CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD

Cambridgeshire County Council

Date:Thursday, 15 September 2016

Democratic and Members' Services
Quentin Baker
LGSS Director: Lawand Governance

10:00hr

Shire Hall
Castle Hill
Cambridge
CB3 0AP

Kreis Viersen Room
Shire Hall, Castle Hill, Cambridge, CB3 0AP

AGENDA

Open to Public and Press

8	**Community Resilience Strategy**	**233 - 242**
9	**HWB Forward Agenda Plan September 2016**	**243 - 246**

10 Date of Next Meeting

The Health and Wellbeing Board will meet next on Thursday 17 November 2016 at 10.00am in the Civic Suite, Pathfinder House, Huntingdon.

The Cambridgeshire Health and Wellbeing Board comprises the following members:

Councillor Tony Orgee (Chairman) Tracy Dowling (Vice-Chairwoman)

Councillor Margery Abbott Dr Catherine Bennett Councillor Mike Cornwell Councillor Sue Ellington Kate Lancaster Adrian Loades Chris Malyon Lance McCarthy Val Moore Dr Sripat Pai Councillor John Michael Palmer Liz Robin Councillor Joshua Schumann Vivienne Stimpson Aidan Thomas and Matthew Winn Councillor Paul Clapp Councillor David Jenkins Councillor Peter Topping and Councillor Joan Whitehead

For more information about this meeting, including access arrangements and facilities for people with disabilities, please contact

Clerk Name: Richenda Greenhill

Clerk Telephone: 01223 699171

Clerk Email: Richenda.Greenhill@cambridgeshire.gov.uk

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Council and political Group Leaders which can be accessed via the following link or made available on request: http://tinyurl.com/ccc-film-record.

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Agenda Item: 2

CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD: MINUTES

Date: 7th July 2016

Time: 10.05 to 12.50

Place: Council Chamber, Fenland Hall, County Road, March PE15 8NQ

Present: Cambridgeshire County Council (CCC)
Councillors P Clapp, D Jenkins (substituting for Cllr Nethsingha), and T Orgee (Chairman)
Dr Liz Robin, Director of Public Health (PH)

District Councils
Councillors M Cornwell (Fenland) and S Ellington (South Cambridgeshire)

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
Jessica Bawden (substituting for Dr Sripat Pai) and Cathy Bennett

Healthwatch
Val Moore, Chair

NHS Providers
Deborah Cohen, Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) (substituting for A Thomas)
Matthew Winn, Cambridgeshire Community Services NHS Trust (CCS)

Voluntary and Community Sector (co-opted)
Julie Farrow, Chief Executive Officer, Hunts Forum of Voluntary Organisations

Apologies: Councillors Lucy Nethsingha, Joan Whitehead and Peter Topping, (CCC); Adrian Loades, Executive Director: Children, Families and Adults Services (CCC); Councillors Margery Abbott (Cambridge City), David Brown (Huntingdonshire) and Joshua Schumann (East Cambridgeshire); Tracy Dowling (CCG) Dr Sri Pai (CCG); Sylvia Knight (NHS England); Kate Lancaster, Director of Corporate Affairs, Cambridge University Hospitals NHS Foundation Trust (CUHFT) Chis Malyon (Section 151 Officer, CCC) Lance McCarthy (HHCT), and Aidan Thomas (CPFT)

219. APOLOGIES AND DECLARATIONS OF INTEREST

The Chairman welcomed Deborah Cohen and Matthew Winn to their first meeting of the Health and Wellbeing Board (HWB). Apologies were noted as listed above.

There were no declarations of interest.

220. ELECTION OF VICE-CHAIRMAN/WOMAN

As an oral update it was confirmed that the Clinical Commissioning Group (CCG) at their meeting the previous day had appointed Dr Cathy Bennett and Tracy Dowling to the two vacancies and reappointed Dr S Pai as the CCG representatives on the Board with Jess Bawden as a substitute. The CCG representatives present put forward Tracy Dowling to be the Vice Chairwoman.

It was resolved unanimously:
To appoint Tracy Dowling as the Vice Chairwoman of the Health and Wellbeing Board.

221. MINUTES – 26th MAY 2016

The minutes of the meetings held on 26th May 2016 were signed as a correct record,

222. MINUTES ACTION LOG UPDATE

The Board received the Action Log.

The Director of Public Health provided the following oral updates:

Minute 149 - Progress and HWB Priority 4 – The action to circulate a briefing to HWB members on the work being undertaken on Universal Credit and provision of support in benefits sanctions cases in Children, Families and Adult Services and in the District Councils still required to go back to District Council leads.

Minute 181 - Older People's and Adult Community Services (OPACS) – Action of the CCG Chief Strategy Officer and the Executive Director CFAS to examine various issues, including Doddington Court, and share the response with both Executive Director and Councillor Cornwell had been delayed as the CCG Chief Strategy Officer had left. Further liaison would therefore need to take place with the CCG in order to provide the necessary response**. Action: Jess Bawden**

Minute 209 – A Person's Story - AGE UK had been tasked with sharing details for the Handyperson scheme with CPFT community nursing teams. **Action: Deborah Cohen undertook to check progress**

Minute 213 - Annual Public Health Report – Building up local infrastructure - This action was to be discussed between the lead officers following the current Board meeting.

Minute 214 - Quality Premium 2016-17 - CCG choice of local indicators - The action to supply a list of factors on which the quality premium would be awarded and to supply an implementation plan was now expected to be actioned in late July.

Minute 216 Better Care Fund (BCF) 2016-17 – the outcome of the BCF submission was still awaited.

Minute 217 – Possible Forward Plan Agenda Item for September - Devolution and possible actions in relation to health and social care – It was not clear at the current time whether this should be a formal item on the Board agenda or whether it was better to be considered as a 'Development Day' topic.

223. A PERSON'S STORY

This item had been withdrawn but the aim would be to try to circulate something to the Board following the meeting. **Action: L Robin / A Lyne**

224. CAMBRIDGESHIRE SUMMARY JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) 2016

This report provided a brief overview and update on JSNA work to date in Cambridgeshire, seeking approval and giving consideration on how it could be promoted within the organisations making up the Board and also seeking comments on the potential value of a 'System Pressures JSNA'.

The summary document identified and flagged up key pieces of information about the health and wellbeing needs of people who lived in Cambridgeshire as well as local inequalities in health for specific population groups. It provided access to an overview summary of what were complex, individual documents.

It was highlighted that the reductions in the local authority public health grant for 2016/17 had resulted in a reduction of the staff capacity available for producing JSNAs going forward. However significant work activity had already been undertaken, and as a result, in addition to the reports included on the current agenda, a JSNA on Drug and Alcohol Misuse was to be presented to the September HWB Board. Reference was also made to the requirement to produce an updated Pharmaceutical Needs Assessment (PNA) for spring 2017.

It was highlighted that officers had been discussing the concept of a 'system pressures' JSNA – taking a 'population' perspective on the demand pressures on health and local authority services. The aim would be to bring together data sources on the different population groups in Cambridgeshire and Peterborough and triangulate this with data on activity in health and care services, to provide a population overview of factors likely to be influencing demand at a local level.

Members discussed the report and provided comments including:

- that the tremendous amount of data gathered in the JSNAs was still not being sufficiently accessed by partner organisations and a Member questioned how it could be communicated better to a wider audience. Cambridge Television was cited as a medium that should be considered for future publicity drives.

- The need to consider producing publicity information that could be sent out to schools and GP surgeries, taking into account the needs of people with low reading and writing levels.

- Val Moore questioned the accessibility of 'Cambridgeshire Insight' for schools and community groups who should be encouraged to undertake their own activity, including being given access to patient's stories. Both Val Moore and Julie Farrow requested more details regarding Cambridgeshire Insight. **Action Liz Robin to arrange a meeting.** *Note: Later in the meeting attention was drawn to the explanation provided on page 28 of the agenda.*

- The idea of having a repository of patient's stories which could be shared was raised, was supported.

- The need for a JSNA on workforce issues was raised, as this was a concern for all partners around the table. In discussion it was suggested there was a need to consider further where this work stream should be included as well as the implications from the recent devolution agreement. Reference was also made to the new skills training opportunities funding being rolled out by the Government and the need for partners to tap into work already being undertaken in this area. There was a need to work closely with local colleges around encouraging young people to train for social care employment**.** A discussion was also required of where people were going to be in the future and how they would be supported. It was agreed that the best way forward to discuss this further was through a development day session on workforce issues. **Action: Development Day session on workforce issues to be set up to include input from officers leading on workforce for the Sustainable Transformation Plan.**

- In respect of the lack of reference to the particular issues prevalent to Fenland, the Director of Public Health highlighted information she had provided to the Chief Executive of Fenland District Council regarding improved statistics from preventative work undertaken to help reduce the number of teenage pregnancies and help prevent heart disease.

- One Member raised the need for local health partners to increase the level of support provided to 'local health partnerships'. In response, details were provided of the work currently being undertaken.

- The Pharmaceutical Needs Assessment should include GP data and illustrative maps.

- Issues around freehold properties estate management issues / key worker housing would be the subject of further discussions between the District Support Officer Iain Green (who was substituting for Mike Hill at the meeting) and Matthew Winn. **Action: Iain Green**

- Capacity issues in Hospital and GP surgeries – One Member made the point that although there were two wards empty in Wisbech Hospital, patients were still being sent to Kings Lynn Hospital for some services and also highlighted that some doctors surgeries were so full they were not taking new patients.

- The need to clarify the role of Patient Forums.

From the discussion the proposal for a 'Systems Pressure JSNA' was supported by the Board.

It was resolved:

a) Approve the Cambridgeshire Summary Joint Strategic Needs Assessment (2016)

b) That partners consider how the use of the JSNA could be promoted within their own organisation

c) support the proposal for a 'System Pressures JSNA' as outlined in para 4.2.

d) agree to a Development session on Workforce issues.

225. CAMBRIDGESHIRE MIGRANT AND REFUGEE JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

This report provided details of the Cambridgeshire JSNA on Migrants and Refugees which was split into sections relating to the determinants that had an impact on the health and wellbeing of migrants namely; education, housing, employment, health, crime and community cohesion. The document was important to help local authorities and health services understand the health needs and pressures of the whole community when planning and delivering their services. The report sought the Board's approval to the recommendations set out on pages 125-127 of the agenda (71-73 of the original officers' report based on the following three themes:

Theme 1 - public health Support and advice – including factors influencing the wider determinants of health
Theme 2 - Primary Care
Theme 3 - Cohesion and Building Community Resilience.

Issues identified included:

- that some migrants were not registering with GP's, as a result of information not being sufficiently or appropriately signposted or sometimes this involved problems of understanding systems which were different from those which they were familiar with.
- The need for better information on nationality, as the 2011 census data was now out of date.

Comments from Board Members included;

- Officers were congratulated on the JSNA's contents and the very helpful data included and its importance to partners when shaping future services and identifying the resources that would be required.

- The need to recognise that not understanding the way the health and care system works due to information signposting not always being readily accessible / understood, was a wider issue than just for migrants with language difficulties and included both local people who had literacy difficulties and also private language school students. There was the need when looking to improve information signposting to utilise social media to help engage with young people. The overriding need was for signposting to be provided in the appropriate format for the target audience and drawn up in very simple, non-ambiguous language, including information included on websites.

- It was suggested that if there was an information pack designed for use by

businesses employing migrant workers, it would be appropriate to seek their contributions towards the production costs.

- Currently there appeared to be no reference to early year support for the 0-5 age group and the links between childhood development and education.

- The document did not adequately recognise increased dentistry pressures.

- In respect of sexual health, the document focussed on HIV and one Member suggested the text should be broadened to include more detail on other infections, including those more commonly associated with young people.

- The need to identify community connectors such as: churches, local community centres and local community leaders as a vital resource for distributing information within a particular community.

- The need to analyse and identify what has contributed to good outcomes in order to share the knowledge wider and add to the overall knowledge base.

- To recognise the link between safety and good health, linked to measures to counter the exploitation of migrant workers. Dr Liz Robin suggested that this might include wider information distribution on workers employment rights. In response to the general discussion on this area, while recognising exploitation as an important issue, it was explained that it was hard to obtain reliable statistics in this area to be able to include it in the document.

- One Member asked whether as there was a large amount of information on Peterborough migrants, whether their Board had considered the report. In response it was indicated that a similar report had been to a stakeholder meeting and was likely to go to the full Board in September.

The Board unanimously resolved to:

a) Approve the Migrant Workers and Refugees JSNA and the recommendations included within it on pages 71 -73 (125- 127 of the agenda pack).

b) To agree to set up an officer group to take forward the recommendations

c) That an update report be received in nine months' time.

226. LONG TERM CONDITIONS JSNA – UPDATE REPORT

The Board received an update report from Dr Angelique Mavrodaris, Consultant in Public Health Medicine on the dissemination, utilisation and application of the Cambridgeshire Joint Strategic Needs Assessment (JSNA) on Long Term Conditions (LTCs) across the Lifecourse.

It was emphasised that while effective dissemination and communication of the work had been undertaken as detailed in the report, there were currently health programmes and developments across the health and care system that had not

implemented and built on the work produced in the JSNA. This was highlighted as a waste of resources and could lead to unnecessary duplication of work. The Health and Wellbeing Board was considered the appropriate vehicle to highlight the areas of concern.

Issues raised in discussion included:

- One member highlighted the long delays in the pain relief clinic at Addenbrooke's Hospital and suggested that there was not sufficient momentum in some areas to improve the service. In response, it was indicated it was being reviewed, including whether all GP referrals were appropriate.

- Several Members of the Board asked for details of the specific work areas which were not implementing the JSNA findings so that they could help unblock them. Others comments suggested that in some cases the findings were being implemented, but that they had not been feedback, or in other areas had not yet found their way down to the operational level. The lead officer did not consider it was appropriate to provide such detail in a public forum. Dr Liz Robin suggested that the details should be provided outside of the meeting, with the aim of undertaking a follow up meeting. The Chairman additionally highlighted the need to circulate the detail to all Board members, as some providers were absent from the current meeting. **Action Liz Robin / Dr Angelique Mavrodaris**

- Concern was raised by one member as a general point, that it appeared that the biggest issue was that agreements made at the Board were not being embedded.

- The need to be clear on the priorities in the JSNA Action Plan and the current progress against them which should be updated and circulated as part of any further discussions. The Chairman made the point that the production of JSNAs should not be seen as the end in itself, and that there was a need to see evidence based results of action undertaken.

- The need for a more strategic multi-partner approach to self-management.

It was resolved:

To note the update provided.

227. GOVERNANCE AND TERMS OF REFERENCE FOR THE HEALTH AND CARE EXECUTIVE

The Board received a report informing the Health and Wellbeing Board of the Terms of Reference and Governance arrangements for the Health and Care Executive to be made up of the partner organisations who were jointly responsible for delivery of the Sustainability and Transformation Programme (STP). There was the expectation that the current consultation round would result in changes to the proposed arrangements which would require a further update report to the next meeting.

The partner organisations would participate in the decision-making processes of the Executive to the extent that they were delegated authority by their respective

organisations. While certain powers would be delegated from the programme's NHS Statutory organisations to the Health and Care Executive and its associated workstreams, it was stressed that decisions would still rest with the CCG and local authorities in respect of those services that they were statutorily required to provide, as these could not be delegated.

The Framework required to be approved /endorsed by the Boards, Governing Bodies and local authority Committees/Cabinets of all partner organisations, and would be reviewed on a regular basis.

Issues raised included:

- Concerns expressed by Councillor Sue Ellington that the references to local authorities / Councils did not include district councils. In response it was indicated that district councils would have representation on some of the working groups. Reference was also made to paragraph 1.3 of the document with the last sentence reading "The role of the City Council and the District Councils exercise a number of relevant housing, planning and other functions which may also align to this programme". As a further response Cllr Ellington indicated she would wish to see the maximum involvement by district councils, commenting that otherwise a whole group of democratically elected people were being excluded.

- Val Moore made the point that much of the document had so far been produced confidentially and that in some areas there would be a benefit to have patient / public involvement so that patient experience could be drawn on when redesigning services. Val indicated that she would be meeting with Jess Bawden the following week to discuss this further.

It was resolved:

To endorse the Governance Framework for the Health and Care Executive.

228. OUTCOMES FROM 14TH JUNE DEVELOPMENT SESSION

The Board received a report presenting the outcomes from the above development session. It was noted that following the discussion, attendees had been asked to prioritise five key actions or priorities that the Cambridgeshire HWB Board should focus in in the next 12 months which were agreed as follows:

1) Review how and when the Cambridgeshire HWB meets - suggested that there should be more development sessions for the HWB and fewer formal board meetings.

2) Organise themed development workshops on particular issues, with a focus on problem-solving - with representatives from wider partners not represented on the HWB and/or internal subject matter experts, could be invited to contribute to these sessions.

3) Agree a programme management approach - To ensure capacity for the Board's recommendations to lead to action.

4) Establish the HWB's relationship with the Sustainability and Transformation Plan (STP)

5) Develop a vision for integrated health and care So the HWB is clear on its aims for the future of health and care integration.

In the course of discussion,

- One Member suggested that number 5 should be 1.

- In terms of the resource implications for the new board referred to in the previous report, whether there could be shared support provided from the Sustainability and Transformation Plan Unit.

- The need for clear linkages to be made with the work of the local health partnerships.

It was resolved:

To endorse the five priorities as outlined above and in paragraph 3.1 of the report.

229. FORWARD AGENDA PLAN

The Board considered its forward agenda plan and noting the number of reports relating to safeguarding on the September Board meeting, suggested and agreed that:

- the four safeguarding reports should be amalgamated into two reports followed by the JSNA Report and that at the close of the meeting a development session on programme management arrangements. **Action: Ruth Yule / Adrian Lyne / Liz Robin**

In discussion and having already earlier discussed using some of the Board meeting days as development days to agree to use the November Board meeting slot as a Development Day, even if there was a need to have a short Board meeting to agree any urgent business. The Development Day to include the following topics:

- Devolution – As there was an expectation that Devolution issues should have been clarified by this date, having an item to discuss identifying what the Government should be asked to fund. **Action: Liz Robin / Adrian Lyne**
- A session on Workforce Development. **Action: Liz Robin / Adrian Lyne**

Other Issues

- STP should be added as a standing item to each meeting. Action: **Ruth Yule**
- Reports on the Better Care Fund should only come forward where the Board was required to make a decision.

The Board noted the forward agenda plan subject to the agreed changes.

230. DATE OF NEXT MEETING - 15TH SEPTEMBER 2016 AT SHIRE HALL, CAMBRIDGE

Board members noted the above date and also those set out on the agenda and agreed that some of these should be utilised as Development days, with more detail on a programme to be provided at the next meeting. **Action Liz Robin / Adrian Lyne**

Chairman

HEALTH & WELLBEING BOARD ACTION LOG AND UPDATES FROM 7 JULY 2016

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
180. Community Resilience Strategy	The Board's District Council support officer undertook to liaise with the Service Director on local planning in South Cambridgeshire, with the aim of avoiding duplication and identifying gaps in what was in place **Action: S Ferguson/ M Hill** **UPDATE:**	**ON-GOING**
207. Minutes action log update	Director of Public Health (DPH) and Democratic Services Officer to seek final updates on longstanding outstanding actions prior to next meeting **Action: L Robin / R Yule** **UPDATE:** Efforts to secure final updates have met with some success – see above and minute 222 below.	**ON-GOING**
222. Minutes Action Log update	Minute 149: Progress on HWB Priority 4 Circulate a briefing to HWB members on the work being done on universal credit and provision of support in benefits sanction cases in Children, Families and Adults Services (CFA) and in the District Councils **UPDATE 07/07/16:** The CFA Child Poverty Group was considering the wider issues; District Councils leading on Universal Credit. District Council leads to progress provision of information on universal credit. **Action: I Green / M Hill**	
	Minute 181: Older People's and Adult Community Services (OPACS) Contract The CCG Chief Strategy Officer and the Executive Director: CFAS were examining various issues including Doddington Court; Chief Strategy Officer to share his response to the Executive Director with Councillor Cornwell **UPDATE 07/07/16:** This action had been delayed as the CCG Chief Strategy Officer had left. Further liaison would therefore need to take place with the CCG in order to provide the necessary response to the Executive Director and Councillor Cornwell. **Action: J Bawden**	

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
	Minute 209: A Person's Story Age UK to share details for the Handyperson scheme with CPFT community nursing teams **UPDATE 15/08/16:** The scheme is being publicised internally and work is in hand to establish whether a link can also be included on the main CPFT website. **D Cohen**	**COMPLETED**
	Minute 213: Annual Public Health Report Director of Public Health to work with Julie Farrow of Hunts Forum and Val Moore of Healthwatch to see what they could do together to build up local infrastructure **UPDATE 07/07/16:** A meeting has been held by J Farrow, V Moore and L Robin which is being followed up by further engagement with voluntary sector organisations. **Action: J Farrow / V Moore / L Robin** **UPDATE 31/08/16:** Two meetings have been held and further actions agreed with the CVS, to take forward engagement with volunteers and parish Council infrastructure**.**	**COMPLETED**
	Minute 214: Quality Premium 2016-17 – CCG choice of local indicators CCG Head of Operational Planning to supply list of factors on which the quality premium bonus would be awarded, and to supply implementation plan **UPDATE 07/07/16:** This work was expected to be completed in late July, when the information requested could be supplied to the HWB. **Action: J Bawden / S Shuttlewood**	
	Minute 216: Better Care Fund Plan 2016-17 Outcome of BCF submission to be circulated to the Board **UPDATE 07/07/16:** The final outcome had not yet been received in writing. **Action: G Hinkins**	

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
	Minute 217: Forward agenda plan DPH to explore whether it would be useful to have an item, perhaps in September, on devolution and possible actions in relation to health and social care that might arise in consequence **UPDATE 07/07/16:** It was not yet clear whether this should be a formal item on the Board agenda or whether it would be better to consider it as a 'Development Day' topic. **Action: L Robin** **FURTHER UPDATE:** Devolution added to the forward agenda plan as a topic for the informal development session on 15 September 2016 and possibly also 17 November 2016.	**COMPLETED**
223: A person's story	Information relating to this item to be circulated to Board members after the meeting. **Action: A Lyne / L Robin**	
224: Cambridgeshire Summary Joint Strategic Needs Assessment (JSNA) 2016	Development Day session on workforce issues to be set up to include input from officers leading on workforce for the Sustainable Transformation Plan. **Action: A Lyne** **UPDATE:** Health and social care workforce added to the forward agenda plan as a topic for the informal development session on 17 November 2016.	**COMPLETED**
	Issues around freehold properties estate management issues / key worker housing to be the subject of further discussions between the District Support Officer and Matthew Winn. **Action: I Green**	
226: Long-Term Conditions JSNA – update report	Details of specific work areas which were not implementing the JSNA findings to be circulated to all HWB members so that they could help unblock them. **Action: A Mavrodaris / L Robin**	

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
229: Forward agenda plan	For September 2016: Amalgamate four safeguarding reports into two For November 2016: Use meeting slot for a development day covering devolution and workforce development Every meeting: Add Sustainability and Transformation Programme as a standing item **Action: A Lyne / L Robin / R Yule** **UPDATE:** Agenda plan changed to incorporate above.	**COMPLETED**

230: Date of Next Meeting	To provide more detail about the use of some HWB meeting dates as Development Days. **Action: A Lyne / L Robin**	

Agenda Item No: 4

A PERSON'S STORY

To: Health and Wellbeing Board

Date: 15 September 2016

From: Claire Bruin, Service Director: Adult Social Care

1.0 PURPOSE

1.1 To introduce the person's story being presented to the Health and Wellbeing Board.

2.0 BACKGROUND

2.1 The Cambridgeshire Health and Wellbeing Board have requested that a person's story be presented at the start of each meeting. The story being presented at this meeting will highlight a collaborative approach across agencies to identify the best way to connect with a man being subjected to abuse. The multi-agency approach was successful in supporting the man to identify what he wanted to happen and to take action to achieve this.

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3.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

3.1 This story relates to Health and Wellbeing Board Priority 6: Working together effectively..

4.0 IMPLICATIONS

4.1 There are no direct implications arising from this report.

5.0 RECOMMENDATION

5.1 The person's story is being told as context for the remainder of the meeting.

Source Documents	Location
Health and Wellbeing Strategy	http://www.cambridgeshire.gov.uk/info/20004/health_and_keeping_well/548/cambridgeshire_health_and_wellbeing_board

Agenda Item No. 5

Safeguarding Adults Board (SAB) Annual Report 2015/16 (including details on work with the University of Cambridge and Collaborations for Leadership in Applied Health Research and Care)

To: Health and Wellbeing Board

Date: 15th September 2016

From: Claire Bruin, Service Director, Adult Social Care

1.0 PURPOSE

1.1 Presentation of the Safeguarding Adults Board Annual Report for 2015/16 and an update on the work carried out with the University of Cambridge and Collaborations for Leadership in Applied Health Research and Care (CLARHC) on the implementation of Making Safeguarding Personal.

2.0 BACKGROUND

2.1 The Care Act 2014 (enacted in April 2015) introduced the statutory duty on Local Authorities, Clinical Commissioning Groups and the Constabulary to operate a Safeguarding Adults Board (SAB) to promote and oversee the protection of adults with care and support needs from abuse and/or neglect.

2.2 Cambridgeshire already had a well established SAB with strong commitment from the Cambridgeshire and Peterborough Clinical Commissioning Group (CPCCG) and Police and other key partners and we have been able to build on this foundation during 2015/16.

2.3 The Draft Annual Report (Appendix A) provides a background to adult safeguarding work in Cambridgeshire and a summary of the work undertaken by the Safeguarding Adults Board (SAB), Adult Safeguarding Team and partners. N.B. The Draft Annual Report will be presented to the SAB for approval on 8 September 2016. Confirmation of that approval will be provided verbally at the HWB Board meeting on 15 September 2016.

3.0 PROGRESS ON PRIORITIES IN 2015/16 INCLUDING INFORMATION ON THE RESEARCH WITH THE UNIVERSITY OF CAMBRIDGE AND CLARHC

3.1 The report to the Health and Wellbeing Board in September 2015 identified a number of priority areas of work for the SAB in 2015/16. An update on each of these priorities is provided below.

3.2 *A training strategy for safeguarding and mental capacity work which meets the needs of the social care and health workforce, enabling a better understanding of the decision making process in safeguarding whilst taking*

into account the legal requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

A programme of standard training complemented by bespoke training has been developed and rolled out across social care and health organisations, including provider organisations. In the period of 2015-16 we have had a considerable increase of 28% in attendees including GP's for all courses, especially those that now relate directly to the core principle of Making Safeguarding Personal. Our roll out of training in adult safeguarding and MCA/DoLS has been a real success in this period with a 190% increase in Making Safeguarding Personal and MCA/DoLS an increase of 227%.

3.3 *Introduce changes to practice, procedures and training to support the implementation of the Making Safeguarding Personal approach*

Making Safeguarding Personal (MSP) is a national initiative that is embedded in the Care Act 2014 guidance from Department of Health. It places the person at the centre of any safeguarding action or intervention and sets the expectation that the outcomes that the person wants will inform how the situation is responded to and reinforces the importance of supporting people to recover following abuse.

The MSP approach is now central to all safeguarding training and is reinforced through safeguarding leads who meet regularly to discuss practice issues relating to the safeguarding of adults. Through the training, the MSP approach is being introduced across all health and social care organisations but needs to be reinforced within each organisation to ensure that it is embedded in practice.

3.4 *Working with colleagues from the University of Cambridge and CLARHC (Collaborations for Leadership in applied Health Research and Care [East of England]) to evaluate how Making Safeguarding Personal is embedded within our day to day safeguarding work*

CLAHRC East of England funded a research assistant for nine months from April 2015 to January 2016 for a research project investigating and supporting the work being undertaken to change practice to support MSP. The final report has not yet been presented to the SAB but there has been ongoing feedback during the nine months research.

The work focused on safeguarding within a care home setting, where it is more difficult to maintain a personalised approach because the situations that trigger a safeguarding response often raise concerns about general practice rather than actions specifically focused on individuals.

The researcher identified two distinct elements:

(i) The role of the care home: care provided by staff that should be a person centered activity and

(ii) Undertaking a safeguarding enquiry: a LA's scrutiny of practice in a home (is it good or is bad?) and making recommendations that should ensure good practice while minimizing risks.

Although the safeguarding concern may have been triggered in relation to one individual, the concerns for the population of residents (rather than the individual) leads to a more generalised approach when the Local Authority views the practice in the home, and recommendations and action plans reflect this.

Interviews with the Care Home Managers highlighted that the safeguarding process drove a dictatorial rather than a collaborative approach with managers. They demonstrated their commitment to delivering good quality personalised care and their willingness to explore a more collaborative approach to investigating safeguarding concerns that could assist in keeping the process more focused on individual residents and support them in improving practice.

The Local Authority has started to develop some alternative approaches to focus the safeguarding investigation more specifically on the individual situation(s) that have caused concern. In this way it will be possible to engage with the individual resident(s) and gain a better understanding of what has happened and whether there are patterns of poor practice that are specific to particular care staff or are more systemic. Work will continue to develop these approaches.

Learning from this active research was shared at a conference run by the Local Government Association and Research into Practice for Adults (RiPfA) in April. This has resulted in further interest from Local Authorities across the country because tackling the challenge of how to introduce MSP in a care home context is quite unique.

3.5 *Developing understanding about how to respond to people who self-neglect*

The Care Act 2014 guidance was rewritten during 2015/16 and despite some speculation that is would be removed, self-neglect is still included within the safeguarding section. However, it does recognise that not all self-neglect constitutes a safeguarding issue, but reinforces the personalised approach, supported by multi-agency collaboration, that is required to support people who self-neglect. Self-neglect covers a wide range of behaviours including neglecting to care for personal hygiene, health or surroundings, including hoarding, and can be linked to a complex range of issues that are impacting on the person.

Working with the Association of Adult Social Services Regional Safeguarding Network, we have been involved in a number of workshops to explore how to respond to people who self-neglect and have been able to build this learning into our local training.

3.6 *Closer collaboration with the LSCB with regard to:*
o Safer recruitment
o Working collaboratively to support young people who may need to be safeguarded as they reach 18.

Best practice in safer employment has been reinforced across all services and issues relating to safeguarding are being considered as part of the transition planning for young people moving from children to adult services, where this is relevant.

4.0 SAFEGUARDING ACTIVITY IN 2015/16

4.1 The Annual Report provides the detailed information on activity during the last financial year, which is summarised below:

4.2 The number of incidents referred to the Council has increased this year from 1355 in 2014/15 to 1499.

4.3 The most commonly reported type of abuse continues to be physical abuse (42%) although this has reduced from 48% of referrals in 2014/15.

4.4 Neglect, which has been given greater prominence through the Care Act 2014 has increased slightly from 22% in 2014/15 to 24%.

4.5 The location of incidents continues to follow the same pattern as previous years with the highest number being in care homes, followed by the person's own home and hospitals.

4.6 The alleged perpetrator also continues to follow the same pattern with other vulnerable adult being the most prevalent, reflecting the incidents between residents in care homes that cater for people who present behaviours that can challenge, specifically people with dementia, mental health issues and learning disabilities. Although there are questions about whether all these incidents meet the criteria for safeguarding, it is important that providers continue to report and respond to these situations and that commissioners are aware and can follow up as necessary with the providers. For this reason, these situations will continue to be captured through the safeguarding reporting process.

4.7 The Care Act 2014 has changed the reporting regarding the outcome of safeguarding enquiries, so rather than collect whether a safeguarding allegation has been substantiated or not, we now record whether the actions taken in response to the allegation has led to the following:

- Risk reduced
- Risk remains
- Risk removed
- No action taken under safeguarding

In the majority of cases, the risk was reduced, with a small number where the risk was removed or where the risk still remains. This emphasises the importance of working with the person to agree the personal outcome that

they want from the safeguarding intervention and the follow up that will be required to minimise the impact of remaining or reduced risks.

4.8 During 2015/16 agreement has been reached with Peterborough City Council to combine SAB subgroups that focus on training, procedures and performance. This collaboration will support agencies that work across Peterborough and Cambridgeshire who have been asking for more alignment to support their staff in fully their responsibilities around safeguarding in an efficient and effective manner.

5.0 MULTI-AGENCY SAFEGUARDING HUB (MASH)

5.1 During 2015/16 work has been undertaken to develop the adult presence in the MASH. The MASH brings together Cambridgeshire children's social care, the Police, Probation, the Fire Service, NHS organisations, key voluntary sector organisations, Peterborough City Council and currently one representative from the Council's adult social care services in a collaborative working arrangement, where information can be quickly and easily shared (subject to information sharing agreements) and decisions made on how best to approach specific safeguarding situations and which agency should take the lead. It enhances timely, effective and comprehensive communication between the partners through co-location or integration and greater partnership working.

5.2 In addition to the benefits of closer partnership working, the developments in the MASH will mean that inappropriate safeguarding referrals can be diverted away from the Adult Social Care Teams. Where there is a safeguarding issue, the staff in the MASH will gather information on a multi-agency basis to inform the response. This will ensure that different agencies work together to prevent abuse and neglect and stop it quickly when it happens.

5.3 Staff in the MASH have been seconded from existing staff who are experienced in leading safeguarding investigations. They are seconded initially for 12 months with the potential to extend this to 24 months. The use of time limited secondments will ensure that the staff in the MASH will have had recent operational experience and will support ongoing professional development.

5.4 The MASH Manager, the four MASH Safeguarding leads and the administrator took up their posts by the middle of March. From the 1st April, all safeguarding concerns have been referred to the MASH team for triage and to initiate immediate action if required. Situations that require a safeguarding enquiry are passed on to the Safeguarding Lead of the relevant service. Early indications are that the triage function is identifying situations that are not safeguarding and the MASH team are signposting people to appropriate services. Responses to safeguarding issues are being dealt with either in the MASH or are being passed to the relevant locality team, where this is appropriate.

6.0 Priorities for 2016/17

6.1 The following priorities have been identified for 2016/17.

6.2 Embedding the practice of MSP across all organisations involved in safeguarding. Use feedback from a "Temperature Check" commissioned by ADASS and due out in the Autumn to focus further development of MSP practice.

6.3 Embedding the MASH arrangements and understanding the impact on numbers of safeguarding referrals being passed to locality teams. Explore why cases that are not safeguarding are passed to the MASH and provide guidance as necessary to other organisations.

6.4 Confirm the appointment of an independent chair for the SAB. Review the operation of the SAB with the new chair.

6.5 Develop the joint working arrangements across SAB subgroups with Peterborough colleagues, including agreement on joint procedures.

6.6 Review dataset of information that allows effective monitoring of safeguarding activity and outcomes, doing in depth data and trend analysis.

7.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

7.1 The work on safeguarding adults from abuse and neglect supports the implementation of the following priorities in the Cambridgeshire Health and Wellbeing Strategy:
Priority 2: Support older people to be independent, safe and well.
Priority 3: Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices.
Priority 4: Create a safe environment and help to build strong communities, wellbeing and mental health.
Priority 6: Work together effectively.

8.0 RECOMMENDATION/DECISION REQUIRED

Members of the Board are invited to:

(i) Comment on the content of the covering report and the Cambridgeshire Safeguarding Adults Board Annual Report 2015/16

(ii) Ask officers to present the next Annual Report (for 2016/17) at a future Health and Wellbeing Board meeting in 2017.

Source Documents	Location
Terms of reference and annual reports for Cambridgeshire Safeguarding Adults Board	http://www.cambridgeshire.gov.uk/downloads/download/147/cambridgeshire_safeguarding_adults_board

Cambridgeshire Safeguarding Adults Board

making a difference together

Annual Report

April 2015 – March 2016

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1. Welcome from the Chair

The Cambridgeshire Safeguarding Adults Board (CSAB) is the key body for the coordination of the various statutory, independent and voluntary organisations in Cambrigeshire to safeguard and promote the wellbeing of "adults at risk" and for ensuring that this work is effective, transparent and continues to improve in response of the needs of people in our communities.

The Care Act 2014 introduced the statutory duty on Local Authorities, Clinical Commissioning Groups and the Constabulary to operate a Safeguarding Adults Board (SAB) to promote and oversee the protection of adults with care and support needs from abuse and/or neglect.

Cambridgeshire already had a well established SAB with strong commitment from the Cambridgeshire and Peterborough Clinical Commissioning Group (CPCCG) and Police and other key partners and we have been able to build on this foundation during 2015/16.

The CSAB vision is that all Cambridgeshire is a place where people should be able to live free from harm and abuse and where communities:

- have a robust culture that does not tolerate abuse.
- can recognise abuse and neglect and individuals know how to raise concerns.
- people and professionals work together to prevent abuse, the person is at the centre of the safeguarding process, ensuring that safeguarding is person-led and outcome-focused.
- ensure safeguarding is everyone's business.

The role of the CSAB is to:

- seek assurance that the safeguarding practice delivered by all the key organisations in Cambridgeshire is maintained at the highest level and meets appropiate organisational and professional standards.
- maintain and develop inter-agency frameworks to safeguard adults at risk within Cambridgeshire.
- challenge safeguarding practice and work to improve practice and continue to ensure that people are in control of the safeguarding process.

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- scrutinise the outcomes of Safeguarding Adult Reviews and the key performance data analysis produced by Key agencies to ensure the effective delivery of safeguarding practices in Cambridgeshire.
- develop a dataset of information that allows effective monitoring of safeguarding activity and outcomes.
- develop a culture of learning with robust internal systems to support this.
- promote early help to prevent abuse from happening in the first place.
- develop seamless pathways that promote joined up working at every level.

This annual report provides a background to adult safeguarding work in Cambridgeshire and a summary of the work undertaken by the Safeguarding Adults Board (SAB), the sub groups, the Adult Safeguarding Team and partners with insight into local issues. It showcases the team's developments and initiatives pertaining to safeguarding that have taken place during April 2015 to March 2016.

In doing so, it aims to provide a level of assurance that the organisation is fulfilling its statutory duties and responsibilities for safeguarding adults in Cambridgeshire.

The agenda continues to evolve and its workload continues to escalate in line with national direction, new legislation, emerging findings from critical incidents and serious case reviews. The underpinning message however remains the same in that safeguarding is everyone's business irrespective of role or position. It is everyone's responsibility to safeguard and protect the most vulnerable adults in our society. The adult at risk must remain at the centre of all our actions.

Adrian Loades, Executive Director Children, Families and Adults Services

2. Members of the Cambridgeshire Safeguarding Adults Board

Chairperson: **Adrian Loades** - Executive Director – Children, Families and Adults Services
Cambridgeshire County Council (CCC)

Representatives from:

Addenbrookes Hospital, Cambridge University Hospital NHS Foundation Trust
Adult Safeguarding Team, CCC
Adult Social Care, CCC
Age UK Cambridgeshire
Anglia Ruskin University
Cambridge Regional College
Cambridgeshire and Peterborough NHS Foundation Trust
Cambridgeshire Community Services NHS Trust
Cambridgeshire Constabulary
Cambridgeshire Fire Service
Cambridgeshire Learning Disability Partnership, CCC
Care Quality Commission
Children Safeguarding and Standards Unit, CCC
County Councillor, CCC
Drug and Alcohol Action Team (DAAT), CCC
East of England Ambulance NHS Trust
Healthwatch Cambridgeshire
Hinchingbrooke Health Care NHS Trust
NHS Cambridgeshire and Peterborough Clinical Commissioning Group
NHS England
Papworth Hospital NHS Foundation Trust
Papworth Trust
Procurement (Social Care), CCC
South Cambridgeshire District Council representing District Councils across Cambridgeshire

3. Safeguarding Nationally

The wider context of safeguarding continues to grow and change in response to the findings of large scale inquiries such as the Francis Report, Winterbourne View and new legislation such as the Care Act 2014.

The Care Act 2014

Part 1 of the Care Act 2014 came into force on 1 April 2015 establishing a clear legal framework for how Local Authorities and other agencies should protect adults at risk of abuse and/or neglect. The Act puts Adult Safeguarding on a statutory footing for the first time, embracing the principle that the 'person knows best'. It lays the foundation for change in the way that care and support is provided to adults, encouraging greater self-determination, so people maintain independence and have real choice. There is a greater emphasis on working with adults at risk of abuse and/or neglect to have greater control in their lives to both prevent it from happening, and to give meaningful options of dealing with it should it occur.

The Care Act 2014 introduces additional **categories of abuse:**

Modern Slavery

This includes slavery, servitude and forced or compulsory labour. A person commits an offence if:

- The person holds another person in slavery or servitude and the circumstances are such that the person knows or ought to know that the other person is held in slavery or servitude, or
- The person requires another person to perform forced or compulsory labour and the circumstances are such that the person knows or ought to know that the other person is being required to perform forced or compulsory labour.

Contemporary slavery takes various forms and affects people of all ages, gender and races. Adults who are enslaved are not always subject to human trafficking.

From 1 November 2015, specified public authorities have a duty to notify the Secretary of State of any individual identified in England and Wales as a suspected victim of slavery or human trafficking, under Section 52 of the Modern Slavery Act 2015.

Self Neglect and Hoarding

The Care Act 2014 identifies Self Neglect as a safeguarding responsibility and defines self-neglect as covering a wide range of behaviours such as neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. Falling under the safeguarding policies and procedures means that all safeguarding adult duties and responsibilities apply.

The safeguarding duties apply to an adult who:

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- has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- is experiencing, or at risk of, abuse and/or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse and/or neglect.

In Cambridgeshire and Peterborough a Multi-Agency Protocol for Working with People with Hoarding Behaviours was devised and finalised in March 2016. This multi-agency protocol offers clear guidance to staff working with people who exhibit hoarding behaviours. It sets out a framework for multi-agency partners to work together, using an outcome focused, solution based model and was developed in partnership with a range of statutory and non-statutory partners across Cambridgeshire and Peterborough. The protocol recognises that responding to a situation which involves a person compulsively hoarding is highly complex, as it involves risk to life, is subject to more than one area of legislation and involves the health and wellbeing of the person at risk and any others in the household. It therefore requires a multi-agency approach. The protocol aims therefore to ensure this collaborative approach through coordinated multi agency partnership working in a way that is meaningful to the person who has hoarding behaviours and their families in a way that reduces duplication of effort for the agencies involved. The protocol aims to facilitate positive and sustainable outcomes for people who demonstrate hoarding behaviour, by involving them in the process of managing their behaviour at all stages.

Domestic Violence

Domestic violence including: psychological, physical, sexual, financial abuse and so called 'honour' based violence.

The cross government definition of domestic violence and abuse is:

- Incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse by someone who is or has been an intimate partner or family member regardless of gender or sexuality.
- Includes: psychological, physical, sexual, financial, emotional abuse, so called 'honour' based violence, female genital mutilation, forced marriage.
- Age range extended down to 16.

Many people think that domestic abuse is about intimate partners, but it is clear that other family members are included and that much safeguarding work (that meets the criteria set out above) that occurs at home, in fact is concerned with domestic abuse. This confirms that domestic abuse approaches and legislation can be considered safeguarding response in appropriate cases.

Front line staff are well placed to intervene and disrupt patterns of domestic violence. The Government Strategy "Ending Violence against Women and Girls" has been recently refreshed (February 2016). This document promotes early intervention by all agencies and supports professionals to identify and deal with the earliest signs of abuse. In Cambridgeshire we currently run a

course called “Domestic Abuse Awareness” tailored specifically to look at the impact to adults at risk. The course is open to a variety of professionals such as mental health practitioners, social workers, adult support coordinators, recovery workers, benefits advisor and advance nurse practitioners to mention a few. The monthly Domestic Abuse course now relates specifically to adults with care and support needs and how they may be supported and includes forced marriage, female genital mutilation and honour based violence.

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Female Genital Mutilation (FGM)

As part of a world wide effort to eliminate FGM, the Department of Health’s FGM Prevention Programme aims to improve the way in which the NHS responds to the health needs of girls and women who have had FGM, and to actively support prevention. It aims to support professionals to be confident when having discussions with women and girls, to record and share FGM information appropriately and to take the necessary action to safeguard girls against risk.

Serious Crime Act 2015 introduced mandatory reporting by regulated professionals from October 2015. This means that whenever regulated professionals (health, social care and education) identify that a girl under 18 has had FGM, or if the girl discloses this herself, the professional must make a report to the police.

Coercive Control

Section 76 of the Serious Crime Act 2015 came into force in December 2015 and criminalises patterns of coercive or controlling behaviour where they are perpetrated against an intimate partner or family member. A number of other criminal offences can apply to cases of domestic violence - these can range from murder, rape and manslaughter through to assault and threatening behaviour.

Other Multi-Agency Arrangements

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The CSAB links to a number of other arrangements that are detailed below:

The Counter-Terrorism and Security Act 2015: PREVENT and CHANNEL

The Act received Royal Assent on 12 February 2015 with relevance to *PREVENT* and includes a duty on specified bodies, including the police, prisons, local authorities, schools, universities and health, to have due regard to preventing people being drawn into terrorism. It also makes Channel (the voluntary multi-agency programme for people at risk of radicalisation) a legal requirement for public bodies so that it is delivered consistently across the country. The Statutory guidance issued under section 29 of the Counter-Terrorism and Security Act 2015 became statute on 1 July 2015. The Counter-terrorism strategy has several strands:

- ***PURSUE*** - to disrupt terrorist activity and stop attacks;
- ***PREVENT*** - to stop people becoming or supporting violent extremists and build safer and stronger communities;
- ***PROTECT*** - strengthening the UK's infrastructure to stop or increase resilience to any possible attack;
- ***PREPARE*** - should an attack occur then ensure prompt response and lessen the impact of the attack.

Specified authorities such as local authorities, NHS trusts, schools and providers of certain services to those authorities to "have due regard to the need to prevent people from being drawn into terrorism" in accordance with the PREVENT duty outlined in Section 26 of the Act. This has meant training staff so they know what 'Prevent' is, and how to escalate concerns regarding people believed to be vulnerable.

Certain areas of the UK are designated as priority areas under Prevent. These are areas from where people have travelled overseas to join extremist groups.

Locally we have a joint CHANNEL panel covering both Peterborough and Cambridgeshire that meets on a monthly basis. The panel membership consists including the probation service, the police, adult mental health, social care, education, further education, safer schools, the youth offending service and children's social care.

The panel will consider referrals and panel members are asked for feedback on the relevant information their agencies hold on the individual. All of the information will be considered by the police and a detailed assessment is presented to the panel who then determines whether the case should be adopted. For the cases adopted an intervention plan is agreed involving support from local agencies or a Channel interventionist depending on the level of risk.

Multi-Agency Risk Assessment Conference (MARAC)

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The MARAC is the multi-agency forum of organisations that manage high-risk cases of domestic abuse, stalking and 'honour'- based violence.

MARAC considers cases identified as 'high risk' by use of the Domestic Abuse, Stalking and Harassment and 'Honour'-based violence and develops a coordinated safety plan to protect each victim.

At the heart of a MARAC is a working assumption that no single agency or individual can see the complete picture of the life of a person at risk, but all may have insights that are crucial to their safety, as part of the coordinated community response to domestic violence.

Multi Agency Public Protection Arrangements (MAPPA)

MAPPA provide a national framework for the assessment and management of risks posed by serious and violent offenders, including individuals who are considered to pose a risk or potential risk or harm to children. Children who are at risk of danger due their own behaviour by not engaging with services are also discussed here.

4. Analysis of Adult Safeguarding Referrals

Table 1: Number of incidents received per year

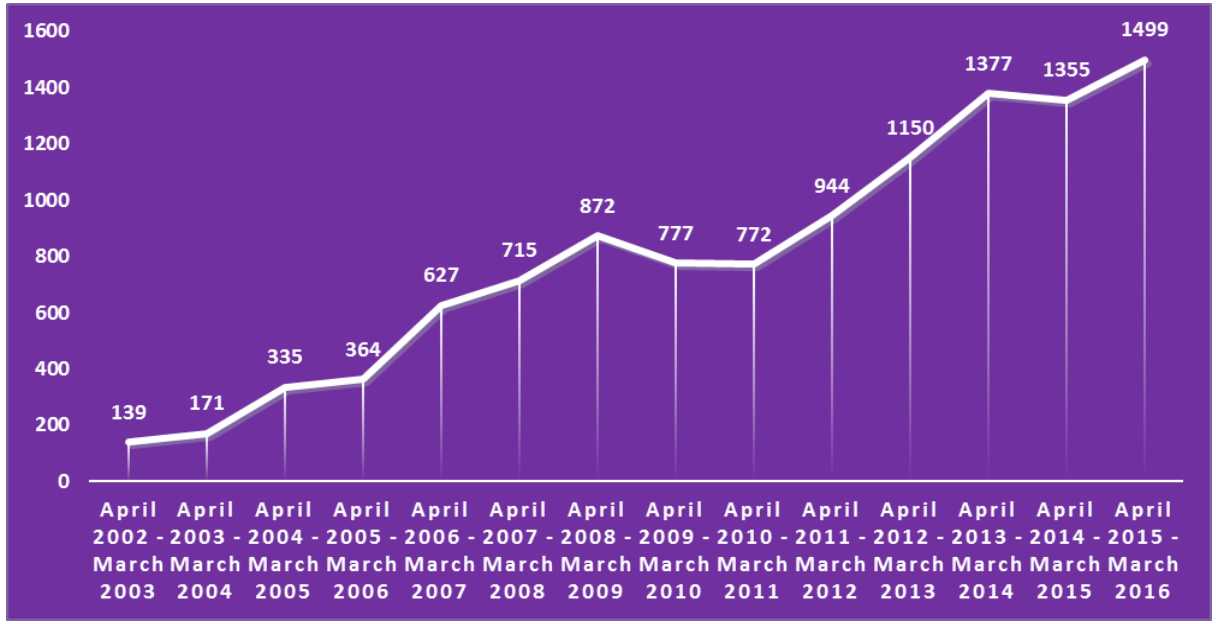


Table 1 indicates the number of safeguarding referrals made in Cambridgeshire from April 2002 through to March 2016.

Though there was a slight reduction in the previous year, the period of April 2015 to March 2016 shows an increase of 144 referrals which constitutes a 10.6% increase in the number of adult safeguarding referrals. The rise could be attributed to the increase in our training provision, with ever more people being aware of what constitutes abuse and being informed about how to report concerns.

Understanding the reasons for this upward trend is key to the Board. In response and through their creation of the adults Multi Agency Safeguarding Hub (MASH) we are now capturing more relevant information at referral point that will better provide the required insight for the Board to revise it's plans and make the necessary changes.

Table 2: Types of Abuse

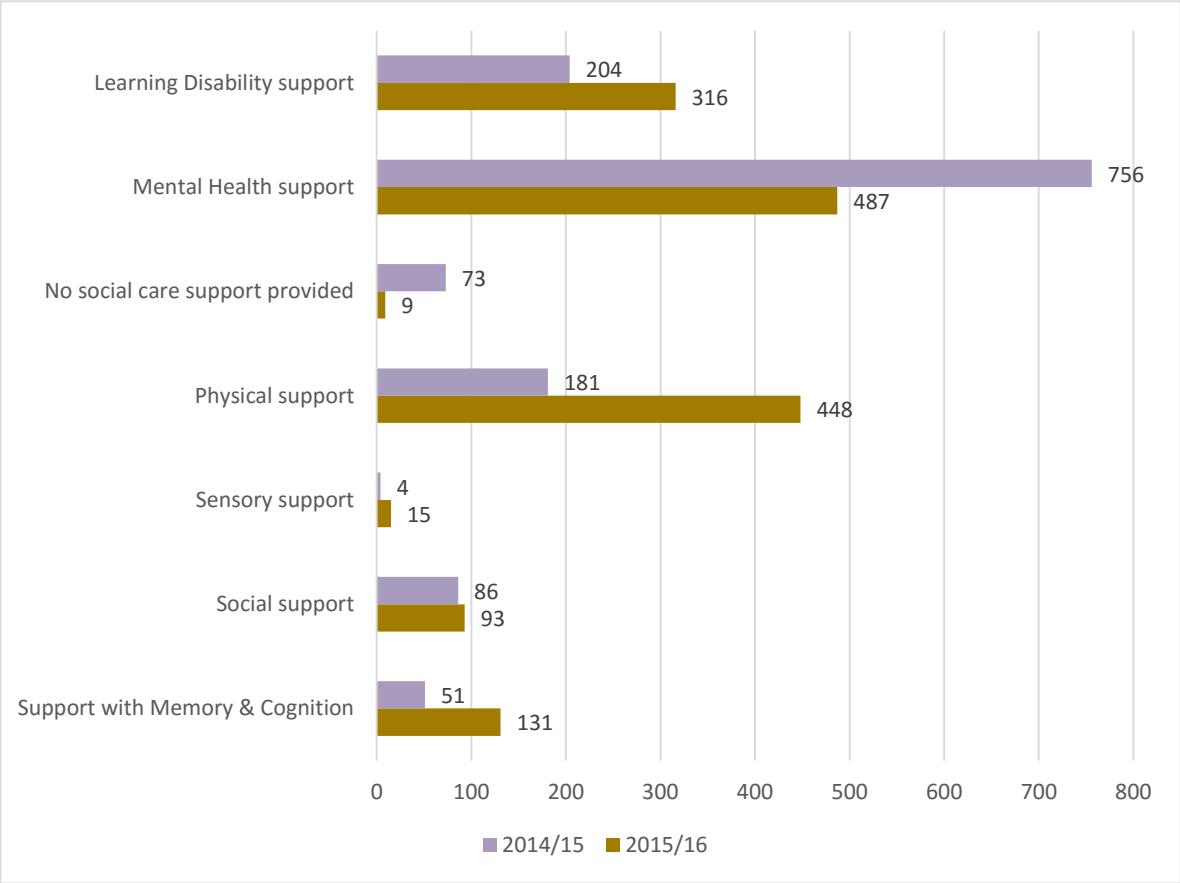
	2013-2014	2014-2015	2015-2016	Trend
Discriminatory abuse	1%	0%	0%	⟷
Domestic violence	-	-	6%	
Emotional/Psychological abuse	11%	13%	10%	↓
Financial abuse	10%	9%	9%	⟷
Neglect and/or acts of omission	22%	22%	24%	↑
Modern Slavery	-	-	0%	
Organisational abuse	2%	2%	2%	⟷
Physical abuse	49%	48%	42%	↓
Self neglect	-	-	3%	
Sexual abuse	5%	6%	4%	↓
Sexual exploitation	-	-	0% (5 cases)	

The most commonly reported type of abuse continues to be Physical abuse 42% of all of the referrals received. Significantly there has been a reduction of 6% when compared to the period of 2014-2015.

Neglect, which has been given greater prominence through the Care Act 2014 has increased slightly from 22% in 2014/15 to 24%.

It is noticeable, that there has been a slight increase in the number of referrals for neglect and or acts of Omission from 22% in 2013 -2014 reaching 24% of all referrals in 2015-2016. There has also been a 2% decrease of referrals relating to sexual abuse.

