London Ambulance Service NHS
NHS Trust

Safeguarding Annual Report

2017/18

In everything we do, we will provide

Care	Clinical Excellence	Commitment

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Introduction

In 2017/2018 the London Ambulance Service NHS Trust (LAS) has continued to ensure the safeguarding of children and “adults at risk” remains a focal point within the organisation and the Trust is committed to ensuring all persons within London are protected at all times.

The Safeguarding Team have worked hard to support staff, monitor and review safeguarding practice and raise the profile of Safeguarding during 2017-18 and have undertaken a number of audits and established several review group to assure practice.

The Trust serves a population of 8.78 million, covering 8,382 square miles and is made up of 32 boroughs.

The Trust responds to over 5000, 999 calls every day and in 2017/18 we raised safeguarding concerns for an average of 1.9% of incidents received. The Trust 111 service answered 356,826 calls and raised 699 safeguarding referrals and concerns in 2017/18.

This report provides evidence of the Trusts commitment to effective safeguarding processes and procedures. The report details the structure and assurance measures within the Trust to ensure compliance with the Care Quality Commission Key Lines of Enquiry, the Children Act 1989/2004, the Care Act 2014 and the NHS contract requirements.

The Trust has 64 Safeguarding Boards it engages with. This is either in attending meetings or providing information to support the work of the boards. The Trust has Brent Children and Adult Boards as its lead safeguarding board. Scrutiny of the Trust practice is assured through Brent. Reports and audits provided for Brent are also available to other boards across London.

Safeguarding Structure

Chief Quality Officer Trisha Bain
The Executive Director Lead for Safeguarding
Ensures that safeguarding is positioned as core business in strategic and operational plans. Oversees implements and monitors the ongoing assurance of safeguarding arrangements.
To ensure the adoption, implementation and auditing of policy and strategy in relation to Safeguarding

Non- Executive Director (NED)
Bob McFarland
The **NED lead for Safeguarding**
Ensures appropriate scrutiny and provides assurance of the Trust safeguarding performance to the Board

Head of Safeguarding & Prevent
Alan Taylor
The statutory **Named Professional for Safeguarding**. Responsible for ensuring the Trust is compliant with legislation and practices best practice in relation to safeguarding. Setting Trust strategic objectives and promoting good professional practice within the organisation. Ensure the Trusts acts to safeguard children, young people and adults at risk.

In everything we do, we will provide

Care Clinical Excellence Commitment

Safeguarding Team

The safeguarding team led by Alan Taylor Head of Safeguarding and Prevent consists of:

Safeguarding Specialist Children	Safeguarding Specialist Adults	Safeguarding Officer	Safeguarding Administrator	Safeguarding Supervision Manager
Ginika Achokwu	Julie Carpenter	Dawn Mountier	Elizabeth Ogundipe	Stuart West

The Safeguarding Team provides expert, evidence based clinical leadership on all aspects of the safeguarding agenda. The team has a responsibility for the development and implementation of systems and processes, working with partner agencies in line with local and national standards and legislation.
The team ensures the implementation of appropriate CQC core standards, and other relevant external targets and standards, contributing to national and local inspections and assessments of safeguarding arrangements. The team provides information and support to partner agencies for example in undertaking safeguarding investigations, Serious Case Reviews (SCR) Safeguarding Adult Reviews (SAR), Care Proceedings, Child Death Overview Panels (CDOP's), Section 42 enquiries, Domestic Homicide Reviews(DHR) and Multi Agency Risk Assessment Conference's (MARAC).

The team supported by local Quality Governance Assurance Managers (QGAMs) and Stakeholder Engagement Managers (SEMs) work with the Local Safeguarding Children Boards (LSCB) and Adult Safeguarding Boards (LSAB).

The Emergency Bed Service (EBS) managed by Alan Hay, processes all safeguarding concerns from staff and sends to the relevant local authority or partners. They have a close working relationship with the Safeguarding Team.

Trust Safeguarding Responsibilities

In addition to the responsibilities of the Executive and the Safeguarding Team outlined below are other staff responsibilities.

ALL Staff have a responsibility to report safeguarding concerns either in relation to the public or a member of staff

Local Safeguarding leads

Quality Governance Assurance Managers (QGAMs) and Stakeholder Engagement Managers (SEMs)

- Attend local Safeguarding Boards and other safeguarding meetings.
- Provide assurance on local partnership working to safeguarding team.

Emergency Bed Service

- Manage timely referral to social services via MASH (Multi Agency Safeguarding Hub) or Front Door.
- Collates information on referrals
- Receives feedback from the LA or referrals which is recorded on datix and feedback to staff.

Local Managers

- Support staff with safeguarding concerns, audit compliance of Clinical Performance Indicators and feedback to staff.
- Provide attendance at Rapid Response Meetings and support staff with safeguarding allegations which are referred to the Head of Safeguarding and Chief Quality Officer.

Governance Arrangements

The Trust has a Safeguarding Assurance Group (SAG) that meets Quarterly to monitor the Trusts safeguarding activity and provide assurance on safeguarding practice. The SAG has a sub group called the Safeguarding Operational Group (SOG) which the local safeguarding leads, Non-Emergency transport Service (NETs), EBS manager and NHS 111 attend. They provide assurance on safeguarding activity and this group provides two way communication of safeguarding compliance and partnership engagement.
The SAG reports to the Quality Oversight Group (QOG) quarterly providing assurance and raising issues for escalation.

QOG reports to Quality Assurance Group (QAG) which is the assurance committee of the Trust Board Chaired by Bob McFarland the Non-Executive Director.

Practice review groups established in 2017/18

- Child Death Review Group
- Safeguarding Incident Review Group
- Care Home Review Group
- Prevent Review Group.

Safeguarding Team are members of the LAS:-

- Serious Incident Group
- Mental Health Group
- Patient Experiences Group
- Patient Safety Group
- Mortality and Morbidity Review Group
- End Of Life Care Steering Group

Reporting arrangements

The Trust provides reports both internally and externally and produces in excess of 65 reports a year in relation to safeguarding. These include:-

- Monthly Scorecard and Key Performance Indicators (KPI) (see appendix one)
- Monthly Quality Report
- Monthly Area safeguarding reports
- Quarterly Safeguarding Health Outcomes Framework report for commissioners
- Quarterly Prevent Report
- Quarterly Report from Safeguarding Assurance Group to Quality Oversight Group
- Annual Section 11
- Annual Safeguarding Adults Risk Assessment Tool
- Annual Safeguarding Report

Any concerns identified by the Care Home Review Group are investigated and then if required reported to the CCG/CQC.

In addition information on attendance a Care Homes is also produced quarterly and provided to commissioners and CQC.

Safeguarding Risks

The Trust has a number of risks that have been mitigated during the year. The chart below shows the progress made in 2017/18.

Health and Safety Risk Tracker				Initial Risk Rating	Current Risk Rating	Target Risk Rating	Current position
Risk No.	Risk description	Risk Owner	Exec Lead		March		
63	There is a risk that the Trust is unable to meet the obligation of engagement with partner agencies notably MARAC Original Risk ID 426.	Alan Taylor	Trisha Bain	12	8	8	Closed
65	There is a risk that due to our inability to link safeguarding referrals	Alan Hay	Trisha Bain	12	4	4	Closed
69	Compliant with safeguarding training requirements for clinical and non-clinical staff.	Alan Taylor	Trisha Bain	12	8	4	Trust has now moved to ESR for recording all training. Agreed to reduce risk but to keep open as ESR still not 100% reliable with names etc. at present.
495	Children involved in youth violence may suffer greater harm as a result of a safeguarding referral not being made	Alan Taylor	Trisha Bain	12	6	6	Closed Referrals now being made to Red Thread in addition to local authority.

Current safeguarding risks held by other areas of the Trust.

EBS – Resourcing to enable move to 24/7 telephone referrals system and removal of fax machines.

EBS- Fall back business continuity

EBS- Delay of installation of taped line for governance and assurance

P&OD- Managers and clinical staff patient facing without current DBS

Safeguarding Work Plan

The work plan (see appendix one) is monitored by the SAG. Good progress has been made this year with all elements in the work plan. The only outstanding areas for completion are

1. The move to 24/7 telephone referrals for all safeguarding concerns and the recording of telephone lines within Emergency Bed Service who process safeguarding concerns.
2. Electronic solution for recording safeguarding supervision compliance.

Area	Number of actions for year	Number of Red actions	Number of Amber	Number of Green actions	Number of Blue actions
EBS	5		1		4
Equality and Vulnerable	2				2
Training	3				3
Strategic safeguarding	1				1
Child & Adult Safeguarding	4				4
Safeguarding Supervision	2		1		1
Red	• Not started or way off track & past completion date with no clear plan				
Amber	• Started but past the identified completion date but with a robust plan in place to achieve the action				
Green	• On track and within completion date				
Blue	• Complete				

Safeguarding Supervision

During 2017/18 the Trust has been supported by NHSE funding a Safeguarding Supervision Project Manager post to introduce safeguarding supervision across the Trust.

The Trust identified those key staff requiring supervision and have introduced both 1 to 1 and group supervision sessions in line with the Trust Safeguarding Supervision policy which was published in January 2018.

Number of supervision sessions in 2017/18

	Q3	Q4	Year End
Total Supervision Facilitated	13	13	26
• Group	10	11	20
• Individual	1	0	1
• Externally Facilitated	2	2	5
Mandatory Compliance	33%	60%	60%

Feedback from supervision sessions held	Yes	No
Did safeguarding supervision take place as arranged and on time?	**100%**	**0%**
Was the session private and free from interruption?	**100%**	**0%**
Did the supervisor explain the process of safeguarding supervision at the beginning of the session?	**100%**	**0%**
Did the supervisor explain the purpose of the safeguarding supervision agreement and supervision record?	**86%**	**14%**
Did you feel that that the safeguarding supervision was a safe and supportive learning environment?	**100%**	**0%**
Did safeguarding supervision meet your expectations (all or part)?*	**100%**	**0%**
Would you recommend safeguarding supervision to a colleague?	**100%**	**0%**

Safeguarding Internal Audits

During 2017/18 the Trust has undertaken a number of safeguarding audits, details of which are below.

