NHS
South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	56/24

Name of meeting	Quality and Patient Safety Committee
Date	22nd August 2024
Name of paper	Annual Safeguarding Report
Responsible Executive	Margaret Dalziel 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 2023/2024 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>**

Best placed to *care,* the *best* place to *work*

Safeguarding Annual Report 2023/24

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Introduction

Throughout 2023/24 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.

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 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 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 2023/24
- Assurance that the Trust is meeting its statutory obligations and the required national standards about safeguarding
- An overview of any significant issues or risks regarding safeguarding and the actions being taken to mitigate these.

Highlights of 23/24

The safeguarding team had another busy year with referrals increasing nearly 20% as well as adapting to a new referral system in Datix Cloud.

A notable highlight was the Safeguarding Team being nominated for, and winning the Team of the Year award for 2023. An excerpt from one nomination is below;

> *'The team are fantastic. They're good to get on with. You can have open conversations with them. They're fantastic for shared decision making. So, I think it's only right that they're recognised. They're a very behind the scenes team but if you see how many patient contacts we have each year, how many colleagues we've got spanning the organisation they make an absolutely critical impact every day despite only being a very small number of actual people.'*

The Safeguarding Team have been working remotely since the start of Covid in March 2020, although this was critical for the safety of the team and their families, it quickly became clear as lockdowns were lifted, the team needed an office space to call its own. This space was needed to be a private space for the team to have those confidential discussions that the work requires. A space was found alongside Driver Training at East Grinstead this space has ensured a private space for case discussions, supervision, and a meeting space to work collaboratively together on.

Innovative work

To ensure the Safeguarding function continues to meet demand, other areas of focus and improvement throughout the year include:

- A threshold document for Nursing and Residential care homes to ensure referrals for these providers are being triaged and processed by the safeguarding team in the same way. This document agreed at Safeguarding Sub Group is the first in what will be a suite of documents to support the triaging of referrals. The patient safety benefits of this document ensures that each concern is shared with the correct team who can provide the appropriate support, training and any necessary quality improvement recommendations.
- Referral round table meetings, once a month the team comes together to review the current referral list and benchmark a range of them, discussing the concerns raised and where best to share if appropriate. This provides assurance that all of the team with its collective expertise are following local multidisciplinary policies and national guidance with the sharing of concerns raised for adults and children at risk.
- There was recognition of a gap in safeguarding training for new starters, where there seemed to be a very low uptake. The quality of safeguarding referrals was lower amongst this cohort of staff. Subsequently, a member of the Safeguarding Team developed a collection of video voiceover demonstrations of 5 bitesize pieces that all colleagues can access where needed.

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 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 (QPSC). 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 Quality & Nursing. 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 the Executive Director of Quality & Nursing 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
Specialist Safeguarding Practitioners	7	2
Safeguarding Coordinators	5	5.8

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 continued 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. The team continues to focus its efforts on delivering L3 training to all registered clinicians within the first 6 months of them starting and on a 3 yearly cycle alongside any requested bespoke training and safeguarding supervision.

Safeguarding Team Governance Days and Meetings

The safeguarding team have bi monthly -to-face Governance Days that to provide a forum to team build, to consolidate ways of working, including devising internal team Standard Operating Procedures. The team have welcomed several external speakers, that have developed greater understanding of areas such as non-accidental injuries suffered by children, the role of the Local Authority Designated Officer (LADO) and the Independent Chair of the West Sussex Safeguarding Adults Board.

Safeguarding Sub-Group (SSG)

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 Abuse Fatality Reviews, Safeguarding Adults Reviews or Section 11 returns.

SSG is regularly attended by external partner agencies including Designated Professionals from commissioning agencies and local authorities. Attendance from external partners provides increased opportunities for independent scrutiny of SECAmb's overall safeguarding practice.

SSG is chaired by the Nurse Consultant for Safeguarding, meets six times a year; key themes and discussions from SSG are escalated by exception to QGG jointly chaired by the Executive Medical Director and Executive Director of Quality & Nursing.

