NHS

London Ambulance Service

NHS Trust

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NHS Trust

Building a world-class ambulance service for a world-class city

INTEGRATING ACCESS TO URGENT & EMERGENCY CARE
ON SCENE • ON PHONE • ONLINE

Safeguarding Annual Report 2019 – 2020

Introduction

In 2019/2020 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 has expanded this year and have worked hard to support staff, monitor and review safeguarding practice and raise the standard of safeguarding training. This in turn has enabled us to increase the profile of safeguarding and the team both internally and externally during 2019/20.

With Safeguarding Leads and teams for both Children and Adults there is a much greater focus on both and we have seen improvements across safeguarding throughout the year.

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 2019/20 we raised safeguarding concerns for an average of 2.0% 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 Joint Agency Review 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.

With Covid-19 happening at the end of this financial year this report may not contain the depth of information we would usually provide as we are still in the response mode and resources are actively working on the Covid-19 response.

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

LAS Safeguarding Achievements 2019/20

Published quarterly safeguarding newsletters	Use of alternative pathways for Hoarding with LFB, DA with Women's Aid and Youth Violence	Developed Safeguarding Star badge and certificate to recognise good and outstanding safeguarding practice
All clinical staff being trained to Level 3 Safeguarding	Improved Partnership working and engagement	Introduced Twiddle Mitts onto all ambulances to support dementia patients
Split welfare/care concerns and safeguarding processes	Safeguarding Specialist for each operational area including IUC/ EOC	>90% safeguarding training compliance. Level 2 & 3 face to face
First Ambulance Trust to introduce contextual safeguarding pilot	Maintained safeguarding focus and practice during Covid - 19	Moved safeguarding training to be delivered by specialists

Senior Safeguarding Structure

Dr. Trisha Bain

The Executive Director Lead for Safeguarding

Dr. Bain ensures that safeguarding is positioned in core business in strategic and operational plans. Trisha oversees, implements and monitors the ongoing assurance of safeguarding in the trust.

This ensures the adoption, implementation and auditing of policy and strategy in relation to safeguarding.

Dr. Mark Spencer

The Non-Executive Director (NED) for Quality Inc. Safeguarding

Dr. Spencer chairs the Quality Assurance Group (QAG)

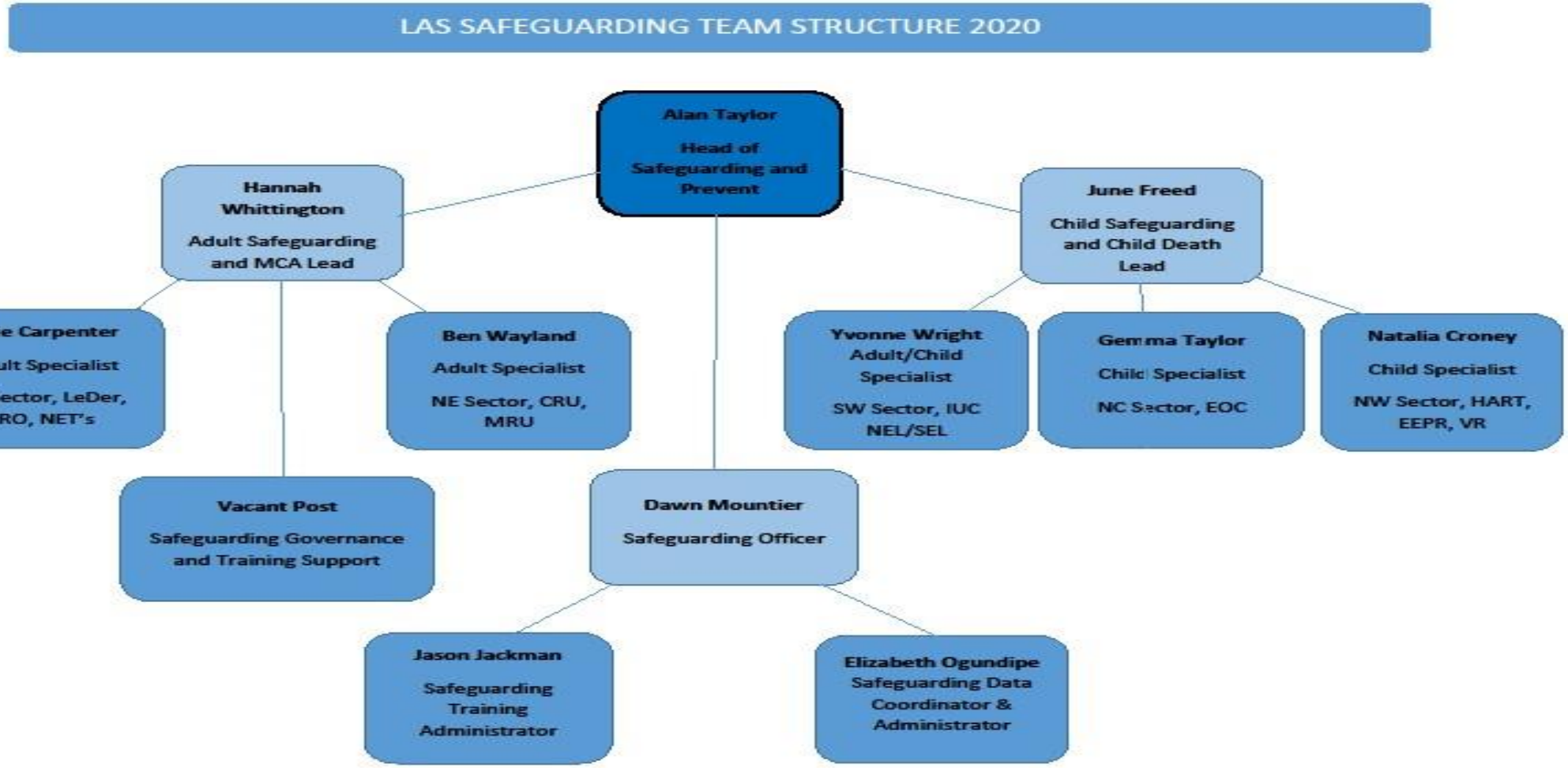
Alan Taylor

Head of Safeguarding and Prevent

Alan is responsible for ensuring that the trust is compliant with legislation and practices in relation to safeguarding and setting strategic objectives for the Trust.

Alan ensure that the Trust acts to safeguard children, young people and adults at risk.

Safeguarding Team Structure



Safeguarding Team cont.

The Safeguarding Team are responsible for all the Trust safeguarding processes and functions, providing expert, evidence based clinical leadership on all aspects of the safeguarding agenda. The team has a responsibility for ensuring the development and implementation of systems and processes across all areas of the Trust, working with partner agencies in line with local and national standards and legislation and delivering safeguarding training and education and raising the standard of safeguarding concerns/referrals.

The team ensures the implementation of appropriate CQC core standards and other relevant external targets including 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) now known as Local Child Safeguarding Practice Reviews (LCSPR), Safeguarding Adult Reviews (SAR), Care Proceedings, Child Death Overview Panels (CDOP's), Section 42 enquiries, Domestic Homicide Reviews(DHR), Multi –Agency Safeguarding Hub enquiries (MASH) and Multi-Agency Risk Assessment Conference's (MARAC).

The team supported by local Managers, work with the Local Safeguarding Children Boards (LSCB) and Adult Safeguarding Boards (LSAB) ensuring attendance at safeguarding review meetings.

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 recruited 6 more staff into the Safeguarding Team this year to strengthen the resource requirements with the introduction of the 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.

Trust Safeguarding Responsibilities

'All staff have a responsibility to protect children and adults at risk from harm and report safeguarding concern's either in relation to the public or a member of staff'

Safeguarding requires a whole trust approach and in addition to the responsibilities of the executive team, the Head of Safeguarding and the Safeguarding Team, we are reliant on EBS, local managers and staff to implement safeguarding practice.

Emergency Bed Service (EBS)

- Manage timely referral to Social Services (LA) via MASH (Multi Agency Safeguarding Hub) or Front Door.
- Collates information on referrals
- Provide a focal point for staff safeguarding questions 24/7
- Receives feedback from the LA for referrals which is recorded on Datix and fed back to staff.

Local Managers

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

Safeguarding Governance Arrangements

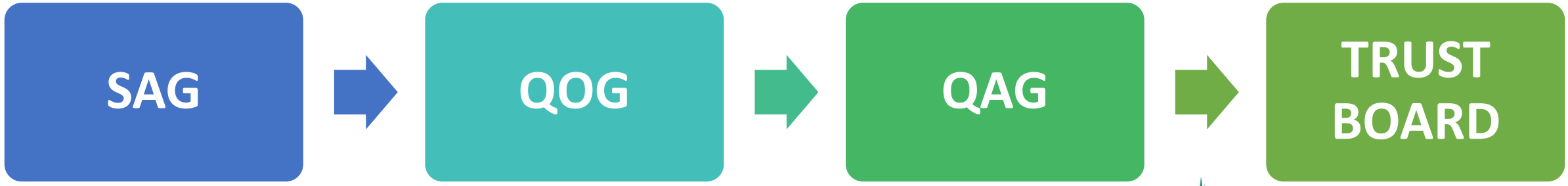
The Trust has a Safeguarding Assurance Group (SAG) that meets Quarterly to monitor the Trusts safeguarding activity and provide assurance on safeguarding practice.

SAG reports to the Quality Oversight Group (QOG) bi-monthly providing assurance and raising issues for escalation to the 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.

These reports contain safeguarding assurance for all areas of the Trust including Integrated Urgent Care in NE and SE.

Members of the safeguarding team attend the following committees; Serious Incident Group, Serious Incident Learning and Review Group, Patient & Clinical Effectiveness Group, Patient Safety & Effectiveness Group and Quality Oversight Group. The Safeguarding Specialists are members of their local area governance meetings.



Safeguarding Governance Arrangements

POLICIES

- Safeguarding Children Policy TP018
- Review due **Oct 22**
- Safeguarding "Adults at Risk" Policy TP019
- Review due **May 20**
  - Domestic Abuse Policy TP102
- Review due **Nov 22**
  - Safeguarding
  - Supervision Policy TP119 review due **Feb 22**
- Chaperone Policy TP118 review due **Oct 22**
- Prevent Policy TP108 review due **Nov 22**
- **HR Policy**
  - Allegations Against Staff Policy HR039 review due **Jul 21**
- **Medical Directorate Policies**
  - Operational Procedure for the use of
  - Restraint of Patients OP0 -review due **under review**
- Consent to Examination or Treatment OP031review due **Dec 19**

COMMITTEES

- 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)
- **Review groups:**
- Safeguarding Incident Review Group
  - Care Home Concerns Review Group
  - Prevent Review Group
  - Child Deaths are reviewed virtually

REPORTS

- 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

RISKS

- EBS business continuity
- Safeguarding risks in relation to Covid-19 have been established and are ongoing

AUDITS

- Internal audit by Grant Thornton looking at
- Policy/Safer
  - Recruitment and
  - Referral processes
- EBS audit quality of referrals on each call taker during the year.
- NASG looking at undertaking peer reviews during 2020

SAFEGAURDING LEADS

- Executive Lead - Chief Quality Officer
- Non-Executive Director for Safeguarding
- Head of Safeguarding
  - (Named Professional)
  - Safeguarding Lead Children
  - Safeguarding lead – Adults & MCA
  - Safeguarding Specialist in each area including EOC/ IUC
- EBS manage:
  - safeguarding referrals
  - & concerns
- Additional members of
  - Safeguarding Team
  - Safeguarding Officer
  - Safeguarding
    - Governance and
    - Training Support
- Safeguarding Data
- Coordinator and Administrator

Safeguarding Work Plan

The work plan (see appendix one) is monitored by SAG. The Trust has made progress with all elements in the work plan in 2019 -2020. Some aspects have been put on hold due to our vacant Governance and Training during this period. The role has now been recruited to and work will restart and is highlighted in the 2020-21 work plan.

