ADULTS AND HEALTH SCRUTINY COMMITTEE	AGENDA ITEM No. 6
11 JANUARY 2022	PUBLIC REPORT

Report of:	Charlotte Black, Chair of Cambridgeshire & Peterborough Safeguarding Adult Board	
Cabinet Member(s) responsible:	Councillor Irene Walsh Cabinet Member for Adult Social Care, Health and Public Health	
Contact Officer(s):	Jo Procter Head of Service – Cambridgeshire & Peterborough Safeguarding Partnership Boards	01733 863765

CAMBRIDGESHIRE & PETERBOROUGH SAFEGUARDING ADULT BOARD ANNUAL REPORT 2020-21

RECOMMENDATIONS	
FROM Charlotte Black – Chair of Cambridgeshire & Peterborough Safeguarding Adult Board	**Deadline date:** *N/A*
It is recommended that the Adults and Health Scrutiny Committee receive and note the content of the annual report.	

1. ORIGIN OF REPORT

1.1 The report is submitted to the Adults and Health Scrutiny Committee following sign off and publication of the Cambridgeshire and Peterborough Safeguarding Adult Board Annual Report 20/21 in November 2021.

There is a statutory requirement under the Care Act 2014 that Safeguarding Adult Boards publish an annual report detailing the work of the Board.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of the report being brought to the Adults & Communities Scrutiny Committee is to ensure members are fully aware of the work and progress of the Cambridgeshire and Peterborough Safeguarding Adult Board.

The report covers the period from April 2020-March 2021 and was published in December 2021.

2.2 This report is for the Adults and Health Scrutiny Committee to consider under its Terms of Reference Part 3, Section 4 - Overview and Scrutiny Functions, paragraph No. 2.1 Functions determined by Council:

4. Adult Social Care;
5. Safeguarding Adults.

2.3 *How does this report link to the Corporate Priorities?*
The extent to which Safeguarding is delivered effectively will have an impact on:

- The capacity of families to meet their own needs independently
- The long term health of vulnerable adults

3. TIMESCALES

Is this a Major Policy Item/Statutory Plan?	**NO**	If yes, date for Cabinet meeting	N/A

4. BACKGROUND AND KEY ISSUES

4.1 The annual report includes information on the work that has been undertaken by the Cambridgeshire and Peterborough Safeguarding Adult Board in the period April 2020 to March 2021.

Partner agencies, including Peterborough City Council, contributed to the information contained within the annual report.

The annual report highlights the significant events during the last year, summarises both the work of the Safeguarding Adult Board and the work of the sub committees. It highlights areas of good practice and presents statistical information about safeguarding performance.

The annual report was approved by the Safeguarding Adult Board in November 2021 and was subsequently published on the Boards website (www.safeguardingpeterborough.org.uk) and shared on social media.

Members are requested to note the contents of the report.

5. CONSULTATION

5.1 Partner agencies, including Peterborough City Council, contributed to the information contained within the annual report.

6. ANTICIPATED OUTCOMES OR IMPACT

6.1 The annual report highlights the significant events during the last year, summarises both the work of the Safeguarding Adult Board and the work of the sub committees. It highlights areas of good practice and presents statistical information about safeguarding performance.

The report has been brought to the Adults and Health Scrutiny Committee for information purposes.

7. REASON FOR THE RECOMMENDATION

7.1 There are no recommendations for the Committee to consider as the report is for information only.

8. ALTERNATIVE OPTIONS CONSIDERED

8.1 There was no reason to consider alternative options. It is a statutory responsibility of the Safeguarding Adult Board to produce an annual report.

9. IMPLICATIONS

Financial Implications

9.1 There are no financial implications

Legal Implications

9.2 There are no legal implications

Equalities Implications

9.3 There are no equalities implications

Rural Implications

9.4 There are no rural implications

10. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985

10.1 None

11. APPENDICES

11.1 Appendix 1- Annual Report of Cambridgeshire and Peterborough Safeguarding Adults Board 2020-21

Cambridgeshire and Peterborough Safeguarding Adults Partnership Board

Annual Report 2020/21

TABLE OF CONTENTS

FORWARD

We are pleased to present the annual report of the Cambridgeshire & Peterborough Safeguarding Adults Partnership Board for 2020-21. This is presented on behalf of the three statutory partners and the local multi-agency safeguarding arrangements.

The annual report outlines the key activities and achievements of the Board and its partners over the last year. You will see in the report that we have worked through our priorities throughout the year. The multi-agency safeguarding training has continued to develop and grow, front line practitioners' voices have been captured through a series of consultation surveys and forums, and quality assurance and scrutiny activity has taken place. One of the key roles of the Board is to ensure that partners continue to work together effectively and this has been evidenced throughout the year. We continue to work closely with other partnerships to ensure that the work is delivered jointly and consistently and there is no duplication or gaps.

Safeguarding is about people, their safety, wishes, aspirations and needs. The partnership has been active in identifying and learning lessons through the Safeguarding Adult Review subgroup. We have published six case reviews within the time period covered by this review. The learning from these reviews has been identified and disseminated through various activities including briefings, workshops and learning lessons training. The dissemination of the learning is explored in greater detail within the report.

Over the last 12 months the safeguarding landscape has been complex, presenting many new challenges, in addition to those faced day-to-day. We want to assure people that throughout the Covid pandemic to date, the Board has continued to work closely with both statutory and wider partners to scrutinise how safeguarding issues are addressed, gain reassurance that they are dealt with appropriately and provide a forum for sharing best practice across the partnership. It has also ensured that safeguarding adults remains a key focus for agencies across the County.

Finally, we would like to thank all members of the Board for their professionalism, commitment and support. We would also like to say thank you to all agencies and frontline staff for the incredible work that they do to keep adults safe from abuse and neglect.

Wendi Ogle-Welbourn	Carol Anderson	Vicki Evans
Executive Director, People and Communities	Chief Nurse	Assistant Chief Constable
Cambridgeshire County Council PETERBOROUGH CITY COUNCIL	NHS Cambridgeshire and Peterborough Clinical Commissioning Group	Creating a safer Cambridgeshire

ABOUT THE BOARD

The Care Act 2014 makes Safeguarding Adults Board a statutory requirement.

The Cambridgeshire and Peterborough Safeguarding Partnership Board is made up of statutory and non-statutory organisations representing health, care and support providers and the people who use those services across Cambridgeshire and Peterborough.

The membership of the Partnership Board is made up of the following organisations/agencies:

Cambridgeshire County Council
Peterborough City Council
Creating a safer Cambridgeshire
NHS Cambridgeshire and Peterborough Clinical Commissioning Group
NHS England
NHS Cambridgeshire Community Services NHS Trust
healthwatch Cambridgeshire
NHS Royal Papworth Hospital NHS Foundation Trust
NHS Cambridgeshire and Peterborough NHS Foundation Trust
healthwatch Peterborough
NHS Cambridge University Hospitals NHS Foundation Trust
NHS North West Anglia NHS Foundation Trust
HUC
NHS East of England Ambulance Service NHS Trust
PCC Police and Crime Commissioner Cambridgeshire and Peterborough
Cambridgeshire Fire & Rescue Service
CKH Cross Keys Homes
National Probation Service
Peterborough College
City College Peterborough
Working together, learning together
The Diocese of Peterborough
The Church of England Diocese of Ely
Care Quality Commission
Department for Work & Pensions

[1] Cambridgeshire County Council and Peterborough City Council representatives include Adult Social Care, Public Health and Elected councillors

What we do

The overarching purpose of the SAB is to safeguard adults with care and support needs, and assure itself that effective local adult safeguarding arrangements are in place. As a Board, we support the systems that keep adults with care and support needs safe, preventing abuse where possible and hold partner agencies to account.

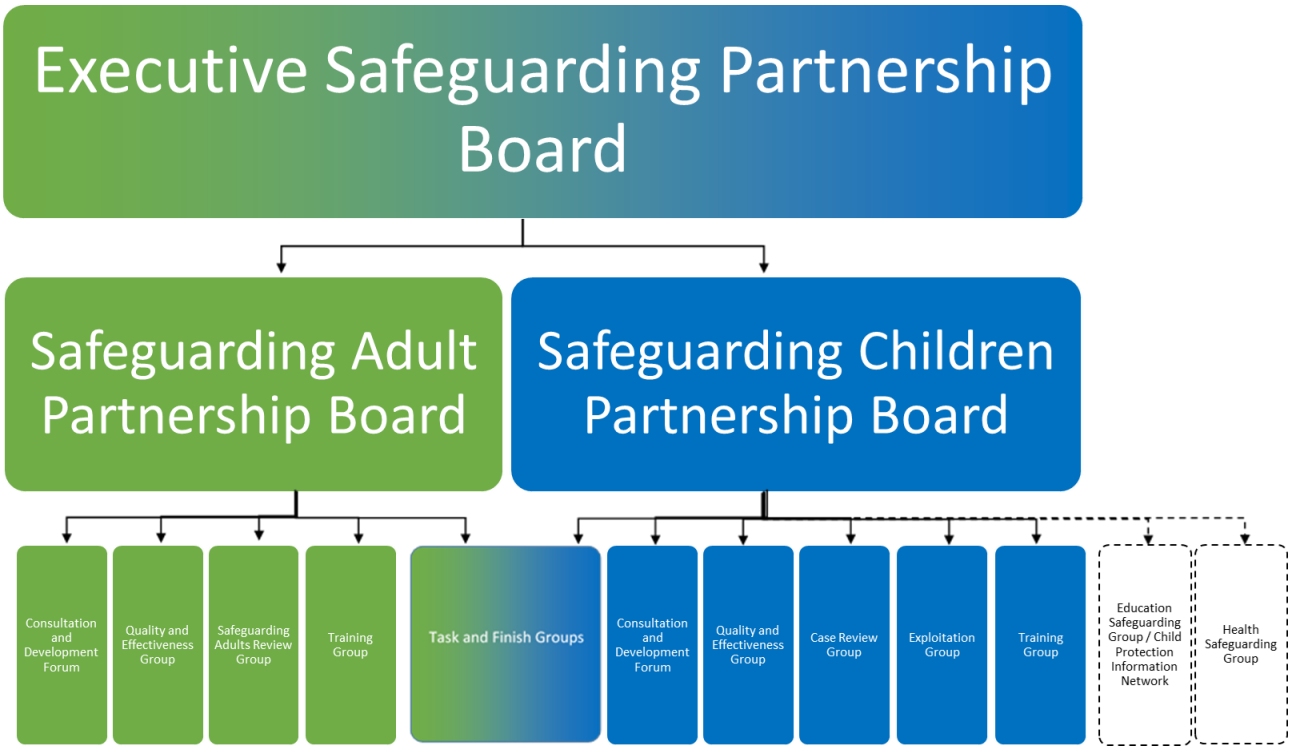
We do this by:

- Proactively identify and respond to new and emerging safeguarding issues and develop multi-agency policies, procedures and work streams.
- Communicate widely to persons and bodies of the need to safeguard and promote the welfare of adults, raising their awareness of how this can best be done and encouraging them to do so.
- Oversee, evaluate and seek assurance on the effectiveness of single/multi-agency safeguarding practice in order to drive improvement.
- Undertake Safeguarding Adults Reviews to identify learning and improve practice.
- Raise awareness and train the multi-agency workforce to promote a common, shared understanding of safeguarding and local need.