Provision of Regional Safeguarding Assurance

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. Similar assurance is also provided to the Kent & Medway (K&M) ICS regarding SECAmb's activity across its commissioned NHS111 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 Sussex ICS Designated Safeguarding team of Section 11 audits undertaken across the region
- 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
- Completion of two-yearly Self-Assessment Framework audits across Kent, Surrey and pan-Sussex

- 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 subgroups
- Participating in Surrey Heartlands ICS Designated Safeguarding team and SSCB and SSAB audits and inspections
- Providing quarterly assurance to K&M commissioners on SECAmb's NHS111 safeguarding provision
- Demonstrating the Trust's commitment to preventing modern slavery and human trafficking by evidencing a Modern Slavery Act statement on its public facing website

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 are in date. The policies are:

- Managing Safeguarding Allegations Policy and Procedure
- Safeguarding Policy and Procedure for Children, Young People & Adults
- Mental Capacity Act Policy
- Safeguarding Supervision Policy
- Domestic Abuse Workforce Policy

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 2023/24 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.

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 and web based learning, so learning via Microsoft Teams.

During 23/24 SECAmb welcomed international paramedics and Nurses to its workforce. As part of their Transition to Practice course bespoke safeguarding training that alongside pre reading and online learning covers elements of Level 2 and 3 training.

Level 3

During 23/24, 739 SECAmb staff completed Level 3 Safeguarding Adults and Child sessions delivered over Ms Teams with a PowerPoint presentation facilitated by a member of the safeguarding team. These sessions were interactive with Q&A sessions throughout as well as videos and images.

L3 compliance remains at 85% compliance across the Trust.

During 2023/2024, Safeguarding Level 3 training was continually refreshed with updated changes of legislation and recommendations from reviews that SECAmb featured SECAmb's contribution.

The cohort were asked to complete a feedback form with their thoughts and suggestions for improvement and to rate their knowledge pre and post training. Below are the results.

The overall trend was that participants felt that their knowledge improved because of completing their training. With all participants rating their knowledge at least fair/average with majority rating their knowledge as good.

The other key parts of the training focused on, raising concerns and, knowing where to go to seek extra support. It is clear from the feedback that those that undertook the training now feel they have the knowledge of where to go for support where needed.

Feedback from 215 staff members attending training between February 2023 – March 2024.

How would you rate your knowledge of safeguarding adults and children prior to this training? – Staff response

- 1% minimal
- 4% excellent
- 6% limited
- 37% good
- 52% fair/average

How would you rate your knowledge around safeguarding adults and children after undertaking this training ? – Staff response

- 8% fair/average
- 14% excellent
- 28% was left blank and not answered
- 50% good

How confident are you in your knowledge of the different types of abuse adults and children may experience? – Staff response

- 11% extremely

- 26% fairly
- 63% very

How confident do you feel in knowing how to raise a Safeguarding Allegation? – Staff response

- 1% Neutral
- 2% somewhat not confident
- 2% extremely not confident
- 45% somewhat confident
- 50% extremely confident

There was a 35% increase in staff response to good knowledge from pre-training to post-training.

250% increase in excellent knowledge from pre- to post-training.

The Safeguarding Team asked for suggestions on how to improve the training, many comments were extremely positive with a selection of them below.

- 38 said no improvements needed.
- ¼ of comments said face-to-face training
- Additional training for OTLS/EOCMs for complex situations as they are likely to be called to the scene to assist with scene management before on call is contacted this would be useful.

Lots of staff praised the course and the facilitators. It was felt any questions were answered promptly and well explained. The delivery was good and engaging throughout even after a heavy session. The facilitators had an empathetic approach and are extremely knowledgeable in their job roles. Staff said the trainers were warm and welcoming and delivered a good, structured course which was well led and informative. There were not any negative comments.

In Addition, bespoke training has been delivered to the Patient Experience and Wellbeing Teams.

Effective Supervision and Reflective Practice

The Safeguarding team in line with the Safeguarding Supervision Policy provide mandatory supervision to a set group of staff. Ad hoc supervision to all staff is provided that promotes reflective practice within these sessions.

During 23/24 peer supervision was undertaken with on a quarterly basis with South Central Ambulance Service Safeguarding team.

Effective Multi-Agency Working

2023/2024 Safeguarding Referral Information

The department has continued to see increases in referral activity. During the 2023/24 a total of 33,972 safeguarding referrals were made to local authorities across Kent, Surrey, Sussex and Hampshire. This equates to an increase of 16% increase

compared to the previous year. All referrals continue to be triaged by members of the Safeguarding team before forwarding to the relevant local authority.

During the winter of 2023/24 there was an increase in self-harm in patients with care and support needs or those patients who had dependents such as a child. We know this is reflected in referrals being made by our partners in other emergency care settings. We continue to contribute to multi-disciplinary meetings for children are presenting as high-risk self-harmers.

