Safeguarding

Annual report 2025

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1. Foreword

As Executive Director of Nursing, Midwifery and Quality, and Executive Safeguarding Lead, I am pleased to present MSI UK's Annual Safeguarding Report for 2025.

> **Safeguarding is fundamental to our care. People often access sexual and reproductive healthcare at moments of vulnerability, when wider pressures in their lives may affect their safety, wellbeing and ability to seek support. This report reflects both the complexity of the safeguarding needs we encounter and the responsibility we hold to deliver care that is safe, compassionate and respectful.**

Mental health continues to be the most frequently identified safeguarding concern across our services. Many individuals present with emotional distress alongside other challenges such as domestic abuse, housing instability or involvement with statutory services. This matters because it underlines the role of sexual and reproductive healthcare as a trusted point of contact for people who may not be engaged with support elsewhere, and highlights the need for skilled, confident clinicians able to respond proportionately while supporting autonomy and access to care.

Domestic abuse and reproductive coercion remain a significant concern. Pregnancy can increase risk, and individuals may seek care while living with abuse that is not visible to others. Safeguarding in this context relies on professional judgement, trauma-informed conversations and close partnership working. The activity in this report shows how our services can provide a safe space for disclosure and timely intervention, helping to reduce harm while respecting individual choice.

The safeguarding activity described this year continues to show that complexity is now the norm. Many cases involve multiple, overlapping risks rather than a single issue. This reinforces the importance of continuity, consistent documentation and specialist oversight, and of safeguarding approaches that reflect real lives rather than rigid categories.

This report also demonstrates growing maturity in MSI UK's safeguarding practice and governance. The Advanced Safeguarding Practitioner model is now embedded, strengthening consistency, decision-making and continuity of care. Improvements in data, reporting and assurance processes have enhanced transparency and oversight, with safeguarding firmly integrated within our wider governance framework.

Safeguarding is demanding work, and it is important to acknowledge the emotional labour involved. I want to recognise and thank our colleagues across the organisation for the professionalism, compassion and resilience they bring to this work every day. Our continued focus on safeguarding supervision, reflective practice and supportive leadership is essential to sustaining safe care and staff wellbeing.

Looking ahead, our Safeguarding Strategy will continue to focus on strengthening consistency and resilience, improving understanding of risk – particularly mental health and cumulative vulnerability – and building confidence across the workforce to manage safeguarding complexity with assurance. This work will remain grounded in proportional, trauma-informed practice and strong partnership working.

Safeguarding is not separate from care; it is integral to delivering safe, ethical and person-centred services. This report reflects our ongoing commitment to learning, transparency and continuous improvement, and to keeping the safety and dignity of those who access our services at the centre of everything we do.

Nicola Moore
Director of Nursing, Midwifery and Quality
and Executive Safeguarding Lead

2. Introduction

Welcome to the 2025 Annual Safeguarding Report for MSI UK. This report provides assurance to internal and external stakeholders that safeguarding is embedded across all services and remains a core organisational priority. It outlines how safeguarding concerns are identified, assessed and responded to, and how risks are managed and escalated to support safe, high quality care.

Safeguarding practice at MSI UK is informed by statutory guidance and national standards and is delivered through a proportionate, trauma informed approach. Many people access sexual and reproductive healthcare at times of increased vulnerability. Safeguarding therefore plays a key role in ensuring care is delivered safely, respectfully and without unnecessary barriers, while supporting autonomy and informed choice.

During 2025, further progress was made in strengthening safeguarding oversight and consistency across the organisation. Improvements to safeguarding data collection and reporting now provide a clearer and more accurate picture of safeguarding activity and risk. Continued embedding of the Advanced Safeguarding Practitioner (ASP) role has strengthened professional support, decision making and continuity of care for clients with complex safeguarding needs.

This report also reflects the importance of partnership working. Safeguarding concerns often extend beyond organisational boundaries and require coordinated responses with statutory services, specialist organisations and community partners. The activity and assurance set out in this report demonstrate MSI UK's role within the wider safeguarding system and its ongoing commitment to transparency, accountability and continuous improvement.

Ailish McEntee RM, MSc
UK Named Midwife for Safeguarding Adults and Children

3. Background and context

Safeguarding needs in these settings are often complex. Many clients experience multiple, overlapping risks, and disclosure may be affected by fear, stigma, controlling environments or previous negative experiences of services. Wider factors such as language barriers, immigration status, disability, trauma and financial insecurity can further limit access to support. Services that offer flexibility, choice and trauma informed care play a key role in improving safety and access.

MSI UK delivers care within a national legal and policy framework that continues to develop. In 2025, the Victims and Prisoners Act 2024 came into force, reinforcing the seriousness of controlling and coercive behaviour within criminal justice processes. National rollout of Domestic Abuse Protection Orders and Notices continued, strengthening protections across family and criminal courts. The Domestic Abuse Act 2021 also reached fuller implementation, including recognition of children as victims of domestic abuse and expanded definitions of economic abuse. Alongside this, ongoing national discussion has highlighted the importance of professional judgement alongside risk assessment tools.

Access to abortion care continues to be subject to public and parliamentary discussion. In this context, the availability of safe, lawful services that prioritise dignity, autonomy and informed choice remains essential. Providing both telemedicine and face-to-face pathways allows services to respond to the varied and often complex circumstances in which people seek care.

Safeguarding risk is not experienced equally. Children and young people, care experienced individuals, disabled people, non-English speakers and those experiencing abuse or severe socioeconomic disadvantage may face greater barriers to support. Safeguarding at MSI UK therefore extends beyond individual clinical encounters. Through strong governance, professional judgement, effective use of safeguarding information and partnership working, we remain committed to protecting safety, supporting autonomy and promoting equitable access to care across the client journey.

4. Safeguarding structure

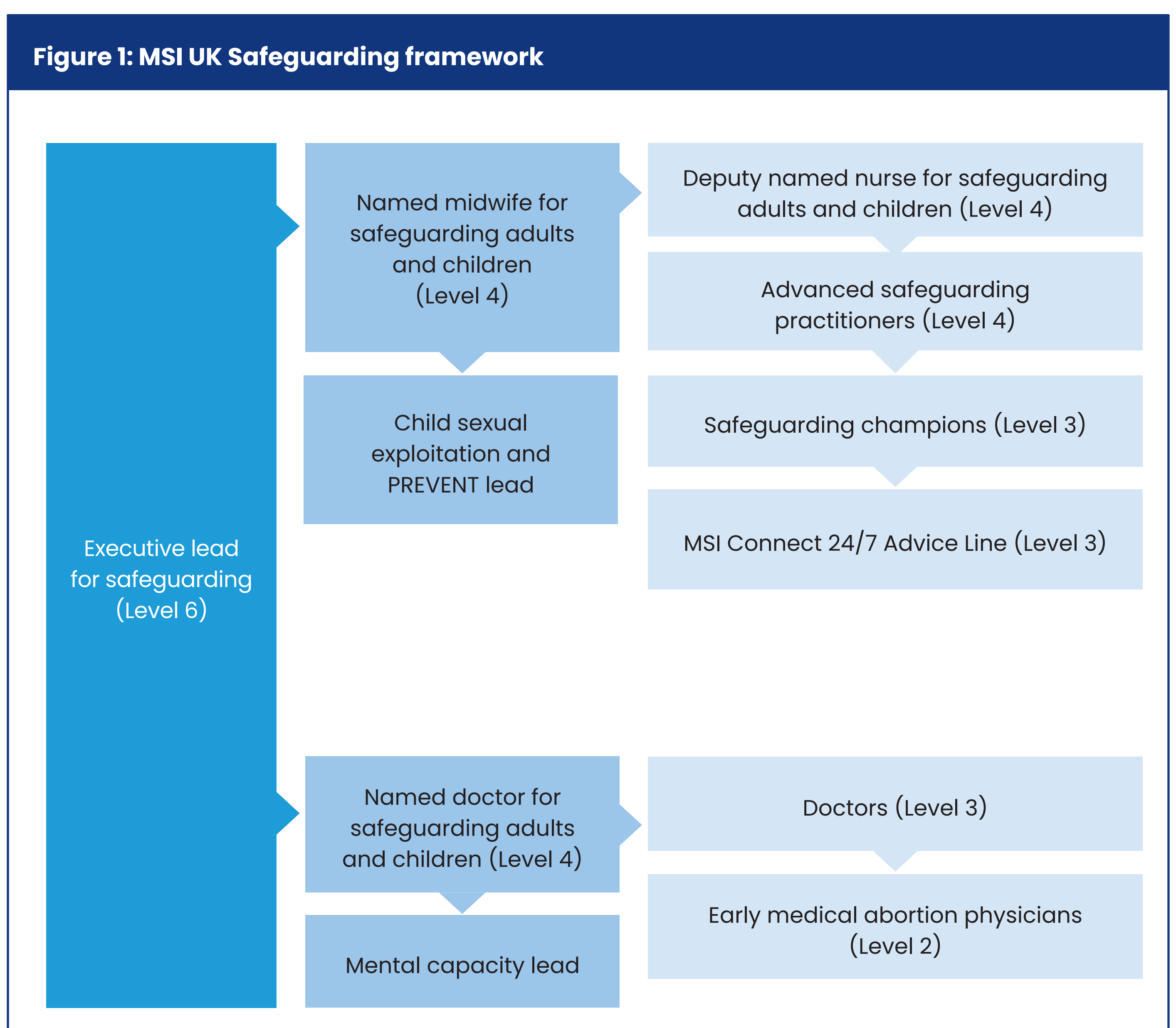
This section outlines MSI UK's safeguarding governance, leadership structures, and named roles, demonstrating how responsibility, accountability, and oversight are embedded across the organisation.

4.1 Safeguarding governance framework

Safeguarding at MSI UK is underpinned by a clear, robust governance structure and is embedded at every level of our organisation, from our Executive Management Team to the teams working across our clinics and contact centre.

This structure supports us in meeting statutory and regulatory safeguarding duties in line with NHS England's Safeguarding Accountability and Assurance Framework (2022). Named professionals are in place for safeguarding children, young people, and adults, including key leads for Child Sexual Exploitation, the Mental Capacity Act, and PREVENT. Clear escalation pathways and on call safeguarding support reduce reliance on any single role holder.

Figure 1: MSI UK Safeguarding framework



4.2. Advanced safeguarding practitioners (ASP) model

4.2.1. Overview

In recent years, the rising volume and complexity of safeguarding disclosures has increased the pressure on colleagues to provide timely, safe support for vulnerable clients. Within abortion care – where discretion, confidentiality, and trauma informed practice are essential – this highlighted the need for enhanced specialist oversight. In response, the Advanced Safeguarding Practitioner (ASP) role was developed to provide focused support for clients with multiple or overlapping vulnerabilities, strengthen clinical safeguarding decision making, and improve consistency across regions.

The ASP model has been positively recognised by the Care Quality Commission (CQC), and findings from the pilot were published in the Nursing Times, demonstrating its value and potential for wider adoption across the sector. The ASP model is now embedded as MSI UK's standard safeguarding delivery framework across all Regional Treatment Centres (RTCs).

4.2.2. ASPs at MSI Connect

As a key first point of contact, MSI Connect has strengthened its safeguarding approach by enhancing specialist oversight within the existing ASP workforce. Level 4 trained practitioners now support the service, enabling earlier identification of risk and more consistent, trauma-informed responses. This provides staff with clearer access to expert advice, improving both client safety and overall experience.

4.2.3. Continuity of care

ASPs provide consistent safeguarding oversight by triaging clients with identified concerns and following them throughout their treatment pathway. This approach reduces repeated disclosures, supports trauma informed practice, and ensures proportionate follow up for clients who do not attend or do not proceed with treatment. Their caseloading of high risk or particularly vulnerable clients strengthens safe planning and enhances person centred care.

4.2.4. Multi-agency collaboration

Using a 'think family' and contextual safeguarding approach, ASPs play a key role in strengthening local multi-agency partnerships. During the pilot, they supported Equality Impact Assessments to identify local demographic needs and align community partnerships accordingly, ensuring clients have access to appropriate regional support.

4.2.5. Enhanced support

ASPs undertake Level 4 safeguarding and safeguarding supervision training, enabling them to provide expert advice and support practice development within their region. Their supervision role promotes reflective practice, contributes to staff confidence, and improves the quality and consistency of care for vulnerable clients.

4.2.6. Governance oversight and sustainability

ASPs oversee regional safeguarding assurance through monitoring training compliance, supervision activity, and adherence to policy. They escalate concerns promptly and contribute to wider organisational governance via the Safeguarding Group. Their assurance reporting to Integrated Care Boards supports transparency and strengthens commissioner understanding of local safeguarding themes.

Working alongside Named Safeguarding Professionals, ASPs support the delivery of the safeguarding strategy and contribute to succession planning, ensuring sustainable and safe organisational growth.

