




Safeguarding Referrals Procedure

Contents

2	Procedure	2
3	Responsibilities	10
4	Audit and Review	11
5	References	11
6	Equality Analysis	12
	Appendix A: Safeguarding Referral Flowchart (999 service).....	13
	Appendix B: Safeguarding Referral Flowchart (EOC)	14
	Appendix C: Safeguarding Referral Flowchart (111 service).....	15
	Appendix D –.....	15
	PAP referral form	16
	 blank PAP referral form - NOV 2018.doc	16

Scope

- 1.1. This procedure defines the process for raising concerns regarding adults at risk and children and outlines how concerns are received and recorded in accordance with the Safeguarding Policy of South East Coast Ambulance Service NHS Foundation Trust (the Trust).

2 Procedure

- 2.1. Concerns regarding an adult or child can be identified at any stage of contact with patients and their families, for example during a telephone call, at the patients' home or during case reviews etc.
- 2.2. This procedure is aimed at supporting all Trust staff that have direct or indirect contact with patients where concerns are raised around patient safety and wellbeing, however, irrespective of the source of information, **any** member of Trust staff identifying a vulnerable person potentially at risk should follow the Trust's referral procedures by completing a safeguarding referral (child/adult at risk form). The following procedure must be followed by all Trust staff (this also includes private ambulance providers (PAP) working directly on behalf of SECAMB).
- 2.3. For concerns relating to members of the public who are not SECAMB patients, please see the Trust website safeguarding pages, or search for the relevant Adult/Child social care team to make a direct referral to the appropriate area team.
http://www.secamb.nhs.uk/about_us/our_performance/how_we_safeguard_patients.aspx. Assistance or support may also be sought from the safeguarding team.
- 2.4. If the concern is in relation to a member of SECAMB staff, support should be sought in the first instance from their line manager, if this is not an option for any reason, then alternative sources of support may be the Trust Wellbeing hub, HR, freedom to speak up guardian or the safeguarding team (safeguarding@secamb.nhs.uk) directly.
- 2.5. **Guidance for Trust Staff completing safeguarding referral forms**
 - 2.5.1. Trust staff can become aware of potential concerns from a variety of sources. These can include Emergency Operations Centre (EOC), 111 calls, from the person concerned, disclosure by a third party, or from visual signs such as physical injury or the environment in which the patient lives (e.g. the story given for an injury may be inconsistent with what is observed or very poor hygiene standards/hoarding behaviours/self-neglect).
 - 2.5.2. Safeguarding concerns relate to potentially abusive situations where others, who are providing care (paid, or unpaid) may be neglecting the needs of a patient, or causing physical harm etc. through their actions, or through their failure to act to keep a patient safe. These can include the actions of other care providers, or care delivered by SECAMB staff.

- 2.5.3. Social Care concerns relate to incidents where patients may possibly require care or support in the home either because of increasing care needs or social deprivation.
- 2.5.4. Observations about the condition of other adults or children in the household/environment might suggest risk (e.g. living in an environment where domestic abuse has taken place or carers suffering from a mental health crisis or struggling with substance misuse). Staff may observe hazards, or find signs of distress shown by others in the home. These may alert Trust staff to potential abuse or patients in need of safeguarding. The Care Act (2014) defines this as an adult who has needs for care and support (whether or not the local authority is meeting any of those needs) and is experiencing, or at risk of, abuse or neglect; and as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect. Working together to Safeguard Children (2015) describes the need for all Professionals working in universal services having a responsibility to identify the symptoms and triggers of abuse and neglect, to share that information and work together to provide children and young people with the help they need.
- 2.5.5. Trust staff may often be the first or only professionals on scene or in contact with the patient and the actions taken and accurate recording of information may be crucial to subsequent referrals or enquiries.
- 2.5.6. Staff should be mindful that they are not there to investigate concerns. The task for ambulance staff is to be aware of the signs of potential abuse, take a clear and appropriate history and to document all concerns in a factual manner.
- 2.5.7. Should Police be required (i.e. if the risk of harm is significant and immediate intervention is required) then this must be escalated immediately via EOC. Out of Hours social care may also need to be contacted, these details can be found via the SECamb website, or by performing an internet search. Staff in the Emergency Department (ED) should be informed of any concerns when handing over a patient and the Safeguarding Team must be informed (even if you have made a direct referral over the phone, or hospital/police colleagues also indicate that they will be completing a referral) using the safeguarding reporting procedures detailed below.
- 2.5.8. **Staff** (direct patient contact, including PAP) responsibilities are:
 - 2.5.8.1. To listen to the person telling them about the abuse.
 - 2.5.8.2. Following a dynamic risk assessment, ensure own safety and the safety of patients.
 - 2.5.8.3. To report the abuse via the appropriate channels.
 - 2.5.8.4. To make a detailed record of their observations and/or what they have been told.

