ICHT Executive Management Board
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Safeguarding Annual Report 2024/25

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Purpose of report (for decision, discussion or noting)

Purpose: Assurance

Report history

Trust Safeguarding Committee 17/06/2025	EMB – Quality 16/06/2025

Executive summary and key messages

This report provides a comprehensive overview of safeguarding activities at Imperial College Healthcare NHS Trust during 2024/25. The Safeguarding Team continues to meet statutory duties outlined in Section 11 of the Children Act 2004 and the Care Act 2014, with all safeguarding policies up to date. There has been a notable increase in referrals across the safeguarding agenda, indicating improved risk recognition and engagement from frontline staff.

Achievements include the implementation of new pathways for patients with learning disabilities and autism (LD/A), launch of the ICON Cope initiative, and strong multi-agency collaboration on safeguarding reviews and audits. The Trust has met compliance targets for mandatory safeguarding training in most categories, though work is underway to improve compliance at Level 3 Adults and expand the Oliver McGowan training.

The report highlights pressures faced by the safeguarding team due to increased activity and complexity, and notes areas for development including embedding Reasonable Adjustment Digital Flags into Cerner, enhancing safeguarding supervision for adults, and ensuring sustainable IDVA support across sites.

The Trust remains engaged in numerous local and national safeguarding forums, audits, and reviews, demonstrating commitment to ongoing improvement. The safeguarding annual plan

was achieved, with positive audit feedback and staff reporting that they feel supported in managing safeguarding concerns. A full review of the safeguarding staffing, service and training provision is planned for 2025/26 to ensure sustained delivery and assurance.

This report reflects the commitment and professionalism of both the safeguarding team and wider Trust staff in protecting children, young people, and vulnerable adults.

Imperial College Healthcare NHS Trust

Safeguarding Annual Report
2024/25

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1. Foreword

The Imperial College Healthcare NHS Trust (ICHT) recognises that effective, timely and robust safeguarding is fundamental to protecting those at risk in our care and that this requires constant vigilance and a readiness to act where we suspect abuse, exploitation or neglect. The landscape of safeguarding is constantly evolving and as a Trust we endeavour to embrace and shape our key priorities in support of this. ICHT is an organisation with a vital role to fulfil in protecting the vulnerable whilst demonstrating a concerted obligation to respond with haste and flexibility to meet new demands as they arise. Above all, we are dedicated to ensuring that we listen to the voices of the vulnerable and act upon what we hear. Safeguarding is everyone's business.

> "*Safeguarding helps all children and adults who are at risk of abuse. It protects children from harm and neglect and provides them with the best chance of developing into happy, well-adjusted and successful adults. It brings kindness, respect, dignity and support to vulnerable adults, however challenging their lives may be, and protects them from harm. It falls to all of us in the NHS to give our best efforts to these endeavours.*" Ref: Dr Peter Green, Chair, National Network of Designated Health Professionals and Designated Doctor for Child Safeguarding, NHS Wandsworth

2. Introduction

This Annual Report highlights the work undertaken by Imperial College Healthcare NHS Trust (ICHT) in respect to its commitment and responsibilities in maintaining the safety and protection of those at risk of abuse and neglect. The report pertains to adult, children and maternity functions as well as Learning Disability and Autism services.

The statutory duties and Trust legislative responsibilities for safeguarding children are set out in the Children Act 1989 and 2004 and Working Together to Safeguard Children 2023, furthermore for Safeguarding Adults at risk, the Care Act 2014. Effective safeguarding and promotion of the welfare of children, young people and adults relies upon joint working and constructive relationships that are conducive to robust multi - agency partnership working. This can only be effective when all staff are knowledgeable, confident and equipped with the skills to deal with process and procedures when concerns arise relating to patient safety.

The annual report covers the period of April 2024 to March 2025 and will provide assurance to the Board by detailing priorities and activity, highlighting areas requiring focus and development and to inform of the intervention and change that has been made to strengthen the safeguarding processes within ICHT. Safeguarding has a high emphasis on a competent well-established workforce; up to date policies and procedures, robust governance arrangements and collaborative practices. This report details how this has been achieved in 2024/25.

3. Key Legislation

Children and Social Work Act 2017
Counter Terrorism and Security Act 2015
Serious Crime Act 2015 Care Act 2014

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

National Guidance

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

4. Definitions

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

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

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

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

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

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

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

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

5. Governance

The ICHT Chief Nurse is the executive lead responsible for ensuring that the Trust complies with its statutory duty for safeguarding. The safeguarding team is led by the corporate director of nursing and the consultant nurse for safeguarding.

The team as illustrated below work together to provide a family-based service across the Trust and in partnership with external agencies to ensure safeguarding legislative, statutory and regulatory obligations are stringently met.

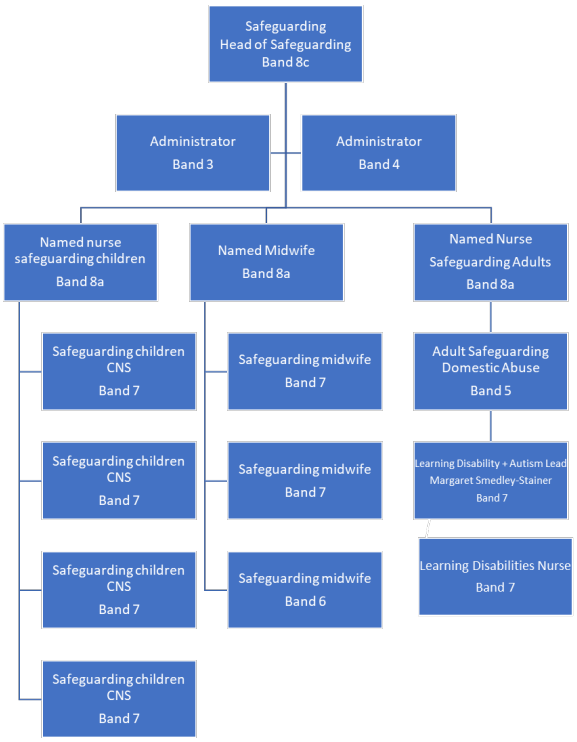

Figure 1. Structure chart

The Safeguarding Team aim to ensure that all children and adults are effectively protected when using services provided by ICHT and that processes are robust for the early detection of abuse and neglect and the corresponding referral procedures. Working Together (2023) highlights that staff working within the Trust:

- Understand risk factors and recognise children and adults in need of support and/or safeguarding.
- Recognise the needs of parents who may need extra support in meeting the needs of their children and know where to refer for help.
- Recognise the risks of abuse or neglect.
- Communicate effectively with children and adults and stay focused on the child and/or adult's safety and welfare.
- Liaise closely with other agencies including other health professionals and share information as appropriate.

The Safeguarding Team:

- Provide advice, support and guidance to members of staff regarding safeguarding children matters.
- Ensure relevant policies and procedures are in place to support all staff.
- Provide supervision to staff to support areas of challenging work ensuring the focus of work remains on the safety and wellbeing of the child and / or adult concerned.
- Provide training and education for all staff to support them with their safeguarding work.
- Support staff in the production of statements to court or attendance at court for matters relating to safeguarding children.
- Undertake a program of audit to provide assurance.
- Work closely with key stakeholders and other agencies to safeguard children.
- Supporting the Trust in governance arrangements.
- Disseminating good practice and learning outcomes across the organisation.
- Liaising with other agencies as a point of contact for safeguarding issues.
- Maintaining regular attendance at the partnership board meetings and subgroups.

5.1. Internal reporting and assurance

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

The Safeguarding also provide quarterly assurance to the following committees.

Figure 2. Reporting Structure

5.2. External reporting and assurance

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

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

Figure 3. Safeguarding Health Outcomes Framework (SHOF Standards)

5.3. Risk Register review

The Risk Register supports safe, effective and robust management of risks pertaining to safeguarding of children, young people and adults. The identification of safeguarding risks is fundamental to providing assurance of continued improvement and mitigation of risk.

The Trust continues to refine its approach to capturing emerging safeguarding concerns and escalating these for executive-level visibility.

6. Safeguarding Activity

6.1. Children Safeguarding Activity and Performance

Safeguarding children activity is monitored across 6 areas:

- Referrals to children social care
- Safeguarding Liaison
- Serious youth violence and trauma attendances
- Maternity cases
- Child protection medicals
- Child protection Information System (CP-IS)

6.1.1. Referrals to Children Social Care

Safeguarding referrals for children have increased by 31% during 2024/25 (Fig 4) with a total of 2867 referrals, averaging 239/month – last year that figure was 165/month.
The most common themes are neglect of children; frequent attendance to unscheduled care, exploitation of children; assaults on children; effects of domestic abuse; alcohol/drug use in families (especially in pregnancy) and criminality in one or both parents to be.
Children requiring mental health admissions remained consistent, two Deprivation of Liberty were granted for under 18s (one on the paediatric ward and one in unscheduled care).

