



Cambridgeshire and
Peterborough
Safeguarding Children
Partnership Board

Annual Report 2019/20



Foreword

We are pleased to present the annual report of the Cambridgeshire & Peterborough Safeguarding Children's Partnership Board for 2019-20. This is presented on behalf of the three statutory partners and the local multi agency safeguarding arrangements.

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

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

Over the last 12 months the safeguarding landscape has continued to be complex, presenting many new challenges in addition to those faced day-to-day. The final quarter of the year has been dominated by the COVID crisis and its impact: globally, nationally and locally. This report focuses on the period 1st April 2019-31st March 2020, when Covid was at the start of the outbreak. We want to assure people that throughout the Covid pandemic to date, the Board has continued to work closely with both statutory and wider partners to scrutinise how safeguarding issues are addressed, gain reassurance that they are dealt with appropriately and provide a forum for sharing best practice across the partnership. It has also ensured that safeguarding children remains a key focus for agencies across the County.

Finally, we would like to thank all members of the Board, particularly the chairs of the sub-groups, for their professionalism, commitment and support. We would also like to say thank you to all agencies and front line staff for the incredible work that they do to keep children safe from abuse and neglect. Thank you to Jo Procter and her staff in the Independent Safeguarding Partnership Service for their hard work and support.

Wendi Ogle-Welbourn

Executive Director, People &
Communities

Carol Anderson

Chief Nurse

Vicki Evans

Assistant Chief Constable



Report of the Independent Scrutineer

BY DR RUSSELL WATE QPM, INDEPENDENT CHAIR CAMBRIDGESHIRE AND PETERBOROUGH SAFEGUARDING PARTNERSHIP



Working Together 2018 states at Chapter 3: Multi-agency safeguarding arrangements. Independent scrutiny: *'The role of independent scrutiny is to provide assurance in judging the effectiveness of multi-agency arrangements to safeguard and promote the welfare of all children in a local area, including arrangements to identify and review serious child safeguarding cases.'*

I am totally independent of any of the agencies within the partnership and have been appointed by them to carry out an independent scrutiny role. I can confirm with confidence, the assurance, that the Multi-agency Safeguarding Arrangements for Cambridgeshire and Peterborough Safeguarding Children Partnership are compliant with the statutory requirements of Working Together 2018. These arrangements ensure safeguarding and promoting the welfare of children in Cambridgeshire and Peterborough is happening.

I have also scrutinised this annual report for the period 2019-2020 and I can confirm that this report is compliant with the requirements of Working Together 2018.

Working Together 2018 states: *'The safeguarding partners should agree the level of funding secured from each partner, which should be equitable and proportionate.'* I have examined the discussions relating to the budget and the budget itself and confirm it is equitable and proportionate.

The partnership arrangements have been evolving over the last two years. This is a well thought out structure that has been designed to ensure that safeguarding is prioritised, discussed and acted on in the right forum to provide an appropriate response.

All three statutory partners are totally engaged and committed to a shared vision and work plan. This includes, providing support and commitment throughout all of the safeguarding structure and various Boards, sub groups and task and finish groups.

A large amount of independent scrutiny takes place through the Independent Safeguarding Partnership Service. This in essence is the engine room for the partnership and contributes greatly to the work of safeguarding children in Cambridgeshire and Peterborough. The Independent Safeguarding service team is led by an extremely able Head of Service, who is extremely well thought of and is clearly doing some outstanding work. One word of caution is that the three statutory partners should seek to maintain support for this individual and her team to ensure sustainability.

The Child Safeguarding Practice Review (CSPR) sub-group has an independent chair who is very experienced and able. This is a good appointment by the partnership. It ensures independent scrutiny of the most serious child safeguarding cases. The CSPR sub group carries out all of its statutory responsibilities and although at times overworked it has made good progress on child safeguarding practice reviews and iterations to its processes during the year.

The Multi-Agency training provision is extremely thorough and wide reaching. The provision of online training through Covid-19 is excellent and widely used and very well thought of by all partners including the voluntary sector.

Links should continue to be strengthened and developed directly by people, who represent the partnership, not just the Head of Service for the safeguarding partnership, with for example the LFJB, LCJB, MAPPA SMB, Health and Wellbeing Board, YOS Management Board.

The Quality and Effectiveness Sub Group operates well with the data it has and has an extremely good multi agency audit programme. Partnership performance scrutiny could be enhanced by agencies providing detailed performance narratives and further information on the outcomes of their single agency audits.

Working Together 2018 states that: *In situations that require a clear, single point of leadership, all three safeguarding partners should decide who would take the lead on issues that arise.* The three statutory partners have made a decision that each agency will chair the Executive Safeguarding Board for a year and then the Chair will rotate on an annual basis. This person should act as the lead figure but with support from, when required, the Independent Scrutineer.



Dr Russell Wate QPM

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About the Board



Leadership and Governance

Our Annual Report for 2018/19 detailed a number of changes within the safeguarding arena for both children and adults at risk. These changes led to the creation of a single Safeguarding Children's Board and a single Safeguarding Adults Board across the local authority areas of Cambridgeshire and Peterborough. Further details on these changes can be found here: <https://safeguardingcambspeterborough.org.uk/about-the-partnership-board/>

The structure combines the governance arrangements at a senior level to look at safeguarding arrangements holistically across both the children's and adults safeguarding arena.