The work plan focused on 6 key areas:

- Development of the Safeguarding Team
- Successful delivery of safeguarding training plan, local education and supervision
- Safeguarding innovation and review current practices to identify cost savings.
- Ensure integration of 111 & IUC
- Forge effective relationships internally and externally to safeguarding children and adults
- Excellent governance and assurance of the Trusts safeguarding processes and compliance (on hold)

Key Achievements

- All areas in the 2019/20 work plan have been achieved.
- The Trust is providing a good standard of safeguarding practice and assurance.

Top Priorities

- To deliver on the 2020/21 work plan
- Implement thorough audit and assurance process.

Safer Recruitment

The Trust has a Policy/Standard Operating Procedure for safer recruitment and includes permanent, fixed term, bank agency, students and celebrity visitors.

The Trust has a three yearly programme of checking staff and as at 31st March 2020 we have completed 99% of these rechecks.

All staff in patient facing roles can only commence if all of their employment checks have been completed, 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 which is the equivalent of a National Police Check and is DBS equivalent.

Key Achievements

- 99% of eligible workforce are compliant within the requirements of Safer Recruitment.
- In 19/20 we completed 2,000 DBS rechecks.

Top Priorities

- To start the next programme of DBS rechecks in 20/21.
- To refresh our DBS Policy.

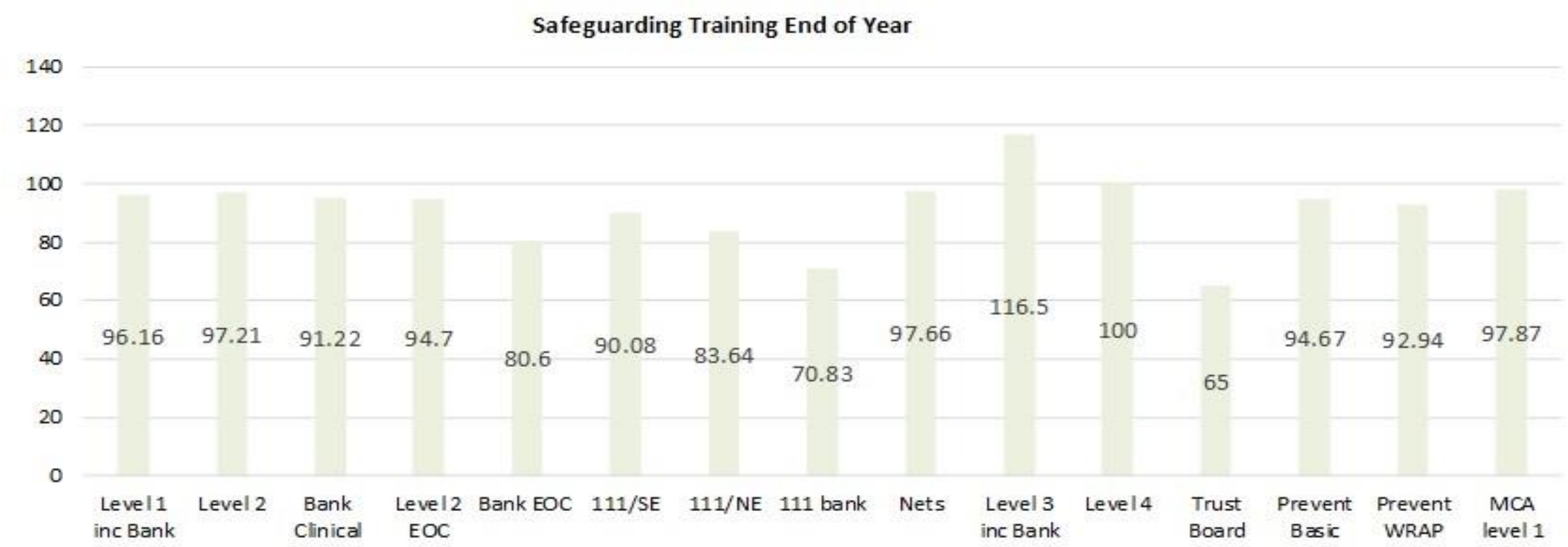
Child Protection Information Sharing (CP-IS)

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 to or aid decision making.

Currently introduced into clinical Hub and looking to introduce into 111 once external Adastra issues have been fixed. Once EPCR is embedded will look to introduce for all at patients side.

Safeguarding Education and Training

An extensive amount of safeguarding training has been undertaken during 2019-20. The safeguarding team would like to thank the Clinical/EOC Education Tutors and the Safeguarding Specialists for all their work to achieve the target. Overall the Trust is compliant with Safeguarding Training for 2019-20.



Staff feedback on training

''Specialists were able to happily talk around the course in a very Knowledgeable and competent way.

It was also very clear that they had a passion for safeguarding that was infectious as they were able to make what could have been a very dry day both interesting and informative".

''It was obvious that both members of staff had knowledge far above what was needed for the cours e content …it has left me regretting that I must wait three years for further safeguarding training!''

"Best Training I have had in the LAS".

Key Achievements

- Overall Trust compliance is:
- Level 1 96.16%
- Level 2 96.19%
- Level 3 116.50% (against trajectory of 800. 932 received training)
- Commissioning target for Safeguarding Training is 90%
- Trust Board was on target for 100% compliance with training booked prior to Covid-19

Top Priorities

- Continue to deliver level 3 to all clinical staff over the next year, whilst recognising meeting next year's target maybe challenging with Covid-19

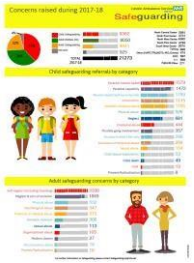
We have developed a range of educational materials to support safeguarding education and training.

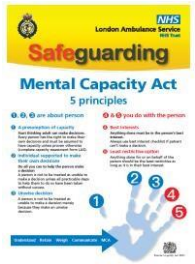
This included four posters which have been distributed to staff within the Trust. This includes, referral/concern raised in 2019/2020, Domestic Abuse and Mental Capacity Act and Youth violence/ knife crime.

The Trust also continues to issue the third edition off Safeguarding Pocket Books which were issued to all clinical staff (see image front page).

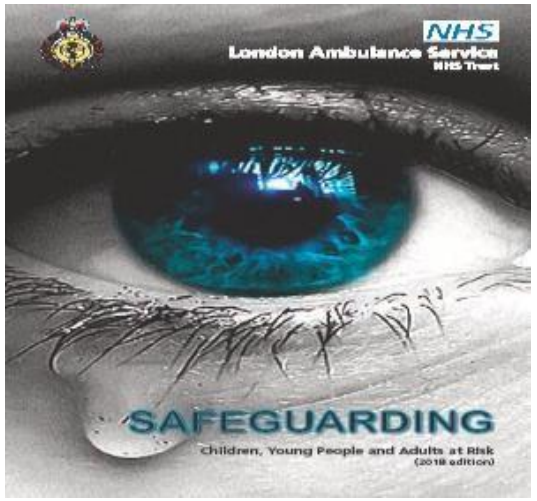
The Trust also introduced the Safeguarding Star Badges & certificates. These are given to staff who demonstrate outstanding or good safeguarding practice.

Posters

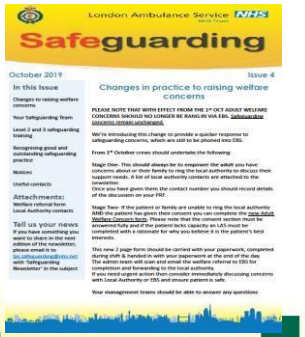




Booklet



Newsletters



Star badges and certificates

This year we introduced a new staff recognition award for good and outstanding practice in safeguarding.

We award a star when the safeguarding team agree staff actions were outstanding or over and above what would be expected. We issue a certificate when a member of the safeguarding team feels that staff have done a good job in supporting a vulnerable person.

Those who have received a Star Badge for excellent/outstanding safeguarding are:

- **Alan Hay (EBS Manager)**, this was awarded for his ongoing to support the LAS safeguarding process.
- **Mark Burnell- Emergency Medical Technician**

Marks's Story

- Mark attended a patient who was taken to hospital following a fire. The patient absconded from hospital the following morning. The patient was found by LAS in the burnt out property, there was no electric or water and extensive smoke damage. The patient had extensive physical and mental health needs and Mark made every effort to ensure this patient received the required help. Mark contacted multiple services to access help for the patient and after discussing with the housing association, they were able to organise emergency accommodation, food and clothing for the patient. Mark stayed with the patient, spending a considerable amount of time with her.

Brent Complex

Deptford Complex

Hanwell Complex

HQ

North West IRO

New Malden Complex

Trauma Response Unit

Westminster Complex

Twiddle Mitt's

This year the Trust working in partnership with Knit for Peace a not for profit organisation has placed Twiddle Mitts on all frontline ambulances.

The Safeguarding Team and Fleet & Logistics have developed a plan for ensuring every ambulance has 2 twiddle mitts per ambulance.

What are Twiddle Mitts?

Twiddle mitts are knitted mittens or hand warmers with beads, buttons and other objects sewn on to them. These are useful for patients with dementia as having something to "twiddle" helps to calm agitation and restlessness- both of which are common symptoms of dementia.

Why did we introducing them?

People living with dementia are sometimes less able to interpret process and adapt to both environmental and psychosocial stimuli. Once this happens, those living with dementia can experience an increase in levels of stress which can manifest in anxiety, agitation or aggression. This can make things difficult for our staff in trying to manage the scene and treat the patient.

Providing sensory stimulation at this stage can be hugely beneficial, improving mood and encouraging positive behaviours, achieving or maintaining a state of well-being, and bringing a kind of relaxation. When the quality of life improves for the patient, it does for our staff as well.

"I gave him a twiddle mitt and he was instantly clam and put it straight to he's face as if to comfort him''

"These things are amazing"

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:

- Safeguarding team
- EBS staff
- Frequent Caller team

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

The Safeguarding Team were **100% compliant** with safeguarding supervision target for 2019/20. With Covid-19 and remote working the safeguarding team are currently setting up a process for virtual safeguarding supervision.

