NHS
London Ambulance Service
NHS Trust

INTEGRATING ACCESS TO URGENT & EMERGENCY CARE
Building a world-class ambulance service for a world-class city
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Safeguarding Annual Report 2020 – 2021

Introduction

In 2020/2021 the London Ambulance Service NHS Trust (LAS) has continued to ensure the safeguarding of children and “adults at risk” during this pandemic year despite the challenges the Trust has faced.

The Trust serves a population of 8.78 million, covering 607 square miles and is made up of 32 boroughs. The Trust responds to over 5000, 999 calls every day and in 2020/21 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 and the Trust also acquired the call taking element of 111 North West.

The Trust remained committed to ensuring all persons within London were protected at all times and ensured best practice. The Trust adapted quickly and put in place recommendations outlined by NHS England in relation to safer recruitment practice to enable it to quickly increase our staffing to best manage demand during the pandemic.

The Safeguarding Team has evolved this year and we have worked hard to support operations and other departments during the pandemic. We have achieved this by amending our working practices, whilst continuing to monitor, review, promote and raise the standard of safeguarding practice across the Trust. By being adaptable, present and accessible this has enabled us to increase the profile of safeguarding and the team both internally and externally during 2020/21.

This report provides evidence of the Trusts commitment to effective safeguarding processes and procedures. The report details the structure and assurance measures in place 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.

Due to Covid-19 impacting this financial year this report will contain different information to what has been provided in previous years. **The Trust would like to thank all staff who have played a part in protecting children and adults a risk throughout this challenging year.**

LAS Safeguarding Achievements 2020/21

Published quarterly safeguarding newsletter

Issued a number of safeguarding star badges and certificates to recoginise good and outstanding safeguarding practice

Trained 1717 clinical staff to Level 3 Safeguarding requirement

Restructured the Safeguarding team to introduce the Deputy, Governance and Learning Disabilities and vulnerabilities post

Maintained safeguarding focus and practice during the height of the pandemic, whilst also supporting other areas of the Trust

Introduced Domestic Abuse stickers for staff to raise awareness and support for patients and staff

Gained approval to move to electronic safeguarding referrals

Working with internal and external partners we have developed the Youth Alliance project which launches later this year

Improved partnership working and engagement during the pandemic

Senior Safeguarding Structure

Dr. John Martin

The Chief Paramedic & Executive Director Lead for Safeguarding

Dr. Martin joined LAS in March 21 and has ensured that safeguarding is positioned in core business in strategic and operational plans. John 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 (QOG)

Alan Taylor

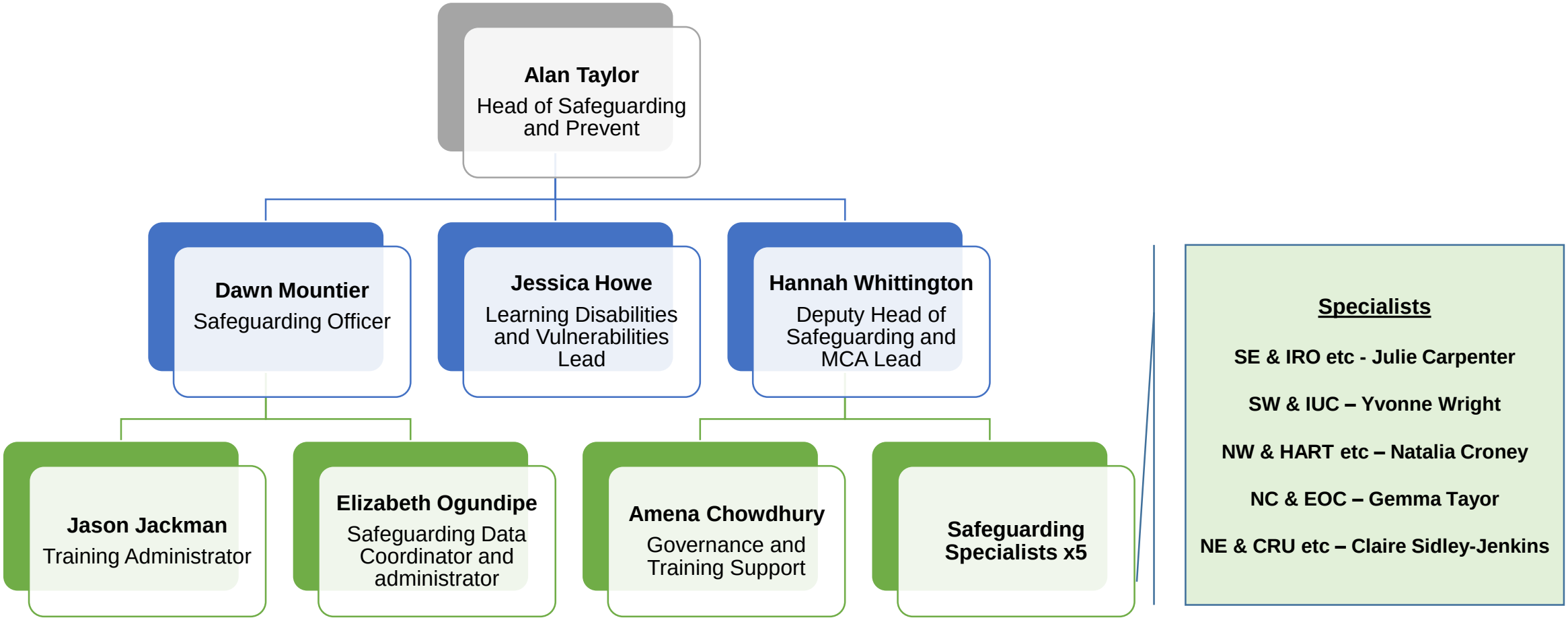
Head of Safeguarding and Prevent

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

Dr Trisha Bain who has been the Chief Quality Officer & Executive lead for safeguarding retired in February and we would like to thank her for all her work in championing safeguarding and supporting the growth of the team and raising the profile in the Trust.

Safeguarding Team Structure



In 2020-21 we said goodbye to June Freed & Ben Wayland and wished them both well for their new roles in safeguarding outside London and we welcome Claire & Jessica to the team in May and very much look forward to working with them in the coming year.

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).

We introduced a new role at the end of this financial year the Learning Disability & Vulnerabilities Specialist and appointed Jessica Howe who joins us in May. This is an exciting new role for the Trust and we look forward to Jessica driving forward best practice, education and training support for staff on all types of vulnerable patients. We are also excited for the new LAS Youth Alliance Project that Jessica will also be managing (further information later in report).

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

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.
- Supports staff with safeguarding allegations which are referred to the Head of Safeguarding and The Chief Paramedic & Executive Director Lead for Safeguarding.

Safeguarding Governance Arrangements

POLICIES

- Safeguarding Children Policy TP018
- Review due **Oct 22**
- Safeguarding "Adults at Risk" Policy TP019 Review due **Nov22**
- 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.

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.
- NASAG undertook review of all ambulance Trusts Report with recommendations submitted to QGARD in March 2021

SAFEGUARDING LEADS

- Executive Lead - Chief Paramedic & Quality Officer
- Non-Executive Director for Safeguarding
- Head of Safeguarding & Prevent (Named Professional Children)
  - Deputy Head of 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
- Appointed to new post of Learning Disability & Vulnerability Specialist

Safeguarding Governance Arrangements

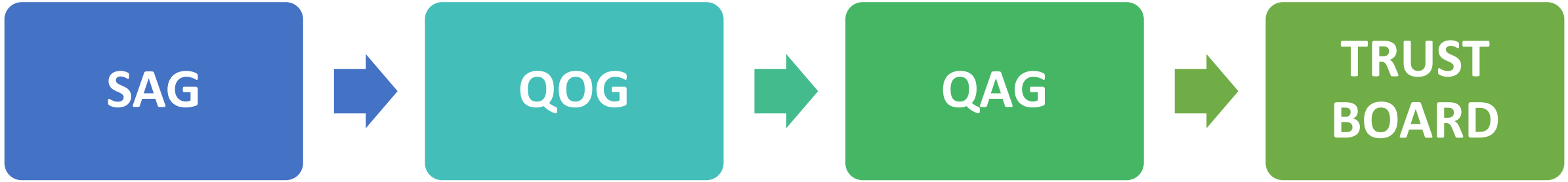
The Trust has a Safeguarding Assurance Group (SAG) that meets Quarterly to monitor the Trusts safeguarding activity and provide assurance on safeguarding practice.

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 Nurse/professionals 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 Work Plan 2020-21

The work plan is monitored by SAG (see appendix 1)

The work plan for 2020-21 focused on 6 key areas:

- Excellent Governance and Assurance of Trusts safeguarding processes and compliance
- Learning from incidents and embedding into practice
- Enhance safeguarding education and training
- Ensure integration of IUC
- Maintain and improve relationships internally and externally.
- Introduction of new electronic safeguarding referral system

Key Achievements

- We are now able to track all cases & reviews through to conclusion and recommendations and evidence embedding learning.
- Safeguarding training across the Trust is now delivered by the Safeguarding Specialists.
- LAS have been fully engaged during COVID-19 with NHSE London and National NHSE COVID cell.
- Dedicated Safeguarding Specialist for IUC engaged with governance and management teams in IUC and expansion of service
- Progress on the electronic safeguarding referrals has been slower than anticipated due to complexity and availability of LAS ePCR team & cleric to progress. It is expected to be delivered towards the end of 2021

Governance and Training Support

The role

- 3 days a week training
- 2 days a week governance

Achievements

- Learning log developed and implemented to track learning/recommendations from statutory and internal reviews and track implementation of learning
- Training evaluations forms
- Trainer self assessment and audit forms
- Domestic Abuse audit with focus on referrals during the pandemic

Future development

- With the introduction of PSIRF there is a really good opportunity for further integration within the Trust between the Quality Learning and Improvement team and safeguarding governance.
- Further audits of emergent themes

Learning Log

The learning log is intended to be used as a single database for all learning identified in our practice (including learning from missed opportunities, audits, DHR, JARs etc.). Using the database we are able to identify categories of abuse, emerging themes and evidence implementation of learning with tracking of actions taken and identifying who the learning is for and whether it will benefit the wider Trust.

The learning log is contributed to and added to by the whole team.

Below is an example of an entry into the learning log and actions taken.

