Agenda Item No: 11

Cambridgeshire and Peterborough Safeguarding Adults Partnership Board Annual Report 2021-22

To:	Adults and Health Committee
Meeting Date:	15 December 2022
From:	Service Director: Adults & Safeguarding
Electoral division(s):	All
Key decision:	No
Outcome:	The Committee members are asked to note the contents of the annual report
Recommendation:	Adults and Health Committee is recommended to: a) receive and note the contents of the 2021-22 annual report. b) recommend that work is undertaken by Adult Social Care officers on how transparency and accountability can further be improved in safeguarding case reviews, not simply in promoting organisational learning and seeking to prevent recurrences in relation to failings identified; but also in seeking for the County Council to provide clear and timely acceptance of responsibilities to relatives for any failings including apologies where appropriate. Any recommendations would be further shared with partners in the Safeguarding Board for their consideration.

Officer contact:
Name: Joanne Procter
Post: Head of Service- Cambridgeshire & Peterborough Safeguarding Partnership Board
Email: Joanne.procter@peterborough.gov.uk
Tel: 01733 863765

Member contacts:
Names: Cllr Howitt
Post: Chair
Email: Richard.howitt@cambridgeshire.gov.uk
Tel: 01223 706398

1. Background

1.1 The annual report includes information on the work that has been undertaken by the Cambridgeshire and Peterborough Safeguarding Adult Board in the period April 2021- March 2022.

Partner agencies, including Cambridgeshire County Council, contributed to the information contained within the annual report.

The annual report was approved by the Safeguarding Adult Board in November 2022 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

2. Main Issues

2.1 The annual report summarises both the work of the Safeguarding Adult Board and the work of the sub committees and highlights the significant events from April 2021- March 2022. It recognises areas of good practice and presents statistical information about partnership safeguarding performance.

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 two 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.

In the time period covered by this report, we have introduced a process (MARM) to help practitioners work together to support those individuals who have care and support needs but do not want to engage with services.

We have also worked with our partners in the community safety partnerships to develop a cuckooing policy. This was supported by a week of community action to raise awareness.

Our multi-agency safeguarding training programme has continued to be well attended. Just under 1,000 people accessed training and the virtual briefings had been viewed a total 26,134 times. This is almost two and a half times the number of views on the previous year.

The virtual training continues to be greatly received with 98% of professionals reporting that they felt that the safeguarding virtual training content met their training needs and 97% of professionals stating that the delivery of the training was right for them.

The report has been brought to the Adults and Health Committee for information purposes. An alternative format for the annual report can be requested.

3. Alignment with corporate priorities

3.1 Environment and Sustainability

There are no significant implications for this priority.

3.2 Health and Care

The report above sets out the implications for this priority throughout the report

3.3 Places and Communities

The report above sets out the implications for this priority throughout the report

3.4 Children and Young People

There are no significant implications for this priority

3.5 Transport

There are no significant implications for this priority

Cambridgeshire & Peterborough Safeguarding Adults Partnership Board

Annual Report 2021/22

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FORWARD

We are pleased to present the annual report of the Cambridgeshire & Peterborough Safeguarding Adults Partnership Board for 2021-22. 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 continued to work on our priority areas throughout the year. The multi-agency safeguarding training has moved to a virtual delivery and continued to develop and grow, policies and procedures have been updated and implemented, 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 to avoid 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 two 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.

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.

Charlotte Black

Executive Director, People and Communities

Cambridgeshire County Council
PETERBOROUGH CITY COUNCIL

Carol Anderson

Chief Nurse

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Vicki Evans

Assistant Chief Constable

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.

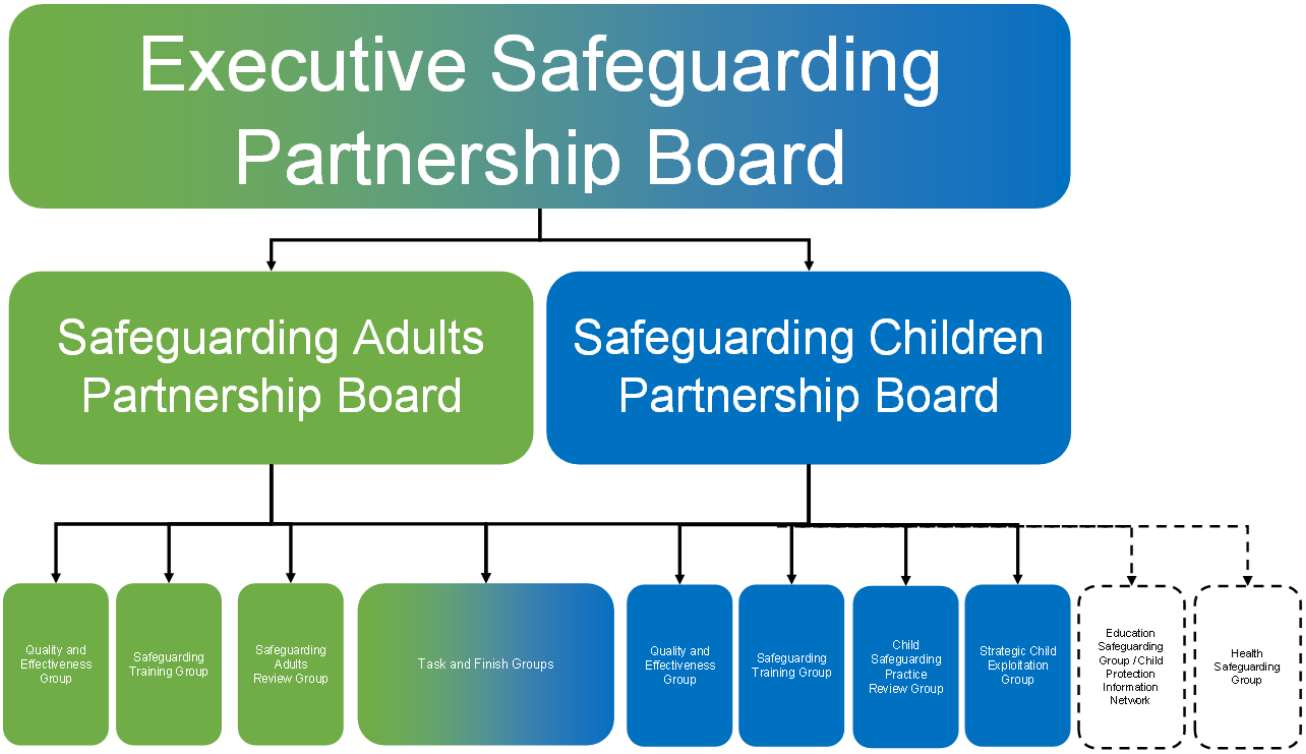
We do this by:

- 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
- 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). It also includes members from 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 Education in Safeguarding Group/ Child Protection Information Networks and Health Safeguarding Groups are in dotted lines as they are not Safeguarding Board groups but are established under education and health governance arrangements. 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]

894,300

Total population
(Census 2021)

430,885

(49.4%)
Male population
(Census 2021)

452,300

(50.6%)
Female population
(Census 2021)

208,400

(23.3%)
Aged 0 - 19 estimate
(Census 2021)

528,900

(59.1%)
Aged 20 - 64 estimate
(Census 2021)

157,100

(17.6%)
Aged 65+ estimate
(Census 2021)

The Census 2021 total usual resident population for Cambridgeshire and Peterborough is 894,300. This is an increase of 11.1% (89,500 residents) compared to Census 2011. There has been particularly high population growth in the urban local authorities of Cambridge and Peterborough, with rises of just over 17% in both areas. Cambridge and Peterborough have seen some of the highest percentage increases in population in England since Census 2011 when compared to other local authorities, topped only by Tower Hamlets, Dartford, Barking and Dagenham, and Bedford.

Between Census 2011 and Census 2021 Peterborough's usual resident population has increased by 32,100, 17.5%, to 215,700 from 183,600. It has been one of the fastest growing local authorities both in the East of England and England.

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

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 July 2021, there were a total of 1,681 caravans on authorised (socially rented and private) and unauthorised sites. 36% of these were located in East Cambridgeshire and 35% were in Fenland[3]

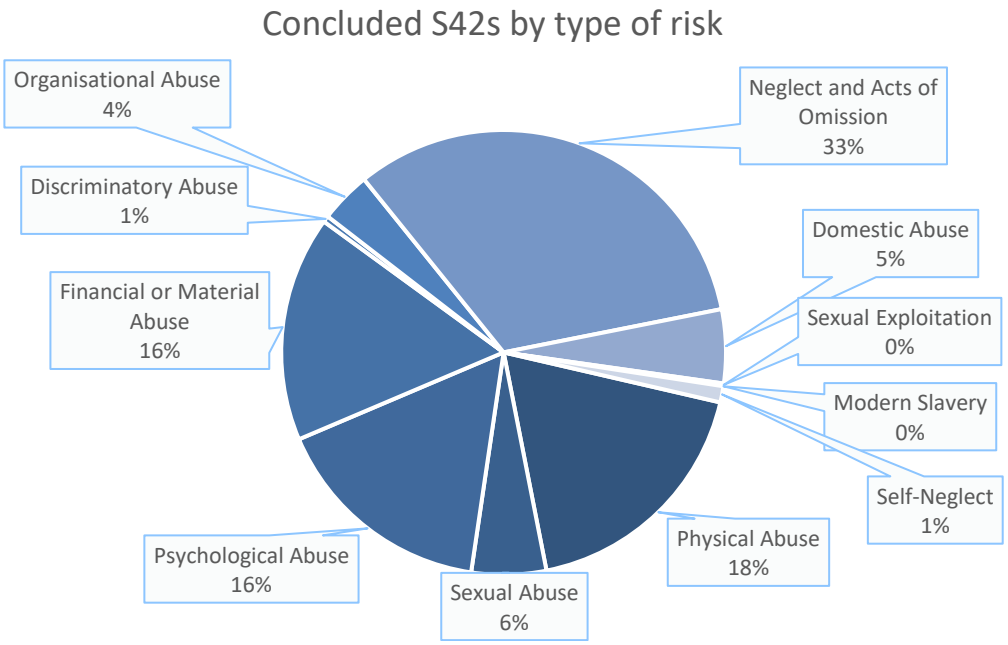
Safeguarding Adults Data 2021-22

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 7823 concerns of abuse raised involving 4823 individuals; this is a decrease of 449 concerns on the previous year. 15% (1,136) of concerns led to a Section 42 safeguarding enquiry, involving 962 individuals, being commenced.

During the year, 1,308 Section 42s had concluded. Neglect and Acts of Omission were the most prevalent type of risk identified in Safeguarding Enquiries (33%), followed by Physical Abuse (18%).

[3] https://www.gov.uk/government/statistics/traveller-caravan-count-july-2021



The majority of risks were located in their own homes, followed by residential care homes. 63% of Safeguarding Enquiries identified a risk and action was taken. 91% of completed Safeguarding Enquiries had removed or reduced the risk identified.

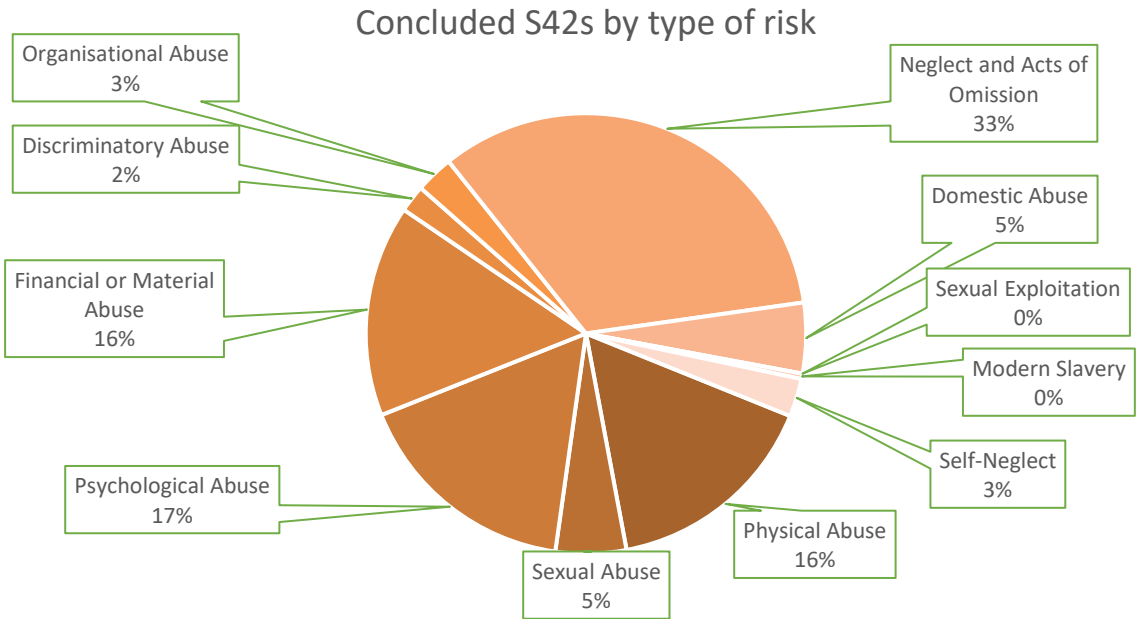
45% of concluded enquiries found the person at risk had lacked mental capacity, of these 91% had support provided by an advocate, family or friend.

