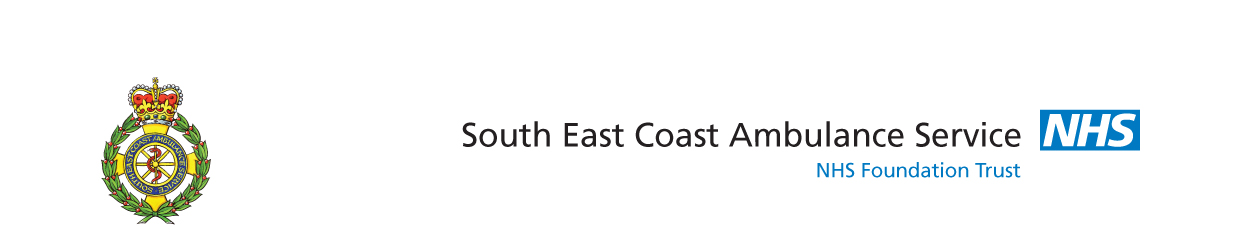


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| --- | --- |
| Agenda No |  |
| Name of meeting | Quality and Patient Safety | | | |
| Date | 20th May 2021 | | | |
| Name of paper | Safeguarding Annual Report | | | |
| Responsible Executive | Bethan Eaton-Haskins  Executive Director for Nursing & Quality | | | |
| Author | Philip Tremewan, Nurse Consultant for Safeguarding | | | |
| Synopsis | The Annual Report seeks provide assurance to patients, service users and key stakeholders that South East Coast Ambulance Service NHS Foundation Trust is discharging its Safeguarding responsibilities. The report provides evidence on how these responsibilities were discharged and highlights priority areas for Safeguarding during 2021/22. | | | |
| Recommendations, decisions or actions sought | The Executive Management Board is asked to recommend approval of the report to the Quality & Patient Safety Committee | | | |
| Does this paper, or the subject of this paper, require an equality impact analysis (‘EIA’)? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases). | | **Yes/No** | | |



**Safeguarding Annual Report 2020/21**

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# **1. Introduction**

Throughout 2020/21 South East Coast Ambulance Service NHS Foundation Trust (SECAmb) has striven to meet its statutory responsibilities in the care and protection of patients of all ages. This report demonstrates to the Trust Board and external agencies how SECAmb discharges these statutory duties and the report offers assurance that the Trust has effective systems and processes in place to safeguard patients who access our services. We continue to deliver a high-quality credible service to patients and families, whilst reflecting continually on areas for learning and improvement.

2020/21 has been dominated by the considerable challenge of the Covid-19 pandemic that have impacted on the majority of departments across the Trust including the Safeguarding Team. However the team are confident that diligent business continuity planning has ensured that vulnerable children, looked after children, young people and adults at risk have been protected and supported during these challenging times.

The existing statute which continues to underpin the work of colleagues who support healthcare practitioners delivering services to children is in line with Working Together to Safeguard Children 2015 guidance and Section 11 of the 2004 Children Act. All staff have a statutory responsibility to safeguard and protect the children and families who access our care.

The legislation which frames the work of colleagues in adults’ services is influenced by the introduction of the 2015 Care Act. The introduction of The Care Act put adult safeguarding on a statutory footing for the first time in addition to embracing the principle that “the person knows best”. In addition our work to safeguard adults is informed by The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards amendment in 2007.

SECAmb acknowledges that safeguarding is everyone’s business and strives to support the Department of Health’s six principles of Safeguarding:

• **Empowerment** – People feel safe and in control, give consent to decisions and actions about them. They should be helped to manage risk of harm either to themselves.

• **Protection** – Support and help for those adults who are vulnerable and most at risk of harm

• **Prevention** – Working on the basis that it is better to take action before harm happens

• **Proportionality** – Responding in line with the risks and the minimum necessary to protect from harm or manage risks

• **Partnership** – Working together to prevent or respond to incidents of abuse

• **Accountability** – Focusing on transparency with regard to decision making.

The Annual Report provides the readers with the following detail:

• An overview of the national and local context of safeguarding

• An overview of the areas of practice included in safeguarding within the Trust

• An update on safeguarding activity within 2020/21

• Assurance that the Trust is meeting its statutory obligations and the required national standards with regard to safeguarding

• An overview of any significant issues or risks with regard to safeguarding and the actions being taken to mitigate these

• A briefing on the challenges and work to be addressed by the safeguarding teams in 2020/21.

# **2. Governance and Commitment to Safeguarding**

As an NHS Service provider SECAmb is required to demonstrate that they have safeguarding leadership and commitment at all levels within the organisation and that we are fully engaged in support of local accountability and assurance structures, via the Safeguarding Boards across Kent, Medway, Surrey, Sussex and NE Hampshire.Most importantly, SECAmb reinforces the principle that safeguarding is everybody’s responsibility and develops a culture of continuous learning and improvement to promote the safety and welfare of adults at risk, children and young people and looked after children.

SECAmb ensures that its senior management is committed to safeguarding demonstrated at Executive and Non-Executive level at Trust Board. Safeguarding is always included in the annual cycle of business and comes within the scope of influence and scrutiny of the Quality & Patient Safety Committee. The Trust have robust governance structures and systems in place in line with Working Together to Safeguard Children 2015 and the Care Act 2014.

Evidence of SECAmb’s commitment to safeguarding includes clear statements on the Trust’s website demonstrating how our services safeguards the welfare of children, young people and adults. The Trust’s Five-Year Strategic Plan for 2017-2022 also recognises how safeguarding and patient safety underpins its core services.