Safeguarding referrals for children constitute 22% 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 Practitioners, Safeguarding Lead and Safeguarding Nurse Consultant have continued to work collaboratively with NHS England safeguarding teams, Local Authorities, ICSs, Local Authorities as well as other health partners such as hospitals, Midwifes, Health Visitors and GPs to ensure the pathways used to send SECAmb referrals onto are correct and are meeting the needs of the Making Safeguarding Personal agenda.

The recognition by the SECAmb workforce of patients who have potential unmet care and support needs across a frail and vulnerable population are highlighted clearly in the safeguarding referrals received by the Safeguarding team for both self-neglect and increasing care needs. Although a portion of initial concerns may not be 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. It is also encouraging that in line with the Care Act 2014, SECAmb staff are recognising the rights of carers and referring with consent to the local authority for a carers assessment.

One of the six principles of safeguarding is prevention and working on the basis that it is better to act before harm happens. During 2023/24 SECAmb have contributed to several Safeguarding Adult Reviews commissioned by the Safeguarding Adults Boards across the region. Analysis of the initial contacts SECAmb had with the subjects of these reviews, the emerging concerns were not necessarily overtly safeguarding concerns, but were indicators that the individuals were beginning to struggle. These were people who ultimately died, or were at risk of dying, because of known or suspected abuse or neglect.

Despite the continued increase in referral number and subsequent pressure on the team's capacity there is overwhelming assurance that SECAmb are escalating concerns appropriately and in a timely way. This claim is further supported by regular meetings with heads of service across the SECAmb patch in both adult and children's social who confirm that there is very little and often no challenge is received regarding the levelling of referrals against local authority threshold of need documents.

Demonstrating Resilience

In January 2024 and in line with wider organisational incident reporting, the team moved from Datix Web to the new cloud-based referral system hosted on DCIQ. the team managed the challenges well and there was no recorded difference in the processing time of referrals. While there were difficulties caused by a high number of duplicate referrals, the team continued to prioritise referrals in line with the expectations of its business continuity procedures.

In the meantime, work is on-going with the Head of Patient Safety, the Incident Reporting Team and RLDatix to satisfactorily resolve the duplicates issue.

Safeguarding On-Call

The Safeguarding On-Call service is provided by 2 Specialist Safeguarding Practitioners and one Safeguarding Lead, 365 days a year, 24 hours a day on a rota basis. SECAmb is the only ambulance service across the country to offer round the clock access to a safeguarding specialist. It has proven to be effective and valuable, 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 it is meeting the needs of the staff who use the service and during the year 23/24 the on-call service took 542 calls, an increase from 497 since 22/23.

Below are some examples of feedback and details below to give an idea of vulnerable patients that have been supported.

> *I always find talking an incident through with whoever is on call so valuable. On one occasion we researched policies, cultural differences and law together which i found really interesting. We went through everything bit by bit and it really helped me have an understanding of what was actually happening on*

scene. i have always been met with a real professionalism and its always informative rather than just do this. You should be proud as a Team.

I attended a very stressful job where I was immediately concerned of the safety of two young children. I called the on call team and my call was answered by a lady which instantly put me an ease. She reminded very calm and took the time to listen to my concerns even though I had a lot to talk about. The lady that took my phone call was very knowledgeable and explained everything to me that was going to happen. The safeguarding lady called me back and kept me updated with what was going on so I could inform the hospital. I can not stress enough how professional she was and it went along away with me after going to such a tough job.

He was extremely helpful and very supportive I was very pleased with how they handled supporting me to reach a safe decision for the patient

A 999 call was received on a Friday evening from social care requesting SECAmb's attendance to an 11 year old child who was suffering neglect and self-neglect. The child had not left the house, attended school, or washed for several months.

Due to the low acuity of the call, a paramedic crew attended the patient on Saturday morning. The child was reluctant to engage and became quite distressed at the clinicians' presence and worry about attending A&E. Whilst a clinical review would have been well placed, it was not indicated as an emergency that day requiring immediate conveyance.

The clinicians on scene contacted Safeguarding On Call for support and, following discussion, the Children's Services Emergency Duty Team was contacted. A thorough discussion was held between a Specialist Safeguarding Practitioner and the Duty Social Worker, who agreed that conveyance to A&E was not appropriate for this child and a hospital admission should be one that had been formally arranged, with input from the mental health team. The Social Worker accepted responsibility for the child's case again and assured SECAmb she would make an urgent referral to the Emergency AMHP Team with a recommendation for assessment.