In 75% of concluded Safeguarding Enquiries, the person at risk was asked and expressed what their desired outcomes were. Of these, 96% had their outcomes fully or partially achieved in the safeguarding enquiry. 15% of concluded Safeguarding Enquiries, the person at risk was asked but did not express what their desired outcomes were.

Peterborough Data

In Peterborough, there were 2,170 concerns of abuse raised involving 1,471 individuals. This is an increase of 795 on the previous year. 8% (178) of concerns led to Section 42 safeguarding enquiries, involving 165 individuals, being commenced.

During the year, 251 Section 42s had concluded. Neglect and Acts of Omission were the most prevalent type of risk identified in Safeguarding Enquiries (33%), followed by Psychological Abuse (17%).



As in Cambridgeshire, the majority of risks were located in their own homes, followed by residential care homes. 65% of Safeguarding Enquiries identified a risk and action was taken. 94% of completed Safeguarding Enquiries had removed or reduced the risk identified.

33% of concluded enquiries found the person at risk had lacked mental capacity, of these 92% had support provided by an advocate, family or friend.

In 68% of concluded Safeguarding Enquiries, the person at risk was asked and expressed what their desired outcomes were. Of these, 91% had their outcomes fully or partially achieved in the safeguarding enquiry. 17% of concluded Safeguarding Enquiries, the person at risk was asked but did not express what their desired outcomes were.

SAFEGUARDING ADULTS PARTNERSHIP BOARD PRIORITIES 2021/2022

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.

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. For the first time a multi-agency MSP audit took place during 2021 and included, 25 safeguarding referrals across agencies being analysed against an agreed MSP audit tool. The findings from the audit surrounding adults at risk included consideration of utilising an independent advocate, consent was generally obtained and recorded by agencies in some instances, there may have been discussions regarding what an adult wanted to happen but this was not always recorded in agencies records. . There was good evidence that the safeguarding process was explained to the adult at risk and that the individual's outcomes were generally achieved.

In addition to this audit, a professional survey on MSP was conducted. The findings from the survey corroborated the audit findings and also provided some excellent illustrations of good MSP practice when working with adults at risk. These illustrations will be put into the lived experience guidance to support other practitioners and managers

As a result of the audit and survey recommendations for single agencies were made in relation to recording and using advocates. It was recognised that further work needs to be undertaken across the partnership regarding mental capacity and this is an identified partnership board priority for 2022-2024. To support learning and understanding around MSP an initial virtual training session was offered which has now been developed into an MSP Microsoft Teams Sway.

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".

Multi-Agency Risk Management (MARM)

The MARM process applies to adults with care and support needs who are not engaging with agencies. It provides a process for partner agencies to come together and agree a partnership approach to

supporting an adult who is not engaging with services. A MARM audit was undertaken in early 2021 and made several recommendations, a MARM task and finish group was set up to address them. The MARM process has been in place since 2019 and during 2021-2022 the MARM guidance has been refreshed. The guidance includes a simplified flow chart process. To help practitioners in their understanding of the benefits of using the MARM we also included a number of anonymised cases of instances where the MARM was used effectively. This is to provide a real life lived experience and to show how the MARM can be used to support those adults at risk who refuse to engage and who put their lives at risk. The MARM guidance launch, virtual training workshops and MARM Sway are due to be launched later this year and the impact of the training and refreshed guidance will be discussed in next year's annual report.

Cuckooing

Across Cambridgeshire partner agencies recognise that vulnerable adults are being targeted by groups involved in County Lines in a process known as "cuckooing" Often their homes are taken over by gangs or groups of individuals to store and distribute drugs. The addresses often attract anti-social behaviour which can lead to an increase in calls to both police and housing partners. In conjunction with the Safer Peterborough Partnership we have created a "Cuckooing " policy to support the vulnerable adults and reduce the opportunity for them to be exploited and potentially evicted. The Partnership carried out a week of action with the police under "Operation Spotlight" where known addresses were visited and support offered.. The policy and week and action are currently being evaluated but it is anticipated that this will now be rolled out Countywide.

OVERVIEW OF 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.

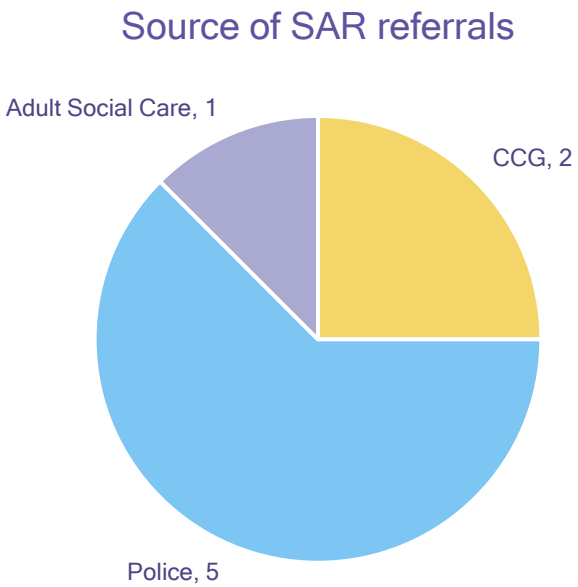
A Safeguarding Adults Board (SAB) may also arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

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. The purpose of a Safeguarding Adult Reviews is not to apportion blame but to identify lessons to be learnt in order to prevent similar occurrences from happening.

8
Safeguarding Adult Review Referrals

2
Referrals met criteria for a SAR

6
Referrals did not meet criteria for a SAR



From April 2021 – March 2022 we received 8 referrals from agencies for consideration of whether the case met the statutory criteria for a SAR, the criteria for a SAR is specific and it must include an adult with care and support needs. All of the referrals were scoped and discussed at the multi-agency SAR sub group meetings. Of the 8 referrals, 2 met the criteria for a SAR and 6 did not the criteria.

5
Safeguarding Adult Reviews ongoing from 2020/21

2
Safeguarding Adult Reviews commenced during 2021/22

2
Safeguarding Adults Reviews completed during 2021/22

5
Safeguarding Adults Reviews carried over to 2022/23

In the time period covered by this annual report there were already 5 SARs that had commenced prior to March 2021. 2 of these were completed and published within the timescale covered by this report. Further details regarding these SARs can be found below. The remaining 3 SARs that had commenced prior to March 2021 are still ongoing and are due to be completed post April 2022 along with 2 new SARs that had commenced during the year. These will be detailed in next year's Annual Report.

