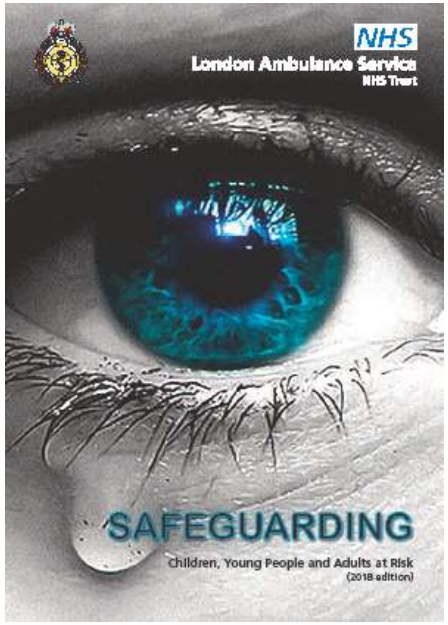
Safeguarding Annual Report



2018/19

Contents

1. Introduction

In 2018/2019 the London Ambulance Service NHS Trust (LAS) has continued to ensure the safeguarding of children and “adults at risk” remains a focal point within the organisation and the Trust is committed to ensuring all persons within London are protected at all times.

The Safeguarding Team have worked hard to support staff, monitor and review safeguarding practice and raise the profile of safeguarding during 2018/19 and have undertaken a number of audits and established several review groups to assure practice.

The Trust serves a population of 8.78 million, covering 8,382 square miles and is made up of 32 boroughs.

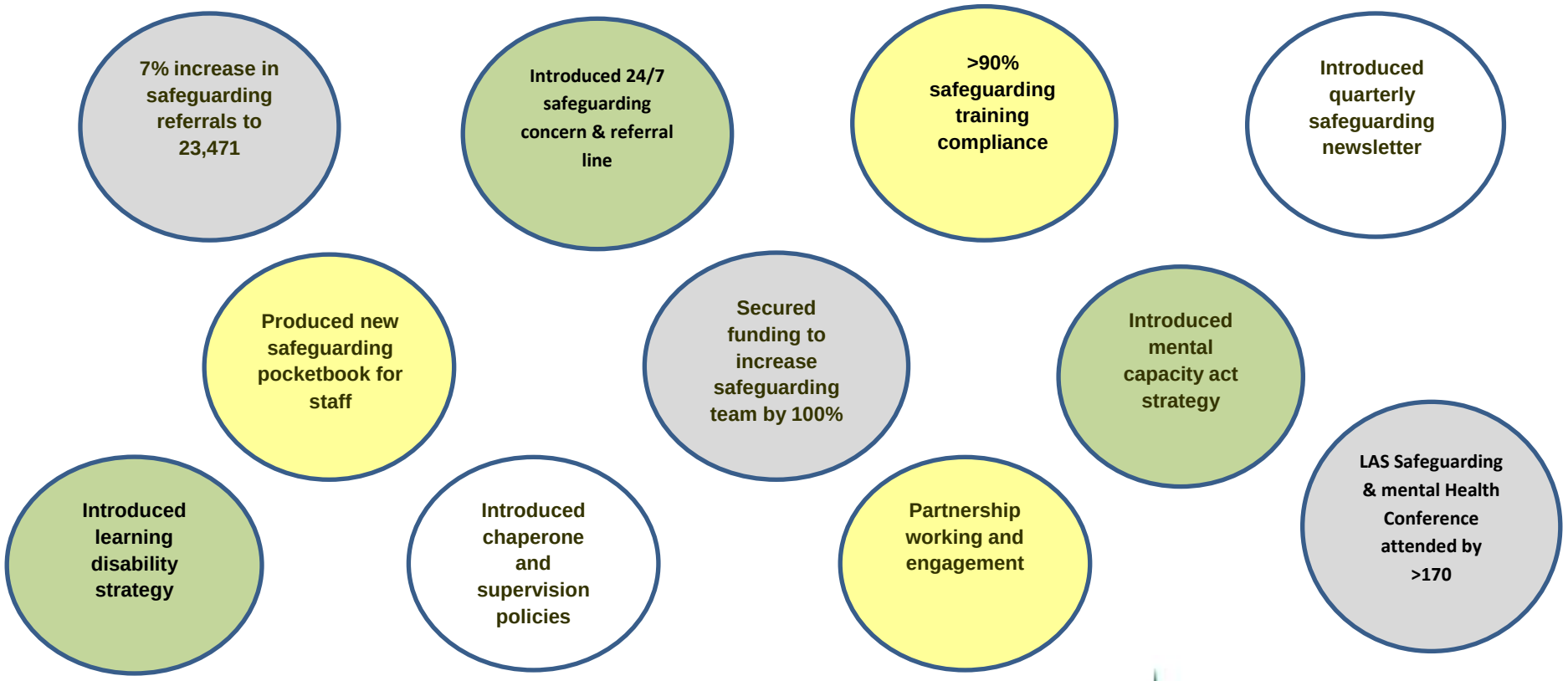
The Trust responds to over 5000, 999 calls every day and in 2018/19 we raised safeguarding concerns for an average of 2.1% of incidents received. The Trusts 111/ Integrated Urgent Care services in SE and NE London also raised safeguarding referrals and concerns via the Trusts reporting process.

This report provides evidence of the Trusts commitment to effective safeguarding processes and procedures. The report details the structure and assurance measures within the Trust to ensure compliance with the Care Quality Commission Key Lines of Enquiry, the Children Act 1989/2004, the Care Act 2014 and the NHS contract requirements.

The Trust has 64 Safeguarding Boards it engages with. Whilst it is not possible for the Trust to attend all Boards we do support local Strategy and Rapid Response meetings and provide information to support the work of the Boards. The Trust has Brent Children and Adult Boards as its lead safeguarding Board. Scrutiny of the Trusts practice is assured through Brent. Reports and audits provided for Brent are also available to other boards across London.

The Trust would like to thank all staff who have played a part in protecting child and adults a risk throughout the year.

2. LAS Safeguarding Achievements 2018/19



3. Safeguarding Structure

The Executive Director Lead for Safeguarding
Chief Quality Officer

Trisha Bain

Dr Bain ensures that safeguarding is positioned as core business in strategic and operational plans. Trisha oversees, implements and monitors the ongoing assurance of safeguarding within the Trust. This ensures the adoption, implementation and auditing of policy and strategy in relation to safeguarding.

The Trust would formally like to thank **Non- Executive Director (NED)** Bob McFarland who has recently resigned as a NED for all his support and scrutiny of the Trusts safeguarding practice for many years.

The Trust is currently looking to appoint a new NED in the coming weeks.

Head of Safeguarding & Prevent /
The statutory Named Professional for Safeguarding

Alan Taylor

Alan is responsible for ensuring the Trust is compliant with legislation and practices in relation to safeguarding. Setting Trust strategic objectives within the organisation. Alan ensures that the Trust acts to safeguard children, young people and adults at risk.

4. Safeguarding Team

Safeguarding Specialist Children Ginika Achokwu	Safeguarding Specialist Adults Julie Carpenter	Safeguarding and Training Governance Lead Inma Galvan-Navarro	Safeguarding Officer Dawn Mountier	Safeguarding Data Coordinator and Administrator Elizabeth Ogundipe

The Safeguarding Team provides expert, evidence based clinical leadership on all aspects of the safeguarding agenda. The team has a responsibility for the development and implementation of systems and processes, working with partner agencies in line with local and national standards and legislation.

The team ensures the implementation of appropriate CQC core standards, other relevant external targets, standards contributing to national and local inspections and assessments of safeguarding arrangements. The team provides information and support to partner agencies for example in undertaking safeguarding investigations, Serious Case Reviews (SCR) Safeguarding Adult Reviews (SAR), Care Proceedings, Child Death Overview Panels (CDOP's), Section 42 enquiries, Domestic Homicide Reviews(DHR) and Multi Agency Risk Assessment Conference's (MARAC).

The team supported by local Quality Governance Assurance Managers (QGAMs) and Stakeholder Engagement Managers (SEMs) work with the Local Safeguarding Children Boards (LSCB) and Adult Safeguarding Boards (LSAB).

The Emergency Bed Service (EBS) managed by Alan Hay, processes all safeguarding concerns from staff and sends to the relevant local authority or partners. They have a close working relationship with the Safeguarding Team.

The Trust is currently recruiting 6 more staff into the Safeguarding Team to strengthen the resource requirements with the introduction of the new intercollegiate documents on "Roles and Responsibilities of Health Care Staff" and the requirement to train all registered professionals to level 3 and provide safeguarding supervision across the Trust.

5. Trust Safeguarding Responsibilities

In addition to the responsibilities of the executive and Safeguarding Team.

All staff have a responsibility to report safeguarding concern either in relation to the public or a member of staff

Local Safeguarding leads

Quality Governance Assurance Managers (QGAMs) and Stakeholder Engagement Managers (SEMs)

- Attend local safeguarding meetings.
- Provide assurance on local partnership working to Safeguarding Team.

Emergency Bed Service

- Manage timely referral to Social Services (LA) via MASH (Multi Agency Safeguarding Hub) or Front Door.
- Collates information on referrals
- Receives feedback from the LA for referrals which is recorded on Datix and feedback to staff.

Local Managers

- Support staff with safeguarding concerns, audit compliance of Clinical Performance Indicators and feedback to staff.
- Provide attendance at Rapid Response meetings and support staff with safeguarding allegations which are referred to the Head of Safeguarding and Chief Quality Officer.

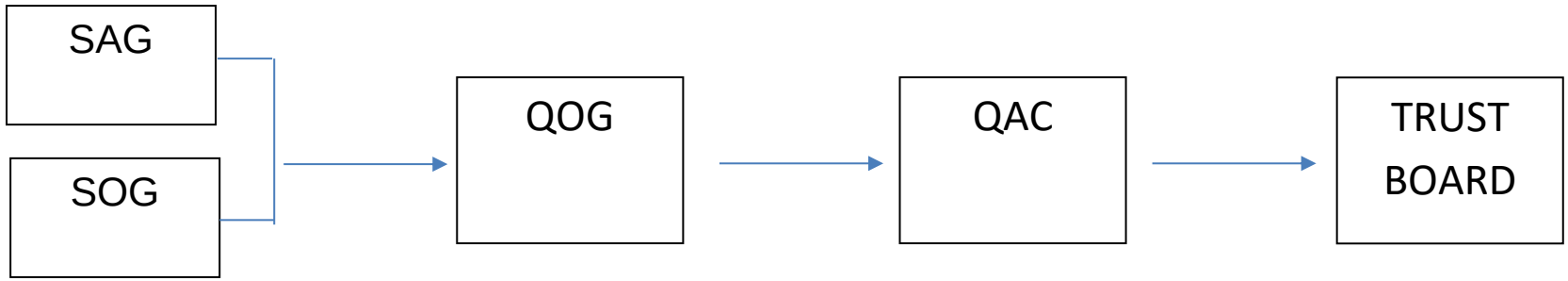
6. Governance Arrangements

The Trust has a Safeguarding Assurance Group (SAG) that meets Quarterly to monitor the Trusts safeguarding activity and provide assurance on safeguarding practice. The SAG has a sub group called the Safeguarding Operational Group (SOG) which the local safeguarding leads, Non-Emergency Transport Service (NETs), EBS manager and NHS 111 attend. They provide assurance on safeguarding activity and provide two way communication of safeguarding compliance and partnership engagement.

