Cumbria Safeguarding Adults Board

Annual Report 2022-23

@cumbriasab

cumbriasab.org.uk

Cumbria Safeguarding Adults Board

Contents

Glossary of Terms

ADASS **Association Directors of Adult Social Services**
An organisation working with Director's of Adult Social Care across council's as a leading voice for adult social care.

CSAB **Cumbria Safeguarding Adults Board**
The overarching purpose of an SAB is to help safeguard adults with care and support needs.

CSCP **Cumbria Safeguarding Children's Partnership**
The purpose of CSCP is to support and enable local organisations and agencies to work together to ensure children are safeguarded and their welfare promoted.

CSPR **Children's Safeguarding Practice Review**
A Child Safeguarding Practice Review (previously known as a Serious Case Review) is undertaken when a child dies, or the child has been seriously harmed and there is cause for concern as to the way organisations worked together.

DHR **Domestic Homicide Review**
Domestic Homicide Reviews enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. This also includes suicides where domestic abuse may have been a contributory factor.

GP **General Practitioner**

HMICFRS **His Majesty's Inspectorate of Constabulary and Fire & Rescue Services**

HMP **Her Majesty's Prison**

HMPPS **Her Majesty's Prison & Probation Service**

ICC **Integrated Care Community**
An Integrated Care Community is a community where professionals from a range of backgrounds work together as a team to improve the overall health and wellbeing of their community.

LFH **Local Focus Hubs**
Local Focus Hubs provide a joined-up approach to community engagement and are made up of partners from Cumbria Constabulary, Cumbria County Council, the Fire and Rescue Service, Mental Health services and more.

LGR **Local Government Review**
Local Government Review of the provision of local, district and county council arrangements.

LPA **Lasting Power of Attorney**
A lasting power of attorney is a legal document that allows a person to appoint one or more people (known as 'attorneys') who can make decisions on their behalf in the event they lack capacity to do so themselves.

LSCFT **Lancashire & South Cumbria NHS Foundation Trust**

LSCICB **Lancashire & South Cumbria Integrated Care Board (NHS)**

MCA **Mental Capacity Act 2005**

MDT **Multi-disciplinary Team**
Or MDT for short is simply a diverse group of professionals working together. The MDT would aim to deliver person-centred and coordinated care and support for the person with care needs.

MSP	**Making Safeguarding Personal** Making Safeguarding Personal aims to develop a personal outcomes focus to safeguarding work, with a range of responses to support people to improve or resolve their circumstances
NHS	**National Health Service**
NWAS	**North West Ambulance Service**
P&QA	**Performance & Quality Assurance Group** This is a sub-group of Cumbria Safeguarding Adults Board.
RSC	**Recovery Steps Cumbria, Humankind** Recovery Steps Cumbria, Humankind is the provider of drug and alcohol services in Cumbria.
SAB	**Safeguarding Adult Board** The overarching purpose of a SAB is to help and safeguard adults with care and support needs.
SAC	**Safeguarding Adults Collection** The Safeguarding Adults Collection is a national record which collects details from Council's about safeguarding activity for adults aged 18 and over in England.
SAR	**Safeguarding Adult Review** A Safeguarding Adults Review takes place an adult who has needs for care and support has experienced abuse or neglect and agencies could have worked better together to protect them.
SCIE	**Social Care Institute for Excellence** Social Care Institute for Excellence supports professional practice through co-producing, sharing, and supporting the use of the best available knowledge and evidence about what works in social care and social work.
SPA	**Single Point of Access** The Single Point of Access is the first point of contact for both the public and other professionals about social care needs or for reporting safeguarding concerns.

1. A message from the Independent Chair

As the Independent Chair of the Cumbria Safeguarding Adults Board, I would like to thank you for your interest in Safeguarding across Cumbria. I hope this Annual Report serves its purpose of bringing to life the work and efforts of all our partners in protecting the lives of our most vulnerable people.

April 2022 to April 2023, saw the culmination of several huge organisational restructures, among our partners. We now have two new Integrated Care Boards (ICB); the North East and North Cumbria ICB and the Lancashire and South Cumbria ICB, and through Local Government Reform, the introduction of two new Local Authorities; Cumberland Council, and Westmorland and Furness Council.

As well as demanding huge restructures in Health and Councils services, these changes have required further changes across the whole partnership of agencies as they have had to adapt to work alongside these new organisations.

This period of change was always a safeguarding concern with the possibility of heightened risk. The Safeguarding Board received regular reports during this time and continue to examine the progress of these changes and their effect on the safety and well being of our most vulnerable citizens.

Whilst we remain in the early days of these changes, we as a Board have throughout this year been assured that services continued to operate, and the needs of our populations are being met throughout the changing lines of governance and structures. This has been a mammoth task for staff in all services across the partnership and is worthy of our congratulations.

Since the inauguration of these new organisations, we have witnessed a renewed enthusiasm across the partnership of services eager to capitalise on the benefits of these changes, whilst building on the experience and history of previous structures and alliances.

All of this at a time of; continued pressure of a pandemic which refuses to end, a war in Europe, and this coupled with a national economic crisis that is severely impacting locally on our already most challenged communities.

Our public sector and third sector colleagues have been operating at full peak without respite now for over three years, and yet they continue to achieve, serve, and protect.

The report that follows, tells some of that story.

These pressures are not expected to wain in this forthcoming year. We can however take assurance that the commitment, efforts, and determination of our staff, will endure.

Kind regards,

Rob McCulloch-Graham
Independent Chair
Cumbria Safeguarding Adults Board

2. Introduction

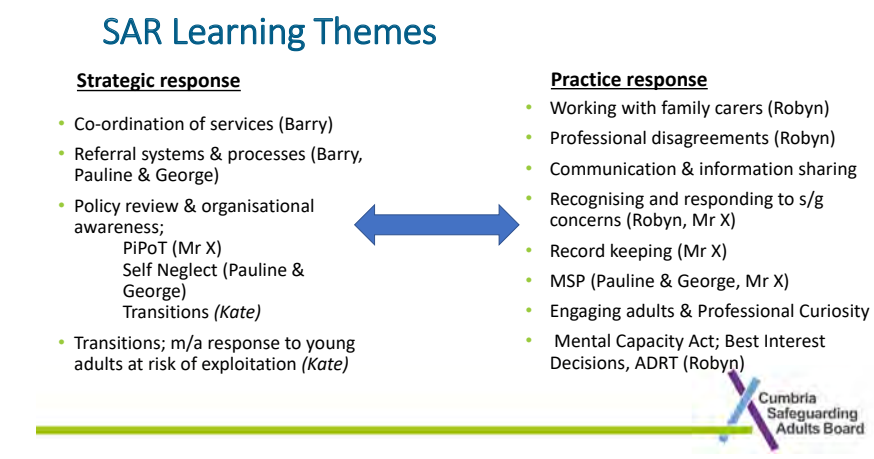
This report will provide an update regarding what Cumbria Safeguarding Adults Board (CSAB) and our partner agencies have done during 2022/23 to safeguard adults at risk of abuse or neglect. During the year we seen a period of major system change including the transition of Clinical Commissioning Groups to Integrated Care Boards in July 2022 now operating at a regional level. CSAB continued to work with safeguarding leads in Cumbria to ensure a "place" based response to safeguarding adults at risk of abuse or neglect. In preparation for Local Government Reforms, we engaged with the new 'shadow authorities' for Cumberland and Westmorland & Furness Council's to agree the 'shared' delivery model agreeing to retain one Safeguarding Adults Board serving Cumbria.

At the end of 2021/22 we said farewell and thank you to our Independent Chair, Jeanette McDiarmid who helped to steer and improve the Board during her 4-year tenure and we welcomed Rob McCulloch-Graham as the new incoming Chair.

During 2022 we published a new **5-year Strategic Plan 2022-2027**. The development of this Strategic Plan was informed by a Peer Review of CSAB's structures, systems and processes. The indings and the Peer Review report was presented to a Development Session involving members of the Board and sub-groups in May 2022. An invitation was extended to our sub-group members to attend and represent contributions from front line practice through asking practitioners to identify their 'top 3 priorities for CSAB'.

Themes and learning from SARs were also considered to agree our new objectives and inform the **2022-2027 Strategic Plan**.

In this report we will describe the activity and achievements of the Board and sub-groups during Year 1 of our 5-year Strategic Plan. We have measured our achievements against the goals and initiatives outlined in our **2-year Business Plan 2022-24**. The development of the 2-year plan intended to provide continuity during a period of system change and ensure that the SAB and its members continued to prioritise safeguarding and the strategic objectives for the Board. Delivery of the Business Plan will continue into the 2023/24 period.