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



IMAGE 1 - LINKS TO OTHER STATUTORY BOARDS

Cambridgeshire and Peterborough Safeguarding Partnership Boards

The two Safeguarding Partnership Boards (adults and children's) sit below the Executive Safeguarding Partnership Board (see Figure 2). The Safeguarding Partnership Boards are responsible for progressing the Executive Safeguarding Partnerships Board's business priorities through the business plan; authorising the policy, process, strategy and guidance to effectively safeguard children and adults at risk. The two Safeguarding Partnership Boards scrutinise, challenge and maintain an overview of the state of children's and adults safeguarding in Cambridgeshire and Peterborough; undertaken through quality assurance activity, learning and development programmes and commissioning and overseeing Child Safeguarding Practice Reviews / Safeguarding Adult Reviews / multi-agency reviews. The Safeguarding Partnership Boards have wider partner membership including probation, health providers, Healthwatch, education, voluntary sector, faith communities and housing. A full list of the Safeguarding Children's Partnership Board's partners can be found in Appendix 1.

To support the two (adults and children's) Partnership Safeguarding Boards are a range of sub groups and task and finish groups. These groups are responsible for a range of areas, including policies, training, consultation and quality assurance. The function of these groups are detailed below.

- Two consultation and development forums (one for adults and one for children's) responsible for securing the "voice" of practitioners and ensuring that learning is used to inform and improve practice.
- Two Quality and Effectiveness Groups (QEG), one for adults and for children's. Chaired by the Head of Service for the Safeguarding Partnership Boards, the group's membership includes senior managers from the safeguarding partners and other relevant agencies that have

responsibility for safeguarding performance within their organisation. These groups scrutinise safeguarding effectiveness and co-ordinate improvement activity by; quality assurance activity (both single and multi-agency), performance management information and overseeing of action plans.

- A single countywide Children’s Case Review Group, that examines children’s cases and a countywide Safeguarding Adults Review group which deals with adult’s case reviews.
- A single countywide Training Subgroup monitors both multi-agency and single agency training offered by the safeguarding partners.
- Task and finish groups are established to progress themed areas, e.g. child sexual abuse, criminal exploitation. Each group is responsible for producing resource packs for practitioners which include strategies/ guidance, training, leaflets and tools.

- The structure also includes those forums who have a “dotted line” to the Safeguarding Boards (Education Safeguarding Group, Child Protection Information Network).

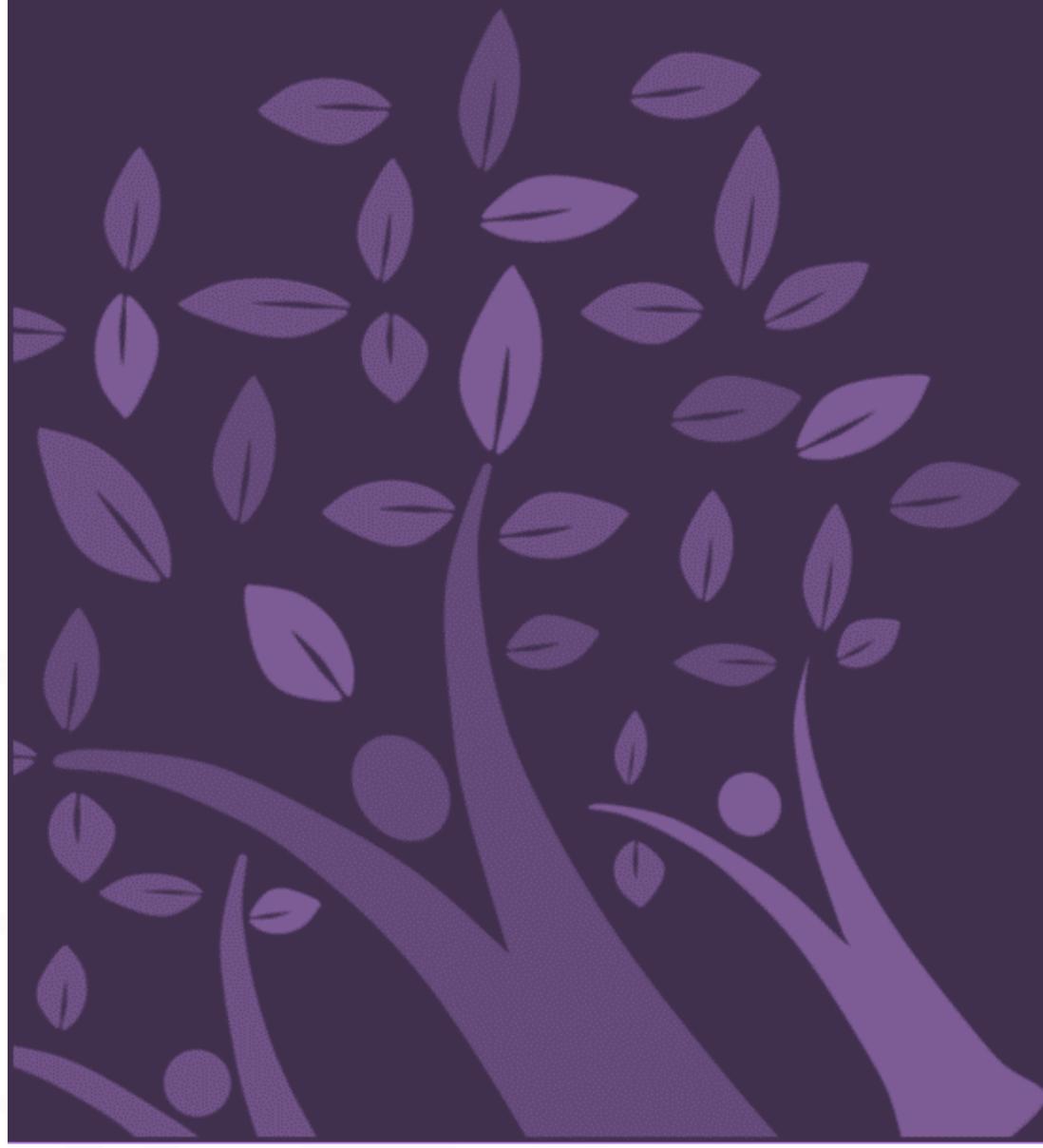
Independent Safeguarding Partnership Service