SAG reports to the Quality Oversight Group (QOG) bi-monthly providing assurance and raising issues for escalation to Quality Assurance Committee (QAC). This is the Trust assurance committee that feeds into the Trust Board. QAC is chaired by a non-executive director Mark Spencer.

Safeguarding reports to commissioners via the Brent CCG Designated Safeguarding Leads and the Clinical Quality Review Group currently provide them with a deep dive into safeguarding practice in the LAS.

Members of the safeguarding team attend the following committees; Serious Incident Group, Serious Incident Learning and Review Group, Mental Health Group, Patient Experiences Group, Patient Safety & Effectiveness Group, Mortality and Morbidity Review Group.



LAS Safeguarding Governance and Assurance Overview

Policies	Committees	Reports	Risks	Audits	Safeguarding Leads
• Safeguarding Children Policy TP018 Review due **Jan 21** Safeguarding "Adults at Risk" Policy TP019 Review due **May 20** • Domestic Abuse Policy TP102 Review due **Nov 21** • Safeguarding Supervision Policy TP119 Review due **Feb 22** • Chaperone Policy TP118 Review due **Mar 19** • Prevent Policy TP108 Review due **Dec 21** **HR Policy** • Allegations Against Staff Policy HR039 Review due **Jul 21** **Medical Directorate Policies** • Operational Procedure for the use of Restraint of Patients OP072 Review due **2018** • Consent to Examination or Treatment OP031 Review due **Dec 2017**	• Safeguarding Assurance Group SAG (which reports to) • Quality Oversight Group (that reports to) • Quality Assurance Group of the Trust Board. (SAG has a sub group and two practice review groups) • Safeguarding Operational Group **Review groups** • Safeguarding Incident Review Group • Care Home Concerns Review Group • Prevent Review Group • Child Deaths are reviewed virtually	• Safeguarding Annual Report • Section 11 • Safeguarding Adults Risk Assessment Tool (SARAT) • Safeguarding Health Outcomes Framework (SHOFT) • Safeguarding Balanced Score Card • Quality Report • Area Safeguarding Reports Concerns identified by the Care Home Review Group are investigated and then if required reported to the CCG/CQC Information on attendance at Care Homes is also produced quarterly and provided to commissioners and CQC	• 24/7 Telephone referral • Call recording • EBS business continuity All three risks currently sit within Emergency Bed Service (EBS) under Operations	Safeguarding has an annual audit plan 2018/19 consisting of • Auditing last year's referrals for • Child FGM • Discriminatory abuse • Historic CSA/CSE • Patients with a Learning Disability and Safeguarding Concerns. • Undertake QA audit of referral process • Knowledge and retention of staff learning internal audit by Grant Thornton looking at Policy/Safer Recruitment and Referral processes NASG looking at undertaking peer reviews during Q3-Q4	• Executive Lead - Chief Quality Officer • Non-Executive Director for Safeguarding • Head of Safeguarding (Named Professional) • Safeguarding Specialist - Children • Safeguarding Specialist - Adults Quality Governance Assurance Managers (QGAM) - Operational Leads for safeguarding in their area EBS manage safeguarding referrals & concerns Additional members of Safeguarding Team • Safeguarding Officer • Safeguarding Governance and Training Lead Safeguarding Data Coordinator and Administrator

The Trust has also agreed Mental Capacity Act Strategy 2019/2021 and Learning Disability Strategy 2019/21 including Learning Disability Improvement Standards for NHS Trust

7. Safeguarding Risks

The Trust has a number of risks that have been mitigated during the year. The chart below shows the progress made in 2018/19.

Safeguarding Risks				Initial Risk Rating	Current Risk Rating	Target Risk Rating	Current position
Risk No.	Risk description	Risk Owner	Exec Lead		March		
63	There is a risk that the Trust is unable to meet the obligation of engagement with partner agencies notably MARAC Original Risk ID 426.	Alan Taylor	Trisha Bain	12	8	8	Closed
65	There is a risk that due to our inability to link safeguarding referrals LA may not action concerns raised.	Alan Hay	Trisha Bain	12	4	4	Closed
69	Compliant with safeguarding training requirements for clinical and non-clinical staff.	Alan Taylor	Trisha Bain	12	4	4	Closed
495	Children involved in youth violence may suffer greater harm as a result of a safeguarding referral not being made	Alan Taylor	Trisha Bain	12	6	6	Closed referrals now being made to Red Thread in addition to local authority.

Current Safeguarding risks held by other areas of the Trust.
EBS – Resourcing to enable move to 24/7 telephone referrals system and removal of fax machines. **Closed now 24/7**
EBS - fall back business continuity - **Open**
EBS - Delay of installation of taped line for governance and assurance – **Open** P&OD- Managers and clinical staff patient facing without current DBS. **Closed all staff complaint and rechecking underway.**

8. Safeguarding Work Plan

The work plan (see appendix one) is monitored by SAG. The Trust has made significant progress with all elements in the work plan completed, there are no outstanding actions.

The work plan focused on 5 key areas

1. Secure sufficient resources to develop safeguarding in the Trust
2. Monitor the Trust's safeguarding processes and compliance
3. Support the Trust with safeguarding practice & requirements
4. Assure the Trust's processes by driving consistency & improvement in safeguarding practice
5. Forge effective relationships internally and externally

The 2019/20 work plan will focus on the following 6 key areas

1. Excellent governance and assurance of the Trusts safeguarding processes and compliance
2. Development of the Safeguarding Team
3. Successful delivery of safeguarding training plan, local education and supervision
4. Safeguarding innovation and review current practices to identify cost savings.
5. Ensure integration of 111 & IUC
6. Forge effective relationships internally and externally to safeguarding children and adults

Key Achievements:

- All identified areas in the 2018/19 work plan have been achieved.
- The Trust is providing a good standard of safeguarding practice and assurance.

Top Priorities:

- To deliver on the 2019/20 work plan
- Increase the Safeguarding Team to deliver on the new Safeguarding Roles & Competencies intercollegiate documents requirements.

9. Safeguarding Audits

During 2018/19 the Trust has undertaken a number of safeguarding audits, details of which are below.

Female Genital Mutilation

Recommendation	Action Taken	Outcome
FGM to be included in CSR 2018.3.	Included in CSR 2018.3	Currently being delivered. Completed
Revision of FGM flowchart used in line with Department of Health.	Currently scoping and reviewing LAS documentation and national documentation	Ongoing.
Continue staff retention and knowledge audit that includes questions on FGM.	Include question: Have you attended CSR 2018.3 that included additional FGM training	Governance and Training Lead to amend audit questions
Liaise with relevant staff in Emergency Operation Centre/Maternity regarding when triage system (MPDS) will be updated to scope possibility of FGM being included in triage questions for maternity/birth calls.	Initial contact made with EOC management. Awaiting meeting with Maternity colleagues.	Ongoing.
Feedback system once a referral has been submitted to a local authority's CSC needs to be made more robust.	EBS employing staff member to chase for feedback. Feedback percentages included in annual report Head of Safeguarding & Prevent raised issues around feedback with Pan London Mash group. Head of EBS to engage with poor performing local authorities.	Ongoing. Feedback has increased to 19% this year from 2% two years ago.

Discriminatory Abuse Audit

Recommendation	Action Taken	Outcome
Need for a more robust feedback process post the submission of safeguarding concerns, as no feedback received from local authority until requested.	• Remind LA of need for feedback • A dedicated person in EBS to contact LA for feedback • Head of EBS & Head of Safeguarding & Prevent to continue to raise importance of feedback LA.	• % of feedback has increased • Continue to raise at Pan London forums
Need to raise awareness of what discriminatory abuse is within Operations and EBS.	• Article written for Clinical Newsletter • Discriminatory abuse enhanced in level 3 training.	• Article in next edition of the Clinical newsletter.

Learning Disability Audit

Recommendation	Action Taken	Outcome
Need for more robust feedback process post the submission of safeguarding concern, as no feedback received from local authority until requested	• Remind LA of need for feedback • A dedicated person in EBS to contact LA for feedback • Head of EBS & Head of Safeguarding & Prevent to continue to raise importance of feedback with MASH and LA	• % of feedback has increased with dedicated person within EBS • Continue to raise at Pan London forums
To ensure patient is spoken to and wishes and feelings are considered and documented	• Updated level 3 training to include more on communication with patients with a Learning Disability	• Included in training will audit improvement during the year
Raise general awareness of learning disabilities	• Written a LeDeR article for publication	• For inclusion in next Clinical Newsletter

Historic CSA/CSE

Recommendation	Action Taken	Outcome
Explore feasibility of information sharing with Police in the Multi Agency Safeguarding Hub (MASH) around hot spots in their locality	Initial contact made with Brent police	Implementation plan required - ongoing. Governance and Training Lead to take on this stream of work
Explore possibility of directly referrals to Multi Agency Sexual Exploitation (MASE) Panels with Brent.	Initial contact made with MASE chair and coordinator in Brent	Initial findings are that there is considerable administration requirements and commitment required. At present LAS unable to commit to this work
Undertake an audit in 2018/19 with MASH colleagues/Team manager around the quality of information provided from LAS	Initial contact made with MASH team manager in Brent	To be undertaken in 2019/20 facilitated/managed by Governance and Training Lead
Improve feedback immediately post submission of a referral and upon request	• Amended the referral document that is sent to the local authority (LA) to include a easier to complete feedback page • Raise issue of lack of feedback with LA's. Head of Safeguarding and EBS manager to meet with MASH managers.	• Form being used by some LA's and there has been an increase in % of feedback received to 19% • Feedback logged on Datix, crews sent email to view feedback • EBS have a member of staff who chases for feedback
Findings regarding ethnicity recording to be shared with Trust Lead for Equality	Share findings to Trust Equality lead	Information shared. Ongoing work in this area around capturing demographics of patients we treat. It is believed that electronic Patient Report Forms will assist with this
Additional training to be delivered to staff around professional curiosity	To be included in the Core Skills Refresher (CSR) training and in the Safeguarding Level 3 training	Included in CSR 2017.3 completed
Raise awareness of CSE in LAS	Information in the RIB for all staff, that included the SAFEGUARD Mnemonic for national CSE Awareness day	• Continue to scope ways to raise awareness within the Trust • SAFEGUARD Mnemonic included in updated version of pocketbook

10. Safer Recruitment

- The Trust has a Policy/Standard Operating Procedure for safer recruitment and includes agent staff volunteers and celebrity visitors
- The Trust is continuing to recheck all existing staff requiring DBS.
- All staff in patient facing roles can only start if all of their employment checks have been completed and they have a completed DBS check or one in progress and a risk assessment has been undertaken.
- Our international Paramedics require a certificate of good standing from their home country National police Check/DBS equivalent.