3. Who are we?

Cumbria Safeguarding Adults Board (CSAB) is a statutory body, which works in partnership with organisations across Cumbria to help protect adults with care and support needs from abuse or neglect. There is a strong focus on partnership working with the statutory partners* being supported by the following organisations represented on the Board and sub-groups:

- Cumbria Constabulary*
- North East & North Cumbria Integrated Care Board*
- Lancashire & South Cumbria Integrated Care Board*
- Cumbria County Council*
- Cumbria Fire & Rescue Service
- Her Majesty's Prison Service, Haverigg
- North Cumbria Integrated Care NHS Trust
- University Hospitals Morecambe Bay NHS Trust
- Cumbria, Northumberland Tyne & Wear NHS Trust
- Lancashire, South Cumbria NHS Foundation Trust
- Recovery Steps Cumbria, Drug & Alcohol Service
- Healthwatch Cumbria
- People First Independent Advocacy
- Lay Membership
- National Probation Service North West
- District Council Representation; Barrow Housing
- Care Quality Commission
- North West Ambulance Service
- Department Work & Pensions

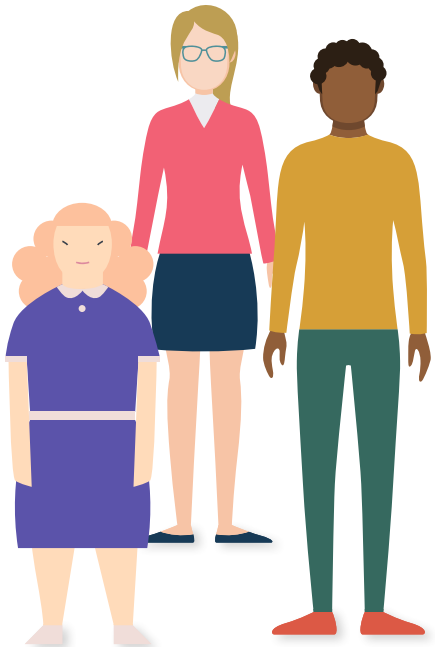
The Board leads adult safeguarding across Cumbria and works with organisations and our partners to ensure that they have effective safeguarding arrangements in place, ensuring adults who may be at risk of abuse or neglect are able to:

- Live as safely and independently as possible
- Make their own decisions
- Take control of their own lives.

4. What is our vision and commitment?

Our **vision** is to put the people of Cumbria at the centre of everything we do

Cumbria Safeguarding Adults Board is **committed** to support the protection of and appropriate service provision for vulnerable people living in Cumbria. We listen; we learn; we proactively support all agencies to improve, share, embed and deliver effective practice.



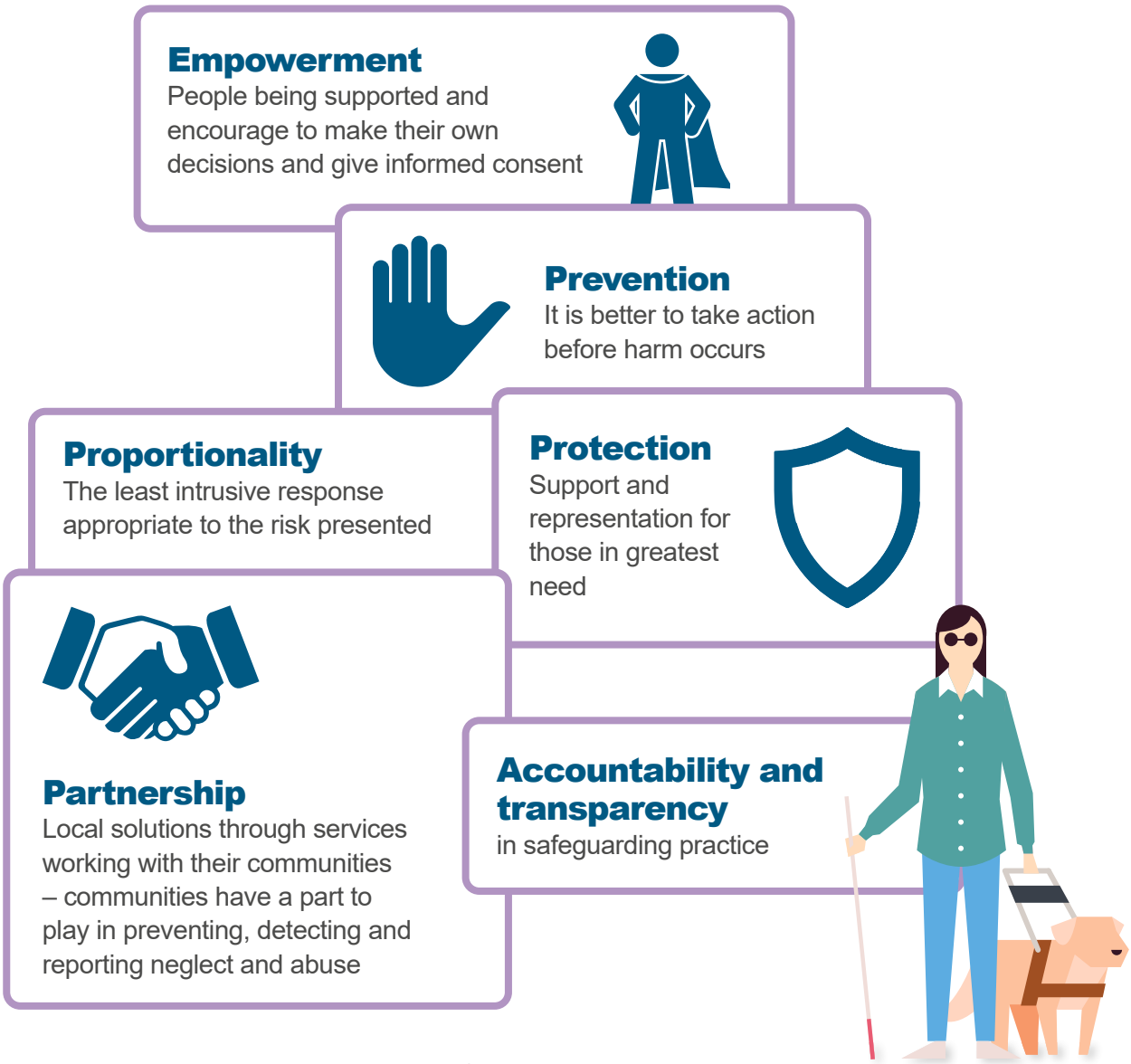
5. What does safeguarding adults mean?

Safeguarding means protecting an adult's right to live safely, free from abuse and neglect. It is about organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure the adult's wellbeing is promoted including, where appropriate having regard to their wishes and feelings when deciding on action.

Safeguarding is everybody's business and duties apply to an adult who has needs for care and support; is experiencing or at risk of abuse or neglect and because of their care and support needs, they are unable to protect themselves.

6. What is Making Safeguarding Personal?

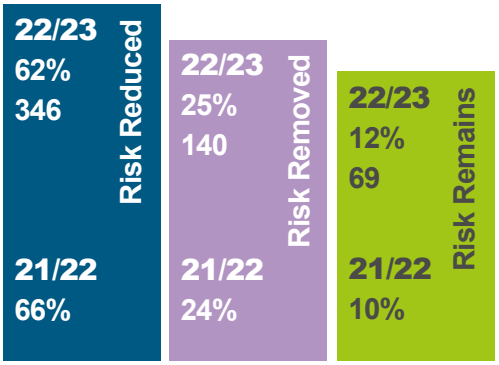
The Care Act says that adult safeguarding is about protecting individuals, but people are all different. So, when we are worried about the safety of a person, we should talk to them to find out their views and wishes. Then we should respond to their situation in a way that involves the individual as much as possible, enabling them to have choice and control over what happens in their life, so they can achieve an improved quality of life, wellbeing, and safety. This is referred to as Making Safeguarding Personal (MSP). CSAB recognise the values contained in Making Safeguarding Personal and ensures that work across the partnership is underpinned by the six key safeguarding principles.



6.1 Making Safeguarding Personal: risk & outcomes

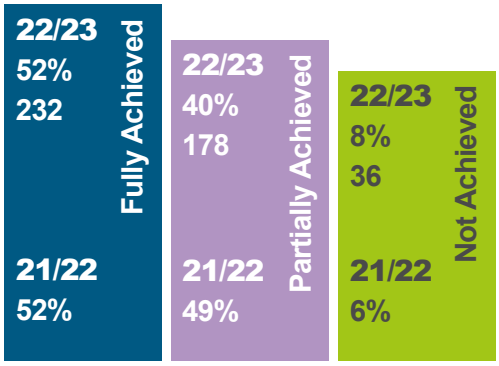
Adults who have been through the safeguarding enquiry process are asked for their feedback on whether they felt their engagement with services had been effective and worthwhile. In some cases, an advocate or representative will provide feedback on the adult's behalf.

Making Safeguarding Personal and speaking to adults about their views and wishes enables and involves the individual as much as possible, to have choice and control over what happens in their life, so they can achieve an improved quality of life, wellbeing, and safety. However, this can mean in some cases that adults continue to live with some element of risk.



The data for 2022/23 illustrates that the risk reduced or removed is comparable to the previous year.

There was a total of 87% where the risk was either reduced or removed for the adults subject to the safeguarding concern.



This table outlines those adults who have been through the safeguarding process and have been asked if their outcomes have been achieved. The figures for the 'fully' or 'partially' achieved are comparable with the previous year 2021/22. With a total of 92% of adults indicating that their desired outcomes were either fully or partially achieved.

6.2 Lisa's story

Lisa is a 60-year-old woman who lives at home with a family member and her two dogs. Lisa has a daughter who lives outside of Cumbria. Lisa has some physical health needs which are managed independently and with medication.

A safeguarding concern was received by Adult Social Care via a local hospital with concerns regarding Lisa's partner. There were previous similar concerns however previously Lisa did not want to engage with Adult Social Care and the case was closed.

The concerns were regarding emotional abuse and potential coercive control. Lisa had disclosed to a local hospital a concern regarding her partner and the way he would speak to her and control her. The hospital then immediately reported the concerns to Adult Social Care.

Adult Social Care initially contacted the local hospital to gather further information when the hospital advised they were concerned about the partners behaviour in respect of potential emotional abuse towards Lisa and concerns about her becoming isolated from her family and friends.