Table 3: Client category

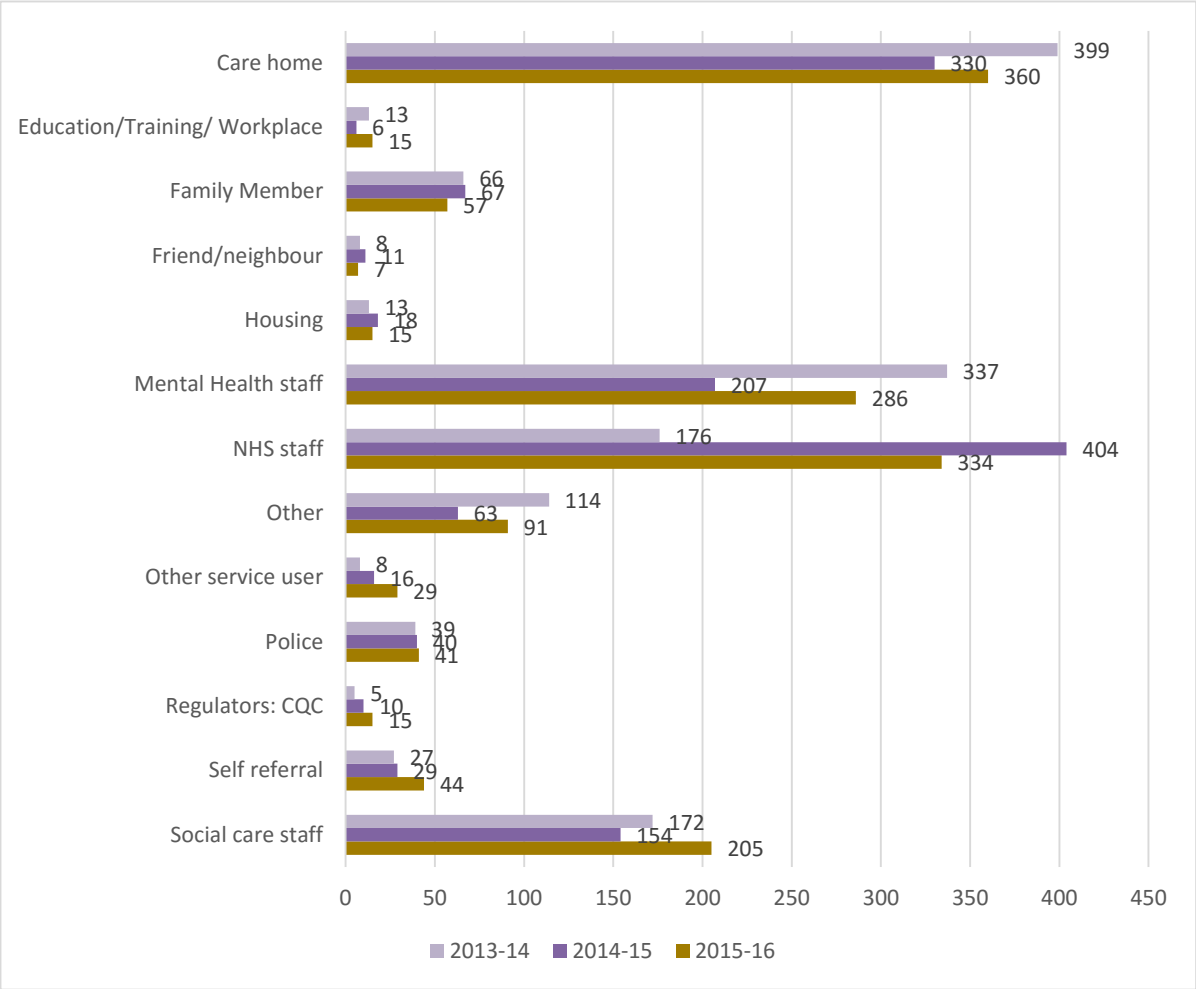


This table shows the 'client category' where there has been a section 42 enquiry. It only shows two years' worth of data due to a change in categories in 2014-15. In the period of 2015-2016, there has been a significant reduction of 35.6 % in the reported "Mental Health support" category.

This data places mental health support only just above physical support which has seen a very sharp increase of 147%. There has also been a very sharp increase for learning disability support (54.9%) and in the number of people requiring "support with memory and cognition" with an increase of 156.9%.

Such drastic changes pose serious questions and further analysis and investigation is needed in 2016-2017 to understand if the change to categories in 2014-2015 disrupted recording or whether there are other reasons.

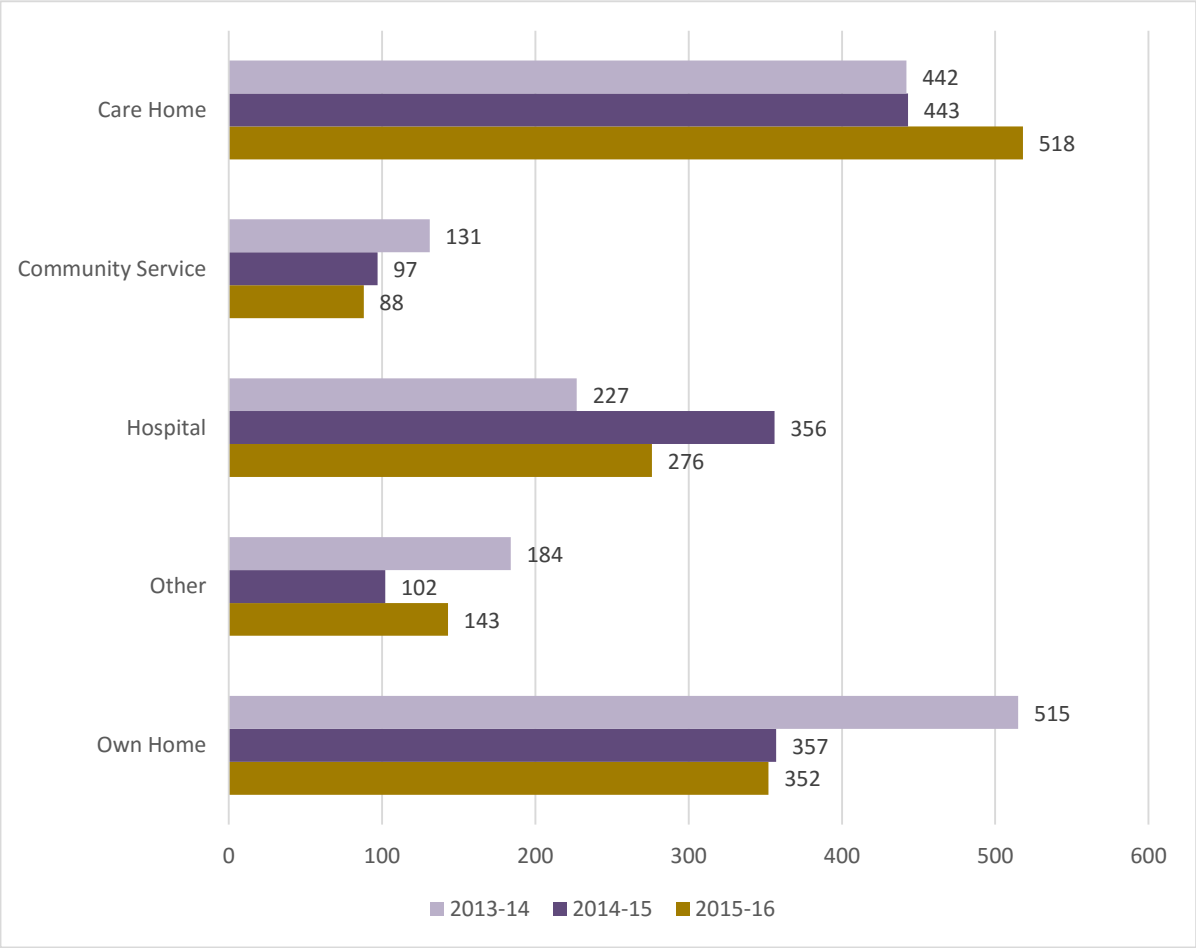
Table 4: Source of referral



The number of people reporting that they themselves have experienced abuse and/or neglect has risen by 51.7%. This suggests that people are aware of adult safeguarding and an increase in awareness this year may be attributable to the DH Care Act 2014 campaign. Locally, The Network Group (representatives from service users, carers and the wider public) have been very supportive in helping to raise awareness of the signs of potential abuse in the wider community by providing input into training development, attending training and evaluating courses.

The number of reports received from social care staff has also increased by 33.1%. Training to homecare staff continues to be reinforced at provider meetings and through contract monitoring. A real success in the period has been that training provided to domiciliary care agencies, care homes and general practitioners amongst others increased by 190% when comparing to the year before (source “In Service” training data).

Table 5: Number of incidents at each location



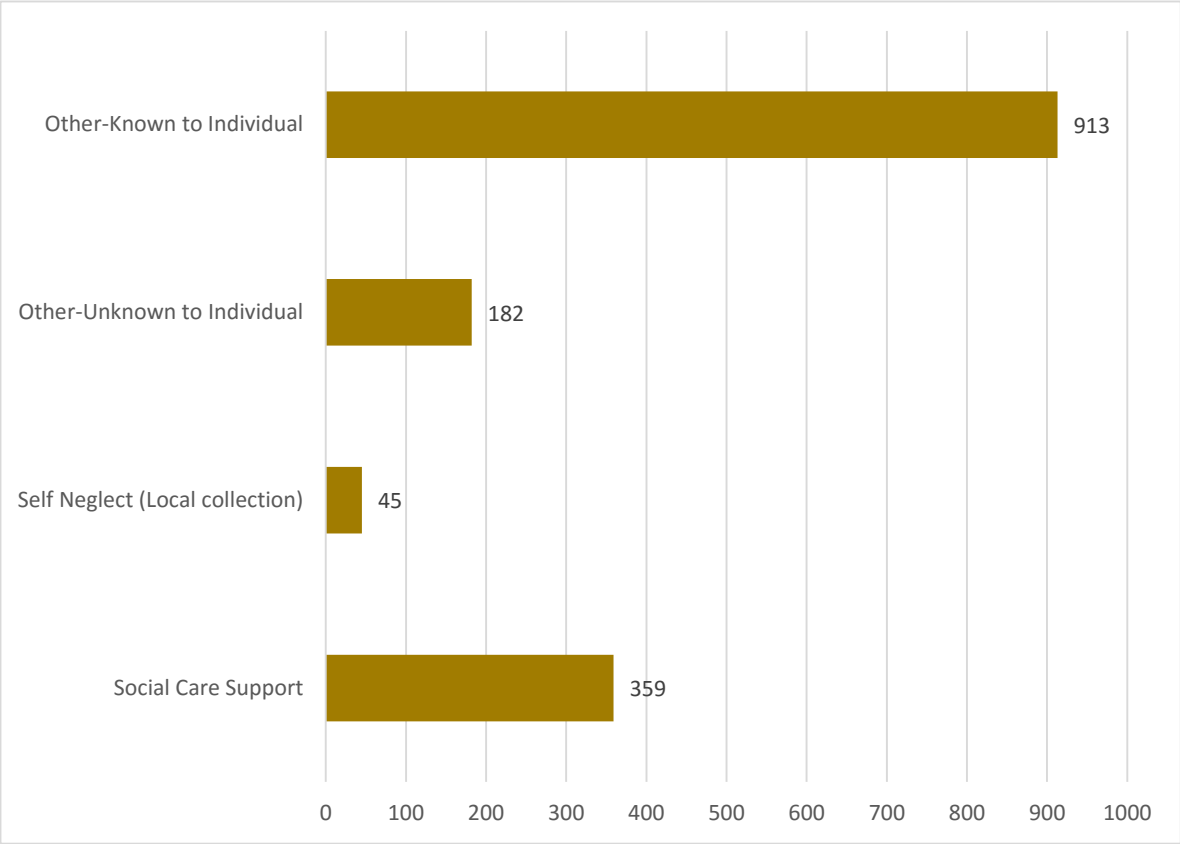
The most common place where abuse and/or neglect has taken place is in care homes which has increased by 16.9%. This may be explained by Serious Concern investigations in large establishments which can lead to reviewing the impact of one reported incident to multiple individuals.

The second most common location of incidents is the person's own home, followed by hospitals. There is a reported 22.5% decrease in the number of reports at hospitals which needs further consideration and trend analysis in 2016-17.

The number of incidents occurring in people's own homes continues to present a challenge though this year shows numbers almost par with last years.

There has been a very strong focus from our training department in raising awareness of safeguarding and the Mental Capacity Act 2005 with GP's and healthcare professionals across Cambridgeshire and Peterborough.

Table 6: Alleged perpetrators – 2015-2016



Due to a change in the way that safeguarding information is being collected in the “alleged perpetrators” category we are only able to show one years’ worth of data, the preceding years has been attached to the next page.

The alleged perpetrator continues to follow the same pattern with “other known to individual” being the most prevalent, reflecting the incidents between residents in care homes that cater for people who present behaviours that can challenge, specifically people with dementia, mental health issues and learning disabilities.

Although there are questions about whether all these incidents meet the criteria for safeguarding, it is important that providers continue to report and respond to these situations and that commissioners are aware and can follow up as necessary with the providers. For this reason, these situations will continue to be captured through the safeguarding reporting process.

Table 7: Alleged perpetrators – 2013-2015

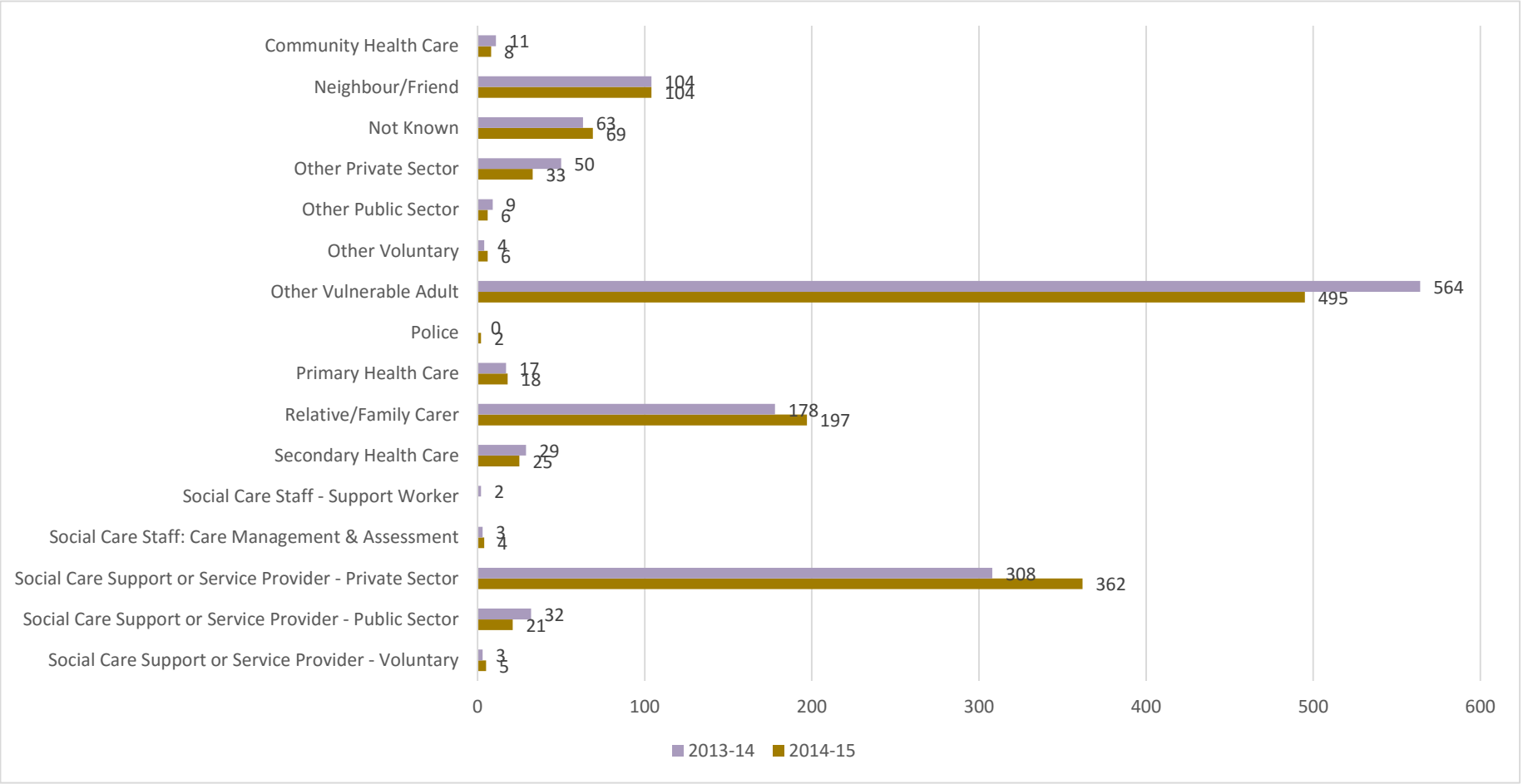
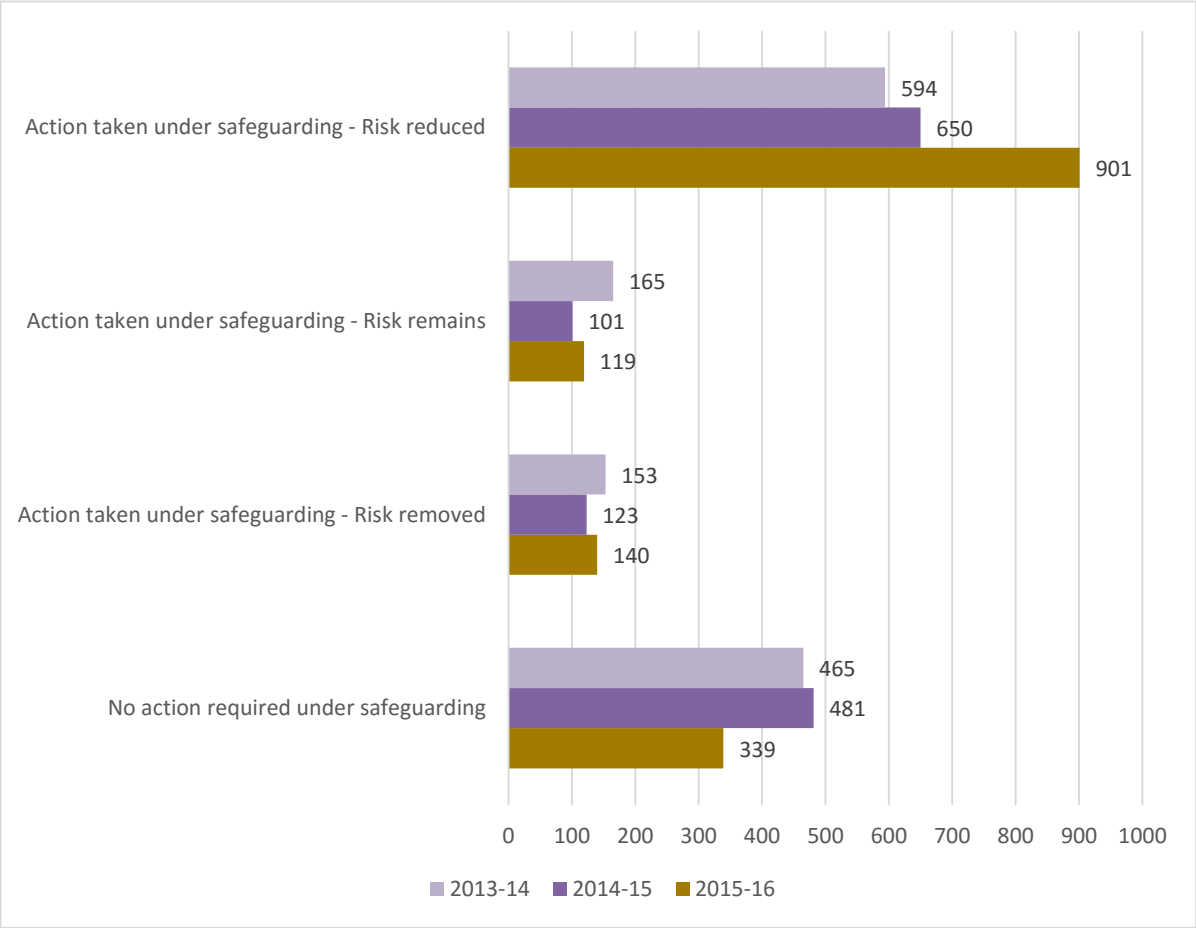


Table 8: Outcomes for victims



The Care Act 2014 has changed the reporting regarding the outcome of safeguarding enquiries, so we no longer collect whether a safeguarding allegation has been substantiated or not. We continue to record whether the actions taken in response to the allegation has led to the following:

- Risk reduced
- Risk remains
- Risk removed
- No action taken under safeguarding

This table shows the recorded outcomes for victims of abuse for the past three years. In the majority of cases, the risk was reduced, with a small number where the risk was removed or where the risk still remains.

It is encouraging to see that “risk removed” slightly increased in 2015-2016 and even more encouraging to report a 38.6% increase in the number of cases reporting “risk being reduced” as an outcome.

Our training, practice and quality monitoring emphasises the importance of working with the person to agree the personal outcome that they want from the safeguarding intervention and the follow up that will be required to minimise the impact of remaining or reduced risks.

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The success in embedding “Making Safeguarding Personal” into everyday practice may be the cause for the reported number of risks being reduced; this may happen where a person who lives in their own home may choose not want to move away from the alleged perpetrator but other measures are considered as part of the safeguarding protection plan where appropriate.

The number of “no actions required under safeguarding has also drastically reduced from 481 in the previous year to 339 in the 2015-16 period; a 29.5% decrease. This may be due to incidents in care homes being addressed by other interventions rather than under safeguarding.

5. How have we worked together to safeguard adults from abuse – Case Study

TO BE ADDED

6. Quality Assurance

Monitoring quality in practice in safeguarding adults was a key priority for the Board in 2015-16. Safeguarding practice has been included on the framework Shaping our future: A Quality Assurance framework for Adult Social Care Practice.

The framework was developed in 2015-2016 and auditing to assure CCC social work practice began in a consistent way in April 2016 with Safeguarding being one of the 6 areas of practice which will be consistently audited. The 6 practice areas which are audited are:

- Assessment
- Care and Support
- Review
- Safeguarding
- Mental Capacity Assessments
- Case recording

The expected standards of practice for each of the 6 areas are set out in the QA case file audit toolkit as prompts for practitioners and managers. The toolkit was developed with practitioners and specialist teams within ASC. The safeguarding standards of practice were written by the Safeguarding Team ensuring we meet our legal duties and the experience of people who use the service is of a standard we would expect. Making Safeguarding Personal is at the heart of the practice expected and measured in the case file audit.

The Process

The QA practice audit has now been implemented across ASC including mental health social work within CPFT. The following process is consistently applied across all social work teams and includes the work of Adult Support Coordinators.

- Case file reviews are carried out by supervising managers
- Each practitioner has their practice audited once every three months
- Measurement is by grading which reflects the CQC grading of quality these are *outstanding, good, requires improvement and inadequate*.
- Monthly reporting of the results of the audits is broken down by team and reported through the Performance Management portal which is presented to OP &MH Performance Board, ASC Performance Board, CPFT Integrated Service Committee and Adults Committee and Safeguarding Board.
- The results and analysis of performance inform the continuous improvement cycle as illustrated below. The areas of practice which are identified as requiring improvement are presented to the Practice Governance Group (referred to below as the Quality Forum.) where the actions to be taken are agreed and monitored. The Practice Governance Group will meet for the first time on 23 August and is chaired by the Principal Social Worker.
- The Continuous Improvement Cycle as detailed below shows how the information from the audit process is used ensuring we have the mechanism to improve practice and answer the “so what” question from the collection of the results.

Continuous Improvement Cycle

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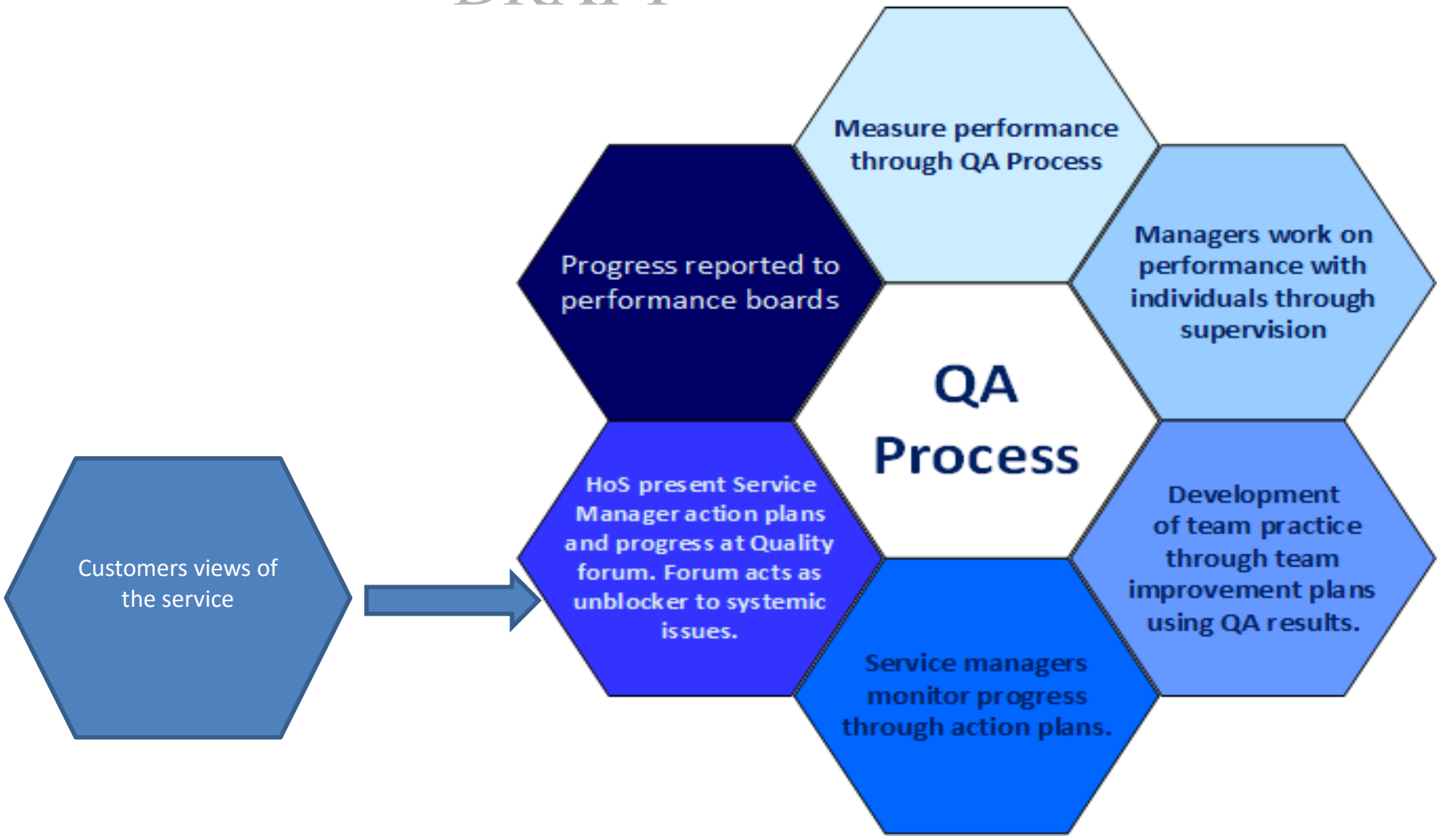


7. Service User Experience Survey 2015-16 – Feeling Safe

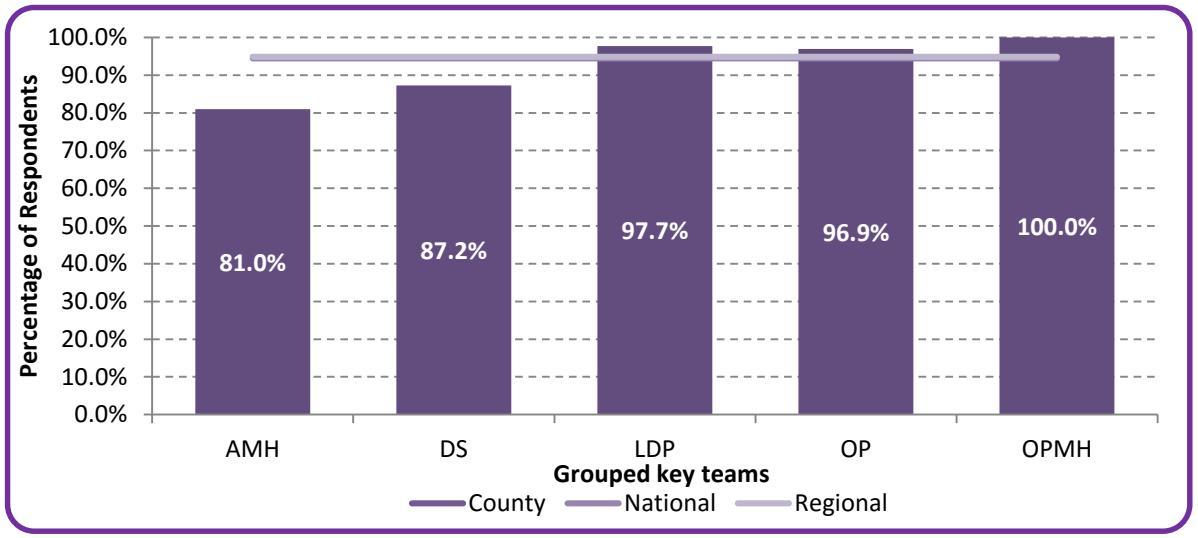
ASCOF Performance Measure	2013-14	2014-15	2015-16	Direction of Travel	2015/16 Comparisons
(4A) The proportion of people who use services who feel safe	67.8%	67.9%	68.9%	↑	National Average 69.0% Eastern Region Average 68.4%
(4B) The proportion of people who use services who say that those services have made them feel safe and secure	76.1%	78.1%	81.9%	↑	National Average 85.5% Eastern Region Average 82.7%

(4A)The proportion of people who use services who feel safe has risen by 1%. Cambridgeshire is above the regional average and almost par with the national average.

(4B)The proportion of people using services who say that those services have made them feel safe and secure has risen by 3.8% slightly below the Eastern Region target and moving closer to the national average.

Source: Adult Social Care user survey 2015-2016

Table 1: Percentage of Service Users who reported that they feel as safe as they want or adequately safe

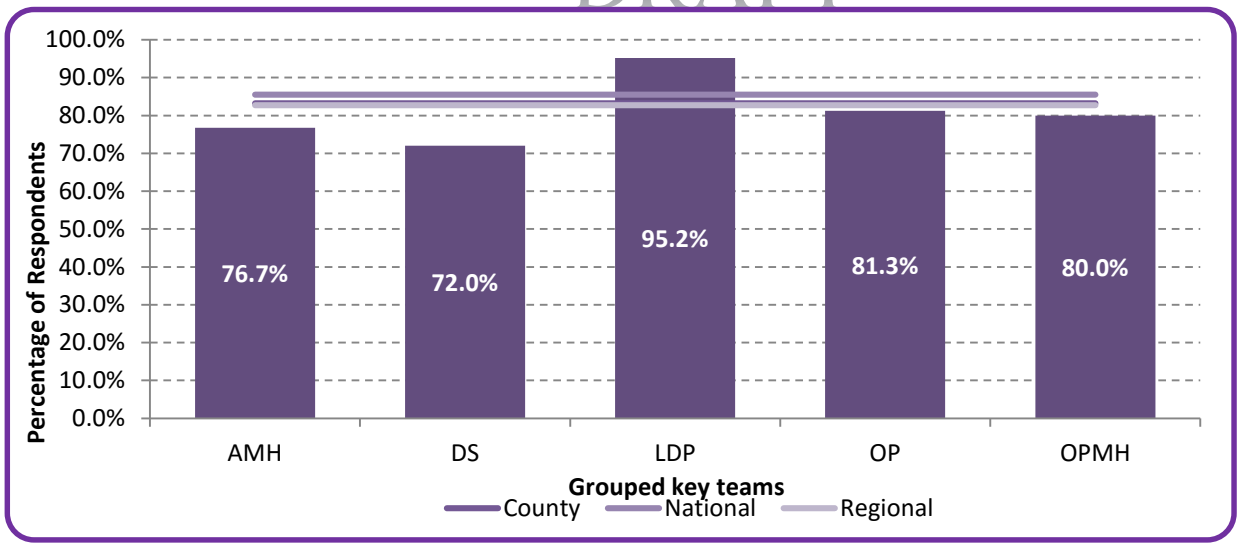


- 19.0% of service users with an Adult Mental Health key team felt less than adequately safe or not safe at all.
- Cambridgeshire perform the same as the national regional average.

Source: Adult Social Care user survey 2015-2016

Table 1	AMH	DS	LDP	OP	OPMH	Total
I feel as safe as I want	24	50	141	226	9	450
Generally I feel adequately safe, but not as safe as I would like	10	32	30	89	3	164
I feel less than adequately safe	6	8	3	8	0	25
I don't feel at all safe	2	4	1	2	0	9
Subtotal	**42**	**94**	**175**	**325**	**12**	**648**
Declined to answer	2	2	2	6	0	12
Total	**44**	**96**	**177**	**331**	**12**	**660**

Table 2: Percentage of Service Users who reported that care and support services help them feeling safe



- There are some variations between key teams and the way service users feel that the care and support services are helping them feel safe. Service users with a Learning Disability key team were more likely to feel safer as a result from their care and support than a service user with a Disability Service key team.

Source: Adult Social Care user survey 2015-2016

Table 2	AMH	DS	LDP	OP	OPMH	Total
Yes	33	67	158	256	8	522
No	10	26	8	59	2	105
Subtotal	**43**	**93**	**166**	**315**	**10**	**627**
Declined to answer	1	3	11	16	2	33
Total	**44**	**96**	**177**	**331**	**12**	**660**

8. Progress on priorities in 2015/16 including information on the research with the University of Cambridge and CLARHC

The report to the Health and Wellbeing Board in September 2015 identified a number of priority areas of work for the SAB in 2015/16. An update on each of these priorities is provided below.

"A training strategy for safeguarding and mental capacity work which meets the needs of the social care and health workforce, enabling a better understanding of the decision making process in safeguarding whilst taking into account the legal requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards"

A programme of standard training complemented by bespoke training has been developed and rolled out across social care and health organisations, including provider organisations. In the period of 2015-16 we have had a considerable increase of 28% in attendees including GP's for all courses, especially those that now relate directly to the core principle of Making Safeguarding Personal.

Our roll out of training in adult safeguarding and MCA/DoLS has been a real success in this period with a 190% increase in Making Safeguarding Personal and MCA/DoLS an increase of 227%.

Introduce changes to practice, procedures and training to support the implementation of the Making Safeguarding Personal approach

Making Safeguarding Personal (MSP) is a national initiative that is embedded in the Care Act 2014 guidance from Department of Health. It places the person at the centre of any safeguarding action or intervention and sets the expectation that the outcomes that the person wants will inform how the situation is responded to and reinforces the importance of supporting people to recover following abuse.

The MSP approach is now central to all safeguarding training and is reinforced through safeguarding leads who meet regularly to discuss practice issues relating to the safeguarding of adults. Through the training, the MSP approach is being introduced across

all health and social care organisations but needs to be reinforced within each organisation to ensure that it is embedded in practice.

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Working with colleagues from the University of Cambridge and CLARHC (Collaborations for Leadership in applied Health Research and Care [East of England]) to evaluate how Making Safeguarding Personal is embedded within our day to day safeguarding work

CLAHRC East of England funded a research assistant for nine months from April 2015 to January 2016 for a research project investigating and supporting the work being undertaken to change practice to support MSP. The final report has not yet been presented to the SAB but there has been ongoing feedback during the nine months research.

The work focused on safeguarding within a care home setting, where it is more difficult to maintain a personalised approach because the situations that trigger a safeguarding response often raise concerns about general practice rather than actions specifically focused on individuals.

The researcher identified two distinct elements:

(i) The role of the care home: care provided by staff that should be a person centered activity and
(ii) Undertaking a safeguarding enquiry: a LA's scrutiny of practice in a home (is it good or is bad?) and making recommendations that should ensure good practice while minimizing risks.

Although the safeguarding concern may have been triggered in relation to one individual, the concerns for the population of residents (rather than the individual) leads to a more generalised approach when the Local Authority views the practice in the home, and recommendations and action plans reflect this.

Interviews with the Care Home Managers highlighted that the safeguarding process drove a dictatorial rather than a collaborative approach with managers. They demonstrated their commitment to delivering good quality personalised care and their willingness to explore a more collaborative approach to investigating safeguarding concerns that could assist in keeping the process more focused on individual residents and support them in improving practice.

The Local Authority has started to develop some alternative approaches to focus the safeguarding investigation more specifically on the individual situation(s) that have caused concern. In this way it will be possible to engage with the individual resident(s) and gain a better understanding of what has happened and whether there are patterns of poor practice that are specific to particular care staff or are more systemic. Work will continue to develop these approaches.

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Learning from this active research was shared at a conference run by the Local Government Association and Research into Practice for Adults (RiPfA) in April. This has resulted in further interest from Local Authorities across the country because tackling the challenge of how to introduce MSP in a care home context is quite unique.

Developing understanding about how to respond to people who self-neglect

The Care Act 2014 guidance was rewritten during 2015/16 and despite some speculation that it would be removed, self-neglect is still included within the safeguarding section. However, it does recognise that not all self-neglect constitutes a safeguarding issue, but reinforces the personalised approach, supported by multi-agency collaboration, that is required to support people who self-neglect.

Working with the Association of Adult Social Services Regional Safeguarding Network, we have been involved in a number of workshops to explore how to respond to people who self-neglect and have been able to build this learning into our local training.

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Multi-Agency Safeguarding Hub (MASH)

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During 2015/16 work has been undertaken to develop the adult presence in the MASH. The MASH brings together Cambridgeshire children's social care, the Police, Probation, the Fire Service, NHS organisations, key voluntary sector organisations, Peterborough City Council and currently one representative from the Council's adult social care services in a collaborative working arrangement, where information can be quickly and easily shared (subject to information sharing agreements) and decisions made on how best to approach specific safeguarding situations and which agency should take the lead. It enhances timely, effective and comprehensive communication between the partners through co-location or integration and greater partnership working.

In addition to the benefits of closer partnership working, the developments in the MASH will mean that inappropriate safeguarding referrals can be diverted away from the Adult Social Care Teams. Where there is a safeguarding issue, the staff in the MASH will gather information on a multi-agency basis to inform the response. This will ensure that different agencies work together to prevent abuse and neglect and stop it quickly when it happens.

Staff in the MASH have been seconded from existing staff who are experienced in leading safeguarding investigations. They are seconded initially for 12 months with the potential to extend this to 24 months. The use of time limited secondments will ensure that the staff in the MASH will have had recent operational experience and will support ongoing professional development.

The MASH Manager, the four MASH Safeguarding leads and the administrator took up their posts by the middle of March. From the 1 April, all safeguarding concerns have been referred to the MASH team for triage and to initiate immediate action if required. Situations that require a safeguarding enquiry are passed on to the Safeguarding Lead of the relevant service. Early indications are that the triage function is identifying situations that are not safeguarding and the MASH team are signposting people to appropriate services. Responses to safeguarding issues are being dealt with either in the MASH or are being passed to the relevant locality team, where this is appropriate.

Priorities for 2016/17

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The following priorities have been identified for 2016/17.

Embedding the practice of MSP across all organisations involved in safeguarding. Use feedback from a “Temperature Check” commissioned by ADASS and due out in the Autumn 2016 to focus further development of MSP practice.

Embedding the MASH arrangements and understanding the impact on numbers of safeguarding referrals being passed to locality teams. Explore why cases that are not safeguarding are passed to the MASH and provide guidance as necessary to other organisations.

Confirm the appointment of an independent chair for the SAB. Review the operation of the SAB with the new chair.

Develop the joint working arrangements across SAB subgroups with Peterborough colleagues, including agreement on joint procedures.

Review dataset of information that allows effective monitoring of safeguarding activity and outcomes, doing in depth data and trend analysis.

9. Safeguarding Adults Team Training and Development

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Introduction

The County Council's Safeguarding Adults Training Team offers training to our statutory partners and independent, private, voluntary and charitable organisations across Cambridgeshire.

A commitment towards improving the lives of adults at risk remains central to the work of the team, which is reflected in the changes that have been made during the past year, and are planned for the coming year.

Staffing

The Safeguarding Adults specialist training team is currently made up of three part-time trainers and a manager, supported by 1.5 administrators.

During the year two training organisers left the team, resulting in a period of three months from August to November 2015 with the training manager and two part time trainers, and February to April 2016 with only the training manager and a half-time trainer. Two new part-time trainers have been recruited during April/May 2016.

Work completed during 2015 – 2016

Core objectives for the team for the year included targets set in the Training Teams Care Act Action Plan, May 2015. The Action Plan was updated June 2015 to have a clear definition of tasks required, which included a complete review and redesign of the range of courses, and content of all courses, to ensure compliance with The Care Act 2014 and Cambridgeshire County Council Safeguarding adults Procedures.

To be able to take a systematic approach to updating courses, as identified in the action plan, a framework, with SMART targets, was used by the team, whereby, every course was scrutinised and either radically updated, or removed.
Main drivers for training courses from this year was to meet the requirements of the Care Act, provide practical guidance relating to the different types of abuse (including domestic abuse, self-neglect and modern slavery) and guidance on how to respond to concerns and how to evidence decisions made – with a central theme of Making Safeguarding Personal – the adult at risk is central and involved in any safeguarding activity or decision made. All course outcomes are aimed at meeting the learning needs of course attendees and ultimately appropriate responses for adults who may be at risk.

A joint training programme between the Safeguarding Adults Team and the Education Child Protection Service was developed, in light of the changes from the Care Act, and will be revisited this coming year.

An effective working relationship has continued with the Diocesan of Ely Safeguarding Officer to review their training and contribute towards updating knowledge of internal trainers on adult safeguarding.

Course and Resource Development during 2015 to 2016

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All Safeguarding Adults courses have been updated and are compliant with the Care Act and Making Safeguarding Personal. The new Training Programme was launched in April 2016, with Making Safeguarding Personal training running from July 2015 and other courses being launched throughout the year as their content was finalised.

Due to the reduction in team members, this took longer than first considered, as remaining team members were tied up with delivering training and not available to complete the development work required.

Bespoke training sessions for specific groups of people are now being developed and are being finalised this month. The Framework used to monitor the development and delivery of the training is still being used to maintain the momentum of work required.

This year has been a very busy one for the whole training team, with every team member being involved in updating materials and courses and in the organisation and delivery of courses, with constant reviewing following first delivery, to ensure learning outcomes have been met.

Training Figures

- We have had a considerable increase of 28% in attendees for all courses, especially those that now relate directly to the core principle of Making Safeguarding Personal.

- All new courses directly link to the Training Strategy 2015-2018.

- 10 different programmed courses are now provided via the Safeguarding Adults Training Programme, which do not include courses that are provided on a ‘bespoke’ basis for services. The courses can be found in the Safeguarding Training Programme launched in April 2016.

- Booking cancellations are negligible for the past year for two reasons:
    - firstly, fewer courses were arranged to run during the recording year (due to lack of trainers) from August to November 2015 and from February to April 2016;
    - and secondly, requests for training have increased due to the new Care Act learning requirements.

Making Safeguarding Personal training is provided by a half-day course and is available for all levels of employee, across all service and agencies. Some agencies have chosen to arrange bespoke Making Safeguarding Personal training for the employees, to ensure consistent practice of their workforce.

Table 1: People Attended All Courses

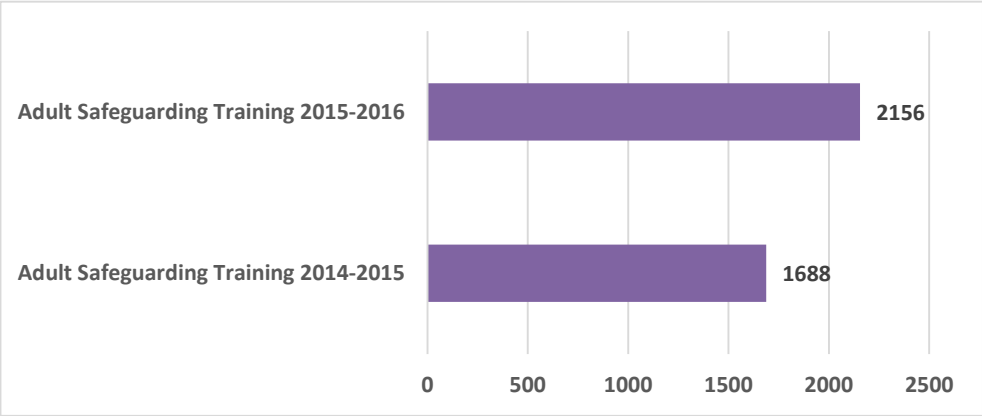
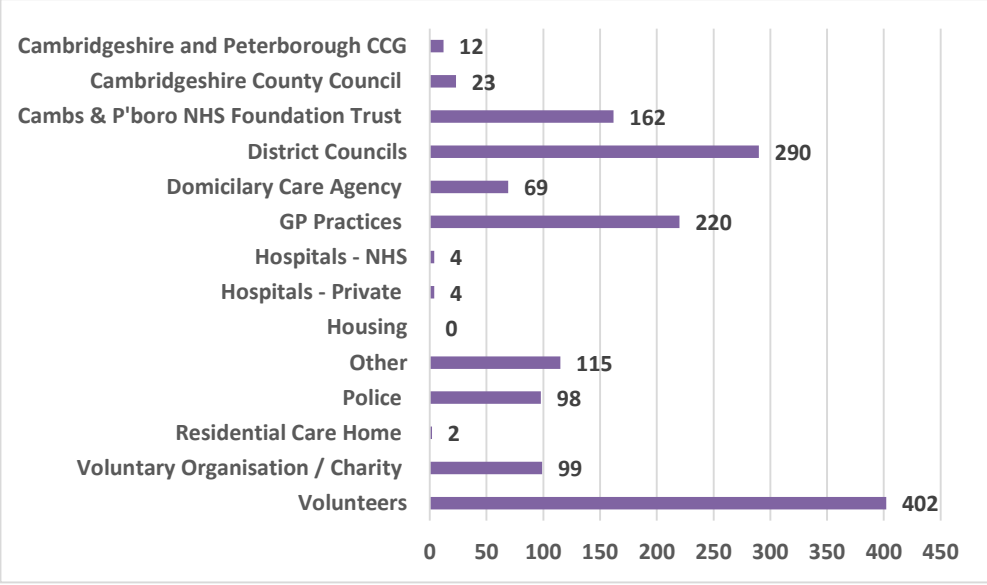


Table 2: Service/Sector Attendance (All Courses)



- Safeguarding Adults Leads training provided to CCC and CCG – three 4 day courses were run between October 2015 to January 2016, two more courses have run since then in April and July 2016, which will be included in next year's report.
- Self-neglect and Hoarding: this has proved very popular since its first launch in October 2015.
- Making Safeguarding Personal Advanced, for professionals who are involved in supporting people to manage their own risks and decision making: launched in March 2016 and has had a good response, with future courses filling quickly, the course runs monthly.
- The Domestic Abuse course now relates specifically to adults with care and support needs and how they may be supported and includes forced marriage, female genital mutilation and honour based violence. This course runs monthly.
- The Management Responsibilities course for the independent sector has been completely updated, to now include the responsibilities and accountabilities for providers in relation to their role in Making Safeguarding Personal. This course most often is arranged as a bespoke in-service course.
- In 71 separate sessions, 696 people from 18 Independent sector providers, have received training via a bespoke in-house course. These courses were mainly for Making Safeguarding Personal, Making Safeguarding Personal Advanced and Management Responsibilities.

Table 3: Making Safeguarding Personal Sector Attendance

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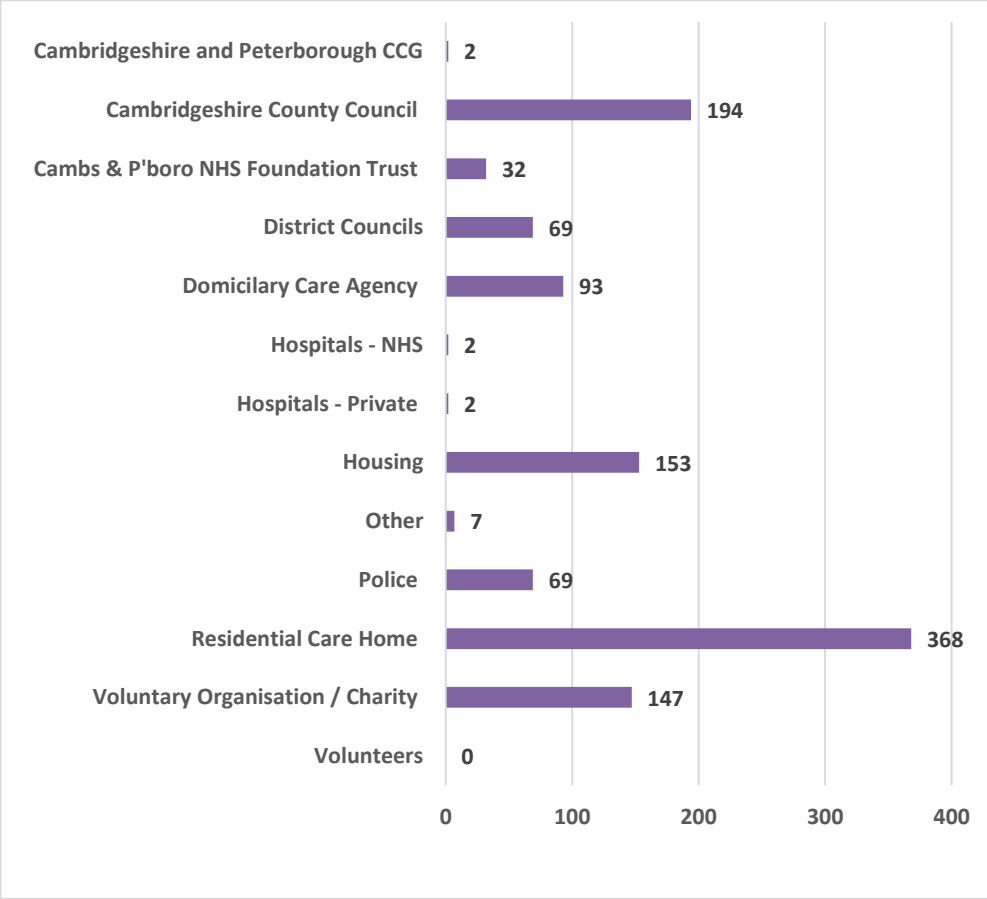

- In total, there were 185 sessions provided during the year, an increase from 126 the previous year; with 2185 attendees this year – which is an increase of 29.4%.
- Taking into consideration all the development work during the past year and lack of staff in the team, this year has proved productive and positive for the team.
- GP Practice training was a shortened, summary version of the Making Safeguarding Personal course, mainly delivered by MCA and DoLS trainers.

The team administrators also support the Mental Capacity Act and Deprivation of Liberty Safeguards Team with their training programme. These figures are not included in these statistics.

Table 4: Course Attendance by Course and Sector

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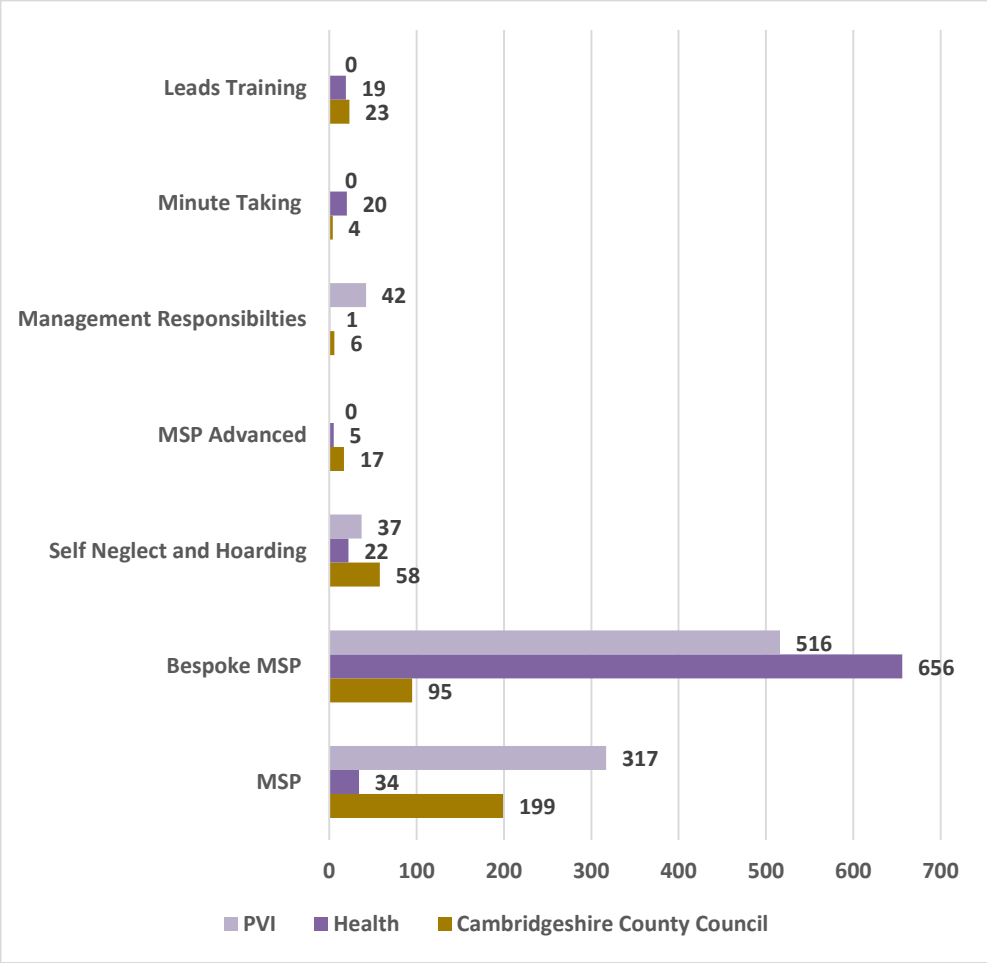
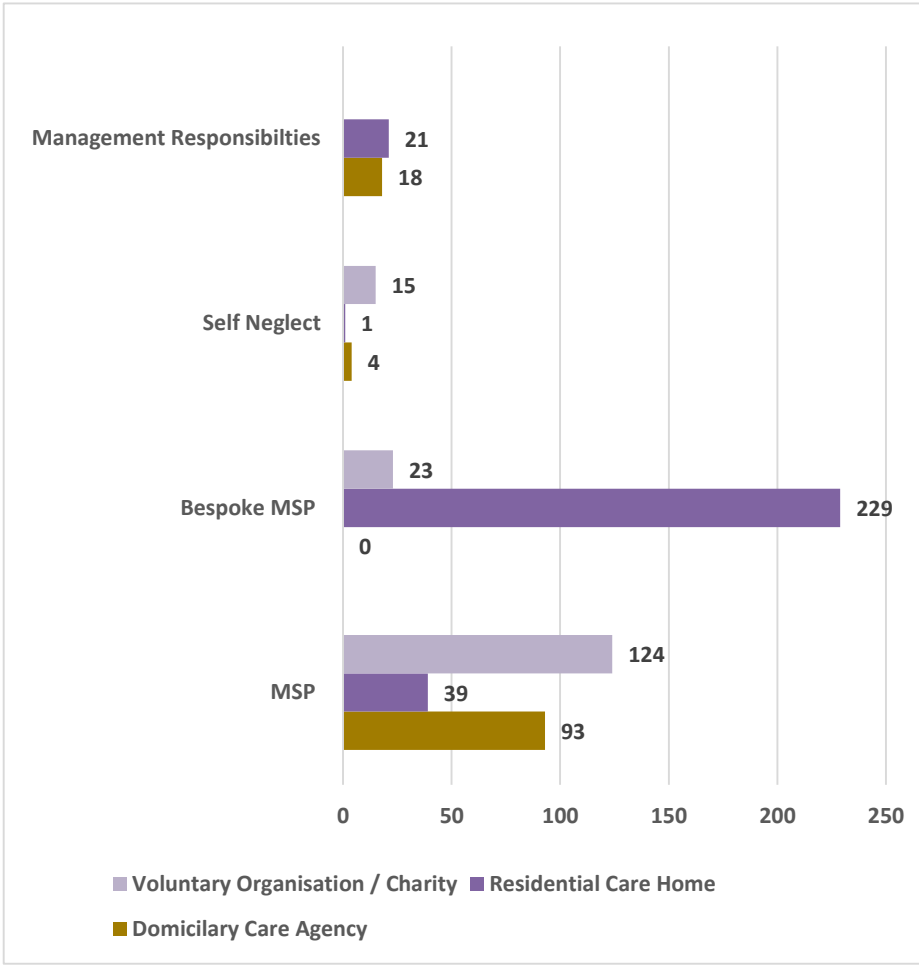


Table 5: Course Attendance for PVI Sector



Training evaluation comments

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"The course was involving and the trainer enabled everyone to participate and engage. Videos helped as well in terms of watching the reality that happens in different settings"
Professional Responsibilities – 14 May 2015

"Looking at how you put the person at the centre of safeguarding and it becoming less of a policy lead activity"
Making Safeguarding Personal - 8 December 2015

""Very well presented training, thank you. Enjoyed the informative & participation nature of the delivery. I feel that I have learned a lot of skills to take back to make the necessary changes and improvements in the workplace"
Management Responsibilities – October 2015

"Really good course, I found it very interesting and informative. Thanks."
Minute Taking - 1 October 2015

"Leaving the course feeling: Refreshed, reinvigorated, enthused"
Leads training - 27 January 2015

A greater understanding of the complexities of self-neglect and Hoarding. How to respond appropriately and sensitively. It was a very thought provoking day. The use of legislation was extremely useful, as were the scenarios."
Self-Neglect & Hoarding - 10 February 2016

Future work plan

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- Mandatory Safeguarding Adults training for Cambridgeshire County Council staff:
    - A new programme of one day mandatory training for new employees, to be attended during the first six months of employment, will begin in September 2016 and will run monthly. This is a joint initiative between the Safeguarding Adults Training Team and Workforce Development Team. The morning will be the Making Safeguarding Personal course delivered by the Safeguarding Adults Training Team; the afternoon will cover Child Protection delivered by Workforce Development.
- Referring to the Training Strategy, the Adult Safeguarding Training Team are working with the SAB Community Network Sub Group on two separate sessions specifically for service users and carers. These should be available in the autumn and will be provided directly for adults with care and support needs and/or who may be at risk; and for informal carers of people who have needs for care and support.
- With the updated and new training programme now in place, the training provision is increased, with a substantial rise in attendee numbers for all programmed courses.
- Bespoke in-service training has increased over the last year and is set to rise with requests being received. Bespoke training is adapted to meet the needs of particular services, or roles, to enhance practice with service users.
- The Safeguarding Adults Newsletter is also being updated and will be launched in the autumn. It will be made more available for people with care and support needs and for employees in adult social care services. The Community Network Sub Group are involved in its development and circulation.
- Core objectives for the team for the next year include providing all courses as described in the Training Strategy, increased responses for requests for in-service bespoke training, review of attendance and outcomes.
- In the coming year:
    - All courses will be reviewed and updated as a collective, to ensure they meet the learning needs of attendees and
    - All courses will be reviewed and updated to link to Cambridgeshire County Council Safeguarding Adults Procedures and updated with any national guidance.

