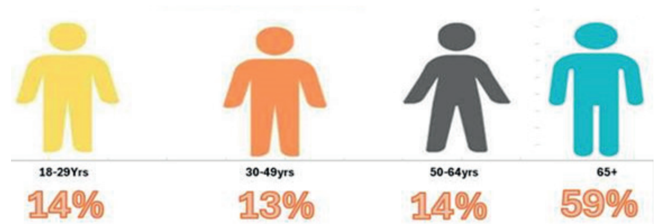
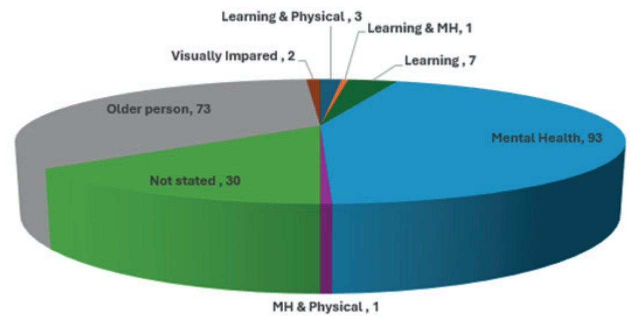


Table 12: Client Groups with perceived Vulnerabilities:



Client Group:

Learning & Physical Disability- 3

Learning and Mental Health Disability- 1

Learning Disability-7

Mental Health- 93

Mental Health and Physical Disability-1

Older person-73

Visually impared-2

Not stated 30

Section 5: Professional Allegations/ Concern Strategy Meetings

The UHB Professional Allegation/Concern guidance updated in 2021 has formalised the approach to address concerns of employees' behaviour in or outside of work. The UHB has published an internal Sexual Misconduct Procedure 2025. The process is in alignment to the Wales Safeguarding Procedures (2019). UHB employee line management, Police, UHB Safeguarding, UHB People's Service and LA are invited to each meeting to share information and ensure that the UHB is open and transparent in the approach. Concerns include arrest and police investigation around domestic abuse, sexual assault, physical assault etc, outside the workplace. Some cases will proceed through the disciplinary process following closure by police, Local Authority and/or the Court process.

Number of Professional Meetings

Period 2024-2025

Professional allegation/ concern identified in: **234** cases (increase of 6 from previous year), 128 cases were screened out by LA (with no Section 5 action required), 106 cases progressed to Section 5 meetings with LA and police. In addition,70 domestic/self-harm abuse cases were discussed with managers whereby a member of staff has been identified as a "high risk" Domestic Abuse victim or issues around Mental Health. This is likely to be due to a number of issues: Domestic Abuse awareness, Routine Enquiry for all attendees at Emergency Department - this process also includes staff. Improved communication with police, UHB Concern Team, regular meetings with Clinical Boards chaired by the Deputy Executive Nurse Director and UHB People's Services will also factor in the progress made in identifying additional support for staff.

Issues raised with UHB employees relate to allegations made against them by family members, patients or a criminal investigation by police. All employees are notified of the concern raised as appropriate and an immediate risk assessment is completed by the line manager and the People Service Manager (Human Resources) representative to ensure that safeguarding measures are in place. This certifies the protection and support of the member of staff if further allegations are made and gives the UHB assurance that appropriate and proportional measures are in place to protect the public accessing care and services from the UHB. The Head of Safeguarding and the Senior Nurse will provide advice and support to the line manager to achieve a manageable response ensuring that the employee is directed to the well-being service, Occupational Health or General Practitioner (GP) as required.

In the case of commissioned service providers (independent practitioners – GPs, dentists, optometrists, pharmacists), they will be contacted by the Community Director for Quality and Safety/Deputy Clinical Board Director of PCIC, by the Dental Practice Adviser, or Primary Care Optometric Adviser. If the allegation relates to a member of staff as perpetrator, advice will be given to the employer and proportionate measures will be put in place. The circumstances are more complicated regarding Optometric Practices and Pharmacies as many of the practitioners are employed by major multiple organisations (e.g. Boots, Well, Specsavers) as they are guided by their corporate requirements in addition to Health Board expectations.

There has been an increase in national reporting of survivors disclosing domestic abuse during lockdown in 2020. Admissions of people and children <18 years of age presenting with mental health or emotional well-being concerns has also increased. This is corroborated in a recent draft report from the Public Health Wales, Violence Prevention Team analysing data.

Audit, Survey, Professional Presentations and Publications

Public Health Wales Safeguarding Maturity Matrix (SMM)

The purpose of collating the information is to assess quality improvement, compare compliance against agreed standards and to demonstrate the learning from incidents and reviews. Organisations completed self-assessments along with improvement plans that were submitted to the National Safeguarding Service to assemble a National picture and to report the findings. The aim being to provide assurance, share practice and drive improvements. Cardiff and Vale University Health Board (C&V UHB) fully participate, drawing on information from across all Clinical Boards to inform the UHB self-assessment and provide a true reflection of the current situation. Overall, the UHB acknowledges that there are always improvements to be made in an ever-evolving field such as safeguarding. Implementing the recommendations is monitored with CBs and reported through the UHB Safeguarding Steering Group. The peer review report demonstrates that C&V UHB is operating in line with other organisations across Wales.

All Wales Domestic Abuse Routine Enquiry for Midwives and Health Visitors Clare

Routine Enquiry (RE) questions asked by Midwives and Health Visitors (HV) relating to domestic abuse has been maintained; this involves specific questions asked twice to women accessing services in Midwifery and once to women accessing services in Health Visiting. The results for 2024-25 are:

Routine Enquiry Asked:	Asked Once	Asked Twice
Midwifery Service	85%	72%
Health Visiting Service	13%	100%

In total 10% of the number (505) of birth notes were manually checked in Midwifery to calculate the data. 429 women were asked the RE at least once, and 76 women were not asked. In those 76 cases, there is not a clear rationale documented as to why this was not asked, however in some cases, documented rationale includes: notes were not available, or the partner was present so unable to ask.

In addition, 107 positive domestic abuse disclosures were made by women in this period. All survivors were signposted appropriately for expert support and counselling. 35 pregnant women were discussed in MARAC or the high- risk daily discussions during this time period.

The Health Visiting percentage has improved dramatically during this period, this has been achieved through improved reporting mechanisms being implemented. Often HV are unable to ask the RE questions at the birth visit as it is deemed to be unsafe if the partner is in attendance.

A new Routine Enquiry audit tool will be introduced in 2025 which has been developed by Public Health Wales for use across Wales. Data collection from the UHB will involve 10 sets of maternity notes per month being audited, utilising the AMaT system. This will provide richer, in-depth data that will be aligned on an all-Wales basis.

Paediatric Emergency Department (PED) Safeguarding Meeting

The Paediatric Emergency Department (PED) Safeguarding Meeting is held weekly and involves multi-disciplinary practitioners. The meeting identifies and highlights cases where additional referral or information is required.

The Paediatric Emergency Department (PED) recorded 34,102 attendances for the year April 1st, 2024 - March 31st, 2025, compared to 32,059 for the previous 12 months. A total of 1,554 PARIS notifications were submitted by the PED team representing 4.9% of all PED attendances during this period.

The introduction of the new electronic MARF attached to the PED EU workstation programme has simplified the notification process and generated more meaningful, accurate and timely MARF notifications.

The weekly safeguarding meeting remains a feature within the PED governance and Safeguarding Steering Group agenda. A total of 48 meetings were held during this time period. The following table summarises the activity of the meeting:

Injuries <12 months old	499 (542 in previous year)
Fractures <2 years old	80 (70 in previous year)
Thermal Injuries	254 (281 in previous year)
Major Trauma Centre Cases	122 (129 in previous year)
Assaults (from 22/08/2024)	143 (83 in previous year)
Health Visitor/ School Nurse Referrals generated from this meeting	179 HV and 94 School Nurse notifications 103 MARFS for information sharing 51 VPU Referrals
Total Cases Discussed	**Total Cases Discussed 1098 (1105 in previous year)**

The safeguarding Multi-Disciplinary Team (MDT) meeting provides a means of safety netting vulnerable cohorts presenting to PED. The annual review evidenced that PED submitted PARIS notifications for 60% of vulnerable patient cohorts following the initial ED contact. Outstanding referrals were completed following retrospective review at the meeting. However, not all children in the vulnerable cohorts who attend the ED will automatically require a PARIS notification, the notification will alert the healthcare professionals to be more vigilant about the circumstances of the presentation. The review indicates improvements can be made, particularly with regards to notifying Health Visitors of fractures in infants under 2 years after initial attendance to ED (38%) as per recommendations from a Child Practice Review in 2018.

The PED in Cardiff is the Major Trauma Centre where 122 severely injured children were brought for assessment and stabilisation from across Mid to South Wales in the observation period. The safeguarding implications of each individual presentation as part of the governance requirements of the South Wales Trauma Network (SWTN) must be considered. Practioners are able to access information from PARIS to identify any pre-existing safeguarding concerns for patients who reside in Cardiff and Vale. However, this resource is not available to obtain relevant information for children from other regions across Wales. During this period a MARF was submitted for 56% MTC cases from ED following the initial attendance with the remainder completed after the outcome of the Safeguarding meeting.

Families are increasingly bringing their children to the PED with medical conditions which could be assessed and managed in primary care. This is reflected by the number of Paris notifications completed to Health Visitors and School Nurses to inform them of families frequently attending PED (341).

PED submitted 2 MARFS last year for concerns of maltreatment of any child/young person under 16 years of age. A further 71 MARF notifications were submitted for information sharing with Children's Services. Indications for the notification include assessment of a 'Child Looked After' or for families consenting for additional support.

Children and young people struggling with mental health concerns continue to represent a high proportion of PED attendances. A total of 279 notifications were made to Children's Services, Health Visitors and School nurses during 2024/25 (143 cases with OD/Self harm, 129 children with behavioural concerns and 7 presentations of alcohol or substance intoxication). Concerns about parental behaviours or anxiety contributed a further 40 referrals.