Child Protection Information Sharing (CP-IS)

- CP-IS scheme is a national project lead by NHSE to ensure agencies share information of children or unborn children who are subject to a child protection plan. Local authorities are uploading CP plan flags onto the NHS spine. There is a requirement for all NHS staff to access this information when dealing with patients, this information will add decision making.
- Currently the national CP-IS team have removed Ambulance Trusts and 111 attached to Ambulance Trusts from the requirement, as issues have arose around multiple notifications to Local Authority for one attendance. A pilot with one Ambulance Trust will be undertaken prior to introduction.

Key Achievements:

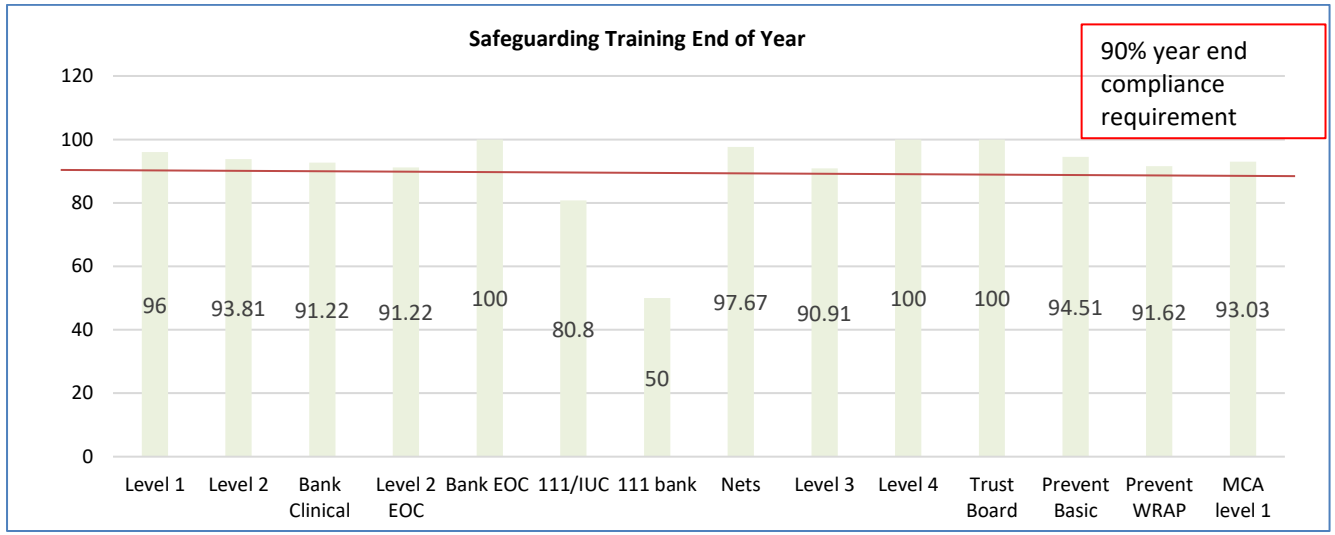
- 99% of eligible workforce are complaint within the requirements of Safer Recruitment.
- 1,874 staff have completed DBS recheck.

Top Priorities:

- To complete DBS re check for remaining 1,810 staff by September 2019

11. Safeguarding Education and Training

An extensive amount of safeguarding training has been undertaken during 2018/19.
The safeguarding team would like to thank the Clinical/EOC Education Tutors and the Safeguarding Specialists for all their work to achieve the target.
NHS111/ IUC and 111 Bank staff were the only areas below the compliance target set by commissioners.



Overall the Trust is compliant with Safeguarding Training for 2018/19

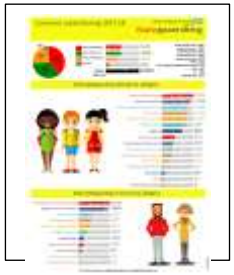
Key Achievements:

- **Overall Trust compliance is**
- **Level 1 96%**
- **Level 2 92.81%**
- **Level 3 90.91%**

Top Priorities:

- **Trust is committed to training all clinical staff to Level 3 within the next 3 years and has agreed a trajectory with commissioners.**

During 2018/19 we have developed a range of educational materials to support safeguarding education and training. This included four posters which have been distributed to staff within the Trust. This includes Safeguarding Supervision, referral / Concern Raised in 2018/2019, Domestic Abuse and Mental Capacity Act. The Trust also produced third edition Safeguarding Pocket Books which were issued to all clinical staff (see image front page).



Safeguarding Quarterly Newsletter

Key Achievements:

- **Quarterly Safeguarding Newsletter**
- **Continued safeguarding education via**
  - **Clinical update**
  - **Routine Bulletins**
  - **Safeguarding newsletter letter**
- **Safeguarding & Mental Health conference**

Top Priorities:

- **Local area safeguarding events**
- **Continue to learn from incidents and educate staff**
- **Staff recognition**

12. Safeguarding & Mental Health Conference

The LAS held its 4th Safeguarding Conference at Goldsmith University in attendance were over 170 staff and partner agencies. The Trust would like to thank NHSE London region and key speaker Kenny Gibson, Head of Safeguarding for NHSE, along with survivors and experts who presented at the conference for their support.

<u>The team received great feedback from the conference including;</u>

- Well organised and welcoming safeguarding staff
- Best conference I have attended
- Very beneficial day

Safeguarding & Mental Health Conference

Coercive Behaviour

Domestic abuse survivor story

Lived Child Sexual Abuse

Technology assisted internet grooming

Contextual Safeguarding

Case Studies

Building rapport with hoarders

County Lines

Mental Capacity Assessment

Mental Capacity Assessment

Suicide prevention

13. Safeguarding Supervision

The Trust has embedded safeguarding supervision into the Trust with a safeguarding Supervision Policy (TP119) published on the Trusts website.

The policy outlines the staff groups that should have mandatory safeguarding supervision and those that can access it as and when required.

Supervision is provided individually and via group sessions internally and externally for some staff.

Those requiring mandatory supervision internally are:-

Members of the Safeguarding Team

Staff in Emergency Bed Service who take the calls from staff

Members of the Frequent Caller Team.

Clinical Supervision is provided to:

Clinical staff

Mental Health Team

If a safeguarding issue is identified they can be referred for formal safeguarding supervision.

The Safeguarding Team were 100% compliant with safeguarding supervision target for 2018/19.

Feedback from supervision sessions held	Yes	No
Did safeguarding supervision take place as arranged and on time?	**100%**	**0%**
Was the session private and free from interruption?	**100%**	**0%**
Did the supervisor explain the process of safeguarding supervision at the beginning of the session?	**100%**	**0%**
Did the supervisor explain the purpose of the safeguarding supervision agreement and supervision record?	**100%**	**0%**
Did you feel that that the safeguarding supervision was a safe and supportive learning environment?	**100%**	**0%**
Did safeguarding supervision meet your expectations (all or part)?*	**100%**	**0%**
Would you recommend safeguarding supervision to a colleague?	**100%**	**0%**

14. Youth Violence

Safeguarding referrals for Youth Violence

The Trust has raised **381 safeguarding referrals** with Local Authority/ MASH partners across London in 2018-19 and increase of 88.
Since December 2017 the Trust has shared information with Red Thread who support and enable young people to lead healthy, safe and happy lives, working with them in the "teachable moment" after a serious injury. We have made **293 notifications to Red Thread** an increase of 247 from last year.

Prevention activity

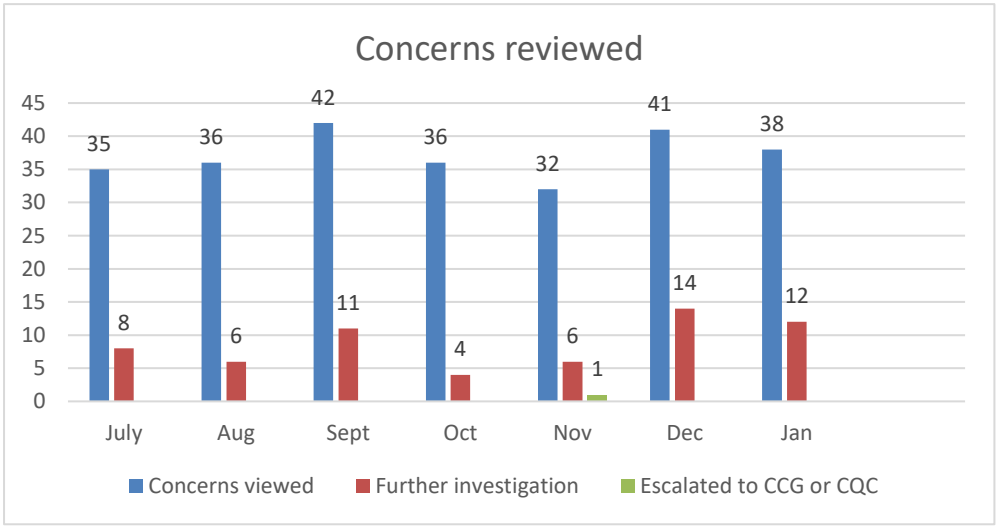
The Trust's Patient and Public Education Team receive requests and manage the delivery of our knife crime presentation from many different agencies across London. Our knife crime presentation covers information on the injuries and potential fatal consequences of knife crime staff discuss their personal experiences of dealing with stabbings. On some occasions we incorporate basic first aid advice about how to safely deal with stab wounds and what to do when someone stops breathing. The sessions last up to an hour, and is delivered up to 6 times a day depending on the total number of children.

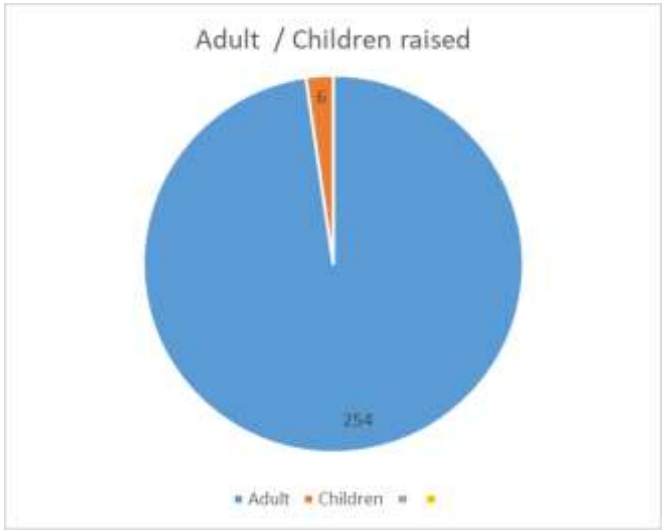
Title	**Partnership**	Number of events	Audience	Area/Borough
Your Life You Choose	**Local Magistrates/ Police/Prison Service**	18	Year 7 and 8	Brent, Barnet, Ealing and Hillingdon
The Prince's Trust	**none**	2	Age 16 to 25	London wide
One Life	**LFB**	2	Age 16 to 18	West London
PRUs	**none**	3	Age 14 to 18	West and North West London
Youth Offending Teams	**none**	1	Age 16 to 19	Ealing
Community Centres	**none**	1	Age 14 to 17	Croydon
East Area Knife Crime Workshops	**Met Police/Robert Levy Foundation**	28	Age 13 to 14	Redbridge, Havering, Romford and Barking and Dagenham

15. Care Home review Group

The Care Home Review Group is an internal group that was set up in July 2018 and meets on a monthly basis to review all safeguarding concerns raised by ambulance staff relating to incidents in care, nursing or children's homes.