SARs published between April 2021 and March 2022

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

Carol

Carol was a 58 year old woman who died of acquired pneumonia in February 2019 after being admitted into hospital at the end of January 2019. She lived with her husband and one of her daughters, on the Cambridgeshire and Suffolk border. Whilst the address was actually in the Cambridgeshire area some of the services that Carol received were delivered by agencies in Suffolk. Carol's daughter who lived at home has learning difficulties and she and Carol's husband found caring for Carol both challenging and stressful.

Carol struggled with her mental health and her family described that she 'gave up on life' and ceased to care for herself and the house, Carol was admitted into hospital a number of times and the family informed services that they could not cope but felt that they were not listened to. The family regarded the 'system' as having 'failed Carol'.

Areas of Good Practice

There were a number of good practice areas identified within the report including appropriate referrals being made by the ambulance service and use of the clutter scale to support the referrals.

Key Learning Points for Professionals

In Carol's case there was a wealth of evidence to suggest that Carol would not be able to care for herself, without considerable support, when discharged from hospital. Any reduction in this care should have initiated an ***assessment of mental capacity***. A more detailed examination of Carol's mental capacity is likely to have shown that she lacked the insight to understand that the impact of her neglecting her own care was having a significant impact on her overall health. If this was not the case, the Multi-Agency Risk Management (MARM) process would now be initiated to provide multi-agency support with a view to working with the adult at risk to reduce the risks to life.

Two agencies working with Carol questioned whether she had possible learning difficulties. However, a ***learning disability assessment*** was not undertaken. Carol was struggling with her mental health and this was linked to the death of her parents. Although bereavement counselling as an outpatient was discussed it was never delivered or followed up.

Professionals failed to consider the ***case holistically*** and to explore what the root causes were for Carol failing to care for herself

Apart from the cross-County issues of services there was a lack of joined up working between agencies involved with Carol.

Information that was known to agencies, particularly the ongoing risk of self-neglect, did not follow Carol through the system and was not available or considered when making decisions.
Agencies providing daily community care need to be aware of the impact of self-neglect and where necessary make appropriate safeguarding referrals.

Where a safeguarding referral is made it should not be closed on the basis that another agency is involved, without understanding that the care being provided will address the concern and that the other agency is aware of the concerns and the onus on them to address them.

Where there is a recognised need for services in the community, such as bereavement counselling to a person, this should be communicated to the relevant GP and measures put in place to ensure that it is delivered as intended.

Miss Y

The name Miss Y is used as a pseudonym to anonymise and protect the adult at risk's identity and wider family.

Miss Y was diagnosed with phobic anxiety disorders, borderline learning difficulties, obsessive compulsive traits and emotional dysregulation traits and was accommodated in 2004 within a supported complex of flats in the Cambridgeshire area. Miss Y had a part time job and was well known locally. Miss Y's family described her as a very happy, loyal and likeable person. Tragically, Miss Y was murdered by another resident of the complex in 2019. Her murderer was sentenced to life imprisonment.

Key Learning from this Review Includes

- Risk assessments and Care and Support Plans need to be ***up to date*** and include all risk information with measures to mitigate the risk. This should be ***person centred*** and include the voice of the subject of the plan.
- It is important that ***records of care are accurately maintained*** and that the expectation for this to happen is supported.
- It is important that there is an appropriate ***understanding of risk*** that the communal area of a setting presents.
- Consideration needs to be given to risk at every stage, the consideration needs to be dynamic and continuous and take into account all available information. There also needs to be clear oversight and all persons involved in the management of that risk have a responsibility to challenge and build on the mitigation of risk.
- All staff must ***respond to safeguarding concerns*** adhering to their own policies and those of the Cambridgeshire and Peterborough Safeguarding Adults procedures.
- Agencies need to be aware of the ***guidance on self-neglect*** and what action can be taken to address this. In particular how this is impacted by mental capacity and mental health.
- Professionals and managers need to be aware of situations where they can become ***desensitised*** to situations due to familiarity.
- More consideration should be given to the use of ***advocates*** for persons who may have a substantial difficulty in being fully involved in the care and support process or would benefit from independent advice and support.

Local Learning from SARs

To support partners in promoting the key findings from case reviews the independent partnership board service has developed and provided supportive multi-agency training and information packs. At the conclusion of a SAR, an action plan is developed and implemented. This is monitored through the SAR sub-group. This is followed by a series of multi-agency workshops being held to ensure that the learning is disseminated across the partnership and electronic learning packs on each case are cascaded across the partnership. The packs include a professional's briefing on the case review, a seven-minute briefing and a set of power point slides with information and practice links contained

within. The learning pack can be used in single agency training or discussed as bite sized sessions within team meetings and supervision.

The lessons learned both nationally and locally feature within the biennial Thematic SAR report that are presented at the QEG and held as discussion points at the Training Subgroup for implementation into wider workforce practice. Additionally, the cases and the learning are written into the virtual briefings and online training and are promoted at termly safeguarding workshops.

During 2021 a 'Database of Learning' was developed. The data base records the details and findings from all SARs across the county. This allows further scrutiny of themes and trends arising from case reviews and is reported within the Thematic SAR report back to the SAR subgroup, QEG and Training Subgroup.

CONTRIBUTIONS FROM THE STATUTORY SAFEGUARDING PARTNERS

Adult Social Care

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

Adults Safeguarding is led by the Assistant Director for Safeguarding, Quality and Practice, Donna Glover. Charlotte Black chairs the Safeguarding Adults Board (SAB) on behalf of the whole system. Safeguarding adults remains a high-profile commitment for the Adults and Safeguarding Directorate. The Adults Multi Agency Safeguarding Hub (MASH) is a well established service within the directorate, triaging all incoming safeguarding concerns about adult at risk across Cambridgeshire and Peterborough. However, safeguarding activity takes place across many of our front-line teams and our commitment is to continuing to strengthen our practice across all areas. Good practice and continuous improvement is supported by the Principal Social Worker and a dedicated Quality, Practice and Standards team as well as by each social work team across the area.

Donna or the Principal Social Worker attend the Safeguarding Adults Review (SAR) sub-group to ensure that we are fully involved in making SAR referrals, considering referrals from other agencies. We are then actively engaged in panels who undertake the reviews, identifying with system partners where we have potential to improve and then embedding that change into practice.