Figure 2: Key aspects of the advanced safeguarding practitioner role

5. Safeguarding activity and risk identification

5.1 Safeguarding activity in 2025

Safeguarding risk assessment underpins all care at MSI UK and informs decision making across every service pathway. These include:

- **Age-specific safeguarding proformas**
- **Vasectomy safeguarding proforma**
- **Domestic abuse, stalking, harassment, and honour-based abuse assessment**
- **Child sexual exploitation assessment**
- **Drug and alcohol assessment**
- **Mental capacity assessment**
- **Visual assessment**
- **Professional judgement**

All colleagues are aware of their safeguarding responsibilities and the importance of accurate, proportionate documentation. Safeguarding practice across MSI UK is grounded in a client-centred, holistic approach, with a focus on preventing harm, supporting autonomy, and responding appropriately to identified risks.

5.2 Safeguarding pathways

Safeguarding is embedded at every stage of the client journey, from first contact through to treatment and follow-up care.

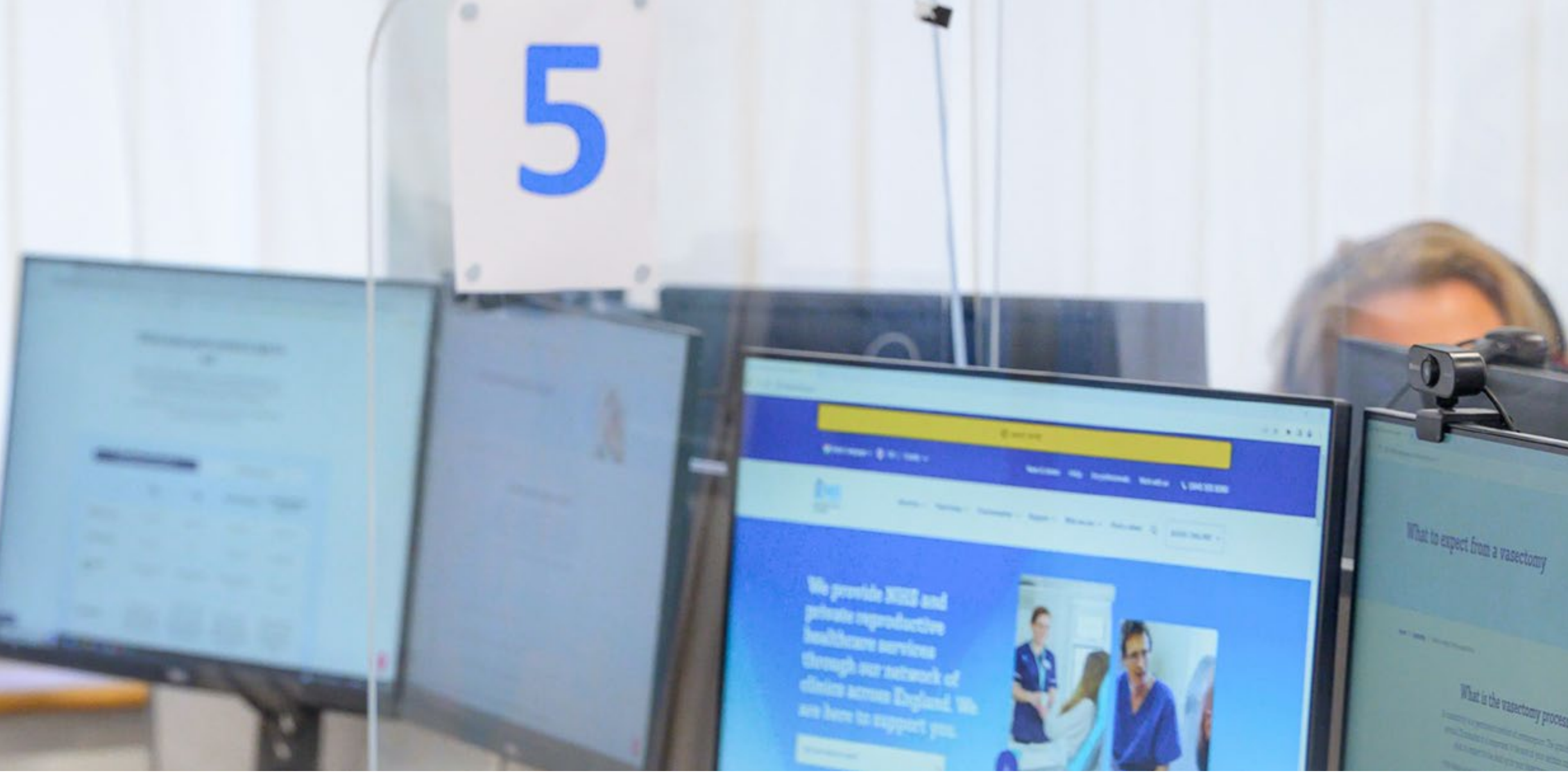
5.2.1. First contact: MSI Connect

All clients access our services via MSI Connect, our central contact centre. Clients can contact the service in a range of accessible ways, including:

- Blue Door online portal
- Webchat
- Telephone

Blue Door lets clients create accounts, complete health forms, and book, amend, or cancel appointments for abortion, vasectomy, and contraception services. Maintaining multiple routes of contact supports accessibility and enables clients to choose the method most appropriate to their circumstances.

Safeguarding oversight is built into the system. Blue Door mirrors telephone-based safeguarding checks, with monitoring by client care coordinators and oversight from the safeguarding team. It is designed with strong security and confidentiality to protect client information and wellbeing throughout the digital journey.



5.2.2. Treatment centres and clinical assessment

Following initial contact and screening, clients are offered an appointment at the most appropriate treatment centre for their needs. Care is delivered across twelve Regional Treatment Centres (RTCs), supported by additional by additional Community Treatment Hubs (CTHs) that improve local access. Expanding the availability of locations and appointments enables us to respond flexibly to safeguarding needs. In some circumstances, this allows clients to be seen away from their immediate environment, including where there are concerns relating to honour based abuse, coercion or exploitation.

Appointments may be face-to-face or via telemedicine for clients aged 13+, depending on clinical history and preference. Safeguarding assessments are conducted by Level 3–4 trained clinicians, with escalation to ASPs as needed. Frameworks are informed by external experts (e.g. ManKind, Karma Nirvana) to ensure robust, evidence-based, and responsive care.

5.3. Safeguarding data and reporting

5.3.1. Changes to reporting

In 2025, safeguarding reporting was improved. Data is now based on episodes of care rather than individual clients, reflecting repeat service use and providing a more accurate picture of activity.

Safeguarding data is also drawn from wider sources and reported consistently across services. These changes mean 2025 figures are not directly comparable with previous years, reflecting improved reporting rather than inaccuracies, and supporting stronger monitoring and assurance.

5.3.2. Overview of 2025 safeguarding activity in 2025

Episodes of care

During 2025, we recorded 183,503 episodes of care across abortion, contraception and vasectomy services, averaging more than 15,000 episodes per month. This represents an increase in activity compared to 2024.

Initial safeguarding concerns

Initial safeguarding data includes all episodes where a flag, disclosure, or trigger was recorded. Some categories (e.g. age-based flags) support screening and triage but do not indicate confirmed concerns.

Where concerns were confirmed, they were recorded under relevant categories (e.g. domestic abuse, mental health, exploitation). Where none were identified, they were excluded from final figures.

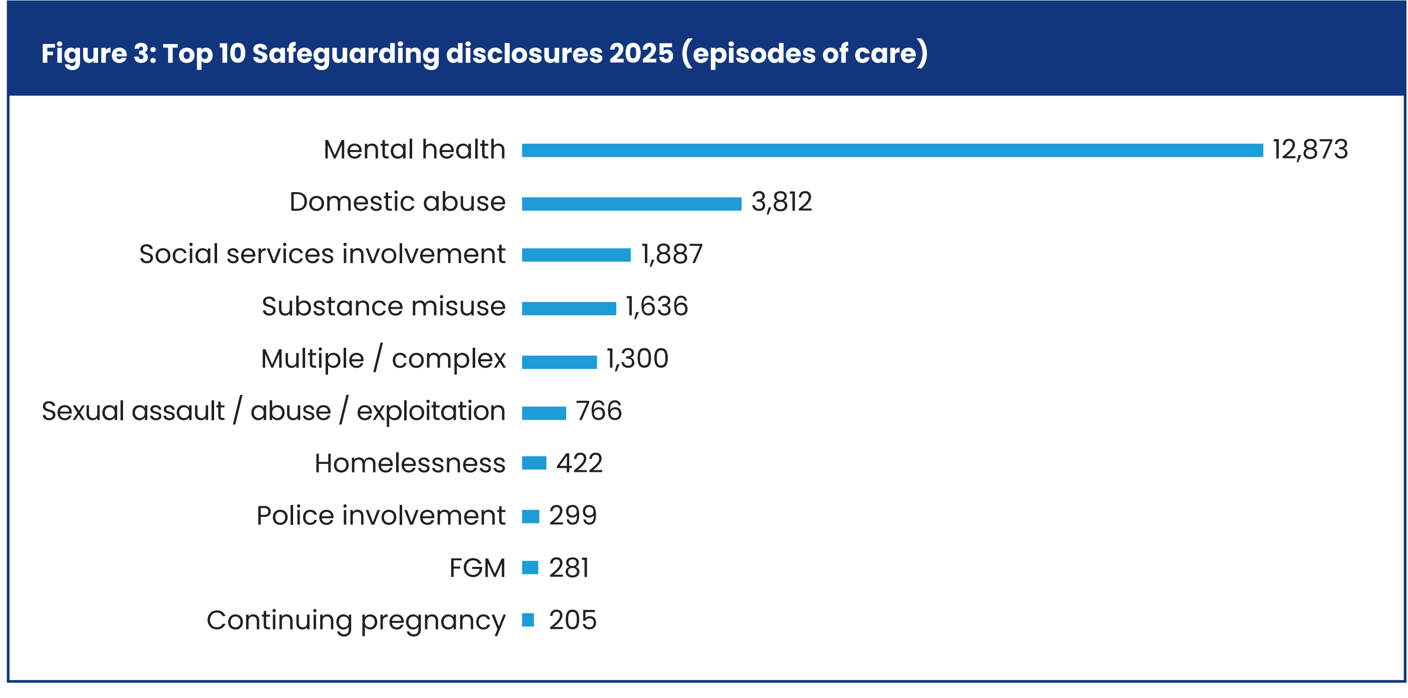
After removing screening categories, 24,145 of 30,271 episodes in 2025 involved a confirmed safeguarding concern, ensuring reported data reflects verified need.

Safeguarding concerns identified across MSI UK services in 2025 highlight the complex and overlapping vulnerabilities experienced by clients. Mental health and domestic abuse were most common, often occurring alongside issues such as substance misuse and social services involvement. Assessments therefore require a nuanced, proportionate approach that considers how risks interact.

> **These patterns emphasise the need for a skilled workforce confident in managing sensitive safeguarding conversations within sexual and reproductive healthcare. The data shows concerns are consistently identified and addressed, supporting safe clinical decision-making and appropriate support, signposting, and referral.**

Safeguarding concerns identified within MSI UK services reflect the most common issues disclosed in abortion and sexual and reproductive healthcare. These include domestic abuse and reproductive coercion, modern slavery, human trafficking, child sexual exploitation, sexual violence, substance misuse, homelessness, honour based abuse, mental capacity concerns and learning disabilities.

The themes below represent the most frequently disclosed safeguarding issues in 2025 and are explored further in this report.



In-year safeguarding activity

Across 2025:

13.1%

of all episodes of care included at least one safeguarding disclosure

53.3%

of disclosures related to mental health

15.8%

related to domestic abuse

8.8%

of safeguarding disclosures required external escalation

6.8%

related to substance misuse

6. Key safeguarding themes

6.1. Mental health

6.1.1. UK context

Mental health remains a significant national concern, with 1 in 5 adults in England experiencing a common mental health problem. Demand continues to exceed capacity, with a 15% increase in referrals to secondary mental health services in 2024/25, alongside longer waits and more complex presentations.

Mental health is closely linked to other safeguarding risks. In 2025, parental mental health overtook domestic abuse as the leading cause of child protection referrals in England, reflecting wider pressures such as poverty, housing instability, and reduced access to early help.

Research also highlights complex relationships between mental health and pregnancy choices.

Some individuals experience increased risks of depression, anxiety, PTSD, substance use, and psychiatric hospitalisation following abortion, while inability to access abortion care is associated with greater psychological distress and socioeconomic harm.

These factors underline the need for skilled clinicians who can provide holistic, client-centred care when mental health concerns are identified.

6.1.2. MSI UK context

Mental health concerns frequently intersect with other safeguarding risks, making them a key driver of complexity within MSI UK services and the most significant safeguarding theme.

In 2025, 12,873 mental health-related concerns were recorded, accounting for 53.3% of all safeguarding concerns. This reflects national trends and highlights widening health inequalities and the challenges faced by clients accessing our services.

6.1.3. Data interpretation and limitations

This data provides a broad overview of mental health related safeguarding concerns. However, it does not currently differentiate between low level or well managed conditions (such as anxiety) and higher risk or more complex presentations (including psychosis or schizophrenia). At present, all mental health concerns are captured under a single category. As mental health continues to represent the largest proportion of safeguarding activity, greater differentiation is increasingly important to support accurate risk assessment and proportionate intervention.