- 2.5.8.5. To seek consent to share relevant information unless this will put the patient(s) or member of staff at risk. **Consent should always be sought where there are concerns around social care (adults) or early help (children) issues.**
- 2.5.9. In the event of Trust staff having concerns regarding abuse, they must do nothing to alert or confront the alleged abuser as this could result in a person either being abused further or being denied treatment. Wherever possible the person at risk should be removed to a place of safety.
- 2.5.10. Although carers should generally be kept informed of the actions required in the interest of the patient, including where staff feel that a safeguarding referral would be necessary, this may not always be practicable for Trust staff. It is particularly important that carers should not be informed of ambulance staffs concerns in circumstances when this may result in:
 - 2.5.10.1. A refusal to attend hospital/allow treatment;
 - 2.5.10.2. Any situation where a person at risk may be placed at further risk; or
 - 2.5.10.3. In cases where Trust staff are concerned that carers may be the person(s) alleged responsible for the abuse and informing them may lead to destruction or removal of any potential evidence.
 - 2.5.10.4. Trust staff should follow the normal history-taking route, taking particular note of any inconsistency in history and any unexplained/significant delay in calling for assistance. They should ask open questions, ideally away from any potential abusers, allowing opportunity for the patient to disclose abuse and making a full assessment including checking for marks/injury which may indicate non accidental injury. It is important not to ask leading questions or be judgemental about information received.
 - 2.5.10.5. Staff should try to listen and react appropriately to instil confidence. They should avoid unnecessary questioning or probing, as this may affect the credibility of subsequent evidence. **They should write down exactly what they have been told whenever possible.**
 - 2.5.10.6. Where it is not possible or appropriate to ask for consent (as outlined above) this **MUST** be clearly documented on the safeguarding referral. Context regarding why it was not possible to gain consent must be included (i.e. it was not possible to gain consent because the patient was unconscious, rather than just it was not possible to gain consent).
- 2.5.11. Staff should accept the explanations given, and not make any suggestions as to how an injury or incident may have happened. Similarly, if they are told of abuse, they should not question the person about it, but should accept what they are being told and act appropriately.
- 2.5.12. Staff should treat the presenting signs and symptoms normally and in line with clinical protocols. However, they should be particularly aware of the circumstances they were presented with and any verbal comments made to them about alleged abuse.

- 2.5.13. If someone says that they have been abused (disclosure) they should be moved to a private place if possible. Let them tell you what happened in their own words. Reassure them that they have done the right thing in telling someone about the abuse.
- 2.5.14. Staff should never promise to keep a secret. Tell the patient as soon as possible that the matter will have to be reported to at least one other person, as it is our duty to do this. This will give them the chance to stop talking if they are not happy for this to happen. If there is a direct report of, or staff suspect that a criminal incident has occurred, then Police should be contacted via EOC.
- 2.5.15. Staff must not talk to anyone who does not need to know about the allegation or suspicion of abuse, this includes witnesses if there were any, hospital reception staff, or other colleagues not directly involved in the case. By inadvertently telling the alleged abuser for example, any criminal investigation may be affected or compromised. Any discussions required with other professionals, such as hospital staff or police, who do need to be informed, must be undertaken as discreetly as possible.
- 2.5.16. Any allegation or suspicion of abuse must be taken seriously and reported immediately. Staff must complete a safeguarding referral form with as much detail as possible and follow this procedure for reporting the abuse, or neglect.
- 2.5.17. It should be remembered that as health professionals who may come into contact with adults at risk and children, we have a duty to report concerns about abuse. Information can be shared without patient consent if they are at risk of suffering or have suffered harm, or if it is in the interest of the public, however, best practice would involve gaining consent to share information and asking the person affected what action they would like to have taken whenever possible. If we do not report the disclosure or our concerns we may be putting the victim at greater risk, and may also discourage them from disclosing again, as they may feel they were not believed. Failure to share information as detailed above may put other people at risk.
- 2.5.18. Reporting concerns around social care issues, such as patients finding it difficult to cope in their home unsupported, can follow the same reporting process. Consent must be sought wherever possible for concerns of this nature as it may not be possible to share this type of information without consent. Please see flowchart at Appendix A regarding completing a referral.