The Board has three core duties. They are:

- Develop and publish a ***strategic plan*** setting out how we will meet our objectives and how our member and partner agencies will contribute.
- Publish an annual report detailing how effective our work has been.
- Commission Safeguarding Adults Reviews (SARs) for any cases which meet the criteria for these.

The local safeguarding arrangements have a number of Boards and subgroups that oversee the Safeguarding Partnership. The most senior Board is the Executive Safeguarding Partnership Board, which is made up of membership from the 3 statutory partners (LA, CCG and Police), public health, Healthwatch and the voluntary sector. The Executive Safeguarding Board considers both the children's and adults safeguarding agenda. The Safeguarding Adult Partnership Board sits directly below the Executive Safeguarding Partnership Board and has wider partnership membership (Appendix 1 details those agencies who are members of the Board). The diagram below details the current governance structure.



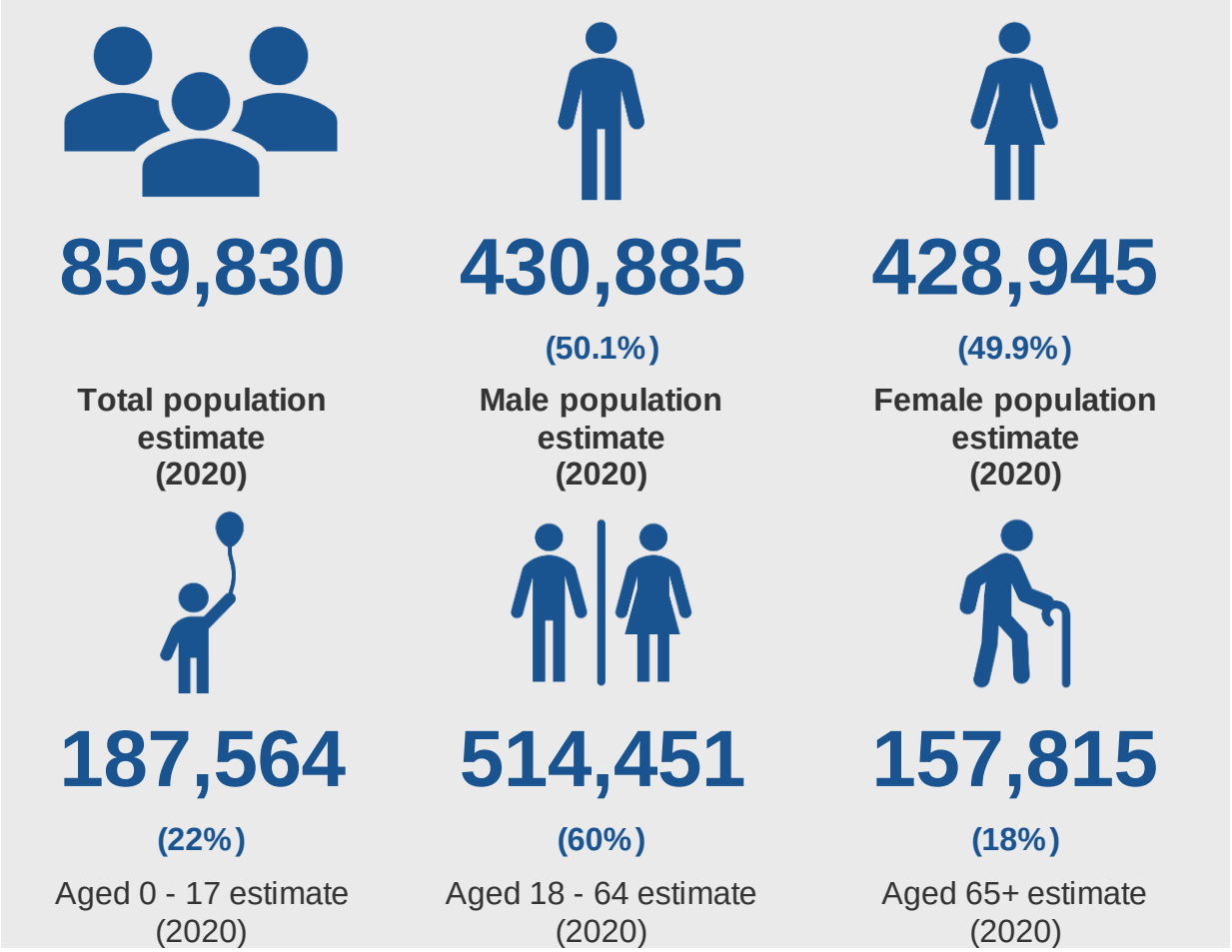
The Executive Safeguarding Partnership Board has maintained it's links with other groups and Boards who impact on child and adult services this year. These are illustrated in Figure 1. This ensures that all aspects of safeguarding are taken into account by the other statutory Boards and that there is a co-ordinated and consistent approach. These links mean that safeguarding vulnerable people remains on the agenda across the statutory and strategic partnership and is a continuing consideration for all members.

Links to other statutory Boards

DEMOGRAPHICS

Cambridgeshire covers an area 1,309 sq miles in the East of England bordering Lincolnshire to the north, Norfolk to the north-east, Suffolk to the east, Essex and Hertfordshire to the south, and Bedfordshire and Northamptonshire to the west. The county is divided between Cambridgeshire County Council and Peterborough City Council, which since 1998 has formed a separate unitary authority. In the non-metropolitan county there are five district councils, Cambridge City Council, East Cambridgeshire District Council, Fenland District Council, Huntingdonshire District Council and South Cambridgeshire District Council.

Population of Cambridgeshire and Peterborough at a glance[2]



Cambridgeshire and Peterborough's ethnic composition is primarily White (90.3%). The next largest ethnicity group is Asian (5.9%) and Black (1.3%)

The ethnic composition of Cambridgeshire and Peterborough differs between areas. Peterborough is much more ethnically diverse, with a larger proportion of people from 'Asian; Indian/Pakistani/Bangladeshi' and 'White Other' ethnicities. There are more than 100 languages spoken in Peterborough with more than a third of children speaking English as their second language. In Cambridgeshire districts, Cambridge City is much more ethnically diverse than Fenland. Within Cambridge City 82.5% of residents identified as White compared to 97.2% of Fenland residents.

According to the Census 2011 figures, there were 2,068 people identified with the ethnic background White: Gypsy or Irish Traveller.

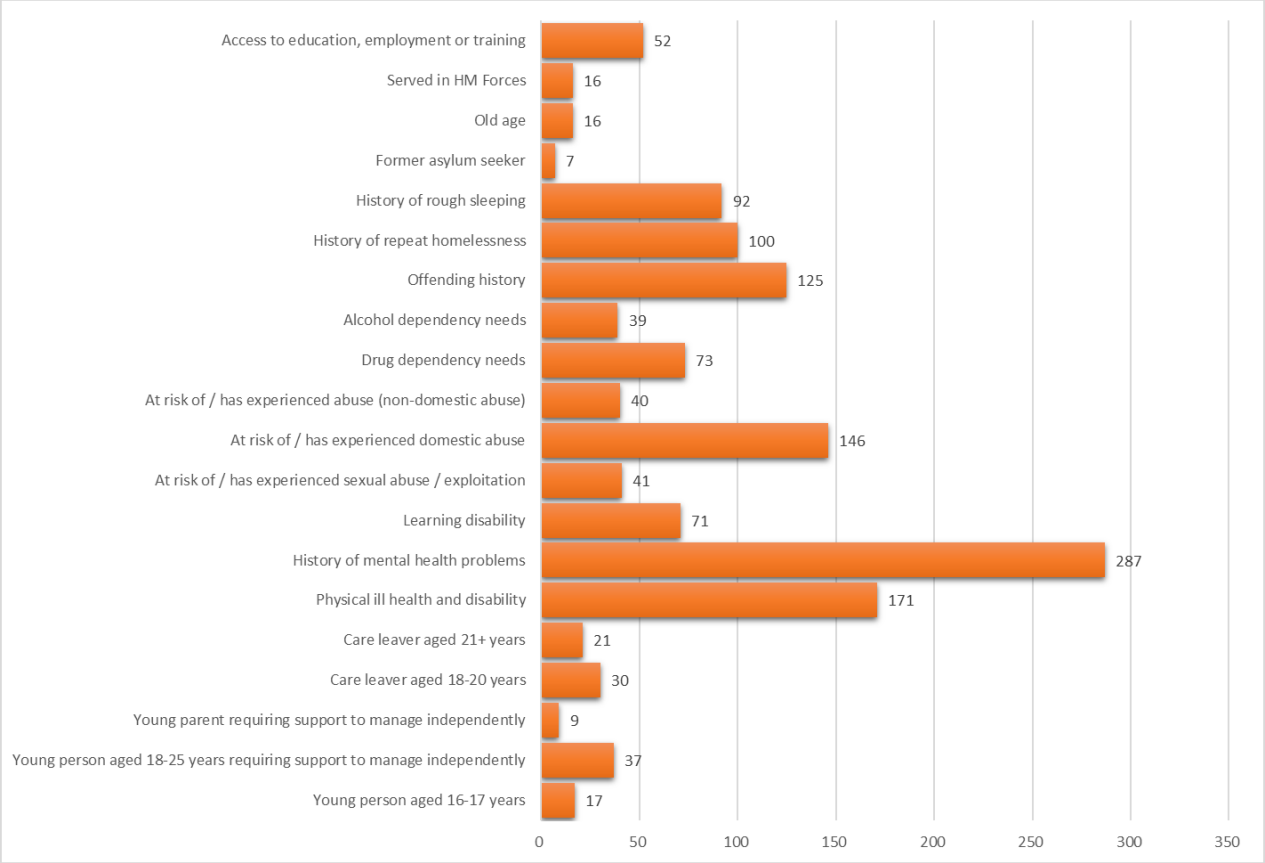
The traveller caravan count data provided by local authorities on the number of caravans and traveller sites, does not cover the number of occupants residing in these caravans or caravan sites. In January

[2] https://cambridgeshireinsight.org.uk/population/report/view/9eb28cf5b5d045d28eeabce7819ba4f6/E47000008

2020, there were a total of 1,650 caravans on authorised (socially rented and private) and unauthorised sites. 35% of these were located in East Cambridgeshire and 34% were in Fenland[3]

Homeless population

At the end of March 2021 there were 961 households assessed as homeless or threatened with homelessness. 49% were from Peterborough and Huntingdonshire. Of the 961, 535 households were identified as having support needs.