All concerns are sent to the LA and the group considers the quality of care being provided by the staff in the home and whether there are concerns that should be investigated further or escalated to the CCG, CQC or professional bodies.



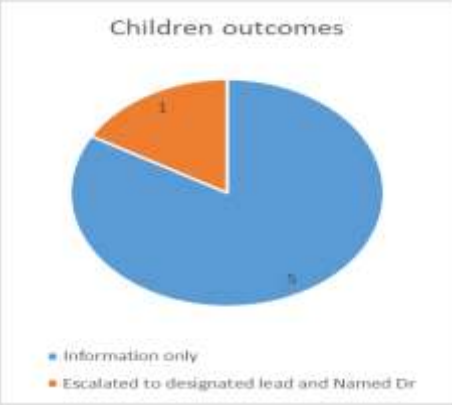


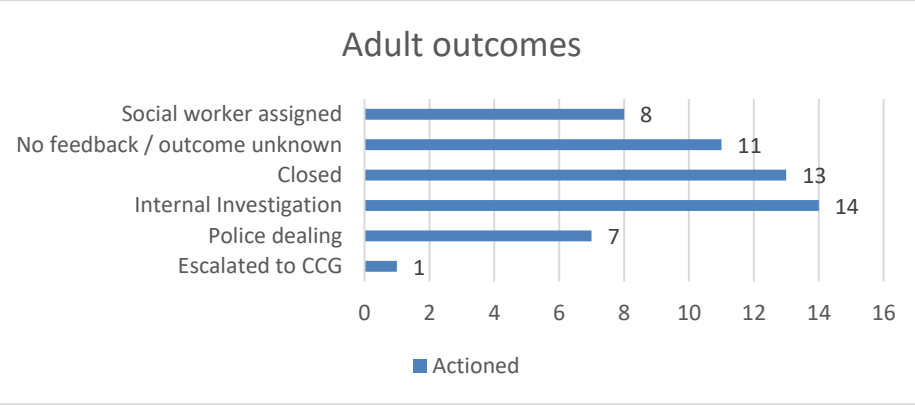
Figures are only available for July 2018 - January 2019.

260 safeguarding concerns/ referrals were reviewed. 254 were for adults and 6 for children. 54 adult cases were followed up on where home had 2 or more concerns raised in last year and there were issues that needed further investigation.

16. Outcome of Care Home Reviews

Children outcomes
The local authority were contacted for 5 child cases to alert them to the referrals.1 case was escalated to the designated lead and named doctor.





Feedback from the local authorities has not been forthcoming in 11 of the incidents.

Boroughs providing good feedback	Boroughs who have <u>not provided feedback</u> from escalated concerns
Barking & Dagenham	Bromley
Bexley	Croydon
Greenwich	Hillingdon
Havering	Hounslow
	Wandsworth
	Westminster

17.Serious Case Reviews (SCR)

A SCR is commissioned by the local Safeguarding Children Board and undertaken when abuse or neglect of a child is known or suspected; and either, the child has died or the child has been seriously harmed and there is a cause for concern about partnership working.

Serious Case Reviews (SCR)										
Borough	**Gender**	**Age**	**Type of abuse**	**Type of Case**		**Borough**	**Gender**	**Age**	**Type of abuse**	**Type of Case**
Barking & Dagenham	Male	1	Parental Neglect	SCR		Islington	Female Female	17 12	Suicide Parental Neglect	SCR SCR
Bromley	Male Female	5 7	Parental Neglect FGM (Nil Return)	Learning Review Learning Review		Lewisham	Female	5 Days	Parental Neglect	SCR
Croydon	Male	3	Parental Neglect	SCR		Redbridge	Female	9 Months	Parental Neglect	SCR
Ealing	Male	13	Suicide	Potential SCR		Wandsworth	2 Females Male	1 & 4 1	Parental Neglect Parental Neglect	SCR SCR
Essex	Female	6 Months	Parental Neglect	SCR						

18. Safeguarding Adult Reviews (SAR)

A SAR is commissioned by Local Safeguarding Adult Boards and is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently to prevent harm or a death from taking place. The purpose of a SAR is to promote effective learning and improvement to prevent reoccurrence of future deaths or serious harm, not to apportion blame.

	Safeguarding Adult Reviews (SAR)									
Borough	**Gender**	**Age**	**Type of abuse**	**Type of Case**		**Borough**	**Gender**	**Age**	**Type of abuse**	**Type of Case**
Bexley	Female	42	Unknown	SAR		Havering	Female Male	56 74	Suicide Possible Agency Neglect	SAR Potential SAR
Bromley	Female	88	Unknown	Potential SAR		Lambeth	Male	51	Possible Multi Agency Neglect	SAR
Camden	Female	93	Unknown	SAR		Lewisham	Male	35	Possible Neglect in Care	Potential SAR
Croydon	Female	81	Unknown	SAR (Nothing Found)		Newham	Male	92	Self-Neglect	Potential SAR
Enfield	Male Female	62 81	Possible Multi Agency Neglect Possible Multi Agency Neglect	Potential SAR SAR		Wandsworth	Male	37	Mental Health	SAR
Greenwich	Male Female Female	82 82 68	Possible Care Home Neglect Unknown Unknown	SAR SAR SAR						

19. Domestic Homicide Reviews (DHR)

A DHR is a review commissioned to consider the circumstances in which the death of a person, aged 16 or over has, or appears to have been as a result of violence, abuse or neglect by a person to whom they were related or with whom they had been in an intimate personal relationship. The LA commission the DHR and our local managers attend when requested.

Domestic Homicide Reviews			
Year	**2016/17**	**2017/18**	**2018/19**
Number LAS supported.	5	5	11

20. Multi Agency Risk Assessment Conference (MARAC)

MARACs are meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. By bringing all agencies together at a risk focused MARAC, coordinated safety plans can be drawn up to support the victim. Over 260 MARACs are operating across England, Wales and Northern Ireland managing over 55000 cases a year. The Trust does not attend MARAC meetings but provides information to support discussions. In 2018/19 the LAS has supported over 2343 cases which is an increase of 63% in the last 3 years;

Multi-Agency Risk Assessment Conference (MARAC)			
Year	2016/17	2017/18	2018/19
Number of cases LAS have provided information to.	1439	1910	2343

21. Child Death

The Local Safeguarding Children Boards (LSCB) are responsible for ensuring a review of each unexpected death of a child who resides in their area is undertaken by the Child Death Overview Panel (CDOP). The CDOP has a fixed core membership drawn from organisations represented on LSCBs with flexibility to co-opt other relevant professionals to discuss certain types of death as and when appropriate (Working Together 2015).
The Trust has a duty to provide information to the CDOP on child deaths we have been involved with, along with attending meetings when required.

Child Death Overview Panel Requests			
Year	2016/17	2017/18	2018/19
Numbers information provided to	206	230	241

All unexpected child deaths the Trust receives notification of, are reviewed by the Child Death Review Group and any concerns identified are escalated to the Trusts Serious Incident Group.

Trust Child Death Reviews 2018-19	
Number reviewed	162
No further action	149
Number referred for Serious Incident Group Consideration	14
Number declared	6

22. Learning from reviews

MCA & Consent has been highlighted in a couple of reviews. **Action taken:** 1. Trust has produced a poster on MCA principles, 2. Re issuing pull out pens with MCA stages on. 3. Trust also agreed an MCA strategy to 2021.

Incidents of youth violence continues to rise. Number of missed referrals has decreased due to continued focus on area. **Action taken:** 1.Article in Safeguarding Newsletter. 2. Discussions with Incident Response Officers who attends these scenes

There have been a couple of cases where domestic abuse in pregnancy was not referred to child social services. **Action taken:** 1. wrote an article in Safeguarding Newsletter. 2. Added to safeguarding refresher training.

From the themes from SI's. **Action taken**: Quality bulletin issued on Learning Disabilities

Learning from SI's excellence reporting on communication with elderly confused / MH patients. **Action taken**: Awareness and safeguarding added to level 3 refresher training

Safeguarding adult a risk
Feedback from safeguarding adult concern

Call details

Call received for a female fallen 30 mins ago pain all over in a funny position. Son on scene. Call came from the patient.
Chub call back and son said he lived with his mother and she has Carer twice a day. CMC records held.
On LAS arrival the son was with the patient, he told LAS crew that his mother has dementia and learning disability and is confused and that she had fallen, it happens a lot and she blames him.

Observations

Patient was very distressed. Alert, observations within normal range. Patient had bruising to her face which was not consistent with a fall. Her speech was difficult to understand.

History

Initially patient was hard to understand due to dysphagia. Patient had history of CVA and paralysis on right side, Residual dysphagia. HTN, Basal ganglion implant, chronic back pain.
Patient disclosed Son had pushed her to the ground and hit her on the face. Son has just been evicted from his shelter, now "no fixed abode" She said he occasionally pops round with other people/friends and tells them she has dementia and a learning disability.
She disclosed she was scared of her son and afraid to be left with him.
It was unclear if son had keys to property.
The patient stated she does not have dementia or a learning disability.

Crews Actions

The Crew requested police to scene as concerned for patient's safety & as this was criminal matter.
Discussed safeguarding concerns with patient who consented to safeguarding concern being made, (although not required as sufficient evidence of coercion) for multiple incidents of domestic violence and physical abuse.
Patient was not conveyed as no medical concerns.
The crew had a discussion with the daughter (next of Kin) and patient was left with the Carer.

Outcome

Police arrested the son and also agreed they were submitting a Merlin (their vulnerability alert to local authority). Crew also discussed with them that if released the son may have access to the property again.
EBS immediately passed the referral to the Duty Social Worker as this was a Sunday.
They confirmed that they had instigated a Section 42 Safeguarding Enquiry. Had met with the patient and confirmed she did not have dementia or a learning disability.
A protection plan was put in place immediately.
The patient has been taken to a sheltered housing scheme as a place of safety, where she can stay for 72 hours.
Her locks were changed.
The son was still in police custody at time of feedback.

Feedback

The local authority praised the LAS for their quick response (Crew & EBS) to notifying them out of normal office hours.
This enabled them to put into place appropriate protective measures to safeguard the adult at risk.
The crews' diligence in spotting the signs of abuse and checking information was key to safeguarding this lady.
By acting on concerns straight away, by calling the police, enabled the son to be arrested and the police to secure the evidence they required.
The lady has been given the option of moving permanently into sheltered housing.

Her allocated social worker was visiting to ascertain what she would like to do going forward.

Well done to this crew and the EBS call taker and to all crews who are regularly acting on concerns of abuse and neglect. Your actions really do help protect the most at risk in our society

23.Safeguarding Allegations against Staff

Allegation of abuse against Children	Total Number	Not safeguarding	Staff conduct	CSE	Internet offences	Outcomes
	5	1	1	1	2	1 closed Trust disciplinary process followed where appropriate 1 Staff member dismissed from service. DBS informed Local Authority Designated Officer (LADO) and Professional body informed where appropriate

Allegation of abuse against adults	Total Number	Psychological Abuse	Inappropriate treatment	Theft	Physical abuse	Sexual assault	Not safeguarding	Safer recruitment	Prevent	Outcomes
	23	1	1	3	5	1	9	2	1	15 closed not all proven Trust disciplinary process followed where appropriate Engagement with police and Safeguarding Adult Manager (SAM) where appropriate

24. Prevent

The Head of Safeguarding is the Prevent Lead for the Trust. The Trust has a Prevent policy and concerns are raised by staff via our safeguarding processes.