2.6. **Transported Patients**

- 2.6.1. If the person at risk is the patient, and he/she is to be conveyed to hospital, staff should not let any carers know they have concerns if there is any suspicion of them being the person(s) alleged responsible for the abuse as this may result in refusal to go to hospital or destruction of evidence.

- 2.6.2. Patients must not be left unattended whilst preparing to convey or during any part of the transfer process. Additional vigilance should be used when conveying a child or a patient of any age who may be at risk of harm (i.e. from a third party causing harm, possible abduction or if the patient may be unable to keep themselves safe, for example if the patient has dementia).
- 2.6.3. Staff should ensure that the Patient Clinical Record (PCR) contains a brief outline of concerns and notes the name of the receiving member of staff at hospital. The verbal handover should include any social/safeguarding concerns which will enable the immediate involvement of the hospital social care teams if necessary. **A safeguarding referral MUST also be completed by Trust Staff giving full details of concerns.**
- 2.6.4. The referral form can be located through the Staff Zone of the SECAMB website (using the Safeguarding Referrals link - <https://secamb.sharepoint.com/sites/intranet/Pages/default.aspx>). This will open the correct referral form.
- 2.6.5. Completing the safeguarding referral must be considered part of the incident paperwork (such as PCR, falls referrals etc.) and should be completed as part of the incident task cycle wherever possible. The referral form can be accessed using a Trust iPad and ideally should be completed whilst with the patient. Staff will be allowed time to complete the referral form in line with this procedure and should inform EOC about the situation so that they can update the incident log.
- 2.6.6. If staff do not have access to an iPad, they will need to access a Trust computer to complete the referral. Each Trust site (including standby points) has a Trust computer which can be used to complete the referral. Staff will be allowed 15 minutes protected time to complete a referral, however, this may be interrupted to attend Cat 1 and Cat 2 calls. Staff unable to complete the referral because of operational need, should be stood down again as soon as possible to complete the referral.
- 2.6.7. Staff should not routinely be tasked to respond to calls other than Cat 1 or Cat 2 calls whilst making their way to an accessible computer. There may be occasions where lower graded calls may need to be allocated, however, it should not be undertaken as a matter of course.
- 2.6.8. If the form is not completed and submitted prior to being disturbed, unfortunately it cannot be saved to complete later. However, if the form is left 'open' partially completed and the computer is locked (this can be done by pressing the windows key and L at the same time or Ctrl + Alt + Delete then enter), the form will remain on the individual person's log-in on that computer for completion at a later point. Staff should ask to return to the same computer to complete the form if disturbed. Alternatively, staff may exceptionally (i.e. if the likelihood of returning to that particular site is remote), submit a partially completed form; this MUST be followed up with the remaining information being sent to the safeguarding team by SECAMB email to ensure that the record is completed in full. Failure to send the additional information may result in it not being possible to action

the referral. Partial forms must be identified by adding 'partial form' within one of the free-text boxes before submission.

2.6.9. Staff completing the safeguarding referral will be notified by automated email that their referral has been successfully sent at point of submission. This will be followed up by an email from the Safeguarding Team confirming onward submission to social care.

2.6.10. If inadequate time is allowed to complete the referral (i.e. staff are tasked to attend calls other than Cat 1 or 2, or are not returned to complete the form following being disturbed) the referral should still be completed, however the issues around completion must be reported to the safeguarding team by emailing safeguarding@secamb.nhs.uk.

2.6.11. PAP crews do not have access to datix and cannot make referrals using this method and must follow the process outlined below.

2.7. **Non-Transported Patients**

2.7.1. If the person at risk is the patient and they, or any carers refuse transport to hospital, EOC should be informed of the concerns and a safeguarding referral must be completed. Consideration must be made regarding the patient's mental capacity if they refuse treatment and the decision appears to be unwise i.e. it will have a detrimental effect on the patient's health and wellbeing; a capacity assessment should be undertaken (see Mental Capacity Act Policy)

2.7.2. In urgent cases, where there are concerns regarding the immediate safety of a patient, EOC should be asked to call the police and contact Social Services on the appropriate 24-hour emergency number (see SECamb website/internet search). Consideration with regard to contacting the Operational Duty Officer must be made by the EOC Manager (EOCM) on a case by case basis. In these cases the safeguarding referral must also be completed including outlining what actions have already been taken, and if known, by whom i.e. police, social worker etc.