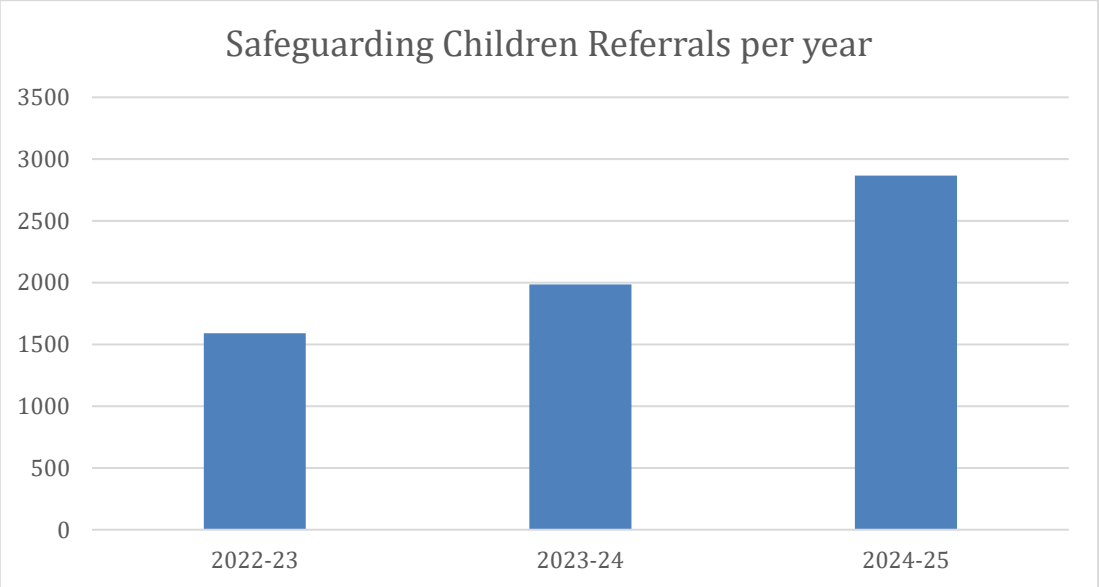

Figure 4. Safeguarding referrals – children for 2022-25

6.1.2. Safeguarding liaison

The safeguarding liaison function ensures that all unscheduled care attendances for children and young people are reviewed for potential safeguarding concerns and that relevant information is shared with community partners. In 2024/25, there was a 13% increase in unscheduled care attendances for under-18s (n=38,189), including 235 trauma cases — an 18% rise from the previous year.

All attendances are reviewed by the safeguarding team to identify concerns and ensure appropriate follow-up. Liaison with school nurses, health visitors, and other community services supports the sharing of proportionate safeguarding information and the review of relevant health plans, such as those for asthma, diabetes, or other long-term conditions.

6.1.3. Serious Youth Violence and Trauma cases

As North West London Trauma centre we receive 2,614, 9% of trauma victims are under 18 (n=235 children and total n=2,614) and include those involved in serious youth violence (stabbings, machete attacks and shootings) as well as road traffic incidents and other trauma events e.g. house fires etc., any trauma in a family setting can have a negative effect on children in that family/household.

This is why all trauma attendances are reviewed by the safeguarding team. An additional 2,379 adult trauma cases were reviewed during the year (Fig 5). The increase of older siblings and (mainly) fathers who are involved in gang violence and violence related injuries or substance misuse related injuries seen last year has continued, there has been an increase of gang related parents to be this year. In all cases there has been liaison with relevant external agencies. Trauma case, recognised as serious youth violence or where family members are involved with gangs will result in a strategy meeting with social care and the police.

The safeguarding team works with the charity Redthread to tackle the causes of youth violence and gang-related crime through education and teaching with first-aid advice and support to the young victims of the violence. However, an increase in exploited children—especially those with Attention Deficit Hyperactivity Disorder (ADHD) and autism—has been noted. This has been raised with the ICB designated nurses and is being considered across the NWL sector. ICHT ensure this is always discussed in any relevant meetings around the child and support enabled for the child and family. The children are also reviewed by the LD/A team if they are inpatients or in unscheduled care.

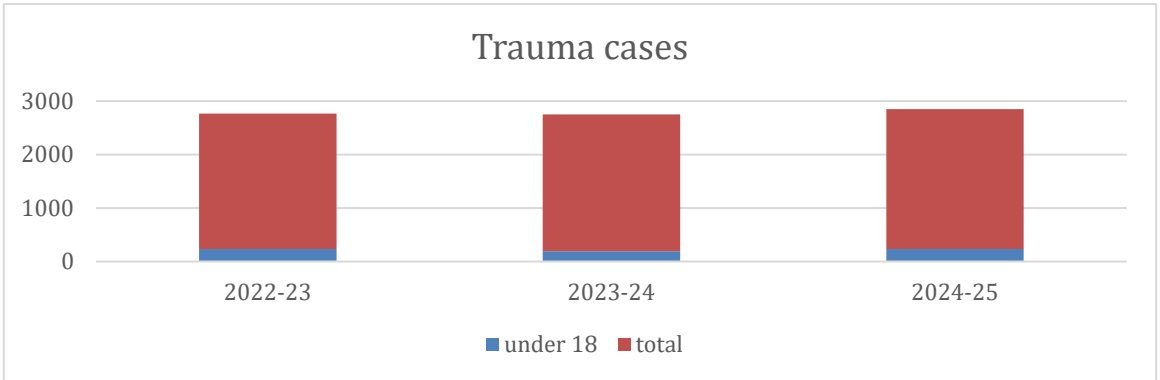

Figure 5. Trauma cases 2022-2025

6.1.4. Safeguarding Maternity

Maternity services recorded 10,771 pregnancy bookings during the reporting period, consistent with the previous year. Of these, 14% (n=1,508) were identified as having Tier 3 vulnerability (as defined in Appendix 1) at some point during their pregnancy. While the proportion remains stable year-on-year, there is a notable increase in the complexity of cases being managed.

The most common themes included delayed access to antenatal care; safeguarding concerns such as domestic abuse and criminal exploitation; significant mental health needs; gang affiliations involving either parent; substance misuse; and challenges faced by young and unsupported mothers.

In this reporting period, 14 infants were removed at birth, which is consistent with the previous year. Vulnerable mothers received individualised safeguarding support and were discharged either to their homes with appropriate wraparound care or to specialist placements, including mother and baby units or supported foster placements. Where infants were removed, the safeguarding team provided trauma-informed care and emotional support, offering keepsakes such as photographs, footprints or a lock of hair, according to the mother's wishes.

A small number of delayed discharges occurred due to unresolved social care needs. In these instances, mothers and infants remained on the maternity ward until suitable discharge arrangements could be secured.

6.1.5. Child Protection Medicals

A child protection (CP) medical is a comprehensive assessment of a child's physical and developmental health, undertaken when there are concerns about potential or actual abuse (RCPCH, 2020).

During the reporting period, 55 CP medicals were undertaken at the Trust, a figure consistent with previous years. These assessments support safeguarding investigations and are being increasingly aligned with RCPCH standards. Where gaps in practice have been identified, appropriate mitigations are in place. For example, while the standard requires medical photography, this is currently undertaken by the police until full compliance can be achieved.

The majority of CP medicals are completed within 48 hours of referral; however, delays do occasionally occur due to external factors such as parental refusal. From 2025, this will be addressed through the introduction of the Alertive application, which aims to streamline notification and escalation processes.

Demographic analysis of this year's cases shows a predominance of male children, with an average age of 7–8 years. In approximately half of the cases, learning disability or ADHD is suspected. Most cases involved identified perpetrators, usually parents, and many included evidence of domestic abuse within the family. Physical and emotional abuse were the most frequently recorded categories of harm. Where needs are identified, follow-up care and referrals are arranged or recommended to the child's social worker and GP, including support from services such as CAMHS and community dentistry.

Work is ongoing to standardise the CP medical process across the three West London Children's Hospital (WLCH) sites. This includes the introduction of fixed clinic slots for CP medicals, harmonisation of referral documentation, and the development of family information leaflets with feedback mechanisms. Further practice reviews and collaborative exploration are planned to ensure consistency with best practice and to support shared learning across the service.

6.1.6. Child Protection Information System (CP-IS)

During 2024/25, the Trust continued to implement the Child Protection - Information Sharing (CP-IS) system across all relevant unscheduled care settings, including emergency departments, minor injury units, and maternity services such as triage and labour wards. This secure digital system enables clinicians to access real-time safeguarding information about children and unborn babies who are subject to a child protection plan or in care, supporting timely and appropriate decision-making at the point of contact.

CP-IS remains fully embedded within frontline practice and has contributed to more effective coordination between health professionals and children's social care teams across the year.

In preparation for national developments, the Trust is undertaking the necessary work to support Phase 2 of CP-IS, which will extend access to scheduled care settings including CAMHS, community paediatrics, and 0–19 services, with implementation expected by October 2025.

6.2. Adult Safeguarding Activity and Performance

Safeguarding activity for adults is monitored across five areas:

- Referrals to adult social care
- Section 42 enquires under the Care Act 2014
- Deprivation of Liberty Safeguards (DoLS) applications
- Advocacy
- Court of protection involvement

6.2.1 Safeguarding referrals to adult social care

In 2024/25, there were 2,547 safeguarding adult referrals made to local authority adult social care teams. This represents a 57% increase from the previous year (n=1,492), equating to an average of 212 referrals per month, compared to 91/month in 2023/24 (see Figure 6).

