NHS
North East
Ambulance Service
NHS Foundation Trust

Annual Safeguarding Children and Adults Report 2021/22

1. Executive Summary

We are delighted to present to you the Trusts' annual safeguarding report for 2021/22. The last 12 months have continued to present challenges brought about by the continued pressures felt both locally and nationally from Covid 19. The resulting pressures were evidenced by the Trust's movement into REAP 4 for a sustained period in this last reporting year.

This report provides an overarching view and assurance that as an organisation we have continued to robustly meet our statutory safeguarding responsibilities under the relevant legal frameworks, as well as investing and prioritising in the training of our workforce to ensure a competent and confident workforce.

Our duties as a Trust for safeguarding are to ensure that we have effective and responsive systems and processes in place to safeguard the most vulnerable people in our society. Our duties are two-fold in that as a provider we must ensure our services are safe and of a high quality, whilst assuring our commissioners and regulators that the service is effective and safe.

There are several legislative frameworks and guidance documents that NEAS needs to be compliant with when discharging our safeguarding duties.

- The Mental Capacity Act 2005
- The Care Act 2014
- The Children's Act 2004 (updated)
- Human Rights Act 1998
- The Mental Health Act 1983
- Modern Day Slavery Act 2015
- Crime and Disorder Act 2015
- Female Genital Mutilation Act 2003
- Working Together to Safeguard Children 2018
- Safeguarding Children and Young People Competencies for Healthcare staff 2019
- Adult Safeguarding: Roles and Competencies for Healthcare Staff 2018
- Deprivation of Liberty Safeguards 2009
- The Domestic Abuse Act 2021

The organisation is required to ensure that as a Trust the following is met:

- The organisation has an identified named lead for safeguarding children and young people with a statutory role for managing children's safeguarding allegations against staff.
- Has an identified named lead for safeguarding adults along with an MCA lead. This must include the statutory role for managing adult safeguarding allegations against staff. Ambulance Trusts can appoint a named professional from any relevant health professional background.
- Safe recruitment practices and arrangements for allegations against staff and a robust allegation against staff policy.
- Provision of an Executive Lead for safeguarding children, adults at risk and Prevent
- Annual report for safeguarding to be provided to the board.
- Safeguarding policies and procedures which support multi-agency safeguarding procedures inclusive of documentation / policies for consent to care and treatment in line with Mental Capacity Act 2005.
- Effective training of all staff in line with their role and in accordance with the Intercollegiate Competencies documents.
- Safeguarding must be included in induction programmes.

- Provision of safeguarding supervision arrangements for staff in line with role, including for named professionals.
- Developing an organisational culture which ensures all staff are aware of their responsibility for safeguarding and information sharing.
- Develops and promotes a learning culture ensuring continuous improvement.

The safeguarding team continue to work hard to support staff across the organisation whilst monitoring and reviewing safeguarding practice in line with legislation and the Trusts responsibilities.

Governance arrangements:

As an organisation we have reviewed the governance arrangements. Below denote the current governance arrangements in line with safeguarding:

- Quality Committee – this sub-committee of the Board reviews information relating to Safeguarding via the Quality Dashboard and through quarterly safeguarding reports on activity across the Trust.
- Strategic safeguarding group – internal and external membership attended by all Clinical Commissioning Groups (CCG's) Designated Nurses from all CCG's covering the NEAS footprint. The meetings have the remit to discuss serious case reviews, provide oversight of audit requirements and feedback from safeguarding adult and children's boards. They also provide support and challenge regarding safeguarding processes within the Trust.
- Care Quality Commission (CQC) monthly meetings with the lead inspector. Safeguarding is discussed through this monthly meeting process and any queries / concerns can be addressed timely.
- Clinical Review Group – internal membership. Whilst there have been some changes to the process throughout the year there are clear arrangements for any safeguarding concerns to be discussed with the internal team.
- Clinical Quality Governance Group (CQGG) – safeguarding is an agenda item for discussion on a quarterly basis, as a minimum, where updates can be given to the wider management team regarding our statutory duties, any regional / national updates and organisational learning.
- Safeguarding strategy and annual implementation plan (3 yearly review)
- Policies and procedures in place including Safeguarding Adults and Children's Policies / Chaperone Policy / Supervision Policy / Safeguarding Allegations Against Staff Policy / Recruitment Policy / Fitness to Practice Policy / DBS policy / Mental Capacity / Domestic Abuse
- Prevent duty is an integrated policy within the Safeguarding Adults policy
- Submission of quarterly data to NHS digital in relation to Prevent
- Membership on the Contest Board – Prevent and yearly review of the Local Engagement Plan
- Ofsted Inspection which includes review of how the Trust safeguards learners
- Membership of the Anti-Slavery network
- Modern-Day Slavery statement, updated annually

