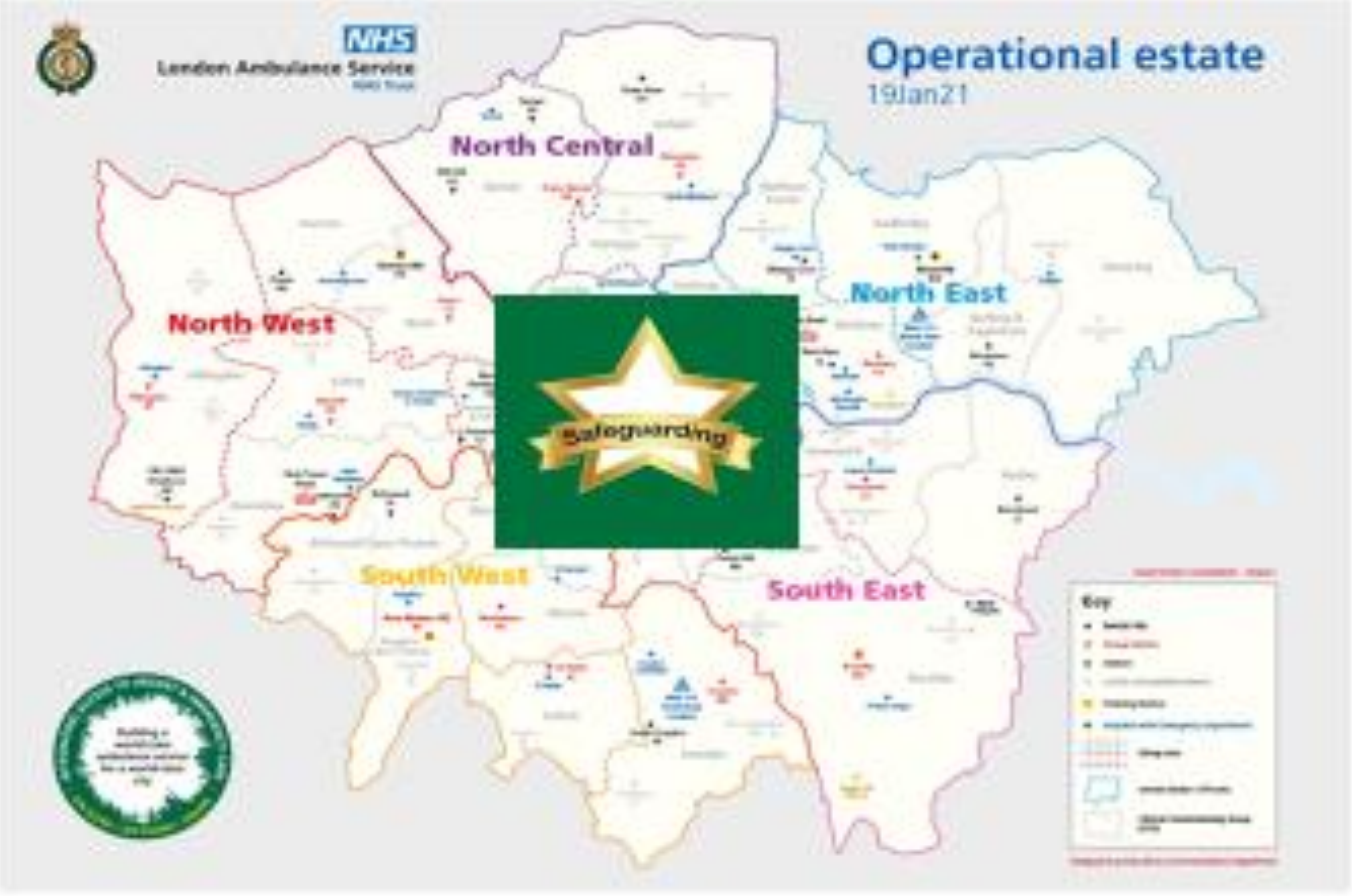
NHS
London Ambulance Service
NHS Trust

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

Safeguarding Annual Report 2021 – 2022



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Introduction

In 2021/2022 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 has responds to over 7000, 999 calls a day and in 2020/21 a raise of 2000 pre pandemic. 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 this year.

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 worked hard to support operations and other departments during the pandemic whilst maintaining the safeguarding functions. This has been achieved by amending 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 2021/22.

This report provides evidence of the Trusts commitment to effective safeguarding processes and procedures. The report details the achievements and learning as well as the structure and assurance measures in place to ensure compliance with the Care Quality Commission, & Ofsted 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.

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 Successes-2021/22

- Published quarterly safeguarding newsletter
- Held Safeguarding Conference for 200 staff and partners
- Gained approval to move to electronic safeguarding referrals
- Developed Fire Safety Referral pathways with LFB
- Agreed Child High intensity users are a safeguarding issue and developing pathway to report
- Issued a number of safeguarding star badges and certificates to recognize good and outstanding safeguarding practice
- Maintained safeguarding focus and practice during the height of the pandemic, whilst also supporting other areas of the Trust
- Ran pilot of the Youth Alliance project for children who are cared for or not in employment, education, or training
- Increase focus on allegations against staff with 45 cases being reported YTD
- Trained clinical staff to Level 3 Safeguarding requirement
- Launched Sexual Safety Charter & Campaign
- Improved partnership working and engagement during the pandemic

Safeguarding improvements during Covid 19

- ✓ Some Safeguarding 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. “nd Wave maintained all core safeguarding functions.
- ✓ 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
- ✓ Produced Domestic Abuse stickers for staff to wear giving clear message to victims and perpetrators
- ✓ Guidance issued to staff attending children and adults at risk who may require alternative care arrangements due to main care giver having Covid-19
- ✓ Developed strong networks with safeguarding partners. Weekly meeting with NHSE Covid19 cell and London NHSE Covid meetings.
- ✓ Introduced monthly meetings and chaired National Ambulance Safeguarding Advisory Group.
- ✓ Head of Safeguarding & Prevent presented with an NHSE Safeguarding Star award for hard work, commitment and partnership working engagement.

Education and raising awareness

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

CPD event Safeguarding vs Welfare referrals

Quarterly Newsletters & safeguarding cases in Clinical update

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

Safeguarding Learning in 2021-22

South East

- Missed opportunities to make referrals. Fed back to crew
- Missed opportunity to explore support for victim and perpetrator. Adult at risk status and coercive control/ domestic abuse- To be included in training for 2022
- Maternity classed as miscarriage Should have been neonatal/ still birth. Maternity team dealing with learning and feedback to crew.

North West

Significance of epistaxis in <2yrs olds- learning to be included in case study in clinical update

South West& IUC

Child Death-problems in care. LAS contribution with cumulative delays. Declared as Patient Safety Investigation (PSII)- Ongoing

Missed opportunity to refer feedback and retrospective referral made.

CP-IS NEL call not entered on adastra. CP-IS flag was checked triggered LA call back but nothing added to notes.

Maternity BBA not conveyed or safeguarded- ongoing learning for crew and trust to be included in training and enhance policy and procedures.

North East

Missed opportunities to refer Alcohol and drug misuse evidence of unconscious bias. To be included in safeguarding training 2022

Welfare concern raised but should have been safeguarding. Feedback to crew training completed.

Learning from DHR
No evidence that amb crew explored support being received or needed for alcohol dependant. There was also evidence of Domestic abuse. Child safeguarding referral completed but no adult referral or discussion had with adult regarding support mechanisms following assault . Learning to be included in newsletter and training on unconscious bias

North Central & EOC

Missed opportunity to explore domestic abuse
Incorrect call categorisation.
Missed opportunities to refer – feedback to crew provided

High level learning from range of safeguarding reviews undertaken throughout the year for trust areas.

Safeguarding Child Practice Review for 'CHLOE'

Who was 'CHLOE'?

"Chloe" was a 17 year old who tragically took her own life. She had been through some very difficult times and was in the care system, she also had interactions with LAS in the past and around the time of her death. This is a summary of our learning from the event.

TRAUMA

- Chloe had a **traumatic past**, she had been known to social care and police from a young age. Her history includes witnessing **domestic abuse, parents with mental health and drug issues** and as well as experiencing **neglect**. Her school attendance was of concern including a considerable period out of school.

RISK

- Chloe was a child at risk , at 11 she came to the attention of Croydon and she was the victim of a **serious sexual assault** which resulted in her needing treatment for multiple sexually transmitted diseases. Chloe was recognised to be a **child at risk of sexual exploitation** and was made subject to a **Child Protection Plan**. She became a **Looked After Child (LAC)** in February 2015.

LAC

- Chloe was a looked after Child and prior to her death she **was living in a semi-independent unit** in the borough of Croydon. Chloe was **reported missing** from the unit on the evening of Wednesday 4th March 2020, having been last seen by her placement at 2.30 that afternoon.

SUICIDAL

- On the morning of Thursday 5th March 2020 Police (MPS) were called, where **they found Chloe deceased**. The post mortem confirmed that she had died from suspension, in that she had hung herself.

LAS

- Throughout Chloe's short life and time living in London, she came into contact of LAS on 15 occassions, seeking interventions in relation to her health and wellbeing.