The work of the various Boards and groups within the governance arrangements is overseen by the Independent Safeguarding Partnership Service. The service is managed by the Head of Service and includes roles that cover both adults and children’s agendas. Some of the roles are specialised in quality assurance and improvement, exploitation, training, communication and there are more general adult and children’s leads and dedicated administrative roles. The service ensures that there is robust, countywide independent scrutiny and oversight of multi-agency practice.



IMAGE 2 - DIAGRAM SHOWING THE STRUCTURE OF THE CAMBRIDGESHIRE AND PETERBOROUGH SAFEGUARDING PARTNERSHIP BOARD

Work of the Safeguarding Partnership Board



Board Priorities 2019-2020

The Cambridgeshire and Peterborough Executive Safeguarding Partnership Board agreed the following priorities for the Safeguarding Children Partnership Board for this year. The four priorities were identified as areas that require further development through learning arising from case reviews and quality assurance activity.

1. To understand what the neglect landscape looks like across the county and embed the neglect strategies and tools across the partnership to achieve better outcomes for children and their families
2. To understand what the sexual abuse landscape looks like across the county and embed the child sexual abuse strategy and tools across the partnership to achieve better outcomes for children and their families
3. To agree a multi-agency approach to identifying, assessing and responding to cases of child criminal exploitation. To develop an effective approach to identifying at risk groups and preventing them from being exploited
4. Lessons from child safeguarding practice reviews (CSPRs) and Multi-Agency Reviews (MARs) are effectively disseminated and the impact of the learning is evidenced

1. Neglect

Neglect remains the most common form of child abuse across the UK. Partners across Cambridgeshire and Peterborough aim to ensure that there is early recognition of neglect cases and that from early help to statutory intervention there should be appropriate, consistent and timely responses across all agencies.

A dip sample was completed in late 2019 of child neglect tools to determine how widely these were being used within child in need and child protection cases across the county. The findings from this activity were presented to the Quality and Effectiveness Group (QEG) and have informed continuing discussions at The

Safeguarding Partnership Board regarding the use of assessment tools. The outcome of these discussions led to a move to a countywide assessment tool to ensure consistency.

This subject area was discussed at the Development and Consultation Forum in October 2019 to gain feedback from frontline managers on the use of the tools across the county. The feedback has been instrumental in shaping the work around a single countywide neglect tool. The feedback has also been used to refresh the neglect training.

Performance monitoring has been strengthened this year. Single agency performance is reviewed and monitored by the Quality and Effectiveness Group (QEG). This process requires partners to present a qualitative report which looks at the following areas:

- What is working well,
- What could be improved
- What each agency is doing to progress the improvements
- Details of any improvements that require a multi-agency response.
- Any information which needs to be escalated to the Safeguarding Children's Partnership Board or Executive Safeguarding Partnership Board

The group have a discussion regarding individual performance relating to the Board's priorities based on these reports. Each priority is considered by the group twice a year. This revised performance reporting process has provided a forum for agencies to work through multi-agency practice issues. The discussions have led to change in processes and policies. Where discussions have not resulted in resolving practice issues there is a direct escalation by the chair to the Safeguarding Board.

In February 2020 a review of neglect training offered by the Independent Safeguarding Partnership Service commenced to ensure consistency of messages. Delivery of updated

training has been delayed but is due to be delivered virtually in September 2020.

The s11 self-assessment tool was completed by safeguarding partners in March 2020. The tool included a specific section on the Neglect. Strategy, training and use of assessment tools for neglect. Findings from the section 11 are currently being analysed and will be reported on in the 2020/21 Annual Report.

Alongside the section 11, a practitioner survey with questions on similar areas of safeguarding, including specific questions on neglect was also completed by partners. The aim of this survey was to correlate the responses of practitioners and senior managers.

A dedicated neglect page on the Safeguarding Partnership Boards website has been created which includes local and national information and resources for practitioners. The page has been accessed 577 times within the time period of this Annual Report. The page can be found here:

<https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/child-neglect/>

2. Child Sexual Abuse

The last four decades have been witness to a changing landscape of language and framings for child sexual abuse (CSA). The Cambridgeshire and Peterborough Safeguarding Children Partnership Board recognises the need for cases of CSA to be acknowledged and addressed and as such it is one of the core objectives of its work.

Front line practitioners and managers provided feedback on current challenges and issues relating to child sexual abuse at the Development & Consultation Forum in April 2019. The subject area was then revisited following the results of the Section 11 self-assessment to focus on the use of assessment tools relating to child sexual abuse 10 months later.

The subject of child sexual abuse has been included within the practitioner workshops delivered this year. This has included information

specifically around the tools available to assess child sexual abuse.

An audit of forensic medicals was completed December 2019. The processes for forensic medicals was amended as a result of the audit.