The Trust’s Safeguarding function sits within the portfolio of the Nursing and Quality Directorate and is led by the Executive Director for Nursing & Quality. The work of the department is scrutinised at the Safeguarding Sub-Group (SSG) meeting jointly chaired by the Nurse Consultant for Safeguarding and Safeguarding Lead. Terms of Reference for the group highlights the required core membership and includes senior roles and individuals from a wide range of operational, educational, HR, staff partnership and commissioning colleagues.

2020/21 evidenced a continued investment by the Trust in its safeguarding function. During the year the Safeguarding Lead continued to provide strong leadership on operational safeguarding across the Trust and support the Nurse Consultant for Safeguarding and Director of Nursing & Quality in delivering high standards of care and experience to patients. At the time of writing the total skill mix of the Safeguarding Team at SECAmb is:

|  |  |  |
| --- | --- | --- |
| Job Role | Band | WTE |
| Nurse Consultant for Safeguarding | 8b | 1 |
| Safeguarding Lead | 8a | 1 |
| Safeguarding Practitioners | 7 | 2 |
| Safeguarding Coordinators | 5 | 3.2 |

The total investment allows for greater focus on the Trust’s internal and external safeguarding responsibilities. The focus includes improved representation at Safeguarding Adults Boards, Safeguarding Children’s Partnerships and child death review panels across Kent, Surrey and Sussex. Additionally, during 2020-21 there had been continued investment in the Trust’s approach to safeguarding training, including the introduction of Level 3 face to face training via Teams for registered clinicians across SECAmb’s 999 and 111 services.

Standing agenda items at each SSG meeting provide assurances to the Trust Board and Executive Team. These include a review of the Trust’s Safeguarding policies and procedures, departmental workplan, safeguarding risks and monitoring progress against safeguarding action plans following Serious Case Reviews, Domestic Homicide Reviews, Safeguarding Adults Reviews or Section 11 returns.

Regular assurance evidencing how the trust is discharging its safeguarding responsibilities is provided to the Designated Professionals at the Trust’s lead CCG; this includes:

* Submission to the Surrey wide CCG Designated Safeguarding team of an annual report and 6 monthly update that provides a narrative and data against each of the standards
* Submission of exceptions reporting for any areas of non - compliance with the standards as identified
* Submission to the Surrey wide CCG Designated Safeguarding team of Section 11 audits undertaken and resultant action plans for the Surrey Safeguarding Children’s Partnership
* Providing evidence at Contract Quality Review Meetings (CQRM)
* Providing evidence at other contract monitoring meetings
* Named / Lead professionals meetings/supervision with Surrey wide CCG Designated Safeguarding team and use of the Annual Assurance Framework Report
* Providing information to the Surrey wide CCG Designated Safeguarding team in the twice yearly Dashboard on safeguarding activity.
* Providing evidence at Surrey Safeguarding Adults Board, Surrey Safeguarding Children Partnership meetings and sub groups
* Participating in Surrey wide CCG Designated Safeguarding team and SSCB and SSAB audits and inspections
* Demonstrating the Trust’s commitment to preventing modern slavery and human trafficking by evidencing a Modern Slavery Act statement on its public facing website

Although the Surrey Safeguarding Adults Board and Surrey Safeguarding Children Partnership remain lead Boards for SECAmb, throughout 2020/21 continued commitment have been noted in SECAmb’s representation at Safeguarding Board meetings across Kent, Medway, Surrey and Sussex. The Trust has continued to invest in senior safeguarding leadership across the organisation resulting in greater capacity to contribute to the priority areas of each Board.

**Safeguarding Risks**

During 2020/21, a total of three safeguarding risks were formally recorded on the Trust’s Risk Register. These related to:

1. **Non-compliance with Mental Capacity Act assessments**

Safeguarding training for all clinical staff for 2019/20 has, through Key Skills and e-learning had a greater focus on the Mental Capacity Act. Additionally, developed within the electronic Patient Care Record (ePCR) is an improved section that promotes improved compliance with the expectations of the Mental Capacity Act. The ePCR requires clinicians to complete mandatory fields before progressing onto the recording of any subsequent best interest decision making.

The July 2020 Safeguarding Sub-Group recommended to the Clinical Governance Group that actions were in place to mitigate the risk and subsequently the risk was closed.

1. **Private Ambulance Providers - Delay in making safeguarding referrals**

There was a risk that safeguarding referrals were not being received and processed in a timely manner from PAP partners. This was as a result of;

* + PAP providers being unable to access Datix
  + Unclear processes around sending paper-based referrals to safeguarding team
  + Points of failure resulting in lost referrals.

This may lead to a vulnerable adult or child being placed in danger through not being referred to an appropriate agency.

To provide optimal assurance that safeguards patients and effectively manages the timely processing of paper safeguarding referrals the Trust, through an operational bulletin in June 2019 ensured the following actions are adhered to:

* All individuals that complete paper safeguarding referrals must ensure that they have access to new orange safeguarding referral envelopes (all Private Providers and back-up mechanisms for internal Datix failure)
* All crews must complete the front box identified as ‘Crew to Complete’ and hand the sealed envelope to the Duty Operational Team Leader or placed into the Patient Care Record box on station
* All Duty Operational Team Leaders must:
  + Complete the front of the orange envelope identified as ‘OTL to Complete’ which identifies all required action has been taken. This identifies the process of scanning the referral to the Safeguarding Team dating the time scanned and marking whether the process followed is an internal Datix failure or not.
  + Ensure that any orange Safeguarding envelopes are processed as above and PCR boxes checked for any orange envelope

The risk was monitored regularly at the Trust’s Safeguarding Sub-Group and in July 2020 a recommendation was made to the Clinical Governance Group that actions were in place to mitigate the risk and subsequently the risk was closed.