A total of 143 children/young people attended PED following an incident of alleged assault. Referral rates to the VPU following initial presentation to ED were recorded at 62%, however, this increased to 100% as an outcome from the meeting.

In accordance with departmental Did Not Wait Pathway, 21 PARIS notifications for families who 'self-discharged' were submitted.

Future Projects for 2025: to design and promote injury prevention and home safety information boards in the waiting area based upon common themes seen in the PED.

Adolescent Safeguarding Meeting

This meeting commenced in September 2018, following a pilot scheme in Cardiff and Vale UHB which gathered the opinions of over 300 children and highlighted that 16- and 17-year-olds were seen in the adult ED and not paediatrics. This identified gaps and areas for development. The findings dictated that the aim of the initiative was to 'Improve the Safeguarding processes in the Adult ED and introduce a holistic assessment tool for 16- and 17-year-olds. The meeting is held on a fortnightly basis. Attendees are a Consultant and Lead Nurse from ED, Violence Prevention Unit, Safeguarding Team, Department of Sexual Health (DOSH), Children's Rights Advocate/Children's Charter & Youth Board, CAMHS and Child Looked after Team (CLA).

The following are areas which require improvement, identification and additional staff training within ED:

- Only the physical symptoms identified and treated
- Not seen as children
- Safeguarding documentation missing
- Referrals to social services not completed
- Warning signs not noticed (CSE, DA)
- No School noted
- No School Nurse referral
- No signposting
- Missing an opportunity for an intervention

This approach aims to empower staff working particularly in health services, but also partner organisations, to recognise the role they have in promoting healthy lifestyles, supporting behaviour change and contributing to reducing the risk of chronic disease.

A casualty card which incorporates the HEADSS (Home, Education, Activities, Drugs/alcohol, Sexuality and Suicide) and CSERQ15 (Sexual Exploitation Risk Assessment Framework) indicators is used. Questions around these areas are asked when red flag attendances occur.

This table identifies the safeguarding cases:

Total number of adolescent attendances in the period April 2024- March 2025	3210
Number of cases discussed at safeguarding meeting	694
Attendance average with safeguarding needs	21%
Average number of actions required following meeting	18 average actions per meeting
Average retrospective referrals	35%
Retrospective Referrals: Figures in brackets represent the year 2021-22	
Violence Prevention Team	118 (29)
CAMHS Referrals	6 (6)
DOSH	15 (2)
Child Looked After (CLA) Notifications	8 (9)
School Nurse Notifications	37 (17)
Safeguarding Referrals	247 (196)
Emotional Well-Being Team	32 (7)
Drug and Alcohol Services	18 (9)
Total Retrospective Referrals	**481 (246)**

During this period, DOSH and CAVDAS have been attending the meetings in person which has resulted in an increase in retrospective referrals to these services.

Indications highlighted are an increase in overdose since the pandemic. The ED are planning to update the current casualty card which will be used with children >12 years of age. The updated card will also incorporate a red flag alert for children suspected of being trafficked or at risk of Female Genital Mutilation (FGM).

Paediatric Medical Student Projects2024/25:

1. Audit looking at the yield of abnormal follow up skeletal survey results .
2. Development of a teaching package and guidelines for assessment of birth marks such as CDM
3. Audit of children admitted to adult areas
4. Safety Poster for parents in ED raising awareness of small babies rolling and experiencing injury

Safeguarding Supervision

The Public Health Wales All Wales Safeguarding Supervision Guidance (2024) states that:

"The aim is to provide guidance on the implementation and utilisation of supervision and support within the context of safeguarding. It sees safeguarding supervision as a priority to which staff are actively supported to have the time to attend".

This approach has been adopted with safeguarding children and adults at risk within the UHB.

Practitioners report to their supervisor that the learning element of the session is interesting and effective and that transitional skills are adopted through peer discussion around complex cases. The HV supervision groups are working well. 1:1 safeguarding supervision is also available for newly qualified HVs, long term sickness returns or, by request. The C&V UHB Pathway has been discussed with other Health Boards through NHS Wales Safeguarding Network meetings. The UHB worked closely with Cardiff University, to assist in the new approach which has been highlighted in a PhD Study. Ref: An evaluation of a new approach to safeguarding children supervision in health visiting practice. (A pilot study). Michelle Moseley MSc, PGCE, BSC, RHV, RSCN, RGN. Lecturer, Specialist Community Public Health Nursing (SCPHN), Director of Learning in Practice, PhD student, School of Healthcare Sciences. Cardiff University

Group Safeguarding Supervision is provided to Midwives, Health Visitors (HV), School Nurses, Multi-disciplinary staff in Special Schools. Safeguarding supervision is provided to other groups such as doctors and acute nurses as required. The aim of supervision is to support staff, facilitate learning and promote best practice.

Following the JICPA review in 2024, it was recommended that all midwives should be accessing safeguarding supervision. Introducing this across the Midwifery service is challenging and has required a stepped approach; specialist midwifery teams who care for vulnerable families (ELAN/Flying Start Midwives) have previously been the only staff group within midwifery accessing safeguarding supervision. However, an agreement with midwifery managers has established the Named Midwife for Safeguarding implementing "virtual" led supervision for the hospital-based midwifery teams. Hospital based midwives are expected to attend once yearly, for an hour. In addition, all generic community midwives are expected to attend group safeguarding supervision, twice per year, on a 6-monthly basis.

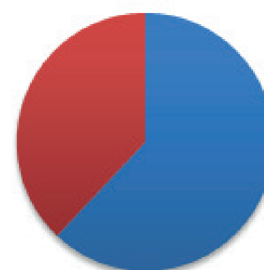
Safeguarding Supervision predominantly for Child Health based staff

Group supervision sessions are structured for two hours and consist of individual case discussion and group learning.

Evaluation questionnaires are shared with participants following the session. This enables e changes to be evaluated, and any new learning explored.
Adult safeguarding supervision is provided by the Senior Nurse for Safeguarding to the HLPs as required and through arranged sessions within each Clinical Board and/or through Development Day sessions. The supervision is ideally provided on a three-monthly basis in group supervision sessions using the same agenda as the children's safeguarding supervision. However, there has been a lapse due to the pressures on staffing. Open adult at risk safeguarding cases are reported to the Executive Nurse Director and Deputy on a quarterly basis and discussed at Nurse Director Professional Performance Reviews. Cases involving staff are reported through the bi-monthly Executive Quality and Safety meetings.

"Signs of Safety" training: The training has been shared with the Safeguarding Team and rolled out to some areas within the Health Visitor and School Nurse service to enhance cohesive partnership working with partner agencies and families. The Signs of Safety approach is used in supervision sessions.

Supervision Data for Child Health Staff:
Table 1 demonstrates: 319 members of Staff received Safeguarding Supervision, 121 members of Staff attended Safeguarding Supervision more than once between April 2024 and March 2025.



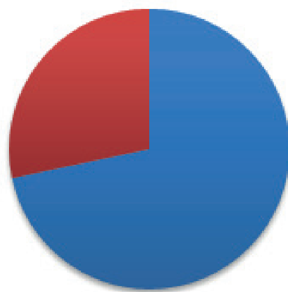
33 sessions of Supervision were completed - Averaging 12.75 health professionals per session. An average of 2.75 sessions a month were completed.

Health Visiting:
90.14% of health visitors, including flying start, specialist and generic health visitors attended supervision at least once.

35.64% of health visitors including flying start, specialist and generic health visitors attended supervision at more than once.

41.17% of community nursery nurses attended safeguarding supervision.

Number of Health Visitors attending Safeguarding Supervision



■ Attending once a year ■ Attending more than once a year

Maternity:
100% of Elan midwives attended supervision, 33.3% attended more than once.

50% of Flying Start Midwives attended safeguarding supervision more than once.

School Nursing:
45% of school immunisation nurses attended safeguarding supervision.

Feedback from Supervision:
8.74% out of 10 of Staff attending Safeguarding Supervision felt their supervision needs were met. 100% of staff attending found the learning and education within safeguarding supervision useful.

Example of Feedback:
'Enjoyed the session Was good to have an update regarding changes.

'Really good thank you very useful to hear other experiences as I'm not involved in safeguarding very often'.

'It was great having skill mix and mixed professional group - I brought my query to the group; it was a safe open space and having advice and information from a range of professionals was very helpful'.

'Lots of practical information provided. Useful information was provided on day-to-day practice such as completing MARF's and sharing consent. Useful information also provided on the PLO process which is often mentioned in child protection conferences.'

Paediatric Peer Review

Within Cardiff and Vale UHB, medical staff peer review is held on a monthly basis. It is made available to all doctors involved in child protection work in order that doctors undertaking in this difficult area of work are well supported and have the opportunity to receive peer review and clinical supervision in order to feel confident and competent. Pragmatically, the peer review process encourages paediatricians to meet the expected standards and prevents practitioners working in isolation.

Peer reviews are held for suspected cases of physical abuse at St David's hospital; additionally, a separate peer review is held at the Sexual Assault Referral Centre (SARC) for cases of suspected sexual abuse.

The meeting is chaired by the Named Doctor for safeguarding children or the Medical Lead for Sexual Assault Referral Centre (SARC).

Attendance is consistently good. All child protection cases from the previous month are presented to ensure the management of the case meets the expected standard of practice. The process involves review of the medical report, photo documentation and the multi-agency working. It is an opportunity for professional development and learning within an appropriate environment and allows staff to debrief following difficult cases. This meeting is the medical supervision equivalent.

Expert Advice

Partnership Working: Cardiff MASH changes

The implementation of the SS&WB (Wales) (2014) Act and VAWDASV (Wales) (2015) has encouraged partnership working across strategic partner organisations and third sector agencies. Ensuring that compliance, knowledge and awareness raising is understood within each agency has required joined up thinking through shared training and guidance from the Cardiff and Vale Regional Safeguarding Board.