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A dedicated area on the Safeguarding Partnership Board's website was created in this year on the subject of child sexual abuse which includes resources for professionals on areas such as online abuse and female genital mutilation. The page has been accessed 217 times within the time period of this Annual Report. These can be found here:
<https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/csa/>

The Section 11 self-assessment audit tool included a specific section on child sexual abuse. Including the implementation of the strategy, training and use of tools. Findings from the section 11 are currently being analysed and will be reported on in the 2020/21 Annual Report.

3. Child Criminal Exploitation

Child criminal exploitation (CCE) is increasingly being recognised as a major factor behind crime in communities in the UK; it also victimises vulnerable young people and leaves them at risk of harm. The oversight of practice around criminal exploitation of children and young people is governed by the Cambridgeshire and Peterborough Safeguarding Partnership Board and Countywide Community Safety Partnership. The multi-agency partnerships work closely together to ensure that young people are supported and perpetrators are brought to justice.

Multi-agency information sharing has allowed us to create a series of localised problem solving groups known as 'mapping' to specifically concentrate on environmental issues and ensure that robust plans are in place for both victims and perpetrators of criminal exploitation. The mapping has significantly contributed to our understanding of serious street based violence involving children and has allowed us to be proactive when creating interventions. The mapping has been used to support the objectives set out by the wider partnership.

Child criminal exploitation training has been delivered to over 800 members of staff and partners. Training has been delivered to all the Language Schools which have always been viewed as a significant omission.

As a partnership we have developed and delivered an "enhanced offer" to all schools highlighted as risk areas through mapping activity and have presented at the Annual Cambridgeshire and Peterborough Teacher Training Conference.

We have continued to develop the Risk Management Tool and create and maintain a Strategic Delivery Plan which has been enhanced to include a robust action plan for all partners

This year we have developed our links with the Design out Crime Officers to highlight issues of child criminal exploitation and how new building developments could effect it. This has led to some significant involvement from us at the planning stage with new builds such as Soham railway station and the new area development at Cambridge City. We have been able to influence planning design of major residential builds along with brown field infrastructure such as shopping areas and railways.

The Section 11 self-assessment audit tool included a specific section on child criminal exploitation. Including the implementation of the strategy, training and use of tools. Findings from the section 11 are currently being analysed and will be reported on in the 2020/21 Annual Report.

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Ongoing Developments

The wider partnership has been successful in a number of areas to secure funding to tackle wider exploitation and ensure focus at every level of risk identified. Work is continuing with the Safer Relationships for Exploited Children (SAFE) teams to work with those children deemed at “significant risk”.

The Youth Justice Board awarded Essex, Norfolk, Suffolk and Cambridge Youth Offending Teams funding to establish a ‘County Lines Pathfinder’ post that will seek to develop effective practice that can be disseminated across the Youth Justice system. Cambridgeshire planned to test innovative ways of working across the partnership with a focus on ensuring that all agencies are taking an effective practice collaborative response to County Lines and Child Criminal Exploitation across the county. This work will be reported upon in greater detail in the 2020/21 Annual Report.

4. Lessons from Child Safeguarding Practice Reviews (CSPRs) and Multi-Agency Reviews (MARs)

Working Together to Safeguard Children 2018 states:

‘The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policymakers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system

being dynamic and self-improving’.

‘The responsibility for how the system learns the lessons from serious child safeguarding incidents lies at a national level with the Child Safeguarding Practice Review Panel (the Panel) and at local level with the safeguarding partners.’

More details can be found in the document:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

Across Cambridgeshire and Peterborough safeguarding partners have adopted a ‘learning culture’. The countywide Panel which monitors local child safeguarding practice reviews will consider and agree those cases which do not meet the criteria for a CSPR but are worthy of review with the aim of extracting important local practice learning.

Rapid Reviews

Following the issue of Working Together 2018 the Safeguarding Partnership Board developed a process including a new Rapid Review Referral Form and wrote the "Guidance on Child Safeguarding Practice Reviews" in line with this new statutory guidance. Partners have had to adapt to this new faster process, this has undoubtedly added extra pressure onto partners. The form has had to be reviewed and adapted

further:

<https://www.safeguardingcambspeterborough.org.uk/children-board/serious-case-reviews/>

Other adaptations in line with recommendations from Working Together 2018, National Panel and research findings (Brandon et al 2019) have been made this year. The methodologies for the completion of CSPRs was changed in July 2019 in order to involve more discussion based activities and direct involvement of the practitioners and the different agencies involved in the CSPR, the aim of which is to gain more ‘real time’ learning. This move has been met with positive feedback from those involved.

Learning from CSPRs

In October 2019 the process for implementing learning from case reviews was strengthened following feedback from practitioners and managers at the Development and Consultation Forum. All CSPRs now have a practitioners briefing developed and made available on the website. Safeguarding partner agencies include these briefings in single agency training. In addition, we have put into place workshops that are delivered at the completion of case reviews so that learning can be disseminated across the partnership. Further feedback from frontline practitioners has confirmed that these have proved a useful resource.

The process that is in place for disseminating learning has been highlighted as national good practice. The process was included in the national document *Complexity and challenge: a triennial analysis of SCRs 2014-2017* (July 2019) Brandan et al as a case study.

A thematic review was completed in January 2020 of the learning themes from Serious Case Reviews between 2006 -2019. The findings are being triangulated with the results of the section 11 self-assessment and feedback from the Development and Consultation Forums and are due to be presented to the Safeguarding Partnership Board in July 2020. The section 11 self-assessment tool contained specific questions which sought to identify how this learning is taking place within partner agencies. Findings from the section 11 are currently being analysed and will be reported on in the 2020/21 Annual Report.