Clinical supervision is provided to:

- Clinical Staff
- Mental Health Team

Youth violence

Safeguarding referrals for Youth Violence

The Trust has raised **357 safeguarding referrals** with Local Authority/ MASH partners across London in 2019-20 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 **209 notifications to Red Thread.**

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.

Some of the organisations we engage with include:

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

Care Home Review Group

The Care Home Review Group is an internal group that was set up in July 2018 and meets 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.

During Covid-19 we also reviewed all Datix reports daily relating to care homes from staff and following review relevant concerns were raised promptly with CCG & CQC in order that the relevant bodies could review and support could be provided where issues were potentially arising in care homes.

Serious Case Reviews (SCR) now known as Local Child Safeguarding Practice Reviews (LCSPR)

A SCR/LCSPR 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
Brent	Male	16	Stabbed	SCR		Redbridge	Male Female	17 16	Suicide Suicide	Internal Learning Review Internal Learning Review
Croydon	Female Male	4 Months 1 Month	Parental Neglect Parental Neglect	SCR Safeguarding Practice Review		Southwark	Female	8 Weeks	Parental Neglect	SCR
Ealing	Male	5 Months	Unknown	SCR		Sutton	Male	3 Months	Unknown	SCR
Hackney	Male	15	Stabbed	SCR						
Haringey	Male	15	Stabbed	SCR						

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	Borough	Gender	Ag e
Brent	Male Male	47 75	Harrow	Female	46
Bromley	Care Home	N/A	Hounslow	Female	96
Camden	Female	57	Havering	Male	61
Greenwich	Female Male	81 38	Lewisham	Female Female	10 2 73
Hackney	Male Male	89 63	Redbridge	Male Female	34 23
Haringey	Female	34	Tower Hamlets	Female Female	33 52
Out of London Essex	Male	73			

Domestic Homicide Review

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, our Safeguarding Specialist's local managers attend when requested:

		Domestic Homicide Review		
Year	2016-17	2017-18	2018-19	2019-20
Number LAS has supported/attended	5	5	11	18

The Trust received notification of 18 DHRs this year which is an increase of 7. The boroughs requesting participation were:

- Barnet
- Bexley x2
- Brent x2
- Bromley x2
- Islington
- Lambeth
- Lewisham x2
- Redbridge x2
- Southwark
- Tower Hamlets x2
- Out of London x2

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 2019/20 the LAS has supported 3411 cases which is an increase of 137% in the last 4 years:

	Multi-Agency Risk Assessment Conference (MARAC)			
Year	2016/17	2017/18	2018/19	2019-20
Number of cases LAS have provided information for.	1439	1910	2343	3411

The Trust currently provides information to 9 Boroughs:

Bexley	Ealing	Greenwich	Hammersmith & Fulham	Haringey	Hillingdon	Kensington & Chelsea	Lewisham	Westminster

Child Death

Following the recent changes in the Child Death Review Process in line with the latest Working Together to Safeguard Children (2018) statutory guidance the statutory responsibility for child death reviews is now held by the child death review partners. In order to contribute to this process, the Trust provides appropriate information relating to the death of the child through the meetings that precede the Child Death Overview Panel (CDOP) meeting.

	Child Death Overview Panel Requests			
Year	2016/17	2017/18	2018/19	2019/20
Numbers information provided to	206	230	241	228

All child deaths where the Trust recognise life extinct (ROLE) a child death notification form is completed (Form A) these are reviewed by the Trust Child Death Review process and where any concerns are identified these incidents are escalated to the Trusts Serious Incident Group.

Trust Child Death Reviews 2019-20	
Number reviewed	151
No further action	136
Number referred for Serious Incident Group Consideration	15
Number declared	6

Learning from reviews

MCA & consent has been highlighted in a couple of reviews.

Action taken:

- Trust has produced a poster on MCA principles,
- Issuing pens with MCA stages on.
- Trust also agreed an MCA strategy for 2021.

Incidents of youth violence continues to rise. Number of missed referrals has decreased due to continued focus on area.

Action taken:

- Article in Safeguarding Newsletter.
- 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:

- Article written and published in Safeguarding Newsletter.
- Added to safeguarding refresher training.

From the themes from SI's.

Action taken: Quality bulletin issued on Learning Disabilities

111 SE Call handing error. Feedback, reflection and training provided and case study used in future 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

Safeguarding Allegations Against Staff

The Trust has an HR Safeguarding Allegations Policy that outlines the process to be followed when the Trust receives or is made aware of a potential allegation against a member of staff.

The Trusts Head of Safeguarding & Prevent works closely internally with relevant local managers and the Director of People & Culture and the Chief Quality Officer to review case and recommend action to be taken. Externally the Head of Safeguarding & prevent liaises with the relevant LADO (usually Lambeth) or Safeguarding Adult Manager for the area. During 2019-20 there were 7 investigations and 1 dismissal from service. Most cases were around professional conduct.

Prevent

The Head of Safeguarding & Prevent is the Prevent Lead for the Trust and the Trust has a Prevent policy and concerns are raised by staff via our safeguarding processes. We have a requirement to ensure all staff are trained to the required level in Prevent. The Trust completes a quarterly report for NHSE covering all elements of Prevent training and referrals.

During 2019/20 the LAS raised 6 child Prevent concerns and 21 adult Prevent concerns with the LA. The Trust has reported 1 staff Prevent concern to the Police. The Trust currently raises concerns with the local authority as opposed to Prevent Channel Panels, in accordance with London Prevent.

Key Achievements

- Training compliance above target of 90%
- Quarterly returns completed within timescale
- Trust attendance 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

Private Ambulance Service (PALS) and Voluntary Ambulance Service

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

- The Trust uses 2 CQC registered providers at this time;
- Falck UK Ambulance Service
- St John Ambulance
- SSG (until August 2019)

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 safeguarding training.

The Trust have completed a rolling schedule of quarterly audits which includes a HR dip sample of staff deploying, including checking the DBS status and currency of safeguarding training of each member of staff audited; this is 4 personnel per quarter per site audit (1 site each for SJA, 2 sites for Falck).

PAS/VAS Crews completed 50 safeguarding referrals/ concerns. This is consistent with a similar sized station. The Trust commissions 10 frontline vehicles from Falck on late shifts per day through the weekend and 6 through the midweek, and 2 bariatric vehicles and 1 frontline vehicle per 12 hr day/night from SJA. During Covid-19 a number of private ambulance companies were commissioned for a short period of time to assist with the increase in calls.

Private Ambulance Service (PALS) and Voluntary Ambulance Service cont…

Key Achievements

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

Top Priorities

- Reduce PAS &VAS to zero usage
- St John to do 50% face to face delivery of Safeguarding level3 training by end of quarter 1
- Scoping volunteer ambulance deployment

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.

Metropolitan Police

directors of adass adult social services

Red thread Youth work, health and education

LFB London Fire Brigade

women's aid until women & children are safe www.womensaid.org.uk

NHS

Local Authority

Regulated by Care Quality Commission

Clinical Commissioning Group

National Ambulance Safeguarding Group

NHSE Named Professionals Group

London Safeguarding Adult Board

London Safeguarding Adult & Prevent Provider Network

London Safeguarding Adults Network

Brent Safeguarding Children Board

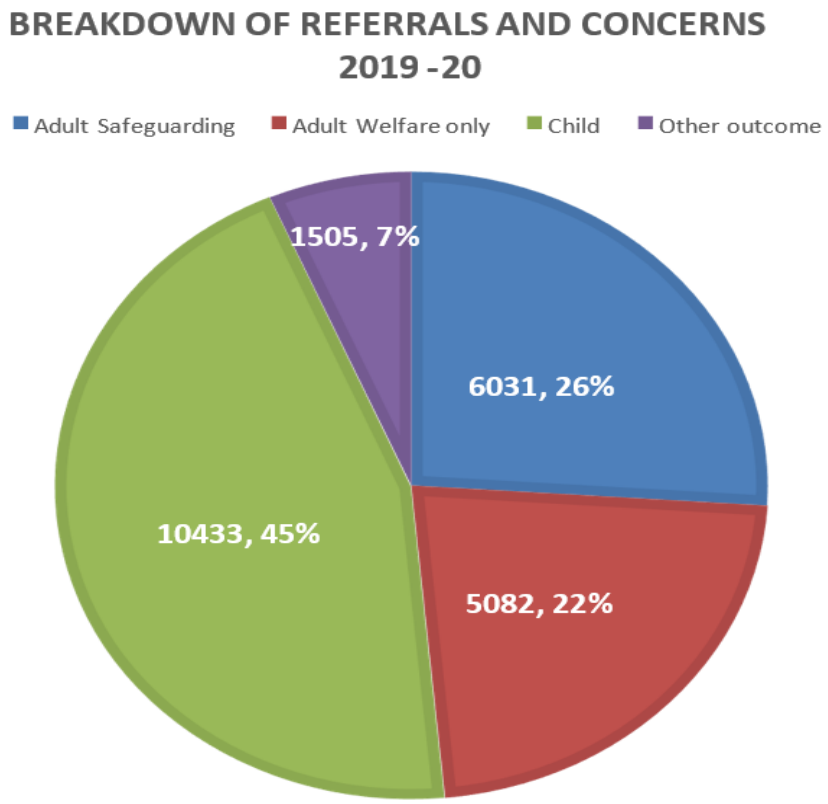
Child Death Overview Panel Reviews

London Safeguarding Children Board

Brent Safeguarding Adult Board

Safeguarding referrals and concerns raised by LAS in 2019 - 20

For 2019-20 the Trust raised **23,051** Safeguarding concerns and referrals.