In 2026, we will undertake a comprehensive review of our mental health categorisation framework, with the aim of distinguishing levels of severity and complexity. This will support clearer data insights, improved identification of risk patterns, more accurate external reporting, and more tailored support pathways for clients.

Across all cases, MSI UK continues to work closely with external agencies – including mental health services, domestic abuse organisations, community support providers, and multi agency safeguarding hubs – to ensure clients receive holistic, integrated care that reflects the complexity of their needs.

6.2. Domestic abuse and reproductive coercion

6.2.1. National context

Domestic abuse affects people of all ages and backgrounds and remains a major public health issue. It is often hidden, hard to disclose, and has serious, lasting impacts. It is also recognised as an Adverse Childhood Experience (ACE), with long-term effects on health and wellbeing.

In the year ending March 2025, an estimated 3.8 million people aged 16+ in England and Wales experienced domestic abuse, while police recorded over 816,000 related crimes. However, it remains widely underreported, highlighting the vital role of health services in identifying abuse and providing support.

6.2.2. MSI UK context

Sexual and reproductive healthcare settings are key to identifying domestic abuse and coercive control, particularly during pregnancy. Evidence links domestic abuse with pregnancy and abortion, with young people and those of reproductive age most affected.

Pregnancy can trigger or escalate abuse, including reproductive coercion such as pressure over pregnancy decisions, contraception sabotage, and restricted autonomy. Access to safe abortion care is therefore critical, as barriers can increase the risk of ongoing harm.

We are committed to ensuring all clients feel believed, supported, and safe. Disclosures involving clients, their children, or other vulnerable individuals are managed through consistent safeguarding processes, with partnership working across ICBs, local authorities, and specialist services. Colleagues follow clear internal reporting and external information-sharing responsibilities in line with statutory guidance.

Safeguarding decisions balance risks with protective factors, respecting each client's wishes, circumstances, and safety. This supports proportionate, person-centred care while meeting legal and professional duties.

6.2.3. Domestic abuse disclosures in 2025

In 2025, 15.8% of confirmed safeguarding concerns involved domestic abuse. This includes disclosures relating to:

- Physical abuse
- Coercive control
- Reproductive coercion
- Emotional and psychological abuse
- Economic abuse
- Technology-facilitated abuse
- honour-based abuse

The prevalence and nature of domestic abuse disclosures within our services aligns with national patterns and reinforces the role of sexual and reproductive healthcare in identifying hidden harm.

Figure 4 shows the breakdown of domestic abuse related disclosures. This data informs targeted training, strengthens local partnerships and supports early identification and safe intervention for clients experiencing abuse.

We work closely with specialist organisations, including Standing Together Against Domestic Abuse, Refuge, Women's Aid, the National Centre for Domestic Abuse and ManKind, to support collaborative safeguarding responses for clients and families at risk.

6.2.4. Reproductive coercion

Reproductive coercion is a form of abuse where a person interferes with another individual's reproductive choices, including sabotaging contraception, forcing pregnancy, or controlling decisions about abortion. These behaviours aim to exert power and control and can have serious, long term consequences for survivors. In 2025, 5.3% of safeguarding disclosures at MSI UK related to reproductive coercion. Identifying and responding to these disclosures remains a key safeguarding priority within abortion and contraception services.

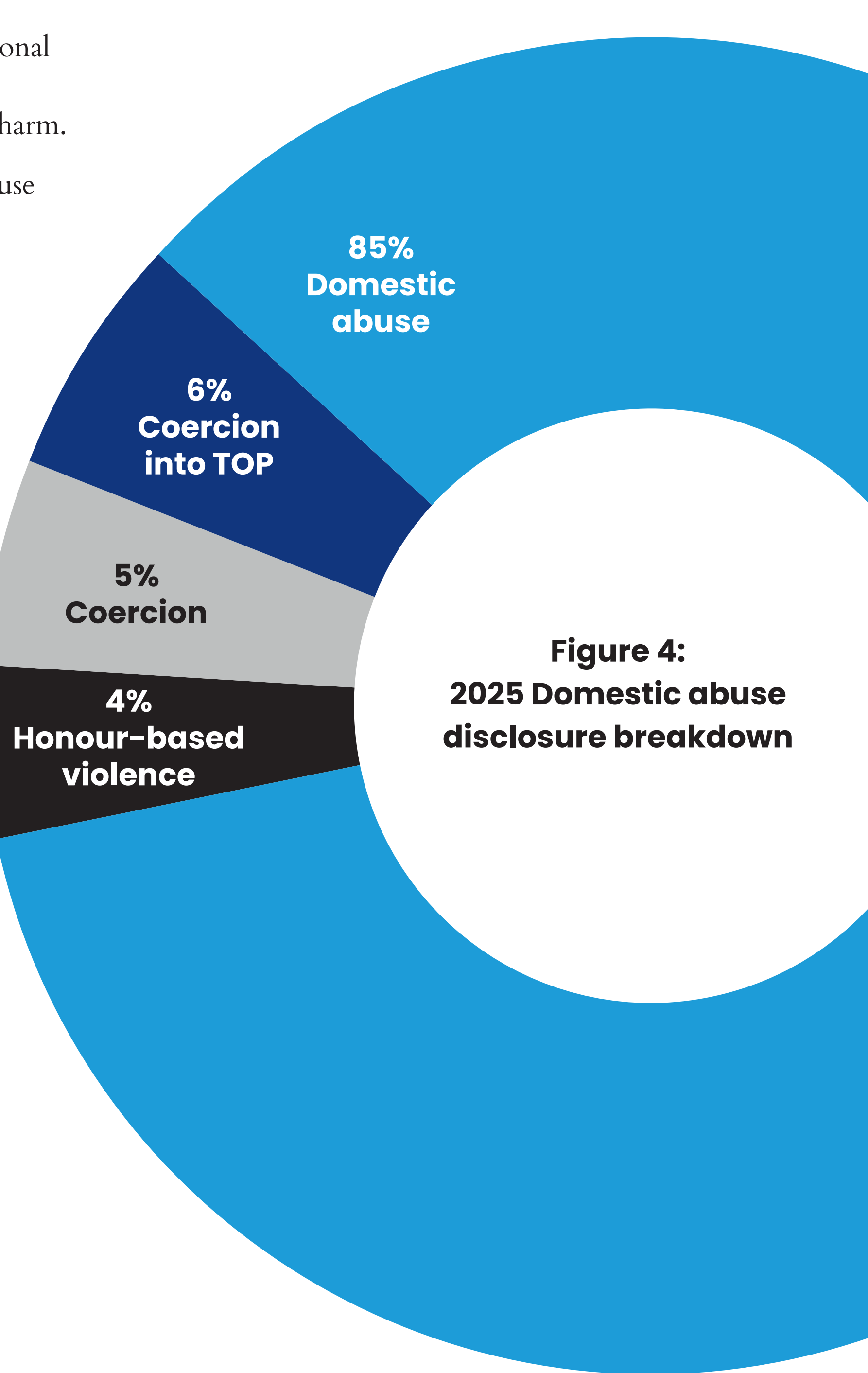


Figure 4: 2025 Domestic abuse disclosure breakdown

6.2.5. Anonymised case study – Aisha

Case overview

Aisha attended MSI UK seeking an early medical abortion while living with significant safeguarding risk. She is a parent, and the father of the pregnancy is also the father of her children.

During her appointment, she disclosed recent domestic abuse, including two incidents of non fatal strangulation, the most recent occurring the day before accessing care. Visible injuries were noted.

Aisha reported that the perpetrator was unaware of the pregnancy and that she feared serious harm if he found out. She had recently separated and was staying with a family member for safety. These factors raised immediate concern for both Aisha and her child.

Risk factors identified

- Recent non fatal strangulation (x2)
- Visible physical injury
- Recent separation from perpetrator
- Pregnancy
- Fear of escalating harm
- Children in the household

Key point: Non fatal strangulation is a recognised high risk indicator and a strong predictor of future homicide.

Safeguarding approach

Although Aisha initially declined referrals, the level of risk remained high. Practitioners:

- Clearly explained safeguarding concerns and risks
- Discussed the role of information sharing in protecting her and her child
- Worked at Aisha's pace, using a trauma informed approach

This supported Aisha to understand the need for wider involvement, and she subsequently consented to referrals.

Safeguarding response

Given the level of risk:

- Case assessed as high risk domestic abuse
- Referrals made to:
  - MARAC
  - GP
  - Children's Social Care
- Safety netting advice provided
- Advised to seek urgent medical assessment for strangulation injuries

These actions ensured Aisha and her child were not managing risk alone and enabled multi agency protection and support.

Outcome

Aisha engaged with safeguarding support following discussion and consented to appropriate referrals, enabling coordinated intervention to reduce risk and support longer term safety.

Learning

- Non fatal strangulation must be treated as a critical safeguarding indicator, regardless of scoring tools
- Safeguarding requires professional judgement beyond thresholds and checklists
- Clear, compassionate communication is essential, particularly where consent is initially declined
- A trauma informed, person centred approach supports engagement while respecting autonomy

This case demonstrates how skilled safeguarding practice, persistence, and clear communication can support protective intervention during periods of acute risk and vulnerability.

6.3. Children and young people

Under 18s accounted for approximately 2.3% of episodes of care in 2025. Although a small proportion of overall activity, children and young people may face additional barriers to accessing timely, high-quality care and can present with increased safeguarding needs.

MSI UK's approach is grounded in statutory guidance and youth-friendly practice, ensuring care is safe, proportionate, and responsive to individual circumstances.

6.3.1. You're Welcome standards

We continue to meet the UK Government's You're Welcome Quality Standards (2023), which set expectations for youth-friendly, accessible, and confidential services. Compliance across all eight domains is supported by trained staff, robust safeguarding frameworks, clear consent and confidentiality processes, and effective partnership working.

6.3.2. Risk assessments and pathways

Age-specific safeguarding risk assessments are used for all clients under the age of 18. Tailored pathways for under 13s, under 16s, and under 18s are in place across services.

These assessments explore key risks, including child sexual exploitation, consent, and wider contextual vulnerabilities. Clear escalation processes and ASP oversight are in place where concerns are more complex.

6.3.3. Adverse childhood experiences (ACEs)

We recognise the impact of adverse childhood experiences (ACEs) on young people's wellbeing and engagement with healthcare.

Trauma-informed practice underpins all safeguarding interactions, ensuring care is safe, predictable, and empowering, while avoiding re-traumatisation and promoting trust and choice.

6.3.4. Care-experienced children and young people

In 2024, 1.63% of clients disclosed that they were currently looked after or had previous care experience. Nationally, there were 81,770 children looked after in England in 2025, a slight decrease from the previous year. Due to changes in reporting and data collection, 2025 MSI UK figures are not yet available.

Care-experienced children and young people are at increased risk of mental ill health, exploitation, and instability. Understanding their prevalence within MSI UK services supports informed safeguarding decision-making, targeted partnership working, and proportionate responses to risk, including enhanced oversight where required.

Figure 5: You're Welcome compliance

You're Welcome standard	Description	MSI UK Compliance summary
1. Involving young people	Young people participate in shaping their care and contributing to service design.	✓ Fully met — young people are involved in feedback, experience surveys, and service improvement discussions.
2. Confidentiality & consent	Clear explanations of confidentiality, safeguarding, and consent processes.	✓ Fully met — Fraser competence assessments, clear consent pathways, and safeguarding proformas used consistently.
3. Welcoming environment	Young people experience a safe, respectful, youth friendly service.	✓ Fully met — trauma informed practice, visible safeguarding materials, and trained staff in all centres.
4. Quality of health & wellbeing services	High quality, evidence based care tailored to young people.	✓ Fully met — strong clinical governance, ASP support, and age appropriate safeguarding frameworks.
5. Digital accessibility	Digital options improve access and choice for young people.	✓ Fully met — MSI Connect, telemedicine options, digital safety netting and follow up processes.
6. Staff training & skills	Staff have the competencies to meet young people's needs.	✓ Fully met — mandatory safeguarding training, L3/L4 clinicians, youth friendly communication skills.
7. Joined up working	Links with other agencies support holistic care.	✓ Fully met — strong partnerships with social care, CAMHS, schools, GPs, and safeguarding midwives.
8. Supporting changing needs	Services adapt to the developmental needs of young people.	✓ Fully met — personalised care planning, safety checks for U16s, and contextual safeguarding.

6.3.5. Anonymised case study – Leah

Case overview

Leah initially contacted MSI UK as an adult client seeking an early medical abortion. Her clinical record included existing safeguarding alerts, including previous involvement with Children's Social Care and a learning disability, with support already in place.

She attended a Regional Treatment Centre accompanied by another adult described as a key worker. During the visit, front of house colleagues noted interactions that raised concern, including the accompanying adult prompting Leah's responses during identity checks. These observations were shared with clinical staff, demonstrating the importance of professional curiosity at all stages of the client journey.

At the time of the appointment, Leah was able to confirm personal details and proceed with routine assessment, and no immediate safeguarding action was required.

Risk identification

Subsequent contact with the service raised serious concerns that the individual who attended may not have been the named adult client, and that a child under 16 may have accessed care using false identification. This represented a significant escalation in risk and prompted immediate safeguarding review.