10. Adult Safeguarding: Workforce Development Group

The Group has met on a quarterly basis and includes strong representation from across the partnership. Colleagues from Health, Higher Education and the Third sector have made a significant contribution with respect to sharing their own practice, identifying emergent training need and highlighting other local and regional initiatives in the context of embedding the new statutory responsibilities as defined by the Care Act. The refresh and thus refocussing of the local authorities training offer has been broadly welcomed.

Links with colleagues in Peterborough and Cambridgeshire LSCB have all been renewed. It is anticipated that this will lead to the development of a shared family based offer recognising safeguarding as a golden thread running through all our work. It is anticipated that the Group's remit will be extended to include MCA and DoLS, as well, as reflecting the Board's closer working relationship with Peterborough.

11. MCA DoLS Team Training and Development

Overview of work completed from June 2015 – June 2016

Cambridgeshire County Council's Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Training and Development Team delivers a range of training and develops a range of practical resources and operational tools for CCC staff, our statutory partners and independent, private, voluntary and charitable organisations across Cambridgeshire.

There is always a commitment in our team towards ensuring professionals understand their legal responsibilities and understand how to improve the lives of children, adults and families in Cambridgeshire and Peterborough through this legal framework.

Staffing

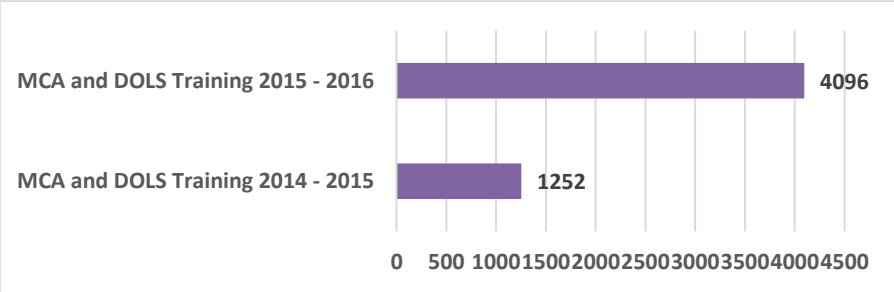
The MCA/DoLS specialist training team consists of two full time trainers (one of whom also manages the team) and they are supported by administrators shared with the Safeguarding Adults Training Team.

There is a wealth of knowledge within each team, all the trainers have frontline experience and knowledge of the law as well as educational experience and expertise that supports them in their roles. This ensures that the training sessions delivered are structured to encourage the maximum learning for the attendees.

This is benefited further by our close ties to the wider MCA and DoLS Team, CFA Directorate and our partner agencies, which allows us to respond proactively to the ever changing legal landscape and in turn improve practice across the wider Health and Social Care Workforce.

Training Statistics for this Period

Table 1: Attendance Increase



Our newly staffed training team came into post in June/July 2015 and has seen a 227% increase in the training we have delivered in this time.

We believe the reason for this is due to; tailoring our training to individual service's needs, offering more training in house (rather than just open-community based sessions), being flexible with timings of training and having a clearer process for engaging with health professionals which has been supported by CPFT and Cambridgeshire and Peterborough Clinical Commissioning Group.

Table 2: Service / Sector Attendance (All Courses)

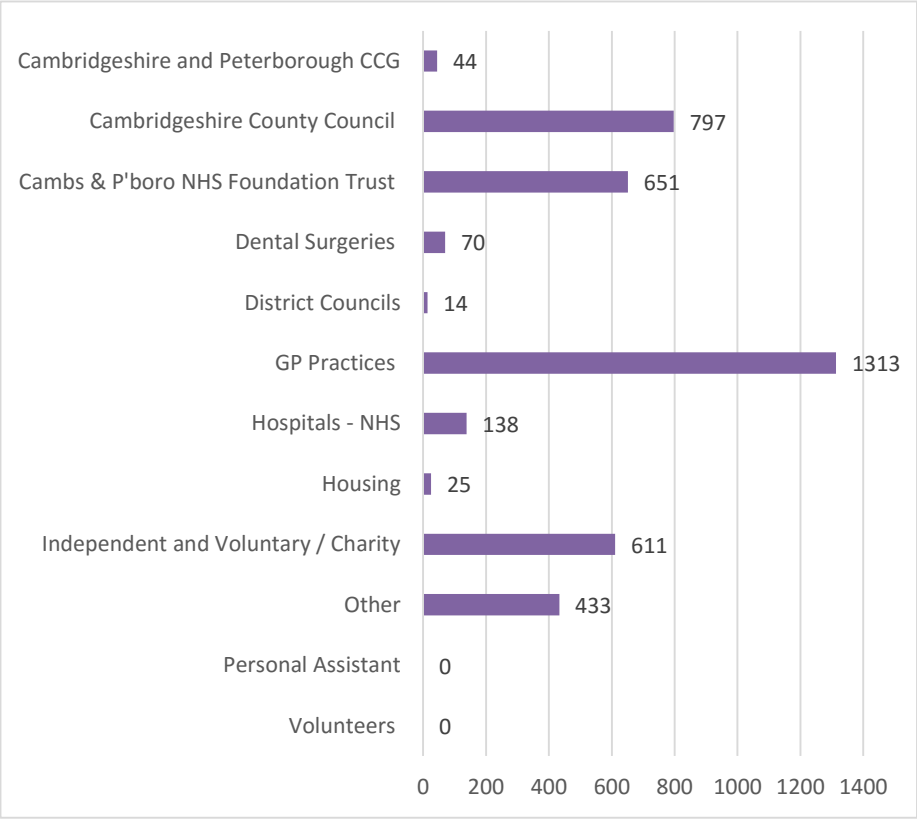


Table 3: Attendance per course

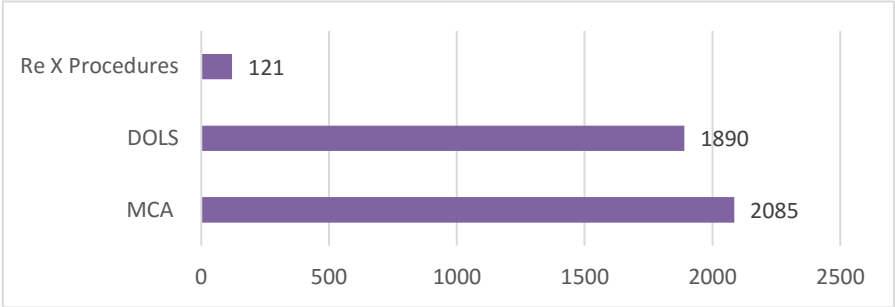
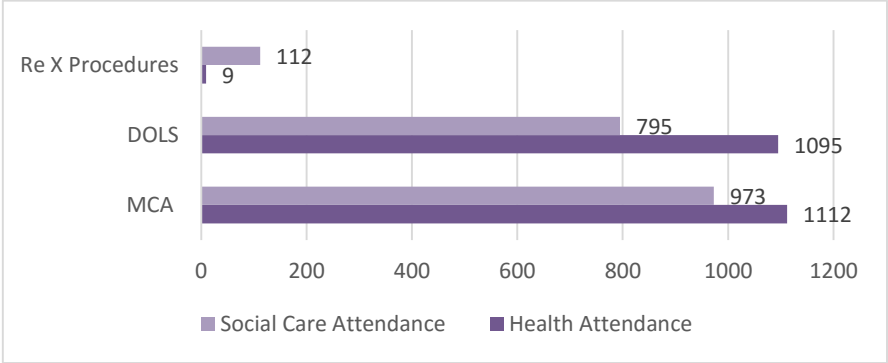


Table 4: Attendance Health and Social Care



Training and Development 2015 – 2016

Core Training Programme

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A review was completed of all of our MCA and DoLS courses (click here for further information), the biggest change being that training for our CCC Social Workers and Adult Support Co-ordinators is now facilitated in the specific locality teams, meaning that all staff will receive mandatory yearly training in this area of law that is tailored to their needs, is practical in application and allows for open case discussions.

New Training Developed this Year

- Deprivation of Liberty Re X training has been developed this year to support our ASC's and SW's to respond to cases of Deprivation of Liberty in the community that fall outside Schedule A1 of the Mental Capacity Act 2005
- There is new training for health professionals (specifically for GP's, Dentists and community based health professionals in CPFT) and offers two levels of MCA/DoLS courses. This has been a huge piece of work that will continue through to 2019 and has been developed in collaboration between our partners in Cambridgeshire and Peterborough Foundation Trust (CPFT) and the Cambridgeshire and Peterborough Clinical Commissioning Group (CPCCG). This allows us to train health professionals not only in Cambridgeshire, but Peterborough as well, ensuring a consistency in the message we give across our borders.

Advice Support

In addition to the training we deliver, the training team receive daily requests from our Locality Teams and providers for advice/support and guidance in these areas of law.

CCC Workforce – Requests from our CCC workforce tend to focus on support with completing the ASC 1708 and CoP 3 and CoP DoL 10 forms. We are asked to comment on completed or ongoing work that our staff may be struggling with and offer guidance to them.

We are also asked to attend locality team meetings in order for us to discuss the cases being worked on and to offer updates on new and developing case law specific to the teams work. This support is often praised by Locality Team Managers and their Senior Social Workers for offering an open and confidential environment in which to discuss cases they are working on.

More recently and supported through the 'Link Worker project', our online forum has been a place in which we respond to professionals questions and share guidance with our wider CCC workforce.

Provider Services – Many providers still require support with their understanding of the MCA and DoLS and we take daily emails and phone calls asking for support and advice. This tends to focus on improving care plans and daily practice. Much of this support arises in response to contractual and/or standards issues that have been picked up by our Locality Teams, our contracts teams and/or the CQC.

The support and advice provided in the MCA/DoLS team that the support offered to our CCC workforce will mean that there are fewer requests to our LGSS legal department for advice. We improve recording capacity assessments and best interests decisions and in doing so improve practice and reduce the risk of reputational and/or financial penalties awarded either by the Local Government Ombudsman or by the Court of Protection.

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Resources Developed this Year

Care Plan Guide for Care Providers – The guide (which is available on our website) supports providers to record consent, capacity, best interests and restraint in their care plans. This resource is used widely, by social care providers and has been a useful resource to both the Access Resources Team and Contract Monitoring Team in helping explain legal responsibilities to our social care providers.

The Link Worker Project - Since May 2016 we have been offering anyone attending our advanced MCA and DoLS courses the opportunity to sign up for our Link worker scheme.

This scheme allows professionals to become the contact person for their team/service and to actively liaise with the MCA/DoLS training team in order to continue updating their knowledge.

In return they are offered continued support from the MCA and DoLS team which will include:

- Access to a web based forum to share good practice, enter into discussion on our board, updates on any relevant developments and access to various resources
- Opportunity to attend half day workshops twice a year to update knowledge
- Regular newsletters from the team

Website Updates – Our CCC homepage for MCA/DoLS has been completely overhauled this year. It now has specific pages for all professional groups as well as information for families and users of services. It offers videos and resources that attempt to bring the MCA and DoLS to life. This has been well received by frontline professionals. Our page for Health Professionals has received particular praise from GP Practices (click here for further information)

The MCA/DoLS Newsletter – We have been developing a MCA and DoLS newsletter for just over a year now, the readership continues to grow. The newsletter brings together all the relevant case law and practice resources that have come to our attention over the past quarter. This resource is now accessed by professionals outside Cambridgeshire and has raised the profile of Cambridgeshire County Council and the important work our team undertakes. In addition to the quarterly Newsletter we have recently created Update Editions making practitioners aware of important Court of Protection rulings and how the Judgements will affect practice.

DoL Screening Tool – Due to the recent decisions of Birmingham City Council v D and Re AB the scope of DoL has been extended. As such the Training and Development Team have worked closely with our partners in the Children's Disability Team, Access to Resources and our Solicitors in LGSS to develop a DoL Screening Tool for professionals who work with people under 18. This resource not only supports day-to-day

practice, it demonstrates that as a local authority we acknowledge our responsibilities and are responding to the changing legal landscape.

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Already in Development for 2016 – 2017

Multi-media E-Learning Centre: Collaborative work with the Medical Protection Society (MPS) - As part of the training already delivered for Health Professionals our training team is developing an interactive e-learning MCA/DoLS resource with MPS that will be made available, free of charge, to all health professionals in Cambridgeshire until 2018/2019 or until such time as the Law Commission's recommendations have been implemented.

This will ensure that NHS Staff within the Cambridgeshire and Peterborough CCG will be able to access a range of resources to support their learning in this area of law.
The resource includes short presentations from the team and partner organisations.

Deprivation of Liberty Safeguards Mapping Tool - By Christmas this year we will map which Residential and Nursing Homes have already submitted DoLS referrals (whether we contract with them or not).

This will enable us to scope which homes may not be meeting their legal requirements, and with our partners (for example, Contracts and Locality Teams and CQC) identify areas of improvement we as a Training and Development Team may be able to offer additional support.

Feedback
Resource Development

"I know this is late to comment, however I would just like to say that I think this is an excellent newsletter and very valuable to Safeguarding Leads as a summary of some key areas and change."
(Feedback on Newsletter from a Safeguarding Lead)

"A brilliant website can you support us to develop a similar tool for our health professionals?"
(This response from a health commissioner regarding our website, led us to support the improvement of their online resources before their forthcoming CQC inspection)

Feedback - Training

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"I just wanted to say thank you for the 2 days of training that you have delivered so far. I have had fantastic feedback from the staff about how good it was. They have really grasped their responsibility and you have made if very real for them." (Private Hospital)

"I can honestly say that I have had so much positive feedback I wanted to feedback to someone. We completed feedback forms but it doesn't seem enough. Everyone found his presentation extremely helpful and it was delivered in such a way that everyone was absolutely clear on what they understood. I have even had the doctors saying how good he was. It was the best training I think we have had as a group and would highly recommend it to anyone." (GP Practice Manager)

"Best training I have attended in 25 years, I will book on to this session yearly." (GP)

"Very good refresher in how to apply the MCA within a practical environment supported with useful scenarios… Fantastic, enthusiastic & knowledgeable trainer, this is so much better than e-learning" (Senior Nurse working in a Sexual Health Clinic)

"Many thanks too for this valuable and very interesting course, the training provided by Emma was excellent and our staff greatly enjoyed the afternoon." (Manager of one of our social care provider services)

12. Cambridgeshire Chronically Excluded Adults (CEA) Service

Cambridgeshire County Council is partnered with other statutory and social sector organisations and is the lead organisation for this service for specific individuals with severe and complex, multiple needs often leading chaotic lifestyles. The success of the service lies in achieving strategic buy-in and bringing the right people and agencies to the table. It also provides a single point of contact for service users to help them navigate access to services, co-ordinate provision and follow and support them through the journey to increased stability and safety with the goal of providing the space to rebuild their lives.

2015-16 Update

The CEA service continues to work with a small number of extremely marginalised individuals on long term plans to try and put them in positions where they can make their own informed choices on which direction their lives go. Fifteen new clients were taken on adding to the existing caseloads on top of the work supporting other professionals and services with their difficult to engage, complex needs cohort. The scope of the work has continued to be active in Cambridgeshire and South Cambridgeshire but 2015-16 has seen a marked increase in referrals from Huntingdonshire and a smaller increase from East Cambridgeshire.

"I would like to express my immense gratitude towards this service and especially to Marie for their professional, honest approach"

Peterborough

Early in 2015 a collaborative bid between a number of the district councils in Cambridgeshire and Peterborough was successful in winning funds to start two projects for single homeless people. One project to set up supported lodgings in the South of the County was led by the Single Homeless Service. The second project, to introduce the CEA work with complex multiple needs in Peterborough, began in September 2015 and is funded to April 2017. The Cambridgeshire CEA team have been supported the operational development of this work which is leading by the Housing Advice team at Peterborough City Council. The Peterborough service will aim to produce a similar economic evaluation to the produced in Cambridgeshire in 2013 and this will hopefully be available later in 2016.

We have appointed a new part time Case Co-ordinator as result of the funding for the work to begin in Peterborough, Cambridgeshire was able to employ and as result of the funding for the work to begin in Peterborough, Cambridgeshire was able to employ an additional half post to support the existing. Ben Harwin started in July 2015 bringing a wealth of experience to the CEA team. Although Ben is only half time, he was almost immediately able to pick up additional clients which has enabled us to maintain a caseload of around up to 30 individuals at any one time.

"As a person who feels rejected from the whole of society, Marie makes me feel I have value as a person"

Making Every Adult Matter (MEAM) National Network

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Cambridgeshire continues to link in closely with the MEAM national network. Attending the twice yearly practice exchange meetings not only enhances the work in Cambridgeshire, it also provides a forum to share innovation and excellence. Cambridgeshire is one of the longest standing services employing the MEAM approach and continues to pass on learning to new areas. Time has been spent with Bristol, Leicester and Lowestoft amongst others. Additionally, the Cambridgeshire service and two of its service users were interviewed by MEAM for a paper on the barriers to multiple needs clients returning to employment. The link for this can be found below.

www.meam.org.uk/wp-content/uploads/2016/07/Steps-towards-employment-FINAL.pdf

National Feature

In November 2015, The CEA service was highlighted in an article in **Society Guardian**, which also featured an interview with a service user. "In the 2015 budget, the chancellor, George Osborne, committed himself to finding ways to integrate spending and better support individuals struggling with homelessness, addiction, re-offending and mental health problems.

It is estimated that in England there are around 58,000 people facing at least three of these problems at once. Campaigners and charities argue that those with the most complex needs are being failed by individual services and so spend their lives moving in and out of homelessness, prison, A&E and rehabilitation services, at an estimated cost to public services of £4.3bn. "For too long, vulnerable people with multiple problems have been falling through the gaps between services," says Christina Marriott, chief executive of the Revolving Doors Agency. At the same time, rising homelessness, welfare cuts and greatly reduced substance abuse services are putting more pressure on already overstretched services.

This month's spending review should spell out exactly how Osborne plans to integrate spending; his aim is "to improve cost-effectiveness". A report by the thinktank IPPR in September called on ministers to allocate £100m for an intensive "troubled lives" scheme modelled on the government's troubled families programme. But Marriott urges caution. "A targeted programme for the most excluded individuals is important, but it won't undo the damage being done by other decisions by the government. It is a big opportunity, but only if the government gets it right. This can't just be another big government payment-by-results scheme that misses those who need the most help." For someone who has been in and out of prison, just been made homeless, suffering repeated mental health crises but not getting into services and drinking to excess and self-medicating – a job isn't their priority, she says. The life expectancy of a street homeless woman is 43. "For people facing this kind of extreme disadvantage, the first priority is stability: a roof over your head, some food in the cupboard, access to healthcare and intensive support that covers all your needs. It's about ensuring people have the opportunity of seeing their 50th birthday." There is a precedent for this kind of programme.

The Making Every Adult Matter (MEAM) coalition of criminal justice, homeless and mental health charities: Clinks, Homeless Link and Mind, has funded a number of pilot projects to improve services for individuals with multiple problems, through intensive support and better coordination. Independent analysis of a pilot in Cambridgeshire calculated it had cut costs by a quarter across the police, courts, NHS and local government, through reduced crime and substance misuse and improved physical and mental health.

Tom Tallon runs the chronically excluded adult service (CEA) in Cambridgeshire with £110,000 annual funding from the city council, county council and supported by Meam. Tallon says much of his role is about coordinating services. “In theory our role shouldn’t need to exist”, he says. “Any one of these services could bring everyone together, providing they can build the relationship with the client and have the time to do so.” Tallon points out that his team typically spends 6-8 hours a week with individuals at the outset.

Kitty Jones, 46, became homeless after a mental health crisis caused by historic domestic violence by her father. In 2014, South Cambridgeshire district council referred her to the CEA service. Jones says that despite having a degree in business law, she struggled to be listened to when she tried to get housing and a proper diagnosis for her post-traumatic stress disorder. “I am highly articulate, yet I couldn’t get my voice heard. I felt I’d stopped being a human being,” she says. “It was only because someone stepped in and helped me that I was listened to.”

That someone was Marie Ludlam, a case coordinator at CEA. “The day I came out of hospital [where she’d been sectioned], there were three or four organisations in my house telling me they were going to help. I am on medication and getting help from the hospital. Now I’m doing a course in improvisation and have started to play the piano again. I’d like to regain the skills I used to have.”

13. Rapid Response Service

The RRS was set up as part of the wider Single Homeless Service (SHS) and aimed to reduce homelessness by providing a swift route in to appropriate accommodation for clients with low support needs. The primary issue for these clients is their housing difficulty and inability to find a route out of homelessness. They are clients where there is no statutory obligation to support but who may end up accessing supported accommodation schemes which they do not need other than to provide shelter.

Referrals and Outcomes

There were 341 referrals to the SHS in 2015/16. This represents a 33% increase from the previous year. Notably, 148 referrals were made by advisers from outside Cambridge City – exactly double the previous year's total.

The service placed 118 people into permanent accommodation (excluding move-ons) in 2015/16 – an increase of 23%. Of these, over half (61) were placed into private rented accommodation, with the remainder being placed into The Springs (accommodation for low needs clients looking to get back in to work, training or education) or other provider-based housing.

In addition, 34 clients were able to find accommodation independently after RRS advice, and 29 were successfully referred to other support services.

The RRS attempted initial contact with 98.7% of clients within two working days. The service commenced work with 92% of clients within seven working days of the referral. Delays were generally as a result of clients being unable to attend initial appointments.

"The whole service has had good communication, well explained and for me a good outcome"

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Single Homeless Service Profile

Over the last year the SHS has extended its reach beyond local authorities. It has provided support to clients who were accessing services such as Wintercomfort, Street and Mental Health Outreach Team and Probation are now all able to refer to SHS.

"I am overwhelmed with the support I have received from Mr Liam Stewart, I am very thankful for his professionalism and kind support"

Relationships with Housing Advisers are paramount. More emphasis has been taken by the Rapid Response Support Worker (RRSW) to be a visible presence. This allows Advisers to discuss current cases and possible cases they want to refer in.

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Future Planning

The RRS as part of the SHS has proved to add an additional support mechanism that allows Housing Advisers an option for low needs clients that did not previously exist. The service currently receives on average between one and two referrals per day, demonstrating that a need for this option is required.

Anecdotal information suggests that there has been a lower number of clients with low support needs clients using supported accommodation options, freeing up space for those who need this type of housing. The effectiveness and need for this type of service to not only provide an option for low needs homelessness but also to free up resource for higher need clients is tangible.

Since January 2016 the SHS has been running at a reduced staff rate - with only one RRSW. To the credit of the service, this has had little effect on the quality the service provides to its clients or on the amount of referrals being placed by local authorities. Given there is no only one full time RRSW, training has also been provided to other staff members on how to deal with the running of the RRS during periods of leave.

"I would just like to say that Liam Stewart [RRSW] was amazing, he was incredibly supportive and was easy to get along with. I'd like him to know that he really helped to boost my confidence; it is partly due to his support that I now have two fantastic jobs and live in a beautiful house near Cherry Hinton. Thank you"

Budget

The RRSW has access to a solutions budget that can make the difference in successfully taking someone from homelessness to independent accommodation. The budget does not replace existing funding streams and is only used where no alternative can be found.

The use of the budget has been entirely within the year 2015/16 which coincides with the majority of private rented accommodation sourced by Town Hall Lettings, the letting agency set up by Cambridge City Council. Approximately 90% of the budget is spent providing the client with furnishings or appliances to make unfurnished properties habitable. Funds have also been used to support clients with food or households goods in the first stages of set up when moving costs have proved prohibitive and with transport to enable clients to access appointments, work or training until they have been paid.

Case Study

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Stefan (23)

Stefan approached the Single Homeless Service in 2015.

At first Stefan was anxious and disheartened for the future – he has just been asked to leave the family home by his mother and was struggling to find work. Stefan had no idea of how to get out of his situation or where to start.

Stefan was adamant that he did not want to go into hostel system due to 'stories' that his heard. Furthermore, Stefan was keen to find work as soon as possible –with supported accommodation being expensive it would make it harder to achieve his ambition to work.

Stefan was directed to Jimmy's Assessment Centre for an interim period. The Rapid Response Service worked with Stefan for 5 weeks – supporting him in finding work opportunities, application forms and interview techniques. Within this 5 week period Stefan managed to get an interview with Addenbrookes for reception role - Stefan got the job.

The Rapid Response Service worked with Stefan in finding affordable private rented accommodation. He moved into a room in a shared house. Over the weeks that followed, Stefan was supported with money management and how to manage relationships with a housemate. He is still currently working for Addenbrookes and his enjoying his own space.

Client Feedback

Every quarter questionnaires are sent to service users who have received some support. The purpose of this is to highlight what the service is doing right and what it could improve on. Some of the responses are contained here.

"The service was fine, no one can do something better"

" I have always paid my taxes from very good paying jobs and because of life's curve balls, the street is only a heartbeat away for anyone .I am now one year in sheltered housing, my life was saved"

14. The Space Service

The Space Project works with women who have had children permanently removed from their care and aims to support these mothers to build more stable lives. Traditionally, once a child is removed, support to the mother from services such as children's social care, health visiting and midwifery ceases. This can leave the mother to cope with the loss of her child/ren on her own and research shows this void is often filled by having another child. Unfortunately, very often, subsequent children are also removed and the pattern continues at great cost to the mother and children emotionally but also at cost to children's social care and legal services.

Based on a successful project 'Positive Choices' in Suffolk, Space launched in December 2015 with 12 month funding via the LAC Commissioning Board, which has been extended to 18 months. One of the first challenges to consider was that the mothers have often had a negative experience of working with professionals over many years and some have totally disengaged from services - a new approach was required to encourage the women to work with the project. The Council's Chronically Excluded Adults Service have a tried and tested approach to working with people who are considered to be "chronically excluded" and with lessons learnt from Positive Choices, Space was able to develop an approach of working with the mothers at their own pace, giving them the control in the interaction and the relationship.

Engagement – both initial and on-going, needs to go to the client, rather than expect her to come to us and allow the woman to engage in a way that she feels comfortable with. Space needs to be flexible and not take it personally when she isn't able to meet with us. The project has found that this works really well, with women who we were told 'would not engage' accepting and working with the project.

"Nothing beats a 'thank you xx'' text – from someone who 'will never engage with any service"

Partnership working has been key to the success of the project so far, with positive relationships built with key professionals such as housing, benefits, domestic abuse and substance misuse services, as well as the iCASH service, with whom a 'fast track' system has been developed to enable the women on the project to access long-acting contraception swiftly.

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The project runs with two experienced project workers. Management support and clinical supervision has been provided from existing resources from experienced professionals within the County Council which has reduced costs usually associated with a new project. In terms of cost savings, the project is currently working with 24 women, these women have had a total of 62 children removed from their care. Utilising known research, it can be predicted that 13.2% of these women will become pregnant again within 1-2 years; therefore statistically 3 of the women working with the Space project could be expected to become pregnant. The legal costs of each child removal are estimated at £75,000 (this does not include social worker time). If the project prevents only 2 recurrent removals, the costs of the project would be covered in terms of the legal costs of removing a baby, however, there are also savings to the health economy in terms of improved mental and physical health and reducing reliance on public sector support. The emotional costs to the mother and children are immeasurable.

"I was a real mess when I first met Sarah, but now I am in a better place because she helped me realise that I needed to look after my physical health (which I wasn't doing) but she never judged me about my drugs and alcohol. I have had a smear, got a full health screen and have some tips and hints on how to manage my anxiety better. She talked to me about the possibility of moving away to get away from 'him' but she never forced or rushed me. She let me decided to come to refuge and now, here I am!"

Other early successes include a 20 year old woman who spent a number of years in care, who had had two babies removed by age 20 and was homeless when referred. She was described by professionals as "almost impossible to engage". She is now in supported housing, has a contraceptive implant and is moving on with her life. This was achieved because her worker developed a relationship with her by driving her where she needed to go, getting lunch together and engaging at a pace with which she was comfortable.

For another woman, who had a history of suicide attempts and hospital admissions, the joint working with mental health services prevented a crisis at a key moment; she didn't attempt suicide or become hospitalised as was feared that she would.

"It's the little things that make a difference, turning up when you say you will, offering to move a client to their new property, making more than one trip, finding a 'man with van', having a laugh with the client – usually at my expense!! Going the extra mile is really appreciated and so worth it – allowing for a deeper relationship to develop, being able to discuss and inform on therapeutic interventions, getting clients consent to make an appointment for counselling."

A project worker describes how she started working with Rachel

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“Rachel was on a methadone script and topping up with street drugs when I first met her. We met in Greggs so that she felt safe and I bought her a coffee. She says this helped with engagement. We talked about budgeting, food etc. Rachel was guarded about most things initially. She knew I would turn up when I had agreed to. As our relationship grew, Rachel disclosed more about her son, her abusive ex-partner, her distress at having chosen him over her son, contact with her son, how she believed she had alienated her family. My agenda took a back seat for ages, with just gentle hints about taking responsibility for health and the importance of regular check-ups. Eventually, we got GP and dental appointments and Rachel attended both, because I took her, I think. We went for colposcopy at hospital following a smear test, which she was really anxious about so we employed some of the anxiety management techniques I’d given her and some positive reality – it’s great that you have taken responsibility for your health and now you are getting what you need.”

The Space Project is still in its infancy; however, we are ensuring we are measuring outcomes to be able to demonstrate value. Cambridgeshire is currently supporting Bedfordshire to set up a similar scheme and will be presenting at national conferences over the next couple of months. Space is also at the forefront of developing a regional learning forum. In May, we were featured in the Local Government Chronicle in an article about the Space Project for their online subscribers.

15. Deprivation of Liberty Safeguards (DoLS)

This report gives an update of the situation as well as the pressures that we are still facing regarding the Deprivation of Liberty Safeguards (DoLS) since the Supreme Court ruling of March 2014 (known as the Cheshire West ruling) which dramatically increased the number of people who now come within the remit of Deprivation of Liberty Schedule A1 legislation. In particular, the financial pressures on CCC as a result of this ruling are assessed to be significant and ongoing. Nationally, the consensus is that every local authority will face a severe financial burden as a result of the increased activity which is likely to continue over the next coming few years.

Local context

Month	Total No. of Referrals	Assessment Completed	Withdrawn	Other
April 2014 to March 2015	743	255	9	32
April 2015	106	42	1	3
May 2015	104	28	3	3
June 2015	126	31	1	2
July 2015	113	40	2	3
August 2015	123	35	2	9
September 2015	98	29	4	0
October 2015	114	40	4	6
November 2015	89	23	2	3
December 2015	78	21	0	0
January 2016	124	13	0	0
February 2016	114	17	0	0
March 2016	146	22	0	0
Total	**2078**	**595**	**28**	**61**

Assessment Completed:
This also includes applications where the individual has been discharged/moved from the care home, hospital or unfortunately passed away amounting to 156 cases. This is in line with HSCIC's request for the annual returns.

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Withdrawn
The reasons given for withdrawing is most often that the person has regained capacity.

Other
The DoLS Team still receives inappropriate referrals for individuals who have been placed here by a different funding body.

In total, there are 1238 cases outstanding as at the 31 March 2016

Actions taken by CCC in addressing the DoLS' waiting list

It is a widely accepted view that if local authorities can show they have plans in place and are actively engaged in trying to meet their statutory obligations under the DoLS' legislation, then the risk of legal penalties for any procedural breaches should be minimized.

To this end, we have taken the following actions:-

- Developed an action plan to address the implications of the judgment and it is being reviewed regularly at the MCA Management and Practice Group meetings.
- Appointment of an additional MCA DoLS' trainer to rollout training for social workers/care managers to undertake capacity and best interests assessments for cases in supported, sheltered or shared lives accommodation for submission to the Court of Protection with assistance of LGSS Law.
- Increasing our current pool of independent Best Interest Assessors (BIA) from 2 to 7, recruited 1 F/T MCA DoLS Operational Manager and 1 additional F/T BIA.
- We have adopted the usage of the ADASS' streamlined forms and this has not only reduced the amount of paperwork involved but also reduced the time taken for BIAs to complete them.
- We have targeted provisions of MCA and DoLS training to care home providers in particular so as to improve their knowledge and understanding of DoLS, which in turn, reduces the percentage of inappropriate DoLS' referrals.
- We have been using the ADASS' DoLS Prioritising Tool to assist us in deciding those situations, which have a more urgent need for speedy assessment.
- We have increased financial resources to our IMCA provider so as to ensure that they are able to fulfill their statutory duties with the substantial rise in demand for their services.
- Working collaboratively with our Coroners in establishing the circumstances whereby the Managing Authority will inform them of the death of their resident or patient.
- Joint working with CQC's inspectors in our locality to promote better understanding of the MCA and DoLS.

16. A word from some of our Partners

Addenbrookes Hospital, Cambridge University Hospital NHS Foundation Trust

Cambridge University Hospital NHS Foundation Trust is a large teaching and academic health science centre providing services for the local community alongside regional and national work for specific conditions.

Achieving our ambition to become the best biomedical campus in Europe, whilst also serving an increasing local population, recognises the need for campus development and expansion.

We continue to work with our campus partners to support and enhance existing on-site activities, ensuring the right infrastructure is in place to deliver world-class care.

Current developments include the new Papworth Hospital, which is expected to complete in 2017, and Astra Zeneca's new global research and development centre and corporate headquarters.

Governance and Accountability

The Chief Nurse is the Executive Director with Board responsibility for Safeguarding across CUHFT. Safeguarding matters are reported through the Trust's quarterly Combined Adult and Children's Safeguarding Committee, chaired by the Chief Nurse, to the Quality Committee, a sub-committee of the Board. The Trust Board receives biannual reports on safeguarding.

The last year has provided the Trust with considerable challenge in terms of services offered and financial constraints. Following the Care Quality Commission and NHS Improvement reports of 2015, we were placed in 'Special Measures'. We have worked hard with our regulators over the course of the last year, and look forward to the opportunity in September 2016 of welcoming the CQC back into in our organisation in order to share with them the improvements we have made in terms of their concerns. Our financial recovery is also currently within the suggested trajectory.

Embedding the Care Act 2014

Cambridgeshire County Council, as the supervisory body for CUHFT, takes a lead role in adult safeguarding enquiries and triggers enquiries to be made at CUHFT in cases where the threshold for criminal investigation is not met. The Adult Safeguarding Lead at the Trust provides clinical reports and takes responsibility for the progression of enquiries so that they may fit appropriately within the delivery of acute clinical services. If safeguarding concerns raised within the Trust are deemed to fit criteria defined within Section 44 of the Care Act, the local authority safeguarding leads will inform the MASH, (Multi-Agency Safeguarding Hub). Contingent upon the MASH triage, any one of the safeguarding partners may subsequently lead an investigation or collaboration may take place jointly.

2015-16 Achievements

- The Adult Safeguarding Steering group meets quarterly, attended by senior staff members from across the Trust. The group reports to the Joint Safeguarding Committee and then into the Quality Committee. A Safeguarding Board report is submitted bi-annually.
- the first NHS Trust in the UK to introduce such a large scale and advanced system. We are continuously learning, and

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- The implementation of an electronic patient record system across the Trust was achieved with a 'go live' in October 2014. CUH was developing the system to provide benefit not only to our patients, but to the NHS as a whole, in line with government plans for digitalisation by 2020. The annual EHI awards are the only national dedicated healthcare IT award scheme, and the Trust was recently informed that we are finalists in three of the competition's categories for 2016.
- Delivery of our safeguarding training plan continues. A clinically developed e-learning package providing adult safeguarding information was installed in November 2015 and became a mandatory training requirement for all clinical staff. The response from Trust employees was very positive, and the update for training was such that we were able to demonstrate a 94.5% compliance with completion of the package, exceeding our goal of 90% staff trained by end of March 2017.
- Added focus on the legislation of the Mental Capacity Act 2005 and associated legal framework (Deprivation of Liberty Safeguards) has continued. Face-to-face training has been delivered by the Named Nurse for Adult Safeguarding to numerous groups of staff by invitation and also as a targeted approach to staff in areas where more detailed understanding of the legislation is required. This has included a presentation to the Medical and Clinical Directors. The training has also been supported by Cambridgeshire County Council, when their MCA/DoLS manager kindly delivered several master classes to CUH staff.
- Following this training, an audit was undertaken in July 2016 to provide a benchmark of staff knowledge of adult safeguarding, the mental capacity act (MCA) and the deprivation of liberty safeguards (DoLS) across the Trust. This will provide a picture of the areas of staff knowledge across the organisation and further inform the training strategy. Headlines from the audit show great improvement from the starting place in relation to MCA and DoLS, along with a good level of knowledge of safeguarding and we await the final report for more specific staffing group detail.
- The PREVENT agenda continues, and the Trust lead for PREVENT has now been able to train a number of facilitators who in turn can disseminate the programme across our organization. We have mapped our training denominator to local LSCB guidelines, and aim to achieve a 90% compliance by end of March 2016. NHS England has taken a lead in providing national updates for health organisations, and the PREVENT lead has also been able to attend several regional conferences over the past year.
- The summer of 2016 has marked the retirement or change of role for a number of supportive colleagues in the local safeguarding partnership. CUH would particularly like to thank those colleagues from Cambridgeshire County Council whose expertise and guidance has been instrumental in establishing and developing the adult safeguarding service within our organisation.

2015-16 Action Focus

- Consolidation of planned integration of the three strands of safeguarding across the Trust, and co-location of wider team – to include added services such as Learning Disability/Mental Health and Dementia.
- Further liaison and cooperation on cases with partner agencies, using the internal ASG policy.
- Continue to pursue better and timelier feedback on case enquiries raised by our staff for patients within the Trust but resident in other localities.
- In light of the Care Act 2014 and the Making Safeguarding Personal agenda, to fully update our processes and policies in line with those of our supervisory body CCC.
- Continued emphasis on training, particularly for MCA/DoLS and the associated duties such as Best Interests process and engagement of advocates.

Age UK Cambridgeshire & Peterborough (AUKCAP)

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Age UK Cambridgeshire & Peterborough is a local, independent organisation, created on 1 April 2016 by the merger of Age UK Cambridgeshire and Age UK Peterborough.

AUKCAP's vision is to help make Cambridgeshire and Peterborough a great place in which to grow old. By working together we will be able to enhance our services by deploying our combined resources strategically across the whole area. There is also a greater opportunity to share learning and develop more integrated support for older people.

We will offer an easy, single point of access. This is especially important for older people, or others concerned for the welfare of a vulnerable older person who may be suffering abuse, for whom we are often the first point of contact. Last year our Help Line in Cambridgeshire took just under 10,000 calls on a variety of topics.

All staff and volunteers undertake specific safeguarding training and the Senior Operations Manager is our safeguarding lead. The Chief Executive is a member of the safeguarding board in both Cambridgeshire and Peterborough and we look forward to closer working between the boards in the future.

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Earlier this year the Trust recruited a Head of Safeguarding who has in their portfolio both the Adults and Children's Safeguarding agenda. This strengthens the relationship of adult safeguarding across the CCS range of services and provides management of the full time Named Nurse for Adult Safeguarding based in Luton.

Senior Trust representatives remain committed to the multi-agency Safeguarding Adult Boards in Cambridgeshire, Peterborough, Luton and Norfolk and as such are integral decision makers in the development and implementation of the local safeguarding agenda.

The Trust continues to be well represented on a number of Partnership Safeguarding Adult Board sub-groups; including Mental Capacity Act/Deprivation of Liberty Safeguards and Training and Development, Policy, Protocols and Procedures, Communication and Community Engagement and Audit, Information Sharing Provider CQC meetings and Best Practice Groups.

The Named Nurse for Adult Safeguarding remains a representative on the East Anglia and Essex Adult Safeguarding Forum.

The Trust has a combined adult and children's safeguarding group which ensures all those with a safeguarding responsibility meet regularly to discuss developments across localities, challenges the safeguarding agenda and service might face and provide a strategic overview of practice. There is regular performance reporting and scrutiny of data and an annual audit programme for safeguarding adults and children.

The Named Nurse for adults has, since CCS took on additional services, worked hard to further develop our programme of MCA and DoLS training.

The organisations PREVENT work has become more integral to the safeguarding agenda with the Named nurse for adults being a member of the CCS PREVENT forum.

The Trust's incident reporting database Datix has provided useful information regarding incidents, trends and has enabled a greater understanding of where practice development is required, work will be undertaken this year to scrutinise in detail those cases brought to our attention where greater single or multi agency safeguarding work needs improving.

The forthcoming year will see specific adult safeguarding audits, implementation of Systm1 adult safeguarding templates for staff recording and further work to imbed and enhance the work of our safeguarding adult champions.

The principles of the new Adult Safeguarding Intercollegiate document are being worked on in readiness for its introduction.

Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

The Trust's safeguarding MCA/DoLS policy has recently been revised with the introduction of an MCA Standard operating procedure to help staff in their understanding of this complex area. All CCS policies are available on the staff intranet, the safeguarding component of this is being revised to make it more user friendly.

CCS Named Nurse for Adult Safeguarding has with agreement from NHS England developed an MCA checklist for staff. This will, once approved by CCS Safeguarding Group be added to Systm1 for staff to use.

Adult Safeguarding Training
The target for compliance for staff attending adult safeguarding training is 95%. Performance against this target is outlined below.

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CCS Adult Safeguarding training figures as of the end of June 2016 are as follows:

- Safeguarding Adults = 93%
- MCA = 87%
- DoLS = 85%

NB the above figures are across the whole of CCS and not specific to Cambridgeshire.

E-learning packages are available on the intranet for Adult Safeguarding, MCA and DoLS and a comprehensive training programme of face to face training has been scheduled for the coming months which will ensure a rise in the MCA/DoLS statistic.

PREVENT
PREVENT is part of the government's anti-terrorism strategy CONTEST, that aims is to stop people being drawn into or supporting terrorism. The Trust is training more PREVENT facilitators who can deliver basic awareness and Wrap3 training. It is envisaged that CCS will reach the target of 85% compliance with WRAP training by end of April 2017. CCS remains committed to this agenda and works closely with partners and continues to be engaged with local and regional CONTEST meetings.

Safeguarding Champions
A small cohort of staff within Luton attended a University of Bedfordshire run course sponsored by Luton CCG and Luton and Dunstable Hospital.

Champions attended one day of learning per month for seven months. Topics covered included domestic abuse, mental capacity, record keeping and deprivation of liberty safeguards. We now have 4 safeguarding champions within adult services in Luton, with a keen interest and increased knowledge of safeguarding issues. It is hoped that a further course will run over 2015 in order to increase Champions at operational level.

Adult safeguarding - key actions for 2015-16:

- Develop Safeguarding Adult Templates for use in the electronic record system.
- Increased number of staff to complete higher levels of adult safeguarding training to provide a more in-depth knowledge of safeguarding and to support the investigation process.
- Audit and review of safeguarding systems and processes, to ensure accurate collection of safeguarding information across the whole organisation.
- Ultimately, no reported cases of adult neglect attributed to CCS.
- Identify further staff to 'champion' safeguarding within CCS operational services.
- Engagement with regional Learning Disability work streams and enlist in-service champions.
- Multi-agency partnership work to focus on reporting mechanisms and thresholds.
- Integration of Care Act 2014 recommendations regarding adult safeguarding into both policy and practice within the Trust as soon as guidance has been completed.
- Ensure that all staff are updated with the new CCS MCA/DoLS Policy and MCA checklist.

Cambridgeshire Constabulary

Cambridgeshire Constabulary continues to work in partnership to safeguard vulnerable adults, whether they be a victim of domestic abuse, elderly, disabled or vulnerable in some other way. All referrals will be subject to an initial triage within the Multi Agency Safeguarding Hub (MASH) from which information is shared and referral pathways established. This will allow the constabulary and other partner agencies to effectively share relevant information to inform a coordinated response in order to provide the necessary interventions to safeguard in a timely way leading ultimately to better outcomes.

Within the Constabulary we continue to have a Domestic Abuse Investigation and Safeguarding UNIT (DAISU) which will investigate cases of domestic abuse, supporting victims and those close to them through positive action and bringing offenders to justice. The DAISU have led the work in relation to training and implementation of the new Coercive Control Legislation that came into force in December. Since then, there have been increasing numbers of cases reported, with Peterborough seeing one of the first cases successfully prosecuted at court. The Constabulary continue to support the MARAC process, working with others to support victims and reduce risk. Work is underway to look to carry out a daily MARAC process, bringing more timely interventions in high risk cases.

The Adult Abuse Investigation and Safeguarding Unit (AAISU) continue to undertake investigations into cases of adult abuse, including those in a health or care setting. These investigations can include physical or financial abuse as well as general neglect.

The Constabulary continue to prioritise on the basis of threat, risk and harm and have an underpinning safeguarding approach, in particular towards those who are vulnerable.

In 2015-2016 we have:

- continued the development of the MASH, firmly establishing Domestic Abuse and Adult Abuse as priority themes.
- continued to work in partnership with Peterborough and Cambridgeshire Safeguarding Adult Leads.
- continued to carry out investigations into cases of Domestic Abuse, safeguarding victims, in particular those that are vulnerable and bringing offenders to justice.
- trained, implemented and prosecuted the new Coercive / Control Legislation.
- continued to investigate those who offend against the elderly, disabled and vulnerable and bring offenders to justice.

Cambridgeshire County Council Drug and Alcohol Action Team (DAAT)

The commissioned substance misuse service, Inclusion, has ensured all frontline recovery workers and supervisors have received safeguarding training. This now forms a mandatory element of the induction training for new members of staff as well as refresher training for existing staff members and is coordinated through a newly appointed training lead.

The Care Act 2014 is fully embedded within the assessment process for service users being referred on to Tier 4 services which includes residential rehabilitation placements and community based care packages. Every assessment is overseen by one of 3 qualified social workers supporting the service.

Cambridgeshire Safer Communities Partnership Team (CSCPT) contributes to the ongoing development of safeguarding training within the wider partnership through regular attendance at the Adult Safeguarding Training Sub Group.

During 2015/16 DAAT worked with Inclusion and VoiceAbility to create awareness materials around drugs and alcohol for adults with learning disabilities and mental health needs. We are also involved with the review of Cambridgeshire Police's Operation Hexham which aims to protect people with vulnerabilities from being targeted by illegal drug suppliers who use them or their homes in the supply of illegal substances to the community.

Cambridgeshire & Peterborough Domestic Abuse and Sexual Violence Partnership

Cambridgeshire DASVP continues to work closely with the Adult Safeguarding Team on awareness raising around adults at risk and an action plan is in place to ensure both services work collaboratively on areas where domestic abuse and sexual violence overlaps with adult safeguarding. A campaign aimed at encouraging older women experiencing domestic abuse to seek support was launched in September 2015 with national organisation Action on Elder Abuse and we continue to work with the Older People's Partnership Board to extend this awareness. Plans are also in place for an awareness campaign aimed at women with disabilities in 2016 and Adult Safeguarding have been involved in the early stages of planning. The Government's national Violence Against Women and Girls Strategy released in April 2016 specifically refers to improvements to services for women with additional vulnerabilities so the DASVP will be working with Adult Safeguarding and specialist service providers to ensure requirements are met. The monthly newsletter produced by the DASVP includes details of Adult Safeguarding training and our website also signposts professionals to the Adult Safeguarding Team.

Domestic Abuse Update

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A Domestic Abuse and Safeguarding of Vulnerable Adults Action Plan was implemented in 2013 and updated in early 2015 to capture work that overlaps or links the two areas. The actions continue to be delivered.

The number of adult safeguarding cases with a domestic abuse element in 2014-15 was 79, this is slightly less than the 84 recorded in 2013-14.

The Care Act 2014 came into force in April 2015, setting out for the first time legislation around adult safeguarding. Domestic abuse is now a national category of abuse for adults at risk from harm (the new term for vulnerable adults).

The Partnership have undertaken some work with VoiceAbility, a support and advocacy organisation for adults with learning disabilities, to raise awareness of domestic abuse amongst this client group. The Speak Out Council of service users at VoiceAbility approached the Partnership as a result of personal experience where a domestic abuse survivor with learning disabilities found it hard to find accessible information and support.

The Partnership Officer worked with the Speak Out Council to develop accessible versions of posters which were distributed to specialist organisations throughout the county. VoiceAbility were also commissioned to create an Easy Read version of the Opening Closed Doors leaflet which they did in collaboration with the Speak Out Council.

The resulting booklet was distributed both locally and nationally and received positive feedback from professionals in learning disability services across the UK. This work was nominated and finalised under the Breaking Down Barriers category at the National Learning Disability and Autism Awards 2015.

Cambridgeshire Fire and Rescue Services vision of a safe community where there are no preventable deaths or injuries in fires or other emergencies continues to be its ethos.

We have instigated multi-agency de-briefs should a fire death occur. Agencies involved with the individual work in partnership to ascertain if together we could have intervened to prevent this fire from occurring, as well as identifying any similarities in individuals' life style choices with incidents of a similar nature.

One finding identified residents that have hoarding tendencies are at a high risk of being injured or dying as a result of fire. CFRS has responded to emergency calls of this nature which has resulted in four fire fatalities in recent years. National research ratifies that people with this disorder fit the profile of having a fatal fire.

As a result of these findings CFRS has instigated hoarding awareness raising and guidance for front line staff to follow.

This includes:

- Home Fire Safety Check guidance for homes where hoarding is present
- Fitting specialist smoke alarms
- Providing carbon monoxide alarms
- How to identify and access the level of hoarding using the Clutter Image Rating scale (CIR)
- What actions to take following identification of hoarding
- How when and where to record this information

The service is up skilling its front line staff to recognise these risks, enabling the resident to be sign posted to agencies that can offer support and guidance to be safe and stay in their own homes.

CFRS has recognised by tackling the issues that make individuals a high risk of fire we can reduce their risk of dying as a result of fire.

Safeguarding training has also been identified as high priority and to support this we have instigated on line learning for front line staff that can be monitored and reported on.

In the last financial year we sent through 116 referrals and we have responded to an additional 80 referrals that have come to the fire service for action from the MASH unit. One finding identified residents that display hoarding behaviour are at a high risk of being injured or dying as a result of fire. CFRS has responded to emergency calls of this nature which has resulted in four fire fatalities in recent years. National research ratifies that people with this disorder fit the profile of having a fatal fire. As a result of these findings CFRS has instigated hoarding awareness raising and guidance for front line staff.

Cambridgeshire and Peterborough NHS Foundation Trust

Statement of Purpose
Cambridgeshire and Peterborough NHS Foundation Trust is committed to the working with partner agencies to ensure the safeguarding of adults at risk of abuse.

Governance and Accountability
Safeguarding matters are reported to the Board via the Quality Safety and Governance Committee. The Director of Nursing is the Executive Director with Board responsibility for safeguarding adults; the Head of Adult Safeguarding is the lead officer for adult safeguarding with responsibility for developing policy and procedures within the Trust.

2014-15 Achievements

- **Training**
  At April 2016 96% of CPFT staff had trained in adult safeguarding. MCA training stood at 92% and 93% of staff had received PREVENT training.

- **Staff Supervision**
  Safeguarding Leads are supported by the programme of peer supervision meetings where safeguarding staff visit the wards and teams in CPFT to discuss cases, issues and developments.

- **Healthcare Services**
  From 1 April 2015 CPFT took on responsibilities for community health care services. Although the overarching commissioning organisation Uniting Care Partnership is no longer in existence, integrated physical and mental healthcare services remain the responsibility of CPFT.

- **CQC Registration**
  CQC carried out an inspection of CPFT services during May 2015. The outcome was that CPFT was rated as "good" overall and CQC reported that *"effective incident, safeguarding and whistleblowing procedures were in place. Staff felt confident to report issues of concern. Learning from events was noted across the trust."*

- **Activity**
  Safeguarding activity showed a decrease in enquiries of 8% compared with the previous year; however there is thought to be some underreporting from some areas.

- **Partnership Working**
  A Multi Agency Safeguarding Hub (MASH) has been developed within Cambridgeshire as a single point for referrals and triage of all adult safeguarding matters. CPFT has appointed an Advanced Practitioner who will undertake this role for mental health referrals.

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- **Care Act 2014**
  CPFT has worked closely with partner agencies to implement the requirements of the Care Act 2014 and Making Safeguarding Personal.

- **Deprivation of Liberty Safeguards**
  The number of DoLS urgent applications increased substantially (28%) during 2015-16. However, standard authorisations were commensurate with the previous year.

- **Policy and Procedures**
  The CPFT adult safeguarding policy has been updated to reflect Care Act changes

- **Serious Case Reviews & Prosecutions**
  CPFT made no referrals for a Safeguarding Adult Review under Cambridgeshire procedures.

Priorities for 2015-16

- Ensure all staff receive appropriate training and are able to identify and respond to safeguarding issues and that the target of 90% for staff training in adult safeguarding continues to be met.
- Ensure compliance with attendance at Mandatory PREVENT training.
- Ensure that each ward and community team in the adult services has a sufficient number of trained Safeguarding Leads.
- Work with partners (including Local Authorities & Police) to develop the working of the Multi-Agency Safeguarding Hub (MASH).

Cambridgeshire and Peterborough Clinical Commissioning Group (CAPCCG)

CAPCCG ('The CCG') has a patient population of approximately 930,000 and is one of the biggest in the country with 105 GP practices as members. The CCG is a commissioning organisation, commissioning health services for the people for Cambridgeshire and Peterborough and is committed to safeguarding adults.

Our main Providers are:

- Cambridge University Hospitals NHS Foundation Trust (CUHFT - encompassing Addenbrookes and Rosie hospitals)
- Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT)
- Hinchingbrooke Health Care Trust (HHCT)
- Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
- Cambridgeshire Community Services (CCS)
- Papworth Hospital NHS Foundation Trust - specialist cardiothoracic hospital

There are also a range of other key Providers such as GP Out of Hours services, NHS 111, East of England Ambulance Trust and many other smaller specialised service Providers.

The monitoring of Providers compliance with the safeguarding adult's requirements in the quality schedule of the NHS contract was undertaken by the CCG on a quarterly basis as part of the Clinical Quality Review meetings (CQRs) held with providers using the quality dashboard with metrics and RAG rated thresholds.

Additional funding from NHS England has helped to facilitate organisations' ability to address issues with compliance with the training requirements in relation to MCA/DoLS.

The CCG is also involved in the quality monitoring of care homes and a new framework is currently under development. Attendance at the local authority and CQC information sharing meetings also supports the CCG in maintaining a soft intelligence database which helpfully provides an overview, useful for quality surveillance and identification of systemic issues. In partnership with the local authority such surveillance led to a large scale safeguarding investigation being convened for a local care home, which is still ongoing.

