South East Coast Ambulance Service NHS
NHS Foundation Trust

	Agenda No	15/22

Name of meeting	Quality and Patient Safety Committee
Date	July 2022
Name of paper	Annual Safeguarding Report
Responsible Executive	Rob Nicholls 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 during 2021/22. The report also evidences areas of good safeguarding practice and highlights how key areas of safeguarding learning have been shared across the organisation.
Recommendations, decisions or actions sought	The Quality & Patient Safety Committee are asked to approve the Annual Safeguarding Report

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/<u>No</u>**

South East Coast Ambulance Service NHS
NHS Foundation Trust

Safeguarding Annual Report 2021/22

Authors: **Philip Tremewan, Nurse Consultant for Safeguarding**
Gareth Knowles, Safeguarding Lead
Jenny Churchyard, Safeguarding Practitioner
Emma Ray, Safeguarding Practitioner

Nursing and Quality Directorate
South East Coast Ambulance Service NHS Foundation Trust
Nexus House
Gatwick Road
Crawley
West Sussex
RH10 9BG

Contents

1. Introduction 4
2. Governance and Commitment to Safeguard 5
3. Policies, Procedures and Guidelines 7
4. Appropriate Training, Skills and Competencies 8
5. Effective Supervision and Reflective Practice 9
6. Effective Multi-Agency Working 9
7. Reporting Serious Incidents (SIs) 16
8. Engaging in SCRs/SARs/DHRs/Partnership Reviews 16
9. Safer Recruitment and Retention of Staff 17
10. Managing Safeguarding Allegations Involving Members of Staff 18
11. Mental Capacity Act Policy 20
12. Conclusion 20

1. Introduction

Throughout 2021/22 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.

2021/22 has been dominated by the on-going challenges of the coronavirus 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 2018 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 The Care Act 2014. The introduction of The Care Act 2014 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 recognises 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 2021/22
- 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 regarding safeguarding and the actions being taken to mitigate these.

2. Governance and Commitment to Safeguarding

As an NHS Service provider SECAmb is required to demonstrate that there is 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, and Sussex. 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 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 2018 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 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.

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	During the year 21/22 the Nurse Consultant acted up into a Deputy Director for Nursing and Quality for 5 months.
Safeguarding Lead	8a	1
Specialist Safeguarding Practitioners	7	2
Safeguarding Coordinators	5	3.5

The skill mix allows for focus on the Trust's internal and external safeguarding responsibilities. However, a continued year-on-year increase in safeguarding referral numbers continues to challenge capacity within the team to meet the expected demand. The focus includes representation at Safeguarding Adults Boards, Safeguarding Children's Partnerships and child death review panels across Kent, Surrey and Sussex. Additionally, during 2021/22 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 Surrey Heartlands Integrated Care System (ICS), SECAmb's lead commissioners for its 999 service.

- Submission to the Surrey Heartlands ICS 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 Heartlands ICS Designated Safeguarding team of Section 11 audits undertaken and resultant action plans for the Surrey Safeguarding Children's Partnership
- Providing evidence at contract and assurance meetings
- Named / Lead professionals meetings/supervision with Surrey Heartlands ICS, Designated Safeguarding team and use of the Annual Assurance Framework Report
- Providing information to the Surrey Heartlands ICS 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 Heartlands ICS 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 2021/22 continued commitment have been noted in SECAmb's representation at Safeguarding Board meetings across Kent, Medway, Surrey and Sussex.

Safeguarding Risks

1) **Capacity within the Safeguarding Team**

   With a 17% year on increase in safeguarding activities, there is a risk that the Safeguarding Team risk burnout unless a system is introduced to manage them in a smarter way.

   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. This is a joint piece of work with other ambulance trusts.

   We have utilised the trusts alternative duties pathway and we had had several staff come and shadow our team to learn how to process referrals under the supervision of the Specialist Safeguarding Practitioners. In Q4 they were processing over 35% of our referrals. Alternative duties placements not only support our team but also gives other members of SECAmb a chance to work within the Nursing and Quality directorate and understand more about the safeguarding function. However, there are inherit risks with non specialist staff undertaking what is a skilled area of work and several incidents have been investigated where the root cause can be attributed to inexpert decision making by alternative duties staff.