Trust Learning from 'CHLOE'

An internal learning event held on April 14th 2021 the following recommendations were identified to improve our response to LAC

Improve staff understanding of LAC	**Enable increased understanding of safeguarding red flags**	**Review policy/process of police cancelling ambulances in MH calls**	**Consider Frequent Caller figures for children in line with national discussion taking place**	**Consider how we can tackle unconscious bias in relation to MH and child MH**
Review child safeguarding policy flowcharts (user friendly)	**Produce quick reference safeguarding guides - JRCALC**	**Disseminate learning from this event to frontline crews**	**Review response to child mental health calls**	**Continue to promote CP-IS to support assessment on scene**

LAS 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)

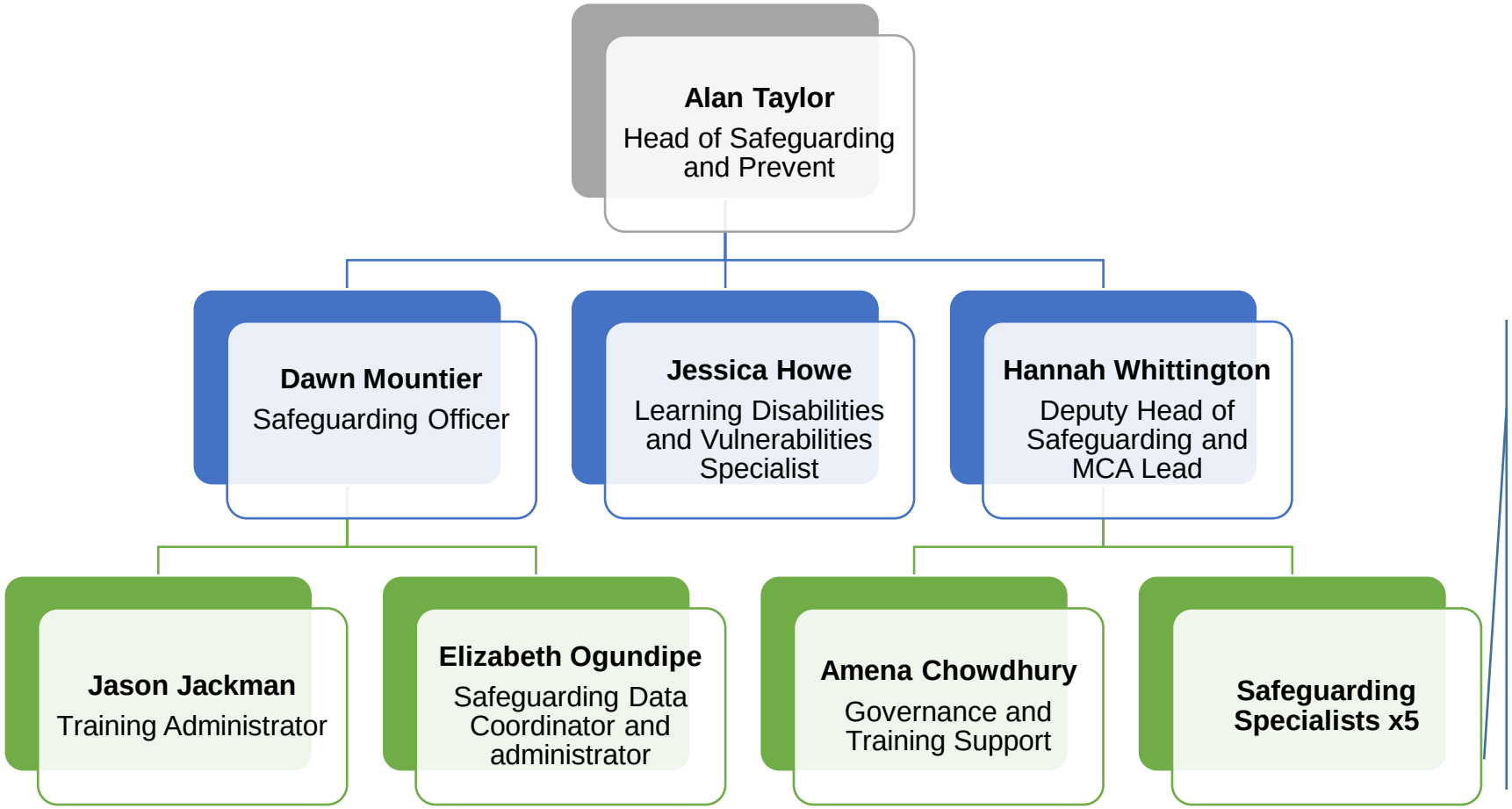
Alan Taylor

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.

Safeguarding Team Structure



Specialists

SE & IRO etc - Julie Carpenter

SW & IUC – Yvonne Wright

NW & HART etc – Natalia Croney

NC & EOC – Gemma Tayor

NE & CRU etc – Claire Sidley-Jenkins

We also were lucky to have secondments and maternity cover within the team.
Thanks for all your support Ross Dobson, Jade Speed and June Singh.

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).

Jess our Learning disability and vulnerabilities Specialist has settled in well and making good progress in improving the support to these patients.

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

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 under review
  - Chaperone Policy TP118 review due **Oct 22**
- Prevent Policy TP108 review due **Nov 22**
- **HR Policy**
  - Allegations Against Staff Policy HR039 under review
  - **Medical Directorate Policies**
- Operational Procedure for the use of
  - Restraint of Patients OP0 -review due **under review**

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)
- 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
- Mobile phones/ipads and security in relation to Prevent.
- Safeguarding concerns being managed as welfare concerns.

AUDITS

- NASAG undertook review of all ambulance Trusts Report with recommendations submitted to QGARD
- Child Mental health pre /during Covid
- LA456 Safeguarding Learning Feedback
- Currently undertaking Audit with Brent Board.

Area safeguarding

North Central

Training % 76.28% **Referrals made** **Meetings**

Camden 68.79% Camden 577 JAR's = 13
Edmonton 81.55% Enfield 823 DHR= 1
Friern Barnet 75.16% Barnet 881
Homerton 62.75% Haringey 661

Islington 640

Awarded 2 Safeguarding Star Badges & 8 Certificates

North West

Training % 78.72%

Brent 72.46%
Hanwell 78.48%
Fulham 74.16%
Hillingdon 91.97%
Westminster 83.33%

Referrals made

Brent 1108 Ealing 1147 H&F 539
Harrow 724 Hillingdon 1010 Hounslow 894
Ken & Chelsea 498 Westminster 612

Meetings attended

JAR's= 21
Strategy Meetings= 5
Planning/ Care Proceed=11
Rapid reviews= 3
DHR's= 2
SAR/ Learning events= 8
Strategic CDOP=3

Awarded 2 Stars and 5 certificates

South West

Training 73.30%

Croydon -72%
New Malden – 72.41%
St Helier – 63.64%
Wimbledon – 86.05%

Referrals made- 4721

Child 2316 **Adult** 2405 (1751 welfare)

Croydon – 1550 Kingston – 393 Merton - 728
Richmond – 498 Sutton – 718 Wandsworth - 834

Meetings attended

JAR, - 22
DHR - 2
SAR - 2 +1 SAER
SCPR – 1

Awarded 2 star badges, 10 certificates

Integrated urgent care IUC/EOC

Training %

NEL – L2 27.42% **L3** 64.52%
NWL – L2 45.45% **L3** 100%
SEL – L2 59.11% **L3** 64.29%
EOC- L2 80.85% **L3** Chub 82.47%

Referrals

NEL - 1033
SEL - 528
EOC & Chub – Child 220 **Adult** 14

Awarded NEL 2 Star badges, 1 certificate Awarded SEL 1 Star badge, 4 certificates

Other areas

IRO 100% Level 3 training NET's 70.19% level 3

North East

Overall Training Compliance **85.42%**
Homerton 81.22%
Newham 84.06%
Romford 89.86%

Referrals made –= 3266 Child Referrals (Adults 3075, Welfare 3371)

Barking & Dagenham 473 City of London 3 Hackney 382
Havering 432 Newham 556
Redbridge 520 Tower Hamlets 498
Waltham Forest 402

Meetings attended

JAR – 42
DHR - 3
CDRM - 1
SAR / Learning events– 10
SPR – 0
LA456 - 9

Awarded 6 star badges and certificates
Number of staff who received safeguarding supervision – 6

South East

Training % 87.36%

Bromley 83.60%
Deptford 86.76%
Greenwich 91.09%

Referrals made

Bexley 831 Bromley 1036 Greenwich 1105
Lambeth 1027 Lewisham 1177 Southwark 1065

Meeting attended

JAR = 22
DHR = 6 – 3x Bexley 1 x Lewisham 1 x Greenwich and 1 x Southwark
SAR = 1 x Greenwich, 3 x Lambeth and 1x Lewisham
SPR = 2 x Greenwich and 2 x Lewisham

Awarded 2 Stars and 5 Certificates

Safeguarding Specialist Achievements

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

The specialists have continued to identify & reward good safeguarding practice

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

The specialists overhauled the Safeguarding Training creating Level 2 & 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 during Covid-19

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

Specialists have provided safeguarding supervision to staff

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

Safeguarding Training

Level 1 Safeguarding Training Total Compliance for Trust

Total Required	Total Completed	Total Outstanding	% Compliance
6643	6305	338	94.91%

Level 2 Safeguarding Training Total Compliance for Trust

Total Required	Total Completed	Total Outstanding	% Compliance
1,142	719	423	62.96%

Level 2 Safeguarding Training Compliance by Sector

Sector	Total Required	Total Completed	Total Outstanding	% Compliance
EOC	590	477	113	80.85%
111 & IUC NE	31	20	11	64.52%
111 & IUC NW	22	10	12	45.45%
111 SE	225	133	92	59.11%

Level 3 Safeguarding Training Total Compliance for Trust

Total Required	Total Completed	Total Outstanding	% Compliance
4,645	3,796	849	81.72%

Level 3 Safeguarding Training Compliance by Sector

Sector	Total Required	Total Completed	Total Outstanding	% Compliance
North Central	550	462	88	84%
North East	772	660	112	85.49%
North West	890	739	151	83.03%
South East	792	695	97	87.75%
South West	527	386	141	73.24%

Bank Staff Level 2

Total Required	Total Completed	Total Outstanding	% Compliance
121	50	71	41.32%

Bank Staff Level 3 Safeguarding

Total Required	Total Completed	Total Outstanding	% Compliance
472	312	160	66.10%

Trust wide Prevent Level 1

Total Required	Total Completed	Total Outstanding	% Compliance
6,986	5,928	1,058	84.86%

Trust wide Prevent Level 2

Total Required	Total Completed	Total Outstanding	% Compliance
4,602	3,691	71	41.32%

Safeguarding Training Feedback

I found the course interesting, useful and enjoyable. The trainer was also very engaging.