1. **Capacity within the Safeguarding Team**

With a 20% year on increase in safeguarding activities, there is a risk that the Safeguarding Team will burnout unless a system is introduced to manage them in a smarter way. Subsequently, and as discussed at the July 2020 the Safeguarding Sub-Group meeting, a risk was added to the risk register on the 31st July.

Mitigating actions are in place where members of the Safeguarding Team continue to work to process and transcribe referrals to Datix and in the meantime the Safeguarding Lead will work with leaders in EOC Systems and IT to implement a Safeguarding module within the Trust’s Cleric system. Implementation of this module will result in a more efficient use of time taken to process safeguarding referrals.

# **3. Policies, Procedures and Guidelines**

As a commissioned NHS provider SECAmb needs to ensure that staff are aware of the Trust’s Safeguarding policy and any relevant guidance and procedures.

The Safeguarding function assumes lead responsibility for several organisational policies, all of which have been ratified and are in date. The policies are:

* Managing Safeguarding Allegations
* Mental Capacity Act Policy – Due to be updated June 2021
* Safeguarding Policy for Children, Young People and Adults
* Safeguarding Referrals Procedure
* Seeking Consent Policy – Due to be updated June 2021.
* Child Death Procedures – Due to be updated in May 2021 however will transfer across to the Medical Directorate for overall governance responsibility
* Freedom to Speak Up: Raising Concerns Policy
* Safeguarding Supervision Policy

# **4. Appropriate Training, Skills and Competencies**

The *Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff* Intercollegiate Document defines the safeguarding training expectations for all individuals working in healthcare. The document sets out five levels of training based on roles throughout the organisation.

During 2020/21 all operational staff were expected to complete a combined level 1&2 Safeguarding Children and Safeguarding Adults training modules. All registered clinicians will over the next three years will be expected to complete level 3 Safeguarding training. Since the start of the 2020/21 over 90% of staff have successfully completed the level 1&2 safeguarding courses. Contracting standards agreed with the Trust’s lead commissioners require 85% training compliance over the course of the year.

Outlined in the Intercollegiate Document are the expected competencies for level 3 training. This is mandatory training that would normally be delivered through classroom-based sessions, so following a pause due to the Covid-19 pandemic, the Safeguarding Team have started to offer web based learning via Microsoft Teams.

All managers across the Trust were sent a briefing highlighting the mandatory requirement together with an FAQ paper that clarifies the content, booking mechanism and the process of assessing competence. This year, the Trust has taken the approach that achieving Level 3 competence will take a modular form, with this course building on what has been learned via the Level 2 training on Discover. This means staff are able to break up the training a little and means no one will be expected to undertake a full day of learning via Teams. Staff must have completed the Discover e-learning before joining this course.

At the time of writing total staff compliance with L3 safeguarding training was around 70%. (Total of 2058 registered clinicians) The approach taken by the safeguarding team has been to target those members of staff whose training had elapsed and to work chronologically through the cohort of staff. In doing so this will ensure that all registered staff will be able to demonstrate compliance with the expectations of the Intercollegiate Document.

*Impact of Training*

The impact of previous training and the online modules became evident as the pandemic and, in particular, the effects of lockdowns progressed. During the first lockdown, through April and May 2020, when 999 calls to children dropped significantly (by almost 50%, maybe due to a lack of outdoor activities, clubs, schools etc), the referral numbers for child concerns initially remained the same – therefore equating to figures that were proportionally higher – and then in May rose a further 50% in numbers.

The trends of note seen were a significant increase in child mental health concerns and exposure to parental substance misuse and mental health issues. The increase in referral numbers demonstrates a heightened awareness of vulnerabilities directly due to the pandemic, where many support networks for these vulnerable children were lost.

An example of a crew being exceptionally vigilant was during an attendance to an apparently rebellious 12-year-old who was drinking and drug taking, not attending school and on occasion, staying out all night. The crew listened carefully to information provided by a sibling which included the child meeting older youths in a park, running errands and having recently been given new trainers and a bicycle. The clinicians requested Police attendance and made a safeguarding referral as they were concerned this child was involved in County Lines activity, which was found to be the case. The child did not live in a secure and supportive family environment, so our staff became excellent advocates for that young person.

# **5. Effective Supervision and Reflective Practice**

# Safeguarding Supervision for the Trust’s Safeguarding Lead and Nurse Consultant is undertaken by the relevant Designated Nurse for Safeguarding within clinical commissioning.

NHS Commissioning Safeguarding Standards highlighted that SECAmb should have a separate safeguarding and looked after children supervision policy. Throughout 2020/21 and despite the coronavirus pandemic members of the safeguarding team have continued to deliver and receive safeguarding supervision in line with commissioning expectations.

**6. Effective Multi-Agency Working**

*2020/21 Safeguarding Referral Information*

The department has continued to see increases in referral activity. During the 2020/21 a total of almost 21,000 safeguarding referrals were made to local authorities across Kent, Surrey, Sussex and Hampshire. This equates to an increase of 28 per cent compared to the previous year. All referrals continue to be reviewed by members of the Safeguarding team before forwarding to the relevant local authority.

2020/21 has seen a significant 68 per cent rise in concerns for patients’ mental health including a 25 per cent rise in parental substance misuse. The Safeguarding team also recorded a 40 percent increase in increasing care needs for patients and carers. Additionally, there was a 25 per cent rise in referrals for individuals at risk of or have suffered domestic abuse (DA) compared to the same reporting period for the previous year.