   A new way of working has been introduced in Q3 which saw the safeguarding coordinators working in a more efficient way to help manage the increasing demands on the service. There is now a Duty Coordinator tasked each day to take ownership of the telephone and email inbox, prioritising referrals and acting as a single point of contact for urgent enquires.

   Additionally, there was increased pressure on team capacity November 21 to the end of reporting period as the Band 8b Nurse Consultant role was not backfilled whilst the post holder was on secondment. However, additional short-term funding was used to increase capacity within the Safeguarding Coordinator function.

3. Policies, Procedures and Guidelines

As a commissioned NHS provider SECAmb must ensure that staff are aware of the Trust's Safeguarding policies and any associated 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 Policy and Procedure
- Mental Capacity Act Policy, currently out to consultation in anticipation of update and review

- Freedom to Speak Up: Raising Concerns Policy
- Safeguarding Supervision Policy

Policies due to be ratified 22/23

- Safeguarding Policy for Children, Young People and Adults
- Safeguarding Referrals Procedure

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 2021/22 SECAmb has delivered L1&2 Safeguarding training to new starters only. All registered clinicians will over the next three years will be expected to complete level 3 Safeguarding training. Since the start of the 2021/22 over 83% 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. Registered practitioners are required to undertake L3 face-face 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 been offering web based learning via Microsoft Teams. These training sessions were delivered in Q1 and Q2 and achieved a total highlighting that a total 65% of eligible staff had successfully undertaken the training during this time. No training was delivered in Q3 or Q4 on the advice of the Executive Management team due to a spike in service demand.

As a result of the increased demand and highest level of surge management throughout the winter, the Trust made the decision to postpone its Key Skills training in an attempt to ensure enough clinicians were able to provide operational support across the service. Subsequently training figures stagnated during this time. The Safeguarding Team are working alongside senior operational leaders to reinstate the required training.

During the autumn of 2021 the Nurse Consultant for Safeguarding delivered Board level training in line with the expectations and competencies outlined in the Intercollegiate Document. The training was delivered as part of a Board Development Day that included CEO, Executive Team, and Non-Executive Directors.

Impact of Training

During 2021/2022, Safeguarding Level 3 training was constantly refreshed with updated changes of legislation and recommendations from reviews that SECAmb had contributed to.

The trends of note that were seen in Safeguarding Adult Reviews and S42 enquiries concerns around self-neglect and those who may refuse a safeguarding referral irrespective of how their self-neglect may be affecting their mental or physical health or having an impact on others around them. Extra guidance was added in around self-neglect and professional curiosity to ensure that staff with patient interface had an enhanced knowledge of the subjects.

A new slide regarding professional curiosity has been included in the Level 3 training. This is to ensure that we are looking at the whole situation when attending a patient including any history we are given as well as the environment the patient is in. A doubled crewed ambulance attended a patient who was displaying signs of self-neglect the crew having recently completed safeguarding training completed a clutter score assessment and made referrals to both the local authority and the Fire & Rescue service via the safeguarding team. Feedback was received from the district council safeguarding officer that an multi agency plan of care had been put in place between housing and social care.

A concern was highlighted to the Safeguarding on-call service regarding a child who was in the company of 4/5 older men and bystanders had raised concerns, but she did not seem to know them well and appeared fearful. The clinician who raised this had undertaken her safeguarding training where information was included of the indicators of sexual exploitation as a result of this the police and local authority put plans in place to support the family and the child in line with the expectations of The Children Act 1989.

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.

- Nurse Consultant has provided supervision to the Paramedic Practitioners on an ad hoc basis where they were requested to by the Deputy Medical Director.

- Specialist Safeguarding Practitioners have provided supervision to Frequent Caller Team and Safeguarding Coordinators in a group format.

- Specialist Safeguarding Practitioners in Q4 took part in a Safeguarding Supervision training course for two days.

6. Effective Multi-Agency Working

2021/22 Safeguarding Referral Information

The department has continued to see increases in referral activity. During the 2021/22 a total of 23,715 safeguarding referrals were made to local authorities across Kent, Surrey, Sussex and Hampshire. This equates to an increase of 18% increase compared to the previous year. All referrals continue to be reviewed by members of the Safeguarding team before forwarding to the relevant local authority.