Key concerns included:

- A child potentially accessing care using false adult identification
- Indicators of coaching or control by the accompanying adult
- Involvement of an adult with a history of child removal
- Concerns consistent with child sexual exploitation and trafficking
- Ongoing risk to the child and potential risk to others

Safeguarding approach

Safeguarding practitioners maintained a clear focus on the child's safety and lived experience. Although initial responses from partner agencies did not fully reflect the level of risk identified, concerns remained unresolved.

MSI UK staff continued to:

- Share information appropriately
- Escalate concerns where necessary
- Maintain professional challenge with partner agencies
- Advocate for the child's safety and visibility within safeguarding systems

This approach ensured that the concern remained active and did not diminish over time.

Safeguarding response

Through sustained safeguarding oversight:

- The case was escalated in line with child protection procedures
- Information was shared with relevant safeguarding partners
- Ongoing professional challenge was applied where responses were not proportionate to identified risk

This enabled a coordinated review of risk and appropriate intervention.

Outcome

As a result of this sustained approach:

- Leah was identified as high risk and is now supported under a Child Protection Plan
- A coordinated multi agency response was established
- Safeguarding partners strengthened their response to similar concerns within the region
- Potential harm to Leah – and possibly other children – was prevented

Learning

This case highlights that safeguarding is not only about making referrals, but about persisting when risk remains unresolved.

Key learning includes:

- The importance of professional curiosity and trusting instinct
- The need to challenge and escalate when responses do not reflect risk
- Keeping the child's safety and lived experience at the centre of decision making
- Recognising MSI UK's role as an active safeguarding partner, with responsibility to advocate and challenge

This case demonstrates how sustained safeguarding leadership, combined with a child centred approach, can lead to meaningful intervention and the prevention of serious harm.

7. Managing safeguarding complexity

Some safeguarding situations involve higher levels of risk, multiple concerns, or changing circumstances. These cases are managed through safeguarding caseloads overseen by ASPs, providing clear oversight and continuity of support.

This approach allows risks to be monitored over time and ensures that people with the most complex needs receive focused support, while maintaining consistency across the organisation.

7.1. Safeguarding caseloads in 2025

For reporting purposes, each caseloaded client is recorded under one primary reason for escalation. This reflects the main safeguarding concern at the point the case was taken onto a safeguarding caseload. While this supports clear reporting, it does not fully reflect the complexity of individual situations, as many people experience multiple concerns at the same time.

The largest caseload category was Complex Needs (see Figure 6). This reflects situations where multiple risks or vulnerabilities are present, often overlapping and increasing overall risk. These cases typically require coordinated and sustained support.

Age-related categories (for example, under 18 or under 13) usually reflect additional vulnerability linked to age, such as reliance on others or reduced ability to keep safe. The Vulnerable Child category more often relates to wider family or environmental risks, including domestic abuse in the household, social care involvement, or reduced engagement with education or support services.

Although a single primary reason is recorded for each case, the data shows that safeguarding concerns rarely exist in isolation. This underlines the need for skilled professional judgement and a holistic approach to assessment.

7.1.1. Identifying complex risk

Most clients requiring safeguarding caseloading were identified before treatment, showing that early screening and safeguarding prompts are effective. Further cases were identified during appointments or following review, reflecting that safeguarding concerns may emerge over time as trust develops, and circumstances become clearer.

Relatively few cases were identified through external referrals. This indicates that most safeguarding complexity is recognised through internal processes, supported by ongoing assessment throughout the client journey.

7.2. External referrals and multi-agency working

Practitioners work with statutory and specialist services to reduce risk and support safety (see Figure 7).

Both referrals and signposting are used:

- Referrals involve direct contact and proportionate information sharing with another agency where further action or oversight is needed.
- Signposting provides clients with information about support they can access themselves.

Referrals were used more frequently than signposting (61.5% compared to 38.4%), reflecting the level of need for direct multi-agency involvement in many cases.

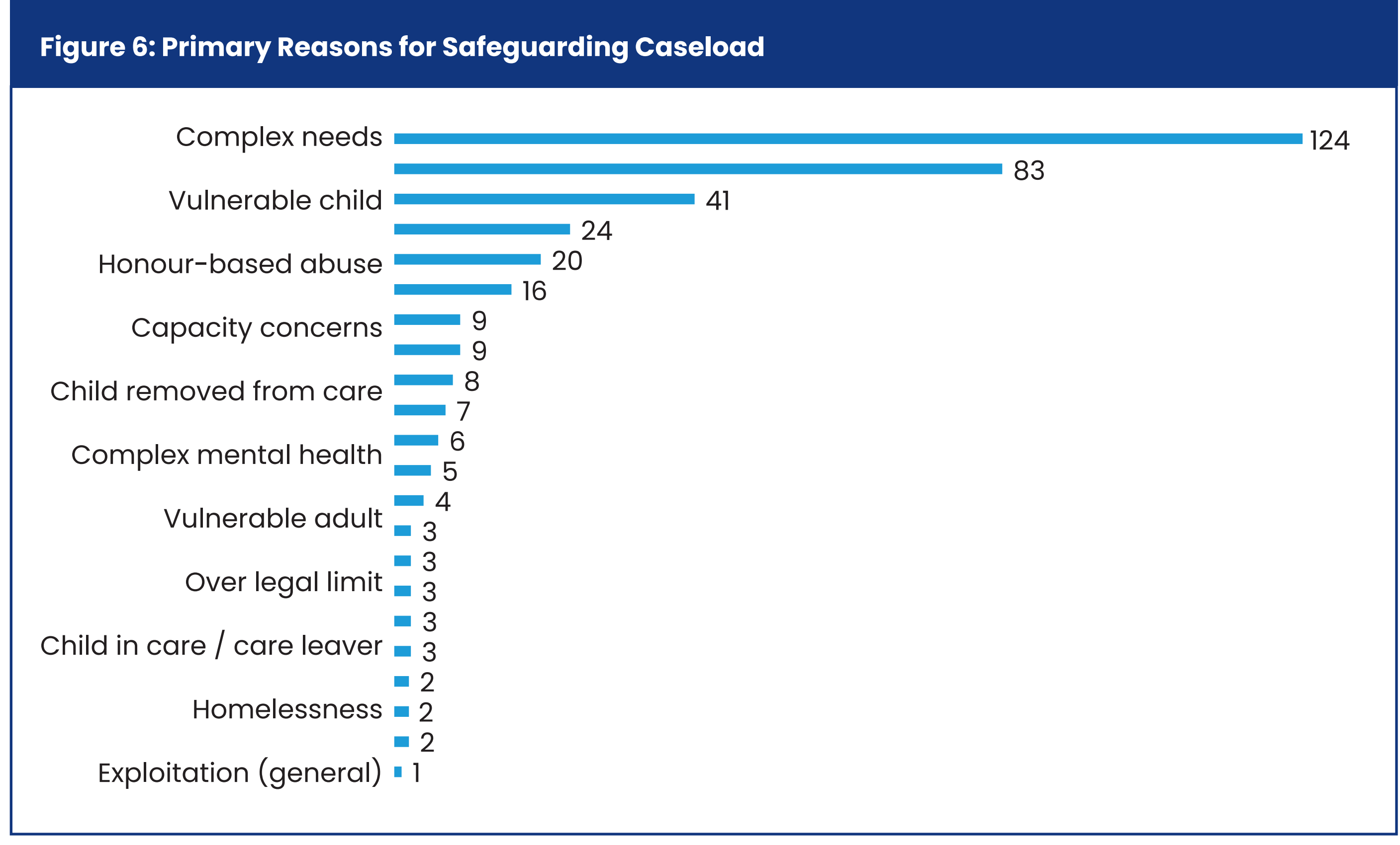


Figure 6: Primary Reasons for Safeguarding Caseload

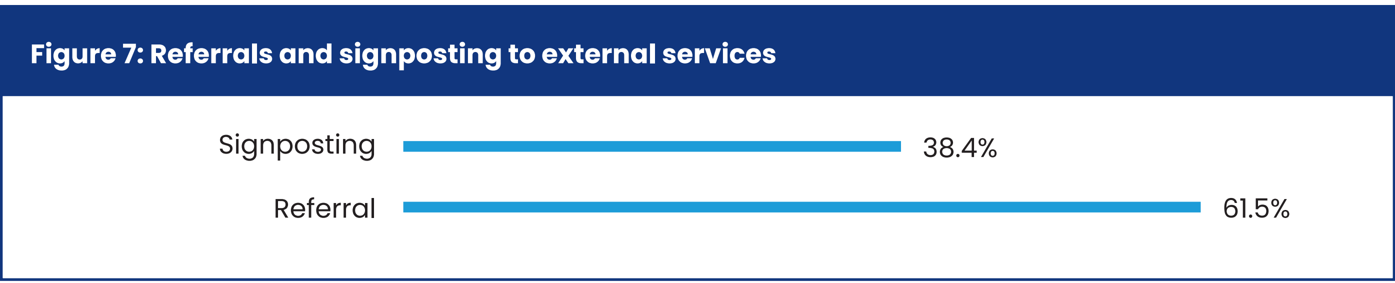


Figure 7: Referrals and signposting to external services

Most clients requiring safeguarding caseloading were identified before treatment, showing that early screening and safeguarding prompts are effective.

7.2.1. Referral activity and partner agencies

In 2025, 8.8% of clients with identified safeguarding concerns were referred to external services. This resulted in 2,139 safeguarding cases involving referral or signposting, and 2,423 contacts with partner agencies. This reflects the complexity of safeguarding work, where one case may involve more than one service.

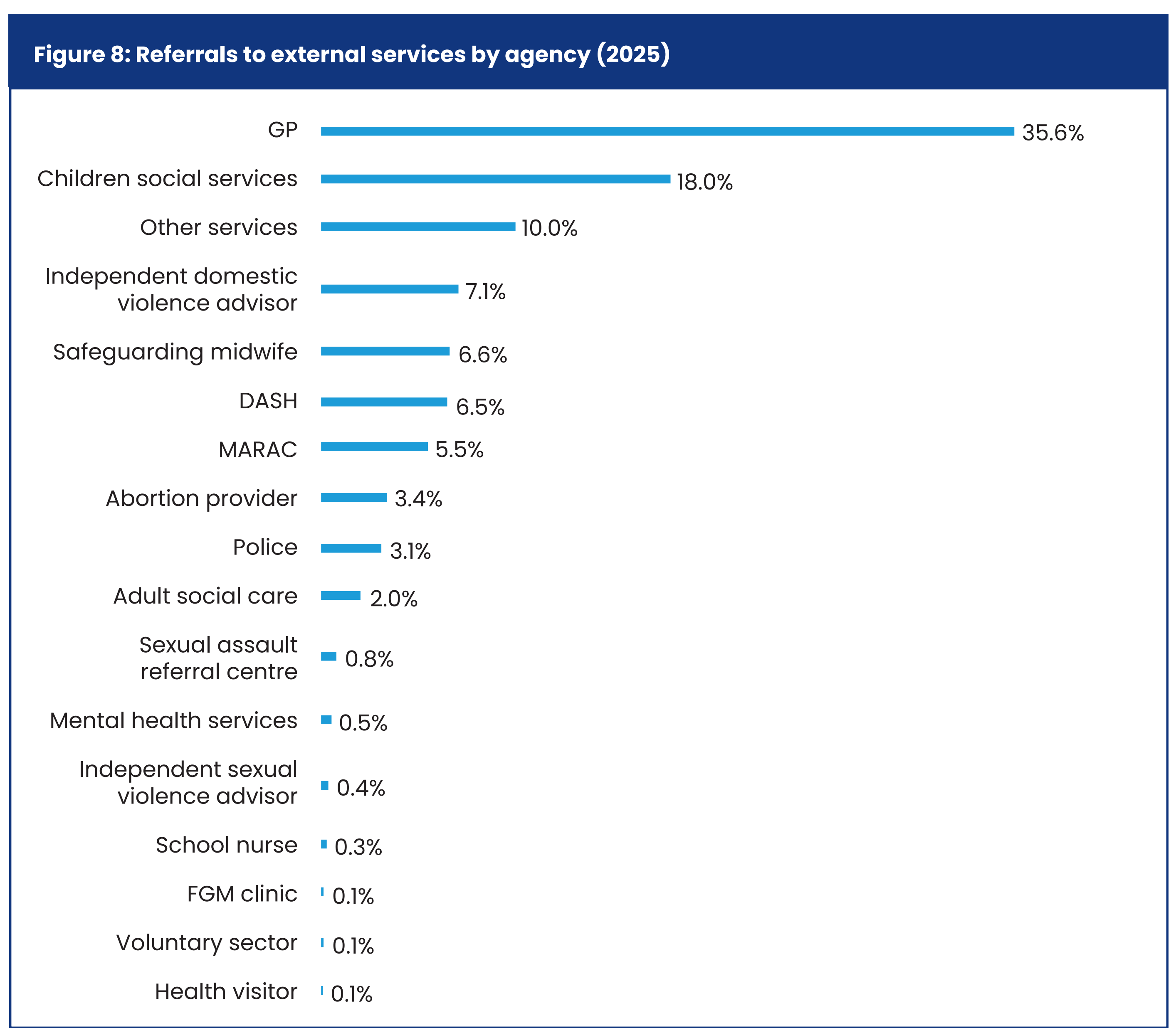
GPs received the highest number of referrals (35.6%), reflecting their role in ongoing health and safeguarding support. Children's Social Care accounted for 18%, highlighting the proportion of cases involving children or wider family risk.