Adult Social Care and the Police worked together as a partnership to determine a plan around how to safely contact Lisa. Adult Social Care identified the local GP practice as a safe place to meet with Lisa. Lisa had previously confirmed with her Social Worker the safest way to contact her was via text message, so the GP appointment was confirmed this way.

Upon meeting with Lisa at the GP practice, she disclosed to the Social Worker emotional abuse of which she had suffered for a number of years. Lisa explained she did not know how to seek support and had not recognised what she was experiencing as abuse. Following the meeting Lisa accepted support from services such as Victim Support and continued to engage with Adult Social Care. Lisa agreed to progress with the safeguarding process and identified her goal to be that she wanted to know what support was there for her in the event she should need it.

Adult Social Care liaised with a local pharmacy where Lisa would pick up her prescriptions and identified this as a safe place to meet with Lisa. Lisa engaged throughout the safeguarding process and eventually decided she would tell her family the truth.

Lisa confirmed that she finally felt confident enough to be open with her family and following this she then spent time with her family outside of Cumbria.

The safeguarding process allowed Lisa to feel that she was heard and the multi -agency response that was used allowed her to see that there were a range of professionals there to support her. Through engaging with these services, Lisa began to recognise behaviours that were abuse and not signs of a healthy relationship and Lisa was then able to see these signs for herself.

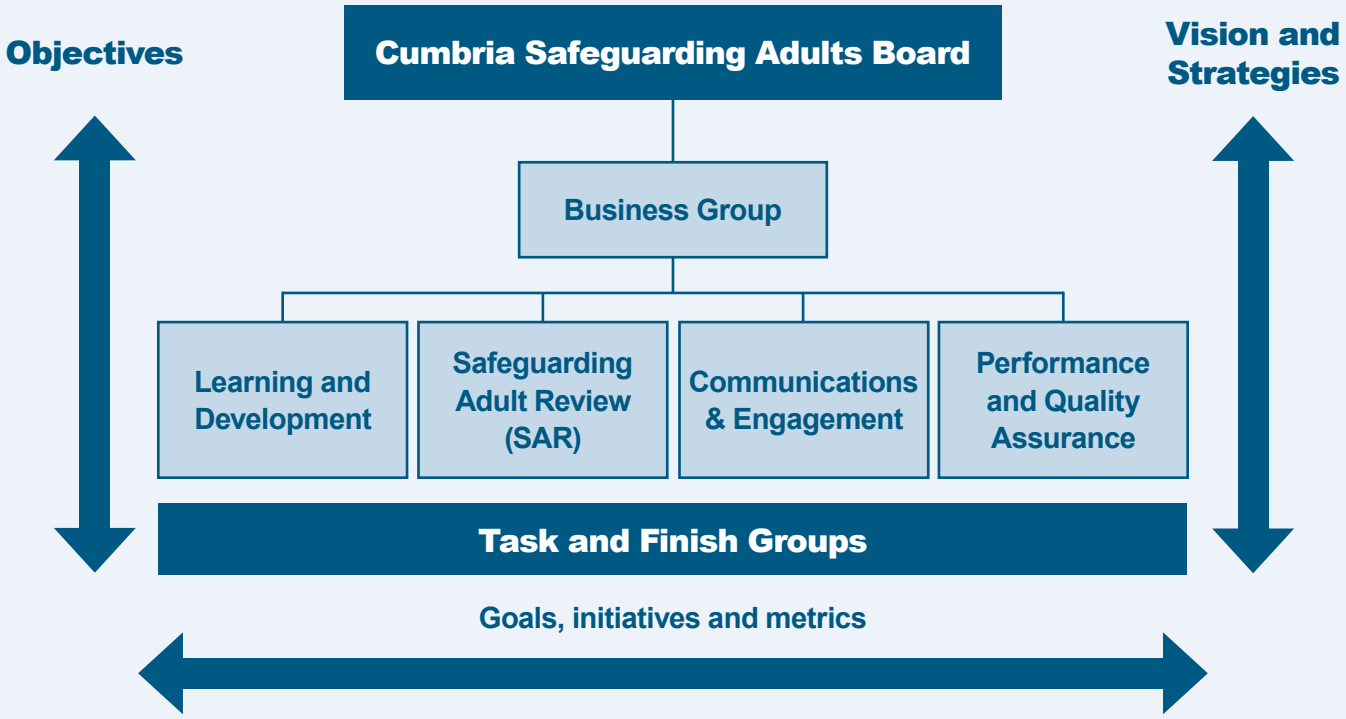
Lisa's goals were achieved in a sense that she knew where to turn for support and changed her initial mindset 'I made my bed I need to lie in it' mindset. The process allowed Lisa to feel believed, which led to her feeling she could be truthful with her family which ultimately led her to have a larger support network.

This piece of work also recognises the importance of making safeguarding personal. Previously Lisa had not wished to engage but upon revisiting the concerns with her, Lisa engaged with the process once she was ready too and her outcomes were achieved. Lisa's story also demonstrates how professionals from a range of backgrounds and agencies worked creatively together to safeguard and support Lisa.

Lisa decided to remain in her relationship but now regularly goes to stay with her family who are part of her support network. Lisa also now has access to the resources and professional advice should she decide to leave, she knows who to contact for future support.

7. What are our objectives?

To deliver our objectives CSAB members agreed 'goals' and 'initiatives' to set the direction and provide a measurement for our progress and achievements. These goals and initiatives form the basis of our Business Plan. Throughout the year our sub-groups and members regularly reviewed progress against the 2022-2024 Business Plan providing quarterly reports to the SAB.



8. What did we achieve during 2022/23?

8.1 Learning & Development sub-group

Delivered **16** 'lunch & learn' style sessions

1075 participants including:

Predatory marriage

The opportunity to listen to someone who has lived the experience and to consider it's relevance to my own area of work.

Domestic Abuse in Older Adults

I found the case study and videos helpful as you can visually see the abuse taking place and helps better understanding.

VS VICTIM SUPPORT

Self-Neglect

Has today's session improved your knowledge and understanding of self-neglect as a safeguarding issue?

Yes: **88%** Partly: **13%**

Trauma Informed

Has today's session improved your understanding of Trauma Informed?

Yes: **80%** Partly: **20%**

SAR Learning sessions

Clear explanation of how practice could be improved-avoided blame focussed discussions.

I think learning from when things 'go wrong' is important and makes you consider your own practice.

Did the session meet your expectations?

Yes: **100%**

It gave good insight into safeguarding and also shows that lessons are being learnt to provide more MDT approaches.

> *I think these sessions are really important so we can improve our practice and provide better support for people accessing our services.*

> *These sessions are always helpful and encourage professional curiosity and reflective practice.*

> *Hearing the lessons learnt in relation to Kate's safeguarding adults review. Also the importance of recognising that exploitation doesn't end at 18 and how professionals can better support young people at risk.*

In collaboration with CSCP delivered a programme of activity for practitioners to encourage Professional Curiosity identified as a recurring theme in all reviews. This included **5 lunch & learn sessions**, publishing **Practitioner Guidance** and **A Quick Guide to Professional Curiosity**.

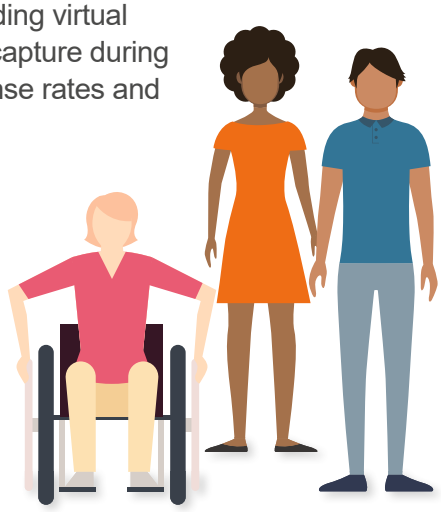
Having heard this presentation on Professional Curiosity, are you more confident to be professionally curious?

Yes: **96%**

> *Thank you, this has helped me to plan for a visit I have next week with a challenging case.*

> *Really enjoyed the discussions and will attend further sessions, as well as encouraging colleagues to attend.*

- During 2022/23 we delivered an audit across the partnership to seek assurance regarding respect of Mental Capacity Act policy, training and leadership. There was a 73% response rate to the audit which informed a report to the SAB and planning for a MCA Week of Action during 2023.
- A dedicated page on the CSAB 'learning zone' has been developed where practitioners can access resources and information to support practice. Members of the public can also access information including Lasting Powers of Attorney (LPA).
- We have adapted the methods used to gather feedback from staff attending virtual events following a response rate of 6% using post feedback surveys to capture during sessions through the use of polls. This has significantly improved response rates and ensure evaluation informs future events.
- Recordings of our lunch and learn sessions are available on our **website**.
- Good practice examples shared by partners to promote and encourage learning from each other across the safeguarding partnership.
- We continued to support our trained facilitators of virtual learning events through a a programme of regular drop-in sessions which provide on-going learning, development and peer support for the group.



8.2 2023 Safeguarding Conference

In March 2023 we delivered our 1st Safeguarding Adults annual conference. The golden thread running throughout the day was Professional Curiosity and Trauma Informed Practice with themes being identified through learning from recent SARs and referrals.

Professor Michael-Preston Shoot delivered learning from self-neglect SARs, locally and nationally considering practice issues in relation to mental capacity when working with adults who self-neglect. The session also considered the impact of trauma on adults who self-neglect, their lived experiences and advice for professionals to improve engagement with adults who self-neglect.