2.8. **Concern for a person at risk who is not the patient**

2.8.1. If the person at risk is not the patient but the circumstances give cause for concern, staff should consider the implications of leaving that person behind should the patient require transport to hospital. This may include making arrangements for the care of the dependent person, such as contacting a family member, out of hours social care, including them in the transport to hospital etc. Details of any actions taken must be included on the safeguarding referral (i.e. child was left in the care of their Grandmother).

2.8.2. Some people can be at higher risk due to mental ill health, substance misuse (either their own or that of a person with caring responsibility), learning or physical disability or domestic abuse situation of a care giver. Consideration must be made regarding the person's immediate safety i.e. if they are a child and the parent needs to be taken to hospital. Any

safeguarding referral should include details of each person identified, multiple people can be included on the same referral by clicking the button marked 'add another' in the person affected section of the form.

2.9. **Special Circumstances**

- 2.9.1. In extreme circumstances, and providing it is safe to do so, it may be necessary to consider moving the patient/ person at risk to the safety of the ambulance for conveyance to the ED. **This is only advisable if the patient/ person at risk is in danger of immediate and significant harm.**
- 2.9.2. Under the Mental Capacity Act (MCA) (2005) Trust staff may remove any ADULT patient (MCA applies to adults and young people over the age of 16) to hospital without their consent if it is proportionate and in their best interest and **they do not have capacity to consent to treatment.** Best interest decisions should be based around what you reasonably believe the patient would have wished if they had the capacity to make a decision. If time allows, this decision should be made following consultation with family members/someone who knows the patient to try and ascertain what their wishes might have been. A capacity assessment and whether the patient was subject to a 'best interest' decision must be documented clearly on the PCR and Mental Capacity assessment and Best Interest plan forms. Capacity assessments and best interest decisions can only be applied to patient's over 16 years of age. See the Mental Capacity Act Policy.
- 2.9.3. Should this course of action be required, staff must inform EOC who may inform the police and receiving hospital should it be necessary i.e. risk of violence or potential crime (such as breach of the peace, criminal damage etc.). A safeguarding referral should also be completed.
- 2.10. **Emergency Operations Centre (EOC) (see flowchart – Appendix B)**
- 2.10.1. Any concerns identified regarding a possible child or adult at risk made during the initial telephone contact must be logged in the call notes.
- 2.10.2. Wherever possible, the concerns noted during a 999 call should be shared with an attending resource before their arrival at scene.
- 2.10.3. The Emergency Medical Advisor (EMA) MUST discuss their concerns with a senior member of staff within the EOC, this should be one of the clinicians based in the EOC so that concerns can be clarified and the safeguarding referral can be completed as fully as possible. If there is no clinician available, this should be discussed with the EOC Manager (EOCM).
- 2.10.4. If a Trust resource is dispatched to the incident, the EMA should try, wherever possible, to discuss the concerns noted during the 999 call with the attending clinicians to enable a decision to be made regarding the level of risk to the patient or others on scene and whether a safeguarding referral needs to be completed. This discussion and outcome, including

who is taking responsibility to complete the referral, must be added to the 999 call notes.

- 2.10.5. Either EOC staff and/or attending clinicians may complete the referral, multiple forms to reflect the different information/perspectives are permissible.
- 2.11. **111 Centre Staff (see flowchart – Appendix C)**
 - 2.11.1. Any concerns identified regarding a possible child or adult at risk made during the initial telephone contact must be identified in the call notes.
 - 2.11.2. If the concern is identified by a Health Advisor (HA) during initial triage of the call, this information must be clearly shared with the Clinical Advisor (CA) if the call is immediately transferred (warm transfer) for further intervention/discussion with the patient.
 - 2.11.3. There must be clear information regarding the concern placed in the notes by the HA if the call is passed to a CA to call the patient back. This will ensure that the CA is aware of the concerns and may be able to gather further information during their discussion with the patient.
 - 2.11.4. If the 111 call needs to be transferred to the 999 service, it would be good practice to share concerns so that the attending staff can be informed of these before arrival at scene.
 - 2.11.5. If no further contact is indicated following the call with the HA, the HA must discuss their concerns with a CA or Senior CA before completing a safeguarding referral. Consideration must be made as to whether an alternative, such as informing the patient's GP, might be more appropriate management for the patient's condition.
 - 2.11.6. HAs or CAs may complete the safeguarding referral
- 2.12. **Private Ambulance Providers (PAP)**
 - 2.12.1. The Trust uses the services of a number of PAPs whose crews are expected to follow the referral processes contained within this procedure.
 - 2.12.2. PAP staff do not have access to the Trust Staff Zone and so cannot complete their referrals using Datix in the same way as SECamb staff.
 - 2.12.3. PAP staff must complete the Trust safeguarding referral form on paper and so must ensure they have sufficient forms available at the start of their shift. The SECamb referral form can be found at Appendix D
 - 2.12.4. Once the referral form has been completed, the form must be sent securely to the safeguarding team for processing. This must be done using the SECamb scanning/printing system where the form should be scanned and emailed to safeguarding@secamb.nhs.uk .
 - 2.12.5. PAP staff must identify a SECamb member of staff at any station who must assist with this (the scanning system requires a SECamb ID badge to activate). Once the document has been scanned and sent, the original