Content was spot on and delivery was excellent.

The training was high quality and more than covered both subjects. 10 out of 10 for everything.

I really enjoyed the training and appreciate the knowledge shared and feel like I would be comfortable making certain decisions and acting on them now.

Very enjoyable session. The fact that we were able to listen at home via MS Teams made it even easier to take in.

I found the course interesting, useful and enjoyable. The trainer was also very engaging .

A great course, well delivered with good interaction and relevant information. Thank You.

The facilitator did a great job of keeping us engaged. Clearly an expert on the subject. Well done.

Safeguarding Allegations Against LAS Staff

49 notifications for 2021/22 (most are concerns for staff members rather than allegations of abuse)

- **37 closed, 13 remain open ongoing**

Of the 37 closed

1. No further action or local support = 30
2. Dismissed or left service = 7

Of the 12 open

1. Suspended or working alternative duties = 5
2. Other = 7

DBS were notified of 5 cases this financial year

The trust also works in conjunction with professional bodies and police where appropriate

Most common themes from contacts were

- **Sexual safety/abuse (18 of which 11 staff on staff)**
- **Domestic Abuse**
- **Staff mental health**

Work on Sexual safety in LAS in 2021/22

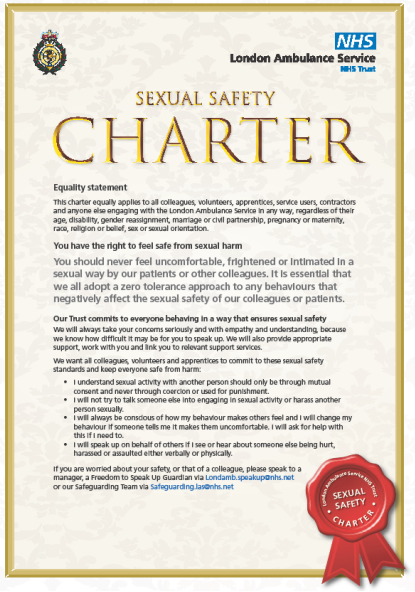
Letter to all new apprentices and clinical staff on sexual safety

LAS has taken sexual safety very seriously this year following a number of allegations, the trust has put in place a range of initiatives

Exec oversight group for allegations established

Managers Sexual Safety Conference planned for 16th May

Trust Charter launched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SEXUAL SAFETY
CHARTER

Equality statement

This charter equally applies to all colleagues, volunteers, apprentices, service users, contractors and anyone else engaging with the London Ambulance Service in any way, regardless of their age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex or sexual orientation.

You have the right to feel safe from sexual harm

You should never feel uncomfortable, frightened or intimated in a sexual way by our patients or other colleagues. It is essential that we all adopt a zero tolerance approach to any behaviours that negatively affect the sexual safety of our colleagues or patients.

Our Trust commits to everyone behaving in a way that ensures sexual safety

We will always take your concerns seriously and with empathy and understanding, because we know how difficult it may be for you to speak up. We will also provide appropriate support, work with you and link you to relevant support services.

We want all colleagues, volunteers and apprentices to commit to these sexual safety standards and keep everyone safe from harm:

- I understand sexual activity with another person should only be through mutual consent and never through coercion or used for punishment.
- I will not try to talk someone else into engaging in sexual activity or harass another person sexually.
- I will always be conscious of how my behaviour makes others feel and I will change my behaviour if someone tells me it makes them uncomfortable. I will ask for help with this if I need to.
- I will speak up on behalf of others if I see or hear about someone else being hurt, harassed or assaulted either verbally or physically.

If you are worried about your safety, or that of a colleague, please speak to a manager, a Freedom to Speak Up Guardian via londamb.speakup@nhs.net or our Safeguarding Team via Safeguarding.las@nhs.net

SEXUAL SAFETY CHARTER


NHS
London Ambulance Service
NHS Trust

Sexual Safety

You have the right to feel safe from sexual harm

Whether working or volunteering for the London Ambulance Service, you should never feel uncomfortable, frightened or intimidated in a sexual way by patients or other colleagues.

The Service is taking a zero tolerance approach to any behaviours that negatively affect the safety of our colleagues.

Behaviours that are not acceptable include:

Verbal and written
- Comments of a sexual nature about a person's looks, clothing, body
- Sexually explicit anecdotes, jokes, banter
- Requests for sexual favours
- Spreading rumours about a person's sex life

Physical
- Frequently following a person, standing too close to them
- Inappropriate touching of a person – massaging, stroking, rubbing
- Purposely brushing up against someone
- Unwanted or coercive and intimidating sexual contact

Non verbal
- Looking someone's body up and down
- Derogatory facial expressions of a sexual nature
- Whistling or sexual gestures
- Genital exposure and masturbation

Visual
- Displaying sexually explicit objects and posters of naked people
- Showing or sending people sexually explicit text messages and images
- Sharing personal or naked images of an individual

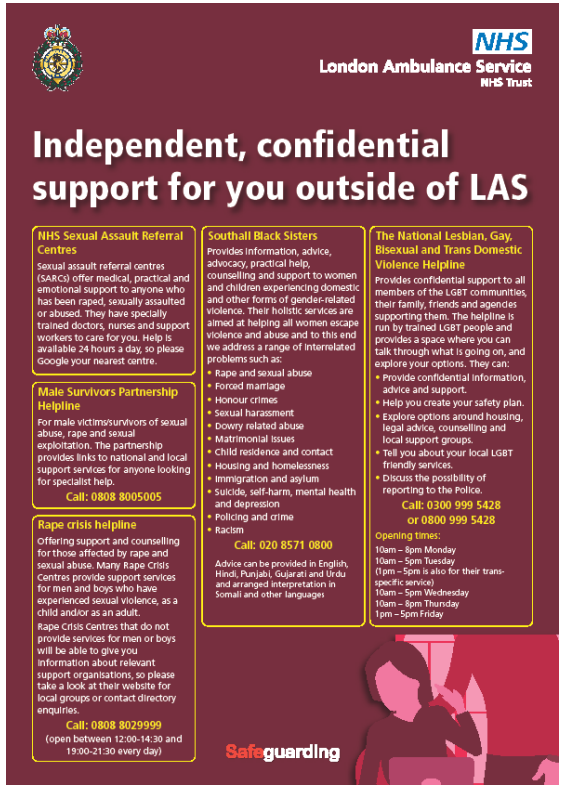
We are committed to supporting anyone who does not feel there is sexual safety at work.

We encourage individuals or witnesses to seek help to report any of the above behaviours.

You have the commitment of the Trust Board that we will act.

If you are worried about your safety or that of a colleague speak to your line manager, a Freedom to Speak Up guardian or our Safeguarding team. londamb.speakup@nhs.net or safeguarding.las@nhs.net

Safeguarding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Independent, confidential support for you outside of LAS

NHS Sexual Assault Referral Centres

Sexual assault referral centres (SARCs) offer medical, practical and emotional support to anyone who has been raped, sexually assaulted or abused. They have specially trained doctors, nurses and support workers to care for you. Help is available 24 hours a day, so please Google your nearest centre.

Male Survivors Partnership Helpline

For male victims/survivors of sexual abuse, rape and sexual exploitation. The partnership provides links to national and local support services for anyone looking for specialist help.

Call: 0808 8005005

Rape crisis helpline

Offering support and counselling for those affected by rape and sexual abuse. Many Rape Crisis Centres provide support services for men and boys who have experienced sexual violence, as a child and/or as an adult.

Rape Crisis Centres that do not provide services for men or boys will be able to give you information about relevant support organisations, so please take a look at their website for local groups or contact directory enquiries.

Call: 0808 8029999
(open between 12:00-14:30 and 19:00-21:30 every day)

Southall Black Sisters

Provides information, advice, advocacy, practical help, counselling and support to women and children experiencing domestic and other forms of gender-related violence. Their holistic services are aimed at helping all women escape violence and abuse and to this end we address a range of interrelated problems such as:

- Rape and sexual abuse
- Forced marriage
- Honour crimes
- Sexual harassment
- Dowry related abuse
- Matrimonial issues
- Child residence and contact
- Housing and homelessness
- Immigration and asylum
- Suicide, self-harm, mental health and depression
- Policing and crime
- Racism

Call: 020 8571 0800

Advice can be provided in English, Hindi, Punjabi, Gujarati and Urdu and arranged interpretation in Somali and other languages

The National Lesbian, Gay, Bisexual and Trans Domestic Violence Helpline

Provides confidential support to all members of the LGBT communities, their family, friends and agencies supporting them. The helpline is run by trained LGBT people and provides a space where you can talk through what is going on, and explore your options. They can:

- Provide confidential information, advice and support.
- Help you create your safety plan.
- Explore options around housing, legal advice, counselling and local support groups.
- Tell you about your local LGBT friendly services.
- Discuss the possibility of reporting to the Police.