There were 595 households in temporary accommodation, 295 households in temporary accommodation had a combined total of 488 children.

There were 41 rough sleepers across Cambridgeshire and Peterborough in Autumn 2020[4], 39% of which were in Cambridge.

Prison Population

HMP Whitemoor is situated in Fenland, Cambridgeshire and is a maximum security prison for men in Category A and B with an operational capacity of 459. An HMP scrutiny visit carried out in August

3

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/891230/Traveller_caravan_count_live_tables_Jan_count.xlsx

[4] The annual rough sleeping snapshot takes place on a single date chosen by the local authority between 1 October and 30 November

2020 found there to be 450 prisoners of which 15% were foreign nationals and 51% from BAME backgrounds.

HMP Littlehey is situated near Huntingdon and is a category C training prison specialising in holding 1,220 prisoners convicted of sexual offences. In July 2019, there were 1,211 male prisoners, all aged 21 and over. 10.2% were foreign nationals and 69% were listed as White British.

HMP Peterborough is situated in Peterborough and is a dual-purpose prison, housing both male and female prisoners. It has an operational capacity of over 1,200 places (868 male, 396 female) including a 12-bed mother and baby unit. Recent HMP Peterborough Inspection reports carried out in September 2017 found there to be 367 women prisoners of which 4% were under 21 years of age, 18% were foreign nationals and 69% were listed as White British. There were 808 male prisoners of which 7.5% were under 21 years of age, 12.5% were foreign nationals and 61.6% were White British.

Safeguarding Adults Data 2020-21

A safeguarding concern is any issue raised with Adult Social Services, which is identified as being about an adult safeguarding matter. If the concern meets the criteria for safeguarding (as defined by the Care Act 2014), a Section 42 Enquiry is raised, which involves fuller investigation and formal intervention.

In Cambridgeshire, there were 8,272 concerns of abuse raised; this is a decrease on the previous year. 15% (1,274) of concerns led to Section 42 safeguarding enquiries involving 1040 individuals being commenced.

During the year, 1,918 Section 42s had concluded. Neglect and Acts of Omission were the most prevalent type of risk identified in Safeguarding Enquiries (31%), followed by Financial or Material Abuse (17%). The majority of risks were located in their own homes, followed by Residential Care Homes. The source of risk came from someone known to the victim. 91% of completed Safeguarding Enquiries had removed or reduced the risk identified.

38% of concluded enquiries found the person at risk had lacked mental capacity, of these 86% had support provided by an advocate, family or friend.

An important measure of the success of safeguarding is the person's desired outcomes being met. This provides an indication of how well the principles of Making Safeguarding Personal are becoming embedded. In 2020/21, in 73% of concluded Safeguarding Enquiries, the person at risk was asked and expressed what their desired outcomes were. 96% of people had their outcomes fully or partially achieved in their safeguarding enquiry where the adult at risk (or their representative), expressed their desired outcomes.

Peterborough Data

In Peterborough, there were 1,375 concerns of abuse raised. This is a decrease on the previous year. 6% (87) of concerns led to Section 42 safeguarding enquiries involving 80 individuals being commenced.

During the year, 123 Section 42s had concluded. Neglect and Acts of Omission were the most prevalent type of risk identified in Safeguarding Enquiries (28%), followed by Financial or Material Abuse (23%). As in Cambridgeshire, the majority of risks were located in their own homes, followed by Residential Care Homes. The source of risk came from someone known to the person at risk. 92% of Safeguarding Enquiries had removed or reduced the risk identified.

49% of concluded enquiries found the person at risk had lacked mental capacity and of these 98% had support provided by an advocate, family or friend.

In 2020/21, 76% of concluded Safeguarding Enquiries, the person at risk was asked and expressed what their desired outcomes were. 86% of people had their outcomes fully or partially achieved in their safeguarding enquiry where the adult at risk (or their representative) expressed their desired outcomes.

COVID 19 AND THE WORK OF THE PARTNERSHIP

Covid 19 has had a significant impact on society during the period of time covered by this annual report. From the outset, partners worked together collaboratively to ensure an effective response to the Covid 19 situation. Partners demonstrated a flexible approach to systems and processes that ensured that the needs of the ever-changing safeguarding landscape were met. At times, these discussions and decisions were challenging as resources were stretched and new ways of working needed to be established quickly. However, the initial responses and ongoing evolving processes, evidence the value and strength of the partnership relationships and working practices.

It is recognised that lockdown resulted in a number of adults becoming increasingly vulnerable and potentially invisible as health services, voluntary sector services and other agencies moved to a virtual world and resources were realigned to meet the needs of the pandemic. The Board played an important role in cascading messages around the need to recognise and report abuse. However, Covid 19 also saw people work together to help some of the most vulnerable people within our communities. There were significant increases in individuals taking up volunteering positions, many of which had no, or very limited, understanding of safeguarding. Within a few days of the Country entering into the first lockdown, the Partnership had developed bespoke guidance and virtual safeguarding training that was specifically tailored to new volunteers and safeguarding during Covid. A Covid Safeguarding Resource page was developed on the Partnership website that contained detailed information and resources on a range of safeguarding and Covid issues. This included information on scamming, online safety, domestic abuse, mental health and talking to children about Covid 19. The website page was launched on the 31st March 2020 and by the 31st March 2021, had been accessed in excess of 18,000 times. As the Partnership Board website is actively used across the partnership, it was used to host the professionals virtual test and trace training and virtual resources.

The Partnership Board played a key role in communicating information about the pandemic, including the need to recognise and report abuse, via its social media platforms. Throughout the year there was an active social media campaign across Twitter, Facebook and Instagram, which had in excess of 190,000 reaches. The Safeguarding Partnership Board was also an active member of countywide Covid 19 communications meetings, ensuring a consistency of messages and a joined up approach.

During the Covid 19 pandemic, the Partnership Board has continued to facilitate partnership meetings and discussion groups, focusing on the Board's safeguarding priorities. Face to face meetings were discontinued due to governmental legislation and virtual meetings initiated.

The Partnership response to Covid 19 and Safeguarding was discussed and agreed at all of the Executive Safeguarding Partnership Board meetings held throughout the year. In addition, Executive Safeguarding Board members met extraordinarily to discuss urgent issues that also occurred throughout the year.

The Partnership was aware of the need to continue to up-skill the workforce on safeguarding issues and as a result developed virtual briefings. Locally, these are referred to as Sways (the software that is

used for the briefings). In essence, these are a presentation but each slide has an audio that discusses the content of the slide. Generally, they last around 20 minutes per briefing. The virtual briefings are available on the Partnership Board website and can be accessed at any time. As a result, staff who are working night shifts, weekends or early shifts can all access the training at their convenience.

The first virtual briefing to be uploaded onto the board's website during April 2020 was on 'Safeguarding for Community Volunteers' closely followed by 'Safeguarding from Online Abuse', a recognised high-risk area of concern during lock down. The virtual briefings that followed focused on safeguarding during Covid and locally identified areas of safeguarding risk, as well as the Board's priorities. However, as the popularity of the virtual briefings increased it was apparent that these were a hugely useful resource and further topics were added. Between April 2020 and March 2021, the virtual briefings had been viewed a total 10,753 times.

SAFEGUARDING ADULTS PARTNERSHIP BOARD PRIORITIES 2020/2021

Priority One: The importance of Making Safeguarding Personal (MSP) is recognised and implemented effectively across agencies

Making Safeguarding Personal (MSP) is a golden thread running throughout everything the Board does and is in all of our multi-agency training, resources and audits. The Importance of listening and acting to the voice of the adults is imperative throughout all safeguarding practice. A dedicated area on the Safeguarding Partnership Board's website has been created for the Board's priority of Making Safeguarding Personal, which includes an overview and resources for practitioners.

Discussion within the Board's Quality and Effectiveness Group determined that practitioners are not always consistent in the terminology and language used. Consultation with front line practitioners confirmed this and established that not all practitioners refer to the process of "making safeguarding personal" and may call it something else. However, many do follow making safeguarding personal processes in their practice. To support practitioners in their understanding of the terminology associated with Making Safeguarding Personal and the wider adult safeguarding context, a 'Safeguarding Glossary', was developed and launched on the website in June 2020. The glossary contains agreed Partnership language and interpretation, and includes the definition of what is an 'Adult at Risk'.

A safeguarding professionals survey was conducted, the findings evidenced that some professionals needed further support in understanding what MSP was in practice and how to ascertain the Lived Experience of the Adult (LEotA). This resulted in MSP workshops being cascaded both face to face and virtually. In addition, a LEotA resource pack was developed that contained resources and information to support practitioners in this important area of safeguarding. The impact of this work is being evaluated and will be discussed in the 2021/22 annual report.

MSP continues to be discussed at the Quality & Effectiveness subgroup as part of the Single Agency Performance monitoring to see how agencies are embedding the assessment and support of MSP

into practice. An MSP audit tool was also developed and agreed at QEG by the partners. At the time of writing this report, the audit had included 25 safeguarding referrals across agencies being analysed against the MSP audit tool. The findings and recommendations are to be discussed at QEG later during 2021 and will be reported on in next year's annual report.

Priority Two: Agree and implement pathways for those vulnerable adults considered "at risk"

We want adults and older people to be safe and healthy, to be independent and maximise their potential, and to be supported to make a positive contribution within their community which reciprocally supports them. This requires the Partnership to have agreed pathways for those vulnerable individuals who agencies consider to be "at risk".

One of the local processes in place to support this cohort of individuals is the Multi-Agency Risk Management (MARM) process. A safeguarding professionals survey was carried out, which identified that professionals needed support in understanding where to find the MARM Guidance (MARM) and how to use it in practice. A MARM audit undertaken in February 2021 made several recommendations and a MARM task and finish group has been set up to address them. Immediate steps were taken to ensure MARM is featured within the Boards multi-agency training and a MARM briefing was developed to support professionals. The MARM process has been in place since 2019 and we are taking this opportunity to refresh the process. In addition to the feedback we have received from practitioners, we are currently seeking the views of individuals who have been the subject of a MARM process. The outcomes of this work will be discussed in the 2021/22 annual report.