Reporting month	Logged by	cad/Adastra and date	datix id	age	source	category	description	emerging theme?	who is the learning for?	summary of learning?	how did we implent learning	Evidence
October	Natalia Croney	4*** OF 29 09 2020	1*****	10	LA456	Mental Health/Self Harm/Suicide	referral not made due to thinking police would be doing one instead	No	Personal Development	safeguarding is everyone's responsibility and the need for LAS to do their own referral regardless of whether another agency like police is doing one too	LA456 feedback given and crew directed to FAQs on pulse	https://thepulseweb.lond-amb.nhs.uk/clinical/safeguarding/categories-of-abuse/safeguarding-faqs/

Domestic Abuse Audit

Aim

- To investigate the effect of the Covid-19 pandemic on domestic abuse/violence safeguarding referrals experienced by the LAS

Hypothesis

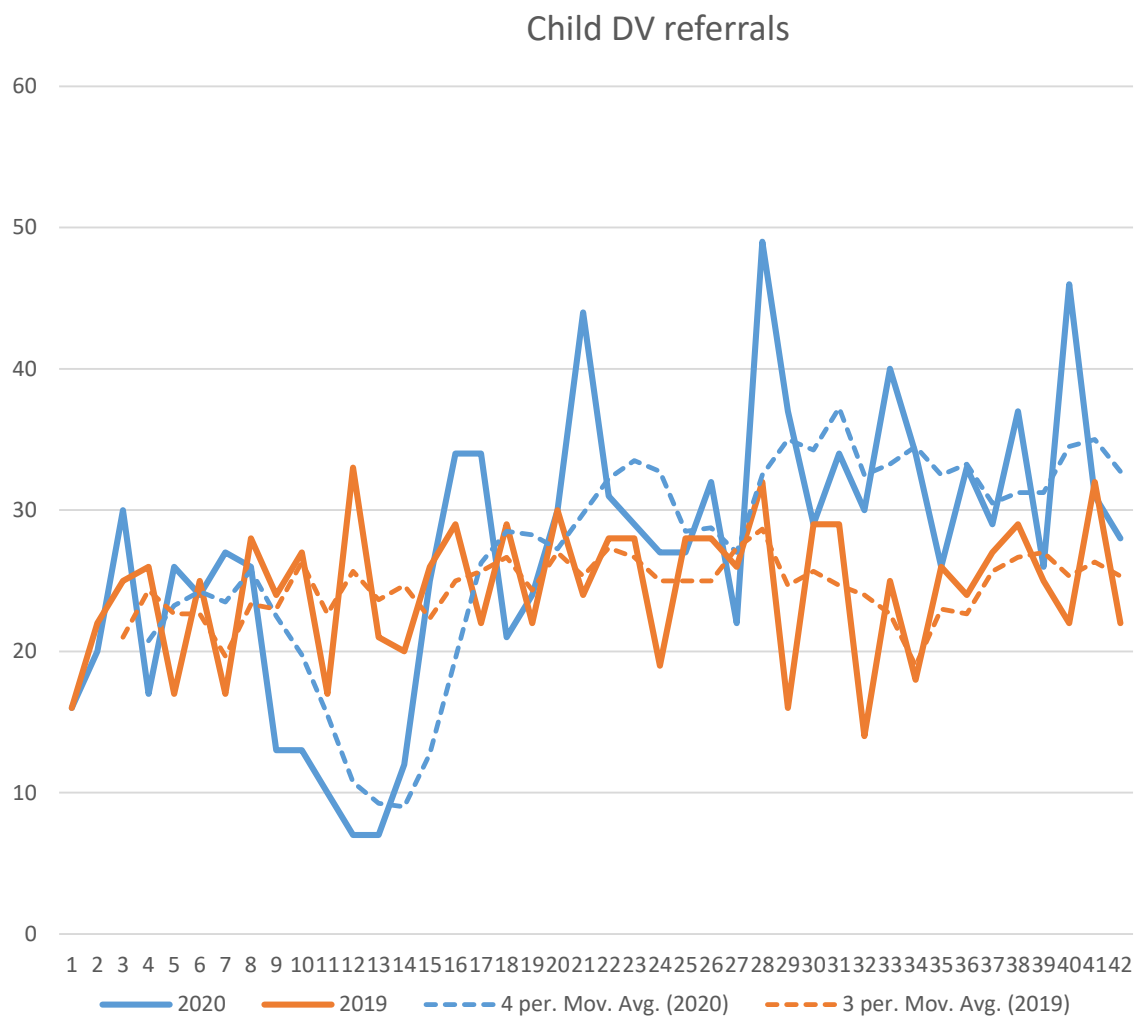
- It is predicted there will be an increase in safeguarding referrals made for domestic abuse/violence concerns. This would be reflective of what has been reported on a national scale by domestic abuse organisations

Methodology

- A retrospective audit was undertaken to look at the number of domestic abuse/violence related safeguarding referrals made by LAS during the Covid-19 period March 2020 - November 2020
- This was then compared against the number of domestic abuse/violence related safeguarding referrals made by LAS in the previous year: March 2019 - November 2019
- Findings were determined using the Datix system, which is used to record safeguarding referrals

Results

- The results of the audit showed a drop in referrals at the beginning of the first lockdown. However the volumes of referrals recovered quickly within a couple of months, then continued to increase so that both adult and child referrals showed significant year on year increase of up to 23% in the 5 months from end of May to start of November 2020
- Although we cannot say covid-19 has directly caused domestic abuse incidents to occur. There is strong evidence to show there has been an impact on the number of referrals we have received as a trust



Safeguarding Specialist Achievements

The specialists continue to work together as well as with other agencies to ensure an exciting and relevant education plan is created

The specialists have continued to identify good safeguarding practice

The specialists have continued to be involved in learning events and organising CPD events

The specialists overhauled the Safeguarding Training creating a Covid-19 secure Level 3 training package.

The specialists have and continue to support the Wellbeing Hub during the pandemic

The specialists were redeployed to support operations, 111, the Covid Hub and the Nightingale during the height of Covid-19

The specialists have continued to attend JARs and MDTs as well as provide feedback and supervision to staff

The specialists created a directory for Covid-19 Hubs and local support in each London borough and provided frontline staff domestic abuse stickers to help promote awareness around the impact of Covid-19 on domestic abuse.

The specialists have supported the Trust with the introduction of CP-IS

Safeguarding Covid-19 Impact & Initiatives

Staff deployed to other areas of the Trust to support the response to the pandemic

1ST wave we adapted our safeguarding practice and wrote to external partners to advise of changes in LAS safeguarding team response with focus on those in immediate risk

2nd wave we learned the lessons from our response from the 1st wave and prioritised safeguarding practice further

JAR meetings attended by Specialists, rather than CTM's this is practice that will remain after the pandemic

Domestic Abuse stickers

Guidance issued to staff attending children and adults at risk who may require alternative care arrangements due to main care giver having Covid-19

Child Protection – Information System (CP-IS)

Benefits for Children

Early detection: CP-IS enables earlier intervention to prevent ongoing abuse or neglect.

Closes the information gap: CP-IS builds a picture of a child's attendance at unscheduled care settings *nationally* using integrated solutions.

Reducing the risks & breaking the cycle: CP-IS promotes working together to focus on the needs of the child and prevent further abuse or harm.

Better use of resource: less time is spent searching for and providing information, freeing up resources to focus on health outcomes.

CP-IS launch

- LAS has implemented CP-IS in stages throughout 2020-21. Initially it was available in our hear & treat (CHUB) first and then launched into IUC, with full implementation across see and treat from 1st March 2021.
- Operational staff can now access Summary Care Record App and view CPIS flags.
- Communications plan to promote CP-IS internally included: LAS TV Live, bulletins, information incorporated into level 3 safeguarding training, pulse information and discussion at local governance meetings along with myth buster and simple flow chart being produced.

LAS
Youth Alliance Project

Reaching out & making a difference for Looked after Children (LAC) & homeless children

What is it?
A scheme where LAS will provide bespoke training, education, mentoring support and work placements for LAC and homeless children from 16 years- 25 years old.

Aim of Project
To provide skills and education to help young people to make better life choices and improve employment chances. To avoid them being drawn into gangs and criminal activity

Programme
The project has 3 parts depending on individual's needs. All can access part one.
Part 2 & 3 are for those children Not in Education or Training (NEAT)
Project starts in June TBC 2021

Part 1
1-2hours a week over 6 weeks

- Introduction to LAS and Urgent & emergency Care. Varied roles in LAS
- First Aid Certificate course.
- Catastrophic Haemorrhage management training.
- CV & Interview skills training
- Visits to HQ, Control, Stn.
- Visit to Hems/ fleet/ make ready

Part 2 Traineeship
12 week programme (35 hrs per week)
Working with external company who provide a 9 week programme of education and training in
English and Maths
Recruitment skills
Employment skills
Life Skills
Managing finance

Part Three Mentoring/ Support
Each Young person on part 2 of the project will be linked with an LAS member of staff.
To provide a role model for the individual and general support and guidance.
Expectation of 1 hour a week for maximum of 6 months from start of part 2 of scheme.
Training provided for LAS staff undertaking mentoring /support

Education and raising awareness

Safer Sleep week comm's across the Trust 15th – 19th March

CPD event Safeguarding vs Welfare referrals

Newsletters every 2 months

NHSE Safeguarding Week 1st March - 4th March made accessible across the Trust

LiA (LAS Facebook page) presence to promote safeguarding

CPD event – Modern Slavery

Twitter account created to promote the team and safeguarding

Articles in Clinical Insight

Domestic Abuse stickers

LAS TV live – CP-IS

Star badges and certificates awarded for good and outstanding practice

'Chloe' learning event

Preventative Safeguarding Work

Staff have this year been working hard to provide support for families and individuals who have been struggling.

Operation Children's Christmas Present:

Nigel Flanagan has organised and mobilised staff to donate food and to help in the delivery to food banks across London – all in their own time.