- Memorandum of Understanding (MoU) that the CCG Designated Nurses will attend SAB/LSCB meetings and feedback to NEAS
- Attendance at Child Death Overview Panel and completion of any formal reports
- Attendance at Serious Adult Review Panels and Domestic Homicide panels and completion of Trust Independent Management Review reports
- Submission of section 42 reports to the Local Authority and CQC relating to allegations made against NEAS staff, where it is alleged care fell short of expectations resulting in neglect / abuse
- Use of the Child Protection Information Sharing (CP-IS) system
- Good working processes with Patient Safety Team / Coroners Team / Patient Experience Team and Operational Managers
- Good working relationships with Local Authority Designated Officers (LADO) across the region
- Good working relationship with all Local Authorities across our regional footprint and those adjoining the Trust's geographical boundary

2. Organisational Structure

Safeguarding Organisationational Structure for 2021/22

Director of Quality, Patient Safety, Innovation and Improvement (Executive Nurse and Executive Lead for Safeguarding)

Deputy Director of Quality and Safety

Named Lead Professional Adults

Named Lead Professional Children

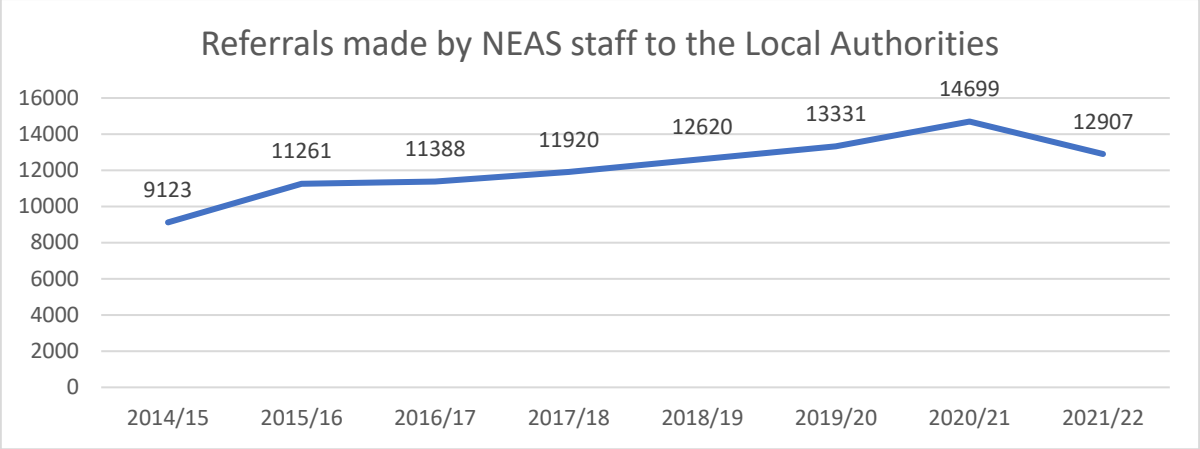
Safeguarding Adults Advisor

Safeguarding Children Advisor
(Seconded post whilst seeking substantive funding)

Safeguarding Administrative Assistant

Safeguarding Officer

3. Safeguarding Activity

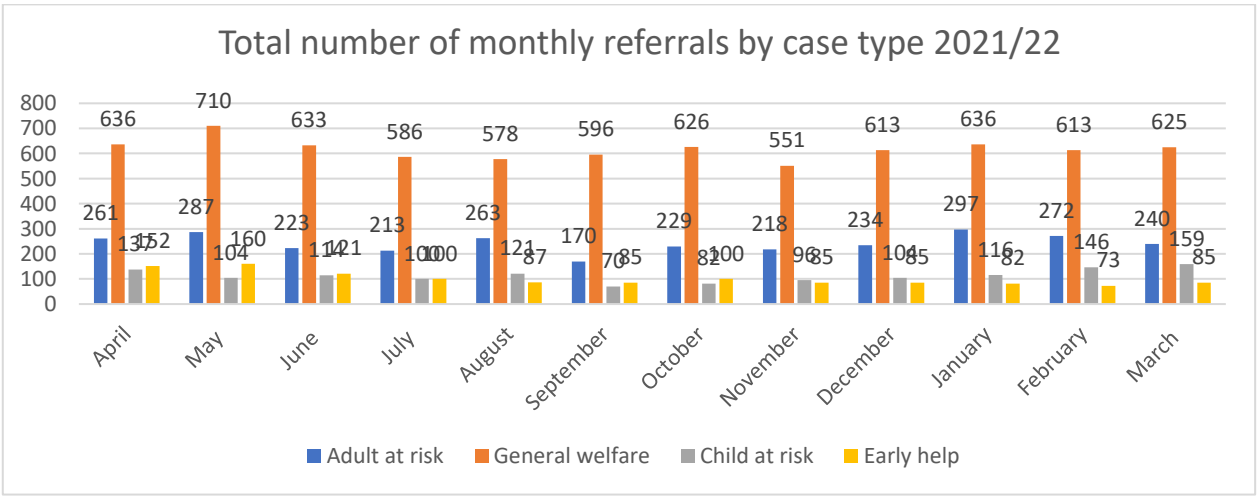


The information within the graph represents the year-on-year number of referrals staff within NEAS make across the region to the Local Authority. The trend generally has shown a year-on-year increase in referrals; however the last financial year has seen a slight decrease.