We continue to see a high level of social concerns which were not self-neglect but where crews felt they had no other path to refer the patient into so a safeguarding referral is reported, to ensure some support is offered to their patient in often complex situations. This lead in 2021/22 to the safeguarding team beginning to use social issues as a primary concern option. The addition of this sub category allows for easier identification of cases that are primarily due to social issues. This enables the team to provide meaningful feedback to the wider system.

Increasing care needs continues to be in the two concern types that the safeguarding team receive. These referrals although the initial concern is not overtly safeguarding, a review of a patients care needs by social care can often identify other concerns such as inadequate care

provision or identifying other unmet needs. Continued inadequate care provision can often lead to poor health outcomes leading to the possibility of more emergency and, urgent care being required. Cases in which SECAmb have had multi agency involvement with, have resulted in patients being moved to residential care homes (With their consent), where perhaps their needs can be better met.

More often than not self-neglect is categorised as increased care needs by the fact that someone is self-neglecting they have an unmet care need. Partners within social care have asked us to share our concerns we see re self-neglect as many cases that have reached Safeguarding Adult Review stage have often begun with self-neglecting behaviours.

Hoarding behaviours as a form of self-neglect, often can be an indicative factor of mental ill health worsening. The SECAmb safeguarding team have become an important ally in the work alongside our partner agencies, working with people who self-neglect, we have often been, especially in the earlier parts of 21/22, one of the only services seeing the inside of a person's home, as although a person may present to their GP/friends/family as a person coping with life their home can often show a different story of a person who is the beginning of their journey to perhaps needing social care support.

Research indicates that a person consenting to early help with an unmet care need will often not require further intensive support later. If there is no consent then the safeguarding team will work in collaboration with social care to establish if this person is already known or if the self-neglect has escalated to other areas of their lives, for example, hoarding behaviours are so severe that reaches Fire & Rescue Service thresholds for mandatory involvement.

Safeguarding referrals for children constitute 20% of the total number of referrals despite the under 18 population accounting for around 10%of SECAmb's workload. This is indicative of staff feeling confident to raise concerns when they identify family or child in need of support. The Specialist Safeguarding Practitioner, Safeguarding Lead and Safeguarding Nurse Consultant have continued to work collaboratively with NHS England safeguarding teams, Local Authorities, CCG, Local Authorities as well as other health partners such as hospitals, Midwifes, Health Visitors and GPs to ensure the pathways we use to send SECAmb referrals onto are correct and are meeting the needs of the making safeguarding personnel agenda.

Safeguarding on Call

The Safeguarding on call service started in September of 2020. Safeguarding on call is staffed by 2 Specialist Safeguarding Practitioners and one Safeguarding Lead, 356 days a year 24 hours a day on a rota basis. SECAmb are the only ambulance service across the country who offer a safeguarding on call service. It has proven to be effective, particularly outside office hours, where specialist safeguarding support was previously not available.

The aims of the service are

- To provide specialist safeguarding advice above and beyond what may be expected of our staff.
- Support with protracted incidents where there is a safeguarding element to support staff in a timelier total scene time and reduce job cycle times
- To enable staff to concentrate on the clinical element of an incident
- To provide links between other emergency services and/or social care
- Escalate concerns to other key services and system partners across the region

- To provide timely information to Child Death teams following a child death this ensures a timely response to the family as appropriate, support for staff immediately after a child death.
- Attend scenes only where necessary to provide specialist advice at incidents such as Free Births where clinicians are not expected to have the required skill set to deal with what can be a difficult scenario. A safeguarding specialist can provide support to the clinicians on scene allowing them to carry on caring for their patients.

Safeguarding on call ask for feedback to ensure we are meeting the needs of the staff who use the service and during the year 21/22 we took 204 calls.

Below are some examples of feedback and details of the incident below to give an idea of incidents we have supported with.

Incident 1

Complex call, for parent critically unwell following an overdose with four young children on scene. Father prevented from attending the property due to injunction, however clinician on scene unable to achieve police attendance, thereby delaying conveyance in a timely manner. On Call escalated to duty inspector and achieved Police patrol on scene promptly.