During 2021/22 our key achievements have been:

- Covid-19: We have continued to adapt due to the ongoing pandemic and legacy of it. There have been challenges around ongoing and frequently changing restrictions and the impact of this, directly and indirectly, on adults at risk.
- Safeguarding Training: Training has continued throughout, maximising the use of online training which has now become embedded as a normal way of delivery with the potential to reach increased numbers of people.
- Adult MASH: The Cambridgeshire and Peterborough Adults MASH teams continue to work under the same leadership which allows us to continuously challenge ourselves about best practice across the whole area and adopt a consistent approach. MASH have achieved a reduction in turnaround times for triaging incoming concerns. The team have also been able to offer support to other parts of the service who have been under extreme pressure to ensure that safeguarding enquiries are completed in a timely way, reducing risk to people in our communities.
- MARM review – we contributed substantially to the MARM review, drawing on the experience of our front line practitioners who were also able to capture some feedback from people who had been the subject of a MARM to inform the updated version. We led workshops with colleagues from across the system to embed understanding of the MARM process.

- Overseeing Practice Standards: There is an established set of practice guidance factsheets relating to safeguarding, the reviewing of which is overseen by the Practice Governance Board chaired by Donna.
- Care Home Support Team: This team started work in January 2021 for an initial one year period and has since been made permanent. A team of five social workers and a team manager work with care homes supporting them to improve quality of care thereby reducing risk to residents
- Improved information for oversight: Significant work has been undertaken to improve the management information available about safeguarding activity. As a result we now have access to dashboards that are updated daily showing all activity from the point of a referral being received to an section 42 enquiry, if needed, being completed. This provides consistent insights drawn directly from our recording system, Mosaic, across Cambridgeshire and Peterborough.
- Learning from SARs, Domestic Homicide Reviews (DHRs) and Complaints: Learning from SAR'S, DHRs and complaints is taken forward into actions which are now all overseen by the Practice Governance Board.

The Adult Safeguarding Priorities for 2022/23 are:

- In alignment with the SAB priority, we want to better understand how we can work with system partners to reduce risk to vulnerable people who may not meet the 'adult at risk' criteria set out in the Care Act.
- To identify opportunities to make actions from SAR recommendations more impactful, working with partners to tackle some tricky system wide challenges where needed
- To capture 'you said, we did' in relation to safeguarding in a really clear way – what are people telling us about their experience of our safeguarding activity and what are we doing differently as a result?
- To strengthen our assurance around safeguarding practice – including undertaking a thematic audit of s42 enquiries.

Cambridgeshire & Peterborough Clinical Commissioning Group

The Cambridgeshire and Peterborough CCG's Safeguarding Team have continued to embed the Think Family approach and work across all age groups since they merged into one team in 2020-2021. 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 Health Safeguarding Group has been amalgamated to enable a 'Think Family' approach across all health safeguarding provider teams. A full review of the terms of reference have allowed for a better platform for sharing learning, risks and updates, with the meetings chaired by the Designated Doctor for Safeguarding Children, the Designated Nurse for Safeguarding Children and the Designated Nurse for Safeguarding Adults.

All Safeguarding People Team policies have been reviewed and updated in readiness for the transition to an ICS on the 1 July 2022. As part of this piece of work the Prevent and MCA policy have undergone a full review, with up-to-date information and resources included. The Safeguarding People Team have reviewed the safeguarding supervision policy to ensure all appropriate practitioners receive regular supervision, and the NHS Cambridgeshire and Peterborough safeguarding policy has been reviewed and now covers both adult and child safeguarding across the life cycle.

In total from April 2021 – March 2022 the Safeguarding People Team have responded to 159 general safeguarding adult enquiries and had a total of 731 interactions with primary care staff to support with safeguarding. The Safeguarding Lead GP forum has seen an increase in attendance throughout the year with ten sessions hosted and 151 GP Lead's in attendance, with a variety of cases discussed and supported by the Safeguarding Named Nurses and colleagues across Primary Care.

The Deputy Designated Nurse for Safeguarding Children has driven forwards the Safeguarding Officer Apprenticeship, with the occupational proposal now finalised and ready to be presented to the route panel for agreement to progress to a full standard. There has been involvement from a wide variety of sectors in support of this, such as, Police, Education, Voluntary sector and Fire & Rescue. We hope this will be agreed in 2022/2023.

As the Safeguarding People Team move into 2022-23, they will continue to align their priorities with that of the Partnership Safeguarding Board and will continue to influence the system wide culture, ensuring that safeguarding is everyone's business and that staff have the right skills and knowledge to recognise and report safeguarding concerns. The Safeguarding People Team will continue to support work towards being a preventative health system, ensuring staff are trained and receiving regular supervision to identify and report concerns at the earliest opportunity.

Cambridgeshire Constabulary

Cambridgeshire Constabulary continues its active membership of the Safeguarding Adults Board. Throughout the previous 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.

The constabulary values, now more than ever, the enduring support of our partners and the insight and perspective that this close working relationship affords us. This has undoubtedly been a challenging year with reported sexual offences increasing significantly and the national response to

Violence Against Women and Girls demanding a new and strengthened approach from the police in particular. However, with the continued assistance of our partners, there is much to be positive about when we reflect on the performance of our co-ordinated initiatives and promising outcomes that we are able to achieve for the vulnerable adults we strive to protect.

Our Vulnerability Focus Desks and Early Intervention Domestic Abuse Desks have been in situ for a year and have seen the number of Domestic Violence Protection Orders increase by over 600% and Missing From Home (MFH) times reduce from an average of 25 hours to just 13. With enormous assistance from the OPCC that helped secure Home Office funding for our expanded IDVA and ISVA cohort, we can now call upon three separate DA-related Perpetrator Programmes all of which are performing well: the Stalking Perpetrator Programme and affiliated staff have ensured a dramatic increase in our use of Stalking Protection Orders and an overall increase in our Prosecution Possible rates for DA.

Co-ordination and governance of this activity is supported through the Constabulary's VAWG strategy which went live at the turn of the year. This contains four strands: Project Kaizen (Domestic Abuse); Project Eleos (Serious Sexual Offending); Project Boyd (Offender Management); and Project Artemis (CSE / CSA). Harnessing national academic research, we have initiated a Victim Feedback Questionnaire and Panel to understand and improve investigative and safeguarding performance; created new rape investigative support roles to increase the adoption of best practice; and invested in bespoke additional training for investigators to ensure a victim focus throughout. These measures will complement our network of ISVAs and Specially Trained Officers that offer support to victims throughout the Criminal Justice process. Again, with full DASV Panel and OPCC assistance, we have secured funding from the government's Safer Streets 3 programme. Broad consultation with partners has seen this funding invested in a forthcoming county-wide public space and social media campaign increasing awareness of sexual offences and street harassment, challenging unacceptable behaviours and attitudes, and giving clarity and reassurance around police action and pathways for reporting. Such elements have helped the constabulary achieve a rating of 'Good' within the Peel Inspection Report in respect of Protecting Vulnerable People.