Staff have been outstanding in their efforts with 35 stations from across London collecting food that was delivered to 44 food banks across the capital and beyond. This has helped those in poverty and try to safeguard them from needing to result to criminal activity to survive

Purley food hub *Homeless shelter Croydon *East Grinstead

*Bromley *Tottenham *North Enfield *Wimbledon *Caterham *Sutton Salvation Army *City of Waterloo *Barking x2 *Bexley

*Newham *Peckham x2 *Hillingdon *Redbridge *Dagenham *Croydon *2nd drop off to Bexleyheath *Edgware *Ealing *Bow *Brixton *Norwood *Brent *New Malden*Women's and children refuge (Croydon)

*Lloyds park baby bank (Walthamstow) *North London food aid *Silver town *Camden *Westerham *Rukhsana Khan foundation (Walthamstow)

*Earl's Court *Euston *Salvation Army Sutton *Barnet *Waterloo *Homeless shelter (YMCA Palmer house)

*Elizabeth house community center (Highbury)

In another scheme staff have been donating coats for the homeless. LAS staff are extremely caring and giving, despite having endured a very challenging year themselves they think of others and **we are extremely proud of all of them and wanted to recognise their contributions.**

Mental Capacity Act

Achievements in 2020-21

- Review and update of the ‘Consent to Examination or Treatment’ policy
- Development of a new LA5 – Capacity assessment form for ePCR which is now live

Aims for 2021-22

- Publication of capacity and consent quick reference guide
- Development of training to include case based scenarios for application of assessment
- Ensure the Trust is compliant and up to date with Liberty Protection Safeguards

Contributions to safeguarding reviews made during 2020-21

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**
B & D	Male	17	Stabbed	PLR		Croydon	Male	17	Stabbed	SPR
Croydon	Female	17	Suicide (Hanging)	SPR		Croydon	Male	17	Looked after Child (Suicide)	SPR
Greenwich	Male	4	Parental Harm	SPR		Hackney	Male	3	Parental Harm	SPR
Harrow	Female	16	Suicide	LLR		Kensington	Female	10 Months	Parental Harm	SPR
Kingston	Whole Family	Children/Adults	Unknown	SPR		Lambeth	Female	19 (Looked After Child)	DA	SPR
Merton	Female	5	Parental Harm	SPR		Merton	Male	17	Stabbed	SPR
W Forest	Male	15	Unknown (Brittle Asthma)	SPR						

Safeguarding Practice Reviews Yearly Comparison			
Year	**2018/19**	**2019/20**	**2020/21**
Number LAS supported	13	8	13

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**	**Age**
Bexley	Female	63	Brent	Male	46
Bromley	Male	30	Camden	Female	65
Ealing	Female Female	75 63	Enfield	Male	71
Greenwich	Male	62	Haringey	Male Male Female	40 51 60
Harrow	Female	47	Havering	Male Female	75 22
Hillingdon	Female Female Male	77 67 72	Islington	Female	66
Lewisham	Female	75	Richmond	Male Female Female	49 27 77
Sutton	Male	58	T Hamlets	Female Female	89 87

Safeguarding Adult Reviews Yearly Comparison			
Year	**2018/19**	**2019/20**	**2020/21**
Number LAS supported	15	19	25

Domestic Homicide Review's

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 Reviews				
Year	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Number LAS supported.	5	11	18	19

The Trust received notification of 19 DHRs this year which is an increase of 1. The boroughs requesting participation were:

- Hammersmith and Fulham x1
- Bexley x3
- Brent x2
- Havering x1
- Kingston x1
- Lewisham x1
- Richmond x1
- Southwark x1
- Out of London x1
- Croydon x4
- Greenwich x1
- Hackney x1
- Wandsworth x1

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. We are currently only asked by 8 boroughs to provide information. Below details the amount of cases we have supported during the last 4 years:

MARACs				
Year	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Number LAS supported.	1910	2343	3411	3701

The Trust currently provides information to 8 Boroughs:

- Bexley
- Ealing
- Greenwich
- Hammersmith & Fulham
- Haringey
- 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.

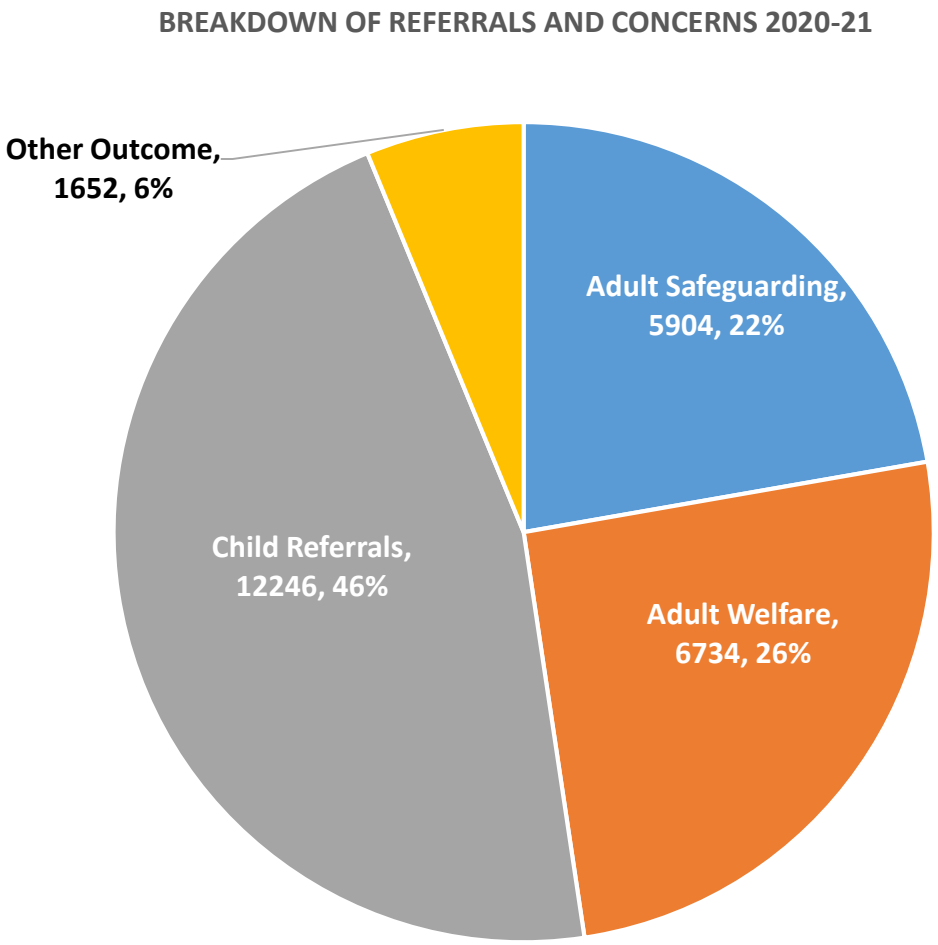
The LAS supports all the London Child Death Overview Panels (CDOP's) by providing information on our involvement with a child that sadly has died. Internally the LAS reviews all Child Deaths whether notified internally or externally. Details below show the numbers for both of these and shows the number that were escalated for serious incident consideration by the Trust.

Child Death Overview Panel Requests				
Year	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Number LAS supported.	230	241	228	207

Child Deaths Reviewed by Clinical Leads	
Number reviewed	112
No further action	106
Number referred for Serious Incident and Declared	8

Safeguarding referrals and concerns raised by LAS in 2020 - 21

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



Overall Referral Volumes

The total number of safeguarding referrals/concerns raised for this year is 24,884

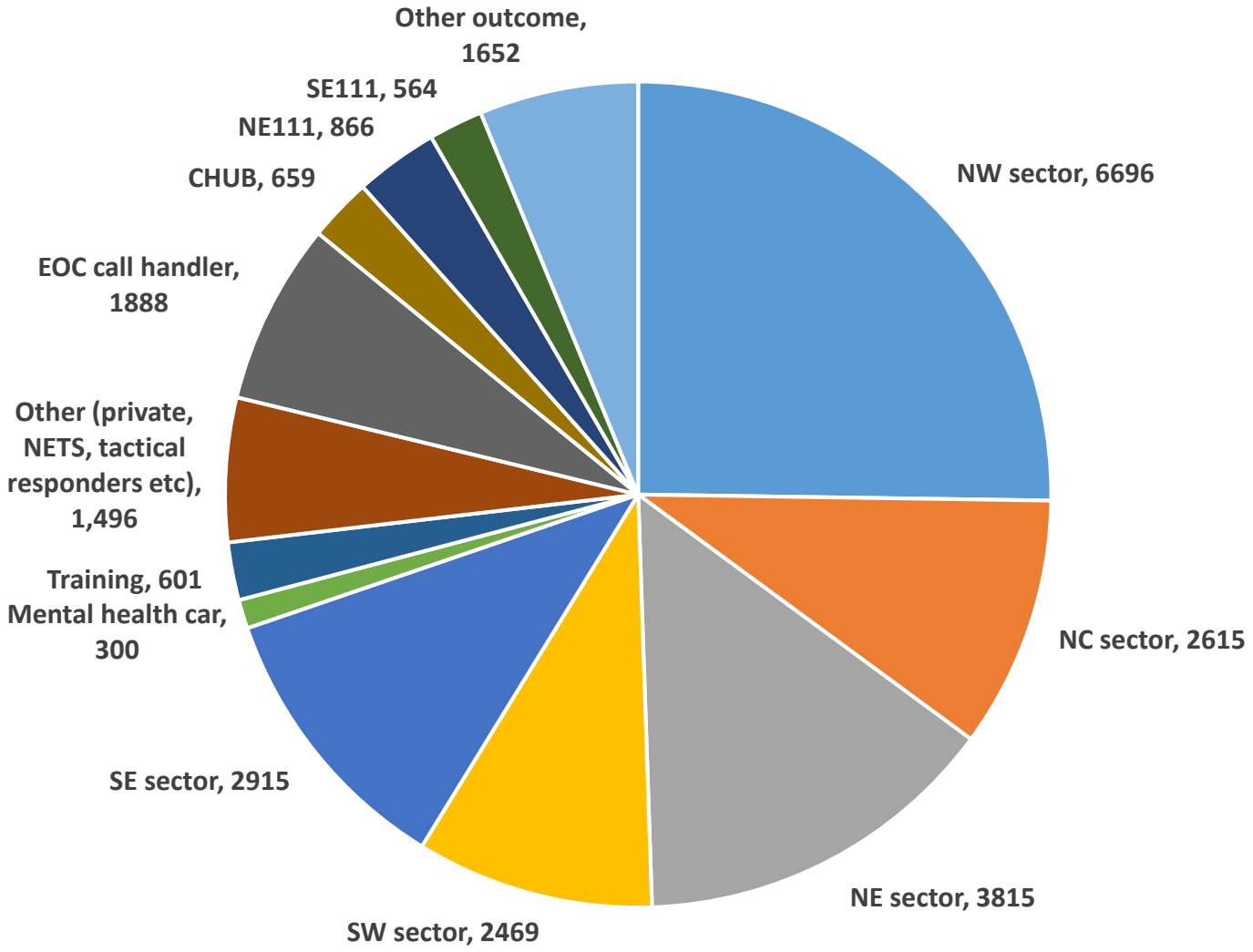
Comparison with 2019/20:

- There is a 14% increase in safeguarding referrals/concern raised on 2019/20's total of 21,671
- There is a 17% increase in child safeguarding referrals since 2019/20
- There is 2% decrease in adult safeguarding concerns since 2019/20
- There is a 29% decrease in Adult welfare concerns since 2019/20

1,652 concerns categorized as 'other outcome' were not passed to the local authority (6%, an almost identical percentage to last year), 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 varied a lot throughout the year due to the impact of Covid on our demand; the overall % for the year is 2.2%, an increase of last year's figure of 1.9%

Source of referrals/concerns raised by Trust



This chart shows how many referrals were made from each part of the trust.