Call: 0300 999 5428
or 0800 999 5428

Opening times:
10am – 8pm Monday
10am – 5pm Tuesday
(1pm – 5pm is also for their trans-specific service)
10am – 5pm Wednesday
10am – 8pm Thursday
1pm – 5pm Friday

Safeguarding


London Ambulance Service NHS Trust

Safeguarding

October 2021 Issue

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Domestic Abuse
Health and well being

Attachments:

Tell us your news
If you have something you want to share in the next edition of the newsletter,

Sexual Safety edition

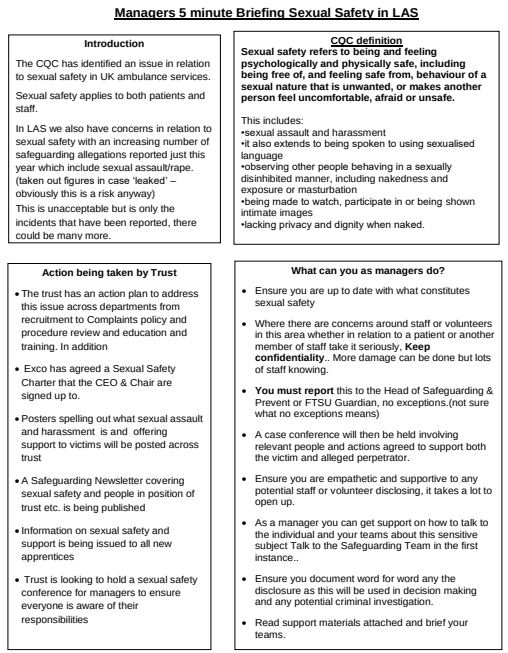
In this edition of the Safeguarding newsletter we will be talking about all things in relation to sexual safety in the LAS. All of which are important to note as could be of help to yourself or a patient or have a impact on your career and life.

CQC definition
Sexual safety refers to being and feeling psychologically and physically safe, including being free of, and feeling safe from, behaviour of a sexual nature that is unwanted, or makes another person feel uncomfortable, afraid or unsafe.
This includes:
•sexual assault and harassment
•it also extends to being spoken to using sexualised language
•observing other people behaving in a sexually disinhibited manner, including nakedness and exposure or masturbation
•being made to watch, participate in or being shown intimate images
•lacking privacy and dignity when naked.

Ambulance Trusts agreed at a recent meeting on sexual safety that there should be no hiding places in the ambulance sector for those who mis-use their position of access and trust.

The LAS is committed to ensuring the sexual safety of our students, staff and patients. We have a number of processes in place to address any concerns about sexual safety and staff should not be frightened in coming forward and reporting concerns. You can raise these with your line manager or speak to Freedom to Speak Up Guardian or Head of Safeguarding & Prevent.

Newsletter & Managers 5 minute briefing on Sexual Safety


Managers 5 minute Briefing Sexual Safety in LAS

Introduction

The CQC has identified an issue in relation to sexual safety in UK ambulance services.

Sexual safety applies to both patients and staff.

In LAS we also have concerns in relation to sexual safety with an increasing number of safeguarding allegations reported just this year which include sexual assault/rape. (taken out figures in case 'leaked' – obviously this is a risk anyway)

This is unacceptable but is only the incidents that have been reported, there could be many more.

CQC definition

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•sexual assault and harassment
•it also extends to being spoken to using sexualised language
•observing other people behaving in a sexually disinhibited manner, including nakedness and exposure or masturbation
•being made to watch, participate in or being shown intimate images
•lacking privacy and dignity when naked.

Action being taken by Trust

- The trust has an action plan to address this issue across departments from recruitment to Complaints policy and procedure review and education and training. In addition
- Exco has agreed a Sexual Safety Charter that the CEO & Chair are signed up to.
- Posters spelling out what sexual assault and harassment is and offering support to victims will be posted across trust
- A Safeguarding Newsletter covering sexual safety and people in position of trust etc. is being published
- Information on sexual safety and support is being issued to all new apprentices
- Trust is looking to hold a sexual safety conference for managers to ensure everyone is aware of their responsibilities

What can you as managers do?

- Ensure you are up to date with what constitutes sexual safety
- Where there are concerns around staff or volunteers in this area whether in relation to a patient or another member of staff take it seriously, **Keep confidentiality**.. More damage can be done but lots of staff knowing.
- **You must report** this to the Head of Safeguarding & Prevent or FTSU Guardian, no exceptions.(not sure what no exceptions means)
- A case conference will then be held involving relevant people and actions agreed to support both the victim and alleged perpetrator.
- Ensure you are empathetic and supportive to any potential staff or volunteer disclosing, it takes a lot to open up.
- As a manager you can get support on how to talk to the individual and your teams about this sensitive subject Talk to the Safeguarding Team in the first instance..
- Ensure you document word for word any the disclosure as this will be used in decision making and any potential criminal investigation.
- Read support materials attached and brief your teams.

Progress on Learning Disability

The Learning Disabilities and Vulnerabilities Specialist started in post at the end of May 2021.

As an innovation within the trust, initially they have been forming and establishing their role within the LAS. Within their title this has focused on patient focused on Learning Disability care and care for Autistic people (under the vulnerabilities element of their title.) A LD&VS has also contributed to a pilot project under the Prevent Programme aimed at providing opportunities for young adults who would be increasingly susceptible to involvement in knife crime/community violence.

Achievements to date

Developed & approved Trust LD Strategy

Scoping exercise to understand the role the LAS currently plays in meeting the individualised needs of patients with a learning disability.
practise based observations.
implementation of clinical and evidence based practise for this patient group

Liaison with other teams across the trust. An example of some of this work is below:

- Reasonable Adjustment boxes for new generation ambulances.
- Partnership working on public education
- Work on Urgent Care Plans
- Pan London data set of key information for LD patients
- Open communication and learning network with regional LEDER programme
- Piloted the Youth Alliance Project supporting looked after and homeless children.

An external stakeholder event was completed - external feedback from services across health and social care, commissioning and third sector organisations. Used to explore themes in barriers patients with a learning disability experience in accessing the LAS.

Local Child Safeguarding Practice Reviews (LCSPR)

A 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.

Safeguarding Practice Reviews (SPR)										
Borough	Gender	Age	Type of abuse	Type of Case		Borough	Gender	Age	Type of abuse	Type of Case
Greenwich (125867) **(140247)**	2 x Males Female	15 & 6 17	Parental Harm Suicide	SPR SPR		Hillingdon (123696)	Females (Twins)	5 Weeks	Parental Harm	SPR
Lewisham (128014) **(135520)**	Female Male	8 17	Parental Harm Stabbed	SPR		Wandsworth (131412)	Male	14	Suicide	SPR

Child Death Reviews 2020/21 =207 2021/22= 266

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 **153403**	Male	35	Ealing Pot 131245 Pot 136077	 Female Female	 45 77
Greenwich **132676**	 Male	 39	Harow 139810	 Female	 72
Havering **125956** **Pot 126599** **135986**	 Male Male Female	 36 45 31	Hillingdon Pot 127612 123251	 Male Female	 63 63
Lambeth **146333** **146337** **146340**	 Male Male Male	 61 65 41	Lewisham 124546 148854	 Male Female	 35 57
Merton **124359** **Pot 131041**	 Female Male	 59 33	Newham 136543 136544 149086 Pot 154071	 Male Male Male Male	 34 31 76 89
Sutton **142384**	Female	48	W Forest 134646	 Male	 68

Domestic Homicide Reviews (DHR)

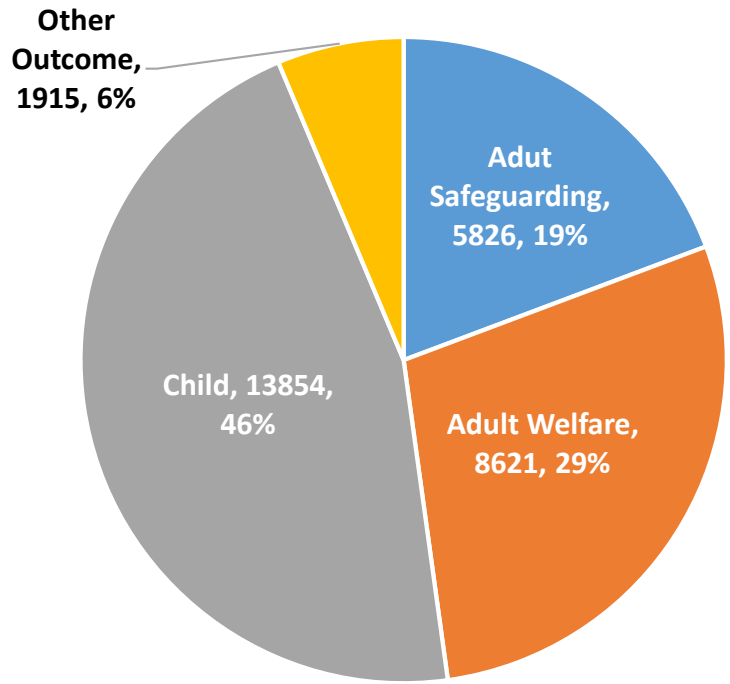
A DHR is a review commissioned to consider the circumstances in which the death of a person, aged 16 or over has, or appears to have been as a result of violence, abuse or neglect by a person to whom they were related or with whom they had been in an intimate personal relationship. The LA commission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

Domestic Homicide Reviews				
Year	2018/19	2019/20	2020/21	2021/22
Number LAS supported.	11	18	19	12 Camden, Croydon x 4, Ealing, Enfield, Greenwich x 2, Hackney, Islington, Lambeth

The Trust received notification of 12 DHRs this year which is a decrease of 7 from 2020/21.