Training has been delivered around thresholds and evidencing these thresholds within our referrals to ensure that those that are submitted to the local authority are high quality and appropriate. 2020/21 saw significant periods of national lockdown which raised the vulnerability of adults and children, who were otherwise hidden from education and other support services. Therefore, the decrease in referrals in this financial year should not be automatically viewed as staff missing referral opportunities with appropriate consideration of the extraordinary societal position of the previous year.

Children's' Rapid Reviews, Local Child Safeguarding Practice Reviews, Safeguarding Adult Reviews, Domestic Homicide Reviews, Section 42 and Section 47 enquiries allow staff within the safeguarding team to scrutinise the contact NEAS has had with members of the public. Any missed opportunities for referrals and any themes are identified through these formal processes and embedded into future training to continue to raise staff awareness.

Staff within the safeguarding team have continued to support staff within the Emergency Operations Centre in making non urgent referrals over the last financial year. This has allowed the safeguarding team to support with operational demand and to review cases where staff are unsure whether a referral is required.



The data suggests that the largest decreases in referrals are from Adult Welfare and Child Early Help. A significant focus in 2021/22 Statutory and Mandatory training has

concentrated on gaining appropriate consent following identification that this was not always obtained prior to submitting these referrals.

For Children, the Safeguarding Lead and Children's Advisor review all children identified as Frequent Presenters to the Service monthly and review cumulative risks which helps to support a more proactive safeguarding approach to ensure any missed opportunities to make safeguarding referrals are identified in these particularly high-risk children.

Category	Q1	Q2	Q3	Q4	Total	vs 2020/21	% variance
Allegations against staff	9	10	16	11	**46**	43	+7%
CHANNEL/PREVENT	-	-	1	0	**1**	-	-
Child frequent presenter	-	1	11	16	**28**	-	-
Child – PREA	0	0	10	5	**15**	5	+200%
Communication	7	11	9	4	**31**	54	-43%
County Lines	-	-	2	0	**2**	-	-
Court Orders	12	8	7	11	**38**	29	+31%
Death – Child	15	14	10	15	**54**	54	=
Death – Child no report	7	6	0	5	**18**	17	+6%
Domestic Abuse (Staff)	2	5	1	1	**9**	9	=
DHR	3	0	2	2	**7**	6	+ 17%
Information requests	34	29	43	53	**159**	150	+6%
MAPPA requests	50	56	55	44	**205**	90	+128%
Rapid Review	1	1	1	0	**3**	-	-
SAR	10	11	15	8	**44**	29	+52%
Section 42	23	30	30	22	**105**	107	-2%
Section 47	1	2	3	0	**6**	7	-14%
SCR	0	1	0	0	**1**	7	-85%
TOTALS	**174**	**185**	**216**	**197**	**772**	**606**	**+27%**

The table evidences a nearly 30% increase in evidenced workflow within the team which has been achievable and sustainable due to continued interim financial investment by the organisation for the Safeguarding Children's Advisor post. The team are continuing to seek substantive funding from CCG's in order to ensure our ability to meet our statutory responsibilities and work in partnership with external agencies to safeguard vulnerable children, young people and adults.

4. Safeguarding Children

The continued use of virtual meeting platforms, predominately MS Teams has enabled the achievement of consistent representation at meetings which facilitate the safeguarding of children across our geographical footprint, such as Section 47 strategy meetings, care team meetings and risk management meetings. A key focus of the work being undertaken in the last 12 months has been around the early identification of escalating vulnerability of children and supporting more proactive and collaborative multi-agency work. Some of the key achievements within this area are listed below.

- The Safeguarding Children Lead participated in a national task and finish group with other ambulance providers to review a standard for frequent callers aged under 18 which was subsequently presented to FREECAN and AACE.

- The Safeguarding Children Lead devised and implemented a process to review children identified as 'frequently presented' across both 111 and 999. This process includes engaging with external partner agencies such as Designated Nurses, Local Authorities and Primary Care and ensures that information is shared to support safeguarding vulnerable children. Benefits from this process include developing multiagency plans such as EHCP's/ Familiar Faces which support operational crews to understand increasingly complex patient presentations as well as identification of any potential risks to staff. Whilst reduction of demands upon NEAS is not a primary goal within frequently presented children work, reduction of contact with ambulance service is often a result.
- The Safeguarding Children Lead attends the regional Safeguarding Professionals Network which aims to share updates from regional work themes, good practice, and key themes. It has had the added benefit of enabling networking with other safeguarding professionals across the region which has been more challenging due to Covid 19 restrictions.
- Following data identified from the frequently presented children work in relation to the over-representation of Looked After children, the Safeguarding Children Lead was invited to participate in a regional task and finish group to explore and scope recent research into early mortality of care experienced children.
- The Safeguarding Children Lead engaged with Senior Managers within our Emergency Operations Centre to reinforce the supervision and support offer for staff surrounding safeguarding children's incidents. Data is now captured in relation to these cases and feedback from staff who have accessed this support has been overwhelmingly positive.