We remain absolutely committed to our presence and role within the Safeguarding Adults Partnership Board and our dedicated Adult Abuse Investigation and Safeguarding Unit reflects our commitment to embed and operationalise partnership best practice. They lead on numerous training inputs such as 'Making Safeguarding Personal', benchmarking and quality assuring the submission of Vulnerable Adult referrals, and coordinating the assimilation of learning from Safeguarding Adult Reviews. We look ahead to the coming year with confidence that this willingness to learn and work closely with partners will continue to bring positive outcomes and increased protection for all vulnerable adults.

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 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, surveys, thematic reviews, dip samples and case reviews.

		Qualitative performance reporting through the Quality & Effectiveness Groups on a quarterly basis. They are held 4x a year, each one addresses one of the business priorities in the form of a single agency commentary. 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. 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 quality assurance activity has taken place:

The impact of Covid 19 pandemic continued to have a huge effect on agencies during the time period covered by this report. During 2021 lockdown restrictions began to be eased as part of the government's road map out of lockdown. Public services began to slowly reintroduce face to face appointments whilst attendance at educational establishments became more open. There was a greater reliance on providing and taking up vaccinations to keep the population safe. However, for a while the more vulnerable members of our society were still required to stay at home and to take extra precautions if venturing outside of the home. The impact of Covid 19 on safeguarding issues and agencies service delivery has continued to be a standard agenda item and is considered at every QEG meeting. This is 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. Coming out of the pandemic and learning to live with Covid, in all its forms, is a learning process for both individuals and service providers.

A Single Agency Performance Commentary is completed by partners for each of the Board's priorities with each priority being reviewed at QEG twice a year. This includes agencies qualitatively reporting on each priority under headings that include: 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 one courses have been endorsed for the Police. A new more streamlined endorsement process covering both the children's and adult's single agency training submissions has been successfully piloted throughout 2021/2022 and will be officially launched during the latter part of 2022.

The **Biennial Thematic Review** of the Professional Themes found within Local Safeguarding Adult Reviews from 2019- 2021 was completed early 2022 and presented to the partnership board groups. During the two-year period ten adult reviews were undertaken. In 30% (3) of these cases there was evidence of good practice involving the areas of mental capacity assessments and multi agency working.. The most common areas for development included sharing information- 70% (7) of the

cases and lack of recording in in 60% (6) of the cases. To provide a regular and a more inclusive local picture surrounding adult reviews, for 2023 the thematic review will become an annual audit.

A Benchmarking Audit of a local Safeguarding Adult Review against the SAR quality markers promoted by Social Care Institute for Excellence (SCIE) and Research in Practice for adults (RIPfa) was undertaken in 2021. Overall, the majority of the questions within the quality markers were effectively evidenced as being 'met' against the local SAR. The completion of the benchmarking exercise showed a number of changes that have been implemented that enhance the practice surrounding SARS. These included an improved SAR referral form, a refreshed Resolving Professional Differences (escalation policy), supportive training on SARs through virtual workshops and online training and the creation of a SAR database of learning. As a result of the benchmarking exercise a shortened version of the quality markers have been put into a check list as an aid for both the partnership board and partners to follow on the process of completing a SAR.

During 2021 the **Self-assessment audit tool** was completed with the agencies of the Quality Effectiveness Group. This audit is undertaken, every two years, to ascertain if agencies across the partnership are effectively safeguarding and promoting the welfare of adults at risk in accordance with their Care Act statutory responsibilities. The self-assessment audit tool had been significantly redesigned to be shorter and to focus on the board's priorities. Alongside the tool a **professionals survey** was launched to gathering the views and experiences of the 290 practitioners who responded. During March 2022 a **challenge day** took place and the findings from this event will be reported within an Addendum report to the self-assessment tool audit later this year.

Findings showed that agencies and professionals were aware of their own single agency safeguarding policies, but fewer professionals (69%) were aware of the safeguarding partnership boards multi-agency policies being disseminated across their organisation. Information disseminated included important areas that covered people in positions of trust (PiPOT), Multi-agency Risk Management guidance (MARM) and Mental Capacity Act assessments. For 2022 – 2023 the MARM guidance has been refreshed and relaunched, the PiPOT guidance is being reviewed in line with the eastern regional approach and MCA is one of the boards new priorities. Further findings from the addendum report will feature in next year's annual report.

A multi-agency **Making Safeguarding Personal (MSP) audit** took place during 2021. The findings from this audit are reported in the MSP priority on page 11.

As a result of the quality assurance activity, several **multi-agency policies, procedures and guidance** were identified as needing to be reviewed and refreshed. Task and finish groups were established to lead on the MARM, Multi-agency partnership procedures and guidance and the Section 42 enquiry guidance. This ensures a multi-agency approach with a view to making documentation more succinct and practitioner focused. In early 2022 the multi-agency procedures and guidance were refreshed and relaunched. The MARM and Section 42 guidance have been launched after the time period of this report and their impact on practice will be examined within next year's annual report.

Independent Scrutineer's Report and Findings

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

The priorities for the year April 2021-March 2022, have been:

- The importance of Making Safeguarding Personal is recognised and implemented effectively across agencies.
- Lessons from Safeguarding Adult Review's (SAR) are effectively disseminated and the impact of the learning is evidenced.
- Agree and implement pathways for those vulnerable adults considered to be at risk. Agreed language and interpretation of language across the partnership.

Any scrutiny of the adult safeguarding board and its 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 the pandemic by agencies, individuals and the partnership can only be described as excellent. Extraordinary effort has been involved to ensure that those who are vulnerable are given as good a service as possible.

The activity by the partners against the current priorities, was discussed at the January 2022 Executive Partnership Board meeting. There was full acknowledgement by the statutory partners including myself, as the independent scrutineer, that good progress has been made in all the three priority areas. The Executive Partnership Board are considering what priorities should be put in place for 2022-2024 at a future meeting.

The combined Cambridgeshire and Peterborough Safeguarding Adult Partnership Board (CPSAPB) is chaired by the Director of Adult Services for both Local Authorities. I have attended two of the CPSAPB meetings during this year and was very impressed by the wide-ranging attendance including all statutory partners and many other partners including the voluntary sector. I have one concern in relation to the partnership board membership and that is how to get service user representation adequately represented. Going forward there are several plans being put in place with a view to gaining service user input. As a final point, the meetings were chaired extremely well and in one of those meetings the focus was on the sign off a number of SARs.