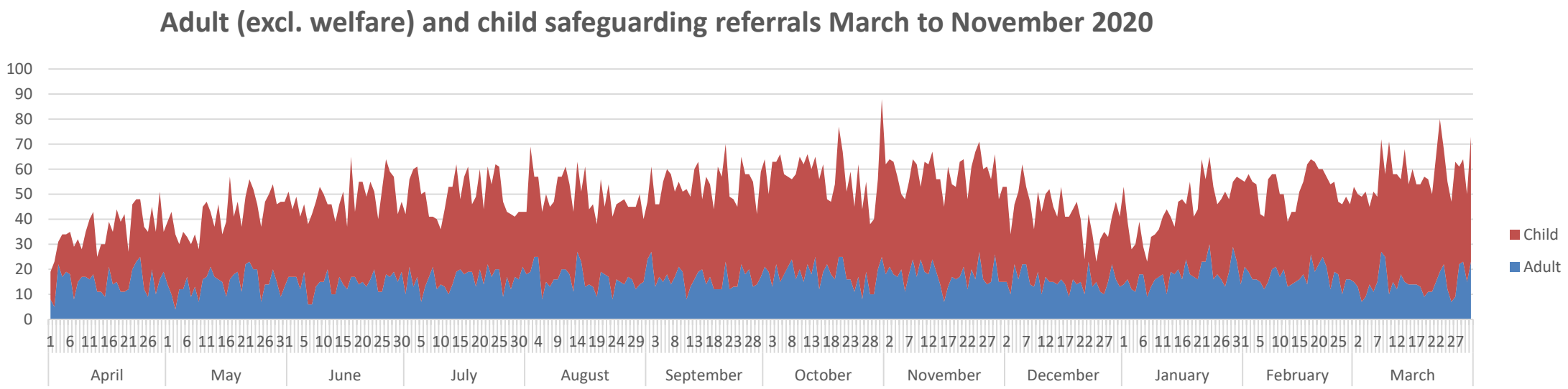
79% of referrals are made by crews working with sector-based call signs, with a further 9% coming from other road staff – training, specialist responders like our Mental Health and Falls cars, private providers, tactical responders, etc.

A further 10% were made by colleagues working in our control rooms – 7% from call handlers and 3% from our Clinical Hub.

5% of referrals were made by clinicians and call handlers working our 111/IUC call centers.

This chart only indicates the source of referral for those referrals made to a Local Authority – a final 6% were not passed as they did not meet the threshold.

Volume of referrals 2020-21

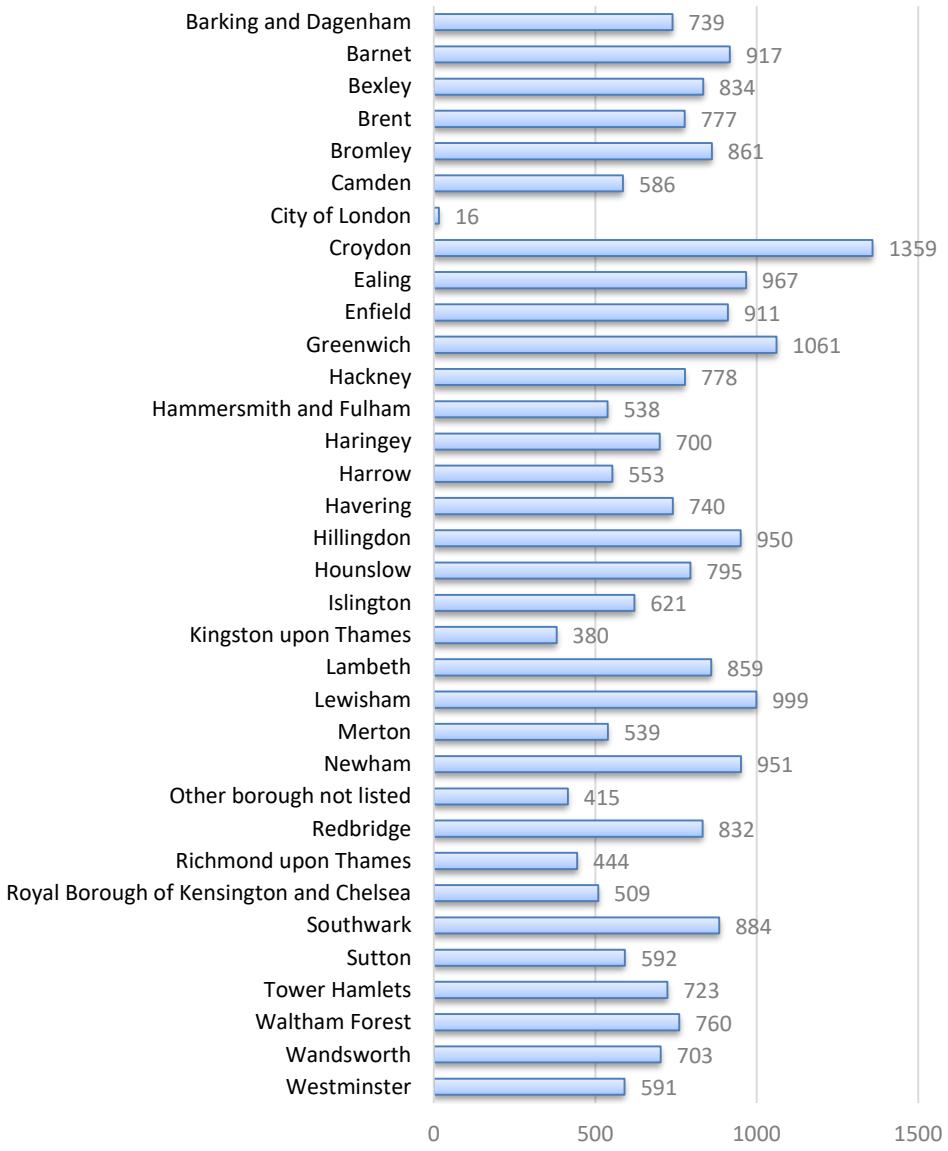


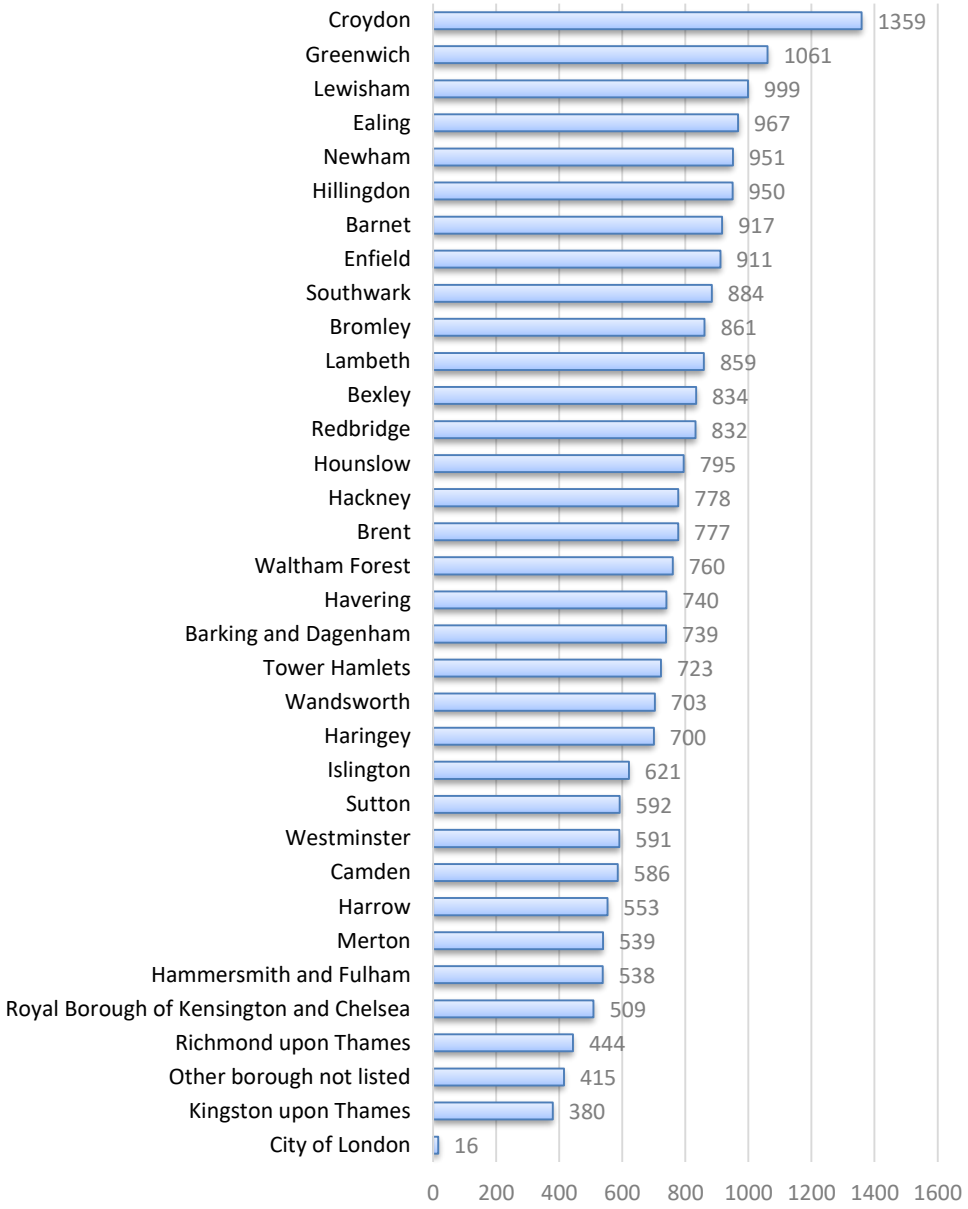
All volumes for this year must be caveated to take note of COVID-19.