Domestic abuse-related pathways also formed a significant proportion of referrals. IDVA services, DASH, and MARAC together accounted for around 18% of external escalations. This reflects the prevalence of domestic abuse within safeguarding activity and the need for coordinated responses.

Referrals to safeguarding midwives (6.6%) and abortion providers (3.4%) demonstrate joined-up working across reproductive healthcare services, supporting continuity of care and safe information sharing.

Overall, this activity shows that referrals are made appropriately and proportionately, based on risk assessment, client views where possible, and professional judgement (see Figure 8).

Figure 8: Referrals to external services by agency (2025)



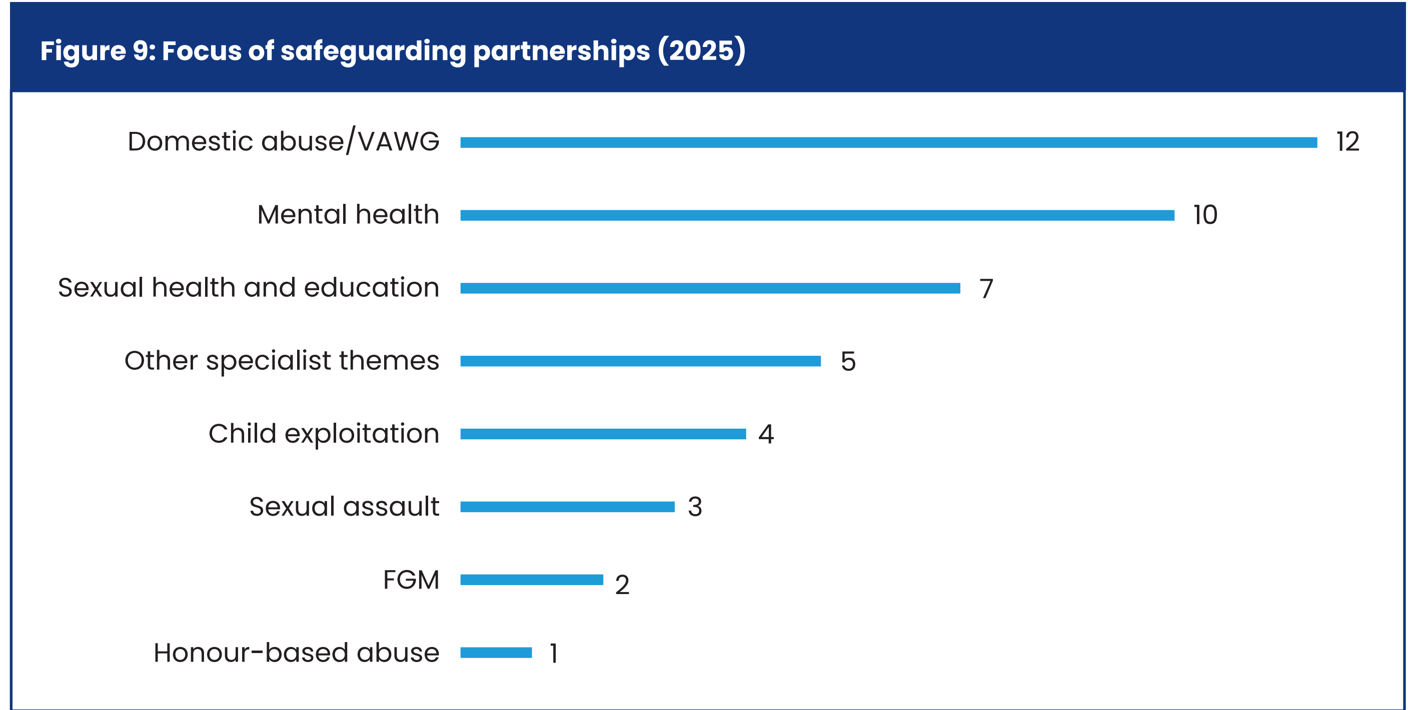


Figure 9: Focus of safeguarding partnerships (2025)

7.3. Safeguarding partnerships

Effective safeguarding depends on strong local partnerships. In 2025, MSI UK strengthened this approach by introducing a structured method to review the purpose and impact of safeguarding partnerships.

During the year, 47 safeguarding partnerships were active. These focused on key safeguarding themes, particularly domestic abuse and VAWG, mental health, and sexual health. Other partnerships addressed a wider range of risks.

These partnerships reflect both core safeguarding priorities and emerging areas of need. They were developed in response to identified needs, such as local service gaps, shared casework, and staff learning. In some areas, this led to clearer referral pathways, multi-agency working, or closer links with specialist services.

Overall, partnership activity demonstrates that safeguarding at MSI UK is collaborative, proportionate, and focused on improving outcomes for people with complex vulnerabilities (see Figure 9).

8. Safeguarding through service delivery

8.1. Telemedicine

Safeguarding oversight is built into the telemedicine pathway to ensure remote abortion care is delivered safely and appropriately. Telemedicine allows clients to use abortion medication at home, with support available at every stage.

Clients can access support by phone, webchat and online resources, including clear aftercare information and step-by-step guidance. A 24-hour clinical helpline is available for post-treatment advice and reassurance.

8.1.1. Safeguarding within the telemedicine pathway

Safeguarding screening begins at first contact through MSI Connect. Initial assessment includes medical and obstetric history, reason for abortion, safeguarding considerations, accessibility needs, contraception planning, and suitability for early medical abortion without ultrasound.

Where concerns are identified, responses are adapted to the level of risk. Disclosures of feeling unsafe prompt immediate safety checks and further assessment. Concerns are recorded using internal alerts to support continuity of care and oversight, with escalation to statutory services where required.

Pathway decisions are reviewed throughout care. Clients who do not meet criteria for no-scan telemedicine, or where concerns arise, are moved to face-to-face assessment and ultrasound.

Pathways are adjusted as new safeguarding information becomes available.

Children and young people

Additional safeguards apply for children and young people. Strengthened processes are in place for those aged 13–15, including assessment of Fraser competence. MSI UK does not provide treatment for children under 13, but safeguarding concerns are responded to through appropriate referral pathways.

Telemedicine is offered only where it is clinically appropriate and safeguarding risks can be managed. Checks include appropriate adult support, privacy, and safe arrangements following treatment.

Risk assessment and decision-making

All clients receive a safeguarding risk assessment carried out by Level 3-4 trained clinicians, using age-appropriate tools. Additional assessments, such as DASH or child exploitation screening tools, are used where needed.

Where consent for information sharing is not given but risk is assessed as high, clinicians seek advice from ASPs or Named Professionals to support lawful and proportionate decision-making.

Call safety and follow-up

Telemedicine calls include safety checks to confirm that clients are alone and safe to speak. Clients under 16 and those with known safeguarding concerns receive additional monitoring.

Missed appointments or cancellations trigger follow up welfare checks. Where treatment outcomes cannot be confirmed, or there are concerns about continued pregnancy with safeguarding risks, information is shared with statutory services where appropriate.

Governance and record management

Safeguarding records and alerts remain visible across future episodes of care to support continuity. Processes for managing duplicate records and long term safeguarding alerts have been strengthened. Some clients are assessed as unsuitable for telemedicine on an ongoing basis. These decisions are now formally reviewed through multidisciplinary discussion and approved by senior medical staff.