The Trust has a requirement to ensure all staff are trained to the required level in Prevent 94.51% have received Basic Prevent training and 91.62% Prevent WRAP training.
The Trust completes a quarterly report for NHSE covering all elements of Prevent training and referrals.
The Trusts Prevent Review Group reviews all Prevent referrals made by staff the group membership is the

- Head of Safeguarding/Prevent Lead,
- Emergency Planning Manager with oversight of Prevent
- EBS Manager

During 2018/19 the LAS raised 5 child Prevent concerns and 22 adult Prevent concerns with the LA

The Trust also reported 1 staff Prevent concern to the Police.
The Trust currently raises concerns with the local authority as opposed to Prevent Channel Panels.
This is in accordance with London Prevent Procedures.
The Safeguarding Team were represented at the NHSE London Prevent conference in November 2018.

Key Achievements:

- **Training compliance above target of 90%**
- **Quarterly returns completed within timescale**
- **Trust attended at Prevent Conference**
- **Attended workshop with Uni of London to look at Prevent and challenges/ pathways**

Top Priorities:

- **Continue to raise profile of Prevent as safeguarding**
- **Work with partners to improve pathways**

25. Private Ambulance Service (PALS) and Voluntary Ambulance Service (VAS)

The Trust commissions support from a number of private ambulance services to assist with increases in workload.

The Trust uses 3 CQC registered providers at this time;

- Falck UK Ambulance Service
- St John Ambulance
- SSG UKSAS

In the last 18 months the Trust has reviewed all policies as part of the contract review. For the new contract the Trust provided training, to the providers training teams, on how to run the LAS PIN course. This included a session on how to report by EBS for Datix
and safeguarding.

The external providers all use the Skills for Health online statutory-mandatory training to ensure it meets the Trusts standards. In the coming year we will be discussing how they can meet the 50% face to face requirement for safeguarding training.

The Trust have completed a rolling schedule of quarterly audits which includes an HR dip sample of staff deploying, including checking the DBS status of each member of staff audited; this is 4 personnel per quarter
per site audit (1 site each for SJA, SSG, 3 sites for Falck)

PAS/VAS Crews completed 512 safeguarding referrals/ concerns. This is consistent with a similar sized station.

The Trust commissions 10 frontline vehicles from Falck on late shifts per day, 1 SSG night vehicle per day, and 2 bariatric vehicles and 1 frontline vehicle per 12 hr day/night from SJA.

Key Achievements:

- **A dedicated PAS/VAS manager oversees contract and compliance**
- **Regular performance reviews**

Top Priorities:

- **Rolling policies review**
- **Started with Medicines management**
- **Safeguarding is next**

26.Information Sharing / Partnership Working

The Trust has a duty to share information to protect children and adults at risk. The Trust shares information on staff concerns for a vulnerable person to the local authority and works in partnership with a number of agencies to support best practice in safeguarding.

The Trust adopts the Pan London Information Sharing Agreement and shares information with several safeguarding partners.

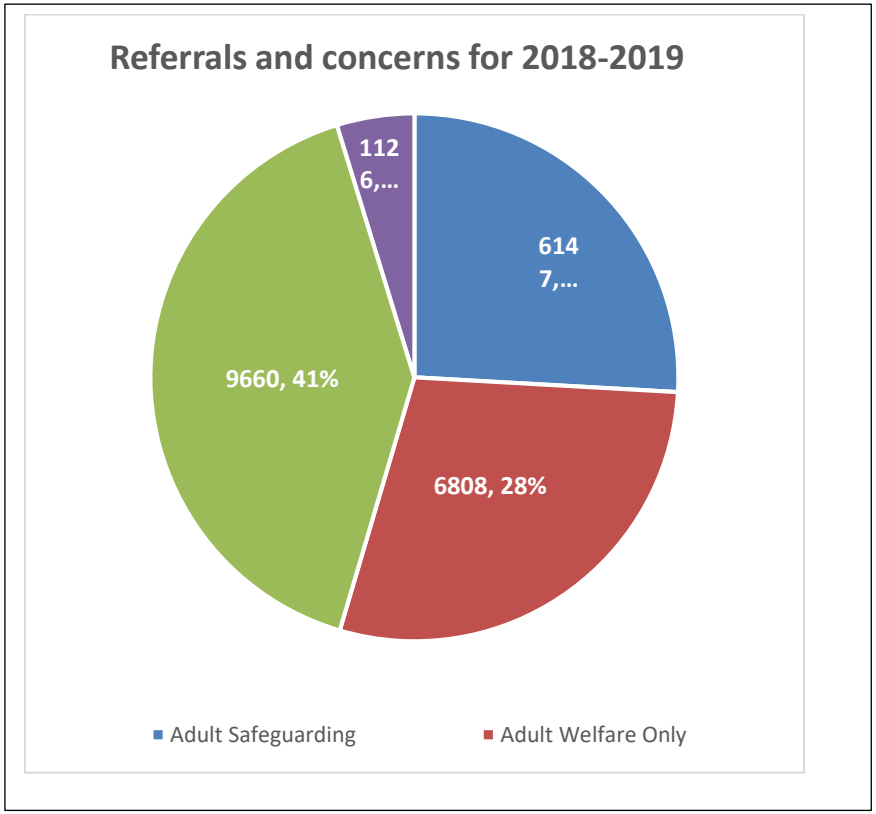
Clinical Commissioning Group

National Ambulance Safeguarding Group ***London Safeguarding Adult & Prevent Provider Network*** ***Child Death Overview Panel Reviews***

NHSE Named Professionals Group ***London Safeguarding Adults Network*** ***London Safeguarding Children Board*** ***London Safeguarding Adult Board***

Brent Safeguarding Children Board ***Brent Safeguarding Adult Board***

27.Safeguarding Referrals and Concerns Raised by LAS in 2018/19



Overall Referral Volumes

The total number of safeguarding referrals/concerns for this year is 23,741

Comparison with 2017/18:

There is 7% increase safeguarding referrals/concerns total of 22198

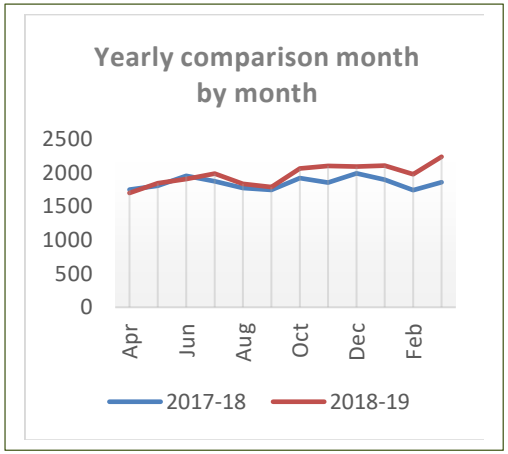
There is 15% increase in child safeguarding referrals

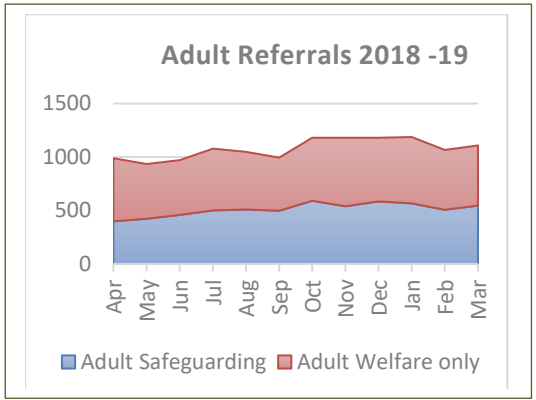
There is 27% increase in adult safeguarding concerns

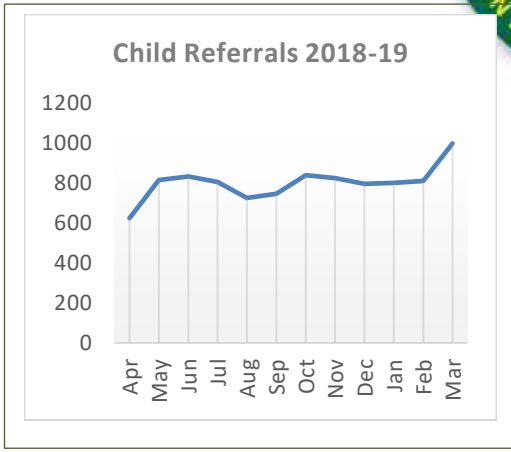
There is 15% decrease in adult welfare concerns

1,126 concerns categorized as 'other outcome' were not passed to the LA, because they were not appropriate and was more appropriate for other partners. The majority of these were either mental health referrals with no safeguarding aspect, welfare concerns where the person or a carer was advised to refer, or cases where we could not proceed because the person did not consent and no overriding factors present. All these 'other outcome' referrals are checked, and information is shared where appropriate with other agencies.

The number of concerns/referrals as a percentage of all incidents has remained stable throughout the year at average 2.1%, which is an increase from last year's figure of 1.9%.







Referrals /concerns made by LAS Area

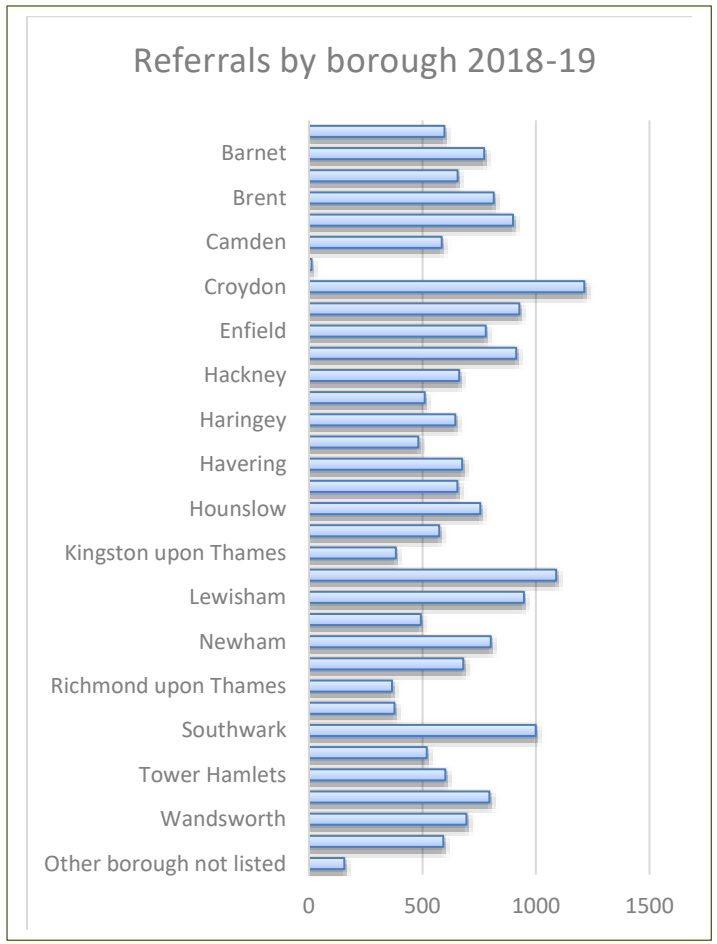
North Central Sector	2727
North East Sector	3777
North West Sector	4540
South East Sector	4646
South West Sector	2929
Training	748
Other (HART, TRU, NETS, IRO, Events)	350
EOC	1250
111	1136
PAS/VAS Other	512
Referrals that resulted other outcome	1126
Total	23741