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

Due to the pressure on the partnership arising from increased SARs activity, I was asked to carry out an in-depth piece of scrutiny to examine the SAR process and its outcomes. I found that the outcomes reached by the SARs are comprehensive and wide reaching bringing about policy, guidance and procedural changes. The partnership is also working to improve changes in professional knowledge and practitioner practice. Finally, I presented a paper detailing my findings on exploring cultural changes within the partnership, agencies and practitioners to the executive board in January 2022. My report concluded that *'There is no doubt that the Cambridgeshire and Peterborough Safeguarding Adult Partnership SAR process, their learning and outcomes, achieve the requirements of The Care Act 2014. The Executive Board can be assured that there is in place a robust and well run process to review serious cases of adult abuse.'*

I have also attended an adult Quality Effectiveness Group (QEG) meeting which is well attended and engaged. However, there are single agency audits and data that should be shared within the QEG meetings. This would help agencies understanding surrounding safeguarding issues for adults at risk and would help them to focus on future work.

The multi-agency training provision has been examined and is extremely thorough and wide reaching to agencies and professionals. 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. Initially SWAYs were produced on safeguarding issues that were prominent during the lockdown (i.e. online abuse for adults, online abuse for children, safeguarding for community volunteers) However, as the popularity of the SWAYs increased it became apparent that these were a hugely useful resource and further topics were added. The SWAYs are accessible via the partnership board's website.

A brief evaluation is conducted at the end of the SWAYs, these have evidenced that people have found them to be useful and increased their knowledge and confidence of a subject area. The introduction of SWAYs 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.

The adult partnership has carried out a self- assessment audit for adult safeguarding and alongside the audit provided a survey for professionals to complete. I chaired a scrutiny and challenge meeting in March 2022 to discuss the findings of the self-assessment audit and professionals' survey. I firstly need to say using a self-assessment audit tool alongside a comprehensive survey is extremely innovative and very few areas nationally carry this out. The analysis was extremely well written and the findings are that the partnership is performing well in how to best safeguard vulnerable adults in Cambridgeshire and Peterborough.

Dr Russell Wate QPM MSc

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

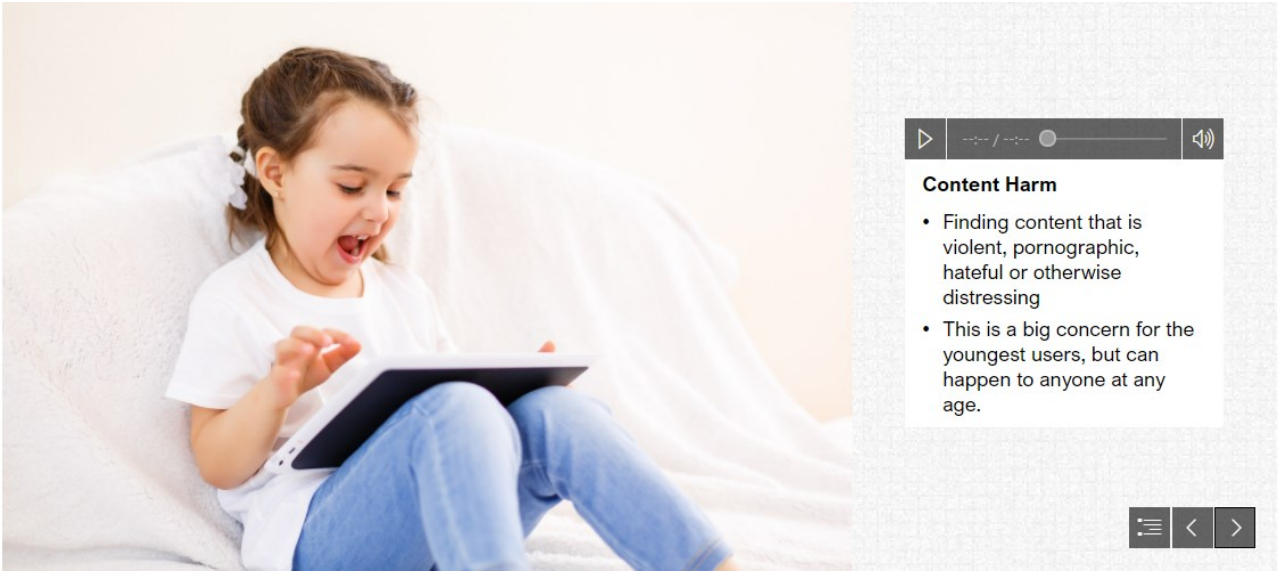
Due to government restrictions during the continuation of the pandemic, most staff from organisations were still required to work from home where possible. Face to face training continued to be suspended whilst the Partnership Boards multi-agency online and virtual training offer grew from strength to strength. In response many of the temporary measures put in place to support professionals learning and to facilitate the training during 2020 have developed into a mainstay programme of virtual online activities and briefings which has grown and diversified to include identified safeguarding areas of need for partners safeguarding training.

The Covid 19 Information page on the Safeguarding Partnership Board website continued to offer supportive information on Covid 19, vaccinations, local safeguarding arrangements, links to useful agency resources, presentations on basic safeguarding children and safeguarding adults at risk, leaflets, briefings and video links and a link to CPSPB online training. Feedback from volunteers and working professionals included that the Sways were clear and concise', 'good', 'informative', 'comprehensive' and 'really useful.' have found the information 'invaluable' and 'informative' to support their knowledge of safeguarding and what to do if they had safeguarding concerns.