Numbers of referrals/concerns generated by Trust

Breakdown of referrals and concerns, 2021/22



Overall Referral Volumes

The total number of safeguarding referrals/concerns raised for this year is **30,216**

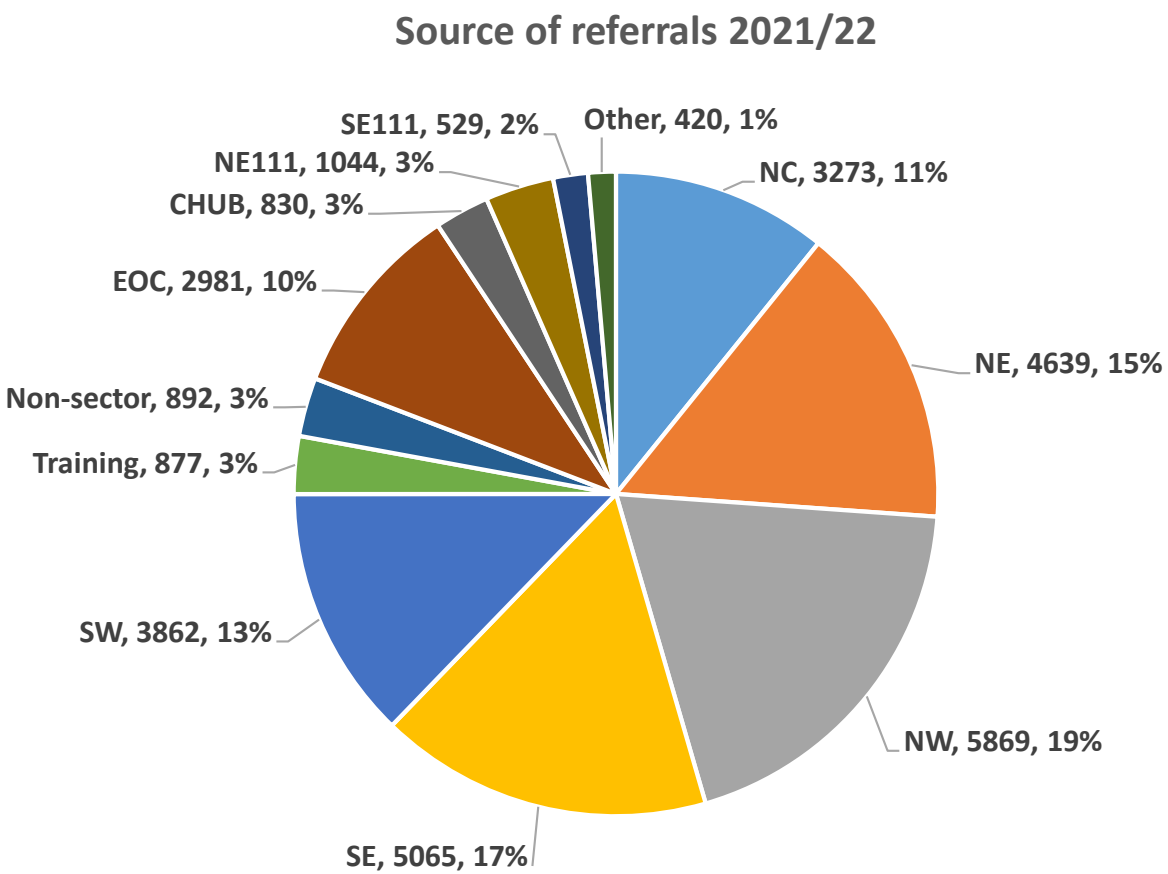
Comparison with 2020/21:

- There is a 21% increase in safeguarding referrals/concern raised on 2020/21's total of 24.884
- There is a 13% increase in child safeguarding referrals since 2020/21
- There is 1% decrease in adult safeguarding concerns since 2020/21
- There is a 28% decrease in Adult welfare concerns since 2020/21

1,915 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 referral within Trust



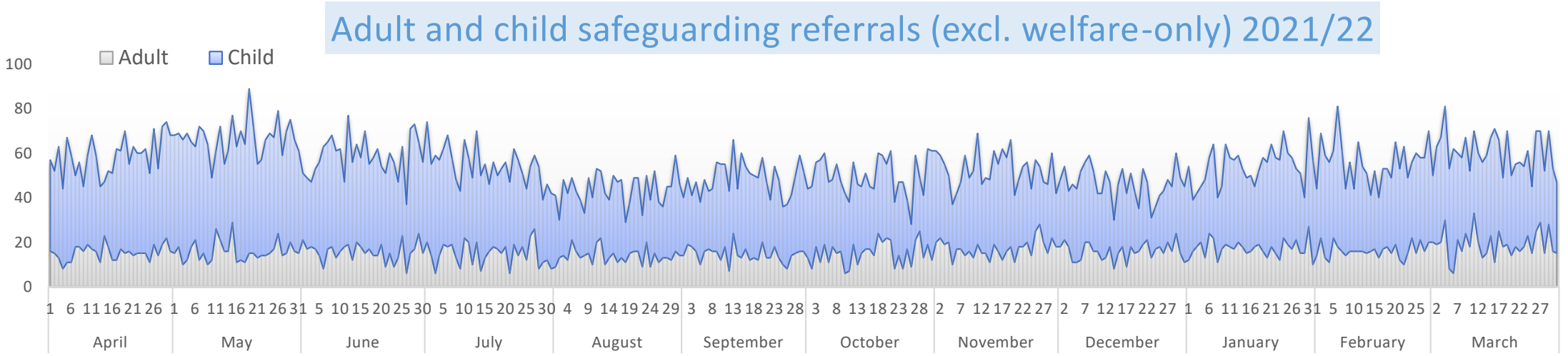
Sources of referral

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

75% of referrals are made by crews working with sector-based call signs, with a further 7% coming from other road staff – training, specialist responders like our Mental Health and Falls cars, private providers, tactical responders, etc.

A further 12% were made by colleagues working in our control rooms – 9% from call handlers and 3% from our Clinical Hub.

5% of referrals were made by clinicians and call handlers working our 111/IUC call centres, and a small number, 1% came from other sources in the trust (retrospectively identified referrals, managers, etc).

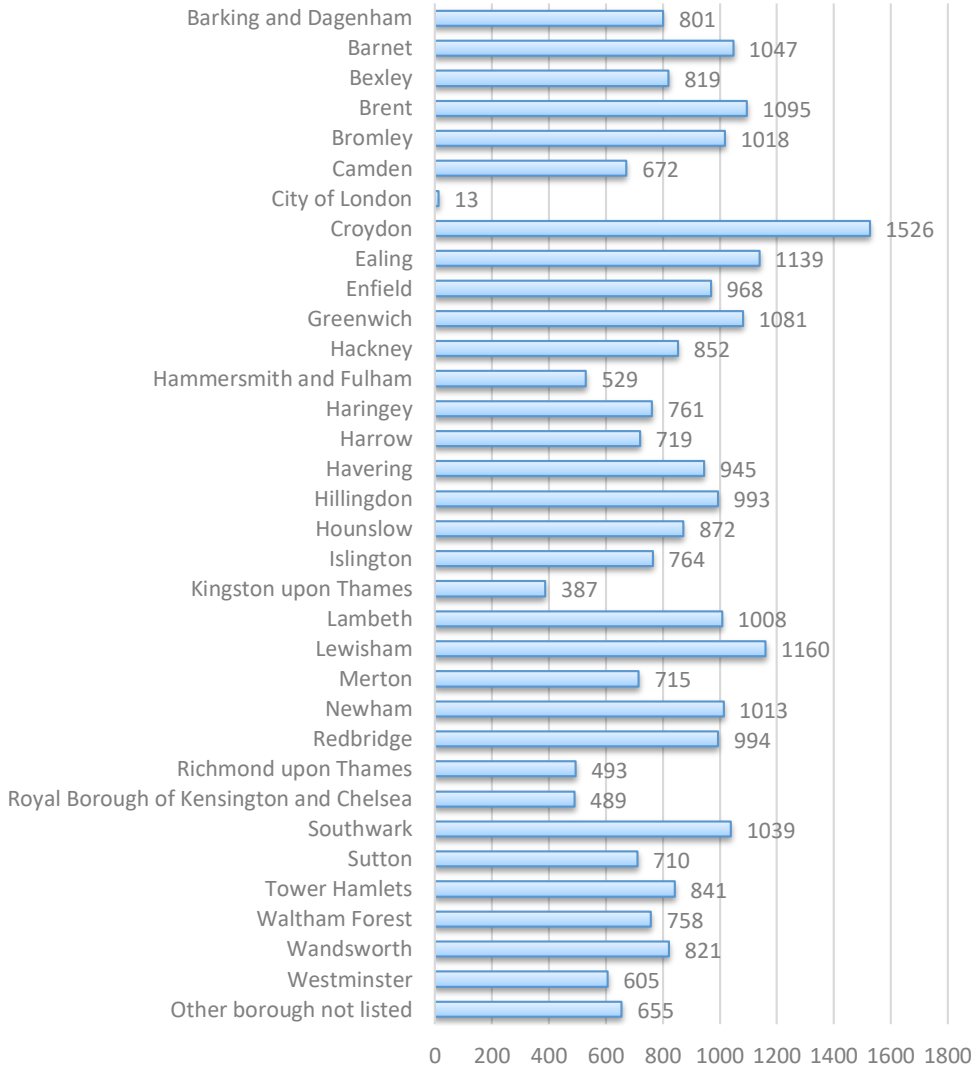


Volumes during the year

The year 2021/22 has been predominantly characterized by the continuation of the Covid-19 pandemic, with significant volumes of cases from Q2 onwards, culminating in a wave which peaked around the turn of the year, and then fell. At the time of writing a new variant, BA.2, is driving an increase in cases although death rates have not risen in line with volumes earlier in the pandemic. Despite these significant variations, the safeguarding referral volumes have not exhibited the significant variations that we observed in the first year of the pandemic. Referrals did decrease as cases spiked in July and August, although we traditionally see volumes drop a little in the summer in any case. Variations in previous waves were driven predominantly by the effects of strict lockdowns and other restrictions which have been less in evidence this year.