Partnership working

CCG staff attend multiagency meetings in order to achieve partnership working. There has been regular attendance at the Cambridgeshire Safeguarding Adult Board meeting and its sub groups, as well the Domestic Abuse Governance Board, the MASH Governance Board and the Prevent Delivery Board.

Health Executive Safeguarding Board

The Health Executive Safeguarding Board (HESB) is a sub group of the SAB and is chaired by the CAPCCG Director of Quality, Safety and Patient Experience. HESB takes a strategic view of health issues around safeguarding adults across the health economy. The membership of HESB works collaboratively with Cambridgeshire and Peterborough local authorities and both Peterborough and Cambridgeshire SABs.

Safeguarding Adults Health Sub Group

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The Safeguarding Adults Health Sub Group (HSG) reports to the HESG and has membership of Health Providers across Peterborough and Cambridgeshire reviewing operational issues. For 15-16 a collective work plan was developed to address issues such as Compliance with the Care Act 2014, Learning Lessons from Safeguarding Adult Reviews and the quality monitoring of care homes. Activity has taken place across the year to address the work plan.

CAPCCG has strived to maintain a high profile around the importance of safeguarding adults to the health and well-being of our population and continues to promote a culture of Making Safeguarding Personal. Prevention is vital and staff training around safeguarding adults to raise awareness is both promoted and monitored closely by the CCG. The responsibility of all staff to recognise and respond to safeguarding concerns is emphasised in the training delivered to staff by Provider Safeguarding Adult Leads.

Priorities and challenges for 2016 -2017

- Review the recommendations from the SARs published and ensure these are being considered within CCG commissioned services.
- To respond to the forthcoming 'NHS England Roles and Competencies for Healthcare staff' document and consider the implications for the learning and development needs of NHS staff locally.
- Consider the impact of increasingly constrained resources upon both the CCG and Providers, while still striving to maintain a robust response to meeting Safeguarding Adults responsibilities.

Care Quality Commission

The Care Quality Commission is the independent regulator of health and adult social care in England.

Our purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve. We will develop our approach to inspection so we can respond to new models of care and new models of service which will develop over the next few years. We are clear that regulation will not act as a barrier to innovation.

Our role is to monitor, inspect and regulate services to ensure they meet fundamental standards of quality and safety and to publish what we find, including performance ratings to help people choose care.

CQC's underpinning priorities are to:

- focus on quality and act swiftly to eliminate poor quality care, and
- to make sure that care is centred on people's needs and protects their rights

Care that fails to meet the expected national standards of quality and safety against which we regulate will not be tolerated. We will use our enforcement powers necessary to stamp out poor practice wherever we find it. Any form of abuse, harm or neglect is unacceptable and should not be tolerated by the provider, its staff, the regulators or by members of the public who become Aware of such incidents. Safeguarding is everybody's business and CQC is aware of the role it can play in striving to reduce the risk of abuse from occurring.

Safeguarding is a key priority that reflects both our focus on human rights and the requirement within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to have regard to the need to protect and promote the rights of people who use health and social care services.

As the regulator of health and adult social care services, our primary role is to make sure that providers have appropriate systems in place to safeguard people who use the service and that those systems are implemented and followed in practice to ensure good outcomes for people who use the service. We will monitor how these roles are fulfilled through our regulatory processes by assessing how providers are meeting the national standards of quality and safety.

The CQC consists of three main inspection directorates of Hospitals, Adult Social Care (ASC) and Primary Medical Services (PMS). We now consider our inspection findings to answer five key questions which we will always ask: Is the service caring? Is the service responsive? Is the service safe? Is the service effective? Is the service well led?

We will continue to implement and improve the new approach to regulation. During 2015/16 (as of June 2016) we have published 19,647 ratings of ASC services. Approximately 4% of which we found to be inadequate. The CQC is in the process of introducing safeguarding leads who will champion this subject through all three directorates. All CQC staff are expected to follow the CQC's Safeguarding handbook which gives guidance and also all the statutory requirements that inspection and registration staff need to be mindful of.

Community Network Sub Group

The three public representatives who make up the Community Network Sub Group have experience of using services as carers and patients and link into other networks in health and social care.

The representatives have been involved in various activities which have helped the Board better understand the patient and public perspective:

- Attending professional training courses and giving feedback
- Helping design public material
- Attending Board meetings and questioning the jargon used and decisions made.

The Community Network Representatives are very plased to do this work and help make safeguarding more meaningful to people. The other Board Members always welcome comments.. It is very rewarding to have our efforts appreciated.

Healthwatch Cambridgeshire

Safeguarding is a key priority for Healthwatch Cambridgeshire and we are delighted to be a member of the Cambridgeshire Safeguarding Adults Board. We welcome the commitment that the Board has made to the Making Safeguarding Personal agenda and are pleased to have worked closely with the County Council on improving the public understanding of safeguarding. The language used in safeguarding is highly jargonised and means little to the general public. By making the language used more understandable, the aim is that we raise awareness of the general public of safety and risk and appropriate ways to respond. By hearing the views of service users and the public organisations can learn from people's experiences; thereby improving their understanding of what helps people stay safe.

Healthwatch Cambridgeshire supports the Board's Community Safeguarding Network and the three representatives that attend the Board meetings. These meeting tend to feature very dry data and processes, the representatives have been vocal in their questioning of the purpose and meaning of these. This has been welcomed by the Board. We have undoubtedly seen an increase in the Board's awareness of how complex safeguarding processes are and the benefits of making safeguarding more meaningful to people.

Healthwatch Cambridgeshire continues to work closely with the Care Quality Commission and the County Council to ensure that there is a robust system for reporting safeguarding concerns and sharing intelligence. All Healthwatch Cambridgeshire staff and volunteers undertake safeguarding training, the CEO is the Safeguarding Lead and there is also a Safeguarding Adults Champion to make sure that safeguarding policies and procedures are current, practical and effective.

National Probation Service (NPS)

The National Probation Service (NPS) is committed to reducing re-offending, preventing victims and protecting the public. The NPS engages in partnership working to safeguard adults with the aim of preventing abuse and harm to adults and preventing victims. The NPS acts to safeguard adults by engaging in several forms of partnership working including:

- Operational: Making a referral to the local authority where NPS staff have concerns that an adult is experiencing or is at risk of experiencing abuse and/or neglect, including financial abuse and is unable to protect oneself from that abuse and/or neglect.
- Strategic: Attending and engaging in local Safeguarding Adults Boards (SABs) and relevant sub groups of the SAB. Through attendance, take advantage of training opportunities and share lessons learnt from Safeguarding Adult Reviews and other serious case reviews.

In 2016, NPS published its new strategic partnership framework outlining the ways in which we work, attend and engage in local Safeguarding Adult Boards (SABs).

The NPS works closely with partner agencies to safeguard adults.

The six safeguarding principles that underpin our work are:

- Empowerment: People being supported and encouraged to make their own decisions and informed consent.
- Prevention: It is better to take action before harm occurs.
- Proportionality: The least intrusive response appropriate to the risk presented.
- Protection: Support and representation for those in greatest need.
- Partnership: Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- Accountability: Accountability and transparency in safeguarding practice.

Much of our work relates to assessing and managing offenders who are registered sexual offenders and offenders with a pattern of serious violent offending. Some of this work involves NPS working with other agencies under Multi-Agency Public Protection Arrangements (MAPPA) and in Multi-Agency Risk Assessment Conferences (MARAC). There are also NPS staff working in the local multi-agency safeguarding hubs (MASHs) to help protect some of the more vulnerable members of our community.

In terms of adult safeguarding, NPS contributes to multi-agency work to protect and support victims of abuse and neglect and adults at risk of abuse and neglect. This includes victims of domestic abuse.

Adult safeguarding is a developing area for work for NPS and progress has been made in the following ways:-

- delivery of adult safeguarding mandatory training for all staff
- appointment of a NPS senior manager to lead on adult safeguarding in Cambridgeshire at a strategic level and who attends the Board on a regular basis
- starting discussions with partner agencies on developing a strategy for managing offenders who pose a serious risk to vulnerable groups but who themselves have acute health and other needs
- roll out of briefings to front line staff on the Care Act.

Papworth Hospital NHS Foundation Trust

Papworth Hospital NHS Foundation Trust is one of the largest specialist cardiothoracic (heart and lung) hospitals in Europe and includes the country's main heart and lung transplant centre. Over the last three years, it has performed the highest number of heart surgery procedures in the UK whilst achieving the country's lowest cardiac surgery mortality rate.

Governance and Accountability
The Director of Nursing is the Executive Director with Board responsibility for Safeguarding. Safeguarding matters are reported through the Trust's quarterly Combined Adult and Children's Safeguarding Committee, which is chaired by the Deputy Director of Nursing. The Trust Board receives annual reports on safeguarding via the Quality and Risk Committee.

The trust has a named professional for safeguarding adults showing the trust's commitment to the safeguarding agenda.

Attendance at the Health Executive Safeguarding Board run by the CCG is prioritised. The Adult Safeguarding Lead attends the Health Sub Group of SAB.

2015-16 Achievements

- The Safeguarding committee which used to meet 6 monthly has been increased to a quarterly meeting to reflect the growing safeguarding agenda.
- Introduction of a monthly operational leads meeting.
- Delivery of safeguarding training continues and has been updated to reflect the introduction of the Care Act 2014 and making safeguarding personal.
- Grand round focusing on MCA and documentation. This is as well as the MCA/DoLS training that has been delivered across the trust.
- Launch of dementia strategy and follow up review with Alzheimers Society.
- Update of Safeguarding Adults Policy in line with Care Act 2014.

2016-17 Action Focus

- Audit numbers of patients with dementia and learning difficulties and review if and what reasonable adjustments have been made
- Quarterly reporting on dementia and Learning Disability activity.
- Embed and re audit actions from chaperone action plan.
- Increase time for safeguarding training on professional updates study dates and include chaperone procedure, Care Act 2014, Modern slavery, DoLS and PREVENT updates.
- PREVENT returns quarterly.
- Commence quarterly reporting on adult safeguarding activity to CCG.
- Safeguarding APP on front page of intranet to give staff an easily identifiable reference and thresholds for safeguarding. This is also to be embedded in the Datix reporting system.
- Review and update VIP policy.

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17. Further information

If you are worried about an adult who is being abused or who is at risk of abuse you should contact the following numbers:

Customer services

For reporting adult safeguarding or urgent contacts between

8am - 6pm Monday to Friday & between 9am - 1pm on Saturday
Telephone: 0345 045 5202
Fax: 01480 498066
Email: referral.centre-adults@cambridgeshire.gov.uk
Minicom: 01480 376743
Text: 07765 898732

If you urgently need to make contact outside of the above hours call **01733 234724**

Cambridgeshire Constabulary

Non-Emergency Contact Centre	**101**

Cambridgeshire and Peterborough NHS Foundation Trust

Huntingdon and Fenland	**01480 415177**
Cambridge and Ely	**01223 218695**
Action on Elder Abuse Response Line	**0808 808 8141**
Age UK Cambridgeshire	**0300 666 9860**

For copies of this annual report or if you would like a copy of this annual report on audio cassette, CD, DVD or in Braille, large print or other languages, please call 0345 045 5202. Or write to Cambridgeshire County Council, Box No. SH1211, Shire Hall, Cambridge, CB3 0AP

We would like to thank everyone who has contributed to this annual report.

We have made some changes to the way this annual is presented, hoping to provide a report that is visually enhanced and that demonstrates the experience of those adults who have experienced abuse and/or neglect in Cambridgeshire.

We welcome any comments on the content or the format of this report to inform the development of future reports to ensure that they are relevant, informative and accesible.

If you would like to comment please email Caroline.webb@cambridgeshire.gov.uk

You can find out more information about safeguarding adults in Cambridgeshire on our website: www.cambridgeshire.gov.uk/safeguardingmca

Agenda Item No. 6

REPORT TITLE: PRESENTATION OF CAMBRIDGESHIRE LOCAL SAFEGUARDING CHILDREN BOARD (LSCB) ANNUAL REPORT

To: Health and Wellbeing Board (HWB)

Date: 15th September 2016

From: Andrew Jarvis, LSCB Business Manager

1.0 PURPOSE

1.1 To present the LSCB Annual Report to the Health and Wellbeing Board (HWB). The purpose of the LSCB Annual Report is:

- to provide an outline of the main activities of the Cambridgeshire LSCB and the achievements during 2015-16 against the objectives in the LSCB Business Plan;
- to comment on the effectiveness of safeguarding activity and of the LSCB in supporting this;
- to provide the public and partner agencies with an overview of LSCB safeguarding activity;
- To identify gaps and challenges in service development in the year ahead.

1.2 To summarise progress to date on enhancing transition arrangements from children to adult services

1.3 To propose that the Chairs of the key partnership arrangements in Cambridgeshire responsible for the safeguarding, safety and wellbeing of the community meet to:

- confirm their priorities for the forthcoming year,
- identify areas of shared interest and responsibility,
- ensure top level plans are aligned
- improve communication to enhance the impact of activity.

2.0 BACKGROUND

2.1 The Cambridgeshire LSCB publishes an Annual Report as required by statutory guidance, Working Together 2015.

2.2 "The Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. The annual report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report should be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the health and well-being board.

2.3 The report should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those

weaknesses and the action being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period…"Working Together 2015

3.0 SUPPORTING PARAGRAPHS

3.1 The Report for 2015-16 is now published and available on the LSCB Website at http://www.cambridgeshire.gov.uk/lscb/

3.2 The Report demonstrates that Cambridgeshire has a functioning and effective arrangement in place that safeguards children.

3.3 Numbers of children within the Child Protection (CP) system are rising. Feedback from Children Social Care (CSC) is that this reflects an increase in demand on the system rather than a change in organisational thresholds. It is an increase that is reflected nationally and regionally.

3.4 Partner agencies have continued to plan for a significant level of resource reduction in line with government requirements. These reductions might be most immediately felt in "Early Help" preventative work. However, it is only by having effective Early Help that the numbers of children coming into the CP system will reduce.

3.5 Agencies responsible for safeguarding children are faced with growing demand on services and reducing resources. To target those resources effectively and to coordinate effort has never been more important. If effective preventative work is to be in place it needs to be delivered in line with the work of other strategic partnerships that have a responsibility for the wellbeing, healthy development and safety of children.

3.6 The Report demonstrates how the LSCB has carried out its role in a way that consistently adds to the quality of safeguarding in Cambridgeshire. It does so by using its position and authority to monitor, audit and assess the effectiveness of services; challenge partner agencies to justify or enhance how they work; prioritise and coordinate improvement; develop a trained and aware workforce and act as a catalyst in the development of key areas of practice.

3.7 The report summarises:

- How proper governance is ensured for the LSCB.
- How it has delivered on its priority areas in its Business Plan 2015-16.
- How it has sought to challenge partner agencies to deliver high quality services.
- How it has delivered its functions as laid down in *Working Together*.

3.8 The Report includes:

- Qualitative and quantitative evidence of agency performance in safeguarding children
- Evidence on Board activity and impact
- The LSCB Business Plan 2016-18

3.9 The LSCB has:

- Built on an innovative and ground-breaking project to improve safeguarding for children in the Eastern European communities.
- Worked to ensure the perspective of children and young people is taken into account by agencies and ourselves
- Met its aims in improving services for children at risk from Child Sexual Exploitation, Domestic abuse and those who were vulnerable through Disability.

3.10 The LSCB has delivered a comprehensive range of high quality training.

- Over 50 high quality courses delivered to 1000 practitioners in 2015-16
- Practice Liaison Groups that attracted over 350 practitioners
- Two successful Conferences:

i. 'When it's one of us: Professionals who abuse'
ii. "Neglect: More than just a grubby child" (jointly with Peterborough SCB).

Its rigorous validation process supports agencies in ensuring the quality of their training and provides assurance that the training is fit for purpose.

3.11 Work has been completed to improve the effectiveness of transition processes between children and adult services. Progress has been made in the management of transfers from YOS to the two probation services providers. Children services are addressing the challenges presented by Deprivation of Liberty Safeguards (DoLS) and the complexity this brings, particularly for young people approaching adulthood. Communication of information between social care and health providers has been given a structure by the recently issued NICE Guidance on "Transition from children's to adults' services for young people using health or social care services".

3.12 The priorities for 2016-18 are:

1. Ensure effective safeguarding of children against Neglect.
2. Child Sexual Exploitation & Missing
3. The Voice of the Child
4. Enhancement of LSCB effectiveness in discharging its responsibilities
5. Developing and Supporting an Effective Workforce

3.13 As an objective under priority 4, the LSCB Business Plan for 2016-17 includes

Objective	Accountability	Success Criteria
Improve effective coordination with strategic partnerships in Cambridgeshire.	Chair of LSCB and Business Unit	To enable Partnership Chairs to meet with the intention to agree a protocol for coordination across Partnerships and a high level plan covering Cambridgeshire priorities and accountability. LSCB, SAB, HWB, CJC. By March 2016

3.14 The HWB is asked to consider the benefits of such an approach and give its approval.

3.15 During 2015-16 the government commissioned a review of LSCBs from Alan Wood. His Report and the Government response can be found at:

https://www.gov.uk/government/publications/wood-review-of-lscbs-government-response

To summarise the proposals:

- The Local Authority (Cambridgeshire County Council), Police and Health will have a strengthened responsibility to ensure there is an arrangement in place to coordinate effective safeguarding of children.
- Subject to the agreement of the Secretary of State, they will have more flexibility in deciding how they will deliver this arrangement.
- There will be new system for Serious Case reviews, with a number of high profile reviews being managed nationally and others remaining at a local level.
- The Child Death Overview Panel will become regional and be located within health.

3.16 The Serious Case Review legislation is before parliament, but the other changes will require legislation and may take some years to implement.

4.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

4.1 Priority 1: Ensure a positive start to life for children, young people and their families
Priority 4: Create a safe environment and help to build strong communities, wellbeing and Mental health
Priority 6: Work together effectively

5.0 IMPLICATIONS

5.1 The proposed high level Plan for Cambridgeshire strategic partnerships is designed to complement and support the priorities and Business Planning processes for the Boards, including the HWB.

6.0 RECOMMENDATION/DECISION REQUIRED

6.1 Acknowledge receipt of the LSCB Annual Report 2015-16
6.2 Approve the proposal to develop a high level plan coordinating the priorities and business plans of the relevant strategic partnerships.

7.0 SOURCE DOCUMENTS

7.1

Source Documents	Location
None except those referenced and linked within the body of the Report	NA

DRAFT

CAMBRIDGESHIRE LSCB ANNUAL REPORT 2015-16

CONTENTS

1. CHAIR'S INTRODUCTION

Introduction

1. 1 It is my pleasure to introduce the Cambridgeshire Local Safeguarding Children Board's 2015 - 16 Annual report.

1. 2 This annual report sets out how, over the last 12 months, we have met our statutory duties and addressed the priorities we set for ourselves in last year's business plan. We have also tried to capture the difference we have made, the impact those differences have had on children and their families and the challenges we still face.

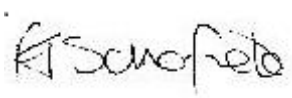
1. 3 I think we have made particularly good progress in the area of child sexual exploitation and children who go missing. This work has been led for the partnership by Dave Sargent, who joined the Board team last summer and whose expertise and commitment has enabled us to increase the pace of change in this challenging area of work.

1. 4 We have also benefited from an Innovations Grant from Central Government which enabled us to work with Peterborough and Norfolk LSCBs to improve our safeguarding services to migrant families and especially families from Eastern Europe.

1. 5 In December 2015 the Government commissioned Alan Wood to undertake a national review of LSCBs, serious case reviews and child death overview panels. This review, together with the Government's response to it, was published in June 2016. It has wide ranging implications for LSCBs and all agencies who work in the field of children's safeguarding. This review will shape our planning and development over the coming year.

1. 6 I should like to thank colleagues from all our partner organisations in contributing to the LSCB meetings, to its subcommittees, its training, multi-agency case audits, serious case reviews and task and finish groups. Most of all, however, I should like to thank the staff in the LSCB Business Unit for their sterling work throughout the year.

1. 7 Finally, this will be my last annual report because from September 2016, I shall step down as Chair. Having never even visited Cambridgeshire before September 2009 when I became Chair, I have become strongly attached to both the area and the fantastic staff who work across all the different agencies. I shall miss you.



Felicity Schofield
Chair
August 2015

2. LAY MEMBERS' STATEMENT

2. 1 There are two Lay Members who, together with the Chair, represent the independent element of the LSCB and serve on the main Board. Our role is to provide a different prospective to the professional Board members, to challenge when required and to act as a critical friend.

2. 2 We have regularly attended Board meetings and have played a full and active part in the work of the Board. We both have a wide experience of local government and the voluntary sector giving us some insight into the difficulties and challenges faced by the statutory services. This is a time of ever tightening budgets and of significant change to the way that services are delivered. It is very important, in the face of these pressures, that the safety of our children remains our top priority. To make sure this is the case is our key role.

2. 3 The Board represents one of the few, possibly the only place where all the most senior officers with responsibilities for the safeguarding of our children come together around a table. If for that reason alone the LSCB plays a key role in making sure that all partner agencies communicate with each other and share experiences.

2. 4 We have been impressed by the commitment and determination of all the partner agencies to learn from shared good practice and to take on the lessons learned from past poor practice. To our mind the LSCB has, and continues to have, an important contribution to make towards protecting our children from harm. We are pleased to have the opportunity to play a small role in this important work.

Anne Kent and John Batchelor
Lay Members
July 2016

3 PURPOSE OF THIS REPORT

3.1 *Working Together* (2015) states:
"The Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. The annual report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report should be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the health and well-being board.

The report should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period…"

3.2 It is the intention of the LSCB to share this report with all partner agencies and with those that have influence over the services provided to children and families in Cambridgeshire.

3.3 In preparing this report, contributions were sought from Board members and the chairs of all sub-groups as well as from other partnerships. It summarises the information contained in reports presented to the LSCB, either on a statutory basis or at the Board's request. A set of data is attached as Appendix 4 summarising the key areas of information about the performance of LSCB partners.

4 EXECUTIVE SUMMARY

4.1 This Report is published in line with the guidance set out in *Working Together* that Local Safeguarding Children's Boards (LSCBs) should provide an account of how they have met their responsibilities in each financial year. *Working Together* was reviewed and republished in 2015, and this report reflects the current requirements as outlined in this Guidance.

4.2 This Report demonstrates that Cambridgeshire has a functioning and effective arrangement in place that meets the needs of the partner agencies but above all meets the need to safeguard children.

4.3 Numbers of children within the Child Protection (CP) system are rising. Feedback from Children Social Care (CSC) is that the complexity and relevance of cases referred has not reduced and that this reflects a genuine increase in demand on the system rather than a change in organisational thresholds. It is an increase that is reflected nationally and regionally.

4.4 Partner agencies have continued to plan for a significant level of resource reduction in line with government requirements. These reductions might be most immediately felt in the Early Help sector, but it is only by having effective Early Help that the numbers of children coming into the CP system will reduce. How to respond effectively to these developments in a way that ensures children remain safeguarded has been central to the work of the Board as it provides a unique forum for partner agencies to consult and develop their strategic approach in the light of the contribution and perspective of their partner agencies.

4.5 **Statutory objectives and functions of LSCBs**

4.6 Section 14 of the Children Act 2004 sets out the objectives of LSCBs, which are:

- To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area.
- To ensure the effectiveness of what is done by each such person or body for those purposes.

4.7 This Report sets out to demonstrate how the LSCB has carried out these objectives in a way that consistently adds to the quality of safeguarding in Cambridgeshire. It does so by using its position and authority to monitor, audit and assess the effectiveness of services; challenge partner agencies to justify or improve how they work; prioritise and coordinate improvement; develop a trained and aware workforce and act as a catalyst in the development of key areas of practice.

4.8 The report will summarise:

- How proper governance is ensured for the LSCB. This includes the independence of the Chair and her access to the critical senior managers and forums. It also covers the structure of the LSCB and how it is aligned with business needs.
- How it has impacted on its priority areas as reflected in its Business Plan.
- How it has sought to challenge partner agencies to deliver high quality services.
- How it has delivered its functions as laid down in *Working Together*. These functions are:

i Developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority.

ii Concerns about a child's safety or welfare and thresholds for intervention.

iii The recruitment and supervision of those who work with children.

iv The investigation of allegations concerning persons who work with children.

v The safety and welfare of children who are privately fostered.

vi Cooperate with neighbouring children's services authorities and their Board partners.

vii Communicate the need to safeguard and promote the welfare of children, raising awareness of how this can best be done and encouraging all to do so.

viii Monitor and evaluate the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve. This section includes a summary of the current position in terms of number and thresholds in the Child Protection process.

ix Participate in the planning of services for children in the area of the authority.

- How it has sought to ensure the voice of the child, the perspective of children and young people, is heard in the LSCB and in partner agencies.
- How it has built on the learning it gained to improve and develop the skills and knowledge of professionals and volunteers working with children. The LSCB has delivered at a low cost a comprehensive range of high quality training. Its rigorous validation process supports agencies in ensuring the quality of their training and provides assurance that the training is fit for purpose.
- The work of the CDOP in Peterborough and Cambridgeshire.

5 GOVERNANCE ARRANGEMENTS

5.1 The statutory objectives and functions of Local Safeguarding Children Boards (LSCBs) are laid out in *Working Together* (2015) pages 65 and 66:

a *"Section 14 of the Children Act 2004 sets out the objectives of LSCBs, which are:*

b *To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area*

c *To ensure the effectiveness of what is done by each such person or body for those purposes."*

5.2 The structure and business planning of the Cambridgeshire LSCB are designed to meet the requirements laid out in this Guidance. They are in place to support it in enabling all agencies to achieve the best possible practice in safeguarding all children across Cambridgeshire.

5.3 The LSCB has the following governance documents:

- Terms of Reference for the LSCB: Approved in November 2013 they lay down the strategic purpose of the partnership and defined the monitoring activity of the LSCB.
- Terms of Reference for the Business Committee: They defined its relationship with the LSCB – the focus being operational and the membership being the chairs of the sub-groups, senior operational managers and safeguarding leads in key partner agencies.
- Terms of Reference and processes for the Serious Case Review (SCR) sub-group: Reviewed this year, they reflect *Working Together* (2015) which defined the purpose of the SCRs but devolved decisions around methodology to the LSCBs.
- Learning and Improvement Framework: A key document that describes how the LSCB generates and embeds learning from its activity. This activity includes SCRs, multi-agency audits, and utilises feedback from children, families and practitioners.
- LSCB Memorandum of Understanding with the Cambridgeshire MAPPA Strategic Management Board.
- Protocol between the Cambridgeshire Health and Well-being Board (HWB), the Cambridgeshire Local Safeguarding Children Board and the Cambridgeshire Safeguarding Adults Board (SAB)

These documents are reviewed as part of the annual reporting/business planning cycle and are available on the LSCB website.

5.4 **Chairing of the LSCB**

5.5 The LSCB is chaired by an independent chair, Felicity Schofield, who has held this role since 2009. Working Together 2015 assigns to the Chief Executive of the Local Authority the responsibility for appointing and holding to account the Chair of the LSCB. The Independent Chair has one to one meetings with Cambridgeshire County Council's (CCC) Chief Executive; the Executive Director for Children, Families and Adults and the Director of Children's Services.

5.6 In Cambridgeshire, the independent chair of the LSCB also chairs the Business Committee, the Serious Case Review Sub Committee, and the Child Death Overview Panel. The latter

also covers Peterborough. This arrangement is designed to bring continuity and consistency to the overall delivery of the Business Plan.

5.7 The chair has the authority and standing to challenge Board members over the performance of their agency, and works to ensure that national policy and strategy has a local response from partner agencies. The independent chair also engages in the national debate and activity around the ever-developing role of LSCBs.

5.8 The independent chair of the LSCB continued her consistent attendance at the Local Authority Next Steps Board and the Domestic Abuse Governance Board. There was also attendance by a member of the LSCB Business Unit at the Children's Trust Area Partnerships.

5.9 The impact of this approach has been to support the spread of significant messages about the quality and importance of safeguarding across the county. There has been a voice of challenge able to enhance the quality and focus of decision making.

Participation of partner agencies in the LSCB

5.10 Partner agencies contribute to the LSCB in many ways. Attendance at meetings and financial support are two key aspects of this, but are far from being the only ones.

5.11 Attendance at the Board, Business Committee and the various sub committees that take forward the work of the LSCB remains strong and shows a continuing commitment to safeguarding. All meetings have been able to function effectively.

5.12 The Business Committee table below includes a number of representatives who were expected to attend only for specific issues or where they have joined or left the Committee over the year.

5.13 The LSCB is grateful for the continued commitment of managers and staff in partner agencies whose time, expertise energy and drive enable it to deliver its statutory responsibilities.

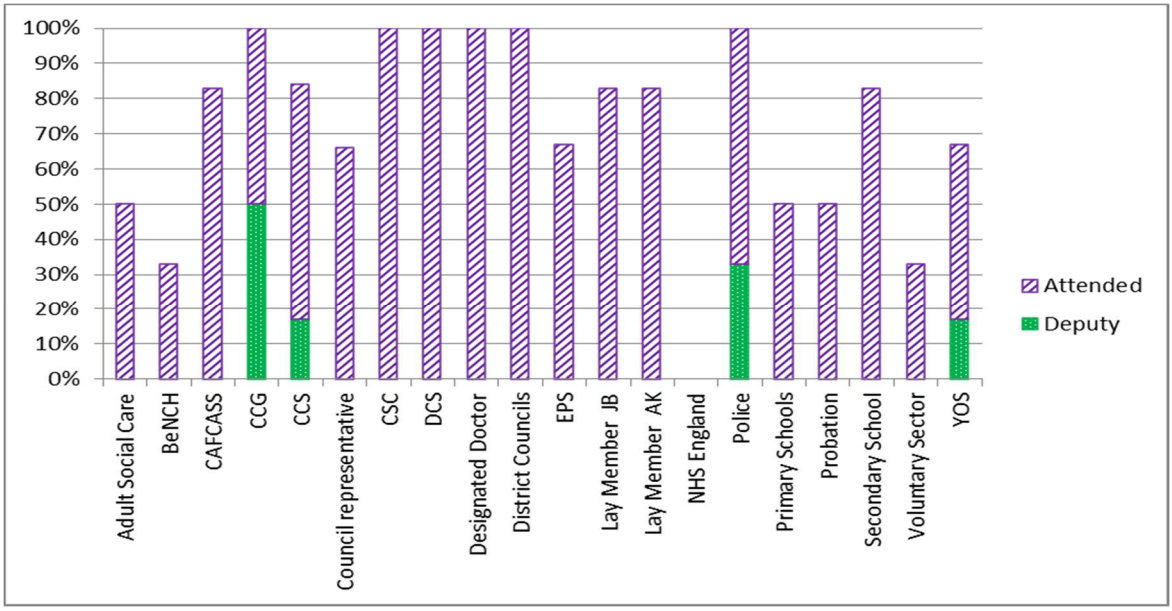


Fig. 1: LSCB Board Attendance 2015-16 (6 meetings)

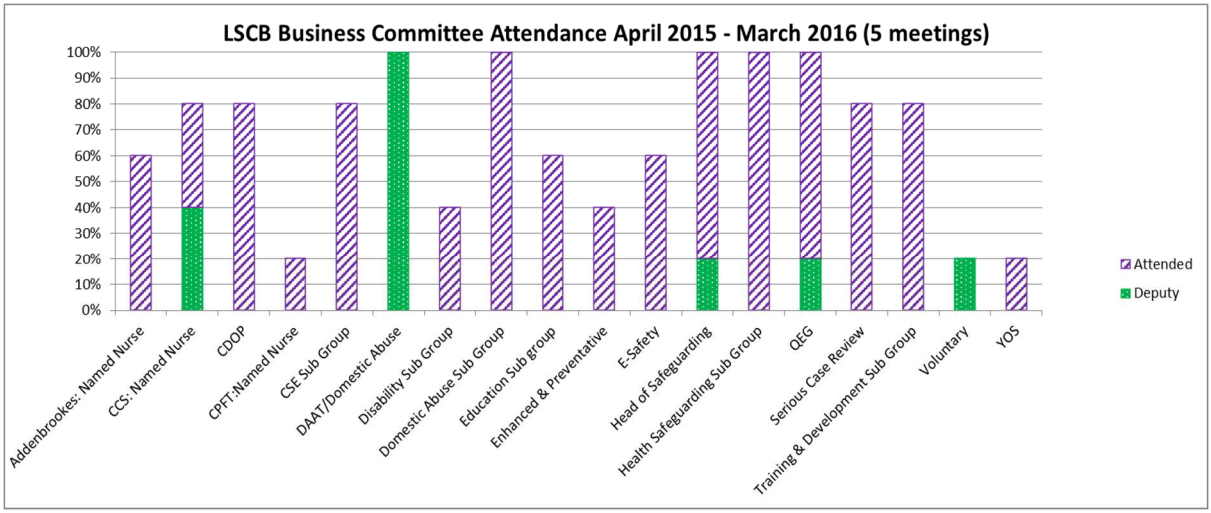


Fig. 2: LSCB Business Committee Attendance 2015-16 (5 Meetings)

5.14 These attendance levels have enabled the meetings to be effective and purposeful. However, there is a constant need to challenge those who don't attend, whilst the Board Unit has reviewed how we work to make the meetings accessible.

5.15 Over the year NHS England has not attended any meetings, citing capacity issues and their national structure as the reason why they are unable to commit to attend. Their role is such that they would have had an important contribution to make on a number of key issues.

5.16 The division of the Probations Service into two agencies, both relatively small in size compared to other Board partners, has made it difficult for them to attend as consistently as they intend. The Voluntary Sector has been represented by a manager from a large national organisation. It had proved difficult for them to attend and representation from a safeguarding manager in another organisation has now been put in place.

5.17 The membership of all meetings is kept under review and amended to meet the needs of effectiveness and efficiency.

Group	Planned	Actual
LSCB Board	6	6
LSCB Business Committee	5	5
SCR Sub Committee	12	5
Training and Workforce Development	6	6
Disability Task and Finishing Group	5	5
Domestic Abuse Task and Finishing Group	4	2
CSE Task and Finishing Group	6	5
QEG	6	6
Joint QEG	1	1
CDOP	4	3
Education Safeguarding Group	4	2
E-Safety	4	2
Health Executive Safeguarding Group	6	6

Fig. 3: LSCB sub-group activity 2015-16.

5.18 The figures above depict the number of LSCB-subgroups that took place during 2015-6. Most groups meet on a bi-monthly basis. The SCR sub-group is scheduled to meet on a monthly basis but will only meet when business requires. Where there were fewer actual meetings than those listed as planned meetings this was due to a proactive decision that a meeting was not required. This approach meets the need of partners without a significant loss of effectiveness. The exception to this was the eSafety Committee which was affected by staff absence due to sickness. The Business Committee is reviewing the most effective way to deliver this workstream.

Coordination with key strategic partnership Boards in Cambridgeshire

5.19 Attention has been given to cooperating with the other key public sector partnerships in Cambridgeshire, including the Health and Well-being Board (HWB), Safeguarding Adults Board and Area Partnership meetings (Children's Trust). To some degree this remains at an early stage and more work is needed to streamline communication and coordinate priorities. However, some work has been undertaken across the Boards, particularly in the area of Transition between children and adult services.

5.20 **The LSCB Budget**

The LSCB has a budget made from multi-agency contributions from the following agencies:

- CCC Children's Services
- Cambridgeshire Constabulary
- National Probation Service
- Cambridgeshire and Peterborough Clinical Commissioning Group
- NHS England
- Cambridgeshire Community Services NHS Trust
- Cambridgeshire and Peterborough NHS Foundation Trust
- Cambridge University Hospitals NHS Foundation Trust
- Hinchingbrooke Hospitals NHS Trust
- Papworth Hospital NHS Foundation Trust.

Details of the budget can be found at Appendix 6.

6. LSCB: PRIORITIES 2015-16

Business Plan

6.1.1 Attached as an Appendix is the Business Plan for 2015-16 with updates on actions taken to complete the tasks as required. All commitments in the plan were met. The plan reflects the Boards priorities:

- CSE
- Safeguarding and Disability
- The impact of Domestic Abuse

6.1.2 Diversity and culturally competent practice across all providers is covered in the Report section on the Innovations Project. This summarises advances in information gathering, good practice guidance and training when working with the East European Communities. In addition, the gender, role and ethnicity of the professionals attending LSCB Training is covered in the relevant training section.

6.1.3 The LSCB continues to improve the range and quality of data available to it, seeking additional information on key areas from the relevant agencies.

6.1.4 The LSCB has developed its administrative systems to record and present clearly to meetings the information it uses and the consequent actions it takes to apply that learning. This process is designed to improve our capacity to identify and act on areas of concern and do so consistently across the whole spectrum of safeguarding activities.

Child Sexual Exploitation and Missing

Child Sexual Exploitation

6.2.1 Child Sexual Exploitation (CSE) remains a high priority for the LSCB with key objectives in the Business plans that have been met. The objectives are outlined below and evidenced in the current structure we as a partnership have developed to respond:

a. Increase the capacity and coordination of agencies in safeguarding children from CSE
b. Create a workforce competent to respond to CSE.
c. Increase public awareness of CSE and enhance the ability of children to recognise and reduce the risk they face.
d. Increase the ability of key professionals and members of the public to recognise and respond to risk of CSE.
e. Provide relevant tools and structure for professionals working with CSE
f. Provide evidence of good practice with CSE.

6.2.2 During the last 12 months Cambridgeshire LSCB have appointed a Coordinator to oversee CSE and Missing Children and along with partners have fully reviewed a number of work streams such as training, awareness raising, communications, prevention and partnership activity. The reviews have centred on national guidance and best practice including Ofsted joint targeted inspection guidance.

6.2.3 The structure of meetings has been clarified to ensure that risk and vulnerability are defined for each case we deal with. This has enabled partner agencies to better understand the thresholds for CSE and identify the correct pathway for each one.

6.2.4 The emphasis is on putting the child first and ensures that any intelligence or information coming into our possession is reviewed and dealt with at the appropriate level. As a partnership we currently have 25 children at risk of CSE and 135 children vulnerable to CSE. Each and every case has been risk assessed and proportionate action taken to ensure risk is mitigated and the relevant intervention put in place.

6.2.5 The structures we now have in place clearly define who has what responsibility with regards to safeguarding children and young adults and more importantly provides a platform for scrutiny and audit. The partner agencies have tested agencies by holding a "deep dive" Ofsted style audit to identify strengths and weaknesses in our current processes.

6.2.6 The Audit established that there was evidence of good multi-agency working but a) there were differences in which children were identified as being at the at highest risk by agencies, and this has been rectified by improved communication b) high quality return interviews are critical to all processes but were not being undertaken as robustly as was required, and a new process, using a new provider, is being put in place to rectify this and c) differences in the definition of key concepts (Missing/Absent, Vulnerable/At risk) led to confused communication, and shared definitions have now been agreed and promoted.

The current meeting structure is as follows and is explained further below.

LSCB CSE Implementation Group

6.2.7 This is a Police chaired quarterly meeting attended by all partners and is jointly attended by Peterborough SCB. The meeting will discuss the joint CSE action plan and highlight any activity taking place against the actions. Any matters arising with partners can be dealt with at this meeting and this is the forum where we would discuss national themes and trends.

CFA Strategic CSE and missing meeting

6.2.8 This is a monthly local authority meeting to provide strategic oversight of the arrangements across Children's, Families and Adults (CFA) for CSE and children missing from home, care or education, ensuring that services are working effectively together and barriers to children's well-being are swiftly addressed.

6.2.9 The role of the LSCB Coordinator at this meeting is to provide an interagency perspective to the development of Cambridgeshire County Council policy and process.

Operation Makesafe

6.2.10 This is a police led monthly meeting concentrating specifically on an identified "cohort" of individuals most at risk. Where any intelligence is received concerning the cohort, clearly defined intervention pathways are put in place.

6.2.11 Intelligence concerning suspects and locations is also shared with the CSE Coordinator who can then seek assistance from wider partners such as Housing Providers and taxi Licensing. A recent example of information sharing and assistance highlighted problematic hotels in the Cambridge City area, through partnership intervention and awareness raising we were able to work with the local policing teams to highlight the hotels responsibility and ensure structures were in place for visiting and training.

MASE Meeting

6.2.12 The group comprises a small number of key partners who meet monthly to review all children who are deemed "most at risk" and have been specifically referred to MASE from Operational Missing and CSE meeting. It is expected that the child in question will be discussed by their key worker who will be invited to the meeting. The panel will then undertake a review of risk and ensure that there are appropriate safeguards and a plan in place. The key objectives are:

a. To review all children who have been referred to MASE from the CFA Operation Missing and CSE meetings
b. To share information in relation to the children who have been referred, undertake an assessment of risk and ensure there are appropriate safeguards and a plan in place
c. To review all new information and intelligence which comes to light, police colleagues to share information from Operation Makesafe
d. To ensure information is shared with the Strategic and Operational groups
e. To review information on the dashboard

Training and Communication

6.2.13 The LSCB have managed and delivered 10 training events throughout the year to over 130 partners. The training has been specific to Child Sexual Exploitation and safeguarding with subjects covered:

a. Introduction to CSE
b. Working with CSE
c. Missing Children
d. Disability and CSE
e. CSE involving boys as victims

6.2.14 The feedback received through course evaluation has been incredibly positive with most partners going on to request further, more advanced, training.

6.2.15 The LSCB website is currently under reconstruction to provide resources for children and young adults, professionals and parents and carers. The intention is to give each group a single point of reference for information specific to their need.

Missing from care, home and education

6.2.16 The effectiveness of the procedures in place to safeguard children who are missing from school, home and care has had considerable attention during 2015-16. Running in parallel with the work on CSE, but with a wider range of children and a more complex picture of vulnerability to abuse and serious harm, major multi-agency process changes have been implemented to improve the impact that services have in protecting these children. Whilst much has been done, all acknowledge that this is a work in progress and we are yet to reach a point where we can be satisfied at our arrangements.

6.2.17 Agencies are continuing to work hard to understand why children/young people go missing and what resources are required to support them. Last year has seen an improvement in information sharing between agencies. The next step is to enhance the timeliness of the recording of return interviews to support an effective understanding of themes and trends.

6.2.18 Every child or young person known to the police as missing from care or home in Cambridgeshire is referred to the local authority and a return interview is offered and, where they agree, is completed.

6.2.19 Each child and young person is considered at the CSE Operational Meeting, even if they refuse an interview and knowledge around their missing episode is shared. This leads to safety plans being reviewed.

6.2.20 It is evident from the stories of the children and young people who go missing the reasons they go are very individual to them. The way to respond to each of these children and young people is to provide an individual response and plan for each child and signpost to services where possible.

CSE and Missing Operational Meeting

6.2.21 There is a multi-agency monthly meeting which carefully monitors children and young people who go missing repeatedly. The meeting ensures that an assessment of risk is considered for each child and where risk of exploitation is identified suitable strategies are put in place. If the assessment is such that the child is deemed "high risk" then this can be immediately referred to the Missing and Sexual Exploitation Group (MASE) that meet shortly after this one. The meeting also scrutinises themes and trends with return interviews and quality of submission of the missing exemplar.

6.2.22 Processes have been in place to keep information on children who are missing from education and steps taken to ensure they are safe. During the course of this year the LSCB has worked with the local authority to develop a proactive approach that identifies the children at most risk and ensure that sufficient resources from partner agencies are in place to take action to locate and safeguard them.

Safeguarding Disabled Children

Safeguarding Disabled Children Task and Finishing Group

6.3.1 Achievements:

a. Two consultations were held to establish the understanding of Safeguarding amongst disabled children. This included a survey at significant depth that covered a range of ages, location, disability and ethnic origin. Both surveys show a very limited level of understanding and interest amongst the children about safeguarding. Given their level of vulnerability to abuse this is a finding of significant concern and further work is required.

b. The service user perspective has been included in the meetings to improve relevant and effectiveness of the work undertaken and parents of disabled children have been members of the group.

c. A Disability Multi-Agency audit has been completed and improvement actions identified and carried out. LSCB and CCC Training has been reviewed and amended. Policy, process and data provision have been reviewed and enhanced, including the on-line LSCB processes and information on allegations against those working with disabled children.

Safeguarding and Domestic Abuse

Domestic Violence Task and Finishing Group

6.4.1 There have been significant changes in governance, with the establishment of a Joint Cambridgeshire and Peterborough Domestic Abuse Governance Board. The Cambridgeshire Implementation Board was disbanded. The Joint Board will oversee a series of discrete workstreams rather than have a fixed sub group structure in place to support its objectives. This area of work has been developed at a time of major reductions in available resources within the public sector and the need to ensure we deliver services efficiently and to best effect.

6.4.2 We have seen an increased focus on violence between and by young people and current domestic abuse structures are not tailored to be effective with this group. The understanding of domestic abuse has moved towards a more refined model where "control" is the driver behind some violence but in other situations the violence is part of a more generalised pattern of pressure and inappropriate or ineffective behaviours.

6.4.3 Achievements:

a. Increased awareness amongst schools and young people about domestic abuse through tailored training and awareness raising programmes.
b. A consultation with young people took place and the learning fed back to the Board and the Group to amend practice as required.
c. A shared language and assessment model was achieved through the roll-out of the DVRIM.
d. Complicated Matters, a major intervention toolkit and training resource was made available to all agencies through the LSCB supported by E-Learning.
e. The Domestic Abuse "Offer" was finalised and gives a practice framework for staff working with Domestic Abuse.
f. The dataset includes police information, and in future the focus will be concentrated on repeat victimisation.

6.4.4 In future, the LSCB will receive a Report from the Domestic Abuse and Sexual Violence Partnership Manager to the LSCB Business Committee on a six monthly basis covering the issues relating to Safeguarding and receive feedback from the Committee.

Other LSCB Groups

eSafety

6.5.1 The group continues to be a joint Cambridgeshire and Peterborough group with meetings being held in alternate venues.

6.5.2 E-safety training has been delivered to staff in Localities to enable them to take on the E-safety Champion role. They will support the work of Localities and deliver sessions to parents also.

6.5.3 The E-safety audit tool and Incident flowchart and accompanying guidance have been reviewed and updated.

Education Sub-Group

6.5.4 The Education Sub Committee continues to ensure the education sector remains informed about issues around safeguarding and the LSCB has an overview of the state of safeguarding in Cambridgeshire schools. Recruitment practices continue to have a high level of scrutiny and remain a key element in Ofsted Inspections. Weaknesses in process were identified but evidence is now available that the required changes have been made by schools.

6.5.5 A comprehensive programme to train school staff about Prevent, and their associated legal responsibilities, has been completed and all schools have had a Prevent Lead trained.

6.5.6 The government's initiative on disqualification by association was managed into practice, including updates on changes in guidance as they were issued. The waiver process was successfully followed as required. No staff member was found to be disqualified by association at the end of the process.

6.5.7 The LSCB was provided with an overview Annual Child Protection Monitoring Report. It showed that 98% of responding schools used the model Safeguarding policy and 100% used trained staff for recruitment.

6.5.8 In addition, the LSCB receives a report on the outcome of the audit of recruitment practice within schools. This has been an area of significant interest to Ofsted and schools have worked with the local authority to ensure robust good practice is in place.

Health Executive Safeguarding Group

6.5.9 The aim of the Health Executive Board is to strengthen and provide direction for the health community as well as agree the work plan for the Health Safeguarding Group. This group was established last in 2013 and through 2015/16 has provided two way communication between the Safeguarding Children and Adults Boards in Cambridgeshire and Peterborough: sharing the key messages from the boards to health partners and providing updates on relevant activity.

6.5.10 In addition the group has focused on the following:

a. Child Protection Information System
b. Domestic Violence Review of Providers
c. Complex Case Management Process
d. Learning from the Verita Report into Dr Miles Bradbury at Cambridge University Hospitals
e. Safeguarding within Primary Care
f. Monitoring of the Health Safeguarding Group work plan.

6.5.11 Meetings of the HSG in 2015/16 were used to focus on specific areas of the work plan, as well as encouraging the sharing and good practice and discussion concerning specific issues. Areas covered by the group in the last year have included:

a. Strengthening the reporting from the Health Economy to the LSCB around Safeguarding activity

b. Strengthening the relationship between Primary Care and Community Providers
c. How to support professionals in hearing the voice of the child
d. How to promote professional curiosity and be aware of disguised compliance

7. LSCB: IMPROVEMENT THROUGH CHALLENGE

7.1 Much of the Board's effort is placed in challenging agencies to improve safeguarding where necessary. There have been three significant examples of challenge over the year.

7.2 Following the presentation of the Private Fostering Report the Board was concerned about the statutory framework for safeguarding children at Language Schools. These have a significant presence in Cambridge. In the light of the considerable evidence available the Chair wrote to the Government demonstrating that the current statutory responsibilities placed on providers and agencies have the potential to allow unsafe practice by poor providers. In addition, the Board responded to a Government Consultation to raise the issue and show the systemic weakness in the current arrangements, including the risk of promoting extremism.

7.3 Many children who are educated at home receive a good education tailored to their needs and those of their families. However, there is a group who not only do not attend an educational establishment but also are not in contact with health or any other professional agency. There was grave concern at the Board about the system's ability to safeguard them. The Chair wrote, together with her peer from Peterborough, Executive Directors and lead Counsellors, to express this concern to the Department of Education. The government has responded and thanked them for broadening the evidence available to them on the issue.

7.4 The NHS in Cambridgeshire was subject to a CQC inspection covering safeguarding in August 2015. In addition to the expected set of recommendations and subsequent Action Plan, the inspection drew attention to the difficulties facing children requiring ADHD and ASD assessments and provision. The situation then impacted on the other staff offering them support. This is part of a more general national picture and agencies were well aware of the concern. The LSCB has worked to support the CCG take forward the development of additional services and the redesign of the CAMH pathway. In the future it will continue to request information about the accessibility and effectiveness of this service as the initiatives undertaken come to fruition. This was an issue where the presence of NHS England could have increased the scope of the Board to impact on this issue.

7.5 The Board has a culture of open challenge at the Board, in meetings and its wider relationships. This is supported by the existence of a "Challenge Log" to keep a record of this process and the changes that come from it, at the centre of its work. Four examples of this would be:

- When a survey of children's health and wellbeing was presented the meeting requested information on the process in place to respond to those who identified themselves as being at risk or showing acute concern. This response was shown to be effective
- The Board has made a number of very specific challenges about the health assessments available to Looked After Children and subsequently significant improvements in compliance were demonstrated.
- The Board Unit required confirmation that the local authority Call Centre was aware of the changes in the reporting requirements for FGM. In the event it was not, but the process was amended to ensure compliance.
- The Board requested that the Local Authority evidence its effectiveness in safeguarding children placed out of county and required further reports to demonstrate progress in meeting their needs.

7.6 Following a presentation on national Guidance on the use of medical examination in cases of sexual abuse, the three central agencies working with the LSCB agreed a new process for the Sexual Abuse Referral Centre (SARC). This was supported by a new and much improved contract for delivering these medical services.

8. THE FUNCTIONS OF THE LSCB

Policies and procedures for safeguarding and promoting the welfare of children in the area of the authority.

8.1.1 The LSCB provides a comprehensive set of procedures and guidance on line. These have been reviewed in 2015 and 2016 to ensure they reflect current national and statutory Guidance and local practice. These procedures are managed in close cooperation with the Local Authority CSC procedures to ensure consistency in expectation.

- A number of key sections were rewritten during the year to reflect changes in good practice or legislation:
- Safeguarding Disabled Children Practice Guidance.
- Managing Individuals who Pose a Risk of Harm to Children (including MAPPA)
- Guidance for Professionals Working with Sexually Active Young People Under the Age of 18
- Female Genital Mutilation.
- Managing Allegations or Serious Concerns in Respect of Any Adult who Works or Volunteers with Children.
- Responding to Complaints About a Child Protection Conference.
- Prevent and Radicalisation/Extremism.

8.1.2 The existence of a reliable and up to date reference on process and good practice is highly valued by practitioners and remains much used.

Concerns about a child's safety or welfare and thresholds for intervention;

8.2.1 Cambridgeshire has a well-established framework for the delivery of services according the needs of the child, the Model of Staged Intervention. This Model is well understood and used by staff and agencies to identify the appropriate approach for working with individual children and families. In a number of areas of practice, including Domestic Abuse and Substance Misuse services, a similar Model has been used to structure the "Offer" of services available.

8.2.2 Prevent and Extremism are safeguarding concerns and the business of the Board. In addition to agenda items at meetings, appropriate identification and referral processes are promoted through the LSCB Website and our generic training incorporates key messages about effective safeguarding from political exploitation. Information on the identification of risk to radicalisation, the referral pathway for Prevent and the referral form have been added to the LSCB's "Reporting a Concern" web page. There are relevant resources and links in the LSCB procedures.

8.2.3 The issues facing Young Carers has been of concern and the Board received assurances through an outline of the plans being put into place by the local authority and requested performance data to enable it to track progress.

The recruitment and supervision of those who work with children

8.3.1 During 2015-16 the LSCB have asked statutory and key voluntary sector agencies to report through a structured "Section 11" audit their compliance with their statutory responsibilities. This has included evidence of proper recruitment process and effective supervision. In the set of questions covering recruitment, vetting procedures and allegations against staff 96% of responses were that the agency "Fully Met" requirements. Where there were gaps or partially met requirements follow up action was taken.

8.3.2 The potential for harm to be done by professionals has been a very significant area of concern for Cambridgeshire, reflected in it being the theme for one of the LSCB Conferences this year (covered more fully under Training chapter of this report). 2015-16 saw the publication of the review by Verita into the context of the offending by a senior health professional. The LSCB Chair decided that the quality and thoroughness of this review meant that any further LSCB Case Review would not be likely to provide any significant learning, and as such not necessary. The LSCB supported this review and held a major Learning Event following up on the recommendations contained in the Verita Report. There will need to be continued emphasis on empowering service users to challenge providers through the provision of good information and on fostering a work place culture that supports Safeguarding.

The investigation of allegations concerning persons who work with children (The work of the Local Authority Designated Officer)

8.4.1 *Working Together* (2015) refers to local authorities having a Designated Officer or a team of Designated Officers involved in the management and oversight of allegations against people that work with children (LADO). This guidance states that any such officer should be sufficiently qualified and experienced to be able to fulfil this role effectively, giving an example of social workers being the relevant professionals for this role. The Cambridgeshire LADO unit meet the requirements of *Working Together*.

8.4.2 A total of 497 'referrals' or contacts were received into the LADO Unit during 2015-16. This is a 17% increase in the number of referrals and contacts over the preceding year, when there were 413 referrals. There is a general picture of increased referrals across the region, which may be a response to the level of attention the issue of staff and volunteer abuse of children has received in the media.

8.4.3 296 were logged and closed, but there is often a considerable amount of work undertaken by Cambridgeshire LADO before this conclusion has been reached. Of these, 144 resulted in an internal investigation by the employing agency and 57 moved to the consideration of a multi-agency approach through a Complex Strategy Meeting.