The increase in referrals reflects the growing complexity of adult safeguarding cases, which often involve multiple concerns within a single case. It also demonstrates the positive impact of safeguarding training and supervision, which have strengthened staff awareness and responsiveness.

The most common referral themes included financial abuse, physical abuse, neglect, and self-neglect. The safeguarding team continues to provide support and advice to clinical teams, particularly in complex cases. Through supervision and training, staff are also encouraged to recognise less visible forms of harm, such as discriminatory abuse, domestic abuse, modern slavery, and harmful practices—noting that many adults may be unaware they are experiencing abuse or exploitation.

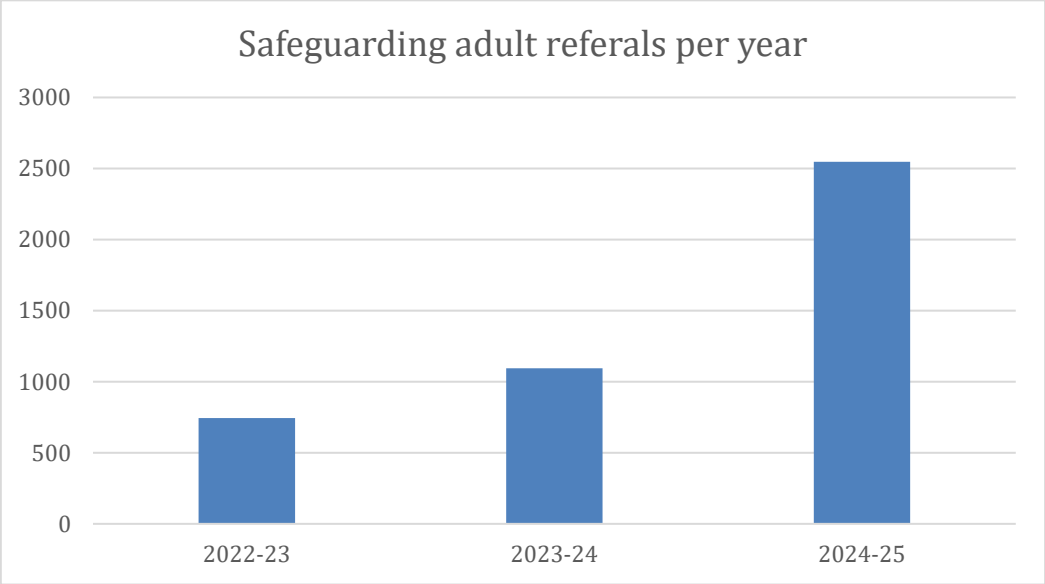

Figure 6. Safeguarding adult referrals

6.2.2 Section 42 enquiries

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

In 2024/25, the Trust received 105 Section 42 enquiries, more than doubling the number received in the previous year (n=48). These enquiries related to a range of safeguarding concerns, with the majority focusing on organisational abuse or omission of care.

Of the enquiries received, 3% specifically involved Imperial College Healthcare NHS Trust. In all cases, the Trust had already completed appropriate investigations as part of local learning reviews or serious incident processes. These findings were shared with the local authority, and the enquiries were subsequently closed. Where required, the Duty of Candour was upheld, and patients or families were informed in line with Trust policy.

6.2.3 Deprivation of Liberty Standards (DoLS)

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

In 2024/25, a total of 153 DoLS applications were submitted, representing a 49% increase compared to 103 applications in 2023/24. This rise is attributed to improved staff awareness and confidence following enhanced safeguarding training across the Trust. A quarterly breakdown of applications is shown in Figure 7: Q1 (n=29), Q2 (n=47), Q3 (n=29), and Q4 (n=48).

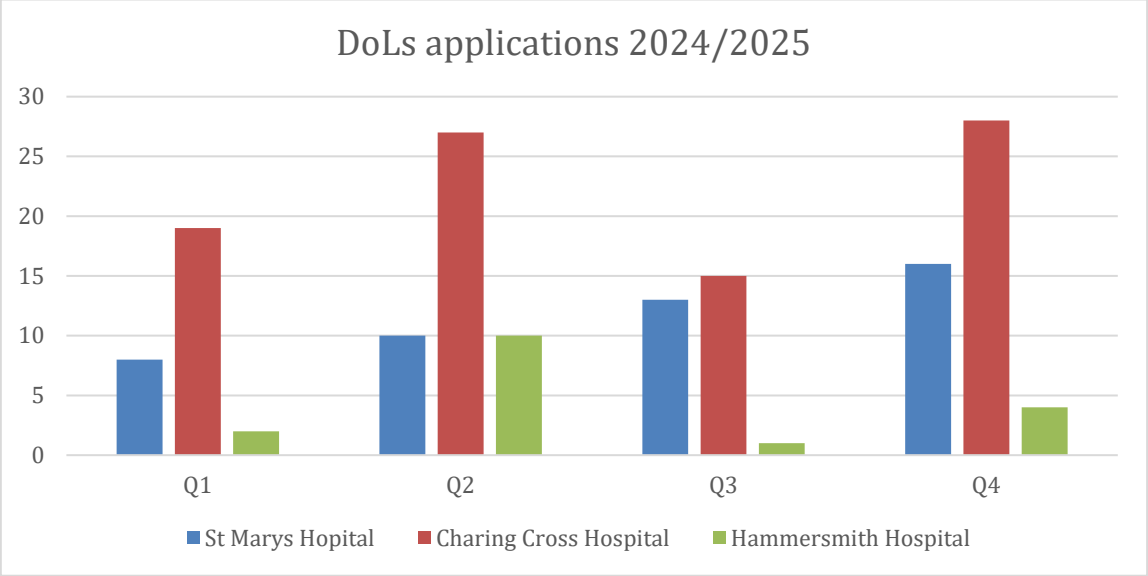

Figure 7. DoLS applications via quarters and via sites.

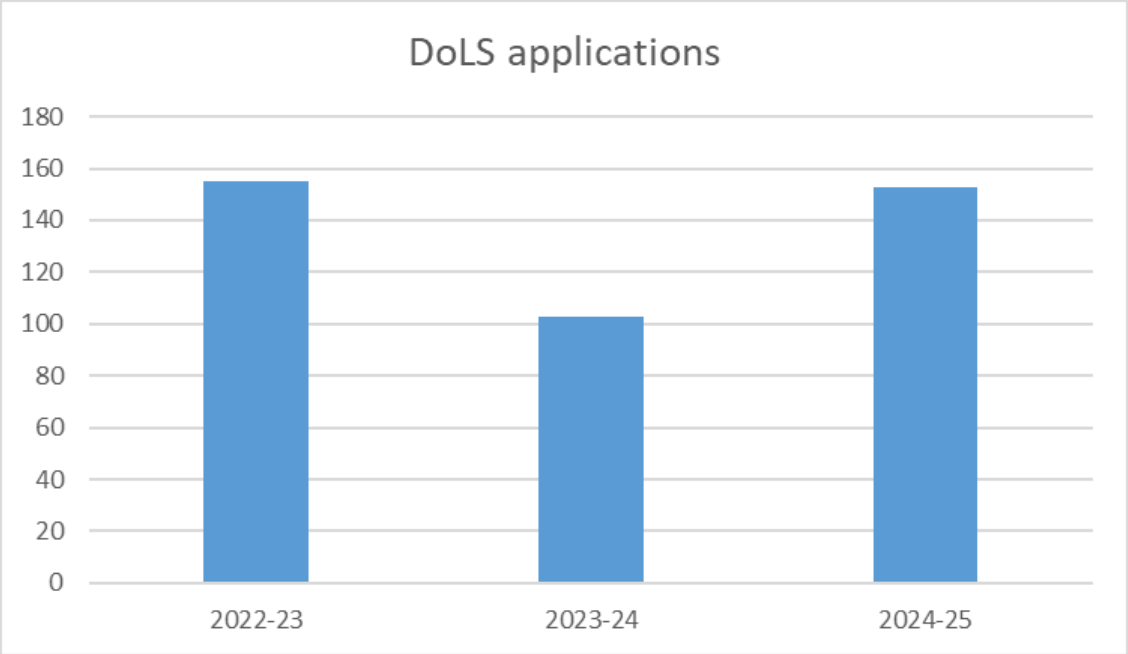

Figure 8. DoLS applications

Of the 153 applications, 11 were granted a standard authorisation by the local authority, an increase on previous years. In all cases, an urgent DoLS authorisation was applied for and granted, enabling the Trust to lawfully deprive a patient of their liberty for up to seven days (or until discharge or local authority decision).

Although Liberty Protection Safeguards (LPS) are expected to replace DoLS in future, no national implementation date was confirmed during the reporting period. The Trust will continue to monitor national developments and begin preparatory work as appropriate to ensure readiness when LPS is introduced.

6.2.4 Advocacy

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

During 2024/25, an IMCA from the Libra Partnership was available one day per week at the Charing Cross Hospital site. Their contribution has been positively received by both patients and staff, and feedback indicates that their involvement is making a meaningful difference to patient care. Options are currently being explored to expand IMCA access to the St Mary's Hospital site.