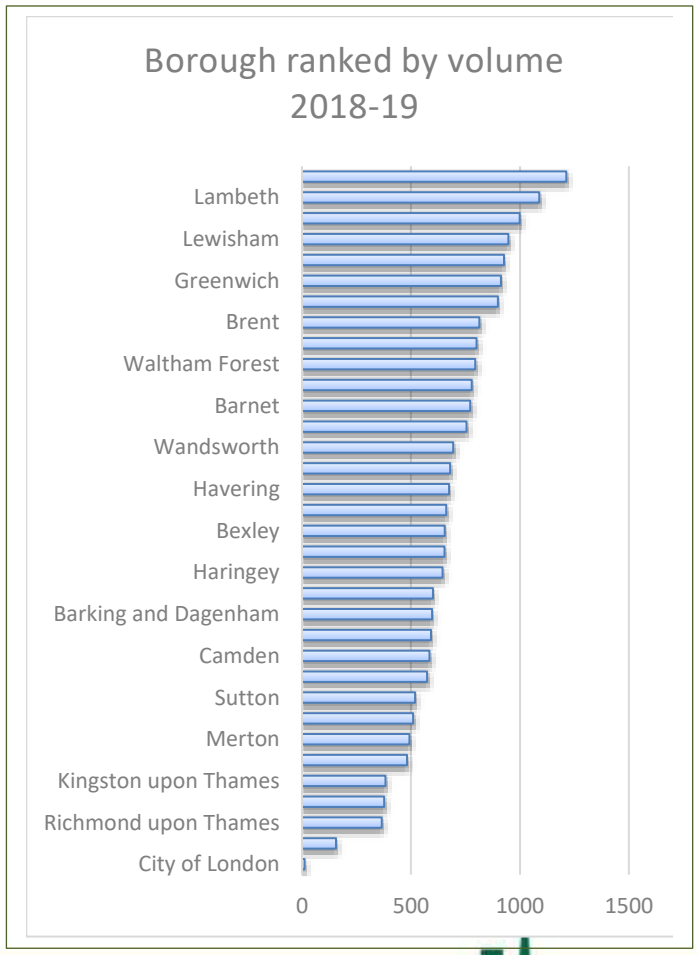
Volumes during the year

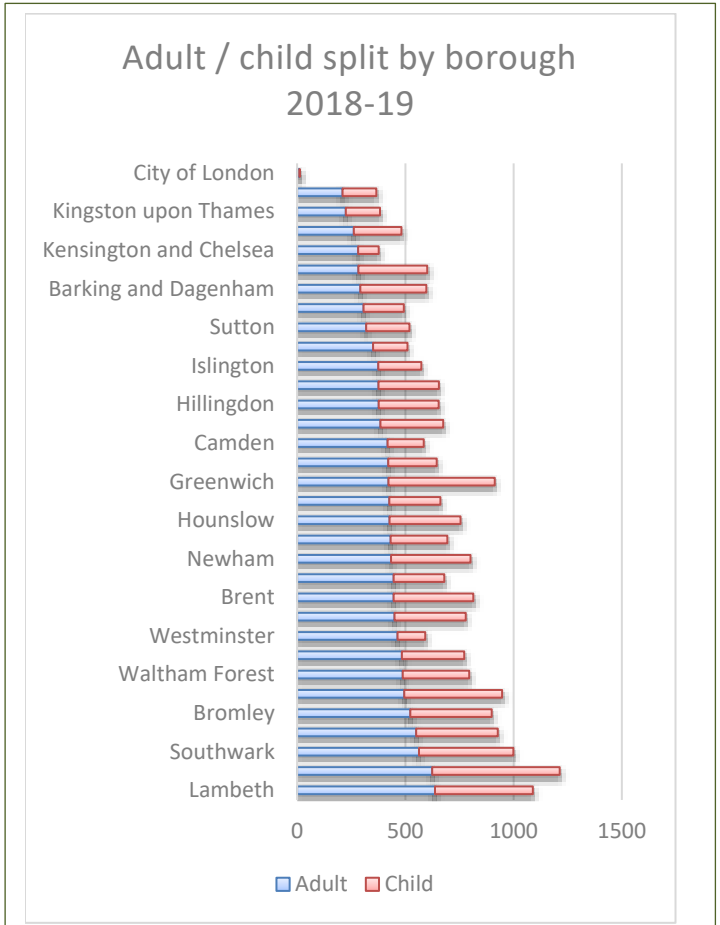
Although there was an increase in adult referrals, the main feature of this year's volume of referrals has been an increase in the volume of child safeguarding referrals. There were two significant periods of increase in April and again in March, linked to the rollout of safeguarding training for staff.

Also, the Trust now runs two of London's 111/IUC providers, who also raise alerts that children on a child protection plan are seeking unscheduled care.

Referrals from EOC, our 999 call-handling team and their clinical advisers, has almost doubled since last year's total of 652, to 1,250. This is due to improvements in training.

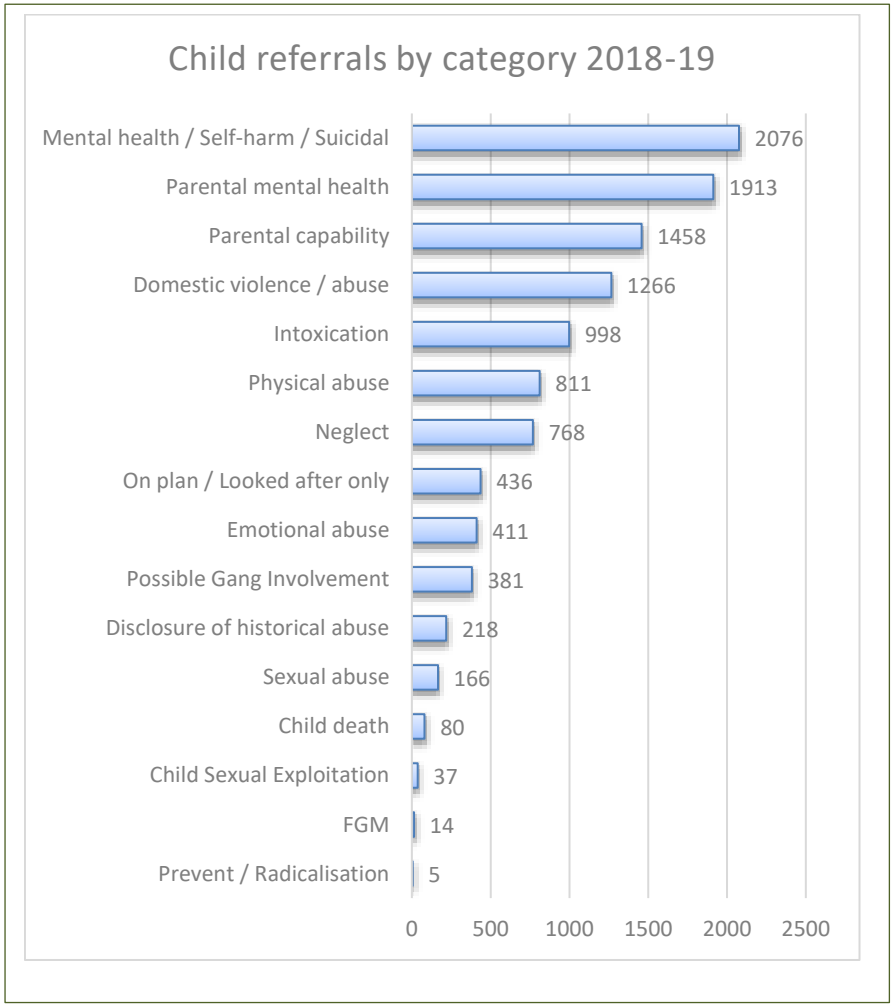

Referrals by borough 2018-19
Barnet
Brent
Camden
Croydon
Enfield
Hackney
Haringey
Havering
Hounslow
Kingston upon Thames
Lewisham
Newham
Richmond upon Thames
Southwark
Tower Hamlets
Wandsworth
Other borough not listed
0
500
1000
1500


Borough ranked by volume 2018-19
Lambeth
Lewisham
Greenwich
Brent
Waltham Forest
Barnet
Wandsworth
Havering
Bexley
Haringey
Barking and Dagenham
Camden
Sutton
Merton
Kingston upon Thames
Richmond upon Thames
City of London
0
500
1000
1500



Referrals/concerns by borough

The pattern of referrals across London is familiar from previous years; Croydon for example has been the highest borough receiving referrals or concerns from the Trust since our records began in 2010, and Richmond, Kingston and Kensington & Chelsea among the lowest.