Key priorities going forward:

- To continue to develop frequently presented children work to include singular high-risk presentations.
- Despite training highlighting the importance of evidencing the voice of children within documentation and referrals, audit suggests further work is required to embed this into practice, therefore further training will be explored for 2022/23 and referral forms will be reviewed to support effective capturing of this information.
- Review of the Safeguarding Supervision Policy and Safeguarding Children's Policy which are both due to be reviewed in the next financial year.

5. Child Death Process

Throughout 2021/22 the Safeguarding team continued to meet its statutory responsibility in relation to engaging in national child death review processes. Meetings have continued to be conducted via MS Teams which supports timely multi-agency response and attendance which facilitates robust case review.

The number of unexpected deaths in childhood attended to by NEAS remains static year on year (54 cases in 2020/21 and the same in 2021/22). Information compiled by the team as part of statutory child death processes continues to show the most at-risk group being under a year of age which corresponds with national data (children under the age of one year, account for 63% of national child deaths according to NCMD statistics).

A review of statement provision was undertaken in the last 12 months and guidance was communicated to frontline operational staff via their statutory and mandatory training. The safeguarding team continues to work closely with colleagues in operations, patient safety, call handling, dispatch and coroners and claims teams to ensure any organisational learning or good practice is identified and shared. The team has good working relationships with the Police forces in the region to support any criminal investigations that are undertaken in parallel with statutory child death review processes.

Key achievements:

- Safeguarding team attended 53 out of 54 Joint Agency review meetings to support information sharing in line with national statutory processes.
- Consistent attendance at Child Death Review meetings and Child Death Overview panels in line with our statutory responsibilities.
- Continued positive working relations with GNAAS to support information sharing to inform child death review processes.
- Safeguarding team has evidenced positive relationships with EOC, audit, patient safety departments in the management of child deaths and in the identification of any organisational learning.

Priorities going forward:

- The Safeguarding Lead for Children has been invited to participate in a working group which will look at infant deaths following periods of sleep where usual sleeping practices have been deviated from. This has followed information shared to one of our CCG Designated Safeguarding Nurses in relation to key themes noted by NEAS regionally.

6. Child Safeguarding Practice Reviews

NEAS continues to work in partnership with the Safeguarding Children Partnerships in our locality, attending a total of three Rapid Reviews following notifications of serious incidents involving children with active involvement in one Child Safeguarding Practice Review.

Priorities going forward:

- A review of the way the NHS Pathways system triages bruising in immobile children to ensure appropriate level of disposition is reached remains ongoing, this has been highlighted as a high priority with NHS Pathways.
- High risk adolescents and extra familial harm has been identified as a key theme with rapid reviews undertaken in the last year. These cases highlight the difficulties and complexities in reducing risks to adolescents and supporting transition to adult services. Therefore, training for 2022/23 will focus around the challenges of safeguarding adolescents and additional vulnerabilities of Looked After Children.

7. Prevent

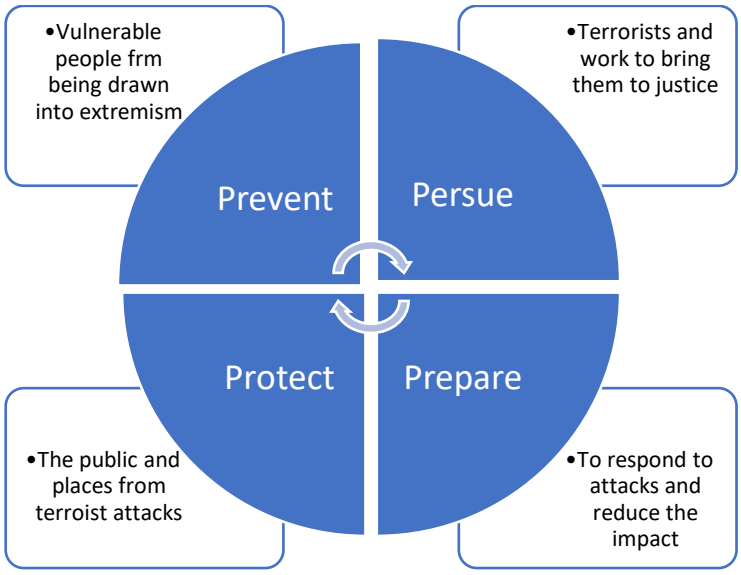
Terrorism remains one of the most direct and immediate risks to national security. CONTEST is the government's strategy and framework to counter terrorism with the overarching aim to reduce the threat to the UK.