Overall referral volumes

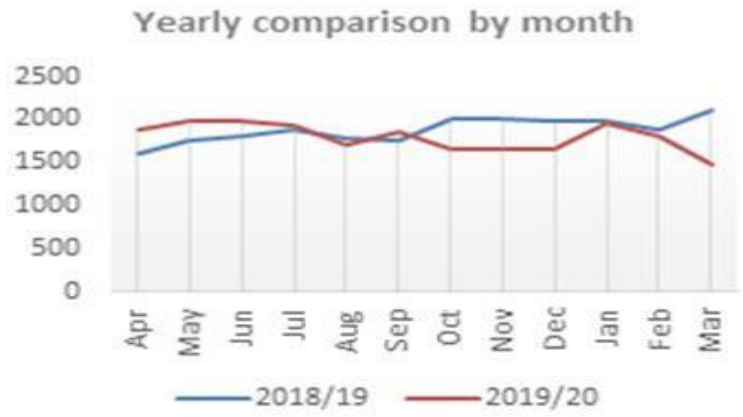
The total number of safeguarding referrals/concerns raised by our staff this year is 23,051 Comparison with 2018-19:

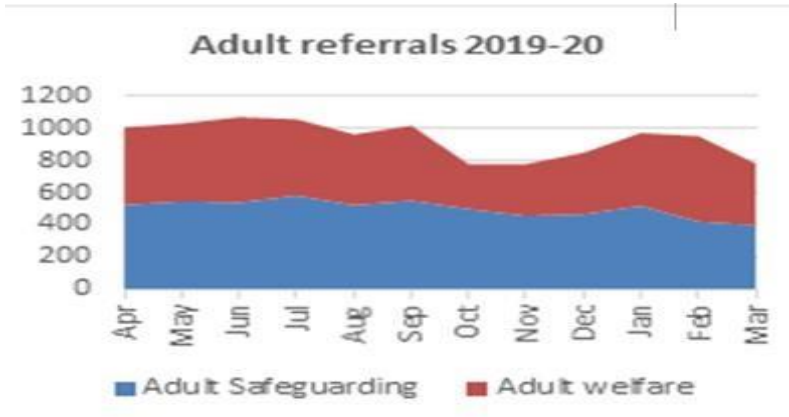
- There is a 2% increase on 2018-19 safeguarding referrals/concerns total of 22,562
- There is an 8% increase in child safeguarding referrals since 2018/19
- There is 1.6% decrease in adult safeguarding concerns since 2018-19
- There is 24% decrease in Adult welfare concerns since 2018-19

1,505 concerns categorized as 'other outcome' were not passed to the local authority, because they were not appropriate. 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. 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 1.9%, which is a decrease from last years figure of 20%.

Volumes during the year

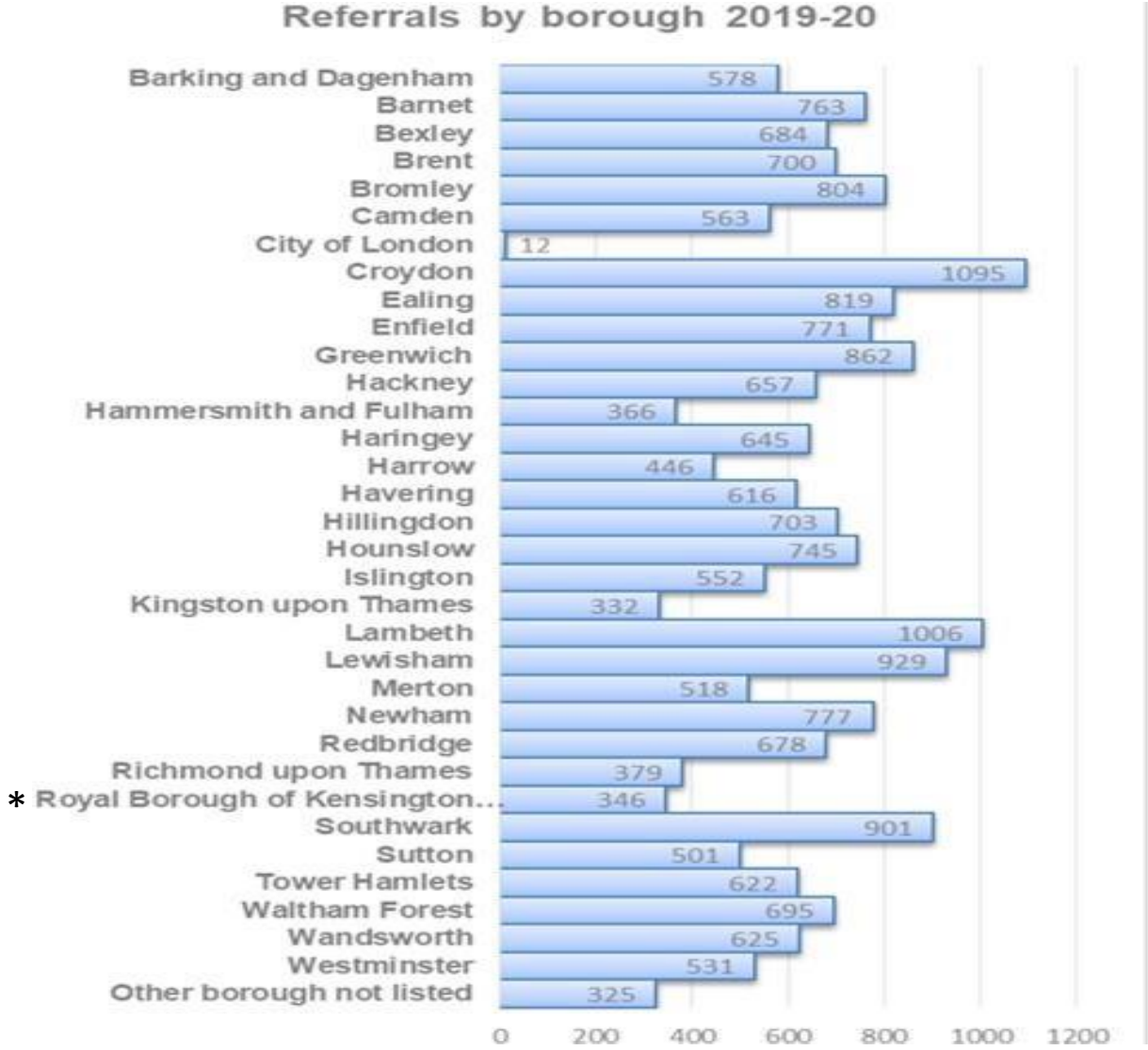


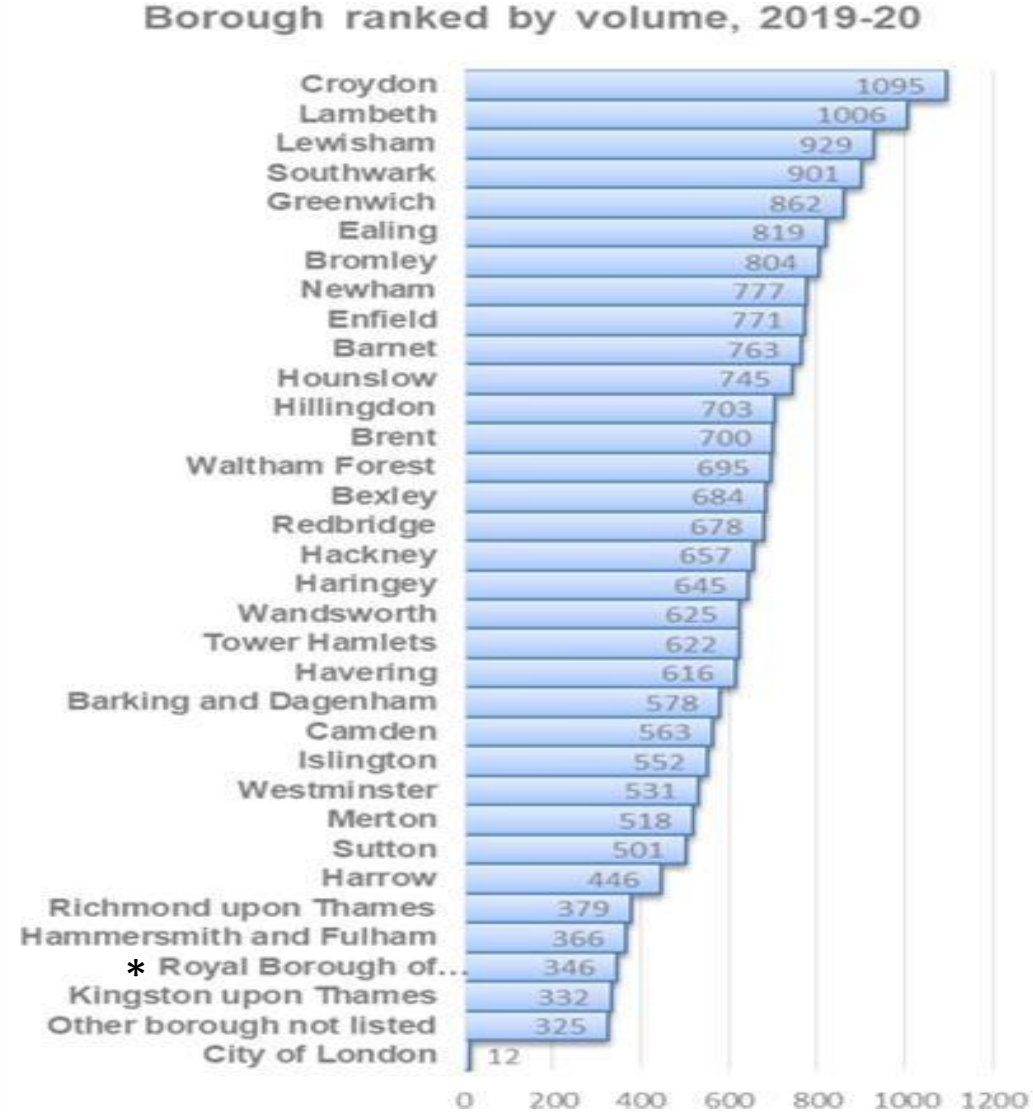


All volumes for this year must be caveated to take note of COVID-19. The Covid-19 impact on referrals took effect around mid-march, and at the time of writing has had the effect of decreasing volumes significantly for the last two to three weeks of the year. This is possibly due in part to effects of the lockdown and in part to changes in the activity of the Trust as a whole.