Cardiff and Vale UHB (C&V UHB) have close strategic and operational links with the Regional Safeguarding Board, The Public Safety Board and the Community Safety Partnership Board.

The meeting is attended by the Executive or Deputy Executive Nurse Director, Named Doctor for Safeguarding Children or the Head of Safeguarding. Minutes for the meeting are shared with Clinical Boards through the UHB Safeguarding Steering Group meeting. Sub-groups of the RSB are the Delivery Group, Case Review Group, the Training Group is expected to be re-scheduled in 2025.

Meeting the demand of the workflow within Cardiff Multi-Agency Safeguarding Hub (MASH) is a daily challenge for the two Safeguarding Nurse Advisors (SNA) representing the UHB in the MASH. - All agencies within the MASH report an increase in the number of referrals and calls made to the MASH in each consecutive year. Both Cardiff and the Vale of Glamorgan Children's Services has commenced scoping work to consider the "front door arrangements" to access services. Cardiff Children's Services are deciding and planning to launch in April 2025. There are no expected changes to the multi-agency approach within the MASH although a change of premises may be considered. The UHB will embrace the change, there are no expected risks evident. The UHB safeguarding advice line which staff members access for advice and support will be called the Professional Advice Line (PAL) in line Children's Services. All advice and support shared with practitioners is recorded on individual patients PARIS records as supervision.

During this period changes to the MARAC meetings has been piloted and implemented successfully. In addition, the Daily Discussions for high-risk domestic abuse cases have been withdrawn. This has resulted in weekly MARAC meetings for both Cardiff and the Vale region.

The Cardiff MASH demonstrates valued multi-agency working, it has evidenced respect and an understanding of roles amongst the different organisations and broken-down barriers to working in partnership.

Partnership working is evident in the Regional Safeguarding Board subgroups; agencies are brought together to consider available training resources and to undertake specific audits from Child Practice Reviews (CPR) or Adult Practice Reviews (APR) and develop action plans.

The UHB works in partnership with the Regional Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) group; to ensure compliance with the training programme in line with the Welsh Government, National Training Framework. The work involves sharing training figures for Mandatory Group 1 training and Group 2. The first Group 3 session has been delivered within the UHB.

The UHB is represented at all Public Health Wales, National Safeguarding Service meetings by the Deputy Executive Nurse Director, Named Doctor for Safeguarding Children and/or the Head of Safeguarding. The meetings bring together Health Boards and Trusts from across Wales, the aim is to maintain standards and to share learning. There are subgroups covering VAWDASV, Training and Child Looked After (CLA), Safeguarding Maturity Matrix. There is representation from the safeguarding team in all meetings, the CLA team attend the subgroup for their service.

Female Genital Mutilation (FGM)

FGM is a term used for a range of procedures which involve partial or total removal of the external female genitalia for non-medical reasons. FGM has been illegal in the UK since September 1985 however in 2015 a number of amendments were made to the more recent 2003 Female Genital Mutilation Act through the Serious Crime Act 2015. It is now illegal in the UK to excise, infibulate or otherwise mutilate the whole or any part of a girl or woman's labia majora, labia minora or clitoris (section 1 of the 2003 Act). For a person to aid, abet,

counsel or procure a girl or woman to carry out FGM on her own genitalia (section 2). To assist a non-UK person to mutilate girl or woman's genitalia outside the UK (section 3). To fail to protect a girl from risk of genital mutilation while they have responsibility for her (section 3A) and for a UK national or resident to commit or allow any of the above offences to be committed outside the UK. The Serious Crimes Act 2015 placed a mandatory reporting duty on all health professionals to report "known" cases of FGM in under 18-year-olds to the police, this duty has been instigated since 31 October 2015.

The All-Wales Clinical Pathway for FGM was ratified in July 2016. NHS Wales National Safeguarding Network with support from Health Boards has updated the pathway and a new version was released in March 2022 and is now in use within the UHB. Specific mandatory training for midwives has been in place since 2014, with approximately 300 midwives receiving the training each year. Additional sessions were introduced to other health professionals through bespoke sessions, an introduction in Level 3 Safeguarding Current Themes and the Level 2 VAWDASV safeguarding training. A continued drive to raise awareness across the UHB has been maintained by the safeguarding team. Midwifery training has been facilitated by the FGM Lead Safeguarding Midwife with additional training across the UHB delivered by members of the safeguarding team. Online FGM training is also available, endorsed by the Home Office; this is accessible to all UHB staff. Welsh Government previously requested quarterly updates from all Health Boards across Wales identifying FGM, this also included statistics related to number of referrals made to Children's Services where mothers of female children are identified as having experienced FGM. The data collection has since been commissioned to the Violence Prevention Unit and continues to be provided. The reason for referring children to Children's Services ensures that professionals are aware of an increased risk that the female children may experience FGM in the future.

The referral process for suspected or at-risk cases of FGM has been reviewed within the UHB, an example child protection referral is available on the UHB's safeguarding SharePoint (CAVweb), and an FGM Risk Assessment (RA) tool has been added to the Multi Agency Referral Form (MARF) this has been agreed with police and local authority. An increase in recognition has been apparent as a result of the FGM working party training, staff have presented at a South Wales Police (SWP) Conference, BAWSO conferences and the Chief Nursing Officer Conference.

An FGM service model, the Women's Well-being clinic continues across the UHB, the clinic opened in May 2018 following funding secured from the Police for the psychosexual element and from the Iolanthe award. The Women's well-being clinic consists of a service held weekly (1 all day session) within CAVHIS (Cardiff and Vale Health Inclusion Service in Cardiff Royal Infirmary), which is centrally placed for easy access and provides support to victims or those at risk of FGM. The first year saw a total of 147 women referred to the Women's Wellbeing clinic, with 102 young people/women being reviewed in this time. The majority of referrals are from UHW maternity. There are varying reasons for referral including gynaecological and psychological issues with the predominant reason being pregnancy. Country of origin has been collated with the majority of women reviewed being from the Sudanese community. Self-referrals at the clinic are accepted. The Clinic has completed its fifth year and numbers remained steady. The Women's Well-being clinic has demonstrated a need for this service within the community and is evidenced by the numbers of women that have been reviewed, future plans include: to continue with the

Quarter during 2023- 2024	**Number of women identified**	**Child protection referral Made**	**Mandatory reporting**
Q1	18	14	0
Q2	17	11	0
Q3	11	6	0
Q4	12	6	0

clinic including engaging with the local communities to promote the services within the clinic. Training for community de-infibulation is also being explored as service development. Furthermore, in 2023 funding was secured from WG to provide psychological support in Womens Wellbeing clinic for women who have experienced trauma from harmful practices, this service has proved to be an essential addition to the clinic and has resulted in additional funding to provide one full day per week for 2024/2025.

Procedural Response to Unexpected Death in Childhood (PRUDiC) launch of new guidance

The process was first introduced across Wales in 2010 with the aim to *"ensure that the multi-agency response to unexpected child deaths is safe, consistent and sensitive to those concerned and that there is uniformity across Wales".*

The National Safeguarding Service in Public Health Wales revised the document in 2023. The procedure sets a minimum standard for a response to unexpected deaths in infancy and childhood. It describes the process of communication, collaborative action and information sharing following the unexpected death of a child. The updated procedures refer to children aged 16 and 17 years old and remind all practitioners that the PRUDiC procedures apply in this age group.

The process within the UHB is established; the Head of Safeguarding or Senior Nurse liaises with police to arrange a multi-agency meeting within 48 working hours of the child's death, the meeting is chaired by police, and attendance includes representatives from Children's Services, Education when appropriate, Welsh Ambulance Service Trust, appropriate representation from health professionals involved with the child. The purpose of the meeting is to ensure that there are no suspicious circumstances surrounding the child's death and to make certain that a robust bereavement package is in place for the family.

C&V UHB are fortunate to have Bereavement Nurses that liaises directly with the family and supports them through this extremely difficult time by discussing with them any pathology information, arrangements for visiting the child in the morgue and registering the death. Referrals are made to charitable organisations to support the family long term, and a memory box is created. The table below identifies the number of child deaths of children residing in the Cardiff and Vale of Glamorgan locality.

Number of Child Deaths
Period 2024-2025
25 Cases, 7 Cases are for children usually residing out of C&V UHB region. The Major Trauma Centre is likely to be the reason for an increase in the figures. Of the C&V UHB Cases, 1 case relate to a possible Young Person Suicide

Single Unified Safeguarding Review including Child and Adult Practice Reviews

The Single Unified Safeguarding Review (SUSR) is a single review process incorporating all reviews in Wales. This ensures affected families can expect a swift and rigorous review process. The SUSR eliminates the need for families to take part in several reviews. This will reduce the trauma and allow learning to be identified and acted upon sooner.

The criteria for conducting an SUSR needs to meet one of the following:

- Adult Practice Review
- Child Practice Review
- Domestic Homicide Review
- Mental Health Homicide Review
- Offensive Weapons Homicide Review

The SUSR brings agencies and individuals connected to the incident into a safe learning environment to:

- build a greater understanding of what happened during an incident and why
- improve the understanding of the impact of the actions of organisations
- look into whether different actions may have resulted in different outcomes for the child or adult at risk
- identify any learning opportunities for the future
- provide a clear action plan on how to improve service provision

Reference: Welsh Government Website accessed June 2025

The process involves agencies, staff and families reflecting and learning from what has happened to improve practice with the focus on accountability and not culpability. This will potentially develop more competent and confident practice, better understanding of knowledge base and perspective of different professional's role and responsibility.