The involvement of vulnerable adults in countylines has been recognised and a new 'cuckooing' policy has been implemented as a pilot in Peterborough, to support those vulnerable adults being targeted by individuals. The policy is one of support and once evaluated will be rolled out across both authority areas.

Work has taken place to help professionals understand more about the Sexual Assault Referral Centre (SARC), the services that they offer and how to support adults at risk. A virtual workshop took place and was recorded. The recording is openly available for all professionals across the county to access via the Safeguarding Partnership Board's website. To date, 115 people have accessed the virtual recording.

There is a dedicated 'Abuse, Exploitation and Wellbeing' page on the Safeguarding Partnership Board's website which includes information and resources for practitioners and service users.

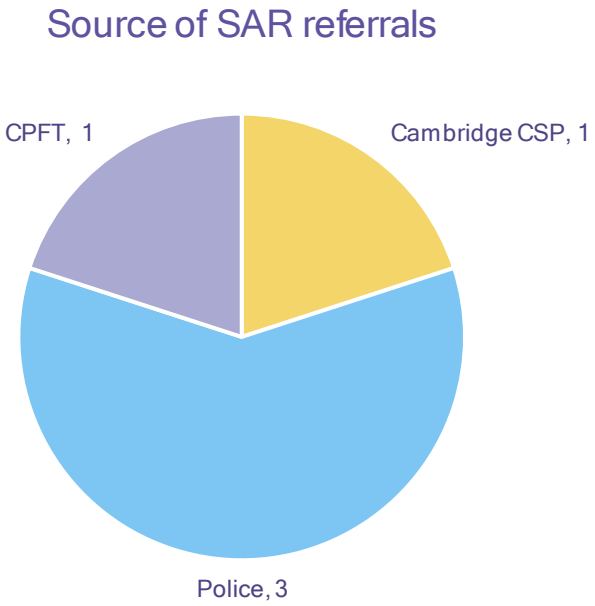
LEARNING FROM SAFEGUARDING ADULT REVIEWS

Section 44 of the Care Act describes the statutory duties placed upon Safeguarding Adult Boards to review cases where a person has died or been seriously injured, and abuse or neglect is known or suspected.

A Safeguarding Adults Board (SAB) may also arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Safeguarding Adults Reviews (SARs) may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases. Safeguarding Adult Reviews are not to apportion blame but to identify lessons to be learnt in order to prevent similar occurrences from happening.

Number of SAR referrals considered within timeframe covered by annual report	Referrals for SAR to CPSAPB		SARs completed within timeframe covered by annual report	SARs still in progress
	Criteria met	Criteria not met		
5	3	2	6	5



Between April 2020 and March 2021 there were 5 new SAR referrals. Of the 5 referrals, 2 cases did not meet the criteria for a review and 3 met the criteria for a SAR. During the year, 6 SARs were signed off by the Board, all of them had commenced prior to March 2020. The 5 SARS that were referred during the timeframe covered by this annual report, will be published post March 2021. These SARs will be detailed in the 2021/22 annual report.

The following SAR's were published during the timeframe covered by this annual report.

Simon

Simon was a 90 year old man who died in 2017. Simon started to become known to a number of agencies around 2008 and in 2009 he was admitted to hospital for the removal of a frontal lobe meningioma (brain tumour). Simon also had a history of pressure ulcers, kidney disease and his mobility and ability to swallow deteriorated progressively over time. Simon died in hospital having developed pneumonia secondary to aspiration, caused by his poor swallow response.

Between 2014 and 2017 professionals identified a number of increasing concerns for Simon in relation to; tissue viability, being drag lifted by family members, poor nutrition, lack of pain relief being administered and the family refusing necessary supportive equipment. On many occasions agencies deemed that care provision for Simon was to increase. However, these additional services were repeatedly declined by the family.

Learning from this review includes:

- Agencies should openly discuss and explain to family members what keeping an Adult at Risk (AAR) safe and well means and make clear that if the AAR is not kept safe and well what might happen, whether that is further intervention or potential legal redress.
- Agencies should have considered whether an advocate working on Simon's behalf would have been beneficial to support Simon's views and working with the family and services to address his care and support needs.
- Professionals should be aware of what the Lasting Power of Attorney means and of the procedures and processes involved with the Office of the Public Guardian when supporting an adult at risk.
- There were a lack of clear agency care plans being completed, recorded and put into place, both in relation to Simon living in the community and prior to his discharge from hospital stays.
- For accountability and safeguarding purposes, it is vitally important that all agencies and professionals record; assessments, care plans, work completed with the AAR, liaison with the family and other agencies and note safeguarding concerns.
- Professionals should consider if an AAR is experiencing neglect and evidence what the signs and indicators are for that individual, whether it be lack of; care, food, treatment, equipment, cleanliness or medication and record the perceived impact on the individual.
- Professionals need to understand what domestic violence is and to be professionally curious to 'rule in or rule out' potential domestic violence, whilst being confident and having 'respectful uncertainty' in order to challenge what is said to them. Professionals need to be able to make appropriate referrals to the police and social care if an adult at risk might be experiencing domestic violence.
- Professionals should be aware of what 'financial abuse' is and consider if an AAR is being financially abused by family members, friends or other people known to them.
- Practitioners should always communicate with the adult at risk and ascertain their thoughts, feelings and wishes; though at the same time, professionals should find out the reasons why

services are being declined and weigh up what the risks of significant harm are for that individual if services are not implemented or are withdrawn. Professionals need to hear the voice of the AAR and not let stronger voices, such as family members, over impose.

Claire

Claire suffered from muscular dystrophy which resulted in having a pacemaker fitted and was diagnosed with recurrent depressive and adjustment order. Claire had three children, two of whom were also born with muscular dystrophy. For the most part, Claire was a single parent but did have an on-off relationship with the father of one of her children. It was recorded that Claire had experienced domestic violence previously from her relationships with men. There were also reports of Claire being violent towards both her partner and her children.

During 2017 Claire suffered a stroke and after several nights in hospital was discharged. After her discharge there were records of her struggling to control her outbursts and that she could be violent towards her children.

After Claire presented at hospital in a mental health crisis with 'thoughts of killing herself' and feeling that she was 'not a fit mother', Children Social Care placed two children into voluntary foster care and placed the third child with their father.

During February 2018 an initial Court hearing took place in respect of the care of the children who were made the subject of a variety of Court orders designed to support and to protect them. An independent psychological assessment and a parenting assessment of Claire was carried out.

In June 2018 Claire received the independent psychologist's report which referred to her 'poor parenting' and news that she was unlikely to have her children returned to her. Later that day Claire tragically took her own life, she was 39 years of age.

Learning from this review includes:

- There were several important high-risk management meetings for both the childrens and adult services where either professionals were not invited or practitioners were required to attend but failed to turn up with their non-attendance not being pursued. Without a full picture of the family's circumstances and all of the agencies involved, the decisions made, risk assessments, along with planning and interventions, might not have been effectively completed and important information may have been missed.
- Claire, on occasions, said that she felt suicidal to different agencies. However, these feelings were not shared with all of the relevant agencies.
- Professionals not being aware of the risks, leads to inaccurate risk assessments and potentially, as in this case, the withdrawal of important health services needed to support the adult at risk.

Alice

Alice lived with her husband and in 2001 was diagnosed with multiple sclerosis (MS) and was able to continue working until 2008. During 2009, Alice requested assistance from adult social care to relieve the pressure on her husband. At around the same time, Alice reported to professionals that she has

been experiencing serious emotional and physical domestic abuse from her husband. There were ongoing disclosures from Alice of continued domestic violence during the subsequent years.

In 2016 Alice left her husband and was accommodated within a local care home. During the year Alice made contact with her husband despite advice and support from her Independent Domestic Violence Advocate (IDVA). Alice returned home to live with her husband but due to the effects of MS, she was confined to her bedroom. Alice was admitted to hospital in 2018 with an infection to her groin and sadly died two days later.

Learning from this review includes:

- Professionals should be aware of what 'coercive control' is and what this might look like between the relationships of the Adult at Risk's (AAR) family members, friends or other people known to them.
- All care homes should review their policies and procedures to develop a means of highlighting important sensitive information regarding certain residents and how and when that information can be shared.
- When working together to secure the wellbeing and safety of an AAR all agencies who have contact with the AAR should be involved when sharing information and holding multi-agency risk meetings.
- Health professionals need to 'look further that an AAR medical needs' and to consider other potential safeguarding concerns such as domestic abuse.
- There must be respectful challenge whenever a professional or agency has a concern about the action or inaction of another. The aim must be to resolve a professional disagreement at the earliest possible stage, always keeping in mind that the adult at risk's safety and welfare is paramount. All agencies and professionals should be aware of and able to use the 'Cambridgeshire and Peterborough Safeguarding Partnership Board Resolving Differences (escalation policy).

Dorothy

Dorothy was a 77 year old female who lived with her daughter.

Dorothy displayed hoarding behaviours and the Housing Association attempted to support Dorothy to address this due to the fire risk that was posed to the other residents residing in the properties either side of Dorothy and Faye's property. In February 2018, the local authority Homelessness team became involved as Dorothy and her daughter were facing homelessness as a result of possible eviction. Both agencies made further attempts to support Dorothy and Faye to clear the property but had limited success.

Dorothy was deemed to have capacity following these earlier referrals and the concerns referred to Adult Social Care did not meet the safeguarding criteria.

In January 2019, after being found unresponsive by her family, Dorothy was admitted to hospital and died on the same day. She had a large open wound from an untreated breast cancer tumour, which had become necrotic with metastatic deposits throughout both lungs. The state of Dorothy's health

was unknown to health agencies, or any other professional before 24th January as she had not sought any medical support.

Learning from this review includes:

- The needs of Dorothy's daughter had been overshadowed and as such, any opportunity to support her had been missed.
- Adult Social Care could have been clearer to other professionals, and Dorothy and her daughter, regarding their role and the support they may have been able to offer.
- There were no indications that Dorothy had been offered mental health support for her hoarding behaviour.
- All referring agencies should be aware of their responsibility to follow up referrals with Adult Social Care if they do not receive a response.

Peter

Peter was a 45 year old man who was an EU national and came to the United Kingdom around 2008. Peter was employed in Poland as an IT professional, but was unable to find employment once he arrived in the UK. He was married twice and became estranged from his second wife, at which time it is recorded that he sought support from his general practitioner for suicidal ideation and alcohol misuse.

Peter returned to Poland for a short time and whilst there he sustained a serious head injury. Peter explained to some people that the injury was from being assaulted and to others that he had been involved in a car accident. As a result of the incident, Peter's frontotemporal region of the brain was damaged and he experienced memory difficulties, headaches and black outs.