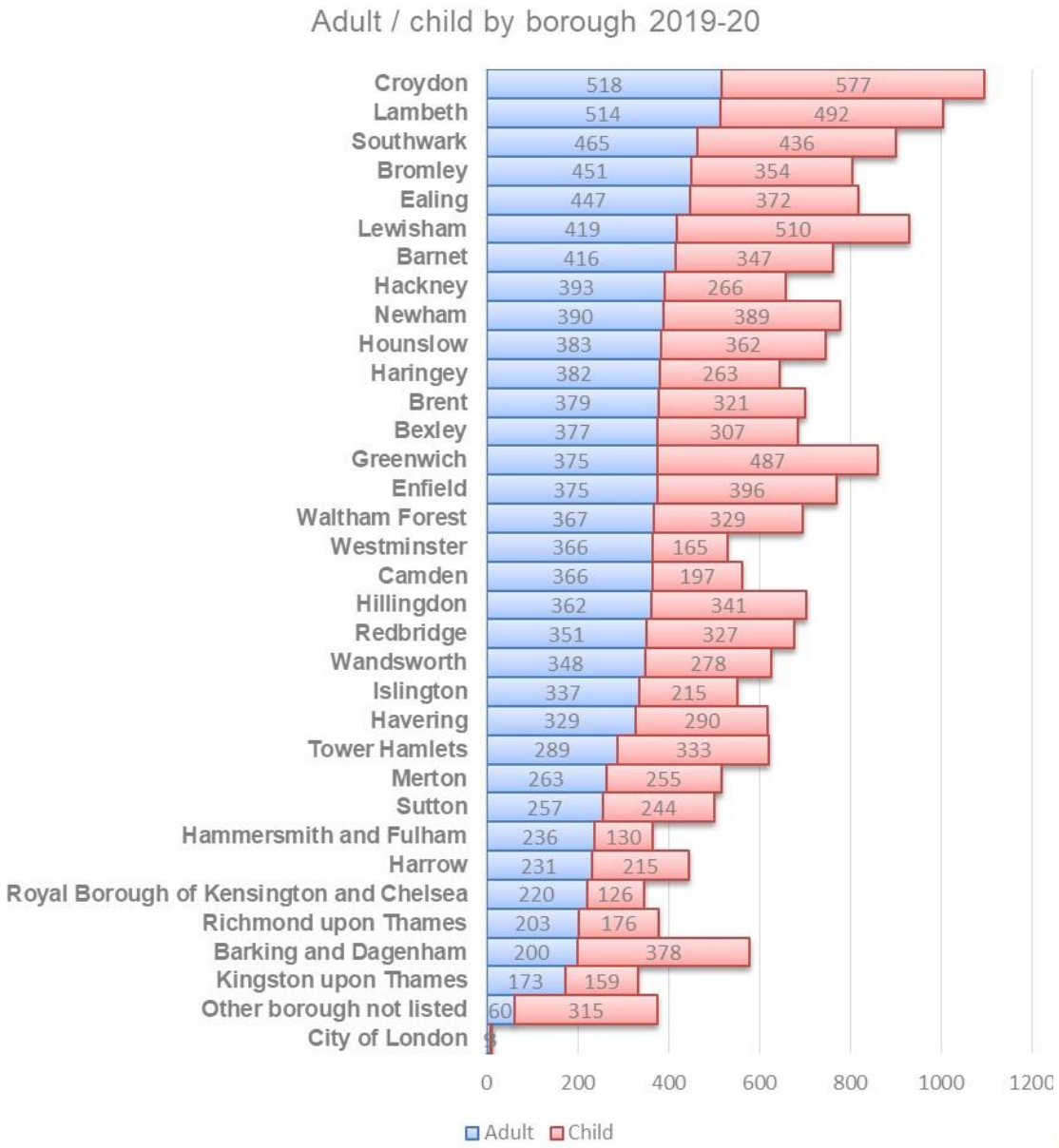
Adult referrals overall have decreased slightly throughout this year; this is attributable to a change in the way the trust manages welfare referrals. More are managed on-scene by crews empowering carers and relatives to refer themselves: the remainder using a slower, less resource-intensive process. This includes an agreed delay in referral of up to five days, which accounts for the drop in volumes in October when this was implemented. Adult safeguarding referral methods are unchanged, and volumes remain stable at around 520 a month. Child referrals have maintained their historically high volume, now typically accounting for almost half of all referrals and averaging 880 a month.

Referrals /concerns made by LAS Area	
North Central Sector	2488
North East Sector	3713
North West Sector	4230
South East Sector	4287
South West Sector	2738
Other (HART, TRU, NETS, IRO, Events)	1362
EOC	1481
111	1197
PAS/VAS Other	50
Referrals not sent / other outcome	1505
Total (including not sent)	**23051**



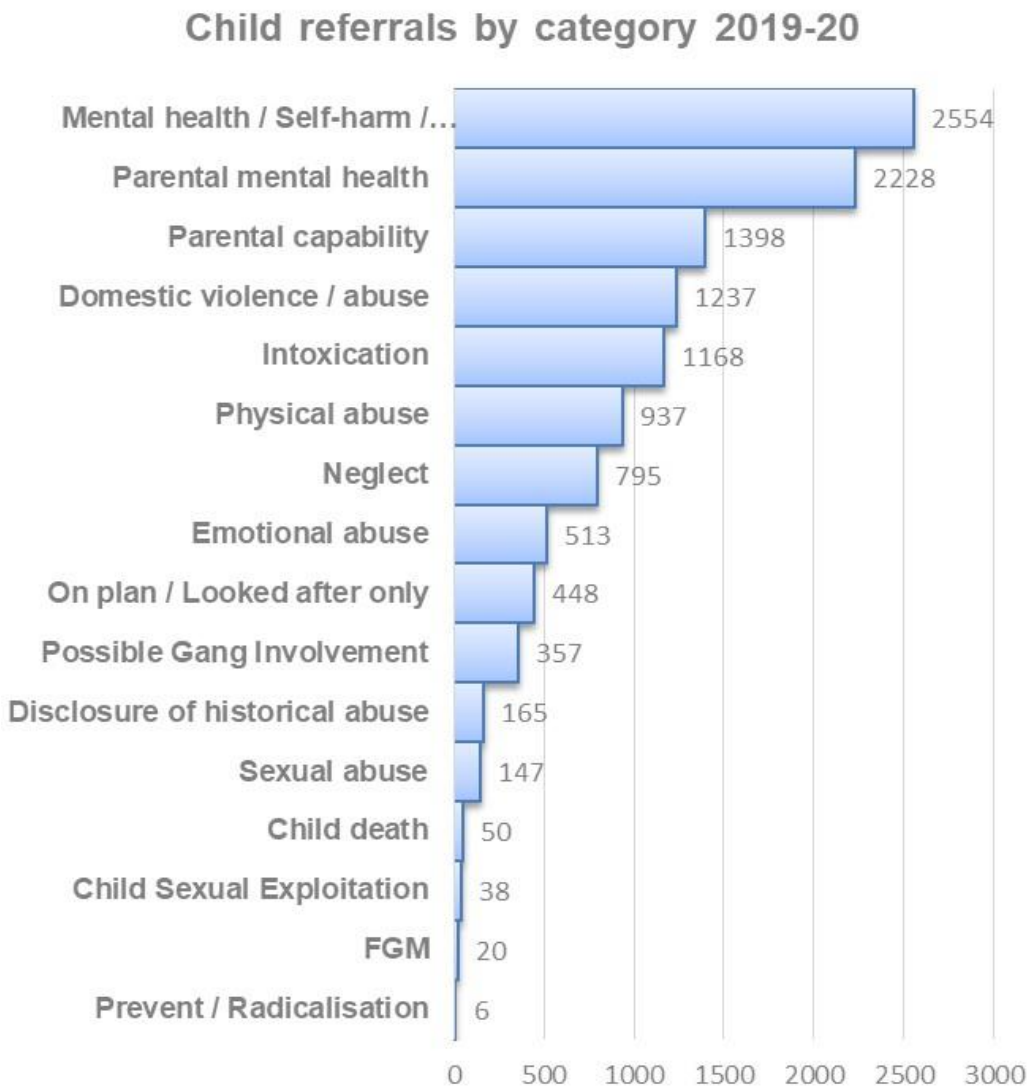


*Royal Borough of Kensington and Chelsea



Referrals/concerns by borough

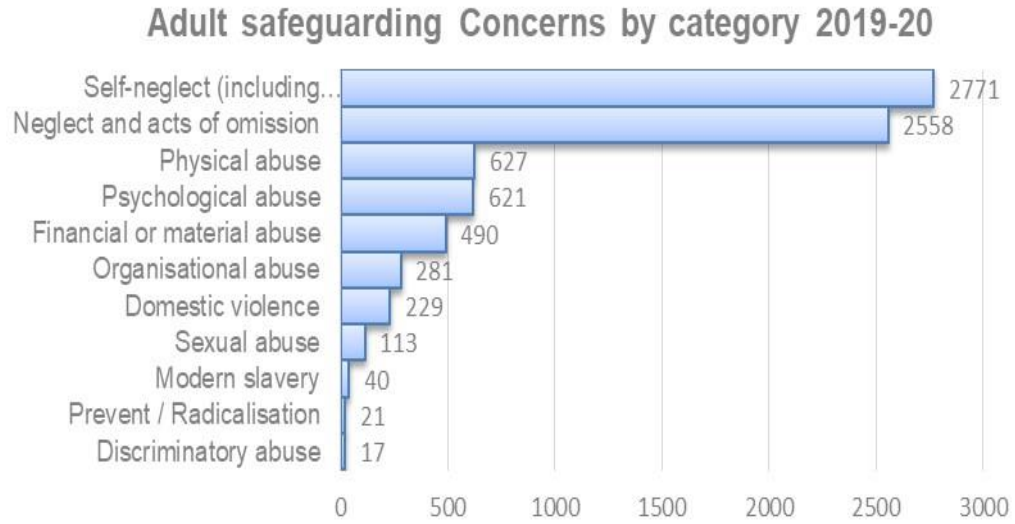
The pattern of referrals across London is familiar from previous years; Croydon for example has been the highest borough receiving referrals or concerns from the Trust since our records began in 2010, and Richmond, Kingston and Kensington & Chelsea among the lowest.

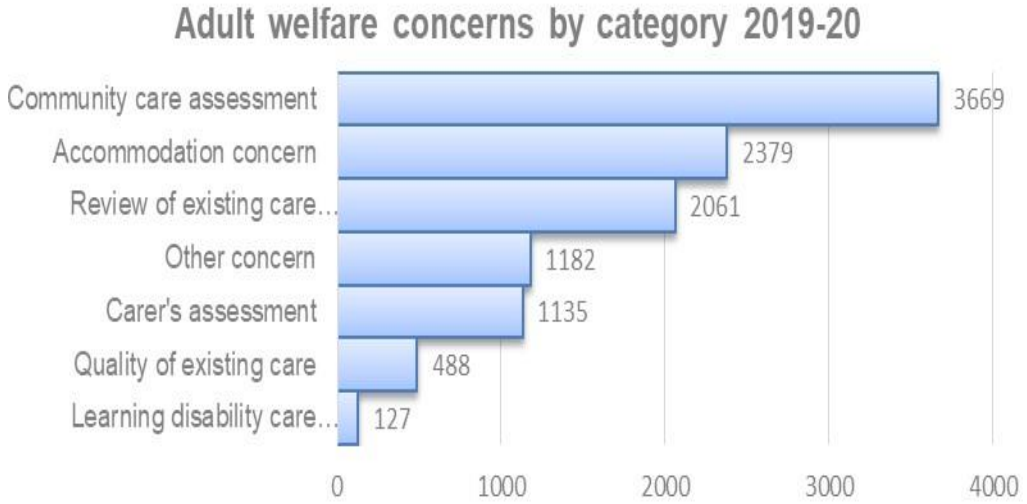


Child referrals

This chart shows the categories of concern the Trust recorded. Multiple referral categories can be selected for an individual referral.
Mental health, self-harm and suicidality are the highest category, this and Parental Mental health and Parental Capacity remain the top child safeguarding concerns identified by staff. This is consistent with previous years.

The 20 concerns relating to FGM did not include any instances of directly observed or disclosed FGM of a child (which requires reporting to the MPS). They were concerns relating to 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, 209 of these referrals have been made.