The clinicians were able to explain this plan to the child and their parents, who were satisfied that this was an appropriate plan and were most grateful for the care and support shown by SECAmb staff.

Developments in Partnership Working

The Safeguarding team have built good relationships with partners across social care and with the Designated Safeguarding Teams within the ICBs. This enables queries to be answered quickly where necessary to ensure there is no delay to patient care, it also raises the profile of the ambulance service within the wider safeguarding network.

Working in partnership with Sussex Police has seen improvements in joint working when sharing referrals. We have established a clear pathway to share concerns in a timely way particularly if there are concerns regarding potential areas of childhood neglect.

The Safeguarding Team continue to work with Worth Domestic Abuse services in West Sussex and started to explore similar pathways of information sharing and support with Domestic Abuse Services in Surrey, Kent, and Medway.

SECAmb reached out to Kent and Medway Adult Social Care teams to look at a new referral triage process for these areas, it would mirror the successful process already in place with Surrey and Brighton & Hove Adult Services. Initial feedback has been positive with regular update meetings taking place.

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 2023/2024, SECAmb has reported on a total of 142 cases: 54 in Surrey, 83 across Sussex including Brighton & Hove and 143 in Kent & Medway, 4 in Hampshire

Adult Death Reviews

SECAmb have contributed to several Adult Death Reviews (IJAMS) during 23/24 the aim of these reviews is to look for any learning that may have occurred in an unexpected adult death. No learning for SECAmb has been identified but the Senior Safeguarding Practitioners and Safeguarding Lead have contributed to wider multi-agency recommendations.

Multi-Agency Safeguarding Assurance

Throughout 2023/24 SECAmb provided regular assurance about its safeguarding function to the Safeguarding Adults Boards, Safeguarding Children's Partnerships and ICBs 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 ICB.

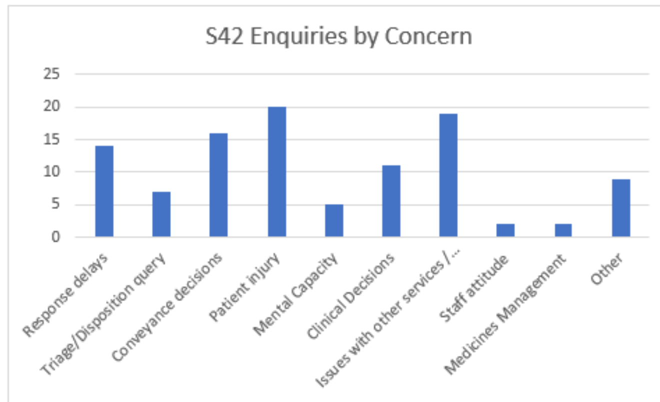
SECAmb's Contribution to wider Multi-Agency Enquiries

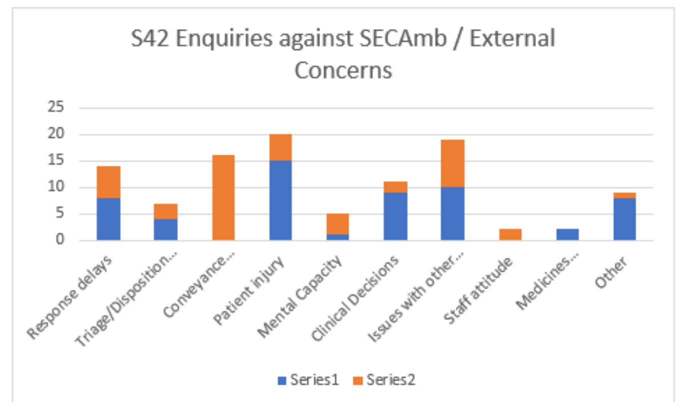
The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so,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

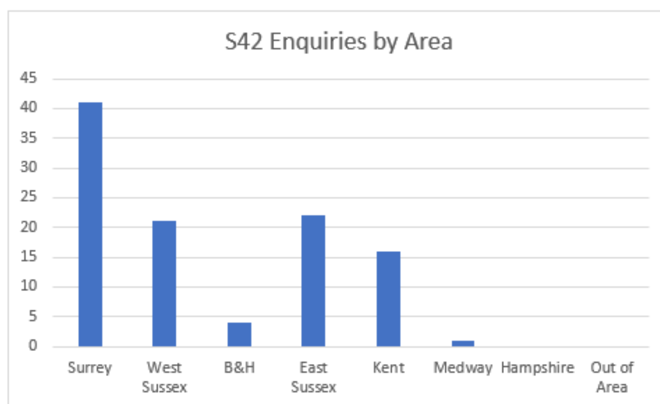
When an allegation about abuse or neglect has been made, an enquiry is undertaken to find out what, if anything, has happened.