The conference was a huge success with 219 individuals attending during the course of the day drawn from across England.

97% of delegates indicated they would feel more confident dealing with cases of self-neglect as a result of the session.

The feedback from the polls identified some improvements for CSAB and the partnership to ensure when SARs are published these are disseminated to front line practitioners.

> ***This has been the most compassionate, person-centred session I have ever heard.***

> ***Fantastic session thank-you real take away is to continue to 'meet people where they are.***

The afternoon session extended an invitation to colleagues working with children to join and opened with a session from Steve Bagley, Education & Community Lead, NWG covering best practice when working with young adults transitioning into adult services who are at risk of exploitation. This session cemented the learning already shared through the **Kate SAR** learning session and promoted best practice for practitioners in Cumbria.

> ***We really need to think lifelong safeguarding without differentiating ages. It's the right thing to do.***

> ***One of the great take aways for me is the need to move towards all age safeguarding; thought provoking presentations thank you.***

The final session of the day introduced by Catherine Randall, Associate Director Safeguarding NHS England. Catherine introduced Mike and Danny from Lads Like Us who are creating a 'trauma informed wave' delivering training to professionals sharing their personal, moving and powerful experiences having been exploited and sexually abused.

During their session, Million Pieces, Mike and Danny focused on the importance of professionals being professionally curious, inviting practitioners to ask why when considering the impact of trauma on behaviours.

> *Thank you I will take so much away from today to influence the direct work we do within children services and ensure that were are curious at all times and do not shy away from questions that we find difficult, like you say it's not about us. I love and agree with your no nonsense view on trauma informed practice.*

> *Very brave of to use your life experiences to teach us professionals. This is one update I will always remember and apply to my day to day practice as a GP.*

> *One of the most thought provoking sessions ever in my 30 years of NHS work Thank you both Danny and Mike you are doing so much good helping us to help others.*

> *Lots of people saying you wish you'd heard the Lad's stories earlier in your careers, remember that you're here today because you want to make a difference and we can always learn how to do that better, but don't know the difference you've made in your careers already. Remember the difference you make and come back tomorrow to do it again.*

8.3 Communication & Engagement sub-group

- During 2022/23 we disseminated newly designed 'see it, report it, stop it' posters and leaflets to 600+ places where members of the public access including; Post Offices, Banks, Sports Centres, Churches and Pharmacies to raise public awareness of abuse and neglect. Further copies are available to download and print from our **website**.
- Developed a campaign calendar for the partnership to support planning for CSAB communications.
- In collaboration with CSCP we developed a 'Keeping Safe' poster translated in Russian and Ukrainian for inclusion in refugee welcome packs with contact numbers for safeguarding concerns about a child or adult. The translation is now being extended into further languages for display in Asylum Seeker Hotels across Cumbria.
- We have developed a Staff Survey aimed at practitioners across the partnership to evaluate the methods CSAB use to communicate with staff and inform planning for the MCA week of action. The survey will be delivered in 2023/24 period.

News for subscribers

Relevant safeguarding messages were shared//disseminated throughout the year using a variety of platforms. This included:

11 newsletters & **31** 5-minute briefings were issued during 2022/23. This included **46,722** individual newsletters and **132,799** individual 5-minute briefings on a range of safeguarding subjects providing information to practitioners and the public, reaching a total of subscribers.

Subscribers to news: **April 2022** **3944**
March 2023 **4573**
↑ **629 new subscribers**

We introduced a new communications tool to support practitioners and staff across the system, A Quick Guide to... Topics published included How to make a Safeguarding Referral in response to feedback from a learning session and also Financial Abuse in response to the rise noted by our Performance & Quality Assurance group. This demonstrates the connectivity and responsiveness across the CSAB sub-group structures.

Published 9 different A Quick Guide to... documents intended to provide information across a range of subjects in a quick and easy read format signposting to guidance and further information for practitioners. Including;

- Advanced Decision to Refuse Treatment
- County lines
- Domestic abuse
- MCA 2005
- Predatory Marriage
- Preventing radicalisation in Cumbria
- Professional Curiosity
- Recording for Practitioners
- Use of emollients and fire risks.

Access our library of Quick Guides **here**.

Twitter

Twitter followers: **April 2022** **656**
April 2023 **708** ↑ increased by **52 followers**

On 15 March 2023 we seen our top tweet with 2646 impressions *'delighted to see the postman today! Thanks **@RandallCath** for the NHSE Safeguarding. Privilege to work with **#NHS** colleagues this shows the strength of our #safeguardig partnership in **#Cumbria**'*

This tweet received 2652 impressions

This was further to the Board Manager being presented with a Safeguarding Star from Catherine Randall, NHS England at our Conference.

Our other top social media activity also related to the Conference;

Key messages from this morning with Professor Michael Preston-Shoot *challenge assumptions about lifestyle choices and remember the importance of language when working with adults who **#selfneglect*** earned **2046 impressions**

Key message from Professor Michael Preston-Shoot ***#askwhy** demonstrate concerned curiosity to understand why a person may be self-neglecting. Safeguarding is everybody's business, not just professionals* **1784 impressions**

*Thank you isn't enough to **@Lads_Like_Us** for sharing their personal experiences this afternoon so powerful, moving and inspiring **#AskWhy*** **39 engagements**

CSAB website

There was a total of **9,087** visits to the website during 2022/23 a significant increase ↑ almost double the **4,968** visits during the previous 12-month period. **44%** of these visitors were direct traffic to the website.

The website seen a spike is visitors during National Safeguarding Week in November 2022 with the highest traffic to the website in March 2023 which can be attributed to increased communications and social media leading up to and following our Safeguarding Adults Conference.

The most visited page following the home page with **2417** visitors was 'how to raise a safeguarding concern'. This is positive evidence of the impact which communications and increased awareness of safeguarding has encouraging individuals to seek out information how to report concerns. The SAR page was the next most visited with **1,164** visits where published learning briefings and SAR reports are hosted. This contributes as assurance to the Board and partners that an increasing number of practitioners seeking out learning from locally published SARs.

National Safeguarding Adults Week – November 2022

In partnership with the Ann Craft Trust, CSAB supported National Safeguarding Awareness Week providing daily safeguarding briefings for **4350+** news subscribers.

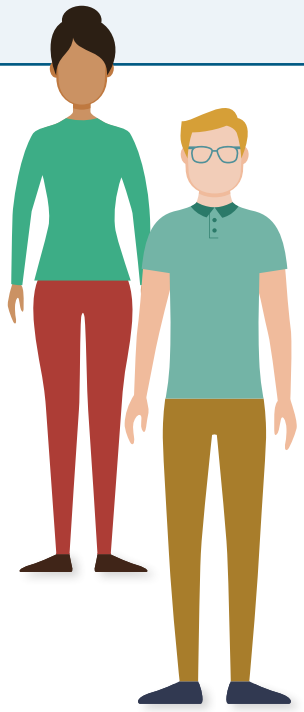
CSAB issued an average of **4366** individual bulletins daily to subscribers with a total of **26,196** during the week ↑ up on the previous year's week of action. Partner agencies also disseminated this further across organisations through team briefings and newsletters.

During the week of action, we increased our social media presence with **57** new followers

Posted **83** tweets with a total of **32k** impressions

Overall, during the week there were 898 visits to the website with 2785 page views suggesting visitors browsed the site.

Tuesday 22 November 2022 seen the highest traffic to the site following the briefing and lunch and learn session in relation to self-neglect both which signposted practitioners to access guidance documents on the website. This was a positive response as self-neglect was identified as a recurring theme in SARs and referrals.



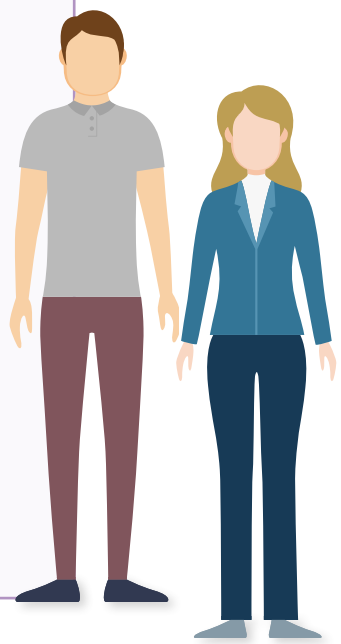
8.4 Performance and Quality Assurance Group

We reviewed the National SAB Performance Toolkit to inform a refresh of the CSAB annual partner assurance framework. This has been reviewed to include prompts and suggested evidence sources which will support partners to present assurance on an annual basis to the sub-group. A rolling programme has been developed to receive this assurance.

Analysis of quarterly safeguarding data noted the following; update include any actions agreed:

- Continued increase in referrals to Adult Social Care including those which progressed to safeguarding. The highest levels of referrals were consistently from Carlisle or the Allerdale districts.
- Additional capacity was allocated to review open safeguarding cases.
- Referrals continued to be prioritised according to risk and those rated as high risk prioritise.
- Noted an increase in Financial Abuse bringing Cumbria in line with regional and national reporting. This was supported by the improvement of operational links with specialist Fraud Officers in Cumbria Police. Furthermore, CSAB Communication & Engagement sub-group continue to raise awareness of financial abuse through briefings and newsletters.
- Conducted a deep dive into an increase in cases of sexual abuse identified no correlation between cases but acknowledge that recording of abuse types can be open to interpretation e.g., Domestic Abuse can be recorded under emotional, physical or sexual.
- Reporting commenced across the new local authority areas in preparation for Local Government Reforms. There was a consistent split of referrals with 65% from Cumberland footprint and 45% from Westmorland & Furness.