- **Child Female Genital Mutilation**
- **Modern Slavery**
- **Adult Sexual Abuse**
- **Child Sexual Exploitation & Child Sexual Abuse**
- **Quality Assurance of the Referral Process**
- **Quality Assurance of Safeguarding Training Delivery**
- **Knowledge and Retention of Staff Learning**

The following pages outline the recommendations and outcomes.

Adult Sexual Abuse

Recommendation	Action Taken	Outcome
The feedback process post safeguarding referral needs to be more robust. The Local Authorities were contacted via a secure email however we only received 8.49 % feedback.	Head of Safeguarding to inform the Local Authority of the lack of feedback. Head of Safeguarding to write to local authorities	To be discussed at next London Safeguarding Adults Network (LSAN). Letter sent
Crews to ask the patient about abused when they are suspicious. Local Authority cannot act on a crew suspicion especially if the patient has not consented.	Included in level 2 safeguarding training CSR2017.2 and new recruits training	Closed
Increase staff awareness on the importance of Police involvement	Included in level 2 safeguarding training CSR2017.2 and new recruits training	Closed

Modern Slavery

Recommendation	Action Taken	Outcome
Consideration is given to having mandatory fields for contact information to be able to process concern	Explore if we can have an additional field for a contact number that has to be filled in	Meeting to be arranged as last one got cancelled.
Education is provided to EBS staff to ensure that all information fields are completed to enable concern to be raised and acted upon	Once the mandatory field is agreed, communication to go to EBS staff as to why this is important.	Ongoing
The EBS managers routinely review quality of data obtained and recorded	Included in Trust quality audit	Ongoing close
Staff receive further education in modern slavery	Included in safeguarding level 2 2017.2	Complete close

Female Genital Mutilation (FGM) Audit

Recommendation	Action Taken	Outcome
Work with local authority to improve feedback post submission of safeguarding referrals.	• Amended the referral document that is sent to the local authority (LA) to include an easier to complete feedback page • Raise issue of lack of feedback with boroughs	• Form being used by some boroughs and there has been an increase in the percentage of feedback received. • Feedback logged on Datix, crews sent email to view feedback. • Head of safeguarding and EBS manager to meet with MASH managers during 2018-19 to improve feedback percentage
EBS operation room managers to continue to review referrals before submission to the LA	Review of 'No sends' in Datix to be undertaken by specialist All reviewed by EBS operation room managers consideration to be given to auditing these in 2018-19	• Regular review undertaken by child specialist • Audit of EBS operations managers reviews added to audit plan for 2018-19
Safeguarding Children's specialist to quality assure EBS child referrals	Percentage audited in 2017-18 Specialist to continue to review when in EBS	Ongoing • Feeding back outcome to staff concerned.
Consider FGM update in Core Skills Refresher (CSR) 2018 – Mandatory reporting duty (Serious Crimes Act 2015). Including NHSE process flowchart.	To be considered for inclusion in 2018-19 safeguarding update	• Agreement to delivered training in CSR 2018.3. • If not then bulletin/ education to be distributed to staff.
Consider role of staff in EOC and FGM referrals particularly childbirth calls	Contacted Quality Assurance Manager, to ascertain how this data is captured.	• FGM bulletin circulated in EOC. • Awaiting response to question
Re-audit FGM referrals made in EBS	Included in safeguarding audit plan 2018-19	Open

Child Sexual Exploitation (CSE) and Sexual Abuse Audit

Recommendation	Action Taken	Outcome
Explore possibility of information sharing with Police in the Multi Agency Safeguarding Hub (MASH) around hot spots in their locality.	Initial contact made with Brent police	Implementation plan required
Explore possibility of directly referrals to Multi Agency Sexual Exploitation (MASE) Panels with Brent.	Initial contact made with MASE chair and coordinator in Brent	On going
Undertake an audit in 2018-19 with MASH colleagues/Team manager around the quality of information provided from the Trust.	Initial contact made with MASH team manager in Brent	Open
Undertake a re-audit of LAS referrals in 2018-19	Will be included in 2018-19 safeguarding audit plan	Open
Improve feedback immediately post submission of a referral and upon request.	• Amended the referral document that is sent to LA to include an easier to complete feedback page • Raise issue of lack of feedback with Boroughs. Head of safeguarding and EBS manager to meet with MASH managers.	• Form being used by some boroughs and there has been an increase in the percentage of feedback received. • Feedback logged on Datix, crews sent email to view feedback
Findings regarding ethnicity code to be shared with Trust Lead for Equality	• Provide report with findings to Trust Equality lead	
Additional training to be delivered to staff around professional curiosity	• Professional curiosity to be included in the Core Skills Refresher (CSR) training and in the Safeguarding Level 3 training	• Included in CSR 2017.3 completed
Raise awareness of CSE in LAS.	Information in the RIB for all staff, that included the SAFEGUARD pneumonic for national CSE Awareness day	• Continue to scope alternative methods to Raise awareness

Knowledge and retention of staff learning

Areas	Staff groups	Mean Score	Conclusions
East Area, Central, North East	Clinical Staff & NETS	85%	1. Small sample group 2. Re audit in 2018/19 with larger staff group 3. Link questions to CSR training previous year
HQ	Support Staff	50%	1. Small sample group 2. Re audit in 2018/19 with larger staff group 3. Link questions to e-learning

EBS Staff referrals quality audit

Number of staff	Total reviews	Percentage	Conclusions
16	50	25%-87.5%	1. The protected characteristics of ethnicity was not always recorded 2. Some questions were not always relevant to the referral being made. 3. The actual safeguarding concern was not always clearly documented

Both audits will be revised following learning and re audited in 2018-19

Safer Recruitment

During 2017-18 the Trust identified some issues with its "Safer Recruitment" processes. A full review was undertaken on staff requiring a Disclosure and Barring Service (DBS) check either basic or enhanced.
Action was taken to mitigate any risk to the public and an action plan was created to identify all DBS related activities. This covers all Trust staff including Bank, the DBS policy (including arrangements for agency staff and voluntary responders), ESR DBS records, data quality, audits, training, reporting and monitoring
Progress against this plan is being monitored by the P&OD Committee and reports providing assurance are also provided to the SAG.
The Trust committed in 2016 to undertake a re check on all patient facing staff following the Savile Enquiry which will be complete by September 2019

Child Protection Information Sharing CP-IS

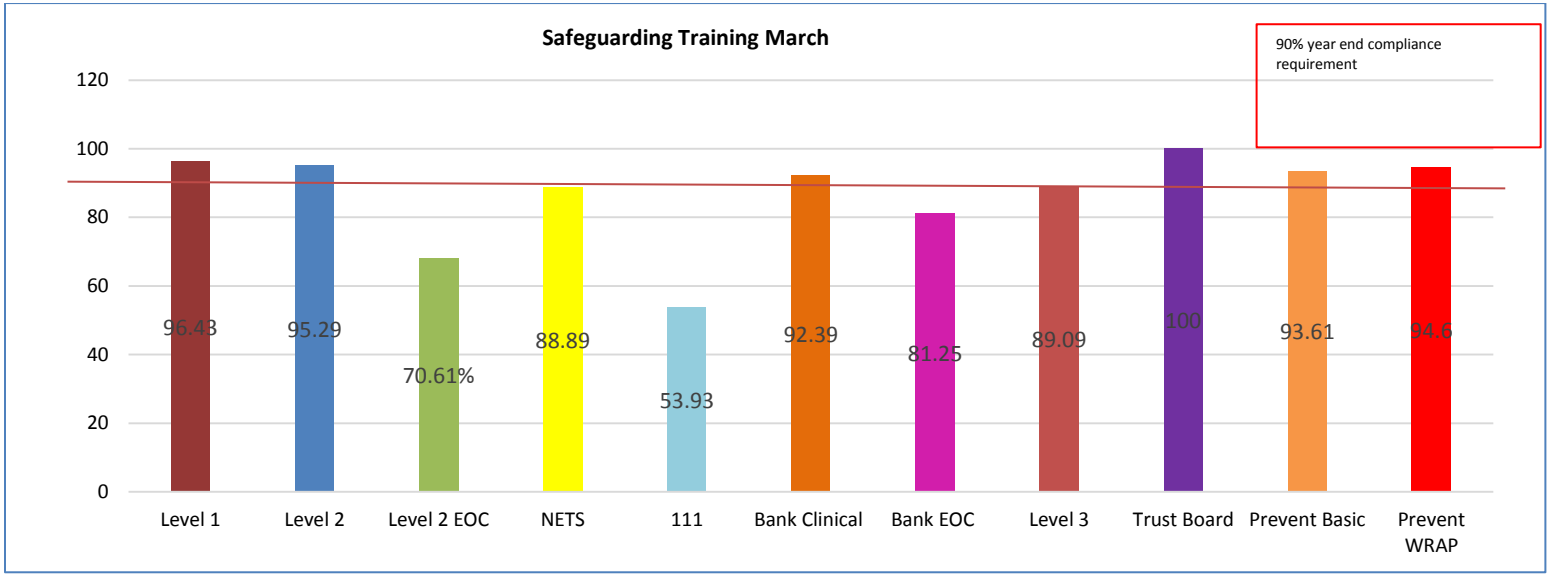
CP-IS scheme is a national project lead by NHSE to ensure agencies share information of children or unborn children who are subject to a child protection plan. Local authorities are uploading CP plan flags onto the NHS spine. There is a requirement for all NHS staff to access this information when dealing with patients, this information will add decision making.
The Trust has this year introduced CP-IS into "Hear and Treat" in our control room for call we do not send a response too.

The National CP-IS team asked ambulance trusts to not implement this further at present, as it has raised issues in relation to the number of notifications being sent to the local authority.

Safeguarding Education & Training

An extensive amount of safeguarding training has been undertaken during 2017-18. The Trust is compliant (> 90%) with Level 1, Operations Level 2, Bank Clinical staff, Trust Board and Basic Prevent and Prevent Health Wrap.

Areas with non-compliance were EOC& EOC bank Level 2, 111 Level 2 and NETS Level 2.
Level 3 was 89% and a further course was held in April 2018.



Also **86.42%** of Trust clinical staff have completed training in **MCA, capacity and consent** training and **83.77%** in **Duty of Candour** training.

Dementia Initiatives

The Trust has had a focus on dementia this year. Below highlights some of the work undertaken.