Safeguarding referrals for children constitute 17% of the total number of referrals despite the under 18 population accounting for around 10 per cent of SECAmb’s workload. Safeguarding training throughout 2020/21 has focused on risks to children and ensuring that the ‘Voice of the Child’ is heard and listened to. This suggests that our staff are able to recognise and escalate safeguarding concerns where there’s an indication of a child is at risk of harm, abuse or neglect.

*Developments in Partnership Working*

Throughout the pandemic the Safeguarding Team have worked very closely with SECAmb’s commissioners, Safeguarding Boards and NHSE/I to highlight the rise in low level safeguarding concerns and the hidden harm. Themes arising from this work recognises the impact that school closures, changes in primary and community care services, and reduction in caring support provided by families have had on vulnerable people across society. Subsequently SECAmb’s figures support the theory that patients have been contacting the NHS111 and ambulance services at the point of crisis when ordinarily contact would have been made with community providers before patients concerns escalate.

During the pandemic the Safeguarding Team produced a suite of resources to support staff who may have come across cases of domestic abuse or heightened parental mental health. The poster provided appropriate links to support services across Kent, Surrey and Sussex and reminded staff to submit a safeguarding referral in the event that vulnerable adults and children were at risk as a result of a deterioration in their mental health.

Throughout the pandemic the Safeguarding Team have received a huge amount of information and safeguarding guidance from commissioners, Safeguarding Boards, local authorities and NHSE/I. An example of the resources included joint guidance from the NSPCC and Department of Education highlighting a toolkit for a helpline aimed at protecting children during the Covid-19 pandemic. Staff were encouraged to use the NSPCC helpline number in their safety netting advice to young people but should continue to make safeguarding referrals in the usual manner.

A further example highlighted the risk of far-right groups exploiting school closures and an increase in gaming during the pandemic to aid recruitment. Although for information only, the Trust would only come across cases of radicalisation as an incidental finding, however staff were reminded that gaming can provide a route for the exploitation and radicalisation of young people.

A rapid read Domestic Abuse During Covid-19 document from NHSE/I was published with a request to disseminate to all staff. This was very relevant at the time, as whilst figures tended to fluctuate the Safeguarding Team’s observations highlighted there had been a significant increase in DA referrals across the Trust. It was decided that as the issue affects patients and staff, the wellbeing bulletin was a good vehicle to cascade this message out across the organisation.

In its response to the significant amount of guidance developed during Covid-19 the Safeguarding Team developed a summary paper that RAG rated the relevance of the information for the Trust and cascaded this out to clinical leaders in the operating units, EOC and 111.

*Developed Guidance for Single Parents with Dependent Children*

With Covid-19 and the associated shutdown of schools affecting large sections of the population, ambulance practitioners were more likely to find themselves facing situations where a child may be left home alone if a single parent needed to go to hospital. Clearly this presented a potential safeguarding concern for the child, parent and attending crew; subsequently the Safeguarding Team developed another safeguarding resource that provided guidance for staff on how these types of situations could be managed safely, sensitively and pragmatically.

The bulletin highlighted important factors to consider, for example age, duration and distance when intervening to support single parents with children. Guidance was also provided on a child’s cognitive ability and competence to make decisions

*Coordinated PPE Concerns in Care Homes Across KSS*

During the early Covid-19 pandemic the safeguarding team at SECAmb were receiving a significant number of concerns from frontline ambulance practitioners with regard to Personal Protective Equipment and Infection Prevention and Control measures in settings such as care homes, nursing homes and domiciliary care.

Taking clinicians concerns seriously the Safeguarding Team worked closely with Clinical Commissioning Groups (CCG’s) and Adult Social Care to escalate taking observations to the right people.

In order to capture this in one place, staff were asked to complete a safeguarding referral, the safeguarding team then coordinated the responses to determine the most appropriate agency to escalate PPE concerns.

By the end of September 2020 the Safeguarding Team submitted 89 referrals to commissioners and local authorities highlighting PPE and infection prevention & control issues.

*Referrals to Local Fire & Rescue Services*

Referrals to other agencies recognises the preventative role that Fire & Rescue (F&R) Services can play in supporting adults at risk. During 2020/21 SECAmb activity indicates that over 1700 referrals have been made to Fire & Rescue services across Kent, Surrey and Sussex. This has seen a considerable rise of 115% in referrals to F&R compared to the previous year. Although it’s difficult to quantify the reasons for such a substantial increase. Embedded changes to the safeguarding referral form have incorporated greater opportunities for staff and crews to recognise and escalate fire risks for vulnerable people. Throughout the coronavirus pandemic the Safeguarding team have received a forty percent increase in referral highlighting increasing care needs for vulnerable people, many of whom are living on their own and haven’t received help from close family members because of lockdown. Subsequently front-line crews have been recognising potential fire risks that would normally be identified by other family members or paid carers.

Thirdly, the safeguarding training delivered throughout the year focused on the area of self-neglect and detrimental hoarding behaviour, including the relative fire risk associated with this behaviour. The training encourages staff to consider a referral to local F&R services if the hoarding reached a pre-determined threshold.

*Child Death Reviews*

Members of the Safeguarding Team continue to be involved in the multi-agency Child Death Review process, which now supplies information to the National Child Mortality Database.

During 2020-2021, SECAmb has reported on a total of cases: 56 in Surrey, 51 across Sussex including Brighton & Hove and 55 in Kent & Medway.