On returning back to the UK from Poland he had no recourse to public funds due to his immigration status and as a result was homeless, spending 'extensive periods' living and sleeping on the streets. Peter suffered from alcohol dependency and due to his lifestyle was regularly admitted to hospital. It is recorded that he attended hospital on 25 separate occasions, either due to being intoxicated or from sustaining injuries whilst falling down inebriated.

Several charitable agencies were involved in trying to support Peter both with his accommodation and engaging him to access support services in relation to his drug and alcohol use. Peter refused to engage and explained that he would continue to 'drink alcohol everyday if he could'.

Medically the general practitioner, hospital, dual-diagnosis team and substance misuse agencies, all tried to support Peter. Agencies stated that when Peter was sober he appeared to have capacity and to be able to make decisions but he did not want to access the help offered.

As time went on and winter approached, Peter's health deteriorated and the risks to his wellbeing and safety increased. Agencies assessed that Peter might die during the colder months and they actively responded by working together and involved Adult Social Care with a view to finding him supportive accommodation to get him off of the streets.

Tragically during 2018, after attending hospital and being discharged, Peter fell into a river and later died of a cardiac arrest.

Learning from this review includes:

- Professionals need to have greater understanding of the long-term effect of alcohol misuse on an individual's mental capacity.
- When undertaking assessments, professionals need to be aware of Alcohol Related Brain Damage as a mental health condition and how this may impact on an individual's behaviour.
- Professionals need to have a greater understanding of the duty of care under the Care Act 2014 and what is available for those individuals who have no recourse to public funding.
- Professionals should be aware of the Cambridgeshire and Peterborough Multi-Agency Risk Management Guidance and consider its use for working with, and supporting, vulnerable adults at risk who struggle to engage with services.
- Professionals working within hospital settings should be aware of the Homeless Hospital Discharge Protocol and ensure that it is consistently applied for each and every homeless person's hospital admission.
- The Local Authority, District Councils and Housing providers should also be aware of the Homeless Hospital Discharge Protocol and of their roles and responsibilities within it.

Alan

Alan was 92 years of age at the time of the incident that initiated this review.

Alan suffered from a number of health conditions including; chronic back problems, diabetic retinopathy, high blood pressure, hearing difficulties and dementia.

Over a long period of time, numerous safeguarding concerns were raised with Adult Social Care over the care being afforded to Alan including incidents of neglect and psychological abuse.

The police were called and found Alan in a poor state of health and the house was reportedly in an 'unsanitary condition' with most rooms covered in pet faeces. It was at this point that Alan was taken to hospital.

Learning from this review includes:

- This omission of key agencies resulted in a lack of sharing information with no coherent and coordinated action plan being formulated to address the presenting issues.
- The history of the case was not reviewed and safeguarding enquiries were often closed without exploring the cumulative effect of the previously reported concerns.
- The RSPCA undertook an unannounced visit and gave a warning regarding the conditions that the pets were left in. Agencies did not follow this up or highlight it as a concerning contributory factor to the case. This resulted in no consideration being given to what the neglect of animals meant within the bigger picture of what was happening within the home.

At the conclusion of a SAR, an action plan is developed and implemented. This is monitored through the SAR sub-group. A series of workshops are held to ensure that the learning is disseminated across the Partnership. A series of written briefings are also produced that focus on the implications for practice.

The latest national research undertaken by Preston – Shoot et al (2020) 'Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for sector-led improvement' was cascaded to professionals through the virtual termly safeguarding workshop. Alongside this report our local findings and latest SARs were also presented and discussed.

The lessons learned from SARs continue to be discussed at the QEG as part of the single agency performance monitoring to see how agencies are embedding the learning from local and national reviews into safeguarding practice.

During 2021, a 'Database of Learning' was developed to record details and findings from all of the Safeguarding Adult Reviews and Child Serious Case Reviews / Child Safeguarding Practice Reviews across the county.

THE LEARNING DISABILITIES MORTALITY REVIEW (LEDER) PROGRAMME

Research has shown that, on average, people with learning disabilities die earlier than the general population, often for reasons that are preventable, and face barriers to accessing health and care services. LeDeR reviews the deaths to see where we can find areas of learning, opportunities to improve, and examples of excellent practice. This information is then used to take action to reduce the health inequalities people with learning disabilities experience.

Established in 2017 and funded by NHS England and NHS improvement, it's the first of its kind. LeDeR works to:

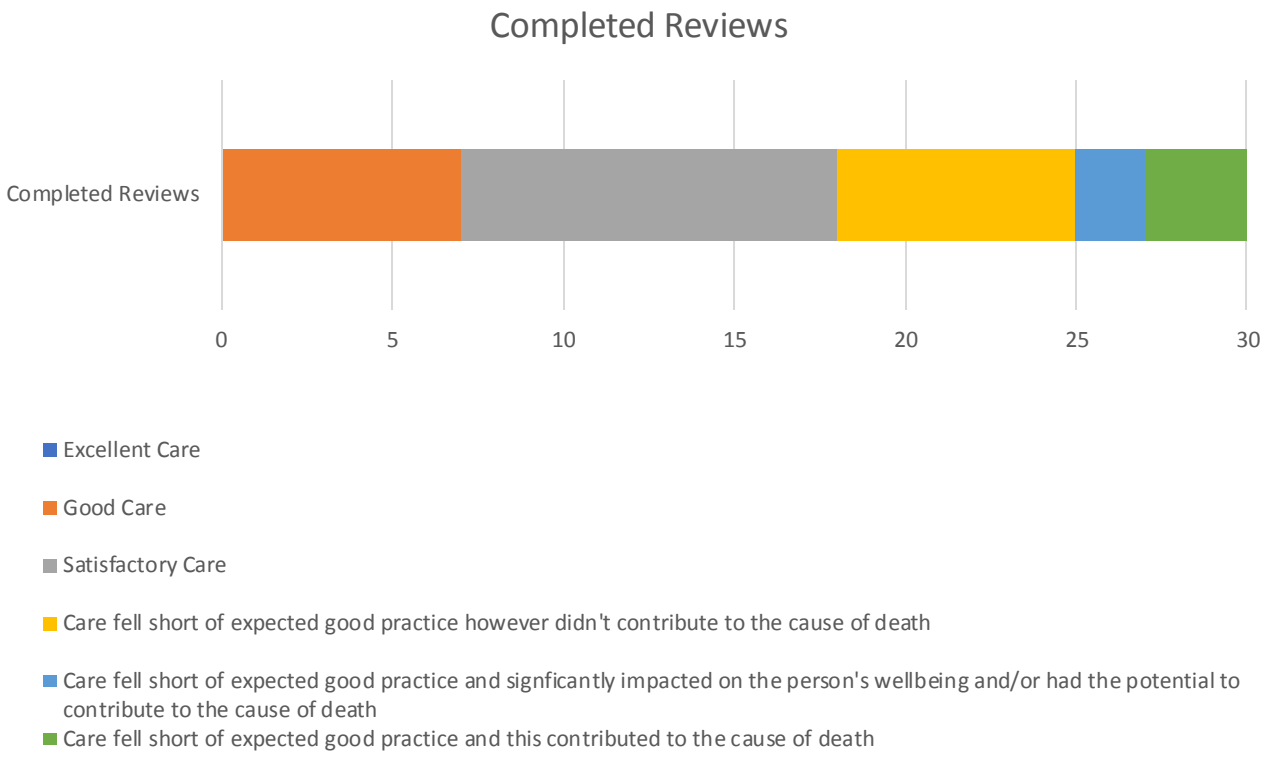
- Improve care for people with a learning disability and autism.
- Reduce health inequalities for people with a learning disability and autism.
- Prevent people with a learning disability and autism from early death.

From September 2021 LeDeR will include improving services for autistic people too.

Annual report Cambridgeshire and Peterborough

LeDeR deaths APR 20 – MAR 21 - 43.

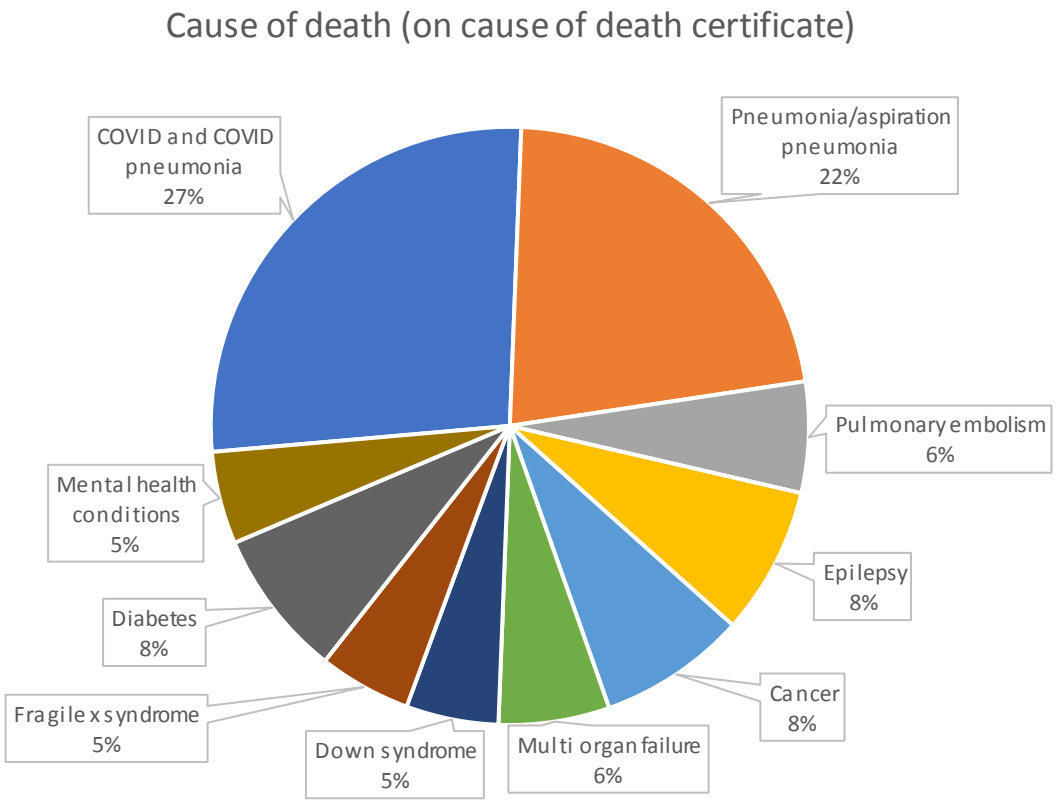
Total notifications for duration of programme - 151



Emerging themes

The stats used underplay the gap in life expectancy, a more illustrative comparison would be (from the LeDeR report):

'During 2018-2019, median age of death data shows that for males with learning disabilities age of death is 23 years younger than the general population and for females 27 years younger. 2020 data is not such a useful comparison as numbers are impacted by Covid.'