While commissioning responsibility for IMCAs lies with the local authority, ensuring consistent and timely access across all Trust sites will be a focus for review and improvement in 2025/26.

6.2.5 Court of Protection

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

No applications to the Court of Protection were made by the Trust during 2024/25, which is consistent with previous years. However, legal advice is frequently sought in complex cases where CoP involvement is considered. Such cases are jointly reviewed by the safeguarding and legal teams to ensure that decisions are made lawfully and in the best interests of the individual.

7. Domestic Abuse

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

In 2024/25, the Trust recorded 556 cases involving domestic abuse a 28% decrease (n=159) compared to the previous year (see Figure 9). These cases included disclosures by patients and staff, and referrals to support services such as domestic abuse charities, Independent Domestic Violence Advisors (IDVAs), and Multi-Agency Risk Assessment Conferences (MARACs).

While the Trust continues to promote routine and selective enquiry around domestic abuse, the reduction in referrals is noted with concern and will be explored further in 2025/26. Although IDVAs have been co-located at times within emergency departments and sexual health services, provision has been limited, with restricted on-site availability, no evening or weekend cover. This may limit access to immediate support for those presenting out of hours, particularly in high-risk settings.

The Trust maintains two policies to support both patients and staff affected by domestic abuse. These are supported by safeguarding training, supervision, and referral pathways. However, further work will take place in 2025/26 to evaluate current IDVA provision, understand the reasons

behind the reduction in referrals, and ensure that support for those experiencing domestic abuse is robust, responsive, and equitable across all services.

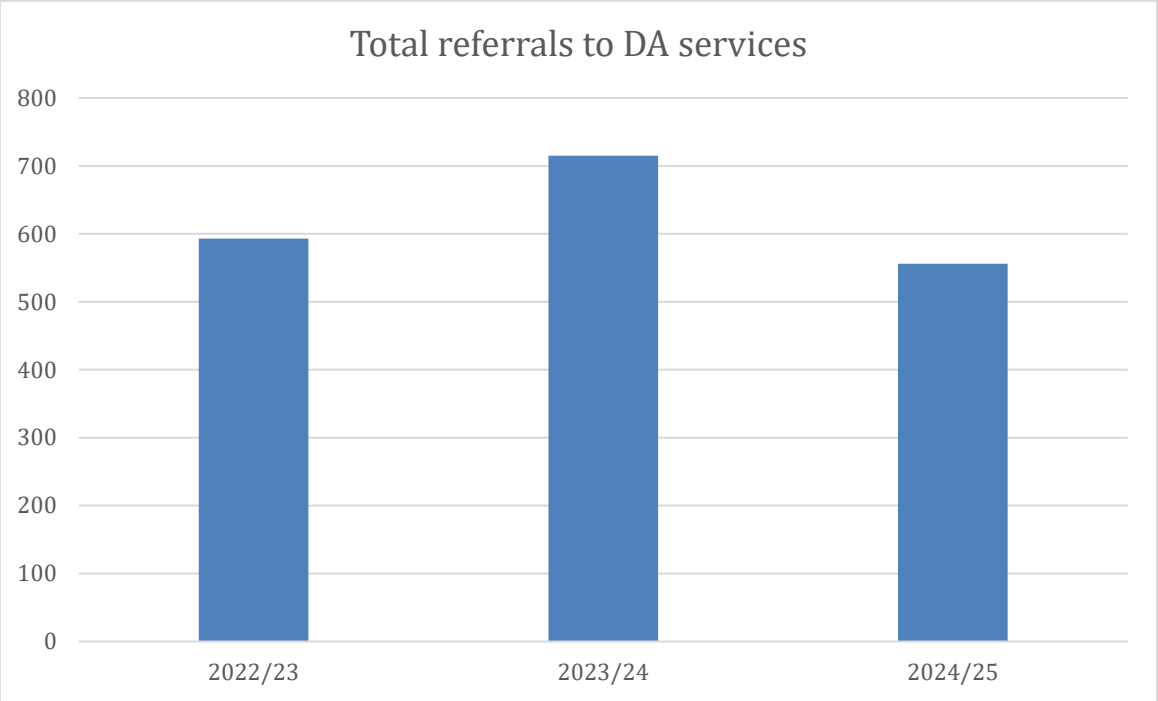

Figure 9. Referrals to Domestic Abuse Services

The Trust's safeguarding team contributes to Multi-Agency Risk Assessment Conferences (MARACs) across the five boroughs it serves. MARACs are held to safeguard victims aged 16 and over who are experiencing high-risk domestic abuse. These meetings bring together a range of agencies—including police, health, social care, and housing—to share information and develop coordinated action plans to reduce risk and protect those affected. MARACs also consider the needs of any children or vulnerable adults, as well as strategies to address the behaviour of the perpetrator.

While the safeguarding team supports this process, current engagement is constrained by available capacity across a large geographical footprint. At present, there is limited visibility of the volume of MARAC referrals, attendance, and contributions made by the Trust. This will be a priority area for review in 2025/26, with plans to strengthen oversight, clarify internal processes, and enhance the Trust's role in supporting high-risk domestic abuse cases through more consistent and informed MARAC participation.

To support long-term improvements in the response to domestic abuse, the Trust worked in partnership to submit two funding bids during 2024/25—one to the National Lottery and one to the North West London Inequalities Transformation Fund. These bids reflected a recognised need to strengthen provision, particularly in relation to early intervention, access to advocacy, and support for those affected by high-risk domestic abuse.

Although both bids were ultimately unsuccessful due to high levels of demand, feedback received was positive and will be used to inform future submissions. The process has reinforced the Trust's commitment to addressing domestic abuse as a strategic priority, and further funding opportunities will be actively pursued in 2025/26.

8. Sexual Safety Charter

The Trust is committed to the NHS Sexual Safety Charter, which sets out a zero-tolerance approach to all unwanted, inappropriate, or harmful sexual behaviours in the workplace. This work is led by the People and Organisational Development team, with safeguarding input as required.

In response to the Worker Protection Act, which came into effect on 16 October 2024, a task and finish group was convened to review the Trust's position against the national assurance framework. As part of this work, an e-learning package has been launched on the LEARN platform and is now incorporated into all safeguarding training.

The safeguarding team also participates in urgent decision-making panels where allegations of sexual misconduct are raised, contributing to timely and informed risk management.

9. Modern Slavery Exploitation and Harmful Practices

9.1. Modern Slavery Exploitation (MSE)

Modern slavery and exploitation remain serious safeguarding concerns, particularly for vulnerable individuals who may not initially be recognised as victims. During 2024/25, the Trust received 85 safeguarding referrals related to Modern Slavery Exploitation (MSE), a figure consistent with previous years. A significant number of these cases involved county lines activity, where young people are coerced or forced into drug trafficking across regional borders.

The Trust has a Modern Slavery and Human Trafficking Policy which guides staff in identifying concerns and taking appropriate action. The safeguarding team continues to advise clinical staff on how and when to escalate cases, including referral into the National Referral Mechanism (NRM).

The Trust's Consultant Nurse and Named Nurse for Safeguarding Children are panel members on local NRM decision-making meetings, where it is determined whether an individual under 18 should be formally recognised as a victim of exploitation and referred to the Home Office. This ensures that young people are treated as victims, not perpetrators, and receive appropriate support and protection.

9.2. Harmful Practices

During the reporting year, the Trust also recorded 75 safeguarding cases under the category of Harmful Practices, which includes concerns such as forced marriage, so-called honour-based violence, and Female Genital Mutilation (FGM).

ICHT remains an active member of the local Harmful Practices Operational Group, contributing anonymised data to support planning and delivery of appropriate community services. Additionally, 897 women were coded as having had FGM, a figure consistent with previous years.

The Trust continues to offer access to the Sunflower Clinic, a specialist service for women affected by FGM, and remains committed to ensuring access to trauma-informed care and safeguarding support.

10. Learning Disability and Autism

10.1. Learning Disability and Autism patients.

The Trust is committed to delivering safe, personalised care for patients with learning disabilities and autism (LD/A), ensuring reasonable adjustments are made to support access, communication, and a positive patient experience.

The LD/A team comprises two dedicated staff who provide advice and support to clinical teams and directly assist patients across inpatient and outpatient services. Purple Pathways have been developed and are available to guide clinicians in delivering appropriate, person-centred care. These include key information on making reasonable adjustments and supporting patients' individual needs.

Demand for LD/A support continues to rise. In 2024/25, the Trust recorded 2,956 inpatient episodes of care involving patients with learning disabilities or autism, up from 2,164 in the previous year, a 27% increase (Figure 11). This increase reflects improved recognition, higher rates of diagnosis, and greater awareness among staff, supported by education and training initiatives.

Referrals to the LD/A team are made for both confirmed and suspected diagnoses, and increasingly include patients with additional neurodevelopmental needs such as ADHD. The team works proactively with services to ensure adjustments are in place in advance of planned admissions or outpatient appointments wherever possible.