Dementia Care Training
Provided in Safeguarding Level 2 training in 2017-18

Safeguarding Specialist for Adults trained as a Dementia Friends Champion

The Trust developed a set of 4 dementia films in 2016 which were used in the Trusts training in 2017 and also shared with national ambulance partners. DVD was shortlisted for a Patient Safety Award.

Trust took part in "World Dementia Day"

Held Dementia Friends Awareness Sessions throughout the day.

90/100 (tbc) staff have had Dementia awareness session.

Dementia Friends

Two members of staff completed UCL Dementia Care Leadership and Quality Improvement 5 Day course. This included completing Quality Improvement Projects focusing on staff dementia awareness

Article on dementia published in Trust Clinical News on "Understanding Dementia"

Youth Violence

Public Education and Partnership working

The Trust's Patient and Public Education Team receive requests and manage the delivery of our knife crime presentation from many different agencies across London. Our knife crime presentation covers information on the injuries and potential fatal consequences of knife crime staff discuss their personal experiences of dealing with stabbings. On some occasions we incorporate basic first aid advice about how to safely deal with stab wounds and what to do when someone stops breathing. The sessions last up to an hour, and is delivered up to 6 times a day depending on the total number of children.

Youth violence events attended from April 2017 to March 2018

Total number of children across London who received knife crime session =4500-5000

Total number of educational establishments visited =50

Title	Partnership	Number of events	Audience	Area/Borough
Your life you choose	Local Magistrates in conjunction with Police and Prison service	11	Years 7 and Year 8	Brent and Newham
Gangs – Making the right Choices	Police	4	Year 6	Enfield
Impact Factor	Police, London Fire Brigade (LFB) and charitable organisations	9	Years 7-9	Haringey, Central and East London
Pupil Referral Units	Police	2	PRU Age	Redbridge, Barking and Dagenham
Redbridge Schools	Police and ex-gang member/ bereaved parent	3	Year 8	Redbridge
Gangs call in	Old Bailey	2		Old Bailey
Youth offending Teams	Police	8	Years 14yrs-18yrs	Croydon x2, Redbridge x2, Haringey, Bromleyx3
Operations Crest	Police and ex-gang member/ bereaved parent	6	Year 8	Haringey, Enfield
School visits	Education	5	Years 6 to Year 11	Newham, Waltham Forest, Greenwich, Croydon, Brent

Youth Violence

Safeguarding referrals in relation to youth violence

The Trust has raised **214 safeguarding referrals** with Local Authority/ MASH partners across London in 2017-18.

In December 2017 the Trust established an information sharing agreement with Red Thread who support and enable young people to lead healthy, safe and happy lives, working with them in the "teachable moment" after a serious injury.

We have made **46 notifications to Red Thread** to date.

Attendance to incidents of stabbings and shootings

We attend on average over **50 incidents a month** (for PRF code stabbed/shot/weapon wounds) in 2017-18; this has risen from 35 a month in 2016/17

Staff education

In our safeguarding refresher training in 2016-17 we included a session on Children and Gangs which was delivered to 77% of staff. The information has also been included in our core safeguarding level 2-3 training for all new clinical staff. We also produced a poster for staff on knife crime and the importance of making a safeguarding referral and contacting police as our compliance with referrals was initial only 40% which was distributed across the Trust.

Prevent

The Head of Safeguarding is the Prevent Lead for the Trust. The Trust has a Prevent policy and concerns are raised by staff via our safeguarding processes.
The Trust has a requirement to ensure all staff are trained to the required level in Prevent (See training records).
The Trust completes a quarterly report for NHSE covering all elements of Prevent training and referrals.

The Trust Prevent Review Group reviews all Prevent referrals made by staff the group membership is the Head of Safeguarding/ Prevent Lead, the Emergency Planning Manager with oversight Prevent and the EBS Manager.

During 2017-18 the LAS raised 24 Prevent concerns with the Local Authority

The Trust currently raises concerns with the local authority as opposed to Prevent Channel Panels. This is in accordance with London Prevent Procedures.

Information Sharing

The Trust has a duty to share information to protect children and adults at risk. The Trust shares information on staff concerns for a vulnerable person to the local authority. The Trust also has information sharing agreements with several other safeguarding partners namely:-

women's aid until women & children are safe www.womensaid.org.uk

LFB LONDON FIRE BRIGADE

Red thread Youth work, health and education

METROPOLITAN POLICE

The Trust follows guidance in the London Multi Agencies Safeguarding Policy and Procedures and "Working Together" Document. The Trust will only share information that is relevant to protect the individual.

Child Protection Information Sharing

The Trust is currently implementing the national Child Protection- Information Sharing (CP-IS) project.

This will enable the Trust to see when a child is on a child protection plan and will aid staff decision making on the best course of action to be taken. In addition when the record is accessed a notification will be sent to the local authority concerned to inform them that a child has accessed the Trusts unscheduled care.

The Trust is adopting a phased approach to introducing CP-IS , the first phase has been introduced within our "hear and treat" incidents (telephone only) and staff check the NHS Spine to aid decision making for all children and pregnant females.

Multi Agency Risk Assessment Conference (MARAC)

MARACs are meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. By bringing all agencies together at a risk focused MARAC, coordinated safety plans can be drawn up to support the victim. Over 260 MARACs are operating across England, Wales and Northern Ireland managing over 55000 cases a year. The Trust does not attend MARAC meetings but provides information to support discussions. In 2017/18 the LAS has supported the following:-

Multi Agency Risk Assessment Conference (MARAC)			
Year	2015-16	2016-17	2017-18
Number	1332	1439	1910

Child Death

The Local Safeguarding Children Boards (LSCB) are responsible for ensuring that a review of each unexpected death of a child who resides in their area is undertaken by the Child Death Overview Panel (CDOP). The CDOP has a fixed core membership drawn from organisations represented on LSCBs with flexibility to co-opt other relevant professionals to discuss certain types of death as and when appropriate (Working Together 2015).

The Trust has a duty to provide information to the CDOP on child deaths we have been involved with, along with attending meetings when required.

Child Death Over View Panel Requests			
Year	2015-16	2016-17	2017-18
	165	206	230

All unexpected child deaths the Trust receives notification of, are reviewed by the Child Death Review Group and any concerns identified are escalated to the Trusts Serious Incident Group.

Trust Child Death Reviews 2017-18	
Number reviewed	119
No further action	102
Number referred for Serious Incident Group Consideration	17
Number declared	4

Domestic Homicide Reviews (DHR)

A DHR is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have been as a result of violence, abuse or neglect by a person to whom they were related or with whom they had been in an intimate personal relationship. The local authority commission the DHR and our local managers attend when requested.

Domestic Homicide Reviews			
Year	2015-16	2016-17	2017-18
Number	4	5	5

Serious Case Reviews (SCR)

A SCR is undertaken when abuse or neglect of a child is known or suspected; and either, the child has died or the child has been seriously harmed and there is a cause for concern about partnership working.

Serious Case Reviews (SCR)									
Borough	**Gender**	**Age**	**Type of abuse**	**Type of Case**	**Borough**	**Gender**	**Age**	**Type of abuse**	**Type of Case**
Barking & Dagenham	Male	3	Fabricated and Induced Illness (FII)	SCR	Hackney	Male Female Female Male Female	1 1 15 16 19	Physical Suicide Hanging Suicide Suffocation Suicide	SCR SCR SCR SCR
Barnet	Female	15	Suicide by Hanging	SCR	Haringey	Female	5	Parental Neglect	SCR
Bromley	Female Male Male Male	15 5 17 19	Suicide by Hanging Unknown Stabbed Emotional	SCR Learning Review Learning Review Learning Review	Havering	Female	7	Parental Neglect	Potential
Croydon	Male Female Male Male Various	17,16 11,4 16 15 Teenagers	Severe Neglect RTC – Stolen Moped Stabbed Various – Stabbed (? Gang Related) Mental Health	Thematic Learning Review SCR Thematic Learning Review search on 58 children Results were found for 15	Hounslow	Female	17	Suicide Hanging	SCR
Essex	Female	7 Months	Unknown	SCR	Kingston	Male	4 months	Parental Neglect	SCR
					Lewisham	Male Female Male	11 2 Months 4	Parental Neglect Neglect/Co sleeping Physical	SCR SCR SCR

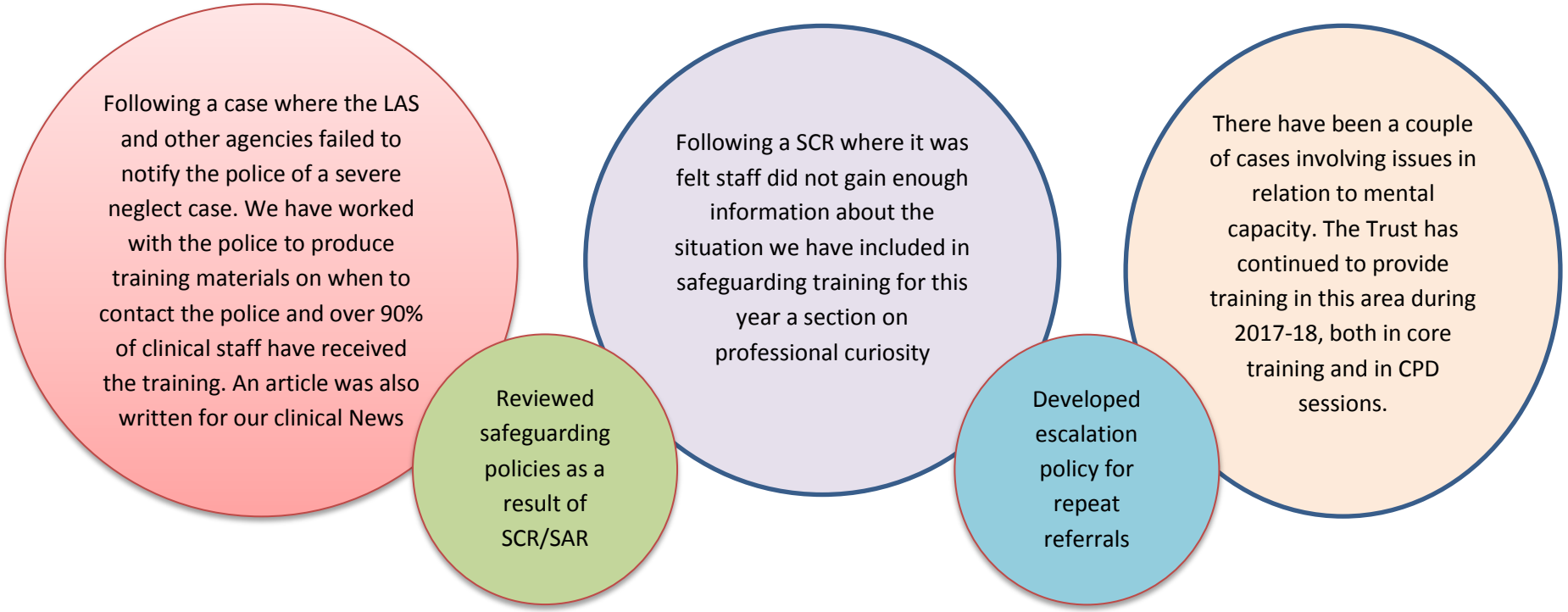
Safeguarding Adult Reviews (SAR)

A SAR is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place. The purpose of a SAR is not to apportion blame. It is to promote effective learning and improvement to prevent future deaths or serious harm occurring again.