document must be sealed in an envelope, clearly labelled as a safeguarding referral and placed securely with the PCRs for removal from station.

2.12.6. If there are no SECamb staff available on site, the safeguarding referral must be placed in an envelope and marked for the urgent attention of the Duty Operational Team Leader (OTL) with a request for them to scan and send the referral form to the email address above as soon as possible.

2.12.7. Referral forms **MUST NOT** be placed with the PCRs for collection prior to them being scanned and emailed to the safeguarding team.

2.13. **Safeguarding Team**

2.13.1. The completed safeguarding referrals will be notified to the Safeguarding (S/G) Team via the incident management system within Datix. Referrals will be reviewed and processed by the S/G team and forwarded to the appropriate social care area/team.

2.13.2. Referrals where the concerns are not clear or where there is a lack of information will be shared as above and the person making the referral will also be contacted to ask for clarification or further information as necessary, staff are expected to respond to these requests on their next working day. If a Trust resource attended the scene and the referral has not been generated by them, or does not reference their information they will be approached by email with a request to provide information gathered on scene.

2.13.3. Referrals from 111 staff, where further information is required will also be sent to the appropriate safeguarding liaison link (network) member of staff (depending on which 111 site the reporting member of staff works from) to help facilitate a response. Where there is a local operational safeguarding network member of staff (operational unit level), they will also be copied in to support this activity. An up to date list of these contacts will be held by the safeguarding team.

2.13.4. The S/G team will endeavour to gather feedback for each referral submitted by sending a feedback request form with each referral. This information will be used to inform future practice and target training as needed. Using this information to report at area/station/team level regarding general referral activity is planned. Once feedback has been obtained, reporting staff will be notified and the case will be closed on the database. Records will be retained in line with SECamb records management policy.

3 **Responsibilities**

3.1. The **Chief Executive Officer** retains overall responsibility for the adherence to, and delivery of this procedure.

3.2. The **Director of Nursing & Quality** is the Executive lead responsible for safeguarding within the Trust

- 3.3. The **Safeguarding Lead** is responsible for identifying the need for change to procedure as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives
- 3.4. **All staff** (for the purpose of this document, the term staff includes 111 centre staff at all locations and PAP working on behalf of SECAMB) must ensure that they are familiar with and follow this procedure when a person at risk of harm has been identified; this may be a child or young person who has not yet reached their 18th birthday or an adult (over 18). Safeguarding duties apply to any adult who: 'has needs for care and support (whether or not the local authority is meeting any of those needs) and; is experiencing, or at risk of, abuse or neglect; and as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect' (Care Act 2014).

4 Audit and Review

- 4.1. The procedure document will be reviewed annually for continued compliance and fully reviewed three yearly by the Safeguarding Lead.
- 4.2. These procedures will be monitored in line with the Trust's internal reporting agenda framework.
- 4.3. Safeguarding will be included in the annual clinical audit plan where appropriate.
- 4.4. Notwithstanding the above specifics, all procedures have their effectiveness audited by the responsible Management Group at regular intervals, and initially six months after a new policy is approved and disseminated.
- 4.5. Effectiveness will be reviewed using the tools set out in the Trust's Policy and Procedure for the Development and Management of Trust Policies and Procedures (also known as the Policy on Policies).
- 4.6. This document will be reviewed in its entirety every three years or sooner if new legislation, codes of practice or national standards are introduced, or if feedback from employees indicates that the policy is not working effectively.
- 4.7. All changes made to this procedure will go through the governance route for development and approval as set out in the Policy on Policies.