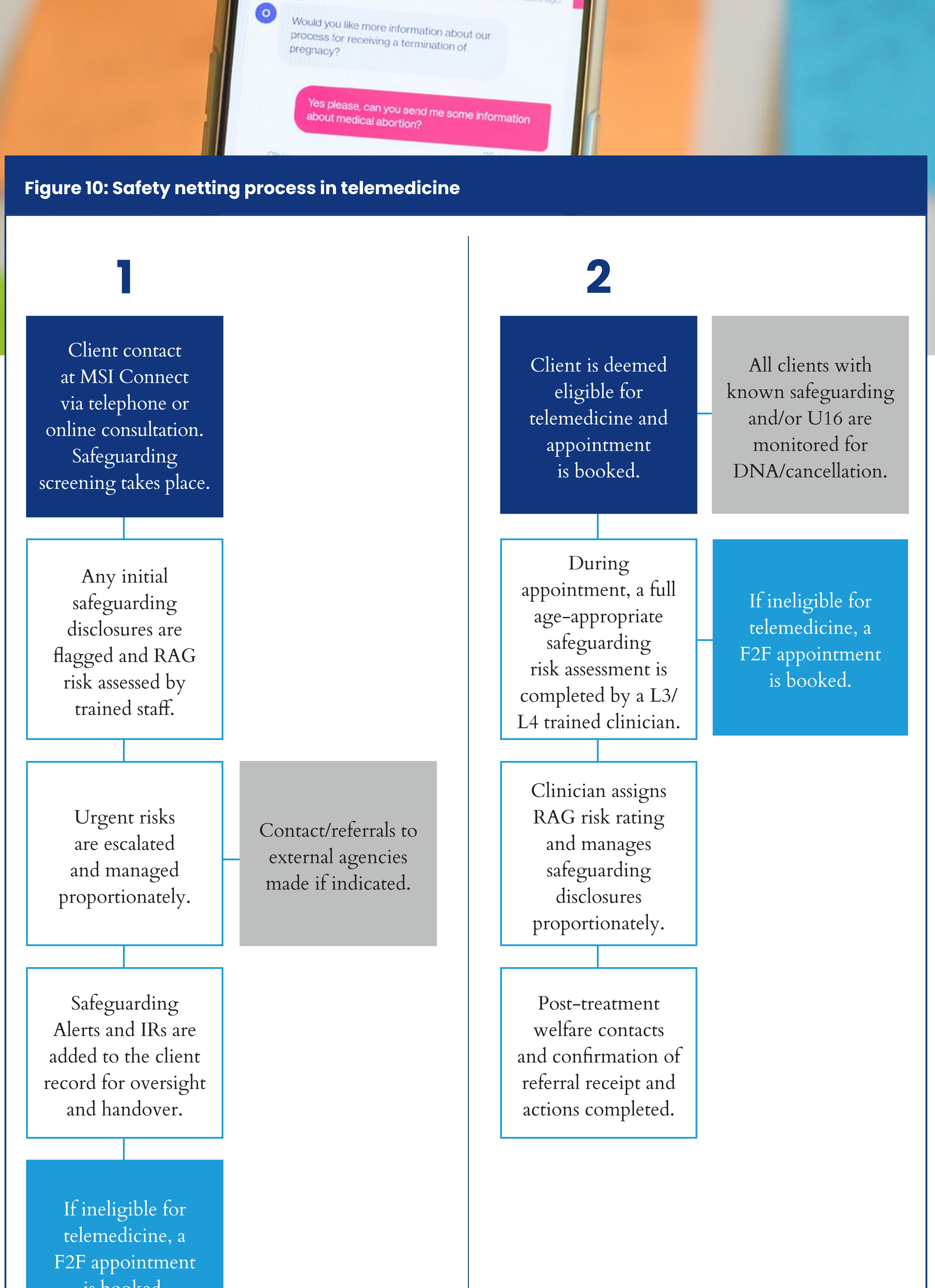


Figure 10: Safety netting process in telemedicine

8.1.2. Safeguarding disclosures in telemedicine

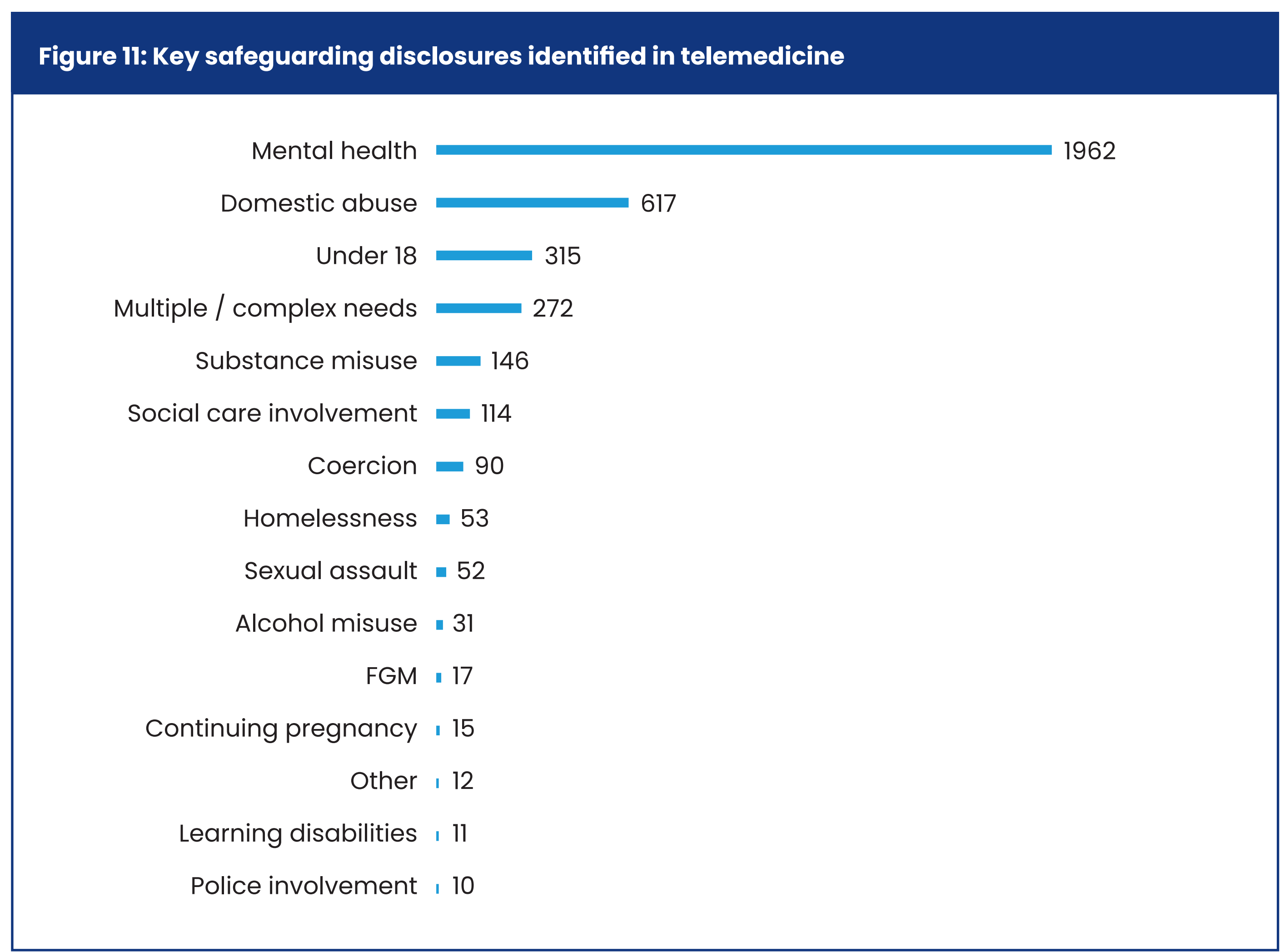
Safeguarding data from the telemedicine pathway provides assurance that risk is identified and managed appropriately within remote care. In 2025, 39,117 episodes of care related to early medical abortion via telemedicine. This demonstrates that telemedicine is a widely used and essential service, supporting timely and flexible access to care.

Of these episodes of care, 3717 included a safeguarding disclosure (9.5%). While many people can receive care safely through telemedicine, some present with more complex needs or disclose concerns during consultations. Where additional support is needed, care pathways are adjusted. This may include moving to face-to-face appointments so that risks can be assessed in more detail and managed with enhanced oversight.

The data reflects the effectiveness of early screening and safety netting processes within the pathway. Clients requiring further support are identified and appropriate adjustments are made to ensure safety and continuity of care.

Safeguarding concerns identified through telemedicine were most linked to mental health, followed by domestic abuse and age-related vulnerability. A significant proportion of cases involved multiple or overlapping risks. Other identified concerns included substance misuse, coercion, social care involvement, and homelessness (see Figure 11).

Overall, this data provides assurance that safeguarding concerns are consistently identified through telemedicine screening and consultation processes. This supports informed clinical decision-making and ensures clients are directed to the most appropriate care pathway.



8.2. Contraception and vasectomy services

Contraception is a core part of MSI UK care. Clients are supported to access the method that works best for them, including independent long acting reversible contraception (LARC) and vasectomy services. Contraception services are also an important safeguarding contact point, particularly for people at risk of reproductive coercion, exploitation, or other forms of harm. Safeguarding is embedded across all contraception pathways.

8.2.1. Independent LARC safeguarding

Where commissioned, clients can access LARC through an independent appointment, without needing to have previously accessed abortion care. This supports timely and flexible access to contraception, while ensuring safeguarding needs are identified and managed.

All clients attending LARC appointments undergo safeguarding screening, with a full assessment and onward management completed where needed.

LARC appointments provide an important opportunity to identify and respond to safeguarding needs. Some clients may attend solely for contraception while experiencing wider vulnerability, including coercive relationships, or exploitation. For some, this may be their only contact with health services.

Disclosures within LARC services most commonly related to younger clients and FGM. This highlights the role of contraceptive services in identifying safeguarding needs that may not be disclosed elsewhere (see Figure 13).

A wider range of lower-frequency concerns was also identified, showing that safeguarding risks often overlap and vary in presentation.

Overall, this provides assurance that safeguarding concerns within LARC services are recognised and managed appropriately, and highlights the importance of these pathways for people who may otherwise have limited contact with health services.

Figure 12: Safety netting process for independent LARC

Client contacts MSI Connect to book a contraception appointment.

Safeguarding screening is completed at first contact.

Alerts or disclosures (including age related flags) are recorded.

A full safeguarding assessment is completed during the appointment.

Safeguarding actions are documented and reviewed.

Referrals are made where needed.

All contraception related safeguarding concerns receive senior safeguarding oversight.

Figure 13: LARC Safeguarding disclosures by type

Type	Number
U18	10
FGM	7
Other	5
U16	5
Substance misuse	5
Domestic abuse	4
Sexual assault/abuse	2
Social services involvement	1
Police involvement	1
Multiple/complex	1
Homelessness	1
Reproductive coercion	1
Care leaver	1

8.2.2. Vasectomy services

In 2025, 0.18% of vasectomy clients disclosed a safeguarding concern.

Disclosures were most commonly related to mental health, with smaller numbers linked to substance misuse and social care involvement (see Figure 14).

Despite lower overall disclosure rates, safeguarding concerns are identified, recorded, and managed appropriately. This supports equitable access to safeguarding across all of our services and highlights the role of sexual and reproductive healthcare as a point of contact for people who may not otherwise engage with support services.

Figure 14: Safeguarding disclosures in vasectomy services by theme (2025)

Theme	Disclosures
Mental health	207
Substance misuse	58
Social care involvement	41
Other	17
Alcohol misuse	13
Domestic abuse	8
Learning disabilities	3
Police involvement	2
Multiple/complex needs	2
Coercion	2
Capacity concerns	1
Homelessness	1
Reproductive coercion	1

9. Development and support

9.1. Safeguarding training

Safeguarding training is mandatory for all colleagues and is provided at a level appropriate to role. Training is aligned with the Intercollegiate Document (2019), covering safeguarding Levels 1–3. Level 4 training is completed externally for colleagues in specialist safeguarding roles.

In 2025, safeguarding training compliance across the organisation was 92.2%, exceeding the organisational target of 85%.

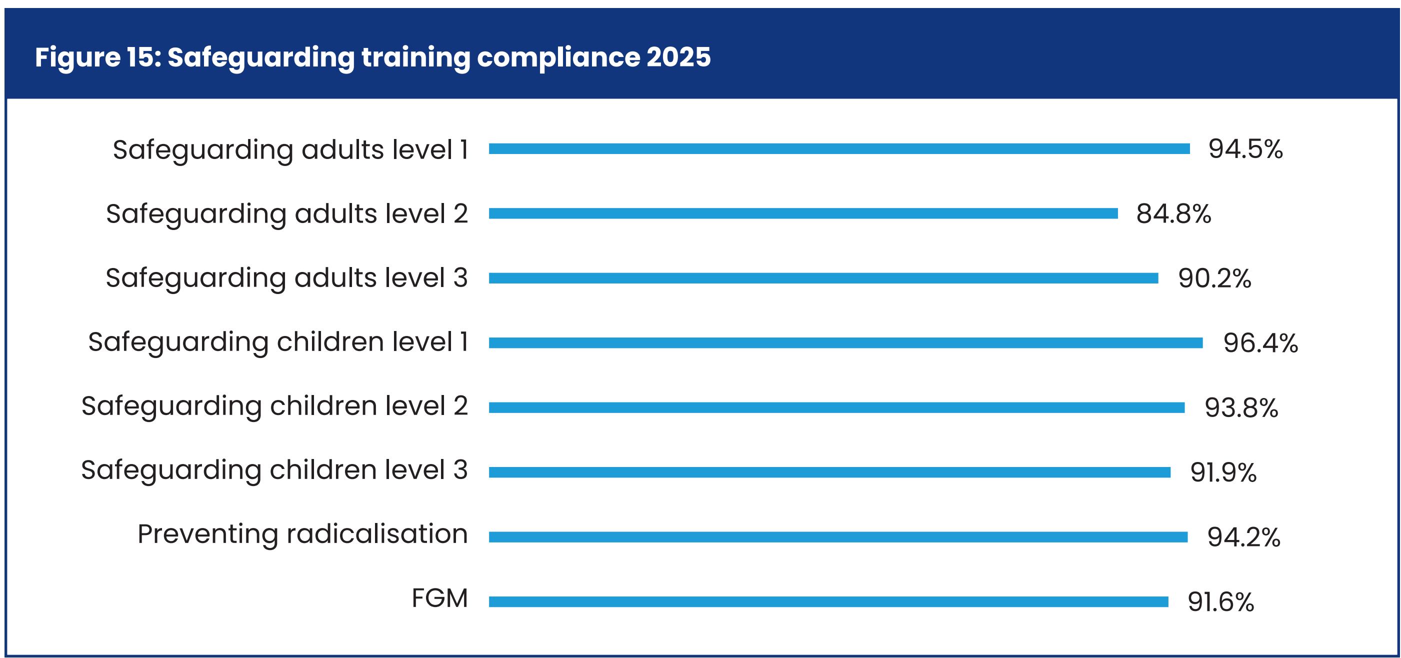
Training is delivered through a mix of online and face-to-face sessions. Level 3 training is co-delivered by the Deputy Named Nurse and ASPs, supporting consistent practice while strengthening internal expertise. Additional learning resources, including workbooks and factsheets, support ongoing learning and reflection. Virtual spaces are also used to support peer discussion and learning between sessions.

9.1.2. Ongoing learning and updates

All colleagues receive six-monthly mandatory safeguarding updates. These updates use real case examples and scenarios drawn from practice, supporting staff to apply safeguarding principles confidently within their roles.

Mandatory safeguarding update topics in 2025 included:

- Child Sexual Exploitation
- Safeguarding documentation
- FGM
- Modern Slavery and Human Trafficking
- Reproductive Coercion
- Safeguarding in vasectomy services
- Trauma-informed practice



9.2. Safeguarding supervision

Safeguarding supervision supports safe decision-making, reflective practice and staff well-being when working with complex or distressing cases. We use a restorative supervision model, which supports staff to reflect on safeguarding risk, explore professional judgement and manage the emotional impact of safeguarding work.

Supervision is available to all client-facing staff across treatment centres, community hubs and remote services, and is tailored to role and safeguarding responsibility. Supervision is provided through:

- Scheduled one-to-one or group sessions
- Ad-hoc sessions where needed
- Protected time for reflection, case discussion and escalation

9.2.1. Supervision compliance and improvement

Safeguarding supervision compliance has continued to improve over the past three years. In 2025, average organisational compliance reached 81%, a 2% increase on the previous year. Four RTCs met or exceeded the organisational target of 85%.

Lower compliance in some centres was linked to:

- Sessional staffing models
- Staff turnover
- Newly opened centres

To strengthen supervision capacity and local support, each RTC will have a dedicated ASP in post from 2026. Monthly drop-in sessions and mandatory updates will continue to support staff confidence, reflective practice and compliance.

In 2025, average organisational compliance reached 81%, a 2% increase on the previous year.