Recurring themes

- No annual health check in last 12 months.
- Insufficient level of care and support.
- Lack of compliance with principles of the MCA.
- No hospital passport and/or not provided or utilised.
- Delayed reviews/assessments.
- ReSPECT/DNACPR's not correctly completed or followed.
- Health screening not up to date – Bowel, breast and cervical cancer screening.
- No flu and/or pneumonia vaccination.
- No learning disability Nurse review while admitted.
- Lack of reasonable adjustments.

CONTRIBUTIONS FROM THE STATUTORY SAFEGUARDING PARTNERS

Adult Social Care

Adults Safeguarding is a core function within the Adults and Safeguarding directorate which is led strategically by Director of Adult Social Care (DASS) for Cambridgeshire County Council and Peterborough County Council, Charlotte Black.

Safeguarding adults remains a high-profile commitment for the Adults and Safeguarding Directorate, with the establishment of a dedicated post of Principal Social Worker and the introduction of the Care Home Support Team being particular highlights. The impact of Covid is still being understood.

The Head of Safeguarding represents the directorate at the SAB and our Principal Social Worker, attends the SAR sub-group ensuring that we are fully involved in making Safeguarding Adult Reviews (SAR) referrals and gathering and analysing information when referrals are received.

During 2020/21 our key achievements have been:

- **Covid-19:** A flexible and adaptable approach was taken to deal with the unprecedented issues raised by the Covid-19 pandemic. There was close engagement with the CQC, private sector care providers and other partners to manage risk. This involved providing advice and support, extra PPE, training sessions, targeted and compliant care home visiting, establishing a Covid Hub, ensuring staff well being.
- **Safeguarding Training:** Training continues by making use of online training and sessions being delivered via teams.
- **Adult MASH:** Work continued with closer working of the CCC and PCC adult MASH teams to ensure consistent and responsive working across both teams. The work flow has been harmonised and it is virtually the same in both areas. Continuous review of work processes to ensure risk to adults at risk is minimised, e.g. the introduction of a MASH Duty function in both areas to work alongside the MASH triage function in order to better understand referrals and ensure the correct response is taken.
- **Quality and Practice:** A dedicated Quality and Practice Team manage a cycle of managerial audits of practice, incorporating safeguarding. Practice guidance on specific safeguarding related topics has been developed; Coercive Control, Medication errors, Safeguarding Adult Reviews, Notice of Concerns Database. We communicate practice and legislative updates in our practice newsletters and in online sessions with staff.'
- **Care Home Support Team:** This new team started work in January 2021 with a team of five social workers and a team manager. The team works with Care Homes across Cambridgeshire and Peterborough, supporting them to improve services and reduce risk to their residents.
- **IDVA Service:** There has been a significant increase in funding with has resulted in the recruitment of a number of new practitioners. The need for a specialist IDVA to work with individuals who are not adults at risk but have increased vulnerabilities had been recognised

and a new worker is due to start soon. They will work closely with MASH and in line with the Care Act principle of early intervention and prevention.

- **Mosaic (CCC's and PCC's Adult Social Care System):** Developments have been introduced to improve the safeguarding information gathering work-step. Inappropriate referrals are now managed in a more efficient manner freeing up lead practitioner time to focus on those most at risk. Organisational/provider records have now been created on Mosaic allowing better provider recording and understanding of organisational risk. The Council's formal separate Notice of Concerns database, that detailed issues with service providers has been incorporated onto Mosaic. This ensures all provider information is on one system. PCC and CCC are now aligned with almost identical safeguarding workflows.
- **Change of roles and responsibilities:** The role of Principal Social Worker was separated from the responsibility of the Head of Safeguarding in order to provide a more focused support with quality practice delivery and safeguarding in the service.
- **CPFT:** There has been increased partnership working to ensure that the relationship between CPFT, both physical and mental health is robust and works towards getting the best outcome for the adult at risk. There is a more streamlined referral route which will support both organisations to ensure that concerns are managed in a timely manner.
- **SARs:** Actions arising from learning from SARs are overseen by the Practice Governance Board. Activities have included specific learning events being held to identify areas where practice needs to improve, learning incorporated into MASH practice guidance and discussions at practice forums.

The Adult Safeguarding Priorities for 2021/22 are:

- Ongoing Covid recovery
- Complete the integration of CCC and PCC Adult MASH process and practice
- Contribute to the MARM review
- Identify opportunities to improve the quality of outcomes in safeguarding enquiries through audit activity
- Explore how Transitional Safeguarding guidance, 'Bridging the Gap' could be embedded into practice

Cambridgeshire & Peterborough Clinical Commissioning Group

The Cambridgeshire and Peterborough CCG's Safeguarding Teams merged into one team in 2020-2021 under a Head of Safeguarding People to help embed the Safeguarding "Think Family" approach. The role of the Safeguarding People Team is to provide support to the health system and provide ongoing monitoring and assurance of safeguarding practice to ensure all providers of health care services have competent and well-trained staff who can safeguard vulnerable people.

The Safeguarding People Team provide bespoke advice, guidance and training as required along with regular safeguarding supervision to each health care provider. The support available is provided across the health system; including acute care, the ambulance service, primary care, community care, nursing homes and across all age groups; children and adults.

We also support our internal CCG workforce with safeguarding decision making. To fulfil our statutory safeguarding responsibilities within the CCG, the Safeguarding Team is comprised of professionals who have different specialisms and expertise.

Throughout 2020-2021 the CCG increased their support to health providers mindful of the pandemic, the pressures on the system and subsequent potential increased risk to protect vulnerable children and adults from harm. Whilst the methods of support may have altered, the amount increased and the CCG thought creatively about how this support could continue. Regular communications were sent out and support was provided virtually. A regular resilience meeting was set up with health providers to provide an opportunity for a systemwide response to managing safeguarding in a pandemic which Safeguarding Health Provider Leads attended chaired by the CCG Safeguarding People Team Lead. The team continued to provide advice to our providers whilst, as commissioners, balancing this with continued assurance with compliance to Safeguarding across the system at a time of increased risk, working closely with CQC, Ofsted, Local Authorities and the Safeguarding Partnership Boards.

During the last 12 months support has been provided to our health providers to progress the aligned model for the Multi-agency Safeguarding Hub to support best practice and information sharing between Health and Partner Agencies, this will support with system wide risk.

There has been a conscious shift to move away from a quality monitoring model to a quality improvement model with an enabling focus.

The Safeguarding People Team will continue to lead on the development of a system wide Safeguarding Officer Apprenticeship which we hope will be agreed in 2021/2022.

Cambridgeshire Constabulary

Cambridgeshire Constabulary continues its active membership of the Safeguarding Adults Board. Over the past 12 months we have been represented at Executive and Board level by Assistant Chief Constable Vicky Evans, Detective Chief Superintendent Mark Greenhalgh (Head of Crime and Vulnerability) and Detective Superintendent John Massey (Head of Protecting Vulnerable People Department). The constabulary is also represented at all the key subgroups to the Board where we continue to engage with all our partners on the Board's priorities, seeking to support, challenge and learn from all our colleagues in our shared goal of continual improvement.

We remain absolutely committed to the principle that it is only through this close working relationship and continual interaction with our partners that we can achieve the best possible outcomes for the most vulnerable adults across Cambridgeshire and Peterborough. The past year has seen notable progress, underlining the strength of our partnerships.

There has been an unprecedented focus on the police response to Violence Against Women and Girls (VAWG), and a rise in Domestic Abuse allegations. Support from our partners, especially through the

Domestic Abuse and Sexual Violence Delivery Group has been pivotal in our formulation of strategies to counter these challenges together.

We have created new Vulnerability Focus Desks and Early Intervention Domestic Abuse Desks to greatly enhance our response to those at risk. We continue to work with great support from local authority partners and the Office of the Police and Crime Commissioner in devising bids for vital central government funding and have recently secured funding for three Domestic Abuse, Child to Parent Violence, and Stalking Perpetrator Programmes that will go live across the county this autumn. Further partnership engagement has been seen within Perpetrator Panels and the DA Scrutiny Group and Rape Scrutiny Panels; these fora provide invaluable opportunities for feedback, transparency, practical direction and shared expertise and an overall 'critical friend' input to help maintain our focus and performance.

A particular highlight of our partnership co-operation came in our collective success in being selected to become one of only 2 areas in the country to have a Specialist DA Court with Mentoring Status. This will equip us with a Programme Manager, 2 dedicated IDVAs and a coordinated evaluation process that will upskill staff and ensure Cambridgeshire and Peterborough can offer the best possible service to those who have been victims of domestic assaults, coercive behaviour, harassment or sexual violence while also reducing the long-term harm caused to children exposed to such behaviours in the home.

As we look ahead to the next twelve months, we are acutely aware of the challenges to come - particularly as we face some of the consequential effects of the Covid lockdown periods. However, we are confident that through our partnership structures and oversight we have both the unified purpose and the coordinated relationships within the Boards to meet these challenges successfully.

SCRUTINY AND QUALITY ASSURANCE

Local scrutiny arrangements

Currently the scrutiny function of the partnership is discharged through an independent scrutineer who provides a scrutiny assurance report at each Executive Safeguarding Board meeting (Quarterly).

In addition to the scrutiny undertaken by the scrutineer, there is a significant range of scrutiny functions that are currently in place that offer additional scrutiny of the safeguarding and partnership arrangements. A number of these functions are undertaken by the Independent Safeguarding Partnership Service (Business Unit).

The table below evidences the additional robust scrutiny of the partnership arrangements across both adults and children's outside of the scrutineer's role.

Type	What we scrutinise	Activity
Single agency operational practice	Quality of single agency and multi-agency practice Decision making Professional challenge/ escalation Impact/outcomes	Single agency quality assurance activity Peer to peer reviews Single agency inspections Serious incidents Performance management information
Partnership working and multi-agency practice	Single agency and multi-agency practice Decision making Professional challenge/ escalation Impact/outcomes	Independent scrutiny of Case reviews through independent chair of the case review groups. Head of Service for Safeguarding Partnership Boards chairs some of the case review panel meetings. Independent authors for case reviews. JTAI and other inspections. S11 self-assessment and adult equivalent – this includes agency challenge sessions. Regular QA assurance activity undertaken by Business Unit staff, including audits, dip samples and case reviews. Consultation and development forums this provides mechanism of front line engagement. They are held 4x a year, each one addresses one of the business priorities.