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Locally, two case reviews were published within the timeline of this report: 'Jack' and 'Eleanor'. The learning from these reports is outlined below. Both of these reports can be found on the Safeguarding Boards website: <https://www.safeguardingcambspeterborough.org.uk/children-board/serious-case-reviews/>

Learning from the case of 'Jack'

Jack was a three month old baby subject to an Interim Supervision Order and was found to have injuries to his head and leg. As a result of the injuries Jack was taken into Foster Care.

Good practice was noted that a number of professionals worked together and visited Jack with his parents regularly over a set period of time

In order to support the identification of child neglect alongside parental involvement, professionals could have considered using risk assessment tools such as the Graded Care Profile.

There were instances where bruising on Jack's face was noted and practitioners were professionally curious by asking parents how the bruises had happened. Professional practice

would have been further supported by agencies following the baby bruising protocol in every case of a suspected bruise for pre mobile babies.

Parents could have been offering limited engagement with professionals and this was discussed at Core groups, although the parents were not actively involved within those groups nor with Jack's plan.

Parental mental health and parents with learning difficulties are complex areas that professionals need to understand in order to work with parents to help safeguard their children

A number of recommendations were made to support identified areas of professionals practice within Jacks case and to date these have been successfully completed.

Children social care's (CSC) pre-birth assessment procedures have clear timescales and multi-agency panels are held for unborn children. Child protection plans are SMART and assessment tools are featured as part of the safeguarding process .Team managers within CSC have management oversight and sign off all assessments.

Guidance on Safeguarding Children who have a Parent or Carer with mental health problems has been reviewed and is available on the safeguarding board website. The legal framework is referred to within the safeguarding partnership board's multi-agency training and is available on training slides developed for single agencies training. Termly workshops on 'lessons learned' have promoted the use of assessment tools to safeguard children and the baby bruising protocol.

Learning from the case of 'Eleanor'

When Eleanor was 19 months old she was the subject of a serious assault perpetrated by her natural father. Subsequent medical examination revealed that Eleanor had suffered a series of significant and serious historical injuries.

This case highlighted several areas of good

practice:

One of the learning points that should be taken from this case is what can be achieved when services work closely together and share concerns in order to manage potential risk. The health visitor and midwife communicated well and involved the police to assist them when they could not contact the family.

Another area which should be highlighted is the desire by professionals to 'do the right thing' even when a case may not fit the given criteria. There was a good demonstration of professional curiosity, with numerous attempts to contact a family, who obviously did not want to be reached, when there was little evidence or information to raise this case above many others. This case should be used to re-enforce with professionals the benefits of following their professional instinct and judgement.

The involvement of the housing departments of both the District Council and Housing Association is difficult to accurately gauge due to the limited access to reliable records. What can be said is that there was information that a vulnerable family were likely to be made homeless and there was no consideration of making a safeguarding referral or seeking their consent to access support from other services. It would appear that 'front facing' staff may not routinely receive safeguarding training.

The District Council has, since the start of this review, considered these areas and where necessary amended or enhanced their practice.

As a direct result of the reviews conducted within the timescale of this report, a review of *Bruising in Pre-mobile Babies: A Protocol for Assessment, Management and Referral by Professionals* was undertaken with involvement from safeguarding partners. The updated guidance can be found here:

<https://www.safeguardingcambspeterborough.org.uk/children-board/professionals/procedures/bruising-in-pre-mobile-babies-a-protocol-for-assessment-management-and-referral-by-professionals/#Documentation>

Practice Improvement and Development



The Lived Experience of the Child

Through the time period covered by this report the safeguarding partners have continued to work to improve the practice of front line professionals by listening to the lived experience of the children they may come into contact with. This work has included the following activities:

Safeguarding Partnership Service: A task and finish group was set up to develop practitioner guidance and a training pack. The pack and guidance was launched via 7 workshops that took place at the start of April 2019. 173 professionals attended. Both the guidance and the training were, written in response to local audits and SCRs identifying the omission of practice from professionals in actively finding out what life's like for the child(ren) that they work with. Subsequent recent quality assurance activity evidences that there has been an improvement in this area.

The practitioner survey undertaken alongside the Section 11 self-assessment activity, included questions focussed on the lived experience of the child. The responses to these questions demonstrated good practice examples such as using art and play activities to gain feedback from children, using the Mind of My Own (MOMO) app with young people to gain their views, observations of pre-verbal children, capturing children's voices in writing or drawings and ensuring the vies of children and young people are recorded within their records. Managers were asked the same question and their responses demonstrated good practice in the form of: ensuring recording includes the views of parents or carers particularly where these differ from the professionals supporting them, scrutiny and quality assurance of practice within their agency and responding to complaints from parent and carers.

Cambridgeshire Constabulary: 'We now have an officer from our Child Abuse Investigation and Safeguarding Unit provide a compulsory training input to our student officers. The Lived

Experience/Voice of the Child is specifically addressed through a video input on Baby P with the main theme and learning point relating to how insufficient direct contact was made with the child by officers despite attending on many occasions; only the parents were spoken to. Input is then given on engaging and making this initial contact with the child without entering into formal/legal interview.'

Children's Social Care: Over the year, in Cambridgeshire and Peterborough Children's Services, all audit activity undertaken by the Quality Assurance Service and by senior managers considers the quality and effectiveness of practice to establish the child's lived experience, thereby keeping the child firmly fixed at the centre of management oversight. This measure of child centred practice is underpinned by an agreed set of practice standards, policies, procedures and a range of tools to support direct work with children to give ear to their voice, expressed views wishes and feelings and construct an understanding of what life is like for that child. For children in care and children who are subject to child protection plans, there are consultation forms and feedback forms for children to complete in advance of and after meetings to ascertain voice and contribute to an understanding of their lived experience.