With the introduction of the revised Child Death Review arrangements from September 2019, SECAmb’s involvement has largely moved from attendance at the Child Death Overview Panels to a more proactive role within the analysis stage of the process, Practitioners attending Joint Agency Review meetings and the Child Death Review Meetings, representing or supporting the operational staff. Child Death Overview (CDR) Panels are attended at the Chair’s request to provide SECAmb specific input for certain cases. During 2020/21 all CDOP meetings have taken place via Microsoft Teams, which has provided a different dimension to the meetings and enabled the Specialist Safeguarding Practitioners to play a more active role, operational staff have not been able to attend these meetings due to the limitations of Microsoft Teams however we would hope as the process becomes more streamlined then this would allow for their attendance again, however it is always insured that information is feedback to the attending crews where they have been requested to be kept up to date.

Through the CDR process, the purpose is to identify “modifiable factors” and identify learning that may help to prevent similar child deaths in the future. Some practical learning has been brought back to SECAmb and passed to operational staff through Informatics posters and informing training and CPD events. A theme which has been identified during the CDRM meetings this year has been SECambs interaction with the Police in both informing at the early stages of a child death call and giving updates if necessary while at scene. There have been a couple of occasions where the phone calls have not taken place and this has been picked up after the call and feedback to the staff involved. It is also clearly mentioned and is an exam question of the Level 3 Safeguarding training that SECAmb provide to all registrants and senior Emergency Operating Unit Staff.

As the ambulance service is often the first agency on scene of an incident and has the opportunity to report its findings in cases of child deaths, it is common that SECAmb’s contribution is often unique and invaluable; informing the CDR process and that information being fed into the wider actions and recommendations for Health, Education and Social Care that result from the panel as well as to the National Children’s Bureau.

*Multi-Agency Safeguarding Assurance*

Throughout 2020/21 SECAmb provided regular assurance about its safeguarding function to the Safeguarding Adults Boards, Safeguarding Children’s Partnerships and Clinical Commissioners across Kent, Medway, Surrey, Sussex and NE Hampshire. Exception reporting and quarterly dashboard returns were submitted in line with other NHS providers to Surrey Heartlands ICS. The information was subsequently shared with all Safeguarding Boards across the region. Regular reporting included assurance on:

* SECAmb’s policy developments in relation to Safeguarding Supervision
* Prevent activity
* Safeguarding training
* Referral activity
* Serious Incidents that had a safeguarding theme

Areas of challenge in SECAmb’s safeguarding assurances and governance are discussed and agreed at the Safeguarding Sub-Group and through Safeguarding Supervision with Designated Professionals at the CCG.

Local Safeguarding Children Partnerships (SCP) seek assurance about organisational compliance under Section 11 of the Children Act 2004. The introduction of the Care Act 2015 placed Safeguarding Adult Boards (SABs) onto a statutory footing and each Board has been developing benchmarking assurance tools to identify good practice for safeguarding adults which broadly replicates the Section 11 requirements.

*Multi-Agency Safeguarding Audits*

Section 11 audits are received every two years; during 2020/21 SECAmb received a section 11 audit requests from the Kent, Surrey and Sussex SCPs. All three audits were completed and submitted during the autumn of 2020; the audit identified three key areas of development:

* Ensure that children who are privately fostered are notified to the relevant local authority
* Ensure safer recruitment processes evidence Safeguarding statements to all job adverts where there is contact with patients
* An induction process needs to ensure a safeguarding component is in place for all staff who have contact with children

Internal governance of the audit returns allow the Safeguarding Sub-Group to scrutinise the audit prior to formal submission. Any concerns regarding the audit are escalated to the Clinical Governance Group before final sign-off by the Trust’s Executive Director of Nursing & Quality. Any actions from the audits are incorporated into the annual Safeguarding Workplan that’s scrutinised at each Safeguarding Sub-Group meeting.

*SECAmb’s Contribution to wider Multi-Agency Enquiries*

The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

When an allegation about abuse or neglect has been made, an enquiry is undertaken to find out what, if anything, has happened.

The findings from the enquiry are used to decide whether abuse has taken place, whether the adult at risk needs a protection plan and whether any wider learning can reduce future risk.

The Trust were requested to contribute to 34 Section 42 enquiries throughout the 2020/21.

In many of these cases the Trust was asked to provide a summary of involvement as concerns had been raised on the care delivered by other providers. Areas of learning for SECAmb are recorded and monitored at the monthly Safeguarding Sub-Group. The example below highlights the outcome of a Section 42 enquiry and the subsequent learning for the Trust in relation to the patient’s mental capacity after multiple call outs to this address.

*Care Act - Section 42 Enquiry - case summary*

An Ambulance had been requested a number of times for a patient who had Anorexia and also the beginnings of kidney failure. The patient repeatedly refused to go to hospital, this case involved lots of professionals including the hospital and social care staff. The mental capacity assessments for this patient were documented well.

*Areas of learning*

It was noted that although the patient had an old Information Based Information system (IBIS) record it had not been accessed by one of the crews which would have given them information they required for this patient and her latest care, this record was also recommended to be updated by the patient main care provider so that the next time we attend this patient the crew will have as much information as possible about her current care.  Mental capacity and the correct recording of all information is covered in our Level 3 training for our staff.

Under the requirement of the Children Act (1989) a Sec. 47 investigation will involve social care receiving a referral from SECAmb or another agency that results in a social worker suspecting that the child is suffering or likely to suffer significant harm. A Strategy Discussion Meeting will be held to decide whether to initiate enquiries under Section 47 of the Children Act 1989.

Strategy Discussions/Meetings will contact SECAmb to establish if the Trust have had any information in relation to the children or family as it is acknowledged that SECAmb will often have information that others will not due to the way our service is accessed. The Safeguarding Team supported 33 Section 47 enquiries during the reporting year.

A S17 is a query in relation to a Child in Need assessment under the Children’s Act 1989. A child is defined as being in need either through disability or poor health and they are unlikely to achieve or maintain a reasonable life or a reasonable standard of health or development, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services by a local authority. There were no Sec. 17 investigations that SECAmb were asked to support during 2020/21.