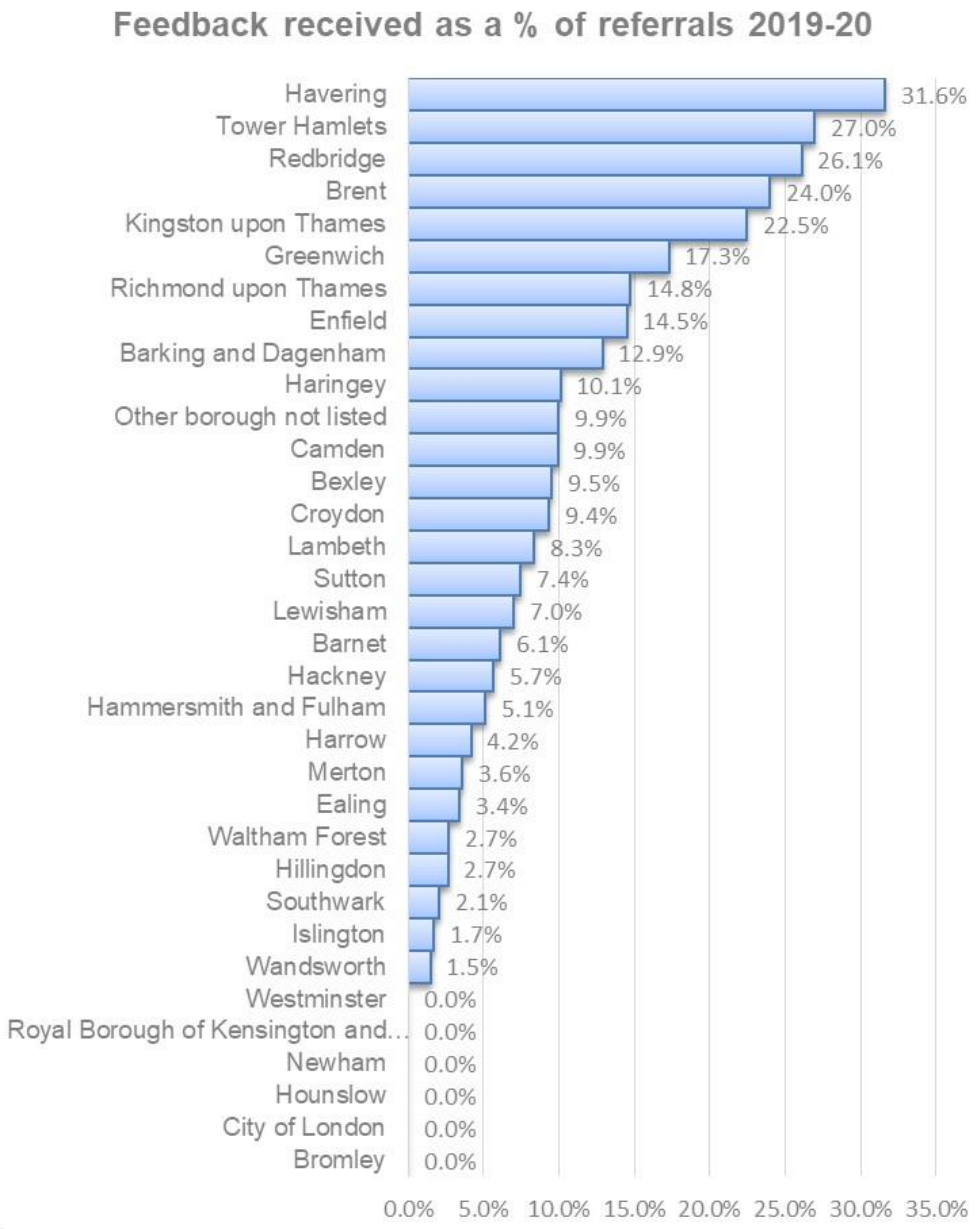
Adult referrals

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 relatively severe hoarding is indicated (scored using a clutter index devised by the LFB as over 4), and where consent is given, it is shared with the LFB. The LFB can then make a fire risk assessment and support individuals. This year we made 1083 such referrals.

In Domestic Abuse cases, staff supply the victim with the telephone number of the Women's Aid Domestic Abuse Helpline number. On rare occasions the victim will ask staff to contract them on their behalf. This has occurred only three times.

For welfare related concerns, crews are encouraged where possible to empower individuals or their families or carers to approach the local authority directly, the Trust does not capture figures on this. Where concerns are raised via the Trust figures are captured and the main reason of concern is the request for a care assessment.



Feedback from boroughs

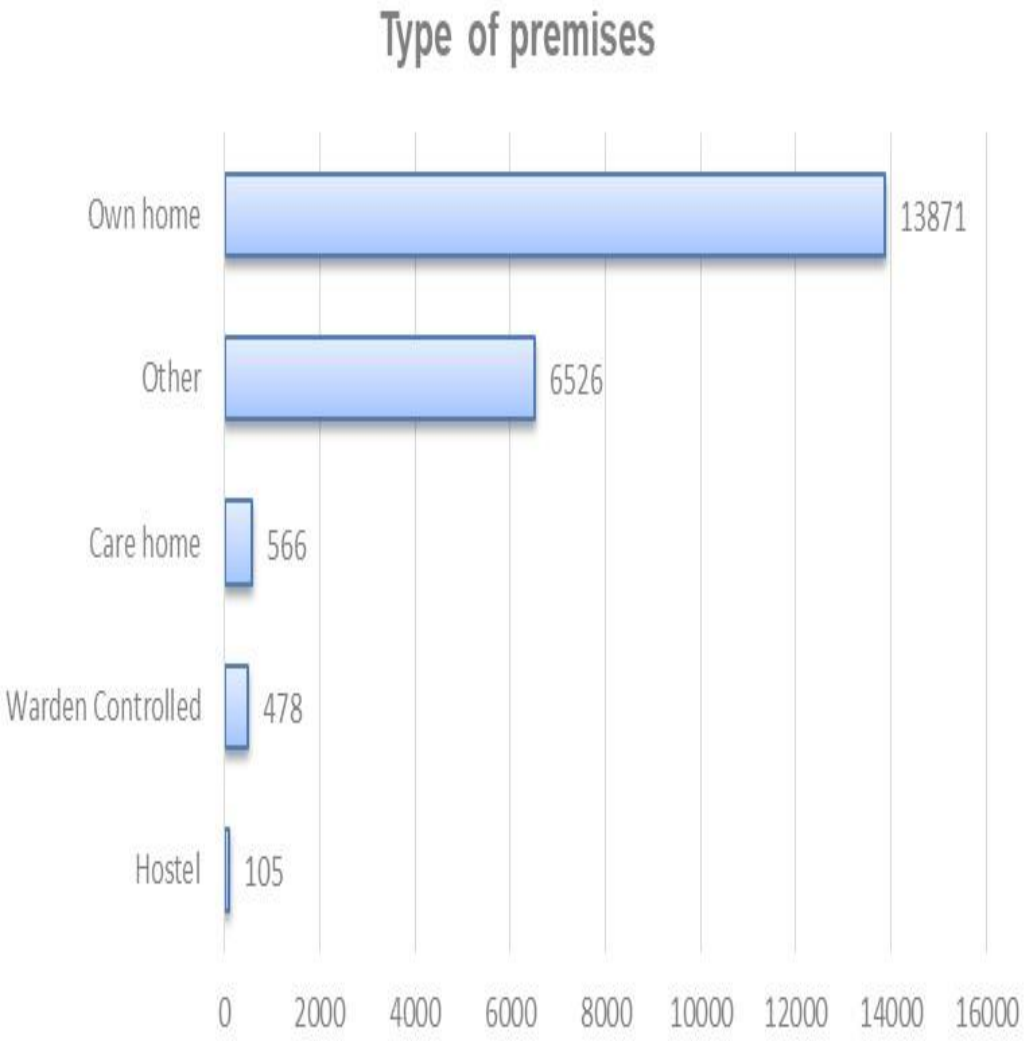
Colleagues in the boroughs provide us with feedback on the outcome of our referrals.

The point of this feedback is to enable us to flag any issues arising from a referral, to gain further understanding and insight into the work of social services, and to learn from the outcomes we receive.

It may be that the feedback enables a staff member to gain closure on an incident they have encountered with the simple yet important reassurance that the matter they have reported is being dealt with.

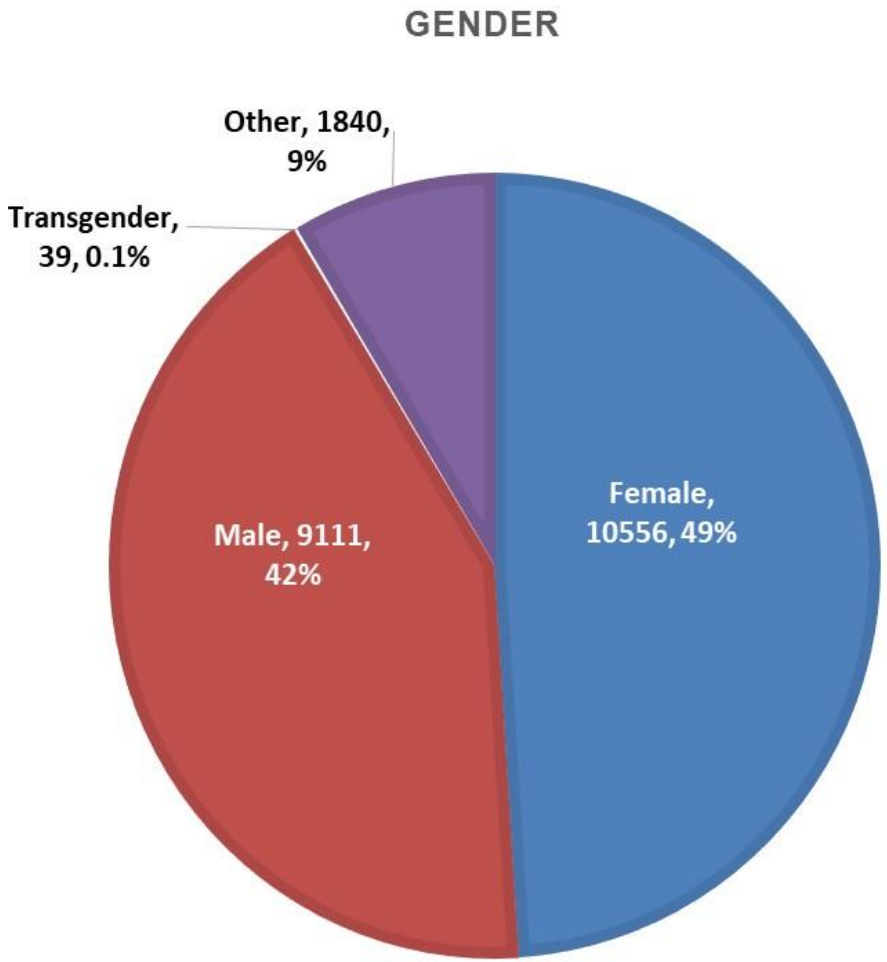
There will also be times when the person who reported the concern, or even the service as a whole, will be able to learn from the feedback and potentially implement changes to improve the quality of future safeguarding referrals.