5 References

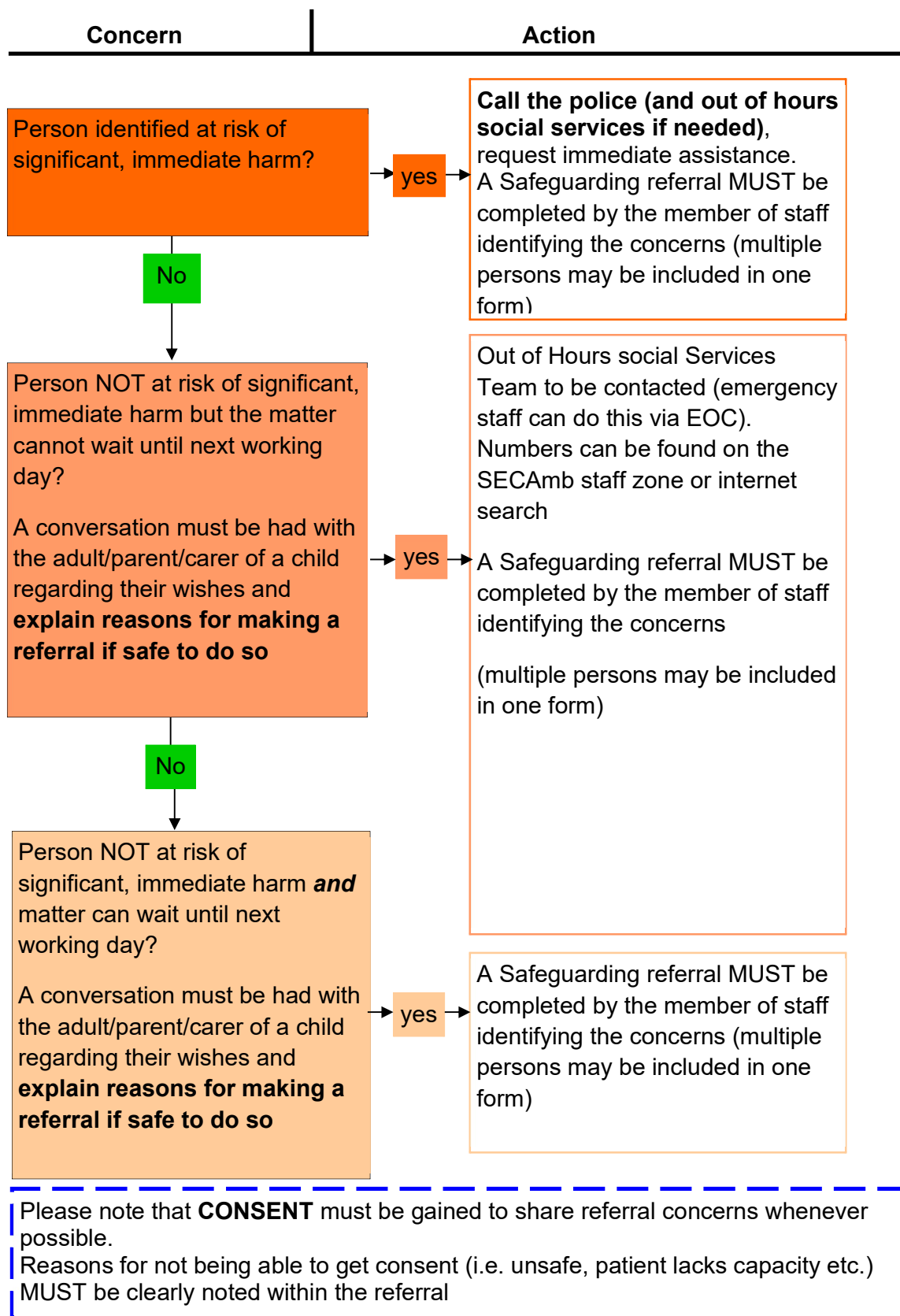
- 5.1. Working Together 2018.
- 5.2. The Children Act 1989 – updated 2004