Safeguarding Adult Reviews (SAR)				
Borough	**Gender**	**Age**	**Type of abuse**	**Type of Case**
Greenwich	Female	75	? Neglect	SAR
Hackney	Female	72	Self-Neglect	SAR
Havering	Male	94	Suicide	SAR
Lewisham	Male	46	Mental Health, Alcoholic	SAR
Wandsworth	Female	77	Unexpected Adult Death	SAR

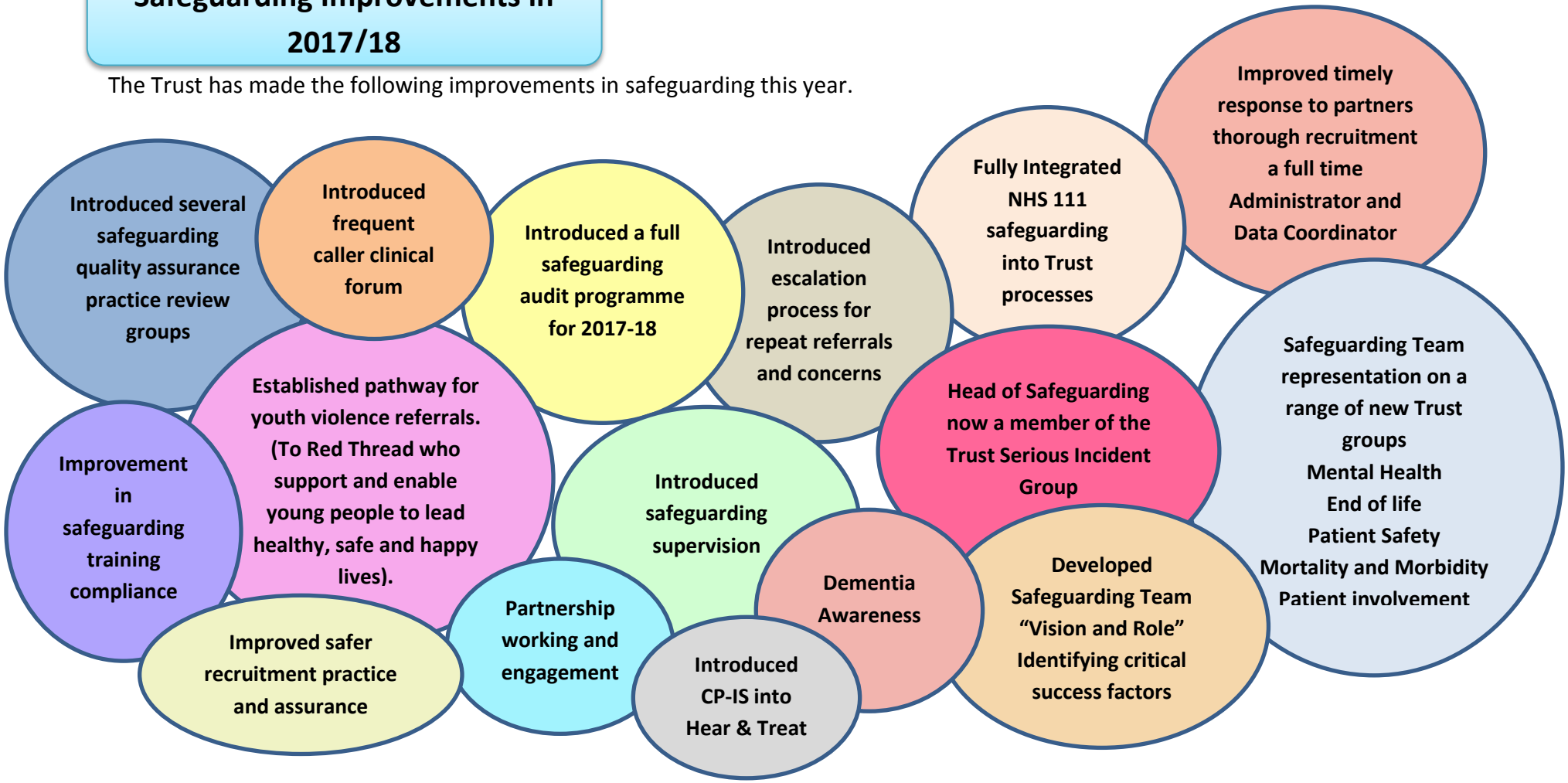
Learning from Reviews

The Trust continually seeks to learn from practice and detailed below is some of the learning the Trust has identified during 2017/18 and actions that have been put in place to ensure learning is embedded into practice. The main learning for 2017-18 has been



Safeguarding Improvements in 2017/18

The Trust has made the following improvements in safeguarding this year.



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Partnership Working

The Trust undertakes a considerable amount of partnership working in relation to safeguarding, the chart on the next page show the engagement with local boroughs in relation to safeguarding meetings.

In addition to these meetings the Trust is a member of the London Safeguarding Adult Board and London Safeguarding Children Board, as well as being a member of the London Safeguarding Adult Network and London Professionals' Network. The Child and Adult Specialists also attend the NHSE child and adult safeguarding groups.

The Trust is engaged with partnership working with all the agencies shown on this page and also engages with the 64 safeguarding boards in London, using Brent as our lead board as our commissioners are based in Brent.

We also provide information on domestic abuse to a number of MARACs and make referrals to Women's Aid.

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2017-18 LAS Local Sector Partnership Engagement												
SCB- Safeguarding Childrens Boards SAB- Safeguarding Adults Boards RRM- Rapid Response Meeting DHR- Domestic Homicide Review SCR- Serious Case Review SAR- Serious Aldult Review	SCB	SAB	Sub group	RRM	DHR	SAR	SCR	Strategy Meeting	Other	TotalAttendance	Total Apologies	Total Invites
North West												
Tri boroughs (West,Ham & Ful , Ken &Ch)				2						2	0	2
Ealing	1			4	1				2	8	0	8
Hounslow					1	1				2	2	4
Brent	1	1		2						4	1	5
Hillingdon				3		1		1		5	2	7
Harrow				5				3		8	6	14
North West Sector Totals	2	1	0	16	2	2	0	4	2	29	11	40
North Central												
Camden				1					1	2	5	7
Enfield	1			5		4		1	1	12	4	16
Haringey	1	1		3		3		1		9	4	13
Barnet		1		3						4	4	8
Islington										0	6	6
North Sector Totals	2	2	0	12	0	7	0	2	2	27	23	50
North East												
Hackney				2		1			1	4	4	8
Newham				6						6	4	10
Tower Hamlets				2				2		4	9	13
Waltham Forest				5						5	6	11
Barking & Dagenham				2			4			6	7	13
Havering				2		1				3	2	5
Redbridge				2						2	4	6
North East Sector Totals	0	0	0	21	0	2	4	2	1	30	36	66
South East												
Bexley		1		4	2	1	2	2	1	13	3	16
Bromley		1		9				1		11	3	14
Lambeth		1		1						2	1	3
Lewisham		1		11	3	1	3	1		20	4	24
Southwark				7						7	3	10
Greenwich		1		6						7	2	9
South East Sector Totals	0	5	0	38	5	2	5	4	1	60	16	76
South West												
Croydon	1	1		8			5	1	5	21	2	23
Kingston	1	1		3			1	1	1	8	4	12
Richmond	1			1		2		2		6	0	6
Merton				3				1		4	0	4
Sutton				2		1		2	1	6	3	9
Wandsworth		1		4		1				6	2	8
South West Sector Totals	3	3	0	21	0	4	6	7	7	51	11	62
Trust Totals	7	11	0	108	7	17	15	19	13	197	97	294

2017-18 has been a challenging year for the Trust with an increase in incidents and pressures on the Trust.

This has impacted on the Trusts ability to attend all the meeting requests in relation to safeguarding it receives.

The Trust prioritises attendance at **Rapid Response Meetings attending over 108** during the year.

In all the **Trust attended over 197** meetings within London boroughs. In addition to this we also attended the London Safeguarding Children Board and London Safeguarding Adult Board meetings quarterly as well as professionals meetings and NHSE providers meetings and London Safeguarding Adult Network.