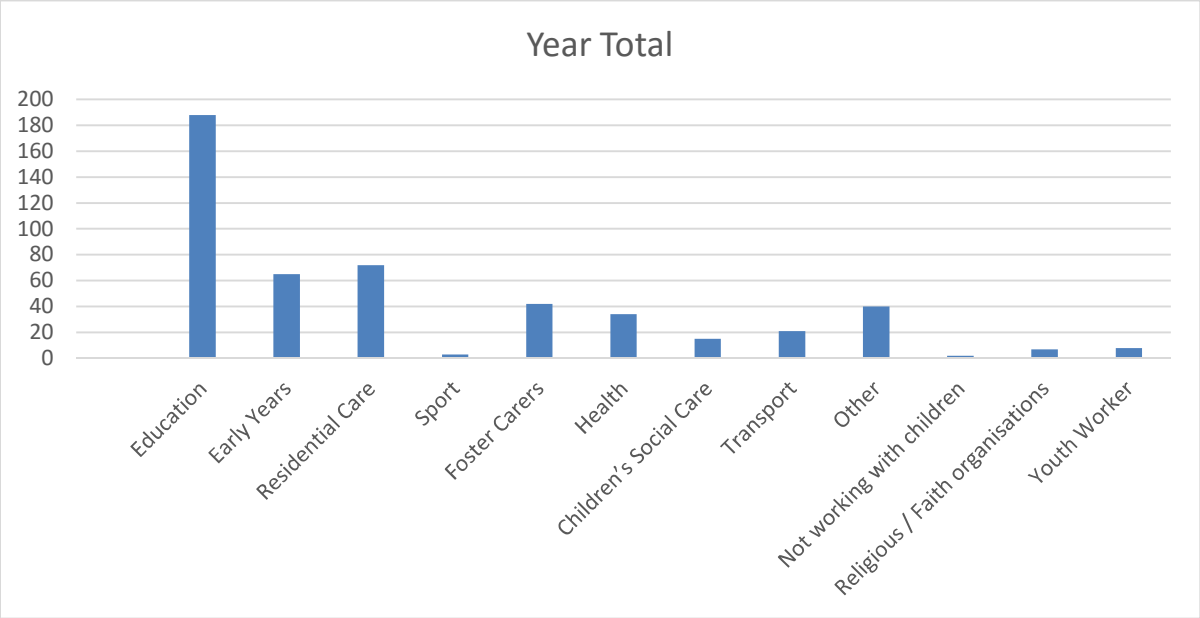


Fig. 4: Staff and volunteers referred by role:

Role	Year Total	15/16	14/15 %
Education	188	38%	36.56
Early Years	65	13%	15.50
Residential Care	72	14%	13.32
Sport	3	1%	3.87
Foster Carers	42	8%	7.51
Health	34	7%	7.51
Children's Social Care	15	3%	2.42
Transport	21	4%	5.08
Other	40	8%	4.85
Not working with children	2	0.40%	0
Religious / Faith organisations	7	1.40%	1.21
Youth Worker	8	2%	1.45

Fig.5: Sources of referrals to the LADO

	Year total	%
Logged and Closed	296	60%
Internal investigation	144	29%
Complex Strategy Meeting held	57	11%

Fig. 6: Outcome of referral

8.4.4 Of the 144 that led to an internal investigation, the outcome was as follows:

	Year total	%
Substantiated	25	27
Unsubstantiated	84	50
Unfounded	4	9
Malicious	2	0
False	10	3
Not concluded/outcome unknown	19	11

Fig. 7: Conclusion from internal investigation.

8.4.5 Disabled children are particularly vulnerable to abuse by carers. In total 21 referrals to LADO were in relation to an adult who worked or volunteered with children with a disability, 4.2% of the total. Of these 21 referrals 10 were in relation to advice and support given and resulted in being logged and closed. 6 resulted in an internal investigation being undertaken by the employer. 5 resulted in a CSM being held. This means that proportionately twice the number of referrals went to Complex Strategy Meetings for disabled children when compared to the total group.

The safety and welfare of children who are privately fostered

8.5.1 There continues to be wide acceptance that many private fostering arrangements are not reported to LA's and therefore cannot be covered in the report.

8.5.2 Cambridgeshire had 110 private fostering cases open between 1 April and 31 March 2016, 33 of which were ongoing arrangements from 2014-2015. Of the 107 new notifications, 29 were determined not to meet the criteria for private fostering or the anticipated arrangement did not commence. The Local Authority was not made aware of any disabled children living in private fostering arrangements over the last year.

8.5.3 Cambridgeshire has considerable numbers of children in private fostering arrangements in comparison to other local authorities. Cambridgeshire's number of cases last year is similar to the whole of the North East region. This is because the Cambridgeshire and national figures are skewed by private fostering arrangements made for educational purposes. There are 453 British Council accredited language colleges in England and 37 in the Eastern region, of which 21 are in Cambridgeshire.

8.5.4 Of the 110 Private Fostering cases requiring statutory monitoring visits at least every 6 weeks, 6 were British children and 104 were foreign national students. Of the 33 ongoing arrangements from 2014-2015, 32 (97%) had monitoring visits completed within the required timescales. The one case when this did not happen was because the carers and child chose to disengage with the service. Of the 77 new arrangements in 2015, 75 (97%) had monitoring visits completed within the required timescales.

8.5.5 Most commonly privately fostered children in Cambridgeshire between April 2015 and March 2016 were aged between 10 and 15 years old, and were from Asia. This number includes two large organised groups who have visited the county regularly.

8.5.6 There are also students from Asia who have come to study in local secondary schools via private arrangements between parents and associated acquaintances who immigrated to the UK. Some of these children have been in placement since 2011 and 2012, they return home regularly during school holiday period and many have regular contact with their families. These arrangements are expected to be long standing with children gaining GCSE's and A-Level's before attending university.

8.5.7 The foreign students generally retain frequent electronic and telephone contact with their families ensuring that they are well supported to maintain a strong sense of cultural identity. Private fostering reports give attention to children's specific needs relating to gender, ability, race, religion and culture.

8.5.8 Seven notifications were received for British children (2 for the same child several months apart). This is similar to 2013-2014. In 2012-2013 and in 2014-2015 there were higher numbers (around 15) of British children.

8.5.9 All mainstream children who are privately fostered continue to be considered to be Children in Need and remain open to Children's Social Care Unit's while they live in private fostering arrangements. This enables a more uniform approach to recognising the vulnerabilities of privately fostered children and ensures that their needs are being identified and appropriate services are sought. After assessment is completed and the arrangements are approved by the Kinship Team, the Unit's undertake the statutory monitoring visits. They work to stabilise and secure their placement or whether the focus is on reunification back home.

8.5.10 Of the 72 private fostering arrangements that ended during the year, 58 children went home directly from the arrangement. This is to be expected given the number of students visiting

temporarily for educational courses. 38 private fostering arrangements continued into the new business year of 2016-2017.

Cooperate with neighbouring children's services authorities and their Board partners; Working with Peterborough LSCB

8.6.1 During 2015-16 the Board has worked with the Norfolk and Peterborough Safeguarding Boards on the development of services with the Eastern European communities. This has been funded by the national Innovations Project. The outcome from this is covered in more detail in the Cultural Competence section of the Report. A number of the initiatives from this project will now be taken forward jointly by the three Boards.

8.6.2 Cambridgeshire and Peterborough have a strong historical link, and many LSCB agencies deliver services to both Local Authority areas. As such, the two Boards have sought to develop the level of co-working across the two areas. The primary purpose has been to reduce duplication of work, have consistent expectations placed on partner agencies and increase the efficiency of meetings. There have been some savings in LSCB resources which have allowed other work to be progressed.

8.6.3 There have been joint sub-groups looking at E-Safety and CSE. The impact of the latter is outlined in the relevant section.

8.6.4 There has for some years been a significant level of cooperation over training and the provision of a number of joint programmes. In February the two LSCBs ran a highly successful joint Neglect Conference, reflecting the importance of Neglect in both areas. Working together on this Conference proved productive, and a fuller account is given in the Training section. It is anticipated that the next step will be a joint Neglect Strategy.

8.6.5 This year has seen the development of more formal ties between the Quality and Effectiveness Groups. The first joint QEG Meeting was held in November. Future Section 11 audits will be jointly delivered, simplifying the process for partner agencies and reducing the resources required from them. However, Cambridgeshire and Peterborough have very different demographics and not all the key agencies cover both areas. For this reason there will always remain differences in some priorities that will need to be reflected in the audit plans.

Communicate the need to safeguard and promote the welfare of children, raising awareness of how this can best be done and encouraging all to do so.

8.7.1 The LSCB has run three Conferences this year:

- When it's one of us: Professionals who abuse
- Learning from the Verita Report
- Neglect: More than just a Grubby Child

8.7.2 Between them these covered two of the most significant issues facing partner agencies, managing the risk from abuse by staff and Neglect. The latter represents far and away the most common category of abuse identified in the Child protection process.

8.7.3 Whilst no Serious Case review has been commenced this year, there has been the publication of Reviews undertaken last year. This has been supported by the distribution of Posters and summary materials, the delivery of specific training programmes and presentations to an Area Partnership and Local Practice Groups (LPGs).

8.7.4 Local Practice Groups provide a less formal forum for practice development and discussion, remain a key part of raising awareness across staff in all agencies, and it is encouraging that numbers of attendees has risen in 2015-16.

8.7.5 The Website has been further developed after its earlier move to a platform within the CCC website. This has involved looking at the overall appearance of the website, making the structure more logical and easy to use, and enhancing the content of individual pages and sections.

8.7.6 In partnership with colleagues in the local authority, the LSCB has reviewed and re-launched its leaflet covering the Child Protection Conference. Designed to ensure families and professionals alike have a good understanding of the purpose and process of the meetings, it was informed by feedback on the experience of members of the public and staff.

8.7.7 In addition to the above, we have also provided materials covering:

- The new requirements to report Female Genital Mutilation
- Expectations over smacking
- Safeguarding and Disabled Children
- A range of CSE leaflets and posters
- Material for professionals who may be involved in a case subject to a SCR.

8.7.8 These have been made available through a variety of media and the majority have been translated into languages other than English.

Monitor and evaluate the effectiveness of what is done by the authority and their board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve.

8.8.1 The LSCB has a responsibility to monitor and evaluate services and it is ideally placed to do so effectively and efficiently. Within the LSCB structure, agencies gain from a shared approach to audit and monitoring that supports learning about how they work together to meet the shared objective of safeguarding children.

8.8.2 Appendix 5 outlines some of the sources of evidence used to evaluate what is done by local agencies to safeguard children. There is a range of material and approaches which together provide a robust and comprehensive range of evidence covering the whole area of safeguarding.

8.8.3 Much of the collating and analysis of this information is done by the Quality and Effectiveness Sub Group, or QEG.

<u>The Child Protection Process in Cambridgeshire 2015-16</u>

8.8.4 At the end of 2015-2016, Cambridgeshire had 439 children subject to a Child Protection plan living in Cambridgeshire, compared to the end of 2014-2015 when there were 387 children. This is a rise of 13% over the year in comparison with 2014/15. Numbers peaked at 443 in February 2016. There is a “wave” pattern of plans being made, with a consistent low point over the summer.

8.8.5 Cambridgeshire is not alone in seeing an increase in these numbers. It is also being seen across the region and in the local authority areas identified as the comparators for Cambridgeshire. This has been noted and reported nationally, and has an impact on capacity for all services.

8.8.6 At the end of 2015-16, Cambridgeshire had 33.39 children per 10,000 subject to a CP plan. This compares with 35.2 for the comparator group and 42.9 nationally.

8.8.7 Within Children's Social Care (CSC), the First Response and Emergency Duty Team (FREDt) and Contact Centre have been dealing with a higher level of contacts to the service. Their triage process, including signposting and referral to other providers delivered a consistent number of cases to the social work units for assessment. However, the level of risk in the cases coming through to the units is increasing, and this is impacting on the requests for Conference, court proceedings and the need to accommodate children and young people. Referrals are stable but the number of cases meeting threshold for assessment and intervention are rising.

8.8.8 The quality of Child Protection Meetings is being enhanced by the development of a more robust approach to timeliness, use of appropriate venue, effective information sharing and the participation of families. LSCB and CCC audits on levels of attendance and Report writing to improve compliance have been used as a key factor in identifying compliance by partner agencies and improve their response. Continued focus on this issue at QEG will ensure agencies give the appropriate priority to resourcing this process.

Section 11 Audit

8.8.9 Undertaken by the LSCB in 2015, the Audit requires agencies to self-evaluate their policies and procedures and provide evidence that they are meeting their requirements to safeguard children.

8.8.10 Overall, 87% of all answers in every Standard were "Fully met" in June 2015.

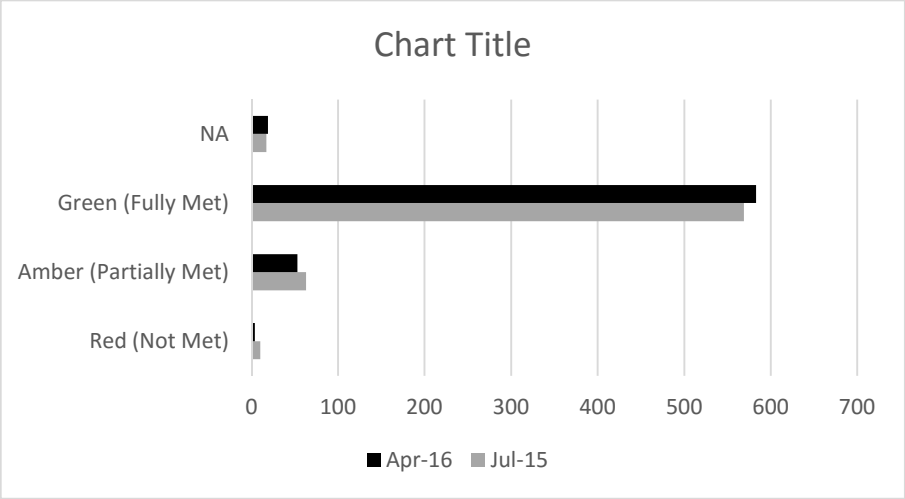


Fig. 8: Summary of self-evaluation judgements in the Section 11 Audit. Initial June 2015 and after improvement action April 2015

8.8.11 Where this was not the case follow up action has been requested and monitored. The audit returns identified which areas required improvement and what actions would be undertaken to achieve it. Update reports were requested and progress measured. Where necessary, failure to respond effectively was escalated to the QEG chair for follow up at a more senior level.

8.8.12 Some areas, such as District Councils, had difficulty in providing the required level of evidence. This may reflect the impact on them of resource reductions and the frequent re-structuring and re-allocation of responsibilities that have gone with it. The issue of reductions in public funding is one that could be faced by a number of LSCB partners and will be monitored by the Board over the forthcoming year.

8.8.13 In addition to monitoring progress on the required improvements, the LSCB has worked with agencies to assist them in making the improvements needed.

8.8.14 Other agencies have a national or regional management structure that makes compliance with local guidance and the provision of local information difficult or impossible. The Board has been made aware of this.

Multi-agency audits.

8.8.15 During 2015-16 Research in Practice published research into the effectiveness of multi- agency audits. The good practice identified by the research was turned into a check list which was used to audit Cambridgeshire's practice.

8.8.16 We were in line with all but three of the good practice criteria, the improvements needed being:

- Including a wider range of front line professionals in the audit process. This is under consideration.
- Obtaining feedback from staff involved in cases covered in the audit. Achieved in subsequent audits.
- Obtaining feedback from families. This has been built into a current audit.

8.8.17 There were three themed Multi Agency Audits:

Disabled Childrens Audit

8.8.18 The Audit Report concluded that "practice is effective" but goes on to comment that there remain areas that could be improved and the summary scores showed a general picture of good work being undertaken. However, there was a need to ensure that risk was assessed on a more consistent basis; that criteria for specific services needed to be understood better; and that work needed to be done on the transition between services, particularly movement between MOSI stages. These findings supported the LSCBs closer involvement in the re-launch and monitoring of the Think Family approach and the effectiveness of the Lead Professional role.

Complex Circumstances Audit.

8.8.19 The overall conclusion was that the audit had found "positive and effective practice" with:

- Evidence of a 'whole-family' approach in some cases and clear demonstration of risk management in trying to keep families together.
- Agencies taking positive and decisive action to safeguarding children – there was clear energy and commitment in practice with the families concerned.
- Impressive examples of agencies working together and the impact of this being evident in the child's or young person's progress.

Recommendations covered:

- A review of practice differences between "Access " and "CIN" social work units, which was undertaken by a CSC Head of Service
- Clarification of the Multisystemic Therapy Service role and communication process

- A focus on ensuring cases are not allowed to "drift" or that complex families generate confused professional practice
- The need for a continued emphasis by the LSCB on cultural competence.

Core Group Meeting Audit

8.8.20 Professionals gave positive responses over attendance, purpose, understanding and effectiveness of the Core Groups.

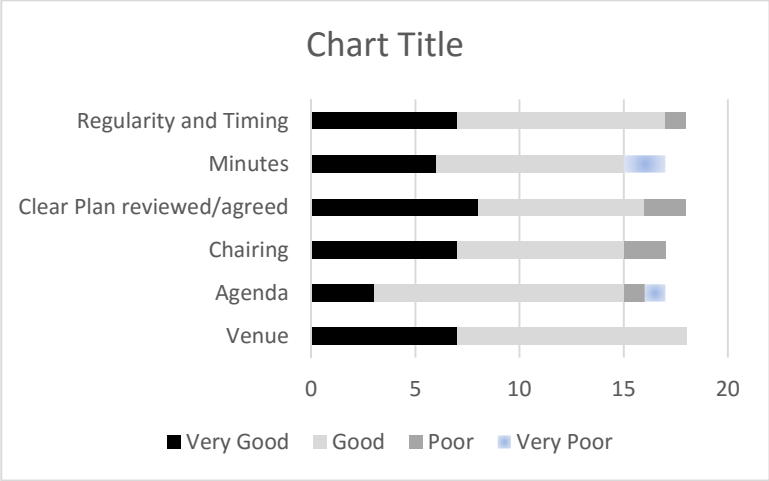


Fig. 1 Judgements on organisation of the meeting.

8.8.21 A high level of attendance by parents was evident, and where the age of the child made it relevant this was mirrored by a good level of attendance by children. They were viewed as participating effectively in the overwhelming majority of cases and this was identified as a real area of strength for CGMs.

8.8.22 There had been improvements in the meeting process but some recording issues remained. CSC therefore added Core Group data into their performance management information, and the impact of this resulted in increased compliance.

8.8.23 By self-report, managers were less confident in their role than front line professionals, and LSCB training has been developed and delivered to address this.

Single Agency Audits

8.8.24 There is now in place a mechanism for agencies to inform the LSCB about the scope of and outcomes from their own internal audits. This enables a level of oversight on issues and progress, but more critically ensures learning is shared and the cross over into the experience of other agencies is not lost.

8.8.25 A range of responses have been received, including:

- Assurance as to the appropriate use of the CP referral process and feedback to specific agencies where improvement was needed through the better use of internal safeguarding leads
- Evidence as to the improvement in the quality of CP Conference reports by CCS staff
- Assurance as to consistent improvement of the quality of work undertaken by CSC in line with Ofsted criteria

- Improvement in the availability and use of the CSE checklist in Enhance and Protective services.
- Learning about effective practice in substance misuse services and in particular use of the CAF

8.8.26 Of note was an internal CCG managed single agency "Section 11" audit of GPs that allowed them to engage with a very busy and relatively hard to reach, but absolutely key, group of professionals on good safeguarding practice. It highlighted with them the need to have up to date policies and procedures in place. The value of the audit was partly to measure compliance but the most significant benefit was to engage GPs in the issue and improve awareness and practice.

Dataset

8.8.27 During the year, work has been undertaken to improve the quality and range of quantitative information available to the Board and partners. Three of the key aspects to this are:

- A dashboard of critical indicators that will be provided to each Board meeting to support their identification of issues arising in safeguarding process and practice
- A set of public health held indicators of the safety of children in the community by geographical area, including level of hospital admissions for injuries and avoidable poor health that could show neglect. This has been developed alongside Peterborough SCB.

8.8.28 At the last inspection, Ofsted felt The Data Set required a broader multi-agency range of information. The Board has been building this up over time. With this data the Board will have a much more informed and accurate picture of safeguarding in Cambridgeshire and where to concentrate its attention to generate required change

Participate in the planning of services for children in the area of the authority

8.9.1 The Board and its Committees have been active in supporting the planning process for the Local Authority and its partners and ensuring that the Board's priorities feature in their planning process and service delivery.

8.9.2 Over 2015-16 two areas of service delivery saw significant strategic developments, Early Help and Looked After Children. Early Help has been challenged by the increasing imperative to prioritise reducing resources by need. There has been an independent assessment of impact and effectiveness, a Strategic review was held, and an enhanced model of working through the Lead Professional role was introduced. The success of the approach in meeting the needs of children and preventing the risk of significant harm depends on the response of all agencies. Given its pivotal role in delivering multi-agency working, the LSCB has actively supported the development and roll-out of the Lead professional role, supporting and challenging agencies to develop their approach. It remains a work in progress to identify performance measures that are timely, robust and outcome centred and this task will need to be completed 2016-17. The LSCB will monitor the effectiveness of the programme and challenge agencies where further progress is required.

8.9.3 The relatively poor outcomes for Looked After Children (LAC) have been known for many years, but making significant inroads in improving the situation has proved to be difficult. Cambridgeshire is no exception, and the Local Authority has initiated a Corporate Parenting Strategy to increase the profile of our responsibilities to these children and the importance of improving their life chances. This has been promoted at the Board and evidence of impact was

requested. There has been significant progress in ensuring they can access medical assessment and intervention but evidence remains needed to establish the impact of the other themes within the Strategy.

8.9.4 The differential impact on LAC who are placed out of County has been a specific concern of the Board, which has challenged the Local Authority to demonstrate progress in ensuring they receive the priority they require. The need to ensure timely health assessments is being pursued via the Regional LSCB Business Managers meeting.

8.9.5 The Local Authority has put resources into developing additional services for families whose child or children are at risk of coming into Care and used the LSCB to increase awareness of this service.

8.9.6 The Health sector was subject to a CQC Safeguarding review and the Police were part of a thematic HMIC Vulnerability Inspection. Whilst the inspections were of single agencies or sectors, the impact of their services was relevant to all and many of the responses to the recommendations were best addressed on a multi-agency basis. By providing a multi-agency forum the Board played a unique role in using the Inspections to improve services. The CQC Inspection featured a number of recommendations around CSE and the LSCB Coordinator was able to work with Trusts to enhance the quality and effectiveness of their capacity to identify, record and report issues.

9. UNDERTAKE REVIEWS OF SERIOUS CASES AND LESSONS TO BE LEARNED.

9.1 There have been no SCRs commissioned in 2015-16, although a SCR completed last year has been published.

- The Action Plans that came from the SCRs in 2014-15 have been implemented and completed.
- The issues include:
- Better understanding of CP process and the use of safeguarding specialists within individual agencies
- A more robust understanding of information sharing requirements
- Ensuring that the Early Help and Lead Professional process supports engagement with families and promotes consistency and good communication across the MOSI "levels"
- That the needs of disabled children and those with complex long term medical conditions are met and the children safeguarded effectively

9.2 Two cases have been subject to a multi-agency review and learning has been identified from both. Both cases originated from the youth offending service and featured vulnerable adolescents. One led to improvements in the guidance on Safety Plans and raised issues about communication and effective intervention across geographical boundaries. The second identified learning about the importance of managing information over time and across agencies, and led to improvements in guidance on communication with hospitals when children who were at risk but also posed a risk required treatment.

9.3 For much of the year the LSCB has been engaged with a local institution which over a number of years has had different staff members investigated for, and charged with, child sex offences. After initially raising awareness as to the significance of the concerns, the LSCB has been able to support the institution in ensuring it now has good safeguarding arrangements in place and can demonstrate effectively that this is the case.

9.4 Following the high profile conviction of a staff member for offences of sexual abuse, a local health provider worked in close liaison with the LSCB, seeking advice or consulting at critical points to ensure that the safeguarding policy response was appropriate

9.5 The terms of reference for the subcommittee and the referral form have been reviewed.

10 INNOVATIONS PROJECT WORKING WITH EASTERN EUROPEAN FAMILIES

10.1 Cambridgeshire, Peterborough and Norfolk Local Safeguarding Children Boards were funded by the Department for Education (DfE) to undertake an innovative project to improve the effectiveness of safeguarding practice with Eastern European migrant families.

Engagement with Service Users.

10.2 Engagement with service users was carried out using three methods: a printed questionnaire (246 responses), one to one discussion and focus groups.

10.3 The main messages:

- There is limited awareness about UK law and legislation
- There is a mistrust of services allied with a common perception that social services will take away their children.
- There is limited awareness about services, what support they can provide and why they are involved. The involvement of services causes anxiety.
- A lack of willingness to engage with services because they do not believe that this will result in positive changes.
- Family problems need to be resolved in the family.
- It is important to keep strong and close relationship between family members and to support each other.
- At the age of seven a child would usually start school. At this age they are expected to have a level of maturity and responsibility for their actions.
- Depending on age and length of time it is OK for older siblings to look after younger ones.
- Parents have strategies to stop a child's behaviour when it is seen to be unsatisfactory, but not to encourage positive behaviour.
- Education is seen as very important.

10.4 Amongst the eastern European community there was limited knowledge about the requirements of UK law regarding the safety and well-being of children. Knowledge was mainly gained through word of mouth from fellow nationals. Despite this nearly all were registered with a GP and the percentage using children's centres were within the range of the UK national average. There is a high level of anxiety and low levels of trust and confidence within eastern European communities about the services that are provided locally. Migrant families are not receiving all the information that they need in order to make informed choices about using services

Engagement with Service Providers

10.5 Engagement with service providers was carried out using an electronic survey, single agency discussion and multi-agency focus groups. There appears to be a lack of confidence amongst some members of staff around engaging with eastern European migrant families. During the consultation there were several individuals and groups who identified that the treatment of eastern Europeans by some service providers was unacceptable ranging from intolerance through to racist comments and behaviours. The range of quality of interpretation and translation services requires greater monitoring and quality assurance.

Analysis of Data

10.6 Key Points:

- Of the Eastern European countries being allocated National Insurance numbers Lithuania, Romania, Poland and Bulgaria have the largest numbers.
- The number of different nationalities is becoming less varied in each of the three authorities but those that remain are less dominated by only one or two nationalities.
- There are no real differences between the three authorities' general pattern of contacts and referrals when compared with those for the Eastern European community.
- Across the three authorities contacts into Social Care are more likely to have come from schools and health visitors.
- Referrals to Social Care in Cambridgeshire and Norfolk are more likely to come from housing or individual acquaintances. In Peterborough referrals are more likely to come from local authority services or health visitors.
- There are more vulnerable children from Lithuania, Latvia and Poland than from other nationalities. In Peterborough there are a large number from Slovakia as well.

Training Programme

Front Line Staff

10.7 A training course was developed using the information and evidence gained from the consultation process and the competencies identified in the LSCBs' practice guidance. Including pilot sessions, 189 staff were trained. Participants were asked to give an overall rating of the course and 89% rated the course as either Excellent or Very Good.

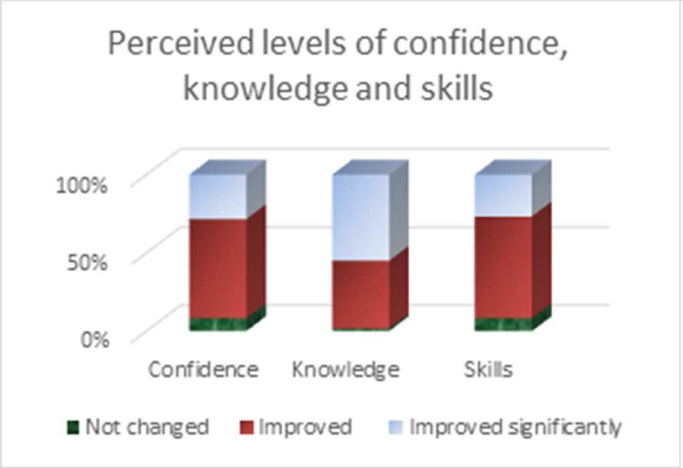


Fig 9. Evaluation Feedback on the impact of the Training to front line staff

Conferences for Managers

10.8 Two events were run aimed at managers and team leaders. They were attended by a total of 120 staff. Alongside the findings from the project, there were presentation of good practice from local voluntary sector providers, video presentations from service users and presentations from teams who had attended the training and made positive changes to their practice as a direct result of this.

Practice Guidance

10.9 Practice guidance across all three local authorities was reviewed and issued. All three authorities are using the same key competencies within their safeguarding procedures and the project and LSCBs have promoted this Guidance.

Outcomes

10.10 Governance and accountability: Through the process of this project Cambridgeshire, Peterborough and Norfolk LSCBs are better informed of the issues and the arrangements in place to meet the needs of this potentially vulnerable cohort. LSCB partners have a greater understanding of the need to incorporate cultural proficiency into all functions and activity from commissioning through to monitoring and evaluation.

10.11 The Boards have greater knowledge and capacity to challenge and hold agencies to account and section 11 self-assessments will be a means to both monitor and evidence cultural appreciation and competence within organisations. All three participating LSCBs are incorporating cultural competence into all their training courses to ensure that this does not appear as a stand-alone subject but acts as a thread throughout all LSCB issues.

Cross boundary working

10.12 Collaboration across the three local authority areas has been seen to be beneficial for all parties. This project has been a successful opportunity for the three Boards to work together. Plans to continue the close relationship have been agreed and the three LSCB business managers will be holding regular meetings to monitor the progress of the legacy of the project and to look for further opportunities for collaboration.

11. VOICE OF THE CHILD

11.1. The LSCB and its partner agencies share a responsibility to use the perspective of service users in their development of services, and in particular the "Voice of the Child". There are challenges in demonstrating where it has had an impact, and improving and developing this work will remain a priority for the foreseeable future.

11.2. In 2015-16 there were six strands to the LSCB's approach:

- The Section 11 Audit showed improvement over time for agencies ensuring service development took into account the need to safeguard children and ensure their perspective is taken into account.
- Commissioned consultation, most specifically with disabled children on their understanding of safeguarding, and young people and domestic abuse
- Reference to the learning generated by specialist consultation professionals, such as Participation (a CSC initiative consulting children and families within the CP system)
- Reference to user feedback in Inspections.
- Awareness of single agency consultation on their own strategies and policy developments, such as by CCC in the development of the Corporate Parenting Strategy and CCG/CPFT around the new CAMH pathway and a survey of school pupils which was wide in scope but covered specific issues including domestic abuse, E-Safety and vulnerability.
- Innovations project for Eastern European communities

11.3. There are major differences between the language and idioms used by professionals and those used by children and young people. The Domestic Abuse consultation showed this up starkly and agencies communicating with young people need to be able to demonstrate they use relevant and effective language as well as appropriate media for communication.

11.4. Attending CP meetings can be alienating and painful for the children concerned. In response, the Board has requested evidence on the effective use of advocates for children.

11.5. The LSCB training continues to invite the voice of the child within its training events to give a real lived understanding of their experiences and how best for professionals to work and support them. Young people's comments and videos are included within the training and for some events there are young people and parents who help to facilitate the day. Out of all the training these are the events which are rated most highly by practitioners in terms of understanding what service users think and need in terms of practice to safeguard them and their families.

11.6. The Board also receives and reviews the CCC Children Services Complaints Report and other agencies have agreed to make the LSCB aware if there is significant learning coming from any Complaint received. The number of complaints remains low and they do not evidence a picture of significant concern about how the system is experienced. Equity of treatment, clear communication and realistic expectations lie at the centre of many complaints. In response, we have reviewed how information and the process is given to families, including what they should expect at key points. In addition, emphasis being given to the timely sharing of Reports with families.

12. LEARNING AND IMPROVEMENT FRAMEWORK

12.1 The LSCB has a Learning and Improvement Framework, the dynamic process within which is shown in Fig 10

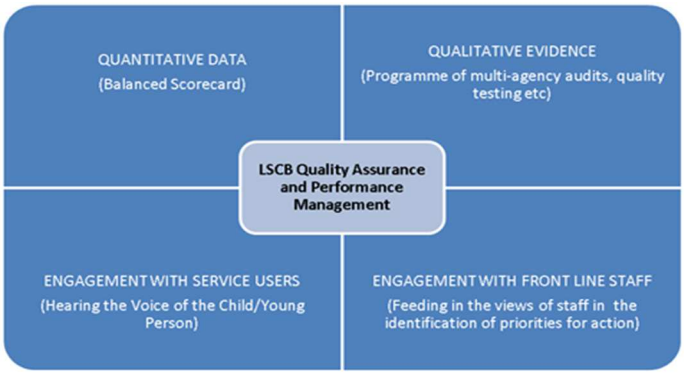


Fig. 10: LSCB Learning and Improvement Framework

Cambridgeshire LSCB Training 2015 - 2016

12.2 Gail Herbert, a valued member of the LSCB team, has successfully supported the LSCB training whilst the Training Manager has been away on sick leave; ensuring that the safeguarding training programme has run smoothly and that many opportunities have continued to be available for professionals.

Attendance

12.3 LSCB training attendance remains strong and the demand for LSCB training places increases year on year. 2015 – 2016 has seen a continued increase in attendance and the training opportunities offered to agencies through Cambridgeshire LSCB.

12.4 61 training courses were provided to practitioners covering 51 safeguarding topics with 931 attendees (96% attendance), which included 6 additional courses as compared to last year. Additionally, there has been a reduction in the number of courses which had to be cancelled, due to improved administrative processes of advertisement and booking.

12.5 Cambridgeshire LSCB continues to offer high quality safeguarding multi-agency training covering a range of topics and priority learning points for professionals which is extremely well attended.

Impact and Evaluation

12.6 93% of attendees completed and returned evaluation forms on the training day and continue to rate the training as 'good', criticisms include; room temperature and parking. Two courses have been identified as needing changes and those specialist trainers are developing the training to accommodate the concerns raised. Comments on how the training will impact on practitioners practice remain positive with themes including;

- *Confidence / More awareness of social media and technology that children and YP are accessing which will enable me to support them/guidance on accessing certain sites and make parents aware.*
- *Make sure the child's voice is head and question views of other professionals to check that they have also talked to the child.*

- *I am more aware of how CSE can affect any gender, age and race which isn't often how it is reported in the media.*
- *Through the exploration of local SCR with other people on the course it was clear that sometimes culture influences professionals practices and sometimes the child gets lost.*

It is extremely difficult to measure the impact on children and families in terms of safeguarding, from practitioners attending the LSCB training events. Indicators currently used are self - reflection and practice observation from managers. Within this area professionals continue to report that attendance at LSCB events and what they have learned has impacted on practice and contributed towards improved safeguarding outcomes for children and their families.

Local Practice Groups

12.7 The LSCB continues to support the 5 regional areas, including the MASH, who organise and facilitate safeguarding workshops throughout the year for sharing information and practice learning. In total there were 31 groups facilitated with a recorded 633 attendees, this is a 39% increase on last year's figures indicating the continued need for these and the valued contribution of these learning events.

12.8 The two hour workshop sessions are a valuable resource for getting safeguarding messages out to a wide range of professional people and are highly regarded by practitioners. Overall sessions evaluate as interesting, well presented with clear presentations and speakers, a good opportunity to network and supporting changes to practice.

12.9 Some salient feedback points from the practitioners who attended the groups were:

- *Informative – good level of appropriate info – helped to support working knowledge*
- *It was useful to unpick some of the more complex issues within the protocol with very experienced practitioners from a range of agencies*
- *Hearing views of other agencies working with YP/ All really useful – just good to see issues being discussed and not hidden*

LSCB Conferences

12.10 The LSCB has provided and joint facilitated three conferences over the year.

<u>'When it's one of us: Professionals who abuse' – 2 July 2015</u>

12.11 There were 174 attendees at the conference (10% increase on last year's figures from the annual conference) and of those 61% worked directly with children, young people and their families. There was an increase in attendance from both the Health sector and Enhanced and Preventative sector but disappointingly there was a drop in attendance from the Education sector.

12.12 Of the 66% of participants who completed evaluations forms (an improvement on last year), over 90% rated the presentations of the speakers as 'excellent'. The five agency workshops at the event were overall received well and noted as 'good to excellent'. Some of the comments to support the success of the event include:

- *Remain vigilant and know who to talk to in regard to safeguarding concerns with children*
- *Overall delivery was very informative but also humorous. Food for thought, well done!*

12.13 Professionals reported that this day lead to a 'lot of self-reflection' in practice terms when working with team members and other professionals ('thinking the unthinkable' and not being complacent with the practice of professionals who 'you think you know'). Many managers were very clear that they would be looking at their own policies, procedures and recruitment processes as a result of attending this event.

'Addenbrookes & Cambridgeshire LSCB Joint Learning Event' – 8 December 2015

12.14 Following the publication of the Verita report in October 2015, an event was run in conjunction with Addenbrookes hospital to enable the learning from both the report and the experience of the staff involved to be shared. 82 professionals attended, with the majority (74%) from the Health sector and other sectors including; Children's Social Care, the Enhanced and Preventative sector, Early Years, Police, District Councils and the Voluntary sector.

12.15 Of the 52% of evaluations forms returned 96% thought that the organisation of the event was 'excellent to good'. The afternoon event consisted of 4 speakers, with over 80% of participants rating speakers 'excellent to good'.

'NEGLECT: So much more than just a grubby child', - 11 February 2016

12.16 194 attendees attended the joint Cambridgeshire and Peterborough LSCB event (63% of Cambridgeshire delegates). There was good representation across all sectors and working groups, the majority of attendees represented practitioners predominately working with children, young people and their families (84%). 74% of participants returned evaluation forms. All presentations were well received with over 80 'excellent to good'. Eight workshops were facilitated and the Cultural Competence workshop and the Evidence Led Practice workshop were the most highly rated.

GP training

12.17 Three courses were facilitated with 177 attendees in total; this is a 72% increase on last year with the same number of courses facilitated.

E Learning

12.18 The LSCB commissioned an e learning platform on 'basic safeguarding', though few practitioners signed up or completed the training. The contract has not been renewed given the training was not reaching targeted groups, 'value for money' and therefore not impacting positively on safeguarding practice.

Serious Case Reviews and Child Death Overview Panel

12.19 To improve knowledge and safeguarding practice leaflets summarising the SCR cases have been published by the LSCB.

Single Agency Training – Validation

12.20 As part of Working Together 2015 the LSCB has a duty to make sure that single agencies provide safeguarding training to staff and facilitate training which is 'fit for purpose'. Part of that process entails members of the LSCB workforce group 'validating' the training. Figures of staff needing the training and being trained are being collected by partners, however, of those courses provided for validation, the LSCB have validated 5 courses, for this training year (similar to previous years). There are also a number of courses, which with the LSCB support, are being rewritten and resubmitted in order to meet the criteria of validation process and thereby improving outcomes for safeguarding children in terms of professionally trained staff.

Training Reviews

12.21 The number of training review forms completed continues to be low though delegates are now sent an electronic Smart Survey to complete, to encourage an increase in returns by making the completion of the training review quicker and simpler. Salient points which show how the learning has improved practice to safeguard children and families are listed below.

Practitioner Comments:

12.22 I have used the training notes given to feed into our supervisor training and also help in how we record incidents and concerns on our report forms

12.23 I am interacting more with the carers of the children with disabilities and letting them talk while I give my full attention

Managers Comments:

*12.24 Since attending the training **** has working with two cases where the children are self-harming. **** was able to identify the self-harming behaviours and offer strategies to both children and parents.*

*12.25 **** has discussed with me how we can use some of the course resources to support our parents especially those with learning difficulties. We will be looking at building a portfolio of information that all our colleagues can use.*

*12.26 This course has given **** the confidence to discuss Parental Mental Health and liaise with the multi-disciplinary team that looks after the child*

13. CHILD DEATH OVERVIEW PANEL

The process

13.1 The primary function of the Cambridgeshire and Peterborough Child Death Overview Panel (CDOP) is to review all child deaths in the area, which it does through two interrelated multi-agency processes; a paper based review of all deaths of children under the age of 18 years by the Child Death Overview Panel and a rapid response service, led jointly by health and police personnel, which looks in greater detail at the deaths of all children who die unexpectedly.

13.2 This is a statutory process, the requirements of which are set out in chapter 5 of *Working Together* (2015). The CDOP is chaired by the independent chair of the LSCB. The CDOP annual report can be found on the LSCB website. There are two versions of the annual report, one for professionals and one for general publication. This second version summarises some information in order to prevent individual children from being identified.

13.3 The information in this summary relates only to Cambridgeshire children.

Numbers of child deaths reported and reviewed

13.4 Over the last year, 29 children's deaths were reported in Cambridgeshire, which is one death less than last year and a similar number to previous years. Of those children who died, 62% were less than a year old, the majority of whom never left hospital.

13.5 Not all the children who died this year have been reviewed by the CDOP panel, which this year reviewed the deaths of 20 Cambridgeshire children (some of whom had died the previous year or even earlier). There is often a gap of several months between a death and that death being reviewed, whilst all relevant information is gathered.

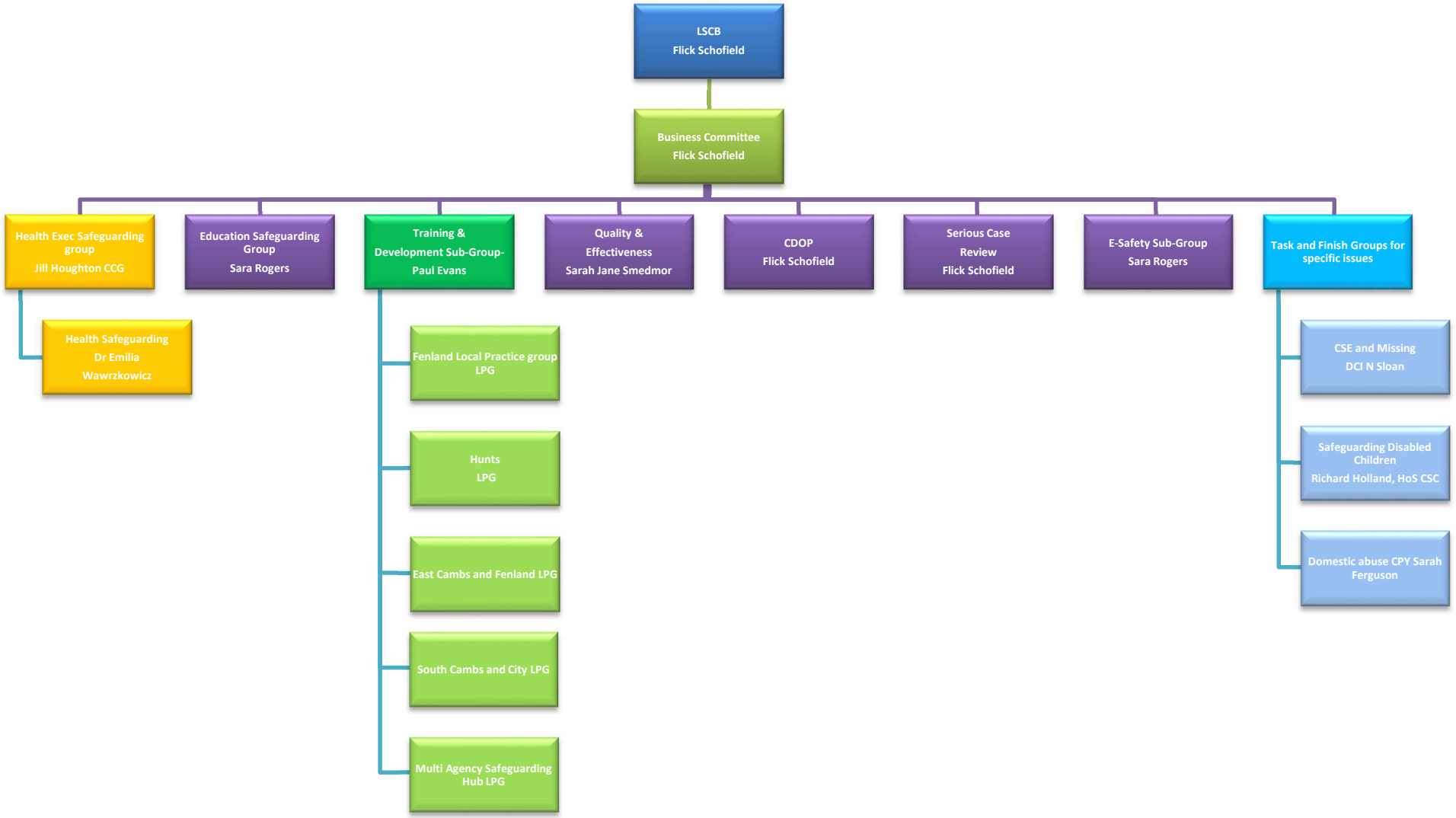
Modifiable factors & Safe Sleeping

13.6 It is the purpose of the child death overview panel to identify any 'modifiable' factors for each death, that is, any factor which, with hindsight, might have prevented that death and might prevent future deaths.

13.7 There were six cases in Cambridgeshire where a modifiable factor was identified. Whilst the modifiable factors for two deaths were linked to different medical interventions, the other four deaths were linked to unsafe sleeping arrangements. The excessive use of alcohol in the parents was identified as an additional factor in three of those four deaths.

13.8 The Safer Sleeping Campaign was launched in April 2014 with a programme of workshops across the County. It has been a success in terms of promoting awareness and the safeguarding messages to practitioners working with families about safer sleeping, combined with highlighting other impacting factors on infant death such as parental alcohol behaviours. The safe sleeping campaign was re-launched for 2015 and a further two workshops were held for early help workers, early years, locality teams and children's centres.

Appendix 1. LSCB MEETING STRUCTURE APRIL 2016



Appendix 2

2. LSCB STRATEGIC BUSINESS PLAN (2015-6) START DATE 1 APRIL 2015

End of Year Summary

This plan sets out the planned LSCB activity for 2015-6 and will be reviewed regularly at the LSCB and Business Committee. There are three task and finish groups for each of the first three themes which will take the lead on delivering the outcomes and understanding the impact of the work. Each group has its own more detailed plan. It is planned that these groups will complete their work by the end of 2015-6. This is a working draft and can be amended as agreed by the LSCB when reviewed. The RAG rating reflects the progress being made against actions, more details is provided in the embedded action plans from each task group leading on priorities.

RAG Rating

	Action Plan Completed
	a delay but the action is still planned
	no implementation plan in place

ACCRONYMS

CSE	Child Sexual Exploitation	GCP	Graded Care Profile (structured assessment for neglect)
CYP	Children and Young People	JSNA	Joint Strategic Needs Assessment
QEG	Quality and Effectiveness Group (LSCB audit committee)	HRB	Health Related Behaviours
CSP	Community Safety Partnership	DVRIM	Domestic Violence Risk Identification Matrix
SCR	Serious Case Review	TDWSG	Training and Development Workforce Strategic Group (LSCB Training committee)
OOC	Out of County (placement for a Looked After Child)	CCS	Cambridgeshire Community Services (NHS Trust)
ISEP	Independent Specialist Educational Placement.	EandP	Enhanced and Preventative – Council services for children
SEND	Special Educational Need and Disability	CSC	Children Social Care
MASE	Missing and Sexual Exploitation (victim protection and perpetrator prevention meeting)	CP	Child Protection
HMIC	Her Majesties Inspectorate of Constabulary	CFA	Children, Families and Adults – Council Department
CQC	Care Quality Commission	LPG	Local Practice Group – briefing for professionals
HMIP	Her Majesties Inspectorate of Probation	CIN	Child in Need
NWG	National Working Group for Sexual Exploitation		

LSCB Priority Theme One: Effective safeguarding response to Children Sexual Exploitation and Children who go Missing from Home and from Care						
Objective	**Action**	**By Whom**	**By When**	**Intended Impact**	**Progress and Measure**	**RAG**
Increase the capacity and coordination of agencies in Safeguarding children from CSE.	Implement CSE strategy and action plan	CSE Implementation group	March 2016. Strategy and action plan implemented and reviewed bi-monthly.	Co-ordinated multi-agency response	Through monitoring of CSE action plan and its impact measures • CSE coordinator in post Oct 15 • Strategy Reviewed Oct 15 • MASE meetings established • Multi-agency Intelligence process enhanced • Missing processes, specifically the proactive use of information to reduce risk, enhanced • Multi-Agency "health check" against Ofsted, HMIC, CQC and HMPI criteria currently in process completion by end of Feb • CSE featured as an explicit criterion in the Section 11 audit including structure/lead senior manager, policy and training. • Creation of CFA Missing and CSE Operational Group to review all high risk missing or those at risk of exploitation every month	
Create a workforce competent to respond to CSE	Continue to deliver and review CSE and missing training as per CSE strategy – ensuring that individual teams and agencies are training operational staff	CSE Implementation group/ Training and Dev sub groups.	March 2016 as per training strategy. April 2015 both LSCB's report to	Confident competent workforce	Through training evaluation • Single agency training programmes delivered in Health and other partner agencies • Core LSCB training delivered with positive evaluation	

			have provided training.		• LPG sessions on CSE and a) boys and b) disability delivered with positive evaluation • CSE incorporated into expectations for mainstream safeguarding training • NWG membership reactivated to ensure that current national themes are available to all partners in a timely manner	
Increase public awareness of CSE and enhance the ability of children to recognise and reduce the risk they face.	Ensure children and young people continue to be made aware of risk of CSE through publicity and awareness raising and partnership work	CSE Implementation group/ Business Unit/ Area partnerships QEG audit with young people views on CSE + practitioner survey.	March 2015 CSE leaflets available for young people and children. Resource pack provided to schools. Further productions of Chelsea's Choice arranged for autumn 2015	CYP avoid the risk Of CSE	Direct feedback from children and the public • Chelsea's choice delivery reviewed and to continue within Area Partnership/CSP • Tailored leaflets produced in a range of languages and made available on LSCB website • LSCB website reviewed to include a portal specifically for parent/carers	
Increase the ability of key professionals and members of the public to recognise and respond to risk of CSE	Ensure wider workforce (e.g. taxi drivers, district councils, housing, GP's, hotels and bus drivers) are aware of risk of CSE and missing through awareness raising and partnership work.	CSE implementation group / LSCB training & development manager.	September 2015	Improved awareness of CSE and vulnerability of children and young people	Direct feedback from the identified groups • Work to identify vulnerable locations undertaken and response initiated • Work to raise awareness with taxi drivers and include in their training and licencing processes undertaken • Included as an issue in core single agency training and LSCB training	

Provide relevant tools and structure for professionals working with CSE	Ensure referral process in place for child abuse and child sexual exploitation. Creation of multi-agency forums to discuss children at risk.	CSE implementation group. Operation Shade + multi-agency group to be set up (Business Manager)	New joint referral form implemented April 2015. Op shade ongoing 2015. November 2015	Effective tool to assess CSE risks and support referrals to multi-agencies.	Evidence of use • Police and CSC databases support the identification of CSE victims and perpetrators • Joint CSE management tool provided for staff and made available on LSCB website • Resources for specific agencies e.g. schools on LSCB website	
Provide evidence of good practice with CSE	Ensure children and young people are safeguarded.	CSE implementation group QEG	Audit of selected cases of multi-agencies by November 2015	Young people and children safeguarded in terms of CSE.	CSE recorded on case files, children and young people supported in a timely fashion accessing appropriate inter agency intervention. • Police and CSC databases support the identification of CSE victims and perpetrators • MASE and Missing processes reviewed and good practice identified and built on in future structure • Multi-agency audit completed March 2016.	
LSCB Priority Theme Two; The effective safeguarding of disabled Children at home and in care and educational						
Objective	**Action**	**By Whom**	**By When**	**Intended Impact**	**Measure**	**RAG**
Support the Action Plan through ensuring clarity as to scope of its remit	Develop definition of the cohort [– broader SEND] Focus on OOC and those in ISEP	Safeguarding Disabled Task and Finish group	Feb 2015 May 2015 to include sick children.	Effective multi-agency safeguarding response	Agreed definition on record	
Review and improve services to disabled children	Embed the learning from the multi-agency audit of safeguarding of disabled children and develop actions arising	QEG	November 2015	Improved understanding of safeguarding of disabled children	Review of impact from Audit Recommendations • Lead Professional strategy supported by LSCB and reporting process agreed to allow for monitoring and analysis of	

					evidence as to the effectiveness of the role in coordinating the need and safeguarding of children including disabled children.	
Monitor incidents of abuse by professionals	Ensure that disabled children are represented in LADO data	LADO/ SASU	Sept 2015	Understanding of the safeguarding risk to disabled children	Data to be reported regularly within LADO report to Board • Data now being collected and will appear in future LADO reports	
Establish quality of current practice in Safeguarding disabled children living away from home.	Challenge all agencies to safeguard disabled children that live away from home	LSCB specific monitoring report	September 2015	Effective multi-agency safeguarding response	Inclusion of data regarding the safeguarding of disabled/SEND children to be included within LAC Report to LSCB. • Included as a specific group in LAC report to the LSCB Jan 2016 covering a)type of placement b) voice of disabled children in their own planning and c) issues over communication and safeguarding	
Increased workforce competence to deliver high quality services	Develop and support multi-agency training for wider workforce re SEND children.	LSCB Training and Developmen t sub	September 2015	Confident competent safeguarding workforce	Attendance levels and evaluation of relevant training • Issue of link between SEND and CIN/CP plans was raised by LSCB • CCC and LSCB training reviewed to cover issues over SEND • Disabled children's safeguarding needs included in single and multi-agency training expectations • Neglect Conference covered the needs of Disabled children	
Establish a supportive policy	Review policy and procedure and	Safeguarding Disabled	June 2015	Effective multi-agency	From the report on what young people and their families tell us.	

and procedure working context for professionals, informed by the voice of service users	responses re safeguarding disabled children so that they are effective	Task and Finish group		safeguarding response	• Procedures and policies reviewed end 2015 • Further review to follow completion of consultation with children and families May 16 Report on the findings from the consultation delayed until May 2016.	
High quality of provision through professionals use of effective and consistent assessment framework	Review neglect guidance and LSCB training and GCP to include SEND cohort	Safeguarding Disabled Task and Finish group	November 2015 launch of Graded Care Profile – NSPCC/LSCB	Effective multi-agency safeguarding response	Use of GCP tool and measurement of impact. • "Cambridgeshire" GCP tool developed • To be launched Feb 2016 • Neglect Strategy to be adopted 2016/17 following Neglect Conference • GCP workshop at Neglect Conference A training programme is in place for the first half of 2016-17 to support roll-out of GCP. A Neglect Strategy is a priority for the LSCB 2016-17. On this basis this action for 2015-16 is closed.	
Policies, processes and practice informed by the service user perspective (parents)	Consultation with parents re their perspective on priorities for safeguarding. Parent representative on Disability Task and Finish group.	Safeguarding Disabled Task and Finish group/ Pinpoint	June 2015	Better informed LSCB strategy	Report on what young people and their families tell us. • March 16 is the end date for a major consultation exercise with a range of disabled children over their perception of safeguarding and own needs • Voiceability survey undertaken Report on the findings from the consultation with service users has been delayed until May 2016. A further consultation with the parents of service users will follow.	
Policies, processes and practice informed by the	Consult CYP around safety and safeguarding through survey and audit activity and	Safeguarding Disabled Task and Finish group	May 2015	Better informed LSCB strategy	Report on what young people and their families tell us. • Information for parents/carers provided	

service user perspective (children)	ensure the voice of the child and family is heard in service planning				• Consultation to follow outcome from consulting children • Parents represented on T and F Boar Report on the findings from the consultation with service users has been delayed until May 2016.	
LSCB Priority Theme Three: Prevention and Protection of children and young people to the risk of domestic abuse						
Objective	**Action**	**By Whom**	**By When**	**Intended Impact**	**Measure**	**RAG**
Improve agency capacity to monitor and evaluate the impact of services	Produce data about CYP and families to inform re child's journey and consistency of provision – agreed multi-agency as per JSNA	LSCB Domestic abuse and CYP task and finish group	June 2015	A dataset and map of resources to inform consistency of approach and of commissioning services for CYP at risk	Board approval of dataset • Additional police information now included • Focus in DV services is now on repeat incidence • Feedback from HRB survey on related issues analysed	
Increased effectiveness of services to safeguard children through coordination of agency planning and implementation	Ensure co-ordination interventions for CYP which support protection and recovery within family context (parallel interventions)	LSCB Domestic abuse and CYP task and finish group/ Domestic Implementation partnership	June 2015	Effective prevention, protection and recovery of children and young people	Feedback from CYP and their families on the impact of services. • Programmes developed, delivered and reviewed. However, evidence of impact was disappointing and programmes now discontinued • DV "Offer" and guidance agreed	
Voice of the service user informs policy and practice	Ensure learning from YP consultation is embedded in practice	LSCB Domestic abuse and CYP task and finish group/ Domestic Implementation partnership	Sept 2015	Effective prevention, protection and recovery of children and young people	Feedback from CYP and their families. • Report from consultation given to Board and used by T and F group	

Increase the competence and confidence of the workforce	Provide multi-agency training with DA partnership	Domestic Abuse partnership / LSCB training manager	Ongoing	Confident competent safeguarding workforce	Training numbers and feedback on impact • Multi-agency assessment tools and referral process agreed and on LSCB website • Major programme of training for use of DVRIM delivered	
Support good practice through the use of effective tools	Support development of evidence based tool kit (HfCF/ DViP)	LSCB Domestic abuse and CYP task and finish group/ EPS work	June 2016	Confident competent safeguarding workforce	Evidence from audits of the effective use of tools • Complicated Matters toolkit endorsed, made available on LSCB website and promoted • Supporting eLearning package promoted	
Voice of the service user informs policy and practice	Report and embed learning from Domestic Abuse consultation including considering the communication with CYP	LSCB Domestic abuse and CYP task and finish group	Report to DA T and F group on 29.04.15	Better informed LSCB / DAIB strategy	Feedback from CYP and their families. • Audit of agency communication to confirm compliance planned for May 16	
Voice of the service user informs policy and practice	Conduct focus groups with victims/ survivors re help for their children	LSCB Domestic abuse and CYP task and finish group	New approach required. Focus groups arranged July 2015	Better informed LSCB / DAIB strategy	Feedback from CYP and their families. • Changes in the governance of DV across Cambridgeshire and Peterborough, together with major resource reductions has made it necessary to delay consultation until its focus is clearer.	
LSCB Priority Theme Four: Ensure LSCB fulfils its statutory functions of co-ordination of safeguarding work and the evaluation of this work (Link to all subgroup work plans)						
Objective	**Action**	**By Whom**	**By When**	**Intended Impact**	**Measure**	**RAG**
Better co-ordination and effectiveness of	Embed Learning and Improvement	LSCB Business Committee/	March 2016	Well informed LSCB developing a	Evidence available in Annual Report • Principles of Learning and Improvement framework agreed at	

safeguarding system.	framework and audit programme	LSCB Business Manager/ QEG		learning culture	Business Committee after review of current processes • Supporting processes ready to be put in place prior to end Mar • TDWSG discussion about effective support for improvement and agreed process for ensuring messages become embedded • Training validation process reviewed to ensure all key themes included in training • SCR learning disseminated through leaflets, website, LPG sessions and training programme	
Improve LSCB capacity to monitor and evaluate the impact of services	Challenge agencies regarding data across strategic workstreams	Task and finish groups	To end work and complete plans March 2016	Clear annual work plan for each group	Evidence available in Annual Report that Action Plans have been reviewed and completed • Action plans in place and monitored • "Needs" dimension to dataset under development with public health • Use of HRB survey and other sources of data to compliment dataset • Joint dataset under development with Peterborough SCB	
Increase the impact of cultural competence on service delivery	Challenge agencies around cultural competent safeguarding practice	All subgroups and task and finish groups	To include in sub-group work plans	Each work plan will ensure that culturally competently safeguarding practice is in place	Evidence of relevant outcomes in Action Plans • Inclusion Project has included Cultural Competence training for front line staff • Cultural Competence for managers conferences to be held in March • Model for future delivery in place supported by Train the Trainers session • Innovations Project included consultation with service users over	

					experience of services and with staff over “blocks” to good practice	
Improve LSCB capacity to monitor and evaluate the impact of services	Ensure that the LSCB is assured through review of all monitoring reports, with a focus this year on the Impact of Savings	LSCB Business Manager	Ongoing	That the LSCB fulfils statutory obligation to monitor safeguarding work	Use of dataset to review and set priorities and challenge inadequate services in Board Minutes • Key strategic documents brought to Board for discussion by agencies • Increased use of single agency audits to reinforce evidence of agency practice • Section 11 audit followed up to request information on impact of action plans • Increased provision of evidence from Health in Report format	
Improve impact of learning from SCRs	Application to take part in next phase of ELA LSCB/ NSPCC/ ILCA Embedding the Learning pilot	Embedding the Learning group	March 2016	To embed the learning from SCR in the workforce – changing safeguarding practice	Feedback from the Overview Authors and professionals involved in Serious Case reviews • No further SCRs • Application not successful • Regional and national review of SCR practice will be used to inform future process • Participation in consultation for national review of SCR process	
Increase agency capacity to deliver effective safeguarding services.	Roll out the LSCB multi-agency Training programme	LSCB T and D group/ LSCB training manager	Ongoing – subject to regular review	Confident competent safeguarding workforce	Training numbers and feedback on impact • Training delivered in line with plan despite absence of Training Manager • LPGs have increased attendance 2015-16	
Increase agency capacity to deliver effective safeguarding services.	Review the LSCB training on neglect and risk as per the LSCB SCR recommendation from EB	LSCB T and D group/ LSCB training manager	September 2015	Confident competent safeguarding workforce	Training numbers and feedback on impact • GCP to be rolled out through the LSCB across Cambridgeshire. (Delay caused by absence of Training Manager but now in hand)	

					• Training to support GCP to be in training offer for CCC, CCS and LSCB	
Voice of the service user informs policy and practice	The LSCB will support a planned consultation by the CSC Participation service with the cohort of YP subject	LSCB training and development manager / CSC Participation manager	March 2016 (12 month project)	Improved understanding of experience of children and young people subject to a CP plan	Feedback from CYP and their families. • Participation group now in place and developing its effectiveness • Communication in place with consultation lead in E and P • Participation Group lead reported to the LSCB on key learning and a further Report is scheduled	
Increase agency capacity to deliver effective safeguarding services.	Norfolk, Cambridgeshire and Peterborough LSCB's working together on Innovation bid.	Provide project worker to research and summarise existing local learning and development Multi-agency training. Practice standards development	Start April 2015 – 2016	To improve safeguarding arrangements for the children and families of Eastern European migrant backgrounds within the Wisbech area.	Effective safeguarding for children and young people of Eastern European migrant backgrounds measured through positive outcomes. To be audited six months following the project completion. • Project Plan on track. Final Report being completed	

Appendix 3. BUSINESS PLAN 2016-18

BACKGROUND INFORMATION

Purpose of the Plan

The Business Plan is the way that the Board records how it views its current context and the key areas of work that it should concentrate on during the forthcoming year or years. These areas reflect local needs and national priorities. It is supported by information from partner agencies and the wider Cambridgeshire community. To ensure transparency and accountability to the wider community the Plan is published, and in due course so is a closing report on its implementation and impact.