Key achievements:

- Continued membership of Silver Contests Boards and NHS Prevent forum – relevant leads have access to the ACT app for up-to-date information / training
- NEAS submits quarterly Prevent data to NHS digital
- NEAS have consistently been above the 85% target for WRAP eLearning
- Information has been shared to enable police to complete the Counter Terrorism Local Plan for Durham and Cleveland Police Force
- NEAS have completed benchmarking against the Prevent Toolkit and NHSE Prevent strategy
- NEAS Completed the Prevent Duty self-assessment tool for further education and this has been shared with the Ofsted inspection team
- The link in relation to vehicles being used as weapons was circulated to the relevant managers
- Supportive educational booklet for 2021/22 stat and mand training contained additional information around Prevent and Counter Terrorism. Links to the "report it app" were made available to staff, links to podcasts and relevant government websites were also made available

Key priorities going forward:

- Continued submission of Prevent data to NHS digital
- Continue to achieve above 85% target for training



8. Modern Day Slavery (MDS)

MDS is a complex and largely hidden problem and has no place in society but can cross our path through a multitude of avenues from the items we contract through purchasing to the people we see and treat and signpost. Human rights are a basic need which should be afforded to everyone in society, NEAS are committed to ensuring our systems and processes take MDS into consideration and that staff are cognisant of the threat.

Key achievements:

- Members of the safeguarding team are actively involved in the Cleveland Antislavery network
- Our Modern-day Slavery statement has been reviewed and meets the required standard (see embedded statement)

Modern Slavery Statement 2022-202

Key priorities going forward:

- Continued involvement in Cleveland Antislavery Network
- Update MDS statement and post on Siren
- Consider posting the MDS statement on the government website
- Review the MDS Guidance produced in March 2022 and ensure NEAS compliance

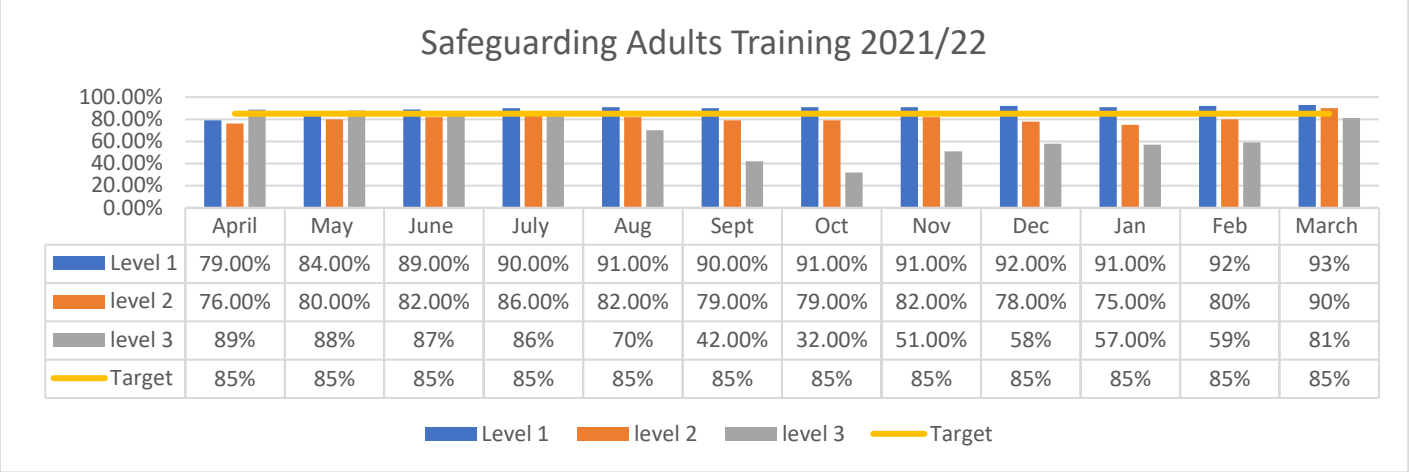
9. Training

A significant amount of effort has been given to deliver training using various methods in the last 12 months. Clinical staff within the Emergency Operations Centre have been extracted and accessed face to face and virtual training at Level 3. eLearning modules both national and locally developed have been used along with face-to-face training, virtual and video presentations for all other staff. Delivery of face to face / virtual training has continued to be a shared role between the safeguarding team and the education department. The safeguarding team have continued to deliver virtual training to students at Sunderland University.