- Through the analysis of data and identifying exceptions the P&QA sub-group worked with other sub-groups to agree data informed communications and actions.
- The group reviewed regional information from North West ADASS and **National SAC return 2021/22** to inform benchmarking discussions with other comparable Local Authorities as assurance for the partnership.
- Partners conducted a case file audit to measure application in practice of MCA and Best Interests across the partnership. Analysis of the information will inform a report back to the SAB and development of an improvement plan in 2023/24.
- Partners completed a self-assessment tool to provide assurance in respect of safeguarding leadership and culture across their organisations. Evidence will be provided to support this self-assessment through a ‘check and challenge’ event during 2023/24.



8.5 Safeguarding Adult Review sub-group

During the year we received assurance and evidence from partners in relation to learning implemented following publication of SARs and actions plans through “check and challenge” discussions. Assurance reports were also provided to CSAB by the Chair of the SAR sub-group.

During 2022/23 CSAB completed and published the learning from 4 Safeguarding Adults Reviews. You can read the learning briefings on our website.

- We reviewed the newly published **SCIE SAR Quality Markers** to ensure best practice is applied when commissioning and conducting a SAR. This identified some actions for the group to take forward including a review of the SAR referral form.
- A Task & Finish Group reviewed and refreshed the templates for gathering information for a SAR. The new templates for SAR chronology and agency reports were shared with the DHR system to consider use and promote consistency and support partners
- Utilised a decision-making tool to ensure robust decision making by the group when considering SAR referrals.
- Established Task & Finish Groups to review information gathered and draft the Terms of Reference for SARs to support SAR Review Panels.
- Received and scrutinised SAR reports for Sarah and Jessica prior to publication. A SAR report for Miss B was also received and will be published in 2023/24.
- Sub-group members reviewed the learning identified in the **Whorlton Hall SAR** to assure the SAB locally of how learning from the SAR is being adopted.

8.6 Policy & Guidance Task & Finish Group

The Task & Finish Group which was established to review safeguarding adults’ policy and procedures continued to meet as required to ensure guidance was reviewed and developed. Review content for this section. During 2022/23 we published a new **Hoarding Toolkit** and **Clutter Image** rating tool for practitioners further to the learning identified in the Pauline & George SAR.

9. Safeguarding Adult Reviews

A Safeguarding Adults Review takes place when agencies who worked together with an adult with care and support needs has been subject to abuse or neglect. Agencies come together to find out if they could have done things differently to prevent the serious harm or death from happening. The purpose is to learn from what happened and not to apportion blame. The SAR sub-group on behalf of CSAB consider all referrals for SARs against the statutory criteria as set out in the Care Act 2014, making a recommendation to the CSAB Independent Chair where cases meet the criteria for a SAR.

During 2022/23, the group received and considered a total of **3** referrals (a decrease from **17** during 2022/23). Members of the sub-group and agencies involved also provide additional information to inform robust decision making applying the decision-making tool.

Of the 3 referrals the sub-group received during 2022/23, it was agreed:

2 did not meet the statutory criteria for a SAR (either a mandatory or discretionary review process). However, in both cases there was single agency learning processes implemented to ensure that learning was identified and appropriate action taken.

1 referral met the statutory criteria for a mandatory SAR and we are in the process of identifying an independent reviewer. This will also be subject to a DHR, members considered a joint process however it was agreed it would be timely and proportionate to deliver as parallel reviews. The SAR will be completed and published during 2023/24 with learning reported in our next Annual Report.

The following SARs were all completed and published during the 2022/23 period. You can access the SAR reports and learning briefs on our website.

Pauline & George

Pauline was a white woman of British heritage who was in her late eighties when she died. Pauline lived with her husband George in their own home. George was also of white British heritage and was in his late sixties. Pauline had care and support needs due to mobility difficulties following a stroke in 2015. Though Pauline could manage some tasks, she was very reliant on George as a carer for many aspects of her day-to-day living. George had his own health needs due to diabetes and cancer of the prostate. The couple attended their GP Practice and outpatient clinics for their various health needs.

Pauline had experienced multiple falls over the years, and these were increasing in frequency. On occasions, the couple called an ambulance to assist, although Pauline did not require a hospital admission, paramedics repeatedly raised concerns about the condition of the environment in which they lived and levels of clutter. Pauline and George did consent to referrals to Adult Social care on some occasions. However, they consistently declined any subsequent assessments or support offered by services.

When George missed an outpatient appointment, a GP made a home visit where sadly, Pauline and George were both found to have died some time previously. It is believed that George died before Pauline.

The review identified learning and made a number of recommendations for CSAB and partners. Actions include the following;

- ✔ Learning from the SAR delivered through a facilitated lunch and learn session attended by 33 professionals across the system. The feedback was positive with 100% of expectations met. The session was recorded and is available on learning zone area of website. CSAB continue to promote the sessions for wider review and dissemination.
- ✔ Practitioners now have access to a range of resources and learning in relation to professional curiosity and working with adults who are difficult to engage.
- ✔ CSAB published a Hoarding Framework & Toolkit in October 2022 supported by a Clutter Image Rating tool intended to support practitioners when dealing with cases of self-neglect and ensure consistency across the partnership.
- ✔ Partner agencies have provided an assurance statement to CSAB on how learning has been disseminated across their agency. Furthermore, we have reviewed our annual partner assurance to includes a request that partners describe how they disseminate learning and ensure this is embedded in front line practice.
- ✔ Work continues to identify a solution which ensures GPs receive all reports of NWAS contacts for their patients to improve oversight of repeat incidents and decline in physical health.
- ✔ The Integrated Care Board's Safeguarding Team have been working towards offering support to strengthen the local Integrated Care Community (ICC) and Local Focus Hub (LFH) in relation to safeguarding minded practice.

Kate

Kate was a young white British woman who died in 2020, aged 18. The cause of her death was established as being a drug related death. Services had been involved with Kate and her family since 2018, when it was identified that she was at risk of Child Exploitation. Kate was open to Children's Services until her 18th Birthday. On reaching 18 years of age, Kate did not receive on-going support from Adult Services as she had no care and support needs under the Care Act 2014 however, drug and alcohol services, the youth offending team and leaving care services remained involved with her. Unfortunately, Kate's situation, including her vulnerability did not improve, and she sadly died as a result of a drug overdose in 2020. Kate had been on the waiting list for a Mental Health assessment at the time of her death and Adult Social Care had commenced a Care Act assessment in the days leading up to her death. Kate's parents were consulted during the SAR process and provided details of their experience to the SAR author. It is acknowledged that Kate's parents made continued attempts to support their daughter and to keep her safe however, agency intervention was not always conducive to their attempts. Kate's parents have also recognised the difficulties faced by partner agencies in keeping their daughter safe.

The learning and recommendations from the Kate SAR prompted a system wide response including the establishment of a Task & Finish Group who through the use of audits and benchmarking will make recommendations to the SAB for system wide improvement.

- In partnership with CSCP we commissioned 5 sessions for staff working with children and young people to ensure that practitioners understand the need to use appropriate language when working with victims or at risk of exploitation.
- The Task & Finish Group reviewed national best practice standards in relation to transitional safeguarding and young people at risk of exploitation to inform a review and development of local guidance.
- Developed and published in partnership with CSCP A Quick Guide to MDS (link) to promote the National Referral Mechanism process, published on Anti-Slavery Day 2022.
- Assurance has been received from partners and strategic partnerships in response to recommendations the Safeguarding Adult Review made.
- Learning from the SAR was shared for consideration by Public Health to inform a established 'Combating Drugs Partnership' linked to the 10 year national strategy "Harm to Hope".
- Work continues identifying gaps in Cumbria for the provision of options for temporary accommodation for those young people with mental health and substance issues (aged 18-24). Housing Providers are asked to consider the Housing First model for any new schemes.

Sarah

Sarah was a white woman of British heritage who was in her forties when she died from self-neglect. Sarah had lived with her father in their Housing Association property. Sarah's father had described her as having undiagnosed mental illness. Sadly, Sarah's father died. Her aunt and uncle were very concerned that Sarah would be unable to care for herself and so approached different agencies to try and get support for her. Police, Housing, Health Services and Adult Social Care were all aware of the concerns about Sarah. Agencies endeavoured to contact her to offer support, but Sarah did not respond or declined services.

Three months after the death of her father, Sarah's body was found at her home. She had died some weeks earlier and the pathologist was unable to determine the cause of death. The coroner recorded the conclusion as self-neglect and issued a report under Regulation 28 to Adult Social Care.

After an inquest, the Coroner can write a 'Prevention of Future Death' or 'Regulation 28' report. This happens especially where the Coroner has heard evidence that further avoidable deaths could happen if preventative action is not taken. Regulation 28 reports must be responded to evidence how changes have been made or will be made in response to the Coroner's recommendations.

The Sarah SAR linked learning to the Pauline & George SAR where similar themes were identified. The following action has been taken to date;

- ✔ Westmorland & Furness Council will pilot an MDT SPA approach to include information gathering and decision making where there is agreement on how best to respond to referrals. The pilot is expected to start in June 2023.
- ✔ We delivered through our Safeguarding Conference CSAB a session in relation to self-neglect including working with adults who may be resistant to support and engaging. This included learning from lived experience of adults to support
- ✔ practitioners to find the right approach and how to apply in practice utilising creative interventions.
- ✔ We have received assurance of improvements across streamlined Local Focus Hubs with Adult Social Care and wider partner attendance improved. There has been a change to recording and sharing of information to ensure all intelligence is captured and shared as appropriate.
- ✔ CSAB are preparing a programme of communication during Carers Week in June 2023 to recognise the role of carers in supporting adults with care and support needs.
- ✔ CSAB have identified membership and are establishing a Task & Finish Group to map out various multi-agency forums in Cumbria where cases of self-neglect and low level concerns may be discussed to ensure appropriate connectivity and governance.