Its Priorities are:

1. **Ensure effective safeguarding of children against Neglect.**
2. **Child Sexual Exploitation & Missing**
3. **The Voice of the Child**
4. **Enhancement of LSCB effectiveness in discharging its responsibilities**
5. **Developing and Supporting an Effective Workforce**

Having decided on the key areas to be covered, the plan summarises what needs doing, who will make sure it happens and by when. During the life of the plan it is regularly reviewed to ensure that what needs to be done is being done. The final review of the Plan is published as part of the LSCB Annual Report.

The Government has published its proposals for the future of multi-agency coordination and oversight for child safeguarding. LSCBs are likely to change significantly and may cease to exist in some areas. Instead there will be more scope for alternative local arrangements tailored to meet local need. The timescale for these changes is likely to be between one and two years. To prevent any loss of momentum in working on the Board's agreed priorities, this Plan has been designed to be delivered over an eighteen month period. Inevitably the current Plan includes work that prepares for a transition into any new arrangement that is put into place.

Board Objectives*

(a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
(b) to ensure the effectiveness of what is done by each such person or body for those purposes.

Board Functions*

1(a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

(i) The action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;

(ii) Training of persons who work with children or in services affecting the safety and welfare of children;

(iii) Recruitment and supervision of persons who work with children;

(iv) Investigation of allegations concerning persons who work with children;

(v) Safety and welfare of children who are privately fostered;

(vi) Cooperation with neighbouring children's services authorities and their Board partners;

(b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

(c) Monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;

(d) Participating in the planning of services for children in the area of the authority; and

(e) Undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

*Working Together 2015

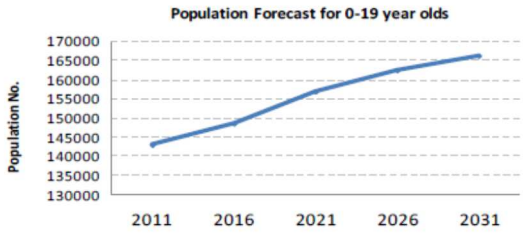
WHAT DID THE BOARD USE WHEN SETTING OBJECTIVES?

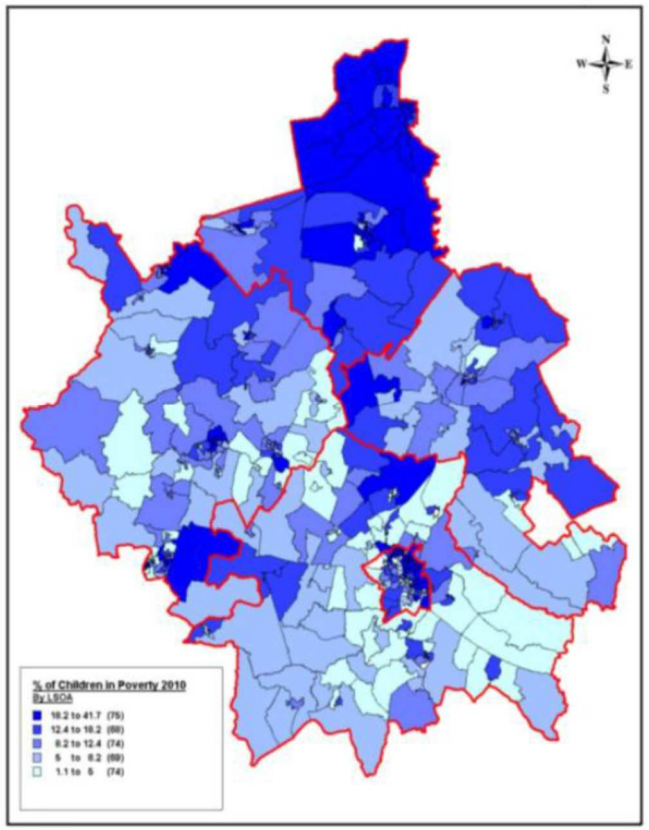
2011 census returns show 621,200 people living in Cambridgeshire, 144,785 (23%) of whom are under 20 years of age. The population of the county grew by 68,500 (12%) in the 10 years since the last census in 2001, rising from 552,700. This was the largest growth in the population in any county council authority in England. The number of children and young people increased by 9,700 to 144,785; a 7% rise compared with a 3% rise nationally.

Looking ahead, current and planned housing developments in Cambridgeshire are expected to create a further major influx of young families. By 2031 the number of children and young people is forecast to grow 16.8% compared to 2011. This equates to an increase of 23,900 more 0-19 year olds over 20 years.

The population growth between now and 2031 will not be spread evenly across the county. The largest increases are expected in Cambridge (39.8%) and South Cambridgeshire (24.1%) whereas in Huntingdonshire we are anticipating a decrease.

The percentage of children in poverty here is lower than the national average of 21.6%. But 13.3% of children are living in poverty in Cambridgeshire - 16455 children. There are pockets of concentrated deprivation including in the Wisbech Waterlees ward where 38.7% of all children are living in poverty.





Distribution of Child Poverty

1. Ensure effective safeguarding of children against Neglect.

LSCB Function

1(a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

(i) the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;

(d) participating in the planning of services for children in the area of the authority

Neglect is the category of abuse identified in about 70% of Child Protection (CP) Plans. It is known to have a major impact on children, but enabling families to make and maintain the long term changes needed to reduce neglect is a significant challenge for practitioners and services. Neglect is associated with a number of issues facing families, including poverty, parental mental illness, domestic abuse and substance abuse. As such tackling neglect crosses the boundaries between adult and child focussed services.

Objective	Accountability	Success Criteria	Progress
To reduce the impact of neglect on children by coordinating and enhancing services.	LSCB Board	A coordinated approach across services to maximise impact. The Board to have in place a Neglect Strategy in a joint approach with the Peterborough SCB **Sept 2016.**	
	Business Committee	Demonstrate the successful Implementation of the Neglect Strategy by: Providing evidence within the LSCB dataset of change in the prevalence and impact of neglect in the wider community. **Nov and July Boards**	

		b) Providing evidence within the Dataset and CP six monthly and annual Reports about change in the prevalence of Neglect as a CP criteria **July and Nov Boards**	
	Business Committee	Staff are equipped to make informed, consistent assessments of families where neglect is an issue. The Graded Care Profile (GCP) in practice by a) providing a Cambridgeshire model assessment tool b) Issuing Guidance on its use c) training staff in its use and d) providing evidence of use in practice through a survey of trained staff a) July 16 b) Sept 16 c) Mar 17 d) Apr 17	

2. Child Sexual Exploitation & Missing

LSCB Function

(b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

(c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;

(d) participating in the planning of services for children in the area of the authority

There is a major national focus on ensuring that children who are vulnerable to exploitation are Safeguarded.

Objective	Accountability	Success Criteria	Progress
Develop an model of staged intervention or "Offer" for the victims and potential victims of CSE	CSE Task and finishing Group	Adoption of the Model by the Board by Sept 16 Model on Website, publicised by Newsletter and incorporated into Training by Nov 16 Survey of staff as to familiarity with and usefulness of the model Jan 17	
Ensure the risk and vulnerability of children Missing from Care, Home and Education has been effectively managed	CSE Task and Finishing Group	That evidence is provided to the Board in Reports as to a) levels of referral into Operational Group and MASE b) the outcomes for children identified as Missing, vulnerable to exploitation and at Risk. Nov and July Meetings	
Safeguard children from the risk of exploitation by Gangs.	Business Committee	That by Oct 2016 the Business Committee is able to show that children are Safeguarded: a) That Guidance is in place and accessible b) B) that the level of gang activity has been measured c) That a proportionate response to coordinate services is in place	
Safeguard children from the risk of exploitation by extremism and radicalisation.	LSCB Board	That the Board is assured appropriate and proportionate arrangements are in place by Jan 2017	

3. The Voice of the Child Relevant to all LSCB Functions			
Objective	Accountability	Success Criteria	Progress
Ensure that examples of good practice in consulting children and service users, including evidence of impact on service design and provision, are available to the Board.	LSCB Board	Two reports to be collated by the LSCB Business Unit that summarise the submissions of good practice from Agencies to the Jan and July Boards and are included in the LSCB Annual report. All LSCB Committees to include demonstrating their use of the Voice of the Child in Business Plans or provide the Board with the evidence as to why this is not appropriate.	
Improve the experience of case conferences for children & the parents/carers	LSCB Board	Provide practical and strategic support to the Participation Project and enable it's continuation in line with learning from the current pilot. A plan for support of the Project to be discussed at the Sept 16 Board. When agreed the Business Unit and Project will be responsible for delivering the Plan and reporting on progress to the July 2017 Board.	

4. Enhancement of LSCB effectiveness in discharging its responsibilities

Relevant to all Functions including 1a (vi) cooperation with neighbouring children's services authorities and their Board partners;

Objective	Accountability	Success Criteria	Progress
Improve effective coordination with strategic partnerships in Cambridgeshire.	Chair of LSCB and Business Unit	Review Communication Strategy. To enable Partnership Chairs to meet with the intention to agree a protocol for coordination across Partnerships and a high level plan covering Cambridgeshire priorities and accountability. LSCB SAB HWB CJC By March 2016	
Maximise opportunity to increase efficiency and effectiveness through closer working with Peterborough SCB	Unit Business Manager/Head of Service	To hold joint Cambridgeshire and Peterborough Committee meetings twice a year to coordinate activity of shared need and identify areas of difference that require local management. This will include, but not be limited to: QEG • Dataset • Joint Multi Agency Audits • Section 11 Audit	

	Staff Development and Training Managers	• Sharing of learning from audits and monitoring Workforce development • Joint Training courses • Shared Training materials • Staff access to training across the Local Authority/LSCB area boundaries • Joint validation process • Joint development of new courses and commissioning CSE • Overarching Strategy CSE strategy • CSE Training and awareness raising materials • Operational activities as relevant To review potential for joint training with SAB Units in Peterborough and Cambridgeshire by April 17 • DoLs, • Safeguarding children for services to adults • Children and adults open to sexual, gang and extremist exploitation,	

	Business Manager/Head of Service Business Manager/Head of Service	• NICE Guidance on transition to adult services within Health and Social Care. To support the implementation of the NICE Guidance on Transition from Child to Adult Services in Health and Social Care Services To request information on the effectiveness of the implementation from the Health Safeguarding Executive and Local Authority is provided to the Boards by Mar 17 To provide both Board with a joint Report on lessons learnt about efficient and effective joint working, Nov 16	
Complete review of Learning and Improvement processes and recording	Business Unit Business Unit and agencies holding data.	By November 2016 to demonstrate an administrative process that supports and records effective learning being used to improve practice and provides transparency around the implementation of actions, recommendations and initiatives identified as required to enhance safeguarding. Performance Information made available through a "Dashboard" for Board by Sept. 2016	

Enhance the capacity of the Voluntary Sector to safeguard children	LSCB Business Unit J Hansen, Cambs City Council	Engage and consult with key providers to increase awareness of safeguarding in July 2016. With key providers and representatives in the sector, to identify priority actions for 16/17 to enhance the capacity of the sector to be self-sufficient in supporting good safeguarding practice, including recruitment, training and policy. To draft and provide a Plan for the implementation of these actions to the LSCB for approval in Sept 2016. To Report on progress to the Board and demonstrate increased capacity and resilience within the voluntary sector in Cambridgeshire, July 2017	

5. Developing and Supporting an Effective Workforce

Function 1a (ii) training of persons who work with children or in services affecting the safety and welfare of children;

(b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

Objective	Accountability	Success Criteria	Progress
Adequate resources and capacity to deliver or commission training;	LSCB	Training delivered within budget and to plan	
Policies, procedures and practice guidelines to inform and support training delivery in line with the	TDWSG	Agencies to provide evidence of compliance with Validation process by March 2017	

Learning and Implementation Framework		Monitor individual agency delivery of training in line with LSCB policy and Standards by March 17	
Identification and periodic review of local training needs, taking into account research, national developments, learning from SCRs and child death reviews(not only those carried out locally), followed by decisions about priorities;	TDWSG	Deliver required training programmes and communicate mandatory content for training programmes identified by the LSCB Learning process. Undertake an annual brief overview of multi and single agency training needs for the medium to long term. Support required content with resources on web-site	

Appendix 4. LSCB DATASET 2015-16.

This dataset is part of the Learning and Improvement Framework. Quantitative data is one of a range of measures of understanding the safeguarding system. These indicators focus on what we are concerned about as stated in the priorities. It is not complete in that there are some pieces of information which are not available at the current time.

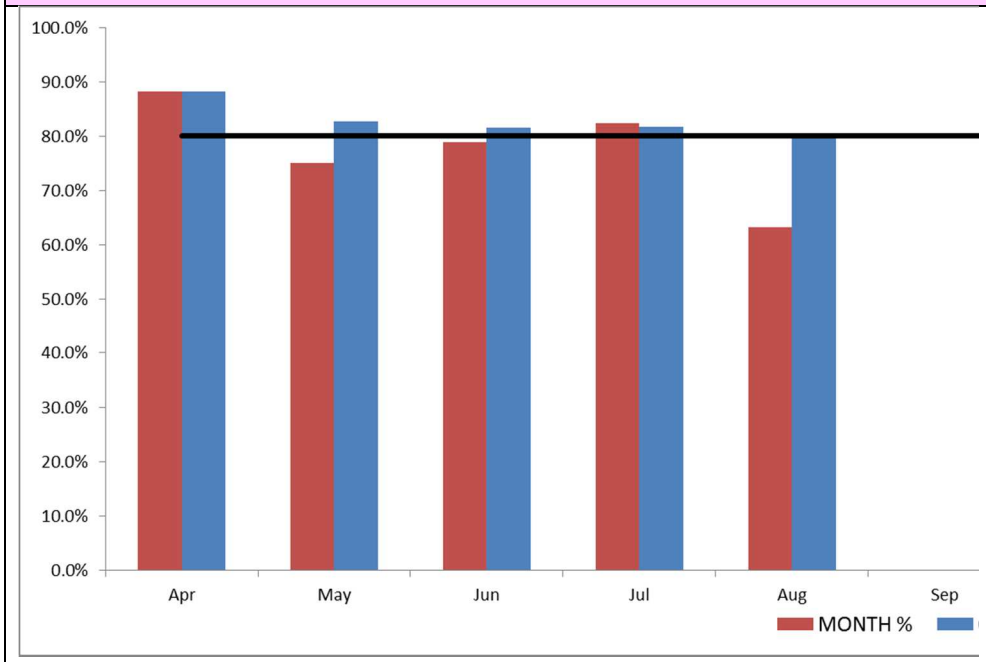
Key Points

- Workload has increased in the CP processes with increased levels of contact and open cases.
- The recorded number of children reported as missing to the police has increased
- There have been changes in reporting mechanisms that have made some comparisons over time difficult. Early Help data has been temporarily unavailable for the last six months of the year whilst new indicators have been developed that are relevant as measures of effectiveness in current practice. The rationale has been to improve the significance of the data and increase the meaningfulness of the exercise.
- We anticipate providing a re-designed dataset next year including:

1. Data on broad indicators of abuse within geographical areas
2. More detailed Early Help data
3. Information on the use of police cells for children
4. Information on outcomes for looked after children, including those placed out of county.

- Improved agency compliance with safeguarding standards following the Section 11 Audit can be demonstrated.

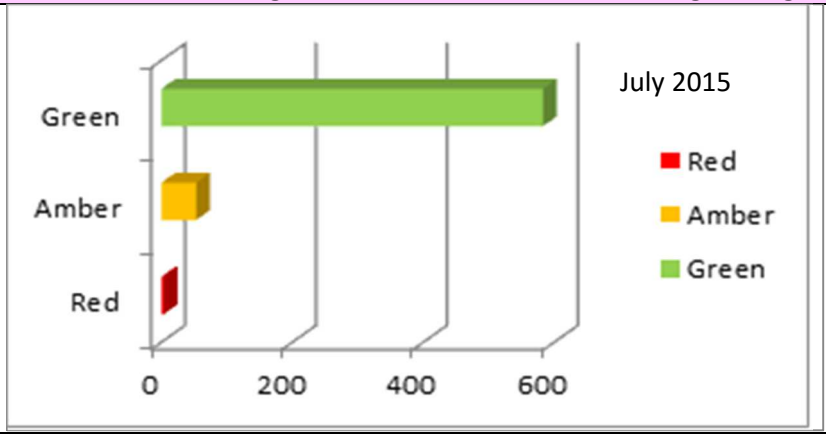
EARLY HELP
How do we know that the early intervention and safeguarding offered to children and families make a difference?
% CAF which achieve the intended outcomes

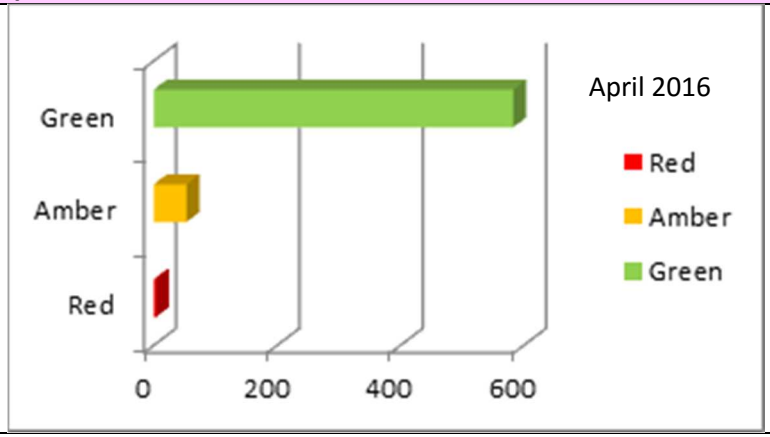


Data on CAFs achieving outcomes has not been made available for the period from September onwards. There has been a major initiative to review the CAF data and improve its relevance as an assessment of effective practice. New indices for effectiveness in Early Help will be available for 2016-17.

Commentary:
Over the last six months Together for Families and Enhanced and Preventative services have consulted with the Board on the meaningful measurement of effectiveness in Early Help. There has been concern that this current measure is not the most reliable basis for a judgment available and as such this data is no longer available. A new set of outcome focused measures is anticipated for 2016-17.

ORGANISATIONAL CAPACITY TO SAFEGUARD: The Findings from the Section 11 Audit 2015.
How do we know that agencies are able to meet their safeguarding responsibilities?





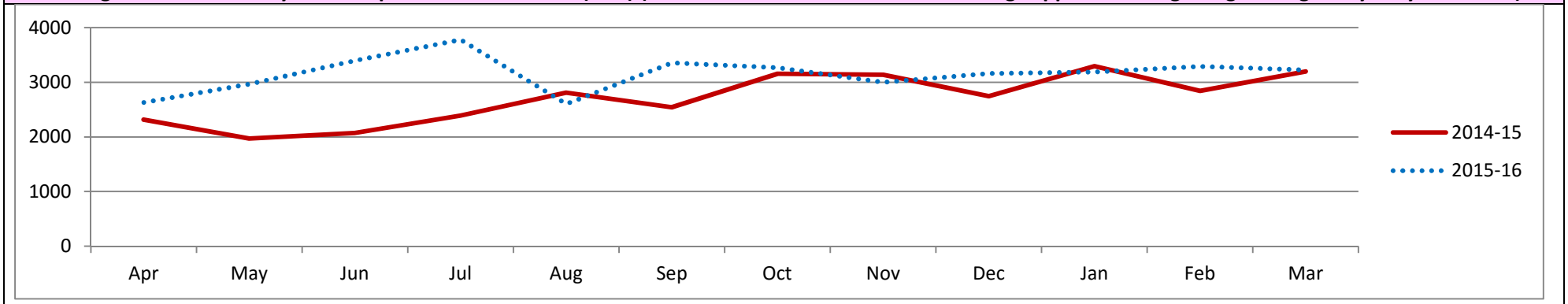
	Jul-15		Apr-16	
	Number	%	Number	%
Red (Not Met)	10	2%	4	0.6%
Amber (Partially Met)	63	10%	53	8%
Green (Fully Met)	569	86%	583	88%
None	17	3%	19	3%
Total	659		659	

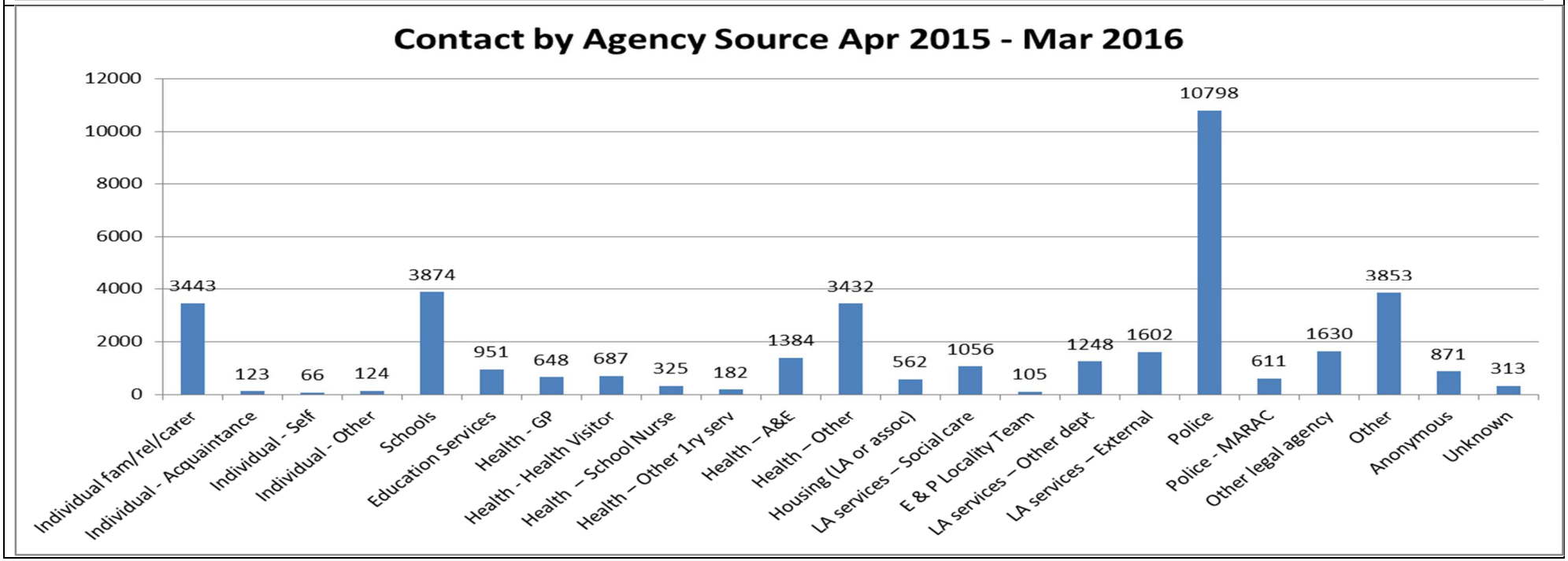
Current Section 11 returns after action plan reports are included.

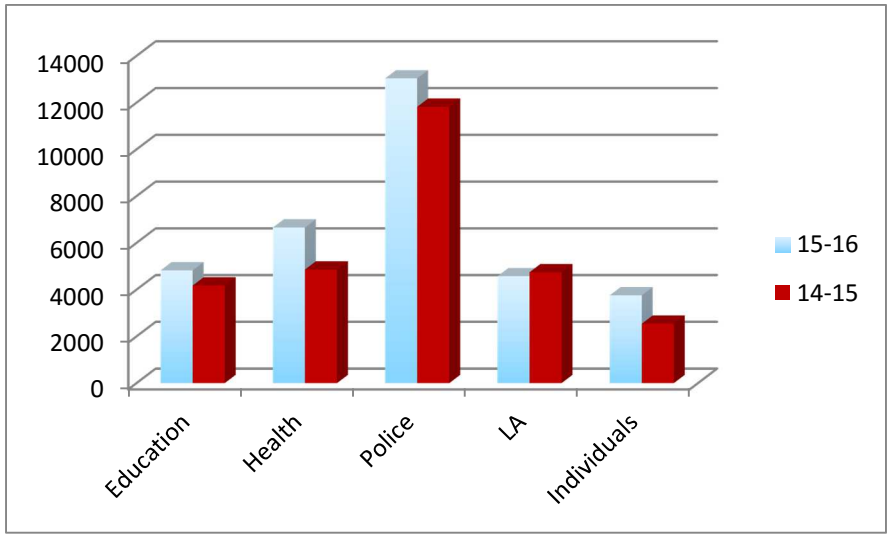
Commentary: Of the remaining "Reds", two relate to issues not readily addressed on an individual county level and apply wider than Cambridgeshire. One relates to an agency that has not reported on progress to date and the other where further re-organisation has delayed implementation. Follow up action is being undertaken on these and "ambers".

DEMAND ON THE CHILD PROTECTION PROCESSES

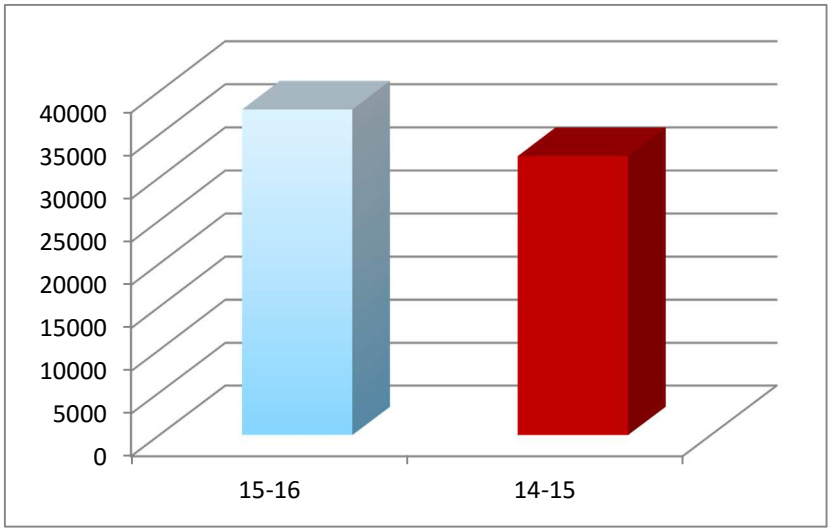
Percentage of all contacts by source April 2015 – Mar 2016 (N10) (How do we know if what we are doing supports making safeguarding everybody business?)







Total contacts by agency groupings 2015-16 compared with 2014-15.



Total Contacts received 2015-16 and 2014-15

Comment: Overall contacts have risen from 32477 in 2014-15 to 37888 in 2015-16. This represents an increase of 17%. Whilst not out of line with the national trend, it does represent a significant challenge for the Child Protection processes to absorb this level of increase. Contacts have increased from Education, Health agencies, the Police, and most noticeably from individual members of the community. The only area where there has been a reduction in referral is from other Local Authorities.

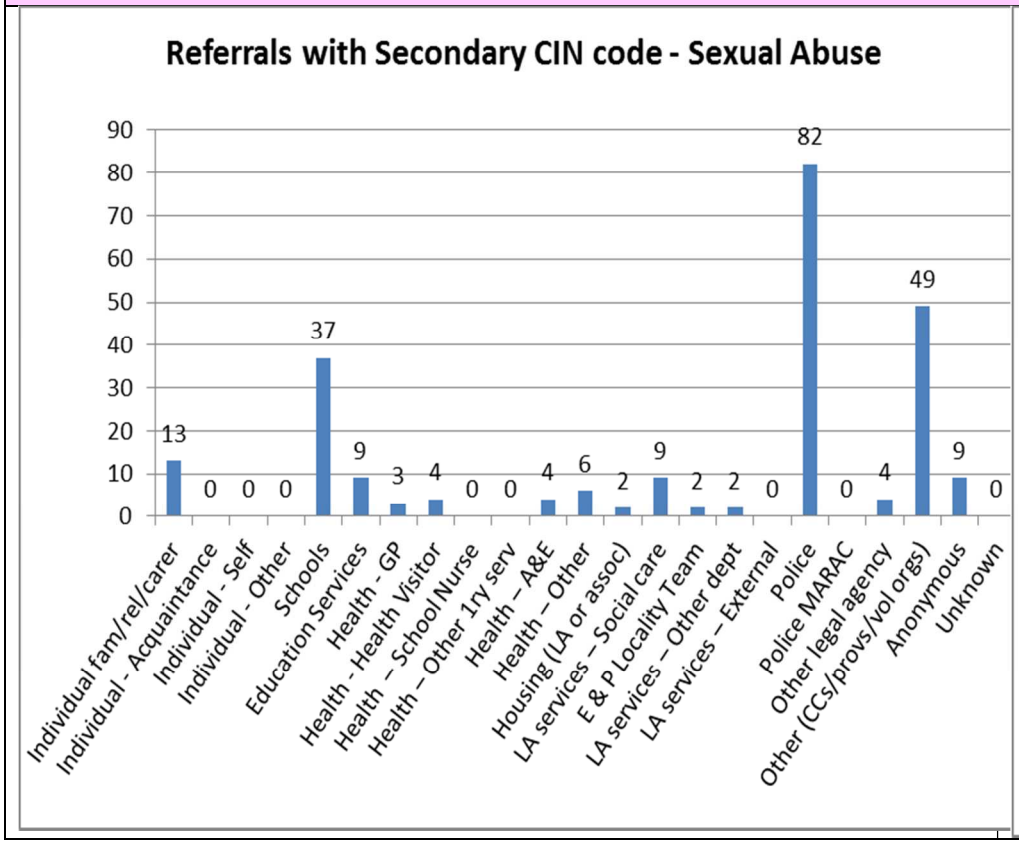
Children's Social Care (CSC), have shown that whilst the First Response and Emergency Duty Team (FREDt) and Contact Centre have been dealing with a higher level of contacts to the service, their triage process that directs contacts to the most appropriate service for the child has referred on to CSC a relatively stable number of cases. However, the risk and complexity of the work coming to CSC is increasing, and this is leading to higher demand on requests for Conference, court proceedings and the accommodation of children and young people.

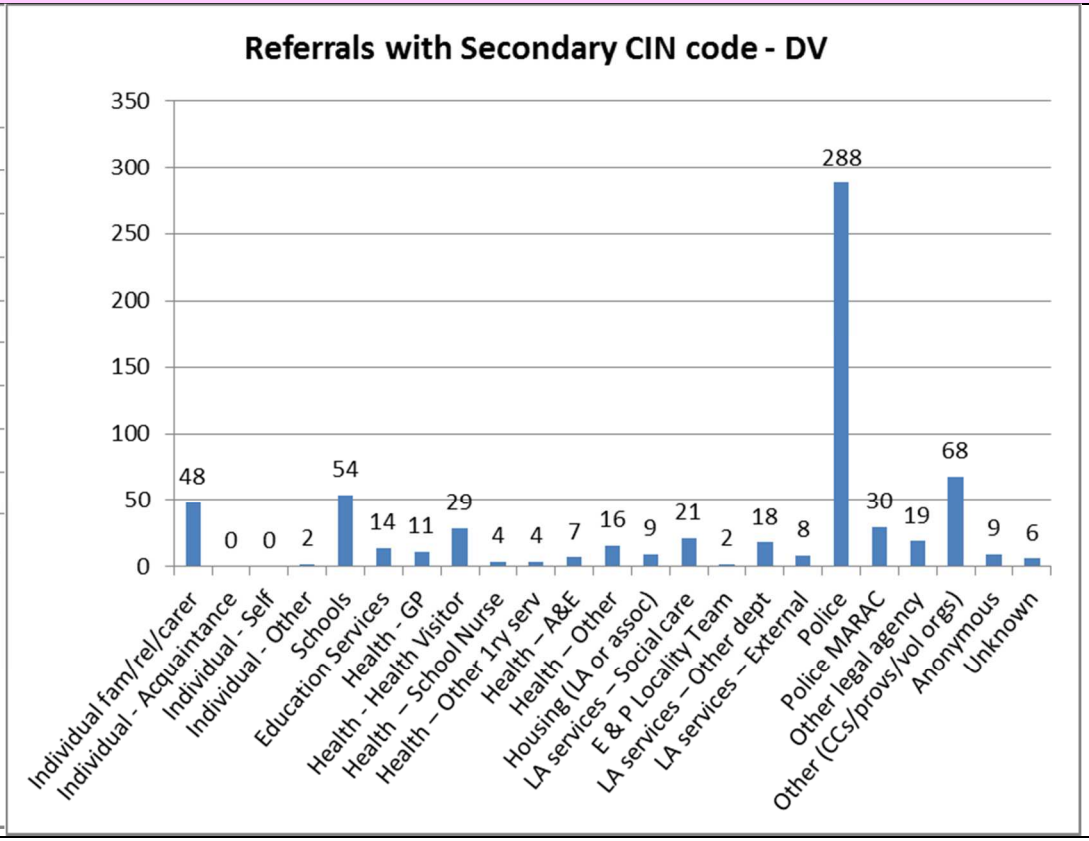
LSCB PRIORITY AREAS

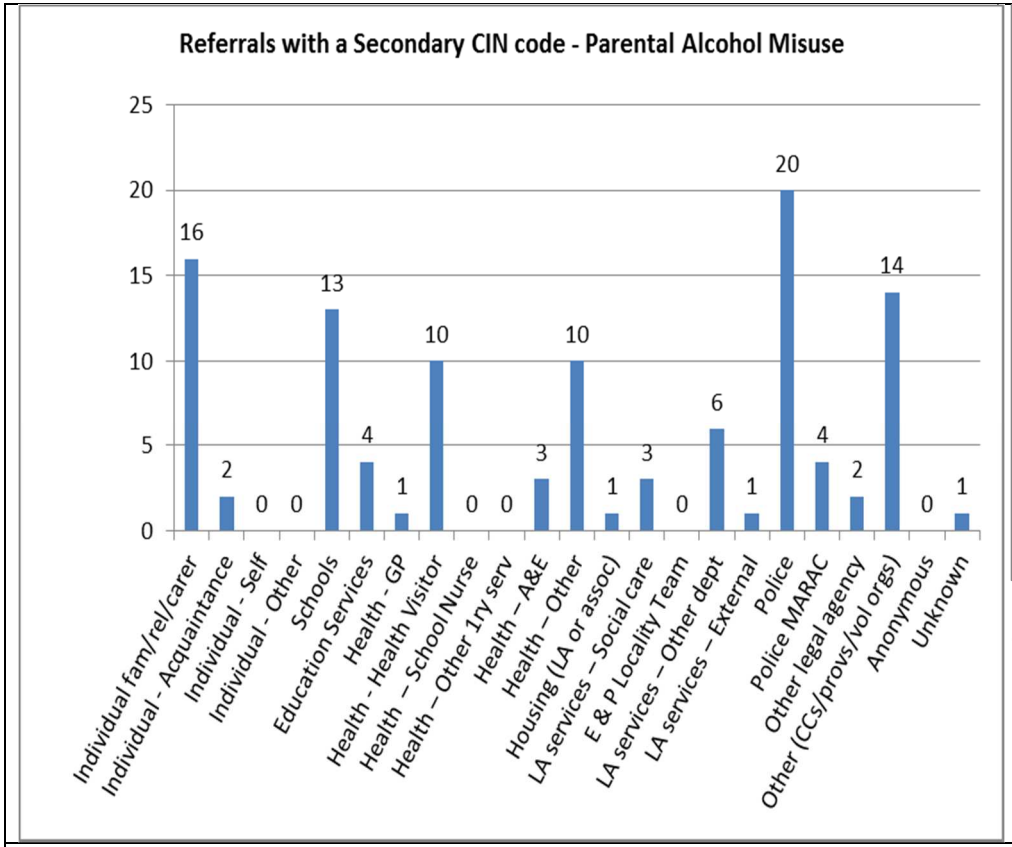
Priority One: Sexual Abuse; Parental Alcohol Misuse; Domestic Abuse; CSE and Missing April 2015 – March 2016 inclusive

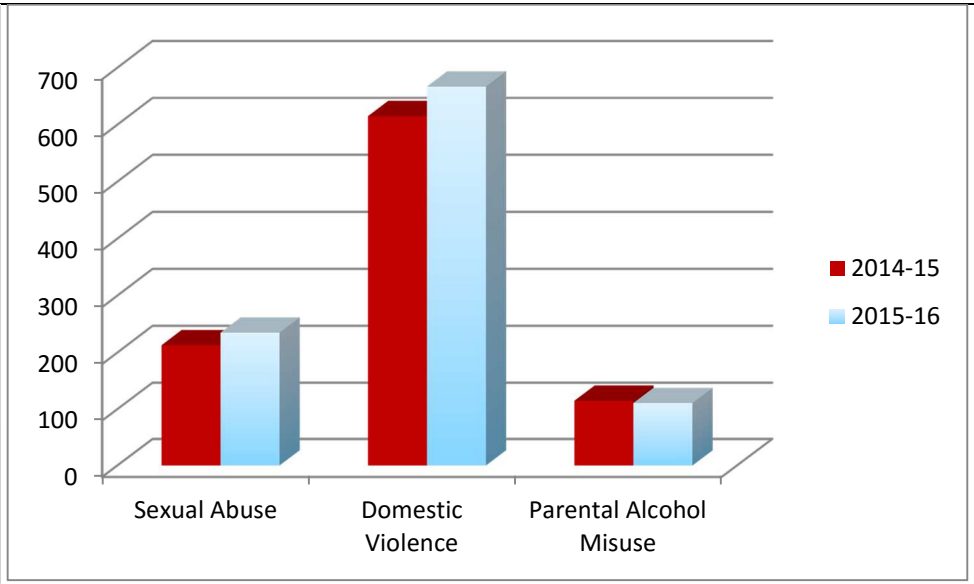
How do we know that our responses to specific safeguarding concerns make a difference to children and young people?

Reporting of concerns is the first stage of an effective response – knowing that agencies are referring concerns is important.









Change in use of secondary CIN codes 2014-5 to 2015-6

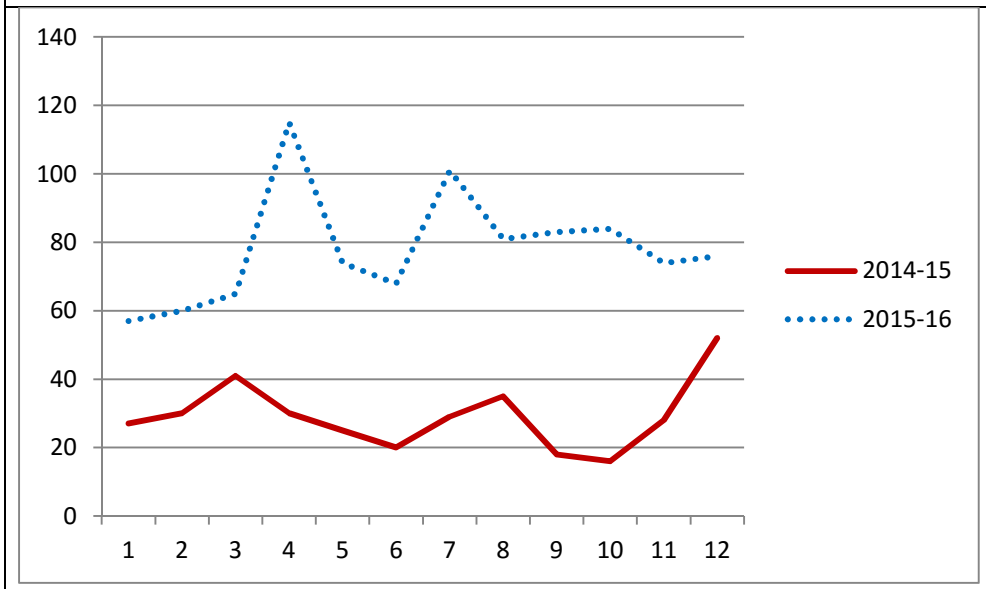
Comment: In 2015-16 there were 4168 referrals to Children Social Care, down from 4168 in 2014-15. A referral can have several secondary CIN codes and it is not possible to identify how many cases had one or more of these codes identified. However, it can be said that 16% of all referrals had domestic abuse present as a factor.

VULNERABLE GROUPS OF CHILDREN

1. Disabled children

	Disability Team	Total	Disability Team as a %
Referrals	193	4168	4.6
Re-referrals	19	753	2.5
Open	416	3048	13.6

As with the six monthly figures, there was a higher proportion of open cases within the disability team compared to the total caseload. This may in part be explained by the fact that the definition of which children goes to a disability Team includes the long term nature of the disability.

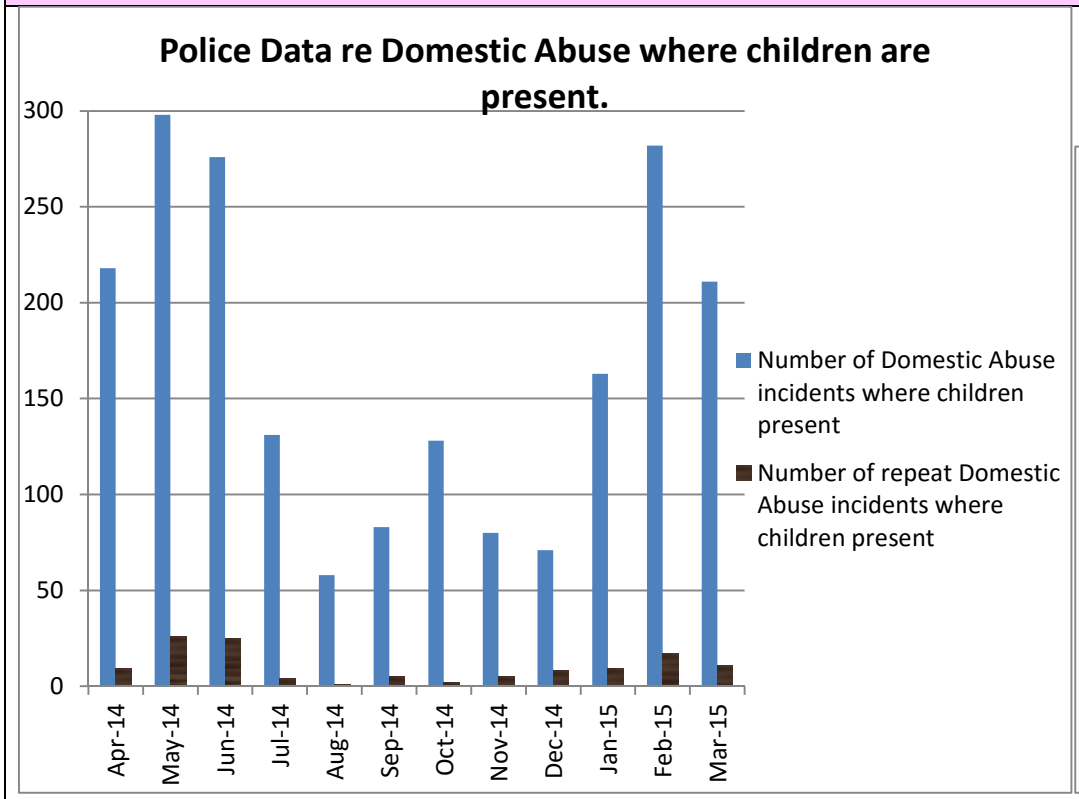


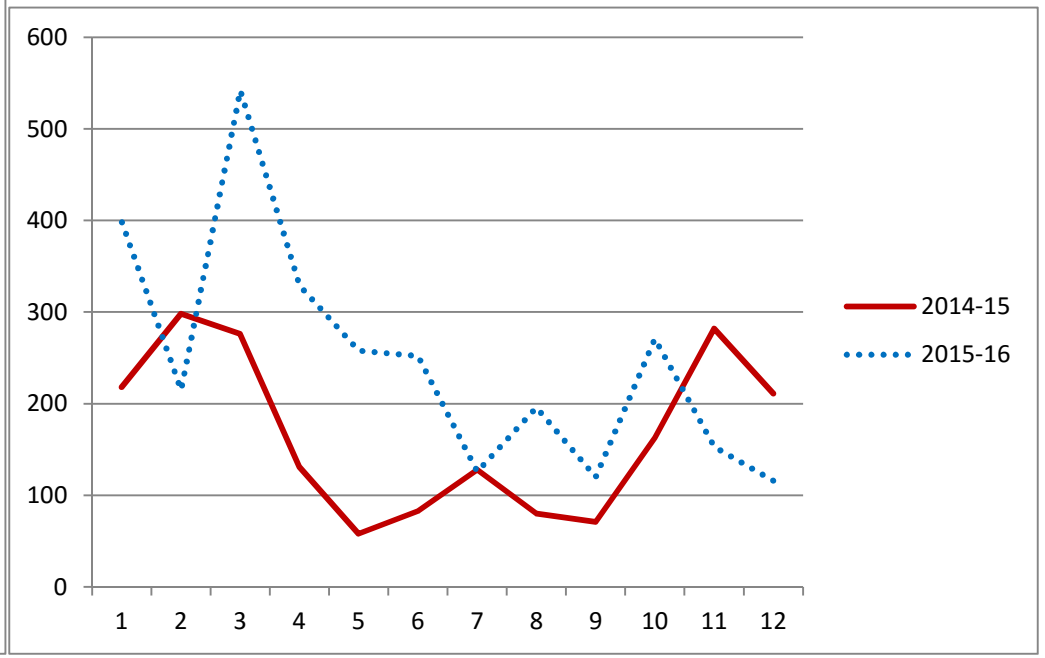
Police: Number of missing person reports for under 18s

2. **Number of missing person reports for under 18s**

The figures clearly show an increase year on year that seems to have started in March and February 2015. This has been a time of focus on Missing Children. There was a change in the police use of Missing and Absent categories and it is possible that these figures have been influenced by changes in definition and approach as much as the overall numbers of children involved

Domestic abuse
Police data regarding Domestic abuse incidents



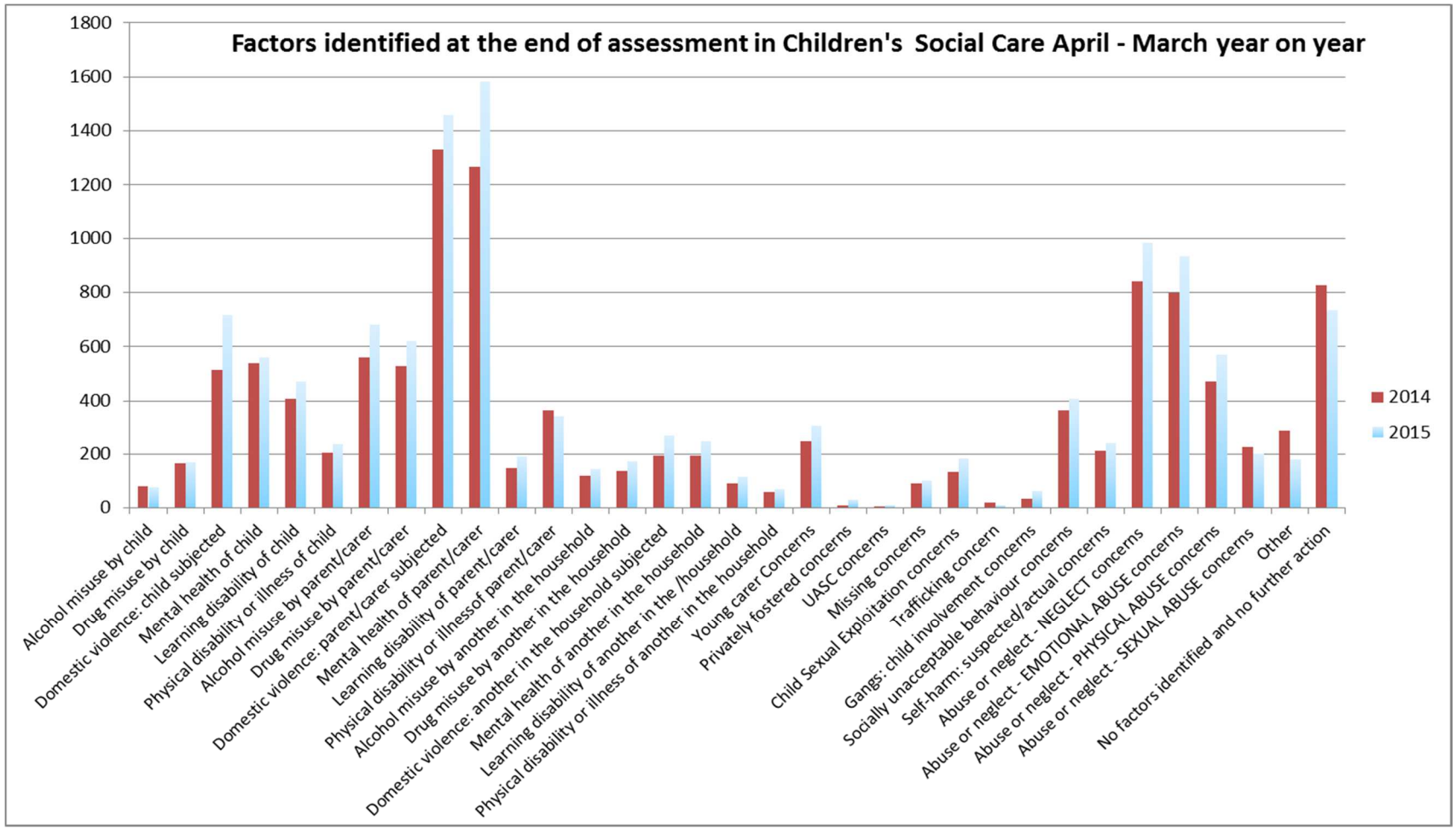


Number of Domestic Abuse incidents where children present

The numbers above are the numbers of children present at domestic incidents. The fluctuation in numbers of incidents is of interest, but these figures may have been strongly affected by police campaigns. Overall however there has been a significant increase in numbers over the past year.