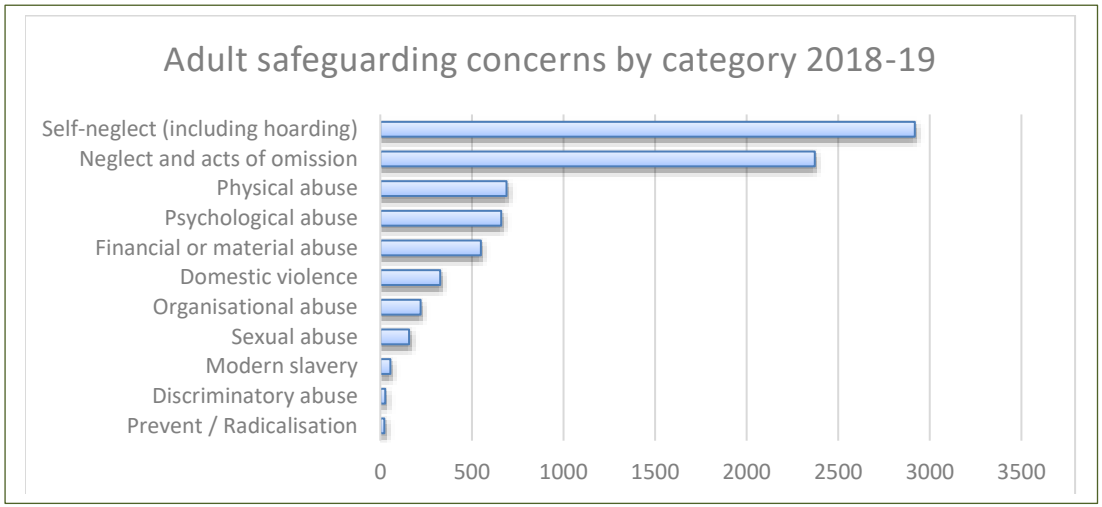


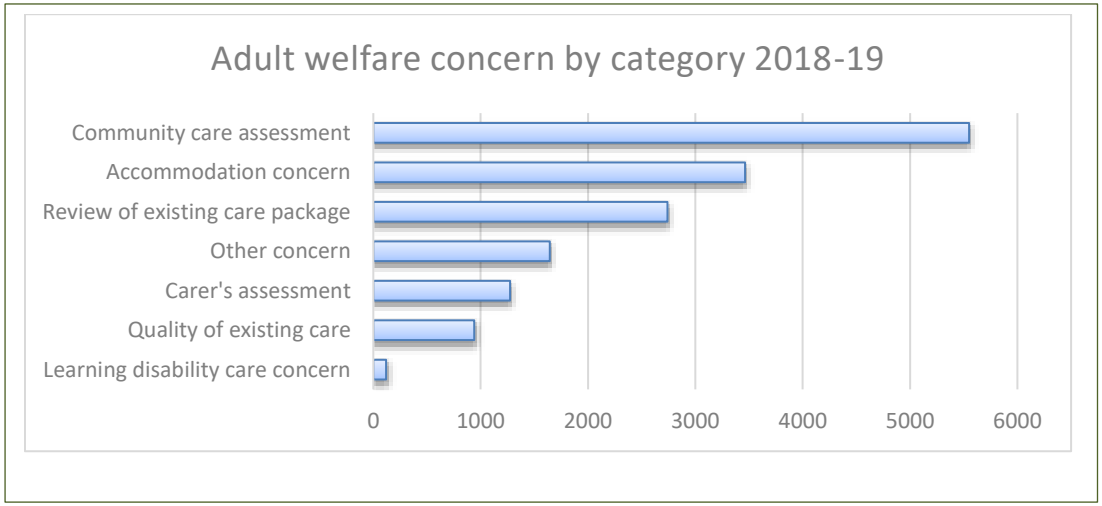
This chart shows the categories of concern the Trust recorded. Multiple referral categories can be selected for an individual referral.

Parental Mental Health and Parental Capacity remains the top child safeguarding concerns identified by staff. This is consistent with other years.

The 14 concerns relating to FGM did not include any instances of directly observed or disclosed FGM of a child (which requires mandatory reporting to the MPS). They related to concerns for children of mothers who had FGM, or other indirect concerns.

For some of our 'possible gang involvement' referrals, where the child is conveyed to a Major Trauma Centre, we also refer immediately to Red Thread, a third sector youth organisation who work to intervene in young people's lives to steer them away from harmful social environments and behaviours. This year, **293** of these referrals have been made.



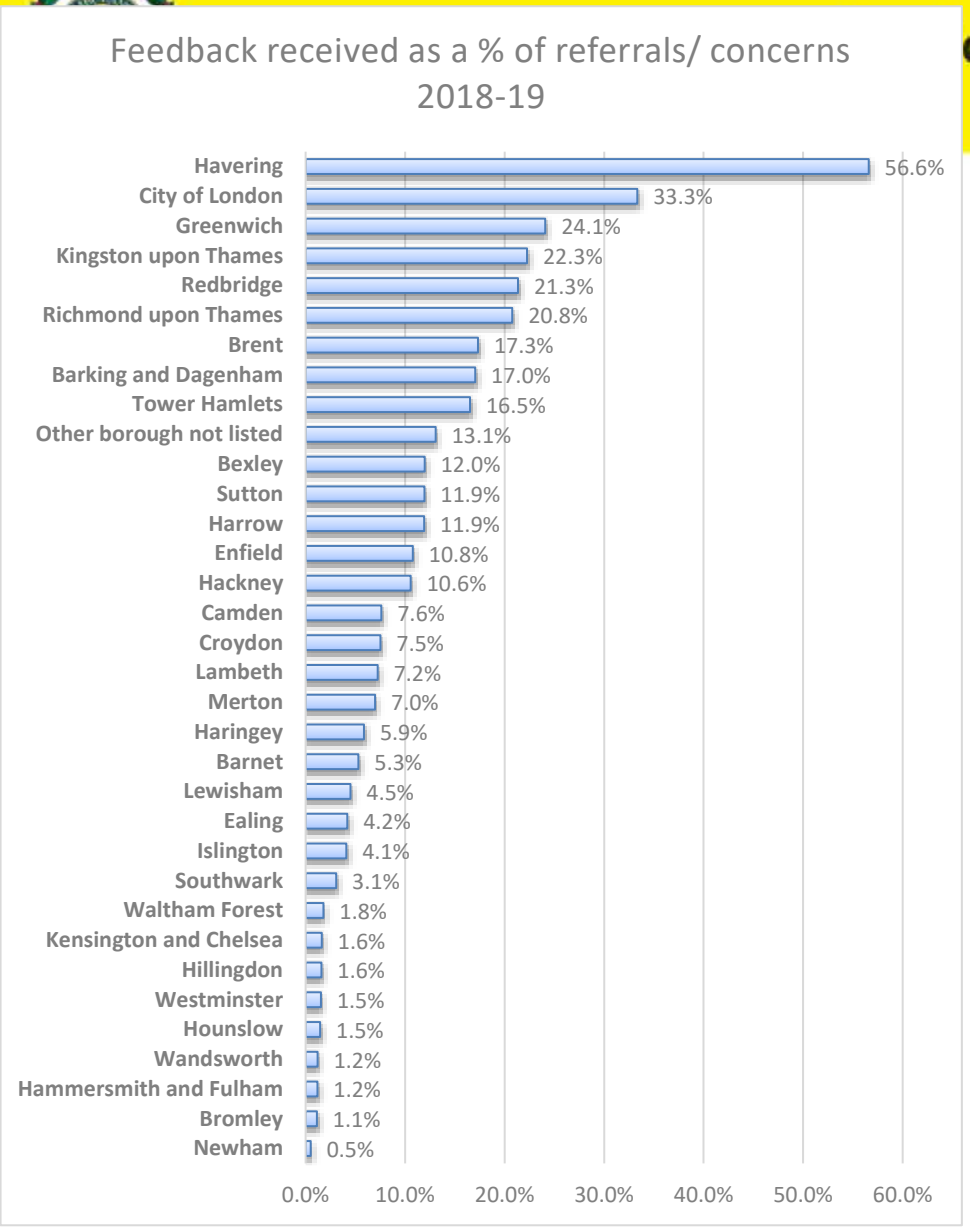


The chart for adult concerns shows self- neglect and neglect as the top reasons for raising the concern. (Multiple categories can be selected for an individual referral).

For those referrals where hoarding is indicated (if scored using a clutter index as 4 and above), and where consent is given, the concern is also shared with the LFB for fire risk support. This year we made **1,017** such referrals.

In Domestic Violence cases, staff supply the victim with the telephone number of the Women's Aid Domestic Violence Helpline. On rare occasions the victim will ask staff to contract the DVHL on behalf of the person concerned. This has occurred only twice this year.

For welfare related concerns, where possible staff should empower individuals or their families or carers to approach the LA directly. Where concerns are raised via the Trust consent must be obtained. The majority of these are for a care assessment.



Feedback from Boroughs

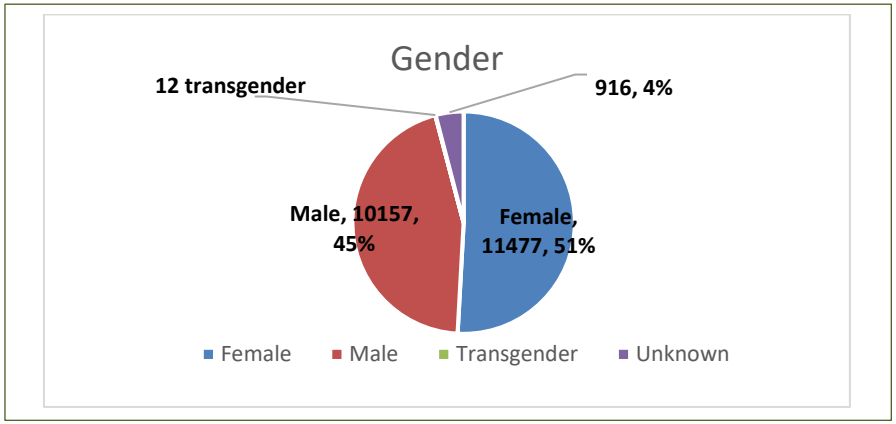
LA's have a statutory duty to provide feedback on safeguarding referrals & concerns they receive. Feedback is important as it enables us to learn from the referral/ concerns and improve our practice. Feedback also enables staff to gain closure on an incident they have encountered with the simple yet important reassurance that the matter they have reported was appropriate and is being dealt with.

Currently the quantity of feedback received is still small – averaging 10% of all referrals.

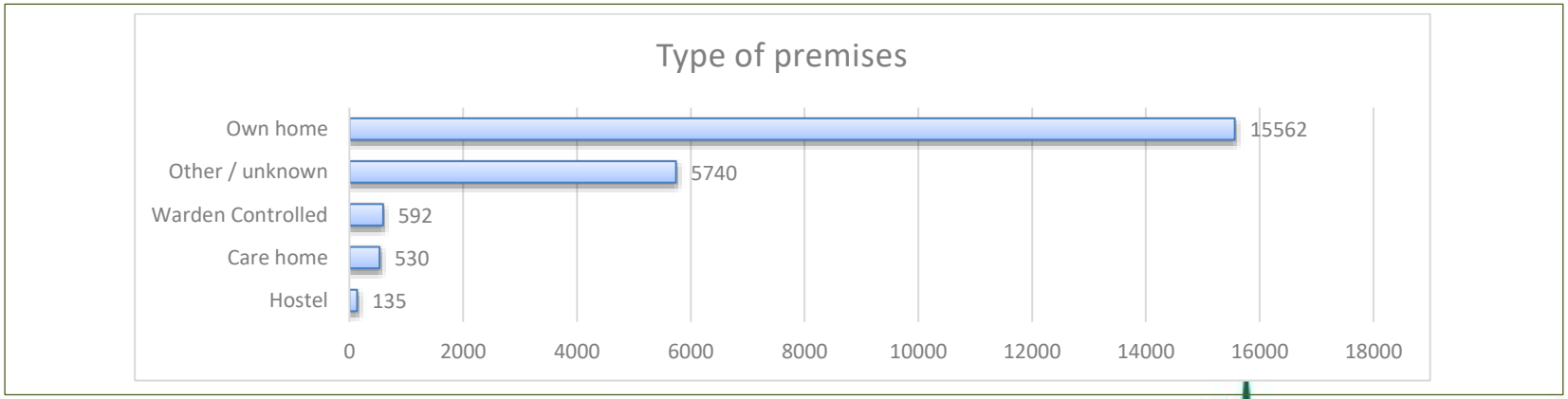
This is an improvement on last year's average of 3%. Feedback is better for child referrals, averaging around 14%, with a couple of boroughs feeding back on almost all child referrals.