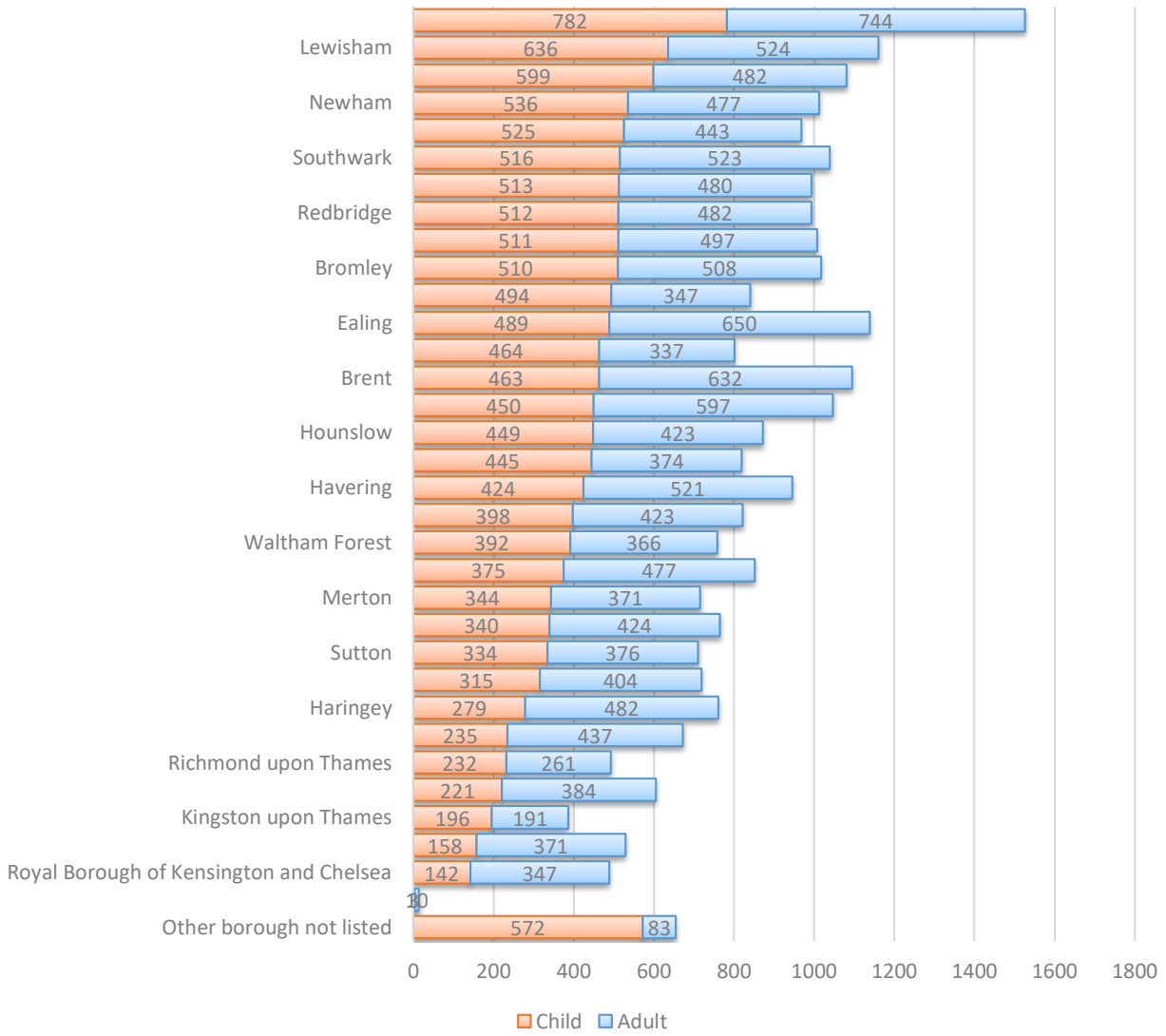
The call-handling team who take safeguarding referrals continued to work from home where possible, allowing vulnerable staff to continue to contribute, and to manage their exposure to risk. Covid safety arrangements were put in place in our HQ, and up to this point in the pandemic we have continued to 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 2021/22



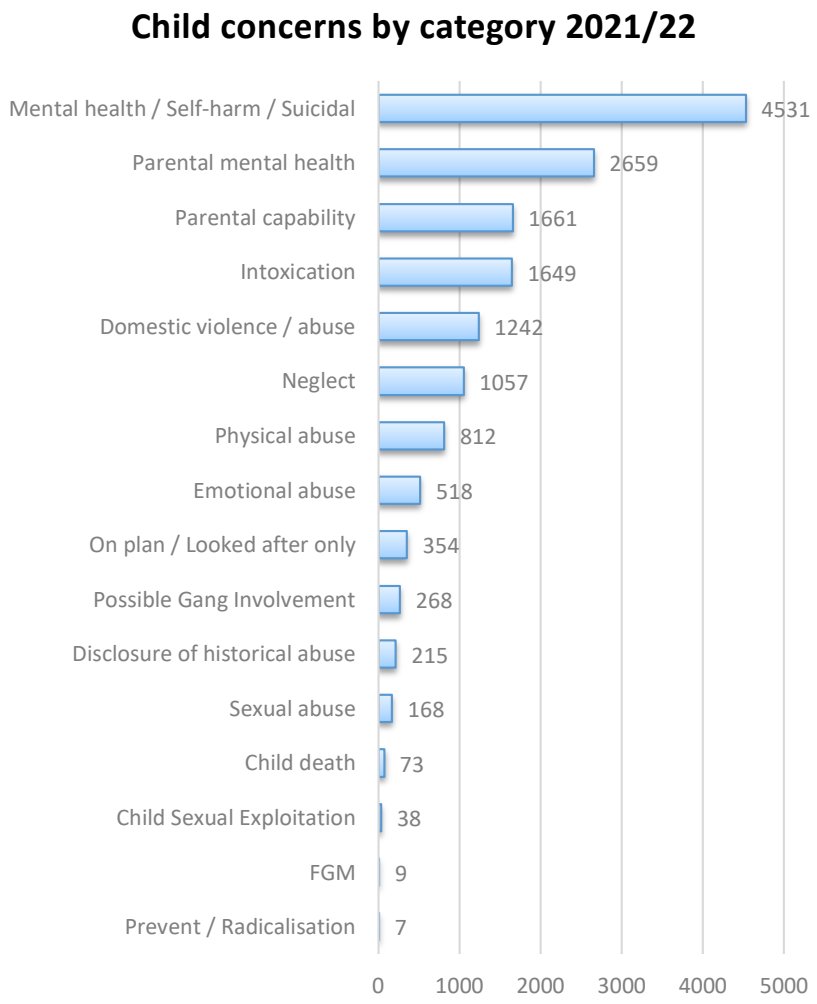
Borough ranked by volume 2021/22

Adult and child by borough 2021/22



Referrals/concerns by borough

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



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

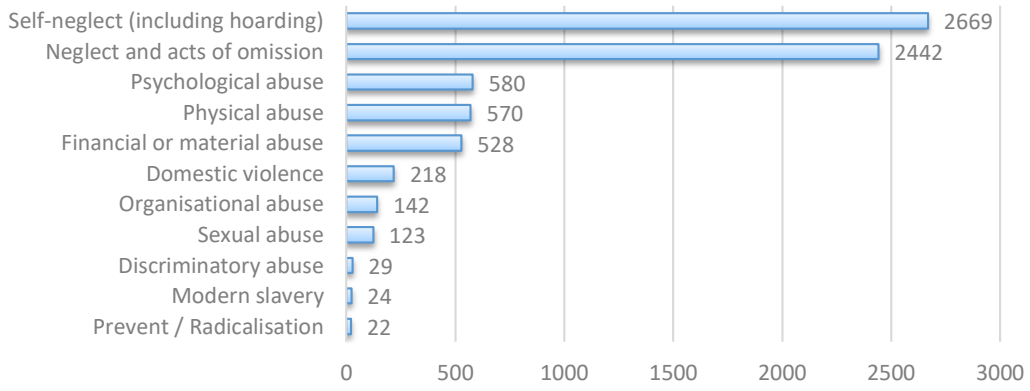
Mental health, self-harm and suicidality are the highest category – this and Parental Mental health and Parental Capacity remain the top three child safeguarding concerns identified by staff, and continue a theme which has persisted throughout the pandemic period of a significant increase in this category of referral. This is currently subject to an audit by the Safeguarding Team.