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Number of missing person reports for under 18s												
Cambridgeshire	57	60	65	115	74	68	101	81	83	84	74	76
Number of Violent or Sexual Offences against under 18s												
Cambridgeshire	155	133	176	136	105	161	206	194	125	128	124	126
per 10,000 CYP population	*12.1*	*10.4*	*13.8*	*10.7*	*8.2*	*12.6*	*16.1*	*15.2*	*9.8*	*10.0*	*9.7*	*9.9*
CP CATS Referrals (Constabulary)												
Child Concern	514	1,099	1,059	1,117	720	853	664	799	513	713	620	547
FGM attempt or risk	0	0	0	0	0	1	1	1	0	2	0	0
Child Abuse Outcomes *												
Cambridgeshire												
Prosecution Possible	10	12	11	16	12	23	6	16	13	17	15	5
Prosecution Prevented	1	0	1	4	-1	1	5	1	1	2	3	0
Prosecution Not In Public Interest	0	0	3	4	0	1	0	0	3	1	0	1
Prosecution Not Possible	34	23	33	43	21	29	40	41	37	21	40	29
Domestic Abuse Outcomes *												
Cambridgeshire												
Prosecution Possible	81	84	102	109	85	107	83	137	103	119	128	105
Prosecution Prevented	2	6	3	3	1	2	4	1	7	0	6	5
Prosecution Not In Public Interest	3	2	9	3	1	2	6	1	0	1	2	1
Prosecution Not Possible	136	132	129	173	146	148	126	137	137	161	133	161
Domestic Abuse incidents (Constabulary)												
Number of Domestic Abuse incidents where children present	398	215	542	329	258	252	126	196	120	271	153	116
Number of repeat Domestic Abuse incidents where children present	23	25	52	19	19	15	7	12	1	16	8	11
MARAC data												
Cambridgeshire Central												
Number of cases discussed	27	28	27	51	38	43	30	24	31	18	5	
Number of repeat cases	11	8	6	13	9	14	10	11	11	7	4	
Number of children in household	43	50	35	64	47	62	28	27	41	29	11	
Number of referrals from police	22	17	22	41	37	41	27	21	27	16	4	
Number of referrals from other agencies	5	2	5	10	1	3	3	3	4	2	1	
Cambridgeshire Southern												
Number of cases discussed	24	42	30	59	34	34	29	30	42	27	4	
Number of repeat cases	7	17	12	20	12	11	7	11	13	11	2	
Number of children in household	30	42	32	92	39	46	47	32	48	38	7	
Number of referrals from police	23	37	29	55	29	31	26	30	38	24	3	
Number of referrals from other agencies	1	5	1	4	5	3	3	0	4	3	1	

WHAT ISSUES ARE PRESENT IN THE CASES
Factors identified at the end of single assessment (April - March) showing 2014 & 2015



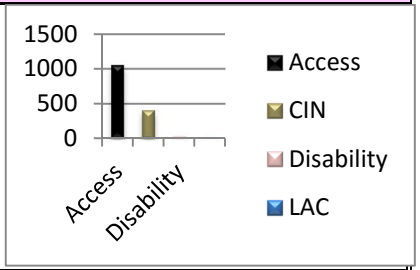
Commentary: The only reduction in numbers is the “No factors identified” column and “other”, both of which lead to a more complete picture of the factors identified. There has been attention given to accurate reporting of these factors within Children Social Care over the year.

IMPACT

How do we know that our responses to specific safeguarding concerns make a difference to children and young people?

NUMBER OF S47 ENQUIRIES

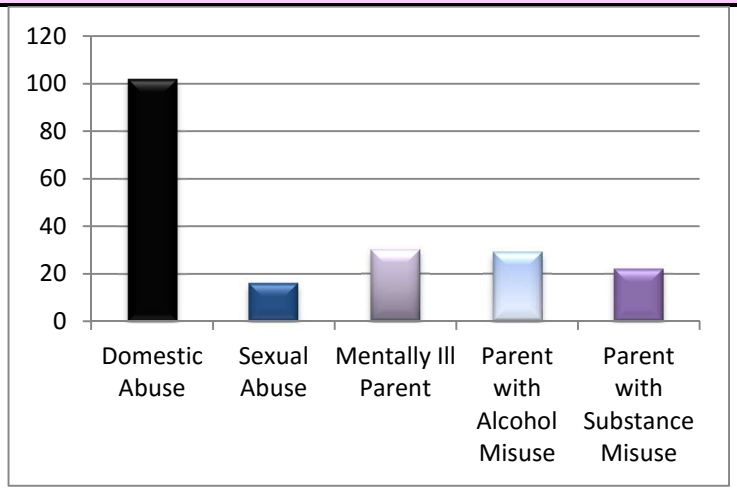
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTAL
Access	101	93	65	88	44	70	79	121	114	84	80	116	**1055**
CIN	18	40	27	25	32	40	42	26	62	24	28	40	**404**
Disability	0	0	0	0	0	4	5	3	2	0	0	12	**26**
LAC	0	0	1	0	0	0	0	3	6	0	1	0	**11**
Total	**119**	**133**	**93**	**113**	**76**	**114**	**126**	**153**	**184**	**108**	**109**	**168**	**1496**
2014	**197**	**155**	**155**	**143**	**103**	**127**	**119**	**124**	**149**	**114**	**90**	**106**	**1582**



As at the six month stage, this information was not available last year so comparison cannot be made. Variation in the number of cases going into Access looks to reflect school holiday patterns.

CP Categories and secondary CIN codes showing: Domestic Violence; Sexual Abuse; Mental Ill Parents; and Parents with Alcohol Misuse or Substance Misuse

Category	All Cases	All Cases 2015	Secondary CIN code showing				
			Domestic Abuse	Sexual Abuse	Mentally Ill Parent	Parent with Alcohol Misuse	Parent with Substance Misuse
Emotional	113	118	43	2	7	5	2
Neglect	289	233	49	8	19	23	20
Physical	21	20	10	0	4	1	0
Sexual	16	16	0	6	0	0	0
Total	**439**	**387**	**102**	**16**	**30**	**29**	**22**
2014	**387**		**92**	**8**	**16**	**21**	**14**



The most remarkable figure is the increase in Neglect cases. This confirms its importance as a priority area for the next Business Planning cycle. Sexual abuse had appeared to be reducing in presence but this has now reversed in the secondary CIN codes.

CHILD PROTECTION CONFERENCES

Levels of attendance. Snapshot from January 2016

	Number of invited attendances	Invited and did attend	Invited and did attend %	Invited but did not attend %
Child	11	3	27.3%	72.7%
Father (no PR)	3	1	33.3%	66.7%
Father (PR)	126	77	61.1%	42.1%
Mother	162	143	88.3%	11.7%
Oth Fam (no PR)	44	33	75.0%	52.3%

Family Member attendance

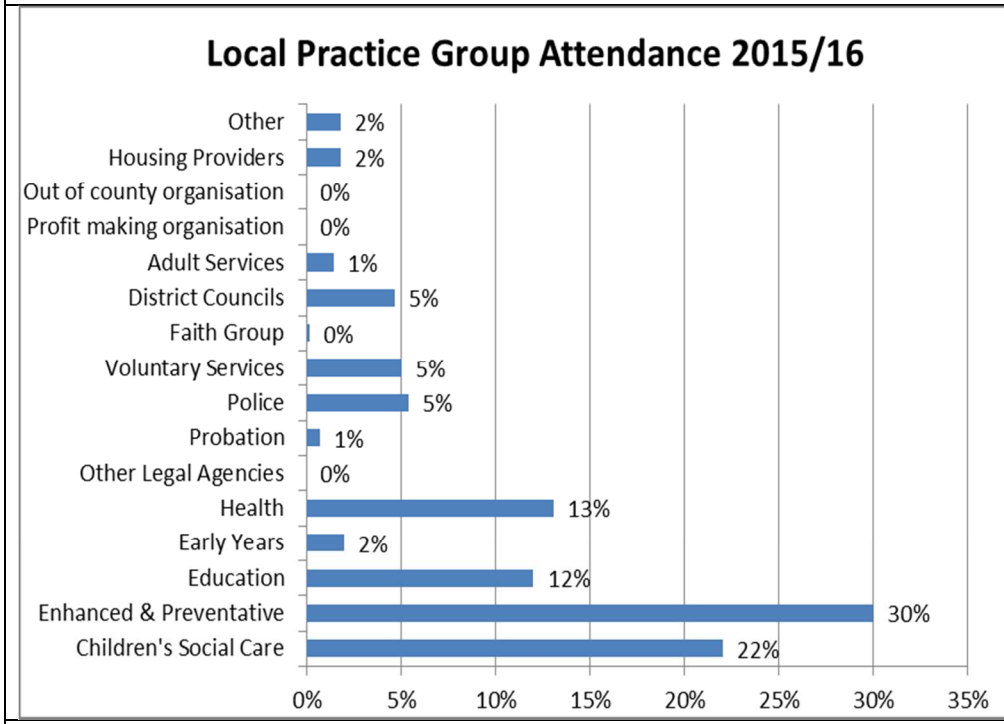
Number of invited attendances	Invited and did attend	Number of reports received	Attendance %	Report %
948	492	486	52	51

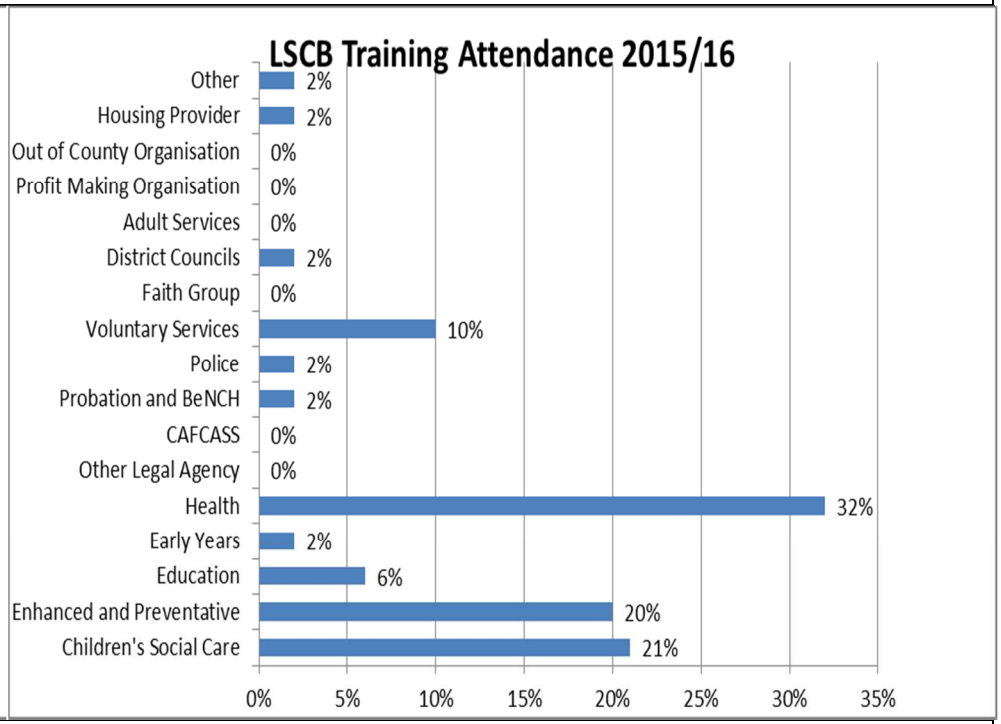
Professionals' attendance and report submission.
(These figures do not include invites for Advocates whose attendance is in line with that of the child they are working with.)

Comment: It is has proven difficult to extract attendance and report writing data from the record. In order to ensure accuracy a "snapshot" was taken for one month with the Conference Chairs actively seeking and confirming the accuracy of the information. Given the levels of attendance this has been the subject of a focused effort to improve compliance through the Business Committee and QEG.

LSCB activity data

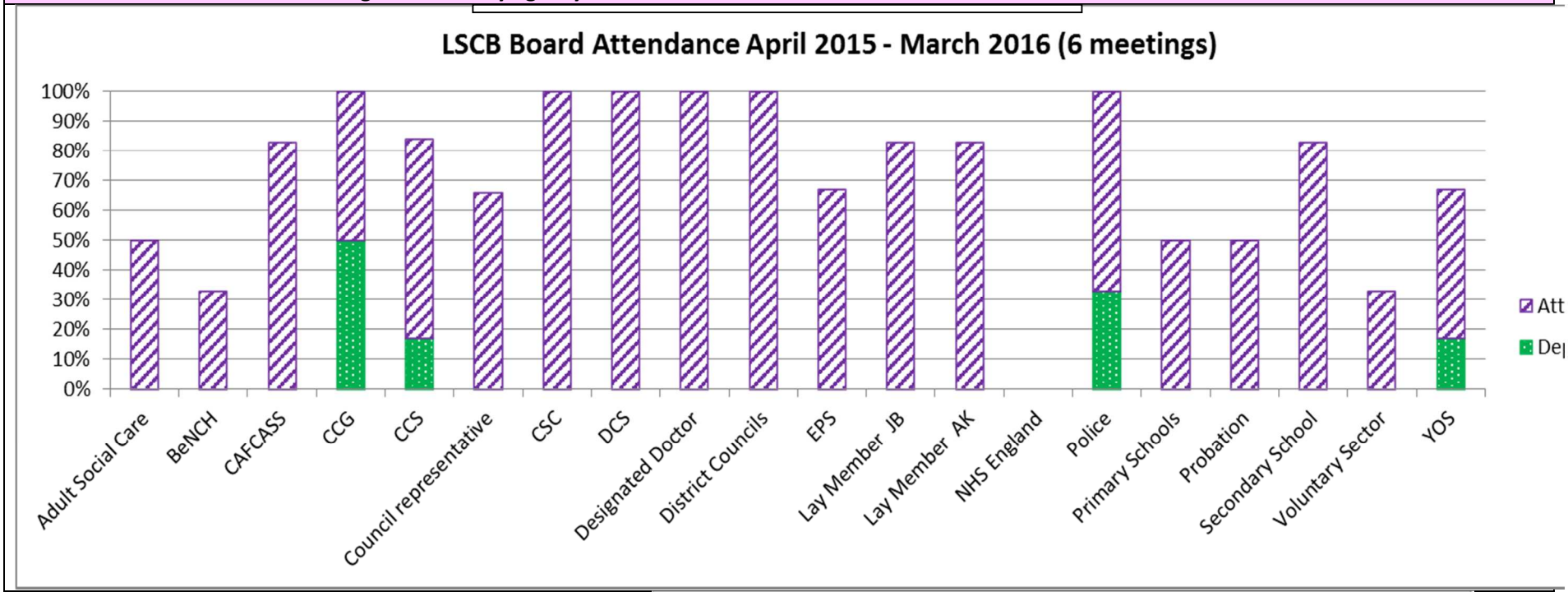
Number and %Attendance at LSCB training / LPG data by agency – this is reported on to the Training and Development subcommittee in full and then to the Business Committee. Non-attendance is also monitored as there are sometimes 'serial' non-attendees on courses that could be attended by someone else





This data is commented on more fully in Training Reports. However, there has been a positive trend in increased attendance over the past year.

LSCB Effectiveness: % LSCB meetings attended by agency



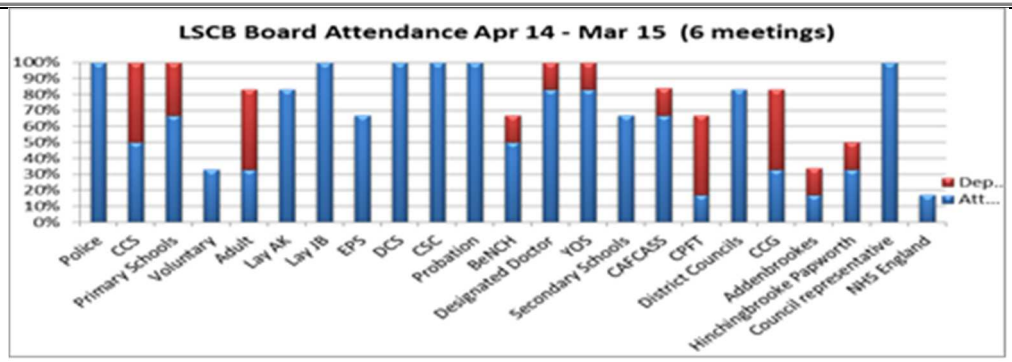
Commentary:

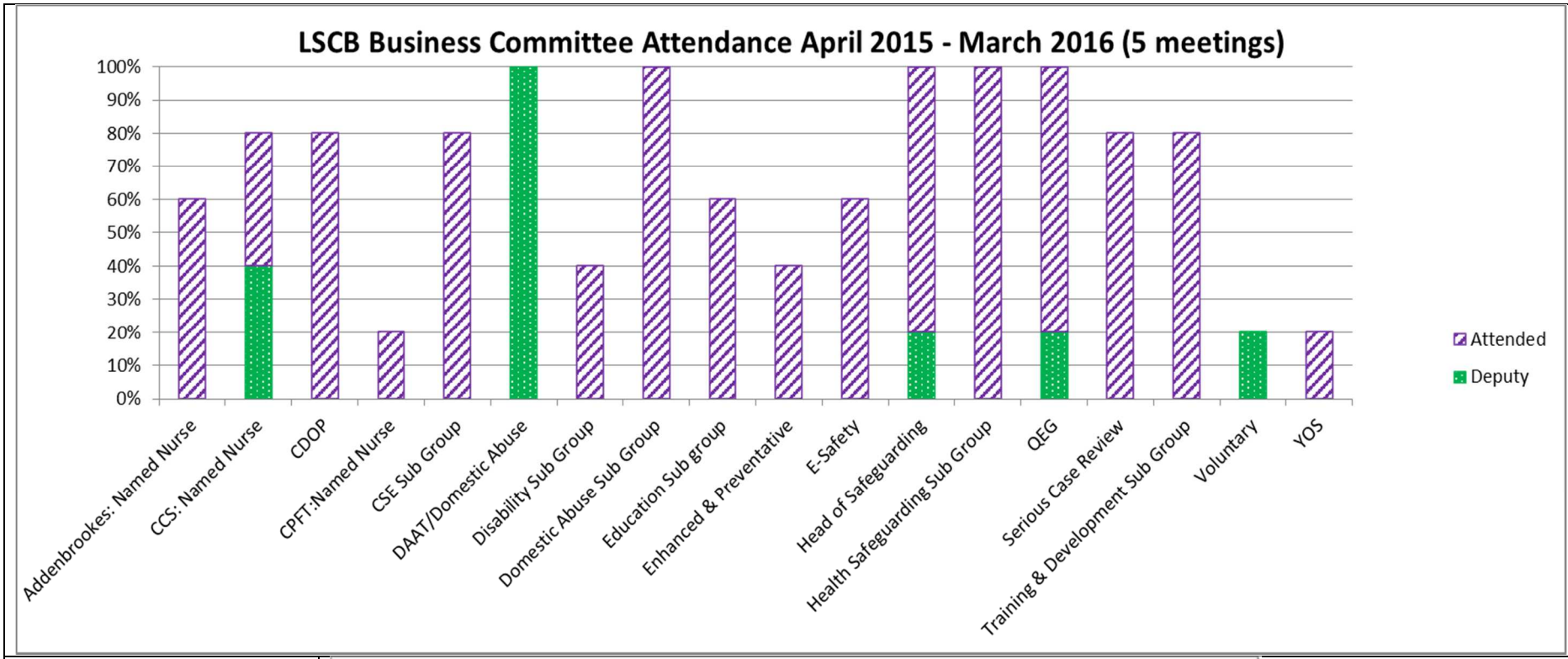
An EPS attendance is always covered as the Executive Director, CFS, has overall accountability.

NHS England have said that they will not be attending LSCB Board Meetings, and their absence is noticed when issues where they have a significant role are discussed.

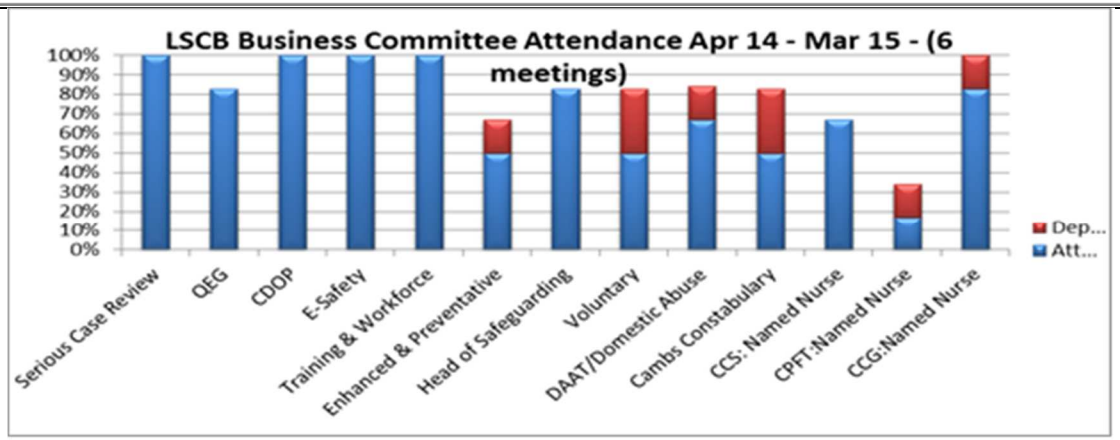
A new representative from the Voluntary Sector has joined the Board.

Were an attendance has not been consistently good this has been challenged by the Chair.





Comment. Following a review of membership, the comparison graphic has attendees in a different order to the previous year.



CDOP
The number of preventable deaths is not statistically significant – every year there are a number of deaths of infants due to unsafe sleeping arrangements. Last year the LSCB launched a safer sleeping campaign to ensure that the message that is given by all professionals is consistent and as far reaching as possible

Number of Deaths reviewed by CDOP where there were modifiable factors	
2011-12	5
2012-13	5
2013-14	6
2014-15	5
2015-16	6

Appendix 5: SOURCES OF INFORMATION ON SAFEGUARDING IN CAMBRIDGESHIRE

Title	Type of Information	Range and scope of the Information
Annual Dataset from LSCB	Data and Statistical Information	A range of relevant safeguarding processes
Agency attendance and Reports at CP conference	Multi-Agency Audit	CP Processes
CCS (NHS Health Community Services) Summary of Audits	Single Agency Audit	Agency or sector specific
Child Abuse Problem profile	Data and Statistical Information	CP Processes
Child Death Overview Panel	Report	CDOP
Children and Young People Survey: Disability 2015	Commissioned Survey of users	Voice of the Child
Children and Young People Survey: Disability 2016	Commissioned Survey of users	Voice of the Child
Children and Young People Survey: Domestic Abuse	Commissioned Survey of users	Voice of the Child
Children held in Cells	Report	Issue Specific
Safeguarding Children in Complex Circumstances Audit	Multi-Agency Audit	Issue Specific
Core Group Audit	Multi-Agency Audit	Issue Specific
CSC CP Annual Report and CP Quarterly Reports	Data and Statistical Information	CP Processes
CQC inspection report & action plan	Report	Agency or sector specific
Disability Audit	Multi-Agency Audit	Issue Specific
Education Annual Child Protection Monitoring Report	Single Agency Audit	Agency or sector specific
Elective Home Education	Report	Issue Specific
Enhanced and Protective Service Summary of Audits	Single Agency Audit	Agency or sector specific
Feedback on parent's perspectives on CP conferences	Report	Issue Specific
Health Executive Safeguarding Board Annual Report and quarterly updates	Data and Statistical Information	Agency or sector specific
Health Related Behaviour Survey	Data and Statistical Information	Voice of the Child
HMIC Inspection of Cambs Constabulary	Report	Agency or sector specific

Innovation Bid Project Dataset and report	Data and Statistical Information	CP Processes
LADO Annual Report	Report	Issue Specific
Missing Children: Care, Home and Education	Report	Issue Specific
Missing in education and home education	Report	Issue Specific
Cambridgeshire Police Summary of Audits	Single Agency Audit	Agency or sector specific
Private Fostering Report	Report	Issue Specific
Referral audit	Single Agency Audit	CP Processes
Report on Safeguarding of LAC placed outside Cambridgeshire	Report	Issue Specific
Safeguarding and Primary Care GP Sec 11 Audit	Single Agency Audit	Agency or sector specific
Section 11 audit 2015	Multi-Agency Audit	Agency or sector specific
The Participation Service Report	Report	Voice of the Child
Young Carers	Report	Issue Specific

Appendix 6 FINANCIAL STATEMENT 2015-16

Income:

Income	Contributions from partner agencies	Training	From Reserves	Total
2015-16	248,269	7,125	15,000	270,394

Up to 2016-17, Contributions from agencies have remained broadly static since the previous agreement to reduce funding by a standard percentage across all contributors. However, the budgets set and actual expenditure have reduced over time. The budget set in 2012-13 was £286,848. The budget set for 2015-16 (excluding the separately funded CSE post) was £244,418, a reduction of £42,430.

Expenditure:
Currently there is money held separately to fund the CSE Coordinator post for two years. The appropriate proportion of the money is brought into the LSCB budget each year to cover the cost involved. In 2015-16 Dave Sargent was in post for six months and £15,000 was transferred into the main budget. The cost of this post appears in the figures given below.

2015-16 Budget in £s	**Actual to End March 2016**	**Budget Remaining**
LSCB Unit Costs		
118,878.00	112,532.19	6,345.81
Chair Expenses		
42,500.00	38,248.48	4,251.52
Training		
75,891.00	68,334.08*	7,556.92
Serious Case Review Costs		
22,149.00	3,340.84	18,808.16
Total for the whole budget		
259,418.00	222,455.59	36,962.41

*income from training is accounted for in this sum

- The Chair expenses and SCR cost underspends exist because there was no SCR commissioned in 2015-16. The demand on these budgets is cyclical and underspends are carried forward to fund future demand, which could very significantly exceed £22,000 in any given year.
- The training underspend reflects the income level, which is variable and not predictable.
- No Business Manager was in post for three months in this financial year. This will have saved significantly more from the budget than the £6,345.81 total underspend. There were some additional costs to cover other staff absence, but less than the savings accrued from the vacancy.

Budget 2016-17

The budget for the current financial year has been set in line with that for 2015-16. However, contributions by one partner agency have reduced significantly and it will need to be reviewed. We have been informed by another statutory funder that they intend to make a reduction in their contribution in future years as they anticipate savings will be realised from closer working with the Peterborough SCB and Cambridgeshire Safeguarding Adults Board.

Appendix 7 GLOSSARY OF ACRONYMS AND TERMS USED

Acronym/Initials Used	Name	Description
CAMH	Child and Adolescent Mental Health	Secondary services covering child mental health
CCC	Cambridgeshire County Council	
CCG	Clinical Commissioning Group	Responsible for organising the provision of health services in the area
CDOP	Child Death Overview Panel	To identify the avoidable causes of child death and reduce or prevent future deaths
CJB	Criminal Justice Board	Strategic Board of agencies involved in the Criminal Justice System
CP	Child Protection	The formal multi-agency process for safeguarding children at immediate risk of serious harm
CPFT	Cambridgeshire and Peterborough Foundation Trust	Local provider of CAMH
CQC	Care Quality Commission	Health Inspectorate and regulatory body
CSC	Children's Social Care	CCC Division working with CP cases
CSE	Child Sexual Exploitation	Child sexual exploitation (CSE) is a type of sexual abuse in which children are sexually exploited for money, power or status
DOLs	Deprivation of Liberty	The legal context that authorises controlling restrictions being placed on children and adults
GCP	Graded Care Profile	An assessment tool for Neglect
GP	General practitioner	
HWB	Health and Wellbeing Board	Statutory partnership responsible for integrating Health and Social Care provision
LPG	Local Practice Group	Open meetings for all staff involved in working with children to improve practice and communicate learning.
LSCB	Local Safeguarding Children Board	Statutory partnership responsible for monitoring and supporting effective safeguarding of children
MASE	Multi-Agency Sexual Exploitation	A meeting to coordinate the protection of individual children at risk from CSE
NICE	National Institute for Health and Care Excellence	National Health body responsible for setting Standards and Guidance on practice issues.
QEG	Quality and Effectiveness Group	LSCB monitoring and audit committee

SAB	Safeguarding Adults Board	Statutory partnership responsible for the safeguarding of adults with care and support needs
SCR	Serious Case Review	A Statutory case review held when a child dies or is seriously harmed where neglect and/or abuse is a factor.
TDWSG	Training, Development and Workforce Strategy Group	LSCB Training Committee

Agenda Item No. 7

DRUGS AND ALCOHOL JOINT STRATEGIC NEEDS ASSESSMENT

To: Health and Wellbeing Board

Date: 15 September 2016

From: Val Thomas, Consultant in Public Health

1.0 PURPOSE

1.1 The purpose of this paper is to present to the Board the key findings and recommendations of the Drugs and Alcohol Joint Strategic Needs Assessment.

2.0 BACKGROUND

2.1 The Health and Well Being Board requested the Drugs and Alcohol Joint Strategic Needs Assessment (JSNA) in January 2015 and it approved the scope in July 2015. The scale of the JSNA is very broad and addresses needs across the life course from prevention through to treatment. It also includes the emerging issues of the misuse of prescription drugs and Novel Psychoactive Drugs (NPS). The cross cutting themes of mental health, the criminal justice system and housing are also considered in the JSNA.

2.2 The development of the JSNA was overseen by a Steering Group that included Cambridgeshire County Council staff, service providers and voluntary sector representation. Its development was informed by a number of consultative activities with a wide range of stakeholders. An initial scoping workshop was held to establish the scope in June 2015. Then over the subsequent months a number of activities were undertaken with commissioners, current and ex service users, staff from various services including the voluntary sector and stakeholders from relevant organisations. This included service user focus groups held around the county along with a survey to secure staff and user views. A final event was held in July 2016 where initial key findings were tested and discussed with commissioners, providers and clinicians from the statutory and voluntary sectors along with service users for accuracy and resonance. This meeting shaped the formation of the recommendations found in the JSNA.

2.3 The JSNA is organised into the following chapters.

1. Scope and Themes
2. The National Picture for Drugs and Alcohol
3. Investing in the Prevention and Treatment of Drug and Alcohol Misuse
4. Prevention
5. Substance misuse across the life course:
   - Children and Young People
   - Adults
   - Older People

6. Changing Patterns of Substance Misuse and Emerging Issues

   Changing patterns of drug misuse
   - Novel Psychoactive Substances
   - Prescribed Drugs

   Emerging Issues
   - Alcohol Related Brain Damage
   - Complex Cases

7. Dual Diagnosis
8. Criminal Justice System
9. Housing and Homelessness

3.0 SUPPORTING PARAGRAPHS

3.1 The scale of this JSNA is broad but there are a number of key themes that are embedded throughout the different sections. These themes informed and are reflected in the specific recommendations that are detailed in the Executive Summary attached as Appendix 1 and are described below. The full JSNA will be available on the Cambridgeshire Insight website. http://cambridgeshireinsight.org.uk/

3.2 The misuse of drugs and alcohol has wide ranging negative effects on physical and mental health which impact upon families, communities and wider aspects of their lives. These are associated with socio-economic costs to society which includes health services, social care, the criminal justice system, employers and housing services. However there are also preventative and treatment interventions that are well evidenced and associated with cost benefits to different organisations.

3.3 Cambridgeshire has a consistent record of having relatively good health and well being but with pockets of poorer outcomes associated with areas of deprivation. This picture is replicated when looking at the misuse of drugs and alcohol where most indicators demonstrate that as a county Cambridgeshire is either similar or better than national or comparator areas. In addition the usual patterns of intra-county variation are found across many of the indicators with poorer outcomes generally being found in Fenland and Cambridge City. However there are a substantial number of people in Cambridgeshire who are starting to or continuing to misuse substances and consequently will have a range of treatment and wider needs. This ongoing level of need calls for sustained prevention interventions across the life course.

3.4 There is a clear message throughout the JSNA that there are areas and certain groups that have a higher risk for misusing substances. For example children of substance misusing parents/carers or looked after children face particular challenges that may make them more susceptible to drug or alcohol misuse. Some individuals who find themselves in the criminal justice system or who have mental health concerns have the potential to be at risk of misusing substances. The risks of substance misuse especially alcohol in older people are becoming more apparent and their prevention and treatment needs require a more flexible approach. Homelessness is a particular high risk factor that can have a negative effect on treatment outcomes as well as creating risks for misuse.

The approach that is embedded both in prevention and treatment interventions is the risk and resilience concepts. These focus upon reducing the risks that individuals have for misusing substances and increasing their resilience through strengthening personal assets such as self-esteem and securing resources such as employment opportunities.
This poses opportunities especially for prevention, using both universal population and targeted approaches for building on existing work to support those most at risk.

3.5 The widely accepted aim of treatment is abstinence at six months, yet this is challenged by data both at national and local levels. For example in 2014/15 , of clients being treated in the Cambridgeshire service for drug misuse, 46% had been in treatment for over two years with the figure for opiate users rising to 60%.

The analysis of the treatment service data indicated that a substantial number of their clients being treated for drug misuse were over 50 years of age and had been in and out of treatment for many years. This data does require further analysis but there is a clear pattern to the age profile of clients in treatment.

In addition analysis of current clients in treatment by Public Health England (2016) has identified the complexity of their treatment needs in terms of the use of multiple substances. It appears that the current model of a successful six month abstinence treatment intervention is at variance with the complexity and length of treatment time. These indicate that although some individuals can be successfully treated within an acute care framework, many patients need multiple episodes of treatment over several years to achieve and sustain recovery. The progress of many patients is marked by cycles of recovery, relapse, and repeated treatments, often spanning many years before eventuating in stable recovery, permanent disability or death. A model of long-term, active care management for substance use disorders is comparable to the way treatments for other chronic conditions are managed in medicine. Further analysis of different service models and their costs would be beneficial.

3.6 A long term care approach to treatment is associated with harm reduction approaches. In their broadest sense, harm reduction policies, programmes, services and actions work to reduce the health, social and economic harms to individuals, communities and society that are associated with the use of drugs. It recognises that a valid aim of drug interventions is to reduce the relative risks associated with drug misuse. This is by a range of measures such as reducing the sharing of injecting equipment, providing support for stopping injecting, and providing substitution opioid drugs for heroin misusers as support for abstinence from illegal drugs.

3.7 Every section references integration through describing informal partnership arrangements, joint project working or more formal pathways. There is the acknowledgement across Cambridgeshire organisations that the varied and multiple needs of those at risk and those in treatment cannot be addressed by one organisation. Although there is limited academic evidence for the integration of drug and alcohol services or wider integration involving other services there are examples across the country where integration of services has been established. There is evidence that suggests that integration is most effective when it is system wide and all organisations are fully engaged strategically along with, where possible, joint commissioning arrangements. Further development of integrated of services should be considered in any service re-design. Although it would require evaluation and monitoring for improvement in costs, outcomes and patient experience.

3.8 The document describes new patterns of drug misuse and other emerging challenges. The misuse of new psychoactive substances and prescribed or over the counter drugs has been emerging in recent years and presents new challenges for prevention and service delivery. New approaches are required that will involve a greater understanding amongst the public and professionals to make them aware of the risks and their roles in preventing harm associated with their use. Another challenge identified by local stakeholders is the lack of identification of and appropriate services for the management of Alcohol Related Brain Damage (ARBD).

4.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

4.1 The JSNA is relevant to priorities 1, 2, 3, 4, and 6 the Health and Wellbeing Strategy 2012-17:

Priority1: Ensure a positive start to life for children, young people and their families.
Priority 2: Support older people to be independent, safe and well.
Priority 3: Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices.
Priority 4: Create a safe environment and help to build strong communities, wellbeing and mental health.
Priority 6: Work together effectively.

5.0 IMPLICATIONS

5.1 The JSNA identifies evidence for the development of and different approaches to prevention, recovery and treatment. This will have implications for the planning and commissioning of services along with future working across the following key areas key areas.

1. Broadening and developing universal and targeted prevention interventions. This will requires support from a range of organisations and from policy makers and commissioners.
2. Increasing the focus upon areas and people most at risk of substance misuse. Services and interventions that are best positioned to identify those at risk will be important for implementing preventative approaches.
3. The changed needs and ageing profile of clients call for a long term care approach that will include the development of more harm reduction interventions. Commissioners should explore the feasibility of these approaches and learn from experiences in other areas.
4. Those who misuse substances have multiple needs that demand support from a wide range of organisations. Integrated approaches across policy, commissioning, pathways and care need further development and evaluation to ensure that resources are most effectively used with client experience and positive outcomes maximised.
5. Changing patterns of drug misuse in particular the growth of new psychoactive substances and prescription drugs along with the emerging issue of alcohol related

brain disorders demand new approaches and ways of delivering support services.

6. The evidence of effectiveness and economic evidence calls for commissioners to review services to ensure that they are effective, offer value for money and address needs and produce positive outcomes.

6.0 RECOMMENDATION

6.1 The Health and Wellbeing Board is asked to approve the JSNA and to note the findings and the areas which are highlighted for further work.

7.0 SOURCE DOCUMENTS

7.1

Source Documents	Location
The full JSNA contains a large number references. The following provides an example of some of main references.	
Advisory Council on the Misuse of Drugs. Prevention of drug and alcohol dependence. 2015.	https://www.gov.uk/government/publications/prevention-of-drug-and-alcohol-dependence
Advisory Council on the Misuse of Drugs: Recovery from drug and alcohol dependence: an overview of the evidence. 2012.	https://www.gov.uk/government/publications/acmd-recovery-from-drug-and-alcohol-dependence-an-overview-of-the-evidence-2012
Crime Survey for England 2014/15	http://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/2015-07-16
Health and Social care Information Centre. Statistics on Drug Misuse 2004/5 to 2014/15.	https://www.gov.uk/government/organisations/health-and-social-care-information-centre/about/statistics
Homeless Link: Annual review of homelessness services in England. 2014.	http://www.homeless.org.uk/facts/our-research/annual-review-of-single-homelessness-support-in-england
Local Alcohol Profiles for England (LAPE).	http://www.lape.org.uk/
National Drug Treatment Monitoring System	https://www.ndtms.net/default.aspx
	https://www.gov.uk/gover

National Offender Management Service. Healthcare fro Offenders. 2015.	nment/organisations/national-offender-management-service
NICE Clinical Guidelines 110 Guidance on Pregnancy and Complex Social Factors. 2010.	https://www.nice.org.uk/guidance/ph24?unlid=145257323201672805923
NICE Clinical Guidance (CG115) Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. 2011.	https://www.nice.org.uk/guidance/cg115?unlid=1046778437201662757
Public Health England: Health matters: harmful drinking and alcohol dependence. 2016	https://www.gov.uk/government/publications/health-matters-harmful-drinking-and-alcohol-dependence/health-matters-harmful-drinking-and-alcohol-dependence
Public Health England: Alcohol and drugs prevention, treatment and recovery: Why invest? 2014.	http://www.nta.nhs.uk/uploads/why-invest-2014-alcohol-and-drugs.pdf
Public Health England: Spend and Outcome Tool	http://www.yhpho.org.uk/default.aspx?RID=49488
Public Health England. The international evidence on the prevention of drug and alcohol misuse. 2015.	http://www.nta.nhs.uk/uploads/unodc-prevention-guide.pdf
Public Health England. Alcohol data: JSNA Support Pack- Key data to support planning for effective alcohol harm prevention, treatment and recovery in 2016/17. Cambridgeshire.	http://www.nta.nhs.uk/uploads/jsnasupportpackpromptsadultalcohol2016-17.pdf
Public Health England: Commissioning treatment for dependence on prescription and over the counter medicines: a guide for NHS and local authority commissioners. 2013.	http://www.nta.nhs.uk/uploads/pheatmcommissioningguide.pdf
Royal College of Psychiatrists: Older Person's Substance Misuse Working Group. Cross Faculty Report. Substance Misuse in Older People: an information guide. 2015	http://ageing.oxfordjournals.org/content/early/2015/08/13/ageing.afv105.full
Royal College of Psychiatrists. Mental Illness, Offending and Substance Misuse. 2012.	http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/mentalillness,offending.aspx
Sheffield School of Health and Related Research (ScHARR) in NICE Interventions on the control of Alcohol Price, Promotion and Availability for Prevention of Alcohol Use Disorders in Adults and Young People 2010.	https://www.nice.org.uk/guidance/ph24/documents/review-1-macrolevel-interventions-for-alcoholuse-disorders-effectiveness-review2

Wadd S., Galvani S. The Forgotten People: Drug Problems in Later Life	https://www.google.co.uk/url?url=https://www.biglotteryfund.org.uk/-/media/Files/Research%2520Documents/Older%2520People/the_forgotten_people.pdf&rct=j&frm=1&q=&esrc=s&sa=U&ved=0ahUKEwje1IPsj_nOAhWEBcAKHe33Cl4QFggUMAA&usg=AFQjCNFoCoyVBubEJ8pxqW7g9bu4HxE8Ug

CAMBRIDGESHIRE DRUG AND ALCOHOL JOINT STRATEGIC NEEDS ASSESSMENT 2016

EXECUTIVE SUMMARY

ACKNOWLEDGEMENTS

There have been wide ranging stakeholder contributions to this Joint Strategic Needs Assessment (JSNA). It has been through a number of consultation events initially to discuss the scope and towards the end of its development to discuss key findings, and a survey has been completed by service users and staff from relevant organisations. A number of information gathering events were held with current and ex-service users. The development was overseen by a Steering Group that had stakeholder representation.

1. INTRODUCTION

The scope of this JSNA is broad, capturing the needs of children, young people, adults and older people in relation to the misuse of both legal and illegal substances. It addresses prevention, treatment and recovery, presenting a wide range of data that incudes local service information. This information is considered alongside the perceptions of local stakeholders regarding their views on needs and how they are being addressed. Misuse of drugs and alcohol is closely associated with mental health, the criminal justice system, housing and other socio-economic factors. The interface between these factors, the complex needs that they create and the challenges in addressing them are reflected in the document. Also factored in the assessment are the wider social and economic factors which play an important part in prevention, effective treatment and recovery. The inequalities associated with substance misuse are described which often reflect the multiple disadvantages experienced by those misusing substances.

The overarching aim of the JSNA is to provide an overview of the current drug and alcohol misuse needs in Cambridgeshire with the following specific objectives.

- Identify the preventative and treatment services and pathways throughout the life course.
- Identify how the pathways, treatment and recovery options in Cambridgeshire are addressing needs in Cambridgeshire.
- Describe the changing patterns of drug misuse and emerging issues along with their implications for services.
- Describe how mental health, the criminal justice system and housing interface with substance misuse and the challenges and opportunities that this presents.
- Present an overview of the evidence and economic evidence for supporting the prevention and treatment of drug and alcohol misuse

The document is divided into separate chapters. Some of the chapters where there is substantial robust quantitative data have headlines and data detail sections. Other chapters are more descriptive and use locally collected data. There is some duplication of the data because of the cross cutting themes in the JSNA.

Each individual chapter also provides evidence for interventions and where appropriate case studies are included to illustrate any issues. Each chapter concludes with “What is this telling us” which summarises the key issues and implications.

The executive summary provides an overview of the issues and presents a number of strategic and action based recommendations for specific areas in the JSNA.

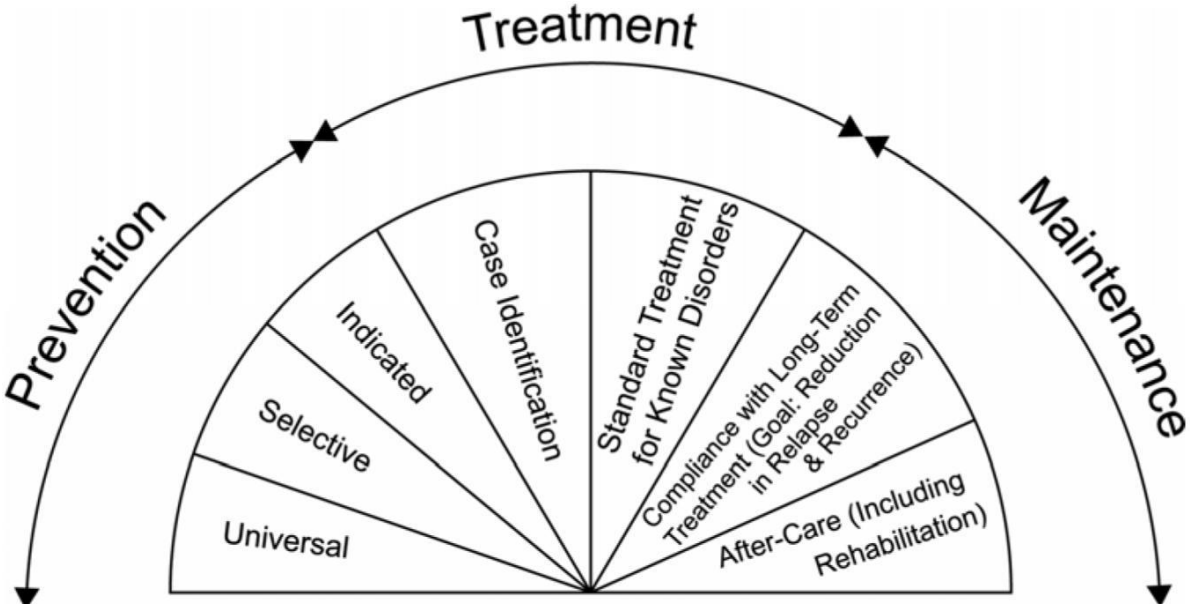
2. Key Themes and Concepts in Scope

The scope of this JSNA is broad and some key concepts are used to indicate how the prevention and treatment of substance misuse is understood and addressed.

Classification of Substance Misuse Interventions

Figure 1 is the United States Institute of Medicine's prevention classification system[1], validated in 2009 and it is used here to capture the scope and complexity of this JSNA. It has been applied [2] to the substance misuse field to illustrate the continuum of services/interventions between prevention, treatment, recovery and harm reduction and is a useful tool for describing a conceptually unified and evidence-based continuum of services. This taxonomy also provides a common language to describe prevention and assist in the planning, delivery, and evaluation of activities.

Figure 1: The Institute of Medicine model of prevention (1994; 2009)



The JSNA addresses prevention through universal interventions which includes media campaigns through to environmental interventions such as licensing regulations.

[1] Institute of Medicine (1994) Reducing the Risks for Mental Disorders: Frontiers for Preventative Intervention Research. In Meazak PJ, Haggerty RJ, editors. Committee on Prevention of Mental Disorder, Division of Biobehavioural Sciences and Mental Disorders. Washington DC. National Academy Press

[2] Advisory Council on the Misuse of Drugs. Prevention of drug and alcohol dependence. 2015

The terms selective and indicated are terms now increasingly applied to substance misuse and are explained more fully in the prevention section. They, to some extent, reflect the traditional models of prevention: primary, secondary and tertiary. However selective refers to the targeting of those at risk and indicated to those who are misusing substances but not yet dependent.

The local prevention and treatment services are described along with any supporting evidence. The current thinking on abstinence, recovery and harm reduction alongside the long term management of substance misuse is described.

How the cross cutting themes of mental health, the criminal justice system and housing impact on the prevention and treatment outcomes is considered

Life Course Approach

Throughout the JSNA the impact of substance misuse is addressed throughout the life course. This allows consideration of key transition periods for prevention and treatment.

Drug prevention and treatment are commonly thought of as being most relevant to young people and most research and activity is concentrated on this age group. However, prevention is relevant across the lifespan, for example, in reducing prescription drug misuse or alcohol use in older adults.

There are many factors associated with an increased risk of the misuse of drugs and alcohol among young people and adults. These factors often lead to risk taking behaviours and poor health outcomes such as mental health problems and offending. The aim of preventative interventions is to tackle risk factors and build resilience to developing drug and alcohol problems

Risk and Resilience

Intervention, whether preventative or treatment, focuses on reducing risk and building resilience in individuals and communities, especially those most at risk. Developed primarily for use with children and young people but applicable to all ages the approach is based on risk and resilience theory.

Resiliency Theory[3] provides a conceptual framework for considering a strengths-based approach to understanding child and adolescent development and informing intervention design. It provides a conceptual framework for studying and understanding why some young people grow up to be healthy adults in spite of risks exposure. Resilience focuses attention on positive contextual, social, and individual variables that interfere or disrupt development from risk to problem behaviors, mental distress, and poor health outcomes. These positive contextual, social, and individual variables work in opposition to risk factors, and help young people overcome any negative effects of risk exposure. The objective is to identify the assets and resources which are positive factors. Assets include for example self-efficacy and self-esteem. Resources refer to factors outside individuals such as parental support and programmes that provide opportunities to learn and practice skills.

[3] Zimmerman M, Resiliency Theory: A Strengths-Based Approach to Research and Practice for Adolescent Health Health Education Behaviour 2013 Aug 40(4) 381-383

The children and young people section includes discussion of those individuals who are less likely to have the assets and resources to develop resilience. The theory and concepts can also be applied to adults and older people.

3. KEY FINDINGS AND RECOMMENDATIONS

The aim of this JSNA is to provide an overview of legal and illicit drug and alcohol misuse needs in the Cambridgeshire population. It is a complex area and consequently the scope and scale of the document is substantial. It includes prevention and treatment throughout the life course.

However, it is possible to identify some key themes throughout the different sections of the document that demonstrate the interconnectivity of the needs and interventions relating to drug and alcohol misuse. These are described below along with a number of recommendations for each section that reflect these key themes.

The cost of drug and alcohol misuse

There are far ranging effects upon the physical and mental health of those who misuse drugs and alcohol which impact upon their families and communities and across wider aspects of their lives that are captured in Figures 2 and 3.

Figure2: Alcohol harms for families and communities

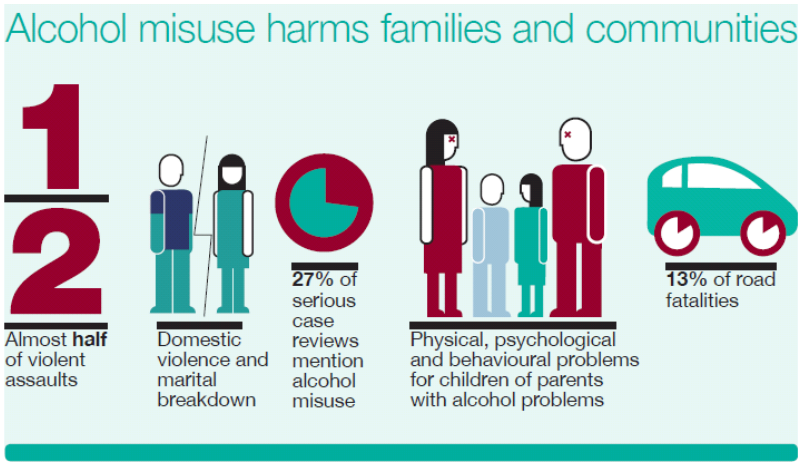
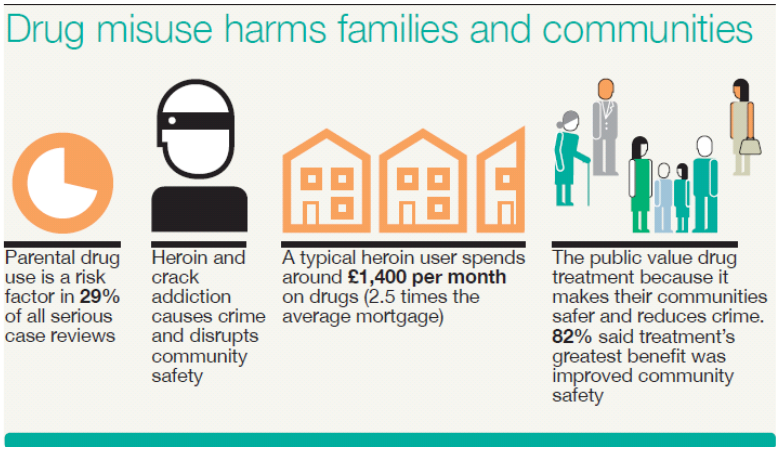


Figure 3: Drug misuse harms for families and communities



There are socio-economic costs to society and services which includes health services, social care, the criminal justice system, employers and housing services. The harms of drug and alcohol misuse have been modelled to show the costs of treating and addressing them. (Figures 4 and 5)

Figure 4: Annual cost of alcohol to society

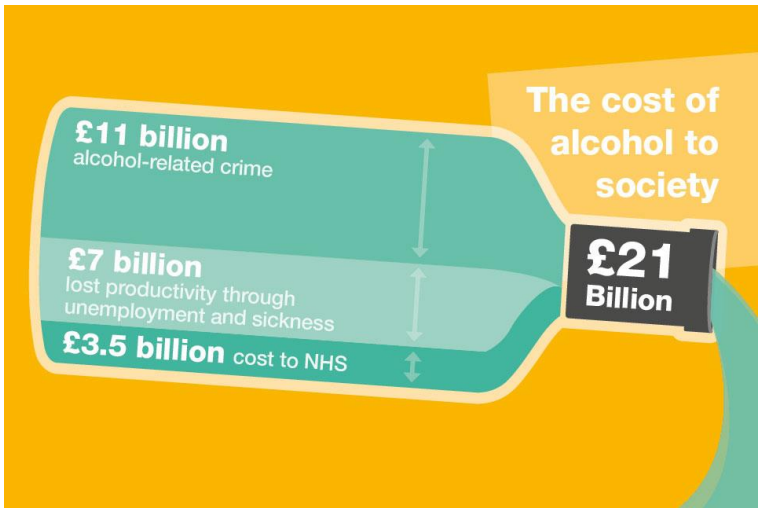
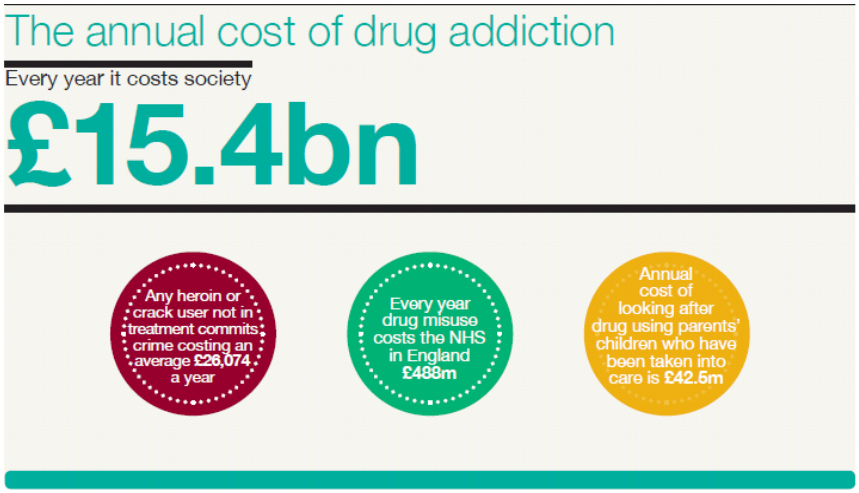


Figure 5: Annual cost of drug addiction to society


The annual cost of drug addiction
Every year it costs society
£15.4bn
Any heroin or crack user not in treatment commits crime costing an average £26,074 a year
Every year drug misuse costs the NHS in England £488m
Annual cost of looking after drug using parents' children who have been taken into care is £42.5m

Key Themes

Against this context a number of key themes were identified in the JSNA which inform the recommendations found in the document.

What is the need?

Cambridgeshire has a consistent record of having relatively good health outcomes but with pockets of poorer health associated with areas of deprivation. This picture is replicated when looking at the misuse of drugs and alcohol where most indicators demonstrate that as a county Cambridgeshire is either similar or better than national or comparator areas. In addition, the usual patterns of intra-county variation are found across many of the indicators with poorer outcomes generally being found in Fenland and Cambridge City.

In terms of prevalence there has been a consistent fall in alcohol and drug misuse amongst young people. In 2014 the Cambridgeshire Health Related Behaviour Survey that is undertaken in secondary schools found that 36% of 15 years olds reported drinking alcohol in the past seven days. A drop from 50% in 2008. The 2014 Public Health England (PHE) Survey "What about YOUth" indicated that Cambridgeshire had similar rates of regular and "drunk in the last four weeks" as national and comparator areas. The same PHE Survey found 12.1% of 15 year olds in the county reported that they had tried cannabis, similar to national rates. The Health Related Behaviour Survey in 2014 found that nearly 17% of Year 10 pupils reported ever having taken drugs with a statistically significant higher rate in Cambridge City.

There is no recent data for adult alcohol misuse prevalence in Cambridgeshire but new figures are expected in 2016. The 2009 figures estimated that 85.8% of over 16 year olds in Cambridgeshire were estimated to be drinkers of alcohol. Of these 21% of drinkers (18% of all over 16s) were estimated to be increasing risk drinkers and 6.8% of drinkers (5.9% of all over 16s) are estimated to be higher risk drinkers. There was an estimated 32,190 people aged between 16-59 years who used illicit drugs in 2014, 8.6% of this age group, with 47% aged between 16 and 24 years.

These figures suggest that there are, despite comparing favourably with national and comparator figures, a substantial number of people in Cambridgeshire who are starting to or continuing to misuse these substances and consequently will have a range of treatment and wider needs. This ongoing level of need calls for sustained prevention interventions across the life course.

High Risk and High Treatment Need Groups

There is a clear message throughout the JSNA that there are certain groups that have a higher risk for misusing substances. Many of those in treatment have multiple complex needs in terms of misuse and vulnerabilities.