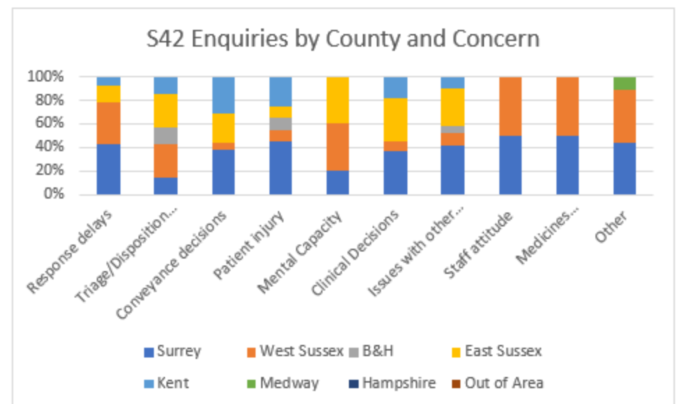
The findings from the enquiry are used to decide whether abuse has taken place, whether the adult at risk needs a protection plan and whether any wider learning can reduce future risk.

The Trust in 2023/2024 were requested to contribute to 157 safeguarding enquires, an increase from 134 throughout 2022/23. The graphs below show the split of concerns and the type of concerns raised.









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

A common theme of S42s during 23/24 has been self-neglect and capacity. During 23/24 the safeguarding team have produced training materials and learning posters on executive function and a part of this included self-neglect.

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 23 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 we received a call for via 111. The child was unwell was a high temperature that parents were struggling to manage. The family were refugees living in a cramped environment with a 15 month old child that had not had access to a GP or Health Visitor. A referral was made into social care to ensure follow up for the family and support with their unsuitable living arrangements.

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 2023/2024.

Reporting Serious Incidents (SIs)

The previously operated Serious Incident Framework was an investigation framework with a strict criterion to determine what must be investigated and how they are to be investigated, under the categorisation of 'Serious Incidents (SIs)'.

In January 2023 and in line with NHS England expectations, SECAmb retired its approach to the SI Framework and adopted the replacement Patient Safety Incident Response Framework (PSIRF). The PSIRF is a different way of working, by which it does not differentiate between the impact of patient safety incidents that have previously been deemed to have a higher harm threshold than others but allows trusts to decide different approaches in investigating patient safety harm events and themes to ensure the best use of resources, to engender learning and improvement. The new framework provides a much broader investigatory approach is to be taken toward incidents which fall within the framework.

Whilst previously under the SI Framework a distinction was made between incidents of moderate harm and above and all other incidents, PSIRF seeks to cover all incidents which caused, or had potential to cause harm. The Safeguarding Team are sighted on the incidents that are discussed at each weekly system Incident Response Group meeting.

Engaging in SPRs/SARs/DAFRs/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 2023.* The Care Act 2015 introduced the requirement to undertake Safeguarding Adult Reviews (SARs). Domestic Abuse Fatality Reviews (DAFRs) 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.

Throughout April 23 to March 24, SECAmb were asked to contribute a total of 128 Summaries of Involvement to commissioning Safeguarding Boards and Community Safety Partnerships this is an increase of 74 on the previous year.
The number broken down into each review type is:

- 41 Safeguarding Practice Reviews
- 46 Safeguarding Adult Review
- 49 Domestic Abuse Fatality Reviews

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

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 consider 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 police and process in place to respond to positive Disclosure and Barring Service (DBS) concerns. The current DBS policy is due for renewal in September 2024. 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 is chaired by a senior HR representative, and vice-chaired by the Safeguarding Lead, with expert input from HR, Operations, EOC, 111 and Community Resilience panel members. Occasionally the panel will draw upon expertise from other disciplines, such as Driving Standards or the Mental Health team. The HR representative will ensure that the decisions made, and the rationale for them, are captured, shared in a timely manner and held securely.