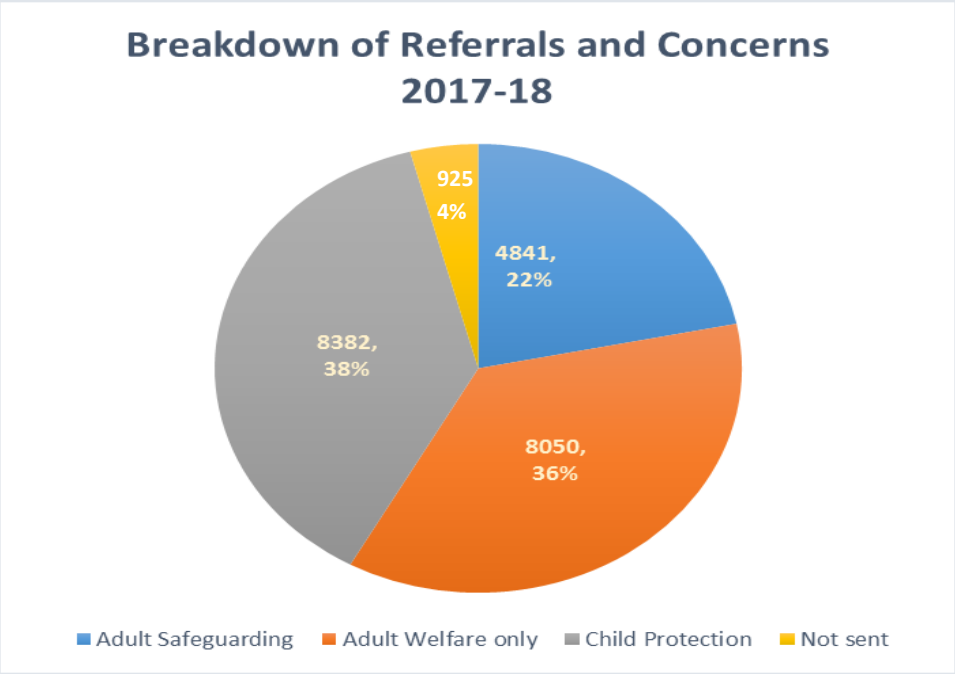
Safeguarding allegations against Staff

Allegation of abuse against Children	Total Number	Not safeguarding	Staff conduct	Historic Sexual Abuse	Outcomes
	7	4	2	1	All closed Trust disciplinary process followed where appropriate. 1 member of staff resigned Local Authority Designated Officer (LADO) and Professional body informed where appropriate.

Allegation of abuse against adults	Total Number	Psychological Abuse	Organisational abuse	Theft	Physical abuse	Serious Sexual assault	Not safeguarding	Outcomes
	17	1	5	5	1	1	4	14 closed not all proven 3 cases ongoing Trust disciplinary process followed where appropriate. Engagement with police and Safeguarding Adult Manager (SAM) where appropriate

Numbers of referrals/concerns generated by Trust

For **2017-18 the Trust raised 22,198** Safeguarding concerns and referrals with the local authority and partner agencies.



Overall Referral Volumes

The total number of safeguarding referrals/concerns for this year is **22,198**.

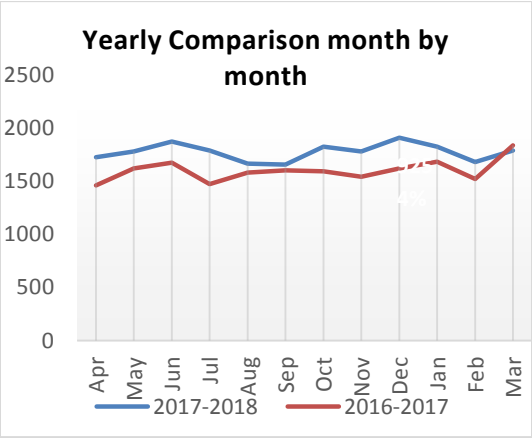
Comparison with 2016-17:

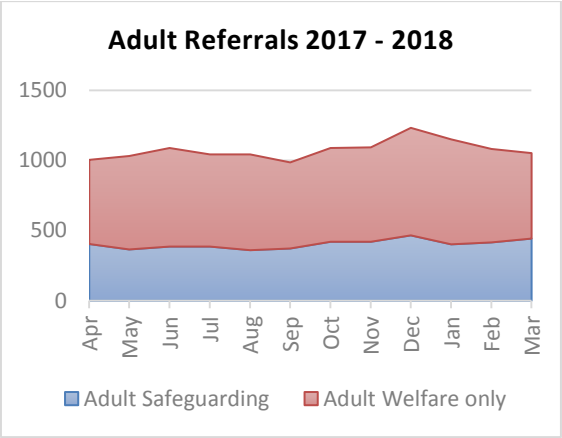
- There is 15% increase on 2016-17 safeguarding referrals/concerns total of 19,196
- There is 26% increase in child protection referrals since 2016-17
- There is 13% increase in adult safeguarding concerns since 2016/17
- There is 7% decrease Adult welfare concerns since 2016-17

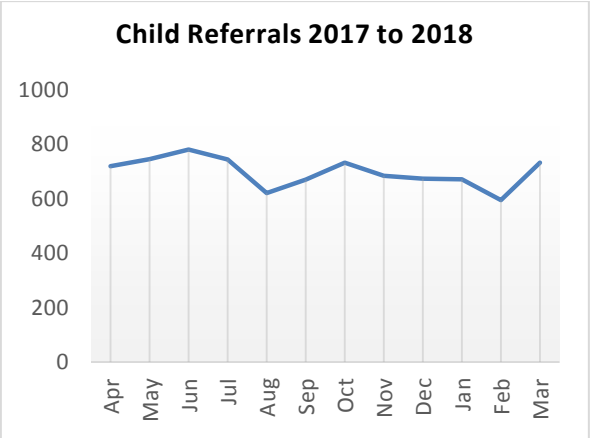
The ratio of adult to child referrals remains at 3:2.

This has been stable since changes in 2015.

The number of concerns/referrals as a percentage of all incidents has remained stable throughout the year at 1.9%, which is an increase from last year's figure of 1.7%.







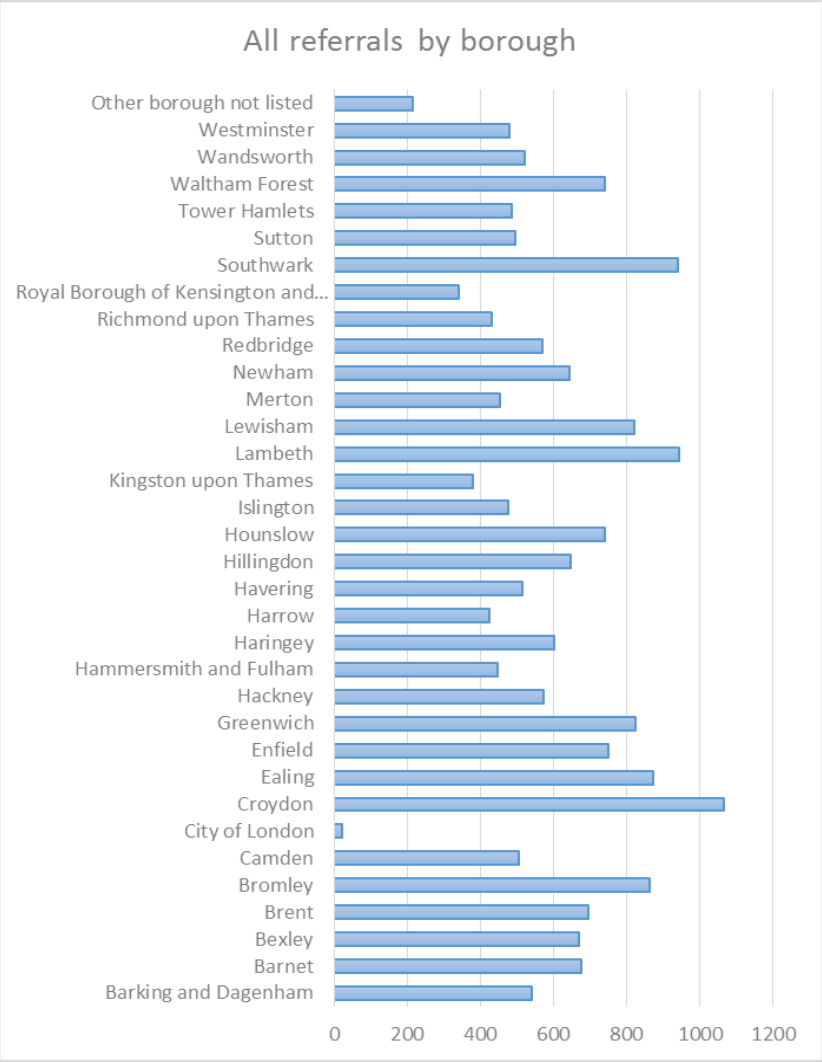
Referrals /concerns made by LAS Area	
North Central Sector	2591
North East Sector	3731
North West Sector	4393
South East Sector	4783
South West Sector	3074
Training	660
Other (HART, TRU, NETS, IRO, Events)	474
EOC	597
111	699
PAS/VAS Other	271
Total	21273

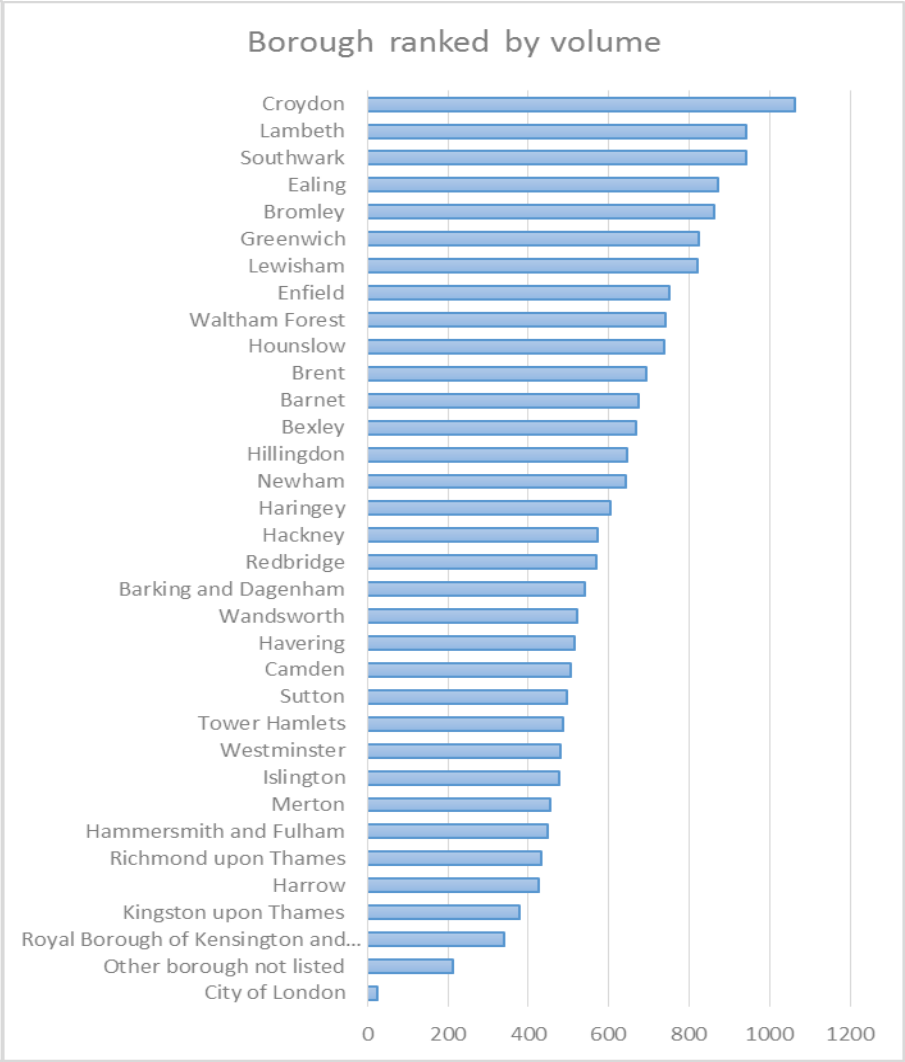
Volumes during the year

There was a slight increase in adult concerns over the winter period; this is consistent with previous years, and attributed to seasonal factors which affect overall call volumes especially for older adults.