Jessica

This SAR was a joint review process alongside a Domestic Homicide Review (DHR) which combined agency reports and chronologies with a learning event for practitioners who had been directly involved with Jessica. This aimed to explore underlying factors including individual interactions and wider system factors that support or create barriers to good practice. The DHR will be published as a separate report.

Jessica was a 36-year-old white British woman with Downs Syndrome. She had a terminal ileostomy[1] after a total colectomy[2] in her mid-teens for complications with inflammatory bowel disease. She had an under active thyroid and on occasions required transfusions due to low iron. Jessica was underweight throughout most of her life and was described as having a restricted diet only eating certain foods with specific eating habits.

Jessica lived at home with her elderly parents, her mother and father were the most important thing to her, especially her mother. Jessica would often mirror her mother's behaviour, if her mother was not well Jessica would "take to her bed". Jessica had a wicked sense of humour; she knew who and what she did and did not like. Jessica was described as often pretending not to be able to do things but whilst in respite care she would do things independently, such as, go into the kitchen to get things out of the fridge and running her own bath, but when Jessica was at home, she insisted that her mother and father did everything for her.

Sadly, Jessica died of multi-organ failure with sepsis and acquired pneumonia following an operation for an obstructed bowel.

The Jessica SAR was published in March 2023, a full report on actions and implementation of learning will be included in 2023/24 Annual Report. Publication of the Jessica SAR report also included a learning brief for practitioners.

We have surveyed practitioners through our 2023 Staff Survey to identify the challenges in practice applying the Mental Capacity Act. Information gathered through the survey will inform our MCA Week of Action in June 2023.

[1] An ileostomy is where the small bowel (small intestine) is diverted through an opening in the tummy (abdomen). The opening is known as a stoma.

[2] Colectomy is a surgical procedure to remove all or part of the colon. Colectomy may be necessary to treat or prevent diseases and conditions that affect the colon.

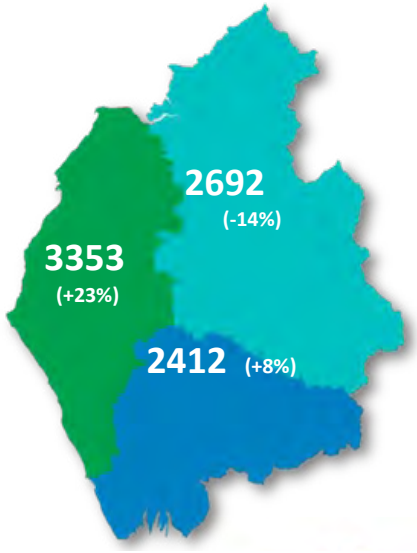
How do we share SAR learning?

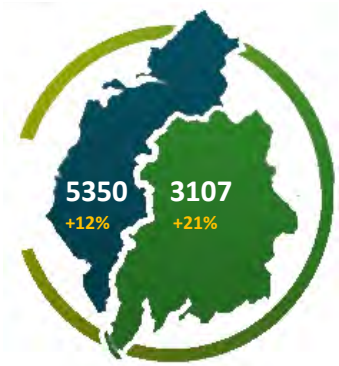
As a Board we have adopted the following methods to share learning and ensure this is embedded into practice:

- SAR lunch & learn sessions to share learning, stimulate multi-disciplinary discussion based on the key learning themes identified in SARs.
- Review and share updated guidance where relevant.
- Publish learning briefings for practitioners to provide a summary of the SAR and learning identified in the report.
- Develop improvement plans and seek to receive assurance from partners that learning has been implemented.

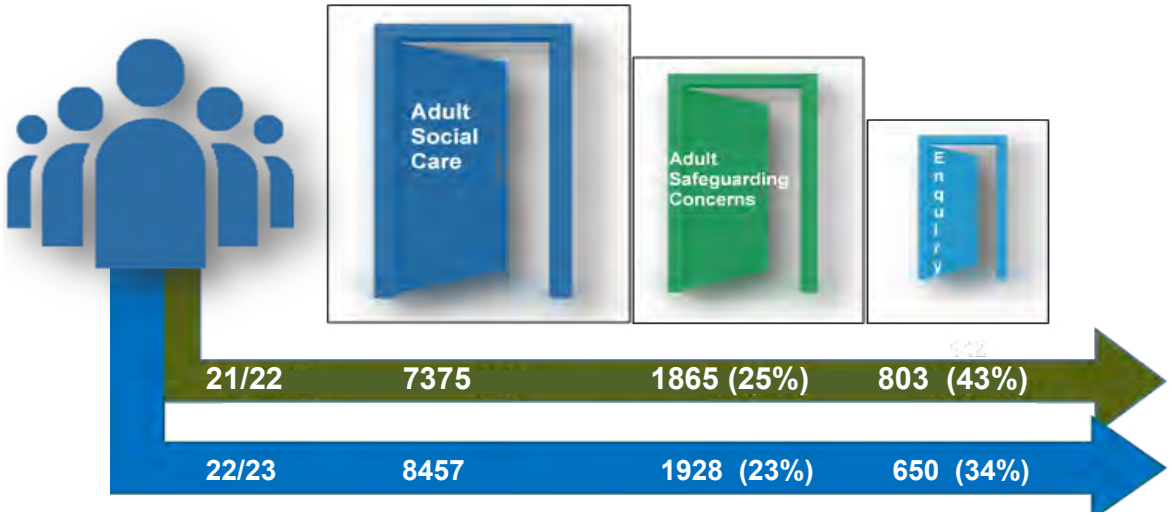
10. Safeguarding; our year in data 2022/23

The map below illustrates the number of referrals which were received by Adult Social Care where the contact either referrer or receiving Officer identified 'safeguarding'.





This map illustrates those referrals received by Adult Social Care across the 2 new Council footprints, Cumberland and Westmorland & Furness.



The above table illustrates referrals made to the Single Point of Access (SPA) Adult Social Care 'Front Door', those which are triaged to Safeguarding for further information gathering and which then progress to a Safeguarding Enquiry.

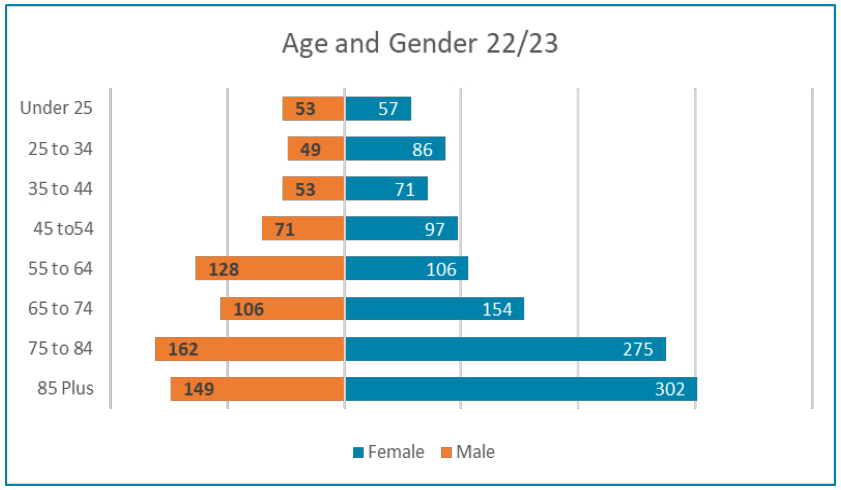
650 of the 1928 'Safeguarding Adult Concerns' were identified as appropriate to proceed and became 'Safeguarding Enquiries'. **618 of the 650** met the criteria for a Section **42** enquiry (adults with care and support needs at risk). 32 adults were identified as being at risk however, did not have needs for care and suport so counted as 'Other Enquiries' and reported in annual Safeguarding Adults Collection (SAC).