Figure 16: Safeguarding supervision requirements

Staff member	Supervised by	Frequency
Named and Deputy Named Professionals	• Any appropriately trained supervisor • MSI UK Named Professionals	• Bi-annual 1:1 supervision, or • Bi-annual group supervision
Advanced Safeguarding Practitioners	• Deputy Named Professional	• Bi-annual 1:1 supervision • Bi-annual group supervision
All MSI UK client-facing colleagues	• Advanced Safeguarding Practitioner • Any appropriately trained supervisor	• Bi-annual group supervision

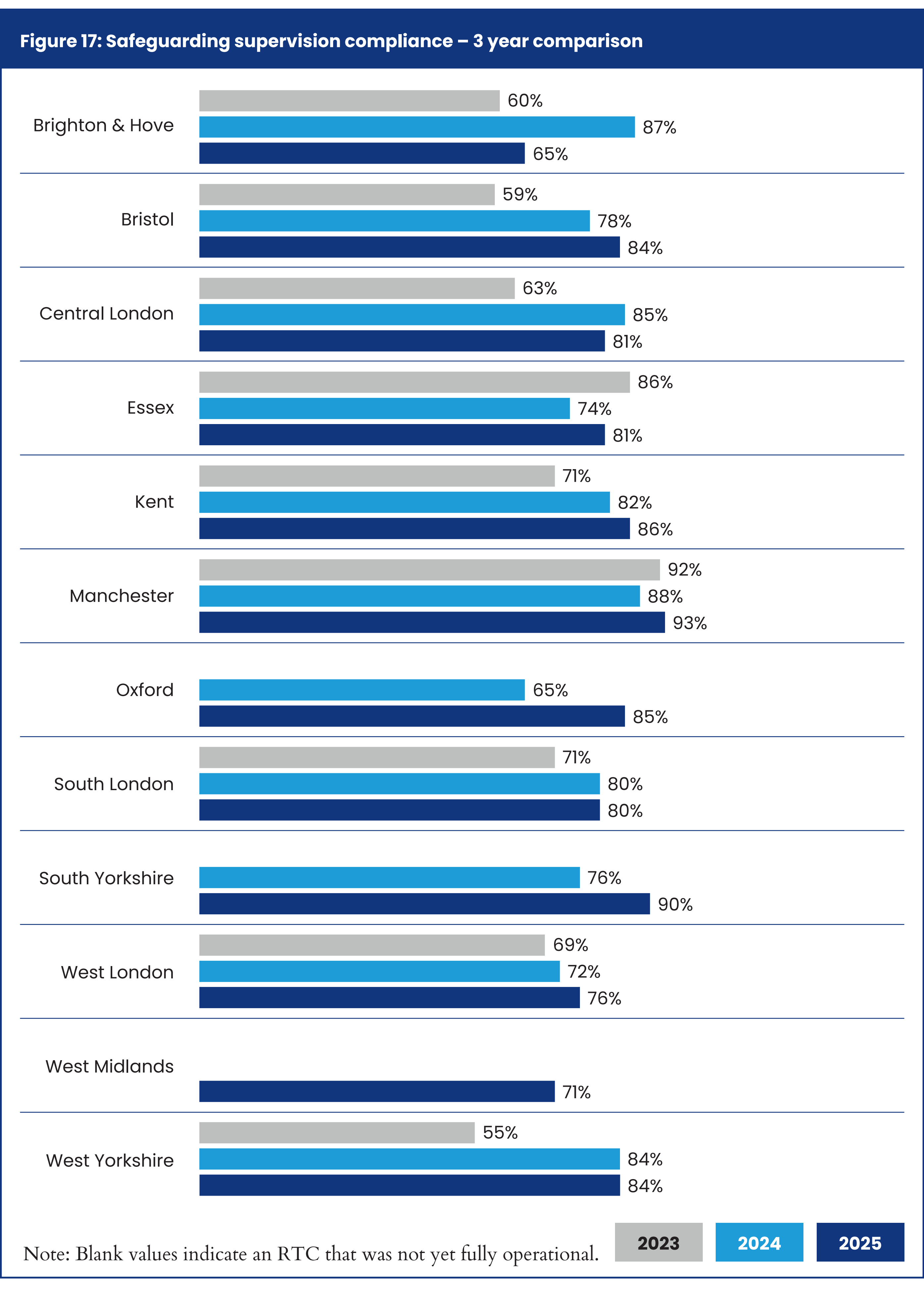


Figure 17: Safeguarding supervision compliance – 3 year comparison
Brighton & Hove
60%
87%
65%
Bristol
59%
78%
84%
Central London
63%
85%
81%
Essex
86%
74%
81%
Kent
71%
82%
86%
Manchester
92%
88%
93%
Oxford
65%
85%
South London
71%
80%
80%
South Yorkshire
76%
90%
West London
69%
72%
76%
West Midlands
71%
West Yorkshire
55%
84%
84%
Note: Blank values indicate an RTC that was not yet fully operational.
2023
2024
2025

Medabon
Combipack
1 tablet 200 mg mifepristone +
4 vaginal tablets 0,2 mg misoprostol
Each blister pack contains:
1 light yellow tablet containing mifepristone 200 mg
4 white vaginal tablets each containing
misoprostol 0.2 mg

10. Governance, audit, and assurance

10.1. Policies and guidance

Safeguarding policies, standard operating procedures (SOPs) and pathways set out clear processes for assessment, escalation and decision making. These documents are available to all colleagues via the internal intranet and support consistent, safe practice across services. In 2025, the following safeguarding policies, SOPs and pathways were reviewed or updated:

Policies

- Care of Clients with Learning Disabilities and/or Autism Policy
- Continuing Pregnancy Policy
- Did Not Attend (DNA) Policy
- Domestic Abuse Policy
- Managing Safeguarding Allegations Against Team Members Policy
- PREVENT Policy
- Record Keeping Policy
- Safeguarding Adults, Children and Young People Policy
- Safeguarding Supervision Policy

Standard operating procedures:

- Children and Young People SOP
- Continuing Pregnancy SOP
- Did Not Attend SOP
- Internal Requests and Safeguarding Referrals SOP
- Management of Clients with Mental Health Conditions SOP
- Non-Booked Clients and Enquiries SOP
- Rape and Sexual Assault SOP
- Referral and Safeguarding for Under 13s SOP
- Responding to Disclosures of Sex Selective Abortion SOP
- Right Care NHS Referral and Safeguarding SOP
- Safeguarding and Clinical Management of Clients with Substance Misuse SOP
- Safeguarding Risk Assessment and Management SOP
- Safeguarding Supervision SOP

Pathways

- U13, U16, U18 Pathway

Safeguarding guidance will continue to be reviewed in 2026 in line with national requirements, local learning and any incidents arising within the organisation.

10.2. Safeguarding governance and accountability

Safeguarding at MSI UK is embedded within the organisation's integrated governance framework. Safeguarding risks, activity and assurance are reviewed alongside quality, safety and performance at both regional and national levels.

The Safeguarding Group and Integrated Governance Committee meet quarterly and receive reports on safeguarding activity, themes, audits and improvement work. External safeguarding leads from ICBs have attended Safeguarding Group meetings, providing challenge and independent oversight. This structure ensures compliance with safeguarding legislation, CQC requirements and national guidance

10.3. Supportive quality assurance reviews (SQAR)

Safeguarding practice is reviewed annually at each centre through the Supportive Quality Assurance Review (SQAR). Reviews assess compliance with CQC standards and support continuous improvement. They are completed by the Named Midwife and Deputy Named Nurse through observation, staff interviews, document review and data analysis.

Actions identified through SQARs are added to local improvement plans and monitored through local governance meetings, with exceptions escalated to the Safeguarding Group. 2025 is the first year that safeguarding SQAR data has been fully collated and analysed across all centres, following the full implementation of the ASP model.

Figure 18: SQAR 2025 Results by centre

Centre	Rating
Brighton	Outstanding
Kent	Outstanding
Manchester	Outstanding
Central London	Outstanding
Bristol	Good
West London	Good
Oxford	Good
Leeds	Good
South Yorkshire	Good
South London	Good
Essex	Good

10.3.1. Themes and improvement priorities

Safeguarding practice was assessed as safe, client-centred and increasingly consistent. Four organisation-wide improvement themes were identified:

Consistency of practice:

Variation in documentation, escalation and care planning across centres.

Capacity and resilience:

Reduced safeguarding capacity during ASP absence.

Clinical confidence:

Ongoing reliance on ASPs for routine safeguarding tasks.

Visibility of safeguarding:

Inconsistent display of safeguarding information and resources in clinical environments.

These themes directly inform the 2026 Safeguarding Improvement Plan, which focuses on training, documentation, supervision, trauma-informed practice, clearer accountability and strengthened safeguarding infrastructure.

10.4. Organisational safeguarding audit

The Annual Organisational Safeguarding Audit (Figure 19) aligns with NHS England's Safeguarding Accountability and Assurance Framework and assesses compliance across governance, policies, training, partnership working, supervision, Prevent duties and complaints handling.

The 2025 audit identified full compliance across all sections, providing assurance that safeguarding requirements for children, young people and adults at risk are being met.

10.5. Compliance monitoring programme (CMP)

The Compliance Monitoring Programme (CMP) staff understanding and application of safeguarding processes, including record keeping, information sharing, supervision and training. Each RTC completes bi-monthly CMP audits (Figures 21 and 22), with issues escalated for action where required.

In 2025:

- General safeguarding compliance was 95% (3% decrease from 2024)
- Safeguarding records compliance was 96% (1% decrease from 2024)

These small reductions reflect updated audit questions, organisational growth, and the onboarding of new staff. Experienced ASPs continue to identify and address issues promptly.

Figure 19: Organisational safeguarding audit compliance

1: Governance and accountability

There are clear governance and accountability structures for safeguarding.

Met

2: Policies and procedures

Safeguarding policies are comprehensive, up-to-date, and accessible to all staff.

Met

3: Training and competency

Staff receive appropriate safeguarding training for their roles.

Met

4: Multi-agency working

Effective multi-agency working is in place to safeguard individuals.

Met

5: Safeguarding practices and pathways

Staff receive appropriate safeguarding supervision for their roles.

Met

6: Safeguarding supervision and support

Staff receive appropriate safeguarding supervision for their roles.

Met

7: Monitoring and quality assurance

Safeguarding performance is regularly monitored and evaluated.

Met

8: Prevent and contextual safeguarding

Safeguarding practice is holistic, contextual and trauma-informed.

Met

9: Complaints and whistleblowing

There are clear organisational complaint and whistleblowing structures in place.

Met

10.6. Raising concerns and freedom to speak up

MSI UK promotes a culture where concerns can be raised safely and taken seriously. Colleagues, clients and members of the public are encouraged to raise concerns about behaviours or practices that may affect safety. Freedom to Speak Up Guardians provide confidential support for colleagues who feel unable to raise concerns through routine channels. Clear leadership structures and governance processes support timely review and action.

Failure to respond appropriately to a safeguarding concern is treated as a zero tolerance event. No incidents of inadequate safeguarding response were identified in 2025.

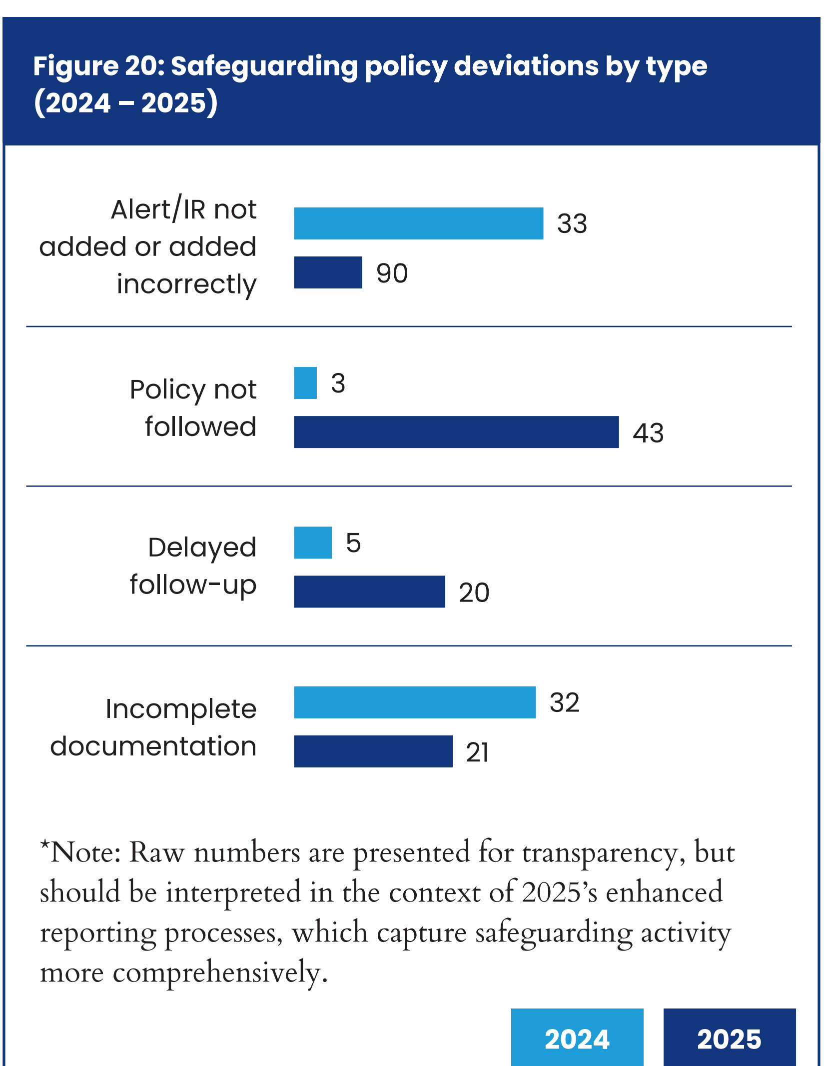


Figure 20: Safeguarding policy deviations by type (2024 – 2025)

*Note: Raw numbers are presented for transparency, but should be interpreted in the context of 2025's enhanced reporting processes, which capture safeguarding activity more comprehensively.

10.7. Incident reporting and policy deviations

Safeguarding policy deviations are reported through incident systems and reviewed weekly to identify learning and required action.

In 2025:

183,503
episodes of care

24,145
confirmed safeguarding concerns

174
safeguarding policy deviations

This represents:

0.09%
of all care episodes

0.72%
of safeguarding cases

Improved reporting systems, expanded services, and increased ASP oversight have strengthened identification and transparency. These figures reflect improved detection rather than reduced compliance.