Feedback from clinician on scene

> '*I was feeling very out of my depth and the Police were not able to attend, on scene and having exhausted all avenues, I called Safeguarding on Call. I am so glad that I did, I spoke to a Safeguarding Practitioner, and she was amazing! Within 10 minutes I had the police at the door of the address to safeguard these 4 vulnerable (and potentially abused) children.'*

Incident 2

This incident was an ongoing issue where SECAmb Safeguarding Practitioners were working alongside Social Workers, Mental Health Professionals, and the patients GP.

The Patient repeatedly refused to work with partner agencies, and they felt their only option was to call the ambulance as the patient had been on the floor for an extended period and was becoming potentially very unwell.

In this complex situation, Safeguarding On-Call were able to offer advice and guidance to the clinicians involved, support their clinical decision making and reassure them what they were doing was appropriate. Using the expertise of the Safeguarding on call service the crew were able to determine the patient's mental capacity and make a best interest plan for this patient. Subsequently there was a safe hospital transfer and outcome for this patient.

Feedback from Clinicians Involved

> *Absolutely invaluable! Collaboration between the Safeguarding On Call and the Ashford Urgent Care Hub resolved a safeguarding and Mental Capacity issue which had been ongoing for almost a month. Where previous GP, Rapid Response had failed to safeguard the patient. A Teams meeting between SGOC and Ashford UCH, formulating a best interest plan and coordinated response to the patient where we were able to admit the patient to hospital after an extended period of laying on the floor and refusing admission.*

Incident 3
This incident involved an intoxicated Mother and her two-year-old. The crew had already been on scene for a while and, the mother was unfortunately not very forthcoming with information that would help them safeguard this patient and her child.

To support the crew and enable them to keep a short on scene time as necessary, Safeguarding on Call supported them by checking with Police, Social care, and NHS Spine that the details patient was giving was correct and establishing if the child on scene had another place of safety to go to. Sadly, the incident did take a turn with Mother becoming aggressive, so the advice to the crew changed, Police were contacted for support of taking Mum and Son to hospital as a place of safety

Feedback from Clinician at Scene

I spoke to the safeguarding on call team, during a difficult job overnight.

They were fantastically helpful throughout, providing both inputs, acting as a sounding board, and reassurance that our plans were appropriate.

Being able to delegate tasks such as contacting social services directly, consulting of NHS spine etc was very helpful in freeing me up at scene to focus on other tasks

Developments in Partnership Working

During 2021/22 SECAmb have been involved with working closely with a number of key partners but in particular the team supporting care homes in Surrey Heartlands ICS. As a result of this work the Trust supported the ICS and wider system partners to recognise a home in Surrey where a number of concerns demonstrated significant concerns for the residents' welfare and safety. This was shared with the CQC and SECAmb were commended in the exemplary work that was carried out to mitigate the risks for vulnerable members of the community.

The Safeguarding Team have worked alongside the Kent Health Visiting teams to develop a mechanism to highlight lower level concerns (eg minor injuries sustained at home) we have received for the youngest patients that we care for and their families. Engagement took place with service delivery leads across Kent to share the work of the ambulance service and the value of the information we hold and has been well received.

Safeguarding referrals that have a Mental Health element make up 31% of the referrals that the team process, with this in mind a new mental health pathway between Kent and Medway Partnership Trust and SECAmb was developed for referrals to be sent for Kent patients directly to them that met the agreed criteria. There are plans to expand this type of arrangement to other areas and localities across SECAmb's footprint during 2022/23.

Safeguarding training delivered and communications circulated throughout the year focused on the area of self-neglect and detrimental hoarding behaviour, including the relative fire risks associated with this behaviour. The training encourages staff to consider a referral to local Fire and Rescue services. Attempts to gain consent are always made, however if the hoarding reaches a pre-determined threshold where it is having an impact on others living in the household or others who live in close proximity, a referral without consent made be reached.

SECAmb have continued their partnership working with local authorities, specifically working with Brighton & Hove City Council and Surrey County Council to develop threshold documents that support the local authorities by streamlining pathways, easing pressure on their services. This process ensure that those vulnerable members of society can receive appropriate care and intervention in a timely and structured way.

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 2021-2022, SECAmb has reported on a total of 185 cases: 54 in Surrey, 76 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, Specialist Safeguarding Practitioners attending Joint Agency Review (JAR) meetings and Child Death Review Meetings (CDRM), representing, or supporting the operational staff. Child Death Overview Panels (CDOP) are attended at the Chair's request to provide SECAmb specific input for certain cases.