Currently the quantity of feedback received is still small – averaging 9% of all referrals, approximately the same as last year. Feedback is marginally better for child referrals, averaging around 14%, with a couple of boroughs feeding back on almost all child referrals



Types of premises

The Trust Safeguarding Team review all concerns regarding quality of care delivered in a residential care facility and take escalatory action where appropriate. This includes sharing relevant concerns to the CQC and or CCG.

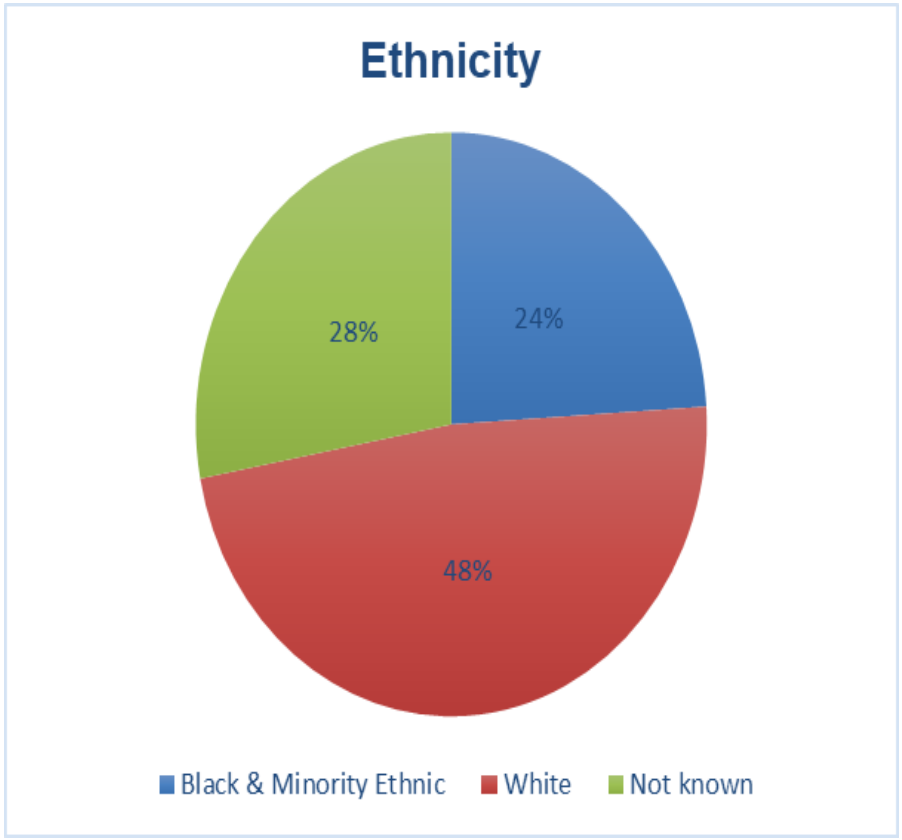


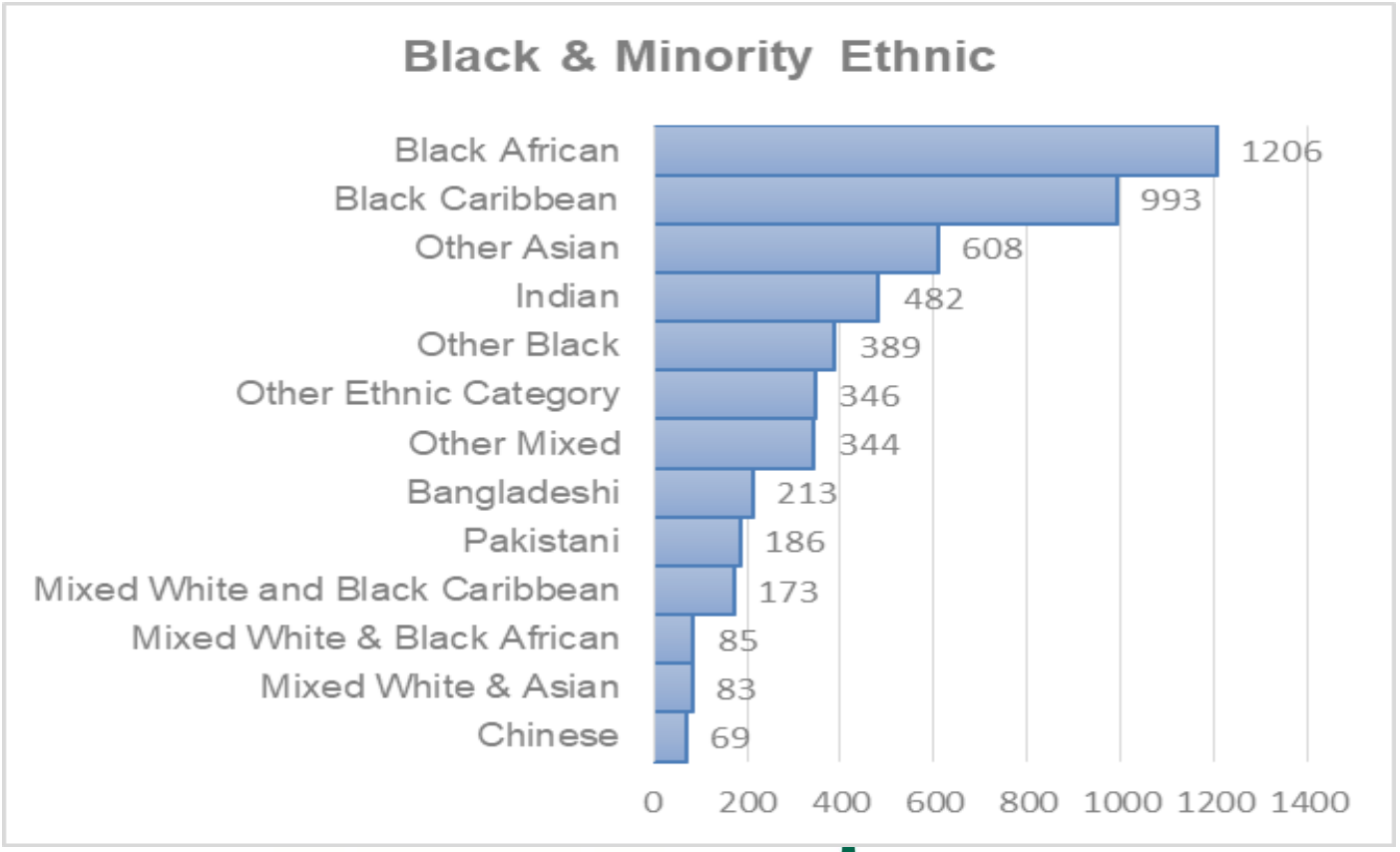
Gender

The majority of the other category 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.

Ethnicity

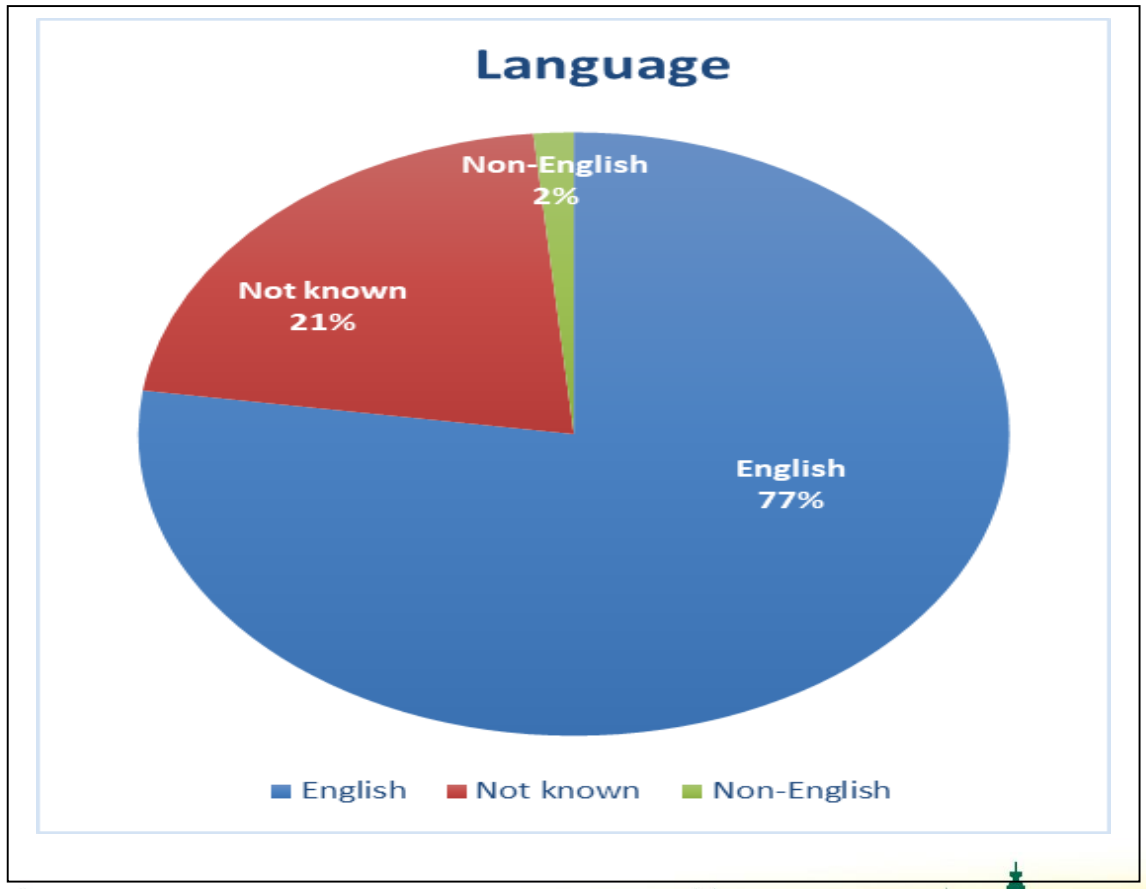
The number of cases where no ethnicity is recorded is similar to last year at 28%, and reflects the nature of the incidents that LAS attends. Often crews are unable to discuss ethnicity because patients are semi-conscious or incapacitated. Also third party concerns – for people we did not see or assess, perhaps carers or partners, or those for unborn children, often provide no opportunity for a determination to be made.