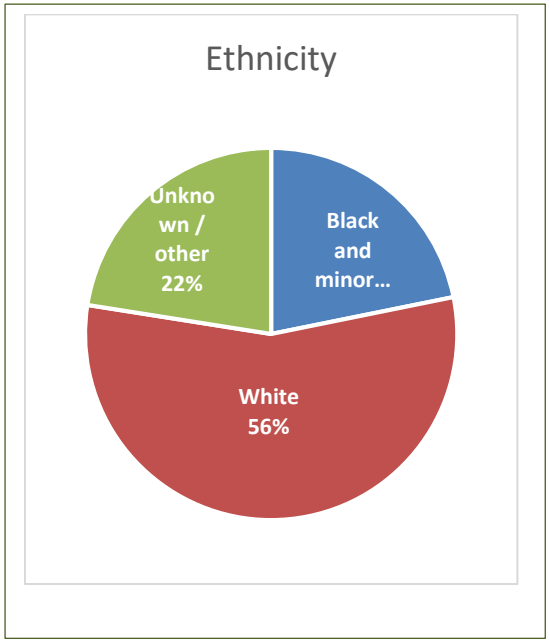
The Trust has developed a new feedback process and is about to recruit to a full-time position which will be responsible for managing this aspect of the process, and we will work to continue to see an improvement in feedback from our social care partners.

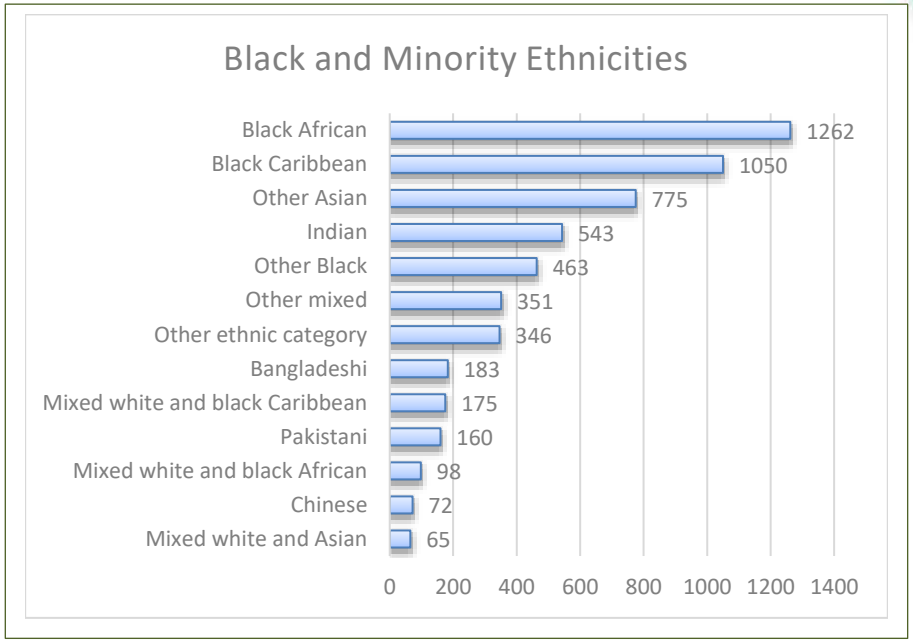
28. Safeguarding Referrals and Concerns Demographics



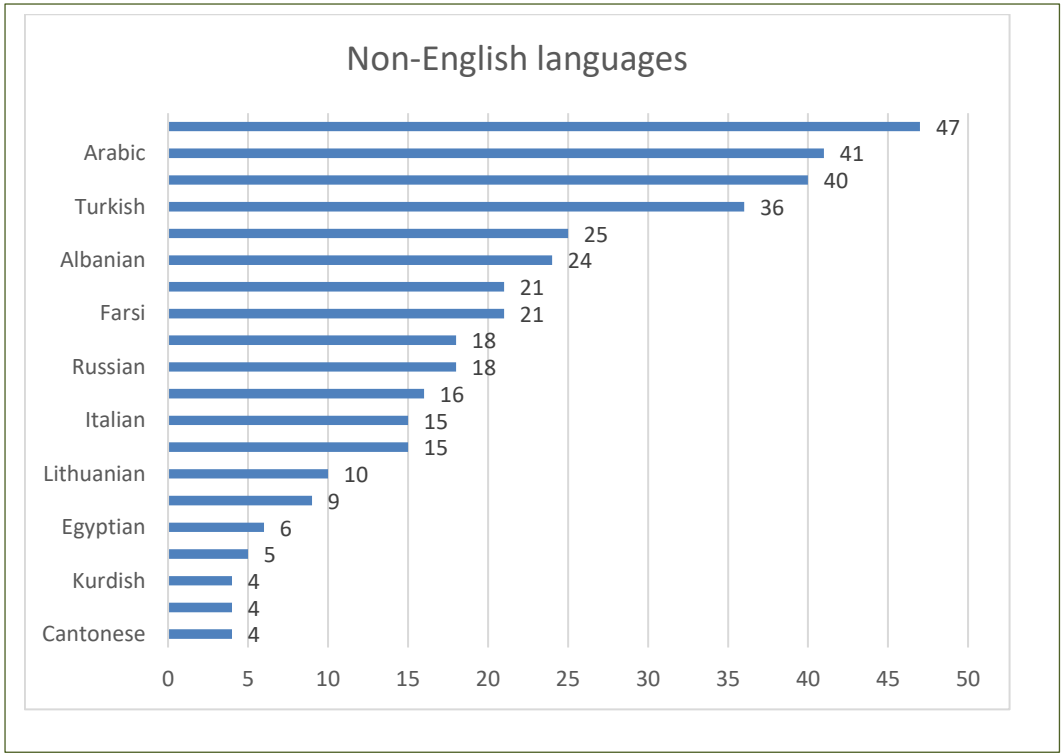
The majority of the unknown are child safeguarding referrals where we are aware that a child is at risk but have not assessed that child face to face (often an unborn child) and have not established their gender.

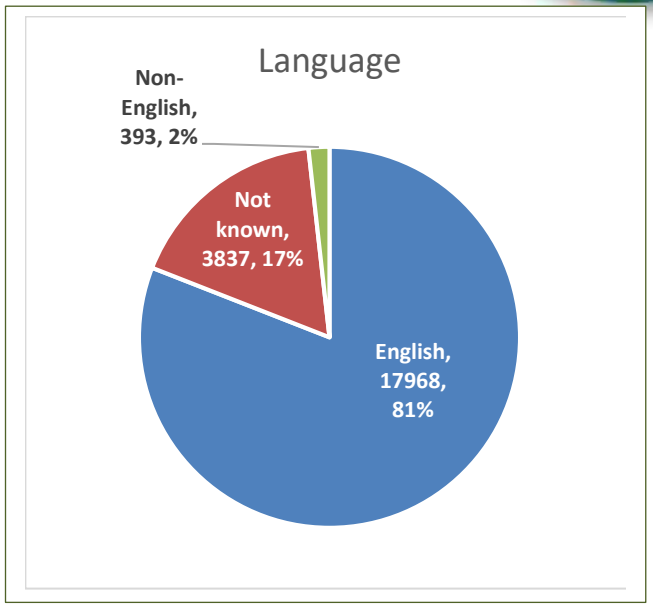




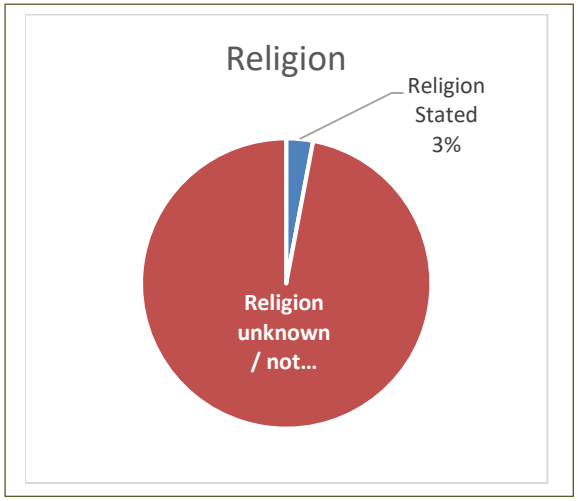


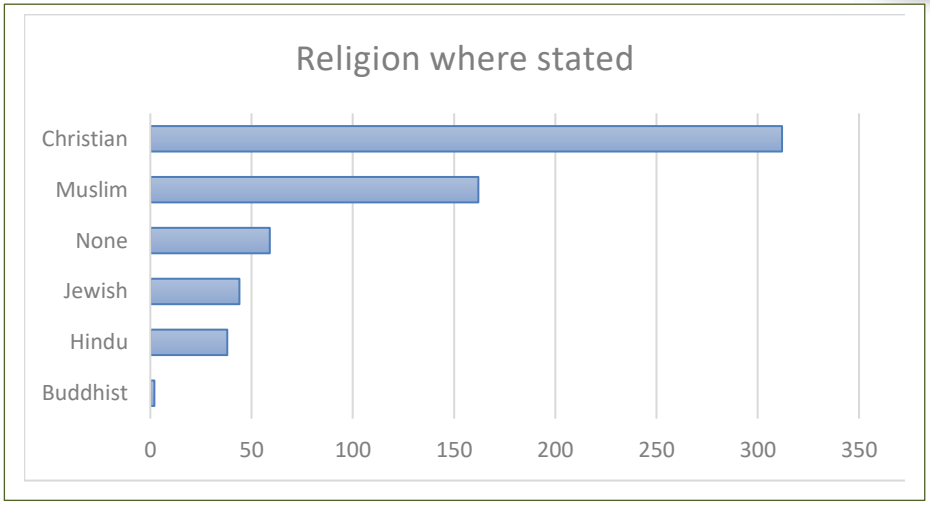
The number of cases where no ethnicity is recorded is similar to last year at 22%, and reflects the nature of the incidents dealt with. Often discuss about ethnicity is not possible over the phone or because patients are not in a position to respond.
Third party concerns – for people we did not see or assess, perhaps carers or partners, or those for unborn children, often provide no opportunity for a determination to be made.





Due to the nature of incidents it is not always possible to ascertain languages spoken. However in cases where there are communication difficulties relating to languages spoken, the Trust has access to live translation services via Language Line.





Religion is not regularly recorded by staff. However these findings will be feed into wider Trust discussions around protected characteristics.

29. Top Priorities for 2018/19

To recruit new members to Safeguarding Team to enable outstanding safeguarding practice across the Trust

Introduce Trust Safeguarding Twitter Account to raise safeguarding awareness

To improve quality of Safeguarding Governance and Assurance

Embed new legislation and best practice. Particularly new Child Death procedures and MCA

Work with partners to

1. Pilot & develop contextual safeguarding arrangements
2. Develop Trauma informed care
3. Improve safeguarding response to Prisons
4. Think Family

Provide a varied safeguarding educational program across the Trust as well as Safeguarding Specialists delivering training at a variety of levels in line with intercollegiate documents and trajectory agreed with commissioners

Contact Details

Should you wish to know more about safeguarding in the London Ambulance Service, have any questions about this report or would like more details on referrals per borough please contact the London Ambulance Service NHS Trust Safeguarding Team on Safeguarding.las@nhs.net

2018/19 has been a busy year for the LAS with an increase in referrals and requests for information. 2019/2020 looks to be an exciting year as the Safeguarding Team grows by 100% and ensures outstanding safeguarding practice. Thank you to all those who provided information for this report.

Alan Taylor
Head of Safeguarding & Prevent

Appendix

X:\Safeguarding File\Action plans work plans\2018-19 workplan\2018-19 workplanFINAL.pdf