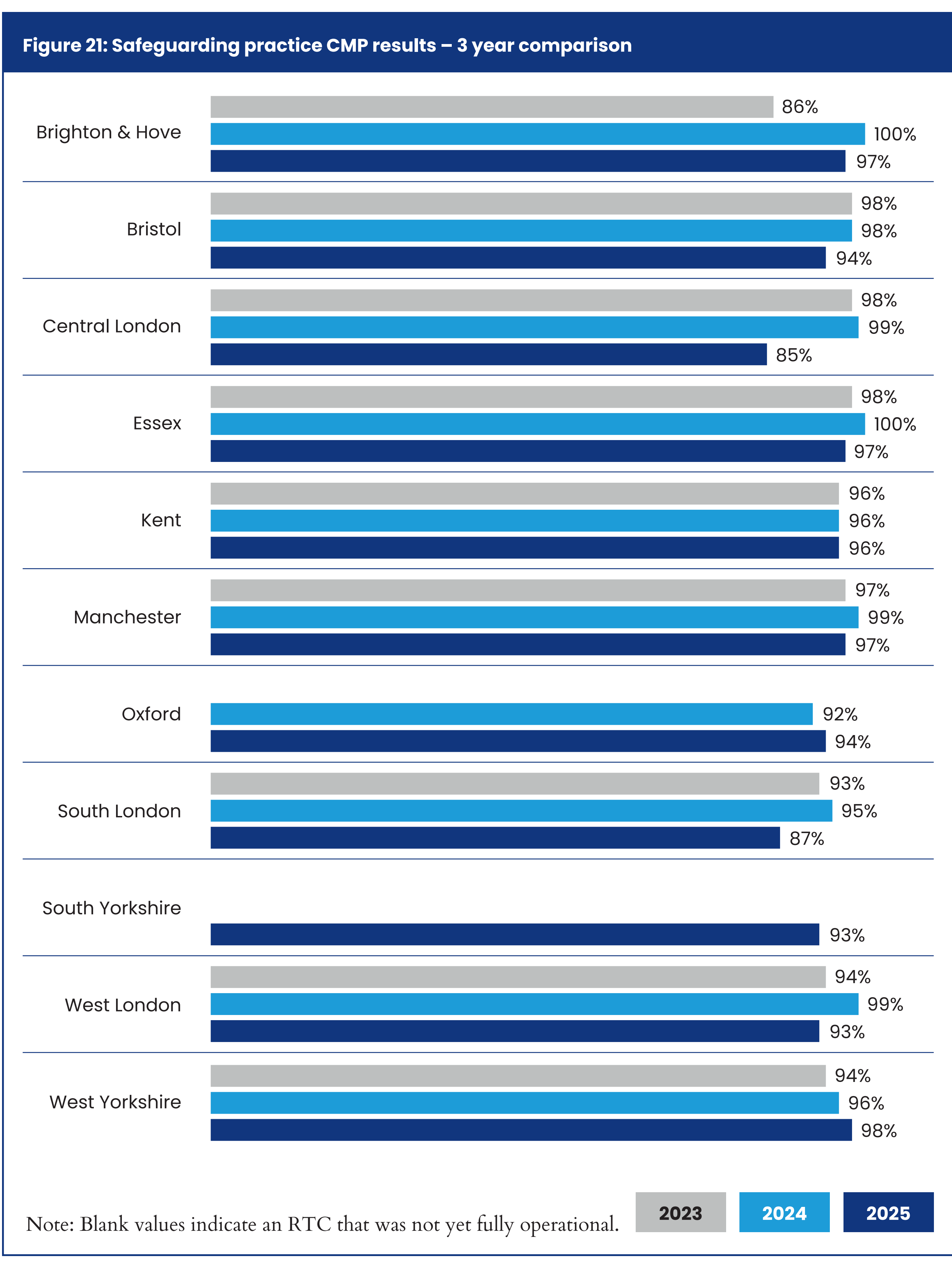


Figure 21: Safeguarding practice CMP results – 3 year comparison
Brighton & Hove
86%
100%
97%
Bristol
98%
98%
94%
Central London
98%
99%
85%
Essex
98%
100%
97%
Kent
96%
96%
96%
Manchester
97%
99%
97%
Oxford
92%
94%
South London
93%
95%
87%
South Yorkshire
93%
West London
94%
99%
93%
West Yorkshire
94%
96%
98%
Note: Blank values indicate an RTC that was not yet fully operational.
2023
2024
2025

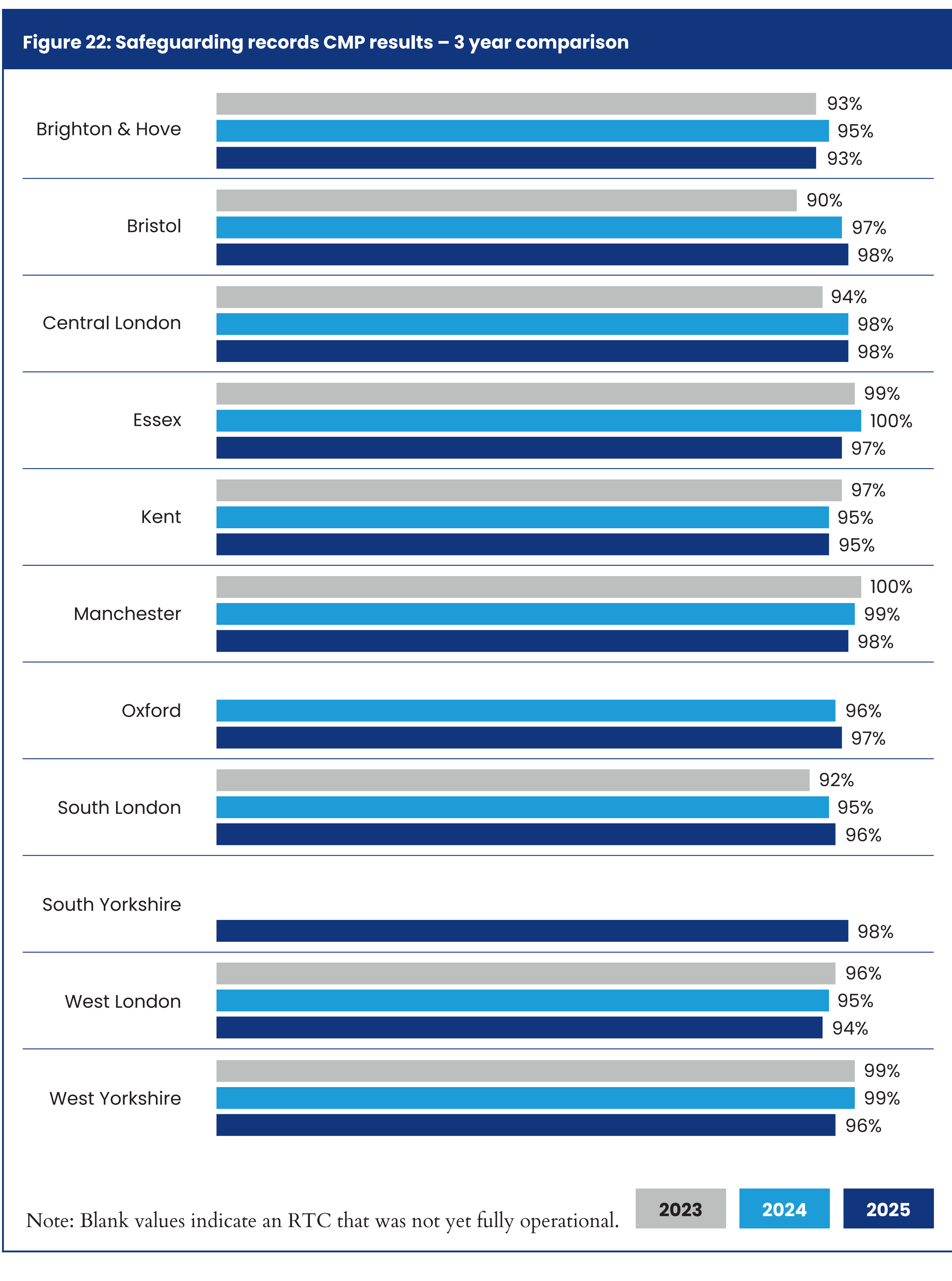


Figure 22: Safeguarding records CMP results – 3 year comparison
Brighton & Hove
93%
95%
93%
Bristol
90%
97%
98%
Central London
94%
98%
98%
Essex
99%
100%
97%
Kent
97%
95%
95%
Manchester
100%
99%
98%
Oxford
96%
97%
South London
92%
95%
96%
South Yorkshire
98%
West London
96%
95%
94%
West Yorkshire
99%
99%
96%
Note: Blank values indicate an RTC that was not yet fully operational.
2023
2024
2025

11. Delivering on our commitments

At the start of 2025, MSI UK set safeguarding priorities focused on strengthening assurance, improving data quality and maintaining proportionate safeguarding during organisational growth. Progress against these commitments is demonstrated throughout this report and summarised on this page.

11.1. Safeguarding quality assurance

Safeguarding Quality Assurance Reviews (SQARs) were completed across all Regional Treatment Centres. Reviews confirmed that safeguarding practice is safe and client centred, while identifying clear organisation-wide themes for improvement. These findings directly inform the 2026 Safeguarding Improvement Plan and are detailed in Section 10.3.

Planned improvement activity focuses on training, supervision, documentation quality, trauma-informed practice and partnership working, supported by strengthened safeguarding infrastructure and clearer accountability.

11.2. Data and dashboards

In partnership with DDaT, the Safeguarding Power BI Dashboard was launched in 2025. The dashboard provides clear, accessible safeguarding data by centre, service type and theme, enabling teams to monitor trends, identify emerging risks and support data-led decision-making.

This has strengthened local and national oversight, informed partnership activity and supported targeted staff learning. Use of the dashboard is embedded across safeguarding and clinical teams, with support provided to build confidence in data interpretation. Further detail is set out in Sections 5 and 8.

11.3. Partnership working

A structured approach to evaluating safeguarding partnerships was introduced, improving clarity around purpose, impact and alignment with safeguarding priorities. This has strengthened collaborative working and ensured partnership activity is focused where risk and need are greatest. Partnership activity and outcomes are described in Section 7.3.

11.4. Caseloading tool development

Oversight of complex safeguarding cases was strengthened through the development and implementation of a safeguarding caseloading tool. This supports consistent documentation, clearer accountability and continuity of care for clients with multiple or escalating risks. Caseloading arrangements and impact are outlined in Section 7.

12. Looking ahead

MSI UK's safeguarding priorities for 2026 align with NHS England's Safeguarding Accountability and Assurance Framework and support our ongoing commitment to protecting children, young people and adults. These priorities reflect learning from 2025, organisational growth, and the changing safeguarding environment.

12.1. Safeguarding priorities for 2026

Deliver consistent and resilient safeguarding practice

We will continue to strengthen consistency in safeguarding practice across all centres. This includes clear standards for documentation and escalation, stronger local safeguarding infrastructure, and formal ASP cover arrangements to maintain safeguarding oversight during periods of absence or service change. Learning from quality assurance reviews will continue to drive targeted improvement at local and organisational levels.

Improve safeguarding data quality and insight

We will further develop safeguarding data to strengthen understanding of risk, including mental health severity, cumulative harm and overlapping vulnerabilities. Building on episode-based reporting and safeguarding dashboards, this work will support clearer trend analysis, more accurate reporting and stronger evidence-based decision-making.

Build workforce confidence in managing safeguarding complexity

We will continue to develop safeguarding capability across the workforce through training, supervision and reflective practice. Clinicians will be supported to undertake safeguarding assessment, documentation and proportionate referrals with confidence, alongside specialist ASP oversight for complex cases. This approach will promote shared safeguarding responsibility and support safe, person-centred care across all services, including telemedicine.

13. Conclusion

This annual safeguarding report reflects continued development and consolidation of safeguarding practice across MSI UK in 2025. Safeguarding activity during the year demonstrates both the complexity of the situations faced by people accessing sexual and reproductive healthcare and the organisation's strengthened ability to respond consistently, proportionately and with confidence.

Safeguarding data shows that concerns frequently involve overlapping risks, most commonly mental health, domestic abuse, exploitation and wider social vulnerability. These patterns reinforce the need for safeguarding approaches that recognise cumulative risk rather than single issues in isolation. Improvements to data collection and reporting have increased transparency and provided clearer insight into safeguarding need across all services.

The continued rollout of the ASP model has strengthened oversight, continuity of care and professional support for staff managing complex cases. This has been supported by robust assurance activity, including quality reviews, audits and compliance monitoring, which together have promoted consistent standards and organisational learning.

Effective safeguarding relies on strong partnership working. Collaboration with statutory and voluntary agencies remains essential where risk extends beyond MSI UK services. Activity outlined in this report demonstrates the value of coordinated, multi agency responses in supporting safety and reducing harm.

Safeguarding priorities for 2026 are grounded in the learning from this report. Focus will remain on strengthening consistency and resilience, improving safeguarding insight, and supporting staff to respond confidently to complex risk.

Above all, safeguarding practice at MSI UK will continue to centre on the individuals accessing our services, ensuring care is safe, lawful and responsive to need.

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