By the start of this financial year, volumes were beginning to recover from a historical low point in March. Adult referrals exhibited some variation, but the effect was most clearly noticed in volumes of child safeguarding concerns raised. From a low point of around 10 a day during the first lockdown period, to around 60 a day at the peak in November, with a similar drop and recovery around the second lockdown in January. During this period, the trust instituted daily, and then weekly update huddles, sharing intelligence about volumes, trends and variation with colleagues across the Ttrust and externally through the Safeguarding Team.

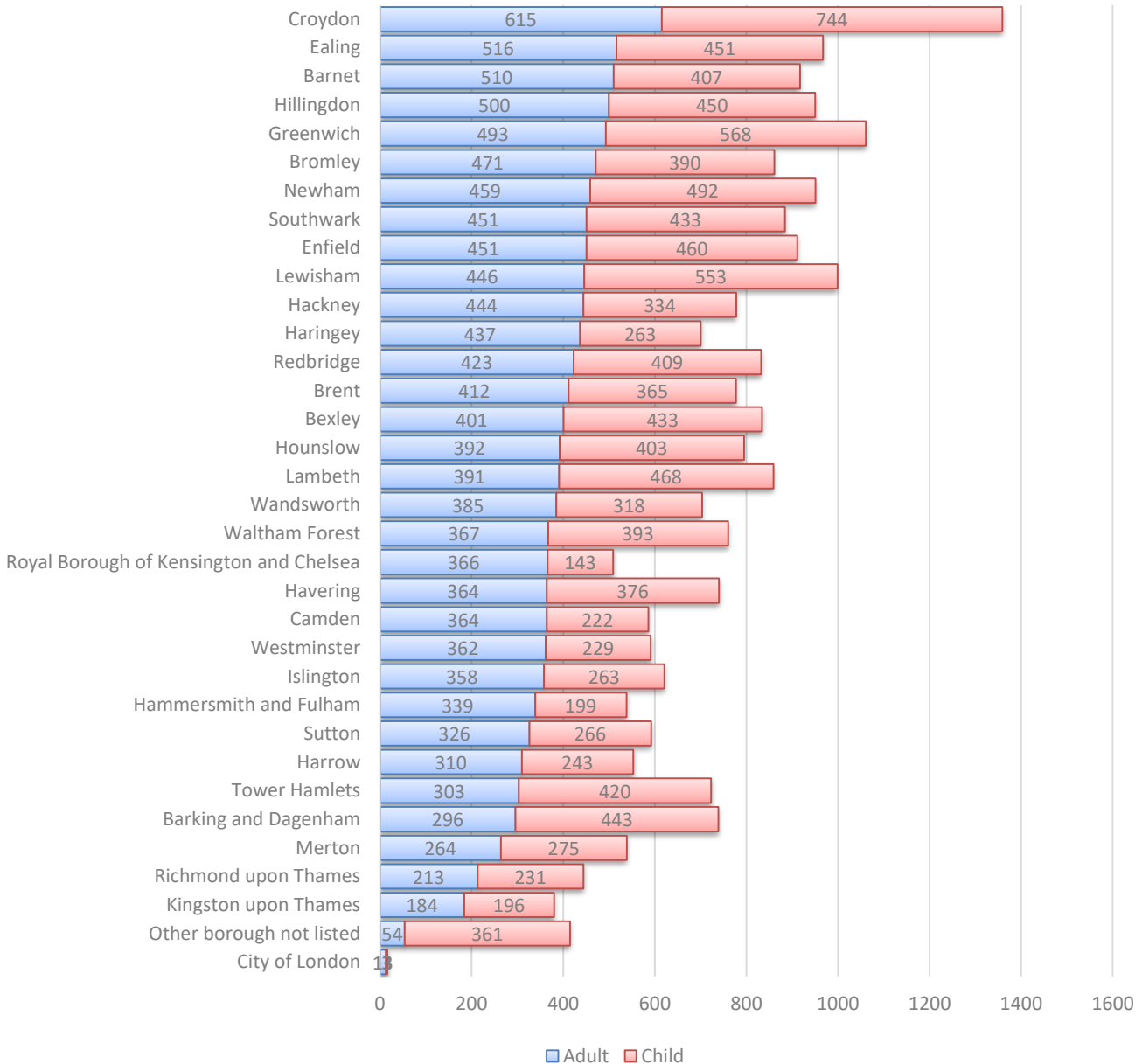
The call-handling team who take safeguarding referrals quickly reconfigured to be able to work from home where possible, allowing staff who were shielding to continue to contribute, and vulnerable staff to manage their exposure to risk. Covid safety arrangements were put in place in our HQ, and up to this point in the pandemic we have continued to deliver the service without interruption, and with no instance we have been able to identify of workplace transmission of Covid-19, although several staff have tested positive during the period.

Referrals by Borough verses ranked by volume





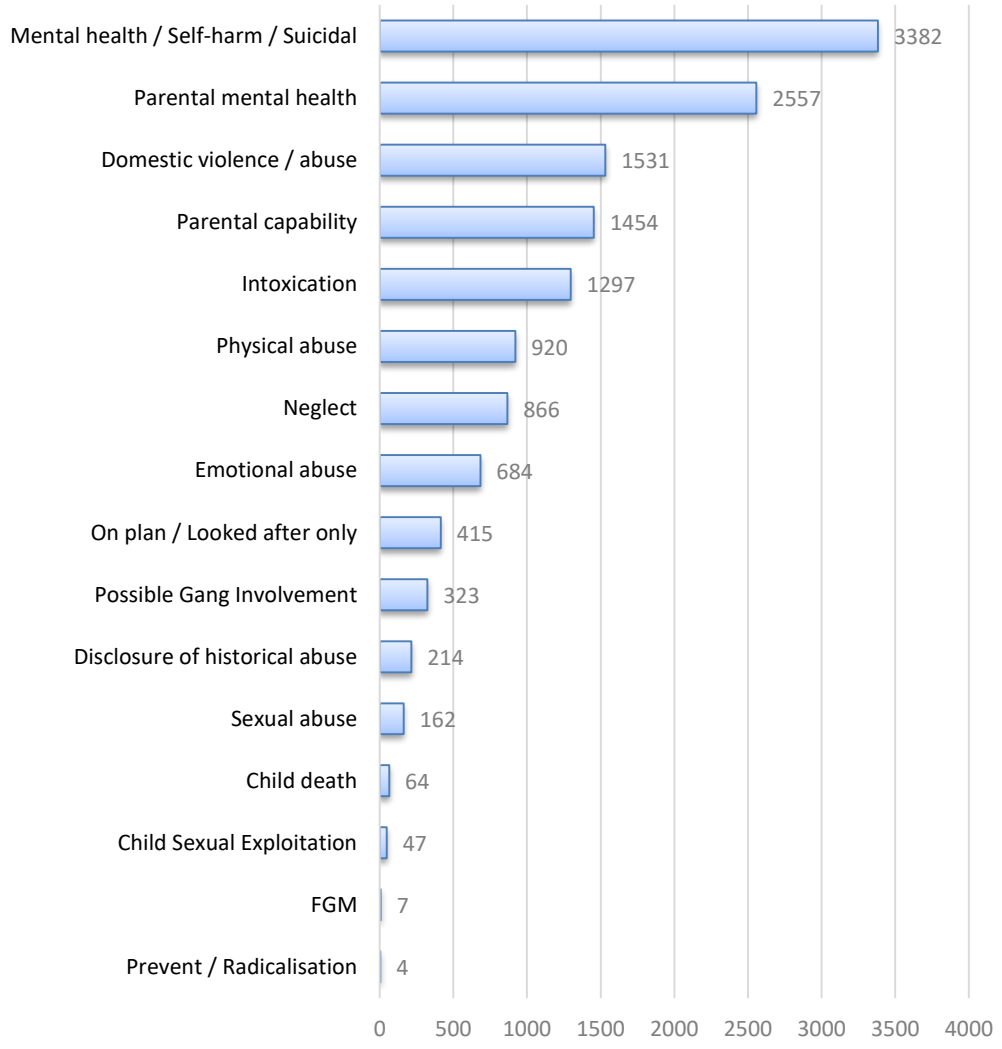
Adult concerns and child referrals by borough 2020-21



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 concerns by category



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

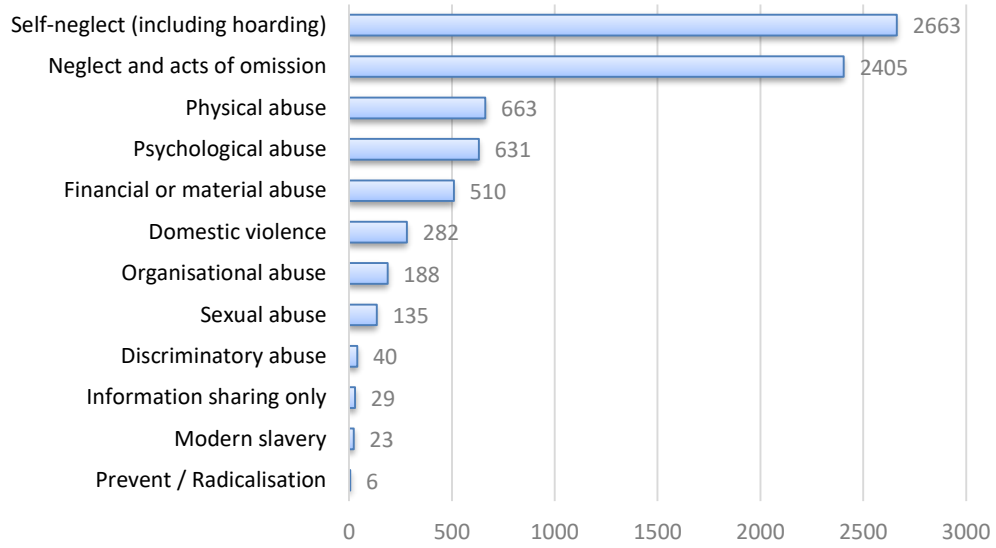
Mental health, self-harm and suicidality are the highest category – this and Parental Mental health and Parental Capacity remain the top two child safeguarding concerns identified by staff.