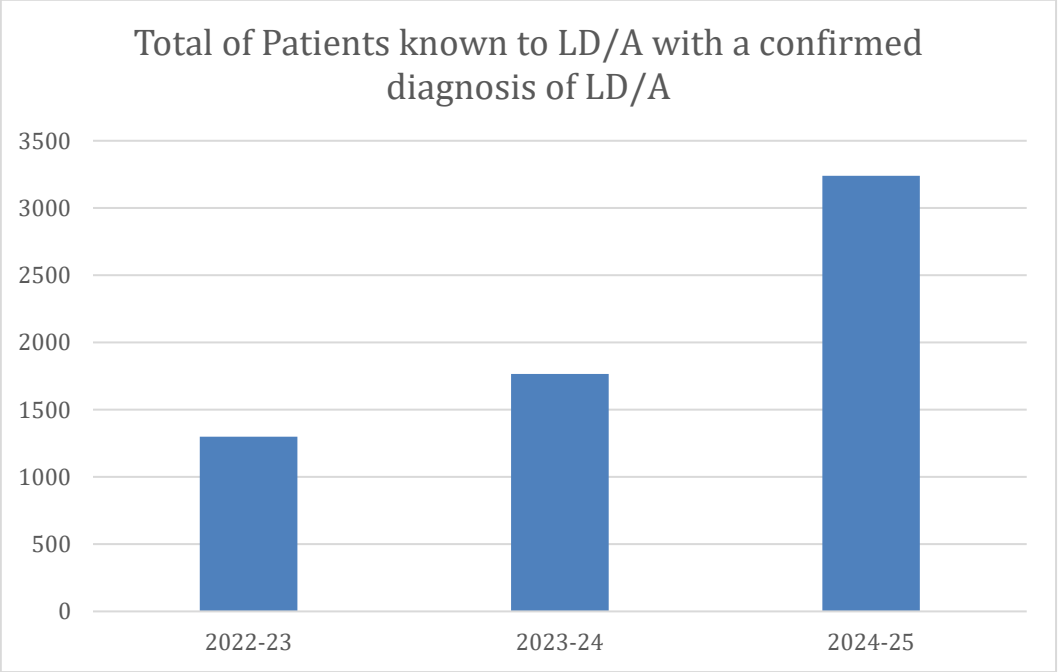

Figure 10. Patients known to the LD/A team with a confirmed diagnosis of LD/A.

Referrals to the LD/A team are made for both confirmed and suspected diagnoses, and increasingly include patients with additional neurodevelopmental needs such as ADHD. The team works proactively with services to ensure adjustments are in place in advance of planned admissions or outpatient appointments wherever possible.

Looking ahead, the Trust recognises the importance of ensuring capacity within the LD/A service aligns with growing demand. Work in 2025/26 will focus on reviewing current provision, strengthening data collection, and exploring opportunities to further embed LD/A informed practice across all sites.

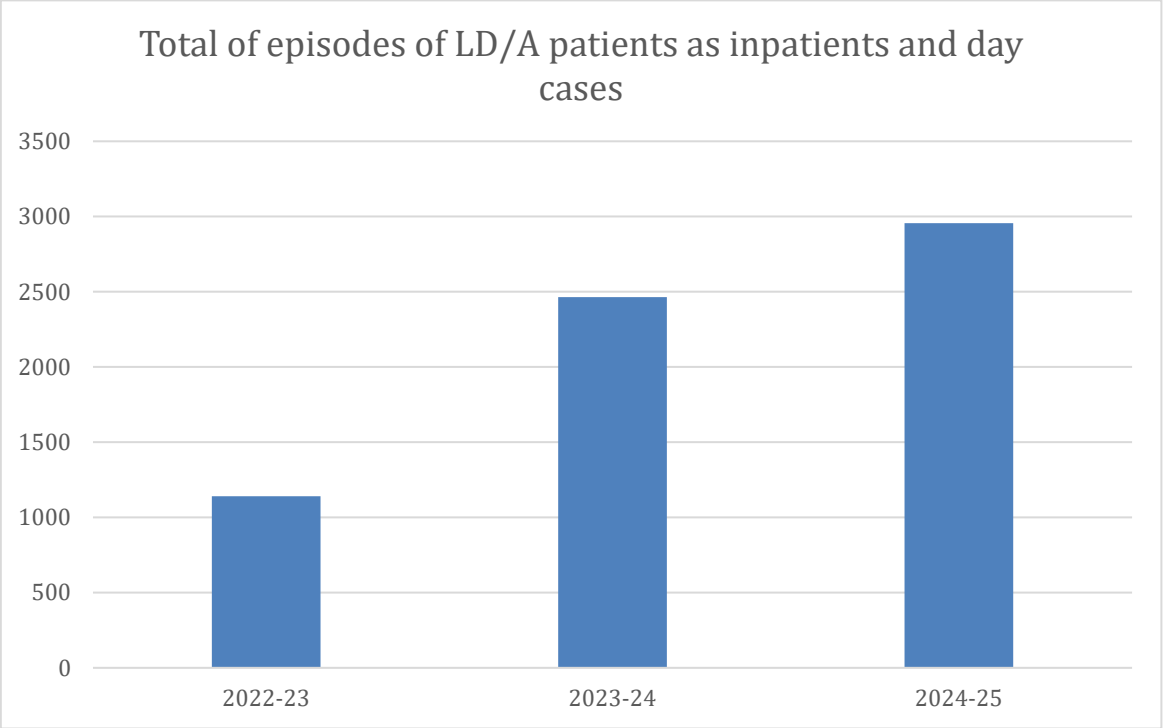

Figure 11. Total of episodes of LD/A patients as inpatients and day case.

In 2024/25, the Trust recorded 34 in-hospital deaths among patients with a diagnosed learning disability, compared to 26 in 2023/24 and 24 in 2022/23. This increase is in the context of a growing number of patients with learning disabilities and autism accessing hospital care.

In line with national requirements, all deaths in this group are subject to external review under the LeDeR (Learning from Lives and Deaths – People with a Learning Disability and Autistic People) programme, alongside internal Structured Judgement Reviews (SJRs). To date, no significant recommendations for changes in Trust practice have been issued as a result of these reviews.

In 2025/26, further work will be undertaken to strengthen oversight, explore any emerging patterns, and ensure learning from both internal and external reviews is actively embedded across services.

10.2. Reasonable Adjustments

In line with the Equality Act 2010, the Trust is committed to enabling equitable access for patients with learning disabilities and autism through proactive reasonable adjustments. The LD/A team works alongside carers and clinical teams to support patients throughout their hospital journey—whether in unscheduled care, outpatient appointments, or inpatient stays.

The national Reasonable Adjustment Digital Flag, hosted on the NHS Spine, enables sharing of specific support needs across care settings. While this functionality is not yet live within the Trust's current Cerner Electronic Patient Record, the LD/A team is actively working with the Digital and

Cerner project teams to enable integration as part of the ongoing EPR development across North West London.

Work is also underway to enhance patient communication by developing easy-read discharge letters and providing translations into first languages where needed.

In 2025/26, the focus will be on implementing the digital flag capability as part of the Cerner build and ensuring personalised communication tools are consistently adopted across all services.

10.3. Martha's Rule

Martha's Rule, a national initiative designed to strengthen patient safety and ensure timely escalation of concerns, continues to develop across the Trust. Feedback from patients with learning disabilities and autism, as well as those with safeguarding needs, has informed aspects of the project's early design and approach.

In parallel, the Helix project is focusing on improving the outpatient experience for patients with LD/A, with further progress to be reported in future updates.

11. Partnership Working to improve outcomes for children and adults

The corporate Director of Nursing and Consultant Nurse represents the Chief Nurse on various safeguarding boards/forums for North West London, namely the boroughs of Kensington and Chelsea (RBKC), Westminster and Hammersmith and Fulham (H&F). RBKC and Westminster work jointly on the safeguarding agenda (bi-borough), H&F function independently. Meetings are varied across the Partnerships (Figure 12).

Kensington & Chelsea/Westminster Local Safeguarding Children Partnership (LSCP)	Hammersmith & Fulham Local Safeguarding Children forum (LSCF)	Kensington & Chelsea/Westminster Safeguarding Adults Executive Board (SAEB)	Hammersmith & Fulham Safeguarding Adults Board (SAB)	Tri-borough learning and development sub-group
H&F Quality assurance group (adults)	H&F Quality, performance and challenge group (children)	H&F (Safeguarding adults review) SAR champions champion group	H&F partnership meeting (children)	Multi Agency risk assessment conference (MARAC) x 5
Children and young people operational group (VAWG)	VAWG(Violence against women & girls) Strategic Board	VAWG Risk and Review	NWL ICS VAWG Health	Modern slavery exploitation operational group
Bi-borough developing best practice and effective outcomes group (adults)	Bi-Borough Case practice review groups x 4 (2 each of adults and children)	Best Practice and Performance subgroup bi-borough	Brent Safeguarding Adult Board	Brent Safeguarding Children Partnership Forum
Mental Capacity Act (MCA) Regional meetings	Harmful practices operational group	Safeguarding adults health leads meeting	NWL ICS Safeguarding leads	Relevant task and finish groups

Figure 12. Partnership Safeguarding Meetings

The Consultant nurse for safeguarding chairs the Bi-borough children's case practice review meeting and facilitates the pan London Senior Nurse & Midwifery Safeguarding network.

In addition to the partnership meetings there are also the meetings that are held for individual people/families. These range from strategy meetings, discharge planning meetings and case conferences. The aim of these meetings is to support and safeguard the patient and families.