The Head of Safeguarding and Senior Nurse participates in the Regional Safeguarding Board, Case Review sub-group when consideration is given to new referrals and the commissioning of a new review. Safeguarding Nurse Advisors (SNA) participate as panel members to individual reviews and complete a health chronology of each health contact to inform the timeline of events that will notify the reviewers preparing the report once collation of each agency's information has been submitted. Clinical Board representatives are also asked to accompany the SNAs as panel meeting when this is deemed as appropriate to individual reviews.

Recommendations and learning from the reviews will be identified in action plans or from the learning event. Organising a multi-agency approach for the learning event allows professionals to consider the case in detail, reflect on their own practice and to take learning back to each organisation to prevent the same situation happening again. There was one published review during this period, six Child Practice Review are on-going, five Adult Practice Reviews are on-going, a total of seven Multi-Agency Professional Forum (MAPF) are in progress with three completed during this period. In addition, one Single Unified Safeguarding Review (SUSR) pilot has completed and published, one Offensive Weapons Homicide Review commenced and remains in progress. A total of 10 referrals were received by the RSB during this reporting period.

Domestic Homicide Review (DHR)

Completed DHR	Ongoing Awaiting Publication
9	1 SUSR in progress 1 Offensive Weapons Homicide Review
In Progress DHR	**Referrals**
1	**0**

DHRs were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The provision came in to force on 13 April 2011. The Home Office Multi-Agency Statutory Guidance for The Conduct of Domestic Homicide Reviews has been updated in 2016. Domestic violence includes physical violence, psychological, sexual, financial and emotional abuse involving partners, ex-partners, other relatives or household members. A domestic violence incident which results in the death of the victim is often not a first attack and is likely to have been preceded by psychological and emotional abuse. It is likely that many people within agencies may have known of these attacks and circumstances. This can sometimes make serious injury and homicide preventable with early intervention.

A DHR means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect. Similarly, to CPR and APR, the DHR will consider what lessons can be learnt by professionals and organisations to safeguard victims, what change can be identified, update policies and procedures, make every attempt to prevent domestic homicide by improving services to individuals and their children through improved inter-agency working.

Child Practice Review	Adult Practice Review	Multi-Agency Professional Forum (MAPF)
6 CPRs on-going	5 APRs are on-going	7 MAPFs are on-going (3 adult/ 2 child)
OWHR Pilot	**SUSR**	
1	1 completed	

As with CPR and APR, safeguarding nurses are identified within the team to collate information from each health contact and develop a timeline to inform the DHR report. Representatives from the safeguarding team attend all DHR meetings and participate in the development of the report. There has been nine DHRs undertaken in Cardiff since 2015 and one case in the Vale of Glamorgan. The Welsh Government Single Unified Safeguarding Review (SUSR) pilot has been launched in the Regional Safeguarding Board area during this reporting timeframe. It is anticipated that the SUSR will officially be launched during 2024. The SUSR process will be adopted for all safeguarding reviews to ensure efficiency, continuity and the reduction of duplication reports. This will include CPR, APR, DHR, Mental Health Reviews/ Mental Health Homicide Reviews and Offensive Weapons Homicide Reviews in some circumstances.

Domestic Abuse

The implementation of the Violence against Women, Domestic Abuse and Sexual Assault (Wales) Act 2015 has seen a change in the referrals, training and width and breadth of the domestic abuse agenda within the UHB as indeed across Wales. More recently the Domestic Abuse Act 2021 has contributed further to this agenda.

The Regional Multi-Agency Domestic Abuse Strategy for Cardiff and Vale of Glamorgan continues to incorporate a plan to address service need and training actions across the locality of Cardiff and Vale of Glamorgan council area. Welsh Government (WG) has provided guidance for all organisations to consider a five-year plan to meet the National Training Framework expectations to raise awareness with all employees within each organisation. Different levels of training are identified with compliance within each organisation expected to be at 100%. No additional resources have been identified by Welsh Government to achieve this target.

The UHB has provided WG with a forecast of the number of staffs completing training over the next five years. During the period April 2024 to March 2025 the Health IDVA (Health Independent Domestic Violence Advisor) has continued to raise awareness of domestic abuse and raise the profile of the IDVA role within the UHB. In line with the Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV) (Wales) Act 2015 the Health IDVA has continued to deliver VAWDASV, Group 1 training which is mandatory for all staff. In addition, the UHB Safeguarding Team also continues to deliver Group 2 training in line with the Welsh Government National Training Framework. There is a requirement within the VAWDASV Act that all professionals working with the public in any capacity must undertake this additional training. A broad estimate of 11,000 staff within the UHB will be expected to complete this training, **411 staff were trained within the UHB during this period. Group 3 VAWDASV Training commenced in 2024/2025 in line with the National Training Framework, all staff attending will be recognised as 'Ask and Act champions.** The Health IDVA has also continued to provide ad hoc awareness raising sessions to departments as and when required including within the Emergency Department.

The UHB is fortunate to now have two Health IDVA positions. During the reporting period, the Safeguarding Team successfully secured additional external fixed-term funding for another Health IDVA post. This demonstrates a positive recognition from the UHB of the need for increased funding in this area.

As an organisation we continue to support the White Ribbon Campaign. Several ambassadors and champions within the UHB have completed online training within their roles and departments to promote awareness and support for patients experiencing these types of abuse. White Ribbon events and awareness raising is delivered annually.

In addition to providing training and raising awareness, the Health IDVA continues to provide support to survivors of domestic abuse. During the period April 2024 to March 2025, **804** Ask and Act (A&A) referrals were received. This has shown significant continued high numbers of referrals with an average of **67 per month**. Following these referrals, safety planning has been completed by the Health IDVA with **344** clients either by telephone call or face to face, with an additional **146** of these referrals already engaged with community domestic abuse services. In cases where contact is made, individualised safety plans have been developed with support including: safety plans in hospital, markers and security measures on properties, assistance to report to the police, Clare's Law Disclosure requests, signpost referrals for counselling and referrals to specialist support services. Furthermore, **6** clients have been supported to access refuge/emergency accommodation directly from hospital.

Of the **804** referrals received **277** declined support. In cases where support is declined, or we cannot make successful contact we still complete safeguarding measures as far as possible. This will include completion of MARFs, AS1s and MARAC referrals on professional judgement where required. We also put in place ED Domestic Abuse markers and update involved staff and GPs with requests to re-visit discussion around domestic abuse support.

Of the **804** referrals received, **242** of these patients presented to ED following a domestic abuse assault however only **162** had reported these assaults to police therefore **80** of these patients could be considered hidden domestic abuse assault victims prior to Ask and Act being completed.

Of the **804** referrals received **211** have been assessed as high risk of domestic abuse by the Health IDVA service or police. In addition, the Health IDVA has made **84** referrals to MARAC.

Following the introduction of Domestic Abuse Routine Enquiry in the Emergency Department in 2020 in response to the COVID-19 Pandemic, Routine Enquiry has continued to be promoted within ED.

Domestic abuse and other forms of violence can impact negatively on an employee's health and wellbeing and staff morale. In addition, in England and Wales domestic abuse has economic costs of £14 billion arising from lost output due to time off work and reduced productivity (The Home Office, 2019). The Health IDVA supports staff members experiencing domestic abuse and within the reporting period The Health IDVA Team have supported **56** staff members. This continues to demonstrate a high number of staff being supported by the Health IDVA team. The Health IDVA supports staff members by completing regular risk assessments and working in a client led way to develop safety plans for them at home and in work. This includes working closely with managers, the UHB Health and Safety Team and UHB Security ensuring that UHB staff members who are survivors of domestic abuse feel safe and supported in work.

The table below demonstrates the sustained high numbers of positive disclosures:

Month/ Year 2024-2025	Total Number of Ask & Acts	Positive Ask and Act referrals	Ask and Act referrals from other departments within UHB	Ask and Act referrals with disclosures from ED	Ask and Act referrals with non-disclosures from ED
April	**106**	69	18	51	37
May	**262**	76	26	50	186
June	**84**	61	18	43	23
July	**111**	111	37	74	0
August	**65**	65	20	45	0
September	**399**	63	10	53	336
October	**260**	61	24	37	199
November	**87**	58	20	38	29
December	**91**	71	20	51	20
January	**96**	55	14	41	41
February	**54**	54	17	37	0
March	**84**	0	0	0	84
Total	**1,699**	**744**	**224**	**520**	**955**

Police and Crime Commissioner Funded Project for: Young Person Independent Domestic Violence Adviser. The first in Wales.

The Police and Crime Commissioner has provided funding to Cardiff and Vale University Health Board (C&VUHB) to commence an exciting project for the first health, hospital based Young Person Independent Domestic Violence Advisor (YP IDVA) service, which commenced in November 2022. C&VUHB identified the need for skilled domestic abuse practitioners within the UHB that are able to respond to any disclosure of Domestic Violence or situations around possible unhealth relationships from young people accessing Hospital Services.

Whilst the legal definition of domestic abuse covers those aged 16 and above, we recognise that children under 16 years are disclosing abusive behaviours within intimate and familial relationships and support is currently limited in this area.

The project aim is to support young people presenting at Emergency Department in the first instance between the ages of 11 -17 years old who have:

- Witness of Domestic Violence within the Household
- Victim of Sexual Violence
- Indicators of Sexual Exploitation
- Honour Based Violence

The Domestic Abuse Act (2021) reinforces and recognises that children who see, hear or experience domestic abuse, are victims in their own right.

The aim of the role is to deliver specialist advocacy and high-quality support, to those highest at risk of domestic abuse, relationship abuse and sexual violence, helping young people to be safe from harm and develop their understanding of healthy relationships.
The role is the first of its kind within Wales and funding has been secured for 3 years.

Some important aspects of the role include:

1. Information and Communication – Timely and accurate information and age appropriate communication is key to meeting young people's needs.
2. The Child's Voice – Victims want to be listened to and their views and needs taken seriously.
3. Support – The support for victims should always be of a consistently high quality and accessible to all.
4. Specialist Support – Recognition that many victims need access to specialised support.
5. Accountability – Victims should be confident that they will receive the services to which they are entitled.