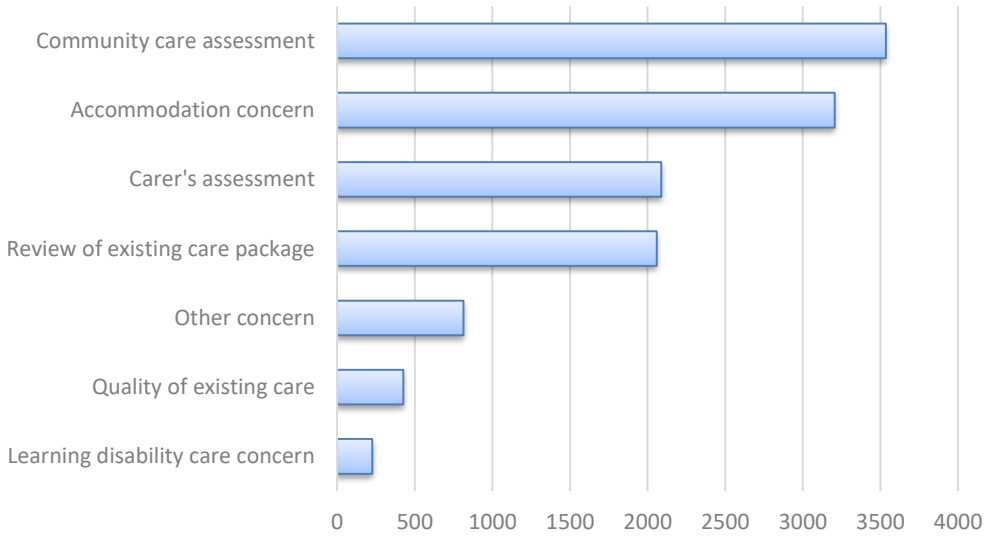
Domestic violence has risen as a share of all concerns – this effect was localized to Covid 19 lockdown periods, which included some weeks which showed an increase of up to 40% year on year.

The 7 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 ‘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, 37 of these referrals have been made.

Adult safeguarding & welfare concerns by category





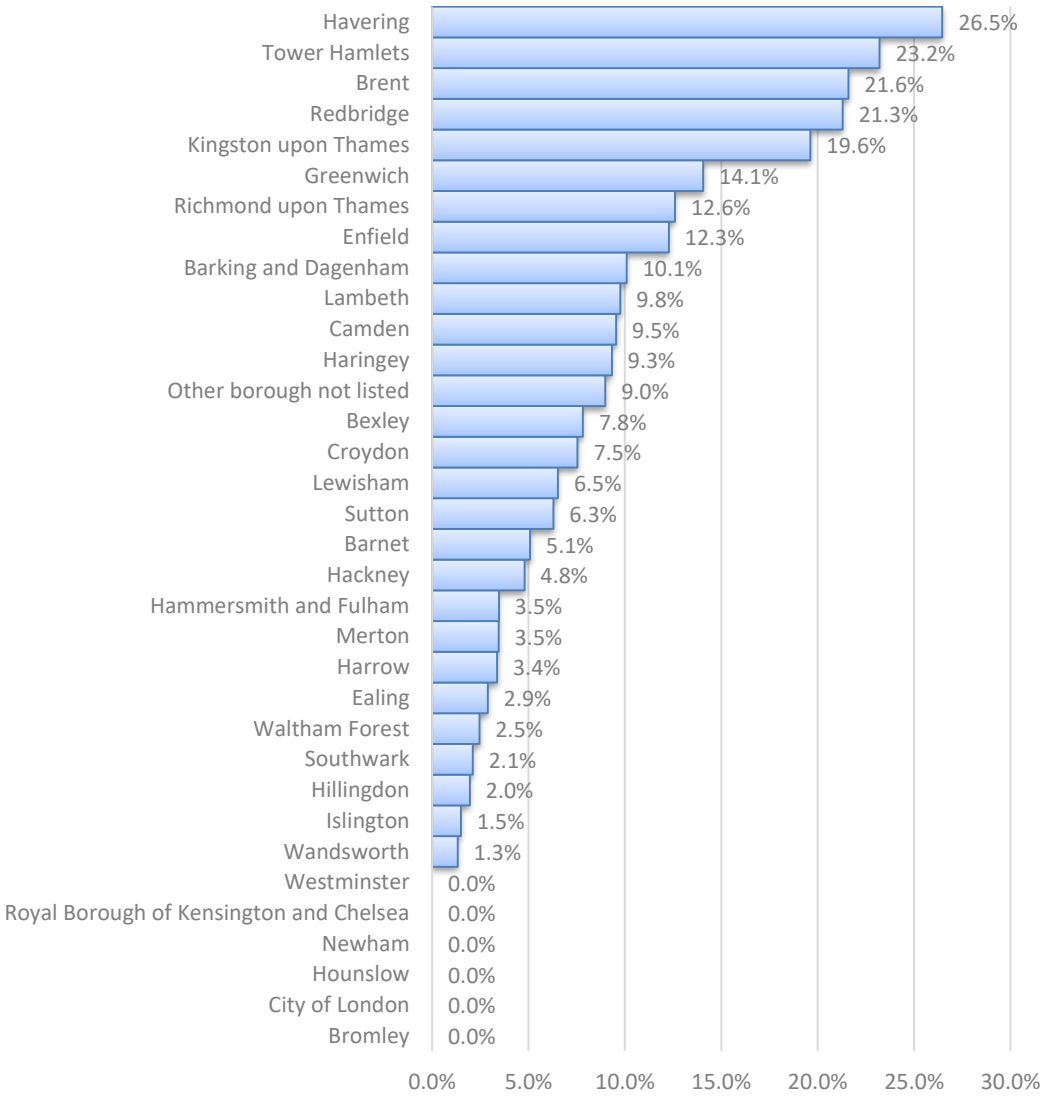
The chart for adult safeguarding concerns shows self- neglect and neglect as the top reasons for raising the concern. Multiple categories can be selected for an individual referral.

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, an alert is shared with the LFB. The LFB can then make a fire risk. This year we made 1552 such referrals.

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

For welfare related concerns, crews are encouraged where possible to empower individuals or their families or carers to approach the local authority directly. The chart for adult welfare concerns shows where concerns were raised via the Trust reporting the main reason of concern is for a care assessment.

Feedback received from boroughs as a % of referrals 2020-21



Feedback from boroughs

Colleagues in the boroughs should provide us with feedback on the referrals and concerns we raise.

The point of this feedback is to enable us to address any issues arising from a referral, to learn from the feedback and improve standards of referrals and insight into the work of social services.

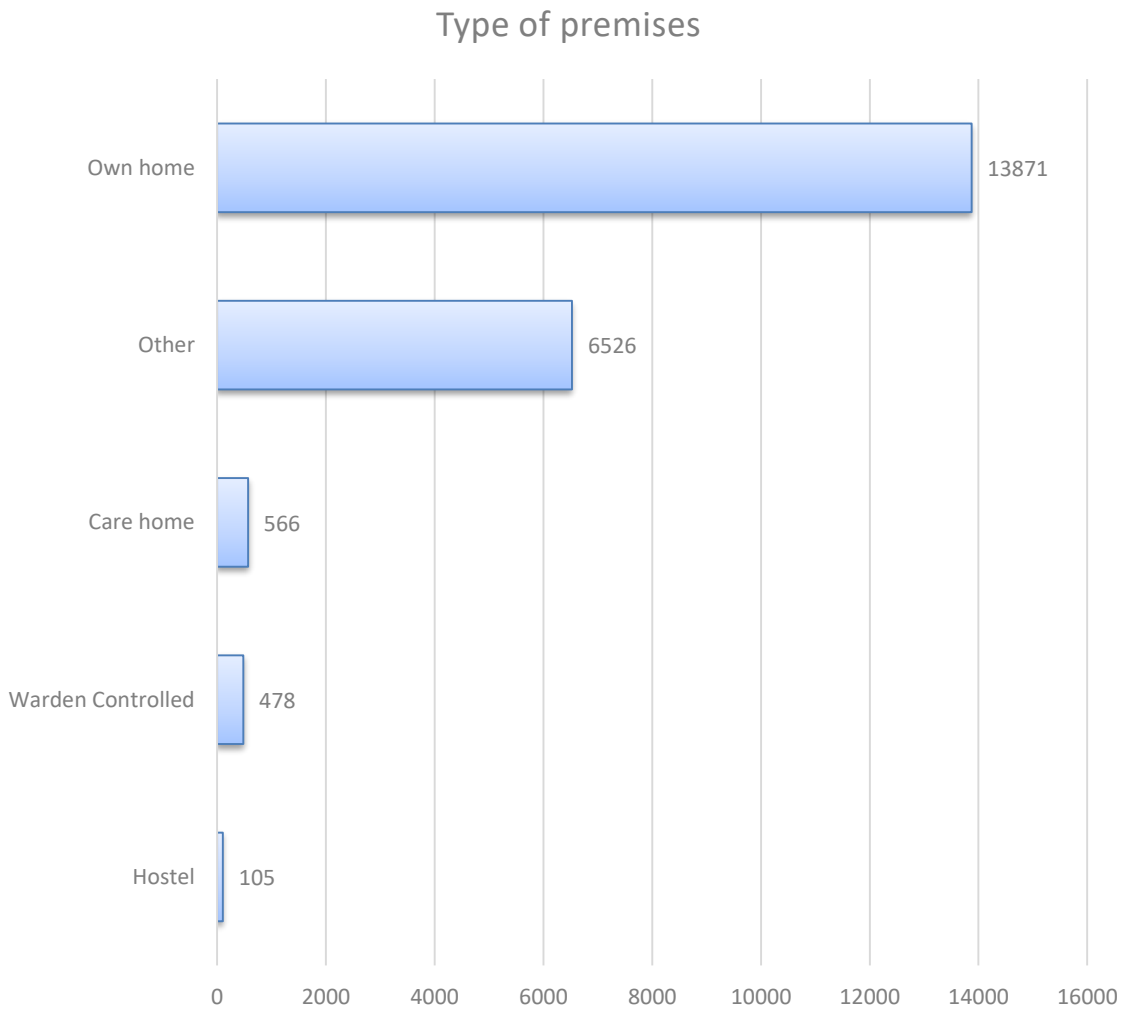
Feedback also enables a staff member to gain closure on an incident they have encountered with the simple yet important reassurance that the matter they have reported is being dealt with.