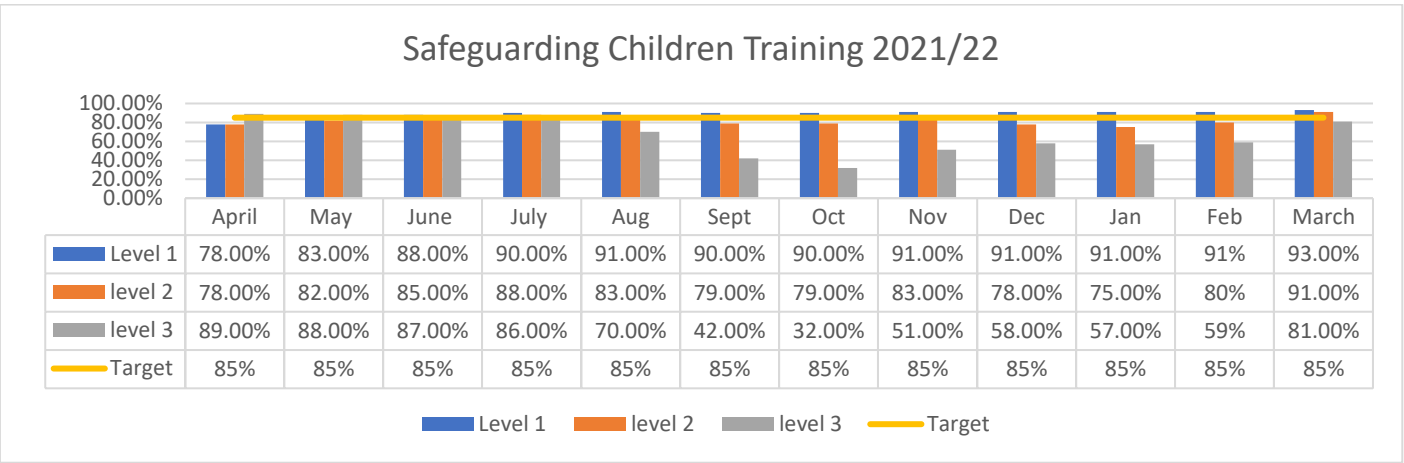
Due to significant operational demand the Trust needed to prioritise patient care and training was suspended to meet the needs of the service. The organisation recognised the importance of ensuring staff are trained and staff who's training was outstanding have accessed this although we recognise that Level 3 overall compliance is 4% below the NHS national target.

NEAS staff receive safeguarding training yearly, all packages are reviewed and updated / changed to reflect required content within the Intercollegiate Documents and to reflect current topics both nationally and locally.

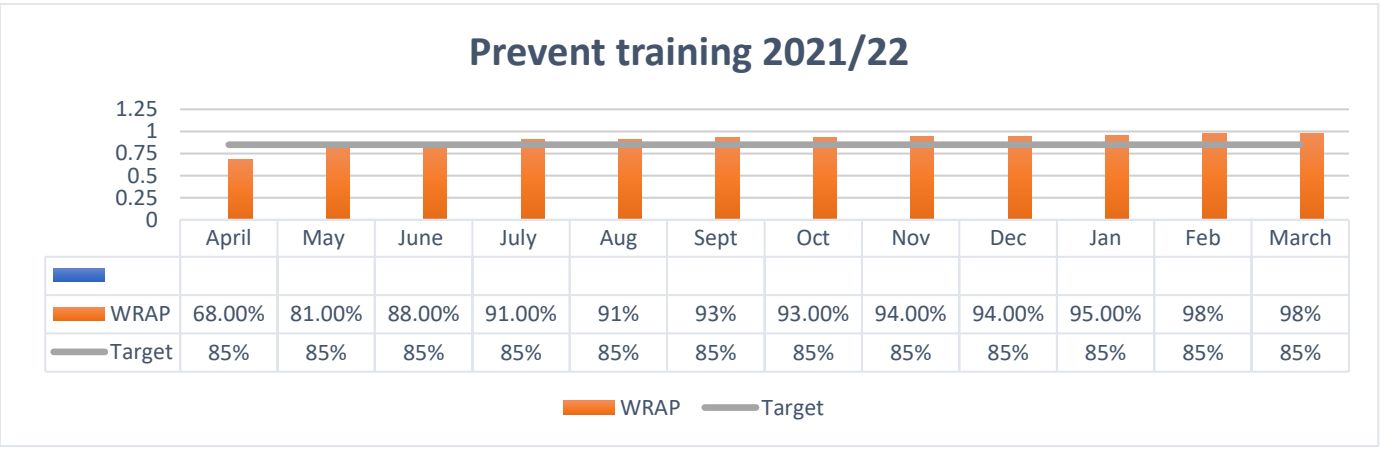
Key achievements:



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Level 1	79.00%	84.00%	89.00%	90.00%	91.00%	90.00%	91.00%	91.00%	92.00%	91.00%	92%	93%
level 2	76.00%	80.00%	82.00%	86.00%	82.00%	79.00%	79.00%	82.00%	78.00%	75.00%	80%	90%
level 3	89%	88%	87%	86%	70%	42.00%	32.00%	51.00%	58%	57.00%	59%	81%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Level 1	78.00%	83.00%	88.00%	90.00%	91.00%	90.00%	90.00%	91.00%	91.00%	91.00%	91%	93.00%
level 2	78.00%	82.00%	85.00%	88.00%	83.00%	79.00%	79.00%	83.00%	78.00%	75.00%	80%	91.00%
level 3	89.00%	88.00%	87.00%	86.00%	70.00%	42.00%	32.00%	51.00%	58.00%	57.00%	59%	81.00%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
WRAP	68.00%	81.00%	88.00%	91.00%	91%	93%	93.00%	94.00%	94.00%	95.00%	98%	98%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

- The NQP training package has been embedded and quality assurance was commenced this financial year
- Additional reading resources have been circulated as part of Statutory and Mandatory training
- Access to regional and national training around safeguarding has been shared via workplace for staff throughout the year
- Positive feedback has been received around training packages

- Safeguarding team supported the education / training department during the Ofsted inspection

Key priorities going forward:

- Continue to deliver training in line with Intercollegiate Document at all levels and identify any key themes from safeguarding processes to identify any additional learning needs
- Ambulance specific Level 2 E-learning module to be devised and delivered for EOC colleagues
- Deliver training around Persons in a Position of Trust via locally devised eLearning module
- Deliver bespoke training packages at Level 3 which incorporate ambulance service scenarios and learning from regional and national reviews
- Maintain safeguarding training compliance for each level to be above 85% target

10. Domestic Homicide Review (DHR)

NEAS works in partnership with the Community Safety Partnership and as such has a requirement to participate in DHR's. The purpose of such reviews is to establish how agencies / organisations worked with individuals and as partners to safeguard victims of domestic abuse. Each organisation / agency identifies their own best practice and learning from such reviews and the chair has the responsibility for looking across all partnerships to understand the wider context and determine whether learning is required in terms of strategic policy.

NEAS is required to review records which date back between 5 – 10 years for DHRs, as part of the process all contacts are required to be reviewed including:

- Cleric log
- EPCR / PRF
- Safeguarding referrals
- Any safeguarding reports or meetings attended in relation to victim or perpetrator
- Calls on the Nice system
- Incidents relating to victim / perpetrator

Each of these contacts needs to be assessed against an agreed terms of reference if NEAS is requested to formally submit and independent management report.

Over the last 12 months NEAS have provided information for 7 new cases which have all been considered under the Domestic Homicide framework. Of those 7 new cases:

- 2 were felt not to meet the DHR criteria

- 1 case required NEAS to submit a chronology of contacts, this review is being managed in another part of the country
- 2 are open DHRs and NEAS have complete independent management review reports
- 1 is pending a decision
- 1 case required a short report only due to limited involvement

Due to the pandemic, police and coronial processes a number of DHR's were delayed therefore in addition to the reviews commenced within the last 12 months the safeguarding team have also worked with the community safety partnership on a further 3 DHR's all of which have required independent management reports.

Single agency learning is incorporated into NEAS training. Substance use, mental health and in some cases self-neglect are common themes across many of the domestic homicide reviews in the region. This does not appear to out with the picture across the country.

11. Safeguarding Adult Reviews

The Care Act 2014 places a statutory responsibility on Safeguarding Adults Boards to undertake a Safeguarding Adult Review If:

- there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and if either of the following are met:
    - the adult has died, and
    - the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

OR

    - the adult is still alive, and
    - the SAB knows or suspects that the adult has experienced serious abuse or neglect.

Over the last 12 months NEAS have been asked to share information in 37 cases which have been considered for a safeguarding adult review across the region. Each initial review requires a search of NEAS systems and records covering a 12 month period. In the last year NEAS have:

- Provided formal IMR's for 3 safeguarding adult reviews
- Participated in 5 learning reviews – some of which required reports others simply required attendance at virtual practitioner events
- There are currently 8 cases that have been agreed meet the criteria for a SAR but have not commenced as yet
- 1 case agreed meets the criteria for a learning review which will not commence until the coronial process has been completed
- There are a further 4 cases which are pending a final decision

Any single agency learning following a safeguarding adult review is embedded into our bespoke training packages. Common themes from reviews completed within the last 12 months also centre around self-neglect, substance misuse and mental health.

12. Safeguarding risks

- There is a continued risk regarding the capacity of the team to meet statutory responsibilities which is currently being mitigated with the use of a seconded Band 6 Children's Safeguarding Advisor. We await clarification of funding prior to this risk being closed or left open as an ongoing risk factor.
- Referral via third party has been identified as a risk our current process requires crews to contact the logistics desk to relay information to a member of staff, who will complete the referral on the crew members behalf and send this to the local authority. There is risk of miscommunication and information degradation within this process. Capacity of operational workforce is also adversely affected due to time taken to reach logistics team to make referrals. A significant level of this risk will be closed in the summer with the use of iPad for frontline staff.