In addition children continue to be supported to attend key meetings to plan and review the progress of their plans and where they do not attend in person, an advocate or other trusted adult such as their IRO; CP Chair or other trusted adult may represent their views. Furthermore all children who are open to children's services are encouraged to use the Mind of My Own App to communicate wishes, feelings and views.

Audits evidence that children are seen regularly and there is a range of direct work undertaken. Where working with children with any disabilities, social workers were skilled at reflecting on children's non-verbal communication and using this to evidence their voice through the case

recording. OFSTED inspection (CCC); peer reviews and internal inspections in both councils evidence that workers know their children and families well and demonstrate a sound understanding of children's lived experience however, audits suggest that the written articulation of the child's lived experience is not as consistent or strong and is an area for further improvement. Audit findings feed into management meetings and service action plans, and audits continue to evidence a trajectory of improvement in this area of practice.

Health Safeguarding Group: All Health Organisations within the Cambridgeshire and Peterborough system seek to support staff to consider the lived experience of the child in a number of ways, through training, supervision and audit of cases. Safeguarding professionals seek to enable staff to "stand in the shoes" of children through case review training, to enable greater understanding of the safeguarding risks to that child or young person. There is significant diversity in the health family around services engagement with children, however championing the child's view in each context is paramount. Organisations will audit the clinical practice within their specific context in line with local guidance. As the health system has begun to adapt in order to respond to the emerging Covid 19 pandemic, ensuring visibility and voice continue to be heard has been paramount and both championed by safeguarding professionals within their organisations and staff being supported to consider how different ways of working may challenge that voice being heard.

Quality and Effectiveness Group (QEG)

Monitors the individual and collective effectiveness of the practice of the Safeguarding Children Partnership Board partners and has a strong quality assurance function undertaking audits, focus groups and surveys. The annual

themed audit programme (quality assurance planner) includes both single and multi-agency audits and are linked to the board's priorities. QEG advises and supports the board in achieving the highest safeguarding standards and promoting the welfare of children in Peterborough and Cambridgeshire by evaluation and continuous improvement. During the twelve months covered by this report the following audits have taken place:

- **Neglect;** this activity focussed on the use of assessment tools for the subject area of neglect across the county. This subject generated discussion at the Safeguarding Board and Executive Board and as a result a Task and Finish Group will be set up to plan the development of a county wide neglect assessment tool.
- **Local Authority Designated Officer (LADO);** originally completed by the Independent Safeguarding Partnership Service considering Cambridgeshire only, Peterborough Children's Social Care then completed an internal audit of their LADO processes and the reports were combined and presented to the Safeguarding Partnership Board. Now both LADO services follow aligned processes and referral paperwork
- **Thematic review on SCRs:** completed in January 2020 focussing on SCRs between 2006 -2019, the report was presented to the Safeguarding Partnership Board in March 2020. The findings were fed into the review of how learning from SCRs and now CSPRs is disseminated across the county, a process which has been strengthened this year. Further work is being undertaken to triangulate the results with the section 11 activity and consultation with safeguarding practitioners.
- **Section 11 self-assessment audit tool and practitioner survey:** Section 11 (s11) of the Children Act 2004 places a statutory duty on key organisations to self-assess the extent to which they meet the safeguarding requirements and standards. This activity was initiated in January 2020 alongside a practitioner survey to correlate the findings

from both pieces of work. Analysis of the results is currently underway.

- **Forensic medicals at the Sexual Assault Referral Centre (SARC):** this audit sought to determine whether children who had disclosed sexual abuse were being referred appropriately for forensic medical examinations at the SARC. The process for forensic medicals has been changed as a result of the audit.

At the conclusion of all audit activity a briefing is prepared highlighting the implications for safeguarding practice across all agencies in terms of roles and responsibilities for safeguarding children at risk of abuse and neglect.

All of the audits have resulted in recommendations and action plans with learning for practice cascaded through the Safeguarding Board Workshops and professional briefings on the Safeguarding Board's website.

Additionally, performance monitoring has been strengthened this year. Single agency performance is reviewed and monitored by the Quality and Effectiveness Group (QEG). This process requires partners to present a qualitative report which looks at the following areas:

- What is working well,
- What could be improved
- What each agency is doing to progress the improvements
- Details of any improvements that require a multi-agency response.
- Any information which needs to be escalated to the Safeguarding Children's Partnership Board or Executive Safeguarding Partnership Board

The group have a discussion regarding individual performance relating to the Board's priorities based on these reports. Each priority is considered by the group twice a year. This revised performance reporting process has provided a forum for agencies to work through multi-agency practice issues. The discussions

have led to change in processes and policies. Where discussions have not resulted in resolving practice issues there is a direct escalation by the chair to the Safeguarding Board.

Multi Agency Training and Development

Over the twelve months from January 2019 to December 2019, the Children Safeguarding Partnership Board provided: workshops, training days and training for general practitioners.

In total there were 1,958 professionals attended safeguarding children training. However, in 2019/20 the safeguarding partnership board did not provide an annual conference but alternatively has provided many more training sessions for hard to reach groups of people.