# **7. Reporting Serious Incidents (SIs)**

Contained within the safeguarding commissioning standards are the expectations that SECAmb will ensure that any serious incidents are reported and are investigated in line with the Serious Incident Framework. Additionally, the Trust needs to ensure that any serious incident related to safeguarding children and adults is reported to the lead commissioners. As has been highlighted elsewhere within this report regular exception reporting to the lead commissioner provides assurances on the overlap between SIs and safeguarding. A senior member of SECAmb’s Safeguarding team sits as a core member of the trust’s Serious Incident Group (SIG). Representation from Safeguarding is also documented in the Terms of Reference for SIG.

According to the Serious Incident Framework developed by NHS England in 2015, the purpose of SI investigations in the NHS is to identify learning to prevent recurrence. The Framework. SIs in the NHS also include ‘actual or alleged abuse…acts of omission and organisational abuse where healthcare did not take appropriate action/intervention to safeguard against such abuse occurring’. This includes abuse that resulted in or was identified through a SPR, SAR, Safeguarding Adults Enquiry where delivery of NHS funded care caused or contributed towards the incident.

During 2020/21 the Trust declared 18 SIs that had a safeguarding element. 9 SIs were declared because of adults or children at risk receiving sub-optimal clinical care where neglectful care met Local Authority safeguarding thresholds. 1 SI was declared as a result of an unexpected child death and a further single SI was declared as a result of the trust failing to follow its staff welfare processes in supporting a member of staff with a confirmed covid-19 diagnosis. 7 SIs were declared as a result of incidents relating to staff conduct that met the safeguarding thresholds documented within the SECAmb’s Managing Safeguarding Allegations policy. Further information on these cases will be addressed in Section 10 of this report.

Examples of safeguarding concerns investigated via the safeguarding route included:

* Patient in the back of an ambulance suffering a burn caused by the ambulance saloon heater
* A delay by a private ambulance provider (PAP) in commencing CPR due to confusion surrounding the correct level of PPE when an aerosol generating procedure (AGP) was implemented
* An allegation has been made by a patient that a member of SECAmb operational staff conducted them self in such a way as to break the level of trust that exists between a patient and attending clinician.

There was no root cause identified as there was no proven incident. The scope of the investigation was changed to look at whether there were any themes around the ethnicity or gender of the staff member identifiable.

Learning from SI investigations with safeguarding concerns is reviewed at the Trust’s Safeguarding Sub-Group where any subsequent assurance or risks are escalated to the Clinical Governance Meeting.

Example of Learning from a Serious Incident Investigations

* Trust to highlight need for due vigilance around the positioning of patients near ambulance saloon heaters via operational bulletin or during key skills training (to include PAP providers) as part of the shared learning process.
* All PAPs have been asked to confirm that they are following all the SECAmb clinical policies, procedures and instructions regarding PPE and AGPs.
* Consideration should be made for situating patients at risk of absconding from a vehicle in the “captain’s seat,” immediately behind the bulkhead and facing the rear exit. This should reduce the opportunities for the patient to exit a moving vehicle.

# **8. Engaging in SCRs/SARs/DHRs/Partnership Reviews**

In line with the Local Safeguarding Children Partnerships arrangements the key guidance for Safeguarding Practice Reviews (SPRs) (formally Serious Case Reviews) is *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children* (D; for Safeguarding Adult Boards (SABs) the Care Act 2015 introduced the requirement to undertake Safeguarding Adult Reviews (SARs). Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004).

Safeguarding activity across our key partners and local authorities continues to demonstrate year on year increase in activity. During 2020/21 SECAmb were asked to contribute to  82 Serious Case Reviews, Safeguarding Children’s Reviews and Domestic Homicide Reviews. This is an increase in the number for the previous year.

Throughout April 2020 – March 2021 SECAmb were asked to contribute Summaries of Involvement to commissioning Safeguarding Boards and Community Safety Partnerships to 24 SPRs/Rapid Reviews, 36 SARs and 22 DHRs across Kent & Medway, Surrey, Sussex and Hampshire. The number broken down into each local authority is:

* 1 Brighton and Hove SCR
* 1 Brighton and Hove SAR
* 1 Brighton DHR
* 1 DHR East Sussex Domestic Homicide Reviews
* 1 East Sussex SAR
* 3 SPR/Rapid Reviews Children East Sussex
* 11 DHR Surrey
* 1 SAR West Sussex
* 5 SCR West Sussex
* 4 DHR West Sussex
* 4 DHR Kent
* 6 SCR/Rapid Reviews Kent
* 29 SAR Kent
* 8 SCR/Rapid Reviews Surrey
* 3- SAR Surrey

Areas of wider learning following these reviews have been shared across the organisation using various methods, including training examples, to cascade. A particular area of achievement which demonstrated great team working was an incident that took place at a Sussex care home following an unexpected death of a resident.

The care home, on the crew’s arrival, appeared to be cold with no working heating, while carrying out treatment for one patient that felt that it would be appropriate to check the temperatures of the other patients, some were found to be hypothermic. They arranged for other crews to come and check the other patients. Our Emergency Operating Centre arranged calls to the police and out of hours social care; crews continued to stay with the patients for a period of 24 hours and they take other patients to hospital where needed.

As a result of the concerns escalated by SECAmb to the police and adult social care the local Safeguarding Adults Board commissioned a multiagency Organisational Learning Review that will make recommendations to reduce future risk to vulnerable residents living in care homes.