There was a slight decline in child safeguarding over quarter 3-4 but increased in last month of the year.

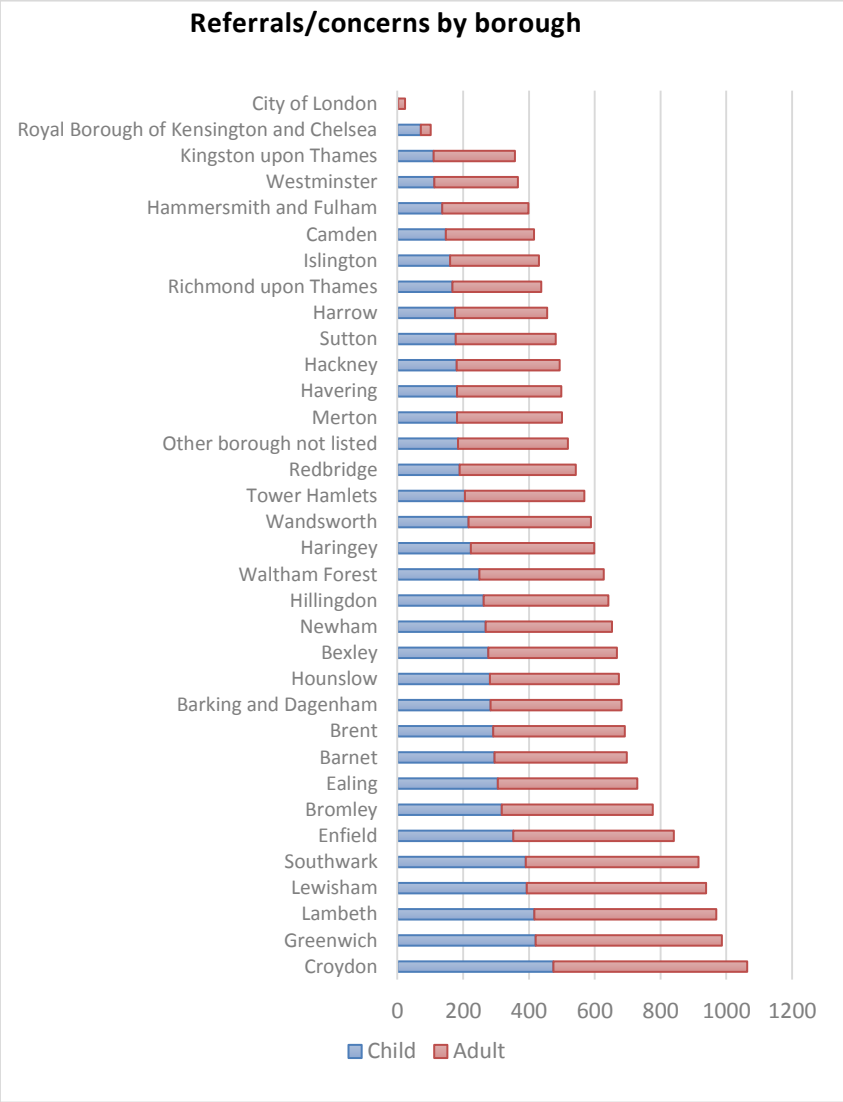
All volumes have remained fairly stable throughout 2017-18





In everything we do, we will provide

Care **Clinical Excellence** **Commitment**

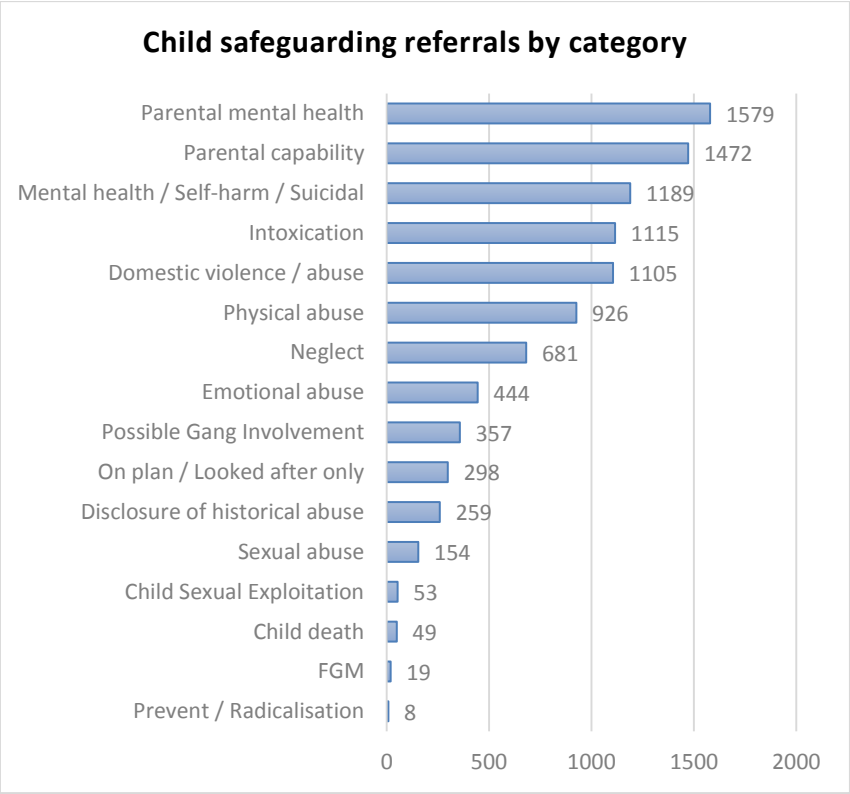


Referrals/concerns by borough

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

Splitting referrals by adult or child does not significantly alter the spread: For example Greenwich has the 10th highest volume of adult referrals and the 2nd highest volume of child referrals.

Improvements in the Trust electronic reporting system (Datix) will enable data such as this, and other detailed information about variations in category across boroughs, to be shared with sector managers and external service partners.

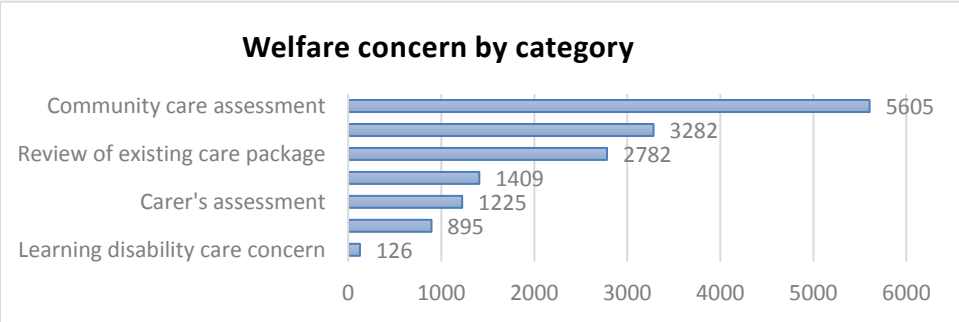


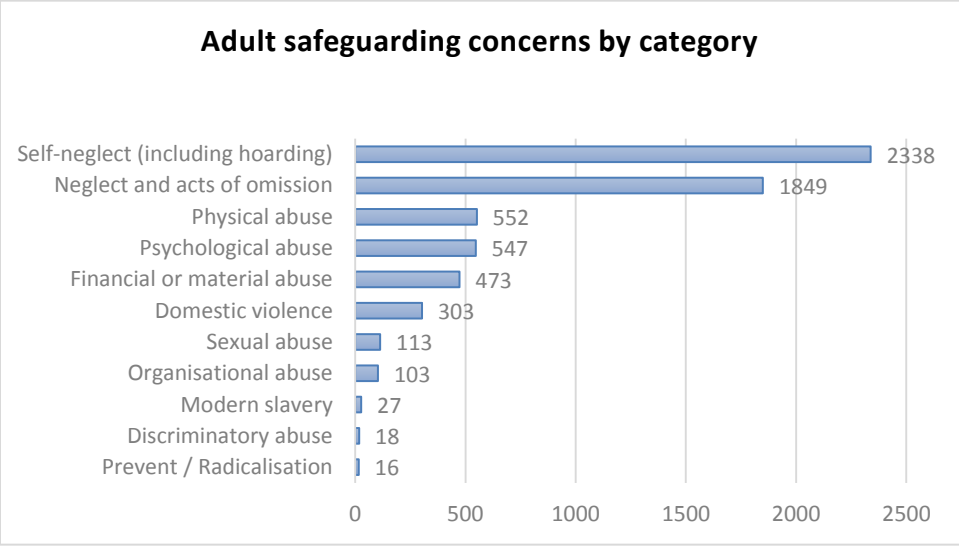
This chart shows the categories of concern the Trust recorded. Multiple referral categories can be selected for an individual referral.

Parental Mental health and Parental Capacity remains the top child safeguarding concerns identified by staff. This is consistent with other years.

The 19 concerns relating to FGM did not include any instances of directly observed or disclosed FGM of a child (which requires reporting to the MPS). They were concerns relating to children of mothers who had FGM, or other indirect concerns.