Practitioner Workshops

It is a priority of the children's Quality and Effectiveness Group (QEG) that workshops on the latest themes and lessons learned from quality assurance activity and case reviews should be facilitated by the Safeguarding Children Partnership Board on a termly basis. Specialist training workshops are a conduit for sharing safeguarding information, localised experiences, networking and are highly regarded by practitioners as an 'excellent' training resource.

- **Lessons learned workshops.** These workshops provide professionals with the latest research and findings from Cambridgeshire and Peterborough multi-agency audits and case reviews. They also serve as a safeguarding refresher highlighting assessment tools and multi-agency policies, procedures and resources for practitioners to utilise within safeguarding practice.

The workshops this year centred on the changes to the board following the abolishment of Local Safeguarding Children Boards (Children and Social Care Act 2017 / Working Together 2018), LADO (Local Authority Designated Officer), cultural

competence, child sexual abuse, child neglect, and the findings from the latest four SCR's and a local thematic suicide review.

- **The Lived Experience of the Child.** During the safeguarding board auditing activity and within local case reviews, a repetitive theme of 'the voice of the child' was consistently found to be omitted from; risk analysis, assessments, referrals and plans. A task and finish group was set up to develop practitioner guidance and a training pack. The pack and guidance were launched via seven workshops that took place at the start of April 2019. 173 professionals attended. The training is available to all safeguarding partner agencies on request and includes PowerPoint slides, trainer notes, case scenarios and the guidance. Monitoring via the Training Subgroup has demonstrated that safeguarding partners are cascading the guidance to their frontline practitioners and are using the material within the training pack to compliment single agency training.
- **Achieving the best outcomes for children and young people: Making the right referrals at the right time.** A number of Multi-agency briefings were held in early 2020 to consider how practitioners can achieve the best long term outcomes for children by making the right referrals at the right time in accordance with the Safeguarding Partnership Board's Effective Support for Children and Families (Threshold) Document.

Training Sessions

The Training Impact Review form which is sent to participants of multi-agency training provided by the Safeguarding Partnership Board six weeks after each course, has also been changed to collect qualitative and quantitative data that is meaningful for analysis and easier for attendees to answer.

Training sessions during 2019/20 were evaluated highly by professionals with 98% rating, both the delivery of the training and the aims and learning outcomes of the training as being 'good' to 'excellent'.

Salient comments from attendees include

- *Gained new perspectives on online sexual abuse*
- *I found the course interesting and relevant to one of the families I am working with now. It has helped me to build a much better relationship with them and has therefore improved the flow of information.*
- *Case based discussions very helpful /Thought provoking*
- *Gave me new skills around how to manage challenging situations*
- *One of the best training for safeguarding I have attended*

In terms of impact of the training on practice 81% of practitioners felt that they had learned a lot and that 93% felt that the training was completely or mostly relevant to their safeguarding role.

92 % of respondents stated that they felt that the training provided supported multi-agency working to safeguard children and young people.

Respondents were invited to make comments in relation to the training enabling future multiagency working to safeguard children and young people. Some of those comments included:-

- *Excellent signposting to relevant agencies*
- *I line manage a team of 8 Young People Workers and this has supported me to support them working with Police on county lines projects*
- *Useful contact numbers for other agencies were supplied.*

A training needs survey was undertaken within the timescale of this Annual Report. Training leads within partner agencies were asked to consider whether the subjects of each of the Board's priorities: neglect, child sexual abuse, child criminal exploitation and learning from child safeguarding practice reviews has been embedded into their safeguarding training. Results of this survey will be triangulated with the results of the section 11 activity and practitioner survey and reported on in the 2020/21 Annual Report.

Finally, two training resources have been designed and reviewed this year on the following subject areas:

'Having difficult conversations' training and resource packs was made available to both the children's and adults workforces and received positive feedback.

The 'Lived Experience of the Child' training and resources have been reviewed and updated training is due to be delivered, now virtually, in August 2020.

Single Agency Training

The Children's Safeguarding Partnership Board has a duty to ensure that single agency safeguarding children training is; robust, up to date with the latest research and lessons learned and is fit for purpose, to ensure that the children's workforce is well equipped, informed and trained to deal with safeguarding issues for children and young people. This year the Board's priorities have been added as key competencies for single agency training.

During the year 8 courses have been validated successfully these courses came from both Peterborough and Cambridgeshire agencies.

In addition to the multi-agency training, members of the Independent Safeguarding Partnership Service have cascaded workshops and presentations to a mixed single agency audience over the past year. Approximately 592 front line practitioners, students and faith groups have been briefed including participants from; education, MASH (Multi-agency Safeguarding Hub), mosques, early help, police, substance misuse agency, children's social care, early help and Anglia Ruskin University.

General Practitioner training ran four times during the year, with 231 General Practitioners and Senior Practitioner Nurses attending.

Raising awareness of the role of the CSPB and safeguarding issues across communities

Promoting awareness is an ongoing activity held throughout the year by the board and its members.

Over the past 12 months, the Safeguarding Board website has been further developed to include briefings, resources and guidance for practitioners across Cambridgeshire and Peterborough and had been viewed 215,000 times by 77,000 users.

The Safeguarding Board also continues to use social media to raise awareness of the work of the board and share messages of local and national importance. During the 12 months, our posts reached approximately 21,000 users.

At the time of writing this report COVID-19 had severely impacted professionals' ways of working including social distancing to prevent the spread of the disease and to support our National Health Service.

As a result, the safeguarding partnership board website has developed a number of resources for professionals and community volunteers, including an informative Covid-19 support page, development of training packs with audio and animation for basic safeguarding,

It is anticipated that some of these new design elements, if successful, will continue throughout 2020 and beyond.