# **9. Safer Recruitment and Retention of Staff**

The Trust’s Recruitment and Selection Policy and Procedure confirms that all job descriptions include a statement on the roles and responsibilities to safeguard and promote the welfare of children, young people and adults at risk of abuse and neglect. The safeguarding statement in all job descriptions take into account the work of all staff and volunteers throughout the organisation. All contracted services or individuals that work in regulated activity for the Trust follow safer recruitment processes.

In line with commissioning standards for safeguarding, SECAmb has a process in place to respond to positive Disclosure and Barring Service (DBS) concerns. All cases whereby a disclosure is made or a DBS check identifies previous convictions/cautions etc. will be reviewed by the DBS panel. The panel will consist of a member of the HR recruitment team, a senior operational manager and a senior safeguarding representative. The HR representative will ensure that the decisions made, and the rationale for them, are captured, shared in a timely manner and held securely. All decisions will be made by the operational and safeguarding representatives.

Assurance provided by the Trust’s Recruitment Service Centre stated that at the time of writing SECAmb had seven employees (0.14% of the total) who were outstanding with DBS renewal. For the new starters in 111 / EOC – they do not have any access to patients for the first 4 weeks of employment whilst they are in training. If the DBS is not back within this timeframe hiring managers are informed and they are not able to work unsupervised for the period until it comes back. For front line Operational staff, there were no new starters who are waiting for a DBS; an enhanced DBS was obtained prior to them starting.

Despite the challenges of the last twelve months, the DBS panel has continued to meet monthly. A senior member of the Safeguarding team has continued to support the employment risk assessment process where concerns have been recorded following a DBS check, this scrutiny is provided for renewals for existing staff and new starters.

# **10. Managing Safeguarding Allegations Involving Members of Staff**

SECAmb is required to adhere to statutory guidance in Working Together to Safeguard Children 2018, the Care Act 2014 and the Safeguarding Boards’ multi-agency procedures. The Trust therefore has a duty to report any incident where a member of staff has behaved in a way that has or may have harmed a child/adult at risk, acted inappropriately towards a child/adult at risk or committed a criminal offence against or related to child/adult at risk.

The Trust’s Managing Safeguarding Allegations policy and procedure sets out how SECAmb manages any allegations against employees relating to the abuse of children and adults at risk.

This policy seeks to prevent and address abuse by those who work with both children and adults at risk, particularly children and adults who may be at increased risk and may be unable to protect themselves from harm because of their care and support needs.

The policy sets out the Trust’s commitment to safeguarding children and adults from abuse and neglect and gives direction to enable the Trust to deliver an appropriate response. ​​The procedures also clarify the actions than the Trust are expected to take in the event to the relevant external agencies including the Local Authority Designated Officer (LADO) and the Care Quality Commission (CQC) if appropriate.

During 2020/21 allegations of a safeguarding nature were made against a total of 35 members of staff. 23 allegations met the threshold of the Managing Safeguarding Allegations policy. Safeguarding were consulted on the remaining twelve cases but did not require escalation via the safeguarding route.

Concerns escalated via the safeguarding route included:

* allegations of sexual harassment both inside and outside of the workplace.
* allegations of serious sexual misconduct
* perpetrating domestic abuse and allegations of controlling and coercive behaviour.

All cases had been managed in line with the Managing Safeguarding Allegations policy with evidence that risk assessments were undertaken as per the Trust’s Disciplinary Policy where concerns arose about the employee’s behaviour occurring outside of their employment with the Trust.

Where allegations have been made either by the patient, member of the public or member of staff, in addition to discussion with police, local authority and CCG, cases have been escalated to the Serious Incident Group for consideration in line with the Managing Safeguarding Allegations policy.

Following an escalation in increased numbers of serious safeguarding allegations made against SECAmb staff, the Safeguarding Lead and Nurse Consultant presented a paper to a dedicated sub-group of the trust’s Quality and Patient Safety (QPS) Committee during the autumn of 2020. The sub-group met three times during the autumn and winter of 2020 and was set up to further explore the issues and to seek assurance that there was senior leadership oversight that provided grip and traction on these concerns. It was chaired by the Chair of QPS and consisted of the NED with responsibility for safeguarding and Executive Directors of Operations, Nursing & Quality and HR. Additionally further support was provided by the Trust’s Freedom to Speak Up Guardian who had also received whistleblowing disclosures identifying concerning behaviours.

The paper highlighted a number of key themes that were consistent across the allegations.

The themes highlighted: -

* 100% of alleged perpetrators were male.
* With the exception of two cases, where the victim’s gender is not known, all the alleged victims were female.
* 33% of the cases involving sexual harm had already come to the attention of the Trust for similar allegations in the past
* 20% of cases involved patients. This could suggest that staff are better at maintaining professional boundaries with patients than their own colleagues.
* It could also suggest that fellow professionals are more likely to raise a concern when something happens to them that they do not find acceptable.
* Finally, it is possible that there is an unconscious bias to give more credence to an allegation from a professional, not a patient. In both cases involving patients, there was a history of poor mental health. This could again invoke bias, although there is no evidence that is the case.

Published in September 2020 was a CQC inspection report conducted at the East of England Ambulance Service NHS Trust. Before the inspection took place the CQC received information from a variety of sources including whistleblowers that related to safeguarding patients and staff from sexual abuse, inappropriate behaviours and harassment. Following the inspection, the CQC recorded action that the trust must take to improve; these actions included effective systems to identify potential safeguarding issues and the management of vulnerable children and adults and to set out a process to deal with allegations made against staff.

The publication of this report clearly highlighted similar areas of concerns within SECAmb. Subsequently the senior safeguarding leadership team reviewed the CQC recommendations and benchmarked SECAmb’s current position.