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 a slightly better for child referrals, averaging around 14%, with a couple of boroughs feeding back on almost all child referrals.

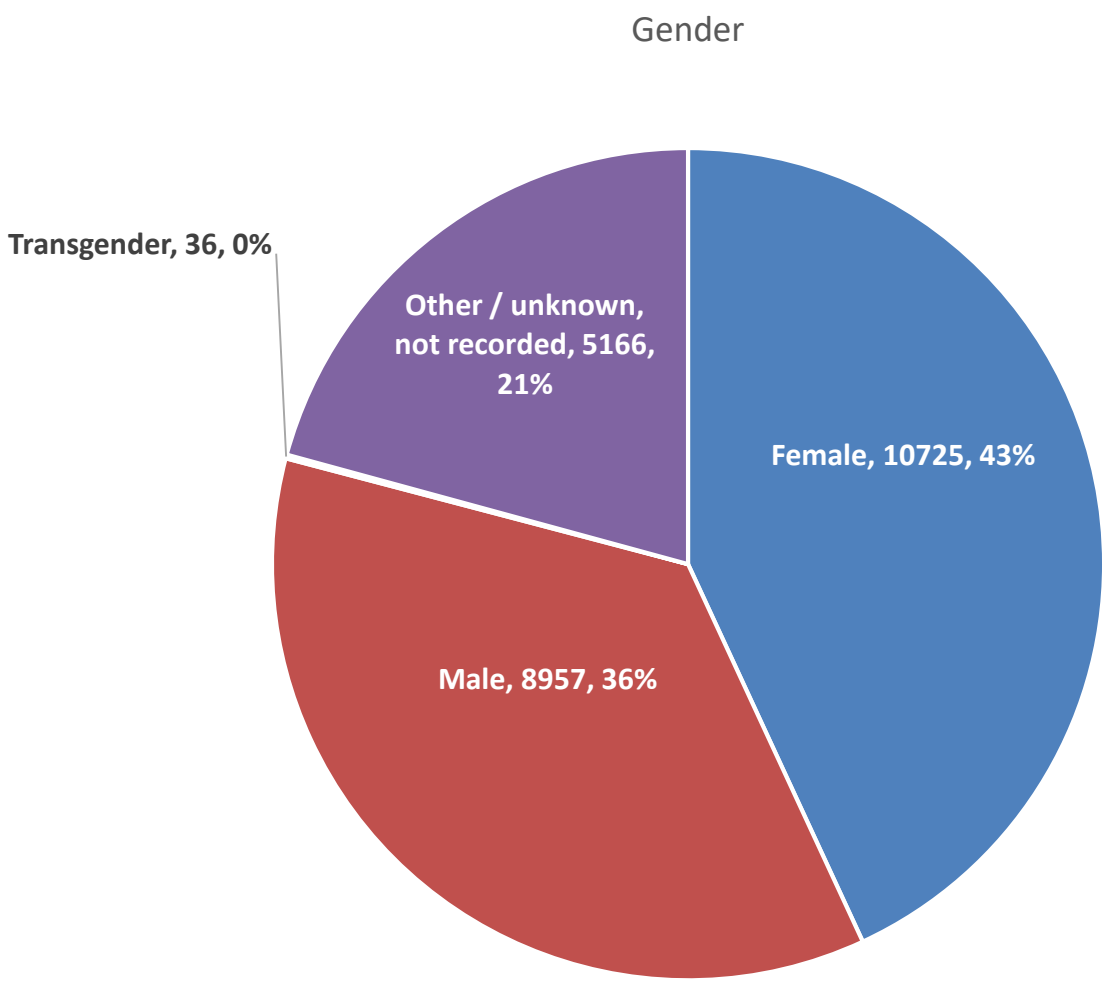
Referrals from locations



The Trust Safeguarding Team review 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.

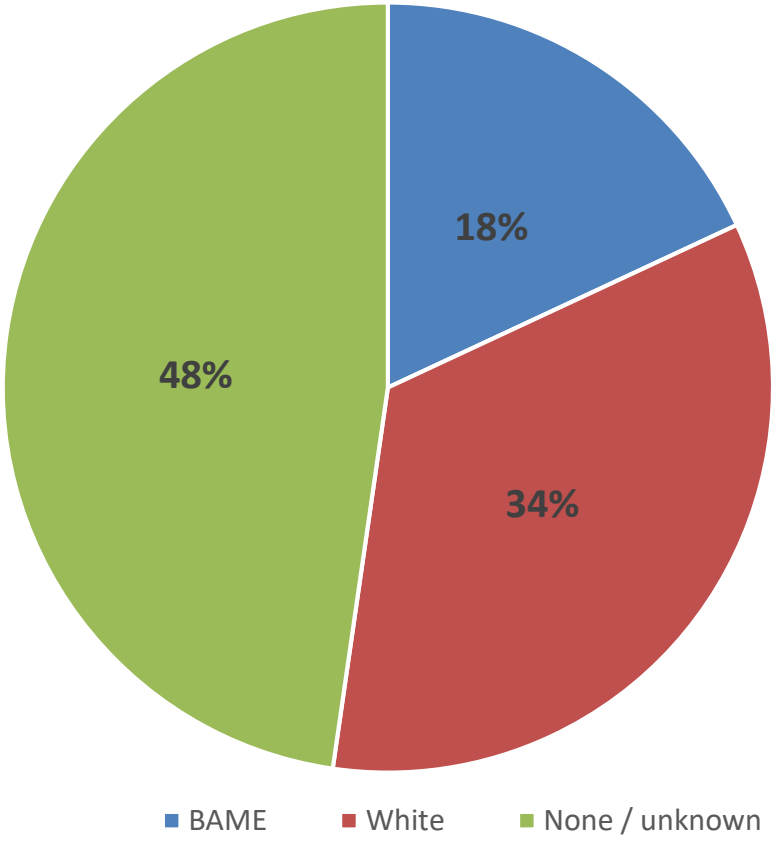
During the pandemic, practice in relation to concerns regarding quality of care delivered in care home etc was escalated with crews asked to complete Datix of concerns. These were then reviewed by the Deputy Head of Safeguarding for review and escalation to to the CQC/CCG if required. During the period from May 2020-July 2020, 4 cases were escalated to the CQC/CCG via Briony Sloper. After July it was agreed to return to normal procedure.

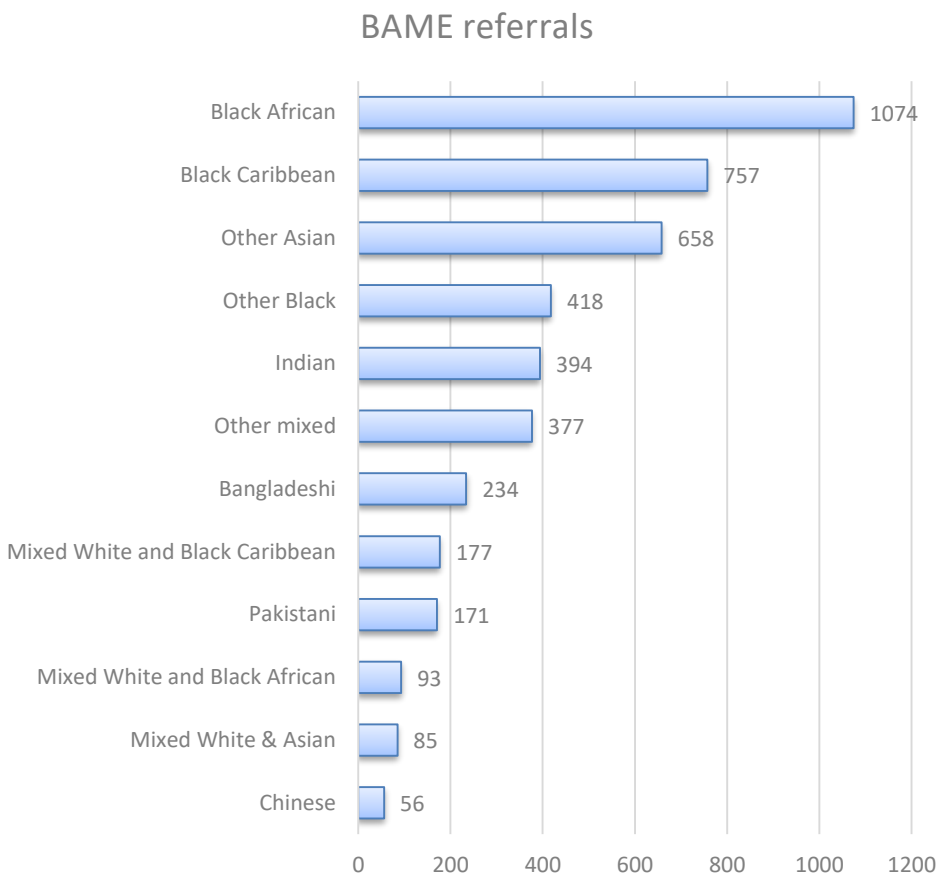
Referrals by gender



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, or where the referral is indicative of concerns about more than one adult or child.