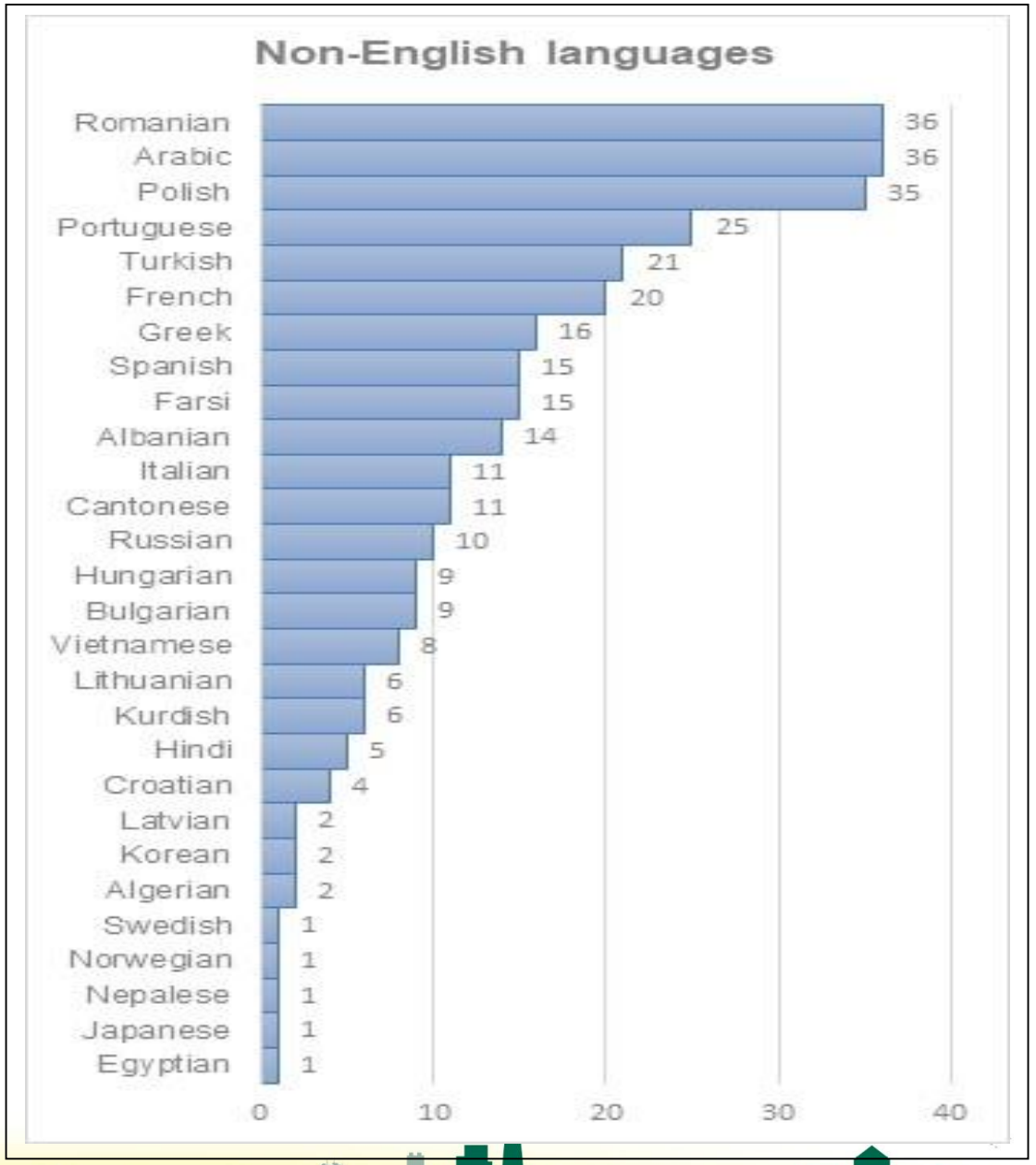




Language

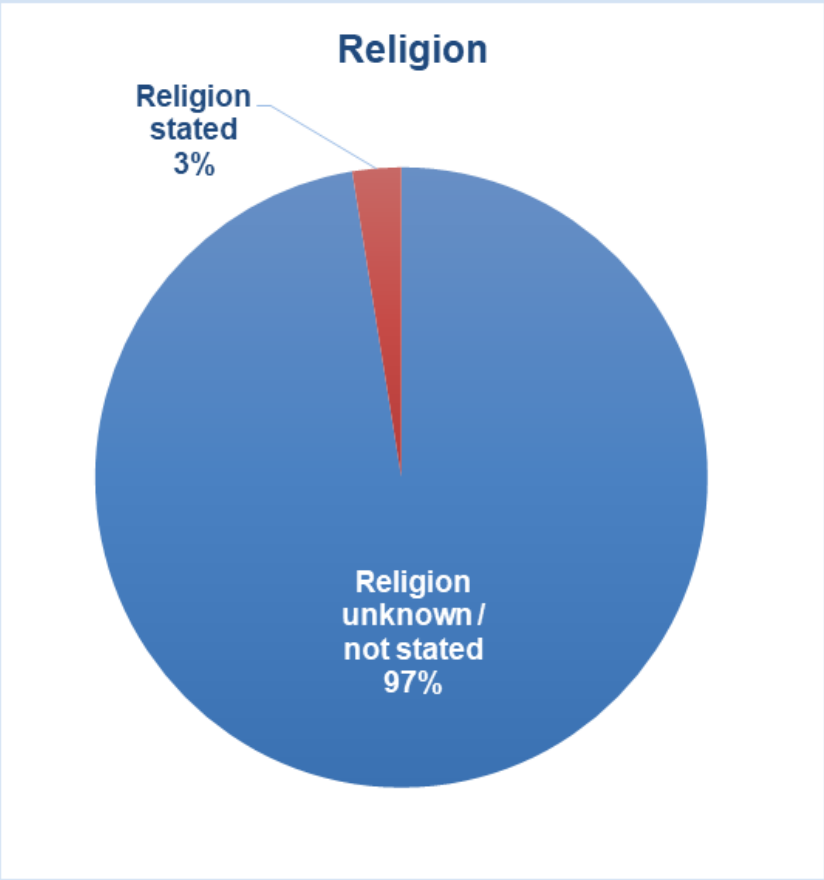
Similar to ethnicity, due to the nature of our incidents it is not always possible to ascertain languages spoken. However in cases where there are communication difficulties relating to languages spoken, the trust has access to live translation services via Language Line.

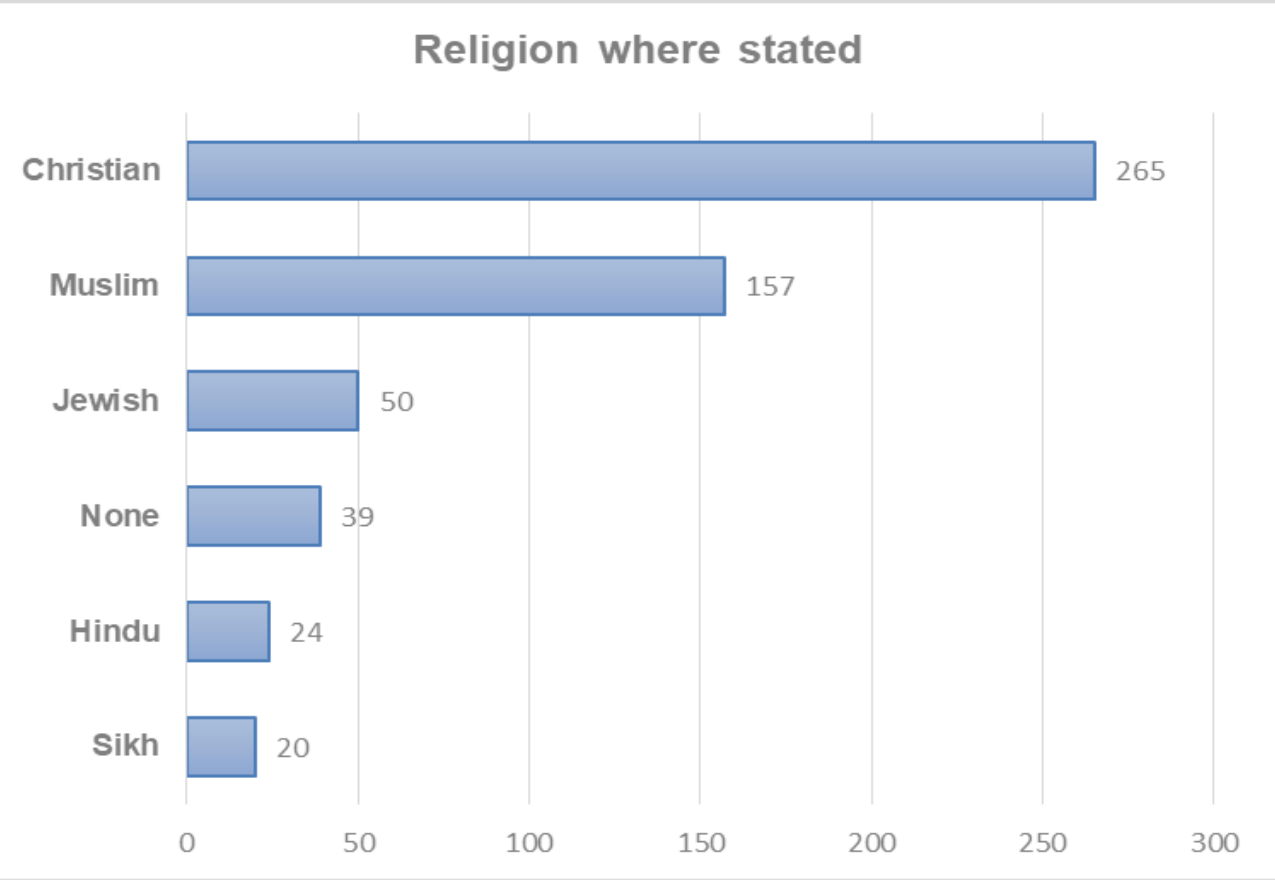




Religion

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





Top priorities for 2020 -21

To rebuild the Safeguarding Team post Covid-19. Consider new Safeguarding practice, opportunities and requirements post Covid-19.

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

Introduce a new safeguarding referral process with the Trust moving to Electronic Patient Care Record (EPCR).

To continue to improve the quality of Safeguarding Governance and Assurance.

Work with partners to:

Develop contextual safeguarding arrangements following pilot Improve safeguarding response to Prisons and referral process Improve feedback from referrals/ concerns.

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.

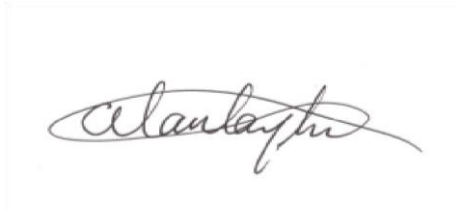
Embed new legislation and best practice. Particularly Domestic Abuse, Liberty of Protection Safeguards & Child Death processes.

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

2019/20 has been a busy year for the LAS with an increase in the resources within Safeguarding Team. 2020/2021 looks to be an exciting year as the Safeguarding Team adjusts to what business is like after Covid-19 and how we might need to adapt and change our practice to maintain outstanding safeguarding practice in the “new norm” post Covid-19.

Thank you to all staff in the Trust who day in and day out do the right thing to protect those at risk and to everyone who has contributed to Safeguarding throughout the year and to the Safeguarding Boards, NHSE Safeguarding Team and Commissioning partners.



Alan Taylor
Head of Safeguarding & Prevent