1937 Closed Safeguarding Cases
↑ **16%** from 2021/22

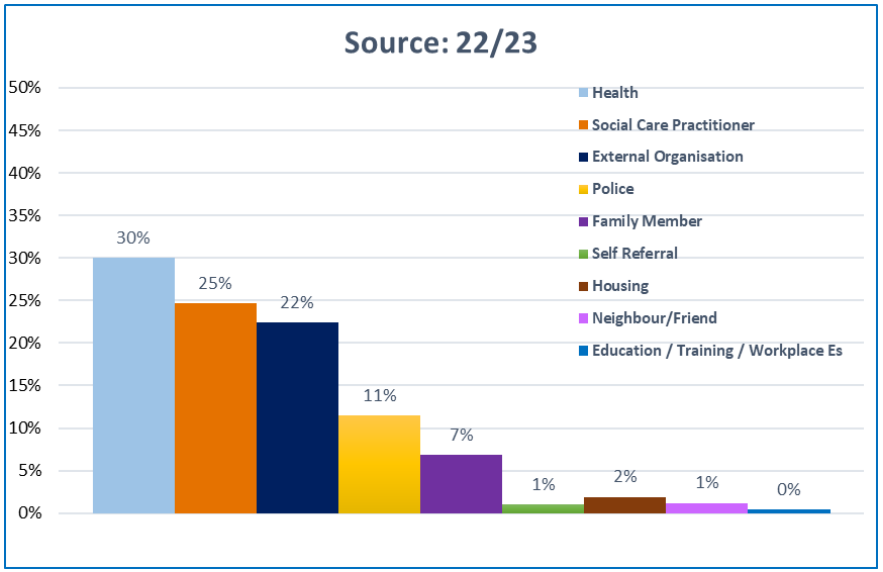
1928 Referrals Passed to Safeguarding
↑**+4%** *from 2021/22*

314
Average Number of Open Safeguarding Cases at any point in time during 2022/2023
-17% from 2021/22

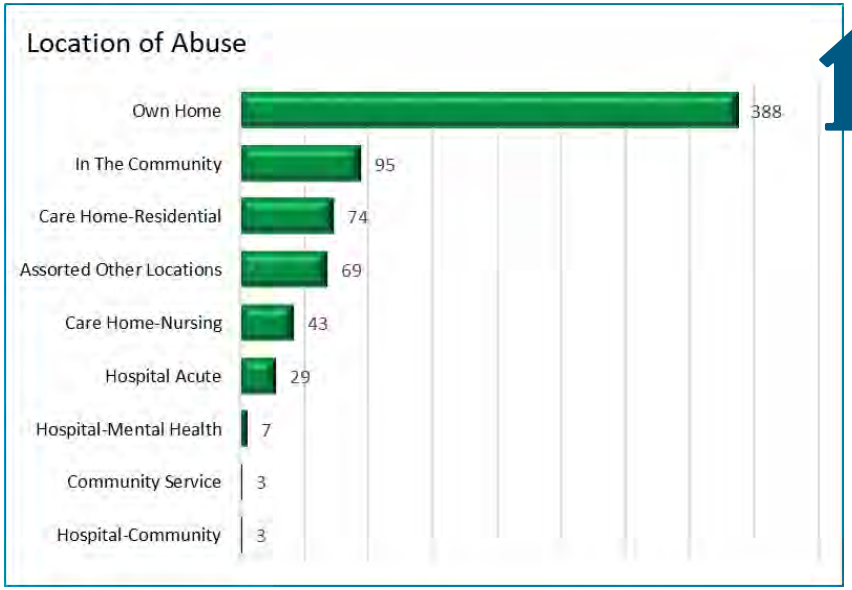
The Age and Gender table below is based on concerns received by Adult Social Care.

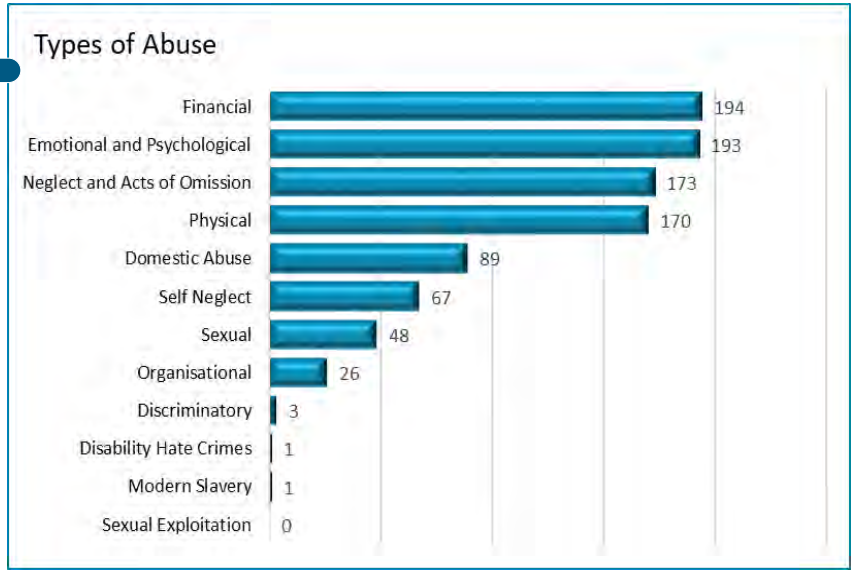


The Source of referral indicates who reported the concern to Adult Social Care



The data concerning the location and type of abuse is based on closed safeguarding enquiries.





11. What have our partners done?

We asked our partners to celebrate and showcase their single agency achievements to reflect "safeguarding is everybody's business" and include examples of how as a single organisation they supported CSAB to deliver our 5 strategic objectives in the 5-year plan.

Agency	Top key achievements during 2022/23
HM Prison & Probation Service	✓ We have rolled out domestic abuse and safeguarding checks in all cases from February 2023 ✓ Our commissioning activity has included support to 1CLIC, intervention developed by Cumbria Constabulary and third sector organisation The Well Communities to identify vulnerable people at risk of being approached by county lines gangs, and divert them away from potential criminal activity ✓ The probation service has continued to support the work of CSAB via our attendance at the SAB SAR sub-group ✓ Improved approach to sharing multi-agency learning by having probation rep on SAB L&D sub-group
NHS Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	✓ Local response to BBC Panorama programme detailing abuse at a Manchester NHS Hospital – Local review of services against CQC closed cultures and paper presented to CSAB. ✓ Continued emphasis on Professional Curiosity which links well with our CNTW "Stop the line approach". ✓ Continued development of our Trust Wide Safety Group which includes oversight of safeguarding and learning from not just Cumbria but also our other Localities. ✓ Continued focus of safeguarding training at all levels e.g. Senior safeguarding staff have accessed NHS Bond Solon Training.
NHS North Cumbria Integrated Care NHS Foundation Trust	✓ We have developed the Trust's approach to Domestic Abuse with a wide-ranging programme of activities in response to an increased number of DHR's, understanding the themes, issues and trends relating to the needs of our population. ✓ We have improved our approach to MCA and appropriately embedding this across the Trust, this work links to our understanding of both internal and Cumbria-wide themes around mental capacity and the outcomes of SAR's. ✓ We have a programme of learning and development which is regularly updated to reflect the learning from SAR's and DHR's, as well as internal Serious Incidents. This has been shared with partner agencies locally and nationally and has received very positive feedback. Our practice educator has been involved in multi-agency training opportunities for the CSAB and offered training across the network.

Agency	Top key achievements during 2021/22
NHS Lancashire and South Cumbria Integrated Care Board	✓ LSCICB continue to chair the L&D sub-group of the CSAB. This has enabled the team to be fully active in the development, and implementation of learning which has been disseminated via the CSAB. This has strengthened our processes, and engagement to support across commissioned services such as Primary Care in relation to Self-Neglect & Professional Curiosity (SAR Sarah recommendations). ✓ In order to signpost Primary Care to easily access information/ briefings/resources/reviews disseminated by the CSAB a Microsoft Teams Channel has been created, which has been positively received. All Named Safeguarding GP's, deputies and administrators have been provided access to the digital platform. We have also strengthened our offer to Primary Care around face-to-face supportive visits, and re-launched our forums and handbooks for safeguarding, both of which look at sharing and embedding learning. ✓ LSCICB participated in the CSAB MCA Organisational Audit, which identified many areas of good practice, and some for improvement. Through undertaking this assurance process, this has allowed the team to strengthen arrangements surrounding the implementation of MCA, offering bespoke advice and support opportunities across the ICB health system. ✓ The LSCICB team were heavily involved with the co-ordination and facilitation of the CSAB Safeguarding Adults Spring Conference held in March 2023. This provided a platform to showcase learning from reviews throughout the last 12 months and capture the key themes around Trauma Informed Practice, Professional Curiosity, Transitional Safeguarding, Self-Neglect and Mental Capacity Act across health partners within our footprint.
People First Listen | Engage | Empower	✓ This year we have supported hundreds of people to have their voices heard and their rights and choices respected across Cumbria. This includes supporting people through 163 section 42 safeguarding enquires. ✓ Cumbria Safeguarding Adults Board recognised a family member of someone subject of a safeguarding Adults Review needed some advocacy support through the process. ✓ Our advocacy team have provided consistency and clarity to our customers during Adult Social Care's transition though Local Government Reorganisation. ✓ As one of the smaller partner agencies we continue to contribute to the work of the Board through supporting the Performance and Quality sub-group
healthwatch Cumbria	✓ Healthwatch Cumbria is the champion of people who use health and social care services. Our role is to gather the experiences of people and share those with people who are able to make decisions to influence change. ✓ This year we reported on the findings of our Discharge to Assess project in partnership with North Cumbria Integrated Care NHS Trust. We made recommendations to the system including improving communication with patients, their families, and care providers to make the discharge process better. ✓ This year we have worked in partnership with local Healthwatch across Lancashire to gather seldom heard communities' experiences of the Covid Vaccination programme across Lancashire and South Cumbria. Learning will be used to inform winter vaccination programmes and future vaccine rollouts.