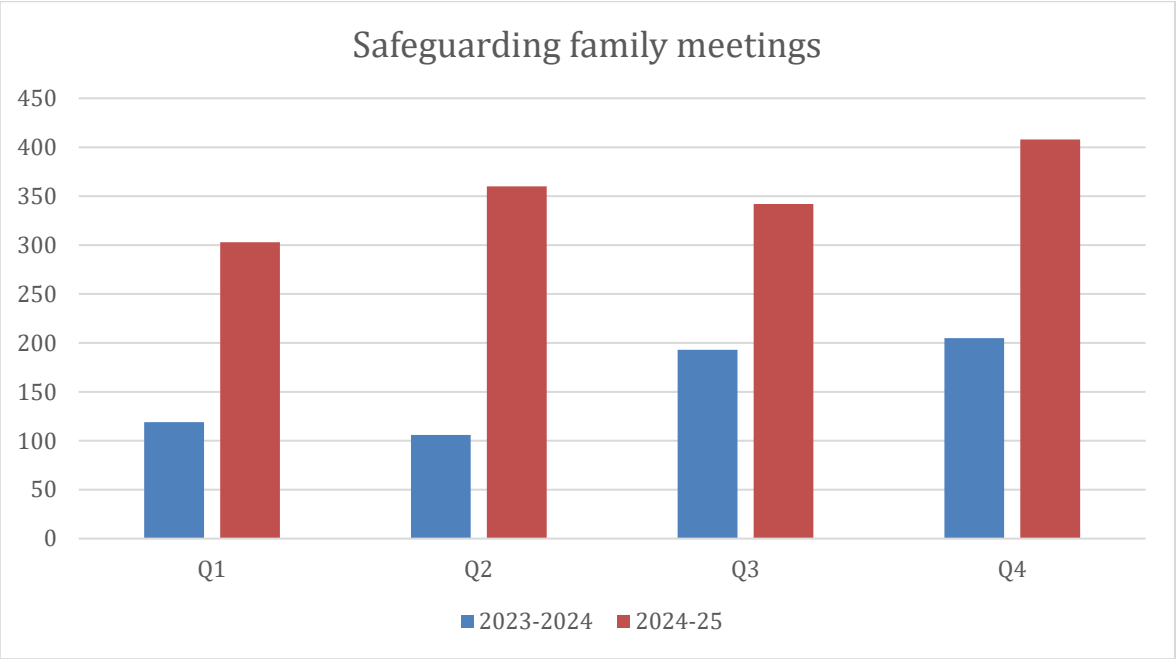

Figure 13. Meetings concerning patients (Adult, child, maternity) for 2024/25

12. Prevent

Prevent is part of the Government's counter-terrorism strategy and forms a statutory duty under the Counter Terrorism and Security Act 2015. It focuses on safeguarding individuals who may be at risk of being radicalised into terrorism or extremist ideologies.

The principles of Prevent are embedded within the Trust's wider safeguarding approach, and all staff receive relevant information through adult and children's safeguarding training, with the depth tailored to the training level. In 2024/25, 71 staff accessed basic Prevent awareness training, and 53 staff completed Level 3 Prevent training via eLearning.

Two Prevent referrals were made by the Trust during the reporting year, which is consistent with previous years. While referral numbers remain low, the Trust continues to promote awareness through safeguarding pathways and training, ensuring staff remain alert to the signs of radicalisation and know how to escalate concerns appropriately.

The Trust will continue to monitor this area as part of wider safeguarding oversight, ensuring that staff awareness, training uptake, and referral pathways remain aligned with national expectations.

13. ICON Cope

The ICON Cope programme (Infant crying is normal; Comforting methods can help; it's OK to walk away; Never shake a baby) has been launched across the Trust to raise awareness of

normal infant crying and reduce the risk of abusive head trauma in babies and young infants. The initiative aims to support parents and carers to understand and cope with infant crying through education, early reassurance, and access to appropriate support.

Initially led through maternity services, ICON is now being embedded more widely across the organisation. A train-the-trainer model is in place, supporting staff in neonatal, paediatric, and emergency care settings to promote consistent messaging. The programme includes five core touchpoints involving midwives, health visitors, and GPs.

Ongoing work continues to strengthen staff awareness, improve documentation tools, and develop a dedicated website page to support consistent, accessible information for both staff and families.

14. CQC Safeguarding Alerts

During 2024/25, the Trust received eight safeguarding alerts via the Care Quality Commission (CQC), all of which had been raised by patients or families through their local authority rather than directly through the Trust's Patient Advice and Liaison Service (PALS) or formal complaints process.

Each alert was reviewed by the safeguarding team within 48 hours, in line with agreed response timeframes, and assessed through a safeguarding lens. The cases were then referred to the complaints team and relevant divisions to initiate formal investigations. Safeguarding colleagues reviewed all outcomes, ensured appropriate action was taken, and shared learning and responses with both the local authority and the CQC.

While none of the alerts met the threshold for a Section 42 enquiry under the Care Act, all were subject to full investigation through the Trust's established safeguarding and complaints processes. This reflects the Trust's commitment to open and timely engagement with external regulators and to ensuring concerns raised by patients and families are taken seriously and responded to with appropriate oversight.

15. Allegations Against People in Positions of Trust

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

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

Between April 2024 and March 2025, the Trust managed 20 PiPoT cases, consistent with previous years (see Figure 14). A recurring theme included concerns relating to staff members' private lives, such as alcohol misuse and domestic abuse. Where appropriate, referrals were made to the relevant professional regulatory bodies, in line with Trust policy.

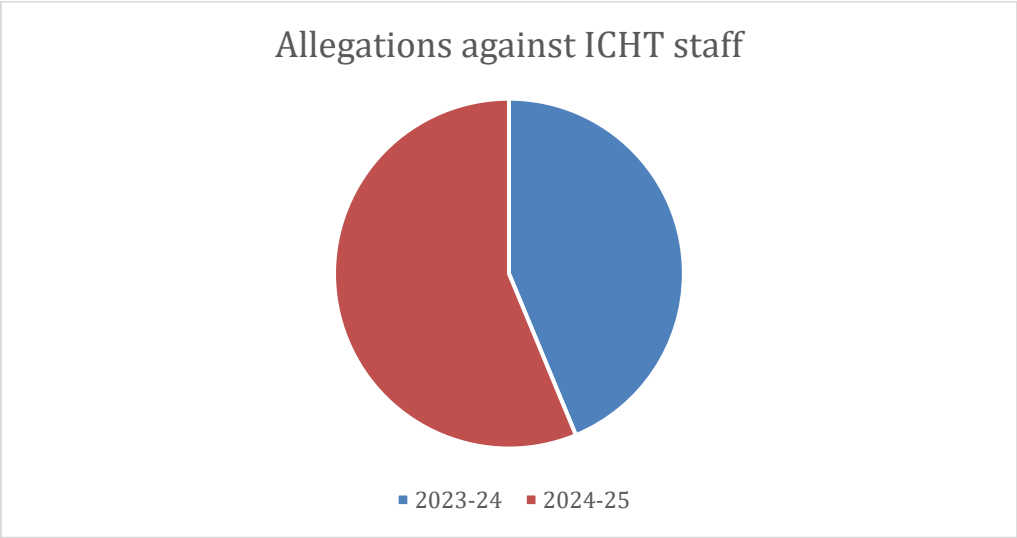

Figure 14. Allegations against people in positions of Trust

16. Learning from Serious Incidents to improve Safeguarding Adults and Children

The Trust is an active participant in the four local Safeguarding Adults Boards (SABs) and Local Safeguarding Children Partnerships/Forums (LSCP/Fs), contributing to their case review sub-groups. The Trust is also included in Brent's review arrangements where relevant.

During 2024/25, the Trust was involved in a total of 25 safeguarding reviews:

- 18 newly commenced during the year
- continuing from previous years
- 3 newly declared towards the end of 2024/25 (2 adult, 1 child), due to begin in the following period

These reviews vary in scope and may, on occasion, involve preparation for media or press statements. Immediate learning is acted upon following the preparation and review of chronologies. Where appropriate, practitioner learning events are attended by frontline staff to ensure reviews are informed by lived clinical experience. All reviews are anonymised, and some are published publicly. Partnership-wide action plans are often developed, and even where the Trust is not directly involved in a case, any relevant learning is implemented where applicable.

Themes for improvement identified from recent reviews include:

- Ensuring clear documentation around domestic abuse and the family/home context
- Strengthening professional curiosity, particularly in cases involving name changes or unexpected reappearances of estranged parents

- Improving selective enquiry around domestic abuse, both for victims/survivors and perpetrators
- Recognising hidden care and support needs in patients
- Promptly updating social workers on significant changes during hospital admissions

These learning points are embedded through training, safeguarding supervision, audit assurance activity, and the annual safeguarding work plan.