Statistics collated from April 2024 – March 2025:

- **189 Referrals (Young People aged 11 – 17 years) a significant increase from 34 in 2023**

Emerging Trends:

- 'Hidden Victims' – Patients presenting with Mental Health Concerns / Deliberate Self Harm and Substance Misuse.
- Increase need for Healthy Relationship advise, specifically for young males.
- An increase in need of support for victims who are witnesses of Domestic Abuse within the Household.
- Frequent Attenders.
- Support being requested for patients under 11 years.

Referrals are generated directly from Emergency Department (ED) attendance at UHW. The service has now expanded to cover the children's wards in the Noah's Ark Children's Hospital, UHW.

It is imperative that the Health based YP IDVA service continues to embed itself within the UHB and continues to grow and develop. Routine Enquiry will continue to be promoted within the ED.

Violence Prevention Team (VPT)

This multi-agency project launched in October 2019 in Cardiff, hosted by the Wales Violence Prevention Unit (VPU) and funded by the Home Office. Cardiff and Vale University Health Board (UHB) were invited to be part of the unit as the Emergency Department (ED) is situated in the University Hospital of Wales (UHW), which is one

of the biggest and busiest in the United Kingdom. Every year thousands of people find themselves within an ED as the victim of serious violence (National Violence Surveillance Network 2019). The Violence Prevention Team (VPT) consisting of two staff members, an Advocate and 2 part time seconded qualified nurses embedded alongside clinicians and trauma practitioners within the ED at UHW. This is the first model of its kind in the UK. Together the VPU comprises of members from South Wales Police, the Police and Crime Commission, Public Health Wales, Her Majesty's Prison and Probation Service, Home Office Immigration and Third Sector support services. Together they take a Public Health approach to prevent all forms of violence across Wales.

The health team based within the ED meet with patients of any age and gender attending with Violence with Injury (VWI). Initially the project concentrated on knife related injuries, however this expanded to include all violence (excluding Domestic Abuse). The team approach the patient to provide support, advice and guidance as soon as it is appropriate. The focus is on building a rapport, providing personalised, holistic and integrated support, and enabling patients to make informed decisions. The aim is to enable empowerment to improve the patient's well-being and then encourage patients to make informed, long-term positive plans to break away from cycles of violence. With the patients consent the team will refer to external agencies, for continued support in the community, if required following hospital discharge.

Violence Prevention Team Training

The VPT training is developed and delivered by its members in a variety of methods, including classroom-based presentations, drop-in sessions, 1:1 on the spot teaching, and recorded/online sessions. ED teaching sessions are arranged by the Emergency Unit Practice Educator often during the departments study days. All levels of staff within the department have received some form of training, including reception staff, doctors and nurses since October 2019.

It has become apparent, that due to staff rotation and turnover of staff within the department, education sessions need to be consistent and regular. The team are also visible in ED to answer staff questions and encourage engagement.

ED staff education entails:

- Raising awareness of the service and its provisions
- Identifying the VPT referral pathway
- Use of referral forms and processes
- Reporting of all knife related admissions
- Encouraging paediatric referrals
- Encouraging all safeguarding measures are met.

The team has also conducted educational sessions on the Level 3 UHB Safeguarding study days. Including the Safeguarding Current Themes full day training, since November 2019, reaching a variety of different UHB staff members.

Raising awareness has been a key part of the VPT and contributes to the quality of service that the team provide. Within the UHB the team has liaised with other specialities, such as Major Trauma, Poisons, Drug and Alcohol Liaison Nurses, Psychiatry and Health Inclusion Services. The VPT have provided training and support to specialist nurses and health care assistants working in the Major Trauma Centre (MCT) and Traumatic Brain Injury Team (TBI), and have developed a clear, robust referral mechanisms between the teams and the VPT. The VPT have recently developed a training package for the Pre-Induction Lectures for new doctors to support them in their new role within the ED.

The VPT have developed a number of service links externally to the UHB with both statutory and third sector agencies. Since the beginning of this project, work with third sector agencies have assisted, developed and enhanced the service now being provided to ED patients. Work streams have been formed allowing the team to make seamless referrals into these services; continuing support for patients from hospital and into the community. To develop external links, the VPT has presented at the Serious Youth Violence in South Wales Seminar outlining their role to a wider range of professionals and developing new operational networks. The VPT have also joined the National Violence Reduction Network, which is a bi-monthly meeting of violence reduction specialist sharing knowledge, practice and learning.

Patient Outcomes: April 2024 to March 2025

Knife Related Injuries	122 patients	77 engaged	64 accepted ongoing support after discharge
Violence Related Injuries	949 patients	644 engaged	325 accepted ongoing support after discharge
Self-Harm Punch Injuries	62 patients	34 engaged	21 accepted ongoing support after discharge
Retrospective MARFS or AS1 submitted	332 patients		

Evaluation

The Violence Prevention Team has worked with Public Health Wales since 2021 to evaluate the programme and services provided. The primary objectives of the evaluation are:

1. To understand the role of the NHS Violence Prevention Team (VPT) in supporting victims of violence-related injury;
2. To assess the efficacy of the VPT in addressing the needs of patients and preventing future violence related injuries;
3. To assess the effectiveness of the implementation and delivery of the VPT within the ED, and identify any developments to further enhance the role of the team;
4. To explore the value of the VPT, and consider sustainability of the model, potential for scale up, and roll-out of the intervention to other health settings in Wales.

Due to the positive outcome from the VPT evaluation, additional funding has now been provided by the Home Office to expand the VPT and develop a similar provision in Morriston Hospital A&E. The C&V VPT are working to support this team and assist them in their development.

CONTEST

Contest[1] is the UK Government's counter-terrorism strategy. It's based on 4 themes:

- Prevent: to stop people becoming terrorists or supporting terrorism
- Pursue: to stop terrorist attacks happening
- Protect: to strengthen our protection against a terrorist attack
- Prepare: to minimise the impact of a terrorist attack

PREVENT is designed to tackle the problem of terrorism at its roots.

The aim of Prevent is to stop people from becoming terrorists or supporting terrorism. Prevent work also extends to supporting the rehabilitation and disengagement of those already involved in terrorism.

The objectives of PREVENT are:

- tackling the ideological causes of terrorism
- intervening early to support people susceptible to radicalisation
- enabling people who have already engaged in terrorism to disengage and rehabilitate

The UHB Safeguarding Team, working directly with the Head of Emergency Preparedness Resilience & Response (EPRR) have developed a UHB referral pathway for UHB employees to follow when they have a concern that a service user or a member of staff maybe at risk of radicalisation.

Training in this area is available as an electronic training programme on the All-Wales ESR system. In addition, the safeguarding team reference the principles of PREVENT during safeguarding training sessions and safeguarding supervision. Further training in this area will be considered in 2025/26.

A small working group from the safeguarding team, the EPRR team and a practice educator from Emergency Department have an on-going annual work plan to ensure that the Prevent Awareness training is delivered to key groups working with members of the public and/or families in the community.

The UHB are working in collaboration with partner agencies to comply with the Department of Health and Social Care NHS PREVENT training framework (September 2022). The Strategic planning team will

[1] *Counter-terrorism strategy (CONTEST) 2023 - GOV.UK (www.gov.uk)*

be introducing a training programme for champions across each Clinical Board and Corporate teams to share awareness and knowledge across the UHB.

The Corporate Safeguarding Team and the UHB EPRR team attend the monthly, multi-agency Channel Panel meeting were cases of potential concern are discussed for information sharing purposes.

Contextual Safeguarding

The contextual safeguarding agenda continues to evolve within adult and child safeguarding practices. Contextual safeguarding seeks to identify and safeguard young people and adults at risk against abuse not just within the home but within the wider environment, this is termed extra-familial abuse (Firmin 2017). Contextual safeguarding seeks to identify how professionals can safeguard children or adults at risk on a wider scale within the community. The way in which individuals can be safeguarded is to disrupt the environment where the abuse is occurring. Contextual safeguarding is important as family members have little influence over these contexts, the only way to access these contexts is through interagency working. Examples of contextual safeguarding are as follows:

- Criminal exploitation/county lines/sexual exploitation
- Peer on peer abuse
- Radicalisation
- Modern Slavery
- Trafficking
- Online abuse

Within the UHB this means increased multiagency partnership working to share information and establish innovative actions to safeguard individuals or a group of individuals within the community. High risk panel meetings within Cardiff driven by Children's Services, have been established to help address contextual safeguarding, these meetings take place once weekly, the SAFE model within Cardiff region has been introduced. Young people aged under 18 years are referred into the high-risk panel meeting that are identified as being at imminent or high risk of serious harm. The high-risk panel identifies risks outside of the family home within the community. The safeguarding team have been involved in attending high risk panel meetings to share information and jointly agree a risk management plan with agencies such as children's services, youth offending services, adult services, police, children's services legal team and education. These meetings are complex and at times a group of young people at risk are discussed where there can be numerous risk factors present.

Child Sexual Exploitation continues to be a priority for Welsh Government, Regional Safeguarding Children Board (RSCB) and the National Safeguarding Service team in Public Health Wales. A National action plan has been introduced to ensure that all statutory agencies and Third Sectors consider how to Prepare, Prevent, Protect and Pursuit (police) will be driven through each organisation. The RSCB endorsed a CSE Strategic Group to consider the prevalence of CSE across Cardiff and the Vale of Glamorgan by undertaking a mapping study and each agency identifying the training that is delivered and sharing the resources available. This challenges the effectiveness of the activity undertaken by the Board to safeguard and promote the welfare of the children who are at risk of, or being harmed by, child sexual exploitation across the region. This is particularly pertinent as a Child Practice Review Multi-Agency Professional Forum presented a CSE case in 2016 whereby a number of children were exploited by the same perpetrator.