For example children of substance misusing parents/carers or looked after children face particular challenges that may make them more susceptible to drug or alcohol misuse. All ages who find themselves in the criminal justice system or who have mental health concerns have a higher risk. The risks of substance misuse especially alcohol in older people are becoming more apparent and their prevention and treatment needs require a more flexible approach.

The relationship between substance misuse and mental ill-health leading to dual diagnosis is well established. It is a cyclical relationship with mental health issues presenting a risk for substance misuse and vice versa and it presents a complex treatment challenge. A similar relationship is found between those experiencing socio-economic pressures who have a higher risk of substance misuse and these issues also may undermine recovery. Homelessness is a particular high risk factor that can have a negative effect on treatment outcomes as well as creating risks for misuse.

The approach that is embedded both in prevention and treatment interventions is the risk and resilience concepts. These focus on reducing the risks that individuals have for misusing substances by increasing their resilience through strengthening personal assets such as self-esteem and securing resources such as employment opportunities.

This poses opportunities especially for prevention using both universal population and targeted approaches to support known to be most at risk. Although the concepts are mostly used in terms of children and young people they also resonate with all ages.

Abstinence and Harm Reduction

The widely accepted aim of treatment of both drug and alcohol misuse is abstinence at six months, yet this is challenged by data both at national and local levels. Generally the age profile of people in treatment for drugs and alcohol is rising.

Nationally the overall numbers accessing treatment for alcohol have increased by 3% since 2009-10, however the number aged 40 and over accessing services has risen by 21% and the number aged 50 and over by 44%. This is reflected in the 2014/15 Cambridgeshire figures when 33% of those in treatment were aged between 40-49, 23% between 50-59 years and 12.1% were over 60 years.

Similarly nationally (2014/15) 44% people in treatment for opiates were aged 40 and over. This is an increase of 21% since 2009-10. Locally in the same period figures indicate for clients being treated for drug misuse 46% had been in treatment for over two years with the figure for opiate users rising to 60%.

The issues that this presents is that many of these people will have been drinking at high-risk levels or misusing drugs for some time and are likely to be experiencing complex health issues alongside long term dependence which makes abstinence at six month especially challenging.

In addition a recent analysis by Public Health England (2016) of current drug clients in treatment by Public Health England (2016) has identified the increasing complexity of their needs in terms of multiple drug misuse. For Cambridgeshire and Peterborough of the high complexity patients 83% had been in treatment previously compared to 27% of very low complexity patients. A similar index for alcohol was not available.

The current model of a successful six month abstinence treatment intervention is at variance with the complexity and length of treatment time along with clinical experience. These indicate that although some individuals can be successfully treated within an acute care framework, many patients need multiple episodes of treatment over several years to achieve and sustain recovery. The progress of many patients is marked by cycles of recovery, relapse, and repeated treatments,

often spanning many years before eventuating in stable recovery, permanent disability or death. A model of long-term, active care management for substance use disorders is comparable to the way treatments for other chronic conditions are managed in medicine.

A long term care approach to treatment is associated with harm reduction approaches. In their broadest sense, harm reduction policies, programmes, services and actions work to reduce the health, social and economic harms to individuals, communities and society that are associated with the use of drugs. It recognises that a valid aim of drug interventions is to reduce the relative risks associated with drug misuse. This is by a range of measures such as reducing the sharing of injecting equipment, providing support for stopping injecting, and providing substitution opioid drugs for heroin misusers as support for abstinence from illegal drugs.

Integration

Every section references integration either through informal partnership arrangements, joint project working or more formal pathways envisioned in the Dual Diagnosis Strategy. Although there is limited academic evidence for the integration of drug and alcohol services or wider integration involving other services there are examples across the country where integration of services has been established. However evaluation information is very limited. Locally projects like the Blue Light initiative which is described in this document indicate a move toward more integrated working. However, the Cambridgeshire Blue Light model is not a formal partnership arrangement as it is in other areas but based on informal arrangements.

The varied and multiple needs of those at risk and those in treatment cannot be addressed by one organisation. For example, for effective working with at risk deprived vulnerable children a number of agencies that includes social and health care, schools and informal networks, are required to work collaboratively. Treatment services cannot just treat, for example with therapies, as a wider range of services that include employment and housing is critical for building resilience and ensuring recovery.

There is evidence that suggests that integration is most effective when it is system wide and all organisations are fully engaged strategically along with, where possible, joint commissioning arrangements. Any integration of services requires evaluation and monitoring for improvement in outcomes and patient experience.

Emerging Issues

The document describes the new patterns of drug misuse and other emerging challenges. Novel Psychoactive Substances and the misuse of prescribed and over the counter drugs have been emerging in recent years and presenting new challenges for service delivery. New approaches are required that will involve a greater understanding amongst the public and professionals to make them aware of the risks and their roles in preventing harm associated with their use. Another challenge identified by local stakeholders is the lack of appropriate services for the management of Alcohol Related Brain Damage (ARBD)

Recommendations

Children and Young People

As indicated above overall substance misuse in Cambridgeshire amongst children is not dissimilar to national figures or its comparator areas. There has been a downward trend in substance misuse in recent years however there are still substantial numbers of children and young people starting and continuing to misuse substances.

Amongst young people admission to hospital for alcohol and drug misuse are statistically significantly lower than the national figures. However in line with national figures the number and rate of admissions have doubled over the last five years. The number of young people in treatment fell in 2014/15 to 200 from 245 in 2013/14 and over 90% of the planned exits from treatment did not re-present within six months. The majority of children and young people have one or more vulnerabilities, the most common being mental health and self-harming. Service data estimates that of the young people who re-present only 5% require treatment. In 2014/15 5% of young people in the service transitioned to adult services, the figure was 1% for 2015/16.

Treatment is provided by the Cambridgeshire Child and Adolescent Substance Use Service (CASUS - part of Cambridgeshire and Peterborough Foundation Trust). It provides a comprehensive treatment service and also capacity allowing, delivers prevention interventions in a number of settings and with different groups.

Prevention interventions are also provided by Cambridgeshire County Council Personal, Social and Health Education Service at PSHE which includes policy and other training or information giving interventions. Cambridgeshire County Council also undertakes checks for under age sales through its Trading Standards Department.

A key concern is the needs of children and young people in vulnerable groups who are at a higher risk of misusing substances for example looked after children and children who live with parents/carers who misuse. This includes those who have not started and those who are using but are not yet dependent on substances.

The numbers of children and young people estimated to be misusing substances and the multiple needs of many of the children and young people in the treatment services requires working across organizations to ensure that there are effective prevention activities and supportive pathways that can address their needs effectively.

Recommendations

1. Although Cambridgeshire compares well in terms of substance misuse in young people there are still substantial numbers who misuse substances. Prevention interventions need to be maintained and developed at a universal or population level and also more targeted interventions in high risk areas and with high risk groups.

2. Many of the children and young people in the treatment services have different vulnerabilities. Looked after children, those with mental ill-health or who are self-harming are examples of common vulnerabilities. There is evidence for early "selective" (targeted) and "indicated" (early interventions) for these groups. These could be more fully developed locally before children and young people enter the treatment services. Interventions for these groups need to be wide–ranging and focus upon developing resilience and resistance to risk factors for drug and alcohol misuse.

3. Children living with parents who are misusing are at high risk of poorer health and wellbeing outcomes. The work that is currently being piloted needs to be fully evaluated to identify learning that can be applied to all the vulnerable groups.

4. Local Safeguarding Children Boards (LSCB) are now the key for organisations to come together to agree on how they will co-operate with one another to safeguard and promote the welfare of children. They often encounter cases which involve an element of substance misuse in parents or carers. The lessons learned from these cases should be used more explicitly to improve interagency working.

5. Any targeted interventions need to be part of an integrated approach with different organisations supporting the development of resilience in children and young people most at risk of misusing substances. This includes the small number of those who transition into adult services.

Adults

As indicated above prevalence relating to alcohol and drug misuse in Cambridgeshire is generally similar to national and comparator areas. However as with children and young people there are still substantial numbers starting and continuing to misuse substances.

Overall in line with national figures hospital admissions for conditions totally attributable to alcohol (specific) and related conditions have increased and they fall within the top 25% of local authorities. In 2013/14 1,890 people in Cambridgeshire were admitted to hospital for conditions totally attributable (specific) to alcohol. In the same year there were around 6,650 people who were admitted to hospital for alcohol related conditions. Taking into account that a person may be admitted to hospital on multiple occasions there were around 12,200 alcohol related admissions in the same time period. Hospital admission rates are generally higher in Fenland and Cambridge. In 2014/15 there were 2,125 hospital admissions due to alcohol related mental and behavioural disorders in Cambridgeshire. Generally these rates are lower than national figures but are

statistically significantly higher in Cambridge along with an apparent increasing trend more widely among men.

There were 211 deaths in Cambridgeshire due to alcohol related causes in 2014. Alcohol specific mortality rates are generally higher in the more disadvantaged areas and average life expectancy is reduced from alcohol related conditions in Fenland. The rate of alcohol related liver disease has increased amongst women in 2012/14 to a level similar to the national figure.

The number of adults in alcohol treatment increased in 2014/15 to 841 from 571 in 2013/14 with most clients being between the ages of 30 and 59 years. The total number in treatment represents 3.8% of the estimated number of high risk drinkers. This is higher that the comparator area (Oxfordshire) but lower than the national figure. 36% of clients completed alcohol treatment and did not re-present within six months, similar to national and comparator figures. The percentage of those in treatment that were also receiving mental health care was 6%, this is lower than the national figure (20%) and lower than the comparator area (15%). There were 36% unemployed or economically inactive and 5% had a known housing problem. These figures refer to those treated by the Cambridgeshire County Council countywide commissioned service Inclusion and exclude the numbers treated by the Gainsborough Foundation (the Service commissioned by GPs for the Huntingdonshire area. Data for this service is not comparable).

In terms of illicit drugs there were 143 hospital admissions with a primary diagnosis of illicit drug poisoning, with rates lower in men and similar in women to national figures. 732 admissions were with a primary or secondary diagnosis of drug-related mental health and behavioral disorders. In Cambridgeshire the annual rate of drug related deaths has been stable for over the past 10 years but they are statistically significantly higher in the more deprived wards.

In 2014/15 there were 1,564 clients who received treatment for drug misuse; nearly 75% were opiate users. Those using opiates spent a longer time in treatment with 60%, higher than the national figure, remaining there for over two years compared with non-opiate users where the figure was 46%. Treatment completion for non-opiates is 34.4% compared to 7% for opiate users, with rates of abstinence for most types of drugs being lower than the national figure. Of those in treatment 23% of newly presenting patients (126 individuals) were also receiving treatment from mental health services. This is higher than the national level of 21%. In addition 63% were known to be unemployed higher than the national and comparator figures. In terms of housing 29% had problems compared to 23% nationally and 35% for the comparator area.

Testing and vaccinating for blood borne viruses is an important element of harm reduction. However in Cambridgeshire the levels of testing and vaccination for blood borne viruses compares particularly unfavourably with national and comparator areas.

As indicated above, there is evidence that the complexity and age profile of people using drug treatment services is changing. A recent report by Public Health England indicates that that nearly one third of clients in treatment have complex treatment needs with over 80% of them having had previous treatment episodes. In addition Treatment service data has also highlighted the ageing opiate user clients with around 270 clients in the Tier 3 services (more complex clients) being over the age of 50. This mirrors the national trend.

This picture of the long term use of drugs with multiple treatment attempts and an aging profile also suggest that there is a higher risk of wider health issues that substance misuse could exacerbate. Poor mental health is often a key challenge for those misusing substances along with housing and other wider socio-economic factors that are associated with substance misuse.

Recommendations

Prevention

1. There is evidence for environmental interventions for alcohol misuse. These include outlet density, reduced licensing hours and minimum pricing; the latter has the strongest cost-effectiveness evidence. Local authorities have the potential to develop local policies that would affect both prevention and treatment outcomes.

2. Formalise and expand identification, brief and extended interventions for alcohol misuse that are evidence based and have cost benefits. Target those who are not dependent and focus on these with high risks e.g. unemployed, those with mental health issues, poor housing or homeless.

3. Identify options for funding brief and extended interventions in areas where they are most effective and have the greatest cost benefits i.e. primary care and Accident and Emergency Departments.

4. Cambridgeshire's low uptake and incomplete vaccination for Hepatitis B and low testing for Hepatitis C will require an innovative approach. There are a number of innovative approaches being utilised across the country that for example provide incentives to clients, these require evaluation. A different commissioning approach could be utilised where incentives are used for providers to increase uptake rates.

Service improvements

1. Hospital liaison services have evaluated well nationally. In Cambridgeshire only Cambridgeshire University Hospitals has a Hospital Liaison Service. Hinchingbrooke Hospital does not have any formalised system for supporting those who are misusing substances who present at the hospital. Some preliminary data indicates that there is a cohort of people who present on numerous occasions i.e. 'frequent fliers'. More investigation is required to identify who these are and the most appropriate intervention. A cost-effective approach would be the development of joint mental health and substance misuse interventions at centres where individuals are presenting.

2. Community detoxification is effective and cost effective. The expansion of provision through greater engagement of GP practices would enable this to increase. Although not all patients are suitable for community detoxification.

3. Develop and expand recovery services that strengthen support from the community and address the complex socio-economic issues with the aim of securing a sustained recovery. This could include expanding the length of time that a person receives recovery support to reflect client need with the objective of reducing the high number of re-presentations within six months.

4. A very common and frequent opinion amongst users and recovery workers who took part in the consultation was that there is limited support during times of crisis especially when they occur outside of service hours. Further development would help prevent relapses or presentations at Accident and Emergency departments. There was a strongly held view that a crisis telephone triage line, similar to that established for mental health services could prevent many relapses. The option of developing a shared crisis management service for mental health and substance misuse could be explored in terms of effectiveness and cost benefits.

5. Maintain the aim of abstinence but acknowledge that many clients require multiple courses of treatment to achieve recovery and may never achieve abstinence, and adopt a model of long-term, active care management for substance misuse.

6. A long-term model of care would require both strengthened recovery services and an increase in harm reduction approaches. Existing schemes such as supervised consumption and needle exchange schemes would require further development and expansion. New commissioning approaches are required to engage more community pharmacists and GPs to undertake shared care. Greater GP involvement would assist in the management also of any physical health co-morbidities.

7. The complex needs of substance misuse clients require an integrated approach with clear pathways to support from a range of different services. Many of these exist and there are some examples of good practice but some client needs are not fully addressed and this undermines treatment outcomes or care management. A more strategic approach to the development of pathways is required that would use resources more efficiently and could involve joint commissioning approaches. There are particular opportunities for integrating elements of the mental health and substance misuse pathways but in addition with criminal justice and housing services (see later). Any integration of services should include evaluation of patient outcomes, experience and cost benefits in the absence of academic and high quality evaluations.

Services and cost benefits

The JSNA provides information about the evidence of effectiveness and also the cost benefits of interventions. The headline figures are as follows and sourced from Public Health England (Alcohol and drugs prevention, treatment and recovery: Why invest? 2014)

- Every £1 spent on interventions on young people's drug and alcohol services brings benefits of £5-£8.
- For every 100 alcohol dependent people treated at a cost of £40,000, £60,000 is saved on 18 Accident & Emergency visits and 22 hospital admissions.
- Every 5,000 patients screened in primary care may prevent 67 Accident and Emergency visits and 61 hospital admissions - costs of £25,000 save £90,000.
- One alcohol liaison nurse can prevent 97 Accident & Emergency visits and 57 hospital admissions so costs of £60,000 saves £90,000.
- For every £1 spent on drug treatment £2.50 is saved through averting costs to society.
- Drug treatment prevents an estimated 4.9 million crimes every year.
- Treatment saves an estimated £960 million of costs to the public, businesses, criminal justice and the NHS.

Through analysis using Public Health England's Spend and Outcome Tool (SPOT) it is possible to compare Cambridgeshire's spend on drug and alcohol services and a range of outcomes found in the Public Health Outcomes Framework against other areas. Both Cambridgeshire's spend and outcomes are below the mean, as is overall public health spend in Cambridgeshire.

Recommendations

1. The SPOT tool does not assess the relative cost-effectiveness of different interventions or assess how to get the best value for money.

2. The SPOT analysis can be considered alongside evidence from the alcohol and drugs Value for Money tools (the Commissioning Tool) and with the evidence that investment in treatment is associated with immediate and long-term savings.

3. It would be useful to apply the Commissioning Tool to identify the spend and outcomes of different types of treatments accessed by opiate users, non-opiate users and alcohol only for the development of evidence based services that are cost-effective and cost saving.

Older People and Substance Misuse

There is an increasing awareness that substance misuse, especially alcohol, is more prevalent in the older population (greater than 65 years) than previously thought. Many of those who misuse alcohol may have started earlier in life but some commence in response to traumatic life events such as loss of a partner. Key factors are loneliness and life changes. In addition professionals often find it difficult to ask 'embarrassing' questions of older people but there are warning signs.

Recommendations

1. Integrate substance misuse amongst older people into the wider work relating to prevention interventions and the development of older people's services.
2. Raise awareness/education about substance misuse amongst older people with statutory and voluntary sector older people's services.
3. Align local clinical pathways for the identification and diagnosis of substance misuse in older people to reflect national guidelines.
4. Scope the service options for developing substance misuse services for older people that will integrate their care into other older people's services to improve identification and management.
5. There are opportunities to adopt a harm reduction approach by addressing their wider issues of isolation, mental and physical health issues.

Changing Patterns of Substance Misuse and Emerging issues

Novel Psychoactive Substances (NPS)

It is estimated that there are nearly 3,400 (aged 16-59) users of NPS in the local population. These are mostly (63%) in the younger age group (16-24 years). 83% of those who have used NPS have previously used illicit drugs.

Recommendations

1. More publicity about the harms associated with the use of NPS that targets high risk young people and those known to have used illicit drugs.
2. Provide statutory and voluntary organisations with information for their staff to provide information and advice both for young people but also parents/carers.

Prescription drugs and over the counter drugs

The broadest definition of this type of substance misuse is the "use of medications for other purposes or ways prescribed or intended". This includes prescription-only medicines (POMs), Over the Counter (OTCs) and pharmacy only medicines for sale under the supervision of a pharmacist.

Based on national prevalence estimates in 2014, 20,212 people in Cambridgeshire aged 16-59 are misusing prescription only painkillers (5.4% of this population). 27% were aged 16-24 years. 25% of those misusing prescription only painkillers reported using an illicit drug in the last year.

It has been found to be more generally spread across the population than illicit drugs. Those at risk of misusing include those using painkillers especially those in the older age groups and those with long standing illness or disability.

Recommendations

There are national guidelines produced by the Royal College of General Practitioners that include the following recommendations for reducing the misuse of POMs and OTCs.

1. Better training of staff across all agencies especially GPs for the identification and management of the misuse.

2. Close working between GPs and substance misuse services to provide GPs with expert advice and support.

3. Further develop the work undertaken by the Cambridgeshire and Peterborough Clinical Commissioning Group Medicines Management Team that undertake audits to identify potential misuse.

4. Ensure local prescribers, pharmacists and dispensers have undertaken training available for their professional bodies and to establish a structured pathway or care approach for identifying and managing POM and OTC misuse. In some areas, community pharmacists are commissioned to proactively work with patients to identify and work with patients to address their misuse.

Alcohol related brain damage (ARBD)

ARBD is an umbrella term for the alcohol related conditions that affects brain function. This includes Wernicke-Korsakoff syndrome, alcohol related dementia and other forms of cognitive impairment. It has been raised by clinicians as an area of concern as there are no local services or pathways in place to manage people with the condition. Case studies and information from the voluntary sector support this picture.

There is no clear picture of the numbers affected in Cambridgeshire. In other parts of the country there have been scoping studies and most notably a specific service has been established on The Wirral.

Recommendations

1. More information should be collected relating to need and current local provision of services to understand how ARBD could be addressed locally.

2. This would include identifying service gaps in terms of pathways and referrals and in the eligibility criteria for third sector provision and the opportunities within existing services for further support.

Dual diagnosis

The term dual diagnosis is generally used to describe individuals who have co-existing substance misuse and mental illness, although the severity of these conditions may vary and the point at which a dual diagnosis is made will vary. Locally the Dual Diagnosis Strategy specifically refers to those individuals who have severe mental illness and who also experience a high level of problematic substance misuse. In 2014/15, 23% of newly presenting clients in substance misuse services were also in contact with mental health services and of those in alcohol treatment 51 (6%) were also receiving care from mental health services. The most common vulnerabilities in children and young people in treatment are mental health problems and involvement in self-harm. This may be underestimated as it is does not include those not in treatment and stigma may prevent clients from disclosing this information.

As indicated above In 2013/14 there were 732 hospital admissions where there was a secondary or primary diagnosis of drug related mental health and behavioural disorders and in 2014/15 2,125 hospital admissions due to alcohol related mental or behavioural disorders in Cambridgeshire. The percentage of those in alcohol treatment that were also receiving mental health care was 6% (51 individuals) this is lower than the national figure (20%) and lower than the comparator area (15%). Of those in drug treatment 23% of newly presenting patients (126 individuals) were also receiving treatment from mental health services. This is higher than the national level of 21%.

In addition, suicide is associated with dual diagnosis, as indicated by national studies. A current audit of suicides in Cambridgeshire and Peterborough is also identifying dual diagnosis in some of the reviewed suicide cases.

The management of dual diagnosis is challenging as it requires an integrated approach across different treatment services. The academic evidence for integrating substance misuse and mental health services is limited but there are examples of integrated services across the country each with their own model of service delivery and differing levels of integration. However there are few evaluations of these services.

In Cambridgeshire in both adult and children and young people services there is some joint working but issues identified by providers are as follows.

- Lack of data sharing that prohibits a good understanding of the extent of dual diagnosis.
- The Improving Access to Psychology Therapies (IAPT) service is for those with mild to moderate mental health issues. It will accept those who misuse substances but not those who have moderate to severe substance misuse problems. There is also a waiting list to access these services. Similarly the personality disorder service that treats clients with both personality disorders and substance misuse has a long waiting list which can impact on an individual's care plan.
- Children and Young People's Mental Health Services (CAMHS) cite transition between services as being problematic as Child and Adolescent Mental Health Services work with those aged under 17 and CASUS with those under 18. There is not any follow on service for discharged clients who have their substance misuse issues under control but whose mental health issues are not managed.
- The rural areas have poor transport links and although CASUS offers home visits the time involved impacts on capacity. CASUS and the Youth Offending Service have found difficulties with academies engaging with the services.
- The Dual Diagnosis Strategy was developed to enhance joint working and enable the efficient and effective use of resources. However there is a lack of awareness of the strategy and there has been little demand for the training.

Recommendations

1. Collaboration between services – there is currently no strong evidence base for the integration of services or a particular model that is favoured, but collaboration between substance misuse and mental health services is clearly a strong theme. There is an on-going need to build collaboration and overcome the organisational challenges between services. Integrated service models that other areas are implementing have not been evaluated in terms of outcomes and cost-benefits.

2. Data collection and sharing are two areas that could benefit from increased collaboration. Sharing data held by substance misuse and mental health service providers could usefully help in estimating the number of people with a dual diagnosis in services. Establishing a standardised practice for collecting data across all services would ensure there is greater recording of dual diagnosis, as well as greater consistency in how this is recorded.

3. One of the key gaps identified is in terms of service provision for those with moderate to severe substance misuse problems and mild to moderate mental health problems. Currently there is not a statutory service that these individuals can access to address their mental health needs. The service pathway and options for addressing this gap need consideration.

4. The Cambridgeshire & Peterborough Suicide Audit will be published in autumn 2016 and it is clear that substance misuse will be highlighted as part of this work. It will be important for the local suicide prevention work to recognise the role of substance misuse as a risk factor locally, and consider the local action plan in light of this.

5. It is important to recognise the importance of engaging the education system in drug and alcohol issues as a whole as initial signs from those working with schools suggest that attitudes are changing as schools change.

6. In terms of dual diagnosis training, it is important to ensure that new or changing services are accessing the training.

7. There is a clear need for more research specific to dual diagnosis including service models, particularly in adolescents. Currently it is difficult to say which interventions are better than mainstream treatment for those with multiple needs. This should be a consideration when looking at local service models, ensuring that there is adequate evaluation in place, which may require consideration of data sharing agreements.

8. The Dual Diagnosis Strategy addresses some of the challenges for the identification and management of this condition. However, there are still many areas that require implementation. This could be accelerated through a dedicated resource to identify and progress the practical steps that need to be undertaken to establish the required changes.

Substance misuse and the criminal justice system

There is a significant relationship between substance misuse and the criminal justice system. Drug or alcohol addiction may fuel or exacerbate criminal activity, for example through theft to meet the cost of purchasing supplies. Managing the care of those who misuse substances and are involved in the criminal justice system presents a challenge similar to that of dual diagnosis, in that it calls for effective working across different organisation. There is also a tension between the needs of the criminal justice system to ensure that the appropriate penalties are enforced that might include a requirement to involvement in treatment, with the ethos of the treatment services where issues like confidentiality are central to care. There is however evidence that it is important to identify individuals misusing substances in the Criminal Justice System and provide treatment in terms of the prevention of further criminal activity and an opportunity to treat the misuse.

Drug users are estimated to be responsible for between a third and a half of acquisitive crime. According to the 2013/14 Crime Survey for England, 53% of violent incidents were alcohol-related. Alcohol and drug misuse related offences are associated with driving with excess alcohol, assault or criminal damage and partner abuse.

Substance misuse is known to be particularly prevalent amongst the prison population. HM Chief Inspectorate Annual Report for 2014-15 surveyed samples from 49 adult prisons found that on arrival at prison 41% of women and 28% of men had problems with drugs and for alcohol the figures were 30% and 19%.

There are difficulties with data collection in these areas both nationally and locally and under-reporting is considered to be an issue. There are local studies and for example data collected between 2011 and 2013 in Cambridge City found that of the 100 crimes studied over 50% were linked with alcohol misuse.

In December 2015, in Cambridgeshire the Criminal Justice Intervention Team had 149 clients on its caseload with the majority being in structured treatment. Of the 149 clients in the caseload, 123 were using opiates, 20 a combination of alcohol and non-opiates and six were using alcohol. Being in treatment and on release transferring to the care of the local treatment service is considered to be important in terms of crime prevention. In Cambridgeshire 43% of users transfer to external services on release compared to 29% nationally.

In addition, it is recognised that there is a high percentage of prisoners who have mental health issues with studies indicating the figure to be as high as 90%. A large proportion of these will also have substance misuse issues especially drug abuse.

There are various pathways in the Criminal Justice System with the route taken dependent on the severity of the crime, whether a community sentence or custodial sentence is imposed and which services are accessed on release from prison.

Substance misuse services within prisons are commissioned by NHS England and delivered by prison in-reach teams. The local Drug and Alcohol Treatment Service, Inclusion, provides the Substance Treatment Action and Recovery Team (START) which provides support to substance misusers on release from prison. For those who misuse substances that are identified within the prison setting,

there is a requirement for those working within the prisons to notify the local START team of clients prior to release. The key concerns are that prisons are only required to inform START of the release of prisoners who misuse opiates and that there is a need to increase engagement and with prisoners prior to release and improving the general level of communication.

In addition there are schemes that focus upon those with complex needs which often includes substance misuse. There is the Integrated Offender Management team where the most problematic offenders are identified and jointly managed by partner agencies working together with the aim of ensuring the most effective release from prison. The Chronically Excluded Adult Services caters for particularly chaotic high need individuals, with a high proportion having links to the criminal justice system. This has evaluated well and found to be cost-effective, demonstrating a fall in arrests and contact with the criminal justice system post intervention. Liaison and Diversion Services are now in place that focus ensuring that those with mental health problems have appropriate support on discharge from prison.

The Cambridgeshire County Council Youth Offending (YOS) Substance Misuse Team delivers substance misuse interventions to young people (10-18 years). The Substance Misuse Team that is part of Cambridgeshire County Council delivers Tier 3 (for those with higher misuse issues) interventions and advises YOS Officers on their delivery of Tier 1 and 2 interventions (less complex clients). Individuals that require higher level Tier 3 interventions and complex cases are referred to the Cambridgeshire Child and Adolescent Substance Use Service (CASUS), which is part of the Cambridgeshire and Peterborough Foundation Trust.

As part of a review (2015) into the provision of specialist substance misuse treatment in Cambridgeshire YOS and CASUS the following data was captured:

- 1/3 of young people working with the YOS have substance misuse issues requiring Tier 3 support from the specialist team.
- 1/3 had substance misuse issues that require Tier 1 and 2 interventions that are delivered by YOS Officers supported by the specialist team.
- 1/3 did not present with substance misuse issues, but at any point, this could become evident.

Between 1 January and 30 June 2015, 176 young people started interventions with the YOS, 35% (62) of these young people were referred to the substance misuse team. Of these individuals 41 required Tier 3 (specialist substance misuse) treatment, 10 required Tier 2 (targeted) treatment and 11 required no further action. There are issues however in particular confidentiality and timeliness, related to the data sharing between the YOS Substance Misuse Service and CASUS that affects the overall management of the clients.

Other issues were identified.

- Some individuals may have a short court order which means that their time in the YOS or prison is limited but they may have complex needs. Linking the individual to community services within the short timeframe can be challenging.

- There can be challenges in sharing information between services. For example some children that are looked after by the local authority may come into contact with a number of services and find themselves relaying information to each organisation.
- Schools: A challenge identified by both CASUS and the YOS Substance Misuse Team was working with different school policies. Both services identified that increasingly schools were implementing zero tolerance policies where a pupil that was found to be in possession of drugs is automatically excluded. This type of action could be considered to be detrimental to the motivation of an individual academically. Both providers reported there was an increase in this type of policy or that schools were becoming increasingly less engaged in substance misuse support as there was a change towards academy status.

Recommendations

1. There are a number of challenges relating to communication or information sharing barriers. In particular in relation to the START team receiving timely notification of potential clients prior to release from prison, and widening these notifications beyond opioid users. There is also a challenge in terms of communication between the YOS and CASUS with issues of confidentiality and timeliness adding barriers. A formal information sharing agreement may help with this process.

2. There is a need to ensure that there are effective pathways between services. The criminal justice system is an area where there are multiple stages and organisations involved, with care being commissioned and provided by different organisations along the pathway.

3. There is little evidence of effective interventions for those beyond that of mainstream services for those in contact with the criminal justice system. A lot of the research that is available is American based and often prison based too, therefore it is important to ensure that local interventions are evaluated in terms of outcomes, patient experience and cost effectiveness where possible to contribute to the growing evidence base.

4. It is important to recognise the importance of engaging the education system as initial signs from those working with schools suggest that attitudes are changing as schools change. It is important to consider this issue as a whole in terms of drugs and alcohol, not just those with a dual diagnosis or engaging with the criminal justice system. This will require engagement with schools to understand the best way to address this issue.

5. It was not possible to access data for the county that identified alcohol misuse hotspots. This information is developed through pooling hospital, ambulance, police and licensing authority information. This information could help understand the causes and shape prevention interventions

Housing and Homelessness

There is well documented evidence of the impact of inappropriate housing and homelessness on mental health and substance misuse. Many people may be misusing substances and will not experience any housing issues. However, vulnerable people who become homeless may be exposed to drug and alcohol cultures that can lead to starting to misuse substances. Substance misuse can increase the risk of homelessness that reflects unemployment, relationship breakdown and other socio-economic issues. It is a cyclical issue, with appropriate housing, support and the avoidance of rough sleeping both preventing substance misuse and improving treatment outcomes.

Cambridgeshire was the fastest growing county authority between 2001 and 2011 and is expected to continue to grow and this growth has created pressures on the housing market. In particular affordability and consequent homelessness are concerns with the most acute pressures in the south of the county. The rates of statutory homeless are statistically higher in Cambridge City and Huntingdon than the figure for England, and have increased since 2010/11 when the situation was relatively stable.

Recent surveys (of homeless people) indicate that around a third of homeless people reported misuse of drug and alcohol. In one audit 39% of participants said they take drugs or are recovering from a drug problem, and 36% had taken drugs in the month before completing the audit. By comparison, national figures at that time indicated that only 5% of the general public took drugs in the past month. Cannabis appears to be the most commonly used drug however 25% of survey respondents said they had used heroin prescription drugs not prescribed for them.

27% of homeless people taking part in the same audit reported that they have or are recovering from an alcohol problem. 39% of homeless men and 25% of women drink twice or more a week, and around two-thirds of homeless men and women drink more than the recommended amount each time they drink. By comparison, one-third of the general public drink more than the recommended amount on at least one day each week.

There are barriers to accessing housing. Feedback from District Council Housing leads and housing providers indicate that throughout the county there are issues related to homelessness and substance misuse along with the level of support that people involved in misusing substances receive. The issues differ to some degree across the county and there is concern that changes to housing benefits will exacerbate the issues.

There is a range of accommodation options in Cambridgeshire for the homeless. Some of these offer additional support for substance misuse and/or mental health issues. There are examples where services are trying innovative approaches that range from abstinence projects and interventions to prevent street drinking, through to projects which focus on addressing the wider socio-economic issues experienced by these clients.

Data from many of the accommodation providers and projects for the homeless is not consistent but that which is available - and reports from staff - clearly reflect that their clients have substance misuse and often dual diagnoses. Staff expressed concern about the need for increased support for the wide range of needs, more joint working and collaboration across the services.

Recommendations

1. The accommodation options for the homeless report that a large proportion of their clients have a known substance misuse issue. However there is limited and varied data collection or capacity to collect information and an associated possible under reporting of the issues. Improvement and standardisation of data collecting across many providers could improve the strategic planning of services.

2. In Cambridgeshire there is a range of housing options available including additional support from different services including Inclusion. Support plays an important part in preventing relapse, promoting recovery and tenancy sustainment. This approach could be further bolstered with clear pathways and referral criteria.

3. There are a number of innovative partnership projects across the county that should be evaluated and inform on-going service development. The impact of these interventions on treatment outcomes, mental health services, Accident & Emergency attendances and involvement in the criminal justice system needs to be captured and cost benefits identified.

4. There is an on-going pressure on the available housing/hostels available for those with substance misuse issues. There are barriers that prevent many clients securing accommodation from housing providers including the definition of statutory homeless. These require further exploration working with statutory and voluntary sector providers and commissioners, substance misuse services, mental health services and the criminal justice system.

Agenda Item No. 8

COMMUNITY RESILIENCE

To: Health and Wellbeing Board

Date: 15th September 2016

From: Sarah Ferguson, Service Director - Enhanced and Preventative Services, Children Families and Adults, Cambridgeshire County Council

1.0 PURPOSE

To share the plans for the delivery of our Community Resilience Strategy and the partnership work being undertaken with a view to considering the implications for the Health and Wellbeing Strategy.

2.0 BACKGROUND

2.1 *Stronger Together – our strategy for building resilient communities* represents a culmination of work that has been happening across the County Council. It proposes a fundamental shift in the way that service provision and local communities interact; essentially, repositioning the Council as part of the wider community, with a real focus on building the capacity of local people to help us to meet local needs together. The full strategy can be accessed here.

2.2 The concepts and actions within this strategy have been informed by officers and Members across the County Council, from a series of meetings, workshops, discussions, Member seminars and more latterly a more formal Programme Board with membership drawn from each directorate. There have also been discussions with statutory sector partners, both individually and through Cambridgeshire's Public Services Board.

2.3 The County Council's General Purposes Committee agreed to adopt this strategy at its meeting in October 2015. Since then officers and Members across the County Council have been developing activity to make this strategy a reality.

3.0 DELIVERING THE STRATEGY

3.1 Our strategy proposes six areas of activity. Each represents a specific part of the work we need to take forward, and there are action plans for each area. The six areas are:

- Communication
- People helping people
- Council members
- Our workforce
- Community Hubs
- Partnerships

3.2 Further detail on each of these areas can be found within the strategy document itself, together with a clear articulation of what the County Council aims to achieve by 2020.

3.3 Communication

3.31 Work started last year in raising awareness of the challenge being faced by the County Council and ways we and the community can help one another as part of the County Council's Budget Challenge Campaign. A structured Communication Plan is under development, with key milestones planned around the deliverables outlined in this paper.

3.32 A regular update is now being sent to parish councils and a letter has also been sent with supporting materials that they can use themselves or in local publications. A menu of ideas and support offers, case studies and online resources are now being developed to help Parish Councils, the community and other organisations to develop their own local activity that will mitigate the impact of our budget and service reductions. Communications to staff have begun and will increase with official launch of the Community Resilience Strategy and the Innovation Fund. We are increasingly publicising the good work that is already happening in local communities, with or without our support.

3.33 The way the County Council is using social media has been changing in order to better place the Council and its services as part of the wider community rather than a centralised provider of services. This means the County Council can actively target communities in a geographic location but also communities who share an interest or need. This in turn allows a much more targeted and cost efficient approach as well as engaging with people where they are having the conversations rather than expecting them to come to the council.

3.4 People helping People

3.41 This workstream aims to facilitate people helping people in a range of capacities across the county. People help people in a broad range of ways – from very informal help for a neighbour, through to more facilitated volunteering such as peer-to-peer support. Within this workstream we are looking at how the County Council can support people helping people in both formal and informal ways. We aim to build on existing good practice across the County Council, for example, in libraries, and develop the links between service provision where this is needed.

3.42 Activity planned includes:

- The delivery of three pilot learning sites aiming specifically to build community capacity. These are taking place in Godmanchester, Ely and Littleport, and the Abbey area of Cambridge. The Godmanchester site builds upon the "mini-patches" work happening through Transforming Lives.
- Work on building peer support mechanisms across the county.
- Aligning the County Council's contracts with the voluntary sector around our Community Resilience strategy.
- Making available a toolkit for staff and Members, providing advice on sources of funding, support and training that community groups can access, useful tools, tips and techniques for building capacity in communities, and examples of successful activities and case studies.
- Identifying occasions where staff working for the County Council may not feel they are able to link vulnerable people with sources of support from within the community

– and making sure our policies and processes facilitate this whilst also keeping people safe from harm.
- Further development of Time Banks and Time Credits.

3.5 Council Members

3.51 Both Councillors as Community Connectors cohorts are now complete. This County Council programme engaged pro-active County Council Members to work together to mutually improve knowledge of how to help build capacity within the communities in their divisions. The material they have covered includes: community engagement techniques, discussions with service leads regarding how the councillors' community role can support services, and practical ideas to take forward. There are plans in place to hold occasional sessions at County Council Members Seminars for Members to share learning and stay up-to-date with this agenda. The guidance on the role of County Council Members has been revised to give a clearer emphasis on Members' roles in building community resilience, and a session is also being planned as part of new Members' induction in 2017.

3.52 The programme has been a conduit for the Cultivating Communities Small Grants pilot through which communities can work with their County Councillor to apply for a grant to fund local community-led partnership projects.

3.53 ***Stronger Together*** has stimulated positive conversations with local parish councils. Some have approached the council to ask what they could do to help mitigate the impact of any service reductions, and a number of County Members have started discussions with their parishes to stimulate ideas. Examples of activity include:

- Histon and Impington parish proactively working with a county officer to further develop their already substantial community offering
- Development of a Parish menu outlining examples and suggestions of ways parish and county councils can work together
- An invitation to officers to attend Huntingdonshire Joint Rural Forum to discuss 'Where will the axe fall and how can towns and parishes help?'
- One County Councillor has convened parish cluster meetings where parishes are now collaborating on projects
- Another Councillor convened a Village Meeting explaining the situation and ideas raised there are now coming forward through their Community Plan.
- Monthly briefings of relevant information to all Local Councils from the County Council Communications team

3.54 At this early stage the approach we are adopting is to work with the willing, engaging with proactive local councils who approach us.

3.55 There is a need to understand the different nature of the geographical communities the County Council serves, particularly in relation to Cambridge City where this local community based work takes on a different complexion, and the task for Members as Community Connectors is highly likely to be different.

3.6 Our workforce

3.61 The County Council's Workforce Strategy has now been revised to incorporate the requirements of our work on community resilience.

3.62 A working group is now meeting regularly to support staff to gain the skills and expertise they will need for this new way of working. The group will plan and deliver a programme of workforce development to equip staff with the skills they will need to work more closely alongside local communities and other local service providers. It will also consider the fundamental way that we develop job roles so that we recruit staff with the key skills to work differently.

3.7 Community Hubs

3.71 We will be rationalising our property and staffing in local areas in order to provide a network of community hubs, co-locating our face-to-face information and advice provision, creating a hub for the delivery of local preventative and early help services for all age groups, and creating a forum for local services to network and plan together.

3.8 Partnerships

3.81 A series of individual meetings have taken place with partners to explore the resonance of the strategy with their own objectives. Discussions are also taking place at partnership boards to establish any cross-cutting strategic links which need to be made. From these discussions, any countywide actions and goals will be developed as well as any specific local activity to take the work forward. In Fenland, initial discussions have been taking place under the auspices of the Fenland Strategic Partnership to look at whether rethinking the totality of the resource being allocated across agencies in a community through the lens of community resilience could assist the process of re-focussing services.

3.82 Plans are underway for the establishment of the County Council's Innovation Fund. This will be a fund for small groups and organisations/businesses with big ideas for transformative preventative work which will make a positive impact on County Council expenditure. The County Council will encourage bids for funds which will demonstrably make an impact on our priority outcomes – particularly in relation to working with vulnerable people, and thereby diverting children and adults from needing high-cost council services.

3.83 We are considering how we can develop a shared narrative across the public sector – a shared communications plan or agreed set of principles. We are now linking with public service colleagues to lead a piece of work which will be presented to the public services board with regard to bringing all public services together to reposition how, as a group, we can manage key community resilience messages, and coordinate communications strategies.

3.84 Our strategy identified social prescribing as a systematic way of linking people who need support with sources of this support within their local communities. Using investment from the Better Care Fund, both Cambridgeshire and Peterborough plan to deliver pilots implementing two different models of social prescribing. The Cambridgeshire pilot will see the voluntary sector (via the Health and Wellbeing Network) working with NHS and Local Authority commissioners to implement models of self-sustainable GP practices, recognising that GPs have to deal with many issues that are social rather than health related. The pilot is planned to be delivered in four GP practices within one of the Trailblazer Neighbourhood teams. The Social Prescribing Business Case is currently being prepared and is subject to approval by the Better Care Fund Delivery Board.

3.85 Social prescribing now has a strong evidence base nationally. Outcomes include marked improvements in self-reported wellbeing amongst the practice populations as well as with practice staff themselves. Reductions in GP appointments and reductions in attendance / admission to hospitals have also been observed due to the increased informal support delivered by citizens of the practice.

3.9 A report on Public Health activity in relation to community resilience was discussed at the County Council's Health Committee in March 2016. An extract from this report is attached at Appendix A.

4.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

4.1 The Strategy aligns with the with the Cambridgeshire Health and Wellbeing Strategy

Priority 3: Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices

- There is evidence that community engagement and resilience supports the adoption of a healthy lifestyle as a community norm and engagement in health improving initiatives
- The benefits to those supported by volunteer s include improvement in health, wellbeing and independence
- Supporting community resilience builds increased social capital; cohesion, empowerment, and improved relationship with organisations.

5.0 IMPLICATIONS

5.1 Supporting and protecting vulnerable people

- The County Council, along with other partners in the public sector, will have to make reductions in front line services in order to meet the significant financial challenges ahead. This strategy is a key aspect of the Council's approach to mitigating the impact of those cuts on those who need support but could manage without the intervention of statutory services.

5.2 Resource Implications

- There are no significant additional costs incurred in the delivery of the overall strategy, though some actions may require short-term revenue input in order to achieve identified savings (invest to save).

5.3 Statutory, Risk and Legal Implications

- The strategy is designed to mitigate the impact of reductions in local government funding, and as such should help to guard against the risks identified in its corporate risk register around failure to deliver the business plan.

- There will be a continuing legal duty on local authorities to ensure that vulnerable people are not exposed to additional or unreasonable levels of risk as a result of the implementation of these strategic objectives.

5.4 **Equality and Diversity Implications**

The following bullet point sets out details of significant implications identified by officers:

- Evidence indicates that services delivered by local people within local communities can be successful at reaching people who do not access Council or statutory services but who may need support.

5.5 **Engagement and Consultation Implications**

- Delivery of this strategy cannot be undertaken unless there is collaboration with agencies across the system. Successful delivery will hinge upon the relationships with other agencies in local communities – at a strategic planning level as well as between people working in local areas. There have been some early discussions with voluntary sector organisations and other statutory agencies further develop a partnership approach to developing and supporting community resilience.

6.0 RECOMMENDATION/ DECISION REQUIRED

6.1 The Health and Wellbeing Board is asked to consider the implementation of the Community Resilience Strategy and in particular the partnership work being undertaken and the implications for the delivery of the Health and Wellbeing Strategy.

7.0 SOURCE DOCUMENTS

7.1

Source Documents	Location
Stronger Together – Cambridgeshire County Council's strategy for building resilient communities	Box OCT 1210 Shire Hall Cambridge http://www.cambridgeshire.gov.uk/downloads/file/4176/community_resilience_strategy

PUBLIC HEALTH SERVICES

Many public health services have been using the principles and practice of community resilience for some years. The Council's Community Resilience Strategy provides a positive opportunity to potentially build further links, particularly through Member training and Parish Councils.

The following are examples of Public Health interventions that involve engaging individuals and communities to develop the knowledge, skills and resilience to enable them to take responsibility for their health and well being. The interventions are delivered by members of the Public Health Directorate or through commissioned services. They include working with a range of different ages and communities in a variety of settings.

Healthy Fenland Fund

Public Health staff have worked to establish the Healthy Fenland Fund to build community resilience and reduce health inequalities in Fenland through engaging communities to take responsibility for their health and well-being. Communities in Fenland are able to access small grants that will enable them to develop local projects and interventions to address their health and wellbeing needs.

This funding may be used to strengthen the community by supporting the "building blocks" or for a specific project that addresses a community issue. Care Network in collaboration with Cambridgeshire Community Foundation has been commissioned to administer the Fund and to engage communities. It has employed community workers who will be responsible for identifying "enablers" and supporting them to work with their communities to realise their assets and manage their own needs. Enablers are community members who identify and use their community strengths, physical and social assets and make connections in their communities to develop resilience and strengthen their communities. The Healthy Fenland Fund acts as an incentive and the community workers will work with communities and advise them how best to access and best use the Fund.

Breastfeeding Peer Support Programme

Members of the Public Health Directorate facilitate a Peer Breastfeeding Programme that currently has Peer Breastfeeding Support Groups in Fenland, East Cambridgeshire and Huntingdonshire where there are lower rates of breastfeeding. There is evidence that breastfeeding has considerable health benefits for the child and mother. Peer support groups are acknowledged as being an effective means for initiating and increasing the length of time women breastfeed. Peer supporters are voluntary lay women, recruited from the local community who have breastfed themselves and successfully completely additional accredited breastfeeding training that is provided by Public Health. Trained peer supporters go on to recruit new members and form their own peer support groups.

In addition to supporting mothers to breastfeed, the peer programme also increases social networking opportunities, provides opportunities for the peer supporters to undertake further education or training and other voluntary roles in the community. It also builds relationships with professionals making them more aware of the contribution that the peer supporters make to the number of women who successfully breastfeed.

KickAsh

Kick Ash Cambridgeshire is a health promotion programme that aims to reduce the prevalence of smoking amongst young people who are 16 and under. It is a school based programme that engages young people in promoting the no-smoking message with young mentors being recruited who represent a wide cross section of students from different social groups. The programme is currently active within 10 schools with over 150 mentors being trained this year (20115/16) and in excess of 500 during the life of the programme.

It is facilitated by Public Health, CAMQUIT (Stop Smoking Services), Personal Social Health Education (PSHE), Communications and Trading Standards. The mentors working with staff from these Departments influence the design and development of the programme within their school and in the wider community.

The Programme is led by mentors from Year 10 (15/16 yrs. olds) who deliver bespoke PSHE units of work to year 8 (13 yrs. old) and year 5/6 (10/11 yrs. old) students. The units focus upon what influences their decision making around smoking and related risk taking behaviour. In addition they undertake a number of events in the community, raising awareness of the issues e.g. flash mob appearances in busy areas, training and workshop activities and communication that includes social media and press releases.

The mentors have expressed the following benefits: acquired new skills, gave them responsibilities which helped build their confidence, gave them leadership opportunities, good for their CVs, made them feel valued and gave them an understanding of the smoking related issues.

Schools have reported the following benefits: opportunities to work with other schools including primaries and the wider community with professional support from an outside agency, provides a focus upon health which is a priority for schools, participation in a high profile programme is good for school reputations and credibility. Those schools which are involved report that that the programme is now a school priority.

Gypsy and Traveller Health Team

The Public Health Directorate includes the Traveller Health Team that works to improve the life chances of Gypsies and Travellers across Cambridgeshire. As the largest ethnic minority group in Cambridgeshire, their life expectancy is approximately 10-12 years less than that of the non-Traveller residents and they are 5 times more likely to experience ill health (Travellers Joint Strategic Needs Assessment [JSNA], 2010). Activities focus on providing the communities with the knowledge and skills to improve their health and wellbeing. Other funding has been secured by the team for specific projects. The Travellers Literacy Project targets those who have none or few literacy skills. The project enables learners to become more aware of how to access GP and other services. Improved literacy also helps with making health choices and the services that will help them with these choices. Literacy tutors report that participant mental health has improved through increasing their self-esteem and confidence building. A number of participants have progressed to employment or transferred to other skills development courses, which for many will be their first experience of achieving a qualification and a route to employability and independence

Health Explorers

A high smoking rate is one of the factors associated with the high numbers of smoking related deaths and illness in Fenland. In 2014 the voluntary organisation Our Life was commissioned by Public Health to facilitate a Citizen's Investigation into Smoking in Fenland.

Our Life specialise in community engagement and carry out high-quality public participation processes, research and training designed to involve local people in local decisions around issues that directly affect them and the areas in which they live. The starting point in Our Life's work was to discover the assets that the local communities already have and how to build on the existing strengths in the communities.

A "conversation" was held with 17 volunteers from Fenland (these were mainly made up from people who use the Rosmini Centre in Wisbech) about tobacco use in the local area. This informed the Fenland Explorer Project which recruited five volunteers from the community. They were trained and undertook street based research by interviewing over 150 local people from Fenland market towns. They used the findings to produce a final report which is being used for the ongoing engagement of communities in smoking prevention and the Stop Smoking Services. The volunteers became the Fenland Health Explorers who created their own identity, logo and reported that they had increased their knowledge, communication skills and confidence.

Health Walks

For a period of 12 years Public Health staff sometimes with partner agencies have trained and supported volunteers to lead Health Walks East Cambridgeshire.

Health Walks are evidence based interventions that support not only the promotion of physical activity but also psychological wellbeing. They bring together groups of up to 40 individuals who may have low levels of physical activity and/or be socially isolated. Local case studies have revealed the social impact of the walks with individuals not able to walk still meeting with the group for social gatherings.

4.8 Health Trainers

Public Health commissions Everyone Health to provide an integrated Lifestyles Service which includes Health Trainers. Historically in Cambridgeshire the Health Trainer Service was confined to the 20% most deprived areas but since 2015 the Service has been commissioned for the rest of the county.

Health Trainers offer tailored advice, motivation, skills and practical support to individuals who want help to adopt healthier lifestyles. They focus on those in greatest need and more disadvantaged communities. The Cambridgeshire Service also includes community engagement workers who develop links with communities to enable health trainers to work with them to develop their knowledge and skills for taking responsibility for their own health. For example they recruit and train volunteers to run Health Walks (expanding the East Cambridgeshire model to the rest of the county) and other community physical activity initiatives or provide cooking classes for mothers.

4.9 Workplace Health Programme

Public Health has a long standing Workplace Health programme which offers support to employers to improve the health of their workforces. There is evidence that workplace health programmes support improvements in employee health and provide financial savings through for example reduced sickness absence. Business in the Community (BITC) has been commissioned to develop the Programme, primarily with workplaces in the private sector in the more deprived areas over the next two years. Support is also being given to Local Authorities and the NHS by members of the Public Health Team.

Integral to the sustainability of the programme is ensuring that workplaces i.e. employers and employees are committed to and own their Programmes along with the securing the skills to ensure that they are sustainable. Volunteer Health Champions are recruited and trained. Their role is to engage the ongoing support of employers and employee, play a lead role in organising initiatives that promote health and wellbeing, as well as signposting to relevant, local services. Employer networks have also been formed where peer support is available for employers who are taking forward workplace health programmes.

Sexual Health Champions

Public Health commissions the a voluntary sector organisation DHIVERSE, to train community volunteers as Sexual Health Champions (SHCs) to work with their communities to promote sexual health and HIV prevention. The project has been especially successful with Black, Asian and Minority Ethnic (BAME) groups with the volunteers playing a key role in developing an awareness of HIV in their communities and ongoing sexual health promotion. More recent work has resulted in the recruitment of volunteers from the Men who have Sex with Men (MSM) communities.

Engaging Retailers - Healthy Options Project

The Healthier Options initiative engages local food businesses in Cambridgeshire to provide healthier food and drink options to customers. Environmental Health Teams from Cambridge, South Cambridgeshire and Fenland Councils have promoted the initiative to businesses in their areas and encouraged them to sign-up to the “Healthier Intention” pledge” to support their communities to make healthier food choices.

Social media, a website, a twitter account and a Facebook page are being used to engage not only with local businesses but also with the community. This has led to some local residents signing up to become Healthier Options Ambassadors and helping to promote the initiative to both local businesses and their communities.

Building Skills for Community Resilience - Public Health Training

Public Health provides various training courses for communities and professionals. These enable them to motivate and provide support for individuals and communities to take responsibility for their health and adopt healthier lifestyles. Examples of training are brief behavioural change interventions and motivational interviewing. More specifically Mental Health First Aid Training teaches people how to identify, understand and help a person who may be developing a mental health issue; this could be with their family, friends, workplaces or communities.

HEALTH AND WELLBEING BOARD
FORWARD AGENDA PLAN

MEETING DATE	ITEM	REPORT AUTHOR	TO DEMOCRATIC SERVICES (R Greenhill) By:
17 November 2016 10.00am (Pathfinder House, Huntingdon)	**Health and Wellbeing Board**		
	Apologies and Declarations of Interest	Oral	**Friday 4 November 2016**
	Minutes of the Meeting on 15 September 2016	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme: Memorandum of Understanding	Jessica Bawden	
	Forward Agenda Plan	Richenda Greenhill	
	Date of Next Meeting	n/a	
19 January 2017 10.00am (Shire Hall)	**Health and Wellbeing Board**		
	Apologies and Declarations of Interest	Oral	**Thursday 5 January 2017**
	Minutes of the Meeting on 17 November 2016	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	Person's story	TBC	

MEETING DATE	ITEM	REPORT AUTHOR	TO DEMOCRATIC SERVICES (R Greenhill) By:
	Developing the Better Care Fund Plan 2017-18	Geoff Hinkins	
	Priority 1 report from Children's Trust	Meredith Teasdale	
	Update on actions arising from the New Communities Joint Strategic Needs Assessment (JSNA)	Iain Green	
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme	Jessica Bawden	
	Forward agenda plan	Richenda Greenhill	
	Date of Next Meeting	n/a	
30 March 2017 10.00am (S.Cambs Hall, Cambourne)	**Health and Wellbeing Board**		
	Apologies and Declarations of Interest	Oral	**Thursday 16 March 2017**
	Minutes of the Meeting on 19 January 2017	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	Person's story	TBC	
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme	Jessica Bawden	
	Developing the Better Care Fund Plan 2017-18	Geoff Hinkins	
	Update on the Migrant Workers and Refugees Joint Strategic Needs Assessment (JSNA)	Katharine Hartley / Liz Robin	
	Forward agenda plan	Richenda Greenhill	
	Date of Next Meeting	n/a	

MEETING DATE	ITEM	REPORT AUTHOR	TO DEMOCRATIC SERVICES (R Greenhill) By:
1 June 2017 10.00am (Shire Hall)	**Health and Wellbeing Board** *(No theme: first meeting of municipal year)*		
	Election of Vice-Chairman/woman	Oral	**Wednesday 17 May**
	Apologies and Declarations of Interest	Oral	
	Minutes of the Meeting on 30 March 2017	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	Person's story	TBC	
	Better Care Fund Plan 2017-18	Geoff Hinkins	
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme	Jessica Bawden	
	Forward agenda plan	Richenda Greenhill	
	Date of Next Meeting	n/a	

Updated: 6 September 2016