Domestic violence have fallen slightly since last year's total of 1,531. 2020/21 had significant spikes in DV referral associated with Covid waves – these were not so apparent this year, perhaps due to lockdowns being less stringent

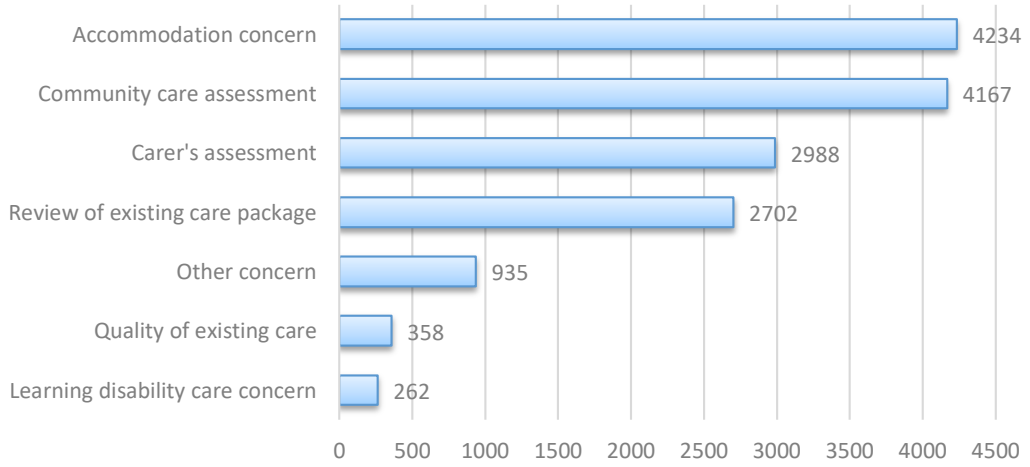
The 9 concerns relating to FGM only included 1 instance of directly observed or disclosed FGM of a child with police involvement. The remainder were concerns relating to children of mothers who had FGM, or other indirect concerns.

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, 27 of these referrals have been made.

Adult safeguarding referral by category of abuse 2021/22



Adult welfare concerns by category 2021/22

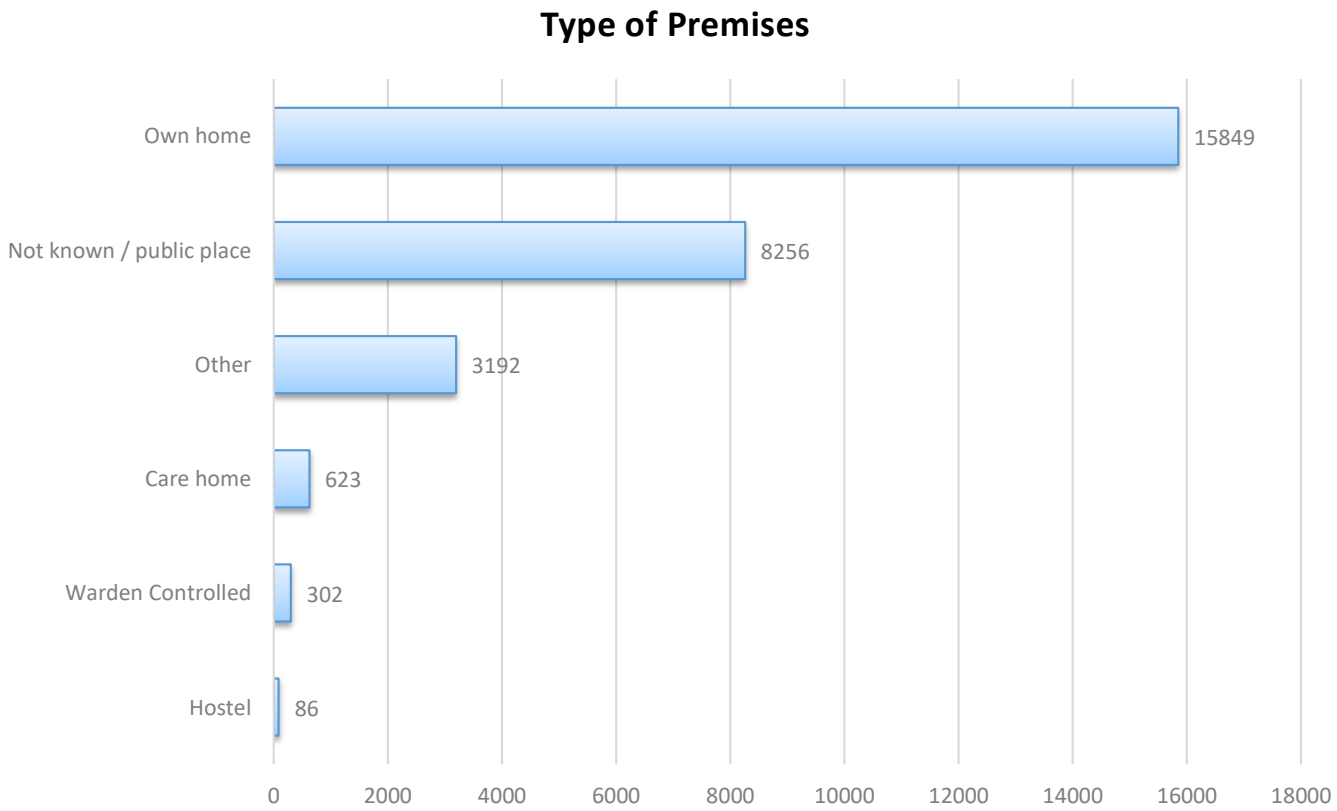


The chart for adult alerts and concerns shows self-neglect and neglect as the top reasons for raising the concern. Multiple categories can be selected for an individual referral.

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. We made 1,277 of these referrals this year. Also included in the self-neglect category are 58 of a new referral type, Fire risk only, which started on Dec 1st allowing our crews to inform LFB of incidents where a vulnerable person is at risk of fire with no hoarding present.

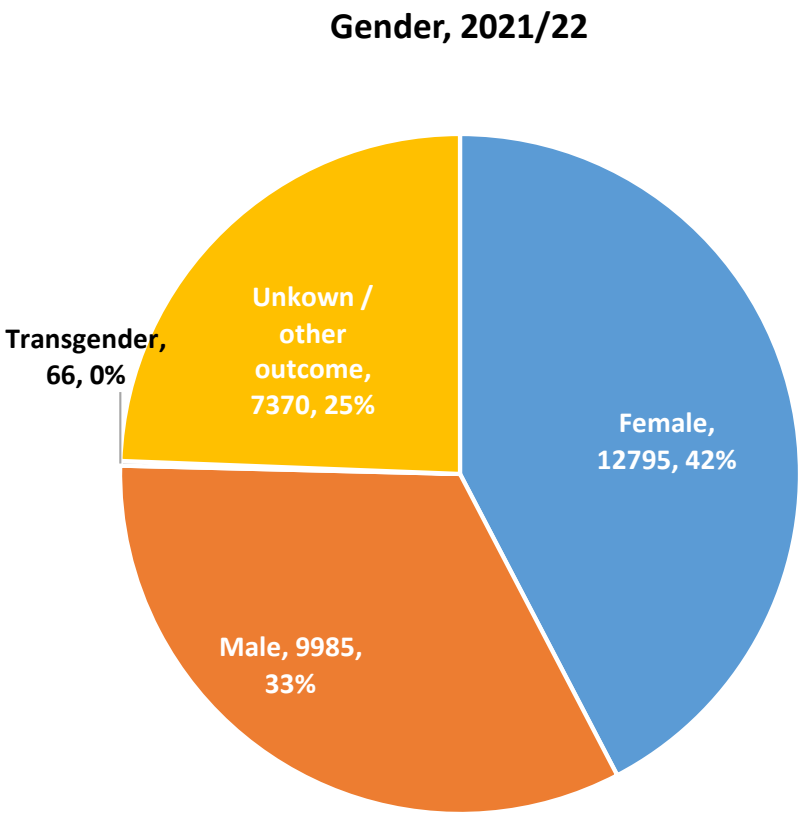
In Domestic Violence cases, staff supply the victim with the telephone number of the Women's Aid Domestic Violence Helpline number. On rare occasions the victim will ask staff to contract the DVHL on behalf of the person concerned.

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



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.