Within the UHB an increase in the workload associated with CSE has continued during 2024-25 following the introduction of additional staff in Children's Services and police to tackle the growing problem in Cardiff. This has led to regular weekly CSE, multi-agency safeguarding meetings (MASM), strategy meetings for individual children suspected to be at risk of CSE. Following a scoping exercise conducted by C&V UHB safeguarding team between October 2022 to December 2022 it was established that a safeguarding nurse advisor (SNA) would attend CSE multi - agency strategy meetings as Health Board representative due to the complexity of the cases and the necessary expertise SNAs have in terms of multiagency working and resources which are available within health. This in turn will continue to reduce the risk to the most vulnerable young people in our locality. This also proved beneficial due to the team being involved within the wider contextual safeguarding meetings and ensuring systematic documentation of the meeting outcomes and actions on PARIS (patient

electronic records) in order for Health Board staff working directly with the young person to be fully informed of the outcomes. As with all strategy meetings held through the Wales Safeguarding Procedures (2019), a plan is implemented to support the child and an attempt made to prevent the child from risk of harm through abuse or neglect. In an attempt to reduce the risk associated with this type of abuse, alert flags in Emergency Department at University Hospital of Wales are placed on identified children and young people, considered to be at risk.

Adults at Risk who are identified as potential victims of contextual safeguarding are discussed in multi-agency strategy meetings led by the Local Authority. The initial referral may be generated and submitted by health staff following an attendance at ED, admission to hospital or a disclosure to a staff member. Health staff are trained as part of mandatory safeguarding training to consider professional curiosity if any potential indicators are evident.

National Referral Mechanism (NRM)

The National Referral Mechanism (NRM) is the framework for identifying victims of human trafficking and modern slavery. Cardiff and Vale UHB Safeguarding team are part of a pilot programme which began in June 2021 with 10 sites across the UK however, between February and April 2023 the sites have increased to 20 pilot sites. The outcome of NRM referrals for children currently residing within Cardiff are no longer decided by the Home Office this has been devolved to a localised multi-agency decision, core panel members are Police, Children's Services and Health. The Single Competent Authority - Home Office will review decisions as part of the pilot, it operates a two- stage decision making process, decisions are made within 45 days to determine whether a child is a victim of Human Trafficking and/or Modern Slavery.

There is a newly developed Safeguarding Adolescents from Exploitation (SAFE) model in place within Cardiff introduced by the Local Authority Children's Services. This model has established additional multiagency meetings to share information and discuss strategies to obtain a multiagency response to contextual safeguarding risks.

High Risk Panel Meetings have been established as part of the SAFE model, Cardiff and Vale UHB Safeguarding team have been representing health at these meetings the meetings take place weekly. The purpose of the panel meetings is to discuss children/young people that are considered at immediate risk of harm in relation to contextual safeguarding, these involve complex criminal exploitation and child sexual exploitation cases. The meetings aim to establish if a young person is at high risk of exploitation and to maintain oversight of the case. Involved agencies jointly agree a risk management plan and have a collective responsibility. Agencies will look at a form of disruption for the individual or group of young people that are being exploited. Many of the young people discussed, have difficulties with engagement, are frequently deemed as missing. This often requires ongoing strategies to try and locate and engage with the young person. We have approximately three to four high risk panel meetings taking place weekly.

SAFE Locality Operational Groups is a further multiagency meeting that has been developed as part of the SAFE model. A pilot for this group has been taking place within North Cardiff. The health Violence Prevention Team (VPT) represent health at these meetings. The group involves a wide range of professionals within the area – head teachers from local schools, local police in the area for example - PCSOs, children's services managers in the area, Media Academy Cymru, Neighbourhood Housing, Early Help, PA Service. The purpose of the operational group is to focus on areas of concern within Cardiff and share information amongst agencies. Information and local intelligence relating to contexts/locations where harm is being seen within the area is shared with partner agencies and information on peer networks. The group discuss strategies to disrupt the context/environment that the abuse is taking place.

Panel meetings held since April 2024 to March 2025 which has safeguarding nurse present as a decision maker include:

Referrals	Year
72	2023-2024
55	2024-2025

Deprivation of Liberty Safeguards (DoLS)

The Cardiff and Vale UHB DoLS team operate the supervisory responsibility on behalf of Cardiff and Vale UHB, Vale of Glamorgan Council and Cardiff Council through a Partnership Management Board consisting of senior representatives of each supervisory body. The DoLS team provide advice to Care Homes, hospital wards and Health and Social Care staff across the sector in relation to Mental Capacity Act (MCA) and DoLS.

The UHB refers, an average of 30 requests for authorisation per week however, a high proportion of DoLS requests are withdrawn within health due to a number of reasons including:

- the patient regaining capacity so authorisation is no longer required
- the patient may be discharged before the assessment process is complete
- or sadly, due to the patient's death.

In previous years, additional funds have been put towards DoLS assessments to increase assessment capacity and improve timescale for assessment however, it has been identified that capacity needs to be increased on a recurring basis.

DoLS training is provided by the UHB's MCA team. 'DoLS In Practice' in-person training is available with 3 sessions available bi-monthly.

There has been no further update from the UK Government in relation to the Liberty Protection Safeguards.

Mental Capacity Act

The MCA Team provides expert advice and guidance to staff in relation to the MCA with the aim to develop and deliver training and appropriate resources for staff. The team are heavily involved in reviews, including Mortality Screening Panel, National Reportable incidents and oversee Datix incidents to provide feedback and learning opportunities. The team undertakes an annual audit of compliance with the MCA across the UHB to identify issues and areas of good practice. This provides assistance to support the teams in identifying work streams, improve practice and consider the UHB's needs as an organisation.

Mental Capacity Act training at Level 1 and 2 is available through Electronic Staff Records (ESR) and forms part of the mandatory training requirements for staff depending on their role. Level 2 classroom-based training is available to all staff on bi- monthly basis. The team offer regular sessions of the 'Practical Application of the MCA: How to assess and support decision making' course, which has been well received by staff attending. Bespoke sessions for clinical areas are available on request, attendance at team meetings and quality and safety forums; to raise awareness and deliver 7-minute briefings around specialist topics and the underpinning principles of the MCA.

The team support Safeguarding Level 3 training by providing sessions in relation to self-neglect and the Court of Protection; for the Vulnerable Adults and Legal Aspects study days respectively.

Sexual Assault Referral Centre (SARC), Ynys Saff

Sexual Assault Referral Centre (SARC), Ynys Saff Cardiff and Vale UHB hosts Ynys Saff, the multi-agency Sexual Assault Referral Centre (SARC), in Cardiff Royal Infirmary. The service delivers a comprehensive quality service for victims of sexual assault for adults and children in Cardiff and the Vale of Glamorgan. Ynys Saff remains the South Wales Paediatric Hub, offering a provision for children across South and Mid Wales region who are victims of an acute assault. The Regional SARC Hub and Spoke model continues to be developed and Ynys Saff is now the main acute SARC Hub for the Southeast area for Wales, with most forensic medicals now being seen within Ynys Saff, rather than in Risca or Merthyr SARCs. This ensures that as we move towards ISO accreditation, forensic medical examinations all take place within facilities that meet the stringent forensic standards. Ynys Saff sits within the governance framework of the Children and Women Clinical Board.

ISO accreditation

Work has been completed to create and update forensic suites to allow forensic medical examinations in line with ISO accreditation. The Quality manual is in place and processes embedded. Ynys Saff are awaiting a date from UKAS for inspection for accreditation.

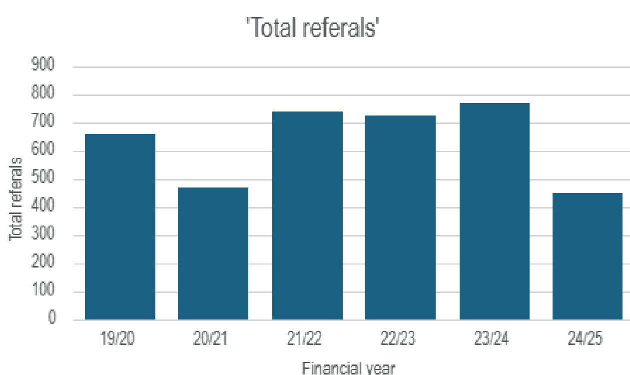
Change in Forensic Provider.

The Police commissioned Forensic provided went out to tender in 2024 and was awarded to Nurture Healthcare from September 2024. The new model provides a dedicated SARC examiner, with a separate service now being in place for custody work. Nurture Healthcare make use of both doctors and nurses as their forensic examiners, and there is increased availability of female examiners. The service has been keen to engage with the NHS to ensure robust care pathways.

With the change in forensic provider, we are now able to offer a therapeutic examination to a client that chooses not to provide forensic evidence. The purpose of a therapeutic examination is to be provided with emergency contraception as well as general wellbeing advice on sexual health and discuss any concerns a client may have with the forensic nurse. This does not replace the need to be seen within a sexual health department but does allow an alternative route for clients to address concerns.

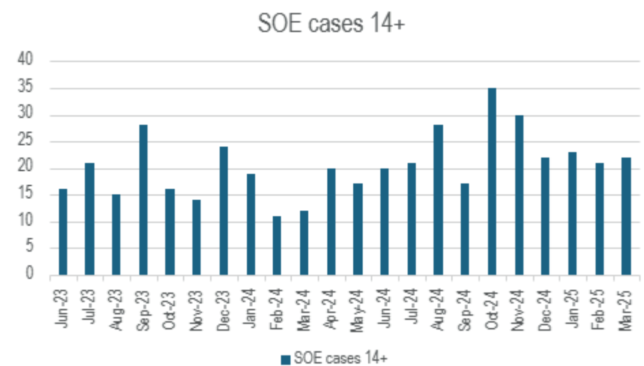
Referral Data.

Total referrals have dropped in the 24/25 financial year; however, this is reflective of the ISVA service recommissioning which was completed in Summer 2024. Previous data included clients who were referred for ISVA support only, without a forensic medical review.