In December, a new pathway was established relating to gang / youth violence in addition to notifying the local authority we also refer immediately to Red Thread, a third sector youth organisation who work to intervene in young people's lives to steer them away from harmful social environments and behaviours. Since December, **52** of





The chart for adult alerts and concerns shows self- neglect and neglect as the top reasons for raising the concern. Multiple categories can be selected for an individual referral.
For those referrals where relatively severe hoarding is indicated (scored using a clutter index devised by the LFB as 4 and above), and where consent is given, an alert is shared with the LFB. The LFB can then make a fire risk. This year we made 1,288 such referrals.
In Domestic Violence cases, staff supply the victim with the telephone number of the Women's Aid Domestic Violence Helpline number. On rare occasions the victim will ask staff to contract the DVHL on behalf of the person concerned. This has occurred only twice.

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

Feedback from local authorities

Feedback from the local authorities on the Trusts safeguarding referrals and concerns remains low.

In previous years we have seen a slight increase from 0.02% to approximately 4% this year.

This year the Trust discussed with the MASH leads the issues and need for feedback to improve referrals.

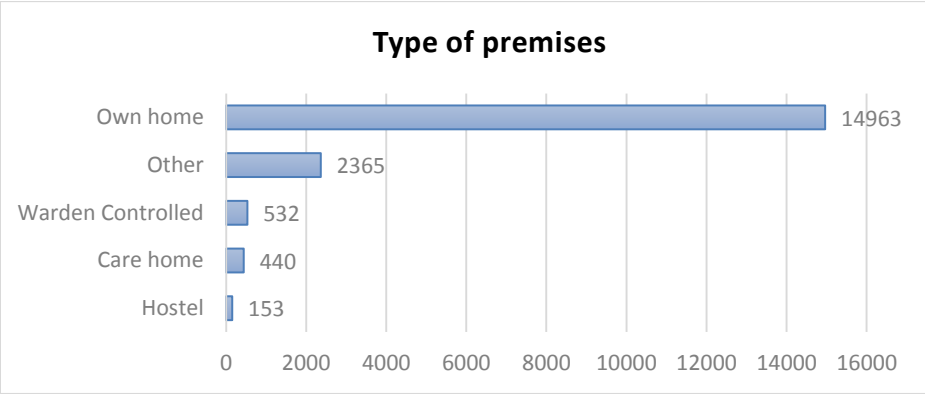
The Trust has begun using the Trust electronic (datix) system to record feedback with the referral so staff are directly informed when feedback is received.

Figures for November 2017- end March 2018 show that 376 items of feedback were received. This is 4.1% of total referrals in the period.

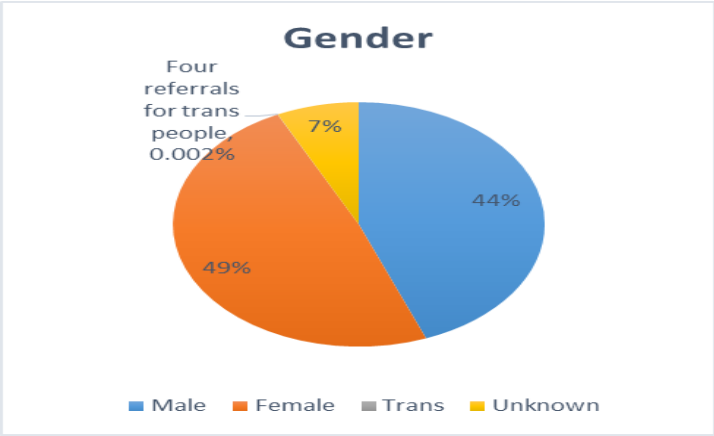
Some boroughs are significantly better at feeding back than others, Greenwich, Barking & Dagenham and Havering account for 38% of all feedback processed.

The boroughs below sent no feedback at all during this period.

- Hillingdon
- Hounslow
- Wandsworth
- Westminster
- City Of London

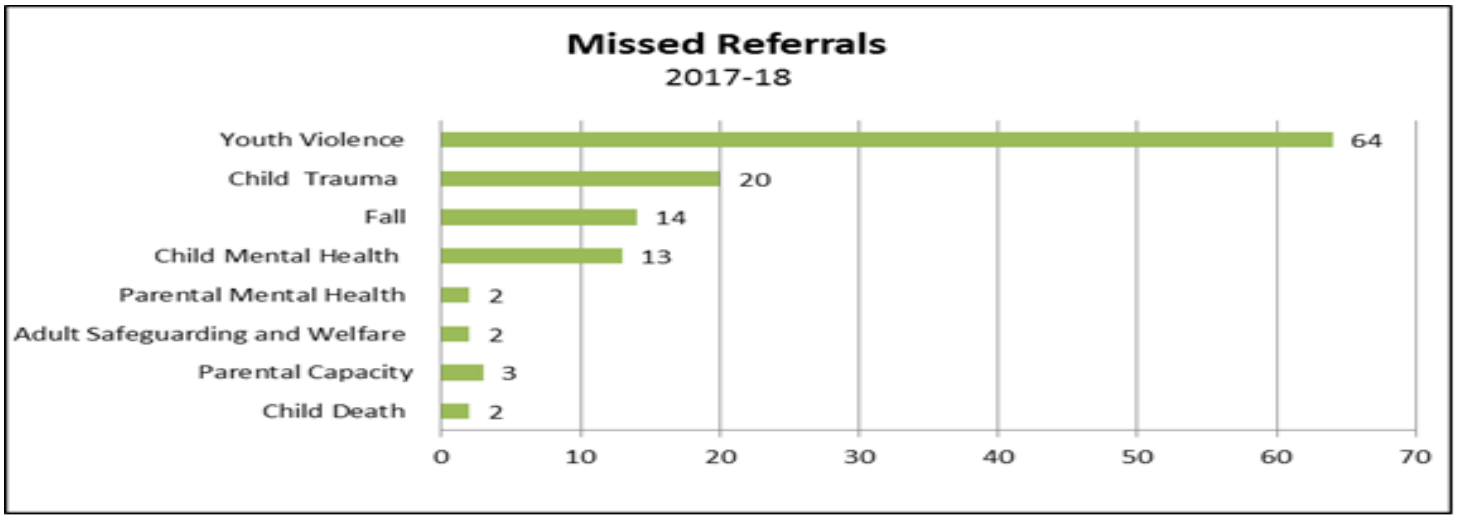


The Trust Safeguarding Team review all concerns regarding quality of care delivered in a residential care facility and take escalatory action where appropriate. This includes sharing relevant concerns to the CQC and or CCG. Since this process was initiated in November 173 such incidents have been assessed.



The majority of the unknown are child safeguarding referrals where we are aware that a child is at risk but have not assessed that child face to face and have not established their gender.

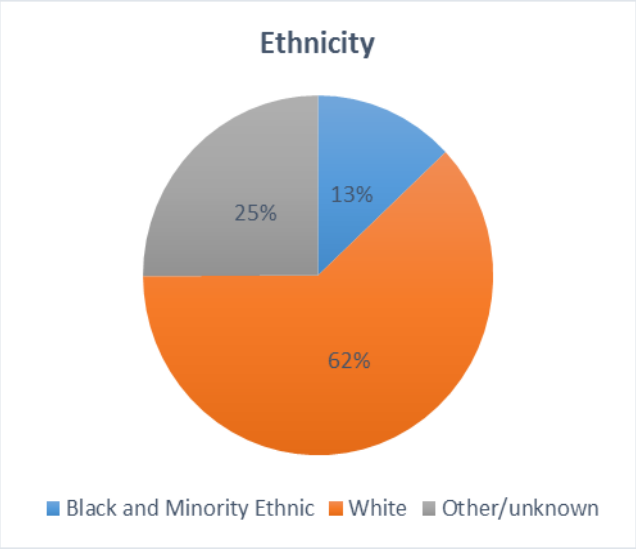
Missed referrals/concerns

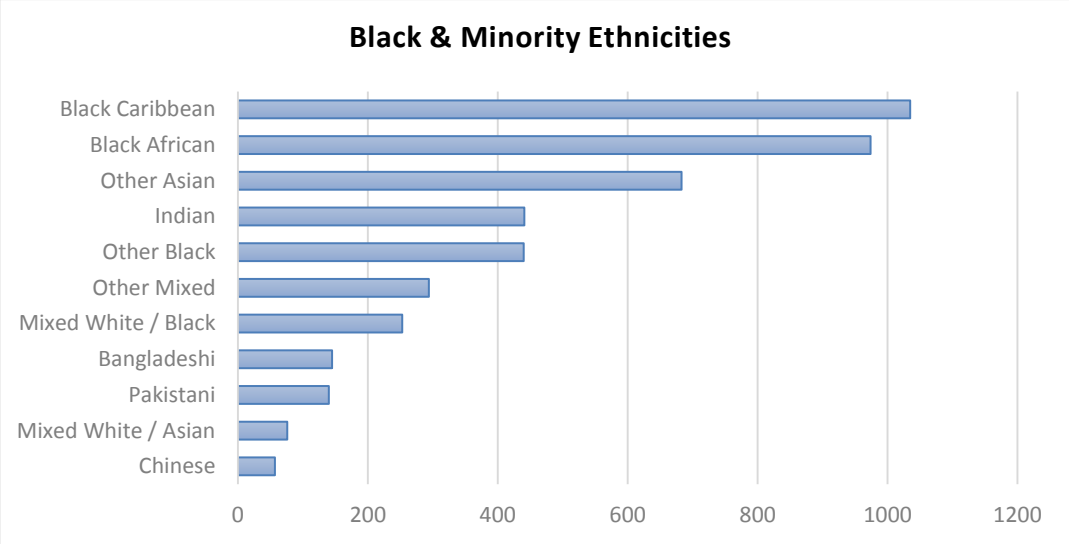


The Trust identifies missed opportunities to raise concerns about safeguarding in a variety of ways, through audits, SCR,SAR and incidents.

During 2017-18 the Trust identified 122 incidents where it was felt a safeguarding concern should have been raised.

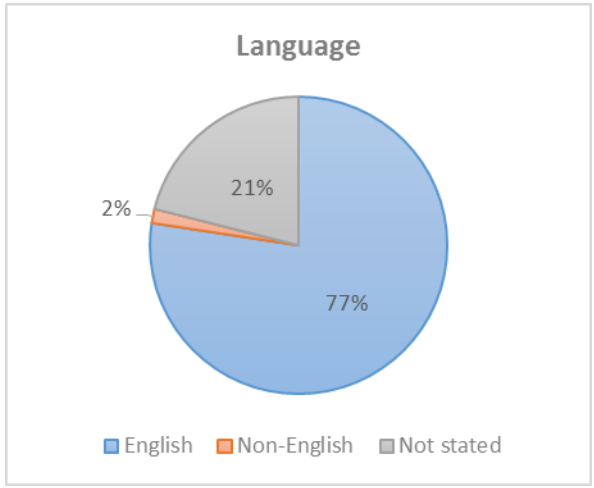
Staff receive feedback on missed referrals via the staff safeguarding action plan form, bulletins, refresher training and articles.