Agency	Top key achievements during 2021/22
Cumbria County Council	✓ CCC continued to provide discrete multi-agency thematic analysis of safeguarding data. This provides assurance across the system and allow for supportive review of response to safeguarding concerns. ✓ The CCC Advanced Practice Leads have supported the facilitation of CSAB multi-agency learning events following the publication of SARs throughout this period. Furthermore, learning from SARs is delivered internally to teams. ✓ Work has been taking place to improve the quality of our collaborative case file audit processes. This has included development of a new ways of gathering data that will enable us to greater understand any key themes which will then in turn support identification of any organisational development needs ✓ Following learning outcomes from SARs, such as SAR Barry, there has been a working group who have developed updated guidance around initial contact into the department. This identifies that all colleagues need to be working together to ensure a timely response to initial contact. ✓ Development of Practice Guidance: Recognising that a key theme with SARs is around the application of the Mental Capacity Act, we have developed Practice Guidance around the Act which is accessible by all practitioners. This is further enhanced through quarterly Mental Capacity Act Forums whereby practitioners attend to discuss the application of the Act in practice and to share resources and knowledge in this area. Practice Guidance around Care Act has also been developed to support practitioners in their day-to-day roles.
NHS Lancashire & South Cumbria NHS Foundation Trust	✓ In creating a knowledgeable workforce, we have updated and merged LSCFT Safeguarding Adults guidance to reflect changes both locally and nationally. Access to this is via the home page of the Trust's intranet and is available to all staff. ✓ All Safeguarding training has been reviewed and updated to reflect local and national guidance. Training content includes the importance of providing a voice for those vulnerable people accessing services. Consideration for people's lived experience and the experiences of the people close to them. ✓ LSCFT continues to be an active member of the CSAB and SAR sub group, strengthening relationships, enabling safe challenge together with contributing and creating system wide learning opportunities.
Recovery Steps Cumbria	✓ RSC have continued to develop our internal safeguarding processes to support effective identification, assessment and response across our service. We have implemented an Integrated Governance Board, with a Safeguarding sub-group, which monitors safeguarding activity both internally and externally, providing required governance and assurance. ✓ RSC continue to develop our links and joint working alongside other safeguarding partners. We have developed interagency meetings with colleagues from across Adult Social Care and Health, which aim to ensure effective safeguarding responses for those using substances. ✓ RSC has continued to champion the links between self-neglect and substance use. We continue to work alongside colleagues to support increased understanding of the impact someone's substance use can have upon increased risk of self-neglect. This is a key safeguarding priority for RSC. We have developed an internal self-neglect pathway to support a timely and effective response to self-neglect from our staff. We have worked to increase awareness of self-neglect and substance use across the system, via supporting the CSAB with development of learning briefings.

Agency	Top key achievements during 2021/22
NHS North West Ambulance Service NHS Trust	✓ Continued partnership working with Social Care departments in improving the feedback received for safeguarding concerns which are raised and the introduction of the new Cleric system. ✓ Full review of the training needs analysis for safeguarding training against the level required for roles against the Intercollegiate document. Ensuring high quality safeguarding training is available across the Trust and compliance levels are monitored, including the level 3 ESR module with all senior team members (including Chief Nurse, Patient safety, Mental health leads) and practitioners trained to Level 4. ✓ Two bespoke safeguarding packages have been written and developed. New packages and scenarios developed for face-to-face mandatory training. ✓ Identified and engaged with staff across the Trust who have expressed an interest in safeguarding and provided workshops and updates to these champions in relation to Cleric and safeguarding in general. These will continue during 2023/2024.
Cumbria Fire & Rescue Service	✓ Building on its safeguarding programme the Service has introduced tailored training to specific scenarios such as Modern Slavery ✓ Changes in the Safeguarding process brought about by the LGR programme have been communicated to all staff ✓ The Services approach to Safeguarding was recognised by HMICFRS in their recent report ✓ Cumbria Fire and Rescue Service represented at the National Safeguarding Board, and Chair the North West Regional Safeguarding Board.
NHS Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	✓ Local response to BBC Panorama programme detailing abuse at a Manchester NHS Hospital – Local review of services against CQC closed cultures and paper presented to CSAB ✓ Continued emphasis on Professional Curiosity which links well with our CNTW “Stop the line approach”. ✓ Continued development of our Trust Wide Safety Group which includes oversight of safeguarding and learning from not just Cumbria but also our other Localities ✓ Continued focus of safeguarding training at all levels e.g. Senior safeguarding staff have accessed NHS Bond Solon Training

12. Our Finances

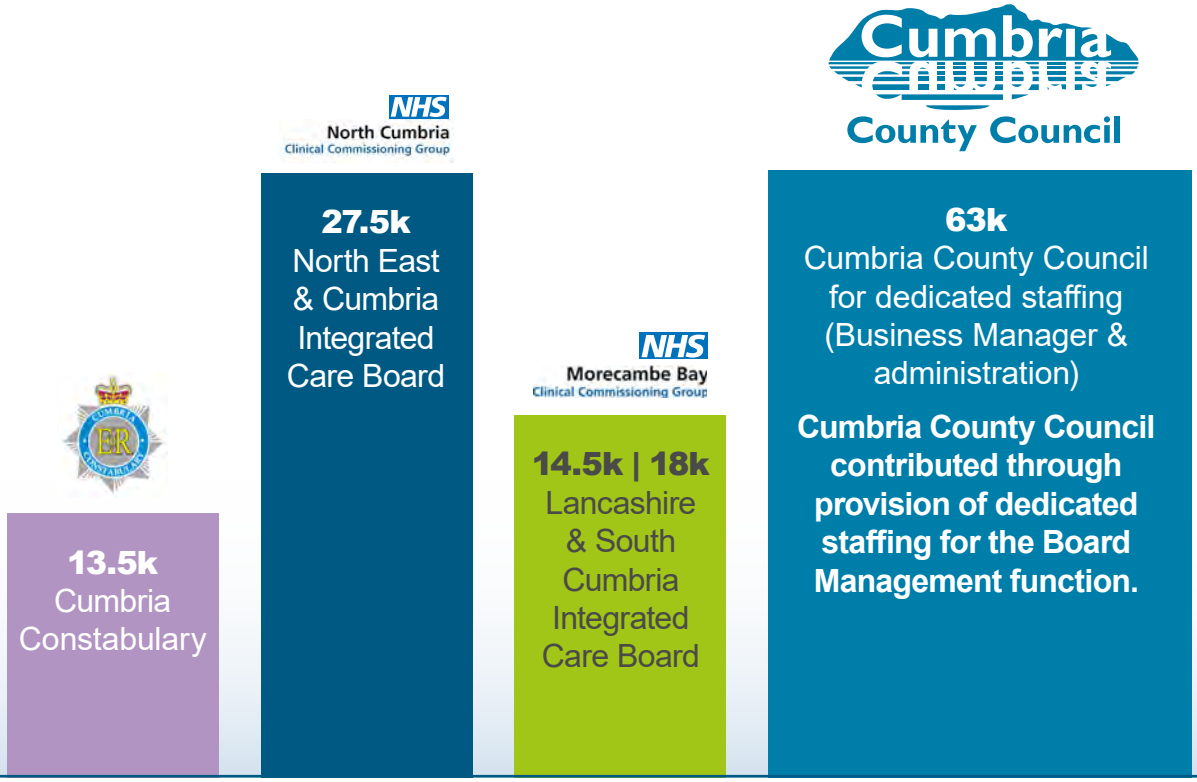
Partner agencies contribute to the work of CSAB in a number of different ways;

- Financial contribution
- Involvement or leading activity on specific areas of work including SARs
- Chair or participation in CSAB and our sub-groups

During 2022/23, statutory partners made varied levels of contributions agreed on the size and footprint of the organisation. There were increased contributions to support the recruitment of additional officer support for the SAB which will take place in 2023/24.

- Cumbria Constabulary
- North Cumbria Commissioning Group
- Morecambe Bay Clinical Commissioning Group

Total income from the above partners for 2022/23: £59k



13. What will we be doing during 2022/23?

As we move into 2023/24 we will continue to deliver the goals and initiatives as set out in our Business Plan 2022-24.

Our Learning & Development sub-group will host an MCA week of action drawing on learning identified in SARs, referrals and recently completed audits. This aim of the week is to improve understanding of the MCA and support practitioners to apply in practice. We will continue to work with our colleagues at the 2 newly established Council's to ensure there is appropriate representation for the SAB. Our partners will provide annual assurance in respect of their organisational safeguarding arrangements through presentations to the Performance & Quality Assurance Group. This group will also facilitate a check and challenge discussion further to the Leadership & Culture self-assessment process. Through the Communication & Engagement sub-group we will continue to raise public awareness of abuse and neglect to ensure that safeguarding concerns are identified and reported in a timely way. This includes the display of our posters on local buses across Cumbria to increase awareness of abuse and neglect. Through our partners and local forums, we will widely disseminate and display materials to support raising awareness.

CSAB will ensure that we continue to work together, to protect adults with care and support needs who are at risk of abuse and neglect. We will work with our partners to support us to understand emerging themes and the prevalence of different types of abuse and neglect in what continue to be challenging times and periods of change. We will continue to regularly review what our data is telling us so that we work together to prevent abuse and neglect in Cumbria.

2023/24 will continue to be a busy and productive year for the safeguarding adult's partnership in Cumbria and through the work of the Board we will ensure that safeguarding remains everybody's business.

If you would like this information in another format (for example in large print or Braille) or provided in your own language please contact Cumbria Safeguarding Adults Board: **csab@cumberland.gov.uk**

Further information can be found by visting our website. If you are concerned about a person's safety or well being report it. If someone is at immediate risk of harm **call 999**.

@cumbriasab

Remember Safeguarding is Everybody's Business and so if you are concerned about an adult who may be at risk of abuse or neglect please report it by contacting your local **Adult Social Care at Cumberland Council or Westmorland & Furness Council**.

If you have concerns about an adult in **Allerdale, Carlisle** or **Copeland** contact **Cumberland Council** on **0300 373 3732**.

If you have concerns about an adult in **Barrow, Eden** or **South Lakeland** contact **Westmorland and Furness Council** on **0300 373 3301**.

Out of hours tel: 01228 526690.