		Qualitative performance reporting through the Quality & Effectiveness Groups on a quarterly basis. Surveys and consultations with children and young people, parents and professionals. Multi-agency workforce development feedback and impact process. The Head of Service for the Safeguarding Partnership Boards chairs the following meetings: • Quality & Effectiveness Groups (adults and children) • Exploitation Strategic Group • Exploitation Delivery Group (CSP's) • Various task and finish groups. The Training & Development sub-group is Chaired by a member of the Independent Safeguarding Partnership Service (Business Unit) Validation of single agency training Head of Service for Safeguarding Partnership Boards has independent oversight of the partnership budget. Head of Service Safeguarding Partnership Boards and other members of the Independent Safeguarding Partnership Service (Business Unit) are members of various Boards/meetings where they scrutinise practice.

Quality Effectiveness Group (QEG)

This group is responsible for monitoring the individual and collective effectiveness of the safeguarding practice carried out by the agencies represented on the Safeguarding Adults Partnership Board. The group has a strong quality assurance function including undertaking audits, dip samples, self-assessments focus groups and surveys. The annual themed audit programme includes both single and multi-agency audits and are linked to the Board's priorities. QEG advises and supports the Board in achieving the highest safeguarding standards and promoting safeguarding across Peterborough and Cambridgeshire through evaluation and continuous improvement. During the twelve months covered by this report, the following audit activity has taken place:

The impact of Covid 19 had a huge effect on agencies during the time period covered by this report. Due to national lockdown restrictions, a number of services ceased to offer face to face appointments, people were asked to stay at home and the vulnerable members of our society became less visible. The impact of Covid 19 on safeguarding issues and agencies service delivery was a standard agenda item and considered at every QEG meeting. This was with a view to assuring partners around safeguarding practice during this difficult period and supporting a systems led approach to the issues being faced across all partners.

Single Agency Performance Commentary completed by partners for each of the Boards priorities with each priority being reviewed at QEG twice a year. Includes what has worked well, areas for improvement and what the agency has done to contribute to those improvements, where multi-agency support is needed and issues to be escalated to the Executive Board. This process has worked well and its impact is evidenced through the numerous changes in processes and policies and additional training courses being offered as a result of the scrutiny at QEG.

Multi-Agency Training Impact on Professional Practice Report completed annually and presented at QEG and the Training Subgroup (see training section below for evidence of impact). The Partnership Board also continues to endorse single agency safeguarding training to ensure that training provided to the wider safeguarding workforce is robust, fit for purpose and contains consistent messaging. In the past 12 months a total of 9 courses have been validated for the Police, Early Years Peterborough, Early Help Cambridgeshire and Peterborough, and Cambridgeshire and Peterborough NHS Foundation Trust.

The Annual Training Needs Survey is undertaken to ascertain what safeguarding training is currently available within agencies, understand how well Safeguarding Board priorities are being incorporated into agency training programmes and identify any potential gaps there may be in safeguarding children's training that need to be met. As a result of this survey, additional training has been developed.

DASH / 102 audit -This audit focused on the quality of Police DASH/102 forms. The aims of the audit were to identify good practice, explore any areas where practice needed to improve in relation to safeguarding assessments and referrals made via the 102 (Safeguarding Adults at Risk Referral/

Assessment) form when related to domestic violence incidents. A dip sample of 40 DASH + combined 102 forms were analysed alongside an audit tool. The findings included good practice of management oversight in every case and all DASH forms being completed with regards to a variety of domestic violence incidents. Areas for improvement included practitioners being clear that the referrals should be made for adults at risk not for all cases. Additionally, explaining and gaining consent from victims was highlighted along with analysing risk and protective factors. Since the audit, the DASH/102 form has been revised and work undertaken with front line practitioners around consent. Currently, the MASH police representative helps to filter out those safeguarding referrals which do not meet the criteria as of an adult at risk and there are regional support desks with experienced staff whom front line police can contact for more specialised support around issues such as safeguarding.

A Thematic Review of the Professional Themes found within Safeguarding Adult Reviews (SARs) and SAR Action Plans from 2015 – 2019 was undertaken. This was in response to requests from the SAR subgroup to explore the changes within SARs since the implementation of the Care Act 2014 in respect of the overall analysis of both 'good' and 'poor' professional practice for improved learning. This included the thematic review of 4 SARs and the findings from this paper were fed back into the Boards training and illustrations given to professionals to incorporate into front line practice at the virtual termly workshop.

Multi-Agency Risk Management (MARM) process was introduced in 2019. An audit was undertaken to look at the effectiveness of the process. Analysed 11 MARM referrals received by the Multi-Agency Safeguarding Hub over a set period of time against a MARM audit tool. Findings included that there were few MARM referrals made, not all referrals met the criteria for a MARM and not all elements of making safeguarding personal were adhered to by professionals. Immediate steps were taken to ensure MARM is featured within the Board's multi-agency training and a MARM briefing was developed to support professionals. The MARM process has been in place since 2019 and we are taking this opportunity to refresh the process. In addition to the feedback we have received from practitioners, we are currently seeking the views of individuals who have been the subject of a MARM process. The outcomes of this work will be discussed in the 2021/22 annual report.

The Safeguarding Adults Practitioner Survey consisted of 14 questions that related to safeguarding practice. 100 professionals from a range of agencies across Peterborough and Cambridgeshire responded. Findings showed that practitioners were working together to safeguard adults, practitioners needed more support in understanding the Multi-Agency Risk Management (MARM) process and struggled in understanding how to ascertain the lived experience of the adult. In response, Lived Experience of the Adult Practitioner Guidance and resources were developed and launched and suite of training developed. Immediate steps were taken to ensure MARM is featured within the Board's multi-agency training and a MARM briefing was developed to support professionals. The MARM process is also being refreshed. The findings from the survey will also help inform the deeper analysis needed for the self-assessment audit to be undertaken in 2021.

Making Safeguarding Personal dip sample audit of adult at risk safeguarding referrals across agencies commenced within the last week of the timeframe covered by this report. The findings and recommendations of the report will be reported within next year's annual report.

Independent Scrutineer's Report and Findings

The main priority during the last year with those providers of adult services has been to ensure that agencies and professionals deliver a service that takes account of the principles of 'Making Safeguarding Personal'.

Any scrutiny of the Adult Safeguarding Board and it's partnership must bear in mind the hard work that agencies and professionals have worked through in relation to COVID-19. The delivery of services through COVID-19 by agencies, individuals and the partnership can only be described as excellent. Extraordinary effort has been involved to ensure those that are vulnerable are given as good a service as possible.

The partnership has in place an Executive Board which combines both adults and children and also combines the Local Authority areas for Cambridgeshire and Peterborough. The three statutory partners as prescribed by The Care Act 2014, being Police, Local Authority and the CCG are all members of this Board and their attendance has been 100% throughout the year, as has their commitment to adult safeguarding.

The combined Safeguarding Adult Board is chaired by the Director of Adult Services for both Local Authorities. I have attended two of the SAB meetings and was very impressed by the wide-ranging attendance including all statutory partners and a large number of other partners including the voluntary sector. One concern on membership is how to get service user representation adequately provided. The meetings were chaired extremely well and in one of them the main concentrated on the sign off a number of SARs.

The SAR sub-group is ably chaired by an Independent chair and further scrutiny in the most serious of cases is provided by this individual who has a vast amount of experience and knowledge. The biggest issue for the partnership and one that causes extreme pressure on not only the Independent Safeguarding Partnership team, but also all agencies is the number of SARs currently in progress. To the partnerships immense credit, that they have managed to conclude and sign off six SARs in the last year and implemented the learning from these cases.

The Multi-Agency training provision has been examined and is extremely thorough and wide reaching. During the initial lockdown all safeguarding Board training was paused due to the regulations. The Partnership was aware of the need to continue to up-skill the workforce on safeguarding issues and as a result they developed virtual briefings. The introduction of SWAY's has provided a platform for training to be available 24 hours a day, 7 days a week. As a result, it is accessible to shift workers and those individuals' working weekends and evenings.

The SWAYs are a huge success for the Partnership Board.

MULTI-AGENCY SAFEGUARDING TRAINING

Safeguarding Partnership Board's Response to Multi-Agency Training During the Covid 19 Pandemic

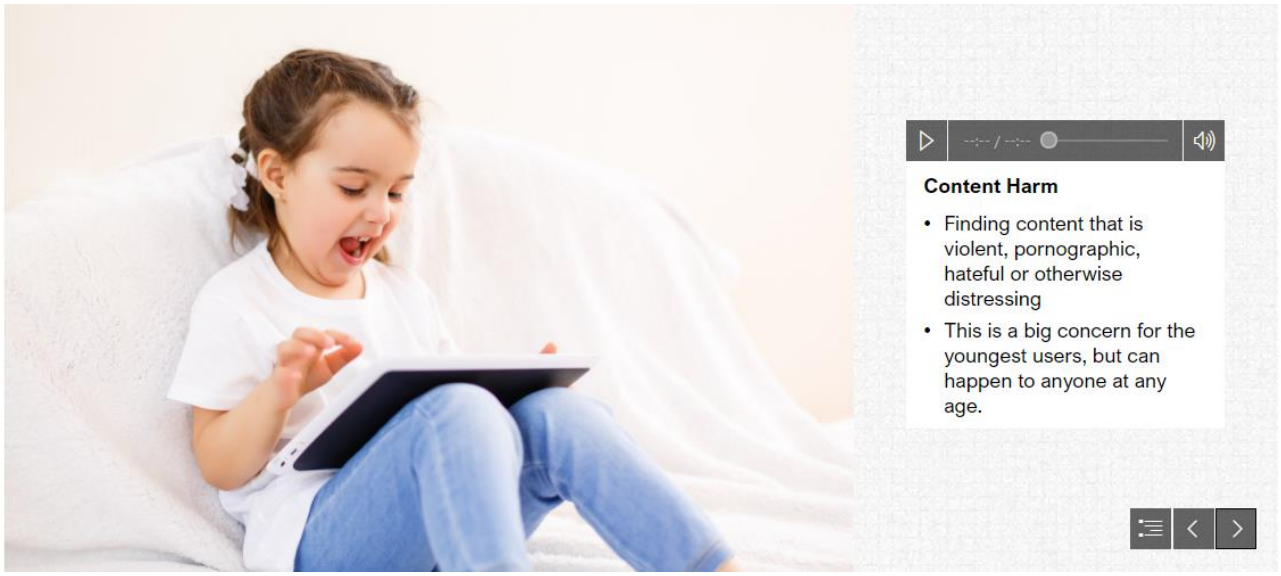
Due to government restrictions during the pandemic, most staff from organisations were either required to work from home, or re-deployed into new roles to help combat the pandemic and support local communities. Face-to-face training had to be suspended and alternatives to learning sought. An urgent response was needed to provide volunteers, who would be visiting shielding members of the public and their families, with safeguarding training.