The number of forensic medicals has increased in clients being seen in Ynys Saff. The total number of medicals performed within Ynys Saff has increased from 245 in 2023/2024 up to 352 in 2024/2025.

The monthly figures for forensic medicals performed by sexual offence examiners are shown in the graph below.



Paediatric Data.

76 children up to the age of 14 have been seen in Ynys Saff in the past year (40 acute forensic cases and 36 non-acute/ historic cases). This is compared with a total of 54 children the previous year (41 acute). Work has been completed to encourage referrals for non-acute/ historic examinations for children outside the forensic window.

The Paediatric service has undertaken significant changes in the last year with the regional out of hours SARC service being launched in January 2025. There are now 8 out of hours clinicians from across the South Wales region who are contributing to the out of hours rota ensuring that children seen in hours and out of hours under 14 years of age can be offered a medical jointly between a forensic examiner, and an NHS doctor with the relevant competencies in paediatric sexual offence medicine. All doctors on the out of hours rota have dedicated time to attend SARC specific peer review (in person or remote) and have attended the RCPCH CSA examination course. The in hours rota for paediatric staff in Ynys Saff is now fully filled.

Support Services.

The service continues to provide interview facilities for the police. ISVA services continue to be provided by New Pathways. Referral pathways and partnership working has been in place to ensure that clients are appropriately referred and confirmed to be under the care of an ISVA prior to the cases being closed in Ynys Saff.

Counselling

There are no waiting lists for adults or children at present and the child counsellor is seeing adult cases. Due to the loss of the ISVA service for counselling referrals, we have approached Sexual Health to discuss a pathway for clients who do not want ISVA support but require counselling whether acute or historical.

A review will be commissioned into counselling services by the regional programme for a service model paper to be submitted to the WSAS Programme Board, there is a possibility counselling services in the SARC will also change.

Sexual Health

Ynys Saff work closely with the Department of Sexual Health, ensuring all options are offered to the client to meet their health needs. Work has been undertaken this year to ensure clear referral pathways from Ynys Saff across the region with a plan to launch a universal referral form soon to simplify processes.

Children Looked After Team

Children Looked After represent one of the most vulnerable groups of children in modern society. It is well evidenced that these children and young people have adverse health outcomes owing to their early life adversity. Cardiff and Vale UHB have both corporate parenting responsibilities as well as statutory obligations to perform health assessments aimed at identifying unmet health needs, improving health outcomes and reducing health inequalities.

Within 5 working days, the UHB should receive notification from the Local Authority that a child has become looked after. The initial health assessment must be completed within 28 days of the child entering care with review assessments required annually for children over the age of 5 years, and 6-monthly for children under 5 years of age. A small but dedicated team of staff are employed to fulfil these requirements. There are currently 6.68WTE nurses caring for all children looked after over the age of 5 years.

In 2024 the team introduced a pilot scheme whereby 4.2WTE health visitors manage caseloads of children looked after under the age of 5 years. They deliver the Healthy Child Wales Programme and any additionality depending on acuity and the need of the child and family. In addition, the health visitors undertake the review health assessments 6 monthly for this youngest cohort. If a child moves home or placement, they remain with the same health visitor ensuring continuity of care and continued communication is maintained. Cardiff and Vale are the first Health Board in Wales to consider provision in this manner which has had a positive impact on the health assessment compliance and continuity of care. The pilot has been so successful that it has continued to date.

Vacancies remain within the medical team for looked after children, adoption and fostering which is having a significant impact on both children where adoption is being considered as in their best interest for permanency and for adult health assessments in adoption, fostering, kinships ad special guardianship. Since 2019 the number of children referred for adoption to be considered as in their best interest has almost doubled.

There has been a consistent increase in children in care in Cardiff and the Vale of Glamorgan rising from:

2023	1,469
2024	1,578
2025	1,586

Of these 147 children were under adoption regulations and 384 are placed outside of the Cardiff and Vale area. It is clear that whilst the numbers are increasing, the complexity of the cases and difficulties faced by these young people are also rising.

Historically, as a city of sanctuary, Cardiff and Vale UHB have always received unaccompanied asylum-seeking children who fall under the remit of Children Looked After being cared for by the Local Authority. The introduction of the National Transfer Scheme across Wales has resulted in Cardiff and Vale UHB receiving 79 unaccompanied asylum-seeking children. No additional resources have been received to meet this increased demand and some cases are allocated to Cardiff and Vale outside of this scheme also.

In addition to the health needs of the children and young people, the paediatricians are responsible for reviewing the health needs of all adults applying for positions as foster carers, kinship carers and adopters and attending adoption and fostering panels.

Learning Disability

Learning from three Serious Incident reviews in 2015 and a Safeguarding an Adult at Risk case in 2016 highlighted the need for service improvements required for Learning Disability (LD) patients within the UHB. Progress has been made to improve the quality of care provided to patients with LD. This has been achieved through the "1000 Lives" care bundle launch and implementation development of a "flagging" system of immediate alerting across acute areas, modification of NEWS escalation of deteriorating condition response, risk assessment of immediate need and reasonable adjustments required to care. 250 resource files giving staff advice on implementing the care bundle has been obtained and distributed across Adult, Mental Health and Children and Women service areas. In addition, a daily Business Intelligence System (BIS) report gives notification of all in-patients with LD allowing prompt review of this vulnerable group. There is also a weekly report of mortality within LD patients, allowing level 2 mortality reviews to be followed up for more specific learning. Easy read qualitative feedback questionnaires are automatically sent out to patients with LD and also to family and carers after an admission or an outpatient appointment in order to enable learning has been introduced.

The launch in November 2018 of UHB LD Champion Roles, identified staff from all wards and departments to take the lead and raise awareness within their clinical area. Over 300 staff have been trained to date with further training scheduled on a monthly basis.

This will enhance dissemination of available resources and share good practice across the breadth of C&V UHB. An additional Level 3 Safeguarding Themes (Adults) training session incorporates information for practitioners, this event was launched in November 2019. We have worked with Hijinks Drama Company to produce 4 film clip learning from real life situations which challenge staff to appropriately care for patients, with LD. The UHB continues to work in partnership with Swansea Bay Health Board for LD services that are commissioned in community settings. In addition, we now have two UHB Acute Liaison Nurses since June 2020. The posts support all areas with training and advice when individuals with LD are admitted to hospital. The post was identified as a priority within the joint LD commissioning strategy developed for the region. This has been augmented by the introduction of an LD liaison role into the Child Health and Disability Team in 2024/25 to provide an interface between hospital service delivery across the Children's Hospitals and community-based learning disability and nursing teams, including young people who are transition age. They will work closely with the LD liaison nurse for adult learning disability which is funded and scope out the opportunities to develop an all-age approach to liaison nursing between the hospitals and community services. The priorities also include the progression of LD primary care liaison targeted at raising awareness and training on management of individuals and to improve the uptake of an annual health check. An action plan to progress work in this area is in place, both Cardiff and Vale of Glamorgan Local Authorities as well as the UHB are committed to this workstream. In 2024 mandatory E-learning module Paul Ridd Learning disability awareness was introduced, with UHB compliance reported in December 2024 as 71%.

Updates include:

- Scoping work with identified GP practices to consider ways to improve access to GP health checks for people with a learning disability across the region has been undertaken as well as working with partners to improve data on individuals with an LD with a view to upscaling across all clusters based on evaluation of the pilot areas. The approach will need to be community focussed, place based, scalable and ensure people with lived experience are involved in design.
- Resources have been secured to deliver training that supports Specialist LD staff in work that involves the court of protection. This will cover the formal elements of CoP work in relation to restrictions placed upon individuals in community settings, statement/report writing, and also practical elements such as attending court, presenting at court and BI decision making. The intention is to ensure staff are confident and supported in articulating least restrictive options for individuals and delivering best outcomes.
- The UHB has signed up to the Paul Ridd Foundation training to be mandatory for all UHB staff.
- The UHB has been successful in establishing a process to upload Health Profiles of individuals with a learning disability into the allergies/alert section

Cardiff and Vale UHB Youth Board

C&V UHB, Children & Women Clinical Board have a well-established Children and Young People's Health Board. There are currently 65 young people aged from 14 – 20 years participating in UHB work, the children and young people are recruited through the UHB Volunteering Department which provides a Governance Framework and induction training for all participants. The purpose of the Youth Board is to fulfil the national recommendations of the Children's Commissioner for Wales to embed a UNCRC Children's Rights approach within all health services across Wales. The Youth Board provide consultation and engages in meaningful participation to develop, improve and evaluate health services across Cardiff and Vale region and beyond in the rest of Wales. Cardiff and Vale UHB is only the second Health Board in Wales to have their own Youth Board and continues to excel in the differences it influences for all children and young people. The Youth Board has been highly commended by the Children's Commissioner for Wales and is described as an exemplar of excellence, being used regularly as an example of best practice in the Children's Commissioners national reports.

Youth Board actions / ideas/ influence has resulted in:

1. The Emotional Wellbeing Website for parents / carers and children and young people. This was designed by the children and young people from concept to launch and continues to be populated by them. There are ongoing improvements and changes required to continue to improve the content and market the website.
2. The Hangout: Six years ago, when the Youth Board began, the children and young people asked for a place for immediate mental health support, somewhere accessible, not looking too clinical and which welcomes their individuality. 'The Hangout' opened in 2023 and was launched by members of the Youth Board (old and new) and the Children's Commissioner for Wales. The children and young people have many ideas about mental health services and support, from prevention, early intervention to crisis support. The success of The Hangout, primarily from listening to what children and young people want and need is evident as they are now opening a new venue in Barry to meet demands on the service. The success comes directly from hearing what is needed from those who use the service, which then impacts positively on financial and treatment success. This was highlighted as an excellent example of direct impact by the Royal College of Nursing in Wales gaining the Youth Board further celebration across National forums. (Impact matters in health care | Royal College of Nursing (rcn.org.uk))
3. Immunization consultations with Public Health Wales, HEIW and School Nursing teams from all across Wales, has resulted in new and innovative ideas on how to educate and reach children and parents with accurate and evidence- based information on vaccination. The Youth Board continues to be a big part of this work which has the potential to save young lives and reduce incidences of disease.