Learning Culture



The Safeguarding Adults and Children Partnership Boards create a culture of openness and facilitate effective and regular challenge to all partner agencies. The Boards do this by the Independent Safeguarding Partnership Service (ISPS) reviewing, scrutinising and challenging local safeguarding arrangements. Findings from

Child Safeguarding Practice Reviews, Safeguarding Adult Reviews and audit activity are cascaded back to practitioners and agencies to embed the learning back into practice. The chart below shows how the Safeguarding Partnership Board identifies learning as part of evidence informed practice.

Learning Framework

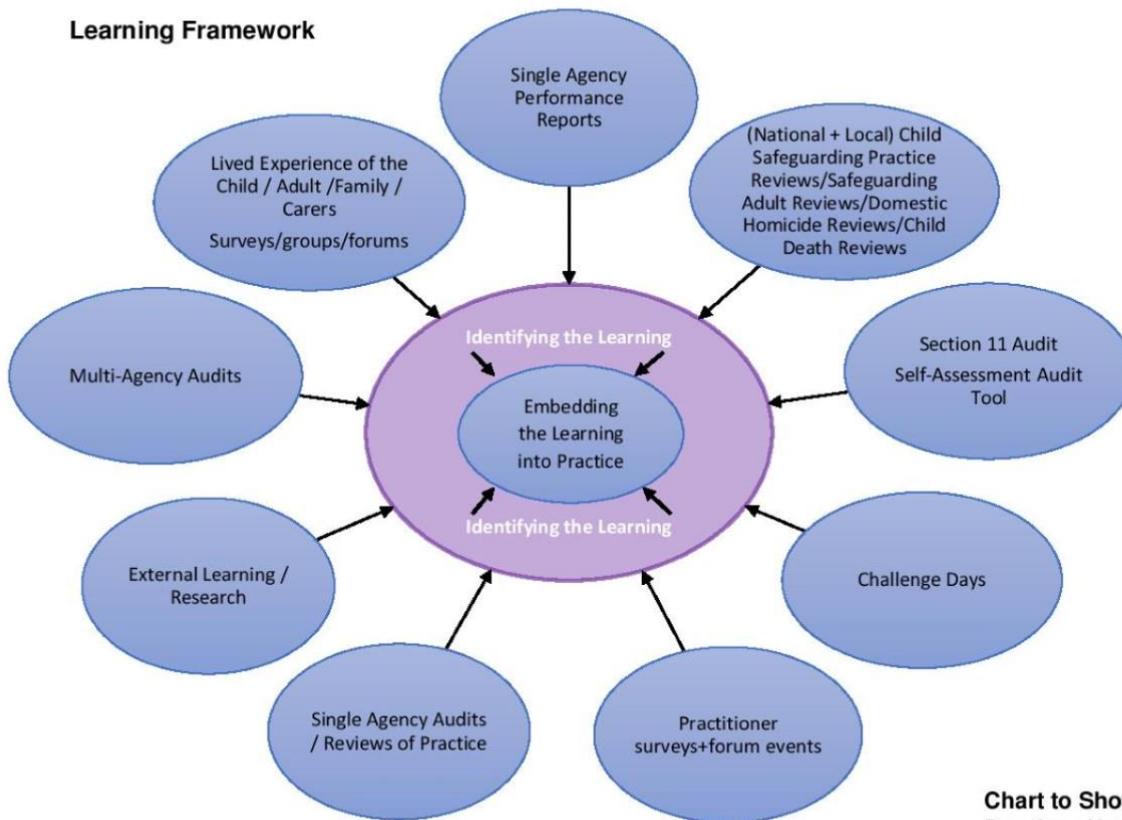


Chart to Show: Evidence Based Practice : How Cambridgeshire and Peterborough Children and Adult Boards Identifies Learning

IMAGE 3 - DIAGRAM SHOWING WHERE LEARNING FOR PRACTICE IS IDENTIFIED

Appendices



Appendix 1: Safeguarding Children Partnership Board Partner Agencies

- Cambridgeshire, Norfolk & Suffolk Clinical Commissioning Group
- North West Anglia Foundation Trust
- Peterborough and Stamford Hospital
- Cambridgeshire and Peterborough Foundation Trust
- Cambridge University Hospitals
- Royal Papworth Hospital NHS Foundation Trust
- East of England Ambulance Service
- Cambridgeshire Constabulary
- Office of the Police and Crime Commissioner for Cambridgeshire and Peterborough
- Children & Safeguarding representatives, Cambridgeshire County Council
- Children & Safeguarding representatives, Peterborough City Council
- Adult Safeguarding representative, Cambridgeshire County Council and Peterborough City Council
- Cambridgeshire and Peterborough Youth Offending Service
- St Johns Primary School, representing Primary Education
- Sir Harry Smith Community College, representing Secondary Education
- Peterborough Regional College representing Further Education
- National Probation Service
- Bedfordshire, Northamptonshire Cambridgeshire and Hertfordshire (BeNCH) Community Rehabilitation Company
- Cambridge City Council
- Cross Keys Homes, representing the housing sector
- Counsellor for Children's Services & Education, Peterborough City Council
- Lead Member Cambridgeshire County Council
- Cambridgeshire Fire and Rescue Service
- Public Health Cambridgeshire County Council
- Public Health Peterborough City Council
- Children and Family Court Advisory and Support Service Cafcass
- Ely Diocese
- Healthwatch, Cambridgeshire and Peterborough



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