Many NHS Trusts do not undertake repeat DBS checks of staff following their appointment, but SECAmb continues to undertake regular checks as a responsible measure to safeguard the public from harm.

Outlined within the recent David Fuller inquiry into unlawful and inappropriate actions at MTW NHS Trust is a recommendation that *'… Trusts must assure themselves that they are compliant with their own current policy on criminal record checks and re-checks for staff.*'

The Trust has excellent compliance (>99%) with all staff having a role appropriate DBS in place dated within the last 3 years. However, the Senior Management Group have raised concerns following an Operations update that the Trust has a number of colleagues without in date DBS as there is no clear process in place to address this.

A small T&F Group has been established and led by the Assistant Director of HR Services and supported by Safeguarding and Operational leaders to update existing DBS processes and to ensure that the Fuller inquiry recommendation is robustly addressed.

Managing Safeguarding Allegations Involving Members of Staff

SECAmb is required to adhere to statutory guidance in Working Together to Safeguard Children 2023, 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 2023/24 the Trust received 34 allegations of a safeguarding nature that were overseen in accordance with the managing allegations policy and procedure. Notably there has been an increase in the number of allegations overall, especially those relating to sexual misconduct. Sexual misconduct (including cases of harassment, assault, and rape) has been a significant theme, making up almost 50 per cent of safeguarding allegations during 2023/24.

Concerns escalated via the safeguarding route included:

- Concerns where an employee's child is subject to Sec. 47 proceedings
- Procurement of Class A drugs
- Neglect of patients who have identified care and support needs

All cases have 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.

Assurance can be provided that Safeguarding involvement in allegations of a safeguarding nature ensures wider patient safety in supporting vulnerable individuals who suffered abuse because 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 ensures that referrals were made to the DBS where appropriate.

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.

There has been significant challenge on the Trust's MCA practice throughout 2023/24. Following the death by suicide of a patient who had recently been discharged by a clinician, the West Sussex Coroner questioned SECAmb's approach to mental capacity assessment in EOC.

In response assurance was provided to the coroner that all clinical staff receive Mental Capacity Act (MCA) training; uptake and compliance figures with the training remains high. MCA practice across the Trust is based on the five principles of the MCA and the presumption of capacity unless determined otherwise.

As an emergency service, it was suggested that the role of the Emergency Operations Centre (EOC) is to triage patients based on the presenting complaint and to signpost onto the most appropriate response or service. Clinicians in EOC do not case manage individual patients, neither do they have responsibility for agreeing a treatment management plan with the patient. The role of clinicians in EOC focuses on a more detailed triage to identify appropriate referral and signposting.

Learning from gaps in MCA highlights that the organisation has reasonable assurance that systems and processes are in place to ensure that relevant staff working with adults at risk are aware of the Mental Capacity Act and how and when to apply it. There is evidence recorded on the CAD and ePCR that clinicians at scene will escalate their concerns to PP Hubs, Clinical Support Desk and Critical Care Desk. However, decision making and mental capacity assessments are not always recorded appropriately.

There is evidence that staff are not always able to complete patient documentation in a way which provides evidence of mental capacity assessment. In particular, staff do not always record the evidence of how best interest decision making was achieved. Additionally, there is limited understanding of Executive Function of capacitated decision making.

Ongoing work and actions to address these deficits over the coming twelve months include:

- Training – focus on ability to decide and whether patients can carry out what they say they want to do.
- Focus on impact of executive functioning on mental capacity assessment
- Two minute briefing on Executive Functioning to raise profile of assessing capacity in practice
- Reported into QGG and QPSC – safeguarding annual report
- Working in partnership with students Bexhill College to produce a short film focuses on the principles of MCA and Executive Function
- Regular attendance at Teams C meetings to raise the profile of MCA, Best Interest Decision Making
- EPCR update now includes the ability to better evidence MCA assessment and best interest decision making
- During 2024/25 the Trust's Clinical Audit team will undertake a review of current MCA practice

Conclusion

During 2023/2024 there was 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. Continued partnership working with the Trust's key stakeholders demonstrates improved outcomes for vulnerable people across Kent, Medway, Surrey, and Sussex.

Learning from incidents, complaints and safeguarding reviews have allowed the team to contribute to organisational learning and the priorities for 2024/2025 will ensure that, despite the continued rise in the overall safeguarding activity, protection and learning will be central to the safeguarding function.