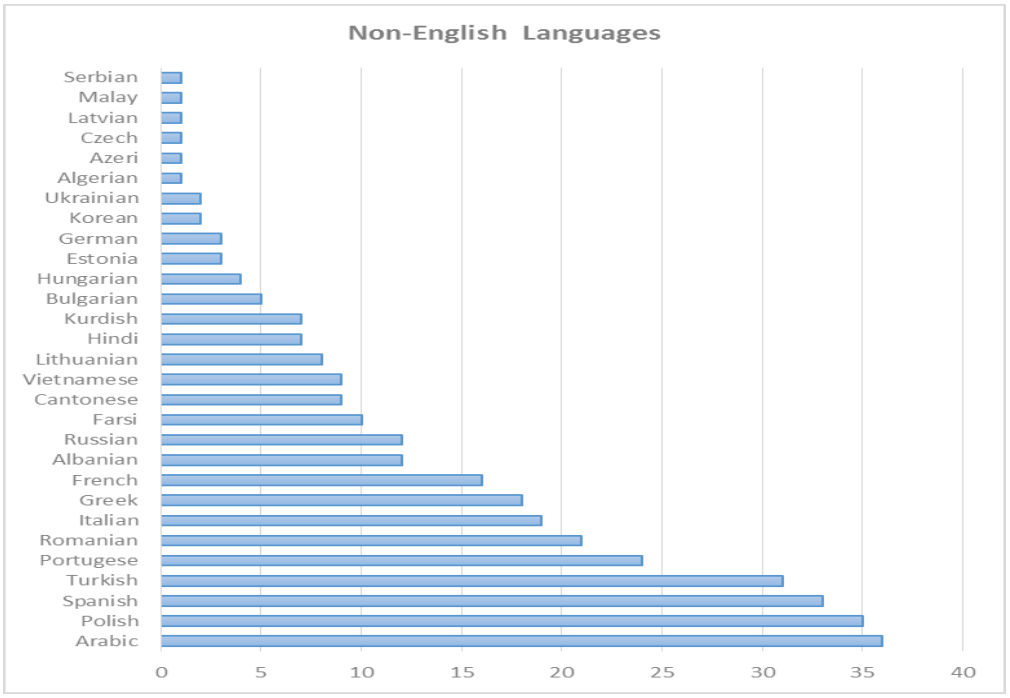




Staff recording ethnicity has greatly improved compared with previous years.

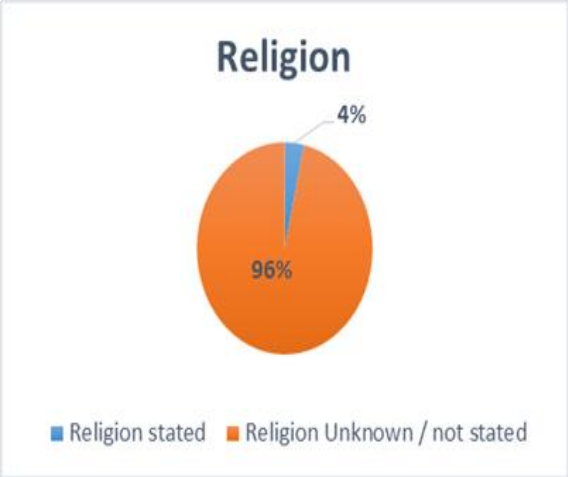
This is largely due to the move to telephone/ electronic recording. The move to 24/7 telephone referral for all referrals will further improve this.

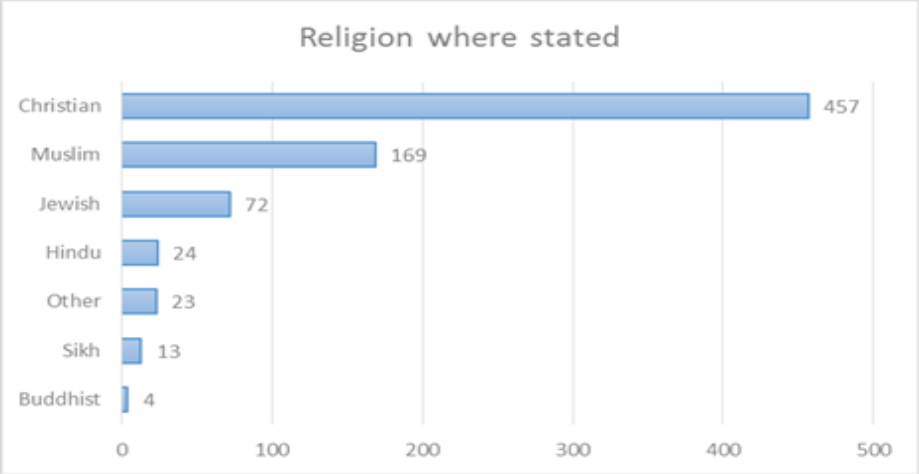




Recording of the language spoken has also improved this year for similar reasons to ethnicity.

The Trust has identified that the reporting system does not capture all languages commonly spoken in London (e.g. Urdu) nor does it capture whether the person speaks English or record their first language. This is being reviewed by the Trust





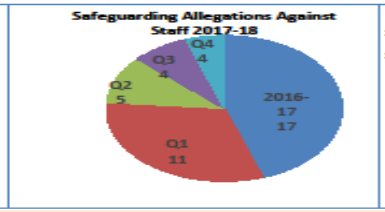
Religion is not regularly recorded by staff. However these findings will be feed into wider Trust discussions around protected characteristics.

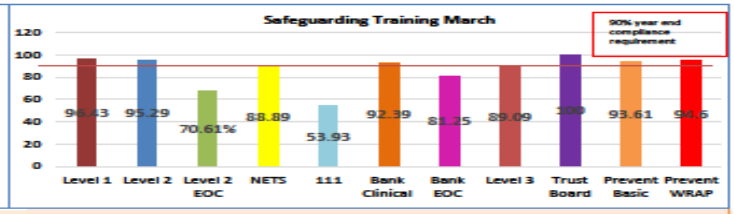
Summary

- This year has been a very busy one for the Trust in terms of safeguarding. The Trust has strengthened its governance and assurance of safeguarding, with the introduction of a number of quality assurance review groups.
- A range of safeguarding audits have been undertaken and recommendations, acted upon.
- Training has been undertaken at all levels of the organisation and the Trust is compliant with the 90% contracted target at level one, level three and Trust Board. Level two is compliant in most staff groups except for NHS 111, NETS and Control Services.
- The Trust held a very successful Safeguarding & Mental Health Conference for 100 staff and partners.
- The Trust has been proactive in developing a range of youth violence initiatives internally and externally with partner agencies.
- The Trust has had an increased focus on dementia in 2017-18 and introduced a number of initiatives including providing dementia awareness to over 100 staff and introduction of dementia care advocate.
- The Trust has continued to learn from SCRs and SARs making a number of changes to practice and policies in 2017-18.
- The Trust has this year introduced Safeguarding supervision to staff with over 60% of identified staff receiving supervision.
- Partnership working has improved both locally and at a pan London level. The Trust is engaging with more safeguarding partners that ever and will continue to build on these in 2018-19.
- Moving to an internal 24/7 telephone referral system for all safeguarding has proved difficult due to resources. The Trust currently undertakes 24/7 for child and 8/20hrs for adult concerns. Staff are currently being trained within EBS and a scoping exercise is underway to understand what further resources may be required.
- This report shows the Trust's commitment to safeguarding and that it is compliant with safeguarding statutory responsibilities.

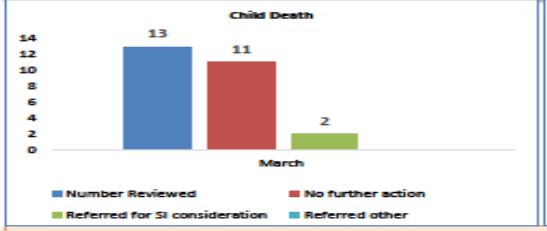
Appendix One

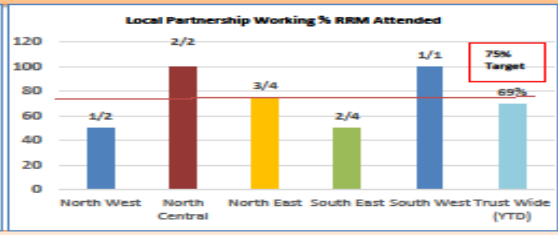
Safeguarding Score Card (March 2018)





Work Plan: Supervision Policy on track EBS 24/7 telephone referrals and taped line still to be realised. **Safeguarding Allegations Against Staff** :2017-18 24 2016-17 17 2015-16 8 . Reason for increase is reporting process now widely established following training. **Safeguarding Training** Trust wide areas met target of 90% in most cases, Exceptions EOC and EOC Bank challenged due to resource pressures .(70.61% & 81.25%)NETS (88.89%) & 111 (53.93%).





Trust safeguarding referrals and concerns raised

Month	Adults Safeguarding	Adults Welfare	Child	Total Referrals	% incidents
Apr-17	406	595	715	1716	1.90%
May-17	366	680	753	1799	1.90%
Jun-17	385	708	787	1880	2.00%
Jul-17	379	656	735	1770	1.90%
Aug-17	366	666	622	1654	1.80%
Sep-17	369	623	667	1659	1.80%
Oct-17	421	666	732	1819	1.90%
Nov-17	420	671	692	1783	1.90%
Dec-17	464	767	674	1905	1.95%
Jan - 18	397	743	672	1812	1.90%
Feb-18	412	668	602	1682	1.95%
Mar-18	442	611	734	1787	1.90%

Child Death: 100% were processed within 3 weeks of receiving. :**Local Partnership Working** Discussed with Operations work ongoing to improve compliance operations managers aware of importance of these meeting. **Trust Safeguarding Referrals & Concerns Raised**- Referrals remain within expected levels .