A COVID 19 Information page on the Safeguarding Partnership Board website was set up within a week of the first lockdown period. The page contained information on COVID 19, local safeguarding arrangements, links to useful agency resources, presentations on basic safeguarding children and safeguarding adults at risk in a COVID context, leaflets, briefings and video links and a link to CPSPB online training. Bespoke virtual safeguarding training for community volunteers, was developed and available within 72 hours of going into lockdown. Feedback from volunteers and working professionals found the information 'invaluable' and 'informative' to support their knowledge of safeguarding and what to do if they had safeguarding concerns

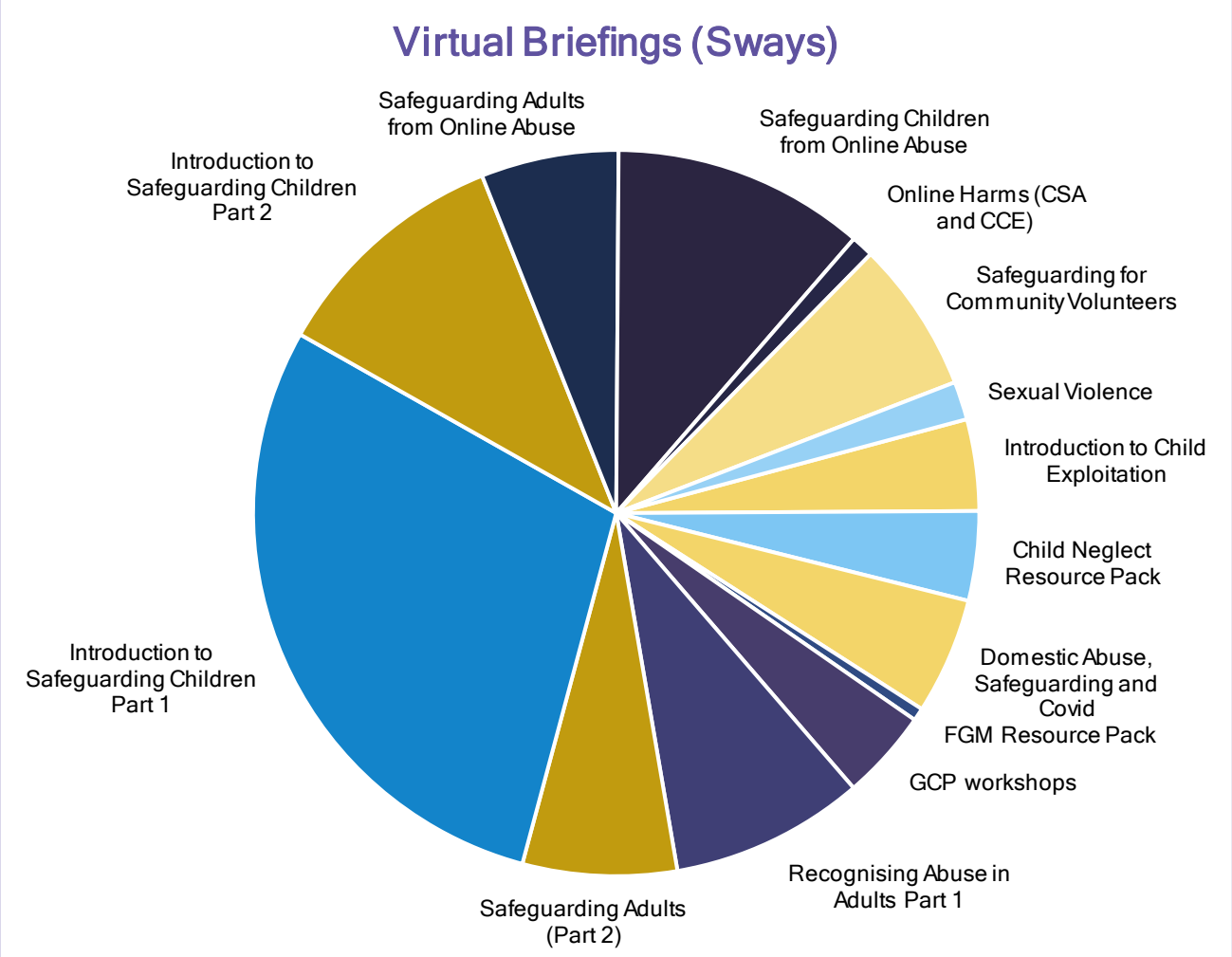
Virtual Briefings (Sways)

The Partnership was aware of the need to continue to up-skill the workforce on safeguarding issues and as a result they developed virtual briefings. Locally, these are referred to as Sways (the software that is used for the briefings). In essence, these are a presentation but each slide has an audio that discusses the content of the slide. Generally, they last around 20 minutes per briefing. The virtual briefings are available on the Partnership Board website and can be accessed at any time. As a result, staff who are working night shifts, weekends or early shifts can all access the training at their convenience.

The first virtual briefing to be uploaded onto the Board's website during April 2020 was on 'Safeguarding for Community Volunteers' closely followed by safeguarding from online abuse, a recognised high-risk area of concern during lock down. The virtual briefings that followed focused on safeguarding during covid and locally identified areas of safeguarding risk, as well as the Board's priorities. However, as the popularity of the virtual briefings increased it was apparent that these were a hugely useful resource and further topics were added. For those professionals who complete the SWAY there is a downloadable certificate as proof of completion. The majority of professionals gave the SWAYs a 4 to 5 star exceptional rating and described them as, 'informative and really useful'. They have been very well received by agencies and have been used and adapted within our local partners' resources and utilised by other Safeguarding Boards across the Country.



Between April 2020 and March 2021, the virtual briefings had been viewed a total 10,753 times.



Virtual Training Webinars

Virtual Training Webinars developed from existing face to face training materials and condensed into 60 or 90 minute sessions were facilitated from September 2020 by members of the Independent Safeguarding Partnership Service.

As with the briefings, the webinars focused on safeguarding risks and the Board's priorities. As part of a rolling training programme, the webinars included Self-Neglect, Hoarding, Making Safeguarding Personal, Sexual Assault Referral Centre (SARC) and Termly workshops on the latest safeguarding messages

8 webinar sessions took place during September 2020 to March 2021, where 192 people attended. Initially groups of a maximum of 20 rising to 40 professionals were allowed to access the training online. However, the demand for the training has been so great that up to 100 places on each course are now available.

As the sessions progressed, a feedback form was developed and 100% of professionals reported that they felt that the safeguarding virtual training content met their training needs and 99% of professionals stated that they felt that the delivery of the training was right for them. Professionals' comments included:

- "Really helpful and useful subject and great to be able to access training, my first online training"
- "Very well delivered – lots of information and links to further reading"
- "It was clear accessible and kept me engaged"
- "Helpful to talk in chat / really good and involved participants"

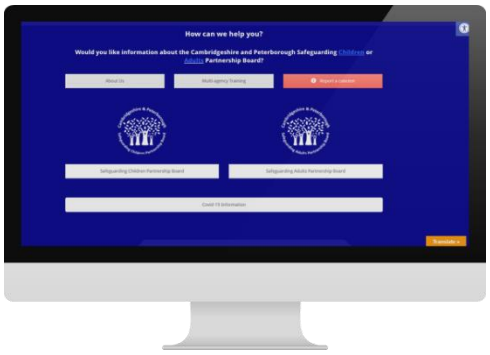
The Sexual Assault Referral Centre webinar which took place during November 2020 was recorded and uploaded onto the Safeguarding Partnership Board's YouTube channel and added to the Safeguarding Partnership Boards website. These video clips are openly available to professionals.

Whilst the face to face training provision has always been well attended it would never have reached the number of people who have accessed the Virtual Briefings and webinars. It is to the credit of the Partnership that whilst other areas in the region stopped all training delivery, locally we evolved and adapted to the lockdown environment.

WEBSITE & SOCIAL MEDIA

Over the past year we have had 275,602 page views and 71,987 users to the website.

On average, a user spent an average 2 minutes per session on the website, and the bounce rate has remained close to 40% which would indicate users find what they are looking for quickly.



Apart from the home page, the Multi-agency training page was the most visited page on the site, followed by 'Reporting a concern' and our virtual Sway briefings pages

52% of visitors reached our site via entering keywords into search engines. 66% accessed the site via a desktop device (i.e. Laptop) and 30% accessed the site via a mobile.

Feedback from visitors includes:

- *Its really easy to use, very clear and content is good.*
- *Easy to manoeuvre around the website*
- *Breadth of training resources available and are easily accessible*
- *the clarity, layout and range of information available far exceeded what was expected*

Our social media presence

The CPSPB uses Twitter, Facebook and Instagram for all sorts of communications from the latest safeguarding news, to events that the Safeguarding Partnership Board are hosting.

During the last year the CPSPB has continued to strengthen its profile on social media. On Twitter, we posted 328 tweets, had 111,383 impressions, were retweeted 292 times, had 1540 reactions and 1,007 followers. On Facebook and Instagram, we put out 400 posts, had a reach[5] of 80,112, with 683 reactions, 57 comments, 768 shares and 458 followers on Facebook and 124 on Instagram.

If you haven't yet followed us, please do!

@cplscb @cplscb @cpsafeguardingboard

[5] The number of people who saw any content from your Page or about your Page, including posts, stories, ads, social information from people who interact with your Page and more. Reach is different from impressions, which may include multiple views of your posts by the same people.

APPENDIX 1 - LIST OF AGENCIES REPRESENTED ON THE SAFEGUARDING ADULTS PARTNERSHIP BOARD

- Cambridgeshire and Peterborough Local Authorities including
    - Adult Social Care
    - Public Health
    - Elected Members
- Clinical Commissioning Group
- Cambridgeshire Constabulary
- Further Education
- East of England Ambulance Service
- Cambridgeshire and Peterborough Foundation Trust
- Cambridgeshire Community Services
- Royal Papworth Hospital
- North West Anglia Hospitals
- Cambridge University Hospital
- Office of the Police and Crime Commissioner
- Ely Diocese
- Cambridgeshire Fire and Rescue
- Cambridge District Council
- Cross Keys Homes – representing Housing
- National Probation Service
- Healthwatch
- Department for Work and Pensions
- Voluntary sector representatives

Cambridgeshire & Peterborough Safeguarding Adults Partnership Board

Contact details: 01733 863744

Email: safeguardingboards@cambridgeshire.gov.uk