13. Work plan for 2021/22

Unfortunately, the workplan for 2021/22 was not achieved in the way we would have liked, many aspects of the workplan were dependent on other functions and in some cases prioritisation of frontline patient systems took precedence. We will endeavour to achieve these in the coming months.

14. Audit plan 2021/22

Due to workload the audit plan has only been partially achieved; those audits not completed will be carried over to the next financial year.

15. Conclusion

This report has outlined the range of safeguarding work undertaken by the Trust in the past year. Review of the workload of the team has seen an increase of nearly 30%, this does not include day to day work, training, development of training packages or many other internal functions.

We continue to support multi-agency working and provide our single agency reports where this has been required.

Appendix 1

Action Number	Priority and Reason	Action required (examples)	By whom	Timeframe	Evidence /Outcome	RAG	Action required/Update
1	Embed Liberty Protection Safeguards within NEAS working systems and processes	Review to Code of Practice (on release) and interpret how this will impact on scheduled and non-scheduled care. Work with CCG's and LA to determine how ambulance conveyance can be embedded within applications to the responsible body. Update training information to ensure staff know the legal parameters within which they are working. Send out a PCU at the relevant time to update all staff of any required changes.	JS JS JS JS	April 2022	Gap analysis paper to be presented to the board when the final code is issued Work through the LIN to embed conveyance within application process Training presentation updated to include the LPS changes and NEAS responsibilities to this Send out PCU when changes are due to commence		The DRAFT Code of Practice was not released until March 2022. Currently open to consultation. Safeguarding adults lead does attend the Health LPS regional group and the lead CCG LPS meetings.
2	Safeguarding referral form to be accessible via the tough book	Meet with EPCR working group to discuss how this can be implemented going forward Meet with Cleric to ascertain the feasibility of this project Internally understand what this will look like and what needs to happen from an IT perspective / risk perspective and Informatics perspective	JS / NH / JK JS / NH / JK – outside agency JS / NH / JK – internal staff	Feb 2022	Referral via the Ulysses web will be accessible to the frontline staff to allow for direct referral form completion rather than via logistics which will reduce the risk of miscommunication.		The Trust is moving to iPad in July / August 2022. Frontline crews will have direct access to the Ulysses web reporting system and therefore will be able to make their own referrals. The Trust will need to consider and agree the referral process for third party providers / volunteer drivers etc Until back of house IT functions are updated there will still be a requirement to download referrals forms from the Ulysses system and directly email these securely to the relevant LA. Agreement will need to be reached between the safeguarding team and EOC Logistics management team re the administrative element of this

Action Number	Priority and Reason	Action required (examples)	By whom	Timeframe	Evidence /Outcome	RAG	Action required/Update
3	Additional operational resources for the Safeguarding Team to meet increasing demand and drive change	Funds to be agreed	SR/NH	Oct 2021	Substantive post holder to be in place		Await funding decision
4	Ensure a process is in place to flag when 3 or more referrals have been made about one individual in a 12 month period	Ulysses process to be implemented	JS / NH / CAM	Dec 2021	Alert process will be sent to the EDG safeguarding team email account to enable the case to be reviewed and accumulative risk assessed. Any concerns will be highlighted to the relevant Local Authority and or SAB / LCSB		Due to Operational demands the Ulysses user group has been stood down for several months. The group recommenced in March 2022 and this is on the action log as a requirement
5	Develop a process to ensure the safeguarding team are aware of patients who are being managed through the frequent caller team where there are safeguarding elements or risks could escalate to safeguarding	Set up a process to be notified of those patients meeting the frequent caller target	JS / NH / GF	Dec 2021	Case will be reviewed by the safeguarding team to assess accumulative risk and concern escalated to partner agencies where necessary		Increased communication between the safeguarding team and frequent caller team in the management of cases which both teams are involved in. Invites to meetings are shared via the safeguarding team and the frequent caller team as and when required. Updates shared both verbally and electronically to ensure good communication and a cohesive approach. Suggestion has been given at the Ulysses user group that a module be developed on Ulysses for the frequent caller team, this would allow cases to be directly linked to safeguarding cases / referrals / incidents and complaints.
6	Ensure a process is in place to alert the safeguarding team when a referral is made under the category of radicalisation / extremism	Ulysses process to be implemented	JS / CAM	Dec 2021	National referral form completion by the safeguarding team and supplied to Special Branch		As point 4

Appendix 2: Safeguarding Audit Plan for 2021/2022

Topic	April	May	June	July	August	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	March
Management of safeguarding allegation against staff												
The voice of the child												
Referrals made relating to mental health						X						
Referrals made which raise concern relating to substance misuse										X		