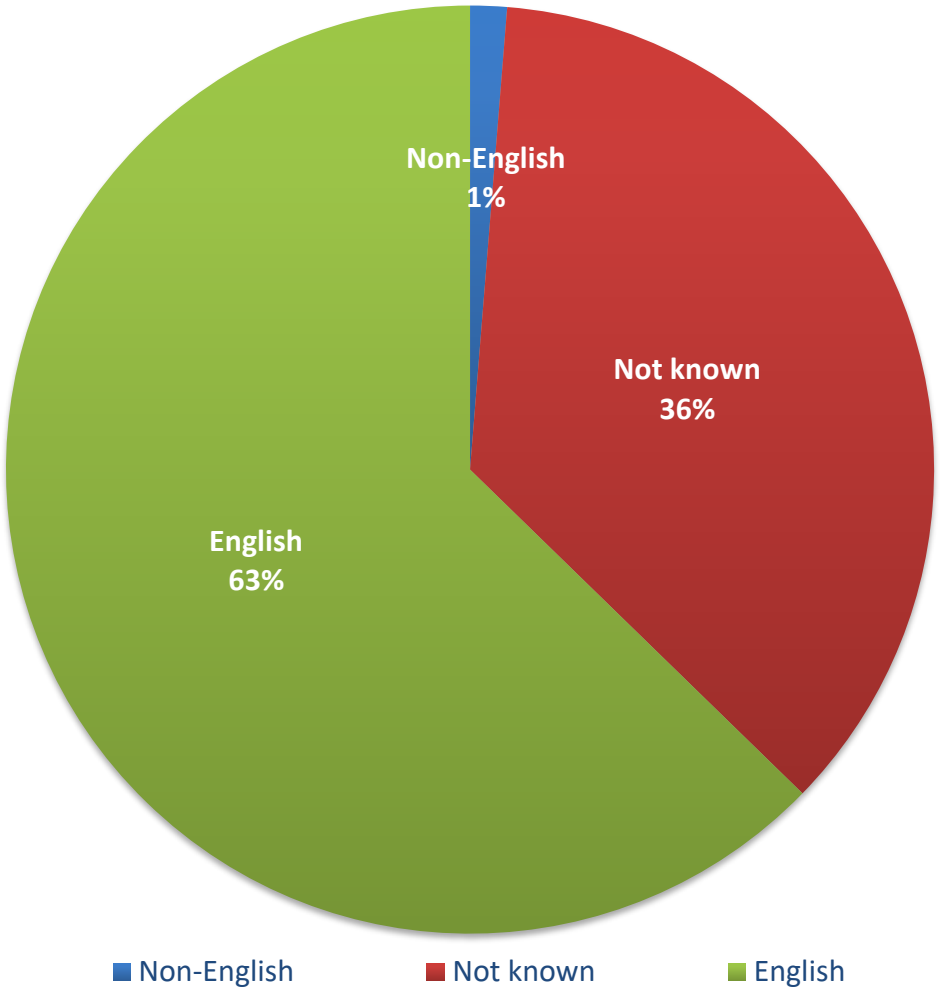
Referrals by ethnicity

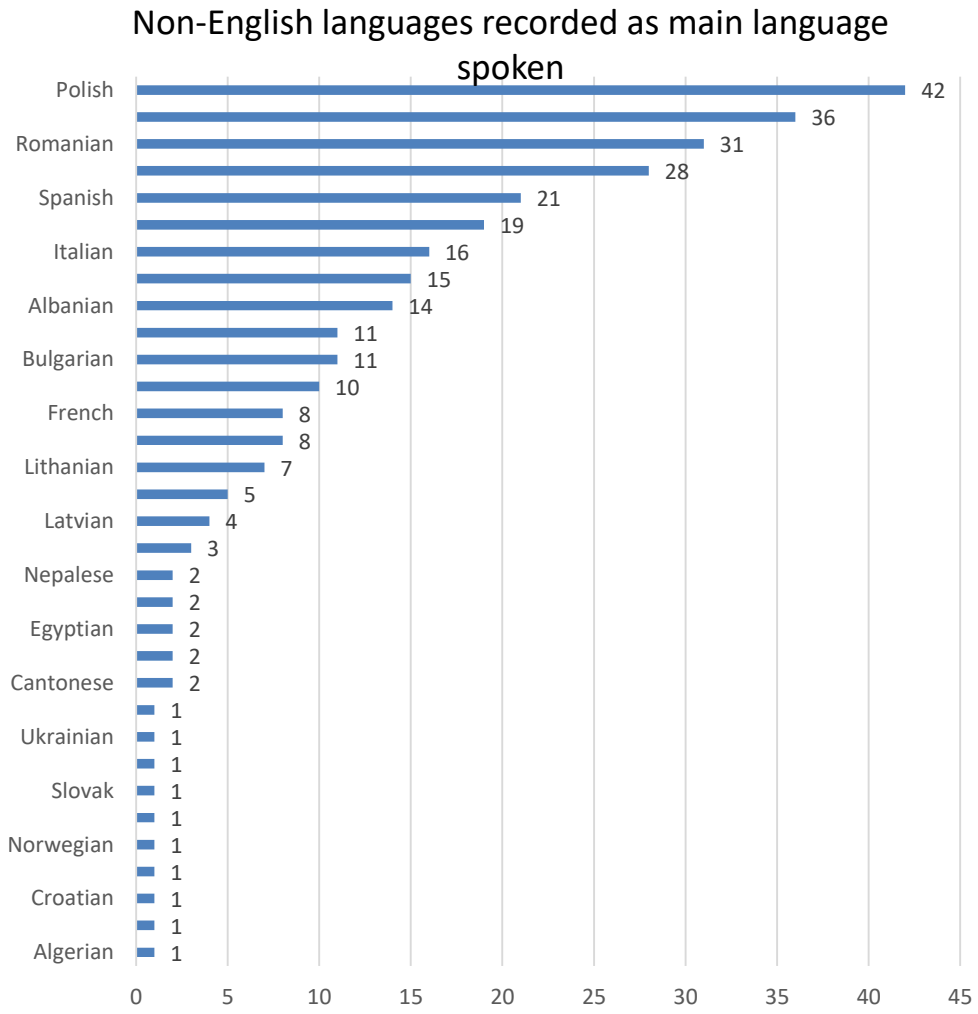




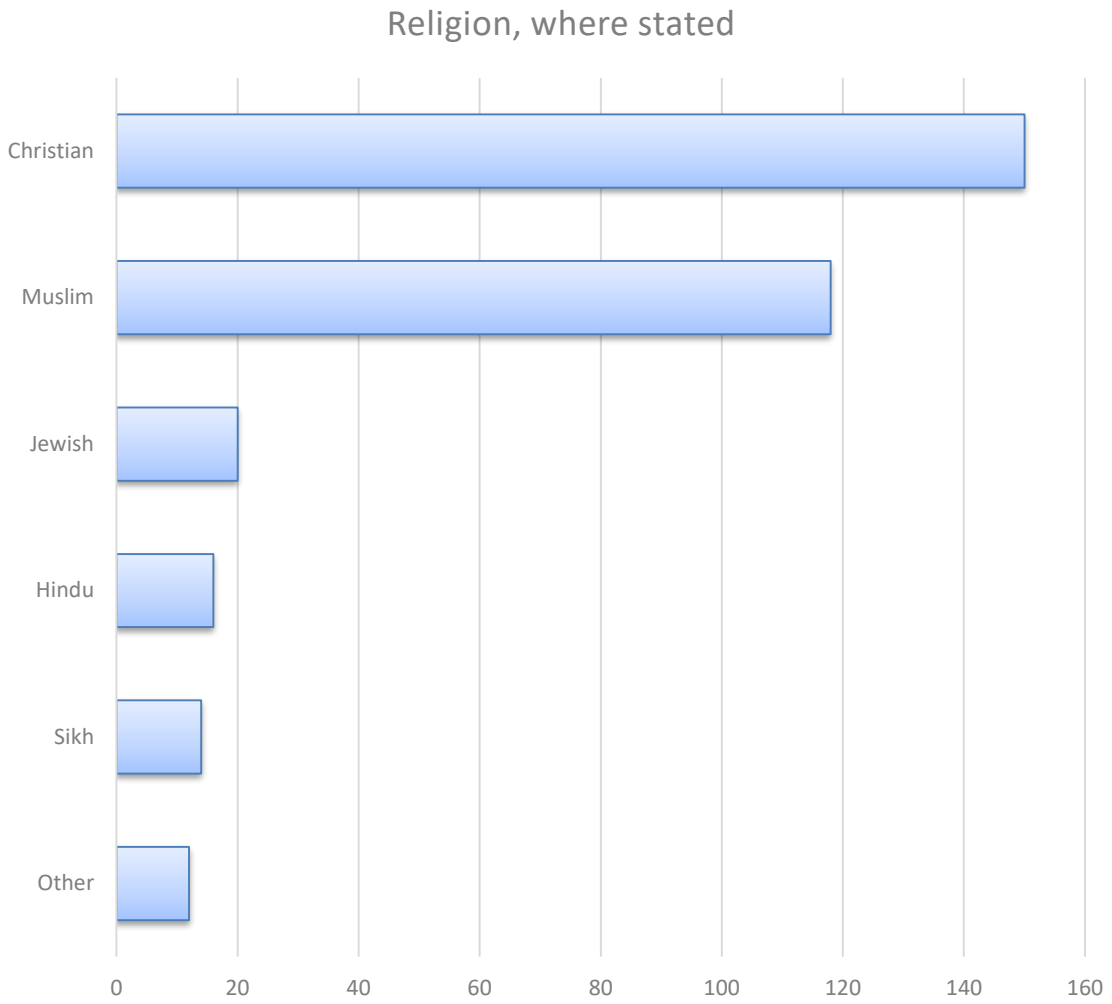
The number of cases where no ethnicity is recorded stands at 48%, and reflects the nature of the incidents that LAS attends. Often crews are unable to discuss ethnicity because patients are semi-conscious or incapacitated. Also third party concerns – for people we did not see or assess, perhaps carers or partners, or those for unborn children, often provide no opportunity for a determination to be made.

Referrals by language spoken





Referrals by religion



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

Priorities for 2021-22

To continue 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 support and enable outstanding safeguarding practice across the Trust and our 111/IUC's

Working with LFB to introduce Fire Safety referrals direct to LFB based on the hoarding referral process already in place

Introduce safeguarding referrals to ePCR

Continue to improve the quality of the safeguarding governance and assurance

Work with partners to:

Develop contextual safeguarding pathways in other boroughs

Improve safeguarding response to prisons

Improve external feedback from referrals

Continue to provide a varied safeguarding educational program

Embed new legislation and best practice. In particular the Domestic Abuse. LPS and Child Death.