During 2021/22 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. During this year we also saw operational staff being able to observe these meetings remotely where it was felt appropriate. Feedback to the attending crews where they have been requested to be kept up to date is provided via email or where, if the Specialist Safeguarding Practitioners feel it is needed, or it has been requested as Covid restrictions were relaxed it was provided face to face.

The purpose of the CDOP process is to identify "modifiable factors" and 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. Following information shared at Sussex CDOP about the ICON programme (Information for parents about infant crying to avoid abusive head trauma) these principles were shared with NHS digital and incorporated into NHS Pathways.

A positive that has come out through the CDRM process is that through the Safeguarding on call provision we are now able to in real time able to inform the Child Death teams in each area that a child has died and is on their way to hospital. This enables Nurse Specialists for Child Death working within clinical commissioning to respond quicker e.g meet the family and crew at the hospital ensuring there is continued support for the family where needed.

As the ambulance service is often the first agency on scene of an incident and can 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 Child Mortality Database. During 2021/22 we began to start collecting more social and environmental information from attending crews by asking them to fill in a child death report form. This is often something that the staff themselves find helpful as a way of writing out what the scene looked like, who else was present and any other observations of note.

Specialist Safeguarding Practitioners now have a regular section on the Learning from Deaths agenda, chaired by the Deputy Medical Director, where they share learning for child deaths that SECAmb have been involved with.

Multi-Agency Safeguarding Assurance

Throughout 2021/22 SECAmb provided regular assurance about its safeguarding function to the Safeguarding Adults Boards, Safeguarding Children's Partnerships and Clinical Commissioners across Kent, Medway, Surrey and Sussex. Exception reporting and six-monthly 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.

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 in 2021/22 were requested to contribute to 70 enquires, an increase from 34 throughout 2020/21. The reason for this increase maybe multifactorial however it is likely to be as a result of increased response times meaning patients waiting longer for ambulances and social care providers working in a tight financial envelope meaning less community resources.

During 2021/22 SECAmb changed the way we record the S42s we receive by differentiating between those where the trust was considered at fault and those where the trust was asked to provide evidence. 13 S42s were about potential harm that a patient may have received in our care or where there has been a time delay. The other 66 were S42s that 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 bimonthly 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 experience whilst waiting for an ambulance.

Care Act - Section 42 Enquiry - case summary

Patient called 111 as her dog had bitten her ear
111 called back on several occasions but closed the call when no contact was made
The patient called back the following day as she had missed the calls and an ambulance was arranged

On hospital examination it was found the damage to the ear was significant and likely to have profound consequences for the patient as she was already hearing impaired and this impacted her ability to wear hearing aids
It was found that the original call have been handled effectively meaning a better experience for the patient and a greater chance of saving the ear.

Areas of learning Section 42 Enquiry
The Trust highlighted the fact that major trauma to the ear was not sufficiently recognised within the NHS Pathways triage system and raised to NHS digital for potential revision in future updates.

Requirements under Section 47 of the Children Act
Under the requirements of the Children Act (1989) a section 47 investigation will involve social care receiving a referral from SECAmb or another agency that results in a local authority 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 be due to the way our service is accessed. The Safeguarding Team supported 21 Section 47 enquiries during the reporting year.

Children's Act - Section 47 Enquiry - case summary
SECAmb were asked to participate in a strategy discussion for a child who we attended when intoxicated. When intoxicated the child disclosed that she had been sexually abused by her father. A Specialist Safeguarding Practitioner attended a strategy meeting and discussed our involvement in the case. SECAmb were thanked for their contribution and vigilance as this was the first time, she has disclosed said abuse.

A Section 17 enquiry 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 Section 17 investigations that SECAmb were asked to support during 2021/2022.

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 Safeguarding Practice Review, Safeguarding Adult Review, Safeguarding Adults Enquiry where delivery of NHS funded care caused or contributed towards the incident.