Positive outcomes noted from review learning include:

- Clinicians considering children left home alone while both parents were in hospital
- Timely and appropriate referrals to agencies such as Galop (for LGBTQ+ domestic abuse support) and mental health services
- Evidence of safeguarding processes being followed
- Use of staff debriefs after safeguarding incidents
- Direct referrals from the Trust into safeguarding case review processes

16.1. Child Safeguarding Practice Reviews (CSPR)

Child Safeguarding Practice Reviews (CSPRs) are commissioned by local safeguarding partnerships or forums when a child or young person has died or experienced serious harm, and where there is potential for interagency learning. Key learning is shared through multi-agency events, learning summaries, and is embedded within the Trust's safeguarding training programme.

There were no published CSPRs in 2024/25 involving Imperial College Healthcare NHS Trust. However, Hillingdon Local Authority declared a new review during the year concerning two infants who sustained injuries in the community. The Trust is involved in one of the cases, having provided antenatal care to the mother. This review remains ongoing and had not concluded by the end of the reporting period.

16.2. Rapid Reviews

Rapid Reviews are initiated by local safeguarding partnerships to promptly assess cases involving serious harm or death of a child, either as standalone incidents or when a trend is identified. These reviews support early identification of learning and help determine whether a full Child Safeguarding Practice Review (CSPR) is required.

During 2024/25, six rapid reviews were conducted across the local partnership footprint. One of these cases is progressing to a local learning review following the death of a child who was looked after and subsequently murdered. The remaining reviews involved the deaths of children, including one resulting from a fall from a window, and another involving a child who was shot.

The team remains committed to contributing to multi-agency rapid reviews and embedding any relevant learning into practice, even where direct involvement is limited.

16.3. Safeguarding Adult Reviews

A Safeguarding Adult Review (SAR) is a statutory, multi-agency process that considers whether serious harm experienced by an adult or group of adults with care and support needs could have been predicted or prevented. The process is designed to generate learning to help improve services and prevent future abuse or neglect.

As of the end of the reporting period, none of the four SARs or the Offensive Weapon Homicide Review have been concluded. The Offensive Weapon Homicide Review model is currently being piloted by the Brent, Harrow, and Hounslow local authorities.

None of the published SARs during 2024/25 have included notable direct involvement from Imperial College Healthcare NHS Trust. The current SARs under review cover a range of issues, including neglect by a family member, trauma-related injuries, use of emergency departments following release from prison, and a death shortly after hospital discharge.

One SAR nearing completion involves a person not known to Imperial. However, as part of a wider multi-agency audit on discharge practice, the Trust participated in a case file review of its own patients. The resulting recommendations currently being finalised are expected to focus on improving staff understanding of early discharge notifications, needs-based discharge assessments, and accurate completion of discharge forms. The draft report has been approved by the relevant clinical divisions, the Trust, and the safeguarding partnership, and is now awaiting publication.

16.4. Domestic Homicide Reviews/ Domestic Abuse Related Death Reviews

Domestic Homicide Reviews (DHRs) and Domestic Abuse Related Death Reviews (DARDRs) examine the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from domestic abuse. These reviews aim to identify lessons that can be learned to improve multi-agency responses and prevent future harm.

Imperial College Healthcare NHS Trust actively participates in DHR/DARDR panels across the boroughs it serves and ensures that relevant learning is shared and embedded within the organisation.

As of the end of 2024/25, the Trust is involved in ten ongoing reviews:

Nine are still in progress, of these three have progressed to the action planning stage and one, known as the ‘Gloria’ case, is awaiting publication

Due to a national backlog in the Home Office sign-off process, none of these reviews have yet been formally finalised.

Emerging themes across the reviews include suicide, murder, and parricide (the killing of a parent by a child). It is important to note that suicides linked to domestic abuse are now subject to DHR/DARDR, which has significantly increased the number of reviews the Trust is involved in—doubling participation during 2024/25.

In the ‘Gloria’ case, the Trust was commended for its practice. The review stated:

“All actions taken by Imperial College Healthcare NHS Trust regarding Gloria evidence good practice on the part of doctors, the Safeguarding Clinical Nurse Specialist, psychiatric liaison and other ED staff.”

This recognition affirms the integrity of the Trust’s safeguarding response. Looking ahead, the Trust will continue to:

- Engage actively with ongoing DHR/DARDR panels
- Implement any learning as each review concludes
- Monitor national processes and advocate for timely conclusion and publication

17. Training

The Key Performance Indicator (KPI) for safeguarding training is locally agreed by the NWL Integrated Care Board. This is set at 90% compliance at levels 1, 2, 3 and 4 are satisfactory. It should be noted that Prevent training is included in all adult and child safeguarding training as well as standalone eLearning sessions. Compliance as of 31 March 2025 is documented in figure 14.

The Key Performance Indicator (KPI) for safeguarding training is locally agreed by the North West London Integrated Care Board and is set at 90% compliance across levels 1 to 4 on a 3 yearly cycle. Training compliance is considered satisfactory when this threshold is met. Prevent training is incorporated within all adult and children’s safeguarding training sessions and is also available as standalone eLearning modules. Training compliance figures as of 31 March 2025 are presented in Figure 15.

Topic	Compliant	Required	%Compliance
Safeguarding Children Level 1	4347	4,639	93.7%
Safeguarding Children Level 2	8,445	8,956	94.3%
Safeguarding Children Level 3	1,230	1,346	91.4%
Oliver McGowan Learning Disability and Autism Part 1	13,483	14,981	90.0%
Safeguarding Adults Level 1	4.938	5,333	92.6%
Safeguarding Adults Level 2	9,127	9,648	94.6%

Figure 15. Compliance levels as at 31 March 2025

17.1. Safeguarding Adults Level 3 Training

During the 2024/25 reporting period, Level 3 safeguarding adults training was mandated for a defined cohort of 125 senior staff across the Trust. This figure was based on an earlier training needs analysis (TNA) that aligned with national expectations at the time. The training comprised both a national eLearning module and a face-to-face session. As of 31 March 2025, compliance within this group was 48%, with local divisions continuing to promote uptake and monitor performance.

It is recognised that the denominator appears low in the context of the wider Trust workforce. However, the national review of the NHS Core Skills Training Framework, which was ongoing throughout 2024/25, meant that major changes to training requirements, including those for safeguarding adults, were paused. The national review has since concluded and a revised framework is due to be implemented during 2025/26. As part of this, a further local training needs analysis will be undertaken to ensure appropriate alignment with the updated national expectations.

The Trust's consultant nurse for safeguarding is contributing as a subject matter expert to the national review of the safeguarding learning framework across all age groups, with implementation expected to commence during 2025/26.

17.2. Oliver McGowan Training

The Oliver McGowan learning disability and autism training is compulsory for all Trust staff, with a 90% compliance target.

Tier 1 comprises e-learning followed by a 1-hour live online interactive session, typically for non-clinical or general awareness roles. Staff required to complete Tier 1 Part 2 reached 25% compliance (among those expected to do so) between its launch in December 2024 and 31 March 2025. The ambition remains to achieve 90%.

Tier 2 applies to staff providing direct care to LD/A service users and includes the same e-learning, followed by a full-day face-to-face session, replacing the Tier 1 interactive session. Facilitator training dates are scheduled to begin in Q1 2025/26, with rollout of Tier 2 sessions to be planned thereafter.

The distinction or staffing denominator is based on role requirements, in line with guidance. Remaining training capacity and roll-out are being planned as part of the phased regional implementation.

17.3. Safeguarding Supervision

Safeguarding supervision is recognised nationally as a key enabler of safe and reflective practice. Within ICHT, the safeguarding supervision and training policy was ratified in 2024/25, providing the foundation for a structured approach. A range of sessions are in place across key areas paediatrics, emergency care, maternity, sexual health and others alongside bespoke sessions by request.

Supervision provision is continuing to mature, with increased attention this year on supporting adult services, including regular drop-ins and focused domestic abuse sessions. The 'Signs of Safety' model is used to support structured reflection and learning.

Over 1,200 staff attended safeguarding supervision during the year, and feedback has been consistently positive.

Looking ahead, the Trust will align its approach to supervision with national best practice standards, focusing on monitoring access and staff participation. While supervision is mandated, encouraging consistent attendance remains an area for development. Addressing this, and

ensuring equitable provision across all staff groups who require supervision, will be a core area of focus in 2025/26.

18. Audits

18.1. Regulatory Partnership Audits

The Safeguarding team completed the Safeguarding Adults Partnership Audit Tool (SAPAT) for the Bi-Borough and Hammersmith & Fulham Safeguarding Adults Boards. The audit assessed current practice, challenges, and progress in areas such as 'Making Safeguarding Personal', strategy reviews, partnership working, and learning from Safeguarding Adults Reviews (SARs). Imperial College Healthcare NHS Trust (ICHT) also participated in associated multi-agency learning events to review shared priorities.

Feedback from the Safeguarding Adults Boards was positive, noting ICHT's active and constructive partnership working. The Trust was recognised for its engagement in task and finish groups, contributions to multi-agency audits, and commitment to disseminating and applying learning across the organisation.

Under Section 11 of the Children Act 2004, organisations have a statutory duty to ensure their functions are discharged with regard to safeguarding and promoting the welfare of children. Although there were no Section 11 audits involving ICHT during 2024/25, the Trust remains committed to this statutory requirement and anticipates future participation when these are next commissioned.