Assurance can be provided that Safeguarding involvement in allegations of a safeguarding nature ensures wider patient safety in supporting vulnerable individuals who suffered abuse as a result of a SECAmb employee. Secondly, assurance can be provided that a senior member of the Safeguarding leadership team is consulted on cases appropriately. Thirdly, assurance can be provided that concerns are escalated to the police, LADO, CQC and commissioners in a timely way. Finally, partnership working between Safeguarding, HR and Operational Teams ensures that referrals were made to the HCPC or relevant regulatory authority where appropriate.

# **11. Mental Capacity Act Policy**

# The Mental Capacity Act 2005 (MCA) provides a legal basis for determining an individual's capacity to make decisions at the time they need to be made.

The Trust’s MCA policy is for all staff working within SECAmb who are involved in the care, treatment and support of people over the age of sixteen (living in England or Wales) who are unable to make some - or all - decisions for themselves.

The policy is designed primarily for all staff who have direct patient contact, however all staff have a duty to act in accordance with the MCA. ​

Following the findings of the 2018/19 Clinical Audit Department MCA audit that demonstrated gaps in the Trust’s MCA compliance, the Trust increased Mental Capacity Act classroom based Key Skills training over the past two years. However, as has been highlighted previously in the report, 2020/21 has seen how the global challenges of the coronavirus pandemic has had on the Trust’s ability to deliver safeguarding training across the Trust.

Despite these challenges a second MCA audit was carried out by the Clinical Audit team in January 2021. However, in the follow-up audit, aspects thought to be due to paper mental capacity assessment forms not being linked to incidents, appear to be borne out in precisely the same percentages as the previous audit for paper PCR’s. This is not the case with ePCR incidents which show a very steep increase in compliance from 4% to 86%. This does not rule out clinical *documentation* issues for paper PCR completion, but it does strongly evidence that ePCR is a more effective tool for this type of assessment.

The audit highlighted that compliance (59%) for completion of a best interest plan / assessment is identical to the overall compliance in the 2018/19 audit. For the 41% of patients deemed to not have capacity that did not have best interest assessment there was no documentation of the rationale for non-completion of a best interest plan. In addition, recording of a best interest plan was not improved by the accessibility of ePCR.

Recommendations have been agreed by the Quality Improvement Lead, Head of Clinical Audit, Operations Improvement Hub Manager and Nurse Consultant for Safeguarding that highlight how improvements can be made to MCA compliance. These recommendations have been approved by the Clinical Governance Group at the March 2021 meeting.

# **12. Review of the Priority Areas for 2020/21 and Look Forward to 2021/22**

The priority areas for 2020/21 are highlighted as below and were included within this year’s workplan. The workplan is scrutinised at the Trust’s monthly Safeguarding Sub-Group meeting

* Reconfigure the Trust’s publicly facing Safeguarding webpages
  + Due to the increased workload on the Safeguarding Team, there has been no review during 2020/21 of these pages
* Embed a safeguarding audit programme – including focus on the Trust’s compliance of the Mental Capacity Act (2005)
  + The Safeguarding Team has worked in partnership with the Clinical Audit Team to develop a follow-up audit on compliance against the expectations of the Mental Capacity Act. Results of the audit demonstrate improvement on practice audited during 2018/19
* Promote the principle of establishing that the ‘voice of the child’ is reflected in escalating safeguarding concerns
  + The principle of the ‘Voice of the Child’ has been incorporated into the Trust’s L3 Safeguarding Training
* Streamline the existing referral process to allow greater focus of wider national safeguarding priority areas
  + The Safeguarding Referral Form hosted on Datix has been adapted to capture information regarding homelessness, care homes and young carers
* Develop a ratified Workforce Domestic Abuse Policy
  + Ratified August 2020
* Embedding the implementation of the updated Managing Safeguarding Allegations Policy across the organisation
  + There has been close oversight from the Safeguarding Lead of all allegations made against SECAmb staff and volunteers that meet the threshold of the policy. The Quality & Patient Safety Committee have provided additional scrutiny of this area of work

**Priority Areas for 2020/21**

* Reconfigure the Trust’s publicly facing Safeguarding webpages
* Consideration to implement Safeguarding Module on Cleric
* Consideration to include Safeguarding within the Induction Tool Kit page for new starters on the Zone
* Consideration to increase oversight in 999 and 111 of frequent calls for 0-18yr olds hear & treat patients
* Recommencing L3 face to face/virtual safeguarding training

# **13. Conclusion**

Despite the significant challenges presented by the Covid-19 pandemic, 2020/21 saw continued developments within the safeguarding function across the Trust. Continued investment in the Safeguarding Team has allowed improved processing of safeguarding referrals submitted by practitioners across the Trust. Safeguarding is ‘everybody’s responsibility’; the year has demonstrated new and innovative practices that embedded safeguarding approaches within other vital functions of the Trust’s business and directorates. Closer partnership working with the Trust’s key stakeholders has demonstrated improved outcomes for vulnerable people across Kent, Medway, Surrey and Sussex.

The work of the Safeguarding Sub-Group continues to flourish and is responsible for scrutinising and gaining assurance of every aspect of the Trust’s safeguarding function. A consistent focus on raising awareness of domestic abuse, low level parental mental health and increasing care needs for vulnerable people as a result of lockdown has seen a considerable increase in referrals to the Safeguarding Team who in turn have contributed to increases in the trust’s contribution to internal and externally commissioned multi-agency reviews across Kent, Surrey & Sussex.

Learning from incidents, complaints and safeguarding reviews have allowed the team to contribute to organisational learning and the priorities for 2021/22 will ensure that, despite the best efforts of a global pandemic, protection and learning will be central to the safeguarding function.