- 5.3. Department of Health publication – Pre and post employment checks for all persons working in the NHS in England 2002.
- 5.4. HM Government publication – Statutory Guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004
- 5.5. Safeguarding vulnerable groups Act 2006
- 5.6. The Care Standards Act 2000.
- 5.7. Death by Indifference (Mencap 2007)
- 5.8. Understanding serious case reviews and their impact – a biennial analysis of serious case reviews 2005–07
- 5.9. Human Rights Act 1998
- 5.10. JRCALC (2006)
- 5.11. NICE guidelines CG89 – When to Suspect Child Maltreatment
- 5.12. Mental Capacity Act 2005
- 5.13. ACPO 2009 Guidance on Investigating Child Abuse and Safeguarding Children
- 5.14. Department of Health -Taskforce on the Health Aspects of Violence against Women and Children: Report from the Domestic Violence sub-group
- 5.15. The Care Act (2014)

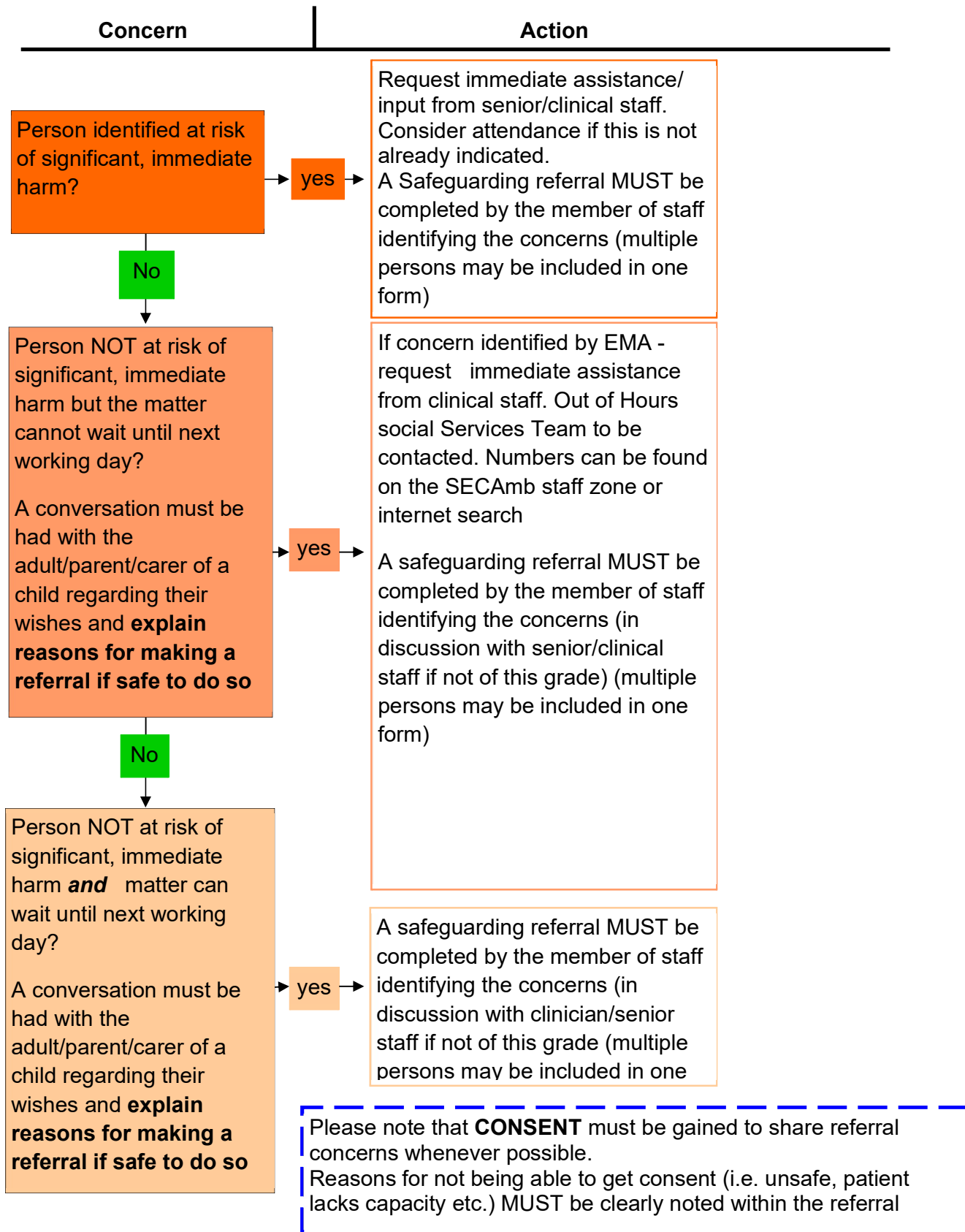
6 Equality Analysis

- 6.1. The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and exclude no-one. It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: Age, Disability, Race, Religion and Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity.
- 6.2. Compliance with the Public Sector Equality Duty: If a contractor carries out functions of a public nature then for the duration of the contract, the contractor or supplier would itself be considered a public authority and have the duty to comply with the equalities duties when carrying out those functions.