During 2021/22 the Trust declared 67 Sis, 7 of these had a safeguarding element because of adults or children at risk receiving sub-optimal clinical care where Local Authority safeguarding thresholds were met. An SI was declared because 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 coordinated by the safeguarding route included:

- Operation Carp – Theft by distraction burglaries of patient's medication by two staff members who are no longer employed.
- Time delays have been escalated via the SI process, during the SI process it has been looked at whether the time delay caused harm to the patient. If the case meets the criteria for a S42 then SECAmb will raise this.

Learning from SI investigations with safeguarding concerns are reviewed at the Trust's Safeguarding Sub-Group where any subsequent assurance or risks are escalated via the Clinical Governance route jointly chaired by the Executive Medical Director and Executive Director for Nursing & Quality.

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 2021/22 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 2021 – March 2022 SECAmb were asked to contribute Summaries of Involvement to commissioning Safeguarding Boards and Community Safety Partnerships to 54 an increase of 30 on the previous year SPRs/Rapid Reviews, 41 SARs an increase of 5 on the previous year and 14 DHRs across Kent & Medway, Surrey, Sussex and Hampshire. The number broken down into each local authority is:

- 1 Brighton and Hove SCR
- 2 East Sussex SAR
- 1 East Sussex DHR
- 9 SPR/Rapid Reviews Children East Sussex
- 7 DHR Surrey
- 17 SCR/Rapid Reviews Surrey
- 3- SAR Surrey
- 10 Rapid Review/Safeguarding Practice Reviews West Sussex
- 1 DHR West Sussex
- 5 DHR Kent
- 17 SCR/Rapid Reviews Kent
- 36 SAR Kent

Areas of wider learning following these reviews have been shared across the organisation using various methods, including training examples, to cascade.

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 eleven employees (0.25% 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

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 2021/22 allegations of a safeguarding nature were made against a total of 27 members of staff. 21 allegations met the threshold of the Managing Safeguarding Allegations policy. Safeguarding were consulted on the remaining cases but did not require escalation via the safeguarding route. This demonstrates over a 20% reduction compared to the previous year.

Concerns escalated via the safeguarding route included:

- allegations of sexual harassment and predatory behaviour 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 for the year from October 2020 – October 2021, the Safeguarding Lead and Nurse Consultant were requested to present a paper to a dedicated sub-group of

the trust's Quality and Patient Safety (QPS) Committee during the autumn of 2021. The sub-group 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: -

- The majority of alleged perpetrators in the above cases are male.
- 8 alleged perpetrators were female, one was engaging with another male perpetrator, 2 female perpetrators were engaging with each other
- Where concerns had been disclosed regarding the female perpetrators, only one was related to inappropriate sexual behaviour
- Where known, all the alleged victims are female.
- 12 cases relate to behaviours IN the workplace. 5 cases relate to conduct outside of the workplace and are a mixture of colleagues and unknown individuals. 52% of the cases relating to sexual harm involve contact with other SECAmb employees.
- 2 cases involving sexual harm involved conduct with or relating to children. This is a reduction in the number compared to last year's figures. The prevalence of paedophilia in the adult male population is notoriously difficult to measure, but it is often placed between 1-5% (this does not suggest 1-5% of people will act on or commit an offence). This suggests that whilst 2 cases in 15 months seems high, it is far less representative than in any similar sized cohort of individuals.
- 5 cases of domestic violence were recorded. In contrast to the observation above, it's known that domestic abuse and violence (DVA) is very prevalent in any given cohort, and estimates suggest between 1 in 3 and 1 in 7 women will experience DVA in a lifetime. This suggests that DVA is under reported.
- 15% (6) of cases involved patients, of these cases were 4 dismissed following review by the police. 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 some of the 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.

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 to three years. However, as has been highlighted previously in the report, 2020/21 and 2021/22 has seen how the global challenges of the coronavirus pandemic has had on the Trust's ability to deliver safeguarding training across the Trust.

The trust during 2021/22 has seen an increase in enquiries through the on-call service in regard to MCA queries.

The trust's MCA policy and procedure has been reviewed and updated in line with national guidelines and terms. This has been done with support from external subject matter experts at Surrey Heartlands and Surrey CC alongside colleagues within the trust.

Liberty Protection Standards information was delayed due to the Covid pandemic therefore information regarding this will be shared with staff where necessary as more information comes in.

12. Conclusion

Despite the significant challenges presented by the Covid-19 pandemic, 2021/22 we saw increasing demand on the safeguarding function 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.