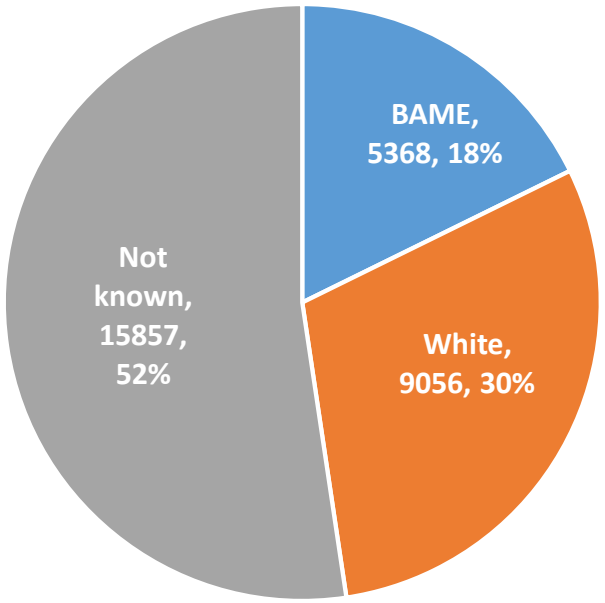
Protected Characteristics



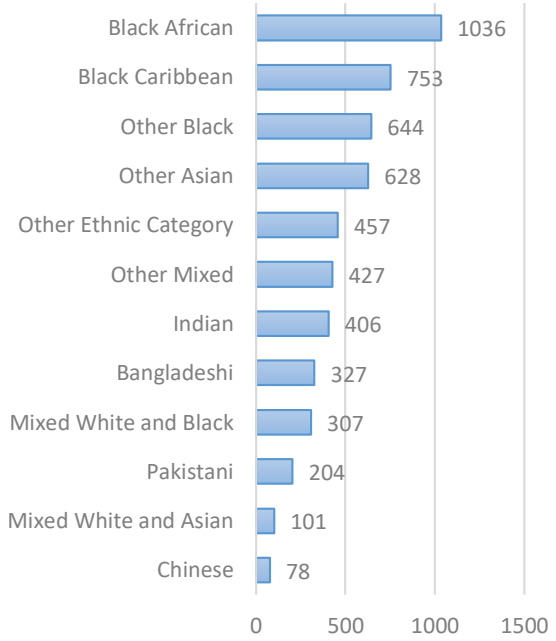
As is seen in previous years, there are more referrals for females than males. This is in line with the age-related element of many safeguarding and welfare referrals. 25% of referrals have no gender recorded. Just under a third of these (1,915) are 'other outcome' referrals for which no safeguarding concern could be identified – these referrals do not have full demographic information taken. The majority of the remainder of unknown gender 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.

Protected characteristics

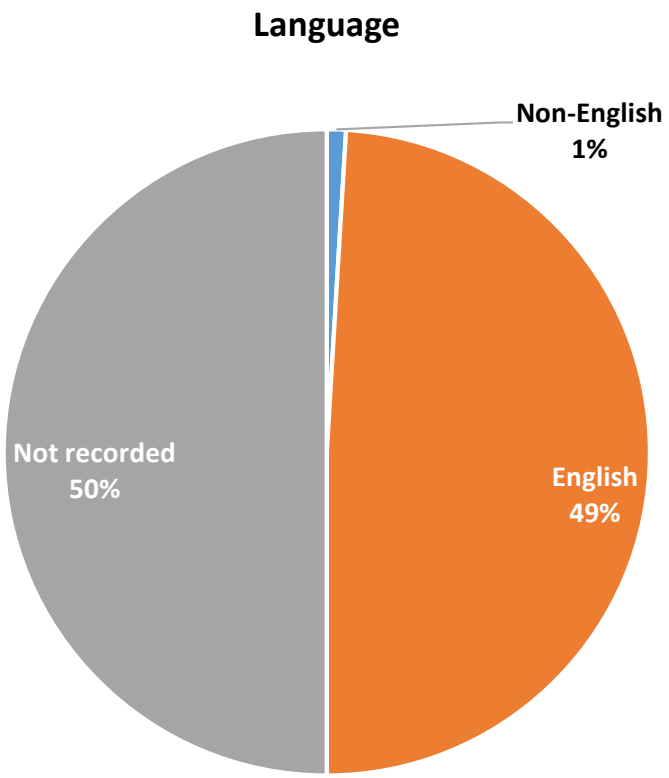
Ethnicity

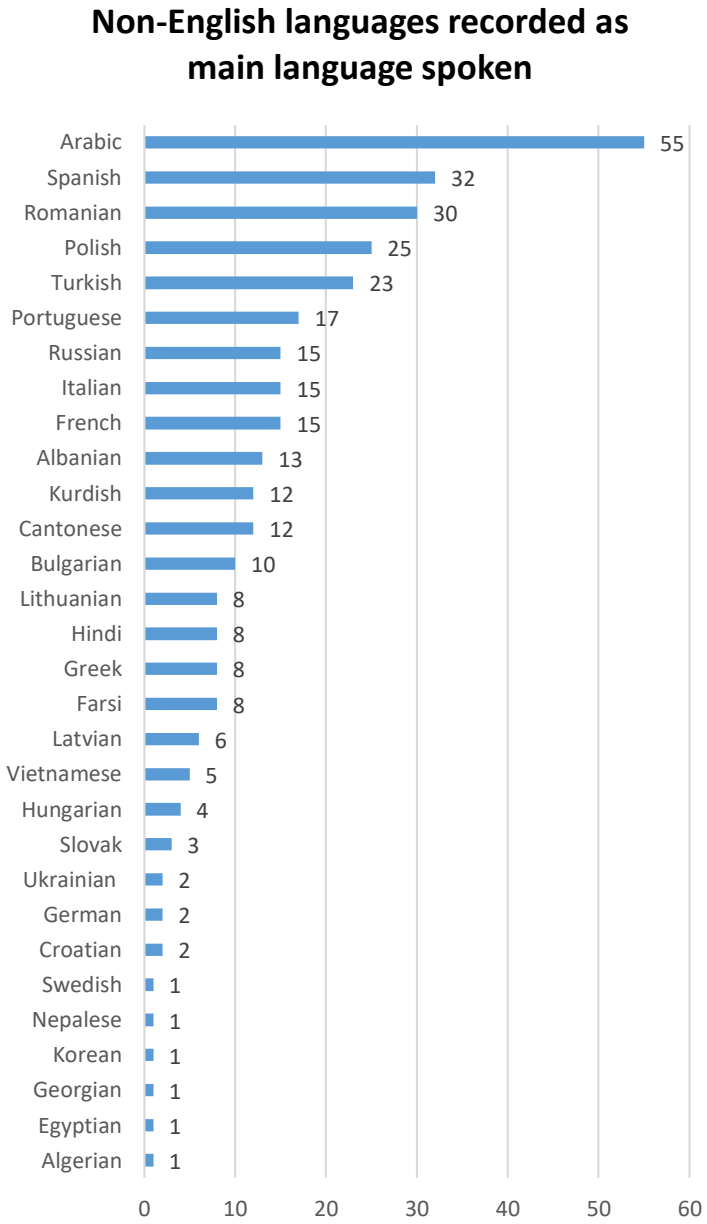


BAME referrals

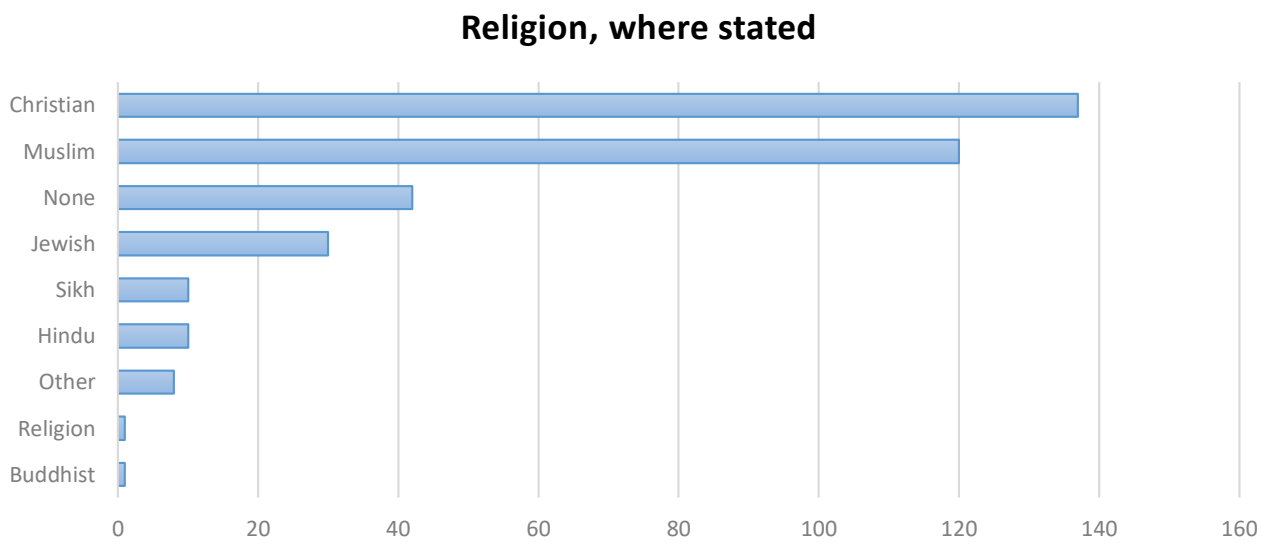


The number of cases where no ethnicity is recorded stands at 52%, and reflects the nature of the incidents that LAS attends. Often crews are unable to discuss ethnicity because patients are semi-conscious or incapacitant. Also third party concerns – for people we did not see or assess, perhaps carers or partners, or those for unborn children, often provide no opportunity for a determination to be made.





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

Priorities for 2022-23

To implement Learning disability (LD) Strategy and
deliver on LD & Safeguarding work plans

To work with the 5 new Integrated Care Systems in London to develop safeguarding partnerships

Work with partners to:

Develop contextual safeguarding pathways in other boroughs

Improve safeguarding response to prisons

Improve external feedback from referrals

Continue to improve the quality of the safeguarding governance and assurance

Introduce electronic safeguarding referrals from ePCR

Continue to provide a varied safeguarding educational program