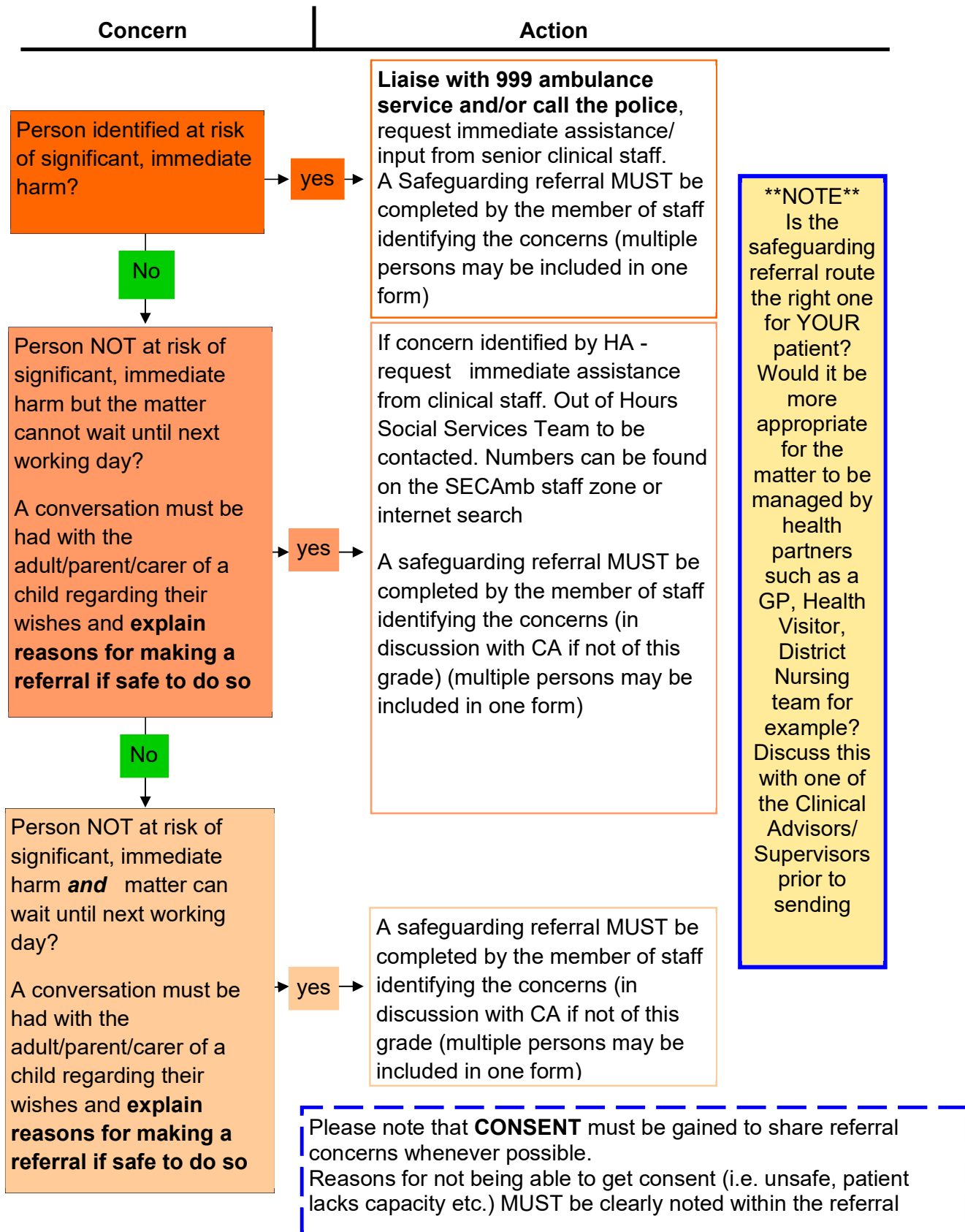
Appendix A: Safeguarding Referral Flowchart (999 service)



Appendix B: Safeguarding Referral Flowchart (EOC)



Appendix C: Safeguarding Referral Flowchart (111 service)



PAP referral form



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