Future work includes close partnerships with the Noah's Ark ambassadors to embed the real lived experience of children accessing health services, decisions and change. More children and young people who experience complex or long-term care will hopefully join the Youth Board team in the future.

Safeguarding Team Achievements

- Launch of Group 3 multi-agency VAWDASV training
- Launch and implementation of Level 3 safeguarding training for Band >6 and F1> staff
- Implementation and completion of actions from the Joint Inspection of Child Protection Arrangements (JICPA) 2024
- Introduction of Health Lead Practitioners from Clinical Boards (HLPs) presenting at Level 3 safeguarding training, sharing experiences of the work they undertake in clinical areas
- Participation by the VPT in research undertaken by Cardiff and John Moore's University
- Wales Violence Prevention Team award presented to the Cardiff and Swansea based teams at the Safer Communities Award for Safeguarding November 2024
- Participate with the Simon Moore, Cardiff University research on dermatology and bruising

Emerging Safeguarding Themes for 2025/2026 requiring additional awareness raising:

- Child Sexual Abuse: complete RSB work to identify champions in each organisation
- Patient de-conditioning when in hospital
- Self-Neglect

Forecast 2025-2026

Continuing with the achievements made, sustaining and maintaining the safeguarding agenda workload is challenging for the UHB safeguarding team. This is an area that continues to evolve with emerging themes such the overarching Contextual Exploitation, Non-Fatal Strangulation and Self Neglect. Ensuring that the UHB staff are prepared and aware of their professional duty to report, through providing specific training has been considered and discussed with all appropriate clinical areas. Additional training resources from within the team will be required through 2025-26 and onwards to provide Group 2 Domestic Abuse Training and Level 3 training across the UHB, in line with WG expectation of 85% compliance. The safeguarding team has proved that it is an innovative team that demonstrates the ability to adapt to contemporary situations. Ensuring that staff resources are available to cover three sites is often demanding, particularly considering the amount of work generated within Cardiff MASH, the multi-agency commitments to the RSB and Public Health Wales Safeguarding Service workplan. The team will strive to resume the energy demonstrated to address the safeguarding agenda and ensure that staff and the public are safeguarded appropriately by the UHB. However, the UHB may need to consider if additional resources are required to bolster the safeguarding team to achieve the ambitious actions for the coming year. Further work during 2025-2026 will include:

Action	Service Delivery
Introduce a robust safeguarding supervision report	Corporate Safeguarding Team
Complete an audit evaluation of safeguarding training	Corporate Safeguarding Team
Introduce Cardiff Children's Service Family Advice, Support, Prevention Hub arrangements across the UHB	Corporate Safeguarding Team & Clinical Boards
Develop a pathway for identifying Congenital Dermal Melanocytosis (CDM) markings in children	Corporate Safeguarding Team & Children & Women Clinical Boards
Share the CDM pathway at a NHS Wales Safeguarding Network meeting	Corporate Safeguarding Team & Children & Women Clinical Boards
Incorporate a monthly NHS Wales Routine Enquiry Audit on AmaT for Midwives, Health Visitors, Neonatal and Mental Health Services	Corporate Safeguarding Team, Children & Women and Mental Health Clinical Boards
Collate a quarterly safeguarding report for the NHS Executive	Head of Safeguarding
Raise awareness of the Serious Violence Duty (2024) across the UHB	Corporate Safeguarding Team & Clinical Boards
Ensure that the Updated Regional VAWDASV strategic Plan 2024 is shared across the UHB and a copy is available on the safeguarding webpage	Corporate Safeguarding Team & Clinical Boards
Implement the Wales Single Unified Safeguarding Review (SUSR) process within the UHB	Corporate Safeguarding Team & Clinical Boards
Incorporate the Intercollegiate Document (ICD) 2024 into the UHB training strategy	Corporate Safeguarding Team
Group 6 VAWDASV training to be presented to Executive Board Members annually	Head of Safeguarding
Develop a Midwifery Safeguarding Newsletter	Corporate Safeguarding Team & Midwifery
Develop a Court of Protection Procedure Guidance for staff use	Mental Capacity Team

Action	Service Delivery
Participate in a multi-agency Offensive Weapon Homicide	Corporate Safeguarding Team
Audit the safeguarding professional advice line logs	Corporate Safeguarding Team
Audit safeguarding training evaluation for Level 3, Group 2 & Group 3 VAWDASV training	Corporate Safeguarding Team and Children & Women Clinical Board
Develop a UHB Level 3 "Self Neglect" Study Day	Corporate Safeguarding Team & Mental Capacity Team
Develop a L3 "What Happens Next" paediatric Study Day	Corporate Safeguarding Team and Paediatrician
Develop a PREVENT Level 3 Study Day	Corporate Safeguarding Team
Develop PREVENT slides to be incorporated into all L3 training to raise awareness	Corporate Safeguarding Team
Develop a robust Mental Capacity Assessment proforma	Mental Capacity Team
Implement the Wales digital MARF/AS1 when prepared by the Wales Safeguarding Board	Corporate Safeguarding Team
Implement the corporate safeguarding teamwork plan prioritising safeguarding training and supervision across the organisation.	Corporate Safeguarding Team
Incorporate updates to the Wales Safeguarding Procedures (2019) as they are released	Corporate Safeguarding Team & Clinical Boards
Complete an organisational self-assessment for the Regional Safeguarding Board on safeguarding arrangements, to provide scrutiny and assurance	Corporate Safeguarding Team
Participate in NHS Executive Health Delivery Group workplan	Executive Corporate Safeguarding Team, Patient Safety Team and Corporate Nursing Digital Team
Review the progression of the newly adapted approach to Mortality & Morbidity reviews incorporating Neonatal cases. To be undertaken by assurance provided to the Safeguarding Steering Group	Corporate Safeguarding Team and Children & Women Clinical Board
Consider findings from a Medical Student audit of CSERQ completion and submission forms	Corporate Safeguarding Team
Incorporate the Alcohol Screening Team within the Safeguarding Hub in Emergency Unit	Corporate Safeguarding Team
Complete RSB work to identify champions in each organisation	Corporate Safeguarding Team and C&V RSB
Raise awareness of patient de-conditioning whilst in hospital and the "Duty to Report" when concerns are identified	Corporate Safeguarding Team and Clinical Boards
Ensure that Self-Neglect in all its forms in relation to children and adults, is recognised across the UHB and appropriate action is taken when required	Corporate Safeguarding Team, MCA team and Clinical Boards
Prepare a Business Case to substantiate the Violence Prevention Team posts, Health IDVA posts and the Young Person IDVA post.	Executive Corporate Nursing Team and Head of Safeguarding

Action	Service Delivery
Prepare a business case to consider the Corporate Team structure and consider an increase in resource and capacity in alignment with the safeguarding landscape	Executive Corporate Nursing Team and Head of Safeguarding
Young Persons Health IDVA to complete Child Sexual Abuse training organised by the Regional Safeguarding Board	Corporate Safeguarding Team
Violence Prevention Team and Young Persons Health IDVA to develop a Sexual Health information leaflet for Emergency Department.	Corporate Safeguarding Team
Poster Presentation to be completed by Violence Prevention Team, Young Persons Health IDVA and Sexual Assault Referral Centre for the Regional Safeguarding Board Safeguarding Week, November 2025	Corporate Safeguarding Team and SARC
Provide assurance through the Regional Safeguarding Board to respond to the CIW Child Protection Rapid Response – Improvement Plan	Corporate Safeguarding Team and Children & Woen Clinical Board

Summary

The National and International safeguarding landscape has broadened and continues to do so rapidly, new emerging themes or additional public protection trends are updated in Acts of Law. We have seen the introduction of two significant Acts of law in Wales the impact on the safeguarding work stream across the UHB, requiring significant changes in process, additional training, supervision as well as relocation of existing resources. Further legislation from the Home Office has also defined the need to raise awareness of Domestic Homicide and FGM. The Modern Slavery Act (2015) is another area whereby the safeguarding team to work with partner agencies to raise staff and public awareness. Emerging Acts and other legislation require significant resources to ensure that Cardiff and Vale University Board is aware and compliant with the duty obligations. Substantial potential risks may be identified should safeguarding training, safeguarding supervision, professional advice and support line, good multi-agency partnership working and immediate safeguarding for individual support to survivors of violent crime, is not in place and accessible to members of the public and employees within the Health Board.

During the time period of this report the NHS has experienced significant issues in recruitment and retention of staff across all areas. The use of agency and bank staff has been widespread across clinical areas. This has identified learning around staff mandatory training and increased professional concerns due to care provided to patients. This has been addressed appropriately at the time however, the increase in advice and management of safeguarding cases has impacted on the UHB Safeguarding Team. The team workplan reflects how we are able to map targeted training and supervision of staff. Through staff surveys and audit of the team service delivery we aim to provide a good quality safeguarding service within the UHB. However, the UHB will need to consider how the corporate safeguarding team are able to achieve the growing demands of an increasing workload and the ability to achieve effective results given the forecast of areas that are needing to be addressed.

The Cardiff and Vale University Health Board Safeguarding Team will strive to continue to meet all of the demands set by the UHB and Welsh Government to ensure the safety and safeguarding of children and adults at risk that become known to us. This will only be achieved by continuing to work collaboratively with our strategic partners and internally within the UHB through the Executive Teams and Clinical Boards; ensuring that communication and decision making is embedded in open, honest and transparent practice.

Acknowledgement is given to all UHB professionals who contributed to this report.