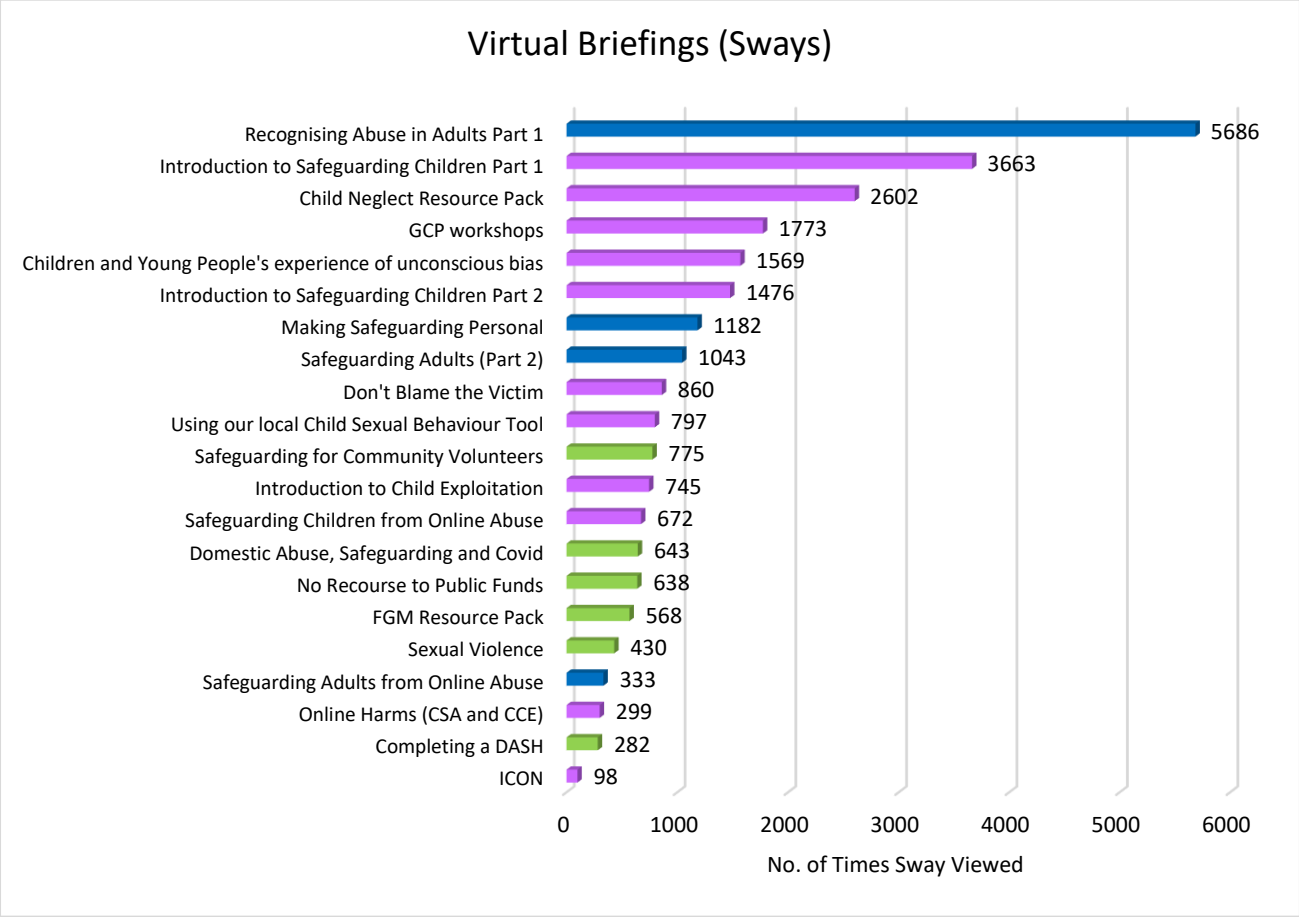
Virtual Briefings (Sways)

Virtual briefings were first developed by the Partnership Board during 2020 as a response to providing safeguarding training / information during Covid times. Locally, these are referred to as Sways (on the Microsoft Team platform). 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. To support a blended approach towards learning, participants of the multi-agency online safeguarding training are also required to access the Sways either prior or post their safeguarding training sessions.

The virtual briefings have continued to be developed and focused on locally identified areas of safeguarding risk as well as the Board's priorities. The Sways are a hugely successful and useful resource. For those professionals who complete the Sway there is a downloadable certificate as proof of completion. Most professionals gave the Sways a 4 to 5, star exceptional rating and described them as, 'clear and concise', 'good', 'informative', 'comprehensive' and 'really useful.'. They continue to be very well received by agencies and have been used and adapted within our local partners' resources as part of single agency training and have been utilised by other safeguarding boards across the Country.



Between April 2021 and March 2022, the virtual briefings had been viewed a total 26,134 times almost two and a half times the number of views on the previous year. For 2021-2022 there were 7 new Virtual Briefings developed.



Key
Adults
Children
Both Adults and Children

Virtual Training sessions were developed during 2020 from existing face to face training materials and condensed into 60 or 90 minute sessions. These sessions were initially facilitated by members of the Independent Safeguarding Partnership Service and during 2021 and 2022 have started to include partners leading specific sessions on identified safeguarding priorities.

As with the briefings, the virtual training has focused on safeguarding risks and the Board's priorities. As part of a rolling programme, the training focused on Self Neglect, Hoarding, Working Together, Mental Capacity Act and Safeguarding and Termly workshops on the latest safeguarding messages. Safeguarding partners have facilitated virtual training on Domestic Abuse, Completion of the DASH and Modern Slavery.

31 virtual training sessions took place during April 2020 to March 2021 where 977 people attended virtually. This is a 75% increase on the virtual courses offered in the previous year. As the demand for the training has been so great up to 75- 100 places on each course are now available for professionals to attend.

The virtual training continues to be greatly received with 98% of professionals reporting that they felt that the safeguarding virtual training content met their training needs and 97% of professionals stating that the delivery of the training was right for them. Professionals' comments included:

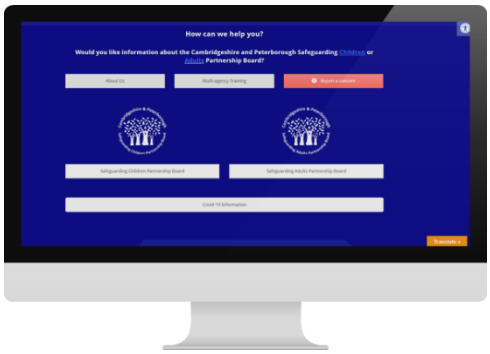
- Good liked the use of videos / liked the use of theory
- Excellent / Brilliant, thank you
- Detailed and informative / concise and to the point
- This was absolutely perfect and very powerful and well presented
- Delivering virtually did not take away from the session at all and still allowed interaction
- I have found online training extremely useful, particularly during the Covid pandemic and associated restrictions. It gives me the opportunity to 'attend' a lot more training sessions over the course of the year without impacting on my work load.

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 training. 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 both the lockdown environment and slowly coming out of the pandemic.

WEBSITE & SOCIAL MEDIA

Over the past year we have had 500,662 page views and 81,669 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 4% which would indicate users find what they are looking for quickly. Apart from the home page, the 'Making a Referral' page was the most visited page on the site, followed by Multi-agency Training page and our virtual Sway briefings pages 54% of visitors reached our site via entering keywords into search engines. 66% accessed the site via a desktop device (i.e. Laptop) and 31% 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.
If you haven't yet followed us, please do!

@cplscb @cplscb @cpsafeguardingboard

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