18.2. Internal Audits

The Safeguarding Team completed fourteen internal audits during 2024/25. These audits focused on areas including: Purple Pathways, hospital passports, the quality of referrals, domestic abuse safeguarding processes, maternity safeguarding discharges, children not brought to appointments, unscheduled care attendances for under-18s, and safeguarding processes within private patient services.

All audits were reviewed by the Safeguarding Committee, and associated actions are being monitored through the Safeguarding Annual Plan. No audit identified the need for immediate change in practice, and each was based on an appropriately sized sample relevant to its focus.

Notably, the audits demonstrate that safeguarding is increasingly embedded in everyday clinical practice. Staff are being empowered by the safeguarding team to follow appropriate processes, professionally challenge, and apply curiosity to ensure safe and responsive care.

18.3. Multi-Agency Audits

Imperial College Healthcare NHS Trust (ICHT) has actively participated in four multi-agency audits during 2024/25:

- Pressure Ulcers and Safeguarding Referrals (with CLCH)

A joint audit with Central London Community Healthcare NHS Trust (CLCH) reviewed over 500 patients across a five-month period via weekly meetings between Tissue Viability Nurses (TVNs) and the safeguarding team. The audit was prompted by concerns that safeguarding referrals were being made for patients with pressure ulcers who were under CLCH's care but

did not meet the safeguarding threshold. Positive outcomes include improved timeliness and appropriateness of referrals. Following feedback to teams and individuals, all safeguarding referrals are now relevant, and CLCH's proposed restriction (requiring review prior to referral) is no longer necessary.

- Brent Children's Mental Health Admissions and Safeguarding of Looked-After Children

ICHT participated in a Brent audit exploring safeguarding concerns in children admitted with mental health needs, particularly those who are looked-after children. The audit reviewed twenty cases involving children aged 13–16. Feedback confirmed that children reported feeling safe at ICHT, and a holistic and contextually informed safeguarding approach was consistently applied.

- Hammersmith & Fulham Stop and Search Audit (ongoing)

ICHT is involved in an ongoing audit relating to police stop-and-search incidents involving children. At the time of reporting, no specific actions have been identified for ICHT.

- Mental Capacity Multi-Agency Audit

A partnership-wide audit into the use of the Mental Capacity Act (MCA) found similar themes to ICHT's internal findings from 2023/24. Key areas for improvement across the system include: use of MCA and Best Interests templates, staff understanding of MCA pathways, verification of Lasting Powers of Attorney, and quality of record-keeping. Although only five of the twenty cases reviewed were deep dived (none involving ICHT), learning materials and training resources have been proactively shared and promoted across the Trust.

In addition, a thematic review into adult suicide deaths in Hammersmith & Fulham is underway, with outcomes to be shared in the 2025/26 report.

19. Policies

The Trust maintains a comprehensive suite of safeguarding policies covering adults, children, and individuals with learning disabilities and autism. All relevant policies remain current and aligned with statutory guidance. In 2024/25, the following key documents were reviewed and ratified: the Domestic Abuse Policy, the Allegations Against People in Positions of Trust Policy, and the Safeguarding Training and Supervision Policy.

20. Key Achievements

- The Trust has continued to meet its statutory safeguarding duties.
- A year-on-year increase in safeguarding referrals across the agenda reflects improved awareness and recognition of risk by staff.
- A "16 Days of Activism" awareness campaign was held during November–December to highlight and address gender-based violence.
- Imperial has led sector-wide work to develop enhanced electronic referral processes and documentation for integration into the new Cerner electronic patient record (EPR) system.

- The number of Deprivation of Liberty Safeguards (DoLS) applications has increased, supporting best practice in mental capacity assessments and legal compliance.

- An additional safeguarding touchpoint was introduced via the outpatient self-check-in app, encouraging patients to disclose abuse with the message: “If you are being hurt, controlled, neglected or abused, please tell one of our staff so we can help you.”

- The Safeguarding Committee has maintained strong oversight through a broad range of agenda items, including assurance regarding Learning Disability and Autism (LD/A) provision.

- Timely and appropriate information sharing has helped safeguard vulnerable patients, families, and unborn children who have presented to the Trust.

- Collaborative work has progressed on key initiatives including Martha’s Rule, ICON (Infant crying), and reducing avoidable safeguarding referrals related to pressure ulcer admissions.

- Staff report feeling well supported by the Safeguarding and LD/A teams, and that training and safeguarding supervision positively influence their day-to-day practice.

- The safeguarding annual plan was delivered in full.

- An Independent Mental Capacity Advocate (IMCA) is now regularly based on site at Charing Cross Hospital (CXH), improving access to advocacy for eligible patients.

- Two key policies developed and ratified: Safeguarding Training and Supervision, and Allegations Against People in Positions of Trust.

- The Trust has received positive feedback from multi-agency audits and case reviews in which it participated.

21. Key Challenges

- Sustaining safe and effective safeguarding practice amid increasing referral activity, rising complexity, and involvement in multiple external reviews.

- Maintaining safeguarding training compliance, particularly improving uptake of Adult Safeguarding Level 3.

- Implementing Tier 1 (Part 2) and Tier 2 of the Oliver McGowan Training programme, and ensuring facilitators are in place for face-to-face delivery.

- Securing sustainable, consistent Independent Domestic Violence Advisor (IDVA) provision across all sites, including evenings and weekends.

- Continued reliance on police-led photography during child protection medicals, which can delay clinical processes.

- Integration of the Reasonable Adjustment Digital Flag within Cerner remains in progress, requiring sustained partnership with the digital team.

- The current discharge system does not yet support automatic generation of easy-read or translated discharge letters, which limits accessibility for some patients.

22. Conclusion

The Safeguarding Team continues to meet its statutory responsibilities under Section 11 of the Children Act 2004 and the Care Act 2014. This year has seen an increase in activity across all domains, particularly in relation to patients with learning disabilities and autism, where demand and complexity are rising.

The Trust's commitment to multi-agency collaboration is evident through our active participation in reviews, joint audits, and wider partnership initiatives. These efforts, including engagement with voluntary sector organisations and local authorities, demonstrate a system-wide approach to identifying risk early and supporting vulnerable patients.

Looking ahead, a review of safeguarding capacity and structure will take place in 2025/26 to ensure we remain fit for purpose, particularly in the context of increasing referrals, training demands, and evolving national frameworks. The integration of new digital tools, including the Reasonable Adjustment Flag and enhanced Cerner functionality, will further strengthen our safeguarding infrastructure.

Finally, the work described in this report is a testament to the professionalism, vigilance, and compassion shown by our front-line staff and safeguarding leads. Their continued dedication ensures that safeguarding remains central to high-quality, person-centred care at Imperial.

Appendix one – Tier 3 Maternity Vulnerability.

Tier 3
Under 15 at point of referral* Younger age may increase level of concern
Currently a LAC or LAC within last 3 years*
Referred to social care in this pregnancy (by any agency) *
Previous involvement with social care – children with CP or CIN plans*
Previous child(ren) removed by care order*
Child(ren) currently on CIN plan*
Child(ren) currently on CP plans*
Currently in prison/on probation*
Previous prison sentence (in context) *
Previous probation (in context) *
Homeless, sleeping rough*
Significant housing issues likely to result in homelessness or homeless but with current place to stay – but no recourse to public funds.
Physical/learning disability likely to significantly impact on parenting ability with little/no support*
History of overdose or suicide attempt within the last 2 years, or longer, but contributing factors have not resolved*
Current substance misuse (opiates) - heroin, methadone etc. or inhalants (aerosols), crack cocaine, class A drug, alcohol - use on-going in pregnancy*
Substance misuse (any substance, including alcohol) used as a coping strategy (e.g., for DV, mental health issues), or requiring use of support services*
History of significant substance misuse, but not currently using (opiates) - heroin, methadone etc. or inhalants (aerosols), crack cocaine, alcohol*
Current domestic abuse, or previous domestic abuse with same partner*
Previous domestic abuse but still in potential high-risk contact with perp e.g., child contact*
History of domestic abuse with father of unborn baby (regardless of contact) *
History of significant MH concerns, including bipolar disorder, personality disorder, schizophrenia, eating disorder, self-harming, OCD **unstable/currently requiring treatment***
Significant deterioration in MH (antenatal or postnatal) *
History of psychosis/psychotic episodes*
Previous inpatient MH care for significant MH concerns (in context) including previous section under MH act*
History of abuse as a child – impacting/likely to impact ability to parent without support*
History of abuse as a child – perpetrator likely to/will have access to child(ren)*
History of sexual assault/rape – currently impacting on life/ability to parent e.g., PTSD, perpetrator poses a current risk etc.*
FGM – child(ren) have had/at risk of FGM*
FGM – woman herself is under 18*
Woman involved with gang/gang-related activity*
Woman victim of CSE or CSE suspected*
Woman has been trafficked/suspected trafficking*
Unbooked/No antenatal care – e.g., presents in labour/late pregnancy with no valid explanation for missing care.
Partner currently in prison/on probation (in context)
Partner/other household member has significant MH concerns e.g., bipolar, schizophrenia, psychosis, requiring MH input.
Partner/other household member currently using heroin, other opiates, crack cocaine, inhalants etc.
Partner currently using other class A drugs on a regular basis.
Booking >30 weeks with no valid explanation